Final Report of the Maine EMS LD2105 Subcommittee

FEBRUARY 1ST, 2021

Executive Summary

The following list some of the major findings from the work of the LD2105 subcommittee:

- Most ambulance providers are not currently in network for most carriers.
- Significant barriers to network participation exist including complexity of contracting, low volume, reported reimbursement levels.
- There is some data that the number of ambulance providers transitioning to out of network is growing.
- There is limited data on the cost of providing ambulance services. There is no current cost reporting requirement, but provider survey data suggests the cost of service for the respondents is significantly higher than current reimbursement with the gap made up by tax support, subsidies (grants, municipal contributions, etc.), and philanthropy. There seems to be lack of correlation between costs and charges, in that some providers likely charge less than their costs while others may be charging more.
- Current charges have remained flat over the last 18 months, reimbursement has declined, and patient responsibility for ambulance services have increased.
- Current Medicare and MaineCare reimbursement amounts are below the cost of service.
- Carriers are currently reimbursing out of state providers at higher rates than in state providers for the same services.
- The impact of higher operating costs for low volume rural providers is recognized by Medicare but not recognized by MaineCare or commercial carriers.
- Many services continue to cost shift to taxpayers, philanthropy[1] and commercial plans to stay afloat
- There is significant variability in the size of EMS provider agencies across Maine with over 50% of provider agencies transporting 350 patients or fewer annually with the 10 largest services transporting 47% of patients annually. Low volume creates challenges in covering fixed costs. Over 23% of patients that are served are not transported to the hospital, and there is no reimbursement.
- It is difficult to apply typical concepts of network adequacy to ambulance services.
- The current interim solution of allowing EMS providers to be reimbursed for charges does not seem to have significantly increased charges although there is some data from carriers this is potentially occurring. The interim solution has not increased the number of providers in-network.
- The delivery system state-wide may have opportunities for enhanced efficiency through efforts like regionalization, informed community self-determination[2], or certificates of need programs.

[1] Committee remembers cited several examples of services that rely heavily on donations of either money or equipment from philanthropic sources

[2] https://nasemso.org/wp-content/uploads/2020-Template-for-Informed-Community-Self-Determination-v-6.1.pdf

Summary of Recommendations:

- Recommendation 1: Balance billing (a.k.a. surprise billing) should be prohibited.
- Recommendation 2: Improve reimbursement for rural low volume providers.
- Recommendation 3: Improve and maintain system efficiency
- Recommendation 4: Align reimbursement with costs to incentivize network participation.
- Recommendation 5: Incentivize network participation by creating a voluntary "standard offer" contract for both carriers and providers.
- Recommendation 6: Establish Cost Reporting program for EMS providers
- Recommendation 7: Replace interim allowed charges reimbursement model with phased reimbursement model for in-network participation.
- Recommendation 8: Establish a process to adjudicate out of network claims.
- Recommendation 9: Establish a system advisory commission to include providers and carriers to evaluate finances and performance with goal of reducing growth of standard ambulance charges.

The recommendations presented in this report represent an attempt to achieve consensus and compromise. Not all participants agree with every component of the recommendations, however the committee unanimously agrees to present this as a consensus document.

Background and Objectives

On February 13, 2020, Legislative Document 2105: An Act to Protect Consumers from Surprise Emergency Medical Bills, was referred to the Committee on Health Coverage, Insurance, and Financial Services. The bill, sponsored by Speaker Sara Gideon, expanded consumer protections to include protection from surprise medical bills for emergency services. It further sought to create an "independent dispute resolution process to determine a reasonable payment for health care services." During the public hearing on February 25th, 2020, 22 individuals spoke with various positions on the bill. Several from the emergency medical services community spoke to the challenges that exist with providers joining carrier networks, and the potential negative economic impact to reducing reimbursement for ambulance service providers that are not in-network with commercial insurers. Insurers spoke to the importance of having ambulance providers in-network to manage costs and protect members from balance billing. It was also stated that cost shifting from public payors and self-pay patients impacts private health insurance premiums.

The Committee adopted an amendment replacing the bill (H-773), and the Legislature enacted the amended bill as Public Law 2019, Chapter 668, effective March 18, 2020. This law, among other things, set reimbursement requirements for fully insured commercial health plans in Maine that apply to a surprise bill or a bill for a covered emergency service rendered by an out-of-network provider. However, the law instead provided that, until October 1, 2021, "[a] carrier shall reimburse an out-of-network provider for ambulance services that are covered emergency services at the out-of-network provider's rate, unless the carrier and out-of-network provider agree otherwise."[3] Relatedly, the law also "require[d] the Emergency Medical Services' Board to convene a stakeholder group to review reimbursement rates for ambulance services." The specific tasks of the stakeholder group were as follows:

1. Consider current reimbursement rates paid by carriers and other payors for ambulance services for ambulance providers participating in carrier networks and for ambulance providers that are out of network;
2. Consider the reimbursement rates required under the Maine Revised Statutes, Title 24-A, section 4303-C for emergency services rendered by out of network providers and the availability of the dispute resolution process under Title 24-A, section 4303-E to those providers;
3. Determine the ambulance providers that participate in carrier networks and identify any barriers to participation in those networks; and
4. Develop recommendations for improving the participation of ambulance services in carrier networks, including proposals to provide assistance with contract negotiation or to amend the reimbursement rates required under law.

The group was tasked to report back to the Committee no later than February 1st, 2021, so that the Committee may have an opportunity to introduce legislation based on the report.

In response to Public Law 2019, Chapter 668, the Emergency Medical Services' Board created a subcommittee, which included the membership outlined in **Appendix A**. The committee gathered substantial data from Emergency Medical Services' providers and stakeholders, health

[3] 24-A M.R.S. § 4303-C(2)(D). An "emergency service," as well as an "emergency medical condition," are defined for purposes of this law and its requirements at 24-A M.R.S. § 4301-A.

insurance carriers, and the Maine Health Data Organization. Further, practices employed by other states were reviewed as part of process of establishing recommendations.

Federal Government Activity

The data included in this report demonstrate that in most instances, government payers are reimbursing below the cost of providing care. Beginning in 2020, MaineCare began reimbursing ambulance providers the average allowable Medicare rate (excluding the rural and super rural add-on payments). However, even so, the data demonstrate that Medicare only covers 60-80% of the costs of service delivery. The committee believes stronger data is needed, and CMS has recognized the need for standardized cost reporting. Ambulance cost reporting begins in 2022n a phased approach. While this is positive and has broad support, it will likely be five or more years before the data is acted upon. Several states, including Massachusetts and Connecticut, have implemented their own cost reporting requirements for ambulance providers.

On December 27th, 2020, President Trump signed into law H.R. 133 Consolidated Appropriations Act, 2021, which on top of Coronavirus Relief Efforts, included sections related to surprise billing for ambulances. Section 117 of Title I (No Surprises Act) establishes an advisory committee to review ground ambulance billing and protect consumers from surprise bills. Recommendations from the committee are required within six months of the first meeting. It appears that the federal government, much like the Maine Legislature, recognized the complexity of the issue at hand. As for air ambulance billing, Section 105 of Title I imposes protections from surprise air ambulance bills for those enrolled in commercial health plans beginning on or after January 1, 2022. Patients are only required to pay the in-network cost-sharing amount for covered services provided by out-of-network air ambulance providers. Air ambulance providers cannot bill patients for more than the in-network cost-sharing amount but may engage in a 30-day open negotiation period with health plans to settle out-of-network clams. In the event the parties cannot reach an agreement, they may access an independent dispute resolution process to be established by the federal government through regulation. Additionally, Section 106 of Title 1 sets forth federal reporting requirements regarding air ambulance services for both health plans and air ambulance providers.

It is not completely clear what effect the new federal legislation will have on providers and carriers operating in Maine, however it was noted by the committee that the federal legislation may prevail on ERISA plans, while commercial carriers may be subject to state laws, which would prevail. The committee further noted that different rules for different funding types (i.e. self-funded plans vs. fully funded plans) could become unwieldy.

Data Review and Analysis:

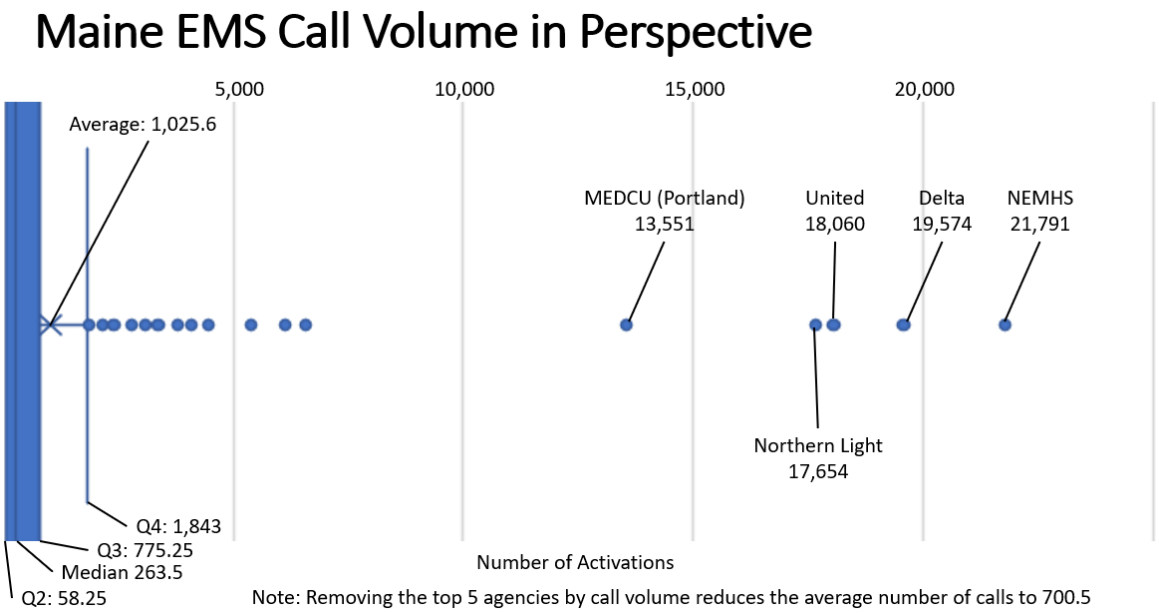
The Committee analyzed three primary data sources. First, a survey of ambulance providers in the State of Maine was conducted using questions designed to elicit both qualitative and quantitative data regarding cost of service and approaches and barriers to contracting with insurance carriers **(Appendix B)**. Second, substantial claims data were reviewed from the Maine Health Data Organization, including both claims from Maine-based and out-of-state providers. Finally, a qualitative survey of carriers was conducted by the Maine Association of Health Plans **(Appendix C)**.

Maine EMS System Information and L.D. 2105 Survey

On October 8th, 2020, Maine EMS and the Maine Ambulance Association provided a presentation to the Maine Rural Health Transformation Team on the state of EMS in Maine. The following data points, based on Maine EMS Licensing Data, were presented (2019 data): 161 Transporting services[4]

- 112 non-transporting services
- One air medical agency
- 5,549 licensed clinicians
    - 24.5% (1,363) EMS clinicians are over 50 years old
- 279,601 EMS activations[5]
    - 203,873 911 activations (73%)
    - 76,736 interhospital transfers / non-emergency activations (27%)

Below is a visualization of activation numbers:



In all, 44 ground transporting services, one air medical service, and 17 non-transporting services participated in the survey. Of the ground transporting services that responded, 3 were hospital- or healthcare system-based, 23 were fire department-based, 9 were municipal non-fire departments, and the remaining 9 respondents were not-for-profit services that were not directly affiliated with a healthcare system. This represents a 27% response rate of the transporting ground ambulance service in the state. 100% of the air medical providers in Maine responded.

Of the ground ambulance (transporting) services that participated, the average number of 911 emergency calls per year was reported as 1,688, with 22.5% of these runs not resulting in a

[4] MHDO Data identified 163 Maine-based providers that billed carriers in the universe of their data. One service has gone out of business, and another operates under two separate NPI numbers.

[5] One 911 request could potentially result in more than one activation, for example if multiple licensed ambulance providers are requested to the same call

transport to the hospital, and therefore, and in most circumstances, receiving no payment. There are several scenarios in which a patient may not be transported to the hospital:

- The ambulance was requested as part of a standard response to a motor vehicle accident or fire call and there are no injuries. While an assessment is done of the patients, the response often doesn't result in a transport to the hospital.
- The ambulance arrives and the clinicians examine the patient(s) and the patient ultimately decides to not go to the hospital or goes by other means.
- Substantial non-reimbursed treatment is provided, such as cardiopulmonary resuscitation, or administration of medications such as Naloxone or Glucose, and the patient ultimately succumbs to their illness or, in the case of overdose or diabetic emergencies, becomes coherent enough to refuse transport.

The unreimbursed cost of care results in the need to further subsidize operations through taxes, municipal subsidies, and commercial carriers. The cost shift is demonstrated in this table, which was acquired from the MEMS survey data:

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

Some services that chose to not participate indicated concern with confidentiality of proprietary data.

Data analysists from Maine EMS calculated that among respondents, the average cost per 911 transport was $1975.72, however the average cost per 911 response (including responses that didn't result in transport) was $653.39. Ambulances are only paid for transports, when there are significant other costs to maintain readiness and reliability for response to non-transport and transport request alike.

While commercial claims account for just over 9% of total claims submitted, most services reported approximately 15-29% of revenue comes from commercial carriers.

There were several comments received on why ambulance services may choose not to contract with commercial insurance carriers:

1) There is a great deal of cost shifting that occurs to municipalities (services charging per-capita subsidies), tax coverage (for municipalities providing EMS), and commercial insurers to make up the losses incurred from governmental, self-pay, and non-reimbursable services. .
2) Cost of emergency response without transport is not reimbursed increasing costs of transport
3) Ambulance providers that do not contract with all or some commercial insurers do so because the rates paid are perceived to be too low, or are below the costs
4) Some ambulance providers also noted that some carriers have been unwilling to increase reimbursement rates with some municipalities reporting current reimbursement has not changed since 2008.
5) The timeframe for initial claim submission is too short; and

6) Rates paid are either too low or below cost of service provision (generally more is collected by not contracting)
7) Contracting requires significant administrative time and expertise not available to small services

The general responses were consistent with the data that was presented to the Legislative Committee in February of 2020. The following conclusions can be drawn:

1) There is a great deal of cost shifting that occurs to municipalities, tax coverage, philanthropy, and commercial insurers to make up the losses incurred from service delivery.
2) Ambulance providers that do not contract with all or some commercial insurers do so because the rates paid are perceived to be too low, or are below their costs

MHDO Data Analysis

MHDO examined data from 2017, 2018, 2019 and quarter one of 2020. The data reviewed came from 693 unique ambulance providers, of which 530 were located outside of Maine (and provided services to enrollees of Maine-based health plans), and 163 were Maine-based providers. In total, 1,197,701 claims were examined, of which 37,054 were from out-of-state providers, with 1,160,647 originating from providers within the State of Maine. MHDO reports that overall, only 3.6% of unique events occurred out of state and 96.4% in-state.

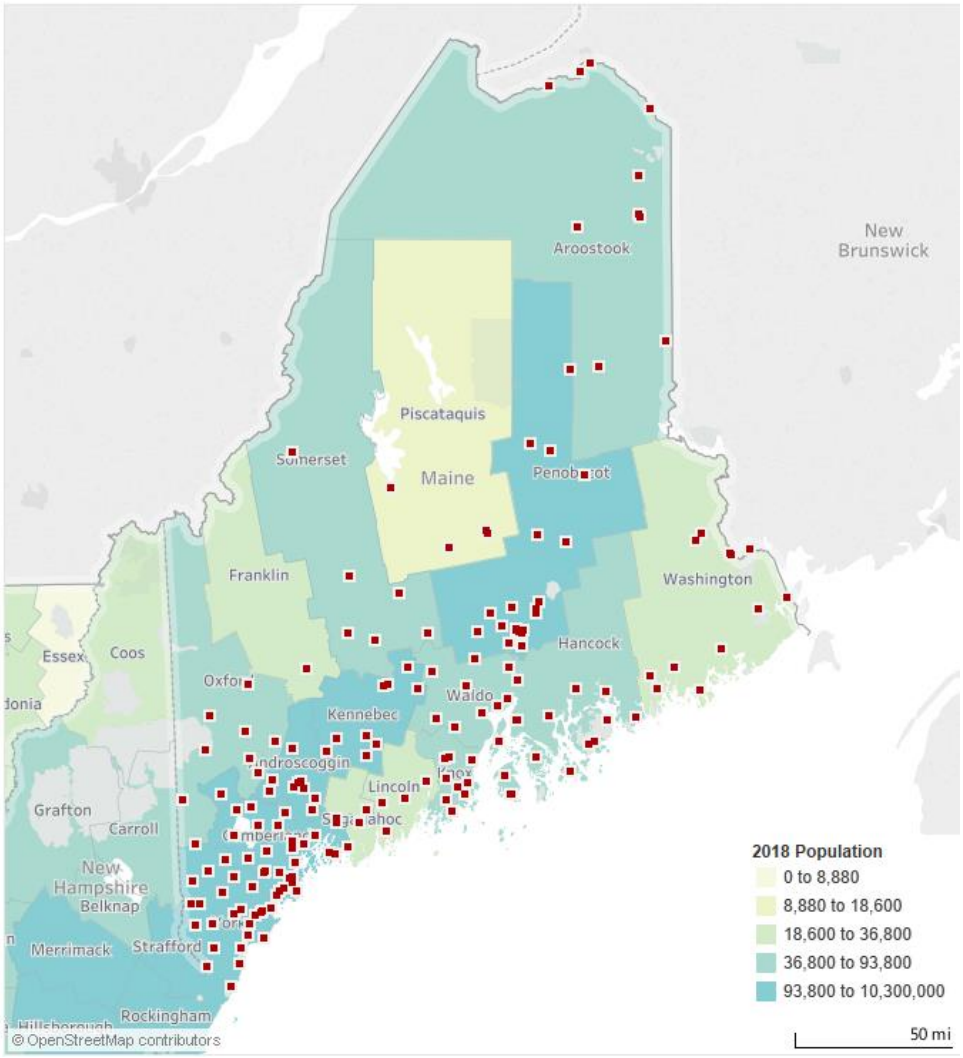
Of note, the top 10 ambulance services submit 44% of all claims, the top two submit 18% of all claims and the top ambulance service submits 10% of all claims.

Reviewing Quarter 1, 2020 data, the following was observed:

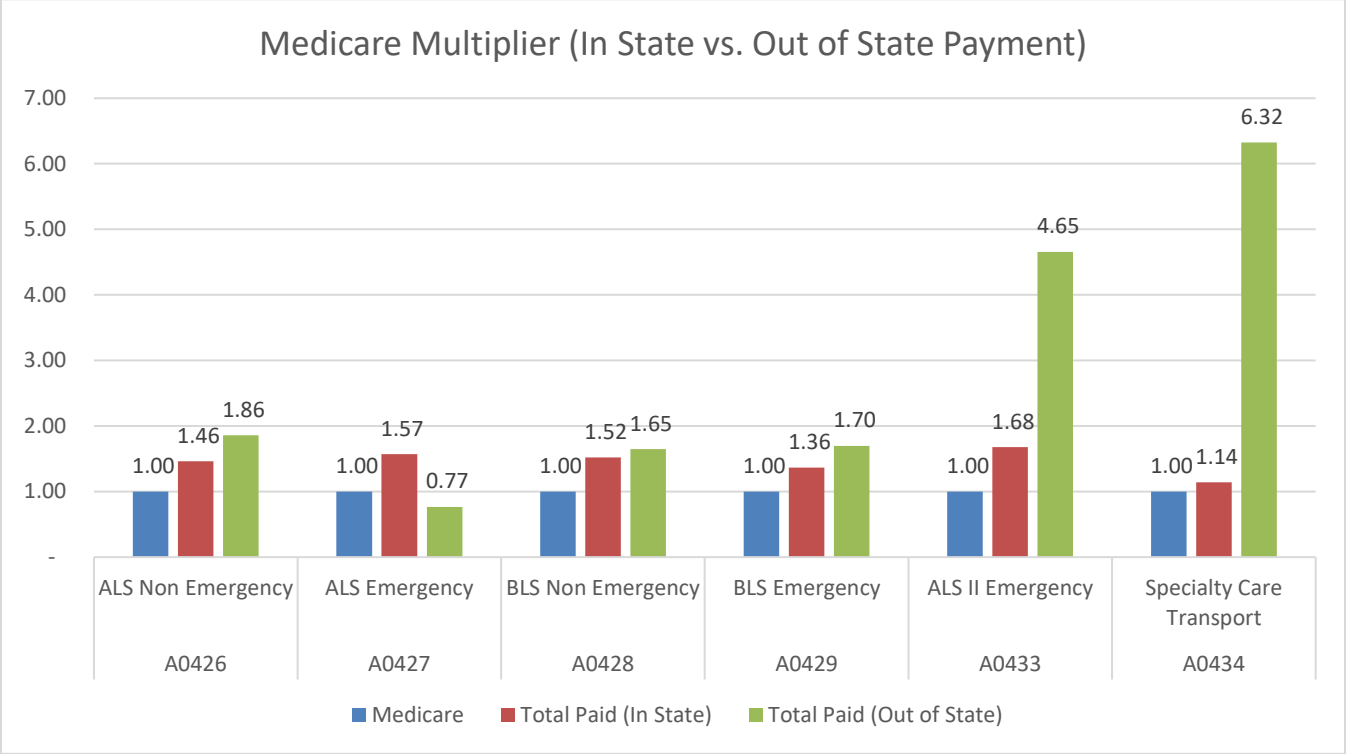
- Based on the data, out-of-state services charge substantially more for every level of care provided. The committee noted that:
    - fixed costs of providing service are likely higher in the metro areas out of state, however;
    - call volume is also likely higher, leading to more efficient use or resources and better coverage of fixed costs.
- Non-emergency charges are between 3.4-3.7 times higher when comparing out-of-state to in-state provider charges
- Emergency charges are all approximately 1.5 times higher for all 911 services when comparing out-of-state to in-state provider charges
- Out-of-state services are also paid more than in-state providers by commercial carriers for all HCPCS codes.
- Specifically, emergency charges (except for ALS II) are paid 1.3-1.7 times more when comparing out of state services to in state services.
- Non-emergency charges are paid roughly 1.2 times higher to out of state providers versus in state services
- Specialty Care Transport and ALS II are substantial outliers, with out-of-state providers being paid 3.4 times and 1.5 times that of in-state services, respectively.

