Legislative Budget and Finance Committee

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

Report Comments by Stevi Sprenkle, Project Manager
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Good morning, Madam Chair and members of the Committee. It is a pleasure to be here to discuss the results of our study pursuant to Senate Resolution 120 (SR 120). Before getting into the results of our analysis, let me briefly describe what SR 120 asked us to research and provide context on the issues related to the resolution.

SR 120 asked us to provide information on the impact of "treat and release" calls on emergency medical services (EMS) agencies, specifically for patients covered by Pennsylvania's Medical Assistance (MA) Managed Care Organizations (MCOs). Treat/no transport (TNT) is a care model in which EMS providers treat a patient on the scene of an emergency call and release the patient without transport to a hospital. This occurs either because medical protocols are followed or because the patient refuses transport against medical advice.

Access to emergency medical care is a critical component of a community's public health. Every day, at all hours, Pennsylvanians rely on the EMS system to provide emergency care. Traditionally, EMS providers were considered a "connector" between an emergency scene and a hospital. With increased technology and more advanced training, TNT emerged as a newer model of EMS care.

The utilization of TNT has increased in recent years. Statewide, it comprised less than 3 percent of total EMS dispositions in 2022. Of those, more patients were released per medical protocols, than patients who refused transport against medical advice. In 2022, Pennsylvania was below the national average for TNT dispositions, particularly TNT against medical advice (nationwide 5.0 percent compared to 0.8 percent in Pennsylvania).

We estimate that of total TNT dispositions, about one-fourth were patients enrolled in one of the MA MCO health plans. Before Act 103 of 2018 (Act 103), there was no mandate for MCOs to reimburse EMS for TNT. According to EMS agencies, Act 103 attempted to resolve concerns around reimbursement for TNT services; however, requiring reimbursement based on the term "reasonable costs" created a practice in which MCOs reimburse EMS agencies at different rates for TNT services.

This differs from other EMS services reimbursed by the MA program. Through the commonwealth's Fiscal Code, specific state-directed or minimum payment requirements set the amount MCOs must pay for other ground ambulance services in which transport to an emergency department (ED) occurs. The reimbursement for these services is based on the base rate of providing emergency services and an additional component that covers mileage to the ED.

The commonwealth has a patchwork of different types of EMS agencies, such as non-profit, fire-based, municipal-based, for-profit, and hospital-based. EMS agencies are also comprised of paid staff, volunteers, or a combination of both. EMS agency funding differs from other emergency

services (such as fire and police), which are primarily funded through taxes and fees. While some EMS agencies receive limited direct support from local government and state grants, all agencies rely on insurance reimbursement and patient payments as revenue.

To answer the objectives of this study, we requested a selected sample of claims data from Pennsylvania's contracted MCOs. In our sample, chosen from 2019 through 2022, we found the reimbursement amount paid by MCOs to EMS agencies for TNT claims varied between MCOs and by year. Across the entire four-year period, the average amount billed by EMS agencies for TNT ranged between $287 and $375. EMS were reimbursed at average rates between $53 and $179 (depending on the MCO). This means that an average of 16.1 to 47.9 percent was reimbursed compared to what was billed (again, depending on the MCO).

Another focus of SR 120 was on TNT claims related to the opioid drug epidemic, as overdoes and reversals via naloxone are what shed light on the practice of TNT. While substance abuse-related claims are part of TNT, we found from 2019 through 2022, only 1.9 to 2.7 percent of total TNT claims were marked as substance abuse-related by MCOs. This means that most TNT claims within the MCO health plans were claims related to other incidents or conditions, including diabetes, falls without injuries, asthma, and seizure disorders.

The final area of SR 120 asked us to provide insight into EMS agency costs for TNT. For this study, we defined EMS costs as the cost of readiness. As explained by the US Government Accountability Office (GAO): "Ambulance [agencies'] total costs primarily reflect readiness – the need to have an ambulance and crew available when emergency calls are received.

Readiness-related costs are fixed, meaning they do not increase with the number of trips provided, as long as [an agency] has excess capacity."[1]

EMS agency costs are not tracked statewide, which poses a challenge in determining EMS costs to provide TNT services. The Centers for Medicare and Medicaid Services (CMS) is collecting EMS agency cost data nationwide through the Medicare Ground Ambulance Data Collection System (GADCS). However, the results are not expected until after 2025. We collected cost-per-response figures from 14 different EMS agencies across Pennsylvania and found the cost-per-response ranged between $246 to $885, depending on the agency. The average of the 14 EMS agencies was $585 per response, which was similar to a figure provided by the Ambulance Association of Pennsylvania (AAP), which estimated a statewide average of $550 per response.

Without more data on EMS costs statewide, it is difficult to conclude the exact impact of TNT underpayments on each agency. For example, MCO underpayments of $100 per claim total over $1.6 million annually across the entire EMS system. The extent to which that impacts individual EMS agencies depends on the number of TNT dispositions each EMS agency services. For these reasons, we recommend that the General Assembly consider requiring a broader study or audit by the LBFC of payments to EMS after CMS releases federal GADCS data.

Medicaid paying the lowest rate of all insurance payers is not exclusive to EMS. It has been well documented across studies for most health services that average Medicaid payments are below Medicare benchmarks and private insurance payments. Payer mix, or the percentage of

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

individuals in a community with different insurance coverage (Medicaid, Medicare, private insurance, and uninsured), is an accounting factor all healthcare providers face.

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

In closing, I would like to thank DHS staff and EMS industry representatives for participating in our study. Additionally, I would like to thank LBFC staff analyst Morgan Smith for her work on this study. I would be happy to answer any questions you may have.