September 24, 2024

Committee on Health Coverage, Insurance, and Financial Services

RE: Final Report of the Community Paramedicine Stakeholder Group

Dear Honorable Members of the Health Coverage, Insurance and Financial Services Committee,

Pursuant to legislation from the 131st Legislature,[1] the Maine Medical Association ("MMA")[2] was asked by you to convene a stakeholder group to review community paramedicine programs in the State and to consider whether and in what manner health insurance carriers should reimburse community paramedicine services.

Committee members recommended the following stakeholders: Maine Ambulance Association, health insurance carriers, Maine EMS Board, Maine EMS Bureau, Maine Bureau of Insurance, Maine Hospital Association, Maine Medical Association, and Maine Osteopathic Association. The committee also requested that legislators and staff on the HCIFS committee be invited to observe the meeting.

MMA sought input from the identified stakeholders and invited the following members:

- Maine Ambulance Association
    - Joe Kellner, FACHE
- Health Insurance Carriers
    - Kristine Ossenfort, Anthem
    - Christiana Lauridsen, Cigna Healthcare - Provider Contracting Lead Analyst
    - David Stuart, Community Health Options – SVP & COO[3]
    - Joe Spicuzza, Harvard Pilgrim Health Care - Sr. Contract Manager, Ancillary Network Contracting
    - Dan Demeritt, MeAHP Executive Director (working group observer)
- Maine EMS Board
    - Amy Drinkwater
- Maine EMS Bureau
    - Soliana Goldrich

[1] L.D. 1832, An Act to Continue the Study of Community Paramedicine and to Make Changes Related to Health Insurance Coverage and Prior Authorization Requirements for Certain Ambulance Service Providers (131st Legis. 2024).

[2] This work was led by Anne Sedlack, Director of Advocacy at the Maine Medical Association, and Lucy Frenette, Maine Medical Association's Hanley Center 2024 Summer Intern.

[3] David Stuart left his role at CHO before this report was finalized.

- Maine Bureau of Insurance
    - Joanne Rawlings-Sekunda, Director of Consumer Health Division
- Maine Hospital Association
    - Mike Senecal
    - Sarah Calder (working group observer)
- Maine Medical Association
    - Kelly Meehan-Coussee MD, FACEP, NRP
- Maine Osteopathic Association
    - Isabella Askari, DO

From June to August, three meetings were held to discuss the state of community paramedicine in Maine, the current work of MaineCare, and reimbursement models of other states, in order to collect recommendations based on our learnings. There was a fourth meeting to review and approve the report. The meetings averaged 23 attendees with hospitals, public health organizations, EMS providers, private insurers, legislators, and HCIFS committee members represented at each meeting; see Appendix A for list of individuals and organizations.

In order to provide members with the same knowledge and ability to provide recommendations, a variety of individuals were invited to present:

1) Joe Kellner, Maine Ambulance Association- Current State of Community Paramedicine in Maine
2) Soliana Goldrich, Maine EMS - Regulatory Framework
3) Amy Drinkwater, Maine EMS Board/ St. George Director - Example of an Active Community Paramedicine Project in St. George
4) Heather Pelletier, Office of MaineCare Services - MaineCare's Ongoing Work in Community Paramedicine
5) Dan Demeritt, Maine Association of Health Plans - Conversation Led by Commercial Payers regarding mechanics and contracting with carriers
6) Lucy Frenette, Maine Medical Association - Reimbursement Models of Other States

This report includes:

1) Background and Objectives
2) Summary of Recommendations:
    a) Patient Identification;
    b) The Interaction of Community Paramedicine and Home Health;
    c) How to Work with Commercial Insurers to Remove Reimbursement Barriers;
    d) Alignment with MaineCare Reimbursement;
    e) Ensuring Appropriate Data Collection;
    f) Education for Clinicians;
    g) New Stakeholder Group.
3) Appendices
    a) Committee Members

b) Appendix B- Referral Plan
c) Maine EMS Unique Patient Count

The recommendations represent an attempt to achieve consensus and compromise. Not all participants agreed with every component of the recommendations; however, the committee agreed to present this as a consensus document. For example, some members hesitated to agree to a consensus because they were just one person representing a larger entity. When appropriate, the report reflects the opinion of the "minority" to give the committee perspective about why there was disagreement.

