

# 2017 National Health Care for the Homeless Conference

## **ED Care Coordination Strategies**

Collaborating with Local Hospitals to Reduce Inappropriate ED Utilization

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# BACKGROUND

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- Uptick in emergency department (ED) utilization, including more ED use for non-emergency conditions
  - The number of ED visits increased by 150% from 1994 to 2014
  - An estimated 13% to 27% of ED visits in the U.S. could be managed in physician offices, clinics, and urgent care centers
  - The average non-emergency visit to the ED is seven times more expensive than an average health center visit
- CMS research indicates that higher ED utilization by Medicaid beneficiaries may be in part due to unmet health needs and lack of access to appropriate settings

# ED CARE COORDINATION

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*"[E]fforts to reduce ED use should focus not merely on reducing the number of ED visits, but also on promoting continuous coverage for eligible individuals and improving access to appropriate care settings to better address the health needs of the population."*

(CMS Information Bulletin, 2014)

# RANGE OF ED CARE COORDINATION STRATEGIES

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- 1. Expansion of Primary Care Access:** Offering extended hours (weekends and evenings), open scheduling, and same day/walk-in appointments, optimally in close proximity to the ED
- 2. Education:** Educating patients regarding services available at the health center, the importance of a medical home that can meet the patient's medical, behavioral, and oral health needs, and managing chronic conditions in a primary care setting
- 3. Health Information Technology:** Establishing an interoperable health information exchange (HIE) system or other information sharing portal that informs the health center when its patient presents at the ED or is admitted and allows for the transmission of patient health information in a timely fashion, thereby enabling the health center to follow-up directly with the patient

# RANGE OF ED CARE COORDINATION STRATEGIES

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4. **Follow-Up Care:** Contacting health center patients (or individuals who indicate that they do not have a primary care provider) upon discharge to discuss the individual's health care needs and to make timely appointments for follow-up care at the health center
5. **ED Diversion Strategy:** Patients who present to the ED with a non-emergency medical condition are presented with the option to receive treatment at a health center site in close proximity to the ED (e.g., on the hospital campus) as an alternative to being treated at the ED. The referral to a health center for contemporaneous service should be made subject to patient freedom of choice

# EMTALA

- **Purpose:** to ensure public access to emergency services regardless of ability to pay (the “anti-patient dumping law”)
- Provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor
  - If screening determines that the individual has an EMC, the ED must provide necessary treatment or at minimum, stabilize the individual
  - **If screening determines that the individual does not have an EMC, then EMTALA obligation terminates**

# CMS AND STATE INITIATIVES

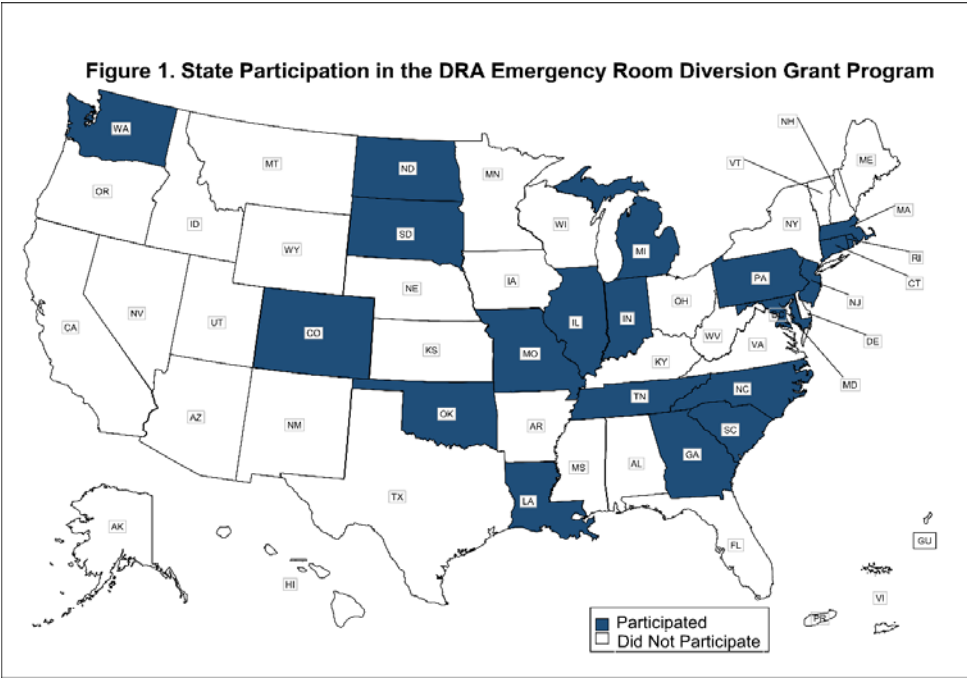
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Deficit Reduction Act of 2005 authorized \$50 million in Federal grants to states to establish non-emergency service providers or networks of such providers. States were encouraged to apply for grant funds to implement projects that would:

- establish new community health centers;
- extend the hours of operation at existing clinics;
- educate beneficiaries about new services; and
- provide for electronic health information exchange between facilities for better coordination of care.

