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Advancing Health in America

The Emergency Medical Center Strategy

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 communities for emergency and outpatient services, without having to provide inpatient acute care services. This chart summarizes three potential options, including the task force's recommendation, that have been developed to meet the need for emergency and outpatient services in vulnerable communities.

	Rural Emergency Medical Center Act of 2018 (H.R. 5678)	Rural Emergency Acute Care Hospital Act (S. 1130)	Save Rural Hospitals Act (H.R. 2957, Section 401)	AHA Task Force Recommendation
Facility	**Rural Emergency Medical Center (REMC)**	**Rural Emergency Hospital (REH)**	**Community Outpatient Hospital (COH)**	**Emergency Medical Center (EMC)**
Qualifications	A hospital must elect to convert and have been one of the following, as of the date of enactment of the bill: 1. A critical access hospital (CAH); 2. A hospital with not more than 50 beds located in a rural county or an area that is treated as being rural pursuant to Section 1886(d)(8)(E); or 3. A hospital described in a) or b) above that closed in the five years prior to the date of the enactment.	A hospital must elect to convert and have been one of the following, as of Dec. 31, 2016: 1. A critical access hospital (CAH); 2. A hospital with not more than 50 beds located in a rural county or an area that is treated as being rural pursuant to Section 1886(d)(8)(E); or 3. A hospital described in a) or b) above that closed in the five years prior to the date of the enactment.	A hospital must elect to convert and have been one of the following, as of Dec. 31, 2016: 1. A CAH; 2. A hospital with not more than 50 beds located in a rural county or an area that is treated as being rural pursuant to Section 1886(d)(8)(E); or 3. A hospital described in a) or b) above that closed in the five years prior to the date of the enactment.	A hospital in a vulnerable community must elect to convert and be a hospital, a part of a hospital or a CAH, as of Dec. 31, 2017. In addition, for rural areas, hospitals also will qualify if they have been a hospital in the five years prior to the date of the enactment, provided the hospital was either: • A CAH; or • A hospital with no more than 50 beds located in a rural county or an area that is treated as being rural pursuant to Section 1886(d)(8)(E).
Inpatient Services	These facilities would not be able to provide acute care inpatient services.			
Outpatient Services	EMCs would provide "qualified emergency medical center services," including: • 24/7 emergency and observation care; • Transportation services for patients needing inpatient acute care services. These facilities also may provide: • Other outpatient services as needed by the community; • Skilled-nursing facility services; and • Telehealth services.	REHs would provide "rural emergency outpatient services," including: • 24/7 emergency and observation care; and • "Other medical services," which the legislation defines to include, but not be limited to, skilled nursing facility care, infusion services, hemodialysis, home health, hospice, nursing home care, population health and telemedicine services; • "Extended care services;"* and • Transportation services for patients needing inpatient acute care services.	COHs would provide "qualified outpatient services," including: • 24/7 emergency and observation care; and • Services that the legislation defines to include medical and other health care services furnished on an outpatient basis by a COH, rural health clinic, federally qualified health clinic (FQHC), or a certified FQHC-look-alike; and • "Extended care services;"* and • Transportation services for patients needing inpatient acute care services.	EMCs would provide "qualified emergency medical center services," including: • 24/7 emergency and observation care; • Transportation services for patients needing inpatient acute care services. These facilities also may provide: • Other outpatient services as needed by the community; • Extended care services (provided the previous facility was a CAH providing swing bed services);* and • Telehealth services.
Payments	Medicare outpatient prospective payment system rate plus an additional facility payment to cover fixed costs for all "qualified emergency medical center outpatient services." Skilled-nursing facility services would be reimbursed at 110 percent of the amount otherwise payable for skilled-nursing facility services.	110 percent of reasonable costs for all "rural emergency outpatient services." **Notes:** Costs associated with having a backup physician available via telemedicine considered a reasonable cost. Payments would be reduced by coinsurance amounts (calculated the same way as coinsurance amounts for outpatient CAH services).	105 percent of reasonable costs for all "qualified outpatient services." **Note:** Costs associated with having a backup physician available via telemedicine considered a reasonable cost.	The AHA task force recommendation includes the creation of a demonstration program to test three payment methodologies for "qualified EMC services," including: • Medicare outpatient prospective payment system rate plus an additional facility payment to cover fixed costs; • a new fee schedule for EMCs; and

** The term "extended care services" is not further defined. As such, the services included would defined by the Secretary, and could include post-acute care services such as skilled-nursing facility care, home health, hospice or nursing home care.*

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Payments Continued	Ambulance services would be reimbursed at 105 percent of the amount otherwise payable for ambulance services. An REMC would be considered a Medicare telehealth "originating site" at which Medicare beneficiaries may receive covered telehealth services.			• reasonable cost payments at 110 percent of reasonable costs for "qualified emergency medical center services." Regardless of the methodology, other outpatient services needed by the community would be reimbursed as appropriate under the applicable Part B payment program; "extended care services" would be reimbursed at rates paid for outpatient CAH services; and ambulance services would be reimbursed at 105 percent of the amount otherwise payable for ambulance services. **Notes:** The demonstration also could incorporate value-based principles. Costs associated with having a backup physician available via telemedicine could be considered a reasonable cost.
Requirements	1. State approval. 2. Federal certification. This would be tied to the following: » The facility has a transfer agreement with a level 1 or level 2 trauma center; and » The facility meets staffing requirements set forth by Secretary. 3. The facility must have protocols in place for the timely transfer of patients who require inpatient acute care services.			
Redesignation	CAHs that convert to an REH, COH, REMC or EMC may revert back to CAH status at any time (in the same manner that the hospital was original designated a CAH).			
Misc. Provisions	• For every CAH that chooses to transform to an REMC, that state may waive the statutory distance requirement for a new CAH facility	• For every CAH that chooses to transform to an REH, that state may waive the statutory distance requirement for a new CAH facility. • HHS shall conduct studies/provide reports that evaluate the impact of rural emergency hospitals on the availability of health care and health outcomes in rural areas. • Emergency medicine would be included under the National Health Service Corps. • Hospitals with approved residency programs in emergency medicine may include time spent by interns/residents in the emergency department of a rural hospital in their full-time equivalent cost.	• For every CAH that chooses to transform to a COH, that state may waive the statutory distance requirement for a new CAH facility. • HHS shall conduct studies/provide reports that evaluate the impact of rural emergency hospitals on the availability of health care and health outcomes in rural areas.	• Since the demonstration program would be conducted under the authority of the Center for Medicare & Medicaid Innovation, it would be evaluated upon completion.