LEGISLATIVE BUDGET AND FINANCE COMMITTEE

A JOINT COMMITTEE OF THE PENNSYLVANIA GENERAL ASSEMBLY

A Study Pursuant to SR 120: EMS Treat/No Transport in Medical Assistance Managed Care

March 2024

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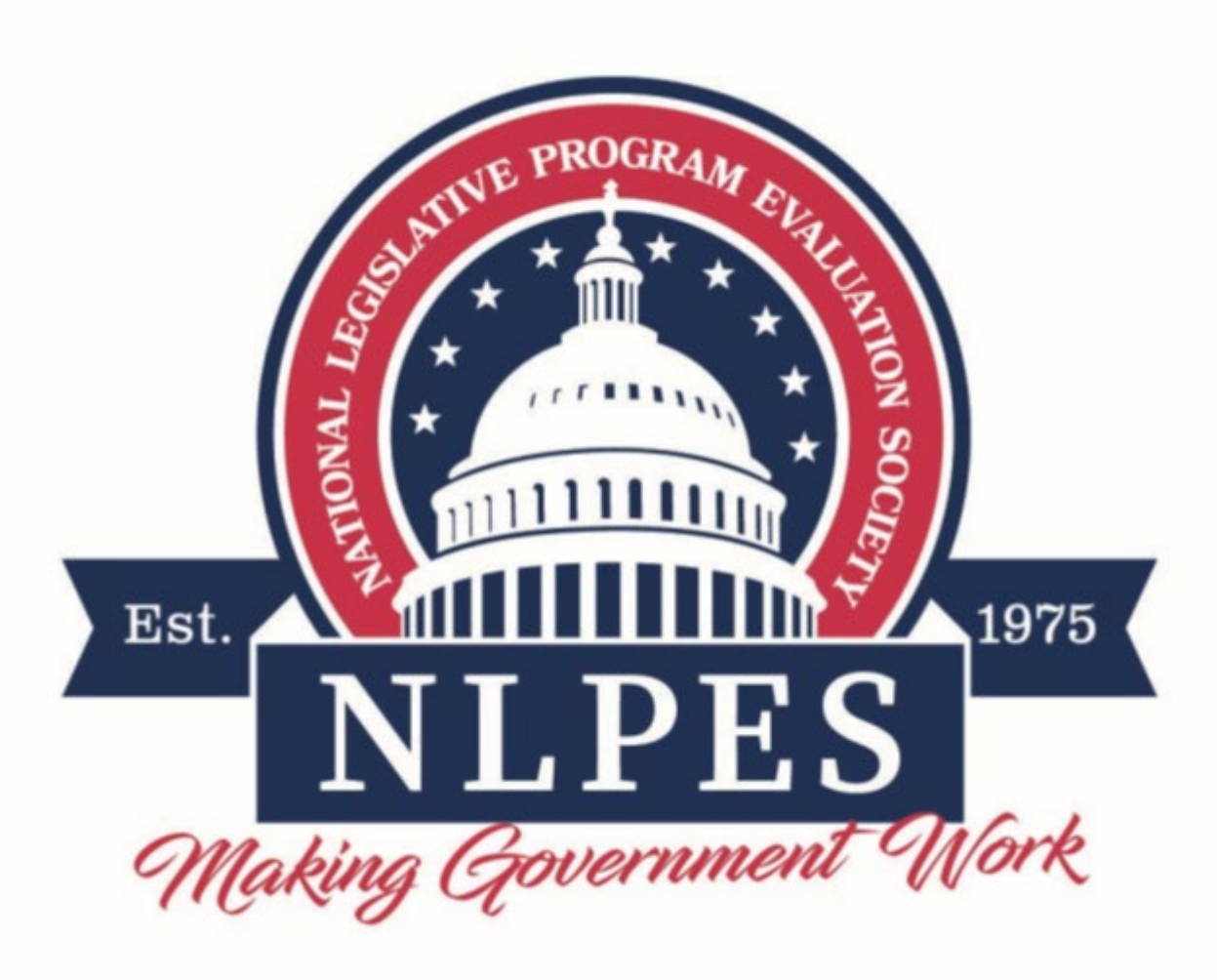

For the eighth straight year, the National Legislative Performance Evaluation Society (NLPES) awarded the Legislative Budget and Finance Committee with a Certificate of Impact. The Certificate of Impact is presented to legislative offices that produce evaluations or audit reports that resulted in documented public policy changes, program improvements, dollar savings, or other public impacts.

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TABLE OF CONTENTS

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REPORT SUMMARY

Objectives

Our objectives for the study were the following:

1. *To obtain and analyze data on treat and release calls involving MA beneficiaries, including the number of incidents, average duration, cost to provide services, and whether payment was received. Further, to evaluate similar data points for substance abuse-related calls to determine if EMS providers are financially harmed through treat and release practices.*

2. *To identify any possible recommendations to ensure that EMS providers are fairly compensated for services provided to MA patients on treat and release calls.*

Report Overview

Emergency medical services (EMS) provide emergency medical care to Pennsylvanians every day. In providing EMS care, a newer model of EMS delivery has emerged, treat/no transport (TNT), which is to treat a patient on the scene of an emergency call and release the patient without transport to a hospital (either per medical protocol or because the patient refused transport against medical advice). Act 2018-103 (Act 103) mandated that all "reasonable costs" for TNT be reimbursed by Pennsylvania's Medical Assistance (MA) Managed Care Organizations (MCOs). According to EMS agencies, reasonable costs are not reimbursed by MCOs.

The Senate adopted Senate Resolution 2023-120 (SR 120) within this context. The objectives for this study were derived from the resolution (and are listed in the left-facing text box). The officers of the LBFC adopted SR 120 as a staff project on October 15, 2023.

Our report is organized as follows:

- **Section I – Objectives, Scope, and Methodology**
- **Section II – Background Information**
- **Section III – Treat/No Transport Utilization and Reimbursement Practices of Managed Care Organizations**

Our findings, conclusions, and recommendations are summarized on pages S-1 through S-4.

Section II
Background Information

Pennsylvania's emergency medical system (EMS) includes 1,200 EMS agencies and over 41,000 certified EMS providers (such as Emergency Medical Technicians and paramedics). The commonwealth has a patchwork of different types of EMS agencies, such as non-profit, fire-based, municipal-based, for-profit, and hospital-based.

The Pennsylvania Department of Health (DOH), through the Bureau of EMS, is responsible for developing and coordinating a comprehensive

emergency medical response system to reduce premature death and disability. The bureau divides Pennsylvania into 13 EMS councils that administer aspects of the EMS program for the department.

Pennsylvanians obtain health insurance coverage through a variety of sources. Around 20 percent of Pennsylvanians are enrolled in Pennsylvania's Medicaid program, called Medical Assistance (MA). The Pennsylvania Department of Human Services (DHS) oversees the MA program. Most of those enrolled in MA are enrolled in Managed Care Organizations (MCOs). Under commonwealth contracts through DHS, MCOs provide health coverage to enrollees for a set per-member, per-month fee called the "capitation rate."

Section III
Treat/No Transport Utilization and Reimbursement Practices of Managed Care Organizations

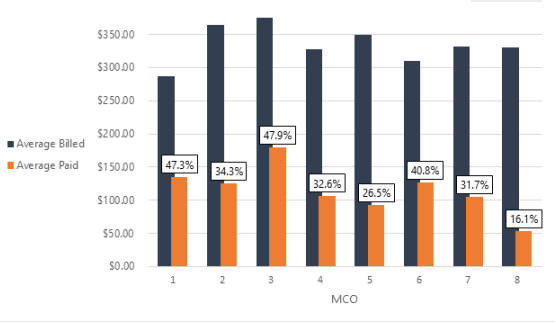
Across the commonwealth, at all hours of the day, citizens dial 911 and request an ambulance due to what they perceive as a medical emergency. Traditionally, an ambulance would arrive, provide some treatment, and transport the patient to a hospital. As previously mentioned, in some instances, this model has changed. EMS providers are equipped with tools and training that allow them to treat and "release" patients without needing additional hospital care (per medical protocol). In some instances, a patient receives treatment from EMS providers but then refuses to be transported to the hospital (against medical advice). In both instances, this is referred to as treat/no transport (TNT).

The utilization of TNT has increased in recent years. In Pennsylvania, TNT comprised less than 3 percent of total EMS dispositions in 2022. We estimate that of total TNT dispositions, about one-fourth were patients enrolled in one of the MA MCO health plans.

Prior to Act 103, there was no mandate for MCOs to reimburse EMS agencies for TNT. According to EMS agencies, Act 103 attempted to resolve concerns around reimbursement for TNT services; however, requiring reimbursement based on "reasonable costs" created a practice in which MCOs reimburse EMS at different rates for TNT services. This differs from other EMS services reimbursed by the MA program. Through the commonwealth's Fiscal Code, specific state-directed or minimum payment requirements set forth the amount MCOs must pay for other ambulance services in which transport to an emergency department (ED) occurs. The reimbursement for these services is based on reimbursement for the base rate of providing emergency services and a component that covers mileage to the ED.

EMS agency funding differs from other emergency services (such as fire and police) that are primarily funded through taxes and fees. While some EMS agencies receive limited direct support from their local government, all agencies rely on insurance reimbursement and patient payments as revenue.

Figure 1. Average Payment from MCO to EMS Agency Compared to Average Amount Bill by EMS Agency for TNT (Selected Sample), 2019 through 2022



To answer the objectives of this study, we requested a selected sample of data from Pennsylvania's contracted MCOs. We found:

- The reimbursement amount paid by MCOs to EMS agencies for TNT claims varied between MCOs and by year in our selected sample.
- Across the four-year period (2019 through 2022), the average TNT amount billed by EMS agencies ranged between $287 and $375. EMS was reimbursed between $53 and $179 at average rates, or 16.1 to 47.9 percent of the average amount billed (depending on the MCO).
- From 2019 through 2022, only 1.9 to 2.7 percent of total TNT claims were marked as substance abuse related by MCOs.

EMS agency costs are not tracked statewide, which poses a challenge in determining EMS costs to provide TNT services. The Centers for Medicare and Medicaid Services (CMS) is in the process of collecting EMS agency cost data nationwide through the Medicare Ground Ambulance Data Collection System (GADCS); however, the results are not expected until after 2025. We collected cost-per-response figures from 14 different EMS agencies and found that the cost-per-response ranged between $246 to $885, depending on the agency.

Recommendations

1. The General Assembly should consider implementing a specific state-directed payment or minimum fee requirement for TNT, similar to the other ground ambulance minimum rates contained in the Fiscal Code.

2. The General Assembly should consider requiring a broader study or audit by the LBFC of payments to EMS after CMS releases federal GADCS data.

3. The General Assembly should consider requiring reimbursement for new models of EMS care delivery, including transport to alternative or non-emergency locations following emergency calls and EMS treatment (i.e., drug treatment facilities, urgent care, etc.)

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SECTION I
OBJECTIVES, SCOPE, AND METHODOLOGY

Why we conducted this study…

The Pennsylvania Senate adopted Senate Resolution 2023-120 (SR 120) on June 27, 2023, and the officers of the Legislative Budget and Finance Committee adopted the resolution as a staff project on October 18, 2023.

SR 120 directs the LBFC to conduct a study of how Pennsylvania's emergency medical services (EMS) agencies may be impacted by "treat and release" calls for Medical Assistance (MA) beneficiaries.

SR 120 also directs LBFC to collect data on non-reimbursable services for substance abuse-related calls.

Objectives

On June 27, 2023, the Pennsylvania Senate adopted Senate Resolution 2023-120 (SR 120). This resolution sought information on the impact of "treat and release" calls on emergency medical service (EMS) agencies, specifically for patients covered by Pennsylvania's Medicaid Managed Care Organizations (MCOs).[1] SR 120 was subsequently adopted by the officers of the Legislative Budget and Finance Committee (LBFC) as a staff project on October 15, 2023. As a matter of practice, once the officers adopt a project, staff develop objectives to answer the resolution's intent and to guide planning efforts further. The objectives for this study were as follows:

1. To obtain and analyze data on treat and release calls involving MA beneficiaries, including the number of incidents, average duration, cost to provide services, and whether payment was received. Further, the analysis shall evaluate similar data points for substance abuse-related calls to determine if EMS providers are financially harmed through treat and release practices.

2. To identify any possible recommendations to ensure that EMS providers are fairly compensated for services provided to MA patients on treat and release calls.

Scope

Our study primarily covered the period from January 1, 2019, through December 31, 2022. Further extending the scope was necessary in some research areas to provide better context about the subject matter.

[1] "Treat and release" in SR 120 refers to EMS calls in which providers administer treatment on the scene of an emergency response, but the patient is not transported to a hospital, either due to medical guidelines or the patient refused additional care against medical advice. We refer to "treat and release" as treat/no transport (TNT).

