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MANDATED BENEFIT REVIEW OF HOUSE BILL 1154 AND SENATE BILL 726

SUBMITTED TO THE 194<sup>th</sup> GENERAL COURT:

# **AN ACT RELATIVE TO INSURANCE COVERAGE OF MOBILE INTEGRATED HEALTH**

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# Mandated Benefit Review of House Bill (H.B.) 1154 and Senate Bill (S.B.) 726 Submitted to the 194<sup>th</sup> General Court

## An Act Relative to Insurance Coverage of Mobile Integrated Health

### TABLE OF CONTENTS

<b>1.0 Mandate Benefit Overview: H.B. 1154 and S.B. 726; An Act relative to insurance coverage of mobile integrated health</b>	<b>1</b>
1.1 What is MIH?	1
1.2 Current Coverage	1
1.3 Analysis Overview	2
1.4 Estimated Cost of Enactment	2
1.5 Efficacy and Equity Impact	2
<b>Endnotes</b>	<b>3</b>
<b>2.0 Medical Efficacy Assessment</b>	<b>6</b>
2.1 MIH Background	7
2.2 Applications of MIH	9
2.3 Efficacy of MIH	12
2.4 Access and Health Equity	22
<b>3.0 Conclusion</b>	<b>26</b>
<b>Endnotes</b>	<b>27</b>
<b>4.0 Actuarial Assessment</b>	<b>36</b>
4.1 Background	36
4.2 Plans Affected by the Proposed Mandate	36
4.3 Existing Laws Affecting the Cost of the Bill	37
4.4 Current Coverage	37
<b>5.0 Methodology</b>	<b>38</b>
5.1 Overview	38
5.2 Data Sources	38
5.3 Steps in the Analysis	38
5.4 Assumptions and Limitations	39

<b>6.0 Analysis</b>	<b>41</b>
6.1 Incremental Cost of Expanded Coverage	41
6.2 Projected Fully Insured Population in the Commonwealth	42
6.3 Total Marginal Medical Expense	42
6.4 Carrier Retention and Increase in Premium	43
<b>7.0 Results</b>	<b>44</b>
7.1 Five-Year Estimated Impact	44
7.2 Impact on GIC	45
<b>Endnotes</b>	<b>46</b>
<b>Appendix A: Membership Affected by the Proposed Language</b>	<b>48</b>
<b>Endnotes</b>	<b>50</b>

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## 1.0 Executive Summary: H.B. 1154 and S.B. 726; “An Act relative to insurance coverage of mobile integrated health”

The Massachusetts Legislature’s Committee on Financial Services referred House Bill (H.B.) 1154<sup>1</sup> and Senate Bill (S.B.) 726,<sup>2</sup> both titled, “An Act relative to insurance coverage of mobile integrated health,” to the Massachusetts Center for Health Information and Analysis (CHIA) for review. This report references H.B. 1154 and S.B. 726 together and hereafter “the bill.”

As submitted to the 194<sup>th</sup> General Court, the bill requires health insurers to provide coverage for medical, behavioral, and health care services delivered by approved mobile integrated health (MIH) programs to the same extent as services provided in traditional health care facilities; it also stipulates that coverage cannot be denied solely because services were delivered by a health provider participating in an MIH program. Additionally, payment rates for covered services cannot be reduced on the grounds that they were delivered through an MIH program, and deductibles, copayments, or coinsurance for MIH services cannot exceed those applied to similar services provided in health care facilities. The bill also exempts MIH programs focused on behavioral health services from application and registration fees.

### 1.1 What is MIH?

MIH is an extensive, patient-centered approach that expands the traditional role of Emergency Medical Services (EMS) to deliver community-based services along the care continuum. MIH programs emphasize collaboration with health care and social services, providing services such as chronic disease management, post-hospital discharge care, and care navigation.<sup>3</sup> These programs integrate telemedicine and preventive health care to support patient needs outside of emergency settings. Defined under Massachusetts 105 CMR 173.000, MIH utilizes EMS personnel, including community paramedics, to deliver care in out-of-hospital environments in coordination with health care providers, home care agencies, and other in-home services. MIH services may include behavioral health care, preventive care, post-discharge follow-ups, and referrals to non-emergency facilities, offering a flexible and innovative model for health care delivery.<sup>4</sup>

### 1.2 Current Coverage

No federal laws, including the Affordable Care Act (ACA), require coverage for services provided by MIH programs. Massachusetts law<sup>5</sup> currently supports the establishment and regulation of MIH programs through the Department of Public Health (DPH).<sup>5</sup> MassHealth has collaborated with health care providers to implement MIH services but is not required to cover these services.<sup>6</sup> MIH program applicants must submit required documentation and associated fees to the DPH, which may choose to expedite their review if the applicant highlights serving an underserved population. The minimum requirements for MIH program approval include applicants identifying current gaps in service delivery, describing how their program will address these gaps, and demonstrating their financial and legal viability.<sup>7</sup>

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<sup>1</sup>105 CMR 17.000 Mobile Integrated Health Care and Community EMS Programs.

BerryDunn surveyed Massachusetts insurance carriers in the Commonwealth, with respondents representing 84% of the Commonwealth's fully insured commercial membership.<sup>ii</sup>

Most carriers indicated that MIH is not currently a covered benefit and that they do not have specific policies or provider contracts in place. While some cover services that align with the MIH definition—such as remote patient monitoring or in-home care—MIH programs as defined in the proposed legislation are not included in current coverage. Several carriers noted that reimbursement would not be possible for unlicensed providers, including community paramedics. If MIH were to become a covered benefit, most carriers anticipate increased utilization, though some carriers noted they are unable to estimate the impact due to limited data.

### 1.3 Analysis Overview

The legislative sponsor indicated that the bill's primary purpose is to create a more cost-effective approach to health care for patients who need medical care but do not require emergency services. The goal of the bill also includes reducing unnecessary hospital admissions, covering MIH services in both home and facility settings, and ensuring non-emergent patients can receive care at home or through community providers. It also seeks to expand access to behavioral health-focused MIH programs by exempting them from application and registration fees. The bill's target population includes individuals with chronic conditions, those in behavioral health crises, and individuals who would benefit from non-hospital-based care.<sup>8</sup>

### 1.4 Estimated Cost of Enactment

Requiring coverage for this benefit by fully insured health plans would result in an average annual increase to the typical member's health insurance premium of between \$0.03 and \$0.12 per member per month (PMPM) or between 0.004% and 0.014% of premium, over a projection period of five years.

### 1.5 Efficacy and Equity Impact

MIH programs are transforming health care by expanding the role of EMS beyond emergency response to proactive, community-based care. Through collaboration with health care and social services, these programs address chronic disease management, post-hospital follow-ups, and emergency department (ED) diversion, improving access, quality, and equity, particularly for underserved populations.<sup>9,10</sup> The integration of telemedicine and specially trained EMS personnel, such as community paramedics, enhances MIH services, enabling care delivery in homes and community settings. Research shows that MIH reduces EMS utilization, hospital readmissions, and costs while improving patient satisfaction and outcomes. By addressing social drivers of health these MIH programs advance health equity for underserved populations, including individuals who have low income and those who have medical complexities.<sup>11,12,13,14</sup> The success of programs in states like Massachusetts, Texas, and Georgia, coupled with supportive policies, highlights MIH's potential to reshape health care delivery, alleviate ED burdens, and enhance community health.<sup>15,16,17</sup>

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<sup>ii</sup>BerryDunn surveyed 10 insurance carriers in the Commonwealth (although Tufts Health Plan and Harvard Pilgrim Health Care recently merged, they are accounted for separately); responses represent six carriers and 84% coverage of members.

## Endnotes

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<sup>1</sup> H.B. 1154. An Act relative to insurance coverage of mobile integrated health.  
<https://malegislature.gov/Bills/194/H1154>.

<sup>2</sup> S.B. 726. An Act relative to insurance coverage of mobile integrated health.  
<https://malegislature.gov/Bills/194/S726>.

<sup>3</sup> National Association of Emergency Medical Technicians. Mobile Integrated Health care and Community Paramedicine (MIH-CP). 2015. Accessed December 16, 2024. <https://www.naemt.org/docs/default-source/community-paramedicine/naemt-mih-cp-report.pdf>.

<sup>4</sup> 105 CMR 173.000: MOBILE INTEGRATED HEALTH CARE AND COMMUNITY EMS PROGRAMS. 10/5/18. Accessed December 20, 2024. <https://www.mass.gov/doc/105-cmr-173-mobile-integrated-health-care-and-community-ems-programs/download>.

<sup>5</sup> *Ibid.*

<sup>6</sup> Mass.gov. Learn about MIH and Community EMS. Accessed December 16, 2024. <https://www.mass.gov/info-details/learn-about-mih-and-community-ems>.

<sup>7</sup> *Op. cit.* 105 CMR 173.000: MOBILE INTEGRATED HEALTH CARE AND COMMUNITY EMS PROGRAMS.

<sup>8</sup> Representative Michael J. Finn. Sponsor Questions Responses. January 29, 2025.

<sup>9</sup> *Op. cit.* National Association of Emergency Medical Technicians. Mobile Integrated Health care and Community Paramedicine (MIH-CP).

<sup>10</sup> *Op. cit.* 105 CMR 173.000: MOBILE INTEGRATED HEALTH CARE AND COMMUNITY EMS PROGRAMS.

<sup>11</sup> *Op. cit.* National Association of Emergency Medical Technicians. Mobile Integrated Health care and Community Paramedicine (MIH-CP).

<sup>12</sup> Wanner GK, Burch KR. EMS Community Paramedicine and Mobile Integrated Health. [Updated 2024 Oct 6]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Accessed December 16, 2024. <https://www.ncbi.nlm.nih.gov/books/NBK608004/>.

<sup>13</sup> Louras, N., Reading Turchioe, M., Shafran Topaz, L., Ellison, M., Abudu-Solo, J., Blutinger, E., Munjal, K. G., Daniels, B., & Masterson Creber, R. M. (2023). Mobile Integrated Health Interventions for Older Adults: A Systematic Review. *Innovation in aging*, 7(3), igad017. Accessed December 30, 2024. <https://doi.org/10.1093/geroni/igad017>.

<sup>14</sup> *Op. cit.* National Association of Emergency Medical Technicians. Mobile Integrated Health care and Community Paramedicine (MIH-CP).

<sup>15</sup> Dörner, S. C., Wint, A. J., et al. (2022). Patient Perceptions of In-home Urgent Care via Mobile Integrated Health. *The American Journal of Managed Care*, 28(4), 152-158. Accessed December 30, 2024. <https://doi.org/10.37765/ajmc.2022.88859>.

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<sup>16</sup> Choi, B. Y., Blumberg, C., & Williams, K. (2016). Mobile Integrated Health Care and Community Paramedicine: An Emerging Emergency Medical Services Concept. *Annals of emergency medicine*, 67(3), 361–366. Accessed December 17, 2024. <https://doi.org/10.1016/j.annemergmed.2015.06.005>.

<sup>17</sup> Tyano, E., Ferrer, E., Mayberry, S. D., Eldridge, R. C., Evans, D., & Simpson, R. L. (2021). Grady Health System's Mobile Integrated Health Program: A Statistical Analysis of Low-Acuity 911 Calls. *JEMS exclusives*, 2021. Accessed December 30, 2024. <https://www.jems.com/administration-and-leadership/community-paramedicine-and-mobile-health/grady-health-systems-ga-mobile-integrated-health-program/>.



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# **AN ACT RELATIVE TO INSURANCE COVERAGE OF MOBILE INTEGRATED HEALTH**

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MEDICAL EFFICACY ASSESSMENT

## 2.0 Medical Efficacy Assessment

The bill requires health insurers to provide coverage for medical, behavioral, and health care services delivered by state-approved mobile integrated health (MIH) programs that use mobile resources to deliver care and services in out-of-hospital settings to the same extent as services provided in traditional health care facilities. It also stipulates that coverage cannot be denied solely because services were delivered by a health care provider participating in an MIH program. Additionally, payment rates for covered services cannot be reduced on the grounds that they were delivered through an MIH program, and deductibles, copayments, or coinsurance for MIH services cannot exceed those applied to similar services provided in health care facilities.<sup>1,2</sup> MIH services may include community paramedic care, chronic disease management, behavioral health, preventive care, post-discharge follow-ups, and transport or referral to non-emergency facilities.<sup>3</sup> The bill also exempts MIH programs focused on behavioral health services from application and registration fees.<sup>4,5</sup>

In response to a request for clarification, the legislative sponsor indicated the bill's primary purpose is to create a more cost-effective approach to health care for patients who need medical care but do not require emergency services. Additionally, the sponsor indicated the bill's intent is to:

- Reduce unnecessary hospital admissions by providing cost-effective, non-acute care alternatives, easing the strain on hospital systems.
- Cover MIH services whether they are provided at home by a state-approved MIH program or in a health care facility.
- Target non-emergent MIH services, helping ensure that patients can be treated in their homes or connected to community providers instead of being taken to the emergency department (ED).
- Exempt behavioral health-focused MIH programs from application and registration fees to encourage their expansion, acknowledging that behavioral health service providers often face financial and structural barriers.