MHDO provided a map showing the distribution of ambulance services overlaid on population by county:

Ambulance Providers, Maine



The following graph compares payments to Medicare rates (as a multiplier of Medicare) by fully insured commercial plans for in-state and out-of-state providers:



*Includes any payments by members

Based on data limitations, mileage rates were not evaluated.

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

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

The committee also attempted to evaluate whether the implementation of Public Law 2019, Chapter 668 impacted provider charges, due to the law's requirement that fully insured commercial health plans reimburse out-of-network providers for ambulance services that are covered emergency services at the out-of-network providers' charge (unless the two parties agree otherwise) until October 1, 2021. It was anecdotally agreed upon that this did not have a material impact on provider charges. Data after 2020 Quarter 1 is not yet available (the law went into effect Q2 of 2020). Charge data (the amount that providers bill insurance carriers) are presented below comparing 2019 to 2020 Q1.

[6] Includes both fully insured and self-funded. Year-over-year, approximately 1/3 of commercial plans in Maine are self-funded (as provided by MHDO claims dataset and may not reflect entire marketplace)

Notably, while services may not have materially changed their charges, those that have moved from in network to out of network services are receiving higher reimbursement from carriers due to the new law.

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

Comparing in-state charges from MHDO data versus the data collected through the Maine EMS survey, it appears many providers are charging less than the cost of providing the service, which suggests the cost is being covered through taxes, philanthropy, or other subsidies.

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The top 10 ambulance services by volume are (in order):[7]

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

MeAHP Study Analysis

The Maine Association of Health Plans (MeAHP) conducted a qualitative survey of their members. The full results are attached as **Appendix C**. There are some key takeaways from the survey results:

[7] Some hospital-based ambulance services may not be listed as their claims may be submitted under the hospital NPI number

[8] Includes both Meridian Mobile Health (dissolved) and Northern Light Medical Transport (absorbed business lines of Meridian Mobile Health in 2018)

Most carriers in Maine have between three and eight participating ambulance providers. Anthem, however, has 86 participating providers. Some plans have seen providers end their contracts since of the L.D. 2105 implementation (likely to take advantage of being paid 100% of charges). It was noted anecdotally that a single billing agency appears to be handling this communication on behalf of their clients as several contract cancellation letters were nearly identical.

The plans noted that many providers, especially municipal providers, don't contract and many don't reply to outreach efforts by health plans. Further, providers struggle to meet operational policies and procedures, including prior authorization requirements. As emergency rates are paid at 100% of charges, it was noted there is no incentive to contract for providers.

Challenges with contracting include huge variances in charges between providers in the state, and plans find it difficult to establish if charges are reasonable and customary. Municipal providers have indicated specifically that there is not enough bandwidth to support contract negotiations. Services also often reference the low reimbursement rates from government payers as the basis for needing higher reimbursement from commercial carriers.

Carriers described challenges with ambulance services (especially smaller services), particularly with administrative contracting requirements and ambulance services in Maine tend to be small with limited administrative support, capacity, or capability

The carriers also commented on challenges finding providers that can transport complex medical patients between facilities, or non-emergently in general; especially in rural areas.

Financial Review

Three of the four largest services in the state report their financial information publicly. As a taxable corporation, the largest service by volume does not. However, all services that commented mentioned narrow margins or recurrent operating losses from operation. Financial data from top services that publicly report their financial data is included in **Appendix D** for illustrative purposes.

Approaches of Other States

The committee explored whether other states had attempted to address similar problems to those that Maine is working to address. The committee found that Colorado, Connecticut, and New Mexico had all taken steps to standardize commercial reimbursement to ambulance services. Connecticut and New Mexico have a standard offer that seems to be in the realm of two times the Medicare fee schedule. Colorado was set at 275% of Medicare, however they recently increased that to be 325% of Medicare. It is unclear in all three cases how the default commercial rates have impacted the financial stability of the services.

Colorado also implemented a pseudo-cost-based reimbursement strategy for their Medicaid program, where services can apply to receive a gap payment to cover the difference between their costs related to the transport of Medicaid beneficiaries, and the Medicaid reimbursement.

Further detail on the approaches of these three states can be found in **Appendix E.**

Air Ambulance Services

While outside of the scope of the work done by this committee, information regarding charges and reimbursement from air ambulance services is included in **Appendix F.**

Recommendations

The committee established several recommendations. The scope of these recommendations includes ambulance services licensed in, and providing services in, the state of Maine. Further, the scope applies to fully insured commercial plans authorized to do business in Maine.[9]

Recommendations established by the committee center around these key issues (in no set order):

- Carriers desire to have more ambulance services in their provider networks
- Ambulance services would more likely join plans if the rates were considered favorable
- Small ambulance services generally lack the sophistication and / or bandwidth to meet plan administrative requirements, and to negotiate contracts
- While they can be reopened by either party, evergreen contracts often go indefinitely without review or rate adjustments.
- Surprise billing to patients should be eliminated
- Government payers appear to be paying less than the cost of the services
- Variation in contract terms can be challenging
- Out of state providers are generally paid more than in state providers for the same services
- Many services continue to cost shift to taxpayers, philanthropy[10] and commercial plans to stay afloat
- Any recommendations will affect a minority of the ambulance claims in Maine.
- Increasing reimbursement to healthcare providers, including ambulance providers, has an impact on health insurance premiums

The Committee on Health Coverage, Insurance, and Financial Services may consider reporting out a bill based on the following recommendations:

Recommendation 1: Balance billing (a.k.a. surprise billing) should be prohibited.

- Providers and carriers should be incentivized to participate in network.
- In no circumstances will subscribers be charged beyond plan co-pay and deductibles that their plan allows for emergency ambulance services.
- For non-emergency ambulance services, patients must explicitly agree in advance and in writing to charges beyond what carriers will reimburse and must be clearly informed in advance about their responsibility for additional charges.
- For emergency ambulance services delivered by an out of network provider disagreement between providers and carriers should be managed through an interim payment of the median in-network rate[11] updated January 1st each year, and both parties able to access an independent dispute resolution process with the patient held harmless.
- Use Medicare definitions for emergency response and non-emergency response. Emergency response is defined as, “Emergency response is a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or the equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly

[9] The recommendations would not apply to Medicare Advantage or self-funded plans
[10] Committee remembers cited several examples of services that rely heavily on donations of either money or equipment from philanthropic sources
[11] As provided by MHDO for the most recent 12-month period available.

as possible to take the steps necessary to respond to the call."[12] Non-emergency response is any other type or response.

Recommendation 2: Improve reimbursement for rural low volume providers.

Medicare recognizes rural and super-rural services with add on payments. MaineCare should adopt this methodology to recognize the higher costs of low volume providers and reduce MaineCare cost shifting to commercial carriers.

MaineCare should also explore cost-based reimbursement for services in areas that are particularly underserved. This could be tied to similar criteria as critical access hospital designations or could be tied to certain pick-up zip codes.

Commercial carriers should consider recognizing increased cost for rural low volume providers.

Recommendation 3: Improve and maintain system efficiency

Require Maine Emergency Medical Services to establish within 12 months, through rule or recommendations on statutory changes, a process by which delivery efficiency must be established before granting a new service license.

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

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

Recommendation 5: Incentivize network participation by creating a voluntary "standard offer" contract for both carriers and providers.

Create standard contract provisions reducing complexity of contracting with minimum provisions to include:

- Contract term: 24 calendar months, with automatic 12 months renewals thereafter. Contracts may be terminated at any time with 180 days advance written notice after the first 12-month period.
- Timely filing: ambulance services will be given 120 days to file their initial claims with payers. Carriers should have an exception process for when providers made good faith efforts to bill the correct carrier on time but had incorrect information.

Recommendation 6: Establish Cost Reporting program for EMS providers

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

[12] Medicare Benefit Policy Manual, Chapter 10 – Ambulance Services

Recommendation 7: Replace interim allowed charges reimbursement model with phased reimbursement model for in-network participation.

- Establish process to review costs and establish standard offer rate after the two-year cost reporting period.
- The initial model will create framework for standard offer.
- The initial model will be in place for 2 years while cost data is established. Subsequently the model must consider median provider cost.
- 200% of the Medicare rate in the locality in which services are delivered, include rural and super rural ambulance add-on rates based on the areas in which the services primarily provide service as determined by the LD 2105 committee and recommended to the legislature.
    - Out of Network Services will be reimbursed 180% of Medicare (and are explicitly barred from balance billing as defined in recommendation one)
- Payment will be based on the lesser of charges or the allowable rate
- Charge increases are capped at 5% per year for services below the 200% of Medicare level.

Recommendation 8: Establish process to adjudicate out of network claims.

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

Recommendation 9: Establish system advisory commission to include providers and carriers to evaluate finances and performance with goal of reducing growth of standard ambulance charges.

Commission to report in 24 months including:

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

Appendices

APPENDIX A COMMITTEE MEMBERSHIP

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

APPENDIX B MAINE EMS SURVEY RESULTS

Maine Emergency Medical Services

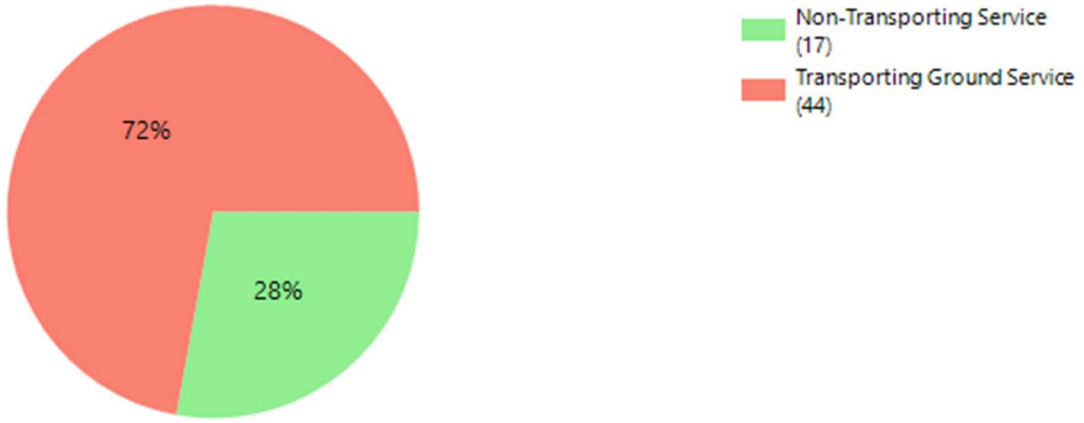
LD 2105 Survey Results

Hours & Contact
Monday to Friday - 8am to 4:30pm
Phone: (207) 626-3860
Fax: (207) 287-6251
TTY: (888) 524-7900
TDD: (207) 287-3659
Email: maine.ems@maine.gov
https://www.maine.gov/ems/

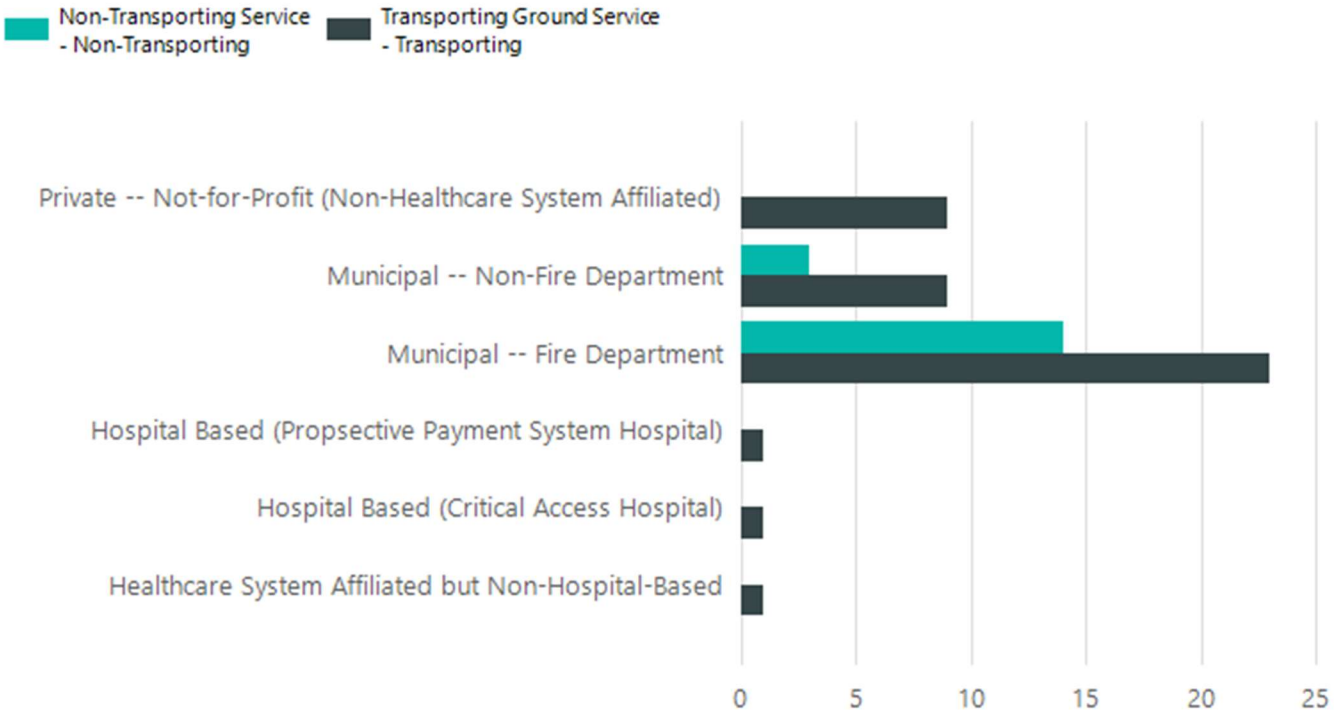
Office & Mailing Address
Maine Emergency Medical Services
Department of Public Safety
45 Commerce Drive Suite 1
152 State House Station
Augusta, ME 04333-0152

Service Profiles

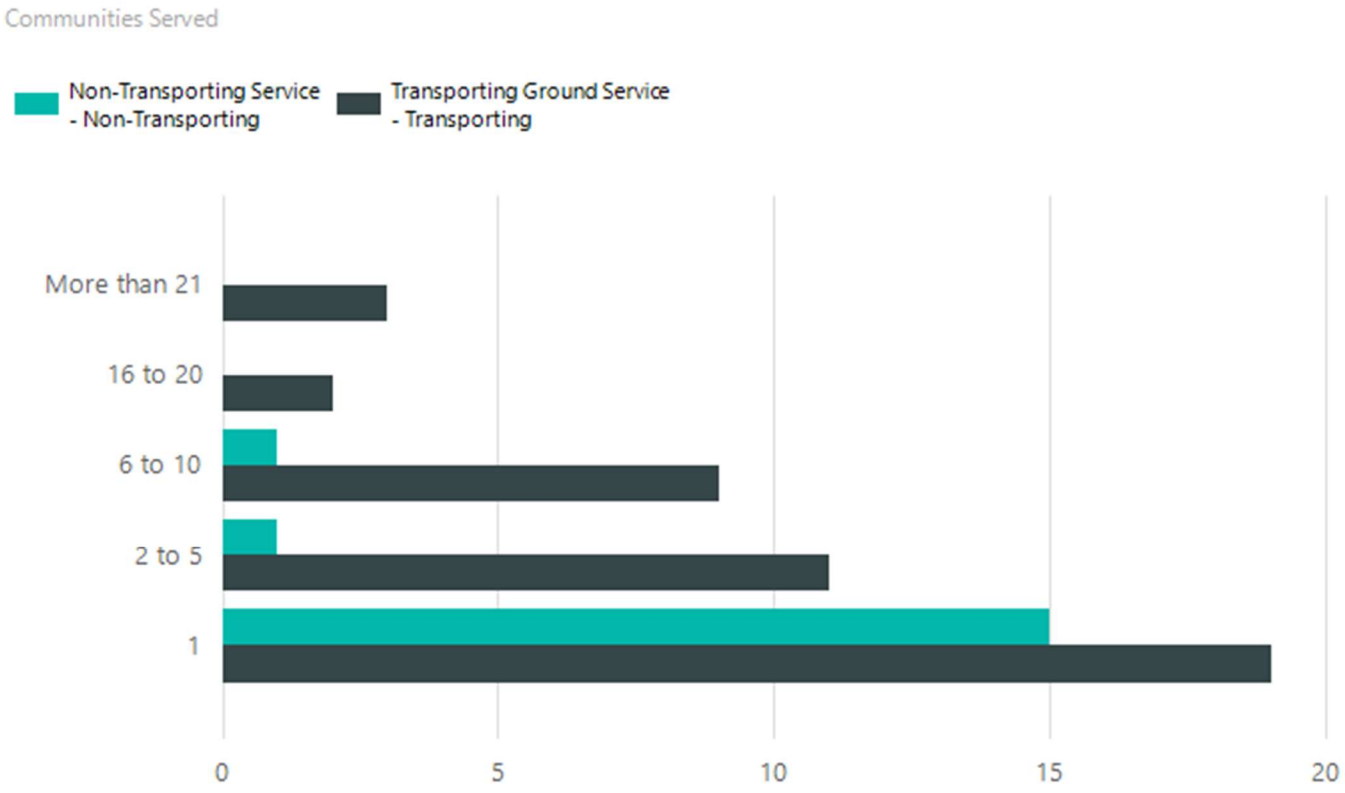
Service Type



Service Structure



Service Structure	Non-Transporting Service		Transporting Ground Service		Total
Healthcare System Affiliated but Non-Hospital-Based	0	0	1	1	1
Hospital Based (Critical Access Hospital)	0	0	1	1	1
Hospital Based (Propsective Payment System Hospital)	0	0	1	1	1
Municipal -- Fire Department	14	14	23	23	37
Municipal -- Non-Fire Department	3	3	9	9	12
Private -- Not-for-Profit (Non-Healthcare System Affiliated)	0	0	9	9	9
Total	17	17	44	44	61



Response Info	Count	Min	Mean	Median	Max
Total Number of 911 Calls where Patient Contact was Made but the Patient was Not Transported	61	0	230.9	584.0	1168
Total Number of Emergency (911) Transports	61	0	994.9	4168.0	8336
Total Number of Emergency IFT Transfers (all NON-SCHEDULED transports conducted outside of the 911 system including, but not limited to, PIFT, IFT, etc.)	60	0	92.1	848.5	1697
Total Number of Non-Emergency Transports (all transports conducted outside of the 911 system including, but not limited to, PIFT, IFT, etc.)	61	0	486.1	4396.0	8792
Total Number of Responses (excluding wheelchair transports)	61	0	2852.2	31023.5	62047
Total Number of Wheelchair Transports	61	0	1041.8	27324.0	54648
Note	*Excludes one value of 2,277,777 for Emergency IFT Transfers as it exceeds known Patient Care Report volume for any given year*				

Excludes one value of 2,277,777 for Emergency IFT Transfers as it exceeds known Patient Care Report volume for any given year	Non-Transporting Service				Transporting Ground Service			
Response Info	Count	Mean	Median	Max	Count	Mean	Median	Max
Total Number of 911 Calls where Patient Contact was Made but the Patient was Not Transported	17	26	50	100	44	310	584	1168
Total Number of Emergency (911) Transports	17	2	21	41	44	1378	4192	8336
Total Number of Emergency IFT Transfers (all NON-SCHEDULED transports conducted outside of the 911 system including, but not limited to, PIFT, IFT, etc.)	17	0	0	0	43	128	849	1697
Total Number of Non-Emergency Transports (all transports conducted outside of the 911 system including, but not limited to, PIFT, IFT, etc.)	17	0	0	0	44	674	4396	8792
Total Number of Responses (excluding wheelchair transports)	17	148	402	804	44	3897	31024	62047
Total Number of Wheelchair Transports	17	0	0	0	44	1444	27324	54648

