

Reimbursement for New Models of EMS Care Delivery

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Executive Summary

Maryland's Emergency Medical System (EMS) is stressed by high 9-1-1 call volumes and overcrowded emergency departments (EDs).^{1, 2} As a way to deal with these pressures, EMS programs have developed new care delivery models for providing treatment to low acuity patients who call 9-1-1:

- (1) EMS treat and release/refer without transport – As a routine part of EMS care, EMS treats a low acuity 9-1-1 patient at the scene, and the patient ultimately refuses ambulance transport to the hospital emergency department. Alternatively, EMS clinicians on the scene assess and identify low acuity patients and offer on-scene treatment provided by a physician or nurse practitioner either in-person or via telehealth (with no transport).
- (2) EMS transport to an alternative destination – EMS transports 9-1-1 patients with low acuity conditions to an urgent care clinic or similar care environment instead of transporting the low-acuity patient to a hospital emergency department.
- (3) EMS mobile integrated health (MIH) services – EMS partners with other health care professionals, such as nurse practitioners, community health workers, social workers, and physicians to conduct home visits to assess, treat and refer low acuity patients with chronic conditions who frequently call 9-1-1 to needed services in the community. MIH programs can also focus on patients identified by hospitals as being at high risk for hospital readmission.

Currently, EMS is not reimbursed by health payers for any of the three models of care. EMS services have historically been viewed as a transportation benefit; as a result, EMS is not reimbursed unless transport to a limited set of reimbursable destinations (primarily emergency departments) actually occurs.

The 2019 Joint Chairmen's Report (JCR) directed the Maryland Institute for Emergency Medical Services Systems (MIEMSS), in consultation with the Health Services Cost Review Commission (HSCRC) and the Maryland Health Care Commission (MHCC), to submit a report that outlines the State's plan for reimbursing the three models of care, identify a timeline for projected milestones in determining sustainable fund sources for the models, and describe any new fund sources, grant programs, and pilot programs. The report is also to include cost estimates for implementing reimbursement for each of the models.

¹ Joint Chairmen's Report on Emergency Room Overcrowding. The Maryland Institute for Emergency Medical Services Systems and the Health Services Cost Review Commission. December 2017.

https://www.miemss.org/home/Portals/0/Docs/LegislativeReports/MIEMSS-HospitalED-Overcrowding-Report_12-2017-FINA.pdf?ver=2018-01-11-145527-537

² Joint Chairmen's Report: Emergency Department Overcrowding Update. The Maryland Institute for Emergency Medical Services Systems and the Health Services Cost Review Commission. October 2019. See:

<http://www.miemss.org/home/Portals/0/Docs/LegislativeReports/miemss-ed-overcrowding-update-10-31-19.pdf?ver=2019-11-19-174743-763>

This report describes changes in MIEMSS protocols and guidance to permit local EMS to expand use of these new models of care; new and developing funding opportunities; and an additional study on the topic. These include:

Changes to MIEMSS Protocols and Guidance

- In 2019, MIEMSS issued Telemedicine Guidance on use of EMS-facilitated telemedicine allowing EMS to establish audio-visual communications between themselves, their patients and clinicians capable of managing the patient's condition via telemedicine linkage, with patient consent. Definitive treatment enabled by such a scenario may obviate the need for the patient to be transported to an EMS-receiving facility.
- In 2019, MIEMSS issued an Alternative Destination Protocol for statewide application to permit any EMS jurisdiction to transport appropriate patients, with patient consent, to an alternative destination, e.g., a stabilization center or urgent care center.

New and developing funding opportunities

- Five (5) EMS programs in Maryland have applied to participate in the “Emergency Triage, Treat & Transport (“ET3”) Program,” a new 5-year Medicare payment program designed to reimburse EMS for Medicare Fee-for-Service (FFS) patients when those patients are treated in place or transported to an alternative destination and to encourage all payer participation in paying for these services. This program does not impact traditional Medicare reimbursement for ambulance transports to hospital emergency departments and other currently permitted destinations. Maryland Medicaid has indicated interest in participating in the ET3 program with those Maryland jurisdictions that are selected to take part in the federal model.
- The Care Redesign Program (CRP), administered by the Health Services Cost Review Commission (HSCRC), provides the opportunity for EMS providers to partner with hospitals to better engage in the Total Cost of Care Model. The HSCRC has received proposals from two hospitals to partner with EMS jurisdictions to implement the new EMS care models.

