LD 2105 Committee Report

FOR THE MAINE LEGISLATURE

JOINT STANDING COMMITTEE ON HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

Committee Members

▪ Tim Beals	EMS Board Representative
▪ Holly Doherty	Maine Bureau of Insurance
▪ Anthony Fournier	Health Plan Representative
▪ Robert Hillman	Health Plan Representative
▪ Tom Judge	Maine Ambulance Association
▪ Joe Kellner	EMS Board Representative, Committee Chair
▪ Kristine Ossenfort	Health Plan Representative
▪ Katherine Pelletreau	Maine Association of Health Plans
▪ Andrew Turcotte	EMS Agency Representative

Presentation Disclaimers (Presenter / Chair)

- Joe Kellner, Paramedic
  VP Finance
    Northern Light Home Care & Hospice
    Northern Light Medical Transport
    LifeFlight of Maine
  Chair, Maine EMS Board
  Treasurer, Maine Ambulance Association

Background on LD2105

- LD 2105: Introduced to HCIFS on February 12, 2020
  - Amended bill enacted as Public Law 2019, Chapter 668
    - Created prohibition on balance / surprise billing for emergency services
    - Developed independent dispute resolution process (IDR)
  - Implementation for Ambulance Services was delayed
    - Temporary provision requiring full payment of charges by fully insured/ conventional health plans
    - Established stakeholder group to review reimbursement rates
      - Consider current rates paid
      - Consider reimbursement rate requirements and IDR (24-A MRS 4303-C, 24-A MRS 4303-E)
      - Determine providers that participate in carrier networks
      - Develop recommendations for improving participating of services in networks

Federal Activity

- H.R. 133, Consolidated Appropriations Act of 2021
  - Sec. 117 of Title 1 (No Surprises Act) establishes an advisory committee to review ground ambulance billing and protect consumers from surprise bills (work is pending)
  - Federal Government, like Maine, recognized this as a complex issue

Maine EMS System (2019 Data)

- 161 Ground Transporting Services
  - Hospital System, Hospital Department, Municipal – Non-Fire, Municipal – Fire, Private Not for Profit, Private For Profit
- 1 Air Ambulance Service (not in scope of committee discussion)
- 112 Non-Transporting Services
- 5,549 Licensed Clinicians
- 279,601 EMS Activations
  - 203,973 911 Emergency Calls
  - 76,736 Interhospital transfer / non-emergency activations

Data Collection and Methodologies

- Three primary data sources
  - Survey of Maine Ambulance Providers
  - Survey of Carriers in Maine Association of Health Plans
  - Data provided by the Maine Health Data Organization

Maine EMS Ambulance Service Survey Key Findings

- Respondents (27% of ground ambulance services)
  - 44 Ground EMS Services (2 Hospital, 1 Healthcare System, 23 Fire Department, 9 municipal non-fire, 9 not for profit)
  - 1 Air Medical Service
  - 17 Non-Transporting Services

- Average respondent
  - 1,688 911 requests per year (22.5% of which do not result in transport – generally no payment for these)

Maine EMS Ambulance Service Survey Key Findings

- Services reported substantial uncovered costs of care, made up through cost shifting

Average of Structure Other Funding (reported by Dollar Amount)	Grant Revenue	Municipal Subsidies	Tax coverage
Healthcare System Affiliated but Non-Hospital-Based		$80,000	
Hospital Based (Propsective Payment System Hospital)	$5,000	$601,140	
Municipal -- Fire Department	$45,617	$46,684	$456,947
Municipal -- Non-Fire Department	$2,000	$62,634	$212,345
Private -- Not-for-Profit (Non-Healthcare System Affiliated)	$34,500	$257,926	

