Executive Summary

The Blue Ribbon Commission To Study Emergency Medical Services in the State, referred to in this report as the "commission," was established by Public Law 2021, chapter 749 (Appendix A).[1] Pursuant to the public law, the commission consisted of the following 17 members: two members of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature; two members who are employed or volunteer in the field of emergency medical services, including one member who represents a community of 10,000 residents or more and one member who represents a community of fewer than 10,000 residents; one member who represents a statewide association of emergency medical services providers; one member who represents a private, for-profit ambulance service; one member who represents a statewide association of municipalities; four members of the House of Representatives, including 2 members of the party holding the largest number of seats in the Legislature and 2 members of the party holding the 2nd largest number of seats in the Legislature; one member who represents a tribal emergency medical service; one member who represents a volunteer emergency medical service; one member who represents a county government; one member who represents a statewide association of hospitals; the Commissioner of Health and Human Services or the commissioner's designee; and the Director of Maine Emergency Medical Services within the Department of Public Safety or the director's designee.

A list of commission members may be found in Appendix B.

The duties of the commission are set forth in Public Law 2021, chapter 749 (Appendix A) and charge the commission to: examine and make recommendations on the structure, support and delivery of emergency medical services in the State; and maintain communication and coordinate with Maine Emergency Medical Services as defined in the Maine Revised Statutes, Title 32, section 83, subsection 16-A so that Maine Emergency Medical Services is informed of the work of the commission and the commission is informed of the strategic planning work of Maine Emergency Medical Services. The commission was charged with looking at all aspects of emergency medical services, including but not limited to workforce development, training, compensation, retention, costs, reimbursement rates, organization and local and state support.

Over the course of six meetings, the commission developed the following findings and recommendations:

Funding

Finding A-1: Recognizing that EMS reimbursements are not keeping pace with the cost of providing services and that current subsidies are increasingly insufficient to fund the gap between those figures, the commission finds that, in addition to existing subsidies, there is a need for $70 million in funding a year for the next 5 years to support transporting EMS services in the State.

[1] Public Law 2021, chapter 749 also amends the Maine Emergency Medical Services Act of 1982 by including a legislative finding that emergency medical services provided by an ambulance service are essential services.

Recommendation A-1: The Legislature should fund the delivery of EMS in Maine by appropriating $70 million per year for the next five years from the General Fund to support transporting EMS services, with such appropriation amount to be reduced to the maximum extent possible through the utilization of public and private Medicaid match programs.

Recommendation A-2: The Legislature should initially allocate $25 million of that $70 million appropriation to specifically target transporting EMS services at immediate risk of failing and leaving their service area without access to adequate EMS.

Recommendation A-3: The Legislature should further fund the delivery of EMS in Maine by appropriating $6 million per year for the next five years from the General Fund for non-transporting emergency medical services.

Workforce Development, Education and Training

Recommendation B-1: The Legislature should explore options for providing staff of non-municipal, nonprofit licensed EMS services access to the Maine State Retirement System and to State of Maine healthcare benefits.

Recommendation B-2: The Legislature should fully fund the Length of Service Award Program.

Recommendation B-3: The Legislature should direct Maine EMS to convene a stakeholder work group that includes the Maine Community College System and University of Maine System to explore EMS career pathways and educational opportunities in the State.

Community Paramedicine

Recommendation C-1: To facilitate the growth of community paramedicine programs in Maine, the Legislature should explore options for addressing a potential disparity created by the statutory definition and licensure requirements of home health care providers and community paramedic requirements.

Continued Study of Emergency Medical Services in the State

Recommendation D-1: During the 131st Legislature, the Legislature should reestablish the Blue Ribbon Commission To Study Emergency Medical Services in the State.

I. Introduction

The Blue Ribbon Commission To Study Emergency Medical Services in the State, referred to in this report as the "commission," was established by Public Law 2021, chapter 749 (Appendix A).[2] Pursuant to the public law, the commission consisted of the following 17 members:

- Two members of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature;
- Two members who are employed or volunteer in the field of emergency medical services, including one member who represents a community of 10,000 residents or more and one member who represents a community of fewer than 10,000 residents;
- One member who represents a statewide association of emergency medical services providers;
- One member who represents a private, for-profit ambulance service;
- One member who represents a statewide association of municipalities;
- Four members of the House of Representatives, including 2 members of the party holding the largest number of seats in the Legislature and 2 members of the party holding the 2nd largest number of seats in the Legislature;
- One member who represents a tribal emergency medical service;
- One member who represents a volunteer emergency medical service;
- One member who represents a county government;
- One member who represents a statewide association of hospitals;
- The Commissioner of Health and Human Services or the commissioner's designee; and
- The Director of Maine Emergency Medical Services within the Department of Public Safety or the director's designee.

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The duties of the commission are set forth in Public Law 2021, chapter 749 (Appendix A) and charge the commission to: examine and make recommendations on the structure, support and delivery of emergency medical services in the State; and maintain communication and coordinate

[2] Public Law 2021, chapter 749 also amends the Maine Emergency Medical Services Act of 1982 by including a legislative finding that emergency medical services provided by an ambulance service are essential services.

with Maine Emergency Medical Services as defined in the Maine Revised Statutes, Title 32, section 83, subsection 16-A so that Maine Emergency Medical Services is informed of the work of the commission and the commission is informed of the strategic planning work of Maine Emergency Medical Services. The commission was charged with looking at all aspects of emergency medical services, including but not limited to workforce development, training, compensation, retention, costs, reimbursement rates, organization and local and state support.

The commission was directed to submit a report, with findings and recommendations, including suggested legislation, to the joint standing committee of the Legislature having jurisdiction over public safety matters.

