DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

October 21, 2024

The Honorable Pamela Beidle, Chair
Finance Committee
3 East Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Joseline A. Peña-Melnyk, Chair
Health and Government Operations Committee
241 House Office Bldg.
Annapolis, MD 21401-1991

Re: Report Required By Health – General Article § 15–114.1 and Chapter 668 of the Acts of 2022: Maryland Medical Assistance Program – Emergency Service Transporters – Reimbursement (MSAR # 14117)

Dear Chairs Beidle and Peña-Melnyk,

In keeping with the requirements of SB 295 (Ch. 688 of the Acts of 2022), the Maryland Department of Health (the Department), in collaboration with the Maryland Institute for Emergency Medical Services Systems (MIEMSS), respectfully submits this one-time report on reimbursement rates for services provided under § 15–114.1 of the Health – General Article, including Emergency Medical Services (EMS) 911 transports, and Mobile Integrated Health (MIH) services and best practices from other states.

As detailed in this report, the costs of EMS services are complex and difficult to determine, and there is a substantial range of EMS costs across the State, from $688 to $3,885 per transport. Nationally, there are several reimbursement methods used, and there is no one national methodology or reimbursement rate for EMS services endorsed by any federal or stakeholder agencies.

Through the EMS Supplemental Payment Program (ESPP), the Department pulls down federal match for the uncompensated costs of public EMS agencies. For FY23, $117,561,343 was given directly to 19 public EMS agencies, covering 84% of Medicaid 911 transports. While other states' rates might be reimbursed closer to the true costs of transport, ESPP does so in a way that is budget-neutral to the state Medicaid program, which makes it a best practice.

If further information about this program is needed, please contact Sarah Case-Herron, Director of Government Affairs at (410) 260-3190 or sarah.case-herron@maryland.gov.

Sincerely,

Laura Herrera Scott
Secretary

cc: Ryan Moran, Deputy Secretary, Health Care Financing and Medicaid Director
Tricia Roddy, Deputy Director, Maryland Medicaid Program
Debbie Ruppert, Executive Director, Office of Eligibility Services
Alyssa Brown, Director, Office of Innovation, Research, and Development
Sarah Albert, Department of Legislative Services (5 copies)

EMS Medicaid Reimbursement in Maryland

The Maryland Medical Assistance Program (Maryland Medicaid) pays for emergency medical transportation on a fee-for-service basis when an ambulance is dispatched due to a 9-1-1 call.[1] Emergency transportation is a carved-out service and is excluded from HealthChoice managed care organization (MCO) capitation rates. Reimbursement is limited to public entities or volunteer fire, rescue, or EMS companies that also must routinely bill all third-party payers for services.

Maryland Medicaid reimburses for emergency medical transports using a single service code, A0427, regardless of whether the care provided is at the advanced life support (ALS) or basic life support (BLS) level. Services, medications, and supplies provided by EMS at a scene or during transport are not eligible for separate reimbursement outside the transport fee. Maryland Medicaid does not reimburse for mileage like Medicare does.

From 1999 to 2022, the reimbursement rate for EMS transports of Medicaid participants was established by legislation as $100. In 2022, the General Assembly passed SB 295, Chapter 668 (2022): Maryland Medical Assistance Program – Emergency Service Transporters – Reimbursement, which increased the rate to $150 in fiscal year 2023 (FY23).

Recent Expansion of EMS Services through Medical Assistance

SB 295 (2022) permanently increased the Medicaid reimbursement rate for EMS transports by $50 to $150 on July 1, 2022. The legislation also authorized coverage and reimbursement at a rate of $150 for three new EMS services starting January 1, 2023:

- Treatment in place (TIP) refers to treatment provided to Medicaid participants in which transportation to a facility is not required or the participant refuses transport. Services are provided to a Medicaid participant in response to a 9-1-1 call.

- Alternative Destinations (AD) refers to the transport of eligible patients with a low-acuity health condition to an urgent care center or Federally Qualified Health Center instead of to a hospital emergency department (ED) when transport is provided to a Medicaid participant in response to a 9-1-1 call. EMS agencies need to establish relationships with these eligible alternative destinations, follow appropriate MIEMSS protocols, and obtain patient consent when determining which patients can be transported to an AD.