# CMS AND STATE INITIATIVES

More information regarding the results of the Emergency Room Diversion Grant Program, including a list of detailed state summaries, is available at [Medicaid.gov](https://www.Medicaid.gov).





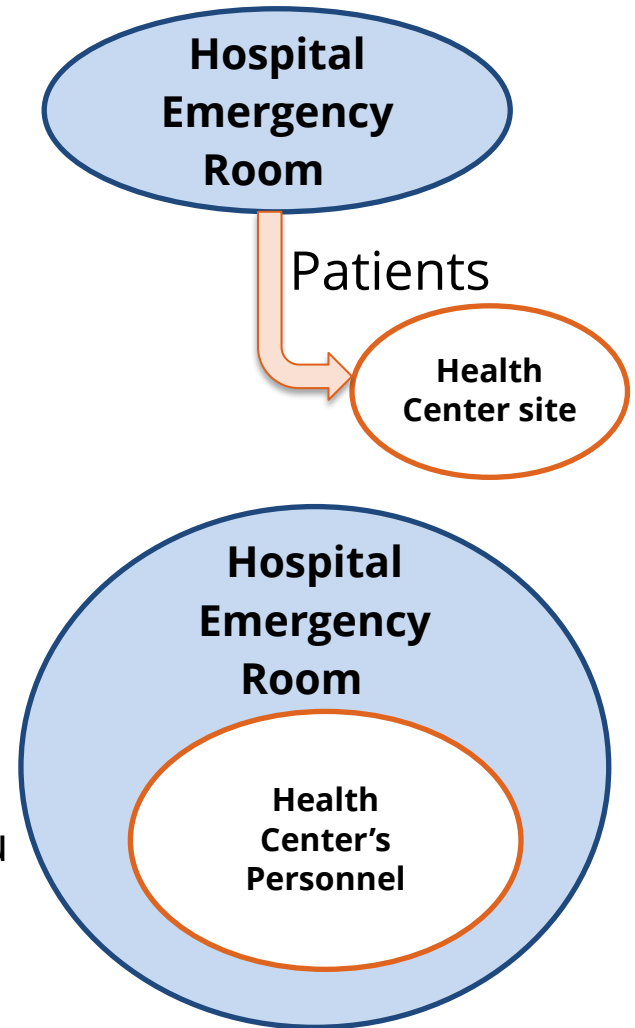
# CMS AND STATE INITIATIVES

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- Many states have adopted alternate approaches to reduce inappropriate utilization of EDs:
  - Co-payments
  - Prior authorization for specific procedures
  - Limiting multiple visits daily
  - Capping number of annual visits
- Consult your state Medicaid agency for more information and current incentive programs

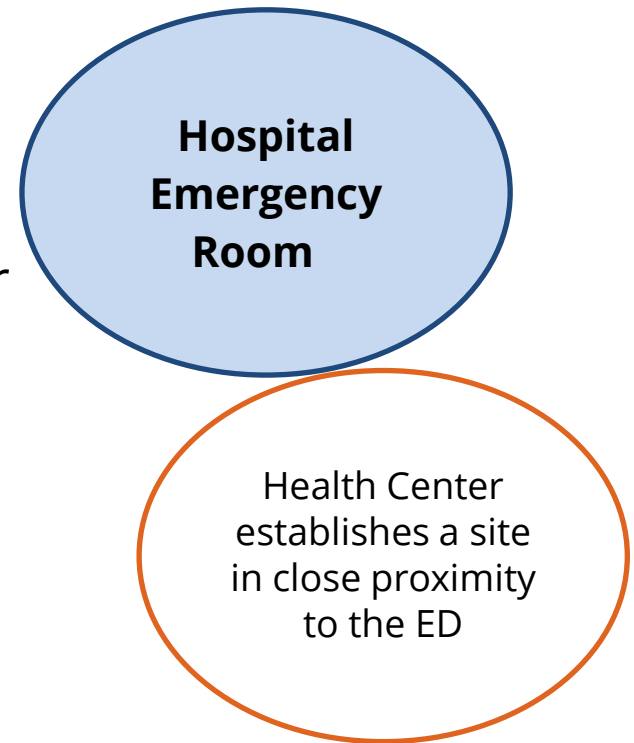
# ED CARE COORDINATION MODELS

- Common Models (for patients presenting at hospital with non-emergent/non-urgent conditions)
  - Hospital refers patients to health center's existing site(s), as appropriate
    - With or without transportation linkage?
    - Before or after treating the patient?
  - Health center places personnel in hospital (or on campus) to conduct intake, registration, and appointment scheduling
    - For contemporaneous appointment in lieu of treatment in the ED or for follow-up appointment?



