

National Association of Community Health Centers

ISSUE BRIEF

Medicare/Medicaid Technical Assistance #89

**Health Center-Hospital Affiliation Opportunities
Under the Deficit Reduction Act**

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The Deficit Reduction Act of 2005 (DRA),¹ which was signed into law on February 8, 2006, provides a host of changes in Medicaid eligibility, cost sharing, benefits and coverage, and compliance. While the DRA addresses several areas of current Medicaid law, this Issue Brief focuses on two sections that offer new, innovative opportunities for health centers to collaborate with their local hospitals to provide alternatives to furnishing non-emergent, non-urgent outpatient care in the hospital emergency department by offering the patient a more appropriate ambulatory care setting in which to receive primary care services.

Co-Payments for Non-Emergency Care Provided in the Emergency Room

Section 6043(a) of the DRA, which amends new Section 1916A of the Social Security Act (SSA), gives States the option to amend their State Plans to permit hospital emergency rooms to charge certain Medicaid patients co-payments as a condition to receiving care for a non-emergency condition if:

- ❖ The emergency room provides an appropriate medical screening exam to the patient, as defined in Section 1867 of the SSA or the Emergency Medical Treatment and Active Labor Act [EMTALA] (42 U.S.C. § 1395dd), its implementing regulations (42 C.F.R. §§ 489.20(l), (m), (q), and (r) and § 489.24), and relevant case law and guidance², and
- ❖ The exam indicates that the patient does not have an emergency medical condition, as defined by EMTALA law, regulation and guidance, but
- ❖ That patient decides to use the emergency room for care anyway.

In order for the hospital to charge the co-payment, it must first meet several conditions. In particular, subsequent to the EMTALA screening exam that resulted in the determination that the patient did not present with an emergency medical condition, but prior to furnishing non-emergency services, the hospital must inform the patient of the following:

¹ Public Law 109-171.

² EMTALA is a patient anti-dumping law that, in general, requires emergency rooms of hospitals participating in Medicare: (1) to provide any patient who presents at the ER and requests services with a medical screening to determine whether that individual has an emergency condition and (2) if the exam indicates that the individual has an emergency condition, either to treat such individual or ensure that the individual is stabilized prior to his/her transfer to another medical facility. For additional information on EMTALA requirements and their interpretation and application by the Centers for Medicare and Medicaid Services (CMS), please see the following NACHC issue briefs: *The Emergency Medical Treatment and Active Labor Act and its Impact on Health Centers* (Issue Brief # 23, Systems Development Series, August 2003) and *Recent Developments in the Implementation and Operation of the Emergency Medical Treatment and Active Labor Act (EMTALA)* (Medicare/Medicaid Technical Assistance Issue Brief # 77, February 2004).

1. That the hospital may require payment of a co-payment prior to furnishing non-emergency services in the emergency room; and
2. The name and location of an “**alternate non-emergency services provider**” that is actually available and accessible and can provide the services without the imposition of cost-sharing; and
3. That the hospital will provide a referral to coordinate scheduling of treatment provided by the alternate non-emergency services provider.

Alternate non-emergency service providers are explicitly defined to include **community health centers**, as well as health care clinics, physicians’ offices, hospital outpatient departments, and similar types of providers, who can furnish clinically appropriate services “**contemporaneously**” with the provision of non-emergency services which would have been provided by the emergency room. However, the DRA does not define the term “contemporaneously.”

\$50 Million in Grants to States for “Alternate Non-Emergency Service Providers”

Section 6043(b) of the DRA, which amends Section 1903 of the Social Security Act (SSA), provides for the payment to States of up to \$50 million in grant funds over a four-year period (which was to begin in 2007) to assist in the establishment of “alternate non-emergency service providers,” (as defined above), or networks of such providers. Preference will be given to States that establish or already have alternate non-emergency services providers, or networks of such providers, that:

- ❖ Serve rural or underserved areas where beneficiaries may not have regular access to providers of primary care services, or
- ❖ Are in partnership with local community hospitals.

Impact on Health Centers

By enacting these two provisions, it appears that Congress has recognized what health centers (and their respective State and Regional Primary Care Associations [PCAs]) have known for years – non-emergent and non-urgent care is more appropriately provided in ambulatory care settings that have the experience and expertise in furnishing primary and preventive health care, rather than in costly and crowded emergency rooms. Hopefully, these provisions will make both hospitals and patients more aware of health centers, in general, as well as of the high quality cost-effective care they provide, resulting in an increasing number of Medicaid and Medicare beneficiaries choosing health centers as their medical homes.

Additionally, those centers that are not already affiliated (or have limited affiliation arrangements) with their local hospitals may want to pursue developing collaborative agreements, including, but not limited to, expanding health center operations by adding satellite sites in or near the hospital and/or extending the health center’s hours (with additional funding from the hospital to assist in defraying a portion of the otherwise

uncompensated costs of doing so).³ Thus, these new provisions may provide an excellent opportunity for initiating or increasing dialogue between health centers and local hospitals on the scope and funding for new or expanded collaborative efforts.