II. Commission Process

The commission was authorized to hold a maximum of six meetings, which were held on the following dates: September 1, September 15, October 6, October 25, November 14, and December 5. Meetings were conducted using a hybrid format, through which commission members could choose to attend each meeting in person or remotely. Members of the public were afforded an opportunity to attend each meeting in person or view a livestream or archived video recording of each meeting through the Legislature's website. Meeting materials, including meeting agendas and background materials can be found at https://legislature.maine.gov/emergency-medical-services-study.

At the first meeting of the commission on September 1st, members gave extended introductions, including information about their background and involvement in or experience with EMS in Maine, the organization or interests they are representing on the commission and any additional information that members felt relevant to share with the commission. Commission staff reviewed the commission's authorizing legislation, Public Law 2021, chapter 749, including the commission's duties, process and timeline for the commission's work. In addition, commission member and Director of Maine Emergency Medical Services (Maine EMS) Sam Hurley provided an overview of EMS in Maine and Dia Gainor, Executive Director of the National Association of State EMS Officials (NASEMSO) provided an overview of EMS nationally. The meeting concluded with commission member discussion regarding the charge and duties of the commission, commission goals and desired outcomes.

The second meeting of the commission took place on September 15th and began with an overview of historical funding requests by Maine EMS and the Department of Public Safety provided by Commissioner of Public Safety Michael Sauschuck. The commission also received an overview on the cost of the provision of services by commission member Joe Kellner. The commission further discussed EMS funding across the State and, at the chairs' request, commission members Carrie Kipfer, Joe Kellner, Chris Baker, Scott Dow and Katelyn Damon provided specific funding information on their respective agencies or organizations. Butch Russell, President and CEO of North East Mobile Health, provided EMS funding information as well from his organization's perspective.

The third meeting of the commission took place on October 6th and began with an overview on EMS workforce development and training programs provided by Eric Wellman, Emergency

Medical Services Project Director at the Maine Community College System and Dennis Russell, Dean, Education Department Manager and Community Paramedicine Manager at United Training Center. The commission next received a presentation on the EMS workforce provided by Glenn Mills, Deputy Director of the Department of Labor's Center for Workforce Research and Information and a presentation on community paramedicine in Maine provided by Karen Pearson, Policy Associate at the Catherine Cutler Institute at the University of Southern Maine. The final presentation of the day was an update on the Maine EMS Strategic Planning Process provided by SafeTech Solutions consultant John Becknell. At the end of the third meeting, commission members discussed the process by which future commission discussion could be narrowed to focus on potential findings and recommendations. To prepare for that discussion at the next meeting, the chairs requested that commission members suggest potential findings and recommendations prior to the next meeting, to be compiled by staff.

The fourth meeting was held on October 25th and began with a presentation by the consulting firm Sellers Dorsey on behalf of the Maine Ambulance Association regarding the potential implementation of an ambulance Medicaid supplemental payment program in Maine. The commission next heard from member Chris Baker regarding the operation of and challenges unique to a joint fire and ambulance service from his perspective serving with the joint fire/EMS in Old Town. Following these presentations, the discussion turned to the potential findings and recommendations to be included in the commission's final report. Prior to the meeting, the commission had received a document compiled by staff that listed what members had identified as potential findings and recommendations and that served as a framework for this discussion. Members opted to begin the discussion by addressing the EMS funding shortfall and potential solutions. Member Joe Kellner provided the Commission with a brief presentation that both sought to identify the amount of that shortfall and provide a number of options for addressing it through State funding. Following additional discussion, the members present unanimously voted to recognize that there exists a funding shortfall in the EMS industry in Maine of roughly $70 million per year and that the shortfall should be addressed through the provision of State funding in that same amount annually over a 5-year period. Although members largely agreed that reporting and accountability mechanisms needed to be built into any such distribution of State dollars, there remained a difference of opinion over whether the funds should be distributed directly, through a Maine EMS-administered grant program or through some other method. Further discussion of the specific method of distributing these funds was accordingly deferred until the next meeting.

The fifth meeting was held on November 14th, during which the commission continued its consideration of suggested findings and recommendations and voted on which findings and recommendations to include in the final report. Those findings and recommendations receiving a majority of votes from the members present and voting at the November 14th meeting, including information regarding the substantive discussions around those findings and recommendations, are included in Part IV of this report.

The sixth and final meeting was held on December 5th...

III. Background Information

A. Overview of EMS in Maine

The Maine Emergency Medical Services program in Maine was initially established as the result of the federal Highway Safety Act of 1966, which provided that each state must formulate an emergency medical services program or it would lose a percentage of its national highway funds allocated for highway construction. Previously, funeral directors had been the primary providers of ambulance services. As funeral directors were ceasing to provide this service, citizens began to create volunteer ambulance services in their place. With the new federal law, the first state-sponsored EMS medical training was developed and by 1970, the Department for Licensure of Ambulance Services, Vehicles and Personnel had been created and began to initiate licensing. Over the next few years, federal grants were awarded to fund various city and regional EMS structures and in 1982, the Maine Legislature enacted the Maine Emergency Medical Services Act of 1982, establishing the basis for the current State EMS laws.

Today, EMS in Maine is comprised of three basic entities: the Bureau of Emergency Medical Services (Maine EMS), which is based within the Department of Public Safety; the Board of Emergency Medical Services (Board), which has statutory authority for EMS system oversight; and the EMS system itself, which is the collection of clinicians, first responders, dispatch centers, resources and medical directors throughout the State.