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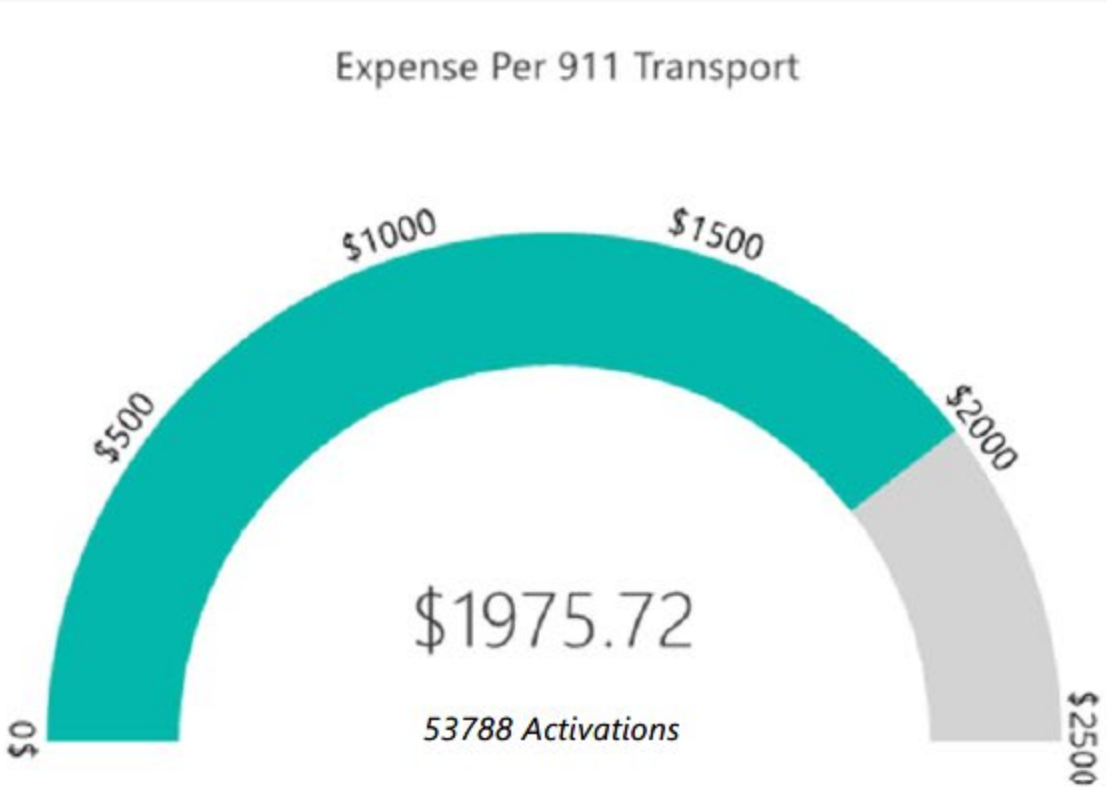

