House Bill 2222 – Sustainable Funding and Support for Mobile Integrated Healthcare
House Behavioral Health and Health Care Committee
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Testimony provided by:
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Chair Nosse, members of the committee, thank you for the opportunity to testify today in support of House Bill 2222.

My name is Madison Riethman, and I serve as a project manager with the Oregon Coalition of Local Health Officials, or CLHO, leading a federal grant program aimed at boosting workforce development in rural Oregon's public health and health care sectors. I also serve on the board of the Oregon Mobile Integrated Healthcare Coalition, a non-profit organization that provides resources and support for MIH programs and providers.

With me today is Scott Willits, a Policy Advisor with The Paramedic Foundation, which provides expert policy recommendations to federal and state offices. Scott has also worked as a Community Paramedic, providing direct patient care through Mobile Integrated Healthcare (MIH) programs in his community. Through his work with The Paramedic Foundation, Scott has advised multiple states and countries as they develop their MIH rules and regulations.

We are here to strongly support House Bill 2222, which will establish a sustainable path for MIH programs here in Oregon. This bill will help close gaps in access to healthcare, particularly for rural and underserved Oregonians, while also reducing unnecessary EMS transports, ER visits, and hospitalizations.

House Bill 2222 is a necessary step to modernize healthcare delivery in Oregon.

If passed, this bill would allow OHA to enroll qualified MIH providers to receive Medicaid reimbursement for their services, and would provide technical assistance to providers and organizations as they go through this process.

MIH services does not replace health systems, clinics, or practice; it strengthens and augments them by ensuring that more Oregonians—especially those in rural and underserved communities—can access care where they are as a form of care team extension and delegation.

Why does this matter? Because too many Oregonians are falling through the cracks. When patients don't have access to routine or preventive care, their conditions worsen, often requiring costly and resource-intensive emergency interventions.

This bill will:

- Brings MIH services to underserved populations, especially in rural, frontier, and healthcare desert communities.
- Established a funding pathway for MIH providers to be reimbursed for services, ensuring sustainability and growth.
- Enable MIH providers to monitor and manage chronic confusions in patients' homes, emergency response and hospital readmissions and resources
- Strengthens collaboration between hospitals, primary care providers, social workers, and MIH providers to close gaps in the clinical continuum.

To illustrate how MIH transforms healthcare, let's consider Gladstone, Oregon.

A local MIH program identified a high-risk patient—a woman with multiple chronic conditions, including diabetes and severe mobility challenges. She had been repeatedly transported to the ER due to uncontrolled symptoms but never received the long-term support she needed.

When our MIH team intervened, we brought care to her home, helping her manage her conditions, access specialist care, and navigate insurance for essential services like dental and vision care. With our involvement, her health stabilized, and her hospital visits drastically declined.

This is the real impact of MIH—providing care before a crisis occurs, reducing the burden on EMS and emergency departments, and improving patient outcomes.

This patient story isn't unique– MIH is a proven care model that brings medical and social services directly to patients in their homes or community settings. It operates as an extension of the healthcare system, filling gaps where traditional services are unavailable or inadequate.

In Oregon, MIH programs have existed for years, but many lack sustainable funding and recognition. While some programs have been able to operate with support from grants, private contracts, or local fundraising, **there are few to no sustainable funding streams for this work. This is the gap HB 2222 aims to address.**

The work on this bill began in 2020, pulling together partners from EMS, public health, hospitals, and community-based organizations to better understand the barriers to providing MIH services. The first draft of this bill was finalized in September 2024, and has been reviewed with input from diverse healthcare partners across the state.

This work continues today, as we collaborate with OHA and other stakeholders on technical amendments to ensure the bill is able to be implemented with available and requested resources. We are committed to continuing to work with invested partner organizations like OHA and others to ensure this bill does not create unnecessary or unanticipated barriers.

Several other states, including Massachusetts, Minnesota, Missouri, Louisiana, and Texas, have already passed legislation similar to HB 2222, allowing for expanded MIH services across the state. Data from these states shows that well-supported MIH programs lead to lower hospital readmission rates, more efficient use of EMS resources, and better patient outcomes, especially for chronic disease management.

While some MIH programs have been able to succeed in the current environment, many struggle due to lack of funding and policy support.

One of our partners, Joan, has lived and worked as an EMT in Wheeler County– one of the most remote areas in Oregon– for nearly 30 years. As such, she knows the people; the resources; the beliefs and dynamics at play in her community. That's why when she, as the county's lone MIH provider, got a call from a bedbound gentleman asking for food assistance, she knew something was wrong. She knew this gentleman. She knew he hadn't been bedbound several months prior, and knew he was not the kind of person who readily asked for help, particularly from the health care system or a public agency.

When she arrived at his home, she discovered that he had fallen seven months prior and broken his hip. His unlicensed caregiver had neglected him, and he had been left in an unsanitary, unsafe environment. When he eventually ran out of food, he called EMT Joan– as a member of his own community, he trusted her in a way that he did not trust others.

Using this trust, Joan acted quickly– arranging a proper caregiver, securing in-home physical therapy, restoring the home to a safe environment, and coordinating with DHS and law enforcement.

Because of EMT Joan's intervention, this man survived. Unfortunately, Joan's MIH program did not. Joan left her position, and there was ultimately no support or funding to sustain the program—leaving patients like this without access to care.

The limited financial pathways currently available support private healthcare entities servicing private contracts and larger organizations that have surplus resources. While their MIH Programs are invaluable to the eligible patients of their agreements, barriers exist today that prevent small, community-based, and volunteer healthcare organizations from providing MIH services to their neighbors.

This bill is critical because:

- MIH providers often come from the communities they serve, building trusted relationships with their neighbors, at-risk and hard-reach or geographically or economically isolated populations.
    - Programs like EMT Joan's in Wheeler County have already shut down and others will follow.
    - Programs like the one I mentioned in Gladstone will be closing.
- Like many states and communities, Oregon is experiencing a shortage of clinic resources, clinicians, and providers - MIH is asking to help and needs your help to do so.
- With Oregon's focus on health equity and value-based care, MIH is asking to help and needs your help to do so.
    - Without action, MIH services will continue to serve selected communities and populations.
    - Without action, MIH services will continue to rely on private contracts or volunteered services and resources.
    - With action, MIH can be a sustainable solution as demonstrated in Massachusetts, Minnesota, Missouri, Louisiana, Texas, and many other states.

This is especially important for rural communities and healthcare deserts, where fire and EMS departments often serve as the first—and sometimes only—medical providers available. By providing additional financial pathways, this bill supports those local providers in addressing their communities healthcare needs.

Passing House Bill 2222 is a timely and necessary action.

Without it, small, community-based, or volunteer MIH programs will cease to exist, leaving vulnerable populations without essential healthcare services.

This bill ensures that Oregon patients—especially those in rural and underserved communities—receive the care they need, when and where they need it.

MIH does not replace hospitals, EMS, or primary care providers—it fills the gaps and strengthens the system. We urge the committee to support HB 2222 and create a sustainable future for MIH in Oregon.

Thank you for your time and consideration. We welcome any questions.