Additional Study

- The Maryland Health Care Commission (MHCC) is conducting an actuarial study to “...assess to the social, medical, and financial impact of establishing a mandate for covering treat and release programs, alternative destination treatment, and mobile integrated health programs...”³ The actuarial study, requested by the Senate Finance Committee and the House Health and Government Operations Committee, will be submitted by December 31, 2019.

³ Letter from Senate Finance Committee Chair Kelley and House Health & Government Operations Committee Chair Pendergrass to the MHCC Executive Director Ben Steffen, April 8, 2019.

Background

There is a clear need for different EMS response models for certain 9-1-1 calls. In Maryland, 9-1-1 call volume for EMS has grown by 8.6 percent between 2015 - 2017.⁴ As a result of increased call volume, the number of EMS transports from 9-1-1 calls is also growing.⁵ Ambulances that respond to 9-1-1 calls transport patients to hospital EDs where they often encounter long wait times. Maryland's ED wait times far exceed the national average and are frequently among the worst in the country.⁶ EMS clinicians wait with their patients in the ED until the transfer of patient care to ED personnel is completed.⁷ This wait time limits the capacity of public safety EMS to respond to additional calls.⁸

EMS data suggests that a significant percentage of EMS transports to emergency rooms in response to 9-1-1 calls are for conditions that are potentially non-emergent, meaning that the patient could be adequately treated at a lower cost non-ED care setting.⁹

Over the past five (5) years, three new models of EMS care have been developed and implemented in some counties in Maryland. These new models operate under MIEMSS protocols and oversight.

- (1) EMS treat and release/refer without transport – As a routine part of EMS care, EMS treats a low acuity 9-1-1 patient at the scene, and the patient ultimately refuses ambulance transport to the hospital emergency department. Alternatively, EMS clinicians on the scene assess and identify low acuity patients and offer on-scene treatment provided by a physician or nurse practitioner either in-person or via telehealth (with no transport).
- (2) EMS transport to an alternative destination – EMS transports 9-1-1 patients with low acuity conditions to an urgent care clinic or similar care environment instead of transporting the low-acuity patient to a hospital emergency department.

⁴ eMEDS data 2015 – 2017 indicates that EMS call volume grew 8.6 percent from 2015 – 2017. eMEDS call volume data is a unit-based report.

⁵ eMEDS data 2015 – 2017 indicates that statewide EMS transports increased by 3.62 percent during the 2015-2017 period. This number does not include patients who accepted EMS treatment but refused EMS transport to a hospital ED.

⁶ Joint Chairmen's Report on Emergency Department Overcrowding. MIEMSS & HSCRC, December 2017.

⁷ The national standard for ambulance turn-around time (the time from off-loading an EMS patient to a hospital ED stretcher, completing the transfer of care, and EMS return to service) is 30 minutes. Ambulance turn-around time in Maryland for low acuity patients exceeds this standard. See "Joint Chairmen's Report on Emergency Department Overcrowding", MIEMSS & HSCRC, December 2017.

⁸ For example, Prince George's County Fire/EMS Department has a "Limited EMS Resource Plan" with two response levels. Level 2 of the Plan goes into effect when 60 percent of all transport units are consumed. During Level 2, the county's dispatch policy changes so that the response to lower acuity calls can be held for up to 45 minutes. See Joint Chairmen's Report on Emergency Department Overcrowding," MIEMSS & HSCRC, December 2017.

⁹ 2015-2017 eMEDS data (data collected by EMS personnel and stored by MIEMSS) shows that "priority 3" and "priority 4" transports make up approximately 60 percent of transports each year. Priority 3 transports are non-emergent conditions, requiring medical attention but not on an emergency basis. Priority 4 transports do not require medical attention. The eMEDS data does not include payer information.

(3) EMS mobile integrated health (MIH) services – EMS partners with other health care professionals, such as nurse practitioners, community health workers, social workers, and physicians to conduct home visits to assess, treat and refer low acuity patients with chronic conditions who frequently call 9-1-1 to needed services in the community. MIH programs can also focus on patients identified by hospitals as being at high risk for hospital readmission.

