



Top 10 MIH or community paramedicine program funding sources

These sources of start-up and long-term funding can help launch and provide economic sustainability for mobile integrated health care

Sustainability - whether you're just venturing into the world of mobile integrated health care, or have been involved for a while, this is the word that scares you the most. It also has perhaps the most important impact on the [survival of innovation](#).

Before we start discussing start-up and long-term funding sources, it's prudent to draw the distinction between the terms MIH and community paramedicine. While the nomenclature is still evolving, for the purposes of this article, MIH is a strategy to enhance the value of EMS service delivery through additional service lines, such as 911 nurse triage, alternate destination transports, assessment and referral services, or the use of specialty providers as part of an EMS system response (NPs, PAs, RNs, social workers, behavioral health specialists, etc.).

In short, CP is one of many service lines that EMS agencies may undertake as part of a MIH strategy.

This series seeks to explore if community paramedicine is diffusing fast enough to impact pre-hospital care, and provide tips for overcoming barriers to community paramedicine and implementing successful programs.

CP is the use of specially trained paramedics in new roles to fill gaps in local health care delivery systems, such as delivering primary care in areas where there is a primary care need, or navigating patients (proactively or episodically) to the best source of care for their medical needs. In short, CP is one of many service lines that EMS agencies may undertake as part of a MIH strategy.

Here are 10 ways to fund your MIH strategy:

#10: Internal funding for MIH

Whether you are a public agency, a private agency or something in between, you could simply build the cost of your MIH program into your operational budget, without the goal of external funding. This strategy could mean your governing body deciding the MIH program is consistent with the overall mission of your agency and allocates financial resources from other sources (e.g., taxes, fee for service ambulance transport, etc.) to cover the cost of your MIH program.

#9: Grant funding for start-up costs

There are foundations or other philanthropic organizations that may choose to fund your MIH program for either start-up or, in rare cases, as an ongoing revenue stream. If used for start-up costs, the funder will likely establish goals or milestones required to measure the effectiveness of the funding. Mutually agree on these early in the process.

One of the likely goals will be to determine a sustainable economic model as the grant sunsets. Start on this process early by involving the likely local funding partners into the grant process with full understanding that when the grant runs out, there will be a need for [sustainable funding](#) from other sources. There are cases where the EMS agency was not able to achieve the sustainability goal and when the grant ran out, [the program ceased](#).

#8: Hospitals are more interested in MIH funding

MIH programs are finding that hospitals today are more interested in funding MIH programs than perhaps they were three to four years ago. There are a few reasons for this. The readmission penalties imposed by CMS are having a bigger impact on their revenue stream as additional diagnoses are added to the penalty list and the national readmission rates continue to decline.

CMS is also now tracking what's called Medicare Spending Per Beneficiary, which tracks the Medicare expenditures for patients discharged from the hospital for up to 90-days post discharge ^[1]. If the cost per beneficiary is higher than the state or national average, the hospital is financially penalized. Consequently, hospitals are looking for cost-effective post-acute solutions, and a MIH program could be the perfect fit.

Hospitals are increasingly joining Accountable Care Organizations, or entering into other contracts with payers that financially reward them for decreasing the cost of care to a defined population ^[2]. Using EMS to assist with improving outcomes, and/or reducing expenditures through an MIH program could significantly help the hospital achieve that goal.

#7: Hospice agencies are finding value in MIH

The hospice economic model pays the hospice agency a per diem payment based on the patient's diagnosis and care setting. The hospice agency is then financially responsible for all costs related to the hospice plan of care. Consequently, costs for hospice-related ambulance trips to the ED, and all the potential down-stream costs associated with that, are paid by the hospice agency. In some cases, if the patient is not being compliant with the hospice plan of care, the patient may be removed from hospice status, which then means the agency has costs associated with the acute event and loses the future per diem payments.

When this all happens, the patient's wishes are not met - overall, a lose/lose scenario. Hospice agencies are increasingly finding value in funding partnerships with MIH programs that are designed to address the patient's immediate medical need, without a resulting ambulance trip to the ED ^[3].

#6: Home health agencies rely on MIH partnerships

Home health agencies have found value in funding MIH partnerships that notify them when patients on their service call 911, and/or adding a community paramedic to the 911 response to assist with on scene care coordination for their enrolled patient ^[4]. Working collaboratively, the home health agency and MIH provider may be able to prevent an unnecessary ED visit.