According to the sponsor, the target population for this bill includes individuals who need health care but are not in an emergency, such as:

- Patients with chronic conditions.
- Individuals experiencing behavioral health crises.
- Those who would benefit from care outside a hospital or ED, including home-based care or community health care providers.<sup>6</sup>

This report proceeds in the following sections:

### 2.0 Medical Efficacy Assessment

- 2.1 MIH Background
- 2.2 Applications of MIH

- 2.3 Efficacy of MIH
- 2.4 Access and Health Equity

### 3.0 Conclusion

## 2.1 MIH Background

The National Association of Emergency Medical Technicians (NAEMT) describes MIH as a comprehensive, patient-centered approach that expands Emergency Medical Services (EMS) capabilities. MIH shifts EMS from emergency response to providing value-based, longitudinal health care. Key characteristics of MIH programs include:

- Collaboration with various health care and social services.
- Patient-centered services such as chronic disease management, post-hospital discharge care, and navigation to appropriate care settings.
- Integration of telemedicine and provision of preventive health care.<sup>7</sup>

According to Massachusetts 105 CMR 173.000, MIH is defined as:

*“A Department-approved program, including MIH Programs with an ED Avoidance Component, that utilizes EMS Personnel, which may include community paramedics to deliver health care services to patients in an out-of-hospital environment in coordination with health care facilities or other health care providers, which may include, but not be limited to, primary care providers, home care agencies, visiting nurse associations, or other in-home services; provided, that the medical care and services may include, but not be limited to, chronic disease management, behavioral health, preventative care, post-discharge follow-up visits, or transport or referral to facilities other than hospital emergency departments.”<sup>8</sup>*

**Table 1 MIH and MIH with ED Avoidance<sup>9</sup>**

PROGRAM	MIH	MIH WITH ED AVOIDANCE
<b>PROGRAM DESCRIPTION</b>	A system of pre- and post-hospital services utilizing mobile resources to deliver a coordinated continuum of care in the community.	An optional additional facet of an approved MIH program that enables management of patients who call 9-1-1 in an alternative setting (e.g., outpatient clinics, psychiatric settings, and patients' homes).
<b>OPERATIONS</b>	Operated by health care entities with partners like ambulance services, hospitals, insurers, or medical practices.	Operated by a Department of Public Health (DPH)-approved MIH program. Uses primary ambulance service and advanced trained paramedics.
<b>SERVICES PROVIDED</b>	Applicants propose services to address gaps in service delivery, improving quality, access, cost-effectiveness, patient satisfaction, and health equity.	Applicants propose services that are in accordance with the DPH ED avoidance protocol to eliminate access gaps. Encounters align with 9-1-1 response and include assessment and consultation.
<b>OVERSIGHT</b>	Medical director designated by the MIH program.	Medical director of the primary ambulance service's hospital affiliation.

**Key Differences: MIH vs. Mobile Health Clinics (MHCs) vs. Hospital-at-Home (HAH)**

MHCs are a related care delivery model that also shifts health care services to meet patients where they are.<sup>iii</sup> MIH and MHCs both extend health care beyond traditional settings, with MIH focusing on proactive, in-home care coordination and MHCs delivering traditional services via mobile units to underserved areas. MIH emphasizes community-based, proactive care by providing health care services directly to patients in their homes or community settings and often involves paramedics or community health workers with advanced training to manage chronic conditions, conduct post-discharge follow-ups, and provide preventive care. MIH programs work closely with hospitals and health care providers to facilitate seamless transitions of care, fostering better patient outcomes. A primary goal of MIH is to address health issues early, preventing unnecessary trips to the ED and reducing health care costs.<sup>10,11,12,13</sup>

In contrast, MHCs are physical vehicles equipped to deliver traditional clinical services in underserved areas. These clinics are outfitted with exam rooms, medical equipment, and sometimes even lab facilities to provide on-the-spot health care. MHCs offer services such as preventive screenings, chronic disease management, primary care, and vaccinations. MHCs target populations with limited access to health care due to geographic, economic, or social barriers.<sup>14,15</sup> Both MIH and MHCs play a critical role in improving health care delivery, particularly for vulnerable or underserved populations, but they address different aspects of care delivery based on community needs.

While MIH brings preventive and chronic care into the home, HaH programs go a step further by delivering hospital-level, acute care to patients in their homes. HaH is designed for patients with serious but stable conditions—such as heart failure, pneumonia, or COPD—who would otherwise require inpatient admission. Unlike MIH, which focuses on

<sup>iii</sup> Services delivered by MHCs are not included in the scope of this bill.

managing ongoing health needs and avoiding emergency care, HaH substitutes for a hospital stay entirely by offering services such as IV medications, diagnostic imaging, and continuous monitoring through a mix of in-person visits, and telehealth. HaH is typically initiated from an ED or hospital and provides a more intensive level of care, often led by hospital-based teams.<sup>16</sup> MIH, by contrast, is more preventive and community-driven, with services often triaged by primary care clinics and treatment led by EMS or community paramedics and designed to keep people out of the ED and hospital.<sup>17</sup>

Massachusetts has MIH programs and MIH with ED avoidance programs. Massachusetts also has community-based mobile crisis intervention (MCI) services, which offer a separate but related model of community-based crisis response for individuals experiencing behavioral health crises. For adults (21+), MCIs provide short-term, on-site crisis assessment, intervention, and stabilization to reduce immediate risks and support transitions back into the community. For youth under 21, MCIs are tailored to their needs, with transition-aged youth (18 – 20) potentially served by adult-trained clinicians and peer specialists. MCI services are associated with Community Behavioral Health Centers (CBHCs), but can occur in various settings, including external to CBHCs at community locations, EDs, or via telehealth.<sup>18</sup>

### *MIH Groups*

The National Association of Mobile Integrated Healthcare Providers (NAMIHP) was founded in 2020 to advance the field of MIH. The organization focuses on:

- **Best Practices:** Promoting standards and innovations within the MIH industry.
- **Education:** Providing resources and training for providers.
- **Collaboration:** Building vendor relationships and partnerships nationwide.
- **Conferences:** Hosting events to foster dialogue among industry pioneers.
- **Standardization:** Establishing unified guidelines across diverse regions and sectors.

NAMIHP aims to unite stakeholders from various areas and regions to enhance awareness, drive business development, and elevate the role of MIH in transforming health care delivery.<sup>19</sup>

The Mobile Integrated Health Advisory Council (MIHAC), formed under Massachusetts General Law Chapter 111O, Section 4, brings together interested parties from nursing, accountable care organizations (ACOs), EMS, hospitals, fire departments, and other health care sectors to review the Agency for Healthcare Research and Quality (AHRQ) focus areas. Its work will support the DPH in defining MIH program activities, implementation, and evaluation of data trends and outcomes.<sup>20</sup>

## **2.2 Applications of MIH**

MIH programs address gaps in health care services and aim to reduce unnecessary ED visits and hospital admissions.<sup>21,22</sup> MIHs programs deliver integrated care by utilizing the skills of EMS clinicians in conjunction with other health care clinicians. MIH expands on community paramedicine (CP), in which the focus is on easing ED burdens by addressing health care needs, such as chronic disease management, post-discharge follow-ups, and health education, by incorporating a broader range of health care services delivered by multidisciplinary teams, including paramedics, nurses, mental health workers, and social workers. MIH programs focus on preventive care,

chronic disease management, ED diversion, and addressing social drivers of health through community partnerships.<sup>23</sup> They also utilize telehealth and remote monitoring technologies to enhance care delivery. Key services provided by MIH include:

- Helping prevent hospital readmissions through chronic disease management and follow-ups, including medication adherence.
- Diverting 911 patients to appropriate care settings, such as urgent care or mental health facilities.
- Providing non-emergency medical advice, telehealth services, and patient education to improve treatment compliance and health outcomes.
- Providing complex services, such as infusion therapies and advanced wound care.
- Collaborating with local healthcare providers and social services to address patient needs.<sup>24,25</sup>

By preventing or diverting patients from visiting the ED, MIH programs have the potential to reduce costs for both patients and the broader health care system. MIH visits do not incur facility fees like ED visits, as the services are delivered directly in the patients' homes. Additionally, MIH programs can mitigate costs by collaborating with primary care providers (PCPs) through telehealth, enhancing patient outcomes in several key areas. These include improved patient communication and engagement, increased utilization of preventive care, better medication adherence, reduced hospital readmissions, and decreased overutilization of emergency services. Enhancing these aspects of care can lead to significant cost savings and a stronger return on investment.<sup>26</sup> While the cost of an MIH visit is difficult to determine due to variation in program structure and differences in service implementation and insurance coverage, results from a 2014 survey of 103 active MIH-CP programs demonstrated that 54% of programs are highly or somewhat successful in reducing per patient health care costs.<sup>27,28</sup>

Massachusetts law<sup>iv</sup> currently supports the establishment and regulation of MIH programs through the DPH.<sup>29</sup> MIH program applicants must submit required documentation and associated fees to the DPH, which may choose to expedite their review if the applicant intends to serve an underserved population. The minimum requirements for MIH program approval include applicants identifying current gaps in service delivery, describing how their program will address these gaps, and demonstrating their financial and legal viability.

Under 105 CMR 17.000, a complete application for MIH program approval must include the following:

1. Identification of service gaps using data and a community health needs assessment.
2. Explanation of how the MIH program will address these gaps and improve quality, access, cost-effectiveness, patient satisfaction, health equity, and care coordination, including reducing ED visits and medical costs.
3. Description of partnerships with health care entities and plans to coordinate resources without duplication.
4. Demonstration of financial, legal viability, sustainability, and compliance.

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<sup>iv</sup> 105 CMR 17.000 Mobile Integrated Health Care and Community EMS Programs.

5. Appointment of a medical director to oversee clinical aspects of the MIH program.
6. Detailed operational plan for medical control, clinical protocols, training, communication, and quality improvement.
7. Description of coordination with 911 EMS systems.<sup>30</sup>

## 2.3 Efficacy of MIH

MIH programs have emerged as an innovative approach that improves health care access, quality, and outcomes, particularly for older adults and underserved populations. Recent studies and evaluations highlight MIH's effectiveness in reducing ED utilization, hospital readmissions, and health care costs, while enhancing patient satisfaction and provider engagement. The integration of telemedicine into MIH programs further extends their reach, addressing disparities in access for older adults, especially in rural or underserved communities.<sup>31,32,33, 34,35</sup>

A 2023 systematic review of 15 studies of MIH interventions for adults aged 65 and older found promising impacts on health care access, quality, and equity. The review highlighted reductions in EMS call volume and ED transport rates, addressing key goals of decreasing ED boarding<sup>v,36</sup> and avoiding hospital-related complications, such as in-hospital mortality. MIH programs were particularly effective in managing complex medical conditions, with one study showing a 50% reduction in 30-day all-cause readmissions for patients with advanced heart failure and no reported adverse events. The review emphasized the role of telemedicine in expanding MIH's reach, with studies indicating its potential to address disparities in access for older adults in rural areas or for underserved racial, ethnic, or socioeconomic groups. Patient and provider satisfaction with MIH was consistently high, with many participants preferring home-based care over hospital settings. However, the review underscored the need for standardized guidelines, consistent outcome measures, and high-quality evidence from randomized controlled trials to enhance the effectiveness and scalability of MIH programs for older adults.<sup>37</sup>

An evaluation of an MIH program targeting acute issues in adults aged 65 and older conducted from June 2021 to April 2023 found that MIH was feasible and safe in managing their care. Results included: 10.4% of participants had ED visits within 72 hours of an MIH visit, with unforeseen ED presentations occurring in only 3.2% of cases, one death occurred within 72 hours and two deaths occurred within 30 days, indicating strong safety performance relative to the population's age and health status. Diagnostic and therapeutic services were frequently administered including echocardiograms (57.5%), point-of-care (POC) bloodwork (34.6%), intravenous (IV) fluids (33.9%), and medications (24.1%).<sup>38</sup>

In 2023, the NAEMT conducted a national survey of EMS agencies operating MIH programs. The survey included 199 valid responses, 78% of which currently offer a MIH-CP program, from programs in 40 states and the District of Columbia. Approximately 50% of the MIH program respondents serve urban/suburban demographics, 30% serve rural demographics, and 20% serve both urban/suburban and rural demographics. The most common services provided by these programs include ED/911 utilizer programs,<sup>vi,39</sup> admission/readmission prevention, and care management coordination. 22% of survey respondents indicated their agency does not currently operate a MIH-CP program. Funding posed a significant challenge, as 45% of agencies that do not currently offer an MIH-CP program reported that they never launched one due to funding challenges. The other 55% of agencies not currently operating

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<sup>v</sup> The American College of Emergency Physicians (ACEP) states that ED boarding occurs due to "dangerous health system overload," in which patients are left in a holding pattern, waiting for an inpatient bed or transfer after receiving initial care. This can result in hazardous delays to care that last for hours, days, or even weeks, exacerbated by staffing challenges and burnout.