Staff	Count	Min	Mean	Median	Max
(Fire Departments Only) Total clinical FTEs allocated to the ambulance service (total worked hours divided by 2080)	37	0	5.0	18.0	36
Number of Full Time Employees (32+ Scheduled Hours)	61	0	10.0	44.0	88
Number of Part Time Employees (16-32 Scheduled Hours)	61	0	3.8	22.5	45
Number of Volunteer Hours per Year used to cover ambulance	61	0	815.2	4380.0	8760
Other than full or part-time (non-volunteer, including per-diems)	57	0	18.5	44.0	88
Total full-time equivalents (FTEs) for the 2019 Fiscal Year (total worked hours divided by 2080)	61	0	13.5	50.5	101

	Non-Transporting Service				Transporting Ground Service			
Staff	Count	Mean	Median	Max	Count	Mean	Median	Max
(Fire Departments Only) Total clinical FTEs allocated to the ambulance service (total worked hours divided by 2080)	14	0	2	4	23	8	18	36
Number of Full Time Employees (32+ Scheduled Hours)	17	0	2	3	44	14	44	88
Number of Part Time Employees (16-32 Scheduled Hours)	17	0	2	4	44	5	23	45
Number of Volunteer Hours per Year used to cover ambulance	17	621	4380	8760	44	890	4380	8760
Other than full or part-time (non-volunteer, including per-diems)	16	5	14	28	41	24	44	88
Total full-time equivalents (FTEs) for the 2019 Fiscal Year (total worked hours divided by 2080)	17	0	2	4	44	19	51	101

Expenses FY2019

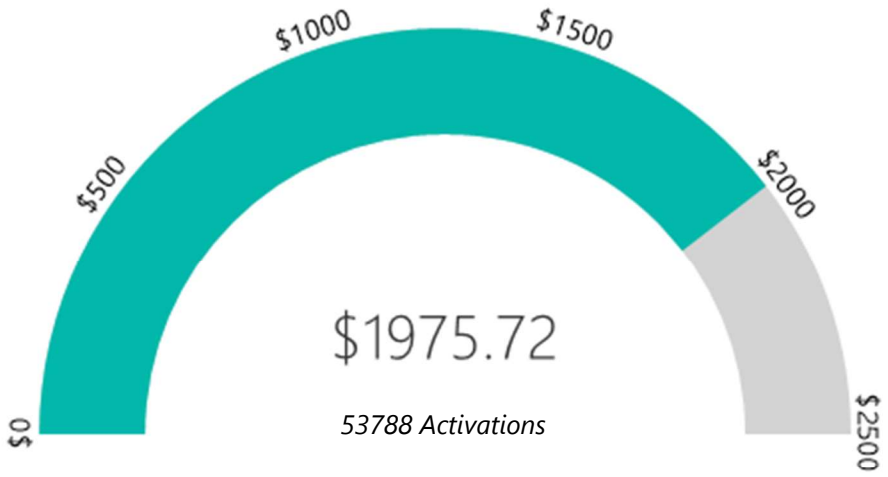
Service Type	Non-Transporting Service			Transporting Ground Service			Total
Service Structure	Sum	Avg	Median	Sum	Avg	Median	
Healthcare System Affiliated but Non-Hospital-Based			$0	$7,768,055	$485,503	$1,464,733	$7,768,055
Hospital Based (Critical Access Hospital)			$0	$1,766,814	$147,235	$281,572	$1,766,814
Hospital Based (Propsective Payment System Hospital)			$0	$5,768,489	$412,035	$1,144,413	$5,768,489
Municipal -- Fire Department	$21,980,634	$305,287	$10,722,012	$29,965,606	$100,556	$3,250,001	$51,946,240
Municipal -- Non-Fire Department	$66,372	$3,493	$19,050	$7,201,404	$53,742	$784,152	$7,267,776
Private -- Not-for-Profit (Non-Healthcare System Affiliated)			$0	$15,003,984	$114,534	$1,935,878	$15,003,984
Total	$22,047,005	$242,275	$10,722,012	$67,474,352	$111,528	$3,250,001	$89,521,357

Expense Info	Count	Min	Mean	Median	Max	Sum
All other expenses	36	$1,500	$156,199	$791,332	$1,581,164	$5,623,169
Ambulance Fuel (If Applicable)	49	$100	$25,357	$148,207	$296,313	$1,242,491
Billing Fees	35	$500	$26,130	$55,780	$111,060	$914,567
Clinical Fringe Benefits and Payroll Taxes (Non-Administrative)	33	$15	$215,249	$786,798	$1,573,581	$7,103,219
Clinical Salaries and Wages (Non-Administrative)	45	$16	$1,190,427	$10,722,019	$21,444,022	$53,569,236
Compliance/Licensing/Quality Management	44	$100	$5,894	$56,141	$112,181	$259,330
Depreciation and Amortization	24	$346	$199,527	$784,238	$1,568,129	$4,788,644
Dispatch Fees and Communication Expenses	34	$538	$63,145	$191,019	$381,500	$2,146,928
Equipment Purchases (not included in depreciation or information technology)	49	$150	$20,012	$111,325	$222,500	$980,570
Information Technology	31	$175	$10,745	$33,669	$67,162	$333,109
Insurance	40	$500	$32,163	$170,786	$341,071	$1,286,536
Leases, Rent, and/or Mortgage for Building(s)	14	$650	$60,947	$154,325	$308,000	$853,257
Medical Director (If Applicable)	23	$1	$4,335	$10,001	$20,000	$99,703
Medical Supplies	57	$500	$25,137	$66,878	$133,255	$1,432,791
Regional Fees/Membership Dues	49	$100	$2,485	$9,420	$18,740	$121,762
Repairs and Maintenance	53	$367	$31,402	$137,050	$273,733	$1,664,280
Total Cost of Bad Debt and Charity Care	34	$732	$180,708	$808,596	$1,616,459	$6,144,076
Utilities	46	$500	$20,819	$107,384	$214,268	$957,688

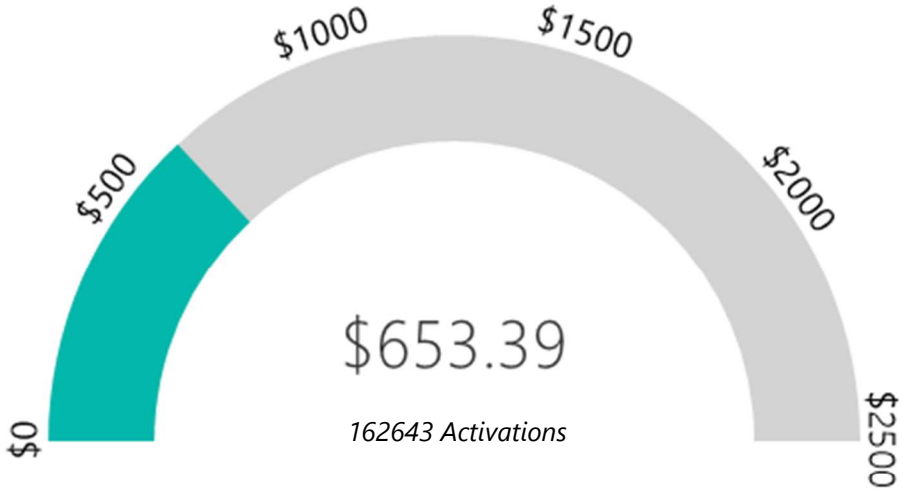
Service Type	Non-Transporting Service ($ in Millions)						Transporting Ground Service ($ in Millions)					
Expense Info	Count	Min	Mean	Median	Max	Sum	Count	Min	Mean	Median	Max	Sum
All other expenses	5	$0.0	$0.0	$0.0	$0.0	$0.0	31	$0.0	$0.2	$0.8	$1.6	$5.6
Ambulance Fuel (If Applicable)	7	$0.0	$0.0	$0.0	$0.0	$0.0	42	$0.0	$0.0	$0.1	$0.3	$1.2
Billing Fees	0			$0.0			35	$0.0	$0.0	$0.1	$0.1	$0.9
Clinical Fringe Benefits and Payroll Taxes (Non-Administrative)	2	$0.0	$0.1	$0.1	$0.1	$0.1	31	$0.0	$0.2	$0.8	$1.6	$7.0
Clinical Salaries and Wages (Non-Administrative)	5	$0.0	$4.3	$10.7	$21.4	$21.7	40	$0.0	$0.8	$3.3	$6.5	$31.9
Compliance/Licensing/Quality Management	8	$0.0	$0.0	$0.0	$0.0	$0.0	36	$0.0	$0.0	$0.1	$0.1	$0.3
Depreciation and Amortization	2	$0.0	$0.0	$0.0	$0.0	$0.0	22	$0.0	$0.2	$0.8	$1.6	$4.8
Dispatch Fees and Communication Expenses	5	$0.0	$0.0	$0.0	$0.0	$0.0	29	$0.0	$0.1	$0.2	$0.4	$2.1
Equipment Purchases (not included in depreciation or information technology)	10	$0.0	$0.0	$0.0	$0.0	$0.0	39	$0.0	$0.0	$0.1	$0.2	$0.9
Information Technology	2	$0.0	$0.0	$0.0	$0.0	$0.0	29	$0.0	$0.0	$0.0	$0.1	$0.3
Insurance	6	$0.0	$0.0	$0.0	$0.0	$0.0	34	$0.0	$0.0	$0.2	$0.3	$1.3
Leases, Rent, and/or Mortgage for Building(s)	1	$0.0	$0.0	$0.0	$0.0	$0.0	13	$0.0	$0.1	$0.2	$0.3	$0.8
Medical Director (If Applicable)	1	$0.0	$0.0	$0.0	$0.0	$0.0	22	$0.0	$0.0	$0.0	$0.0	$0.1
Medical Supplies	13	$0.0	$0.0	$0.0	$0.0	$0.0	44	$0.0	$0.0	$0.1	$0.1	$1.4
Regional Fees/Membership Dues	8	$0.0	$0.0	$0.0	$0.0	$0.0	41	$0.0	$0.0	$0.0	$0.0	$0.1
Repairs and Maintenance	9	$0.0	$0.0	$0.0	$0.0	$0.0	44	$0.0	$0.0	$0.1	$0.3	$1.6
Total Cost of Bad Debt and Charity Care	0			$0.0			34	$0.0	$0.2	$0.8	$1.6	$6.1
Utilities	7	$0.0	$0.0	$0.0	$0.0	$0.0	39	$0.0	$0.0	$0.1	$0.2	$0.9

Transporting	Non-Transporting						Transporting					
Expense Info	Count	Min	Mean	Median	Max	Sum	Count	Min	Mean	Median	Max	
All other expenses	5	$0.0	$0.0	$0.0	$0.0	$0.0	31	$0.0	$0.2	$0.8	$1.6	
Ambulance Fuel (If Applicable)	7	$0.0	$0.0	$0.0	$0.0	$0.0	42	$0.0	$0.0	$0.1	$0.3	
Billing Fees	0			$0.0			35	$0.0	$0.0	$0.1	$0.1	
Clinical Fringe Benefits and Payroll Taxes (Non-Administrative)	2	$0.0	$0.1	$0.1	$0.1	$0.1	31	$0.0	$0.2	$0.8	$1.6	
Clinical Salaries and Wages (Non-Administrative)	5	$0.0	$4.3	$10.7	$21.4	$21.7	40	$0.0	$0.8	$3.3	$6.5	$
Compliance/Licensing/Quality Management	8	$0.0	$0.0	$0.0	$0.0	$0.0	36	$0.0	$0.0	$0.1	$0.1	
Depreciation and Amortization	2	$0.0	$0.0	$0.0	$0.0	$0.0	22	$0.0	$0.2	$0.8	$1.6	
Dispatch Fees and Communication Expenses	5	$0.0	$0.0	$0.0	$0.0	$0.0	29	$0.0	$0.1	$0.2	$0.4	
Equipment Purchases (not included in depreciation or information technology)	10	$0.0	$0.0	$0.0	$0.0	$0.0	39	$0.0	$0.0	$0.1	$0.2	
Information Technology	2	$0.0	$0.0	$0.0	$0.0	$0.0	29	$0.0	$0.0	$0.0	$0.1	
Insurance	6	$0.0	$0.0	$0.0	$0.0	$0.0	34	$0.0	$0.0	$0.2	$0.3	
Leases, Rent, and/or Mortgage for Building(s)	1	$0.0	$0.0	$0.0	$0.0	$0.0	13	$0.0	$0.1	$0.2	$0.3	
Medical Director (If Applicable)	1	$0.0	$0.0	$0.0	$0.0	$0.0	22	$0.0	$0.0	$0.0	$0.0	
Medical Supplies	13	$0.0	$0.0	$0.0	$0.0	$0.0	44	$0.0	$0.0	$0.1	$0.1	
Regional Fees/Membership Dues	8	$0.0	$0.0	$0.0	$0.0	$0.0	41	$0.0	$0.0	$0.0	$0.0	
Repairs and Maintenance	9	$0.0	$0.0	$0.0	$0.0	$0.0	44	$0.0	$0.0	$0.1	$0.3	
Total Cost of Bad Debt and Charity Care	0			$0.0			34	$0.0	$0.2	$0.8	$1.6	
Utilities	7	$0.0	$0.0	$0.0	$0.0	$0.0	39	$0.0	$0.0	$0.1	$0.2	

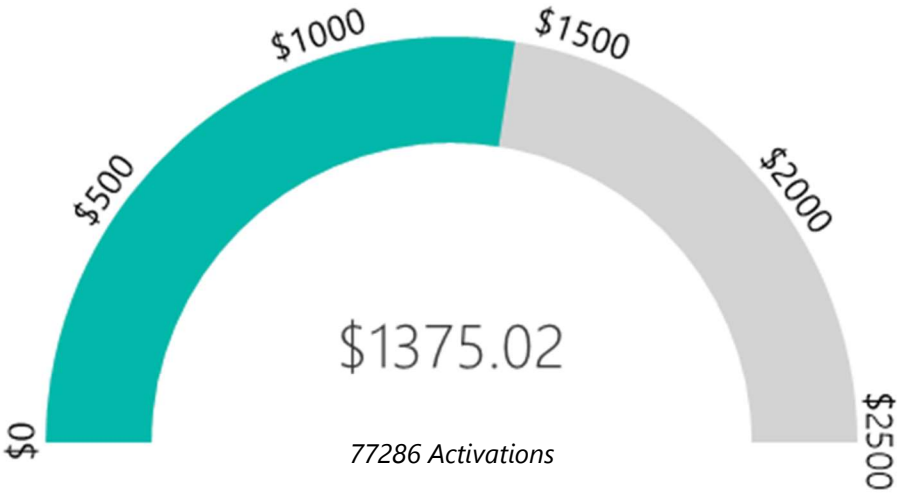
Expense Per 911 Transport



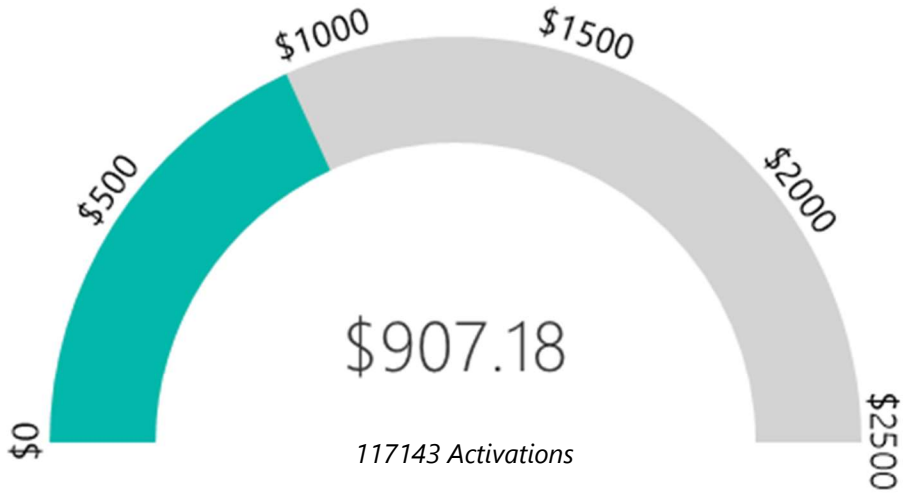
Expense Per Response
(Excluding Wheelchair Transports)



Expense Per Transport
(Excluding IFT and Wheelchair Transports)

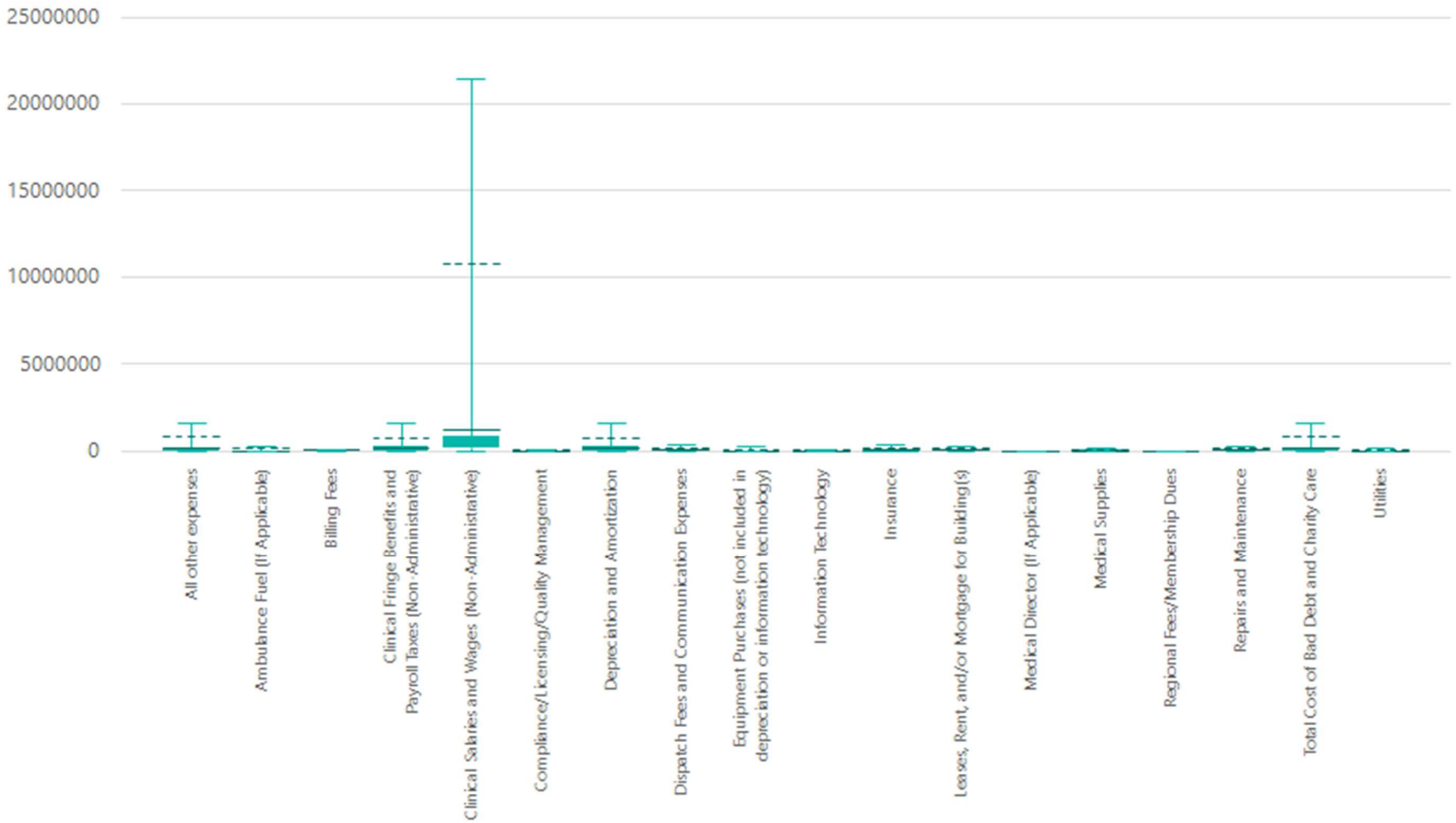


Expense Per Transport
(911, Non-Emergency, IFT and Wheelchair Transports)

