National Emergency Medical Services Advisory Council
DRAFT/INTERIM/FINAL
Advisory and Recommendations

Title: Strategies for Mobile Integrated Health-Community Paramedicine (MIHCP) and Funding and Reimbursement.

As prepared by the Subcommittee on Sustainability and Efficiency

A. Executive Summary:

America is rapidly aging and at the same time, is losing physician providers at an alarming rate. Each year there are more than 1 billion visits to physician offices, this number is expected to increase as our population ages. Access to primary care physicians varies across the nation with some communities having vast resources while others have sparse or no resources at all. The Association of American Colleges (AAMC) estimates that by 2034, there will be shortages of up to 48,000 primary care physicians and 77,000 non-primary care physicians. While some providers and healthcare organizations are augmenting physicians by utilizing nurse practitioners and physician assistants, there remain gaps across the nation with various State, Local, Tribal and Territorial areas that struggle with readily available healthcare resources.

Data from the Centers for Disease Control and Prevention (CDC) indicates there are approximately 140,000,000 visits to emergency rooms in the US annually. It is estimated that approximately 27% of these visits could have been treated in urgent care centers, clinics, physician offices, and other locations resulting in a savings of 4.4 billion dollars a year. Mobile Integrated Health-Community Paramedicine (MIHCP) is an important part of the EMS system and can play a vital role in providing access and care to individuals in the out of hospital setting. MIHCP can play a vital role in meeting the Institute for Healthcare Improvements (IHI) Quadruple Aim's overarching goals of reducing costs, improving patient health, and improving quality of care. To be successful, the MIHCP system must be adequately supported, including payment of services by both government and commercial insurers.

B. Recommendations

National Emergency Medical Services Advisory Council (NEMSAC)

Recommendation 1: NEMSAC shall, on a biennial basis, investigate and review funding mechanisms and opportunities available to enhance the development and sustainability of Mobile Integrated Health and Community Paramedic Programs until such time as established and adequate government payor rules are in place.

National Highway Traffic and Safety Administration (NHTSA) Office of EMS (OEMS)

Recommendation 1: NHTSA should work with the National Association of State EMS Officials (NASEMSO) to develop messaging for state EMS offices that can be used to communicate the benefits of establishing MIHCP programs and payment and reimbursement models through state Medicaid programs and licensed commercial insurance payors**.** Communications should be directed to the state insurance commissioner and/or other entities that have oversight of government and commercial payors within their states**.**

Federal Interagency Committee on Emergency Medical Services (FICEMS)

Recommendation 1: FICEMS will ask, through its CMS representative, that the appropriate CMS sector will identify and work with stakeholders that are operating MIHCP programs that have demonstrated improved patient access to health care for specific and/or various populations, a reduction in hospital admissions and an overall reduction in health care cost, to develop a toolbox to include best practices, and evaluate pathways where MIHCP funding concepts can be built.

Recommendation 2: FICEMS will ask, through its CMS representative, to develop a national payment model for mobile integrated health and community paramedicine recognizing the value and cost savings associated with improving access to health care, improving the health of the population, reducing hospital admissions and per capita cost of health care.

C. Scope and Definition

Scope:
The scope of this Advisory is to set a foundational, continuously updating Advisory that reviews real-time, Treatment in Place, funding matters as nimbly as possible to assist the Secretary, OEMS, FICEMS and the EMS Industry in achieving sustainable MIHCP organizations.

Definitions:

- **Mobile Integrated Health-Community Paramedicine (MIHCP)**: The provision of healthcare using patient-centered- mobile resources in the out-of-hospital environment.
- **Community EMS (CEMS)**: Community EMS, or community paramedicine, is a healthcare model that uses emergency medical services (EMS) providers to provide primary care and other services to patients in their homes or communities
- **Treatment in Place (TIP):** IP is a service that involves treating patients at the scene of an emergency instead of transporting them to a hospital.

- **Quadruple Aim:** The expansion of the Triple Aim (enhancing patient experience, improving population health, and reducing costs) to include an additional goal of improving the work life of health care providers.

