
M E M O R A N D U M

TO: Idaho SIM Team
From: Katherine Heflin & Anna Spencer, CHCS
Subject: Reimbursing CHEMS at the Community Level
Date: March 14, 2016
CC: Bridgette Harrison, CMMI

Introduction

This memo provides information on strategies to reimburse Community Health EMS (CHEMS), community paramedicine, and Mobile Integrated Health Services.

Avenues for Funding/Reimbursement

Local EMS services are financed by both public and private resources, with most communities using a mix of funding. The funding portfolios usually include: state and municipal taxes, state and federal grants, philanthropic and charitable donations, in-kind contributions, subscription programs, patient out-of-pocket payment, and fee-for-service payments from Medicare, Medicaid, and private health insurance.¹ A national estimate of funding sources for average EMS agencies included 42% from Medicare, 23% from miscellaneous subsidization (often local taxes), 19% from commercial insurers, 12% from Medicaid, and 4% from individual patient payments.²

Community paramedicine programs are generally covered by local EMS agencies, which allocate funds directly from their operational budgets. However, other logical funding partners include: Critical Access Hospitals, Rural Health Clinics, and Federally Qualified Health Centers (FQHCs).³

Shared Savings

- Sometimes called “cost-avoidance,” this strategy allows community paramedicine programs to be reimbursed through shared savings with hospitals for reducing readmissions. For example, some community paramedic programs get paid a per-member, per-month or fee-for-service, but these payments are withheld when the patient is readmitted within a certain timeframe.
- In Birmingham, Alabama, Lifeguard Ambulance Service is working with St. Vincent’s Hospital on a pilot project to reduce readmissions. The project includes two urban and two rural hospitals and explores different shared savings strategies including bundled

¹ Wizer, K.W., Shore, K., & Moulin, A. (2013). “Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care.” *UC Davis Institute for Population Health Improvement*.
<http://www.emsa.ca.gov/Media/Default/PDF/CPReport.pdf>

² Munjal, K. and Carr, B (2013). “Realigning Reimbursement Policy and Financial Incentives to Support Patient-Centered Out-of-Hospital Care,” *JAMA*, 309(7): 667– 8.

³ Patterson, D., Skillman, SM. (February 2013). National Consensus Conference on Community Paramedicine: Summary of an Expert Meeting. Seattle, WA: University of Washington.
http://www.emsa.ca.gov/Media/Default/PDF/National_Consensus_Conference_on_Community%20Paramedicine_Summary_of_an_Expert%20Meeting.pdf, pages 12-13.

payments. It is also testing an at-risk payment methodology where the ambulance company receives a percentage of the cost savings for each patient not readmitted within 30 days, with no payment if the patient is admitted within that 30-day window.⁴

- MedStar Mobile Healthcare in Fort Worth, Texas has used a “fee-for-referral” agreements with a local Accountable Care Organization (ACO) for the observation admission avoidance program—a part of the hospice revocation program. It has similar contracts with three local hospitals for a 911 nurse triage program.⁵ The ACO, which has a risk-sharing arrangement with a Medicare managed care organization, and MedStar are moving toward a shared savings model where they would split the savings with the hospital 80/20 for preventing a readmission within 30 days.⁶
- Similarly, Eagle County Paramedic Services (Ambulance District, formerly WECAD) in Colorado uses this type of negotiated contract approach that provides incentives to prevent hospital readmissions. The ambulance company recoups a portion of the savings that results preventable readmissions.⁷

Hospital-Funded

- Hospitals that own ambulance services provide financial support for their community paramedicine programs, with the goal of reducing readmissions enough to result in cost savings.⁸ For example, in 2013, Maine launched 12 pilot community paramedicine programs. Each pilot is responsible for funding their operations; no grant funding was provided by the Maine EMS or from any state-level sources. EMS agencies that are hospital-owned (CA Dean, Crown, Mayo, and NorthStar), fund their community paramedic personnel and equipment needs through the hospital general operating budgets. An evaluation of these pilot projects found that hospitals see the services as essential way to fill gaps in the continuity of care, as well as an effective strategy to reduce the number of ER visits and hospital readmissions.⁹
- In Nebraska, the VA of Omaha, in collaboration with Medics at Home, provides non-emergency ambulance services for their patients in Eastern Nebraska, Western Iowa and surrounding communities. Medics At Home, a pioneer of Community Paramedicine, share in the saving produced by avoidable readmissions.¹⁰

