The Affordable Care Act and Emergency Care

The Affordable Care Act (ACA) will have far-reaching effects on the way health care is designed and delivered. Several elements of the ACA will directly affect both demand for ED care and expectations for its role in providing coordinated care. Hospitals will need to employ strategies to reduce ED crowding as the ACA expands insurance coverage. Discussions between EDs and primary care physicians about their respective roles providing acute unscheduled care would promote the goals of the ACA. (*Am J Public Health.* 2014;104: e8–e10. doi:10.2105/AJPH.2014.302052)

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THE AFFORDABLE CARE ACT

(ACA) focuses on improving access and quality by expanding insurance coverage, using payment reform strategies, and increasing quality reporting.[1] In the ACA, hospital-based emergency departments (EDs) are referenced as places to be avoided and reduced; no new payment models focus on ED care, and there are no plans to broadly address ED-specific quality through new measurement programs.

Promoting value in ED care needs to be a greater focus for policymakers as the ACA is implemented. Emergency departments play a central role in health care delivery as the staging area for the ill and injured, and as an always-available resource for unscheduled care. Emergency department physicians constitute less than 5% of the US physician workforce, yet manage 28% of acute care encounters.[2] Historically, the need for EDs arose from increases in vehicular trauma that accompanied the expansion of the Interstate Highway System in the 1960s.[3] However, EDs also quickly became providers of low acuity unscheduled care as well.[4] The Emergency Medical Treatment and Active Labor Act legislation passed in 1986 institutionalized EDs as provider of last resort for all, regardless of their ability to pay. Emergency departments have replaced the community physician's office as the primary source for hospital admissions and provide a safety net for the uninsured, underinsured, and medically disenfranchised.[5,6]

Several elements of the ACA—the insurance expansion, patient-centered medical homes, accountable care organizations, and bundled payments—will directly affect both demand for ED care and expectations for its role in providing coordinated care. We explore these effects and suggest some practical ways that EDs can be better integrated into these efforts.

THE WAVE OF NEWLY INSURED

As broad populations within the United States gain health insurance through the ACA, emergency department volumes will be affected. Forecasting future demands is challenging; however, data from similar insurance expansions provide some clues. Studies after Massachusetts' expansion showed ED visits increased at similar rates as neighboring states.[7–9] However, a National Health Interview Study report found ED use was higher among the newly insured compared with the continuously insured.[10] One of the largest groups gaining insurance status after ACA is newly eligible Medicaid beneficiaries. In an analysis of Oregon's Medicaid expansion lottery, there was a 40% increase in ED use in this population relative to those who remained uninsured.[11] However, the effect of insurance expansion will vary state-to-state depending upon whether the Medicaid expansion occurs and how local insurance markets handle the existing and newly insured. In states where large numbers move into high-deductible "bronze" plans, it is likely that ED visits will be less affected, while those with large increases in Medicaid patients will experience larger increases.

Looking backward, prereform national ED visit growth outpaced population growth. In 1995 there were 37 visits per 100 persons; by 2010, this number grew to 43 per 100.[2] Growth was fueled by a fee-for-service payment system that underpaid primary care physicians in favor of EDs, hospitals, and specialists. Over the same period, the intensity of ED care grew, as did expectations for diagnostic perfection.[12] The result is an ED system that in many parts of the nation cannot handle demands, resulting in congested waiting rooms and long delays for admitted patients.[12,13] However, a growing number of hospitals have mitigated crowding and improved flow by redesigning ED intake processes and increasing hospital efficiency.[14–18] As the ACA drives additional patients into EDs in many communities through insurance expansion, hospitals will need to employ the strategies proven to reduce crowding. In addition, further scrutiny may be placed on hospitals to reduce crowding through public reporting of ED throughput measures and inclusion of ED metrics, such as patient experience survey data, in hospital reimbursement calculations.

INCREASED HEALTH CARE INTEGRATION

The ACA will change payment methods and provide incentives to

entities such as accountable care organizations to make health care more efficient. Part of this efficiency will be gained through expanded access to patient-centered medical homes, which provide more integrated care and more timely access to providers. In some areas, these medical homes may reduce ED volumes, particularly for low-acuity cases.[5,19] Historically, patients have been commonly directed to the ED; one study found 82% of patients who called their physician before going to the ED were actually instructed to go to the ED.[5] Many patients with regular sources of care have reported using the ED because of lack of timely access.[5,20] Medical homes aim to reduce these referrals through better access; however, EDs will likely continue to provide care for high- and moderate-acuity patients, and play a large role in off-hours care and in communities where the medical home concept is less embraced or effective.

As the outpatient system evolves to take a more active part in acute care, EDs can support and even drive care coordination by engaging with community providers to improve the flow of patients through the continuum of care.[21] Community level discussions between EDs and primary care providers about their respective roles providing acute unscheduled care could lead to national discussions about standard setting and best practice development, which would significantly advance the goals of the ACA.[21,22]

A CONNECTED RAPID DIAGNOSTIC CENTER

The core competence of EDs is the ability to serve as a rapid diagnostic center with 24–7 access to high technology care and specialists.[23] This capacity can play a key supporting role for the medical home, particularly for populations with high-acuity illness. New payment models will also require EDs to play a greater role in care coordination, particularly for patients who do not require hospitalization. These expanded services will likely require expanded ED capacity and an expansion of units, such as clinical decision units.[24] Many EDs are also expanding social-work and case-management intervention programs for high-cost users; some of these programs have been successful in lowering hospital costs and improving outcomes.[25,26] There will be greater focus on hospital admission decisions themselves, which has historically been a process disconnected from outpatient primary care systems and community resources. Finding alternatives to hospital admissions by EDs may be one way of achieving significant cost savings.[27] Just one such alternative, widely used in Europe but facing payment challenges in the United States, is "Hospital at Home." This disruptive innovation, where home-based acute care substitutes for the traditional inpatient admission, has been shown to be well received by patients, effective, and less costly than comparable inpatient admissions.[28–31] Other innovations, such as post-ED follow-up clinics where patients are guaranteed access and ED call-back programs, may also extend the role of the ED beyond a single visit and provide an alternative to admission for some patients. Forward-thinking delivery organizations are already engaging their EDs to improve the efficiency of admission decisions. Payment reform based on episodes of illness and bundled payments may accelerate the development of these programs, as well as the alignment of hospital-based and non–hospital-based providers.

The ACA will have far-reaching effects on the way health care is designed and delivered. EDs are multifunctional units that can deliver great value at the interface between ambulatory and inpatient care. EDs have the potential to be at the center of many of these changes, but system-level engagement is needed to connect EDs with the wider outpatient care system and help the nation move to an integrated delivery across settings. ■

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Human Participant Protection

This article does not report data from human participants; therefore, no ethical approval was sought.

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