These programs have the potential to have a significant impact on health system costs, ED overcrowding and wait times, EMS unit turn-around times, and patient satisfaction. Currently, EMS is not reimbursed by health payers for any of the three models of care. Because EMS services have historically been viewed as a transportation benefit, EMS is not reimbursed by public payers (Medicare and Medicaid) or private payers unless a transport to a limited set of reimbursable destinations actually occurs.¹⁰ As a result, EMS has had to rely for funding on a combination of county / local funds and grants to operate these new models. Long-term viability for new EMS care models depends on securing reimbursement from payers that would otherwise reimburse EMS when the patient is transported to an emergency department.

In the 2018 legislative session, the Maryland General Assembly passed Senate Bill 682¹¹, which mandated that MIEMSS and the MHCC study the issue of reimbursing three models of care provided by emergency medical service (EMS) providers in Maryland. The report validated the need for long-term sustainable funding and set forth several overarching principles, among them were that reimbursement for the three models should (1) include all private and public payers to avoid cost-shifting between payer types and to ensure equitable treatment of consumers, regardless of insurance source; and (2) dovetail with Maryland's Total Cost of Care (TCOC) model.¹²

In the 2019 legislative session, the Senate Finance and the House Health & Government Operations Committees requested that the MHCC "...assess the social, medical, and financial impact of establishing a mandate for covering treat and release programs, alternative destination

¹⁰ Because EMS is viewed as a transportation benefit, EMS is not reimbursed unless a transport actually occurs. Medicare limits EMS reimbursement to patient transports to and from: 1) hospitals; 2) patient homes; 3) critical access hospitals; 4) dialysis facilities for End-Stage Renal Disease patients; 5) skilled nursing facilities; and 6) physician's offices, but even then only when the ambulance is en-route to a Medicare-covered destination, the patient is in dire need of professional attention, and the ambulance continues to the covered destination immediately thereafter. As a practical matter, public safety EMS jurisdictions, which respond to 9-1-1 calls, generally are limited in terms of transport destination to hospital emergency departments, while commercial services, which do not respond to 9-1-1 calls, transport patients to destinations that include patient homes, dialysis facilities and skilled nursing facilities. Other payers, e.g., Medicaid and private insurers, similarly tie reimbursement to the requirement that the patient must be transported to the identified destinations.

¹¹ Chapter 605, Laws of Maryland 2018.

¹² Coverage and Reimbursement for Emergency Medical Services Care Delivery Models and Uncompensated Services. Report required under Senate Bill 682. Maryland Health Care Commission and the Maryland Institute for Emergency Medical Services Systems. January 2019. See https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/EMSReimburs/MIEMSS%20MHCC%201_2_5_2018%20FINAL%20for%20Legislature.pdf

treatment, and mobile integrated health programs..." in the fully-insured private health insurance market.¹³ The actuarial study is due to the Committees on December 31, 2019.

Current Coverage and Reimbursement for EMS

This section of the report covers the three major types of insurance in Maryland: Medicaid, Medicare and private market insurance and details the current payment policies for each type with respect to EMS services and alternative destinations.

Medicaid

Medicaid provides health coverage to 1.3 million Marylanders¹⁴ including eligible low-income adults, children, pregnant women, and people with disabilities. Medicaid provides a comprehensive benefit package, which includes coverage for long term care (i.e. nursing home level care). Medicaid is administered by the Maryland Department of Health according to federal requirements and is funded jointly by the State and federal government.

Medicaid pays for emergency medical transportation on a fee-for-service basis. Maryland Medicaid covers emergency medical transport when an ambulance is dispatched from a 9-1-1 call center, and the ambulance transports a Medicaid enrollee from the site of the incident to the hospital.

Maryland Medicaid pays a flat EMS \$100 per transport using a single billing code, CPT A0427 (Ambulance service, advanced life support, emergency transport, level 1), regardless of the costs to EMS for the care and transport provided to the 9-1-1 patient. The reimbursement amount to EMS is the same, regardless whether the care provided is at the advanced life support (ALS) or basic life support (BLS)¹⁵ level. Services, medications, and supplies provided by EMS at a scene or during transport are not eligible for separate reimbursement outside the \$100 transport fee. Medicaid does not reimburse for mileage. To be eligible for reimbursement, EMS must have been dispatched by a 9-1-1 call center, the ambulance must transport the patient to a hospital ED and meet other requirements.¹⁶

¹³ Letter from Senate Finance Committee Chair Kelley and House Health & Government Operations Committee Chair Pendergrass to the MHCC Executive Director Ben Steffen, April 8, 2019.

