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Indiana's Approach to Supporting Mobile Integrated Health Programs

By Jodi Manz

In the wake of the enormous strain caused by the COVID-19 pandemic across the health care system, states are considering opportunities to improve access to care while identifying ways to innovate the delivery of care. Such potential innovation includes thinking about how to deploy available health care workforce differently and how to better incentivize lower-cost, person-centered care.

[Mobile Integrated Healthcare – Community Paramedicine \(MIH-CP\)](#) – two related approaches that leverage emergency medical responders – can offer states a framework for how to achieve these goals by realigning care delivery to reduce unnecessary emergency department (ED) utilization, which can be costly to states. In 2018, state Medicaid programs were the single most frequent payer for ED visits, covering over [15 percent](#) of behavioral health visits and [37 percent](#) of total ED visits, about a third of which were triaged and determined to be semi- or non-urgent in nature.

Preventing these types of visits by providing community-based care can help states reduce Medicaid costs and improve outcomes.

By leveraging emergency medical services (EMS), which are embedded in communities, trained to respond to a broad array of needs, and available around the clock, MIH-CP programs are poised to help states reimagine how this workforce can be used to increase overall health care capacity and support systemic change. Reimbursement for EMS-delivered services through Medicaid and other payers has typically been tied to transportation, but because MIH-CP programs deliver direct care in the community, states can consider opportunities to develop rate structures and value-based policy to allow for billing. States can discover savings from reduced hospital readmissions and ED usage and at the same time, see improved patient outcomes and connections. These programs not only bring care into the homes of individuals with chronic disease and those needing follow up care after ED visits, they can also help to support connections between patients and other facility-based providers using telehealth technology. Further, MIH-CP provides person-centered care and connection to high-need individuals, including those with mental health and/or substance use disorder (SUD) needs who can be directed to appropriate, non-ED sites for behavioral health services.

The provision of behavioral health services is an emerging practice within MIH-CP programs. As behavioral health needs have [increased](#) throughout the pandemic, and [suicide](#) continues to rank among the most common causes of death nationally, recent federal investments have targeted mental health crisis care as an immediate priority for states. MIH-CP approaches pose an opportunity to provide community based care to prevent the development of crises and, subsequently, to reduce reliance on hospital EDs.



Defining Mobile Integrated Healthcare and Community Paramedicine

According to the National Association of Emergency Medical Technicians (NAEMT), “Mobile integrated healthcare - community paramedicine (MIH-CP) is the provision of healthcare using patient-centered, mobile resources in the out-of-hospital environment. MIH is provided by a wide array of healthcare entities and practitioners that are administratively or clinically integrated with EMS agencies, while CP is one or more services provided by EMS agencies and practitioners that are administratively or clinically integrated with other healthcare entities.”

Building Blocks of Indiana’s Mobile Integrated Health Program

- **Authority.** In Indiana, localities administer EMS programs while the state Department of Homeland Security (IDHS) provides overarching guidelines and policy for training and certification. While a few local EMS provider organizations had been piloting MIH-CP programs for nearly a decade, a [2019 legislative change](#) established a definition of MIH in the EMS section of Indiana’s [code](#): “community-based health care in which paramedics and emergency medical technicians

employed by an emergency medical services provider agency function outside of customary emergency response and transport to...facilitate more appropriate use of emergency care services [and] enhance access to primary care for medically underserved populations or underutilized and appropriate health care services.”

Indiana’s state law also establishes the [Mobile Integrated Healthcare Advisory Committee](#) as a subcommittee of the Indiana [EMS Commission](#). The Advisory Committee, which is chaired by the state EMS Director, includes leadership from the state’s Medicaid and public health agencies as well as community EMS providers and stakeholders. Statutory language provides the Advisory Committee authority to determine the programmatic elements of the state’s MIH program, including training/certification, necessary services to be included, and their own level of oversight of funded programs. Further, it allows the Advisory Committee to create an application process for local EMS providers to develop and implement MIH programs and to make recommendations to the EMS Commission regarding approval or denial of those applications.

- **Funding.** In addition to creating the program and the Advisory Committee, the enabling legislation for MIH in Indiana also created a non-reverting fund to develop grants to help local EMS providers pay for the costs of implementing a program. The following year’s [state budget](#) (state FY21-22) included a one-year \$100,000 appropriation for these grants, which are administered by the Advisory Committee. Ultimately, six local fire departments applied for funds – some to establish MIH services and others to enhance existing programs – and all six were recommended to be [approved](#), though some with less funding than requested to accommodate the grant budget. The EMS Commission followed these recommendations.

Indiana may also have options to leverage Medicaid funding for MIH services. Historically, Medicaid reimbursement for EMS has been limited to a per-mile, transportation-only structure that does not include payment for provided services. A [law](#) enacted in 2020 allows the state Medicaid agency to reimburse for EMS services in the home without transport, including MIH – as long as they are responding to a 911 call. While this does not provide a full suite of reimbursement options for MIH currently, it does “start the process of decoupling reimbursement and transport,” according to one Indiana state leader. Only MIH programs approved by the EMS Commission in accordance with [guidelines](#) established in April 2021 will be eligible for reimbursement for services. While the future of Medicaid reimbursement continues to be discussed in Indiana, the state budget also includes language that allows Indiana to apply for a Medicaid Section 1115 demonstration waiver in support of MIH services or for federal funding through the [American Rescue Plan Act’s](#) (ARPA) new state option for enhanced federal Medicaid match for mobile crisis intervention services.

