NAFEC
National Association of
FREESTANDING
Emergency Centers

March 26th, 2020

The Honorable Alex M. Azar II
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Secretary Azar,

As the COVID crisis has deepened in Texas and across the country, it has become clear that no resources should be left on the sidelines and all providers must do what they can to assist hospitals as they prepare for the expected surge of patients. On behalf of the more than 200 freestanding emergency centers (FECs) in the country, we wanted to reach out to let you know that we stand ready to work with you and the providers in our communities to assist in this fight to ensure that patients in our communities get the care they need. Like many others, these FECs are on the frontline of this fight and have seen thousands of COVID-19 symptomatic patients with a growing number of positive cases.

We are, therefore, writing to request that the Centers for Medicare and Medicaid Services (CMS) utilize its authority under the recent 1135 waiver to provide Medicare and Medicaid reimbursement to FECs that are able to serve Medicare and Medicaid patients during this pandemic.

While FECs have the capabilities of an off-campus emergency department of a hospital, because they are not owned by a hospital, they are not recognized by CMS as facilities eligible for payment under Medicare or Medicaid. FECs have only been in existence for 10 years and have been working with Congress and the American College of Emergency Physicians (ACEP) and Emergency Department Practice

Management Association (EDPMA) to obtain Medicare and Medicaid recognition[1], but the statute has, unfortunately, lagged behind our delivery model.

FECs are fully equipped emergency departments, possess around the clock lab and advanced imaging services and are staffed by Emergency Medicine trained physicians who are on-site 24 hours a day, seven days a week. They are regulated and licensed by states and subject to state EMTALA laws and a panoply of other health and safety regulations that equal or exceed emergency departments operated by hospitals. During this time, all resources should be available to patients, including FECs, especially given that many of those facilities may have key healthcare resources (e.g., respirators, isolation rooms) to assist in caring for the patient overflow from hospital emergency departments.

Across the state of Texas alone, there are more than 1,550 beds in 200 freestanding emergency centers that stand ready to relieve the burden on hospitals. There are FECs in small rural towns and rural counties as well as large, urban and suburban areas. FEC physicians and staff can provide much needed support in the large cities, which will most likely be hit the hardest with COVID-19. As a point of context, budgets for major hospital construction allocate between $1 million and $1.5 million per inpatient bed planned, which includes everything else that goes into a hospital, (operating rooms, cafeteria, physical plant) most of which isn't needed during this pandemic. As such, the cost to build three major 500 bed hospitals, FECs can add an inpatient construction value of $1.5 billion overnight by simply making our more than 1,500 beds accessible to Medicare and Medicaid patients. In addition, FECs small size is strategically perfect to keep patients in smaller groups and minimizes COVID spread to other patients.

But we cannot do that if we do not have the resources to provide care to these patients. Due to CMS's current regulatory interpretation of FEC eligibility for disaster funding, the resources freestanding emergency centers can offer are not being fully utilized.

Based on our legal analysis (attached), we believe CMS has the current waiver authority under the Section 1135 of the Social Security Act to provide Medicare funding for FECs that are providing care to Medicare beneficiaries during the COVID-19 pandemic. This waiver authority under Section 1135 expressly states that

[1] S. 3531 from the 115th Congress

it should be construed, "to ensure, to the maximum extent feasible," that sufficient health care items and services are available to meet the needs of beneficiaries during an emergency and in an emergency area. Id. 1135(a), 42 U.S.C 1230B-5(a). Further, Section 1135 provides that the "term health care provider means any entity that furnishes health care items or services, and includes a hospital or other provider of services, a physician or other health care practitioner or professional, a health care facility, or a supplier of health care items or services." (Emphasis added). Id.1135(g)(2), 42 U.S.C 1320b-5(g)(2).

The definition of "health care provider" is sufficiently broad to include FECs. The waiver authority extends to conditions of participation, certification, program participation and similar requirements, for not only individual providers but also types of providers. Furthermore, nothing in Section 1135 suggests the waiver authority does not extend to payment. The contrary suggestion is without merit as it implies the Secretary could waive program participation, but not be empowered to pay for items or services then furnished.

Section 1135 of the Social Security Act empowers the Secretary to waive participation with respect to FECs providing care during this national disaster and to pay dedicated Medicare emergency facility rates to those centers.

A provider's ownership status should not determine whether they are eligible to serve patients during this national crisis, and all resources must be marshaled and brought to bear.

Enclosed with this letter is a matrix to help demonstrate our current capabilities and a variety of options on how FECs can be fully utilized. We would like to discuss these options with you and collaborate how we can assist immediately and in the longer term based on developments on the ground and where resources are needed. Below are the concepts you can find in our matrix.

- **Option 1. Extend CMS emergency care coverage to FECs**
- **Option 2. FECs to offer outpatient services**
- **Option 3. Observations of patients for over 23 hours**
- **Option 4. FECs to offer inpatient or ICU services**
- **Option 5. FECs to be included as COVID-19 testing centers**
- **Option 6. FECs to be a dedicated facility for Hospitals EDs**
- **Option 7. FECs offering Post-Op for emergency surgery patients**

We look forward to working with you to ensure that Medicare and Medicaid beneficiaries are getting the emergency care they need and require during these dire times.

