MEMORANDUM

TO:	STACEY DURANTE
FROM:	NGA CENTER FOR BEST PRACTICES
SUBJECT:	MOBILE INTEGRATED HEALTHCARE AND COMMUNITY PARAMEDICINE
DATE:	JULY 18, 2018
CC:	LAUREN DEDON, JEFF LOCKE, LAUREN BLOCK

This memo was completed in response to a request for information about state efforts to implement Mobile Integrated Health Care/Community Paramedicine (MIH/CP) programs, specifically regarding fiscal notes, staffing levels, and reimbursements.

Mobile Integrated Healthcare and Community Paramedicine

Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) are two new types of Emergency Medical Services (EMS) delivery systems, in which paramedics or Emergency Medical Technicians (EMTs) provide disease management and other services to patients in their homes, and navigate them to the relevant destination instead of the emergency department to avoid unnecessary hospital visits. MIH-CP is not designed to replace the existing EMS system for 911, but aims to work side-by-side with the existing system, providing services for non-emergent callers who do not require an immediate trip to the emergency room. MIH-CP programs also deploy telemedicine to connect non-urgent 911 callers with relevant caregivers and assistance, instead of sending an ambulance crew.[1]

Prevalence of MIH-CP[2]

- As of April 2018, MIH-CP is offered in 33 states plus Washington, D.C.
- There are over 129 MIH-CP programs operating nationwide.
- MIH-CP programs operate in a wide range of urban and rural settings, and there are both public and private care delivery models currently in use.

Funding and Reimbursement for MIH-CP[3]

The Centers for Medicare and Medicaid Services (CMS) currently categorize EMS as a transportation provider, meaning that EMS is only paid when they transport patients to an emergency department, not for providing patients with care in their home. Some communities are able to support EMS through taxes collected by local or city governments, but the amount of money available for this varies depending on the location in question.

Many states are currently paying for their MIH-CP programs through existing revenue from fire and emergency departments, grants from the federal government, foundations or local hospitals, health insurance plans, or contributions from patients. There is currently no standardized

[1] Mobile Integrated Healthcare and Community Paramedicine (MIH-CP). National Association of Emergency Medical Technicians, 2015, www.naemt.org/docs/default-source/community-paramedicine/naemt-mih-cp-report.pdf?sfvrsn=df32c792_4.
[2] Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey. National Association of Emergency Medical Technicians, 2018, www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92_2.
[3] Ibid

reimbursement for MIH-CP providers on the federal level. Some states (Idaho, Minnesota, Nevada) passed legislation to authorize Medicaid payment for community paramedicine services.

Some states have acted to enable EMS to be paid for community paramedicine services:

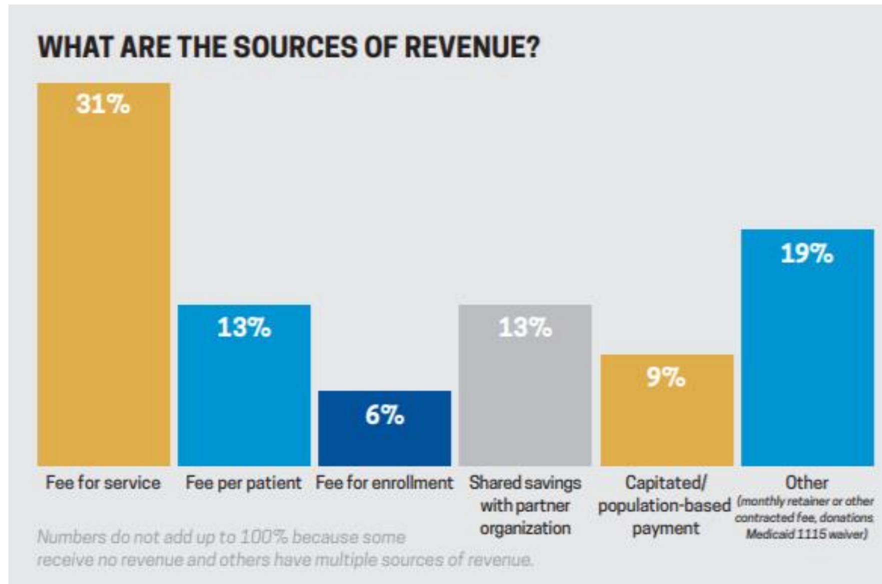
- Arizona, Georgia, Minnesota, Wyoming, and Nevada have Medicaid plans that reimburse at least some community paramedicine services.
- Fourteen states have Medicaid plans which enable reimbursement of some treat and no transport calls.
- Seventeen states have commercial insurance providers (including 14 Anthem BlueCross Blue Shield states starting in 2018) that reimburse some community paramedicine services.