Methodology

We researched and interviewed relevant stakeholders to provide an overview of EMS billing, revenue, and treat/no transport (TNT) utilization.

We reviewed relevant legislation and the Pennsylvania Medical Assistance Ambulance Fee Schedule to provide an overview of EMS billing specific to Pennsylvania Medicaid.

We also reviewed the Pennsylvania Department of Health (DOH) EMS Data Reports from 2019 through 2021 for relevant statewide data, including the number of TNT dispositions. Absent DOH releasing a public report with 2022 data, we requested similar data through an information request. We did not audit the DOH data and assumed it to be accurate.

To determine the average payments made from MCOs to EMS agencies for TNT services, we requested claims data from MCOs through an information request to the Pennsylvania Department of Human Services (DHS). Due to the amount of claims data MCOs process, we selected the winter (January) and summer (July) months with the highest number of naloxone administrations based on DOH EMS data for all TNT claims and the number of naloxone administrations for 2019-2022. We requested all claims for which EMS billed, regardless of whether a transport occurred. We did not audit the claims data and assumed it to be accurate.

With the MCO's claims data, we conducted a comparative analysis of the average amount billed by EMS agencies compared to the amount paid by MCOs for TNT services. Additionally, we also conducted a comparative analysis of the percentage of claims that were indicated as substance abuse or other.

To determine the approximate cost incurred by EMS agencies for TNT, we compiled cost-per-response data from 14 different EMS agencies, including basic life support, advanced life support, combination, urban, rural, and urban/rural combination. While this was not a representative sample, the average of the 14 agencies was in line with statewide averages. In some instances, audited financial data was included in the examples; however, we did not audit the data and assumed it to be accurate.

Finally, we reviewed other states' requirements for TNT reimbursement and other studies covering ambulance reimbursements in other states and at the federal level.

Frequently Used Abbreviations and Definitions

This report uses several abbreviations for government-related agencies, terms, and functions. These abbreviations are defined as follows:

Abbreviation	Name	Definition
AAP	Ambulance Association of Pennsylvania	A trade organization that represents EMS agencies and providers in Pennsylvania.
AMA	Against Medical Advice	A patient declines care recommendations from a medical provider, including EMS. In the case of TNT, a patient accepts treatment from EMS providers but refuses to be transported to the hospital.
ALS	Advanced Life Support	Life-saving skills and protocols extend beyond BLS, including IV access, medication administration, and advanced cardiac life support.
BLS	Basic Life Support	Life-saving skills are used to provide urgent treatment to patients.
CMS	United States Centers for Medicare and Medicaid Services	The federal agency that provides health coverage through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.
CPT	Current Procedural Terminology	A uniform language for coding medical services and procedures to streamline reporting and increase accuracy and efficiency.
DHS	Pennsylvania Department of Human Services	Cabinet-level commonwealth agency in Pennsylvania administers programs and services that provide care and support to the commonwealth's most vulnerable citizens, including overseeing Pennsylvania's Medicaid program.
DOH	Pennsylvania Department of Health	Cabinet-level commonwealth agency in Pennsylvania oversees programs that promote healthy behaviors, prevent injury and disease, and ensure the safe delivery of quality health care.
ED	Emergency Department	The part of a hospital where patients seeking emergency care go and where EMS providers will transport patients.
EMS	Emergency Medical Services	A system of clinicians/providers who respond to medical emergencies.
EMTALA	Emergency Medical Treatment and Labor Act	Federal law guarantees access to emergency medical services regardless of a patient's ability to pay.
FFS	Fee for Service	A payment methodology by which health care providers are paid for each service performed in the MA program.
GAO	United States Government Accountability Office	An independent, non-partisan agency that works for Congress conducting audits and research.
HCPCs	Healthcare Common Procedure Coding System	A standardized coding system developed by CMS to classify medical procedures, services, and supplies used during an emergency response.
MA	Pennsylvania Medicaid Program	Pennsylvania's state-run Medicaid program pays for health care services for eligible members.

MCO	Managed Care Organization	A healthcare company or a health plan focused on reducing costs while maintaining quality of care.
TNT	Treat/No Transport	When an EMS provider administers treatment at the scene of a 911 call but does not transport the patient to a hospital because of medical guidance or the patient refuses additional care/transport.

Acknowledgments

We thank the staff of the Department of Human Services for providing us with timely information. We also thank the Pennsylvania Managed Care Organizations and emergency medical services community members for providing insight and data on the subject areas in this report.

Important Note

This report was developed by the Legislative Budget and Finance Committee staff, including Project Manager Stevi Sprenkle and staff analyst Morgan Smith. The release of this report should not be construed as an indication that the committee, as a whole, or its individual members necessarily concur with the report's findings, conclusions, or recommendations.

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SECTION II
BACKGROUND INFORMATION

Fast Facts…

- *The type of EMS agency available differs between communities in Pennsylvania.*
- *From 2019 to 2022, EMS agencies and workforce decreased while demand for EMS services via 911 calls increased.*
- *There are 13 regional EMS councils in Pennsylvania that plan, develop, and maintain EMS systems within specific regions.*
- *In 2022, over 20 percent of Pennsylvania's population was enrolled in MA.*

Access to emergency medical care is a critical component of a community's public health. Because they help provide access, Pennsylvania's emergency medical services (EMS) are essential to the healthcare system. Traditionally, EMS providers were considered connectors between an emergency scene and a hospital's emergency department (ED). With technological advances and medical delivery systems, EMS providers are increasingly healthcare practitioners.[2]

The focus of this report, treat/no transport (TNT), highlights how, in some instances, EMS providers can treat a patient without additional healthcare utilization. As the name implies, a patient receives treatment from EMS providers during a TNT encounter but is not subsequently transported to a healthcare facility. While there are many reasons, some TNT encounters are due to patients refusing transport to an ED against medical advice.

Health insurance is also a crucial part of public health. Pennsylvanians obtain health insurance coverage through various sources, including employer, individual, Medicaid, Medicare, and military. In 2022, over 94 percent of Pennsylvanians had health insurance coverage compared to around 5 percent who were uninsured.[3] Medicaid is a publicly funded health care program established by a federal and state government partnership to provide coverage to people meeting specific eligibility requirements.

This report section provides background information about EMS and the Pennsylvania Medical Assistance (MA) program to give more context on the topic of TNT later in the report.

Emergency Medical Services (EMS) in Pennsylvania

EMS is a system that includes emergency management, public health, healthcare, and public safety. EMS agencies and providers are most recognizable by their ambulances and helicopters.

[2] *See* https://www.ems.gov/what-is-ems/.
[3] *Health Insurance Coverage of the Total Population*, Keiser Family Foundation, 2022.

EMS Agencies

The coordinated response and emergency medical care system involves numerous EMS agency types, which vary by ownership, staffing, and revenue structure. In Pennsylvania, the categories of EMS agencies include:

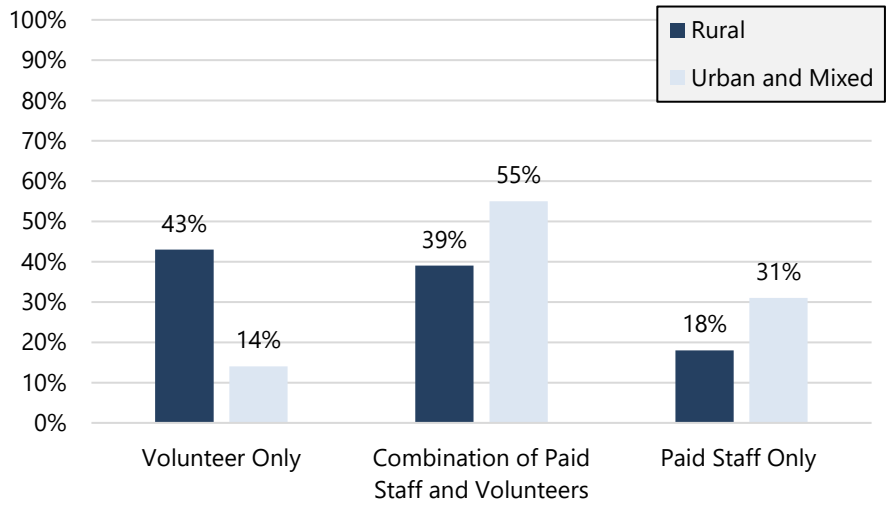
- Fire-based.
- Municipal-based.
- Hospital-based.
- For-profit.
- Non-profit.
- Basic Life Support (BLS).[4]
- Advanced Life Support (ALS).[5]
- Quick Response Service (QRS).
- Other emergency responders.
- Transport services.[6]

The type of EMS agencies available in a community differs among rural and urban areas in Pennsylvania. These differences include the kind of staffing EMS agencies utilize between volunteers, paid staff, or both. Exhibit 1 contains the staffing differences in 2022, according to the Center for Rural Pennsylvania.[7]

[4] BLS is the initial level of care provided by EMS providers. It focuses on basic, non-invasive techniques to support a patient's life until more advanced care can be administered. BLS includes vital tasks such as CPR, controlling bleeding, and providing oxygen therapy. BLS responders are typically EMRs, EMTs, or paramedics in training.
[5] ALS takes patient care to a higher level than BLS. ALS responders are equipped with advanced equipment and have additional training to administer intravenous medications, interpret EKG readings, and perform advanced airway management (such as intubation).
[6] *Staff Study of the Emergency Medical Services System in the Commonwealth of Pennsylvania*. Joint State Government Commission. December 2013.
[7] *Survey of Pennsylvania Emergency Medical Services Agencies*, Center for Rural Pennsylvania, July 2022.

Exhibit 1

Pennsylvania EMS Agency Staffing
Rural Vs. Urban and Mixed
(2022)



Source: Developed by LBFC staff from information obtained from the Center for Rural Pennsylvania.

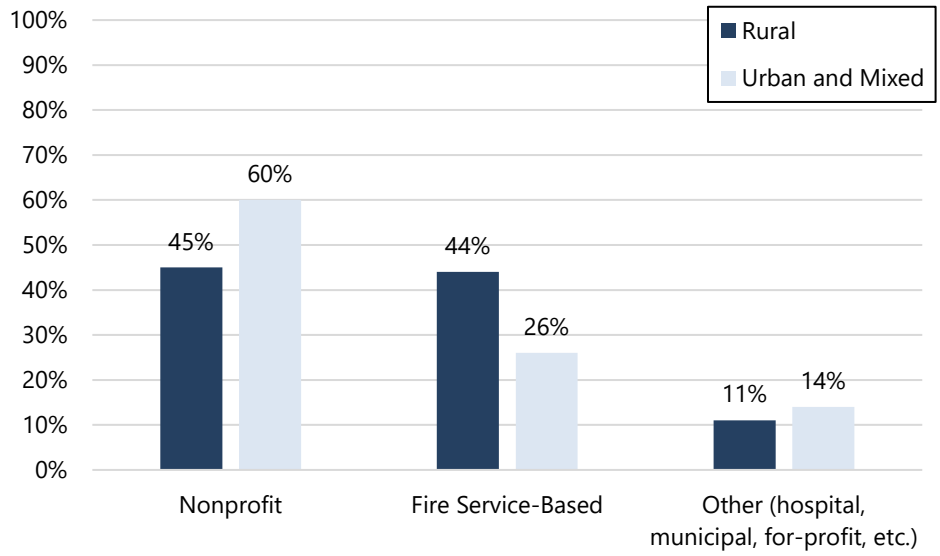
As shown, in rural Pennsylvania volunteering was more common than in rural and mixed communities.[8] A combination of paid staff and volunteers was most common in urban and mixed communities.

Additionally, EMS agency ownership differs in rural and urban Pennsylvania. Exhibit 2 contains the ownership differences in 2022, according to the Center for Rural Pennsylvania.[9]

[8] Mixed EMS agencies are agencies whose service area is in both rural and urban counties.
[9] *Survey of Pennsylvania Emergency Medical Services Agencies*, Center for Rural Pennsylvania, July 2022.

Exhibit 2

EMS Ownership
Rural Vs. Urban and Mixed
(2022)



Source: Developed by LBFC staff from information obtained from the Center for Rural Pennsylvania.

As shown, nonprofits are the most common stateside EMS ownership structures; however, they are more prominent amongst urban and mixed communities.

Statewide, over the four years covered by this study, there was a decrease in the number of EMS agencies and certified EMS providers (certified workforce); at the same time, there was an increase in the number of EMS calls (Exhibit 3 shows these trends).

Exhibit 3

Statewide Number of EMS Agencies, EMS Workforce, and Number of EMS Calls

	2019	2020	2021	2022	Change 2019 to 2022
EMS Agencies	1,339	1,324	1,259	1,217	(9.1)%
Certified EMS Workforce	42,068	41,609	41,708	41,560	(1.2)%
Number of EMS Calls	2,171,285	2,204,969	2,447,932	2,366,831	9.0%

Source: Developed by LBFC staff from information obtained from Pennsylvania Department of Health (DOH) EMS Data Reports 2019 through 2021 and information provided by DOH for 2022.