<sup>vi</sup> High ED/911 utilizer programs involve the MIH-CP program identifying individuals who are high utilizers of emergency services within the program service area and conducting regular home visits with these individuals to assist them with stabilizing their health through services such as medication education, symptom management, lifestyle coaching, connection to primary care, and assessment of the individual's social resource needs.



an MIH-CP program reported needing to cease operating their program due to little to no return on investment, loss of sustainable funding, loss of staffing and/or resources, loss of interest from the community or leadership, and a variety of other reasons.<sup>vii</sup> Across all MIH programs that responded to the survey, the highest volume of calls received were for high ED/911 utilizer services. Higher call volume programs were also more likely to experience higher use of telemedicine facilitated patient navigation and transportation to alternate destinations. Lower call volume programs were more likely to have higher use of observation admission avoidance, home health partnerships, and hospice partnerships. MIH also demonstrated a positive impact in supporting the health system during public emergencies. During the COVID-19 pandemic, The Centers for Medicare and Medicaid (CMS) waived regulations that only reimburse EMS providers for transportation to hospitals and allowed EMS providers to be reimbursed for transporting patients to alternative facilities or for treating them directly, which aided in reducing excessive strain on hospitals. The NAEMT, who advocates for EMS practitioners on issues impacting their work environment and ability to serve patients, recommends the permanent institution of reimbursement practices that reimburse for the care provided by emergency medical technicians (EMTs), and not solely the transportation they provide. This would foster sustainable funding and long-term operation of MIH-CP programs and facilitate patient-centered care. These findings collectively highlight MIH's emerging role in reshaping EMS services to better meet community health needs while emphasizing cost-effectiveness and patient-centered care.<sup>40</sup>

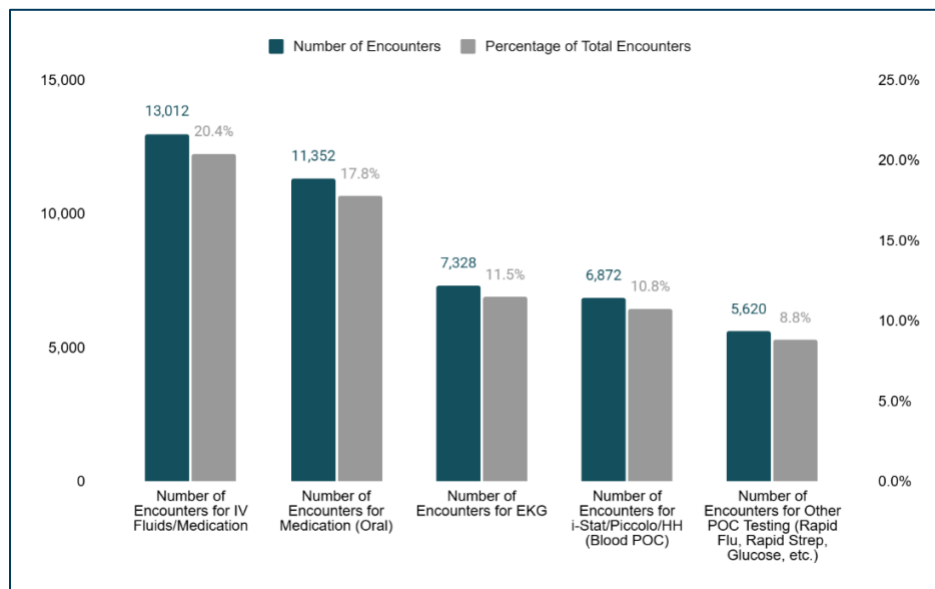
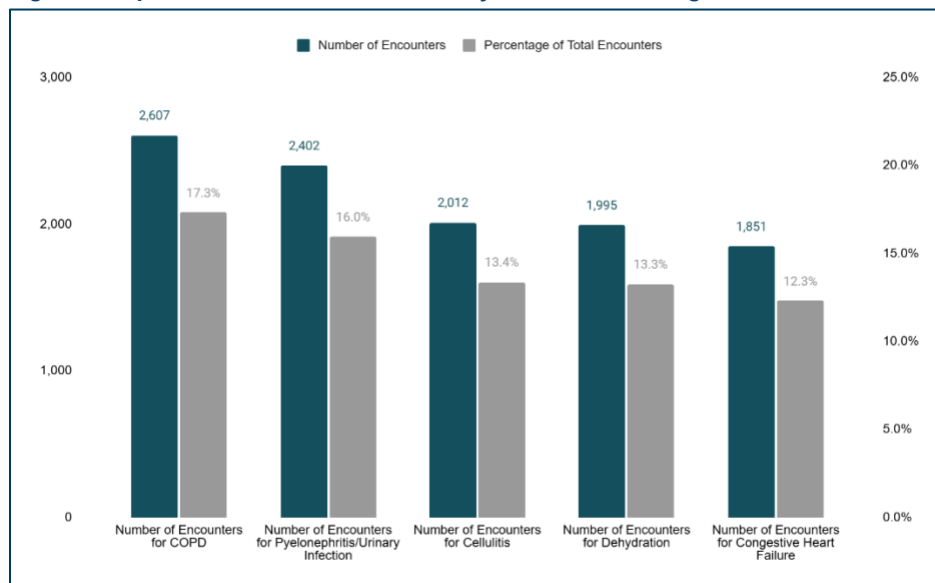
Although there is limited research regarding the payer mix of individuals utilizing MIH services, a study of Prince George's County's MIH program in Maryland (conducted between November 2016 and September 2018) provides useful insights. Among the 110 study participants, all of whom had insurance, 55.5% were covered by Medicare, 31.8% by Medicaid, and 12.7% by private commercial insurance. The study categorized participants as either High-Frequency (HF) or Low-Frequency (LF) users. HF users were defined based on 911 and/or EMS call volume or deemed high-risk by EMS and hospital clinicians. LF users were referred to the program by clinicians due to their medical or social complexity, even if their EMS use was infrequent. Of the 110 participants, 45 were HF users (53.3% Medicare, 37.8% Medicaid, and 8.9% private) and 65 were LF users (56.9% Medicare, 27.7% Medicaid, and 15.4% private). The study population skewed older, with over three-quarters of participants aged 49 and above. Specifically, 31.8% were aged 49 – 64, 30.9% were aged 65 – 78, and 13.6% were aged 79 or older. Only a small proportion were under 49: 12.7% were aged 34 – 48 and 10.9% were aged 19 – 33. This age distribution was generally consistent across both HF and LF user groups, though HF users had a slightly higher proportion in the 49 – 64 age range (40.0%) compared to LF users (26.2%), while LF users had more individuals in the oldest category (79+, 16.9% vs. 8.9%). These data suggest that Medicare beneficiaries, especially older adults, are a primary demographic for MIH interventions, and MIH programs might support both high-volume EMS utilizers and individuals with complex needs who are at risk of becoming frequent EMS users.<sup>41</sup>

### *Massachusetts MIH Overview*

According to the Office of Emergency Medical Services' (OEMS) June 2024 presentation, there are 11 MIH programs, and one ED avoidance program in Massachusetts. Figure 1 reflects key findings on encounters by service type from 2023 data from Massachusetts MIH programs and Figure 2 reflects encounters by condition from 2023 data from Massachusetts MIH programs.

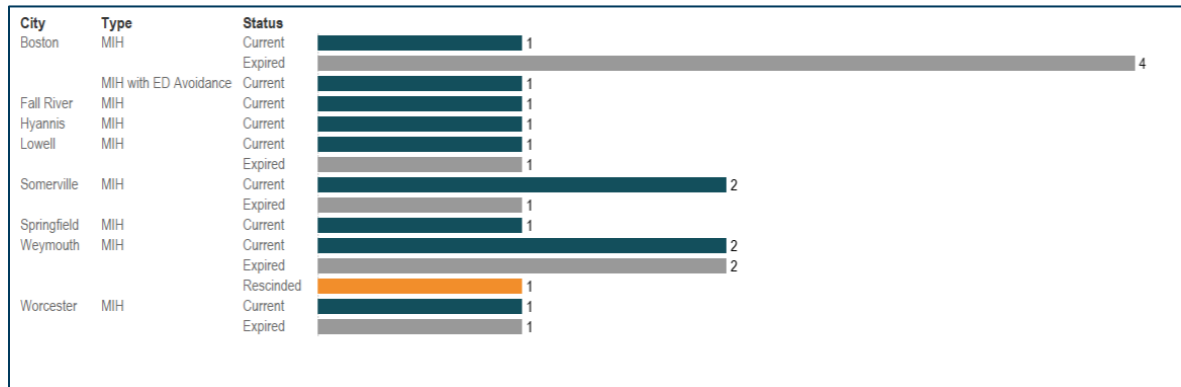
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<sup>vii</sup> Other reasons cited for ceasing MIH-CP programs include poor internet availability, licensing issues, lack of training, and size of service area.

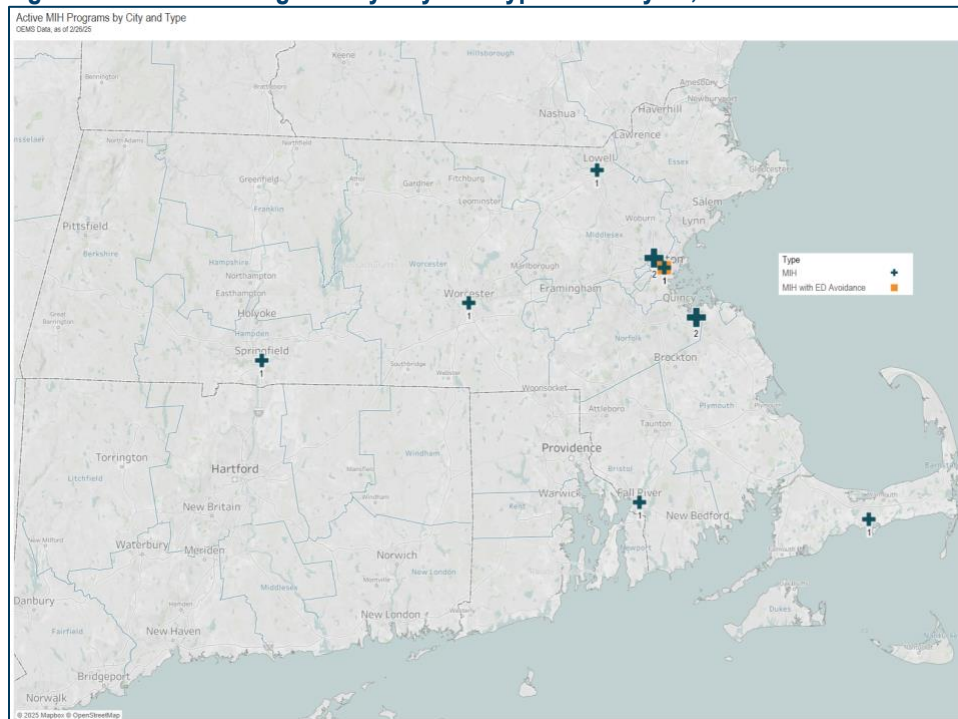
**Figure 1 Top Five Number of Encounters by Service Type Among Massachusetts MIH Programs, 2023<sup>42</sup>**