¹⁴ <https://www.medicaid.gov/state-overviews/stateprofile.html?state=maryland>. As part of the Maryland Medicaid program, the Maryland Children's Health Insurance Program (MCHIP) provides access to health insurance coverage for higher income qualifying uninsured children up to age 19 who are included in this count.

¹⁵ Advanced Life Support (ALS) refers to care provided by licensed, advanced level EMS providers, e.g., paramedics. ALS is provided to a patient who is more critical who requires medications or advanced interventions in the prehospital phase of care. Basic Life Support (BLS) refers to care provided by certified Emergency Medical Technicians to less severe patients who require monitoring and support, but no advanced interventions.

¹⁶ Among other requirements, Maryland Medicaid reimbursement for emergency medical transportation is limited to public entities or volunteer fire, rescue or EMS companies that also must routinely bill all third-party payers for services.

In Maryland, Medicaid uses a statewide managed care¹⁷ program to provide most of its benefits, and 85 percent of those covered by Medicaid are enrolled in managed care plans under the HealthChoice Program.

Some Medicaid covered services, including emergency ambulance transport, are “carved out” of the managed care capitation rates and contracts with managed care organizations (MCO), and are instead paid directly by the State Medicaid agency on a fee-for-service basis. Most behavioral health services, including substance abuse treatment, are also carved out of managed care and paid on a fee-for-service basis. The Maryland Medicaid Program does not cover services at a stabilization center, including the stabilization center being used by the current Baltimore Fire Department alternative destination pilot program.¹⁸

For most Medicaid enrollees, emergency services provided once the enrollee is at a hospital are covered by the MCO.¹⁹ Maryland Medicaid also covers non-emergency medical transportation (NEMT) under certain circumstances.

Medicare

Medicare is a national program administered by the Centers for Medicare & Medicaid Services (CMS). Reimbursement policies are set at the national level. Through the Total Cost of Care (TCOC) Model, the State of Maryland has a unique agreement with CMS that allows the State to set all-payer hospital payment rates at the state level. Maryland’s rate-setting authority for Medicare only applies to Medicare Part A claims (i.e., hospital inpatient and outpatient services) and does not extend to non-hospital Medicare Part B services. Part B claims are currently subject to national Medicare payment policies.

Current Medicare reimbursement for EMS services is paid through Medicare Part B funding, but is only provided if there is a coinciding Medicare Part A, or hospital claim. There is no current structure for EMS to receive Medicare reimbursement for care delivered at the scene or for transport to an alternate destination. In early 2019, CMS announced the “Emergency Triage, Treat & Transport (“ET3”) Program,” a new 5-year Medicare payment program designed to reimburse EMS for Medicare Fee-for-Service (FFS) patients when those patients are treated in

¹⁷ Managed Care Programs seek to appropriately control access to and limit utilization of health care services both to limit health care costs and improve quality of care. Managed care arrangements typically rely on primary care physicians to act as gate keepers and manage the care their patients receive.

¹⁸ <https://health.baltimorecity.gov/baltimore-city-stabilization-center>

¹⁹ In the Maryland Medicaid program, similar to commercial insurance products, the costs associated with emergency care delivered by the hospital ED are reimbursed separately and apart from the costs of EMS care and ambulance transportation. Delivery of hospital emergency services to HealthChoice participants are included in the MCOs’ capitation rates. The MCOs are responsible for reimbursing hospitals and physicians for emergency services, if that care was medically necessary, from the capitation rate that the MCO received from the state Medicaid agency. The MCO may determine that care provided to a Medicaid enrollee in an emergency department for a condition that was non-emergent was medical unnecessary, because that care could have been delivered in a more appropriate setting. To the extent emergency services are determined medically unnecessary, MCOs are only responsible for paying the Emergency Medical Treatment and Labor Act (“EMTALA”) fee and ancillary charges. All other costs (e.g., facility fees) are denied. The Medicaid Program follows this same policy for FFS participants. Commercial insurance programs also make medical necessity determinations before paying claims; this is not unique to Medicaid.

place or transported to an alternative destination. The program will potentially provide an opportunity for Medicare funding for some jurisdictions in Maryland.

Private Market Insurance

Private insurers in Maryland generally provide reimbursement for ambulance services as a transportation benefit, reimbursing only for transport to an emergency department. Some insurers in the state have supported MIH programs through grants.