A decrease in the number of EMS agencies and certified EMS workforce, at the same time as an increase in demand for EMS services, is a national trend from which Pennsylvania is not immune. EMS agencies state that the decline is due to increasing personnel and equipment costs, low insurance reimbursement rates, lack of financial support from local and state governments, and workforce shortages.[10] When EMS agencies close, the demand for services does not disappear. Instead, neighboring agencies take on the call volume left behind, exacerbating the problem.

Studies conducted on the national EMS workforce shortage indicate that low wages, difficult workplace conditions, and burnout contribute to the workforce shortage.[11] EMS provider surveys show the reasons for leaving the profession included furthering one's education and finding better pay and benefits.[12] In 2022, the annual mean wage for Emergency Medical Technicians in Pennsylvania was $35,470 and $52,850 for paramedics.[13]

EMS Workforce

Emergency services in Pennsylvania include a highly trained workforce that responds to emergency incidents, often when patients are medically vulnerable. EMS providers are trained to assess patients and provide the appropriate treatments while in their care. Providers are state certified under the following licensure levels:[14]

- **Emergency Medical Responder (EMR).** EMRs perform essential interventions with minimal equipment and assist other providers at the scene of an emergency or during transport.[15]

- **Emergency Medical Technician (EMT).** EMTs are trained to assess and triage requests for medical care and apply basic knowledge and skills necessary to provide patient care. Depending on the situation, EMTs sometimes provide the highest level of care a patient will receive.[16]

- **Advanced Emergency Medical Technician (AEMT).** AEMTs apply basic and focused advanced knowledge and skills and

[10] *See* https://www.ems1.com/ems-advocacy/articles/ems-in-critical-condition-9KTyx7ElWiHGCQeA/, Accessed February 23, 2024.
[11] Basting, James, et al. *Prevalence of Social Needs and Social Risks Among EMS Providers*. PubMed, October 2023. PMID: 38074527.
[12] Rivard, Madison, et al. *Intentions and Motivations for Exiting the Emergency Medical Services Profession Differ Between Emergency Medical Technicians and Paramedics*. PubMed, 2020. PMID: 32128539.
[13] *Occupational Employment and Wage Statistics*. United States Bureau of Labor Statistics, May 2022.
[14] 28 Pa. Code § 1021.2.
[15] *National Emergency Medical Services Education Standards 2021*. National Highway Traffic Safety Administration.
[16] Ibid.

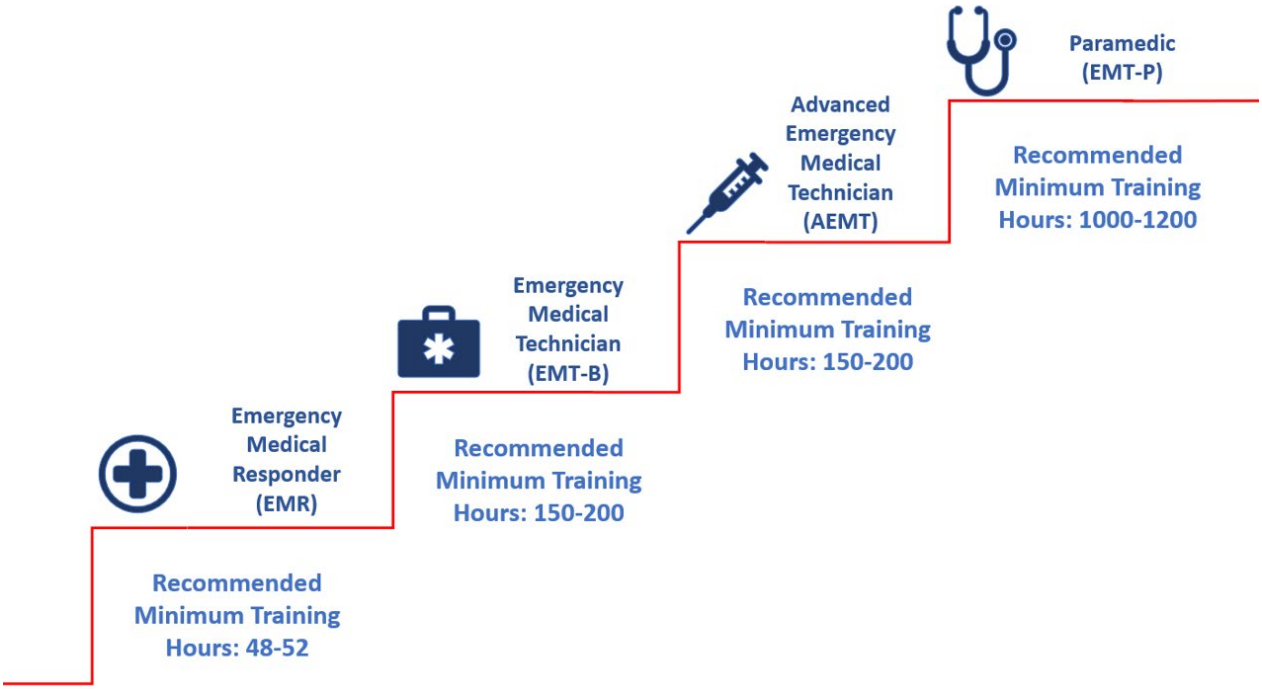
facilitate access to a higher level of care when the patient's needs exceed the capability level of the AEMT [17].

- **Paramedic (EMT-P).** Paramedics apply basic and advanced knowledge and skills to determine patients' physiologic, psychological, and psychosocial needs and administer medications. EMT-Ps also interpret and use diagnostic findings to implement treatment, provide complex patient care, and facilitate referrals or access to a higher level of care when the needs of the patient exceed the capability level of the paramedic. [18]

Pennsylvania utilizes the National EMS Standards, which outline the minimal competencies for entry-level EMS providers to perform their roles. Course completion for each of the certifications is based on competency; however, the National Association of State EMS Officials (NASEMSO) recommends the following minimum hours as shown in Exhibit 4:

Exhibit 4

EMS Certification Levels and NASEMSO Recommended Training Hours



Source: Developed by LBFC staff from information obtained from the Pennsylvania Department of Health.

[17] Ibid.
[18] Ibid.

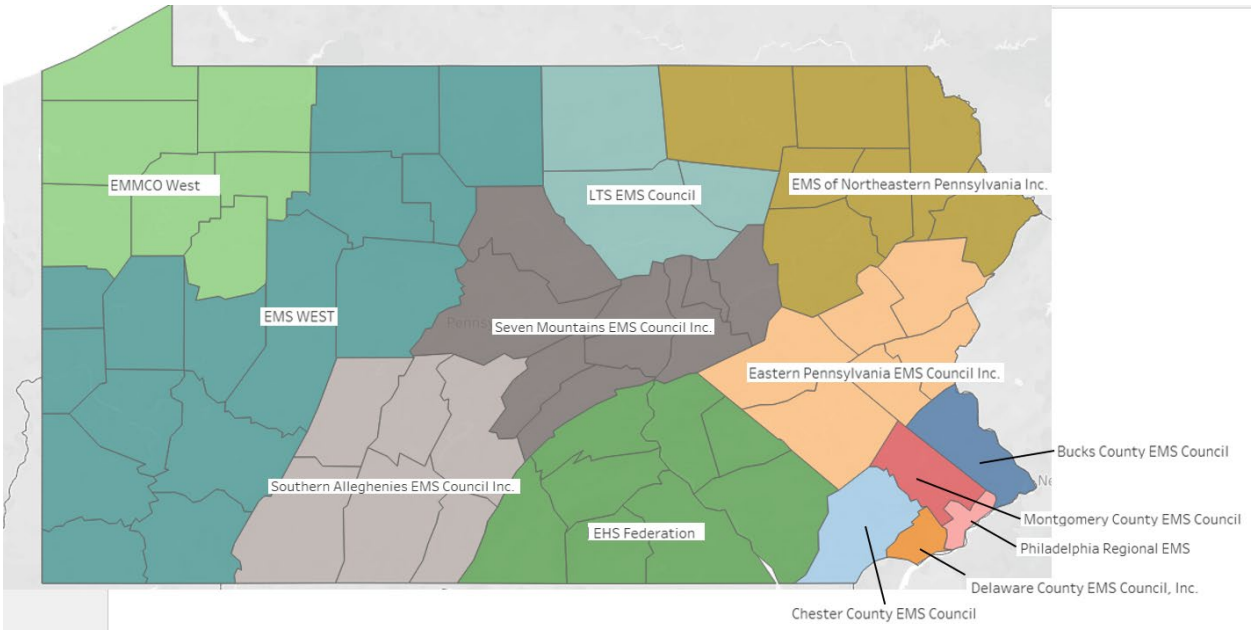
EMS Oversight

The Pennsylvania Department of Health (DOH) is the agency tasked with overseeing state health-related programs. The Bureau of EMS is responsible for developing and coordinating a comprehensive emergency medical response system to reduce premature death and disability. To achieve this goal, the Bureau develops, updates, and maintains all regulations, protocols, training, and continuing education requirements for EMS agencies in Pennsylvania.

Regional EMS Councils. The Bureau of EMS divides Pennsylvania into 13 EMS councils that administer aspects of the EMS program for the department. [19] The areas covered by the 13 EMS councils are shown in Exhibit 5.

Exhibit 5

Regional EMS Councils in Pennsylvania



Source: Developed by LBFC staff from information obtained from the Pennsylvania Emergency Health Services Council.

Regional EMS councils are nonprofit, incorporated organizations that plan, develop, and maintain EMS systems within specific regions of

[19] 28 Pa. Code § 1021.104.

Pennsylvania.[20] Each EMS council has an executive director, a board of directors, and staff members. The councils act as liaisons between the Bureau of EMS and the regional EMS agencies in the following areas:

- Personnel training,
- Ambulance licensure,
- Medical command authorization,
- Treatment and transfer protocols,
- Mass casualty preparation and coordination,
- Public education and information,
- Data collection, and
- Complaint investigation.

Pennsylvania Medical Assistance (MA)

Medicaid was established on July 30, 1965, as a joint federal and state program that helps cover medical costs for individuals and families with limited resources and who meet specific eligibility requirements. The federal government oversees the Medicaid program through federal laws and regulations. Each state administers its own program. States may also provide services beyond the federal requirements. As a result, eligibility requirements and benefits vary from state to state.

In Pennsylvania, Medical Assistance (MA) eligibility is generally based on income level, household size, and disability status.[21] As shown in Exhibit 6, Pennsylvania MA eligibility is grouped by modified adjusted gross income (MAGI) and non-MAGI.[22]

[20] 35 Pa. Code Part IV Chapter 81 Subchapter A. § 8103

[21] *See* https://www.dhs.pa.gov/Services/Assistance/Pages/MA-General-Eligibility.aspx.

[22] MAGI income includes wages, interest, dividends, social security, veterans' benefits, pensions, and spouse's income if living with them. Examples of income not counted when determining eligibility include Temporary Assistance for Needy Families (TANF) benefits, Supplemental Security Income (SSI), Supplemental Nutrition Assistance Program (SNAP) benefits, Low-Income Home Energy Assistance Program (LIHEAP) benefits, foster care payments, certain housing or utility subsidies, weatherization payments, and child support payments (only for MAGI MA).

Exhibit 6

Pennsylvania MA General Eligibility Requirements

Modified Adjusted Gross Income (MAGI)	Non-MAGI
• Children ages 18 and under • Pregnant women • Parents and caretakers of children under 21 • Adults ages 19-64 with incomes at or below 133 percent of the Federal Poverty Income Guidelines (FPIG) • Family planning services	• Individuals ages 65 and older • Individuals who are blind or disabled • Medical Assistance for Workers with Disabilities (MAWD) • Individuals receiving long-term care (LTC) or home and community-based services (HCBS)

Source: Developed by LBFC staff from information obtained from the Department of Human Services.

There are also Pennsylvanians eligible to enroll in both MA and Medicare or MA and private insurance. As shown in Exhibit 7, in 2022, more Pennsylvanians were enrolled in MA only; however, a small percentage of Pennsylvanians were dually enrolled.

Exhibit 7

Pennsylvanians Enrolled in MA (2022)

	MA and Private Insurance	MA and Medicare	MA Only
Number of Enrollees	412,400	494,800	1,784,700
Enrolled as a Percent of the Total State Population	3.3	3.9	14.2

Source: Developed by LBFC staff from Information obtained from the Keiser Family Foundation's "Health Insurance Coverage of the Total Population, Multiple Sources of Coverage" data set.

It should be noted that MA is the secondary payer for dual-enrolled individuals, meaning that the private insurer or Medicare pays first, and then MA pays toward unpaid charges.