- **Leadership and local engagement.** Establishment of the Advisory Committee in Indiana has been key to an organized, incremental approach to the growth of MIH in the state. The Advisory Committee considers itself an approval body that provides recommendations and feedback for the EMS Commission, declining to create a separate state licensing or certification structure for MIH. Indiana policymakers have indicated that ensuring that MIH programs are rooted in a local approach is a priority that allows these programs to be responsive to unique community needs that reduce hospital readmissions and unnecessary ED utilization – a perspective championed by the state legislators who authored the initial bill. The Advisory Committee was intentional about taking a broad approach to considering grantees in order to encourage innovation. Grantees were able to apply for funds for anything that fit the needs of their EMS programs, and requests were varied and included training, equipment, and overtime pay, among other needs.
- **Indiana MIH grantee approaches.** Awarded in July 2021, Indiana’s six MIH grantees are all currently operational. Among them, several themes and innovations emerged in how they are using funding in their communities:
 - **Behavioral health response teams:** All grantees are addressing behavioral health in some way, and notably, at least three are currently working to create or expand response teams for behavioral health crises: two are working toward mental health crisis intervention teams in MIH, and another is integrating an SUD quick response team. The [Noblesville Fire Department](#) has established community partnerships to provide team-based crisis intervention through NobleAct, which includes follow up care and case management.
 - **Hospital partnerships:** Each grantee program has a hospital partner, and several began these partnerships with local hospital systems to reduce readmissions around single diagnoses. The Muncie Community Medic program has been partnering with Ball Hospital for several years, beginning with a project to reduce readmissions related to heart failure and chronic obstructive pulmonary disease. The MIH program in Crawfordsville similarly began as a partnership to reduce heart failure readmissions, and EMS follow ups and in-home care led to zero readmissions in a two-year post-hospital engagement review. The department continues to maintain a chronic disease management-specific project within their MIH program that provides education, early intervention, and in-home care.
 - **Training for EMS providers.** One program is using funds to pay for peer recovery specialist training for paramedics. While these individuals may lack

lived experience with SUD and therefore do not seek certification for Medicaid reimbursement for peer services, the training allows them to better understand the needs and experiences of individuals with SUD whom they may treat in the community.

- **Providing SUD care in the community.** The program in the Crawfordsville Fire Department aims to create a continuum of care, explaining that this program expands the role of the department and not its scope. This includes the dispensing of buprenorphine to individuals who are experiencing withdrawal or may be at risk of overdose. As an EMS entity, the department holds a DEA waiver and can conduct [Clinical Opiate Withdrawal Scale](#) assessments in the home, provide buprenorphine, and access the patient's electronic health record to facilitate physician connections within three days.

Lessons Learned

- **Engage local EMS leaders in state policy discussions.** Indiana leaders note that while localities have been aware of MIH-CP and have been implementing strategies to varying degrees for the better part of a decade, state action is necessary to creating parameters and guidelines, particularly around funding. Because EMS is distinctly a local service, local leaders who are aware of community needs and experiences are well-suited to inform state policy development.
- **Leverage the EMS workforce “physician extenders,” creating programs in which community paramedics can operate to the top of their scope of practice.** Trust for EMS remains high, and Indiana's leaders and grantees expressed that patients are generally forthcoming with EMS about the factors contributing to health challenges. An MIH-CP approach offers opportunities for EMS to both initiate and continue treatment, and to serve as a connector to other providers in the community. Consider as well that while MIH programs can indirectly help to alleviate workforce challenges in hospitals, particularly in the wake of the pandemic, EMS also faces challenges with recruitment and retention and should be included in state healthcare workforce development strategies.
- **Focus on prevention, and start small.** Indiana's grantee-driven approach focuses on how EMS can address the factors that lead individuals to “fall through the cracks” – not filling prescriptions upon discharge, not following aftercare directions, lack of transportation – and implements interventions to address them. As one grantee community medic said, “don't look for the problem, but the why.” MIH-CP is one tool in policymakers' toolbox to reduce hospital readmissions and unnecessary ED visits, and the patient relationships that develop from these programs can help to uncover the “why” quickly.

- **Pose MIH-CP as an economic approach – and maintain data to show how investments in MIH-CP can yield savings.** The NAEMT has provided a [Measurement Strategy Overview](#), which programs can use to identify metrics and learn how to use them. One local leader in Indiana posed the local MIH program as an economic development strategy in which “healthy equals high value” for the community. MIH-CP, like many health care strategies, is cost saving as opposed to revenue generating.
- **Consider opportunities for Medicaid reimbursement.** EMS services remain largely regarded as transportation and are paid on a per-mile basis, even though medical services to stabilize a patient are often necessary for transport. Further, MIH-CP often attempts to avoid transportation altogether, or encourages alternative transport to non-hospital destinations. Leveraging Medicaid authorities to reimburse specifically for services, including preventative MIH-CP services and other approaches that reduce ED visits, contributes to program sustainability. In addition, ARPA’s enhanced federal Medicaid match for mobile mental health crisis services could be an opportunity to fund MIH-CP programs that are focused on behavioral health intervention.
- **Develop partnerships with hospital systems and other community providers.** Several grantees expressed that relationships with local mental health providers, detox centers, and harm reduction services for alternative transport and follow-up navigation were key to keeping high-need individuals in the community and out of hospital EDs. Hospital partnerships – which may be easier to leverage in rural areas with single health systems – create opportunities for MIH-CP programs to integrate their services as part of a continuum of care, providing community follow ups for hospital patients, connecting patients with providers when necessary, and making data connections easier to execute.

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