In general, covered benefits in the private insurance market are determined by the insurers based on actuarial analysis and business decisions, including negotiations with the plan sponsor in group plans, as well as compliance with State and federal law. Developing payment models that include private insurance requires considerations of insurance networks (e.g., for alternative destination programs, not all urgent care centers may be included in an insurer's network). Insurers may provide different levels of reimbursement to providers they have contracted with (i.e., "in-network" providers). Depending on the policy types, out-of-network providers may receive reduced insurance reimbursement or no reimbursement for services, but may bill the individual receiving the services directly. Network status impacts patients, who may have different levels of financial responsibility if their provider is in-network or out-of-network.

New Developments & Current Status of New Model Programs

A number of changes have occurred in Maryland and nationally since MIEMSS and MHCC submitted the January 2019 report on "Coverage and Reimbursement for Emergency Medical Services Care Delivery Models and Uncompensated Services." These include changes in MIEMSS guidance and protocols to allow for broad adoption of new models of care, expansion of MIH programs, and new opportunities for funding these new model programs.

2019 Changes to MIEMSS Protocols and Guidance

Telemedicine and Treat-in-Place

In August 2019, MIEMSS issued Telemedicine Guidance on use of EMS-facilitated telemedicine. This guidance allows EMS to establish audio-visual communications between themselves, their patients and clinicians capable of managing the patient's condition via telemedicine linkage. Treatment enabled by such a scenario may obviate the need for the patient to be transported to an EMS-receiving facility. Telemedicine Guidance may be used by any EMS program in Maryland that meets the requirements contained in the Guidance, regardless of ET3 participation.

Transport to an Alternative Destination

Prior to 2019, two (2) pilot programs in Maryland (in Baltimore City and Montgomery County) were approved where EMS would transport low acuity patients to urgent care centers instead of hospital EDs. In 2019, MIEMSS approved an Alternative Destination Protocol to permit any EMS jurisdiction to transport appropriate patients, with patient consent, to an alternative destination, e.g., a stabilization center or urgent care center. The protocol anticipates varying levels of alternative destination resources within communities and permits EMS to adapt to local needs. The protocol also sets basic requirements for the alternative destinations. For example, an urgent care center (1) must be staffed during operating hours by a physician, physician assistant and/or nurse practitioner; and (2) must possess certain technical resources and capabilities,

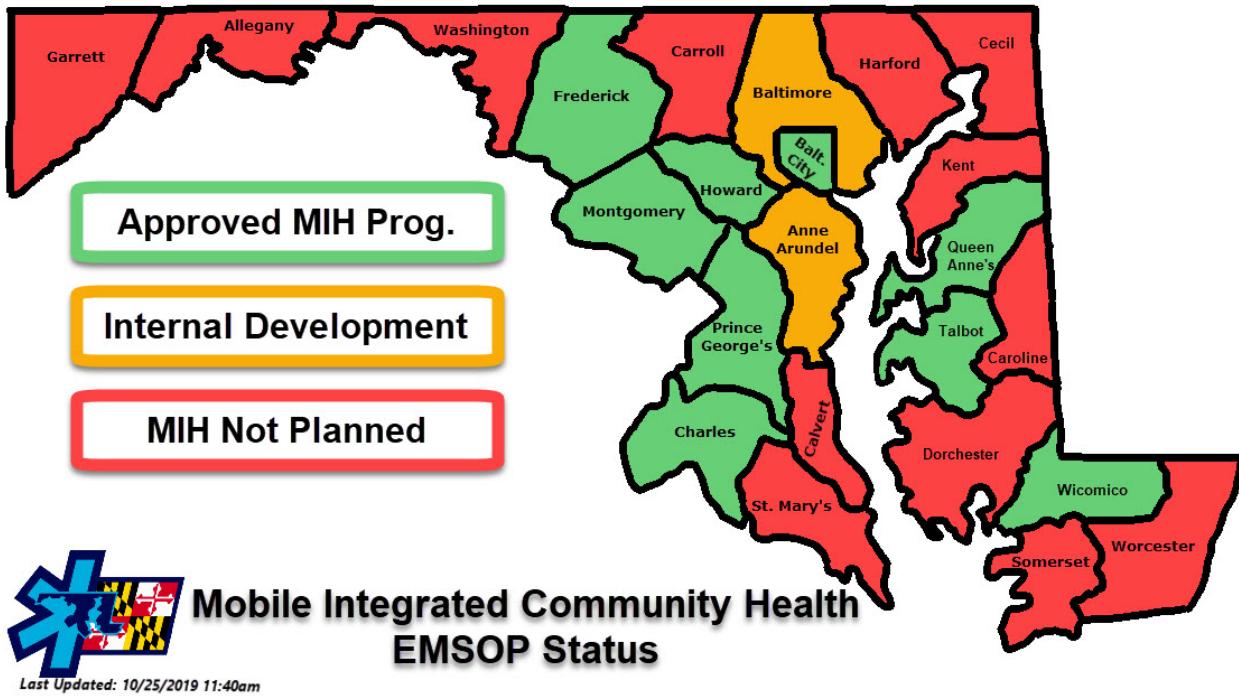
including X-ray capabilities, laboratory testing, and 12 lead ECGs. Under the protocol, EMS is able to transport to urgent care centers, behavioral health / mental health facilities, and other types of clinical facilities or offices. Before implementing the Alternative Destination protocol, EMS jurisdictions must develop an Alternative Destination Plan that identifies and describes the receiving facilities to which EMS will be transporting. Plans must also include quality monitoring and reporting on standard metrics. The Alternative Destination Protocol may be used by any EMS program in Maryland, regardless of ET3 participation.