Analysis:

Each year in the United States, there are more than 1 billion visits to physician offices and as many as 140 million visits to emergency rooms, these numbers are expected to grow as our population ages. A report by the Association of American Colleges (AAMC) estimates that by 2034, there will be shortages of up to 48,000 primary care physicians and 77,000 non-primary care physicians. Access to primary care physicians varies across the nation with some communities having vast resources while others have sparse or no resources at all. The number of Americans ages 65 and older is expected to increase from 58 million in 2022, to approximately 80 million by 2050 (47% increase). According to a Fair Health Report, individuals 65 years and older were consistently the largest age group associated with emergency ground ambulance service. Studies suggest that approximately 15% of all Medicare beneficiaries transported to the emergency department by EMS were either nonemergent or emergent and could have been managed by a primary care provider, costing the health care system approximately $1 billion dollars per year. Additionally, unplanned readmissions cost Medicare $26 billion dollars annually, with an estimated $17 billion spent on potentially avoidable hospitalizations. Unnecessary hospital admissions put additional stress on the health care system especially in areas that have limited hospital in-patient capacity.

Less beds, increased cost, and an aging population:

In 1975, there were approximately 1.5 million hospital beds in the US, by 2022, this number had decreased to roughly 917,000. In 2022, CDC data revealed that national healthcare expenses grew 4.1% to $4.5 trillion, or $13,493 per person, and accounted for 17.3% of gross domestic product. During this same period, hospital expenditure grew 2.2% to $1,355 billion dollars.

Elderly Americans face significant challenges, from age related health struggles, rapidly rising obesity rates, transportation challenges and socioeconomic disparities in health care access that include increased caregiving gap. The demand on the US health care system is already stressed and with a rapidly aging population, the demand will only grow in the future years to come.

Rural Challenges:

Approximately 80% of rural counties covering more than 30 million people are classified as healthcare deserts and access to local care is challenging. For individuals that live more than 30 miles from a medical provider, transportation can be limited or not available leading to the inability to receive preventive health care services. Individuals in rural areas are more likely to die from preventable and treatable causes including heart disease, stroke, chronic respiratory disease, and cancer when compared to those that live in suburban and urban areas. In addition to the chronic and acute medical needs of older Americans, the nation has seen significant increases in individuals with both mental health and substance abuse needs all of which adds stress on an already struggling health care system.

Emergency, urgent, or unplanned care also is often disconnected from the patient's ongoing health care management, resulting in additional financial burden related to duplicate testing, an increase in the risk of medical errors, and a lack of communication and coordination between care teams and settings. MIHCP interventions have the potential to reduce several of these gaps in a fiscally responsible manner and contribute to the goal of the Institute of Healthcare Improvement's Quadruple Aim and Population Health initiative. Currently, most government payors in the US do not recognize or pay for MIHCP services. This greatly reduces the opportunities for MIHCP program growth and sustainment and does nothing to incentivize MIHCP program development. According to the National Association of State EMS Officials (NASEMSO), only five states have Medicaid programs that pay for MIHCP, while 14 states provide some type of payment for treatment without transport. Several MIHCP programs have contracted with hospitals, Accountable Care Organizations and/or directly with commercial payors to provide MIHCP services in the home or health care setting however, there is no uniform fee/payment schedule. Only by ensuring that MIHCP programs receive fair and adequate payment for services, can we continue to build and maintain access to MIHCP across the US.

E. Strategic Vision

Mobile Integrated Health and Community Paramedic programs (MIHCP) will play a vital role in improving access to health care, including preventive, acute and long-term health care of individuals, reduce preventable hospital admissions/readmissions and cost to the health care system. MIHCP programs will seek opportunities to improve equitable access and delivery of health care to those with limited or no ability to receive the care that they require.

F. Strategic Goals

Goal 1: FICEMS members to work with CMS and payors to develop a model of payment for Mobile Integrated Health and Community Paramedicine services.

Goal 2: NEMSAC will continue to evaluate proposals for developing enhanced roles of MIHCP and EMS providers to meet the health care needs of our most vulnerable populations.

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