**Figure 2 Top Five Number of Encounter by Condition Among Massachusetts MIH Programs, 2023<sup>43</sup>**


According to OEMS data, as of February 26, 2025, there were 11 active MIH programs and 9 expired MIH programs, along with 1 rescinded MIH program. Active programs were in cities such as Boston, Weymouth, Somerville, Springfield, Fall River, Hyannis, Lowell, and Worcester, with expiration dates extending through 2025 to 2026. Boston had the highest concentration of MIH programs with five locations, followed by Weymouth with four. The data demonstrates a mix of urban and regional program sites (see Figure 3, Figure 4, and Figure 5).<sup>44</sup>

**Figure 3 MIH Programs by City, Type, and Status, February 26, 2025<sup>45</sup>**



**Figure 4 MIH Active Programs by City and Type February 26, 2025<sup>46</sup>**



**Figure 5 MIH Active Programs by County February 26, 2025<sup>47</sup>**

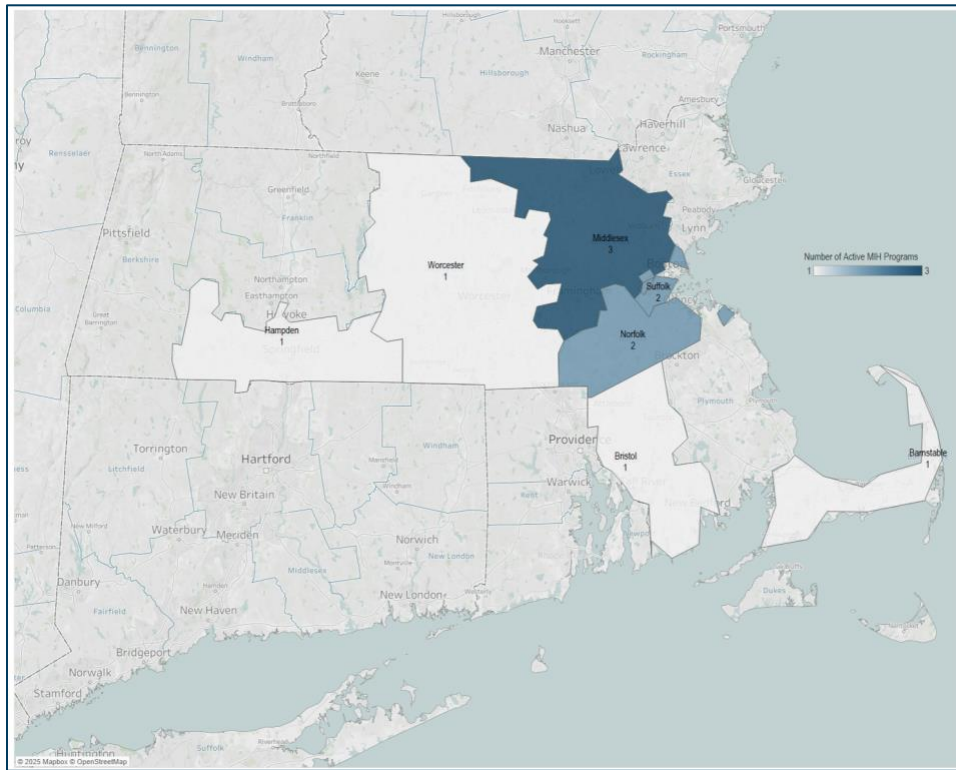
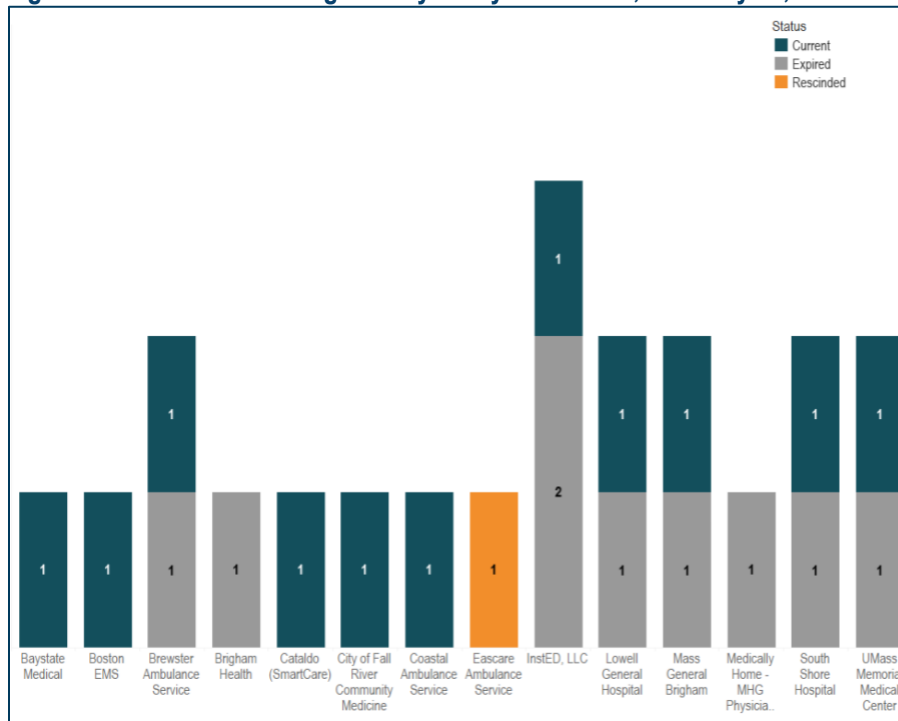


Figure 6 demonstrates entities with MIH programs that are current, expired, and rescinded. Providers such as Boston Baystate Medical and Mass General Brigham show a mix of both active and expired programs, indicating sustained engagement with the MIH model over time. Conversely, some entities like Eascare Ambulance Service, Brigham Health, and Medically Home - MHG Physician Services are represented only by expired or rescinded programs, suggesting limited or discontinued participation.

**Figure 6 Number of MIH Programs by Entity and Status, February 26, 2025<sup>48</sup>**



Massachusetts' MIH programs provide innovative, in-home health care services that reduce unnecessary ED visits, improve patient outcomes, and expand access to care for high-risk populations. Programs like instED, UMass Memorial MIH, and South Shore Health (SSH) MIH leverage paramedics, telehealth, and portable diagnostics to deliver urgent medical care, chronic disease management, and real-time behavioral health support. These programs have demonstrated significant cost savings, improved health outcomes, and enhanced patient satisfaction while ensuring continuity of care.<sup>49,50,51,52</sup>

The instED MIH program delivers urgent medical care directly to patients' homes, helping them live safely and independently while reducing avoidable ED visits. Originally designed for Commonwealth Care Alliance (CCA) members, the program utilizes paramedics to treat a range of acute illnesses, chronic conditions, and minor injuries, bridging the gap between primary and emergency care. With a focus on high-quality, compassionate care, instED has demonstrated high member satisfaction, as reflected in a 91.3 Net Promoter Score<sup>viii,53</sup> that is based on members' likelihood to recommend the program to their family and/or friends. The instED program resulted cost savings of \$6.1 million in 2021 and successfully prevented 82% of emergency visits or inpatient admissions within three days of service.<sup>54</sup> The UMass Memorial MIH program offers 24/7 on-demand care through home visits from paramedics, providing a cost-effective and accessible alternative to ED visits. Using portable diagnostics, remote monitoring, and telehealth technology, paramedics assess patients' symptoms and consult with UMass Memorial physicians in real time to determine the best treatment plan. Services include at-home evaluations that can include imaging, (e.g., X-rays, ultrasounds, and electrocardiograms), basic treatments like intravenous fluids and medications, and, if necessary, transport to the ED. The program integrates patient records into UMass Memorial's electronic medical system, allowing other providers to access visit details. By offering personalized, patient-centered care, MIH expands health care access in Central Massachusetts, reducing unnecessary hospital visits and enhancing continuity of care.<sup>55</sup>

#### *South Shore Hospital (SSH) MIH Program*

The SSH MIH program, launched in March 2020, was designed to address key gaps identified in a 2019 Community Health Needs Assessment, such as challenges in access to care, real-time behavioral health services, and support for aging adults with chronic and comorbid conditions. As the first hospital-affiliated MIH program in Massachusetts, SSH has conducted over 15,000 patient visits, offering 17 visits daily, seven days a week, 365 days a year. The SSH MIH program is designed for patients who require same-day urgent visits for triage and limited treatment. Services provided include:

- An in-home visit by an MIH paramedic.
- A virtual consultation with an MIH or ED advanced practice clinician (APC) or physician.
- In-home diagnostics and treatment tailored to the patient's needs.

MIH services have proven to be a viable alternative to ED overcrowding, with only 5% of MIH patients requiring transfer to an ED. Among visit outcomes in the SSH MIH program, the majority of individuals who received MIH services remained at home, with 44% having an MIH visit scheduled for the following day, 38% requiring no further MIH services, 8% receiving follow-up by their PCP, and 4% receiving a repeated MIH visit later on the same day. The program's outcomes demonstrate its ability to reduce unnecessary ED visits while ensuring high-quality, patient-centered care.<sup>56</sup>

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<sup>viii</sup> The NPS metric yields a range of -100 to 100.

The SSH MIH program was instrumental in addressing health care challenges during the height of the COVID-19 pandemic. Leveraging a hospital-based EMS system, MIH provided in-home care to high-risk patients identified by PCPs or ED staff, with services including physical assessments, lab tests, infusions, and telehealth monitoring. During the pandemic's peak, the program helped maintain hospital capacity by discharging COVID-19-positive patients with moderate illness to their homes and providing over 2,200 community visits, including 150 in-home treatments for symptomatic COVID-19 patients and over 900 COVID-19 tests. This model reduced hospital admissions, improved patient satisfaction, and allowed facilities like nursing homes to manage outbreaks effectively. Funded through telehealth reimbursements and ACO contracts, MIH demonstrated its ability to expand system capacity, improve care quality, and prepare for future health care crises.<sup>57</sup> In 2024, the program served a total of 2,130 patients, with 80% seen through the ED-at-Home program, designed to prevent unnecessary ED visits. Of those patients, 44% were seen within two hours of referral, and 87% remained at home following their MIH visit, successfully avoiding an ED visit. The remaining 20% of patients were discharged early from the hospital with MIH support, reducing inpatient length of stay and facilitating a smoother transition home. Notably, 89% of all MIH patients were over the age of 70. Throughout 2024, SSH MIH program conducted a total of 4,081 visits, with an average of 1.9 visits per patient. The program had an average insurance reimbursement of \$101 per patient visit.<sup>58</sup>

MIH has demonstrated efficacy in improving outcomes for patients with chronic obstructive pulmonary disease (COPD) through in-home care and targeted interventions. The SSH MIH program treated 214 patients with COPD from March 2020 to August 2021, conducting over 650 visits, including 87 urgent cases for symptoms like acute exacerbations of COPD, shortness of breath, and cough. COPD hospital admissions dropped by 42% from 2019 to 2020, though some of this reduction may be attributed to the COVID-19 pandemic. A COPD Discharge Pathway Pilot was implemented, with 10 of 16 enrolled patients completing the 30-day program. Medication reconciliation was a key intervention, identifying an average of 3.6 errors per patient and requiring multiple corrections for most participants. Preliminary results showed a 30-day readmission rate of 10% for pathway patients, compared to 37.7% for those without MIH services. The program not only reduced hospital admissions and improved ED flow, but also addressed care gaps through in-home acute care, enhanced patient education, and personalized support, contributing to higher patient satisfaction and improved disease management.<sup>59</sup>



### *MIH Hygiene, Infection Control, and Equipment Standards*

MIH programs prioritize hygiene, infection control, and equipment reliability to mitigate risks associated with providing health care in non-traditional settings like the patient's home.<sup>60,61</sup> Massachusetts regulations for MIH programs require that programs have, and follow, written policies and procedures that cover infection control, regular maintenance of equipment and medical devices according to manufacturers' recommendations, use of training and assessment standards for all personnel providing treatment and services, processes for serious incident response and reporting, and operation of a continuous quality assurance and improvement program, as well as other program operational requirements.<sup>62</sup> These requirements help ensure that MIH providers maintain a high standard of care while preventing infections. Specifically in Massachusetts, SSH's MIH program emphasizes the reduction of common risks associated with hospitalization, including infections, by caring for patients in their homes. MIH not only reduces exposure to hospital-associated infections, but also addresses risks such as falls by offering care in a familiar, controlled environment. This patient-centered approach, combined with stringent infection control measures, enhances the effectiveness of MIH while ensuring patient and provider safety in a mobile care environment.<sup>63</sup>