We trust the Committee to take the report and determine the best legislative fixes to ensure this valuable program continues growing and providing excellent service to our community. We believe many of the recommendations noted below can and should be used as the basis of legislation during the 132nd Legislature. We would be happy to work with the committee of jurisdiction to draft those bills to ensure that the excellent care provided by community paramedicine continues to progress in this state.

Thank you for your time, and please reach out with any questions. I would be happy to introduce and present the report at a time of your choosing.

Best,

Anne Sedlack, Esq., M.S.W.
Director of Advocacy
Maine Medical Association
asedlack@mainephysicians.org

Background and Objectives

According to the Maine Emergency Medical Services Act, 32 M.R.S. § 84(4), community paramedicine "means the practice by an emergency medical services provider primarily in an out-of-hospital setting of providing episodic patient evaluation, advice and treatment directed at preventing or improving a particular medical condition, within the scope of practice of the emergency medical services provider as specifically requested or directed by a physician."

In 2012, through LD 1837, An Act To Authorize the Establishment of Pilot Projects for Community Paramedicine (125th Legis. 2012), 12 community paramedicine ("CP") pilot projects were approved in Maine. Existing EMS agencies were eligible to apply for CP designation, which was subject to approval by the Maine EMS Board. These programs needed to complete a community needs assessment, identify a primary care medical director, and ensure all requested information was filed to the EMS Board. Once approved, CP programs sought funding and have continued for the past 12 years.

In a 2015 study of community paramedicine pilot projects in Maine, the lack of reimbursement for community paramedicine services was identified as one of the challenges for CP programs.[4] There was no designated funding for the pilot programs, so the programs had to seek additional funding or include it in their operating budget. The Maine EMS Office received federal funding through the federal Healthcare Disparities Grant and published two RFAs; they worked with 10 agencies and completed contracts for just under $1 million in funds. Though grant funding is the biggest source for CP programs, it is the least sustainable. Other funding sources include municipal funding, volunteerism by the providers, or direct contracts with hospitals or insurers, including MaineCare and commercial insurers. The ultimate goal for community paramedicine here is to find sustainable funding to help grow the community paramedicine infrastructure in Maine and help reach all communities (rural and urban) with quality healthcare.

Once a CP program is established and running, it can provide various services to individuals who have received a referral from a physician. These services are usually done in the patient's home, and service varies from medication compliance, post-discharge care, diabetes care, asthma care, heart failure care, stroke care, or other care to prevent re-hospitalization. While care may typically happen in the home, one of the biggest benefits is that it can meet patients where they are, even if it is on the street or not in the same setting each time. The goal of CP is to meet the unique needs of each community and keep patients out of the emergency room to avoid hospital visits when possible. This service not only decreases hospital burdens but can potentially save stakeholders money.[5]

Community paramedicine programs' unique design is to address the needs of the communities

[4] Karen Pearson and George Shaler, USM Muskie School of Public Service, "2015 Maine EMS Community Paramedicine Report," p. 18.
[5] Centers for Disease Control and Prevention. *Division for Heart Disease and Stroke Prevention's Best Practices Clearinghouse*. Evidence of Impact for Community Paramedicine," https://hdsbpc.cdc.gov/s/.

they serve and may look different from program to program, but there are overlaps in the benefits provided by each: (1) they can reduce healthcare disparities for rural, aging, homeless, and chronic care patients; (2) they can improve the continuity of care; and (3) they can help reduce avoidable acute care.

Recommendations

Each of these recommendations are meant to be read as a whole and should not be taken as siloed pieces. Consensus and agreement on these recommendations are the positions of the individuals, not necessarily the positions of their employers or organizations.

Members reserve the right to assess any legislative bills proposed by the Committee on a case-by-case basis.

Recommendation 1: Ensure that requirements for patient referrals are clear

How and when patients are identified for community paramedicine services needs to be standardized to ensure that every stakeholder is comfortable with providing reimbursement. In the current Maine programs, a physician gives a referral to a CP provider through an EMS agency; then, the community paramedicine provider contacts the patient and schedules a time and place to meet the patient for care.