- Mobile integrated health services (MIH) is defined as community-based preventative, primary, chronic, pre-admission, or post-admission health care services. It is also referred to as Community Paramedicine (CP), or MIH-CP. MIH services are not provided in response to a 9-1-1 call, instead, patients can be referred to MIH services by providers and/or MCOs. Only EMS agencies approved by the MIEMSS to provide MIH services can provide MIH services. Agencies may only provide MIH services to a consenting Medicaid participant who is 18 years of age or older.

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[1] For Medicaid participants dually covered by Medicare, Medicaid pays 20% of the Medicare rate, and Medicare covers the rest. As such, dual-eligible participants are excluded from this report.

All three new services allow for increased opportunities for EMS to enhance their revenue streams. TIP allows for reimbursement for previously unpaid work. Before the coverage expansion, Medicaid participants had to be transported to a hospital for EMS to receive reimbursement. Services delivered in the community to someone who refused transport, for example to someone treated for an opioid overdose, were not eligible for reimbursement. AD allows EMS providers to triage patients and transport them to alternative destinations, potentially lessening demand on EDs and enabling EMS providers to respond to a higher volume of calls by reducing their turnaround time. MIH services target patients at risk for avoidable hospital readmissions, such as high ED utilizers or post-operative patients.

While these new programs have the potential to benefit those served, they are not widely adopted by all eligible EMS agencies. Less than a hundred AD and MIH services were billed in 2023. The relationship-building and contracting required for AD and MIH are new processes that can be administratively challenging, and sometimes cost-prohibitive, to EMS agencies, especially from smaller counties.

EMS Supplemental Payment Program (ESPP) Overview

In 2020, the Department submitted a Medicaid State Plan Amendment to create the EMS Supplemental Payment Program (ESPP). The Centers for Medicare and Medicaid Services (CMS) approved ESPP, effective October 1, 2020. ESPP allows eligible EMS agencies in Maryland to receive supplemental payments for emergency medical transportation services provided to Medicaid recipients. To be eligible, a participating provider must be a Jurisdictional EMS Operational Program (JEMSOP), which operates out of local city or county governments and is funded by local public tax dollars. Maryland is one of twenty-five states to have such a program for EMS agencies.

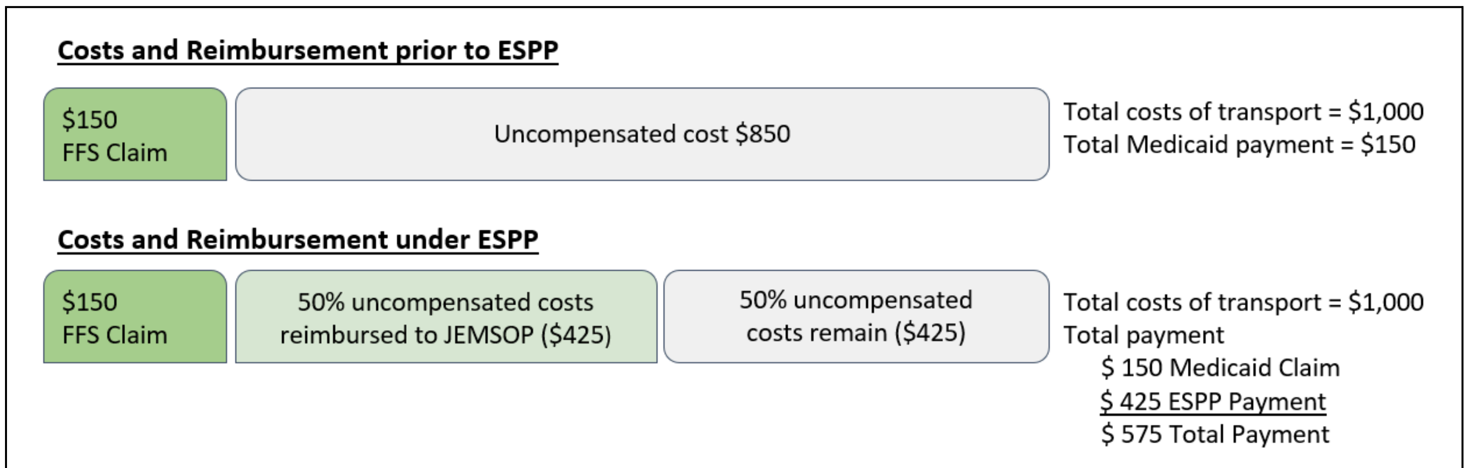
ESPP is budget neutral to Maryland Medicaid and leverages existing local dollars to match and draw down substantial federal dollars that are passed onto JEMSOPs. ESPP is based on the understanding that the true costs of providing transport services are far greater than the Medicaid reimbursement rate and that these uncompensated costs for personnel, equipment, and vehicles are borne entirely by the local government entity funding the JEMSOP. ESPP uses a mechanism called a certified public expenditure (CPE) to pull down a federal match to reimburse 50% of the costs that are uncompensated through Medicaid reimbursement (the other half of the uncompensated costs continue to be covered through local dollars). To use a CPE, a local government entity needs to certify that they have uncompensated costs that are used to support the full cost of providing Medicaid-covered services.