Funding Sources for MIH-CP Programs:[4]

- Internal funding (essentially self-funding through local/state dollars)
- Philanthropic Grants
- Local Hospitals
- Hospice Agencies
- Home Health Agencies
- Care Management Agencies
- State Medicaid Funds
- Subscription Services paid by patients
- Commercial Payers

Sources of Revenue for MIH-CP Programs[5]

The following chart summarizes key sources of revenue for features MIH-CP programs.

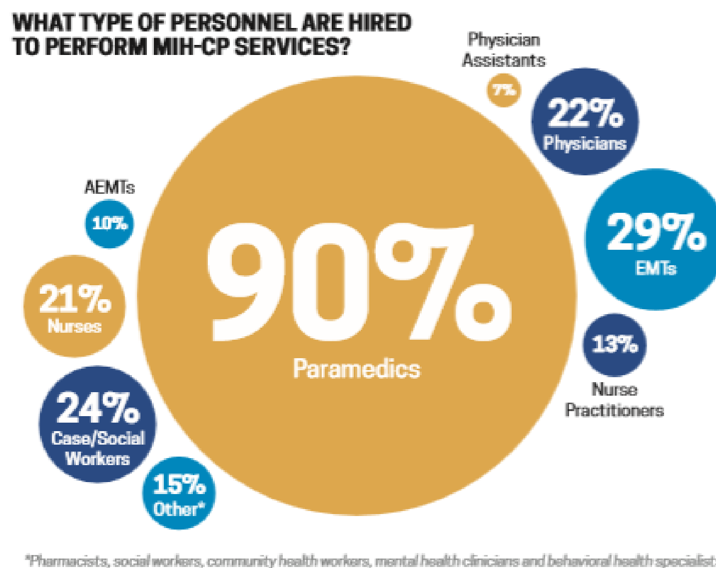


[4] Zavadsky, Matt. "Top 10 MIH or Community Paramedicine Program Funding Sources." *EMS1*, 15 Nov. 2017, www.ems1.com/diffusing-community-paramedicine/articles/361998048-Top-10-MIH-or-community-paramedicine-program-funding-sources/.

[5] Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey. National Association of Emergency Medical Technicians, 2018, www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92_2.

Staffing of MIH-CP Programs[6]

- MIH-CP is most often provided by Emergency Medical Service (EMS) practitioners. Most commonly, this means that MIH-CP services are provided by paramedics.
  - 9 out of 10 MIH-CP programs use paramedics.
- Emergency Medical Technicians (EMTs), Nurses/Nurse Practitioners, Community Health and Social Workers, and Physicians also provide services in MIH-CP programs.
- About 63% of MIH-CP programs have dedicated, full-time clinical staff.
- About 10% of MIH-CP programs use most of all of their existing staff for the program, and do not have any dedicated full-time resources.
- About 38% of MIH-CP programs use some combination of dedicated staff and the utilization of existing personnel and resources.