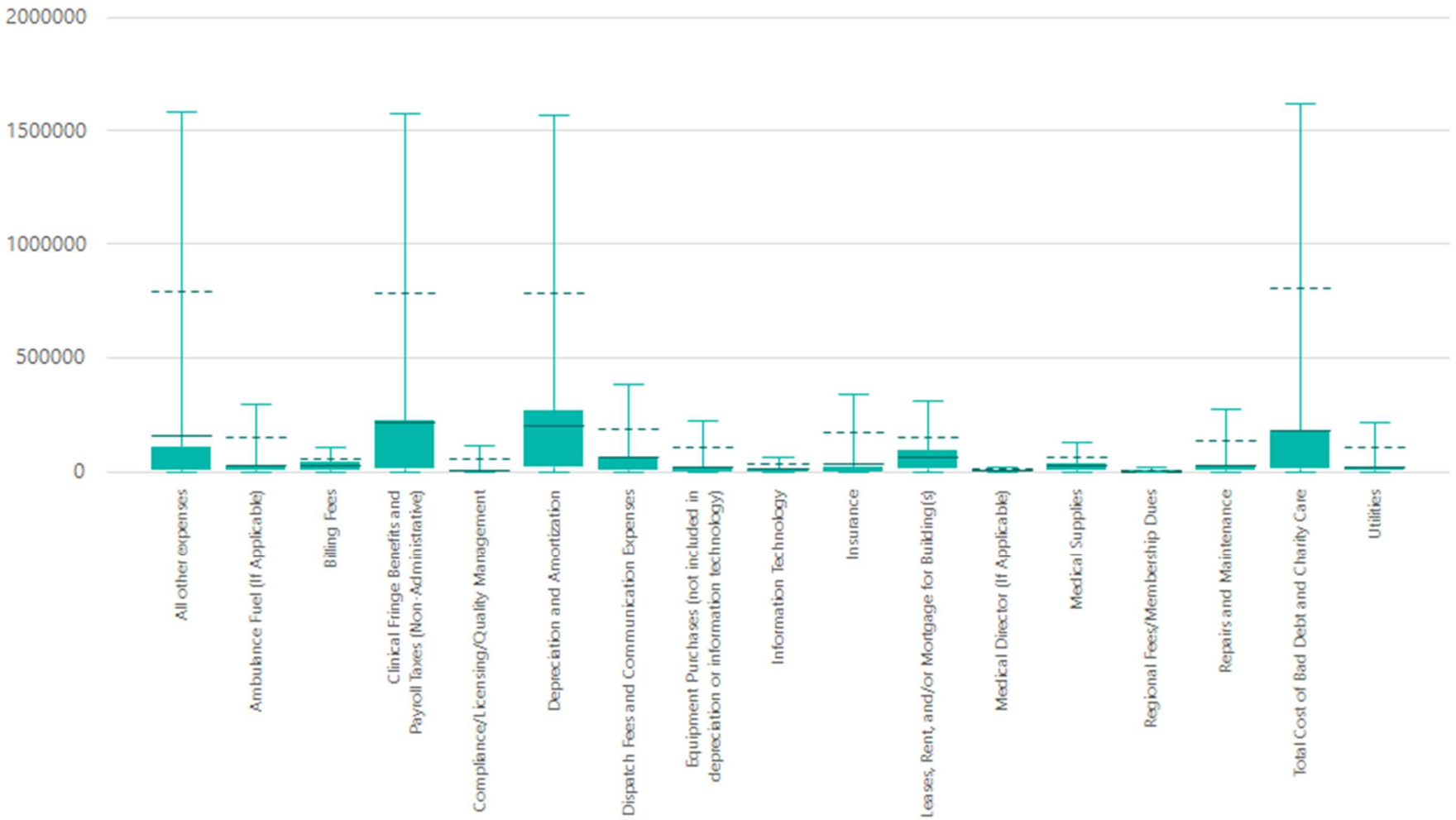


Row Header	Count	Sum	Min	Max	Avg	Mean
Total Response	60	288707	0	62657	4657	31329
Total Response Cost	60	$104,994,547	$0	$21,483,980	$1,693,460	$10,741,990
Emergency Transports	46	60905	0	8336	982	4168
Emergency Transports Costs	46	$19,870,401	$0	$2,855,869	$320,490	$1,427,934
Pt Not Transported	55	14327	0	1168	231	584
Pt Not Transported Costs	55	$5,992,346	$0	$938,168	$96,651	$469,084
Non-Emergency Transports	28	29651	0	8792	478	4396
Non-Emergency Transports Costs	28	$6,110,055	$0	$1,889,194	$98,549	$944,597
IFT Transfers	24	7575	0	2052	122	1026
IFT Transfers Costs	24	$9,602,692	$0	$7,955,045	$154,882	$3,977,523
Wheelchair Transports	4	63550	0	54648	1025	27324
Wheelchair Transports Costs	4	$3,042,062	$0	$1,182,637	$49,066	$591,319

Expense Comparison



Expense Comparison, Excluding Clinical Salaries and Wages (Non-Administrative)



Expense Type	Min	Max	Mean	Median	25th Percentile	75th Percentile
All other expenses	$1500	$1581164	$156199	$791332	$8000	$108400
Ambulance Fuel (If Applicable)	$100	$296313	$25357	$148207	$2662	$17213
Billing Fees	$500	$111060	$26130	$55780	$7408	$40000
Clinical Fringe Benefits and Payroll Taxes (Non-Administrative)	$15	$1573581	$215249	$786798	$16592	$224675
Clinical Salaries and Wages (Non-Administrative)	$16	$21444022	$1190427	$10722019	$158506	$828354
Compliance/Licensing/Quality Management	$100	$112181	$5894	$56141	$250	$3389
Depreciation and Amortization	$346	$1568129	$199527	$784238	$21122	$267798
Dispatch Fees and Communication Expenses	$538	$381500	$63145	$191019	$3500	$59825
Equipment Purchases (not included in depreciation or information technology)	$150	$222500	$20012	$111325	$2125	$20942
Information Technology	$175	$67162	$10745	$33669	$991	$7450
Insurance	$500	$341071	$32163	$170786	$2500	$22486
Leases, Rent, and/or Mortgage for Building(s)	$650	$308000	$60947	$154325	$13934	$90850
Medical Director (If Applicable)	$1	$20000	$4335	$10001	$1000	$5625
Medical Supplies	$500	$133255	$25137	$66878	$5050	$36125
Regional Fees/Membership Dues	$100	$18740	$2485	$9420	$385	$2937
Repairs and Maintenance	$367	$273733	$31402	$137050	$6074	$29503
Total Cost of Bad Debt and Charity Care	$732	$1616459	$180708	$808596	$12315	$173750
Utilities	$500	$214268	$20819	$107384	$3055	$20819

Please give a brief description of your "other expenses" identified in the previous question. Are these expenses your service regularly encounters or one time occurrences?	Other Expenses
Management, Education, Accounting, Legal,; routine expenses	$1,581,164.00
HR, IS, Legal, Compliance,Mgt Salaries.	$1,533,000.00
Hospital cost for HR, billing, compliance, education	$425,000.00
Management and administrative salaries, wages and fringe, facility expenses	$341,017.00
Other expenses are covered within the municipal operating budget. This cost represents 60% of management's time to EMS from total employer cost.	$286,390.75
administrative wages	$176,000.00
transport meal, training, travel, misc. amb expense	$137,692.00
Administration Cost and Benefits	$108,400.00
Regular fees encountered every year: Trainings, uniforms, medical evaluations, PPD tests, ALS intercept charges, legal fees, telephone, heating fuel. We also purchased cardiac monitors in this fiscal year, which is something that happens roughly every 10	$100,177.11
Legal, Accounting, Fund Raising, Office supplies, Business Manager salary all recurring	$93,076.00
Director salary, contracted services for mutual aid, travel and training, Oxygen, minor equipment	$83,705.00
Interest Expense on loans and numerous miscellaneous categories not covered in questions above.	$78,000.00
40% of Chiefs Salary	$70,673.00
Fire Rescue Chief's annual salary plus training and compliance certifications.	$65,000.00
Management salary including insurances retirement, uniforms, Health screenings and new hire screenings and travel for meetings classes and supplies.	$63,444.00
Training & development , clothing/Uniforms, bldg main/repairs/Misc Supplies	$42,600.00
These fees are yearly expenses. They include Audits, Management salaries, uniforms, Office supplies, Education, advertising, travel, Drug testing,and postage	$41,400.00
Public Safety Coordinator budget.	$38,000.00
Accounting fees, investment management fees, office expenses, ALS fees, payroll processing. Regular.	$28,905.00
Officers stipends and accounting	$18,710.00
Training, Building Maintenance. Contractual, Uniforms	$17,500.00
Adm. Costs, Billing Supplies	$10,000.00

$6000 for Chief's salary and $2000 in ALS backup fees	$8,000.00
Training, Building Maintenance, physical,	$7,719.27
Municipal administrative fees and uniform expenses	$6,199.24
Chief Stipend	$5,000.00
Admin Stipend Annually.	$4,800.00
Administrative supplies, Laundering services	$4,570.00
Management Stipend	$3,000.00
Deputy Chiefs Sipend. Regularly	$3,000.00
yes, minor admin expenses	$2,000.00
EMS Coordinator stipend	$1,500.00
Training, innoculations, radio maint. bldg maint.	

Billing Details

Service Type	Non-Transporting Service	Transporting Ground Service	
Service Structure	No	No	Yes
Healthcare System Affiliated but Non-Hospital-Based	0	0	1
Hospital Based (Critical Access Hospital)	0	0	1
Hospital Based (Propsective Payment System Hospital)	0	0	1
Municipal -- Fire Department	14	2	21
Municipal -- Non-Fire Department	3	0	9
Private -- Not-for-Profit (Non-Healthcare System Affiliated)	0	2	7

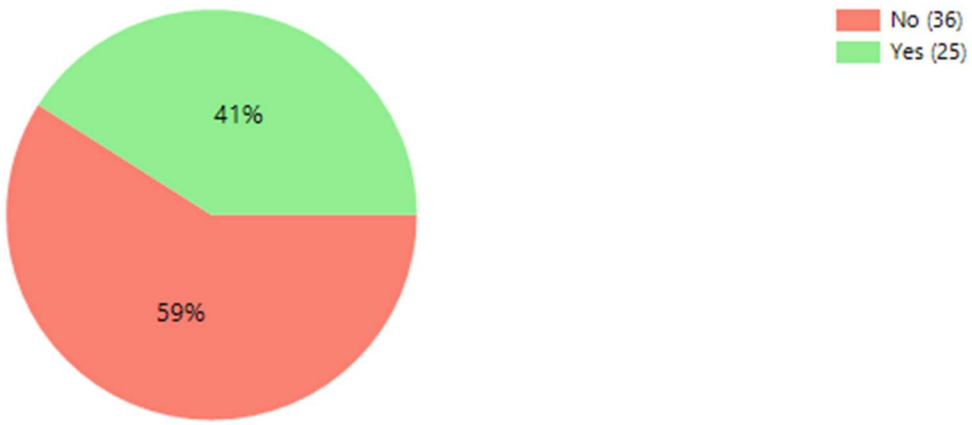
Billing Info 2019	Count	Min	Mean	Median	Max
ALS Non-Emergency (Code A0426)	31	372	553.4	1336.0	2300
ALS One (1) Emergency (Code A0427)	39	500	847.5	1400.0	2300
ALS Two (2) Emergency (Code A0433)	39	700	1197.8	2100.0	3500
BLS Emergency (Code A0429)	40	80	629.9	940.0	1800
BLS Non-Emergency (Code A0428)	34	265	436.1	882.5	1500
Fixed Wing Base (Code A0430)	0			0.0	
Fixed Wing Mileage (Code A0435)	0			0.0	
Ground ambulance mileage (Code A0425)	39	11	16.6	23.9	37
Rotor Wing Base (Code A0431)	0			0.0	
Rotor Wing Mileage (Code A0436)	0			0.0	
Specialty Care/PIFT (Code A0434)	21	850	1601.0	2425.0	4000

Billing Info 2020	Count	Min	Mean	Median	Max
ALS Non-Emergency (Code A0426)	34	372	612.3	1336.0	2300
ALS One (1) Emergency (Code A0427)	39	510	918.1	1405.0	2300
ALS Two (2) Emergency (Code A0433)	39	710	1297.1	2105.0	3500
BLS Emergency (Code A0429)	38	400	685.7	1100.0	1800
BLS Non-Emergency (Code A0428)	36	265	464.4	882.5	1500
Charge for Non-Transports	24	50	171.6	295.5	541
Fixed Wing Base (Code A0430)	1	600	600.0	600.0	600
Fixed Wing Mileage (Code A0435)	0			0.0	
Ground ambulance mileage (Code A0425)	40	11	17.3	24.3	38
Rotor Wing Base (Code A0431)	0			0.0	
Rotor Wing Mileage (Code A0436)	0			0.0	
Specialty Care/PIFT (Code A0434)	20	850	1578.2	2425.0	4000

	Non-Transporting Service				Transporting Ground Service			
Billing Info 2019	Count	Mean	Median	Max	Count	Mean	Median	Max
ALS Non-Emergency (Code A0426)	0		0		31	553	1336	2300
ALS One (1) Emergency (Code A0427)	0		0		39	847	1400	2300
ALS Two (2) Emergency (Code A0433)	0		0		39	1198	2100	3500
BLS Emergency (Code A0429)	0		0		40	630	940	1800
BLS Non-Emergency (Code A0428)	0		0		34	436	883	1500
Fixed Wing Base (Code A0430)	0		0		0		0	
Fixed Wing Mileage (Code A0435)	0		0		0		0	
Ground ambulance mileage (Code A0425)	0		0		39	17	24	37
Rotor Wing Base (Code A0431)	0		0		0		0	
Rotor Wing Mileage (Code A0436)	0		0		0		0	
Specialty Care/PIFT (Code A0434)	0		0		21	1601	2425	4000

	Non-Transporting Service				Transporting Ground Service			
Billing Info 2020	Count	Mean	Median	Max	Count	Mean	Median	Max
ALS Non-Emergency (Code A0426)	0		0		34	612	1336	2300
ALS One (1) Emergency (Code A0427)	0		0		39	918	1405	2300
ALS Two (2) Emergency (Code A0433)	0		0		39	1297	2105	3500
BLS Emergency (Code A0429)	0		0		38	686	1100	1800
BLS Non-Emergency (Code A0428)	0		0		36	464	883	1500
Charge for Non-Transports	0		0		24	172	296	541
Fixed Wing Base (Code A0430)	0		0		1	600	600	600
Fixed Wing Mileage (Code A0435)	0		0		0		0	
Ground ambulance mileage (Code A0425)	0		0		40	17	24	38
Rotor Wing Base (Code A0431)	0		0		0		0	
Rotor Wing Mileage (Code A0436)	0		0		0		0	
Specialty Care/PIFT (Code A0434)	0		0		20	1578	2425	4000

Billing for Non-Transports

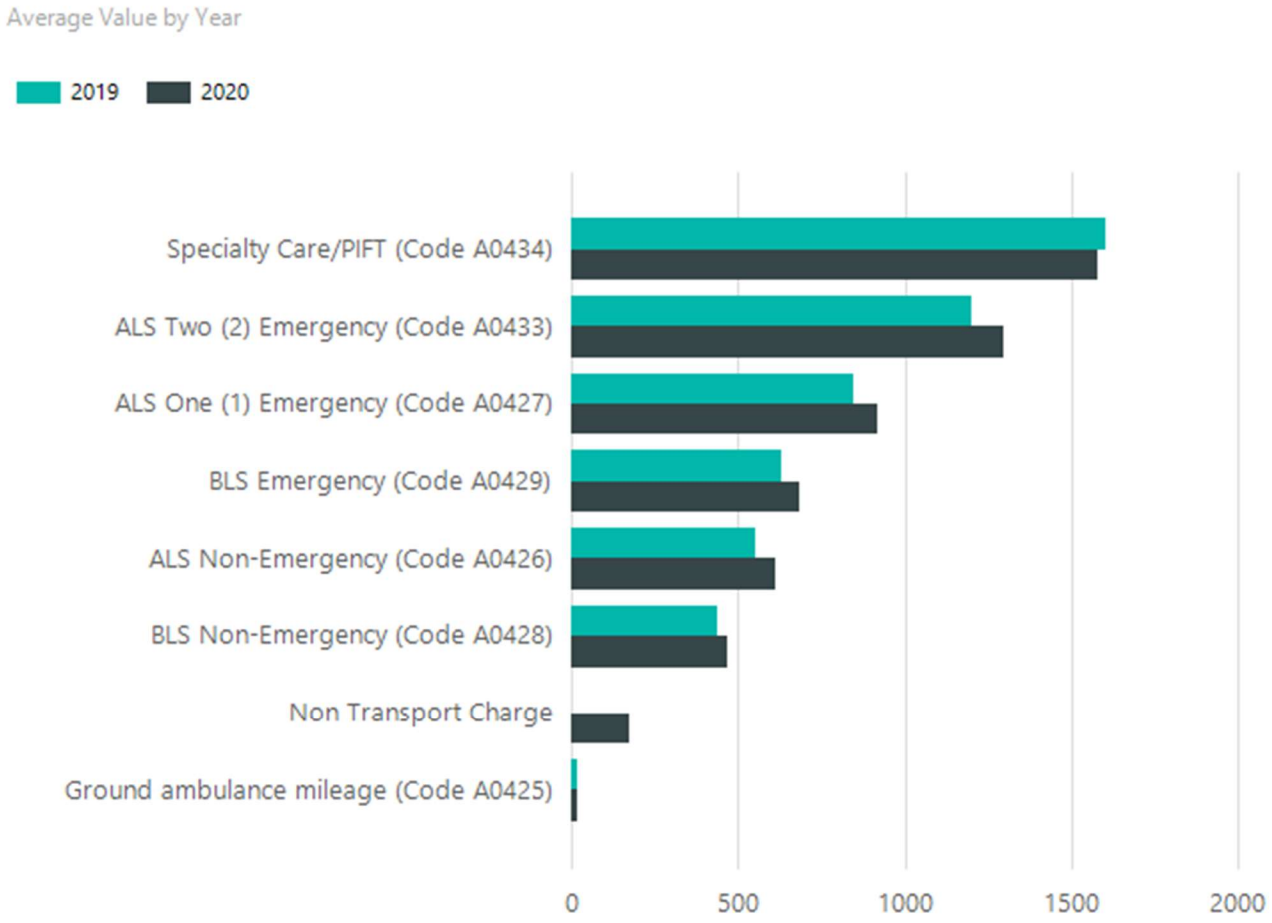


Non Transport Billing by Service Structure	Yes	No	Total
Healthcare System Affiliated but Non-Hospital-Based	0	1	1
Hospital Based (Critical Access Hospital)	0	1	1
Hospital Based (Propsective Payment System Hospital)	1	0	1
Municipal -- Fire Department	12	25	37
Municipal -- Non-Fire Department	7	5	12
Private -- Not-for-Profit (Non-Healthcare System Affiliated)	5	4	9
Total	25	36	61

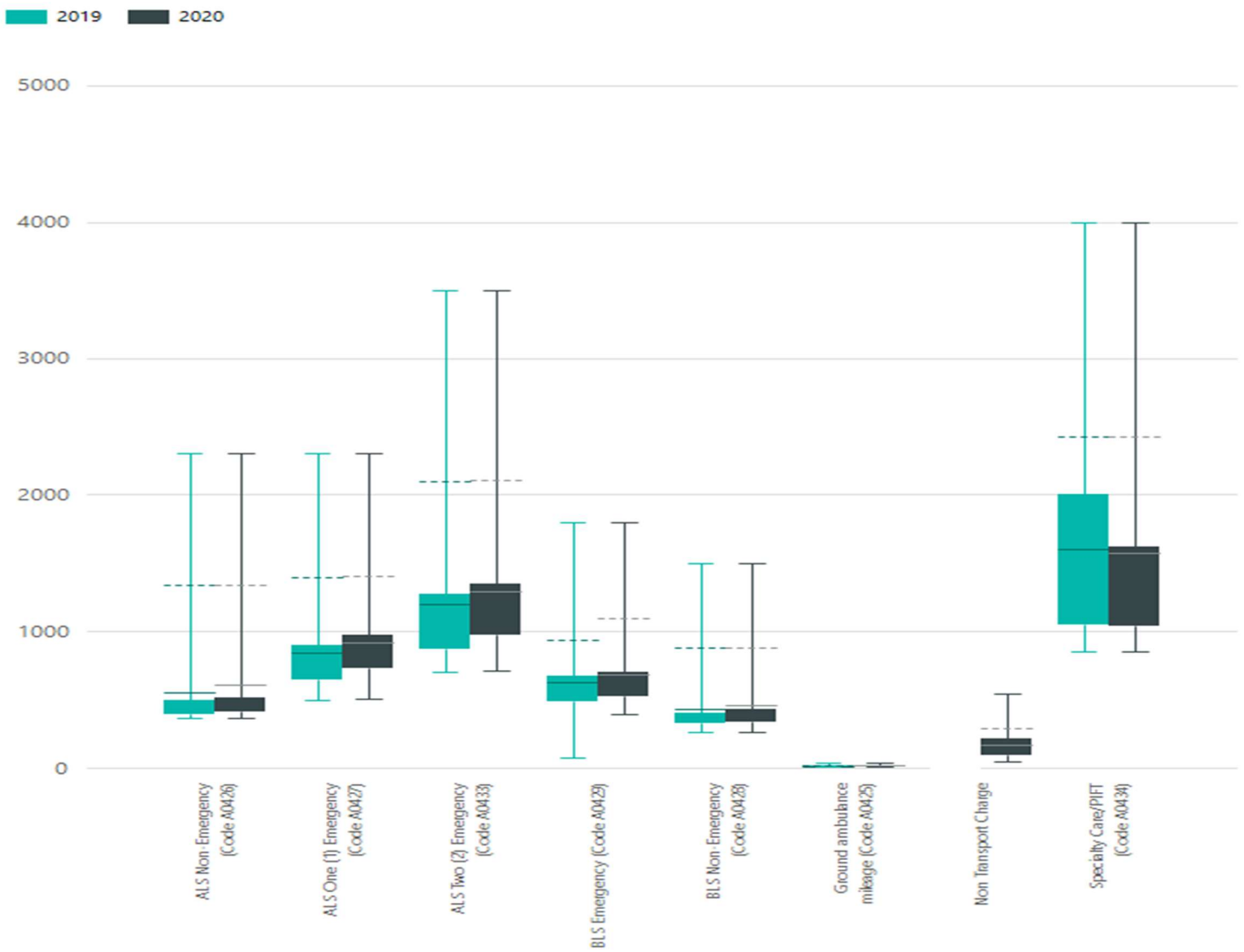
Non Transport Billing by Service Type	Yes	No	Total
Non-Transporting Service	0	17	17
Transporting Ground Service	25	19	44
Total	25	36	61