This recommendation does not seek to significantly alter how referrals are placed now but to clarify the specifics in order to decrease coverage gaps for patients. Depending on a clinician's geographical location, this service may be new for them, so education and program definitions will be needed to ensure that clinicians know how to identify patients and connect them to care. See recommendation 6 for information on clinician engagement and education.

For all who attended the meeting on August 8th, consensus was reached on this recommendation.

I. The current community paramedicine programs identify patients through a physician's referral, which should continue to be how patients gain coverage for services.
II. The committee recognized that many patients may not have a PCP due to the lack of available PCPs in Maine or their lack of ability to access consistent care. This is why some members of the stakeholder group recommend that referrals can originate from more than just primary care providers and could come from emergency physicians or the medical director of the community paramedicine agency.
III. If the referral is not made by a PCP, it must be combined with a plan to connect the patient to a PCP within 60 days of the referral. Patients who do not have a PCP may not be able to access a clinician within 60 days, so we recommend that care navigation services to connect the patient with a PCP must occur within 60 days from the referral, not necessarily that a patient must be evaluated by a PCP within 60 days. This will ensure that patients are connected to the broader healthcare system after their community paramedicine needs are met.
IV. Hospital discharge policies and protocols for in-patient stays should ensure patients are

not discharged undertreated with a referral to CP services to transfer treatment to the patient's home. CP services do not extend an in-patient provider-based department to the patient's home.

V. When a patient is connected with CP, there must be a documented referral for an evaluation for home health services and other services for long term care to make sure that CP is the most appropriate plan of care.
    A. If there is a referral for a home health evaluation, it is being done at the physician, or otherwise qualified clinician, level.
    B. Community paramedicine also provides an opportunity to help get patient care if there are home health evaluation backlogs. If possible, a discrete field in the community paramedicine EMR will be created to document barriers to home health to help resolve backlogs.
    C. Explore telehealth regulations on providing evaluations for home health services. This is under the jurisdiction of the federal government through CMS.

VI. See Appendix B for an example of the referral plan.

Recommendation 2: Monitor and Support Community Paramedicine and Home Health Interaction

Many questions were raised throughout discussions in an attempt to delineate community paramedicine and home health services in order give stakeholders a better understanding of the need for community paramedicine.[6] While some services overlap, the patients who may receive community paramedicine services may not be eligible for the same care under home health criteria. More work is needed to identify where these services overlap and where they are unique, which could be a directive for the stakeholder group as outlined in Recommendation 7. Both groups have evolved to benefit from the care provided by each entity and help support patients as they may transition from home-bound and eligible for home health to only needing episodic treatment through community paramedicine. Home Health should be the lead service, but where Home Health is unavailable or patients don't qualify, then CP is able to bridge those gaps.

For all who attended the meeting on August 8th, consensus was reached on this recommendation.

I. CP Agencies should make sure that they are supportive of each other and refer to each other when necessary (cross-referencing)
    A. If the patient need becomes more than episodic, services other than community paramedicine need to be evaluated
II. Establish pathways through which the clinician managing the Home Health can refer patients to CP when they no longer qualify for Home Health.

[6] *See LD 883, An Act to Exempt Emergency Medical Services Community Paramedicine Programs from Home Health Care Provider Licensing Requirements Under Certain Circumstances* (131st Legis. 2023).

III. Provide a framework about the differences between home health and community paramedicine from groups currently working on collaboration in this space.
    A. Provide guidance about episodic versus long-term consistent with Title 22 section 2147, which defines episodic care to delineate CP services and home health services.[7]
    B. Do not need to be homebound for CP services.

Recommendation 3: Work with commercial insurers to educate clinicians on joining networks and reducing barriers on reimbursement

Collaborating with commercial insurers will ensure the success of all community paramedicine programs in Maine.

In the presentation by Soliana Goldrich, the Maine EMS Community Paramedicine Coordinator, there were 1,796 unique community paramedicine patients between 2018 and 2022, with 1,042 that have MaineCare. This meant that there were 754 patients who needed CP services but would not be covered through MaineCare; see Appendix C for trends in unique CP patients. It is important to note that some of those 754 individuals might be covered by Medicare or insurance plans not subject to Maine regulations.