The Pennsylvania Department of Human Services (DHS) and Fee-For-Service (FFS)

DHS is the state agency that oversees and administers Pennsylvania's MA program. After acceptance into the MA program, enrollees are initially placed into the fee-for-service (FFS) program. In 2021, about 4 percent of MA enrollees were in the FFS program.[23]

Pennsylvania MA Managed Care

Most Pennsylvania MA enrollees participate in the program through the managed care model. Under this model, MCOs accept a set per-member, per-month fee called the "capitation rate." In Pennsylvania, the managed care program for MA recipients is called HealthChoices. There are three main HealthChoices programs in Pennsylvania:

- **Behavioral HealthChoices.** Pennsylvania's mandatory managed care program through which MA beneficiaries receive behavioral health services. Each HealthChoices consumer is assigned a Behavioral Health Managed Care Organization (BH-MCO) based on their county of residence. [24]

- **Community HealthChoices.** Pennsylvania's mandatory managed care program for individuals dually eligible for MA and Medicare, older adults, and individuals with physical disabilities. Members receive physical health services and long-term services and supports (LTSS). [25]

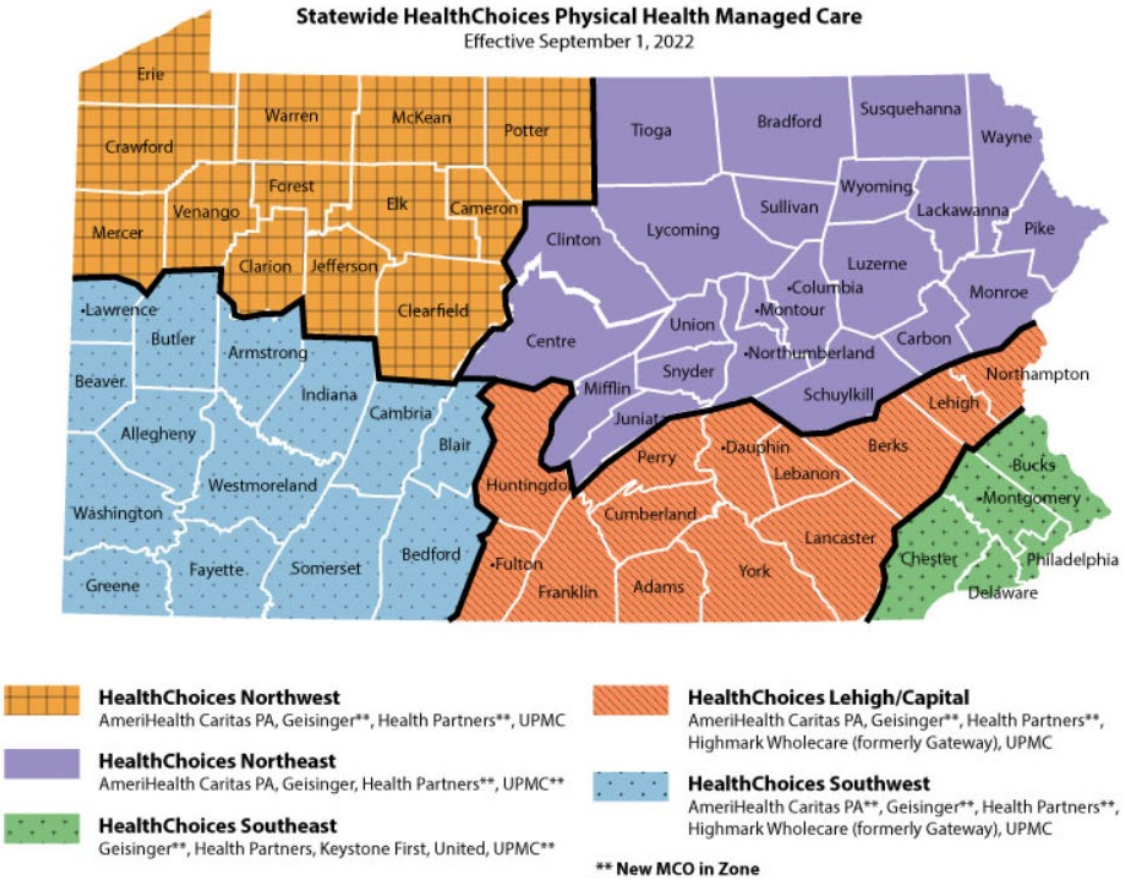
- **Physical HealthChoices.** Pennsylvania's mandatory managed care program through which most individuals who are in managed care receive physical health services. [26]

As shown in Exhibit 8, Pennsylvania, through DHS, contracts with MCOs to cover five regions for the Physical HealthChoices program:

[23] *Managed Care Enrollment Summary*. Medicaid Open Data. 2021.
[24] *See* https://www.dhs.pa.gov/HealthChoices/HC-Providers/Pages/BHProvider-Main.aspx.
[25] *See* https://www.dhs.pa.gov/HealthChoices/HC-Providers/Pages/CHCProvider-Main.aspx.
[26] *See* https://www.dhs.pa.gov/HealthChoices/HC-Providers/Pages/HealthChoicesProvider-Main.aspx.

Exhibit 8

Pennsylvania HealthChoices Physical Health Managed Care Map*



Note: */Aetna Better Health was a HealthChoices MCO in PH HealthChoices for only part of the time period covered by the study. This map reflects the PH HealthChoices MCOs in each zone effective September 1, 2022.

Source: Accessed by LBFC staff from the Department of Human Services website on December 5, 2023.

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SECTION III
TREAT/ NO TRANSPORT UTILIZATION AND REIMBURSEMENT PRACTICES OF MANAGED CARE ORGANIZATIONS

Fast Facts...

- *From 2019 to 2022, TNT made up 2.05 to 2.85 percent of EMS dispositions in Pennsylvania.*
- *Most TNT calls in Pennsylvania are per medical protocol, and fewer are due to the refusal of the patient (against medical advice).*
- *In 2021, Pennsylvania's utilization of TNT as a percent of total EMS dispositions was lower than the national average.*
- *There is variability in the costs to run EMS agencies due to ownership, funding, staffing, location (rural, urban, or suburban), and type of services provided.*

Overview

Emergency medical services (EMS) are essential to the health and welfare of every community in Pennsylvania. There has been an increase in the use of a newer EMS care model, treat/no transport (TNT), or EMS providing treatment on the scene of a 911 call and then "releasing" the patient without transport to an emergency department (ED). Releasing the patient is either in line with medical guidelines or because the patient refuses transport. TNT was less than 3 percent of total EMS dispositions in 2022).

EMS agencies are financially struggling across the commonwealth, and they cite low insurance reimbursements for TNT as a contributing factor. Pennsylvania Act 2018-103 attempted to resolve these concerns between Pennsylvania Medical Assistance (MA) managed care organizations (MCOs) and EMS. According to EMS agencies, vagueness in the law has created a practice in which MCOs reimburse EMS at different rates for the same services. EMS agencies state that they are losing money during most TNT calls.

EMS revenue is unique from other emergency services (such as fire and police) funded through taxes and other fees. EMS agencies rely primarily on insurance reimbursements or patient payments. Some EMS agencies receive financial assistance from local governments, state grants, and community donations; however, even these EMS agencies rely mostly on insurance reimbursements. At the same time, in Pennsylvania, EMS are deemed "essential" and cannot refuse care based on a patient's ability to pay or their health insurance status.

To answer the objectives of this study, we requested a selected sample of data from Pennsylvania's contracted MCOs (see Section I for details on the selection methodology). In our selected sample, we found that the reimbursement amount paid by MCOs to EMS agencies for TNT claims varied between MCOs and by year. Across the four-year period (2019 through 2022), the average amount billed by EMS agencies for TNT ranged between $287 and $375 (depending on MCO). During that same four-year combined timeframe, EMS agencies were only reimbursed at average rates between $53 and $179, or 16.1 percent to 47.9 percent of the average amount billed.

While TNT is often associated with drug overdoses and naloxone administration, we found that from 2019 through 2022, MCOs only designated 1.9 percent to 2.7 percent of TNT claims as substance abuse related.

EMS agency costs are not tracked statewide, which poses a challenge in determining EMS costs to provide TNT services. The Centers for Medicare and Medicaid Services (CMS) is in the process of gathering data on EMS agency costs nationwide; however, it is not yet available.

For this study, we defined EMS costs as the cost of readiness. We gathered cost-per-response data from EMS agencies. We reviewed 14 EMS agencies' cost per response. We found a range of $246 to $860 (average of $585), which was in line with an estimated statewide average ($550) provided by the Ambulance Association of Pennsylvania.

We also identified other factors for the General Assembly to consider in evaluating and determining appropriate reimbursement levels for EMS TNT, including requirements in other states, transparency concerns, and the overall value of TNT.

We recommend:

1. The General Assembly should consider implementing a specific state-directed payment or minimum fee requirement for TNT, similar to the other ground ambulance minimum rates contained in the Fiscal Code.

2. The General Assembly should consider requiring a broader study or audit by the LBFC of payments to EMS after the release of federal GADCS data by CMS.

3. The General Assembly should consider requiring reimbursement for new models of EMS care delivery, including transport to alternative or non-emergency locations following emergency calls and EMS treatment (i.e., drug treatment facilities, urgent care, etc.).

Issue Areas

A. The Rise in Treat/No Transport (TNT) EMS Care Utilization

The traditional emergency medical services (EMS) model has evolved significantly. The traditional EMS model focused on transportation,

including providing some medical services on the scene of an emergency call, with the intent to transport the patient to a local hospital. With technological and training advancements, EMS providers can now provide a higher level of healthcare before and during transport to an emergency department. Additionally, with this transformation, EMS providers treat some patients on the scene of an incident without additional care at a hospital. As previously mentioned, this practice is called TNT. A third EMS model includes treatment and transport to alternative locations (i.e., drug treatment, urgent care, etc.), which we will discuss later. The focus of this report is TNT.

Treat/No Transport

TNT started gaining more attention during the rise of drug overdoses related to the opioid epidemic. When an overdose occurs, time is of the essence to reverse the overdose (if reversal is possible).

From January 1, 2018, through July 15, 2023, EMS in Pennsylvania administered 89,360 doses of naloxone.[27] Naloxone is a drug administered through a nasal spray or injectable that "rapidly reverses an opioid overdose."[28] Through a statewide program called "Naloxone for Responders Program" (NFRP), since 2018, over one million doses of naloxone have been purchased and distributed to first responders in Pennsylvania. NFRP has resulted in more than 24,000 opioid overdose reversals.

Because naloxone can act quickly in returning patients to baseline breathing levels, not every overdose requires transportation to a hospital. EMS providers are critical in saving lives in overdoses, and in some instances, they may be the only healthcare an overdose patient receives.

While the focus of SR 2023-120 (SR 120) is on substance abuse, TNT also has a place in the treatment of other emergency calls in which a patient's condition does not require transport to a hospital. As shown later in this section, the managed care data we reviewed indicated that TNT substance abuse claims were less common than other TNT claims. Examples of other TNT incidents or conditions include diabetes, falls without injuries, asthma, and seizure disorders.

The TNT release of a patient on scene is based on specific medical guidelines, requirements for vital signs, and consultation between EMS and other medical providers. The examples above are scenarios within the

[27] *See* https://data.pa.gov/stories/s/Pennsylvania-Opioids/9q45-nckt/, Accessed February 6, 2024.
[28] *See* https://nida.nih.gov/publications/drugfacts/naloxone., Accessed February 6, 2024. Note: Naloxone is sometimes referred to as "Narcan" because Narcan is the name brand of the opioid reversal medication first approved by the United States Food and Drug Administration. Naloxone is the generic name and covers multiple drug manufacturers.

conditions and incidents listed that EMS providers are trained to treat. Most emergency calls for the listed conditions result in transport to an ED. However, there are times when it is not medically required. For example, EMS may be able to treat a patient experiencing hypoglycemia or low blood sugar quickly, reversing their symptoms and not requiring transport to a hospital.

There are also instances when EMS treat patients, but the patient refuses to be transported to a hospital against medical advice (AMA). EMS providers on the scene encourage patients in the "TNT, released AMA" category to seek additional care at the ED. EMS providers also get patients in contact with off-site medical providers who further encourage the patient to accept transport. Despite these attempts, some patients ultimately refuse transport and further treatment.

According to Pennsylvania Department of Health (DOH) statewide EMS data from 2019 through 2022, more patients were TNT, per protocol than patients TNT, released AMA. TNT dispositions compared to patients treated/transported are further highlighted in Exhibit 9.