Or, if the patient is transported, the home health agency will be aware of the transport and avoid decreased efficiency by sending a provider to an appointment when the patient is not home due to an EMS transport. Home health agencies are also demonstrating increased interest in funding MIH agencies to provide after-hours back-up service to the home health agency.

#5: Care management agencies and MIH partnerships

The changing health care economic environment has given rise to a cottage industry of organizations that are willing to take on coordinating care management, and the financial risk, of high-risk patients. This could be either in the post-acute, transitional care setting, or even high risk patients before they incur an inpatient admission. These organizations are generally data analytic firms that are really good at mining data to identify the high-risk patients, but they do not generally have actual providers to visit and intervene. An MIH partnership is a logical fit for these firms and several MIH agencies are forming financial models with them to become their providers or care navigators.

#4: Medicaid authorized funds

In its July 2015 issue, “Health Affairs” magazine highlighted Medicaid as one of the most innovative health care payers, likely due to the challenging membership they serve coupled with the local (state-level) control of Medicaid funds ^[5]. Several states have authorized the use of Medicaid funds for CP visits due to the demonstrated value of the reduced expenditures and improved outcomes of Medicaid enrollees. This is true for both the traditional fee for service Medicaid and managed Medicaid through commercial, third party payers.

#3: Managed Medicare reduce expenditures

Although traditional Medicare has yet to acknowledge this value, commercial third party payers with members enrolled in managed Medicare plans are realizing the value of MIH programs to improve patient outcomes and reduced expenditures. They have been willing to pay for these services despite the fact that they may not yet be covered medical expenditures that can be calculated into the payments they receive from Medicare.

#2: Patients and concierge medical services

Some MIH agencies have begun experimenting with what may be referred to as concierge medical services. This can potentially be done through a couple of economic models. One is a subscription service, with annual or monthly fees for special response enrollment, or the availability for calling a non-emergency number for episodic care. It could also simply be offering patients the opportunity to request episodic care through a non-emergency number, or an APP through a smart device (the Lyft model).

Another model is a partnership with companies to staff NPs, PAs or even MDs to actually deliver the care in the MIH agency's vehicles, which brings built-in community trust ^[6]. Many third party payers have payment mechanisms for home visits by mid-level practitioners or physicians. Patient visits for this model could also be through the 911 system. Using emergency medical dispatch, or secondary 911 nurse triage, one of the response options for low-acuity medical calls could be the response of the mid-level practitioner.

#1: Commercial payers step up their initiatives

It's taken a few years, but commercial payers have recently awakened to the fact that for 30 years, they have provided us financial incentive to spend their money. By paying EMS only to transport patients to EDs, they encourage us to do exactly that, which not only incurs the ambulance transport expense for the payer, but more importantly, the downstream expenses for the ED visit itself.

As a result, commercial payers have seriously stepped up their initiatives to pay for MIH services. There are numerous examples of payers paying for things like post-acute follow-up visits, enrollment fees for high utilizer patients, and response fees not tied to whether or not patients are transported to the hospital ^[7]. And, some commercial payers have even engaged in the conversations about capitated, per-member, per-month payment models for traditional EMS and MIH services. This population-based payment model has significant advantages for the MIH agency, the payer and the patient.

The key to developing or maintaining any revenue stream for MIH services is the continual demonstration of value the delivery model brings to the funder. To do this, establish and maintain metrics with the payer that they believe demonstrates value to them.

A special note about Medicare: You'll note throughout this article, we did not mention traditional Medicare. The EMS industry has spent countless resources chasing Medicare payment reform, not only to make more efficient and effective use of Medicare dollars for EMS and MIH services, but also to maintain the current funding for EMS transport services.

Changing Medicare payment process is an exceptionally slow and frankly, frustrating process. This author's advice to EMS and MIH services is to reduce our time, energy and effort to convince CMS to make this change nationally, and focus more on local innovation through Medicaid and local payers outlined in this article. These payers have demonstrated the ability to be much more agile and innovative, and able to change payment policy in months or years versus decades.

Additional MIH resources

There are numerous resources that can assist MIH agencies with learning more about financial sustainability:

- [NAEMT's MIH-CP Toolkit](#)
- [NAEMT's 3.0 Resources](#)
- [EMS Today 2018 Preconference on becoming an Entrepreneurial EMS Agency](#)
- [NASEMSO MIH Resources](#)
- [EMS 3.0 Transformation Summit](#)

References

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