### *Findings from Other States*

#### Illinois

Illinois has taken legislative action to support MIH through Senate Bill 3599, requiring Medicaid and MCOs to cover MIH services starting January 2026. The law targets individuals with frequent ED use—defined as three or more ED visits in four months—or those flagged by a provider. Services must be delivered by EMS personnel.<sup>64</sup> A pilot program at Advocate Sherman Hospital showed promising outcomes, including a 59% reduction in hospital admissions and a 28% decrease in ED visits, demonstrating the potential for MIH to reduce unnecessary utilization and improve care coordination.<sup>65</sup>

#### California

California will begin requiring commercial and Medi-Cal managed care plans to cover MIH services—including CP and Triage to Alternate Destination (TAD)—starting July 1, 2025. Under the new policy, MIH encompasses health services provided by a licensed team operating outside traditional health care settings.<sup>66</sup> A 2024 report by the California Health Benefits Review Program (CHBRP) found that while MIH has the potential to lower costs through reduced ED and hospital use, its short-term impact may be limited due to existing program availability, provider shortages, and billing barriers. Nonetheless, the expansion is expected to facilitate greater access over time.<sup>67</sup>

#### Texas

Texas has been a pioneer in MIH through MedStar's well-established program, which serves individuals with chronic conditions, recent hospital discharges, or frequent 911 use. Services include home-based care, remote monitoring, and care coordination. An evaluation of the MedStar MIH program found that congestive heart failure (CHF) readmissions were reduced to 16.3%, significantly below the national average of 23%. The program also achieved a cost avoidance of \$7,620 per participant and reported patient satisfaction scores consistently above 4.9 out of 5, illustrating the program's value in improving outcomes and patient experience.<sup>68</sup>



### Florida

A study among the Medicare Advantage population in Florida (1,074 participants in the intervention group and 1,241 in the propensity-matched control group) found that MIH programs reduced inpatient and ED utilization and achieved net savings of \$2.4 million over six months.<sup>69</sup>

### Maryland

Maryland's MIH efforts include two programs in Baltimore: Transitional Health Support (THS), operated by the University of Maryland Medical Center, and the Mobile Integrated Community Health–Maryland Community Development Network (MDCN), a partnership between Baltimore City Fire Department and Amerigroup. THS provides 30-day post-discharge support and has achieved a 10–11% reduction in readmissions. MDCN addresses low-acuity 911 calls through on-site treatment, reducing EMS time on scene by 26 minutes per call. Patient satisfaction has been quite high—THS clients rated the program 4.8/5, while MDCN clients rated the program 10/10.<sup>70</sup>

### Ohio

Coshocton County, Ohio operates a grant-funded MIH program led by EMS providers to assist patients with chronic conditions and reduce avoidable 911 calls.<sup>71,72</sup> The program offers up to eight in-home visits per enrollee, with an average cost of \$500 per patient.<sup>73</sup> Results have shown a drop in EMS calls from high utilizers—from 472 to 256 calls—resulting in estimated cost savings of approximately \$192,000.<sup>74</sup>

### *MIH Programs' Impact on ED Boarding and Urgent Care Utilization*

Based on the Massachusetts Acute Care Hospital Quarterly Emergency Department Dashboard, hospitals saw an average of 559,800 ED visits per quarter from Q3 2023 to Q2 2024, a number that has been increasing since Q1 of 2020.<sup>75</sup> With EDs seeing a high volume of cases, an issue frequently experienced by facilities is the practice of ED boarding, which refers to when patients remain in the ED after being admitted to the hospital due to a lack of available inpatient beds.<sup>76</sup> Implementing MIH programs could help reduce both the frequency and duration of ED boarding, for which Massachusetts hospitals saw an average of 48 pediatric boarders and 339 total boarders per week in 2024.<sup>77</sup> This practice contributes to ED overcrowding, leading to several challenges, including the need for facilities to divert ambulances, prolonged patient wait times, increased patient distress, and a reduced capacity for the ED to respond effectively to emergencies and disasters.<sup>78</sup>

Reducing the duration and/or occurrence of ED boarding can address these challenges and lead to improved access to services and increased quality-of-care delivery.<sup>79</sup> MIH programs could contribute to this effort by managing lower-acuity cases for individuals who may typically present to the ED, and whose conditions could be effectively treated outside the ED. The potential impact of MIH programs on EDs is supported by the existing relationship between urgent care centers, retail clinics, and ED utilization. Urgent care centers provide a broad range of services, including diagnosis and treatment for various conditions, imaging, and management of non-life-threatening chronic conditions. Research shows that urgent care centers can effectively treat 27% of cases currently seen in EDs. Retail health clinics offer a more limited scope of services than urgent care centers, including vaccinations, diagnosis and treatment of low-acuity conditions (such as upper respiratory and sinus infections), and some wellness exams. Data indicates that retail clinics can safely manage 13% of cases that would otherwise present to the ED. Additionally, a

study from 2010 to 2015 found that urgent care centers contributed to a reduction in both ED and physician office visits.<sup>80</sup>

Since MIH programs can provide many of the same services as urgent care centers and retail clinics—along with additional services not typically offered in these facilities—the widespread implementation of MIH programs would likely yield similar benefits in reducing ED utilization.

## 2.4 Access and Health Equity

### Access

MIH programs enhance access to care by delivering health education, in-home services, telehealth, and community partnerships directly to patients.<sup>81</sup> An MIH program implemented in Ontario, Canada, between 2018 and 2019, reduced ED transport by nearly 50% for low-urgency calls, freeing up resources for urgent cases. In a study population of 1,740 matched emergency calls, the program saved 60% of total costs (including operating costs, personnel costs, and vehicles costs) compared to standard ambulance services and reduced total health care resource utilization while maintaining efficient access to care. While the health care systems in Canada and the U.S. are not directly analogous in part due to differences in funding structures, service delivery models, and regulatory environments, findings from Canada's MIH initiatives can still provide valuable insights into potential cost savings, resource allocation strategies, and improved patient outcomes in a U.S. context. This study's outcomes highlight MIH's potential to enhance community-based services by addressing underserved needs, particularly among those with chronic conditions.<sup>82</sup> MIH also offers a promising solution to alleviate ED overcrowding by addressing non-emergent urgent care needs in patients' homes, alleviating resource strain, and improving access to timely, equitable care for underserved populations.<sup>83</sup> A study of Grady Health System's MIH program (Grady's MIH program) in Atlanta, Georgia, analyzed its impact on low-acuity 911 calls between September 2019 and March 2020. The study population included 2,759 patients who called 911 for non-emergent conditions, including back pain, falls, diabetic alerts, and generalized pain, which often reflect gaps in outpatient care and unmet social needs. MIH units, staffed by APCs and paramedics, mitigated 66.1% of calls on-scene, compared to only 11.4% mitigated by traditional EMS units, significantly reducing unnecessary ED transports.<sup>84</sup>

While MIH programs improve access to care, they may face significant challenges related to scalability. The demand for paramedics and EMTs is expected to rise in Massachusetts and across the United States. In Massachusetts, employment for EMTs and paramedics is projected to grow by 14% between 2020 and 2030, increasing from 6,410 to 7,280 employees, with 530 annual job openings.<sup>85</sup> Despite this projected growth, ambulance services across the country, including in Massachusetts, are struggling with severe staffing shortages. The Massachusetts Ambulance Association estimates a one-third reduction in staffed ambulances since 2015, due to a combination of factors, including low wages, burnout from the COVID-19 pandemic, and training program shutdowns. The results of a 2022 survey by the American Ambulance Association show a national turnover rate of 36% for EMTs and 27% for paramedics, with almost all individuals who left their positions doing so voluntarily.<sup>86</sup> While efforts such as wage increases, temporary staffing adjustments, and reliance on fire departments for non-emergency transport are underway to address the issue, expanding MIH programs may further increase competition for qualified staff, as paramedics deliver MIH services directly, potentially adding to workforce challenges.<sup>87</sup>

The NAEMT notes that EMS agencies are often limited by statutes and regulations that restrict them to emergency response, hindering their ability to expand into broader health care services. Additionally, despite some positive

results from MIH programs, the absence of peer-reviewed studies and a lack of consensus on key performance metrics remain major obstacles to scaling these programs. The NAEMT also highlights the need for reform to align EMS payment structures with performance outcomes, providing incentives for EMS agencies to reduce unnecessary emergency visits and improve patient care.<sup>88</sup> Due to the multidisciplinary structure of MIH programs, it is often difficult for an EMS agency to run an MIH program independently from a health care system or hospital.<sup>89</sup> MIH programs may encounter barriers to widespread access, particularly in rural and underserved communities lacking broadband connectivity and essential infrastructure, as well as among older populations who may face challenges in adopting digital tools, such as smartphones and tablets, that are vital to MIH services.<sup>90</sup>

### *Insights From Experts*

Insights from experts highlight that the proposed legislation could help address financial challenges and support the expansion of MIH services, particularly for behavioral health and chronic disease management. While these programs demonstrate cost-saving potential, they face reimbursement barriers, as paramedic services are often unreimbursed, and billing structures lack standardization. However, some experts caution that current MIH billing rates may exceed actual costs, raising concerns about sustainability and potential double billing. To help ensure long-term viability, collaboration with carriers and the adoption of a structured, value-based payment model is considered critical for MIH integration into the broader health care system.

The MIH program at Lowell General Hospital (LGH) offers urgent and scheduled visits, providing care in patients' homes to reduce ED utilization. Services include managing acute conditions like dehydration and nausea, as well as offering telehealth support, such as facilitating medical clearance for behavioral health (BH) patients. For instance, if a BH patient presents at a community-based clinic, a paramedic can be deployed to perform medical clearance, including toxicology and point-of-care testing, allowing the patient to remain at the clinic for further care instead of visiting the ED. The LGH MIH program commonly addresses urgent conditions like dehydration, nausea, and vomiting, as well as chronic issues such as heart failure that may require interventions like Lasix administration. The program has demonstrated significant cost savings, with the average MIH visit costing under \$200.<sup>91</sup> A recent review of LGH MIH program found that in 2024, the program conducted 468 urgent in-home visits, and 63% of those patients did not visit the ED within 72 hours of their encounter. Because these patients met triage criteria for ED referral, the program estimates it potentially avoided 295 ED visits. Similar impact was seen in 2023, when 522 ED visits were avoided out of 758 urgent encounters.<sup>92</sup> Currently, LGH operates in the clinical innovation space, relying on grants rather than on commercial payer reimbursements, and does not use specific billing codes for MIH services. The program primarily serves a population that has public payer insurance (estimated at 70%). Patients cannot self-refer to the MIH program; instead, referrals must come from health care providers who directly interact with the patient. For example, patients contact their provider's office, and a nurse uses established triage criteria to initiate a referral. LGH has partnered with Vinfen<sup>ix,93</sup> to deliver integrated care. A team comprising LGH's MIH staff and Vinfen representatives responds jointly, with the MIH team focusing on medical interventions and Vinfen addressing behavioral crisis needs.<sup>94</sup>

The SSH MIH program delivers flexible, community-based care designed to reduce ED visits and hospital admissions. Services include telehealth-enabled paramedic visits, mobile imaging, lab work, IV treatments, and

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<sup>ix</sup> Vinfen, established in 1977, is a nonprofit health and human services organization providing community-based care to individuals with mental health conditions, developmental disabilities, brain injuries, and behavioral health challenges.

diagnostics, with a focus on managing chronic conditions, such as COPD and CHF, as well as acute infections. However, the program faces billing and reimbursement challenges. Paramedic time is not reimbursed unless tied to patient transport, and telehealth billing only covers the provider's time for the virtual portion of the visit. The program's broad scope complicates standardization of coverage by payers, and current funding relies on grants, philanthropy, and value-based care contracts. Staffing shortages and competition for paramedics among hospital-based employers and independent ambulance providers further limit scalability. Additionally, while some carriers do not restrict reimbursement based on the site of service, they typically require credentialed providers, which excludes paramedics.<sup>95</sup>