Non Transport Average Billing Amounts by Service Structure	Yes	No
Healthcare System Affiliated but Non-Hospital-Based		
Hospital Based (Critical Access Hospital)		
Hospital Based (Propsective Payment System Hospital)		
Municipal -- Fire Department	$168	
Municipal -- Non-Fire Department	$124	
Private -- Not-for-Profit (Non-Healthcare System Affiliated)	$246	

Non Transport Average Billing Amounts by Service Type	Yes	No
Non-Transporting Service		
Transporting Ground Service	$172	


Average Value by Year
2019
2020
Specialty Care/PIFT (Code A0434)
ALS Two (2) Emergency (Code A0433)
ALS One (1) Emergency (Code A0427)
BLS Emergency (Code A0429)
ALS Non-Emergency (Code A0426)
BLS Non-Emergency (Code A0428)
Non Transport Charge
Ground ambulance mileage (Code A0425)
0
500
1000
1500
2000

Ground Billing



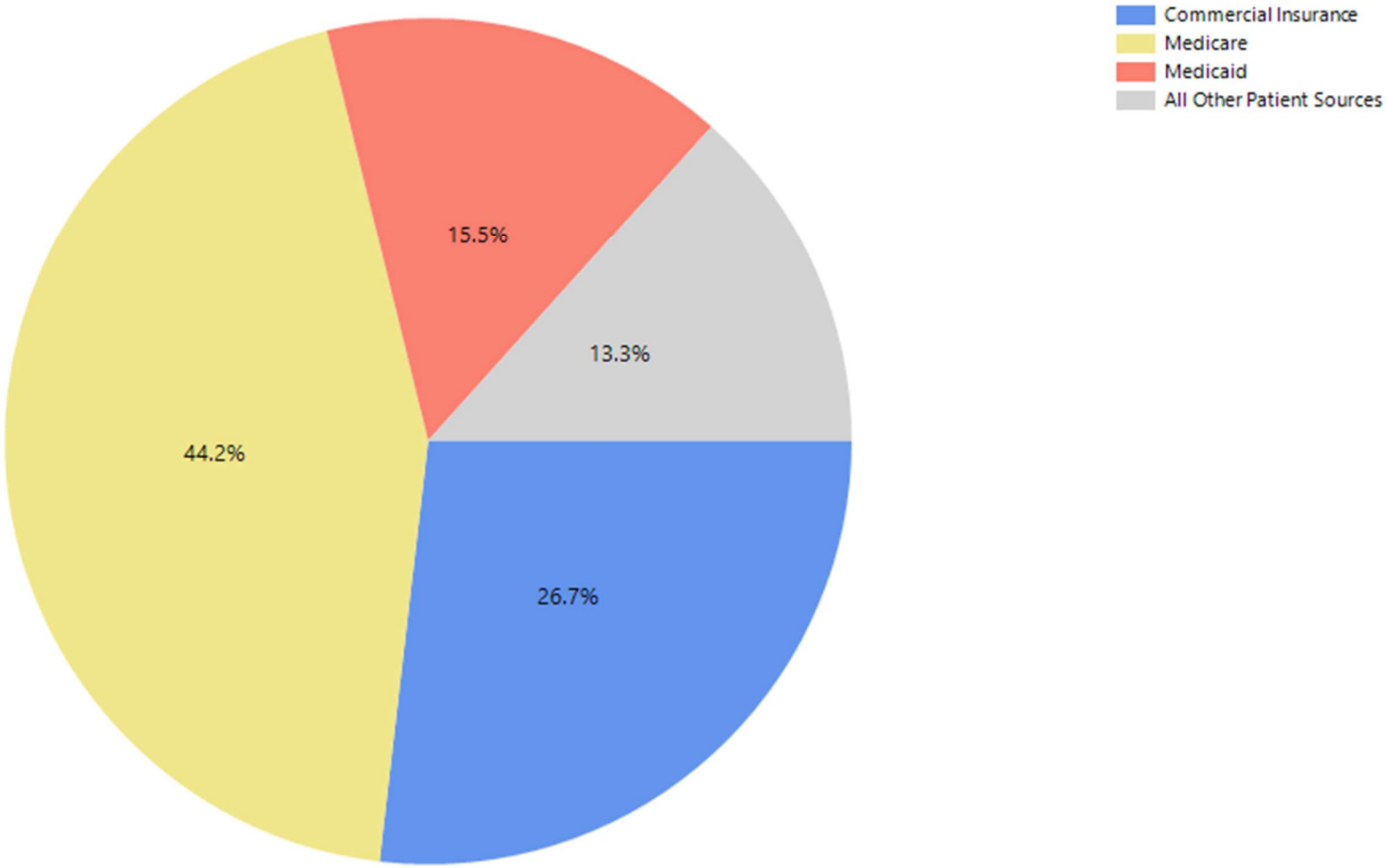
Revenue

Service Structure Revenue Mix	Commercial Insurance	Medicare	Medicaid	All Other Patient Sources
Healthcare System Affiliated but Non-Hospital-Based	21%	53%	12%	14%
Hospital Based (Critical Access Hospital)	0%	0%	0%	0%
Hospital Based (Propsective Payment System Hospital)	15%	60%	18%	7%
Municipal -- Fire Department	28%	39%	16%	15%
Municipal -- Non-Fire Department	29%	50%	17%	12%
Private -- Not-for-Profit (Non-Healthcare System Affiliated)	24%	43%	13%	11%

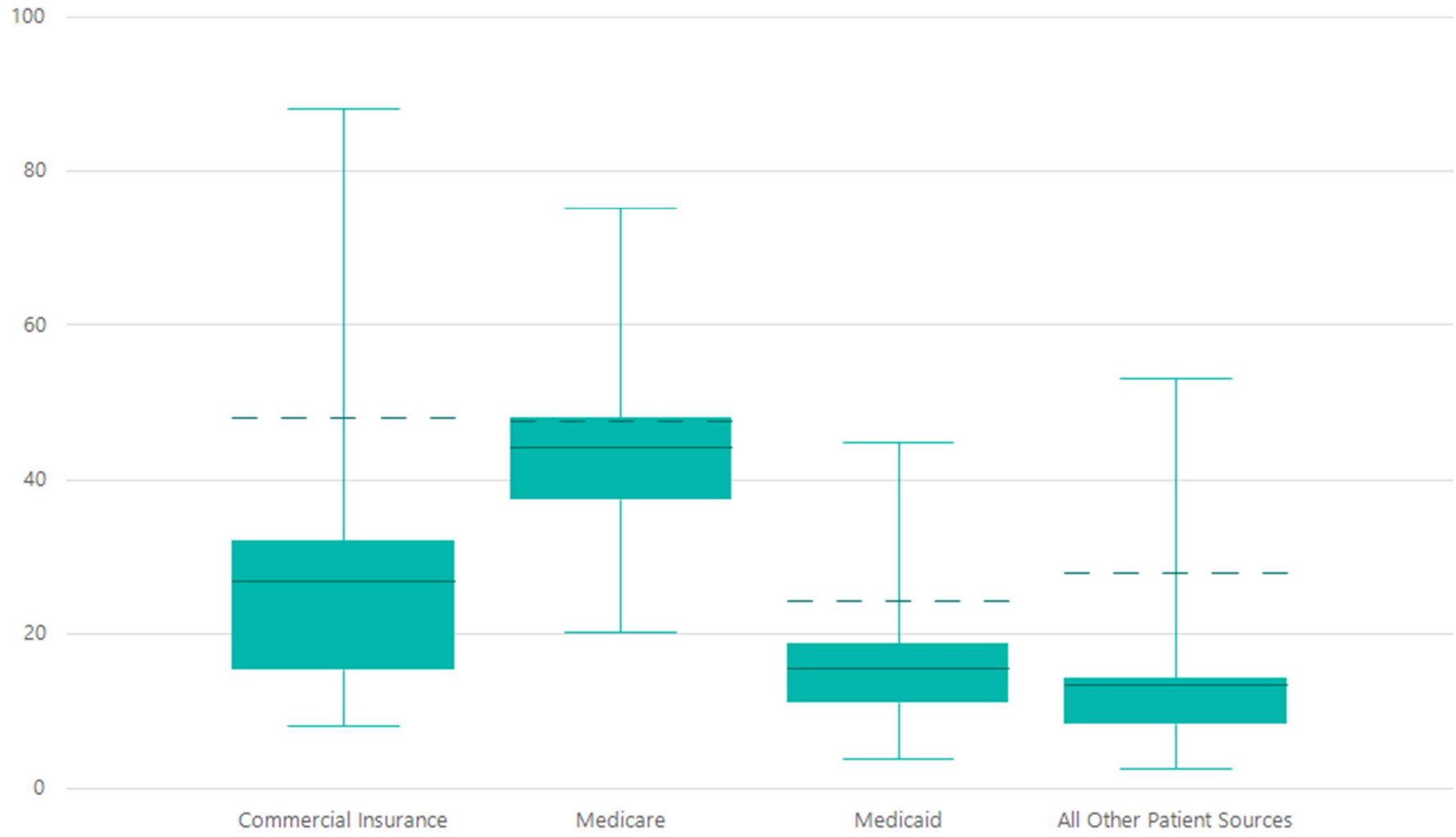
Service Type Revenue Mix	Commercial Insurance	Medicare	Medicaid	All Other Patient Sources
Non-Transporting Service	0%	0%	0%	0%
Transporting Ground Service	27%	44%	15%	13%

Transporting Revenue Mix?	Commercial Insurance	Medicare	Medicaid	All Other Patient Sources
Non-Transporting	0%	0%	0%	0%
Transporting	27%	44%	15%	13%

Revenue Mix


Commercial Insurance
Medicare
Medicaid
All Other Patient Sources
15.5%
13.3%
44.2%
26.7%

Revenue Mix Comparison



Responses in the Other Funding Sources (Grant Revenue, Municipal Subsidies and Tax coverage) was a mix of percentage and dollar values. These have seperated and are reported seperately in the following tables.

Average of Service Structure Other Funding (reported by Percentage)	Grant Revenue	Municipal Subsidies	Tax coverage
Healthcare System Affiliated but Non-Hospital-Based	0%	0%	0%
Hospital Based (Critical Access Hospital)	0%	0%	0%
Hospital Based (Propsective Payment System Hospital)	0%	0%	0%
Municipal -- Fire Department	0%	0%	89%
Municipal -- Non-Fire Department	0%	0%	70%
Private -- Not-for-Profit (Non-Healthcare System Affiliated)	0%	55%	0%

Average of Service Type Other Funding (reported by Percentage)	Grant Revenue	Municipal Subsidies	Tax coverage
First Responder	0%	0%	100%
Ground Ambulance	0%	55%	81%

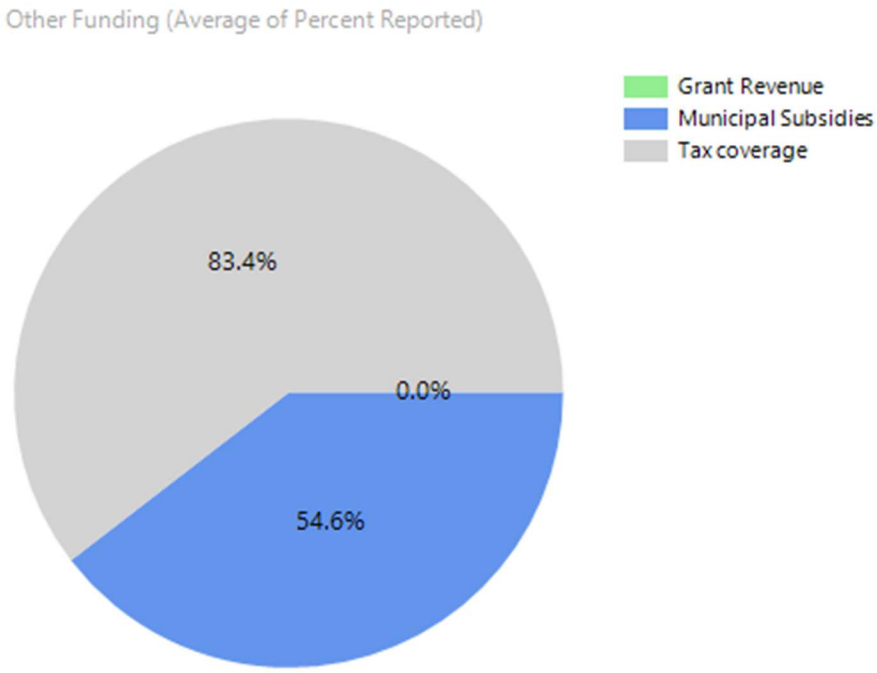
Average of Transporting Other Funding? (reported by Percentage)	Grant Revenue	Municipal Subsidies	Tax coverage
Non-Transporting	0%	0%	100%
Transporting	0%	55%	71%

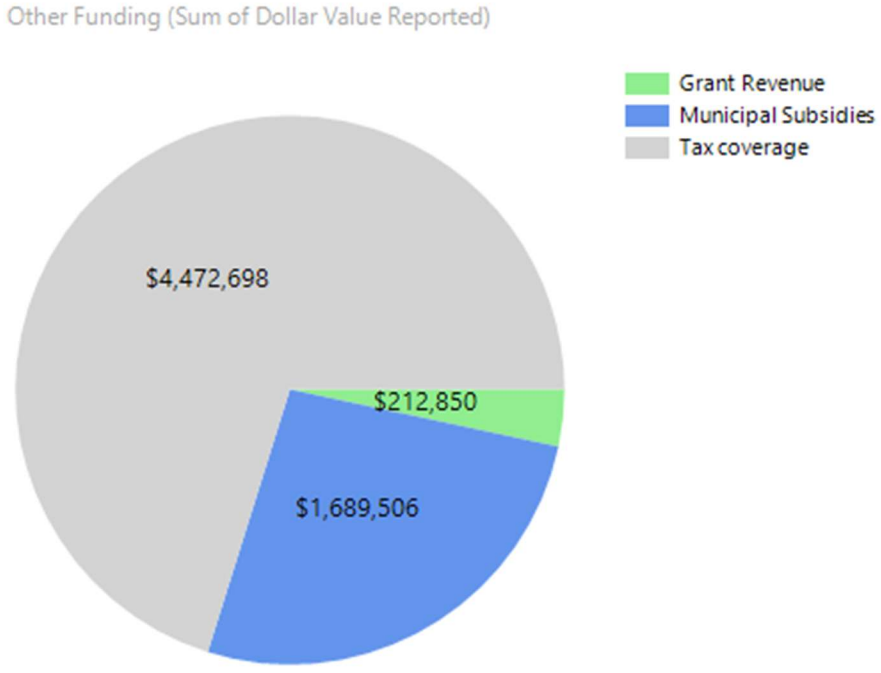
Average of Structure Other Funding (reported by Dollar Amount)	Grant Revenue	Municipal Subsidies	Tax coverage
Healthcare System Affiliated but Non-Hospital-Based		$80,000	
Hospital Based (Propsective Payment System Hospital)	$5,000	$601,140	
Municipal -- Fire Department	$45,617	$46,684	$456,947
Municipal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

Average of Service Type Other Funding (reported by Dollar Amount)	Grant Revenue	Municipal Subsidies	Tax coverage
First Responder			$5,000
Ground Ambulance	$30,407	$187,723	$372,308

Average of Transporting Other Funding? (reported by Dollar Amount)	Grant Revenue	Municipal Subsidies	Tax coverage
Non-Transporting			$5,000
Transporting	$30,407	$187,723	$372,308

Revenue and Expenses	Expenses			Revenue			Revenue/Expense Ratio		
Service Structure	Min	Max	Avg	Min	Max	Avg	Min	Max	Avg
Healthcare System Affiliated but Non-Hospital-Based	$7768055	$7768055	$7768055	$80100	$80100	$80100	0.01	0.01	0.01
Hospital Based (Critical Access Hospital)	$1766814	$1766814	$1766814	$0	$0	$0	0.00	0.00	0.00
Hospital Based (Propsective Payment System Hospital)	$5768489	$5768489	$5768489	$606240	$606240	$606240	0.11	0.11	0.11
Municipal -- Fire Department	$0	$21483980	$1403952	$0	$2317265	$91463	0.00	0.92	0.09
Municipal -- Non-Fire Department	$7272	$2607001	$605648	$0	$520766	$122090	0.00	0.90	0.23
Private -- Not-for-Profit (Non-Healthcare System Affiliated)	$43060	$9172433	$1667109	$0	$470560	$93718	0.00	0.24	0.06

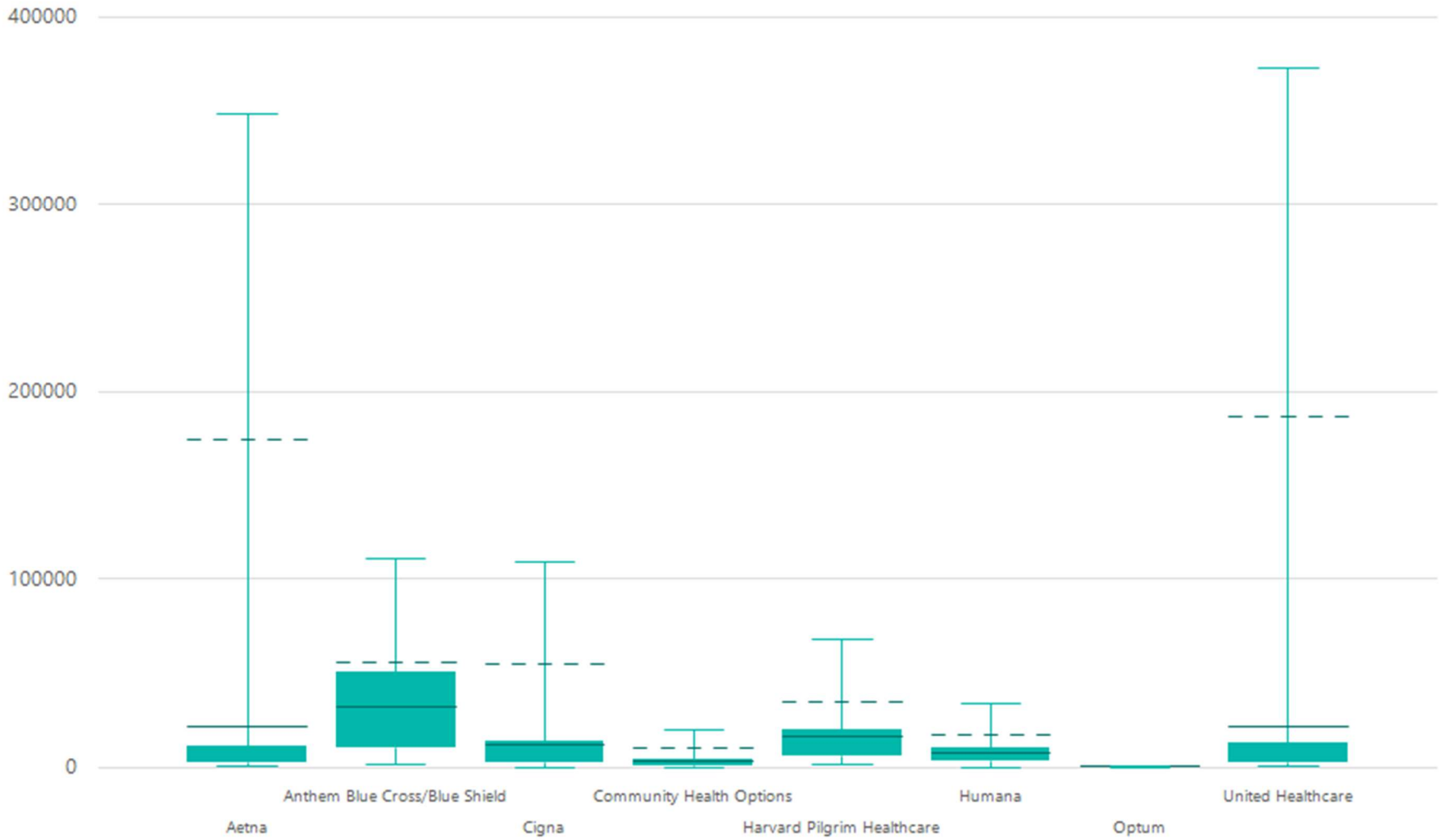

Other Funding (Average of Percent Reported)
Grant Revenue
Municipal Subsidies
Tax coverage
83.4%
0.0%
54.6%


Other Funding (Sum of Dollar Value Reported)
Grant Revenue
Municipal Subsidies
Tax coverage
$4,472,698
$212,850
$1,689,506