Exhibit 9

Statewide Number of EMS TNT Dispositions Compared to Transport Dispositions 2019 through 2022

Incident/Patient Disposition	2019	2020	2021	2022[a]
TNT, Released AMA	11,960 (0.6%)	17,126 (0.8%)	19,707 (0.8%)	18,822 (0.8%)
TNT, Released Per Protocol	32,615 (1.5%)	39,263 (1.8%)	45,928 (1.9%)	48,244 (2.0%)
Patient Treated, Transported by EMS Unit	1,573,055 (72.4%)	1,604,052 (72.7%)	1,773,921 (72.5%)	1,742,494 (73.9%)
Other[b]	553,655 (25.5%)	544,528 (24.7%)	608,377 (24.9%)	547,658 (23.2%)

Notes: [a/]Since 2018, DOH has typically produced an annual EMS data report. At the time of this study, an EMS Data Report with 2022 data was not produced or made public on DOH's website. According to DOH, this was due to staffing issues in the Bureau of EMS. We obtained the 2022 data contained in our study through an information request.

[b/]Other includes assists, canceled calls, patient dead at scene, patient refused evaluation/care, patient treated and transferred/transported by another entity, standbys, and transport of non-patient (i.e., organs), etc.

Source: Developed by LBFC staff from information obtained from Pennsylvania Department of Health (DOH) EMS Data Reports 2019 through 2021 and directly from DOH for 2022 data.

Statewide, TNT accounted for 2.05 percent to 2.85 percent of total EMS patient dispositions from 2019 through 2022. Overall, we found that there was an increase in EMS TNT utilization from 2019 through 2022 compared to total EMS dispositions (on a statewide basis).[29] We also found that Pennsylvania's reported TNT percentage was below the reported national average statewide. For example, in 2021, TNT comprised 7.3 percent of EMS incidents or patient dispositions nationally (2.3 percent were "TNT, release per protocol" and 5.0 percent were "TNT, AMA").[30]

B. Reimbursement Practices of Pennsylvania Medical Assistance Managed Care Organizations (MCOs) to EMS Agencies for Treat/No Transport (TNT) Care

Per SR 120, we reviewed Pennsylvania MA managed care data specific to EMS claims, including TNT. It is essential to understand EMS billing in the context of MA, along with the claims analysis, to understand EMS agencies' concerns with current reimbursement practices.

EMS Revenue

EMS funding differs from other emergency services such as fire and police. Fire and police are primarily funded through federal, state, and local taxes and other fees. EMS agencies depend mainly on insurance reimbursement and patient payments, much like other healthcare providers. EMS agencies in Pennsylvania also differ from non-emergency healthcare providers, as they must provide services regardless of a patient's ability to pay.[31]

In some instances, EMS agencies receive financial assistance from local governments or through community donations. Pennsylvania is among 13 states that deem EMS an "essential service" and provide state funding, primarily through grants.

Billing for ambulance services has been shaped around the traditional model of EMS delivery, with the expectation of patient transport to a hospital. Previously, if EMS responded to an emergency call, provided care, and did not transport the patient (regardless of the reason for the no transport), the EMS agency may not have received insurance

[29] As a note, SR 120 asked for data on time on the scene during a TNT call. This is not something that is currently tracked on a large scale. DOH only had data on response times to emergency scenes.
[30] *2021 National EMS Data Report*. National Emergency Medical Services Information System.
[31] Title 35, Part VI, Chapter 81, Subchapter B, Section 8142 (a)(9).

reimbursement, including reimbursement from medical assistance MCOs. This is still the case when the federal government is the payer (such as Medicare), as a patient must be transported for the federal programs to reimburse EMS agencies.[32]

Pennsylvania MA Ambulance Fee Schedule and Managed Care State-Directed Payments

Pennsylvania MA has an ambulance fee schedule produced by the Pennsylvania Department of Human Services (DHS) that dictates the minimum payment EMS agencies will receive for a service. This fee schedule applies specifically to fee-for-service (FFS); however, changes in the commonwealth's Fiscal Code (outlined below) require MCOs to pay state-directed payments or a minimum fee to EMS agencies at the same rates as the MA Ambulance Fee Schedule. This is an important distinction because DHS' fee schedules for FFS for other health services (non-ambulance) are not always the same rates as those paid by MCOs. Medical providers or health systems often negotiate specific rates with MCOs (for non-ambulance services), and DHS is not involved in that process.

Total payments to EMS agencies from MA (FFS and MCOs) for services rendered are based on the following formula:

Base Rate + Mileage = Total Payment to EMS

The base rate is a fee for providing ambulance services. Mileage is based on the distance from the scene of an EMS incident to the ED with the patient (an ambulance with a patient is also called "loaded").[33]

During the scope of our study, there were three main legislative changes related to the MA ambulance fee schedule and managed care state-directed payments in the commonwealth's Fiscal Code:

- Act 2018-42: Authorized increased MA fees for ambulance transportation services in the FFS and managed care delivery systems. Specifically, Act 42 authorized the following fees: not less than $180 per loaded trip for basic life support ambulance transportation services, not less than $300 per loaded trip for advanced life support ambulance transportation services, and not less than $3,325.53 per loaded trip for air ambulance transportation services. Act 42 also authorized a fee of not less than $2 per loaded

[32] *Medicare Benefit Policy Manual, Chapter 10- Ambulance Services (Rev. 243, 04-13-18)* states: The Medicare ambulance benefit is a transportation benefit and without a transport there is no payable service.
[33] Under private insurance plans there may also be a payment to the EMS agency required of the patient such as a copayment, however, in PA MA there are no copayments for emergency situations. (*See* https://www.dhs.pa.gov/Services/Assistance/Pages/Copay-Help.aspx, Accessed January 16, 2024).

mile for each loaded mile beyond 20 loaded miles for ground mileage and a fee of not less than $22.45 per loaded mile for each loaded mile beyond 20 loaded miles for air mileage.

- Act 2022-54: Authorized increased MA fees for ambulance transportation services in the FFS and managed care delivery systems. Specifically, Act 54 authorized the following fees: not less than $325 for basic life support ambulance transportation services, not less than $400 for advanced life support ambulance transportation services, and a fee of not less than $4 per loaded mile for each loaded mile beyond 20 loaded miles for ground ambulance transportation.

- Act 2023-15: Provided reimbursement for ground mileage for every loaded mile. Additionally, Act 15 provided the greater of the highest Medicare rates published in the Ambulance Fee Schedule Public Use File for the calendar year 2023 or the current Medicaid Ambulance Fees as updated by Medical Assistance Bulletin 26-22-07 (effective date January 1, 2023), beginning January 1, 2024. This change applied to FFS and managed care.

Exhibit 10 contains the emergency ground ambulance minimum reimbursements (which apply to FFS and managed care state-directed payments) since 2019, including the legislative changes above.

Exhibit 10

Medical Assistance Emergency Ground Ambulance Minimum Reimbursements and Legislative Changes

Base Rate or Mileage	Procedure Code	Procedure Code Definition	Effective January 1, 2019	Effective January 1, 2023	Effective January 1, 2024 (pending Federal Approval)
Mileage	**A0425**	Ground mileage, per statute mile	$2 per mile for each loaded mile beyond 20 loaded miles of a trip	$4 per mile for each loaded mile beyond 20 loaded miles of a trip	$13.20 per mile for each loaded mile of a trip
Base Rate	**A0427**	Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 -emergency)	$300	$400	$667.43
Base Rate	**A0429**	Ambulance service, basic life support, emergency transport (BLS, emergency)	$180	$325	$562.05
Base Rate	**A0433**	Advanced life support, level 2 (ALS 2)	$300	$400	$966.01

Source: Developed by LBFC staff from information obtained from the Pennsylvania Bulletin.

At the time of writing this report, the most recent changes (effective January 1, 2024) were pending federal approval.[34]

Ambulance Response and Treatment, No Transport – Code A0998

Effective January 1, 2006, code A0998 was added to the Healthcare Common Procedure Coding System (HCPCS) for "ambulance response and treatment, no transport."[35] However, it was not until Act 2018-103 (Act 103) that Pennsylvania law mandated MCOs to pay for TNT. Act 103 stated:

> All reasonably necessary costs associated with emergency services provided during the period of emergency, subject to all

[34] *Medical Assistance Program Payment for Ambulance Transportation*, 54 Pa.B. 1024, February 24, 2024.

[35] The Healthcare Common Procedure Coding System (HCPCS) is a standardized coding system developed by the Centers for Medicare and Medicaid Services (CMS) to classify medical procedures, services, and supplies used during an emergency response. HCPCS comprises two levels: Level I, which includes Current Procedural Terminology (CPT) codes, and Level II, which uses alphanumeric codes for specific medical equipment, supplies, and non-physician services. EMS agencies use Level II codes. These codes are associated with services, medication, and medical procedures that EMS providers oversee.

> copayments, coinsurances [,] or deductibles… the managed care plan may not deny a claim for payment solely because the enrollee did not require transport or refused to be transported.[36]

After the General Assembly enacted Act 103, A0998, nor any other procedure codes specific to TNT were added to the Pennsylvania MA ambulance fee schedule. DHS did not add A0998 to the fee schedule because the legislation (Act 103) only applied to managed care, and the fee schedule only applies to FFS. DHS did send a memorandum to MCOs on December 20, 2018, formally advising MCOs of their obligation to comply with Act 103 and to pay EMS agencies for services rendered without accompanying emergency transport (see Appendix B). In this memorandum, DHS did not specify an exact minimum required payment, as no state-directed payment was specified in the act.

According to EMS agencies, if they submitted a claim under procedure code A0998, there was no set base rate, and they were not fairly compensated for the TNT. Additionally, EMS agencies stated that if they were paid under A0998, there were inconsistencies in the amount they were reimbursed for the same TNT services and between different MCOs. In the following section, we provide an analysis of actual MA claims data.

MA MCO Claims Data Analysis

To answer the objectives outlined in SR 120, MCOs (through a request to DHS) provided the following MA claims data:

- Procedure code.
- Amount billed by EMS/ambulance company.
- Amount paid to EMS/ambulance company.
- Claim date.
- Payment date.
- MCO/Plan Name/Region (if covering more than one Pennsylvania managed care region).
- Name of EMS/ambulance company.
- Substance abuse related call or Other.

The claims data included all data involving an EMS agency, regardless of whether a transport occurred. We received data from all eight MCOs who contracted with the commonwealth (during the report scope) for our selected months of January and July in calendar years 2019 through 2022 (see Section I for additional details on methodology for data selection). We received data containing over 300,000 claims.

[36] Section 2116 (a) and (b).

We then filtered the claims data to review TNT claims specifically. Exhibit 11 contains our analysis of the average payment from MCOs to EMS agencies for TNT in our selected months, 2019 through 2022.

Exhibit 11

Average Payment from MCOs to EMS Agencies for TNT Claims Selected Sample (2019 through 2022)

MCO	2019	2020	2021	2022
1	$132.00	$144.36	$139.83	$127.15
2	95.00	132.55	122.10	124.94
3	153.13	184.73	183.98	195.83
4	106.80	105.36	251.17	107.57
5	60.37	88.02	99.80	95.08
6	248.86	276.86	129.51	117.10
7	94.62	105.10	106.46	107.22
8	49.31	47.32	55.39	54.13

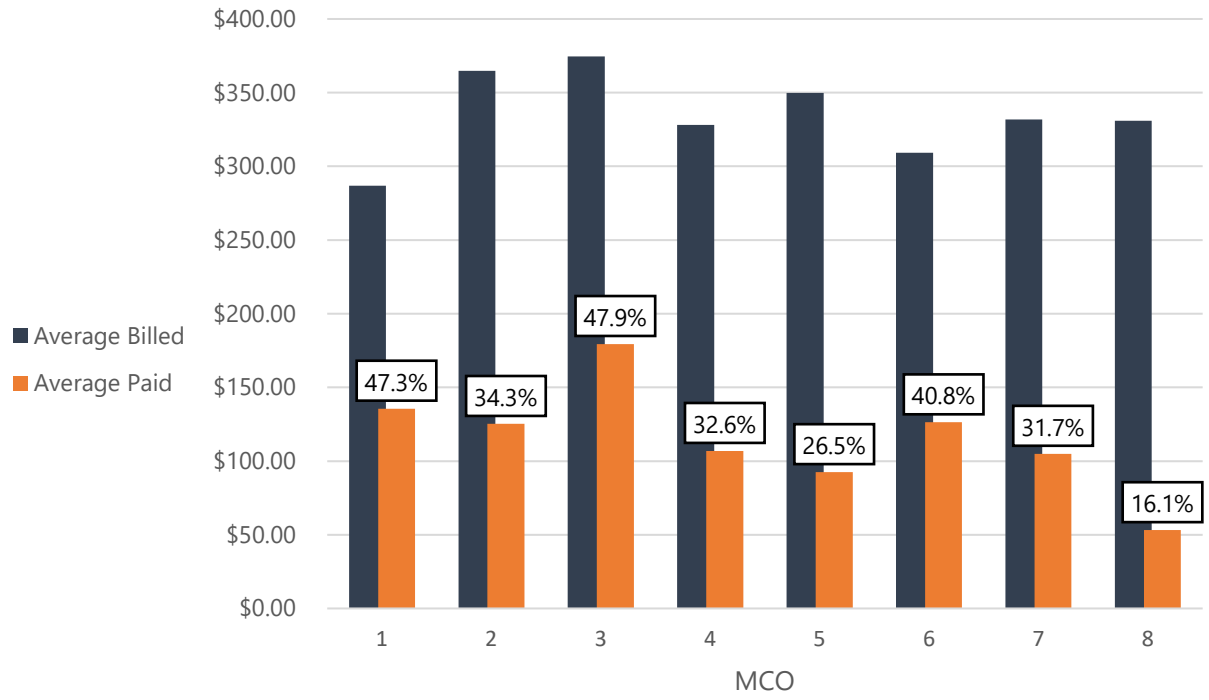
Source: Developed by LBFC staff from information obtained from Pennsylvania MA MCOs.

