Greetings HHS Chairs, Sen. Ingwersen, Rep. Meyer, and members of the HHS Committee. My name is Everett Flannery, EMS Deputy Chief of the Waterville Fire Department. I have 25 years of EMS experience, 22 of those as a paramedic, along with a degree in public administration and experience in teaching, quality assurance, and policy work to improve EMS at local and regional levels. I am speaking in support of community paramedicine and LD 2119 as a critical funding mechanism.

When I was hired three years ago to direct the ambulance program, one of my core tasks was establishing a community paramedicine program. While new to the specialty, I understood its role in community health. In 2023, Waterville faced a significant homeless encampment and record overdose numbers. Through a coordinated effort between fire, police, and our developing community paramedicine program, we were able to bring vulnerable individuals indoors during winter and connect many to needed services. In 2024, we saw multiple success stories—unhoused patients with substance use issues and chronic medical problems who had no primary care. We connected them to providers, secured appropriate medications, and stabilized their conditions. These interventions were lifesaving.

After the closure of Inland Hospital, Waterville experienced several months where many high-risk patients had no primary care access. When healthcare systems fail, EMS and emergency departments absorb the impact. Our community paramedicine program became a stop-gap—checking vitals, ensuring medication access, and coordinating refills through Northern Light until patients could re-establish care. These were simple interventions with profound consequences. They prevented emergency room (ER) visits, hospital admissions, and serious medical events.

Today, we continue to serve Waterville and much of northern Kennebec County as the region's only active community paramedicine agency. We support aging-in-place by monitoring patients at home, ensuring medication compliance, and reporting concerns back to their primary providers. We conduct in-home blood draws for individuals with mobility or transportation barriers. We perform simple wound care and provide the episodic attention that many patients need but do not qualify to receive through home health. We are not a home health agency, but we are often the only bridge available during critical periods after hospital discharge. Delays or lack of access to care in rural Maine increases the burden on EMS, ERs, and hospitals.

All this work is currently funded through grants. To sustain these services, we need a reliable financial pathway. Maine EMS has elevated training and licensure requirements to professionalize community paramedicine, but these come with increased costs—costs we cannot meet without reimbursement. Waterville is only fourteen square miles with a limited tax base, and we are already understaffed compared to other fire departments with similar call volume. We know community paramedicine saves money

for Medicare and Maine Care by preventing avoidable ER visits. One-quarter of our EMS call volume involves Maine Care recipients, and the average ER visit costs Maine Care more than $600. A quarter of those visits are considered low acuity, and more appropriate for walk-in care, or a doctor's office, OR a visit from a community paramedicine provider. Due to barriers, it is simply easier to call for an ambulance for a trip to the ER. We are already preventing many of these unnecessary trips—we simply need support to continue doing so.

Examples:

The average age of a Waterville FD community paramedicine recipient is 62 years old. However, we have had recurring visits for at risk pediatric patients as well. One of which we started seeing has complex medical issues that require him to be on a home ventilator 24 hours a day. We were able to assess the child weekly and provide peace of mind to not only the mother, but to his specialists in Portland in our reporting. We were able to provide care immediately after being discharged from a hospital until home health services were able to take over.

A 72-year-old patient with a significant diabetic wound on his leg was referred to us in the fall of 2025. This patient had multiple risks factors detrimental to his health, such as emphysema, diabetes, high blood pressure, congestive heart failure and was on home oxygen therapy 24 hours a day. Due to not qualifying for home health and the risk of worsening wound infection, we were tasked with changing his dressings and applying antimicrobial medication. By managing his wound effectively and communicating with his primary health care provider, we were able to escalate his doctor's appointments timelier and see progress in his wound healing.

Through community paramedicine, we have also provided vaccinations for homebound and at-risk patient. Vaccinations such as COVID, influenza and pneumococcal are extremely important in community health to provide protections especially for immunocompromised individuals.

Lastly, we see several patients that do not necessarily have complex medical issues but are of advanced age and without family or other important healthcare resources. We have begun to visit them on a weekly or bi-weekly basis to simply assist them in "aging-in-place" which is a valuable service asset as our population grows older. This service provides medication reconciliation, medical assessment and provides an in-depth look into their social determinants of health. Any deviations in their baseline "normal" could be of concern, which is communicated with their primary health providers. This negates EMS/ER utilization and possible lengthy hospital admission for a developing illness. One of our elderly patients we see every week would call 911 for EMS transport 6-8 times a month for complaints mostly related to anxiety and not being healthcare literate.

At this time, this patient has not had to call 911 since her recurring visits started a year ago. She enjoys our visits and just the social interaction alone is therapeutic for her.

It is worth noting that recommendations made in the 2024 Blue Ribbon Commission Study for the 131st Legislature specifically address reimbursement for community paramedicine services stating, ***"The Legislature should enact legislation, whether as an amendment to LD 1832 or otherwise, requiring health insurance carriers to provide coverage in reimbursement for community paramedicine services in state regulated health plans."*** Seeing action on this is paramount.

LD 2119 with its mention to "treatment in place" is currently a payable feature through Maine Care via billing code A0998. This treatment in place is available through the emergency response side of operations (not associated with community paramedicine). However, the Maine Care reimbursement is $95. This must be re-evaluated to bring EMS revenues back into the realm where it is more impactful on economies of scale. For example, based on our EMS budget and call volume, if we could recoup $776 each time an ambulance transports a patient, that would support our EMS operations and personnel. While that benchmark is not feasible, this problem is not exclusive to the City of Waterville. The taxpayers are left with $500k to make up the difference for EMS. Compared to some locales, this could be considered a bargain! Allowing us to appropriately bill for services in cases we do not transport helps sustain EMS operations and ease local tax burden. The idea of receiving very little revenue or not billing at all for the hundreds of "treatment in place" calls should no longer carry the mantra of, "this is the cost of doing business in EMS."

Lastly, "alternate destination" is understandably a protocolized action that Maine EMS should take up. Billing regulation should also allow for appropriate reimbursement. Allowing an ambulance transport destination to be allowed and billable beyond the sole option of the ER, enables more efficient treatment for non-acute complaints while also capturing cost savings by not having to bill for ER services for Maine Care recipients. This initiative also lessens the burdens on the local ER's, particularly here in Waterville with only one stand-alone ER since the closure of Inland Hospital.

I urge you to prioritize the health of Maine people by voting Ought to Pass on LD 2119. Community paramedicine fills critical healthcare gaps and proper reimbursement in all areas of EMS is an absolute for sustainability.