Both insurers and providers are concerned about becoming too prescriptive with recommendations. Each patient's needs are unique, and quantifying the maximum number of visits or types of services may not benefit the community, patients, or insurers. It is important to ensure that the focus is on standardization of billing, not mandated reimbursement. It is also important to note that discussions among both insurers and providers must be mindful of antitrust laws.

There was some debate on the recommendations in this section around multi-payor alignment, and we held a vote via Survey Monkey on how to move forward. We ultimately did not reach a consensus, and as such, there is a majority and minority report associated with recommendations three and seven. For this section, the only difference is that the minority report includes specific recommendations under section II, which has been bolded for the ease of the committee. We hope that by including both viewpoints, the committee members better understand the issue's landscape.

Majority Report (Stakeholders from the Health Insurance Carriers (1 vote), Maine Bureau of Insurance, Maine Hospital Association, Maine Medical Association and Maine Osteopathic Association)

I. Issues identified as needing further discussion include establishing a clear understanding

[7] 22 M.R.S. § 2147 (15).

of the difference between community paramedicine and home health care, medical necessity, the affordability of CP compared to alternatives, and if there needs to be prior authorization before a first visit. Carriers raised concerns about mandating coverage, reimbursement rates, and limitations on utilization management tools such as prior authorization.

II. Carriers note that legislation is unnecessary for them to contract with CP providers. Barriers to contracting include needing a clear understanding of the differences in the services rendered by community paramedicine and home health providers, the types of billing codes that would be appropriate, and the structure of the billing entity. Further discussions are needed to better understand these issues and how they could be addressed.

III. As noted in recommendation 2, the most important difference between community paramedicine and home health is that while CP service *may* occur in the home, patients who are not homebound may need care and may not be eligible for home health reimbursement. Knowing where home health and community paramedicine overlap and differ will help commercial insurers understand where coverage needs to be.

IV. Need to determine how different insurance plans interact with these recommendations, including, but not limited to, public, commercial, Medicare Advantage, and commercial (healthcare exchange plans).

V. One question was raised about a potential patient who is given post-discharge instructions on a Friday night and needs CP services on Saturday, but there is no time for prior authorization to be approved before the patient needs the care. If the service is deemed medically necessary, then the Saturday visit would be covered, but if it is not, then the patient who has already used the service could be responsible for payment. It was discussed whether there should be a first visit pass with prior authorization to ensure that patients get timely care. The opinions of the group were mixed.

Minority Report (Stakeholders from the Maine Ambulance Association, Maine EMS Board, Maine EMS Bureau)

I. Issues identified as needing further discussion include establishing a clear understanding of the difference between community paramedicine and home health care, medical necessity, the affordability of CP compared to alternatives, and if there needs to be prior authorization before a first visit. Carriers raised concerns about mandating coverage, reimbursement rates, and limitations on utilization management tools such as prior authorization.

II. Carriers note that legislation is unnecessary for them to contract with CP providers. Barriers to contracting include needing a clear understanding of the differences in the services rendered by community paramedicine and home health providers, the types of billing codes that would be appropriate, and the structure of the billing entity. Further discussions are needed to better understand these issues and how they could be addressed.

A. **To address billing code differences, efforts should be made toward multi-**

payer alignment.

B. **Plan for monitoring progress towards accepting standardized codes and CP services through a report from the Maine Health Data Organization or a similarly suited agency.**

III. As noted in recommendation 2, the most important difference between community paramedicine and home health is that while CP service *may* occur in the home, patients who are not homebound may need care and may not be eligible for home health reimbursement. Knowing where home health and community paramedicine overlap and differ will help commercial insurers understand where coverage needs to be.