We found that the average reimbursement for TNT varied by MCO and by year. For example, in 2022, one MCO paid an average of $54.13, and a different MCO paid an average of $195.83.

We also calculated the difference in what EMS agencies billed compared to what MCOs paid for TNT. Exhibit 12 contains the summary of the average payment from MCO to EMS agencies compared to the average amount billed by EMS agencies for TNT by MCO.

Exhibit 12

Average Payment from MCO to EMS Agency Compared to Average Amount Billed by EMS Agency for TNT* Selected Sample (2019 through 2022)



Note: */Percentage represents the percent of the average paid by MCOs of the average billed by EMS agencies for TNT. For example, on average, MCO #1 paid 47.3 percent of the average amount billed by EMS agencies for TNT.

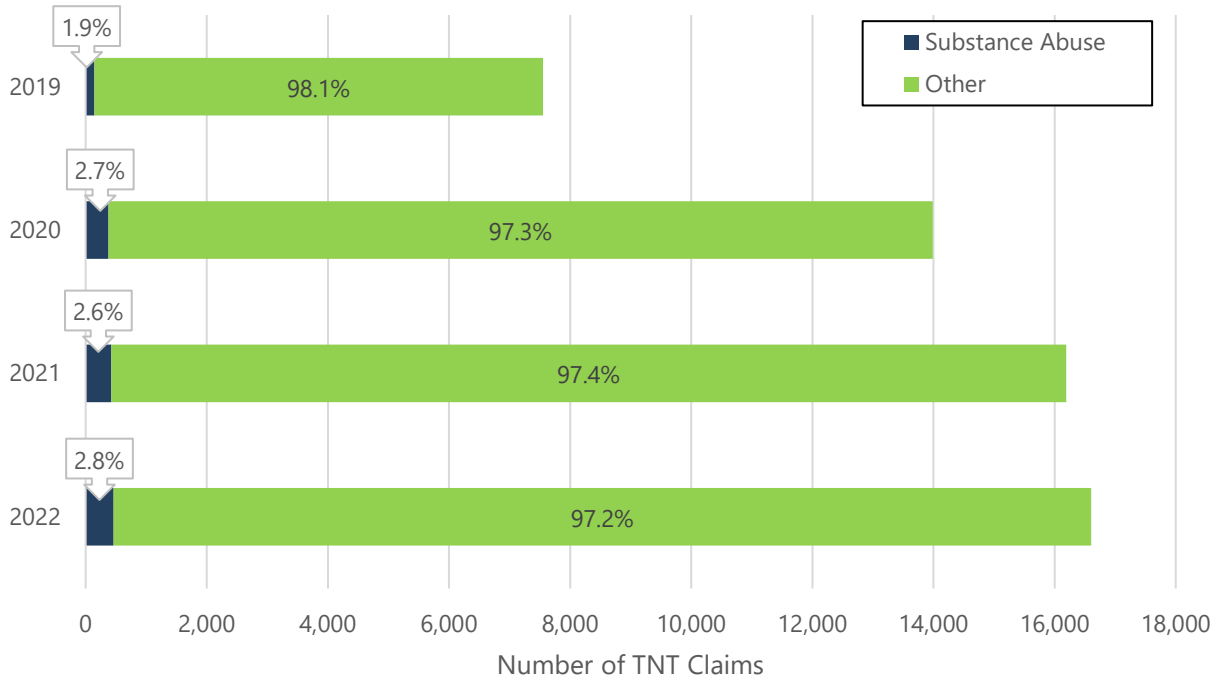
Source: Developed by LBFC staff from information obtained from Pennsylvania MA MCOs.

As shown, during the four-year period (2019 through 2022), the average amount billed by EMS agencies for TNT ranged between $287 and $375 (depending on the MCO). However, EMS agencies were only reimbursed at average rates of between $53 and $179, or 16.1 percent to 47.9 percent of the average amount billed (depending on the MCO).

Substance Abuse Related Claims. As directed by SR 120, to calculate approximately how many TNT claims were substance abuse-related, we requested the total number of TNT claims from each MCO (2019 through 2022) compared to the number of claims that MCOs indicated were substance abuse-related. The results are shown in Exhibit 13:

Exhibit 13

Number of TNT Claims and Percentage of Substance Abuse Related Claims Versus Other Claims in Pennsylvania Managed Care (2019 through 2022)



Source: Developed by LBFC staff from information obtained from Pennsylvania MA MCOs.

We found that MCOs did not identify most of the claims from 2019 through 2022 as substance abuse related. Only 1.9 percent to 2.7 percent of TNT claims were marked as substance abuse related. Therefore, most TNT MCO claims fell into the "Other" category, where EMS providers treated incidents or conditions such as diabetes, falls without injuries, asthma, seizure disorders, etc.

Costs for EMS Agencies to Deliver Emergency Services, Including TNT

There is a commonly used phrase in the EMS industry: "If you have seen one EMS system, you have seen one EMS system." This concept applies to different facets of EMS delivery, especially costs. Nationally, the cost of operating as an EMS agency is highly variable between agencies. This is also true in Pennsylvania. As noted in Section II, the structure of EMS staffing, funding, ownership, etc., differ significantly across the commonwealth. These variables and the location and type of service offered

(basic life support, advanced life support, or mixed) collectively impact EMS agency costs.

After EMS agency coverage boundaries are established, costs can be established.[37] While EMS costs differ between agencies, what agencies have in common with one another is that they have mostly fixed costs or costs that are independent of the number of outputs. For this reason, we define cost from the lens of readiness and a managerial accounting perspective. As noted by the United States Government Accountability Office (GAO):

> Ambulance [agencies'] total costs primarily reflect readiness – the need to have an ambulance and crew available when emergency calls are received. Readiness-related costs are fixed, meaning that they do not increase with the number of trips provided, as long as [an agency] has excess capacity.[38]

In other words, the "cost of readiness" is the base cost of providing emergency services. Despite output, a stocked ambulance with certified personnel must be ready to respond to any emergency call. According to the Ambulance Association of Pennsylvania (AAP), one 24-hour, seven days a week, staffed BLS ambulance costs $550,000 annually, and one ALS ambulance costs $800,000 annually.[39] Variable costs become a factor when the ambulance leaves the station for an emergency call. Variable costs are specific to each emergency call, including supplies used, drugs administered, and transport to the ED (if applicable). The concepts of readiness, fixed costs, and variable costs are illustrated in Exhibit 14.

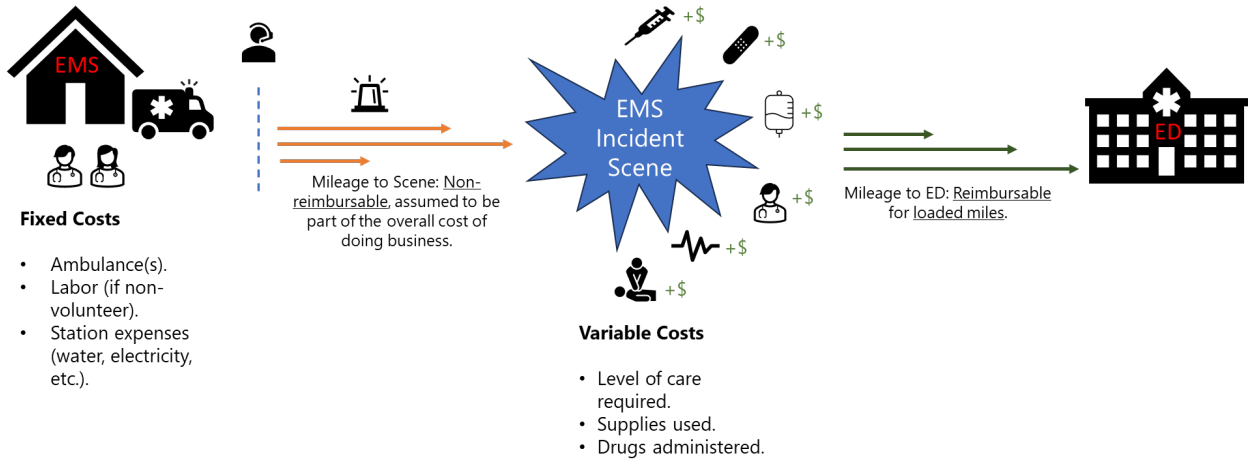
[37] EMS systems are unique from other services. From an economic standpoint, EMS is a common good. A common good is a good "where it is difficult or impossible to exclude users from the benefit, but where there is a marginal cost to provide the benefit to additional individuals." Common goods differ from public goods, where there is no additional cost to provide the service to more individuals (i.e., national defense). (Van Milligan, Michael, et al. *An Analysis of Prehospital Emergency Medical Services as an Essential Service and as a Public Good in Economic Theory*. National Highway Traffic Safety Administration and National Academy of Public Administration. May 2014.) For the scope and objectives of our report, we assume that EMS agency boundaries are established, which include coverage of a certain number of individuals or households, although these boundaries do change from time to time, or EMS agencies are asked to cover additional territories.

[38] *Medicare Payments Can Be Better Targeted to Trips in Less Densely Populated Rural Areas*. United States Government Accountability Office. September 2003.

[39] *See* https://www.lockhaven.com/news/local-news/2023/06/state-ems-consultant-maps-out-crisis-in-county-state/, Accessed January 11, 2024.

Exhibit 14

EMS Agency Cost Flow Chart



Source: Developed by LBFC staff.

The ambulance run volume, or the "output," represents the demand for EMS services.[40] Under the current EMS revenue structure in Pennsylvania, run volume also determines the ability of the agency to recoup its costs. For a simplified example, if EMS Agency A has one BLS ambulance and responds to 1,000 calls per year, $550,000 divided by 1,000 calls equals an average of $550 per response to break even. If EMS Agency B in a different part of the state has one BLS ambulance and responds to 750 calls per year, $550,000 divided by 750 equals an average of $733 per response to break even.

The cost before even arriving at the scene of an emergency run is the same within an agency (fixed costs). Once at the scene, the level of care administered, and supplies used change the cost of the incident (variable costs). For these reasons, EMS agencies in Pennsylvania argue that a TNT call should receive the same base rate reimbursement as the other emergency runs in which a patient is transported to a hospital, minus the mileage component.

Act 103 requires "all reasonably necessary costs" to be reimbursed during TNT; however, reasonableness is open to interpretation with such variability in costs statewide. As shown in the claims analysis, this has led to MCOs reimbursing EMS agencies at different rates for A0998 (TNT).

Costs Per Response in Pennsylvania. EMS agencies' cost per response has yet to be tracked statewide. CMS is collecting data on

[40] There are business efficiency concerns if an agency has too few or too many calls for their capacity.

EMS agency costs through the Medicare Ground Ambulance Data Collection System (GADCS). GADCS data collection is expected to continue into 2025. Despite this data shortfall, we gathered examples of 14 different EMS agencies' cost figures, shown in Exhibit 15.

Exhibit 15

Examples of Pennsylvania EMS Agency Per Response Costs*

EMS Agency	County	Cost Per Response
1	Adams	$800
2	Lehigh	$246
3	Montgomery	$530
4	Philadelphia	$342
5	Lancaster	$500
6	Allegheny	$452
7	Lycoming	$400
8	Montogomery	$810
9	Centre	$885
10	Northampton	$510
11	Allegheny	$530
12	Philadelphia	$860
13	Allegheny	$580
14	Monroe	$750

Note: */The examples given represent a single EMS agency within a county and do not represent the county as a whole or every EMS agency within that county. EMS agencies included in the data include BLS, ALS, combination, urban, rural, and urban/mixed. EMS agencies included those with local government tax support as some revenue and those that rely almost exclusively on insurance reimbursement as revenue.

Source: Developed by LBFC staff from information obtained from EMS agencies.

While the examples of EMS costs per response were not representative samples, they offered a glimpse into actual EMS agency costs per response and were in line with statewide estimates. For example, the average of the 14 EMS agencies was $585 per response, and one statewide estimate from AAP provided in 2023 showed an average EMS agency cost of $550 per response.

