Emerging Strategies to Ensure Access to Health Care Services

Emergency Medical Center

The AHA Task Force on Ensuring Access in Vulnerable Communities examined ways in which the access to and delivery of care could be improved. The emergency medical center (EMC) strategy would allow hospitals that may be struggling, for a variety of reasons, to continue to meet the needs of their community for emergency and outpatient services, without having to provide inpatient acute care services.

The AHA urges Congress and the states to allow certain qualifying hospitals to convert to an EMC. Specifically, EMCs would be required to provide the following services on an outpatient basis:

- **Emergency services**, which would be available to the public 24 hours a day, 7 days a week, 365 days a year; and
- **Transportation services**, either directly or through arrangements with transportation providers, that allow for the timely transfer of patients who require inpatient acute care services.

In addition, EMCs would be able to offer additional health care services to meet the needs of their community. These include:

- **Outpatient services**, which could include primary care services, observation care, infusion services, hemodialysis, population health and telemedicine services;
- **Post-acute care services**, including skilled-nursing facility care, home health and hospice care; or
- **Telemedicine services**, which would allow EMCs to provide or maintain access to additional health care services.

EMC vs. Other Freestanding Emergency Departments

Hospital-based freestanding EDs (FSEDs)

FSEDs are associated with an existing hospital, but provide emergency services in a facility that is structurally and geographically separate and distinct from that hospital. As provider-based facilities, they are reimbursed for emergency services at the rates paid to the existing hospital, including the facility fee.

Independent freestanding EDs (IFSEDs)

IFSEDs are recognized in a limited number of states and provide emergency services without being associated with an existing hospital. Currently, most are not Medicare providers and are not reimbursed by Medicare. Those IFSEDs that are Medicare providers are treated as outpatient clinics and reimbursed under various Medicare Part B payment systems (e.g. the physician fee schedule), but not the outpatient prospective payment system (PPS).

Emergency Medical Centers (EMCs)

The EMC would be a new designation and would need to be recognized at both the federal and state level. EMCs would only arise from a hospital conversion. As such, the number of EMCs would be limited and those hospitals selecting to convert would rescind their current hospital license and certification upon conversion. In addition, EMCs also would remain separate from any existing hospital or health system and would be reimbursed under a payment system developed specifically for EMCs.

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Federal Policy Solutions to Pursue

Congress has debated the creation of similar EMC models:

Rural Emergency Acute Care Hospital Act (S. 1130). This legislation would allow certain rural hospitals to continue providing necessary emergency and observation services by converting to a "rural emergency hospital (REH)." REHs would receive enhanced reimbursement rates of 110 percent of reasonable costs for emergency, outpatient, extended care and transportation services. The AHA supports this legislation.

Save Rural Hospitals Act (H.R. 2957). This legislation also would allow certain rural hospitals to continue providing necessary emergency and observation services by converting to a "community outpatient hospital (COH)." While similar to the REH, COHs would receive reimbursement rates of only 105 percent of reasonable costs for emergency, outpatient, extended care and transportation services.

EMC Demonstration Program. In addition, the AHA urges Congress to direct Centers for Medicare & Medicaid Services to test, through its Center for Medicare & Medicaid Innovation, the feasibility of the EMC and its ability to ensure access to emergency services in all vulnerable communities. Alternatively, AHA urges CMS to adopt this demonstration program independent of Congressional action. This demonstration program should be available to current hospitals in vulnerable rural and urban communities and test at least three payment methodologies for EMC services, including:

- Medicare outpatient PPS rates plus an additional facility payment to cover standby costs;[1]
- A new fee schedule for EMCs; and
- Rates of 110 percent of reasonable costs for EMC services.

The AHA has prepared a *document* that compares the provisions of each of these federal policy solutions.

Hospital and Health System Actions to Deploy

While there is no designation at the federal level for the EMC, hospitals and health systems should consider engaging their boards in conversations related to the services currently offered by the hospital to their community. Hospitals may utilize *AHA's Discussion Guide for Health Care Boards and Leadership* to assist with these conversations. These discussions may then be expanded to key community stakeholders, including patients and clinicians. AHA has developed a *Community Conversations Toolkit* to help hospitals as they engage in discussions related to the emergency services needed in their community.

1. The Medicare Payment Advisory (MedPAC) recommended a similar payment methodology for 24/7 rural emergency facilities in its June 2017 report. That recommendation also provided a fixed payment to cover extra costs and overhead expenses. Accessed at: *http://www.medpac.gov/docs/default-source/reports/jun17_ch8.pdf?sfvrsn=0*.

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