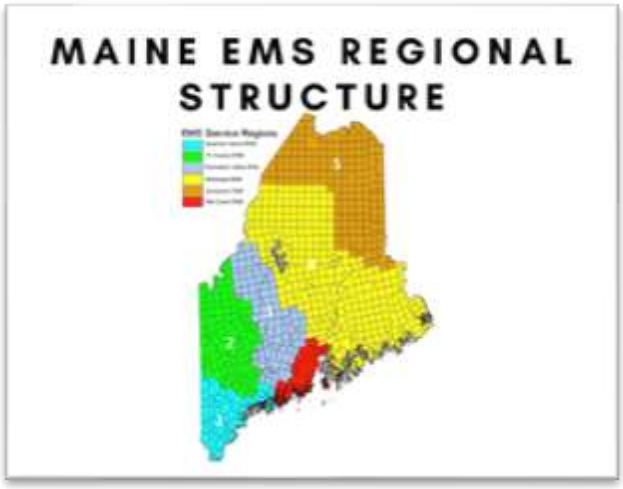
Maine EMS provides regulatory oversight of a variety of entities. These regulated entities include emergency medical dispatchers (EMD) and EMD centers; EMS ambulance operators, emergency medical responders (EMRs), emergency medical technicians (EMTs), advanced EMTs (AEMTs) and paramedics; non-transporting, transporting and air medical services and emergency vehicles (ambulances, response vehicles and air ambulances); and EMS training centers, which include instructors and coordinators and initial and continuing education courses.

As of January 2021, Maine has over 276 licensed services responsible for delivering emergency medical services throughout the State, including:

- 173 fire departments;
- 41 nonprofit, community-based EMS services;
- 35 independent municipal EMS services;
- 11 private EMS services;
- 11 hospital-based EMS services;
- 3 college-based EMS services; and
- 2 tribal EMS services.[3]

[3] *See* https://www.maine.gov/ems/whatisems.

The State is divided into six EMS regions, each with a regional council, office and medical director. The regional EMS offices are each independent not-for-profit 501(c)(3) corporations that contract with Maine EMS to coordinate the EMS system in their respective region. Those six regions are shown in the chart on the left.[4]



The delivery of emergency medical services, however, is exclusively provided at the local level. Accordingly, how the delivery of EMS is organized and financed varies significantly from community to community. Some communities rely on municipal fire departments or dedicated EMS departments, while others may contract with private, non-profit community-based, or hospital-based EMS services. Each service model has its own challenges and advantages but regardless of the type of service and service mix, in each community EMS provides coordinated response and emergency medical care involving multiple people and agencies and has to be ready at all times to respond a call. All of these components as a whole constitute what we think of as "EMS" in Maine.

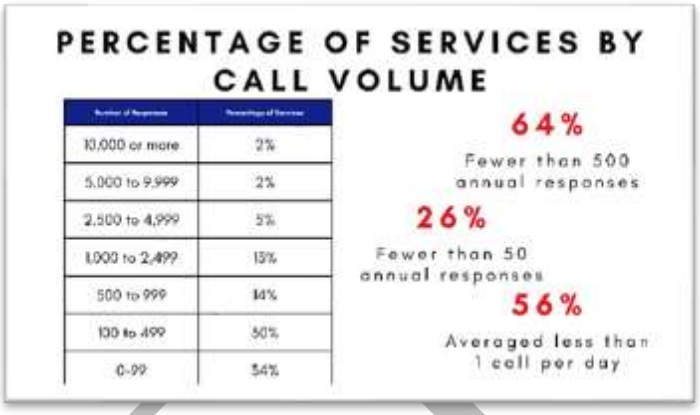
B. Costs of EMS and Reimbursements

Funding of EMS is complicated, partly because each EMS service has different service mixes as noted above, but also because of varying call volumes, geographic areas and structures. EMS is funded primarily through Medicare and Medicaid reimbursement, which is also very complicated. It can be helpful though to understand EMS costs and reimbursements by starting with call volume.

In 2021, there were approximately 288,273 calls for EMS. As shown in the chart on the left,[5] 911 activations accounted for 77.6% of those transports. Interfacility transport (IFT), which is the transport of a person from one medical facility to another medical facility, accounted for 21% of those transports. Community paramedicine, which represents an expanded role for EMS providers to assist with both public health and primary healthcare

[4] *See* Maine EMS September 1st presentation materials, which can be found at https://legislature.maine.gov/doc/8817.
[5] *See id.*

to underserved populations without the duplication of services, accounted for 1.1% of those transports.



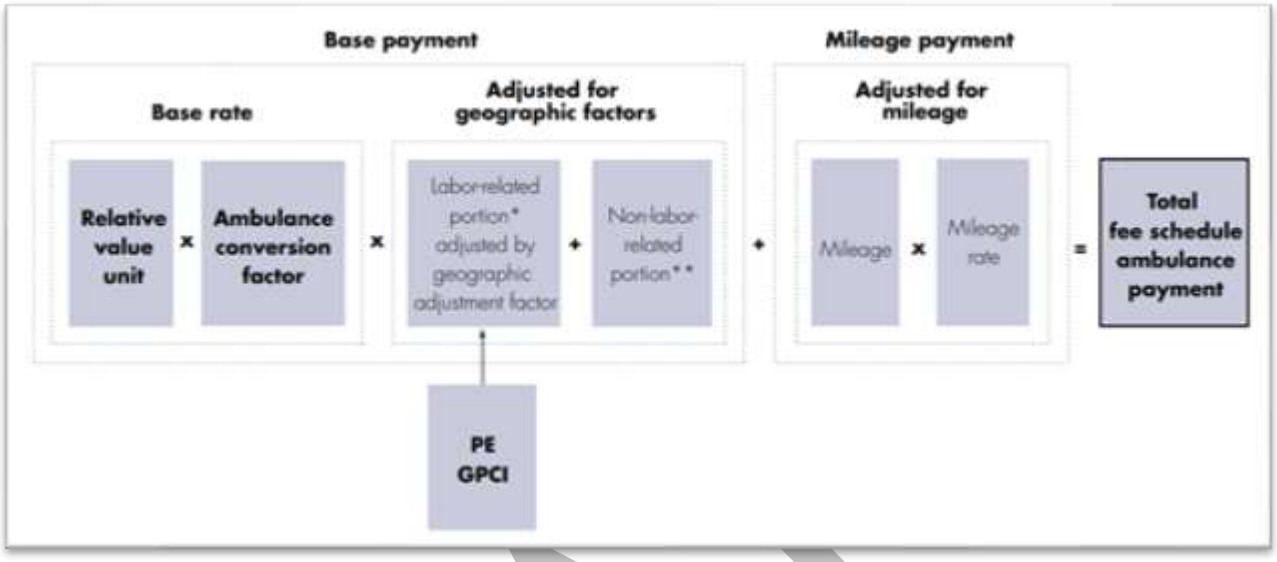
Most EMS services in Maine do not respond to a large call volume. The chart on the right shows the percentage of services by call volume.[6] Even EMS services that have a low volume of calls, however, must have the staff and equipment necessary to be able to provide a continuous, 24/7 ambulance response and services must be geographically dispersed so as to be able to respond to those calls in a timely manner. This is what is commonly referred to as the "cost of readiness." By using call volume as an indicator of "cost-per-call," a service with a low call volume will necessarily have a higher cost-per-call because all of the overhead costs to run an EMS service are spread amongst fewer calls.