An expert at MassHealth, the Massachusetts Medicaid program, indicated that MIH-delivered care appears to be safely delivered under the Massachusetts DPH licensure framework. According to the expert, amounts billed by MIH programs to MassHealth typically range from \$500 to \$1,200 per visit.<sup>96,97</sup> These programs generally operate under a fee-for-service (FFS) model, billing for services they are authorized to provide, such as supervising physician time, facility fees (capped at around \$80 per visit in MassHealth), imaging, lab draws, and medications like IV antibiotics. The expert noted the value of MIH services varies depending on their clinical application. It is important to recognize that these cost estimates reflect MassHealth FFS rates; commercial insurers would typically negotiate contracted rates that may differ significantly.<sup>98</sup>

### *Health Equity*

MIH programs contribute to health equity by addressing social drivers of health and improving patient outcomes through education, chronic disease management, and social services support. Many MIH programs collaborate with community organizations to connect individuals with essential resources, such as housing, food, and transportation.<sup>99</sup> A study evaluating patient perceptions of MIH urgent care compared to ED care among 206 patients treated by community paramedics and 718 patients treated in EDs in Massachusetts from February 2017 to June 2018 found that patients treated by MIH reported higher satisfaction and perceived quality of care. The study population included patients with low income and medically complex conditions, with most patients dually eligible for Medicare and Medicaid. Most patients (87%) who received care from MIH rated their care as "excellent" or "very good," compared to 65% of ED patients. These findings highlight MIH's potential to improve health equity and access by delivering high-quality, patient-preferred care directly to homes, particularly for underserved populations, while reducing reliance on crowded EDs.<sup>100</sup>

Grady's MIH program in Atlanta also exemplifies efforts to improve health equity by addressing key social drivers of health. Through a dedicated nurse navigator, patients are connected to essential resources, such as transportation, medication refills, and appointment scheduling. Additionally, MIH providers conduct home-based interventions for chronic disease management, wound care, and safety assessments, helping to prevent future health crises. These efforts enhance access to care for underserved populations, reduce health care costs, and improve health equity by addressing the underlying social and medical factors that drive health care utilization. The program exemplifies a model for bridging gaps between emergency and outpatient care, particularly in resource-limited settings.<sup>101</sup>

The 2018 – 2021 study evaluated social drivers of health in a MIH-CP in West Baltimore, Maryland and focused on adults with complex medical and social needs, with the goal of transitioning care from hospital to home. The study results demonstrated that 37.7% of identified needs were related to health care coordination, 18.8% to durable medical equipment, and 16.3% to medication. Additional findings revealed that adults with the highest readmission

risk had unmet needs pertaining to utilities (energy assistance and functioning utilities). Additionally, unmet needs in areas like identification documentation and social services were linked to higher 30-day hospital readmission. The results suggest that addressing specific social drivers of health, particularly in health care coordination, equipment access, and utilities, could help reduce hospital utilization and improve patient outcomes.<sup>102</sup>

A 2023 study evaluated the impact of a MIH-CP program on addressing health-related social needs (HRSNs) and their association with hospital readmissions. Among 1,003 patients enrolled from May 2018 to July 2021, addressing medication-related needs significantly reduced overall 30-day readmissions by 65%. However, interventions in other domains were not significantly associated with readmission reductions. The program was most effective for one-step interventions like medication assistance, while addressing more complex social needs required additional time and resources.<sup>103</sup>

## 3.0 Conclusion

MIH programs are emerging as a promising model in health care, expanding the role of EMS beyond emergency response to include proactive, community-based care. By emphasizing collaboration with health care and social services, MIH programs effectively address a range of health care needs, including chronic disease management, post-hospital follow-ups, and ED diversion. These programs demonstrate significant potential for improving health care access, quality, and equity, particularly for underserved populations, by addressing non-emergent health issues and reducing unnecessary ED visits.<sup>104,105</sup>

The integration of telemedicine and the use of advanced trained EMS personnel, such as community paramedics, enhances the reach and impact of MIH services, making it possible to provide care directly in patients' homes or other community settings. Studies show that MIH programs can reduce EMS utilization, hospital readmissions, and health care costs, while simultaneously improving patient satisfaction and health outcomes. Notably, these programs contribute to health equity by addressing social drivers of health and improving access to care for underserved populations, including low-income and medically complex patients.<sup>106,107,108, 109,110</sup>

Massachusetts has been at the forefront of MIH innovation, with programs like CCA's instED, UMass Memorial MIH, and SSH's MIH demonstrating cost savings, improved health outcomes, and expanded care access for high-risk populations. These programs leverage paramedics, telehealth, and in-home diagnostics to deliver urgent medical care, behavioral health support, and chronic disease management while ensuring coordination with primary care and hospital systems. MIH has also played a critical role in pandemic response and COPD management, reinforcing its potential as a sustainable solution for system-wide capacity challenges.<sup>111,112,113,114</sup>

While the model has shown promising results, continued efforts to standardize practices, promote quality measures, and expand the scope of services offered are essential for broadening the impact of MIH programs. As the field grows, organizations like NAMIHP and MIHAC play vital roles in fostering collaboration, innovation, and standardization across regions, paving the way for the wider adoption of MIH programs.<sup>115,116</sup> The success of programs like those already in place, alongside supportive state policies and regulations, demonstrates the potential of MIH to reshape health care delivery and reduce the strain on EDs while fostering greater community health and equity.<sup>117,118,119</sup>

## Endnotes

<sup>1</sup> H.B. 1154. An Act relative to insurance coverage of mobile integrated health.  
<https://malegislature.gov/Bills/194/H1154>.

<sup>2</sup> S.B. 726. An Act relative to insurance coverage of mobile integrated health.  
<https://malegislature.gov/Bills/194/S726>.

<sup>3</sup> M.G.L. c.111O §1. <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111O/Section1>.

<sup>4</sup> *Op. cit.* H.B. 1154. An Act relative to insurance coverage of mobile integrated health.

<sup>5</sup> *Op. cit.* S.B. 726. An Act relative to insurance coverage of mobile integrated health.

<sup>6</sup> Representative Michael J. Finn. Sponsor Questions Responses. January 29, 2025.

<sup>7</sup> National Association of Emergency Medical Technicians. Mobile Integrated Healthcare and Community Paramedicine (MIH-CP). 2015. Accessed December 16, 2024. <https://www.naemt.org/docs/default-source/community-paramedicine/naemt-mih-cp-report.pdf>.

<sup>8</sup> 105 CMR 173.000: MOBILE INTEGRATED HEALTH CARE AND COMMUNITY EMS PROGRAMS. 10/5/18. Accessed December 20, 2024. <https://www.mass.gov/doc/105-cmr-173-mobile-integrated-health-care-and-community-ems-programs/download>.

<sup>9</sup> Mass.gov. Learn about MIH and Community EMS. Accessed December 16, 2024. <https://www.mass.gov/info-details/learn-about-mih-and-community-ems>.

<sup>10</sup> UMass Memorial Health. *Mobile integrated health provides personalized care in patients' homes*. April 6, 2023. Accessed December 20, 2024. <https://pursuit.ummhealth.org/articles/mobile-integrated-health-provides-personalized-care-patients-homes>.

<sup>11</sup> *Op. cit.* Mass.gov. Learn about MIH and Community EMS.

<sup>12</sup> ESO. What is Mobile Integrated Health? February 10, 2021. Accessed December 16, 2024. <https://www.eso.com/blog/what-is-mobile-integrated-health/>.

<sup>14</sup> Malone, N.C., Williams, M.M., Smith Fawzi, M.C. *et al.* Mobile health clinics in the United States. *Int J Equity Health* 19, 40 (2020). Accessed December 20, 2024. <https://doi.org/10.1186/s12939-020-1135-7>.

<sup>15</sup> Mayo Clinic Health System. Mobile Health Clinic. Accessed December 20, 2024. <https://www.mayoclinichealthsystem.org/services-and-treatments/mobile-health-clinic>.

<sup>16</sup> American Hospital Association. Issue Brief Creating Value by Bringing Hospital Care Home. December 2020. Accessed May 28, 2025. [https://www.aha.org/system/files/media/file/2020/12/issue-brief-creating-value-by-bringing-hospital-care-home\\_0.pdf](https://www.aha.org/system/files/media/file/2020/12/issue-brief-creating-value-by-bringing-hospital-care-home_0.pdf).

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# **AN ACT RELATIVE TO INSURANCE COVERAGE OF MOBILE INTEGRATED HEALTH**

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ACTUARIAL ASSESSMENT

## 4.0 Actuarial Assessment

### 4.1 Background

The bill requires health insurers to provide coverage for medical, behavioral, and health care services delivered by approved MIH programs to the same extent as services provided in traditional health care facilities; it also stipulates that coverage cannot be denied solely because services were delivered by a health provider participating in an MIH program. Additionally, payment rates for covered services cannot be reduced on the grounds that they were delivered through an MIH program, and deductibles, copayments, or coinsurance for MIH services cannot exceed those applied to similar services provided in health care facilities. The bill also exempts MIH programs focused on behavioral health services from application and registration fees.<sup>1,2</sup>

Massachusetts law<sup>x</sup> currently supports the establishment and regulation of MIH programs through the DPH.<sup>3</sup> While MassHealth has collaborated with providers to implement MIH services, neither MassHealth nor commercial insurers are required to cover these services.<sup>4,5,6</sup>

### 4.2 Plans Affected by the Proposed Mandate

The bill amends statutes that regulate commercial health care carriers in the Commonwealth. It includes the following sections, each of which addresses statutes dealing with a particular type of health insurance policy when issued or renewed in the Commonwealth:<sup>7</sup>

- Chapter 32A – Plans Operated by the Group Insurance Commission (GIC) for the Benefit of Public Employees
- Chapter 175 – Commercial Health Insurance Companies
- Chapter 176A – Hospital Service Corporations
- Chapter 176B – Medical Service Corporations
- Chapter 176G – Health Maintenance Organizations (HMOs)

The bill includes MassHealth, although an analysis of the impact on its members is outside the scope of this review. This analysis includes members under 65 years of age who have fully insured commercial plans.

#### *Plans Not Affected by the Proposed Benefit Mandate*

Self-insured plans (i.e., where the employer or policyholder retains the risk for medical expenses and uses a third-party administrator or insurer to provide only administrative functions), except for those provided by the GIC, are not subject to state-level health insurance mandates. State mandates do not apply to Medicare, Medicare Advantage plans, or other federally funded plans, including TRICARE (covering military personnel and dependents), the Veterans Administration, and the Federal Employees Health Benefit Plan, the benefits for which are determined by, or under the rules set by, the federal government. Although the bill includes Chapter 118, this analysis does not

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<sup>x</sup> 105 CMR 17.000 Mobile Integrated Health Care and Community EMS Programs.



estimate the bill's impact to MassHealth, nor does it address any potential effect on Medicare supplement plans—even to the extent they are regulated by state law.

This report is not intended to determine whether the bill would constitute a health insurance benefit mandate for purposes of Commonwealth defrayal under the ACA, nor is it intended to assist with Commonwealth defrayal calculations, if it is determined to be a health insurance mandate requiring Commonwealth defrayal.

### 4.3 Existing Laws Affecting the Cost of the Bill

No state or federal laws that would affect the cost of the bill were identified.

### 4.4 Current Coverage

BerryDunn surveyed Massachusetts insurance carriers in the Commonwealth, with respondents representing 84% of the Commonwealth's fully insured commercial membership.<sup>xi</sup> Key findings from this survey include:

- Most carriers indicated that MIH is not currently a covered benefit.
- One carrier shared that it does not have any policy documents or coverage for MIH services and noted that credentialing would depend on whether the provider is licensed at the facility/group level or as an individual clinician.
- Several carriers stated that while there are no explicit exclusions based on provider type or place of service, they do not have specific MIH policies, approved programs, or provider contracts in place. These carriers also emphasized that they would not reimburse unlicensed providers, such as community paramedics.
- One carrier clarified that although it does not cover MIH as a defined program, it does provide coverage for certain services that may fall under the MIH definition—such as mobile crisis intervention (MCI), a remote patient monitoring, or in-home care—and shared related policy examples.

Overall, carriers noted that if MIH services were to become a covered benefit as proposed in legislation, they would anticipate increased utilization, although some noted that they could not yet quantify this impact due to lack of current data.

DispatchHealth could be considered a similar model to MIH. This vendor provides same-day, at-home urgent care services, addressing a broad spectrum of non-life-threatening medical needs and avoiding ED costs and wait times, with patients able to book services directly on DispatchHealth's website. In Massachusetts, services administered by DispatchHealth are currently covered by some commercial payers, with copayments for appointments typically ranging from \$0 – \$45 for insured patients.<sup>8,9</sup>

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<sup>xi</sup>BerryDunn surveyed 10 insurance carriers in the Commonwealth (although Tufts Health Plan and Harvard Pilgrim Health Care recently merged, they are accounted for separately); responses represent six carriers and 84% coverage of members.