# ED CARE COORDINATION MODELS

- Common Models (for patients presenting at hospital with non-emergent/non-urgent conditions) (cont.)
  - Health center assumes operator status for hospital-owned ambulatory clinic or establishes a new health center site located on or near hospital campus to provide a health care home alternative
    - Initial services or just follow-up care
    - Full scope of health centers services or for limited service?
    - 24 hours/day, 7 days per week or part-time?
- Close proximity is essential!



# ED CARE COORDINATION

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## Additional considerations:

- Health center clinicians should not perform EMTALA screenings
- Establish post-EMTALA protocols, including documentation of patient choice and referral protocols
- Make hospital or health center personnel available to make same-time appointments at the health center site?
- Extended hours at health center site?
- Extent of collaboration between hospital providers/staff and health center personnel
- Development, maintenance and sharing of medical records
- Arrangement must include all patients who present to the ED without a primary care provider – should not transfer only those patients who are uninsured or Medicaid-covered

# ED CARE COORDINATION

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## Address:

- Whether patients are referred to health center in lieu of treatment in the ED (post-EMTALA screening) and/or for follow-up appointments
- Separation of EMTALA screening personnel from ED treating clinicians
- Documentation of patient choice
- Development of referral protocols based on appropriate clinical care standards (not payor status)
- Hospital billing and collection policies
- Development, maintenance and sharing of medical records
- Distinguishing health center and the ED: signage, physical space, badges

# ED CARE COORDINATION

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## Address:

- Coordinated risk management and quality assurance activities
- HRSA requirements to add the new site to health center's scope of project
  - Health center must have operational/financial authority and responsibility over the new site
  - HRSA would require that health center document it can operate the site on a break-even basis and demonstrate it will not reduce commitment to current patient population
- HRSA requirement that health center offer its full scope of services to entire community served at the new site, regardless of a patient's ability to pay or insurance status
  - Consider whether the ED care coordination site offers a limited scope of services and/or limited hours of service