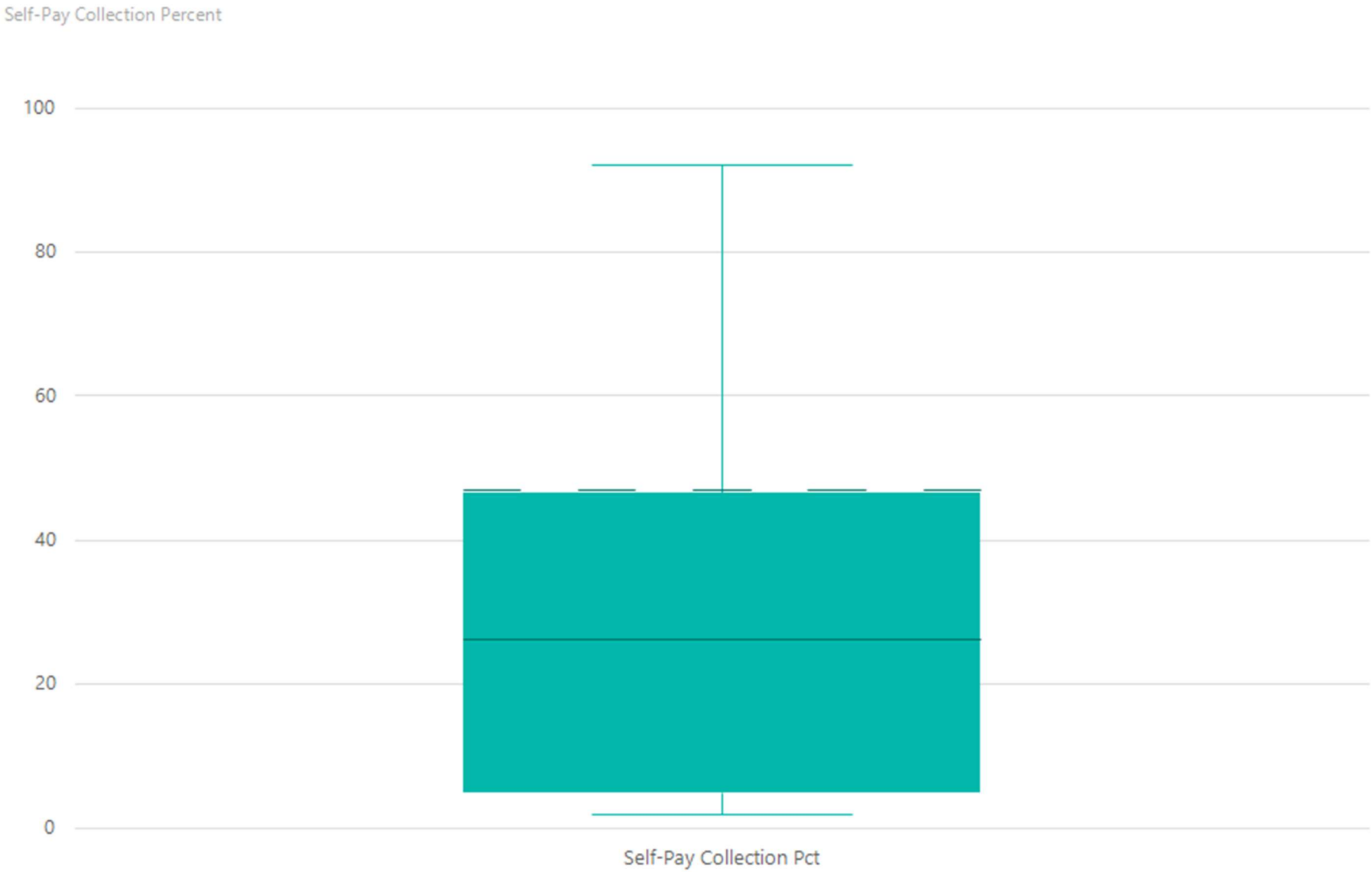
Service Structure Carrier Revenue Amount	Aetna	Anthem Blue Cross/Blue Shield	Cigna	Community Health Options	Harvard Pilgrim Healthcare	Humana	Optum	United Healthcare
Healthcare System Affiliated but Non-Hospital-Based	23311	110509	18814	16783	16273	7513	445	20816
Hospital Based (Critical Access Hospital)			1					
Hospital Based (Propsective Payment System Hospital)								
Municipal -- Fire Department	11964	32968	9382	2517	14693	9782		9921
Municipal -- Non-Fire Department	4555	21202	5566	1384	9214	6571		7641
Private -- Not-for-Profit (Non-Healthcare System Affiliated)	60299	34308	28851	8639	31584	6470	547	79326

Transporting Carrier Revenue Amount	Aetna	Anthem Blue Cross/Blue Shield	Cigna	Community Health Options	Harvard Pilgrim Healthcare	Humana	Optum	United Healthcare
Non-Transporting								
Transporting	21645	32375	12133	3640	16256	8203	496	21555

Commerical Insurance Revenue Amount Comparison

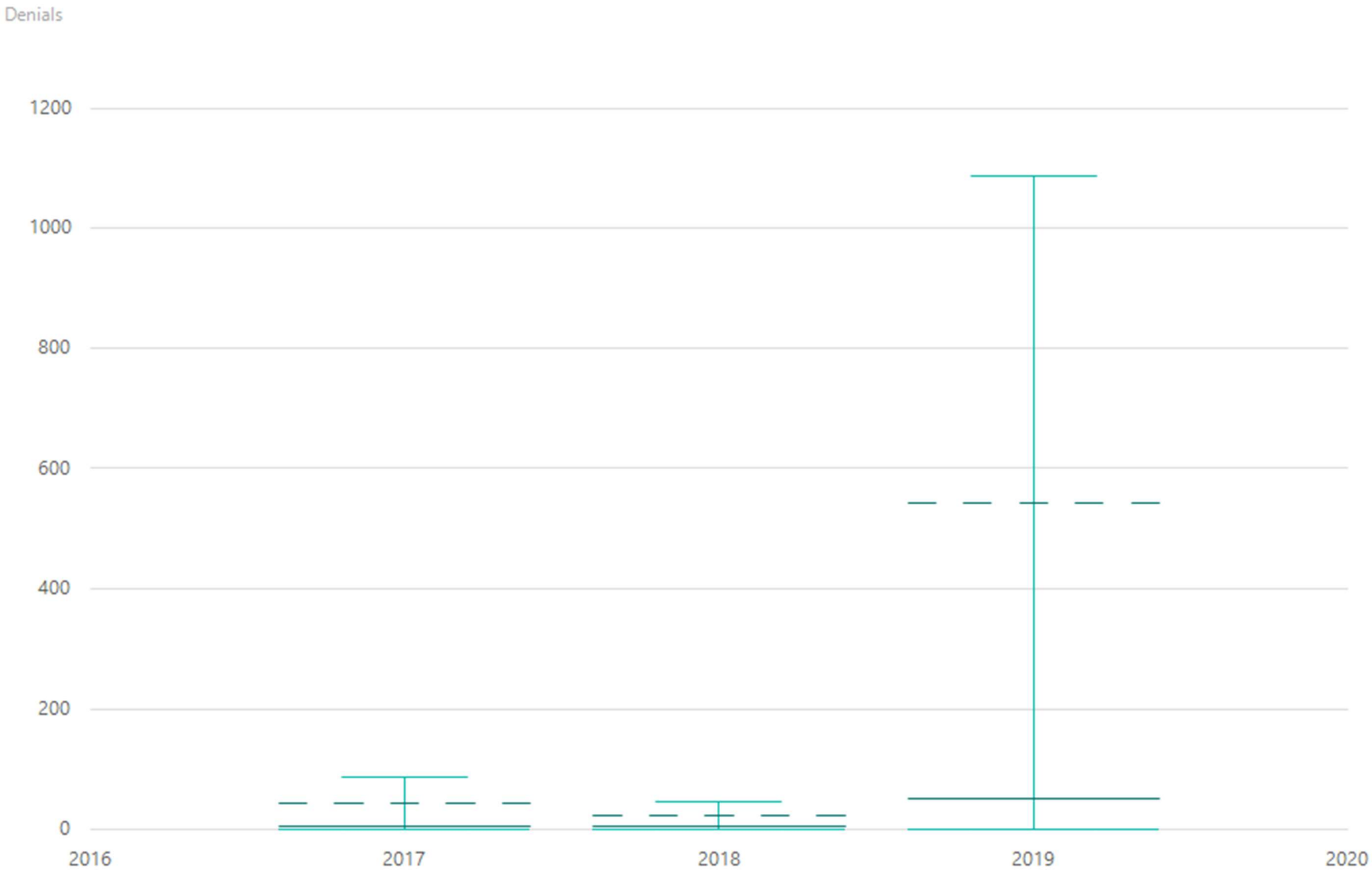


Commercial Insurance Revenue Comparison	Min	Max	Mean	Median	25th Percentile	75th Percentile
Aetna	$1061	$348520	$21645	$174791	$2234	$11684
Anthem Blue Cross/Blue Shield	$1411	$110509	$32375	$55960	$10667	$50515
Cigna	$1	$109110	$12133	$54556	$2809	$13752
Community Health Options	$81	$20502	$3640	$10292	$819	$4077
Harvard Pilgrim Healthcare	$1618	$68240	$16256	$34929	$6354	$19919
Humana	$355	$33754	$8203	$17055	$3470	$10169
Optum	$445	$547	$496	$496	$471	$522
United Healthcare	$463	$372527	$21555	$186495	$2793	$13051


Self-Pay Collection Percent
100
80
60
40
20
0
Self-Pay Collection Pct

Service Structure Insurance Denials	2017	2018	2019
Healthcare System Affiliated but Non-Hospital-Based			1087
Hospital Based (Critical Access Hospital)			
Hospital Based (Propsective Payment System Hospital)			
Municipal -- Fire Department	30	30	33
Municipal -- Non-Fire Department	23	36	29
Private -- Not-for-Profit (Non-Healthcare System Affiliated)	94	60	394

Transporting Insurance Denials	2017	2018	2019
Non-Transporting	0	0	0
Transporting	147	126	1543


Denials
1200
1000
800
600
400
200
0
2016
2017
2018
2019
2020

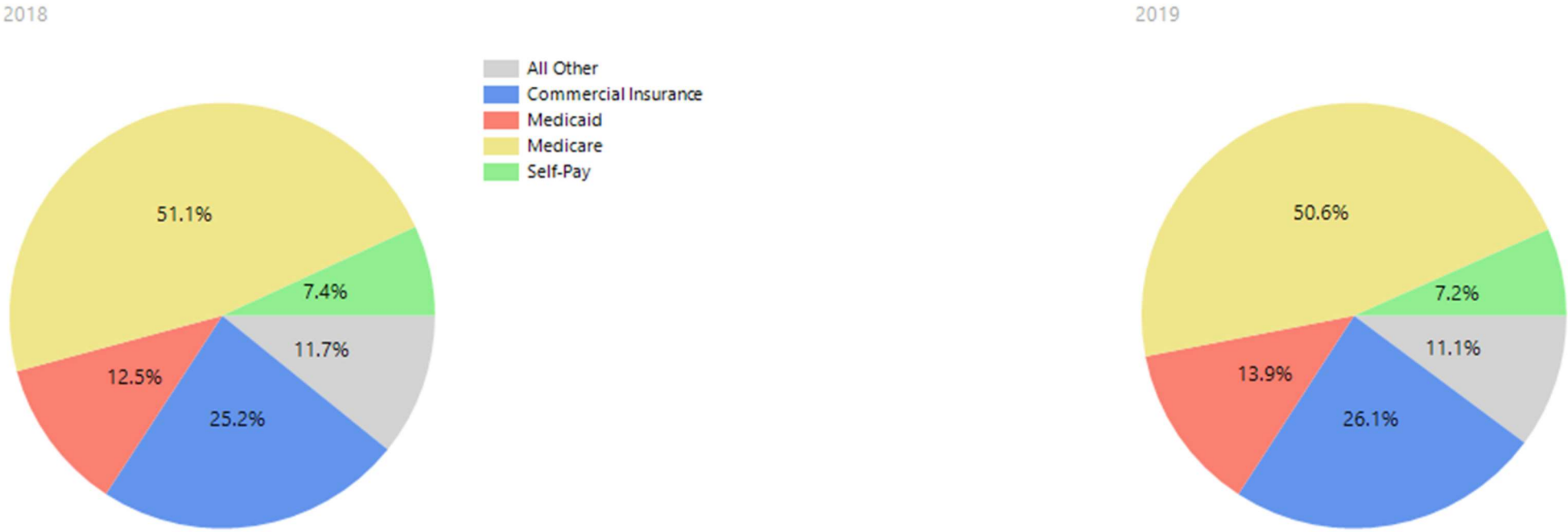
Denials	Min	Max	Mean	Median	25th Percentile	75th Percentile
2017	0	88	5	44	0	0
2018	0	46	4	23	0	0
2019	0	1087	51	544	0	2

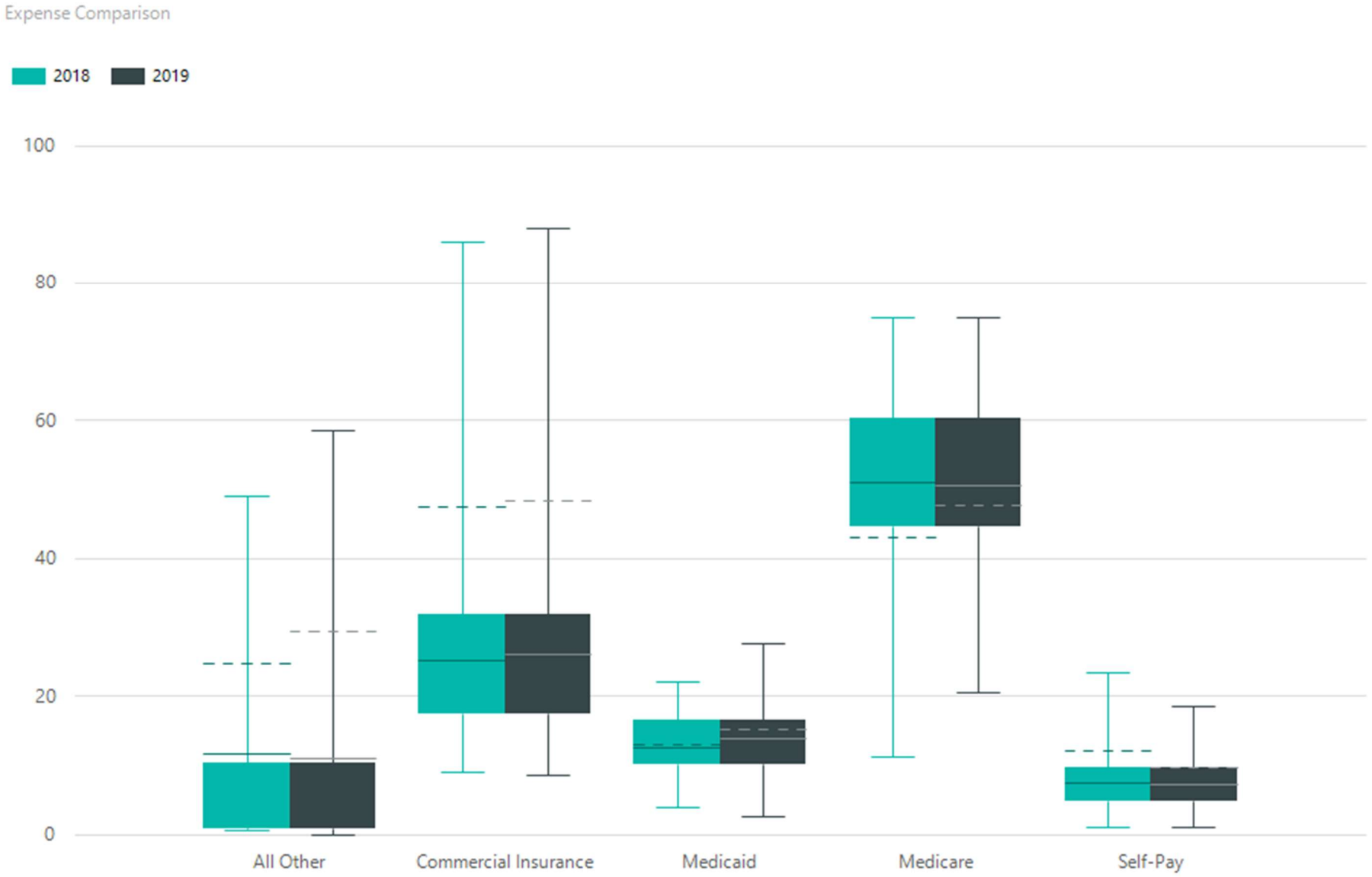
PayerMix

Service Structure	Year	Commercial Insurance	Medicare	Medicaid	Self-Pay	All Other
Healthcare System Affiliated but Non-Hospital-Based	2018	26%	48%	16%	7%	3%
	2019	22%	49%	18%	8%	4%
Hospital Based (Critical Access Hospital)	2018	0%	0%	0%	0%	0%
	2019	0%	0%	0%	0%	0%
Hospital Based (Propsective Payment System Hospital)	2018	18%	56%	15%	6%	6%
	2019	17%	55%	17%	6%	5%
Municipal -- Fire Department	2018	25%	49%	12%	8%	7%
	2019	27%	52%	13%	7%	4%
Municipal -- Non-Fire Department	2018	28%	54%	13%	7%	14%
	2019	28%	53%	14%	8%	15%
Private -- Not-for-Profit (Non-Healthcare System Affiliated)	2018	24%	51%	10%	7%	28%
	2019	24%	43%	14%	6%	32%

Service Structure (Average Weighted Each Row)	Commercial	Medicare	Medicaid	Self Pay	All Other
Healthcare System Affiliated but Non-Hospital-Based	17.51%	71.60%	8.53%	1.60%	0.76%
Hospital Based (Propsective Payment System Hospital)	8.37%	83.05%	7.00%	0.82%	0.75%
Municipal -- Fire Department	19.49%	73.95%	4.66%	1.65%	0.25%
Municipal -- Non-Fire Department	19.56%	73.41%	4.92%	1.49%	0.63%
Private -- Not-for-Profit (Non-Healthcare System Affiliated)	18.52%	73.56%	4.47%	1.37%	2.08%

Service Type	Year	Commercial Insurance	Medicare	Medicaid	Self-Pay	All Other
Non-Transporting Service	2018	0%	0%	0%	0%	0%
	2019	0%	0%	0%	0%	0%
Transporting Air Service	2018	34%	43%	15%	8%	1%
	2019	27%	44%	19%	10%	1%
Transporting Ground Service	2018	25%	51%	12%	7%	13%
	2019	26%	51%	14%	7%	12%




Expense Comparison
2018
2019
100
80
60
40
20
0
All Other
Commercial Insurance
Medicaid
Medicare
Self-Pay

Insurance

Service Structure Insurance Mix 2018	Commercial Insurance	Medicare	Medicaid	Self-Pay	All Other
Healthcare System Affiliated but Non-Hospital-Based	26%	48%	16%	7%	3%
Hospital Based (Critical Access Hospital)	0%	0%	0%	0%	0%
Hospital Based (Propsective Payment System Hospital)	18%	56%	15%	6%	6%
Municipal -- Fire Department	25%	49%	12%	8%	7%
Municipal -- Non-Fire Department	28%	54%	13%	7%	14%
Private -- Not-for-Profit (Non-Healthcare System Affiliated)	24%	51%	10%	7%	28%

Service Type Insurance Mix 2018	Commercial Insurance	Medicare	Medicaid	Self-Pay	All Other
Air Ambulance	34%	43%	15%	8%	1%
First Responder	0%	0%	0%	0%	0%
Ground Ambulance	25%	51%	12%	7%	13%

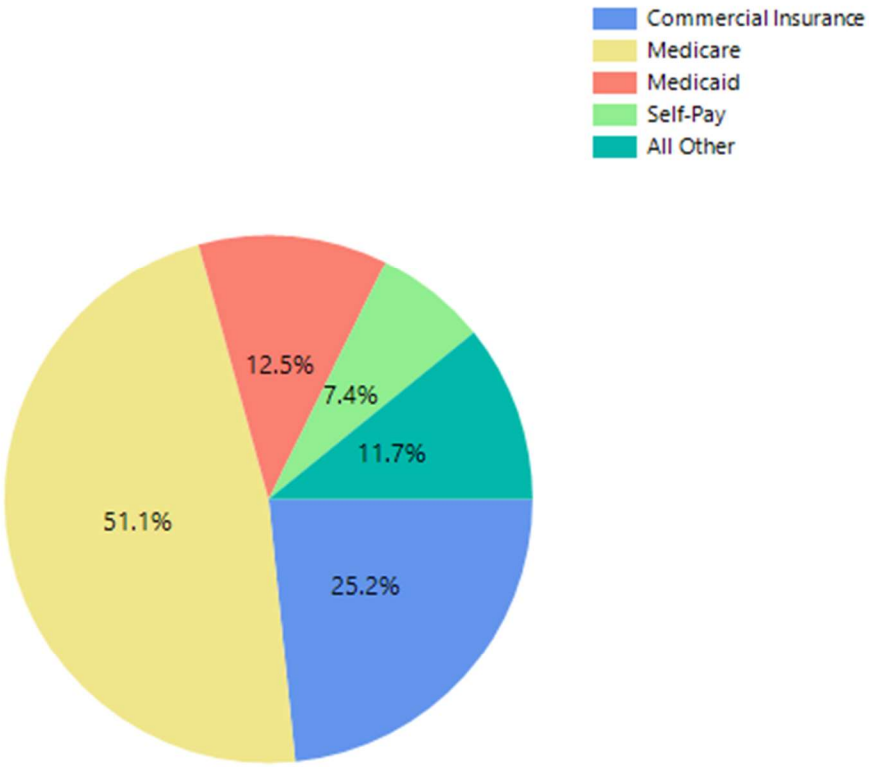
Transporting Insurance Mix 2018	Commercial Insurance	Medicare	Medicaid	Self-Pay	All Other
Non-Transporting	0%	0%	0%	0%	0%
Transporting	25%	51%	13%	7%	12%

