Rethinking EMS Delivery: A New Era of Innovation and Accountability

By Ken Riddle, Senior Advisor, Public Consulting Group (PCG)

Introduction

Emergency Medical Services (EMS) in the United States are undergoing a quiet revolution. As traditional models centered on transport to emergency departments (EDs) strain under rising costs and shifting patient needs, a new generation of EMS strategies is emerging—centered on flexibility, integration, and value-based care.

The early termination of the Centers for Medicare & Medicaid Services' (CMS) Emergency Triage, Treat, and Transport (ET3) model in 2023 left many EMS leaders searching for direction. But the lessons of ET3, combined with the success of peer-led innovations, have created a roadmap for transformation.

From ET3 to Enduring Models

ET3 aimed to reimburse EMS providers for treating patients o n scene or transporting them to non-ED destinations. However, the model faltered due to limited participation, Medicare-only reimbursement, and burdensome reporting requirements. ET3's demise has clarified what EMS systems must avoid—and what they must build.

> "ET3's early termination provides a valuable roadmap of what not to repeat."
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> *- 2023 Health Affairs Forefront, 2023*

Despite its early end, ET3 catalyzed interest in alternative EMS delivery models—many of which are now thriving under state Medicaid programs and local innovation.

Building the Ecosystem for Scalable EMS Innovation

To successfully scale models like Treatment-in-Place (TIP), Transport to Alternate Destination (TAD), and Mobile Integrated Health/Community Paramedicine (MIH-CP), EMS agencies must cultivate a supportive ecosystem built on three foundational pillars:

1. Integrated and Sustainable Funding

Innovative EMS models require diversified and dependable funding streams. Agencies must blend traditional sources—such as Medicaid and Medicare—with Managed Care Organization (MCO) contracts, local government support, and targeted grants. Sustainable reimbursement for non-transport services and community-based care hinges on policy alignment and payer engagement. Agencies should proactively pursue Medicaid waivers, pilot program funding, and value-based care partnerships to ensure long-term viability.

2. Robust Data Infrastructure

Data is the backbone of EMS transformation. Agencies must leverage Computer-Aided Dispatch (CAD), Records Management Systems (RMS), Electronic Patient Care Reports (ePCR), and billing platforms to generate actionable insights. These systems enable performance tracking, clinical quality improvement, and financial modeling. Interoperability with hospital and payer systems further enhances care coordination and outcome measurement.

3. Stakeholder Engagement and Cultural Alignment

No EMS innovation can succeed without buy-in from frontline providers, labor partners, medical directors, and the communities served. Agencies must foster a culture of trust, transparency, and shared purpose. This includes engaging elected officials, educating the public on new care pathways, and aligning with healthcare partners to ensure continuity of care. Political and cultural readiness are as critical as operational capacity.

Treatment-in-Place (TIP): Care Without Transport

Treatment-in-Place (TIP) allows EMS providers to deliver care on scene without transporting the patient, often supported by telehealth or medical oversight. This model is particularly effective for low-acuity cases, chronic condition management, and behavioral health stabilization.

Several states now reimburse TIP services through Medicaid Managed Care Organizations (MCOs):

- Arizona permits both in-person and telehealth-facilitated TIP services under the modifier "CG," applicable to traditional Medicaid and MCO beneficiaries.
- Minnesota supports TIP through PMAP and MinnesotaCare MCOs under MIH-CP waivers.
- Texas requires MCOs to reimburse TIP services, including those billed with modifier "W" for non-transport ambulance treatment.
- Washington has a "Treat and Refer" program that allows ambulance allows publicly owned or operated EMS agencies to bill for on-scene care without transport.

These policies reflect a growing recognition that EMS can deliver effective care without transport—saving costs and improving patient experience.

Transport to Alternate Destination (TAD): Navigating to the Right Care

Transport to Alternate Destination (TAD) enables EMS to bring patients to urgent care clinics, detox centers, behavioral health facilities, or other appropriate sites instead of EDs. This model reduces ED overcrowding and aligns care with patient needs.

Examples of state-supported TAD programs include:

- Arizona, which authorizes TAD when medically appropriate and coordinated with in-network Alternate Destination Partners (ADPs).
- Nevada's REMSA Health program, which facilitates transport to detox and urgent care centers and is recognized statewide.
- Washington State, where Medicaid covers TAD within the state GEMT program based on the average cost for transport.

These programs demonstrate that EMS can serve as a gateway to broader healthcare systems, not just a conduit to hospitals.

Mobile Integrated Health / Community Paramedicine (MIH-CP): Extending the Reach of EMS

Mobile Integrated Health (MIH) and Community Paramedicine (CP) represent a paradigm shift in EMS. These models deploy EMS clinicians—often in partnership with nurses, social workers, and primary care providers—to deliver preventive, chronic, and post-acute care in the community.

According to the National Association of Emergency Medical Technicians (NAEMT), hundreds of EMS agencies now operate MIH-CP programs. These programs:

- Reduce 911 calls and ED visits by managing high-utilizer populations.
- Provide post-hospital follow-up and chronic disease management.
- Connect patients to community resources and social services.
- Operate in both urban and rural settings, often with Medicaid reimbursement.

A 2023 survey found that at least 14 states reimburse EMS for treatment without transport, and seven states reimburse for community paramedicine services under Medicaid. States like California, North Dakota, and Arkansas have integrated CP into EMS licensure and training, while others have launched pilot programs to evaluate cost savings and health outcomes.

MIH-CP programs are particularly impactful in underserved areas, where EMS clinicians are often the most accessible healthcare providers. Their ability to deliver care outside of traditional settings makes them essential partners in value-based healthcare.

Conclusion

The future of EMS lies in flexibility, integration, and accountability. By embracing models like TIP, TAD, and MIH-CP, EMS agencies can deliver care that is patient-centered, cost-effective, and clinically sound.

These innovations are not just theoretical—they are operational, measurable, and scalable. As more states adopt supportive reimbursement policies and EMS systems align with broader healthcare goals, the opportunity to rethink EMS delivery has never been more urgent—or more achievable.

About the Author

Chief Ken Riddle is the Senior Advisor for the Public Safety Consulting Services (PSCS) team and senior leadership at PCG. He brings over 40 years of experience in fire and EMS operations, with expertise in strategic planning, administration, and program implementation. He has led innovative efforts such as EMS billing systems, firefighter wellness initiatives, and revenue-generating EMS transport services. His data-driven approach enhances performance, compliance, and financial sustainability, including securing Medicaid supplemental payments. Clients rely on his deep industry insight and guidance through complex proposals to achieve successful, lasting outcomes.

How PCG Can Help

Public Consulting Group (PCG) partners with EMS agencies across the country to modernize service delivery, expand funding access, and improve operational sustainability. Whether you're exploring Treatment-in-Place, Mobile Integrated Health, or Alternative Destination programs, PCG brings a data-driven, field-tested methodology to support your success.

Our support includes:

- Operational and clinical readiness assessments
- Cost modeling and reimbursement forecasting (e.g., TIP, MIH, TAD)
- Program design and payer negotiation support
- Policy review and Medicaid alignment guidance
- Implementation toolkits and performance dashboards

To learn how PCG can help your organization navigate regulatory shifts, secure sustainable reimbursement, and implement EMS delivery innovations, contact our Public Safety team at:

(800) 210-6113 @ publicsafetystudy@pcgus.com https://publicconsultinggroup.com/industry-solutions/health/fire-and-ems-provider-solutions/

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