There is limited data on the cost of providing ambulance services, which is contributing to low reimbursement rates. It can also be difficult to calculate the exact cost of EMS where, for example, a municipality has a joint fire/EMS department. The commission did receive information from members regarding EMS budgets from a variety of different service types, including services representing a large city service, a joint fire/EMS department, a small/rural service, a volunteer service and a regional service. In addition, commission member Joe Kellner presented on the cost of EMS and provided an illustrative sample ambulance budget.[7] For each service, a number of factors contribute to the cost of providing ambulance services, including, but not limited to: general budget items, such as salaries and wages, supplies, dispatch and billing, equipment, repairs and maintenance and fuel costs; population density; call volume and volume of transports; types of services provided; grants and fundraising; and staffing and level of staff training and use of volunteers. Of course, underlying all of these costs, is the "cost of readiness," as previously described.

Reimbursement through Medicare and Medicaid is based on the ambulance fee schedule, which has two components: a base payment, which contains seven distinct levels of ground transport ambulance service representing varying levels of service intensity, and a mileage payment. There are also add-on payments tied to the mode of ambulance transportation and/or geographic location, which include rural and super rural add-ons as determined by zip code. Rates are updated annually by the ambulance inflation factor, which is an amount equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) reduced by the 10-year moving average of multi-factor productivity. The update for 2021 was 0.2 percent. Ambulance add-on payments, which will expire at the end of 2022, include: 2% for urban, 3% for rural and

[6] *See id.*
[7] *See* September 15 meeting materials, which can be found at https://legislature.maine.gov/ems-study-meeting-9152022.

22.6% for super-rural. MaineCare pays at average Medicare rates based on the lowest geographic practice cost index (GPCI).[8] This equation can also be mapped out as follows.



[9]

It is vitally important to consider, however, that a call that does not result in transport does not result in payment, further exacerbating the gap between the cost of delivering EMS and the reimbursement received. Using the data that is available and by making a few assumptions,[10] the difference between the cost-per-call and reimbursement-per-call can be estimated as follows.

Call Volume	300	600	900	1200	1500	1800	2100
Cost per Call	$2,522.06	$ 1,301.37	$ 894.47	$ 1,177.20	$ 958.99	$ 813.51	$ 709.60
Reimbursement per Call	$ 491.99	$ 491.99	$ 491.99	$ 491.99	$ 491.99	$ 491.99	$ 491.99
Loss per Transport	$ 2,030	$ 809	$ 402	$ 685	$ 467	$ 322	$ 218
Total Gap	$609,020.97	$485,625.81	$362,230.65	$822,253.61	$700,496.45	$578,739.29	$456,982.13

Thus, although the cost per call is much greater for a service with a low call volume, the reimbursement per call remains the same, and even for those services with the greatest call volume, the reimbursement is still not sufficient to cover the costs. This is because the reimbursement through Medicare and Medicaid is antiquated and woefully inadequate, made worse in a state as rural and geographically diverse as Maine.

[8] *See id.*
[9] *See id.*
[10] *See id.*

C. Subsidies

The difference between an EMS service's cost-per-call and reimbursement must be made up through subsidies. Current subsidies take many forms and no EMS services in the State use the exact same model. Subsidies that are utilized include taxpayer support, municipal contributions, commercial payers, philanthropy and grants. One of the biggest subsidies underwriting EMS, however, is volunteer and underpaid labor.

EMS in Maine has been highly dependent on and values the role of volunteerism and service in the creation of locally-developed EMS services. While recognizing that volunteerism will always have a role in EMS, it is admittedly not a reliable solution to the central challenges to the long-term sustainability of the EMS system. Declining volunteerism coupled with a dependence on an underpaid workforce that hampers recruitment and retention has necessarily required greater reliance on other subsidies, thereby increasing costs to local municipalities and taxpayers. Declining volunteerism has also helped to reveal the true cost of EMS, which comes as a shock to many communities now struggling to provide those services locally.

Absent a subsidy, transporting EMS services cannot break even in the State, regardless of service mix, and all transporting EMS services are currently operating at a loss. As demonstrated in the previous chart, to break even, a high-efficiency (1,800 transports per year) service would need a subsidy of approximately $322 per transport; for a more rural, low-volume service (300 transports per year), a subsidy of $2,030 per transport is needed. Relying on current subsidies without additional State assistance is insufficient to meet the existing need for transporting EMS services and, as the commission heard throughout its work, all EMS services in Maine are currently operating at a loss.