To participate in ESPP, JEMSOPs compile and submit documentation demonstrating their total allowable costs of providing transports. These cost reports are audited and certified by a third-party vendor, and presented to the Department. The Department then uses these cost reports to determine what the federal reimbursement would be, in excess of Medicaid reimbursements paid out to the JEMSOP. These funds are pulled from the federal government and passed through directly to the local governments.

For example, assume a JEMSOP’s true cost of providing transport is $1,000 per transport. When they provide transport to a Medicaid participant, they receive $150 in reimbursement. This

leaves $850 in uncompensated costs. The Federal Medical Assistance Percentage (FMAP) for EMS services is 50%, meaning that 50% of those uncompensated costs are eligible for federal funds using a CPE. Through ESPP, a JEMSOP would receive $425 additional federal dollars for that transport, so instead of $150, they would receive $575 ($150 + $425) per transport. See Figure 1, below.

Figure 1. EMS Reimbursement Before and After ESPP



Current ESPP Participation

ESPP is a voluntary program for the twenty-seven JEMSOPs in the state. During the first program year (SFY21), thirteen JEMSOPs participated. This has expanded to nineteen JEMSOPs in the most recently completed program year (SFY23). During this time, several EMS agencies have worked to become recognized by MIEMSS as a JEMSOP to participate in the ESPP program. The Department anticipates there will continue to be small but steady growth in ESPP participation in the coming years by new JEMSOPs until most if not all of the potentially eligible agencies join.

Medicaid EMS transports comprise twenty-one percent of all EMS transports in the state. Eighty-four percent of all transports provided to Medicaid members are reimbursed through the ESPP program. This equates to 18% percent of all emergency transports in the state. In Program Year 3, over 99,000 eligible Medicaid transports delivered in SFY2023 were eligible for reimbursement through ESPP, resulting in the transfer of $118,135,088 in federal matching dollars to the participating JEMSOPs. See Table 1, below.

Table 1. EMS Transport Data SFY21-SFY23

	PY1 (Q2-4 of SFY21)*	**PY2 (SFY22)**	**PY3 (SFY23)**
Number of Participating JEMSOPs	13	18	19

Number of Medicaid 911 transports reimbursed through ESPP	69,387	96,168	99,467
Percent of ESPP reimbursed transports out of all Medicaid 911 transports	85% (69,387/81,979)	84% (96,168/114,009)	84% (99,467/118,203)
Percent of ESPP reimbursed transports out of all transports in State	18% (69,387/387,367)	18% (96,168/537,295)	18% (99,467/554,603)
Total federal match	$91,965,086**	$117,792,269**	$118,135,088

* The first program year started October 1, 2020, and so only covered services delivered in Q2-4 of SFY21.
** For these years, JEMSOPs received an enhanced federal match of 56.2% due to the public health emergency.

The EMS cost reports capture the average cost per transport for each agency. They show a wide range of costs per transport, with agencies ranging from $688 to $3,885 in Program Year 3, with a median cost per transport of $2,342. The high variation in costs is explained by local variations in staffing costs, call volumes, response protocols, and overhead.

Best Practices from around the Country

There is no one national methodology or reimbursement rate for EMS services promoted by any federal or stakeholder agencies. This is in part due to the fact that costs vary widely across the country due to a plethora of factors, including response time standards and performance, clinical sophistication, population and age, call volume, service area (urban to remote), and number of EMS agencies within a service area.[2]

The reimbursement models vary from state to state. Some are flat fee-for-service rates, like Maryland. Others have different rates based on the level of support required for the call, i.e. Basic Life Support (BLS) or Advanced Life Support (ALS). Some states allow EMS agencies to bill additional reimbursements for mileage or specific equipment used, like oxygen or disposable supplies.