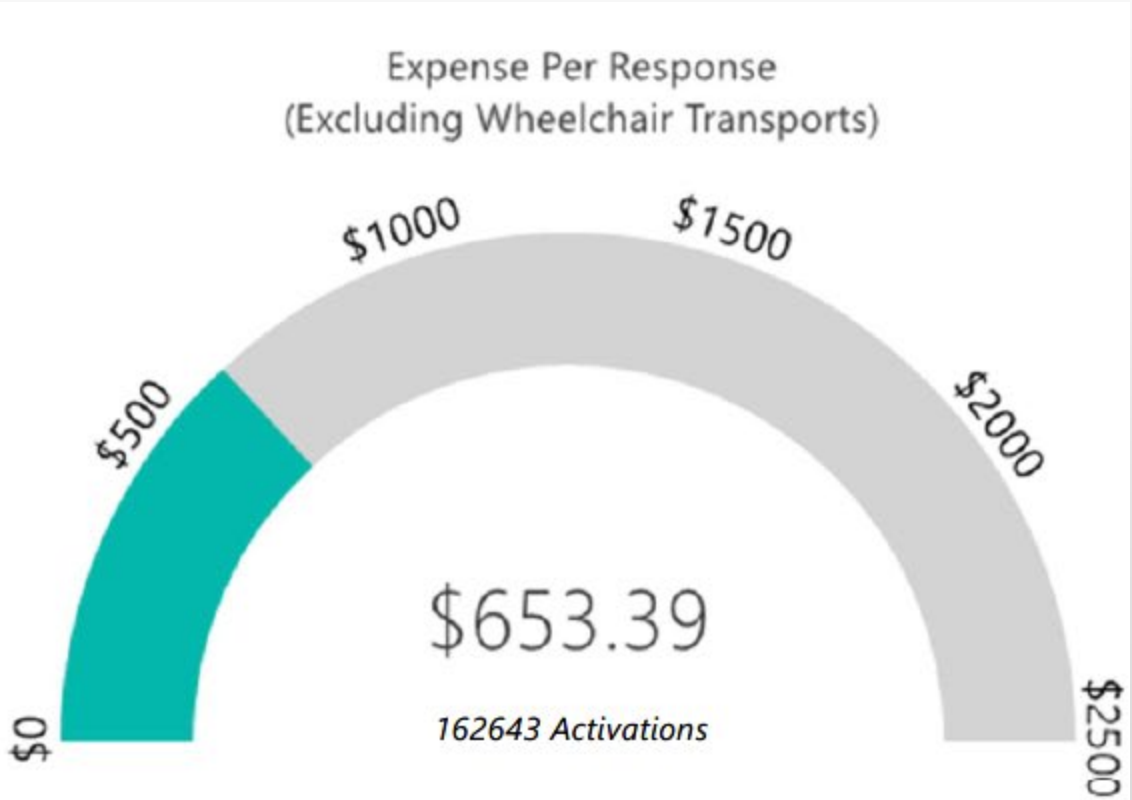

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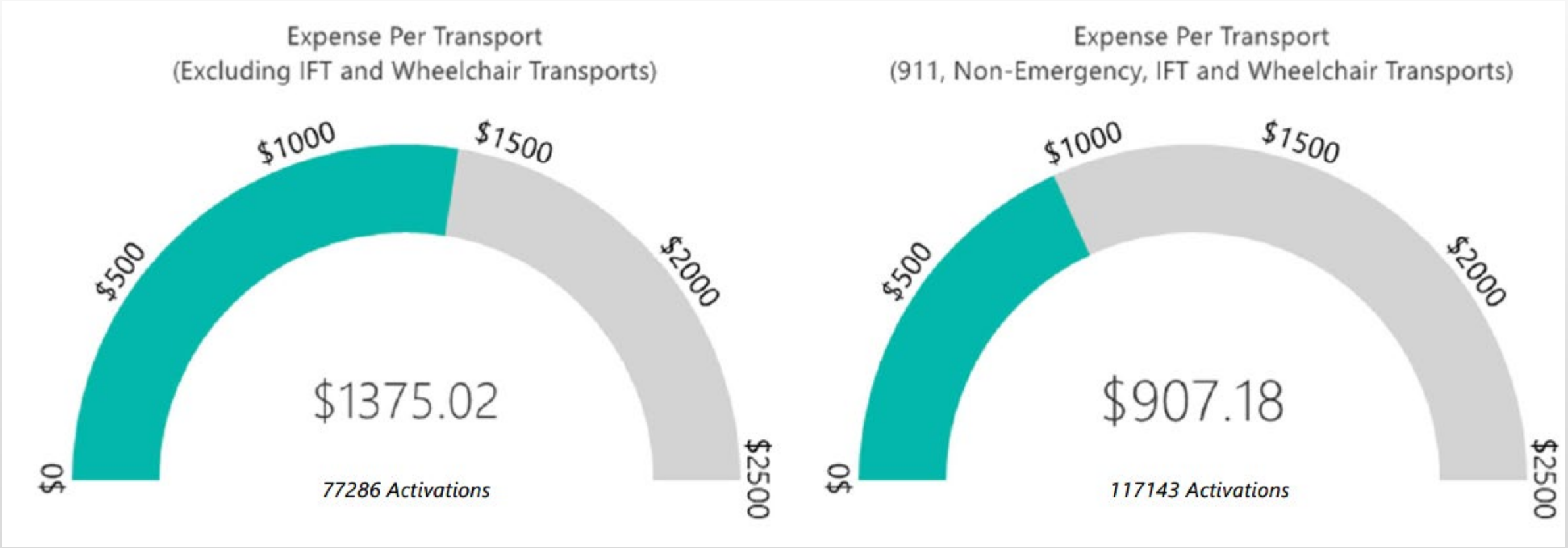