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Recommendation 4: Alignment of reimbursement model with the ongoing work of MaineCare

The Office of MaineCare Services (OMS) is currently working on a reimbursement model for community paramedicine and is looking at other states as models. Minnesota allows EMS to bill Medicaid for Mobile Integrated Health- Community Paramedicine services, with the billing going through PCP in partnership with the contracted EMS agency.[8] Currently, CP is not reimbursed through regular EMS codes because those codes generally pertain to emergency care and transportation. Because CP services are delivered in the patient's place of residence and do not involve emergency transportation reimbursement is not covered through regular EMS codes. States like Minnesota and Indiana have started to change the language of statutes to decouple reimbursement and transportation.[9]

MaineCare's work is informed by Maine EMS Community Paramedicine Licensure and scope of practice rules, which is anticipated to be approved in the fall of 2024 or, at the latest, spring of 2025. Final funding decisions and potential implementation of the Maine OMS Model is not expected until 2025.

[8] Minnesota Statute 256B.0625, Subdivision 60, https://www.revisor.mn.gov/statutes/cite/256B.0625

[9] Indiana Department of Homeland Security, Mobile Integrated Health, https://www.in.gov/dhs/ems/mobile-integrated-health/.

Maine OMS worked with the Cutler Institute to create a report titled "*Community Paramedicine & Medicaid: MaineCare Claims Data Analysis Summary."* This work is also paired with reimbursement rate development following MaineCare's standard rate reform and fiscal and budgetary analysis.[10] The work of Maine OMS is integral to the growing need for community paramedicine in Maine.

For all who attended the meeting on August 8th , consensus was reached on this recommendation.

I. Continue to assess the work of MaineCare on a reimbursement model.
II. Require legislation with allocated funding for the reimbursement of CP services in the MaineCare model.
III. Require regular reporting from MaineCare on their work to implement reimbursement of CP services.
IV. Work toward a consistent code set for simplicity in billing and proper processing of claims for secondary payers.

<u>Recommendation 5: Ensure appropriate data collection with improved certified electronic health record systems</u>

Maine EMS currently requires all services to use the same patient documentation platform, but this platform only allows for limited interoperability in sharing out information with limited ability to receive information. Since each EMS clinician uses the same form, the data collected should be periodically evaluated and updated to ensure that the information most useful for the legislature and Maine EMS regarding the effectiveness of community paramedicine programs is being collected. Certified electronic health record systems (CEHRT) are systems that improve patient care and medical errors, along with meeting federal interoperability standards. CEHRT simplifies patient medical records, can tie in clinical data sets and referrals with the patient records attached, and supports communication between the referring physician and the CP service.

For all who attended the meeting on August 8th, consensus was reached on this recommendation.

I. Be able to track the impact of re-hospitalization, healthcare cost, and healthcare outcomes
II. Evaluate the appropriateness of the current form and see if there are areas of improvement.
III. While it will be considered an unfunded mandate on municipalities, separate legislation should be considered for the allocation of funding for community paramedicine agencies to adopt a certified electronic health record system to help support care coordination and data exchange with the payers, providers, and systems. Without state funding, this may

[10] Heather Pelletier, MaineCare Program Coordinator

lead to CP agencies being dependent on large health systems for these resources, which may reinforce health disparities and inequities driven by rurality.

A. HL7 Interoperability can tie in clinical data sets and referrals with all the patient information while supporting communication between the provider and CP agency. HL7 standardized data sets also allow health care information to be shared with Health Information Exchange to support care coordination and follow-up referrals for both medical and health-related social needs.

IV. Review the Maine EMS rules for compliance and concurrent use with both EMS and CP services

Recommendation 6: Provide state funding for provider engagement and education on community paramedicine

As community paramedicine develops in Maine, providers may not be up to date on any or all available opportunities. In order to make community paramedicine cost-effective and supportive to a community, it must be utilized. Providing education about the service available through CP will make this effort successful.

For all who attended the meeting on August 8th, consensus was reached on this recommendation.

I. Continued provider engagement and education opportunities with funding for this type of education
II. Evaluate the work of The Cutler Institute on CP utilization and savings[11]
III. Consider evaluating this recommendation as an individual piece of legislation

Recommendation 7: New Stakeholder Group

If, following a review of this report, the Health Coverage, Insurance, and Financial Services Committee has continued interest in this issue, we recommend that the Legislature should convene a new stakeholder group for additional discussions, including an assessment of any actions taken by the Office of MaineCare Services.

