June 27, 2018

To whom it may concern,

Thank you for the opportunity to submit this testimony in regard to the proposed amendment to 801 CMR 4.02(105). This amendment proposes a fee structure for the Department's operation of a program to implement M.G.L. c. 111O, Mobile Integrated Health Care (MIH) and 105 CMR 173.000: *Mobile Integrated Health Care and Community EMS Programs.*

We would like to thank the Department of Public Health for its forward-thinking support of Mobile Integrated Health (MIH) programs in the Commonwealth of Massachusetts. The ultimate goal of an MIH program is to improve the quality of care provided to patients and communities in the Commonwealth. Additional benefits of such programs include bridging gaps in healthcare services, providing healthcare access to underserved communities, directing patients to the most appropriate location for healthcare services, and lowering overall healthcare expenditures. MIH programs have a proven track record of success in communities across the United States, and we are confident that the Commonwealth is well positioned for similar success.

However, we fear that the fee structure proposed by the Department will stifle innovation and create a barrier to entry for the very communities MIH is designed to serve. MIH is often referred to as *Community Paramedicine*, and programs by their very nature are designed to match the needs and resources of a particular community. However, the proposed application and biennial renewal fees do not consider the size of the MIH program, its expected revenue generation, or the resources of the community in which it will operate.

The capital investment for a new MIH program can be substantial. Equipment, training, oversight and QI all come with expense, and reimbursement models for MIH programs are still unclear. While larger, more mature programs and their associated EMS services may be able to afford the sizeable fees proposed under the amendment, these fees will undoubtedly create a barrier to entry for many smaller agencies and communities.

MIH programs seek to get the right care to the right patient in the right timeframe in the right location. For many patients, the emergency department is not the right location for their episode of care, and they may be better served in the home or clinic. Research has shown that such care not only improves patient satisfaction, but clinical outcomes. MIH programs focusing on ED avoidance are not revenue generating programs, but rather represent savings to the healthcare system by improving health outcomes and shifting the physical location of care delivery to a more appropriate venue. The proposed amendment would charge these programs an even higher fee than other MIH programs. While the system savings of these programs may be substantial, the opportunity for revenue generation is limited and the proposed fee for MIH programs with an ED avoidance component will disincentivize the propagation of these programs.

In summary, we give our full support to the implementation of MIH programs in the Commonwealth of Massachusetts. However, while we appreciate that there may be some costs associated with the administration of such programs, the fee structure as currently proposed will serve as a barrier to entry and will undermine the advancement of the very programs the Department hopes to develop.

Respectfully submitted,

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