Service Structure Insurance Mix 2019	Commercial Insurance	Medicare	Medicaid	Self-Pay	All Other
Healthcare System Affiliated but Non-Hospital-Based	22%	49%	18%	8%	4%
Hospital Based (Critical Access Hospital)	0%	0%	0%	0%	0%
Hospital Based (Propsective Payment System Hospital)	17%	55%	17%	6%	5%
Municipal -- Fire Department	27%	52%	13%	7%	4%
Municipal -- Non-Fire Department	28%	53%	14%	8%	15%
Private -- Not-for-Profit (Non-Healthcare System Affiliated)	24%	43%	14%	6%	32%

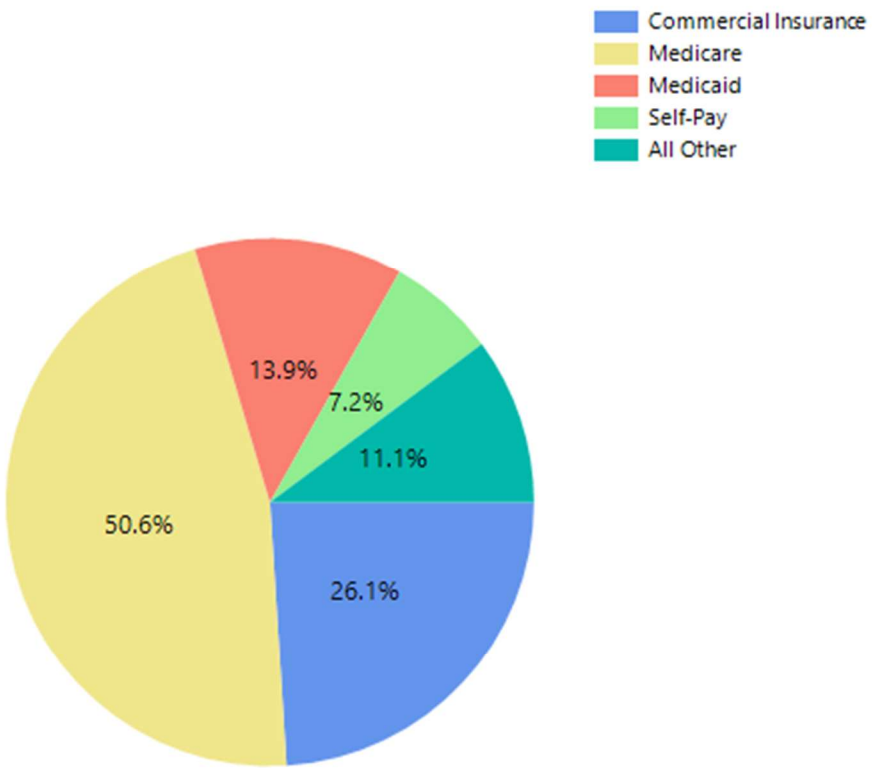
Service Type Insurance Mix 2019	Commercial Insurance	Medicare	Medicaid	Self-Pay	All Other
Air Ambulance	27%	44%	19%	10%	1%
First Responder	0%	0%	0%	0%	0%
Ground Ambulance	26%	51%	14%	7%	12%

Transporting Insurance Mix 2019	Commercial Insurance	Medicare	Medicaid	Self-Pay	All Other
Non-Transporting	0%	0%	0%	0%	0%
Transporting	26%	51%	14%	7%	11%

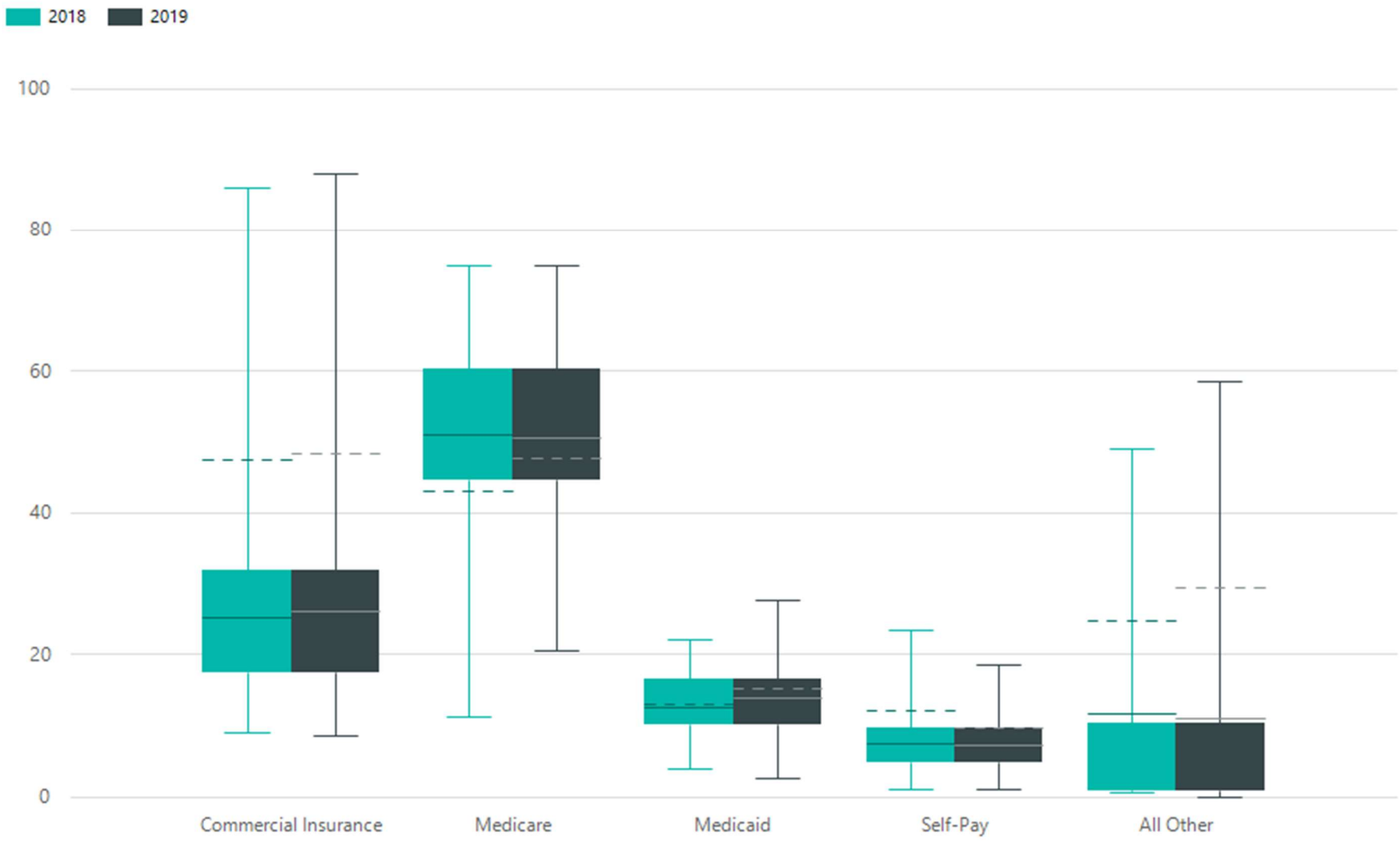
Insuarance Mix 2018



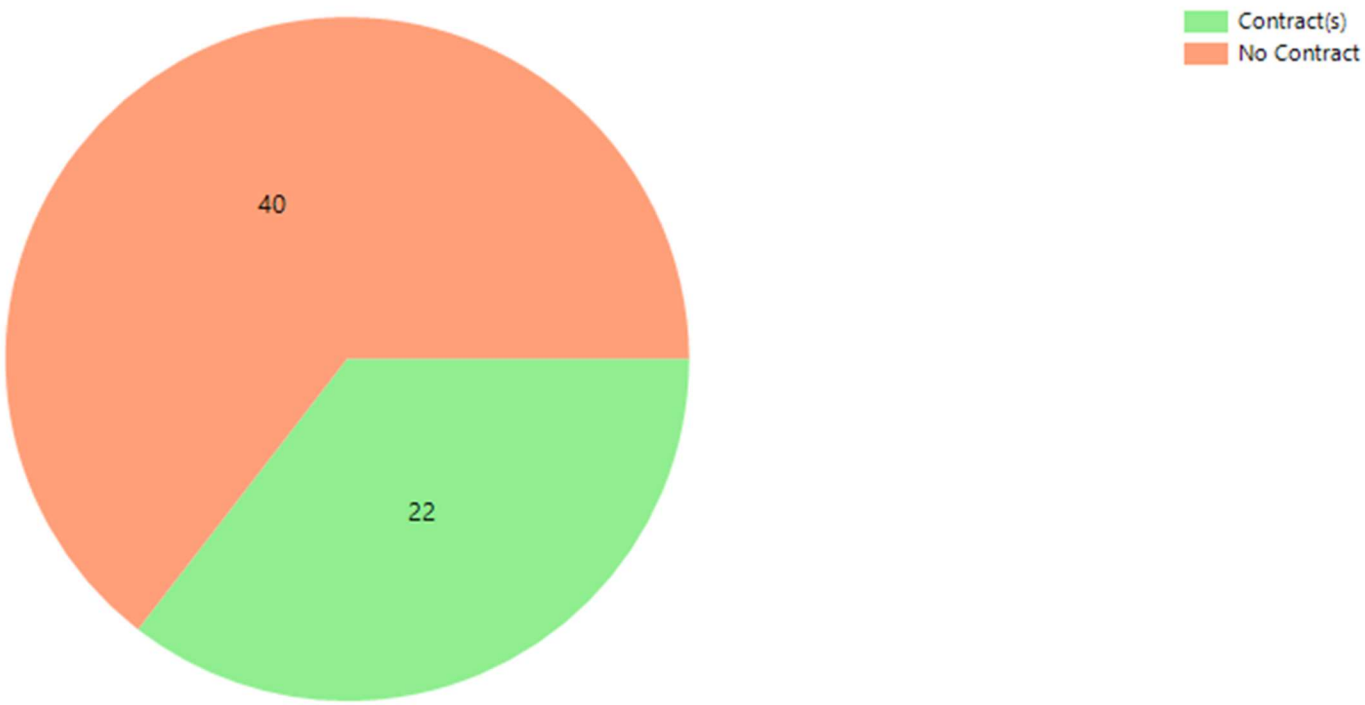
Insurance Mix 2019



Revenue Mix Comparison



Agencies With Contracts



Service Structure	Aetna	Anthem Blue Cross/Blue Shield	Beacon Health	Beacon Hospice	Cigna	Community Health Options	Geisinger	Harvard Pilgrim Healthcare	Humana Commercial	Martins Point	Optum	Tricare	United Health Care	Total
Healthcare System Affiliated but Non-Hospital-Based	0	1	1	1	1	1	1	1	0	1	0	1	0	9
Hospital Based (Critical Access Hospital)	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Hospital Based (Propsective Payment System Hospital)	1	1	0	0	1	1	0	1	0	0	0	0	1	6
Municipal -- Fire Department	4	7	0	0	3	1	0	3	2	0	1	0	3	24
Municipal -- Non-Fire Department	5	5	0	0	2	1	0	2	0	0	0	0	3	18
Private -- Not-for-Profit (Non-Healthcare System Affiliated)	1	4	0	0	1	0	0	1	0	0	0	0	1	8
Total	11	18	1	1	8	4	1	9	2	1	1	1	8	66

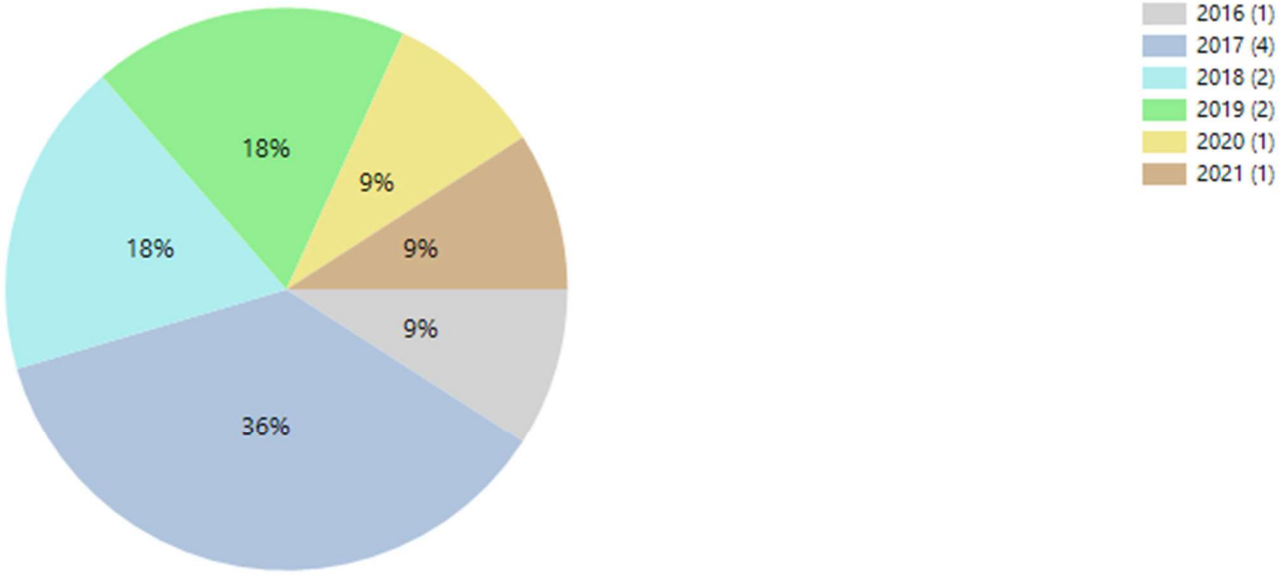
Service Type	Aetna	Anthem Blue Cross/Blue Shield	Beacon Health	Beacon Hospice	Cigna	Community Health Options	Geisinger	Harvard Pilgrim Healthcare	Humana Commercial	Martins Point	Optum	Tricare	United Health Care	Total
Air Ambulance	0	1	1	0	1	1	1	1	0	1	0	1	0	8
Ground Ambulance	11	17	0	1	7	3	0	8	2	0	1	0	8	58
Total	11	18	1	1	8	4	1	9	2	1	1	1	8	66

Transporting	Aetna	Anthem Blue Cross/Blue Shield	Beacon Health	Beacon Hospice	Cigna	Community Health Options	Geisinger	Harvard Pilgrim Healthcare	Humana Commercial	Martins Point	Optum	Tricare	United Health Care	Total
Transporting	11	18	1	1	8	4	1	9	2	1	1	1	8	66
Total	11	18	1	1	8	4	1	9	2	1	1	1	8	66

Reason No Contract
first responder
the fee they are wanting to pay is way below the cost of the service.
non transporting first responders
No billing
We contract with Beacon Hospice, the rates offered from others have not been favorable.
Current rates are to low
Allowed rates are too low and the timely filling period in many cases is too short
Non-Transporting First Responder Service
Allowed rates are too low and the time filing period in many cases is too short.
we do not transport
Municipal Service and we do not bill 0
Get more from Not Contracting with them
Allowed rates are too low and the timely filing period in many cases is too short by the time proper data is collected, verified and billed.
We do not charge
Our small service does not have the resources to negotiate contracts with insurers. If an insurer requires us to sign a contract, we do so.
Do not charge for any services
Aetna Unfavorable rates
Contracts pay less and give less time for billing. The premise of a contract is that the insurance company will refer patients thereby having more patients. As we are an emergency response service we receive calls without a contract.
First responder EMS non transport service
Non-transporting
we do not bill
We do with numerous ones that we deal with on a regular basis, theones we don't just make it so hard to get a hold of or contact with like Mass Medicade
Unknown
Rates or low volume
Volunteer service, funded by local tax dollars

Never been asked or area ware of need
The allowed amount is about the same as the medicaid allowed amount. Also some have a 90 day window to get claims in.
The allowed amount is about the same as the medicaid allowed amount. Also some have a 90 day window to get claims in
no reason
Non billing small service. 100% funded by tax payer dollars.
non transport ems squad
Inappropriate
The allowed amount is not to much higher than medicaid allowed amount. also the time limit is to short of a window
Would have to except a lower reimbursement rate
unknown
The allowed rates are almost the same rates we get from Medicaid. Also the time limit to send claims is so short.
Submit bills
Non transporting service
Less Revenue collected
Time limit to file is too short and the payments received is almost equal to what Medicaid pays.
Waiting on answer form billing company
The allowed amount or what they actually pay is very low. It is about the same amount as what Medicaid pays. Also the time limit to file a claim is too short for some of the insurance companies and makes it cost prohibitive for our type of needs.
We don't bill
non transport service
We do not bill.
The allowed amount is the same as the medicaid amount also have a 90 day window to get claim in
we do
It is not beneficial for Ambulance to contract the premise of a contract that the provider will be refused more patients Ambulance service Contacted by 911. They do not take referrals for EMS calls.
The allowed amount is to low, its almost equal to Medicaid allowed amount. ALS - the time limit to file claim is to short.

Reported Contract Last Updated



Service Structure	Aetna	Anthem Blue Cross/Blue Shield	Cigna	Community Health Options	Harvard Pilgrim Healthcare	Humana Commercial	Optum	United Health Care	Total
Healthcare System Affiliated but Non-Hospital-Based	2	2	2	2	2	2	1	2	15
Hospital Based (Critical Access Hospital)	0	0	1	0	0	0	0	0	1
Hospital Based (Propsective Payment System Hospital)	0	0	0	0	0	0	0	0	0
Municipal -- Fire Department	14	15	13	11	13	10	0	14	90
Municipal -- Non-Fire Department	8	9	9	7	8	5	0	9	55
Private -- Not-for-Profit (Non-Healthcare System Affiliated)	7	7	6	3	5	4	1	5	38
Total	31	33	31	23	28	21	2	30	199

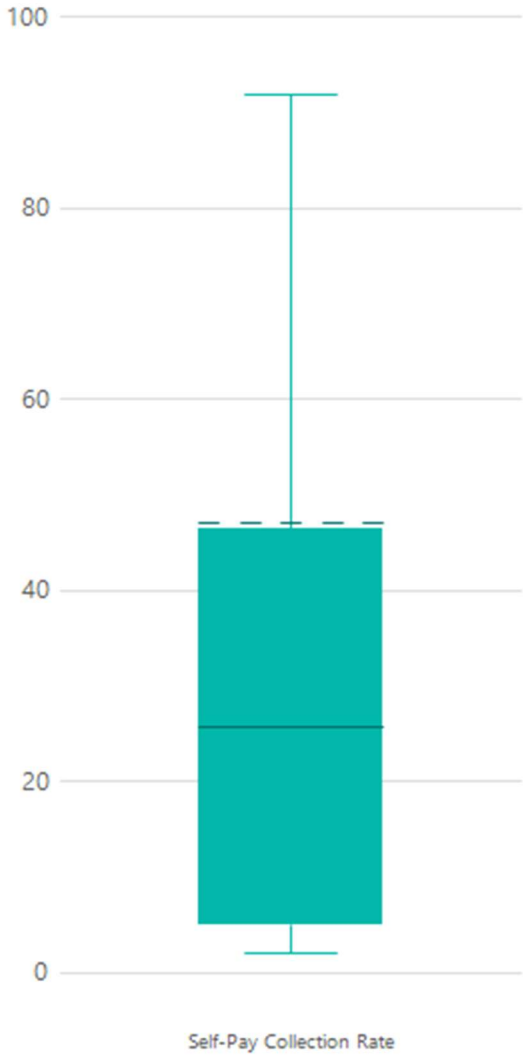
Service Type	Aetna	Anthem Blue Cross/Blue Shield	Cigna	Community Health Options	Harvard Pilgrim Healthcare	Humana Commercial	Optum	United Health Care	Total
Air Ambulance	1	1	1	1	1	1	0	1	7
First Responder	0	0	0	0	0	0	0	0	0
Ground Ambulance	30	32	30	22	27	20	2	29	192
Total	31	33	31	23	28	21	2	30	199

Transporting	Aetna	Anthem Blue Cross/Blue Shield	Cigna	Community Health Options	Harvard Pilgrim Healthcare	Humana Commercial	Optum	United Health Care	Total
Non-Transporting	0	0	0	0	0	0	0	0	0
Transporting	31	33	31	23	28	21	2	30	199
Total	31	33	31	23	28	21	2	30	199

