National Rural Health Association Policy Brief

Bridging the gap: A policy framework for sustainable community paramedicine in rural America

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Introduction

Community paramedicine is an under-recognized part of health care especially in rural areas where access to institutional health care is limited, and patients must travel long distances for services.[9] The community paramedicine model can benefit rural emergency medical services (EMS) agencies by reducing 911 requests for non-urgent, non-transport services that are not reimbursable as emergency services, decreasing the downtime between calls, using their medical skills and expertise, and improving access to providers to meet the community's primary care needs. It also has the potential to increase revenue by billing patients or third-party payers for services provided when appropriate, thereby making it a self-sustaining model.

However, there is no national policy to pay for community paramedicine services, which makes it difficult for this cost-effective approach to survive. Currently, EMS providers are reimbursed as transportation providers by the Centers for Medicare and Medicaid Services (CMS) and are not consistently compensated for health care provided in the field or in transit, though the Medicare ambulance fee schedule has made some modest progress in this area. This is a concerning issue as it limits funding for the important medical care they provide. It also incentivizes EMS systems to transport all patients to the emergency department, which may not be the most appropriate or cost-effective care setting.

This policy paper articulates the need for a national policy that compensates non-physician licensed health care providers for community paramedicine services to ensure rural communities have access to health care.

Analysis

Community paramedicine fills a unique gap by providing non-urgent care services that are often difficult to access in rural regions. Certified EMS personnel are instrumental in delivering this care, yet without national reimbursement policies, these services are financially constrained. Paramedicine's ability to address primary care gaps could significantly reduce health disparities if supported by adequate funding. A strategic shift to recognize EMS as non-physician health care providers can make a measurable difference in health outcomes particularly in remote ambulance deserts that affect 4.5 million people, 52 percent of whom reside in rural areas.[6]

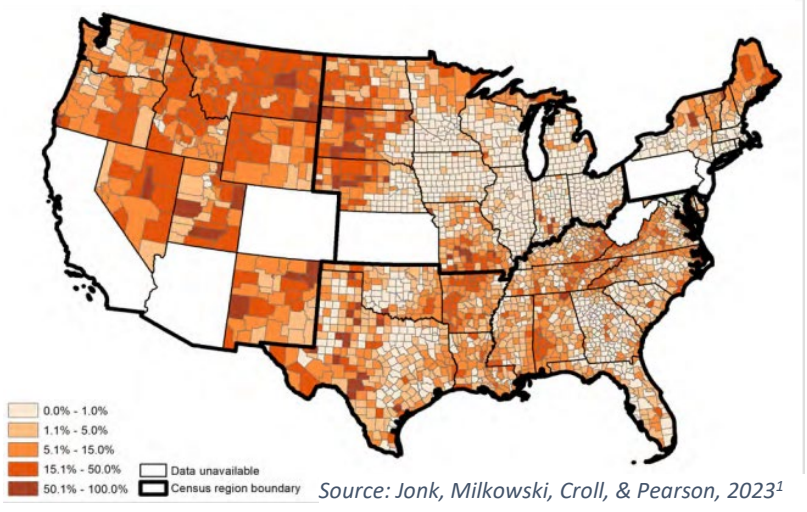
Paramedicine encompasses the provision of medical care outside of the conventional hospital setting, spanning traditional emergency medical services to community paramedicine. The latter emphasizes the delivery of routine, non-urgent medical care by paramedics and EMS personnel. To be recognized as health care providers, these providers must meet specific certification and licensure standards as non-physician community paramedicine professionals. This change is especially important for rural health, where it may be harder for people to get regular medical care due to fewer primary care providers. EMS practitioners often fill this gap by providing necessary medical services, but they are unable to be compensated under current reimbursement rules, including Medicare, Medicaid, and private insurance. To support the sustainability and expansion of community paramedicine, it should be recognized nationally as a formal health care service eligible for reimbursement across all major payer systems.