State Example: Maryland

In 2017, Maryland conducted an evaluation of its seven existing MIH programs. The evaluations found that program participants have decreased usage rates of EMS services, decreased frequency of hospital emergency room visits, and increased usage of non-emergency healthcare services that are available within the community.[7]

Maryland's MIH programs "are funded through a combination of grants, in-kind service donations, and jurisdictional (e.g., county) budgets (usually supported by jurisdictional tax dollars)."[8]

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[6] Ibid

[7] Maryland Mobile Integrated Health Programs Involving Emergency Medical Services (EMS) Executive Summary. Maryland Institute for Emergency Medical Services Systems, 2017, https://www.miemss.org/home/Portals/0/Docs/EMS_News/MIEMSS_Mobile%20Integrated%20Health%20Programs%20Report-2017.pdf?ver=2018-06-20-132037-540.

[8] Ibid

Staffing of Maryland's MIH-CP Programs:

- Queen Anne's County: Using existing resources of paramedics and nurses. Team consists of three (3) members: a public health nurse, a paramedic, and a behavioral and substance abuse counselor. During the home visit, each patient is connected to a Doctor of Pharmacy via telemedicine.
- Prince George's County: Funding for two (2) full-time positions – both paramedics. Both positions are funded through the Fire/Emergency Medical Services (EMS) department's budget.
- Charles County: Funding for three (3) full-time positions – one nurse practitioner, one community health worker, and one paramedic.
- Montgomery County: Funding for 1.5 full-time positions – one full-time paramedic and one part-time firefighter.
- Frederick County: Funding for two (2) full-time resources – one paramedic and one nurse/nurse practitioner.

Funding of Maryland's MIH-CP Programs:

- Queen Anne's County: $50,000 grant from Shore Regional Health; $50,000 grant from Anne Arundel Medical Center; $400,000 grant over three years from CareFirst BlueCross BlueShield (2016) to expand access to health care to underserved communities through the use of telemedicine.
- Prince George's County: EMS participation in the program is funded through the Fire/EMS Department's budget. This funding includes two (2) full-time equivalent positions and logistical resources.
- Charles County: The Charles County MIH Program received a $400,000 three-year grant from the Maryland Community Health Resource Commission and an additional $150,000 over the three-year period from the UM Charles Regional Medical Center.
- Montgomery County: The program is currently being funded by MCFRS out of its operating budget. In FY17, MCFRS spent approximately $200,000 on this initiative. This funding supported 1.5 FTE firefighter/paramedics who were re-allocated from other duties, and a few other paramedics on an occasional overtime basis who assisted with home visits. The nurses for the program are being contributed by various area hospitals.
- Frederick County: The project will be funded by a combination of in-kind services and support from Frederick Memorial Hospital for some personnel costs.

Comparison Chart of MIH-CP Programs' Staffing, Funding, and Patient Population in Pennsylvania, Minnesota, Texas, and New York[9]

The following chart summarizes key features MIH-CP programs in four states from a landscape analysis on MIH-CP programs that serve persons who currently need or who are at risk for receiving Long Term Care.

UCSF Health Workforce Research Center on Long-Term Care
Research Report

Table 1. Key Attributes of MIH-CP Programs Profiled in this Report

Program	Program Setting	Number of CP Staff	Target Population	Estimated Number of Patients Served Annually	Sources of Funding
Pittsburgh, PA: CONNECT Community Paramedicine Program	Hospital-based, non-transporting CP agency in partnership with Allegheny County EMS Council and Congress of Neighboring Communities (CONNECT)	2 full-time and 7 part-time CPs	Allegheny County residents deemed medically vulnerable by a provider	150	Mix of grant funding and contracts with health plans; targeting future contracts with hospital partners
Wadena, MN: Tri-County Health Care Community Paramedicine	Hospital	8 part-time CPs	Patients identified by the hospital as frequent utilizers, recently discharged, having a chronic disease, needing home health services, and/or living in assisted living	300	Hospital budget, and some insurance reimbursement for CP patient encounters
Fort Worth, TX: MedStar Mobile Healthcare Community Health Program	Inter-governmental EMS agency	2 full-time MIH paramedics and 7 critical care paramedics	Two types: (1) High ED utilizers/ Persons at high risk for hospital readmission (2) Hospice and home health patients	724	Contracts with partnering healthcare providers
New York, NY: Northwell Health Community Paramedicine	Hospital	40 CP paramedics	Elderly, home-bound patients served by House Calls and hospice patients	465	A mix of grants, reimbursement from partners and Northwell Health's proprietary insurance plan