## 5.0 Methodology

### 5.1 Overview

Since MIH is not currently a covered benefit for commercial payers, direct cost and utilization data are not available through the All-Payer Claims Database (APCD). Additionally, the existing literature provides limited information on the cost and utilization of MIH services, as these services encompass a broad range of health care needs. Due to these data limitations, BerryDunn began its analysis using patient encounter data from the Massachusetts Department of Public Health (DPH) to estimate the volume of MIH claims applicable to commercial carriers.

To estimate the cost impact, BerryDunn developed a range of per-encounter MIH costs using multiple sources, including expert interviews, comparable service types, and a review of existing literature. These cost estimates were then combined with the estimated volume of services to calculate the potential financial impact. BerryDunn assumed these costs would be borne by commercial payers under the mandate, as the services—previously funded through alternative sources such as grants, philanthropic funding, and value-based care arrangements—would now require reimbursement by commercial insurers. Since any existing cost savings from current MIH services are already reflected in the claims experience, they were not included in the cost estimate.

Under the proposed mandate, making MIH services a reimbursable benefit for commercial payers could result in increased utilization. However, estimating the extent of that increase is challenging due to a variety of influencing factors, including program maturity, public awareness, workforce availability, and broader market dynamics. Moreover, increased MIH activity may reflect a shift in the site of care rather than an overall rise in service use; in some cases, it may help avoid higher-cost interventions, such as ED visits or hospital admissions. The CHBRP, for instance, estimated that similar legislation would not lead to increased utilization in the short term (i.e., within 12 months). Accordingly, BerryDunn did not factor increased utilization into its cost estimates.

### 5.2 Data Sources

The primary data sources used in the analysis are as follows:

- Input from legislative sponsors regarding the intended effect of the bill
- Survey of commercial carriers in the Commonwealth regarding descriptions of current coverage
- Input from medical administrative experts
- Massachusetts APCD data
- MIH program patient and encounter data from Massachusetts DPH
- Published scholarly literature, reports, and population data, cited as appropriate

### 5.3 Steps in the Analysis

This section summarizes the analytic steps used to estimate the bill's impact on premiums.

1. **Estimated the marginal costs for insurers to cover the MIH services.**
  - A. Used encounter data from the Massachusetts DPH to calculate the total number of MIH encounters across all payers in 2023.
  - B. Estimated the percentage of MIH encounters that would be covered by commercial payers under the proposed mandate.

- C. Multiplied the total number of MIH encounters from Step A by the commercial payer percentage from Step B to determine the number of MIH encounters likely to be covered by commercial insurers.
- D. Developed a range of MIH costs per encounter (low, mid, and high scenarios) based on various sources, including expert interviews, comparable services, and literature review.
- E. Multiplied each cost scenario from Step D by the estimated number of commercial MIH encounters from Step C to calculate the total dollar impact under each scenario.
- F. Divided the dollar impact estimates from Step E by the total commercial membership to determine the per member per month (PMPM) cost—representing the incremental cost of the mandate.

**2. Calculated the impact of the projected claim costs on insurance premiums.**

- A. Estimated the fully insured Commonwealth population under age 65 for the next five years (2026 – 2030).
- B. Multiplied the PMPM incremental net cost of the mandate by the projected population estimate to calculate the total estimated marginal claims cost of the bill.
- C. Estimated insurer retention (administrative costs, taxes, and profit) and applied the estimate to the final incremental claims cost calculated in Step 1F.

## 5.4 Assumptions and Limitations

Several important limitations should be considered when interpreting the findings of this analysis. At present, few commercial insurers reimburse MIH services as described in the proposed legislation. As a result, there is limited claims data available, and no standardized billing codes exist in the APCD to clearly identify MIH services. In addition, MIH programs across Massachusetts vary widely in the populations they serve and the types of care they provide.

If the mandate were enacted, the scope and nature of MIH services could evolve. Stable funding from commercial payers may enable programs to expand and serve broader or more complex patient populations. MIH programs are currently funded through a patchwork of grants, hospital subsidies, or other alternative sources. With commercial reimbursement, these funding streams could shift, potentially altering the structure and delivery of services.

To account for these uncertainties, BerryDunn used a wide range of data sources to develop per-encounter cost assumptions and intentionally created a broader-than-usual cost range. BerryDunn also used a simplified approach to estimate the number of encounters likely to be covered by commercial insurers. Any potential cost savings from avoided higher-cost services (such as emergency department visits or inpatient stays) were assumed to already be reflected in the current claims experience and were therefore not separately modeled.

Potential increases in utilization were not explicitly included in the cost estimates. Utilization growth under the mandate would depend on several unpredictable factors, including the availability of trained paramedics, program readiness, provider acceptance, and public awareness. Workforce shortages may limit the pace at which services can be scaled. Additionally, some providers may hesitate to work with unfamiliar paramedic teams, which could hinder implementation. MIH utilization increases may primarily represent a shift in the site of care rather than an overall increase in service volume. Studies have shown that MIH programs can generate cost savings by avoiding more expensive settings, such as EDs or hospitals. However, the extent of those savings is uncertain and would

depend on a range of variables, including care substitution patterns, population health needs, operational capacity, and workforce availability.

Finally, while other states such as Illinois and California have passed similar legislation requiring MIH coverage, these mandates are relatively new or have not gone into effect. As a result, they have not yet produced sufficient claims data or outcome evaluations to meaningfully inform cost or utilization projections specific to Massachusetts. However, MIH programs in others states that have not passed legislation requiring coverage of MIH services have demonstrated measurable cost savings and reductions in avoidable utilization. In Texas, the MedStar MIH program achieved a cost avoidance of \$7,620 per participant, along with improved patient satisfaction and reduced readmissions for conditions like CHF.<sup>10</sup> A study among the Medicare Advantage population in Florida found that MIH programs reduced inpatient and ED utilization and achieved net savings of \$2.4 million over six months.<sup>11</sup> In Ohio, Coshocton County's program cut EMS calls among high utilizers nearly in half, translating into an estimated \$192,000 in cost savings.<sup>12</sup>

## 6.0 Analysis

This section describes the calculations outlined in the previous section in more detail. The analysis includes a best estimate middle-cost scenario, a low-cost scenario, and a high-cost scenario using more conservative assumptions. The analysis section proceeds as follows: Section 6.1 describes the steps used to calculate the incremental cost of the bill. Section 6.2 projects the fully insured population aged 0 – 64 in the Commonwealth over the years 2026 – 2030. Section 6.3 calculates the total marginal medical expense. Section 6.4 adjusts these projections for carrier retention to arrive at an estimate of the bill's effect on premiums for fully insured plans.

### 6.1 Incremental Cost of MIH Coverage

To estimate the cost of MIH coverage, BerryDunn used the annual encounter report from Massachusetts DPH. As these encounters are for all payers, BerryDunn estimated the percentage of encounters that would be covered by commercial carriers. A study of Prince George's County's MIH program in Maryland showed that 12.7% of encounters involved commercial users.<sup>13</sup> Expert interviews and local system data indicated that 60 – 70% of MIH patients had Medicaid or Medicare (e.g., Greater Lowell Health System). BerryDunn also analyzed ED and urgent care (UC) utilization in the APCD and found that 20–30% of individuals using those services had commercial insurance. Based on these sources, BerryDunn adopted a conservative estimate of 30% commercial coverage. This percentage was then applied to the annual number of encounters to estimate the total number of encounters expected to be covered by commercial payers under the mandate.

Next, BerryDunn developed a range of MIH costs per encounter. BerryDunn examined DispatchHealth claims from the APCD, as this vendor offers a care model like MIH. The average cost per claim for DispatchHealth services was \$130 in 2023. A thesis from Worcester Polytechnic Institute estimated that the operating cost of a MIH visit ranged from \$209 to \$729, depending on the scenario modeled.<sup>14</sup> Estimates from expert interviews varied, with target operating costs cited around \$200, and visit charges ranging from \$500 to \$1,200. According to a study by AHRQ, the average cost of treat-and-release ED visits is approximately \$750.<sup>15</sup> BerryDunn also analyzed ED claims from the APCD using ED revenue codes and found that the average ED cost was approximately \$1,300 for the commercially insured population under age 65. Because this figure includes all ED visits—including high-acuity cases—BerryDunn used the \$750 treat-and-release estimate to inform the upper bound of MIH cost assumptions, as those visits more closely reflect the acuity level typically addressed by MIH programs.

BerryDunn then calculated the dollar impact to commercial insurers by multiplying the number of commercially covered encounters to the cost per MIH encounter to determine the dollar impact. Finally, the total dollar impact was divided by the combined commercial membership to calculate the overall PMPM impact of the mandate.

Table 2 summarizes the MIH cost per encounter assumptions and presents the resulting incremental PMPM costs associated with the mandate under each scenario.

**Table 2. Marginal Costs to Insurers for Coverage of MIH Services**

	MIH COST PER ENCOUNTER ASSUMPTIONS	TOTAL INCREMENTAL PMPM COST UNDER MANDATE
Low Scenario	\$200	\$0.02
Mid Scenario	\$500	\$0.05
High Scenario	\$800	\$0.08

BerryDunn trended the PMPM impact from Table 2 in Table 3 from calendar year 2025 to calendar year 2030 and forward using the long-term average national projection for cost increases to physician and clinical services (calculated at 4.4%<sup>16</sup>).

**Table 3. Projected PMPM Costs to Insurers for Coverage of MIH Services**

	2025	2026	2027	2028	2029	2030
Low Scenario	\$0.02	\$0.02	\$0.02	\$0.03	\$0.03	\$0.03
Mid Scenario	\$0.06	\$0.06	\$0.06	\$0.06	\$0.07	\$0.07
High Scenario	\$0.09	\$0.09	\$0.10	\$0.10	\$0.11	\$0.11

## 6.2 Projected Fully Insured Population in the Commonwealth

Table 4 shows the Commonwealth's fully insured population (ages 0 – 64) projected for the next five years. Appendix A describes the sources of these values.

**Table 4. Projected Fully Insured Population in the Commonwealth, Ages 0 - 64**

YEAR	2026	2027	2028	2029	2030
Total (0 – 64)	2,069,210	2,061,977	2,055,073	2,048,499	2,042,252

## 6.3 Total Marginal Medical Expense

The analysis assumes the mandate would be effective for policies issued and renewed on or after January 1, 2026. Based on an assumed renewal distribution by month, market segment, and the Commonwealth market segment composition, 72.1% of the member months exposed in 2026 will have the proposed mandate coverage in effect during calendar year 2026. The annual dollar impact of the mandate in 2026 was estimated using the estimated PMPM and applying it to 72.1% of the member months exposed.

Multiplying the total estimated PMPM cost by the projected fully insured membership over the analysis period results in the total cost (medical expense) associated with the proposed requirement, shown in Table 5.

**Table 5. Estimated Marginal Claims Cost**

	2026	2027	2028	2029	2030
Low Scenario	\$424,266	\$612,017	\$636,632	\$662,337	\$689,182
Mid Scenario	\$1,060,665	\$1,530,043	\$1,591,581	\$1,655,842	\$1,722,955
High Scenario	\$1,697,063	\$2,448,069	\$2,546,530	\$2,649,347	\$2,756,729

#### 6.4 Carrier Retention and Increase in Premium

Assuming an average retention rate of 13.1%—based on CHIA’s analysis of administrative costs and profit in the Commonwealth<sup>17</sup>—the increase in medical expense was adjusted upward to approximate the total impact on premiums. Table 6 displays the result.