Implications of TNT Underpayments on EMS Agencies. Without more data on EMS costs statewide, it is difficult to conclude the exact impact of TNT underpayments on each agency. We estimate that MA claims are about one-fourth of TNT dispositions in Pennsylvania. An underpayment of $100 per claim totals over $1.6 million annually across the entire EMS system. The extent to which that impacts

individual EMS agencies depends on the number of TNT dispositions each EMS agency services (which is also not tracked statewide).

Medicaid paying the lowest rate of all insurance payers is not exclusive to EMS. It has been well documented across studies for most health services that average Medicaid payments are below Medicare benchmarks and private insurance payments.[41] Payer mix, or the percentage of individuals in a community with different insurance coverage (Medicaid, Medicare, private insurance, and uninsured), is an accounting factor all healthcare providers are faced with.[42] EMS agencies in Pennsylvania have often cited Medicaid and Medicare payments as resulting in net deficits that contribute to the agencies' financial challenges.[43] Medicaid also differs from private insurance, as EMS agencies cannot bill a patient for any remaining charges that the insurer (Medicaid) does not pay.

While the term "reasonable costs" (in Act 103) is open to interpretation, the General Assembly has previously and very clearly determined minimum reimbursement rates for BLS and ALS base rates in the Fiscal Code. The base rates represent the cost of readiness, not transport. The transport cost is reimbursed under a separate mileage fee. Absent a standard rate paid by MCOs, the General Assembly may need to explicitly define "reasonable costs" for TNT reimbursement.

C. Other Factors to Evaluate and Determine Appropriate Reimbursement for EMS TNT in Pennsylvania

In completing the other objectives of this study, we identified additional factors for the General Assembly to consider in evaluating and determining appropriate reimbursement for EMS TNT in Pennsylvania. These other factors include the overall value of TNT, requirements in other states, and transparency concerns.

[41] Mann, Cindy and Adam Striar. *How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost*. Commonwealth Fund. August 2022.
[42] Zavadsky, Matt. *The EMS Economic and Staffing Crisis Creates an Opportunity for Improved System Design*. ICMA. October 2023.
[43] *See* https://www.lockhaven.com/news/local-news/2023/06/state-ems-consultant-maps-out-crisis-in-county-state/, Accessed January 11, 2024.

The Overall Value of TNT

While TNT remains less than 3 percent of total EMS dispositions in Pennsylvania, TNT utilization has benefits. One of those benefits includes the possibility of reducing the number of ED visits and the cost savings associated with that reduction. Overutilization of the ED is a commonly researched topic in the United States.[44] Specific to MA, research has shown that Medicaid enrollees utilize the ED at higher rates than private insurance enrollees.[45] Identifying the causes for this is outside of the scope of this study; however, in theory, fewer patients unnecessarily transported to the ED, the fewer patients are utilizing the ED.

If there is a reduction in ED utilization, TNT also has potential cost savings for insurers, including Medicaid. In 2017, federal data showed the average ED cost paid by Medicaid was $420 per visit (this average does not include pre-ED costs such as EMS or transportation costs to the ED).[46] While the average per Medicaid patient was lower than Medicare ($660), private insurance ($560), self-pay or no charge ($460), and other ($510), Medicaid enrollees made up the largest group of ED visits (45.6 percent compared to the next highest group, private insurance, which was 41.0 percent of ED visits).[47]

TNT is also helpful from the patient's perspective, as Pennsylvania has the longest ED wait times in the top 10 states.[48] It is beneficial for the healthcare system and patients individually if EMS providers can treat patients who believe they are facing a medical emergency without going to the ED. Promoting a reduction in ED utilization (including cost savings) when medically appropriate should be another factor when considering reimbursement practices for TNT.

Other States

Our research indicated that over 20 states required minimum reimbursement (base rates) for A0998 (TNT) in their Medicaid programs.[49] Not all states are comparable to Pennsylvania, as some states utilize FFS and

[44] *Trends in the Utilization of Emergency Department Services, 2009-2018*. United States Department of Health and Human Services. March 2021.
[45] Bakara, Akintujoye, Gbemudu, et al. *Medicaid Coverage and Emergency Department Utilization in Southeastern Pennsylvania*. Cureus. September 2023.
[46] Moore, BJ, and Lan Liang. *Costs of Emergency Department Visits in the United States, 2017*. Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project. December 2020.
[47] Ibid.
[48] *See* https://www.lehighvalleynews.com/health-news/pa-is-in-the-top-10-states-with-the-longest-er-wait-times, Accessed December 20, 2023.
[49] The states were Arizona, Georgia, Hawaii, Indiana, Iowa, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New Mexico, North Carolina, North Nakota, Oklahoma, Oregan, South Carolina, Tennessee, Vermont, Washington, West Virigina, Wisconsin, and Wyoming.

managed care differently. However, we believe the trend of states requiring a minimum reimbursement for TNT shows that other states have recognized the value of TNT.

Some states started requiring reimbursement for TNT before the COVID-19 pandemic, and many began the practice during the pandemic to reduce the number of patients in EDs and incentivize treatment on emergency call scenes. Some states ended the practice when the COVID-19 emergency declarations expired.

While it is different from TNT, in our research of other states, we found another model of EMS that is not currently utilized statewide in Pennsylvania and may have similar benefits as TNT. As previously mentioned, this third model of EMS is to treat and transport to an alternative location.

Treat and Transport to an Alternative Location.

Under the treat and transport to alternative location model, EMS providers respond to an emergency call, provide treatment, and then, following specific protocols, transport the patient to other healthcare that aligns with the patient's needs. Drug treatment, mental health services, or non-emergency levels of care, such as urgent care, are facility examples used under this model.

One pilot program in Houston, Texas, saw a 56 percent reduction in ambulance transports to the ED with the use of treat and transport to alternative locations. Their research also noted no statistically significant differences in mortality or patient satisfaction.[50]

Another study done for the State of Maryland's alternative pilot program found that 7.8 percent of all EMS transports in Maryland were eligible for an alternative destination, with 58 to 69 percent of patients willing to be transferred to an alternative destination if it was a more clinically appropriate setting.[51]

CMS also had an alternative location pilot for Medicare FFS beneficiaries through a grant program called Emergency, Triage, Treat, and Transport (ET3). CMS allowed participants in ET3 to: 1) transport to an alternative destination partner, such as a primary care office, urgent care clinic, or a community mental health center (CMHC), or 2) initiate and facilitate treatment in place with a qualified health care partner, either at the scene

[50] Langabeer, James, et al. *Telehealth-Enabled Emergency Medical Services Program Reduces Ambulance Transport to Urban Emergency Departments.* The Western Journal of Emergency Medicine. November 2016. PMID: 27833678

[51] *Actuarial Consulting on Proposed Mandated Health Insurance Services: EMS Treat and Release Programs, EMS Alternative Destination Programs, and EMS Mobile Integrated Health Programs*. BerryDunn, prepared for Maryland Health Care Commission. December 2019.

of the 911 emergency response or via telehealth.[52] However, CMS ended this program earlier than planned due to low enrollment.

The alternative location model may be a third option of care for Pennsylvania to consider. This model would require new legislation to reimburse EMS agencies for services provided. Additional protocols would also be needed to guide EMS providers in determining if alternative locations are appropriate (see Appendix C for Maryland's protocols as an example).

Transparency

A common complaint we heard from EMS agencies was the need for more transparency in the rates paid by MCOs for TNT. Within the scope of this study, there is a complicated balance between MA capitation rates being affordable for the commonwealth and access to expedient and thorough EMS for all communities. However, a lack of transparency in TNT reimbursements does not allow EMS agencies to properly account for projected revenue.

In a study of ambulance service reimbursements under Medicare, the GAO found EMS agencies "paid under a fee schedule generally have an incentive to keep their costs to deliver services at or below the fee schedule rate. Some providers rely heavily on Medicare revenues, and adequate Medicare margins for these [agencies] may help ensure that beneficiaries have access to ambulance services."[53] We believe this sentiment is true for Pennsylvania MA ambulance services. Without a specific state-directed payment for TNT, EMS agencies provide TNT services without knowing how much they will be reimbursed by MCOs.

[52] *See* https://www.cms.gov/priorities/innovation/innovation-models/et3#:~:text=The%20ET3%20Model%20ended%20early,and%20lower%20than%20projected%20interventions, Accessed February 2, 2024.
[53] *Ambulance Providers, Costs and Medicare Margins Varied Widely; Transports of Beneficiaries Have Increased*. GAO. October 2012.

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APPENDICES

Appendix A – Senate Resolution 120

PRINTER'S NO. 805

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE RESOLUTION

No. 120 Session of 2023

INTRODUCED BY BROOKS, BARTOLOTTA, HUTCHINSON, DUSH AND FARRY, JUNE 2, 2023

REFERRED TO HEALTH AND HUMAN SERVICES, JUNE 2, 2023

A RESOLUTION

Directing the Legislative Budget and Finance Committee to conduct a study on the emergency medical services providers in this Commonwealth and the financial impact of nonreimbursable services for emergency response calls not resulting in a medical assistance beneficiary receiving transportation to a hospital or treatment facility and to issue a report of its findings and recommendations to the Senate.

WHEREAS, According to the Office of Attorney General, 5,168 Pennsylvanians died from overdoses in 2021; and

WHEREAS, On average, 15 Pennsylvanians died every day from an overdose in 2021; and

WHEREAS, The introduction of overdose reversal medications and Statewide orders to ensure free access to these tools in 2015 for emergency personnel has undoubtedly saved thousands of lives throughout this Commonwealth; and

WHEREAS, Emergency medical services providers are required to carry overdose reversal products like Naloxone and to administer them free of charge to those they treat; and

WHEREAS, The substance-use-related calls that do not result in a transport to a hospital or treatment facility are costly to

the emergency medical services providers on scene who are not reimbursed by the medical assistance program for their response or the treatment that they provide to medical assistance beneficiaries; and

WHEREAS, The intent of this resolution is to collect data that will support policy changes to make emergency medical services providers financially whole because their communities, constituents and health care systems depend on them; therefore be it

RESOLVED, That the Senate direct the Legislative Budget and Finance Committee to conduct a study on the emergency medical services providers in this Commonwealth and the financial impact of nonreimbursable services for emergency response calls not resulting in a medical assistance beneficiary receiving transportation to a hospital or treatment facility and to issue a report of its findings and recommendations to the Senate; and be it further

RESOLVED, That the study include all of the following, using the most recent data available, regarding the medical assistance program in Pennsylvania:

(1) The average dollar amount that managed care organizations contracted to provide services to medical assistance program beneficiaries reimburses emergency medical services providers, pursuant to Act 103 of 2018, for all reasonably necessary costs associated with emergency medical services provided during the period of an emergency, subject to all copayments, coinsurances or deductibles, when the beneficiary did not require transport or refused to be transported.

(2) Approximately how many beneficiaries were treated by

emergency medical services providers and did not require transport or refused to be transported.

(3) Approximately how many beneficiaries were treated for a substance-use-related overdose by emergency medical services providers and did not require transport or refused to be transported.

(4) The approximate number of emergency response calls in which services were rendered by an emergency medical services provider and the beneficiary did not require transport or refused to be transported, and in which the emergency medical services provider was not paid, whether partially or in full, for the services rendered.

(5) The approximate average time spent by emergency medical services providers at emergency response calls that involve a beneficiary who did not require transport or refused to be transported.

(6) The approximate cost incurred by emergency medical services providers for an emergency response call that involved a beneficiary who did not require transport or refused transport, for any other rationale than a substance-use-related overdose.

(7) Consideration of any other factors that enables the General Assembly to evaluate and determine how to ensure that emergency medical services providers in this Commonwealth are being fairly and justly paid for their services;

and be it further

RESOLVED, That the Legislative Budget and Finance Committee report its findings to the General Assembly no later than March 1, 2024.

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Appendix B – Department of Human Services Act 2018-130 Memorandum to MCOs

Managed Care Operations Memorandum
General Operations
MCOPS Memo # 12/2018-024

Date: December 20, 2018

Subject: HealthChoices Physical Health Managed Care Organization (PH-MCO) Responsibility to Pay for Licensed Emergency Medical Agency Services When Emergency Medical Transportation is Not Provided ("Treat-No Transport")

To: Physical Health HealthChoices Managed Care Organizations (PH-MCOs) – Statewide

From: Laurie Rock, Director, Bureau of Managed Care Operations, Office of Medical Assistance Programs

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Purpose:

To inform HealthChoices PH-MCOs of their obligations pursuant to the act of October 24, 2018 (P.L. 681 No 103)(Act 103), which provides for payment to emergency medical services agencies in circumstances in which the member is NOT also provided with emergency transportation ("Treat-No Transport").

Background:

Act 103 provides that, effective December 23, 2018, all managed care plans, including HealthChoices PH-MCOs, are prohibited from denying claims by emergency medical services agencies solely because the service did not include transportation.