[9] LaFrance, Alicia, and Janet Coffman. *Mobile Integrated Health Care - Community Paramedicine: A Resource for Community-Dwelling People at Risk for Needing Long-Term Care*. UCSF Health Workforce Research Center on Long-Term Care, 15 Nov. 2016. https://healthworkforce.ucsf.edu/sites/healthworkforce.ucsf.edu/files/REPORT_2016_Mobile_Integrated_HC_Paramedicine.pdf

Challenges for MIH-CP Programs Going Forward[10]

- Reimbursement/Funding: In a 2017 national survey, 86% of MIH-CP programs who responded said that obtaining reimbursement or funding was a significant obstacle to their continued operations.
    - When asked whether their program was financially sustainable, only 36% of respondents agreed or strongly agreed. 25% disagreed or strongly disagreed, and 37% said they were "neutral."
    - There is also currently no standardized reimbursement for MIH-CP for providers on the federal level.
- State Laws on Scope of Practice: Some states, such as California, define the scope of practice, (SOP) the functions that Emergency Medical Service (EMS) providers can perform, very narrowly. Expanding the Scope of Practice of EMS providers is a key issue to address in order to allow practitioners in MIH/CP programs to continue to provide services beyond those they would provide as part of normal emergency response functions.
- Opposition from Other Healthcare Providers: In 2017, 36% of MIH-CP programs surveyed agreed or strongly agreed that opposition from other healthcare providers such as physicians, nurses, or home health care agencies was a significant obstacle to growing or sustaining MIH-CP.

Additional Resources

1. Memo on State and Local Community Paramedicine Models (Attached to this email)
   This NGA memo describes state and local community paramedicine models from California, Minnesota, Colorado, Massachusetts, and Wisconsin. In the attached memo, you will find information on the background and purpose of community paramedicine and challenges that states and emergency medical services face when implementing community paramedicine programs. Further information is provided on descriptions of selected models, including relevant legislation and regulations, financing mechanisms, and outcomes including ROI. If you would like additional information about any of the programs described, we would be happy to schedule a call or conduct more research with relevant experts.

2. The Business Case for Community Paramedicine: Lessons from Commonwealth Care Alliance's Pilot Program (attached to this email)
   This Center for Health Care Strategies (CHCS) brief highlights the Massachusetts-based Commonwealth Care Alliance (CCA) pilot of a community paramedicine program, Acute Community Care (ACC), to serve its members in the Greater Boston area in 2014 and 2015. This brief summarizes ACC's business case assessment, which showed that increasing patient volume after the pilot period would result in net savings given the program's success in averting unnecessary emergency care. By illustrating cost considerations for an expansion of MIH-CP services, this brief may inform the design and sustainability planning of other MIH-CP programs. The business case assessment was conducted by Mathematica Policy Research through support from the Center for Health Care Strategies' Complex Care Innovation Lab, a Kaiser Permanente Community Benefit-funded initiative.

3. In February 2018, the NGA Center conducted a call for state leaders about community paramedicine. There are three slide decks attached with the following information:

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[10] Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey. National Association of Emergency Medical Technicians, 2018, www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92_2.

a. Slides from Matt Zavadsky, Chief Strategic Integration Officer, MedStar Mobile Healthcare about their community paramedicine work.
b. Slides from Taylor George, Section Chief, Services and Development, Bureau of EMS and Trauma System, Arizona Department of Health Services about their Medicaid payment for treat and refer.
c. Slides from Anne Mosbach, Mental health Initiative Coordinator, Douglas County, Colorado on their county community response teams.