D. EMS Workforce, Education and Training

As mentioned above, one of the largest subsidizations of EMS services in Maine is a volunteer and underpaid workforce. Volunteerism, however, is declining and struggles with EMS employee recruitment and retention have exacerbated problems for a workforce that is already stretched too thin. A primary contributor to these recruitment and retention issues is the generally inadequate compensation and benefits offered to many EMS employees. As noted by the Maine Department of Labor (MDOL), the average annual salary for an EMT in Maine varies, depending on location, from $29,225 to $35,542, while the annual average salary for a paramedic varies from $38,836 to $53,244. Due to the significant funding problems that all EMS services face in Maine, the compensation, benefits and working conditions generally offered to EMS employees are often insufficient to recruit and retain the workforce needed to effectively and efficiently deliver EMS across the State. Per a 2021 MDOL survey, EMS services generally reported difficulties hiring EMTs, AEMTs and paramedics and consequently have had to rely on per diem staffing and volunteer positions to fulfill their workforce needs.

At the same time that EMS services are reporting such significant staffing issues, the commission also received information suggesting an increasing recent demand for EMS educational and training programs in the State. There are multiple EMS training centers in Maine provided through regional EMS offices, private ambulance services and the Maine Community

College System, which offer education and training opportunities for EMRs, EMTs, AEMTs and paramedics. Additionally, the MDOL has also partnered with other State agencies and the University of Maine System to offer continued healthcare training and career advancement opportunities for EMS staff through the Healthcare Training for ME program. Funding for many of these programs for both participants and educators remains an outstanding need and it was noted to the commission that the retention of individuals completing those programs in the traditional EMS field has been problematic.

All of these factors are contributing to bringing EMS in Maine to a breaking point. Legislative action will be necessary to ensure the short-term and long-term future of EMS in the State. Accordingly, the commission makes the following findings and recommendations.

IV. Findings and Recommendations

A. Funding

From the very first meeting of the commission, members expressed grave concern that EMS in the State is not only at the edge of a cliff but that in many areas of the State, particularly rural areas, EMS is already over that cliff. The primary issue facing EMS is a lack of funding. As discussed previously, funding comes down to two key components: the cost of providing services – including the cost of readiness – and the funds necessary to cover those costs, currently fulfilled through Medicare and Medicaid reimbursement and other subsidies.

The federal Centers for Medicare and Medicaid Services is currently conducting a cost study on ground ambulance services. This study is anticipated to more accurately identify how much it costs to actually deliver EMS and to result in a corresponding increase in reimbursement rates. That cost study will take time, however, and it is unlikely that any of those reimbursement rate increases will be implemented within the next five years.

In the meantime, it is critical that the State support EMS in Maine to avoid EMS service closures and to ensure that, when Mainers call for EMS, there are services able to respond wherever they are needed in a timely manner. Accordingly, the commission makes the following findings and recommendations relating to the funding of EMS in Maine.

Finding A-1: Recognizing that EMS reimbursements are not keeping pace with the cost of providing services and that current subsidies are increasingly insufficient to fund the gap between those figures, the commission finds that, in addition to existing subsidies, there is a need for $70 million in funding a year for the next 5 years to support transporting EMS services in the State.[11]

While it is apparent to those involved in EMS that current funding is woefully inadequate, it is harder to determine exactly what the actual need is to ensure that EMS services have the funding

[11] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Doane, Damon, McGinnis, Kellner and Dow. Commission members Hurley and Letourneau abstained from the vote and commission members Mason, Theriault and Morris were absent at the time of the vote.

necessary to provide their critical services. The commission recognized from the beginning of its work that funding this need is crucial to ensuring the survival of EMS services in Maine.

As noted previously in this report, there is limited data on the cost of providing ambulance services. Additionally, even with examining the actual cost data available, that data is necessarily deficient because it relies on the provision of EMS through volunteerism, low wages and donated labor. Without subsidies and with reimbursement rates only covering 60-80% of the cost of service, it is clear that the shortfall between cost of service and revenue is greater than $70 million.

Nevertheless, a majority of commission members recognize the importance and immediate need of funding transporting services in a way that will make a meaningful difference. Those members accordingly determined that, at a minimum, there is a need for $70 million in funding each year for the next five years – in addition to current subsidies – to support transporting EMS services in Maine.

To determine the amount of this need, the commission utilized the calculation of loss per transport as explained in a presentation by commission member Joe Kellner.[12] Essentially, this calculation begins with a base rate, suggested at what is deemed to be a high-efficiency EMS service with about an 1,800 call volume annually. At that annual call volume, it is estimated that such a service will lose approximately $325 per transport, including all types of transport, such as 911 calls, interfacility transport, etc. Not all EMS services operate with that level of call volume, however, and in fact many services in Maine are rural services with a much lower annual call volume. Accordingly, the commission included a "rural adjustment" utilizing the USDA zip-code-based rurality scores to determine a multiplier. Thus, for each EMS service, the commission was able to roughly determine the amount of need per call necessary to better support that service.

The commission used this calculation method to determine that the total need throughout the State for transporting EMS services is $70 million per year, which can be broken down, depending on the chosen disbursement method, either by transporting service, by service mix or using some other methodology. This total number is essentially the minimum amount necessary to support transporting EMS services in Maine over the next five years until increased Medicare and Medicaid reimbursement rates are expected to be available.

Recommendation A-1: The Legislature should fund the delivery of EMS in Maine by appropriating $70 million per year for the next five years from the General Fund to support transporting EMS services, with such appropriation amount to be reduced to the maximum extent possible through the utilization of public and private Medicaid match programs.[13]

[12] *See* Maine Ambulance Association EMS Funding Proposal presentation from the October 25th Meeting, which can be found at https://legislature.maine.gov/doc/9181.

[13] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Damon, Doane, Kellner, Dow and McGinnis. Commission members Hurley and Letourneau abstained from the vote and commission members Mason, Theriault and Morris were absent at the time of the vote.