Maine EMS Ambulance Service Survey Key Findings

- Why do ambulance services choose to be out of network?
  - Commercial insurers relied upon to cover losses from Medicare, MaineCare & Self-Pay (in-network reimbursement historically lower)
    - Rates perceived to be too low / below cost
  - Some services report carriers unwilling to negotiate for higher rates
  - Timeframe for initial claim submission is too short
  - Significant administrative time / expertise required for contracting not often available in smaller services

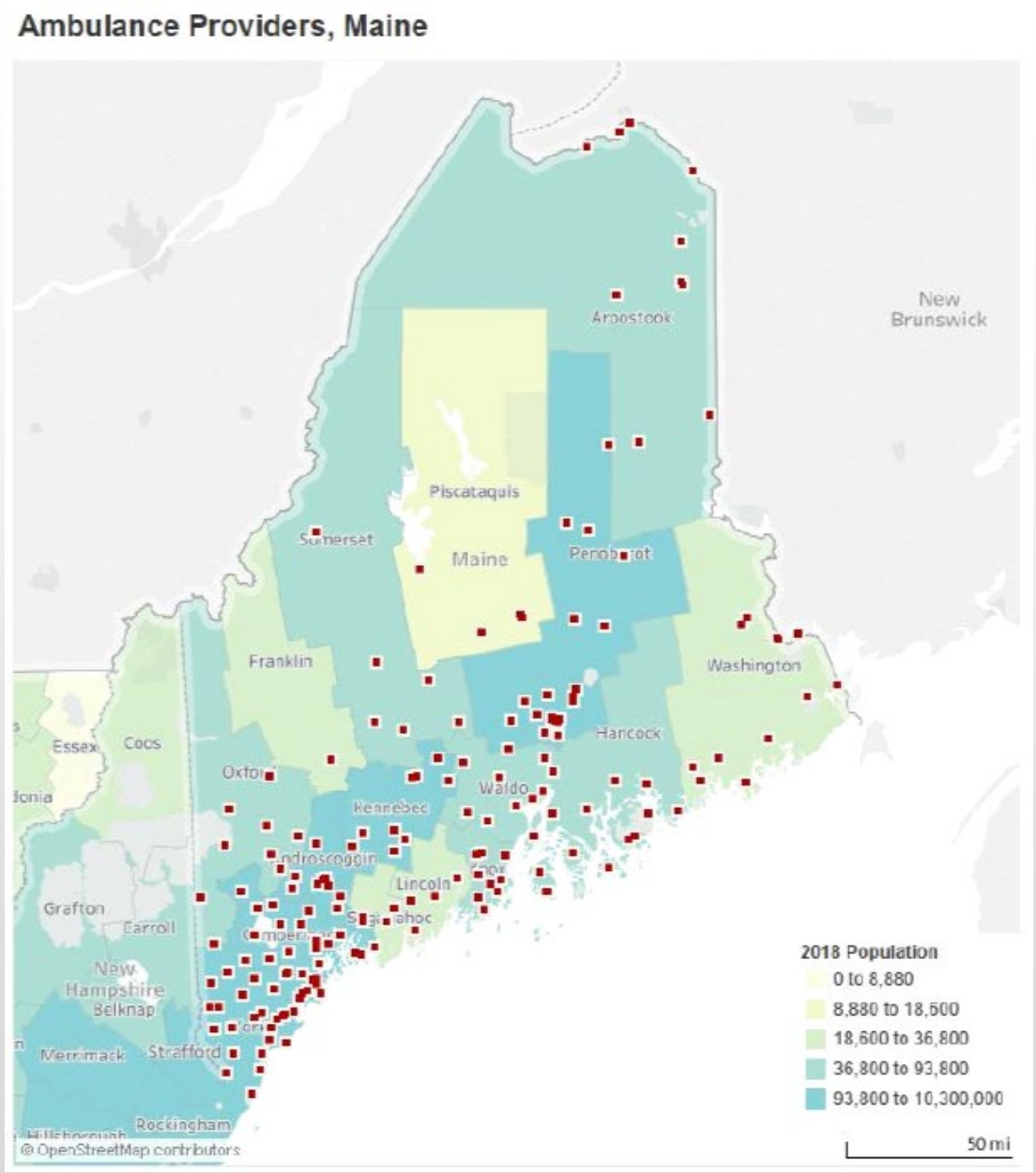
(These are themes from open-ended survey questions)