Increased Adoption of Mobile Integrated Health (MIH)

MIH continues to grow in Maryland, with nine (9) public safety MIH programs currently operating in the state and two (2) more in the planning stages.²⁰ MIH programs link patients who are high utilizers of 9-1-1 (e.g., 5 or more calls to 9-1-1 in a six-month period) or who are referred by allied health professionals or EMS so that these patients can better connect with community resources or medical / social programs that are able to meet their needs. The target populations of the program are as follows:

- Baltimore City Fire Department – Complex patients referred to the program are followed for 30-days post-hospital discharge.
- Charles County – Patients at high risk for hospital readmission, high utilizers of EMS, or who are referred by their primary physicians.
- Frederick – Patients who are high utilizers of EMS.
- Howard County – Patients who are high utilizers of EMS.
- Montgomery County – Patients who are high utilizers of EMS and top institutional users (nursing homes and homeless shelters).
- Prince George’s County – Patients who are high utilizers of EMS
- Queen Anne’s County – Patients who are high utilizers of EMS or patients who are referred to the MIH Program.
- Salisbury – Wicomico County – Patients who are high utilizers of EMS
- Talbot County – Patients who are high utilizers of EMS >age 65.

²⁰ Only seven programs were operating in the State in December 2018. At least one commercial ambulance company in the State also provides services that are similar to MIH, focused on reducing readmissions.



New Opportunities for Sustainable Funding Emergency Triage, Treat & Transport (“ET3”) Program

In February 2019, the Center for Medicare & Medicaid Innovation announced a new five-year program, the “Emergency Triage, Treat & Transport (“ET3”) Program,” to reimburse EMS for Medicare Fee-for-Service (FFS) patients when those patients are treated in place or transported to an alternative destination.²¹ Under ET3, Medicare fee-for-service reimbursement will cover instances where a low-acuity Medicare patient calls 9-1-1 and:

- EMS transports the low-acuity patient to an alternative destination, such as an urgent care clinic or doctor’s office. Medicare has indicated that ambulance payment for these transports will be at a rate equivalent to the Medicare Part B ambulance fee schedule base rate for basic

²¹ There are two other components of ET3. Component 2 – Aligned regional care: For local governments, designees or other entities that operate or have authority over one or more 9-1-1 dispatch centers, cooperative agreements will be available to establish medical triage lines for low-acuity calls in certain regions where ambulance providers and suppliers have been selected to participate in the new payment options (i.e., Component #1 above). Medicare will make available 40 cooperative agreements nationwide. Cooperative agreements are to run for a period of two years. (Note: not all ambulance providers / suppliers approved Component 1 will be located in 9-1-1 dispatch areas that will participate in Component 2). Component 3 – Enhanced quality monitoring and enforcement: Medicare will monitor specific quality metrics, adverse events and enforcement to ensure patient safety and program integrity. Information on the ET3 program is available at <https://innovation.cms.gov/initiatives/et3/>

life support (BLS) ground ambulance in addition to mileage and any other applicable add-on or adjustment to the BLS rate. OR

- An EMS team responds and includes a qualified health care practitioner that treats the low-acuity patient either on scene or using telehealth. A qualified health care practitioner is a Medicare-enrolled health care practitioner who meets state, local, and professional requirements to render particular health care services to beneficiaries, e.g., a physician or nurse practitioner, who partners individually or through their group practice with a participant to render services through the ET3 Model.