A majority of commission members recommend that the Legislature fund this identified need over a five-year period. The commission, however, emphasizes and recommends that this amount be offset through the use of federal funds. In particular, the Legislature should pursue the use of the Medicaid Supplemental Payment Program for non-municipal ambulance services and Certified Public Expenditure (CPE) programs for municipal services to maximize Medicaid matching.

For non-municipal ambulance services (for-profit, non-profit and volunteer services), federal Medicaid law allows states to establish a program under which the state collects an assessment from those services and uses that money as the state share for federal Medicaid matching funds, thus increasing Medicaid rates by making supplemental payments to those services. Similar assessment programs have been used to benefit hospital and nursing home industries here in Maine and nationally. To establish such an assessment program, the Legislature should direct the Maine Department of Health and Human Services to collect the assessment from each non-municipal ambulance service (for-profit, non-profit and volunteer service) and, with the funds generated from the assessment, match available federal Medicaid dollars. MaineCare would then make the corresponding supplemental Medicaid payments to these non-municipal ambulance services. Draft legislation provided by consultant Sellers Dorsey, which presented to the commission at its October 25th meeting, is included as Appendix __. Sellers Dorsey estimates that the net gain – the increase in supplemental payments minus the assessment paid – to each service will vary but, for the industry as a whole, the supplemental payments should be at least two times the amount of the assessments paid by all such services, which will help offset the funds needed from the State to meet the identified need.

For municipal EMS services, the commission recommends the use of CPE programs to help offset the identified need. A CPE program is a Medicaid financing approach by which a governmental entity, including a governmental service such as a municipal EMS service, incurs an expenditure eligible for federal financial participation (FFP) under the state's approved Medicaid State plan. The governmental entity is required to certify that the funds expended are public funds used to support the full cost of providing the Medicaid-covered service or the Medicaid program administrative activity. Based on this certification, the State then claims FFP.[14] To maximize the use of the federal funds available under a CPE program, the Legislature should direct the Department of Health and Human Services to include such a program in its Medicaid State plan and to provide the support, resources and education necessary for municipal EMS services to most effectively take advantage of the program.

Recommendation A-2: The Legislature should initially allocate $25 million of that $70 million appropriation to specifically target transporting EMS services at immediate risk of failing and leaving their service area without access to adequate EMS.[15]

[14] *See* https://www.macpac.gov/subtopic/non-federal-financing/#:~:text=A%20CPE%20is%20a%20statutorily,Act%3B%2042%20CFR%20433.51).

[15] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Damon, Doane, Kellner and McGinnis. Commission members Hurley and Letourneau abstained from the vote and commission members Mason, Theriault, Morris and Dow were absent at the time of the vote.

The commission consistently recognized that there are two components to funding EMS needs the State: (1) immediate crisis funding for EMS services at the highest risk of failing and (2) long-term funding for the sustainability of the future of EMS in the State. Accordingly, a majority of commission members recommend that of the $70 million in funding identified in the prior recommendation, during the first two years in which that funding is available, $25 million in each year should be immediately set aside in a non-lapsing fund to be targeted specifically to those EMS services at immediate risk of failing and leaving residents of those service areas without adequate EMS.

When a person calls 911, the person expects that an EMS service will provide an immediate response and be able to provide the necessary medical care and transport, if required, to the patient. There are EMS services in this State, however, that are in danger of failing due to a lack of funding, not only from low reimbursement rates but from difficulty in finding volunteers and a high workforce turnover. These services need immediate assistance and, without that assistance, their service areas will no longer have necessary EMS coverage. By specifically targeting this funding initially to those services with the greatest need, the residents of those areas will not lose access to EMS and the immediate influx in funding will allow those services to better plan for long-term sustainability.

Recommendation A-3: The Legislature should further fund the delivery of EMS in Maine by appropriating $6 million per year for the next five years from the General Fund for non-transporting emergency medical services.[16]

In addition to the 171 transporting EMS services in the State, there are 103 non-transporting EMS services. A non-transporting EMS service is defined as any organization, person or persons who hold themselves out as providers of emergency medical treatment and who do not routinely provide transportation to ill or injured persons, and who routinely offer or provide services to the general public beyond the boundaries of a single recreational site, business, school or other facility. Non-transporting services generally respond to a location of a medical emergency to provide immediate medical care but do not provide patient transport. Examples may include fire apparatus, response cars or other non-transport vehicles.

The commission identified that non-transporting EMS services are also in need of funds. Accordingly, a majority of commission members recommend that the Legislature fund $6 million per year over the next five years for non-transporting EMS services. This infusion of funding will help non-transporting EMS services with their immediate need, thereby allowing them to put plans in place for their long-term sustainability following the five-year period.

B. Workforce Development, Education and Training

The commission dedicated a substantial portion of its time discussing and identifying potential solutions to EMS workforce issues, which are significantly impacting the delivery of EMS in

[16] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Doane, Damon, McGinnis and Kellner. Commission members Hurley and Letourneau abstained from the vote and commission members Mason, Theriault, Dow and Morris were absent at the time of the vote.

Maine, leading to delayed emergency response times and to an overworked and overstressed workforce.

Recommendation B-1: The Legislature should explore options for providing staff of non-municipal, nonprofit licensed EMS services access to the Maine State Retirement System and to State of Maine healthcare benefits.[17]

As previously noted, a primary contributor to the EMS employee recruitment and retention issues faced by EMS services across the State are the insufficient compensation and benefits offered to EMS employees. Although the provision of supplemental funding for EMS services proposed in the prior recommendations will allow for enhancement of employee compensation and benefits during the period in which that funding is available, the commission recognized that there are other mechanisms that might be employed to address those same concerns. One such mechanism, which was supported by a majority of commission members at the fifth meeting, is for the Legislature to explore options for providing staff of non-governmental, nonprofit licensed EMS services access to the Maine State Retirement System and to State of Maine healthcare benefits.