Maine Association of Health Plans Survey

- Most carriers have between 3 and 8 providers in network
  - Anthem is an outlier with 86 participating providers
- Some providers have exited networks since passage of LD2105
- Many providers (especially municipal) don't contract and don't respond to outreach efforts to contract
- Providers struggle to meet plan operational policies and procedures
- Large variation in charges making it difficult to establish "reasonable and customary"

Maine Association of Health Plans Survey

- Challenge finding providers that can transport complex patients between facilities (especially in rural areas)
- No incentive with current statutory language to incentivize participation
- Providers have taken advantage of higher reimbursement by being non-participating with health plans



Maine Health Data Organization

Maine Health Data Organization

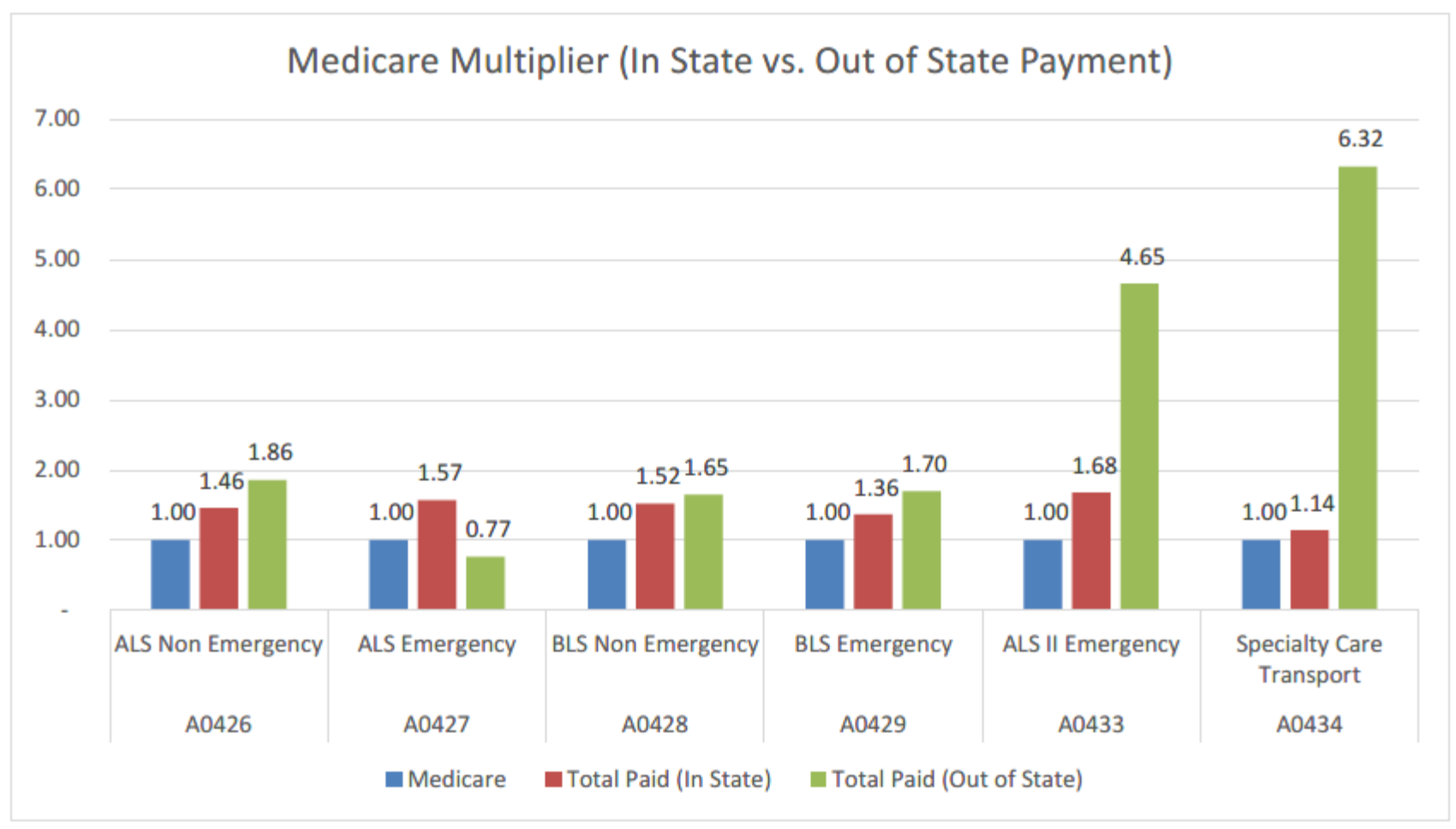
MHDO data shows the following mix of payer types in the 2019 dataset:

Type of Coverage	Percent of Claims
Commercial[6]	9%
Medicaid	23%
Medicare Advantage	17%
Medicare FFS	28%
Mixed - Dual Eligible	22%
Mixed - Other	2%

Maine Health Data Organization

- 693 Unique Ambulance Providers, 530 located outside of Maine
  - 1,197,701 claims (37,054 from out of state)
- Top 10 ambulance services submit 44% of all claims
  - Top 2 submit 10% of all claims
- Out of state services charge substantially more than in-state services and are paid somewhat more (1.2x -3.7x depending on charge code)
- Maine services generally paid 1.14x-1.68x Medicare rates

Maine Health Data Organization



Maine Health Data Organization

		In State		
Code	Description	2019 Median Charge	2020Q1 Median Charge	Change
A0426	ALS Non-Emergency	$ 518.75	$ 500.00	-4%
A0427	ALS Emergency	$ 850.00	$ 850.00	0%
A0428	BLS Non-Emergency	$ 440.00	$ 550.00	25%
A0429	BLS Emergency	$ 602.59	$ 600.00	0%
A0433	ALS II Emergency	$ 1,291.50	$ 1,375.00	6%
A0434	Specialty Care Transport	$ 1,398.00	$ 1,500.00	7%

Comparing in-state charges from MHDO to Maine EMS survey data, it appears many providers charge less than cost, which suggests cost is being covered by taxes, philanthropy, or other subsidies

Rank in Volume	EMS Service Name	Anthem	Community Health Options	Harvard Pilgrim	Aetna	Cigna
1	NORTHEAST MOBILE HEALTH SERVICES	YES	NO	YES	YES	YES
2	DELTA AMBULANCE CORP.	YES	NO	YES	YES	YES
3	NORTHERN LIGHT MEDICAL TRANSPORT[8]	NO	NO	NO	NO	NO
4	UNITED AMBULANCE SERVICE**	YES	YES	NO	NO	NO
5	CITY OF PORTLAND	YES	NO	NO	NO	NO
6	CITY OF BANGOR	YES	NO	NO	NO	NO
7	AUGUSTA FIRE DEPARTMENT	YES	NO	NO	NO	NO
8	MAINEHEALTH (Incl. PACE, NORTHSTAR, NEONATE)	YES	NO	NO	NO	NO
9	REDINGTON-FAIRVIEW GENERAL HOSPITAL	YES	NO	NO	NO	NO
10	MAYO REGIONAL HOSPITAL AMBULANCE	YES	NO	NO	NO	NO