Community paramedicine models

Mobile integrated health care-community paramedicine (MIH-CP) programs have demonstrated substantial success in various regions, showing how community paramedicine can effectively address health care gaps. These programs reduce emergency department visits by offering preventive care, chronic disease management, and follow-up services, which are especially impactful in rural and underserved communities. For example, MIH-CP initiatives in Texas and Minnesota have improved patient outcomes by reducing hospital readmissions and enabling paramedics to deliver care directly in patients' homes, decreasing the strain on local health care facilities and ensuring timely care. The MIH-CP model underscores the potential of community paramedicine to deliver accessible, cost-effective health care tailored to community needs. Expanding MIH-CP programs nationwide, particularly in rural and underserved areas, could improve health care access, enhance patient outcomes, and reduce the burden on emergency services and health care systems.[11]

Transportation to and from places of care/transportation access demonstration (TIP/TAD) programs serve as successful models demonstrating the effectiveness of community paramedicine. These initiatives highlight how paramedics and EMS personnel can provide health care services beyond traditional emergency response roles. By integrating these programs, communities have improved access to essential medical care, especially in rural and underserved areas with scarce health care facilities.

Figure 1 Ambulance Deserts in the US



Source: Jonk, Milkowski, Croll, & Pearson, 2023[1]

The report "Ambulance deserts: Geographic disparities in the provision of ambulance services" examines the unequal access to ambulance services across 41 U.S. states, identifying areas where individuals live more than 25 minutes from an ambulance station, known as ambulance deserts.[6] The study found that 4.5 million people lived in these ambulance deserts, with 52 percent (2.3 million) residing in rural counties. Additionally, 82 percent of counties had at least one ambulance desert, and 84 percent of rural counties were affected. The regions most affected by limited access to ambulance services include the Appalachian South, the mountainous western states, and rural mountainous areas in states like Maine, Vermont, Oregon, and Washington. Eight states, primarily in the West and Midwest, had fewer than three ambulances per 1,000 square miles, further exacerbating access issues in sparsely populated areas. The report also highlights several structural challenges faced by ambulance services, particularly in rural areas, including low reimbursement rates, insufficient staffing, and the growing costs associated with maintaining advanced life support capabilities. The study findings emphasize the need for reforms in funding and reimbursement mechanisms to address these disparities and ensure more equitable access to emergency services. Given these challenges, there is a strong case for the recognition and reimbursement of community paramedicine as health care providers, particularly in underserved rural regions where long travel times and limited health care infrastructure exacerbate access to medical care.

State Medicaid programs have successfully integrated community paramedicine, demonstrating its efficacy in expanding health care access and improving patient outcomes. These states have implemented policies that recognize paramedics and EMS personnel as essential health care providers eligible for reimbursement under Medicaid. States that have included paramedicine in their Medicaid programs include Minnesota, Texas, California, and North Carolina.

The Emergency Triage, Treat, and Transport (ET3) Model CMS demonstration began in 2020 to give EMS providers greater flexibility in responding to emergency calls, with the ultimate goals of improving care quality, reducing costs, and enhancing patient outcomes. The model tested two new ambulance payments. Instead of automatically transporting patients to emergency departments, EMS personnel could address certain medical issues at the scene or through telehealth consultations or patients could be taken to appropriate alternative care sites, such as primary care clinics. While the model ultimately ended early, lessons could be learned for future community paramedicine efforts.

Policy recommendations

NRHA recommends establishing a comprehensive national reimbursement policy to recognize EMS workers as non-physician health care practitioners within the Medicare and Medicaid systems. Specific policies include:

- Enabling CMS recognition for community paramedicine services to be billable under Medicare.
- Defining clear standards of care to support quality assurance.
- Adopting a fee-for-service model with specific HCPCS codes, to ensure that EMS services are sustainable and adaptable, especially for rural communities.

Recommended actions

NRHA supports legislatives measures aimed at enhancing the recognition and support for community paramedicine programs across the United States. The Community Paramedicine Act of 2024 (HR 8042 in the 118th Congress) seeks to establish a framework that acknowledges EMS clinicians as integral health care providers.[4] This recognition is crucial for enabling these professionals to bill for the health care services they provide outside of traditional medical settings, thereby facilitating sustainable funding for community paramedicine initiatives.

Conclusion

A national reimbursement policy is essential to sustain and expand community paramedicine. By enabling EMS personnel to be recognized and compensated for their health care contributions, rural and underserved areas stand to gain improved health outcomes, enhanced access, and reduced disparities. It is vital for policymakers to support these measures to ensure EMS professionals can continue their work effectively, particularly in isolated communities.

Setting up a national reimbursement policy and recognizing EMS workers as health care providers, will improve health outcomes, reduce disparities, and sustain these important programs. It is important to provide sufficient funding to keep these programs operational to ensure they have a positive impact. This will help EMS workers and practitioners continue providing essential services especially in rural areas, offering a path to better health care access for all Americans.

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