In addition to offering potential new revenue sources for health centers, **the new provisions establish an important legal principle that, upon determination through an appropriate EMTALA screening that a patient has presented with a non-emergent or non-urgent condition, the individual has a choice as to whether to receive care from the hospital or to choose an alternative non-emergency service provider. If the patient chooses to see an alternative provider, assuming that the hospital performed a valid screening, the hospital has fulfilled its EMTALA obligations and should not face liability based on the patient's choice.**

Despite the positives presented by the legislation, several issues could arise in its implementation. To date, CMS has not provided formal guidance on how to interpret and implement these provisions, leaving many unanswered questions. Several of those questions are discussed below.

Definition of the Term “Contemporaneously”

The definition of “alternate non-emergency services provider” requires that the alternate provider be able to furnish appropriate services “contemporaneously” with the provision of non-emergency services that would have been provided by the hospital emergency room. The DRA does not define the term “contemporaneously,” and CMS has yet to provide formal guidance as to its interpretation. Nonetheless, when the CMS guidance is published it may interpret “contemporaneous” to require health centers to establish, either directly or indirectly, a 24-hour, 7-day week operating requirement to meet this standard. However, such a narrow interpretation of the term “contemporaneous” should not prevent or impede health centers from pursuing arrangements with hospitals to function as the emergency room’s preferred alternate non-emergency services provider. While in the past questions arose as to whether hospitals could engage in such arrangements without exposure to EMTALA violations, as discussed above, the new DRA provisions set forth an important legal principle that, once a hospital has determined through an appropriate EMTALA screening that a patient has presented with a non-emergent or non-urgent condition, the patient can choose to receive services from an alternative non-emergency service provider without the hospital incurring liability under EMTALA.

Taking into consideration that the “contemporaneous” standard is an element in the arrangement only if the hospital wants to impose co-payments for the provision of non-emergency services or the parties wish to avail themselves of the \$50 million in grant funds, if the parties decide to forego these payments/funds, establishing a health center as an alternative

³ If a health center decides to expand its operations by adding a new site, unless it is able to obtain additional grant funds pursuant to a New Access Point funding opportunity, it would have to secure prior approval from the Bureau of Primary Health Care (BPHC) by submitting a request for a change in scope in which the health center assures BPHC that, among other things, it will not need additional Federal funds to implement the change. With this in mind, using best efforts to obtain financial support from their collaboration partners should be a key element in all affiliations involving expansion of health center services/sites without additional Federal funds.

non-emergency services is still a cost-effective substitute for emergency room services. **Thus, health centers may want to proceed with arrangements, which would take into consideration the health center’s regular hours of operation. Alternatively, if a hospital and a health center agree that it would be beneficial for the health center to expand its hours (either on a full-time or a part-time basis) or to establish a site at or close to the hospital to accommodate emergency room referrals closer to the time of the actual referral, the parties could proceed assuming additional funding from the hospital or another donor is available.**⁴

Existing Arrangements for Health Center Physicians to Participate in Emergency Room On-Call

Existing health center-hospital affiliation agreements may include arrangements for health center physicians to participate in emergency room on call. Often, on-call participation is required for the health center physician to secure admitting privileges. If, however, a health center physician covering the emergency room refers the non-emergent, non-urgent patient to the health center for alternate non-emergency services, a question may arise as to whether this arrangement could result in prohibited referrals under the anti-kickback statute and/or conflicts of interest (either actual or perceived)? **It is important to ensure that arrangements under which the health center serves as the alternate non-emergency service provider to the hospital, as well as those under which the health center participates in emergency room on-call arrangements, address and incorporate compliance with all relevant Federal and State laws.**

Process for Securing State Grant Funds

With respect to the provision of grant funds to States to establish alternate non-emergency services providers, CMS has yet to issue guidance on the process by which States can apply for the funds (despite the fact that the 4-year limitation on funding was supposed to begin in 2007). Further, neither the DRA nor CMS guidance provides requirements or a procedure by which the alternate non-emergency services provider can apply for such funds. In fact, other than specifying preferences in awarding funds to States, the DRA is very vague regarding this new grant opportunity, simply stating that “[P]ayment to a State í shall be made only upon the filing of such application in such form and in such manner as [DHHS] shall specify.”

Nevertheless, depending on the size and amount of grants awarded, and assuming that health centers can satisfy the contemporaneous standard which is discussed above, these funds could represent a significant influx of cash for health centers. As such, it certainly makes good sense for PCAs and health centers to remain diligent in working with their States to provide necessary guidance **to implement this provision of the DRA, as well as in stressing the importance of providing a preference for health centers, many of whom already function in the role of “alternate non-emergency services provider,” albeit informally.**

Conclusion

⁴ See footnote #3 above.

The section of the DRA addressing the provision of non-emergency services by alternate providers (rather than by the emergency rooms themselves) offer opportunities for health centers to initiate and/or expand collaborative efforts with their local hospitals. However, as with any new legislative program, along with the opportunities come issues that need to be addressed to appropriately implement the provisions. Obviously, PCAs should keep their health centers up-to-date on this issue and initiate or continue to work with their state Medicaid agencies both before and after the anticipated the Federal guidance is released.