Top Services (by volume) contract status

Committee Recommendations

Recommendation 1: Balance / Surprise billing should be eliminated

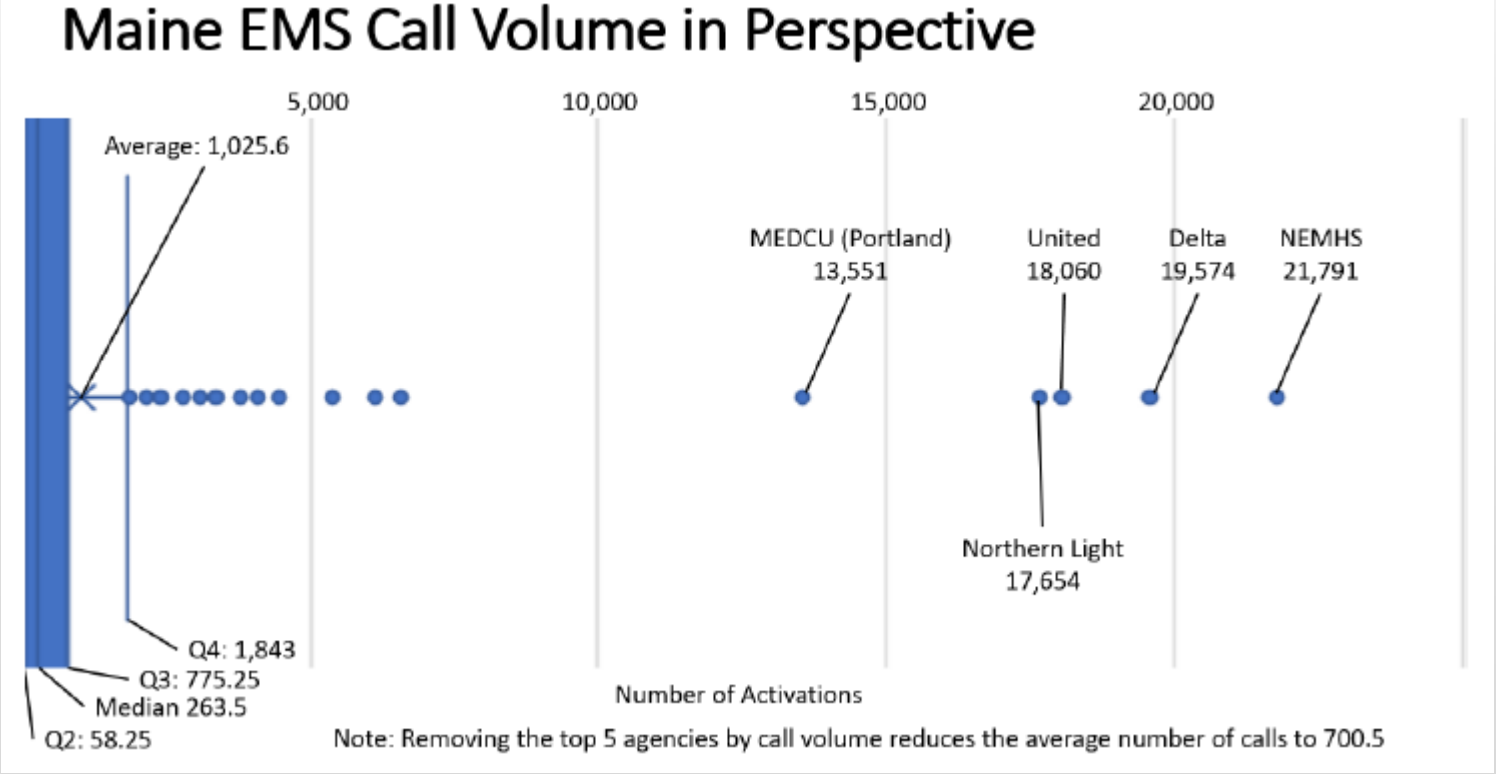
- Incentivize providers to participate in network
- No charges to patients beyond co-pay and deductibles in emergencies
- Patients must agree to any non-covered charge in advance and in-writing for non-emergency services
- Interim solution: Disputed charges paid at median in-network rate (MHDO) (updated 1/1 each year)
- IDR Process – patient held harmless
- Adopt Medicare definitions for Emergency and non-emergency response