There have been steady calls from the industry to increase the reimbursement rates for EMS transports for years, as current rates do not adequately cover costs. Central to the work of creating an improved EMS reimbursement model is a call by stakeholders to have a comprehensive understanding of EMS costs across the country.[3]

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[2] National Association of Emergency Medical Technicians, "Adequate Medicaid Reimbursement for Emergency Medical Services," July 2023. https://naemt.org/docs/default-source/advocacy-documents/positions/adequate-medicaid-reimbursement-for-ems-7-14-23.pdf

[3] The National EMS Advisory Council, "EMS System Performance-based Funding and Reimbursement Model," September 2019. https://www.ems.gov/assets/NEMSAC_Advisory_EMS_System_Funding_Reimbursement_Sep_2019.pdf

In 2022, the CMS launched the Medicare Ground Ambulance Data Collection System (GADCS), as required by the Bipartisan Budget Act of 2018.[4] As a part of GADCS, CMS requires selected ground ambulance organizations to collect and report cost, revenue, utilization, and other information, preferably reporting total amounts rather than just a Medicare share. The collected information will be provided to the Medicare Payment Advisory Commission (MedPAC), which is required to submit a report to Congress on the adequacy of Medicare payment rates for ground ambulance services and geographic variations in the cost of furnishing such services. The first report will be released in December of 2024, and an updated report each December subsequently thereafter.

Current 911 Transport Rates
The American Ambulance Association's 2023 survey of state Medicaid agencies found that the average Medicaid reimbursement for an advanced life support (ALS) transport is $232.72.[5] The table below compares Maryland's reimbursement rates against regional EMS Medicaid reimbursement rates, as well as against Medicare's Maryland rates.

Ambulance transports for Medicare recipients are reimbursed using the Ambulance Fee Schedule (AFS),[6] which contains complex formulas that are updated annually. The AFS establishes a base rate that varies by the level of transport provided (e.g., basic life support vs. advanced life support). The AFS also includes a per-mile rate applied to the distance traveled with the patient. Both base and mileage payments are updated annually to account for inflation, and are adjusted by Geographic Practice Cost Indices (GPCI) that account for variation across different states and localities. Since the inception of the AFS in 2002, the base and mileage payment formulas have been further adjusted by three different modifiers that are higher for transports originating in rural, and extremely rural areas.[7] The rates for the three different geographic modifiers - urban, rural, and lowest quartile rural, are shown in Table 2, below.

[4] Center for Medicare and Medicaid Systems, "Medicare Ground Ambulance Data Collection System," February 2024. https://www.cms.gov/medicare/payment/fee-schedules/ambulance/medicare-ground-ambulance-data-collection-system

[5] National Association of Emergency Medical Technicians, "Adequate Medicaid Reimbursement for Emergency Medical Services," July 2023. https://naemt.org/docs/default-source/advocacy-documents/positions/adequate-medicaid-reimbursement-for-ems-7-14-23.pdf

[6] Center for Medicare and Medicaid Systems, "Ambulance Fee Schedule Public Use Files," December 2023. https://www.cms.gov/medicare/payment/fee-schedules/ambulance/ambulance-fee-schedule-public-use-files

[7] Center for Medicare and Medicaid Systems, "Medicare's Ground Ambulance Data Collection System: Sampling and Instrument Considerations and Recommendations." July 2019. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/Downloads/Ground-Ambulance-Data-Collection-System-Sampling-Instrument-Considerations-Recommendations.pdf

Table 2. Comparison of State and Federal 9-1-1 Transport Reimbursement Rates

Code	Definition	Maryland Medicare Rates			Medicaid Rates				
		Urban	Rural	Rural Lowest Quartile	MD	VA[8]	PA[9]	D.C.[10]	DE[11]
A0425	Mileage	$8.94	$9.02	$13.53*	N/A	$2.74	$4**	$34.04	N/A
A0427	ALS Transport	$556.82	$562.28	$689.36	$150	$159.86	$400.00	$2,588.96	$63.11
A0429	BLS Transport	$468.90	$473.50	$580.51	N/A	$134.62	$325.00	$2,180.17	$69.49

*Rate paid for miles 1-17 only
**Paid for distance beyond first 20 miles of a transport

Other States' Practices around MIH reimbursement
There is no standard procedure code established for MIH services by CMS, making it difficult to confirm Medicaid reimbursement rates for MIH-CP services across the nation. For the seven states other than Maryland for which it is reported that Medicaid covers MIH-CP services,[12] reimbursement rates can only be confirmed for MIH-CP services delivered independently of 9-1-1 calls for three of them: Minnesota, Nevada and Wyoming.