Sincerely,

Brad Shields, Executive Director
National Association of Freestanding Emergency Centers (NAFEC)

CC: Senator John Cornyn and Senator Ted Cruz

Texas House of Representatives Delegation

Snapshot of Conditions that FECs can Evaluate, Stabilize and Treat

Adrenal emergencies	DVT/PE	Pleural disease
Altered mental status	Epilepsy	Pneumonia and pulmonary infections
Airway emergencies	Exposure	Pregnancy and complications
Allergic Reaction	Fever in Adult and ped	Pyelonephritis
Anemia	Fluid and electrolyte disorders	Renal disease and failure
Asthma/COPD	Foreign Bodies	Respiratory illness, mild and severe
Back Pain	GI disease	Sepsis
Bacterial infections	GI infections	Sports injuries
Biliary Disease	GI Bleed	STDs
Cardiac arrhythmias	Headache	Soft-tissue and bone infections
Cancer emergencies	Hyper and Hypoglycemia	Syncope
Cardiovascular disease	Hypertensive Urgency	Thyroid disease
Cellulitis	Kidney Stones	Trauma, all except major
Chest Pain/Myocardial Infarction	Neurologic emergencies	Tachyarrhythmia
Cirrhosis	Neuropathies	Urology and urologic emergencies
CHF	Ob/Gyn emergencies	Vertigo
CNS infections	Ophthalmology	
Closed Head Injury	Pancreatic disease	
Coagulation disorders	Pediatric illness and injury	

Option 1. Extend CMS Emergency Care Coverage to FECs

Proposed Services	Requirement	Regulations Needed
Coverage of services provided to Medicare and Medicaid Patients	-Coordination with EMS -Adherence to EMTALA or state version	Inclusion in 1135 Waiver/Temporary Medicare Billing Number or Amend Social Security Act

Option 2. FECs to offer outpatient services

Proposed Services	Requirement	Regulations Needed
Full Radiology and imaging services including CT, X-ray, and ultrasound. Broad Laboratory and testing services.	FECs would have ability to offer non-emergent care in the facility and use existing equipment without having to utilize health system resources.	State or Federal waivers to allow for non-emergent care at State Licensed FECs Commercial carriers, CMS, Tricare

Option 3. Observations of patients for over 23 hours

Proposed Services	Requirement	Regulations Needed
Extended observation services at FECs to avoid hospital transfer/admission. Hospitals who are in diversion mode will not be able to accept patients. FECs can evaluate, stabilize and treat patients without transferring them to a hospital outside of the county or region.	Patients would be kept under observation at the FECs using current protocols, medication and capabilities. The 23-hour rule would be waived. Coordination with EMS	State or Federal Waiver to permit FECs to keep patients up to 72 hours, without the need to report, similar to CMS regulations Commercial, CMS, Tricare

Option 4. FECs to offer inpatient or ICU services

Proposed Services	Requirement	Regulations Needed
Ability to immediately convert patient rooms into inpatient and ICU rooms. Utilizing up to 2000 FEC beds. Budgets for major hospital construction allocate between $1,000,000 and $1.5 million per inpatient bed planned. A full-scale hospital can cost $500-800M. If you look at just the cost to build major hospitals, FECs' already existing capabilities add an inpatient construction savings of $1.5 billion overnight. Not to mention the ability to perform hundreds of thousands of lab tests every day. FECs smaller size makes them the perfect "pod" in which to treat patients in smaller groups and minimize spread to others.	FECs have flexibility to convert rooms for ICU purposes. FECs currently have mobile ventilators often used by EMS. FECs have ventilator capacity for up to 20% of their beds. Hospitals typically have ventilator capacity for only 10% of their beds. FEC would need assistance with staffing capabilities, respiratory therapists. FECs don't currently store blood products may need additional IV pumps. FECs facilitate specialty and surgical consultants. Coordination with EMS	State/Federal Waivers for inpatient designation. Commercial plans, CMS, Tricare

Option 5. FECs to be included as COVID-19 testing centers

Proposed Services	Requirement	Regulations Needed
FECs are strategically located to provide regional testing services. Convenient parking as well as drive-through resources are available.	Need testing kits and/or direct involvement with public/private labs	State/Federal Waivers for coverage Commercial plans, CMS, Tricare

Option 6. FECs to be a dedicated facility for Hospital EDs

Proposed Services	Requirement	Regulations Needed
FECs to help unburden Hospital ERs. FECs focus on emergency services that are not immediately life-threatening while hospital ERs could be dedicated to higher acuity patient needs	A small percentage of FECs may need additional staff. Coordination with EMS	TBD State/Federal Waivers for coverage Commercial plans, CMS, Tricare

Option 7. FECs to offer post-op care for emergency surgery patients

Proposed Services	Requirement	Regulations Needed
FECs to receive Hospital post-op patients who are recovering from emergency surgery. Patients receiving post-op care in a FEC would allow Hospitals to maximize their beds for new emergent cases, inpatient care or additional emergency surgeries.	Coordination with EMS	TBD State/Federal Waivers for coverage Commercial plans, CMS, Tricare