Medical Surge Capacity: Who Pays?

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Words are important!

- System can't afford to pay for unused or rarely used "capacity."
- Would we be more apt to pay for "capability?"
- Would money be found to adhere to "standards?"

Do we really need to spend money?

- EMS gets less than 5% of all of all grant funding for first responders
- Emergency medical services (ED and prehospital) already under stress
- No sustaining funding for "preparedness"
- No sustaining money for surge medical response planning and exercises

Why not just more grant money?

- 4,900 hospitals with emergency departments
- Requirements easily > $1 million
- Total of all DHS grant funds < $4 billion (aviation security, port security, UASI, SHSGP, first responder)
- Hospital Preparedness Program (~ $400 million)
- Grants on 1-year cycle with changing requirements

Where *could* funds come from?

- Hospitals?
  - No cost shifting available – all squeezed out
- Emergency services patient pass-throughs?
  - 40% funded by federal programs
  - 30-40% with no source of funds
- Local and state governments?
  - Is terrorism now a local offense?
  - Public health already under stress
  - High-threat UAs with disproportionate cost
- Federal government?
  - New funding model required

Whose responsibility is it?

- "...to provide for the common defense..."
- Shared responsibility
- Sustained needs require sustainable funding
- It's a cost of doing business
  - Non-discretionary funding treated like discretionary

CMS sets the bar for federal and state programs and private insurers

- Is a higher state of preparedness a surrogate for quality of care?
- Is this really a “zero sum game?”
- How long can we defer a non-discretionary cost?
- Does federal health policy support measurable surge medical response capability or not?