Mobile Integrated Health is not eligible for inclusion in the current ET3 model. Traditional Medicare reimbursement for ambulance transports to hospital emergency departments and other currently permitted destinations are not impacted by the ET3 program.

In order to participate in the ET3 program, ambulance providers and suppliers must apply and be approved by Medicare to participate in the program. The anticipated performance period for the ET3 program will start in Spring 2020 and end December 31, 2024. After 3 years of participation, Medicare may make performance-based payment adjustments based on key quality measures. CMS is encouraging (but not requiring) all-payer participation in this model. Maryland Medicaid has indicated its interest in participating in the ET3 program with those Maryland jurisdictions that are selected to participate.

Five (5) Maryland EMS jurisdictions applied to participate in ET3:

- Montgomery County Fire & Rescue Service (MCFRS) – Montgomery County has over 35 urgent care centers. MCFRS proposes to partner with specific urgent care centers (identified in their application) that meet MIEMSS requirements for Alternative Destinations. The Treat-in-Place via telehealth option will be used to meet patient needs every day between 9 pm and 7 am, but that the telehealth option will also be available for use 24/7. MCFRS is partnering with a national physician provider group that specializes in emergency medicine that has physicians in Maryland who will be on-call to deliver the telehealth solutions. MCFRS projects that, under the protocols, 2,800 patients/year would be eligible for transport to an Alternative Destination and 1,680 patients / year would be eligible for treatment in place by a qualified health care practitioner using a telehealth connection.
- Howard County Department of Fire & Rescue Services (HCDFRS) – HCDFRS' ET3 plan anticipates partnering with area urgent care centers; at the time of ET3 application submission, HCDFRS had not yet selected specific urgent care centers for partnership. The Treat-in-Place component is planned to occur using a combination of telehealth, as well as Nurse Practitioners in the field who would pair with EMS personnel. HCDFRS projects about 2,200 patients could be redirected to alternative destinations through the ET3 model and approximately 1,000 patients could be treated in place.
- Charles County Department of Emergency Services (CCDES) – CCDES plans to focus on two separate groups of frequent 9-1-1 users for potential transport to alternative destination: 1) non-compliant diabetic patients who frequently call 9-1-1 who, once stabilized by EMS at

the home, could be transported to an alternative destination should further care be needed; and 2) “sick calls” where patients complain of feeling ill, weak or sick who would otherwise be transported to a hospital emergency department to receive primary care. CCDES also plans to offer telehealth services for the ET3 treat-in-place requirement. CCDES projects about 1,500 patients could be redirected to alternative destinations through the ET3 model.

- Baltimore City Fire Department (BCFD) – BCFD previously implemented an alternative destination pilot program that will serve as the basis for their ET3 participation. BCFD envisions partnering with a large number of outpatient care entities, e.g., Federally Qualified Health Centers, urgent care centers, dialysis, optometry, dental health and primary care. BCFD envisions a phased-in approach, with initial focus on the West Baltimore area, followed by East Baltimore, and then citywide. Regarding treat-in-place, BCFD plans that between the hours of 8 am – 4 pm (Monday-Friday), a team of advanced license providers, including nurse practitioners and physicians, will respond to low acuity 9-1-1 calls to evaluate and treat patients on site and, if necessary, recommend transport to an alternative destination or emergency department. Off-peak hours will be covered by an urgent care facility that operates 24/7 or via telehealth provided through University of Maryland Medical Center. BCFD projects that 8,325 patients could be treated through the ET3 model.
- Annapolis Fire Department (AFD) – AFD is in the process of determining urgent care partnerships to function as alternative destinations. AFD anticipates operating under the MIEMSS protocol for alternative destination transports. AFD is in discussions with its local hospital to offer treat-in-place for patients who are frequent users of its emergency department, as well as for recently discharged patients. AFD projects about 670 patients would be eligible for alternative destinations through the ET3 model and approximately 200 would be eligible for treat-in-place.

Options under the Total Cost of Care Model

The Total Cost of Care Model envisions the design and implementation of new models of care delivery. In addition to the available federal programs and new Maryland-specific MIEMSS protocols, there are options to:

- Design and submit ideas for new EMS-specific interventions and payment programs through the Stakeholder Innovation Group (SIG); and
- Develop EMS Partnerships with hospitals on the Care Redesign Program (CRP).