As noted in Recommendation 3, there was a split in membership around multi-payor alignment. As such, we had a majority and minority report associated with recommendations 3 and 7. For this section, the only difference is that the majority report includes additional recommendations, which have been bolded for the ease of the committee.

Majority Report (Stakeholders from the Health Insurance Carriers (1 vote), Maine Bureau of

[11] Pearson, K. B., & Shaler, G. (2015). Maine EMS Community Paramedicine pilot program evaluation. Portland, ME: University of Southern Maine, Muskie School of Public Service.

Insurance, Maine Hospital Association, Maine Medical Association and Maine Osteopathic Association)

I. Evaluate the progress of the recommendations in this report
II. Further address billing code differences
III. Plan for monitoring progress towards accepting standardized codes and CP services through a report from the Maine Health Data Organization or a similarly suited agency.
IV. Define and evaluate the feasibility of multi-payer alignment.

Minority Report (Stakeholders from the Maine Ambulance Association, Maine EMS Board, Maine EMS Bureau)

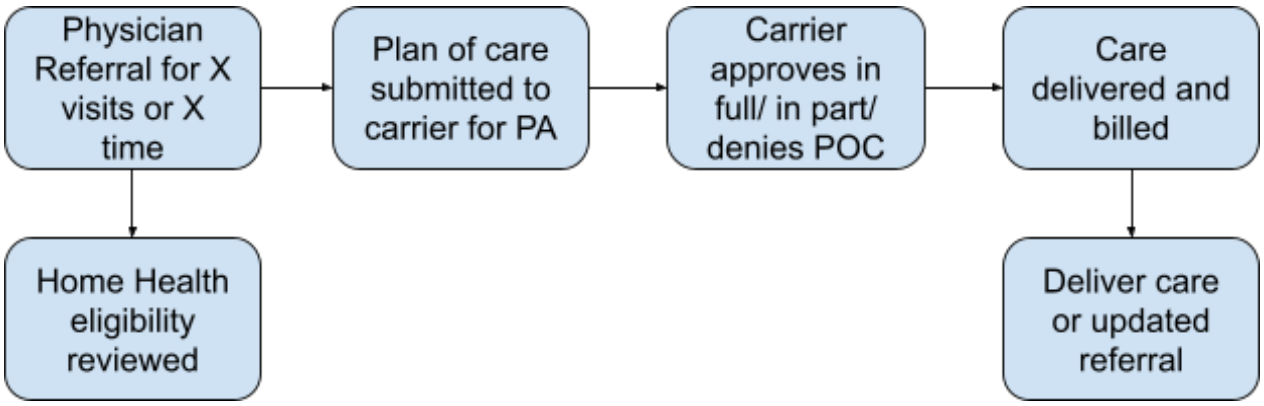
I. Evaluate the progress of the recommendations in this report