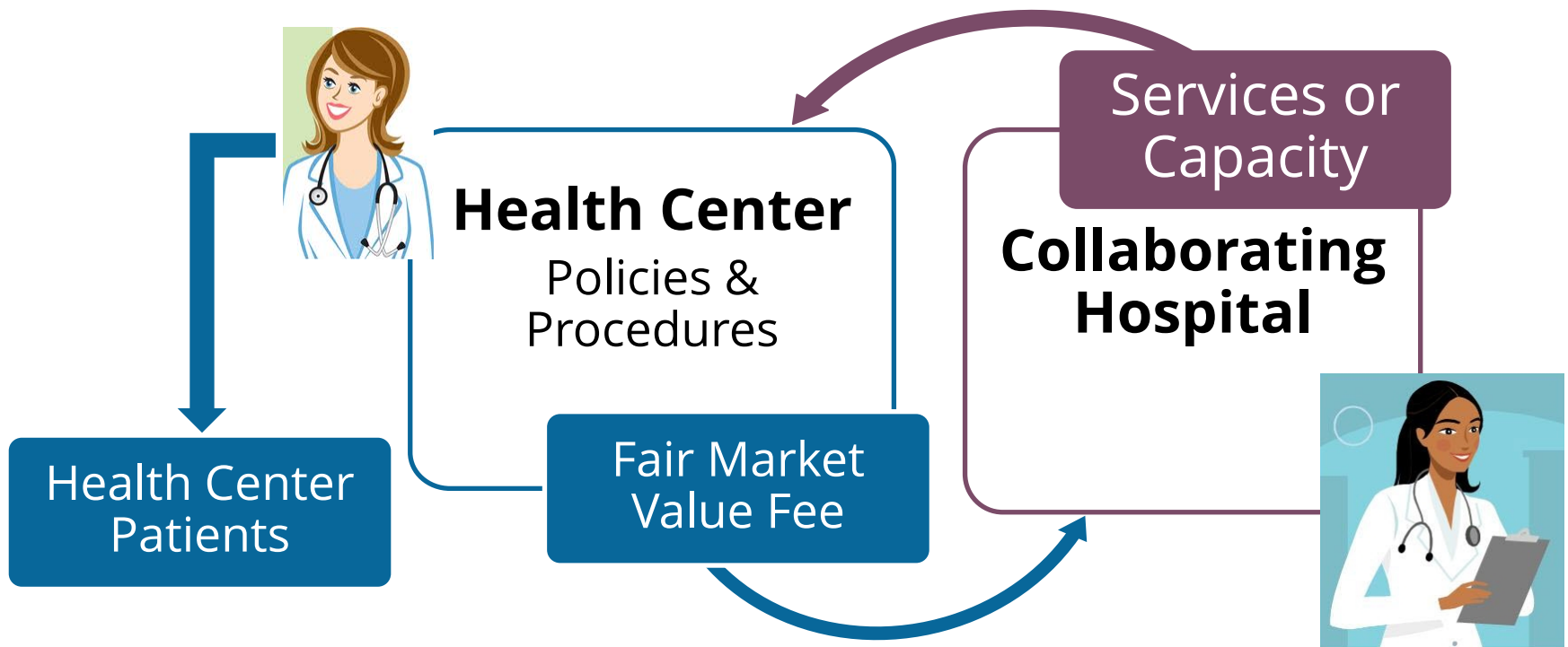
# AGREEMENTS

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Agreements necessary to implement ED care coordination may include:

- ED Care Coordination Referral Agreement (See slides 9-10)
- Lease of Clinical Capacity
- Community Benefit Grant Agreement
  - Renovation costs
  - Anticipated otherwise uncompensated costs associated with serving additional low-income uninsured and underinsured patients
- Facility Lease

# LEASE OF PERSONNEL / SERVICES



- Health center contracts with collaborating hospital (and/or vice versa) to furnish:
  - Clinical services to the health center’s patients on behalf of the health center (e.g., Care Coordinator) and/or
  - Administrative services to the health center



# LEASE OF PERSONNEL / SERVICES

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- Health center is financially, clinically and legally responsible for the leased services
  - Patients receiving services pursuant to the lease from the hospital's personnel are considered health center patients and health center is accountable
  - Health center bills and collects from third party payors/patients and retains all revenue secured for services provided by the hospital
  - Health center pays a fair market value fee to the hospital (not a pass-through of PPS or cost-related reimbursement rates) for all health center patients served under the agreement

# COMMUNITY BENEFIT GRANT: SAFE HARBOR FOR HEALTH CENTER GRANTEES

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- Health center will typically need financial support in order to cover the following types of costs:
  - Serving low income, uninsured and underinsured patients
  - Providing access to its full scope of services

# COMMUNITY BENEFIT GRANT: SAFE HARBOR FOR HEALTH CENTER GRANTEES

- Health Center Safe Harbor under Federal Anti-Kickback statute: final OIG rule issued October 4, 2007 [42 C.F.R. 1001.952(w)]
  - Purpose: protect from prosecution under the federal anti-kickback law
  - Certain arrangements between health center grantees and providers/suppliers of goods, items, services, donations and loans **that contribute to the health center's ability to maintain or increase the availability, or enhance the quality, of services provided** to a medically underserved population served by the health center
    - This expectation (and the arrangement) should be re-evaluated at least annually

# COMMUNITY BENEFIT GRANT: SAFE HARBOR FOR HEALTH CENTER GRANTEES

- The arrangement must be set out in writing, signed by the parties, and specify the amount of all goods, items, services, donations, or loans to be provided to the health center
- The arrangement must cover goods, items, services, donations, or loans that are medical or clinical in nature or relate directly to services provided by the health center as part of the scope of project
  - Typically, the grant covers otherwise uncompensated costs the health center will incur as a result of the collaboration
- The arrangement may not include any restrictions on referrals to protect provider professional judgment

# COMMUNITY BENEFIT GRANT: SAFE HARBOR FOR HEALTH CENTER GRANTEEES

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- The arrangement may not restrict the health center's ability to contract with other providers/suppliers (health center must employ reasonable selection methodology)
- The health center must provide effective notification to patients of their freedom to choose any willing provider or supplier
- The health center must disclose the existence and nature of an agreement that falls under this safe harbor to any patient who inquires in a timely fashion and in a manner reasonably calculated to be effective and understood by the patient

# HEALTH CENTER PROGRAM REQUIREMENTS

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Health center must maintain compliance with all core requirements

- **Requirement #10:** Health center exercises appropriate oversight and authority over all contracted services
- **Requirement #11:** Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center

# STEPS FOR PLANNING ED CARE COORDINATION INITIATIVES

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- Execute a Confidentiality Agreement
- Document the parties' agreement to analyze potential ED care coordination collaborative opportunities in a Memorandum of Agreement
  - Prioritize identified initiatives
  - Establish timelines
  - Specify that no affiliation will be established without the respective Boards' approvals
- Establish a Joint Steering Committee
  - Specify charges to planning teams designed to address the key clinical, financial, and operational considerations
  - The Joint Steering Committee's decisions are subject to final approval by the applicable Boards
- Commence financial feasibility analysis

# QUESTIONS?

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