

**PROPOSED RECOMMENDATIONS INCLUDED IN LD 2105 REPORT RELATED TO AMBULANCE REIMBURSEMENT RATES**

Public Law 2019, chapter 668 directed the Emergency Medical Services' Board to convene a stakeholder group to review issues related to reimbursement rates for ambulance services. The law directed the stakeholder group to 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 law authorizes the HCIFS Committee to report out a bill based on the report to the First Regular Session of the 130th Legislature.

<b>Recommendation</b>	<b>Include?</b>
Balance billing for ambulance services should be prohibited	
Improve reimbursement for rural low volume providers by requiring MaineCare to adopt similar methodology used by Medicare and encouraging carriers to recognize increased costs for rural providers	
Require EMS Board to establish recommendations within 12 months for a process to evaluate delivery efficiency before granting new service license	
Establish standardized reimbursement rates tied to multiplier of Medicare rates <ul style="list-style-type: none"> <li>• Base on the urban rate in the locality in which the services were delivered;</li> <li>• Apply different multipliers to network and out-of-network providers</li> </ul>	
Establish “voluntary standard offer” contract for carriers and ambulance providers <ul style="list-style-type: none"> <li>• 24-month term;</li> <li>• 180-day notice of termination;</li> <li>• 120 days to submit claims</li> </ul>	
Require EMS providers to annually report cost and performance metrics	
Replace interim allowed charges reimbursement model with phased-in reimbursement requirements tied to Medicare rates <ul style="list-style-type: none"> <li>• 2 years initially, while cost data evaluated; consider median provider cost after 2 years;</li> <li>• 200% of Medicare with add-on rates for rural and super rural areas;</li> <li>• 180% for out-of-network providers;</li> <li>• Limits on annual charge increases for services below 200% of Medicare rates</li> </ul>	
Allow use of dispute resolution process for disputed claims	
Establish an advisory commission to evaluate finances and performance to report back in 24 months	