Many of the 272 licensed EMS services in Maine are governmental services and are therefore able to provide staff with access to the Maine State Retirement System. Staff of non-governmental EMS services may be offered access to a retirement benefits package through their employer although the benefits offered to such individuals varies across Maine. Offering access to State retirement benefits and State healthcare benefits to employees of licensed non-governmental, nonprofit EMS services may serve to boost employee recruitment and retention for those services, which fill a critical need for the delivery of EMS in many areas of the State. The commission is committed to supporting the Legislature as it explores this recommendation, recognizing that facilitating this change will require the consideration of a myriad of factors and, potentially, the expenditure of State funds.

Recommendation B-2: The Legislature should fully fund the Length of Service Award Program (5 MRSA §3372).[18]

The Length of Service Award Program (LOSAP), 5 MRSA §3372, was enacted in 2015 to provide paid length of service awards to eligible volunteers. Under the program, an "eligible volunteer" is an active part-time or on-call member of a fire department or a volunteer firefighter or a licensed EMS person or ambulance operator who provides on-call, part-time or volunteer emergency medical response under the direction of a fire department chief or for an ambulance service or a non-transporting EMS. The LOSAP rewards these eligible volunteers for the service to their communities with contributions to a retirement program. Participants are generally

[17] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Doane, Damon, McGinnis and Kellner. Commission member Hurley abstained from the vote and commission members Mason, Theriault, Dow, Morris and Letourneau were absent at the time of the vote.

[18] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Doane, Damon, McGinnis and Kellner. Commission member Hurley abstained from the vote and commission members Mason, Theriault, Dow, Morris and Letourneau were absent at the time of the vote.

eligible for such benefits at the earlier of attaining sixty-five years of age or 20 years of service credit.

The LOSAP can accept funding from the federal government, the State or a municipality; however, when it was established in 2015, no State funds were provided and since that time, there have only been three one-time funding initiatives enacted totaling $2 million.[19] At this time, there is no dedicated funding source for the LOSAP and it is unclear what the anticipated needs of the program currently are or are anticipated to be beyond the $2 million already appropriated. Commission members, however, believe that the benefits that can be provided through the LOSAP represent another important mechanism by which EMS staff recruitment and retention rates can be improved. Consequently, a majority of commission members at the fifth meeting support the Legislature funding the LOSAP at a level necessary to meet that programs current and anticipated future needs, with consideration given to the establishment of a dedicated funding source.

Recommendation B-3: The Legislature should direct Maine EMS to convene a stakeholder work group that includes the Maine Community College System and University of Maine System to explore EMS career pathways and educational opportunities in the State.[20]

Although, as the commission heard, there exist a number of public and private educational and training programs for EMS providers in Maine that have seen an increasing demand for services, the retention of the individuals completing those programs in the traditional EMS field has been problematic. To ensure that the educational and training options available in the State are best designed and coordinated to enhance the recruitment and retention of EMS service employees in the traditional EMS field and where the staffing demands of EMS services are the greatest, a majority of commission members at the fifth meeting support the Legislature directing the convening of a stakeholder workgroup to explore EMS career pathways and educational opportunities in the State.

To ensure that a broad spectrum of experiences and backgrounds are present on the workgroup, it should include representatives of Maine EMS, the Maine Community College System, the University of Maine System, other public and private entities that provide EMS educational or training programs in the State and other individuals with relevant backgrounds and experiences in EMS education and training and in the delivery of EMS generally. To facilitate consideration of any findings or recommendations that may arise out of this workgroup, the Legislature should consider requiring the submission of a report by the workgroup outlining the activities of the workgroup and any recommendations proposed by its members, including proposed legislation where appropriate.

[19] *See* Public Law 2021, Chapter 444, which provided a one-time General Fund appropriation of $500,000 in Fiscal Year 21-22; Public Law 2021, Chapter 721, which provided a one-time General Fund appropriation of $500,000 in Fiscal Year 22-23; Public Law 2021, Chapter 635, Section A-16), which provided a one-time General Fund appropriation of $1,000,000 in FY 22-23.

[20] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Hurley, Kipfer, Doane, Damon, McGinnis and Kellner. Commission members Mason, Theriault, Dow, Morris and Letourneau were absent at the time of the vote.

C. Community Paramedicine

As the commission heard during their October 6th meeting, community paramedicine is an evolving model of healthcare delivery in both rural and urban areas as EMS services look to reduce the use of EMS for non-emergency 911 calls, the overcrowding of emergency departments and healthcare costs. There is no single model of community paramedicine – rather programs are based on community needs and services. Community paramedicine pilot projects were authorized by the 125th Maine Legislature and expanded during the 128th Maine Legislature. There have been additional studies, including the Lincoln County Community Paramedicine Data Collection Initiative in 2019 and, in 2022, Maine EMS contracted with the Catherine Cutler Institute to expand this pilot study and evaluate programs in Maine. The commission believes in the importance of community paramedicine but identified a potential disparity in statutory and licensing requirements and accordingly makes the following finding and recommendation.

Recommendation C-1: To facilitate the growth of community paramedicine programs in Maine, the Legislature should explore options for addressing a potential disparity created by the statutory definition and licensure requirements of home health care providers and community paramedic requirements.[21]

One of the challenges with growing community paramedicine programs is the potential overlap between community paramedics and other home health care professionals. The commission identified a potential disparity in the statutory definition and licensure requirements of home health care providers and community paramedic requirements that jeopardizes the community paramedic programs that the Legislature should address.