Minnesota Medicaid is the first State Medicaid Agency in the nation to cover MIH services, starting in 2012.[13] It allows for unlimited reimbursement of MIH-CP services at a rate of $12.88 per 15 minute unit.[14] Nevada has a dynamic fee schedule, allowing for multiple codes for both new and established patients at a variety of units of time, including $117.79 for 60 minutes for

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[8] Virginia Department of Medical Assistance Services. "Fee For Service (FFS) Ambulance Services Adjusted Rates Beginning with Dates of Service on or after July 1, 2012." July 2012 https://www.dmas.virginia.gov/media/1560/dmas-ffs-ambulance-rate-table-with-dos-on-or-after-07-01-12.pdf

[9] Pennsylvania Department of Human Services, "Ambulance Services Medical Assistance Program Fee Schedule," January 2024. https://www.dhs.pa.gov/providers/Documents/Ambulance%20Fee%20Schedule.pdf

[10] DC Department of Health Care Finance, "Updates to Reimbursement Rates for Ambulance Emergency Medical Services," December 2023. https://www.dc-medicaid.com/dcwebportal/documentInformation/getDocument/32159

[11] Delaware Health and Human Services, "Physician Fee Schedule Effective January 1, 2022," January 2022. https://medicaidpublications.dhss.delaware.gov/docs/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1306&language=en-US&PortalId=0&TabId=94

[12] California Health Care Foundation, "Left Behind in California: Comparing Community Paramedicine Policies Across States," November 2019. https://www.chcf.org/wp-content/uploads/2019/11/LeftBehindCaliforniaComparingCommunityParamedicine.pdf

[13] Minnesota Department of Health, "Community Paramedics (CP)," February 2024. https://www.health.state.mn.us/facilities/ruralhealth/emerging/cp/index.html

[14] Minnesota Department of Health, "Community Paramedic Services," September 2023. https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_177475

new patients.[15] Wyoming reimburses $44.36 for one home visit by EMS agencies.[16] See Table 3, below.

Table 3. Comparison of MIH Reimbursement Rates

	MD	MN	NV	WY
MIH Reimbursement Rate	$150	$12.88	$117.79	$44.36
Unit	per visit, no time limit	per 15 minutes	Per 60 minute visit	per visit, no time limit

Conclusion

As the ESPP program demonstrates, the costs of transports vary widely across the state, and are complex to determine. The range of costs per transports for individual ESPP agencies range $688 to $3,885. This makes establishing a standard reimbursement rate on a statewide basis difficult. This challenge is echoed by national stakeholders, and evident in the complexity of Medicare's reimbursement model for EMS transports. The State will be tracking the results of the GADCS program closely, and will look for the recommendations out of MedPAC to Congress on Medicare's rates.

Because of these constraints, ESPP is a powerful tool to help reimburse EMS agencies for their uncompensated costs. It provides significant funds to JEMSOPs, which use these funds to reinvest in their personnel and equipment, improving care for all Marylanders, including Medicaid participants. In FY23, ESPP leveraged federal authority to bring over $118 million dollars of new funding to the state, covering 84% of Medicaid transports. ESPP is budget neutral, making it a best practice to reimburse the uncompensated costs of EMS agencies.

[15] Nevada Medicaid, "Provider Type 32 Specialty 249 Billing Guide," November 2019. https://www.medicaid.nv.gov/Downloads/provider/NV_BillingGuidelines_PT32_Spec_249.pdf

[16] Wyoming Medicaid, "Manual CMS 1500," April 2024. https://wyomingmedicaid.com/portal/sites/default/files/inline-files/Manuals_and_Bulletins/Manual_CMS-1500.pdf