Appendices

Appendix A - Stakeholder Group Attendees

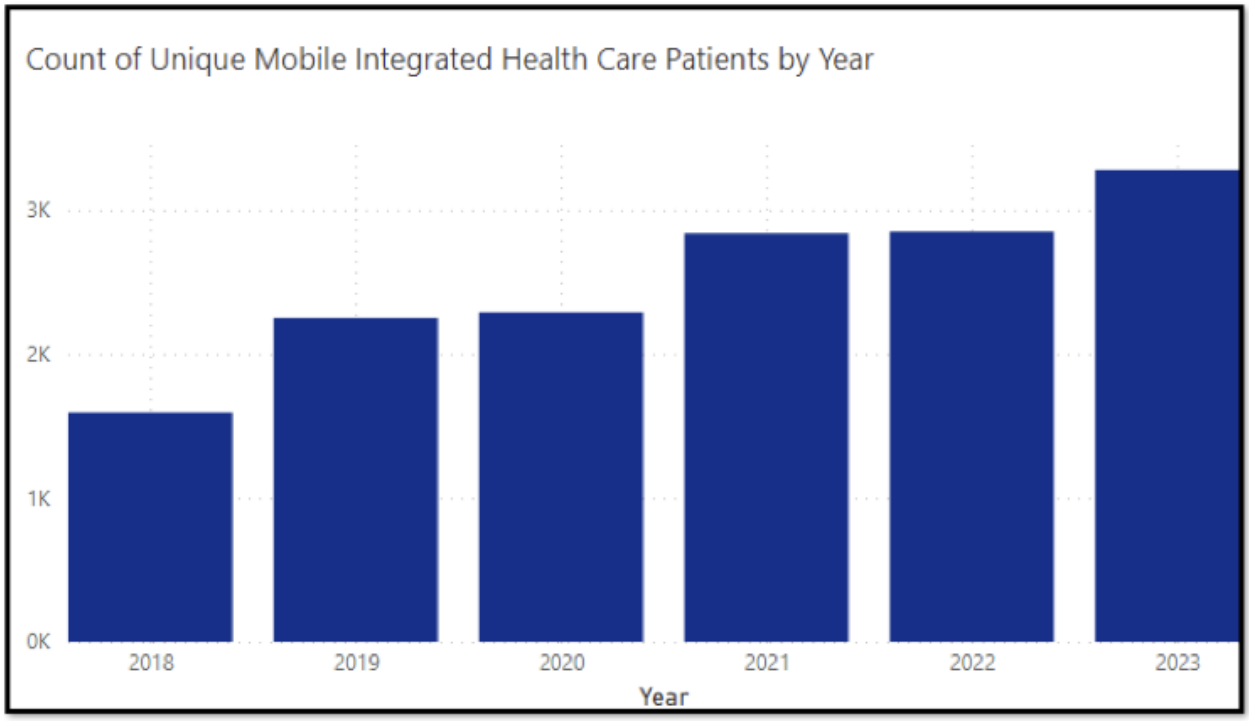
Invitee	Interest	Organization
Anne Sedlack	Public Health	Maine Medical Association
Andrew MacLean	Public Health	Maine Medical Association
Molly Bogart	Public Health	Maine DHHS
Amanda Mahan	Public Health	Maine Osteopathic Association
Isabella Askari	Public Health	Maine Osteopathic Association
Joe Kellner	EMS/ Ambulance	Maine Ambulance Association
Anne Drinkwater	EMS/ Ambulance	Maine EMS Board/ St. George
Soliana Goldrich	EMS/ Ambulance	Maine EMS
Kelly Meehan-Coussee	EMS/ Ambulance	Emergency Medicine and EMS Physician
Gregory Milliken	EMS/ Ambulance	LifeFlight Flight Paramedic
Dennis Russel	EMS/ Ambulance	United Ambulance
William Ferdinand Jr.	EMS/ Ambulance	Maine Ambulance Association
Kristine Ossenfort	Insurance	Anthem Blue Cross and Blue Shield
Heather Pelletier	Insurance	Office of MaineCare Services
Christiana Lauridsen	Insurance	Cigna Healthcare
Dave Stuart	Insurance	Community Health Options
Joseph Spicuzza	Insurance	Point32Health
Dan Demeritt	Insurance	Maine Association of Health Plans
Joanne Rawlings-Sekunda	Insurance	Maine Bureau of Insurance
Michael Senecal	Hospitals	Maine Hospital Association
Sarah Calder	Hospitals	MaineHealth/ Maine Hospital Association
Tessa Byard	Hospitals	Northern Light
Poppy Arford	Legislature	State Representative
Sally Cluchey	Legislature	State Representative
Colleen McCarthyReid	Legislature	HCIFS Committee
Jane Pringle	Legislature	State Representative/ HCIFS Committee
Anne-Marie Mastraccio	Legislature	State Representative

Appendix B- Referral Plan



- The PCP or physician may refer for up to 6 months or up to 12 visits within the 6 months before another referral is necessary
- If referred by a non-PCP, CP agency medical director can extend care up to 6 months or 12 visits within 6 months
    - Patients without PCP must have attempt for coordination of primary care within 60 days

Appendix C- Maine EMS Unique Patient Count[12]



Between 2018 and 2022, there were 11,749 CP visits and 1,796 unique patients; each patient averages about 6.5 visits.

[12] This information was included in the presentation to the Community Paramedicine Stakeholder group by pulled from Soliana Goldrich's, the Maine EMS Community Paramedicine Coordinator, on June 13th, 2024