Title 22, section 2143 of the Maine Revised Statutes prohibits a home health care provider from providing home health services without a license. A home health care provider is defined as "any business entity or subdivision thereof, whether public or private, proprietary or not for profit, that is engaged in providing acute, restorative, rehabilitative, maintenance, preventive or health promotion services through professional nursing or another therapeutic service, such as physical therapy, home health aides, nurse assistants, medical social work, nutritionist services or personal care services, either directly or through contractual agreement, in a client's place of residence."[22] This term does not apply to any sole practitioner providing private duty nursing services or other restorative, rehabilitative, maintenance, preventive or health promotion services in a client's place of residence or to municipal entities providing health promotion services in a client's place of residence.[23] It also does not apply to a federally qualified health center or a rural health clinic as defined in 42 United States Code, Section 1395x, subsection (aa) (1993) that is delivering case management services or health education in a client's place of residence.[24] Beginning October 1, 1991, "home health care provider" includes any business entity or

[21] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Hurley, Baker, Kipfer, McGinnis, Damon, Doane and Kellner. Commission member Letourneau abstained from the vote and commission members Mason, Theriault, Dow and Morris were absent at the time of the vote.
[22] 22 MRSA §2142(3).
[23] *Id.*
[24] *Id.*

subdivision thereof, whether public or private, proprietary or nonprofit, that is engaged in providing speech pathology services."[25]

Community paramedicine, on the other hand, is established as "the practice by an emergency medical services provider primarily in an out-of-hospital setting of providing episodic patient evaluation, advice and treatment directed at preventing or improving a particular medical condition, within the scope of practice of the emergency medical services provider as specifically requested or directed by a physician" and operates under the rules established by the Maine EMS Board.[26]

These overlapping concepts have created confusion over the licensure requirements for community paramedics and the licensure requirements for home health care providers and a majority of commission members believes that there needs to be clearer delineation between the requirements applicable to these two categories of regulated entities.

Accordingly, a majority of commission members recommend that the Legislature further explore this potential disparity with the goal of better delineating in statutory definitions and licensure requirements the differences between the two roles, which will, in turn, grow and further enable community paramedicine programs in the State. Members of the commission noted that community paramedic programs do not have, and should not need, home health service licenses, as they are licensed separately under the rules established by the Maine EMS Board. Some members did caution, however, about potential unintended consequences of simply exempting community paramedics from home health service licensure requirements.

D. Continued Study of Emergency Medical Services in the State

Through six meetings, the commission heard from its members, stakeholders and others about EMS in Maine and many of the challenges to the funding, support and delivery of EMS services and regarding how all aspects of EMS, including workforce development, training, compensation, retention costs, reimbursement rates, organization and local and state support, contribute to the system. Although many of these aspects are touched on in the commission's findings and recommendations, there remain many aspects of that system and identified issues the commission was not able to fully explore or examine in its limited time.

In addition, as recognized in the commission's duties, the commission's work was conducted parallel to the strategic planning work undertaken by Maine EMS. Maine EMS contracted with a consultant, SafeTech Solutions, to engage in strategic planning process of Maine EMS and the EMS Board to put forward a vision and plan for the future of Maine EMS and to make recommendations on its short-term and long-term sustainability. The commission heard from the consultant, John Becknell, during its October 25th meeting, however, the work of the strategic planning process was not completed by the time the commission held its final meetings and voted on its findings and recommendations. Accordingly, a majority of commission members make the following recommendation.

[25] *Id.*
[26] *See* 32 MRSA §84(4).

Recommendation D-1: During the 131st Legislature, the Legislature should reestablish the Blue Ribbon Commission To Study Emergency Medical Services in the State.[27]

A majority of commission members do not feel that the commission's work is complete and recognizes that there are still outstanding issues that need to be addressed to ensure the short-term and long-term sustainability of EMS in Maine. This can best be accomplished by continuing to bring together legislators, experts and EMS providers to collaborate and advise the Legislature on the best paths forward. This need is particularly acute as the Maine EMS strategic planning process concludes and makes its recommendations to Maine EMS, the EMS Board, the Department of Public Safety and ultimately the Legislature.

From the beginning of its work, the Legislature and the commission recognized the need for the strategic planning process to inform the work of the commission and vice-versa. The commission believes that reestablishing this commission in the 131st Legislature will allow that communication to continue. A reestablished commission would be better positioned to evaluate the strategic planning recommendations as well as progress made on EMS as identified in this report. It is critical that the State continue to support the structure, at the state and local level, and the delivery of EMS in the State and continuing the work of this commission as proposed above will help to fulfill that important purpose.

V. Conclusion

The commission's work and publication of its report comes at a time when EMS in the State is in crisis. EMS services in Maine are at the edge of a cliff, or over it, and changes must occur to ensure that when someone calls with a medical emergency, EMS services are able and ready to assist. This requires, first and foremost, increased funding for the delivery of EMS. Current subsidies, especially volunteerism, are declining and revealing the true cost of EMS, and the State must step in to ensure that EMS does not disappear in parts of this State.

Of course, this work does not end with the commission's report and the commission hopes that the findings and recommendations contained in this report demonstrate not only the dire needs of the EMS system but also the first steps towards ensuring both the short-term and long-term sustainability of the system. Members of the commission look forward to working with the 131st Legislature to refine the details of these recommendations and maintain focus on this critically important issue and workforce.

Finally, the commission would like to thank all of its members and presenters for generously offering their time, expertise and advice on the complicated issues involved in funding and supporting EMS in the State. Their knowledge and perspectives were invaluable in developing the findings and recommendations of the commission. Additionally, the EMS system in Maine would not exist without EMS providers and the commission would like thank all of them who dedicate their time – often overburdened and underpaid – to serving their communities and the State.

[27] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Doane, Kellner, Damon and McGinnis. Commission members Hurley and Letourneau abstained from the vote and commission members Mason, Theriault, Dow and Morris were absent at the time of the vote.