

Emergency Department Care Coordination: Health Center Frequently Asked Questions (FAQs)

The Centers for Medicare and Medicaid Services and state Medicaid agencies are incentivizing hospitals to establish linkages with primary care providers. Through these incentive programs, health centers can explore new collaborative opportunities with hospitals leveraging the health center's patient-centered medical home model of care. This FAQ summarizes important legal and policy issues that are key to successfully establishing ED care coordination programs for health centers.

Q: Based on current health center experience, which care coordination strategies seem to be most effective in reducing unnecessary emergency department (ED) utilization for non-emergent conditions?

A: Health centers across the country are implementing a variety of different strategies to reduce inappropriate ED utilization. Co-locating a new health center site in close proximity to the ED as an alternative to being treated at the ED can be successful but also difficult to implement. One of the most effective and simplest strategies is to expand access to primary care services through an existing site by offering extended hours, open scheduling, and same day/walk-in appointments. These strategies tend to have maximum effect when done in combination with a concerted effort to educate patients (both globally (e.g., through publicity efforts) and individually (i.e., for those ED "super users") about these efforts to expand access, and the convenience and health benefits to managing chronic conditions in a primary care setting. Some health centers have also effectively reduced inappropriate ED utilization by using case managers to coordinate timely follow-up care at the health center for both existing health center patients (and individuals who indicate that they do not have a primary care provider) upon discharge from the hospital's inpatient care.

Q: Does EMTALA prevent a hospital from participating in an ED diversion strategy with a health center to refer patients to the health center who have come to the ED, but do not have an emergency condition?

A: In a word, no. The Emergency Medical Treatment and Labor Act (EMTALA), enacted in 1986, was established to ensure that patients receive emergency services regardless of their ability to pay. EMTALA requires hospitals with emergency departments (EDs) to: (1) provide a medical screening examination to every individual who comes to the ED seeking examination or treatment for an emergency medical condition; and (2) as necessary, provide care to stabilize that individual if they have an emergency medical condition.

If the process to refer patients to a health center occurs after the hospital has determined, through an appropriate medical screening examination, that the individual does not have an emergency medical condition, the hospital has met its EMTALA obligation. Therefore, EMTALA should not be seen as a legal barrier for the referral of patients to a health center.

Q: In developing an ED diversion strategy with my local hospital, how should we address HIPAA?

A: Under the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), health care providers may disclose and exchange patient health information (PHI) for treatment purposes. Treatment is defined to include the provision, coordination, or management of health care and related services for an individual by one or more health care providers, including consultation between providers regarding a patient and referral of a patient by one provider to another. Accordingly, transmitting PHI between the hospital ED and the health center to facilitate treatment is allowed without need for a specific written authorization from the patient.

However, in addition to complying with HIPAA's Privacy Rule, it is critical that the exchange of PHI between providers occurs consistent with the HIPAA Security Rule. As such, it is critical that the information technology infrastructure utilized is sufficiently robust to appropriately safeguard the security of such information.

Q: In order to support our ED care coordination efforts, the local hospital will provide the health center with a financial subsidy, as well as free IT equipment and facility space. Will a referral from a hospital ED to a health center violate the federal Anti-Kickback statute?

A: The federal Anti-Kickback Statute prohibits the offer or exchange of anything of value to induce the referral of business paid by a federal health care program (e.g., Medicaid). Violation of this statute can have hefty criminal and civil penalties. Nevertheless, for health centers, there is a unique safe harbor that can be used to protect arrangements between health centers and other providers (e.g., hospitals) involving the provision of financial assistance and/or the donation of , equipment (or other goods/items) and/or services (either at no cost or for below fair market value) 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.

To benefit from this safe harbor, certain requirements must be satisfied. At a minimum, 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. Second, the arrangement must cover goods, items, services, donations, or loans that are either medical or clinical in nature, or relate directly to services provided by the health center as part of the scope of project. The arrangement may not include any restrictions on referrals to protect provider professional judgment. If your health center is considering partnering with a hospital for ED diversion, we recommend consulting with counsel to ensure that each and all of the necessary requirements are properly satisfied to fall under the safe harbor.

Q: How do HRSA requirements factor into ED diversion efforts?

A: Health centers embarking on ED diversion must ensure that they remain compliant with Health Resources and Services Administration (HRSA) requirements. In structuring an ED diversion strategy, health centers should evaluate whether HRSA approval to modify its scope of project will be required. This occurs most often if the care coordination strategy involves the establishment of a new site or transferring an existing hospital-owned site to the health center's auspices. In such cases, health centers must add the new site to their scope of project. To do so, the health center must have operational/financial authority and responsibility over the new site. Moreover, the health center must document that it can operate the site on a break-even basis and demonstrate it will not reduce its commitment to its current patient population. In addition, approval of a change in scope may also be required if a chosen strategy will result in the addition of a new service (e.g., substance abuse) beyond what the health center currently directly provides in its HRSA-approved scope of services.

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