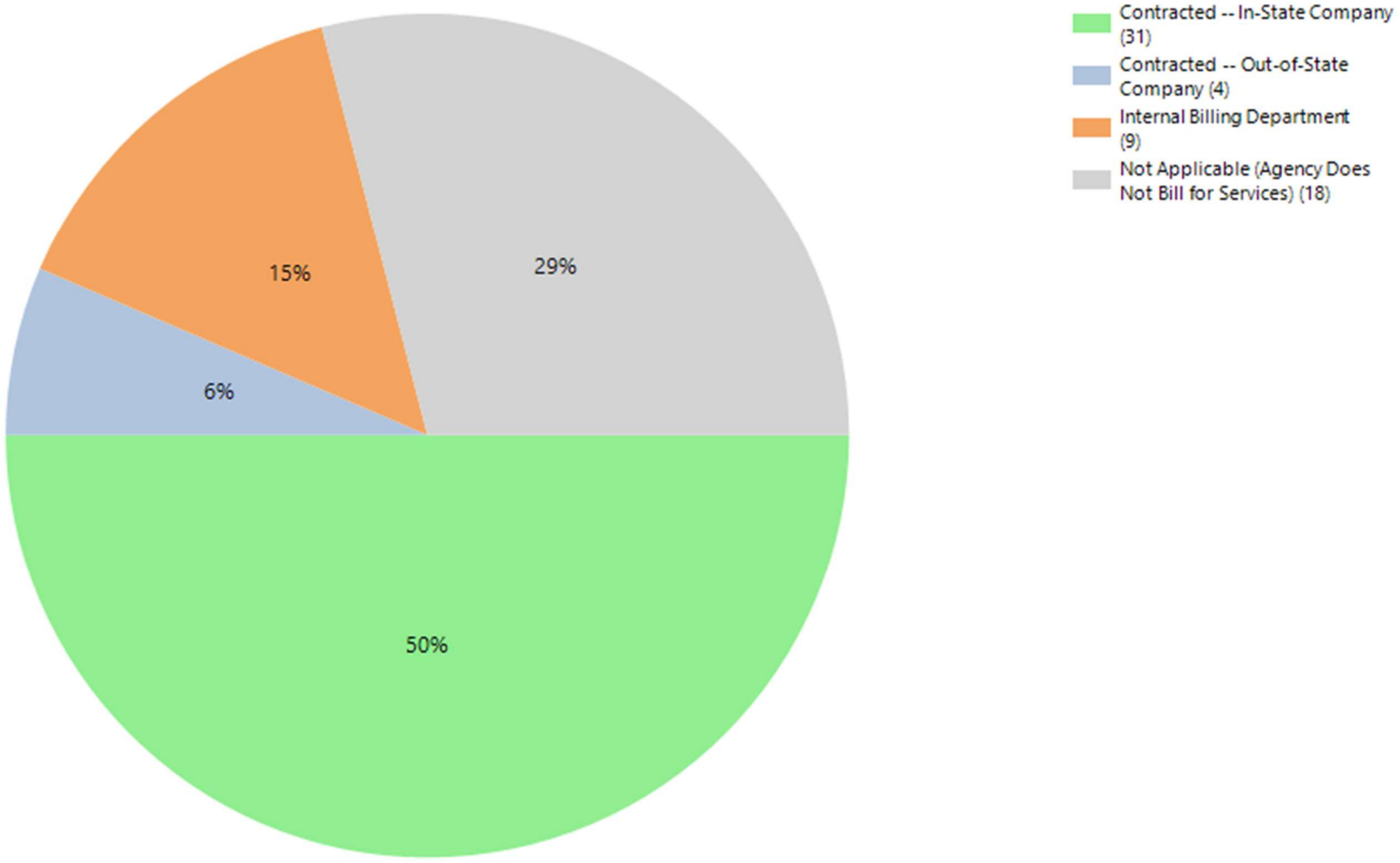
Service Structure	Aetna	Anthem Blue Cross/Blue Shield	Cigna	Community Health Options	Harvard Pilgrim Healthcare	Humana Commercial	Optum	United Health Care	Total
Healthcare System Affiliated but Non-Hospital-Based	$185638	$1336331	$201307	$249233	$279665	$15582	$445	$116575	$317940
Hospital Based (Critical Access Hospital)			$1						$1
Hospital Based (Propsective Payment System Hospital)									
Municipal -- Fire Department	$11964	$32968	$9382	$2517	$14693	$9782		$9921	$13771
Municipal -- Non-Fire Department	$4555	$21202	$5566	$1384	$9214	$6571		$7641	$8407
Private -- Not-for-Profit (Non-Healthcare System Affiliated)	$60299	$34308	$28851	$8639	$31584	$6470	$547	$79326	$37954
Total	$32171	$109035	$24122	$24424	$35070	$8939	$496	$27915	$39764

Service Type	Aetna	Anthem Blue Cross/Blue Shield	Cigna	Community Health Options	Harvard Pilgrim Healthcare	Humana Commercial	Optum	United Health Care	Total
Air Ambulance	$347964	$2562153	$383799	$481682	$543057	$23650		$212334	$650663
First Responder									
Ground Ambulance	$21645	$32375	$12133	$3640	$16256	$8203	$496	$21555	$17492
Total	$32171	$109035	$24122	$24424	$35070	$8939	$496	$27915	$39764

Transporting	Aetna	Anthem Blue Cross/Blue Shield	Cigna	Community Health Options	Harvard Pilgrim Healthcare	Humana Commercial	Optum	United Health Care	Total
Non-Transporting									
Transporting	$32171	$109035	$24122	$24424	$35070	$8939	$496	$27915	$39764
Total	$32171	$109035	$24122	$24424	$35070	$8939	$496	$27915	$39764


100
80
60
40
20
0
Self-Pay Collection Rate

How Billed


Contracted -- In-State Company (31)
Contracted -- Out-of-State Company (4)
Internal Billing Department (9)
Not Applicable (Agency Does Not Bill for Services) (18)
15%
29%
6%
50%

Service Structure Insurance Denials	2017	2018	2019	Total
Healthcare System Affiliated but Non-Hospital-Based	370	230	1219	1819
Hospital Based (Critical Access Hospital)				
Hospital Based (Propsective Payment System Hospital)				
Municipal -- Fire Department	30	30	33	93
Municipal -- Non-Fire Department	23	36	29	88
Private -- Not-for-Profit (Non-Healthcare System Affiliated)	94	60	394	548
Total	517	356	1675	2548

Service Type Insurance Denials	2017	2018	2019	Total
Air Ambulance	370	230	132	732
First Responder	0	0	0	0
Ground Ambulance	147	126	1543	1816
Total	517	356	1675	2548

Transport Insurance Denials	2017	2018	2019	Total
Non-Transporting	0	0	0	0
Transporting	517	356	1675	2548
Total	517	356	1675	2548

Air Ambulance

Question	Response
Service Structure	
Population Served by the Agency	
Number of towns/cities/unorganized townships for which the service is the primary service provider	
Total Number of Responses (excluding wheelchair transports)	2267
Total Number of Emergency (911) Transports	215
Total Number of 911 Calls where Patient Contact was Made but the Patient was Not Transported	242
Total Number of Non-Emergency Transports	0
Total Number of Emergency IFT Transfers	2052
Total Number of Wheelchair Transports	0
Total full-time equivalents (FTEs) for the 2019 Fiscal Year (total worked hours divided by 2080)	108
Numer of Full Time Employees (32+ Scheduled Hours)	103
Number of Part Time Employees (16-32 Scheduled Hours)	5
Other than full or part-time (non-volunteer, including per-diems)	0
Number of Volunteer Hours per Year used to cover ambulance	0
(Fire Departments Only) Total clinical FTEs allocated to the ambulance service (total worked hours divided by 2080)	0
Clinical Salaries and Wages (Non-Administrative)	4196728
Clinical Fringe Benefits and Payroll Taxes (Non-Administrative)	1974930
Medical Supplies	270557
Medical Director (If Applicable)	284884
Dispatch Fees and Communication Expenses	498316
Repairs and Maintenance	2400419
Equipment Purchases (not included in depreciation or information technology)	1317057
Ambulance Fuel (If Applicable)	707229
Leases, Rent, and/or Mortgage for Building(s)	190786

Air Ambulance

Compliance/Licensing/Quality Management	131892
Regional Fees/Membership Dues	9258
Utilities	40287
Information Technology	84285
Billing Fees	204703
Insurance	341025
Depreciation and Amortization	911244
Total Cost of Bad Debt and Charity Care	1716609
All other expenses	3235042
Please give a brief description of your "other expenses"	
Ground ambulance mileage (Code A0425)	
ALS Non-Emergency (Code A0426)	
ALS One (1) Emergency (Code A0427)	
BLS Non-Emergency (Code A0428)	
BLS Emergency (Code A0429)	
Fixed Wing Base (Code A0430)	8633.61
Rotor Wing Base (Code A0431)	9654.49
ALS Two (2) Emergency (Code A0433)	
Specialty Care/PIFT (Code A0434)	
Fixed Wing Mileage (Code A0435)	62.01
Rotor Wing Mileage (Code A0436)	88.54
Ground ambulance mileage (Code A0425)	
ALS Non-Emergency (Code A0426)	
ALS One (1) Emergency (Code A0427)	
BLS Non-Emergency (Code A0428)	
BLS Emergency (Code A0429)	
Fixed Wing Base (Code A0430)	9703.34
Rotor Wing Base (Code A0431)	10426.96
ALS Two (2) Emergency (Code A0433)	
Specialty Care/PIFT (Code A0434)	
Fixed Wing Mileage (Code A0435)	69.45
Rotor Wing Mileage (Code A0436)	95.62

Air Ambulance

Do you bill for care in cases where patients are not transported?	
If yes, what is the charge?	
Commercial Insurance Payment Service Revenue (Percentage of Total Claims)	50
Medicare Patient Service Revenue (Percentage of Total Claims)	40
Medicaid Patient Service Revenue (Percentage of Total Claims)	9
All Other Patient Service Revenue (Percentage of Total Claims)	1
Grant Revenue	6
Municipal Subsidies (non-municipal services only)	
Tax coverage (municipal services only)	
Medicaid Percentage (Percentage of Payer Mix 2018)	15
Medicare Percentage (Percentage of Payer Mix 2018)	43
Commercial Insurance Percentage (Percentage of Payer Mix 2018)	34
Self-Pay (Percentage of Payer Mix 2018)	8
All Other (Percentage of Payer Mix 2018)	0.5
74 Medicaid Percentage (Percentage of Payer Mix 2019)	19
75 Medicare Percentage (Percentage of Payer Mix 2019)	44
76 Commercial Insurance Percentage (Percentage of Payer Mix 2019)	26.5
77 Self-Pay (Percentage of Payer Mix 2019)	10
78 All Other (Percentage of Payer Mix 2019)	0.5
Does your service have a contract with any of the following insurance providers?	
If your service does not contract with an insurance carrier, why not?	
If your service does contract with an insurance carrier, when was your contract last updated?	2019
Please indicate how much revenue was received from Aetna in FY2019.	347964
Please indicate how much revenue was received from Anthem Blue Cross/Blue Shield in FY2019.	2562153

Air Ambulance

Please indicate how much revenue was received from Cigna in FY2019.	383799
Please indicate how much revenue was received from Community Health Options in FY2019.	481682
Please indicate how much revenue was received from Harvard Pilgrim Healthcare in FY2019.	543057
Please indicate how much revenue was received from Humana Commercial in FY2019.	23650
Please indicate how much revenue was received from Optum in FY2019.	
Please indicate how much revenue was received from United Health Care in FY2019.	212334
What percentage of your self-pay charges did you collect in FY019?	8.8
How is your billing completed?	
What is your total number of insurance denials in fiscal year 2017	370
What is your total number of insurance denials in fiscal year 2018	230
What is your total number of insurance denials in fiscal year 2019	132
Notes	

APPENDIX C MeAHP SURVEY RESULTS

December 11, 2020

MeAHP Membership Survey Results
Public Law c. 668 -- Ambulance Work Group

Please note: summary responses are compilations of comments received and therefore not every response is reflective of every plan.

QUESTION	RESPONSES
Q1: How many ambulance services does your plan contract with? How long have you had those contracts?	***MeAHP summary response:*** Respondents report between 3 and 8 contracts with ambulance providers. Some contracts signed within the last three years; others are more than 10 years old. Note: Some Plans have seen ambulance providers drop their contracts since the passage of LD 2105/PL c. 668, presumably to take advantage of the new requirement that carriers pay charges until Oct. 2021.
Q2: What is your experience with ambulance providers going OON? Why do they do so?	***MeAHP summary response:*** Respondents indicate that ambulance providers decline to contract and/or don't respond to health plan outreach efforts. This is especially true for municipal services. There is no incentive to contract when full charges are paid to OON providers. In addition, OON providers preserve the ability to balance bill patients. Ambulance providers struggle to meet operational policies and procedures, including prior authorization requirements.
Q3: What do you see as common billing and/or contracting challenges for ambulance services?	***MeAHP summary response:*** • Base charges for services and mileage vary widely, and therefore are difficult to substantiate whether they reflect actual costs plus margin, or some overestimation without foundation. • Non-response to outreach attempts at establishing a contract for their services. • Municipal operated ambulance providers have indicated that their fiscal budgeting needs have to be flexible and that they are not staffed to support negotiation of contracts with commercial plans.

	• Resistance to comply with plan payment policies and procedures. • Since the services are largely provided in an emergency, there is little incentive for an ambulance provider to agree to contract reimbursement. • A lack of providers offering non-emergent transportation when medically necessary often leads to extreme difficulty locating providers who are able to medically transport complex patients for certain care. • Low payment rates from Medicare and Medicaid are commonly referenced as the rationale for requiring higher reimbursement.
Q4: What would you recommend to get ambulance services to contract with health plans?	***MeAHP summary response:*** • Standardize or cap payment rates • Eliminate balance billing • Offer better or zero cost-sharing provisions that reduce the administrative burden and write-off portfolio of the ambulance service in exchange for favorable rates.
Q5: What are typical reasons for denials for ambulance services? What are the complexities in measuring denial rates?	***MeAHP summary response:*** • Ambulance provider inability to file claims within reasonable time frames/claim filing limits – can be exacerbated by coordination of benefits with VA and Medicare • Seeking coverage for services that are not medically necessary (e.g. non-emergent transports) • Typical denials are related to eligibility – services billed for individuals that were either former members, or that are members of another health plan.
Q6: Are there geographic areas of Maine where your plan struggles with contracting? Are there certain services your plan struggles to contract for?	***MeAHP summary response:*** • The lack of providers offering non-emergent transportation when medically necessary is an issue. It is challenging to locate providers who are able to medically transport members with complex conditions for care. • Challenges exist across the state, especially with private ambulance companies. Ambulance services owned by hospitals typically do have contracts. • Rural areas where larger ambulance companies do not have a presence can be difficult.

APPENDIX D FINANCIAL REVIEW

Publicly available data allows for the analysis of financial performance for not-for-profit ambulance companies in the state. The below lists the 2nd, 3rd, and 4th largest services by volume and their financial performance by year. Financial data for the largest service is not publicly reported.

Service Name	FY2017 Net Income / Margin	FY2018 Net Income / Margin
United Ambulance Service*	$65,830 / 0.6%	($21,856) / -0.5%
Delta Ambulance	($525,538) / -7.2%	$126,543 / 1.5%
Northern Light Medical Transport	N/A	($617,913) / -7.5%

*United Ambulance Services operates under the NPIs of Central Maine Medical Center and St. Mary's Regional Medical Center

APPENDIX E APPROACHES BY OTHER STATES

Connecticut

The **Connecticut** Office of Emergency Medical Services ("OEMS") has been maintaining the rates ambulance services are paid for several decades. The basis for the original rate set is unknown to the person currently responsible for the rate schedule within OEMS. OEMS auditors annually adjusts the previous base amounts based upon a federal cost index (3.1% for 2021). To use the OEMS approved rates, services must submit a short form annually that is reviewed within OEMS. Unless otherwise approved as part of a long form process (explained below), the rates set by OEMS are the rates paid for each category, whether billed directly to the patient or through contract. Services who either did not participate in the prior year or who want to petition to charge a different rate must submit a more detailed long form financial statement that is reviewed by a non-OEMS auditor. In a typical year there are only one or two services who pursue a long form process. This year due to COVID, the commercial ambulance services submitted a long form request for a 25% increase. A decision on that application is pending.

OEMS does not have an assessment of how this rate structure has impacted providers.

Connecticut does have a Certificate of Need ("CON") process that includes an application for a new or expanded transporting service, which involves an application to OEMS and a hearing conducted by a hearing officer with interested or affected parties able to participate. The decision of the hearing officer is final.

New Mexico

The rate in **New Mexico** is established by the Transportation Division of the Public Regulation Commission. The Commission establishes an ambulance tariff, which establishes the rate for each category. Each provider also has the right to apply for their own tariff through the Public Relations Commission.

New Mexico also has a CON process that is handled by the Public Regulation Commission. Both the CON and tariffs have been in place since the mid-1970s to resolve literal fights happening between competing ambulance services at emergency scenes.

Similar to Connecticut, they do not have data on the impact of the rates on services.

Colorado

Colorado went through a process similar to Maine in 2018-19 and established a non-contract rate of 275% of the Medicare fee schedule, that has subsequently been increased to 325% of Medicare. This rate was set by the Division of Insurance as a compromise between insurance carriers and ambulance providers. An untoward consequence of the legislation is a provision that exempts fire-based ambulance services from this rate and a subsequent interpretation that this exemption also includes non-fire county-based services of which there are many.

These non-fire-based county EMS services are working with the Bureau of EMS to resolve the issue of being able to bill at the same rate as private services and are hopeful this can be done through a departmental rulemaking process.

It is unclear if an assessment has been done on the impact of this rate upon service financial stability.

Another reimbursement mechanism for Colorado services was enactment is the Ground Emergency Medical Transport ("GEMT"), which provides a supplemental payment that covers the funding gap between a provider's actual cost per GEMT guidelines and the amount paid by their state Medicaid plan. Funding for GEMT is part of the federal Medicaid program.

APPENDIX F AIR AMBULANCE REVIEW

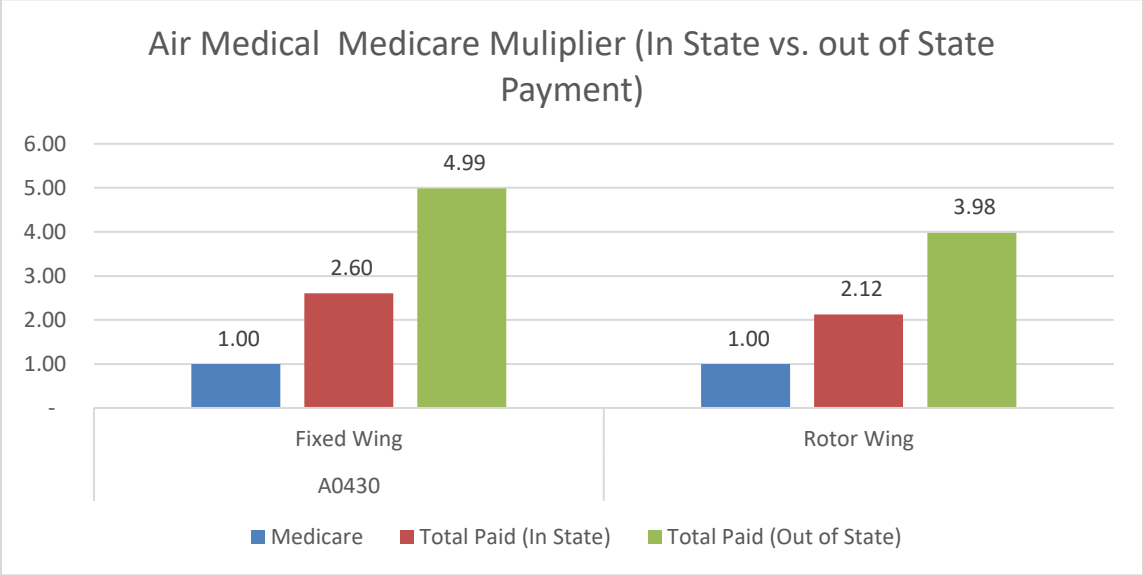
Air Ambulance Review

Air ambulance information was analyzed separately from ground ambulance. Maine currently has one air ambulance provider based in Sanford, Lewiston and Bangor, which provided fixed and rotor wing air ambulance services. The service reports its charges to be among the lowest in the nation. Publicly available financial information from 990 reports revealed the following financial information.

Organization Name	FY2017	FY2018
LifeFlight of Maine**	$250,524/ 1.7%	$-($487,964) / (-4%)

**Net gain/loss includes significant offset of contributions from LifeFlight Foundation to support operations. $1,842,473 in FY18 and $2,481,170 in FY19

Data from MHDO also showed that Maine-based providers of air medical services are paid just over half of what out-of-state providers are paid.



The committee discussed applicability and enforceability of balance billing restrictions on air ambulance providers. The Airline Deregulation Act of 1978 created a situation of federal preemption, where because patients of air medical services are passengers, states' restrictions on air ambulance balance billing have been invalidated by courts. The 2017 issue of "Health Policy Report" published by Consumer Reports cited several court cases that upheld this interpretation, including Northwest, Inc. v. Ginsberg, 134 S. Ct. 1422 (2014); Med-Trans Corp. v. Benton, 581 F. Supp. 2d 721, 732-33 (E.D.N.C. 2008); Eagle Air Med Corp. v. Colorado Bd. of Health, 570 F. Supp. 2d 1289 (D. Colo. 2008), aff'd on other grounds, 377 F. App'x 823 (10th Cir. 2010). See also Letter from D.J. Gribbin, DOT Gen. Counsel, to Greg Abbott, Tex. Att'y Gen. (Nov. 3, 2008).

Based on this case history, state surprise billing restrictions on air ambulance providers are likely to be challenged and could be invalidated. However, as discussed above, recent federal government action through the Consolidated Appropriations Act, 2021, provides new protections from surprise air ambulance bills for those enrolled in commercial health plans.