**Table 6. Estimate of Increase in Carrier Premium Expense**

	2026	2027	2028	2029	2030
Low Scenario	\$488,020	\$703,984	\$732,298	\$761,865	\$792,745
Mid Scenario	\$1,220,049	\$1,759,961	\$1,830,746	\$1,904,663	\$1,981,862
High Scenario	\$1,952,079	\$2,815,937	\$2,929,194	\$3,047,461	\$3,170,979

## 7.0 Results

### 7.1 Five-Year Estimated Impact

For each year in the five-year analysis period, Table 7 displays the projected net impact of the proposed language on medical expenses and premiums using a projection of the Commonwealth's fully insured membership. Note that the relevant provisions are assumed effective as of January 1, 2026.<sup>xii</sup>

**Table 7. Summary Results**

	2026	2027	2028	2029	2030	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
Average Members (000s)	2,069	2,062	2,055	2,048	2,042		
Medical Expense Low (\$000s)	\$424	\$612	\$637	\$662	\$689	\$641	\$3,024
Medical Expense Mid (\$000s)	\$1,061	\$1,530	\$1,592	\$1,656	\$1,723	\$1,602	\$7,561
Medical Expense High (\$000s)	\$1,697	\$2,448	\$2,547	\$2,649	\$2,757	\$2,564	\$12,098
Premium Low (\$000s)	\$488	\$704	\$732	\$762	\$793	\$737	\$3,479
Premium Mid (\$000s)	\$1,220	\$1,760	\$1,831	\$1,905	\$1,982	\$1,843	\$8,697
Premium High (\$000s)	\$1,952	\$2,816	\$2,929	\$3,047	\$3,171	\$2,949	\$13,916
PMPM Low	\$0.03	\$0.03	\$0.03	\$0.03	\$0.03	\$0.03	\$0.03
PMPM Mid	\$0.07	\$0.07	\$0.07	\$0.08	\$0.08	\$0.07	\$0.07
PMPM High	\$0.11	\$0.11	\$0.12	\$0.12	\$0.13	\$0.12	\$0.12
Estimated Monthly Premium	\$737	\$780	\$825	\$872	\$923	\$827	\$827
Premium % Rise Low	0.004%	0.004%	0.004%	0.004%	0.004%	0.004%	0.004%
Premium % Rise Mid	0.009%	0.009%	0.009%	0.009%	0.009%	0.009%	0.009%
Premium % Rise High	0.015%	0.015%	0.014%	0.014%	0.014%	0.014%	0.014%

<sup>xii</sup> With an assumed start date of January 1, 2026, dollars were estimated at 72.1% of the annual cost, based upon an assumed renewal distribution by month (Jan – Dec) by market segment and the Massachusetts market segment composition.



## 7.2 Impact on GIC

The proposed mandate would apply to self-insured plans operating for state and local employees by the GIC. The benefit offerings of GIC plans are similar to most other commercial plans in Massachusetts. This section describes the results for the GIC.

Findings from BerryDunn's carrier survey indicate that benefit offerings for GIC and other commercial plans in the Commonwealth are similar. For this reason, the cost of the bill for GIC will likely be similar to the cost for other fully insured plans in the Commonwealth.

BerryDunn assumed the proposed legislative change will apply to self-insured plans that the GIC operates for state and local employees, with an effective date of July 1, 2026. Because of the July effective date, the results in 2026 are approximately one half of an annual value. Table 8 breaks out the GIC's self-insured membership, as well as the corresponding incremental medical expense.

**Table 8. GIC Summary Results**

	2026	2027	2028	2029	2030	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
<b>GIC Self-Insured</b>							
Members (000s)	309	308	306	305	304		
Medical Expense Low (\$000s)	\$44	\$91	\$95	\$99	\$102	\$96	\$431
Medical Expense Mid (\$000s)	\$110	\$228	\$237	\$247	\$256	\$240	\$1,078
Medical Expense High (\$000s)	\$176	\$366	\$380	\$394	\$410	\$384	\$1,726

## Endnotes

<sup>1</sup> H.B. 1154. An Act relative to insurance coverage of mobile integrated health. <https://malegislature.gov/Bills/194/H1154>.

<sup>2</sup> S.B. 726. An Act relative to insurance coverage of mobile integrated health. <https://malegislature.gov/Bills/194/S726>.

<sup>3</sup> 105 CMR 173.000: MOBILE INTEGRATED HEALTH CARE AND COMMUNITY EMS PROGRAMS. 10/5/18. Accessed December 20, 2024. <https://www.mass.gov/doc/105-cmr-173-mobile-integrated-health-care-and-community-ems-programs/download>.

<sup>4</sup> Massachusetts Department of Public Health. MIH Forum. June 27, 2024. Accessed December 30, 2024. <https://www.mhalink.org/wp-content/uploads/2024/06/MIH-Forum-6.27.2024.pdf>.

<sup>5</sup> Mass.gov. Learn about MIH and Community EMS. Accessed December 16, 2024. <https://www.mass.gov/info-details/learn-about-mih-and-community-ems>.

<sup>6</sup> EMS1. Mass. lawmakers approve expansion of mobile health program. August 8, 2019. Accessed December 20, 2024. <https://www.ems1.com/mobile-integrated-health-care/articles/mass-lawmakers-approve-expansion-of-mobile-health-program-iDiQupwrJcTN3bTT/>.

<sup>7</sup> The bill, as currently written, does not include Chapter 176A. However, the Sponsors confirmed that the bill's intent is to include Chapter 176A.

<sup>8</sup> DispatchHealth. FAQ. Accessed January 21, 2025. <https://www.dispatchhealth.com/faq/>.

<sup>9</sup> DispatchHealth. Cost & Insurance. Accessed January 21, 2025. <https://www.dispatchhealth.com/cost-insurance-coverage/>.

<sup>10</sup> Choi, B. Y., Blumberg, C., & Williams, K. (2016). Mobile Integrated Health Care and Community Paramedicine: An Emerging Emergency Medical Services Concept. *Annals of emergency medicine*, 67(3), 361–366. Accessed December 17, 2024. <https://doi.org/10.1016/j.annemergmed.2015.06.005>.

<sup>11</sup> Roeper, B., Mocko, J., O'Connor, L. M., Zhou, J., Castillo, D., & Beck, E. H. (2018). Mobile Integrated Healthcare Intervention and Impact Analysis with a Medicare Advantage Population. *Population health management*, 21(5), 349–356. Accessed December 30, 2024. <https://doi.org/10.1089/pop.2017.0130>.

<sup>12</sup> HealthCall. "Using Grants to Secure Sustainable Funding for Mobile Integrated Health Care," n.d. Accessed March 20, 2025. <https://www.healthcall.com/using-grants-to-secure-sustainable-funding-for-mobile-integrated-healthcare/>.

<sup>13</sup> Pinet-Peralta, L. M., Glos, L. J., Sanna, E., Frankel, B., & Lindqvist, E. (2021). EMS utilization predictors in a Mobile Integrated Health (MIH) program. *BMC medical informatics and decision making*, 21(1), 40. Accessed May 9, 2025. <https://doi.org/10.1186/s12911-021-01409-w>.

<sup>14</sup> Dunn, O., Merolle, S., Salaun, C. & Valentiner, B. Evaluating the Operations and Cost Effectiveness of the UMass Memorial Health Mobile Integrated Health Program MQP. Worcester Polytechnic Institute. October 11, 2024. Accessed May 9, 2025. <https://digital.wpi.edu/pdfviewer/bn999c59b>.

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<sup>15</sup> Marc Roemer (2021), M.S. Costs of Treat-and-Release Emergency Department Visits in the United States, Statistical Brief #311 September 2024 Accessed May 9, 2025 <https://hcup-us.ahrq.gov/reports/statbriefs/sb311-ED-visit-costs-2021.pdf>.

<sup>16</sup> U.S. Centers for Medicare & Medicaid Services, Office of the Actuary. National Health Expenditure Projections. "Table 8, Physician and Clinical Services Expenditures; Levels, Percent Change, and Percent Distribution, ; Private Insurance." Accessed April 25, 2025. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>.

<sup>17</sup> Massachusetts Center for Health Information and Analysis. Annual Report on the Massachusetts Health Care System, March 2025. Accessed April 25, 2025. <https://www.chiamass.gov/annual-report/>.

## Appendix A: Membership Affected by the Proposed Language

Membership potentially affected by the proposed mandated change includes Commonwealth residents with fully insured, employer-sponsored health insurance (ESI) issued by a Commonwealth-licensed company (including through the GIC); nonresidents with fully insured, ESI issued in the Commonwealth; Commonwealth residents with individual (direct) health insurance coverage; and lives covered by GIC self-insured coverage. Other populations within the self-insured commercial sector are excluded from the state coverage mandate due to federal Employee Retirement Income Security Act (ERISA) protections of self-insured plans. The membership projections are used to determine the total dollar impact of the proposed mandate in question; however, variations in the membership forecast will not affect the general magnitude of the dollar estimates. To assess how recent volatility in commercial enrollment levels might affect these cost estimates, please note that the PMPM and percentage of premium estimates are unaffected because they are per-person estimates, and the total dollar estimates will vary by the same percentage as any percentage change in enrollment levels.

CHIA-reported enrollment data formed the basis for membership projections. CHIA publishes a biannual enrollment trends report and supporting databook (enrollment-trends-Data Through September 2024 databook<sup>1</sup>), which provide enrollment data for Commonwealth residents by insurance carrier for most carriers, excluding some small carriers. CHIA uses supplemental information beyond the data in the Massachusetts APCD to develop its enrollment trends report and adjust the resident totals from the Massachusetts APCD. For the base year 2020 in the membership projection, the 2020 Massachusetts APCD and published 2020 membership reports available from the Massachusetts Division of Insurance (DOI)<sup>2,3</sup> were used to develop a factor to adjust the CHIA enrollment data for the few small carriers not present in the enrollment report. The adjustment was trended forward to 2024 and applied to CHIA enrollment data.

In 2021, commercial, fully insured membership was 5.6% less than in 2019, with a shift to both uninsured and MassHealth coverage. As part of the public health emergency (PHE), members were not disenrolled from MassHealth coverage even when they no longer passed eligibility criteria. Shortly before the PHE ended, redetermination efforts began in April 2023 and were anticipated to occur over a 12-month period. Many of the individuals subject to redetermination will no longer be eligible for MassHealth coverage. It is anticipated that a portion of individuals losing coverage will be eligible for coverage in individual ACA plans and ESI. MassHealth's monthly caseload reports<sup>4</sup> indicated that coverage redeterminations were largely completed by June 2024. The Massachusetts Health Connector's monthly reports<sup>5</sup> showed that membership growth stabilized through December 2024, likely due to disenrolled MassHealth members enrolling in individual plans. CHIA's quarterly enrollment trends report<sup>6</sup> showed stable total membership in private commercial group insurance, with a shift from fully insured to self-insured plans. Based on this information, BerryDunn estimated the final 2024 membership impacted by the proposed mandate.

The distribution of members by age and gender was estimated using Massachusetts APCD population distribution ratios and was checked for reasonableness and validated against U.S. Census Bureau data<sup>7</sup>. Membership was projected from 2025 – 2050, with growth rate estimates by age and gender derived from a Massachusetts population projection from UMass Donahue Institute.<sup>8</sup>

Projections for the GIC self-insured lives were developed using the GIC base data for 2018 and 2019, which BerryDunn received directly from the GIC, as well as the same projected growth rates from the Census Bureau used for the Commonwealth population. Breakdowns of the GIC self-insured lives by gender and age were based on Census Bureau distributions.

## Endnotes

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<sup>1</sup> Center for Health Information and Analysis. Estimates of fully insured and self-insured membership by insurance carrier. Accessed March 27, 2025. <https://www.chiamass.gov/enrollment-in-health-insurance/>.

<sup>2</sup> Massachusetts Department of Insurance. HMO Group Membership and HMO Individual Membership. Accessed March 27, 2025. <https://www.mass.gov/info-details/hmo-membership-reports>.

<sup>3</sup> Massachusetts Department of Insurance. Membership in Insured Preferred Provider Plans. Accessed March 27, 2025. <https://www.mass.gov/info-details/insured-preferred-provider-membership>.

<sup>4</sup> MassHealth Enrollment and Caseload Metrics Accessed March 27, 2025 <https://www.mass.gov/lists/masshealth-enrollment-and-caseload-metrics#2025-masshealth-monthly-caseload-reports->.

<sup>5</sup> Massachusetts Health Connector. Membership During MassHealth Redeterminations. Accessed March 27, 2025. <https://betterhealthconnector.com/wp-content/uploads/Health-Connector-MassHealth-Renewals-Dashboard-12-17-24.pdf>.

<sup>6</sup> *Op. cit.* Center for Health Information and Analysis. Estimates of fully insured and self-insured membership by insurance carrier.

<sup>7</sup> National Population by Characteristics: 2020-2024. Accessed March 27, 2025 <https://www.census.gov/data/tables/time-series/demo/popest/2020s-national-detail.html>.

<sup>8</sup> Massachusetts Population Projections. Accessed March 27, 2025. <https://donahue.umass.edu/business-groups/economic-public-policy-research/massachusetts-population-estimates-program/population-projections>.