Grants

- South Carolina (Abbeville Area Medical Center and County EMS) and Washington (Prosser Memorial Hospital and EMS) are using foundation and federal grant funds, respectively, for their pilot community paramedicine programs. Colorado’s funding stream for their community paramedicine program includes local foundation support; additionally, they are

⁴ Pearson et al (February 2014). “Policy Brief--Community Paramedicine in Rural Areas: State and Local Findings and the Role of the State Flex Program,” *Flex Monitoring Team*. <http://www.flexmonitoring.org/wp-content/uploads/2014/03/pb35.pdf>

⁵ Jacob, S. (2014, Feb. 12). “EMS Loyalty Program Slashes Emergency Room Trips, Saves Millions.” *Healthcare Daily*. <http://healthcare.dmagazine.com/2014/02/12/ems-loyalty-program-slashes-emergency-room-trips-saves-millions/>

⁶ Pearson et al (February 2014).

⁷ Pearson et al (February 2014).

⁸ Pearson et al (February 2014).

⁹ Pearson, K. and Shaler, G. (November 2015). “Maine EMS Community Paramedicine Pilot Program Evaluation.” *Maine EMS, Department of Public Safety*. http://www.maine.gov/ems/documents/cp_muskie_report.pdf

¹⁰ National Association of EMS Officials. *EMS Office Assessment of the Status of Community Paramedicine/Mobile Integrated Healthcare in the States and Territories*, May 2015. <https://www.nasemso.org/Projects/MobileIntegratedHealth/documents/CP-MIH-Survey-2014-2015.pdf>

looking to local hospitals to reimburse for community paramedic services to offset the cost of an additional FTE community paramedic.¹¹

Municipality

- Of Maine’s twelve community paramedicine pilot projects, four are based out of municipal EMS agencies (Calais, Castine, Searsport, and Winthrop). These municipal-based projects are supported as part of their regular EMS town budgets. For example: Calais Fire and EMS, a municipal fire-rescue unit, is funded by the municipality to conduct in-home management of chronic diseases.¹²
- Through a California program called the Maddy EMS fund, counties may designate a portion of traffic fines to support EMS services for uninsured persons. Additional funding for local EMS agencies is often derived primarily from revenues generated from patient transport—a careful balance that is based on the number of transports and depends on the payer mix to remain stable.¹³

Stakeholders

- Due in part to Colorado’s long history of rural community paramedicine, the state programs have developed good stakeholder involvement processes. Stakeholders include: the Colorado Department of Health and Environment, the Colorado Rural Health Center, the nursing association, and the medical society. Some of these stakeholders, such as Colorado Rural Health Center, have provided financial support, meeting facilitation, and meeting spaces/ an administrative home for the SORH and Flex offices.¹⁴

Additional Resources

- **National Conference of State Legislatures: “Beyond 911: State and Community Strategies for Expanding the Primary Care Role of First Responders”**
This NCSL piece on paramedicine presents strategies for states and local regions to expand paramedicine and it examines the challenges and opportunities related to implementation of community paramedicine initiatives. The following link contains the 7-section toolkit: <http://www.ncsl.org/research/health/expanding-the-primary-care-role-of-first-responder.aspx>
- **2012 National Consensus Conference on Community Paramedicine: “Summary of an Expert Meeting”**
For a summary of the expert meeting on community paramedicine in Atlanta, GA, please refer to the following document page recommendations: http://www.emsa.ca.gov/Media/Default/PDF/National_Consensus_Conference_on_Community%20Paramedicine_Summary_of_an_Expert%20Meeting.pdf
 - Pages 25-28: Promising **resource suggestion**
 - Pages 30-34: **Contact information** of the 90 special-invite conference attendees including state EMS directors, state rural health offices, EMS professional organizations, representatives from local community paramedicine programs, cross-sector healthcare and government agencies, and healthcare economists

¹¹ Pearson et al (February 2014).

¹² Pearson, K. and Shaler, G. (November 2015).

¹³ Wizer, K.W., Shore, K., & Moulin, A. (2013). “Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care.” *UC Davis Institute for Population Health Improvement*.
(<http://www.emsa.ca.gov/Media/Default/PDF/CPReport.pdf>)

¹⁴ Pearson et al (February 2014).

- Pages 37-40: The conference agenda which specifies **expert panelists who presented best practices/pilot results** and who may be helpful for following up