Recommendation 2: Improve reimbursement for rural, low-volume services

- MaineCare must adopt Medicare recognition of rural and super-rural add-on payments
- MaineCare should explore cost-based reimbursement for services in underserved areas (similar to CAH model)
- Commercial carriers should also recognize increased cost for rural and low-volume providers

Recommendation 3: Improve and maintain system efficiency

- Require Maine EMS to establish, within 12 months, through rule or recommendations on statutory change, a process by which delivery efficiency must be established before granting a new service license



Recommendation 4: Better align reimbursement with costs to incentivize network participation

- Set standardized reimbursement rates to levels that strike an appropriate balance between ambulance providers and plan participants.
- Tie the standardized rates to a multiplier of Medicare so that contract rates don't become stale over time. There are two localities in Maine. The multiplier should be based on the urban rate in the locality in which services were delivered for simplicity. Multipliers are different for out-of-network providers and in-network providers to provide incentive to join the carrier networks.

Recommendation 5: Incentivize participation through voluntary standard offer contract

- 24-month term, automatic 12-month renewals
- Termination any time with 180 days advance notice after first 12-month period
- 120 days to file initial claims
- Reimbursement rates as outlined in recommendation 7 initially, then based on cost reporting

Recommendation 6: Establish Cost Reporting Program

- Using template developed by Medicare require EMS providers to annually report cost and performance metrics to the State of Maine including ancillary costs for higher acuity patients.
- Services must provide cost reporting to participate in standard offer as outlined in Recommendation Four.

Recommendation 7: Phased reimbursement model for participation

- Establish review process of cost report data
- Establish standard offer rate after two-year cost reporting period
  - Consider using median cost by location
- In-network services paid 200% of Medicare rate, plus any rural or super rural add-ons
  - Out of network paid at 180% of Medicare (and no balance billing)
- Lesser of charges or allowance methodology
- Limitation of 5% per year charge increase for services below 200%

Recommendation 8: Establish process to adjudicate out of network claims

- Continue to utilize independent dispute resolution (“IDR”) process as defined by LD2105 for disputes regarding how carriers are paying out of network services and seek to apply this approach to in-state and out-of-state providers of services.

Recommendation 9: Establish advisory commission

Commission to report in 24 months including:

- Impact of adding community paramedicine reimbursement including telehealth to decrease overall system costs and admissions.
- Variable reimbursement based on patient acuity
- Alternate destination reimbursement
- Reimbursement for services that do not result in the patient being transported to a hospital
- Incentives to increase efficiency in provider organization
- Make recommendations on standardization of prior authorization, medical necessity, and medical reasonableness
- How carriers pay for ancillary services above and beyond the mileage and base rates.
- Establishing reimbursement for innovative service models

APPENDIX – Approaches of Other States

- Connecticut:
  - Office of EMS maintains rates, adjust base amounts based on federal cost index
  - Services must submit short form to accept rates or long form to argue for increased rates
  - No impact studies on this approach
  - CON process for creation of ambulance services
- New Mexico
  - Transportation Division of Public Regulation Commission sets tariffs, which establish rates
  - Each provider can apply for independent rates
  - CON Process
  - No impact studies

APPENDIX – Approaches of Other States

- Colorado
  - 325% of Medicare, fire-based services excluded (this is up from 275%)
  - Rate set by Division of Insurance as a compromise
  - Unclear on impact
  - GEMT (Ground Emergency Medical Transport) Provision
    - Creates supplemental payment that covers funding gap between provider's actual cost per GEMT guidelines and the amounts paid by Medicaid
    - Essentially equivalent to cost-base approach