Proposals through the Stakeholder Innovation Group

The Stakeholder Innovation Group (SIG), created in 2018 by the Secretary of the Maryland Department of Health, serves as a forum to vet innovative ideas to transform healthcare in Maryland. This multi-stakeholder led group is composed of healthcare industry leaders representing physicians, hospitals, post-acute and behavioral health providers, payers, and consumers. While the State does not lead this group, meetings are open to the public.

The SIG vetting process aims to evaluate innovative proposals submitted from stakeholders across the care continuum. Proposals are then discussed by members of the SIG and must achieve provider consensus before being recommended for further action. If the SIG approves a proposal, it is then reviewed by State agencies that would be responsible for formal design and

implementation. This review includes financial analysis to estimate the cost of the proposal. After confirming the value, feasibility, and implementation requirements of proposals, the State agencies may forward the proposal to the Secretary's Vision Group (SVG) for final review. The SVG, which is made up of healthcare leaders from around the State and led by the Secretary of Health, would then review the recommendations, suggests revisions, or reject the proposal. Ultimately, the Secretary of Health makes a formal determination to pursue federal waivers as needed and to assign resources required to implement approved ideas.

Care Redesign Program (CRP)

The Care Redesign Program (CRP), administered by the HSCRC, provides the opportunity for EMS providers to partner with hospitals to better engage in the Total Cost of Care Model. New CRP tracks are subject to SIG and state staff review (above). This review includes financial analysis to estimate the cost of the proposal.

The CRP began in 2017 and is designed to encourage greater provider alignment between hospitals and non-hospital providers. The CRP functions as an additional tool for care transformation efforts that require a waiver from the federal government. Under CRP, the HSCRC may create voluntary, hospital-led care redesign tracks on an annual basis. Additionally, the HSCRC may modify or remove tracks based on stakeholder, State, or federal input. Hospitals sign one Participation Agreement with the State and federal government which allows them to participate in multiple CRP tracks. Hospitals participating in the CRP identify care partners to collaborate with on patient care improvements that lead to improved health outcomes and opportunities to reduce total costs. The program structure allows for hospitals to share resources with care partners, such as EMS providers, and provide incentives based on performance within the track.

The State has the ability to add or amend an existing track during an annual review period with the Centers for Medicare & Medicaid Innovation. To the extent a proposed CRP track may change Medicare reimbursement, federal waivers will be required. A potential new track could allow a hospital to share financial resources with EMS providers for care and transport that does not result in hospital utilization, unlike current Medicare Part B reimbursement which requires transport to a hospital. A number of programs and EMS interventions that link with hospitals could be considered for CRP track development. If no federal waiver is needed, hospitals and EMS can work together to implement these programs without developing a CRP track.

Currently, the HSCRC has received proposals from two hospitals to partner with EMS jurisdictions to implement the new EMS care models. The SIG will be considering these proposals during the first half of 2020.

Cost Estimates

In addition to the cost estimates that will be developed for review of proposals and CRP programs described above, MHCC is currently conducting an estimate of costs in private insurance market. Under Insurance Article 15-1501, Ann. Code Maryland, the MHCC is conducting an actuarial study to "...assess to the social, medical, and financial impact of establishing a mandate for covering treat and release programs, alternative destination treatment,

and mobile integrated health programs...” in the fully-insured private health insurance market.²² The actuarial study, requested by the Health Committees, is to be submitted by December 31, 2019.

The results of the actuarial analysis of the impact of private market insurance providing reimburse for these three models of care will be essential to the on-going policy discussions specific to developing sustainable funding sources for these models. Cost estimates will be available for consideration upon completion of the analysis.

Timelines

The results from the actuarial study (above) that are due by the end of the 2019 calendar year will provide important and useful information for the development of sustainable funding for new EMS models.

The Centers for Medicare & Medicaid Innovation will likely announce in early 2020 which jurisdictions have been selected to participate in ET3.

The Care Redesign Programs to create hospital – EMS partnerships will be considered by the SIG during the first half of 2020.

²² Letter from Senate Finance Committee Chair Kelley and House Health & Government Operations Committee Chair Pendergrass to the MHCC Executive Director Ben Steffen, April 8, 2019.