Discussion:

The language of Act 103 that addresses the newly established obligations for managed care plans amends Section 2116 of the Insurance Company Law and is reproduced below for your reference (language being deleted is shown in brackets [], language being added is shown in **bold)**:

> *Section 1. Section 2116 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended to read:*

*Section 2116. Emergency Services.--**(a)** If an enrollee seeks emergency services and the emergency health care provider determines that emergency services are necessary, the emergency health care provider shall initiate necessary intervention to evaluate and, if necessary, stabilize the condition of the enrollee without seeking or receiving authorization from the managed care plan. [The managed care plan shall pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency.]* ***The managed care plan shall pay all reasonably necessary costs associated with emergency services provided during the period of emergency, subject to all copayments, coinsurances or deductibles.*** *When processing a reimbursement claim for emergency services, a managed care plan shall consider both the presenting symptoms and the services provided. The emergency health care provider shall notify the enrollee's managed care plan of the provision of emergency services and the condition of the enrollee. If an enrollee's condition has stabilized and the enrollee can be transported without suffering detrimental consequences or aggravating the enrollee's condition, the enrollee may be relocated to another facility to receive continued care and treatment as necessary.*

(b) For emergency services rendered by a licensed emergency medical services agency, as defined in 35 Pa.C.S. § 8103 (relating to definitions), that has the ability to transport patients or is providing and billing for emergency services under an agreement with an emergency medical services agency that has that ability, the managed care plan may not deny a claim for payment solely because the enrollee did not require transport or refused to be transported.

(c) For emergency services provided to medical assistance participants, the following provisions shall apply:

(1) The provisions of subsection (b) shall apply to the same services provided to medical assistance participants under Article IV of the act of June 13, 1967 (P.L.31, No.21), known as the Human Services Code.

(2) Payment for the services shall be in accordance with the current managed care contracted rates.

(3) Sufficient funds shall be appropriated each fiscal year for payment of the services.

(d) The provisions of subsection (b) shall apply to all group and individual major medical health insurance policies issued by a licensed health insurer.

Effective immediately, for all claims submitted for dates of service on or after October 24, 2018, HealthChoices PH-MCOs shall not deny claims for such emergency services provided to their members by *"a licensed emergency medical services agency, as defined in 35 Pa.C.S. § 8103 (relating to definitions), that has the ability to transport patients or is providing and billing for emergency services under an agreement with an emergency medical services agency that has that ability,"* solely because the member did not require transport or refused to be transported. If any claims for dates of service on or after December 23, 2018, are denied before the PH-MCO is able to implement this requirement, they shall be reprocessed, and if there is no other basis for the denial, paid consistent with existing requirements for claims processing.

The Department of Human Services (DHS) requested its actuarial consultant to complete an analysis of whether a rate change is appropriate as a result of this program change. DHS determined that the rates as presented and agreed upon remain actuarially sound.

Next Steps:

DHS will issue an ad-hoc data collection request in Spring 2019 to gather data related to utilization of this program change and determine whether capitation rates should be changed. If a PH-MCO is not able to implement this requirement by December 23, 2018, it should advise its assigned BMCO Contract Manager of the implementation date.

PH-MCOs should submit any questions regarding this Operations Memorandum to their assigned BMCO Contract Manager.

Obsolete:

This MCO Ops Memo will remain in effect until further notice.

Attachment:

N/A

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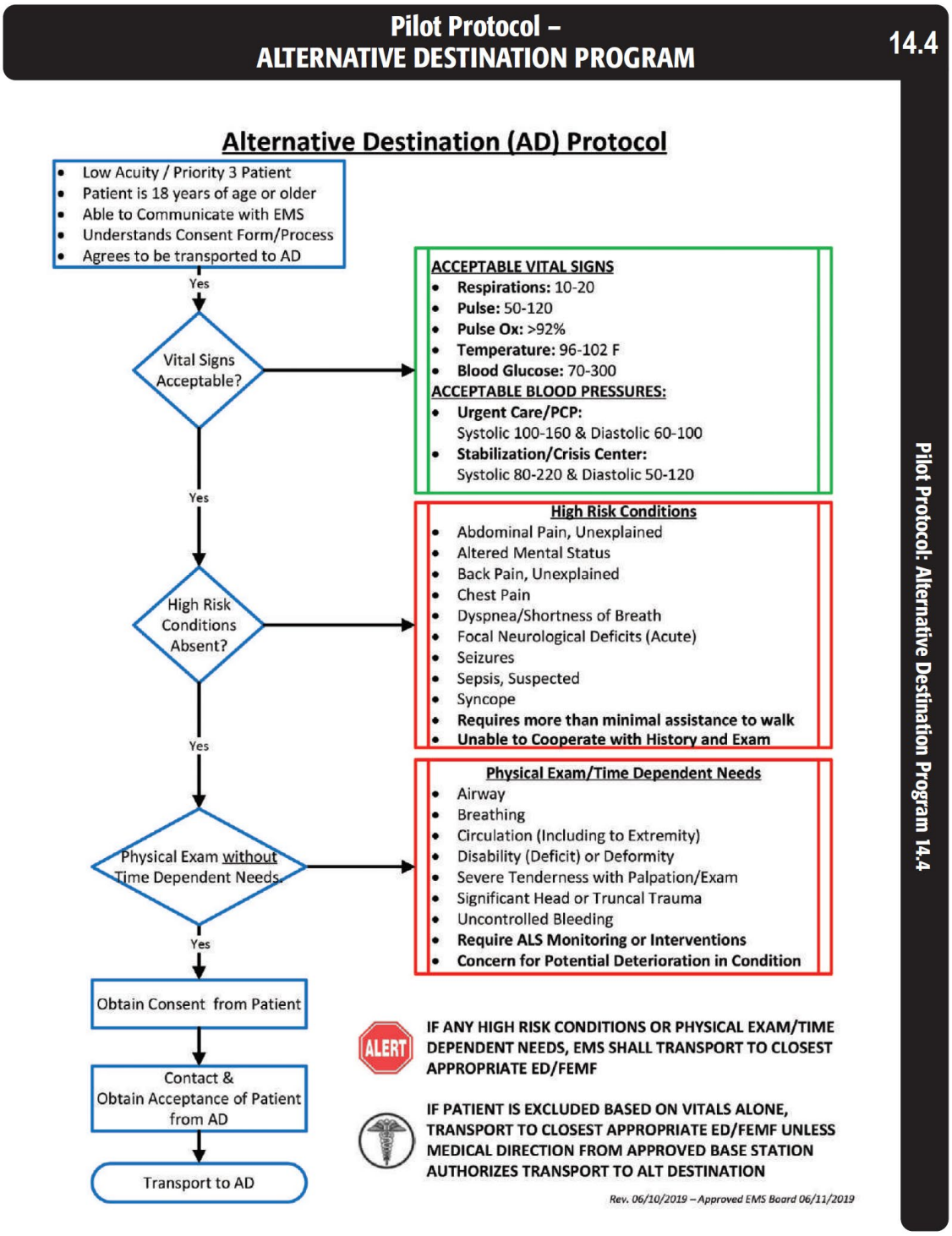
Appendix C – Maryland Alternative Destination Pilot Protocol



Source: *The Maryland Medical Protocols for Emergency Medical Services.* Maryland Institute for Emergency Medical Services Systems. July 2023.

Appendix D – Department of Human Services Response to Draft Report

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

March 15, 2024

Mr. Christopher R. Latta
Executive Director
Legislative Budget and Finance Committee
Room 400 Finance Building
613 North Street
Harrisburg, Pennsylvania 17105

Dear Mr. Latta:

Thank you for the opportunity to review an advance draft of the study conducted pursuant to Senate Resolution 2023-120, *EMS Treat/No Transport in Medical Assistance Managed Care*. The Department of Human Services (DHS) appreciates the advance copy and opportunity to submit written comments to the report.

Medicaid, called "Medical Assistance" ("MA") in Pennsylvania, is a cooperative federal-state program by which the federal government provides funds to states to enable those states, "as far as practicable," to make medical assistance available to eligible individuals. 42 U.S.C. § 1396-1. The MA program in Pennsylvania, as in most states, has two systems through which eligible recipients may obtain services: "fee-for-service" and "managed care." Under the traditional fee-for-service system delivery system, providers are paid directly by the DHS. Under the managed care delivery system, managed care organizations ("MCOs") are paid a capitation payment and are required to provide and pay for covered services.

Federal law does not require that the Medicaid program reimburse providers at the provider's costs. In the Medicaid fee-for-service program, states are required to make payments "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A). Providers are paid based on a fee schedule or other methodology that is described in the State Plan. If the fee schedule rates are changed, the DHS provides a public notice and seeks federal approval.

The DHS administers MA primarily through managed care. Over 95 percent of MA beneficiaries receive services through managed care. The DHS pays each managed care organization a capitation rate that is actuarily sound to cover medically necessary covered services. For most covered services in the MA program, the managed care plan can select the network providers and negotiate rates. The report states that EMS agencies have complained about the lack of transparency in rates which prevents EMS agencies

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from accounting for projected revenue. However, the negotiated rates are in the provider agreements entered into between the MCO and the provider.

The report also notes that MCOs are not required to pay for TNT using a Fee Schedule rate. As indicated above, MCOs generally negotiate rates with network providers. An exception, however, is for ambulance services. As outlined in the report, there is legislation that required the managed care organizations to pay minimum rates. Most recently, Act 15 of 2023 requires that subject to federal approval, the MA rate on the MA fee schedule and paid by the managed care organizations for ambulance services is the higher of the Medicare or Medicaid rate. This legislation will change ambulance rates retroactive to January 1, 2024, if approved by CMS.

The report also compares the average amount billed by EMS agencies to the amount paid, noting that the average rate of reimbursement was 16.1 to 47.9 percent of the average amount billed. It is likely for MA MCOs to pay less than the billed amount as they negotiate payment rates with providers. It is also not known or disclosed in the report how the EMS agencies determined the amount to bill or what "costs" were included in the average cost provided.

DHS reviewed the three recommendations in the report and provides the following comments.

1. Recommendation 1 is that the General Assembly consider implementing a specific state-directed payment or minimum fee requirement for TNT, similar to other ground ambulance minimum rates contained in the Fiscal Code.

As noted above the requirement for a managed care organization to pay a specified rate is not how rates are generally established in the managed care delivery system. DHS assumes that the reference to the Fiscal Code is referring to Act 15 of 2023, which was recently signed into law. Act 15 of 2023 requires that, subject to federal approval, the MA rate on the MA fee schedule and paid by the managed care organizations for ambulance services is the higher of the Medicare or Medicaid rate. TNT is not currently a covered service under the PA Medicaid State Plan and thus does not have a fee assigned to it on the MA fee schedule. As noted in the report, TNT is also not compensable through Medicare. Should the General Assembly consider such legislation, the legislation should not set the minimum fee by reference to the MA Fee Schedule or Medicare, as there are no such rates.

2. The General Assembly should consider requiring a broader study or audit by the LBFC of payments to EMS after the release of federal GADCS data by CMS.

Again, while MA does not customarily reimburse providers for covered services at the provider's cost, this is a recommendation that may be helpful in understanding what the service costs are to provide a service, without factoring in costs the provider may have which do not reflect the reasonable cost of providing services.

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3. The General Assembly should consider requiring reimbursement for new models of EMS care delivery, including transport to alternative or non-emergency locations following emergency calls and EMS treatment.

The MA program, as a state and federal partnership, must utilize an approval process to add covered services. State Plan Amendments must be submitted for approval to the Center for Medicare and Medicaid Services. To the extent that the General Assembly considers such legislation, to ensure federal financial participation any requirement should be subject to federal approval. In addition, this recommendation should also include the provision of funding by the General Assembly to DHS for any new service costs for alternative transport or non-emergency transports.

DHS encourages the LBFC and the General Assembly to consider current statutory and regulatory provisions for EMS services. The Emergency Medical Services provisions of state law, contained at 35 Pa.C.S.A. §§ 8101 to 8158, address ambulance services. In addition, Department of Health regulations in 28 Pa Code Part VII, Emergency Medical Services, contain requirements for the provision of EMS services and these should be considered when making recommendations for new models of care to alternative and non-emergency locations.

Current MA Program regulations provide for ambulance transportation to the nearest appropriate medical facility site; to a nonhospital drug and alcohol detoxification or rehabilitation facility from a hospital when a recipient presents to the hospital for inpatient drug and alcohol treatment and the hospital has determined the required services are not medically necessary in an inpatient facility. 55 Pa. Code § 1245.11.

Again, I appreciate the ability to submit comments and information in response to the LBFC report and I look forward to working with your organization.

Sincerely,

Valerie A. Arkoosh, MD, MPH
Secretary

cc: Sally A. Kozak, Deputy Secretary, OMAP
Juliet Marsala, Deputy Secretary, OLTL
Hannah Krantz, Director, Legislative Affairs
Michele Minter, Director, BFM, OMAP
Eve Lickers, Director, BPAP, OMAP
Jamie Buchenauer, OMAP

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