

Policy Implications of Freestanding Emergency Departments

Statement of
Mouhcine Guettabi, PhD, Assistant Professor of Economics
Rosyland Frazier, MSPH, Senior Research Associate

Institute of Social and Economic Research
College of Business and Public Policy
University of Alaska Anchorage
3211 Providence Drive
Anchorage, Alaska 99508

Public Comments for Certificate of Need,
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For more information please contact: Mouhcine Guettabi, email: mguettabi@alaska.edu,
phone: 907-786-5496 or Rosyland Frazier, email: rrfrazier@alaska.edu, phone: 907-786-5432.

Thank you, Alexandria Hicks, certificate of need coordinator, Office of Rate Review, for the opportunity to submit comments about the Certificate of Need applications for emergency room expansion for the Anchorage area. My name is Mouhcine Guettabi, and I am an assistant professor of economics and researcher at the Institute of Social and Economic Research (ISER) at the University of Alaska Anchorage. My colleague Rosyland Frazier is a senior research professional at ISER.

Providence Alaska Medical Center contracted with us to assess the policy implications of introducing freestanding emergency departments into a community. Our assessment is based entirely on a review of publicly available information on freestanding emergency departments in other states. Although Providence funded this research, it has neither influenced nor approved our findings. ISER researchers have been doing non-partisan public policy research in Alaska for more than half a century. You can find out more about ISER at our website, www.iser.uaa.alaska.edu.

IMPLICATIONS OF ALLOWING FREESTANDING EMERGENCY DEPARTMENTS IN ALASKA

Policymakers have a responsibility to look at both the short- and long-term implications of their decisions. The state's current fiscal situation, coupled with rising health-care costs makes "budget neutrality" highly desirable in decision-making.

In spite of efforts to bend the cost curve, health expenditures have grown inexorably in Alaska. As of 2009 our health expenditures per capita were the second highest in the nation. This means that the state spends a larger portion of its budget on health costs, employers allocate more of employees' compensation to health premiums, and households spend more of their disposable income on out-of-pocket costs, premiums, and co-pays.

The evidence we provide in this analysis consistently shows that freestanding emergency departments charge higher prices for services that are available for considerably less in traditional settings. Allowing freestanding emergency departments to enter the Alaska market goes against the many efforts being undertaken to contain health-care costs. Market forces explain a significant portion of the high health-care prices charged in Alaska, but in this case the state has an opportunity to use its regulatory authority to help prevent even higher prices in the future.

Putting costs aside, in considering emergency services one needs to rationalize the hospital and clinical capacity across a region and the needs of the population. In the Alaska health-care system there are problems with coordinating the delivery of care. Freestanding emergency departments pose the risk of exacerbating that lack of coordination, if people use them in lieu of seeing their primary physicians—which can disrupt the continuum of care and potentially hurt outcomes for patients.

WHAT ARE FREESTANDING EMERGENCY DEPARTMENTS?

Freestanding emergency departments are structurally separate from hospitals. They may be operated by hospitals or by separate legal entities (like a group of doctors, or business people who aren't doctors). They offer a higher level of care than urgent-care clinics, and are typically staffed by doctors who are board-certified in emergency medicine.

More than 90% of these freestanding departments nationwide are open 24 hours per day. They can handle some life-threatening emergencies, but patients who need to be hospitalized or require the highest levels of cardiac or other intensive care or surgery have to go to hospital emergency rooms. Analysts have found that most of the patients at freestanding departments are walk-ins who are less likely to be critically ill or injured (California HealthCare Foundation, 2009).

There are currently no emergency departments operating outside traditional hospital settings in Alaska. The first freestanding emergency departments in the U.S. were opened in the 1970s, and in the past five years or so a few states have seen fast growth in their numbers. In 2008, an estimated 222 were operating in 16 states. About 85% were affiliated with hospitals (California HealthCare Foundation, 2009). Table 1 on page 5 provides more details.

HOW ARE FREESTANDING EMERGENCY DEPARTMENTS REGULATED?

- *Freestanding emergency departments that are affiliated with hospitals and accept patients with government health insurance (Medicare, Medicaid, or Tricare) have to provide emergency medical treatment to all patients, regardless of ability to pay. That's a requirement of the federal Emergency Medical Treatment and Active Labor Act (Ayers, 2012).*
- *Freestanding departments not affiliated with hospitals can choose not to accept government health insurance and therefore don't have to meet the federal requirement (Ayers, 2012). That means an independently owned emergency facility could turn away patients with government health insurance. Analysts have found that hospital emergency rooms nationwide are profitable because of privately insured patients, who account for 35% of emergency room visits but approximately 54% of revenue. Other payer groups cost the emergency departments money (Abaris Group, 2015).*
- *Alaska's state government licenses and regulates health facilities, but since there are currently no freestanding emergency departments in the state, the standards for emergency services don't talk about them (Alaska Department of Health and Social Services). There are several ways the state could regulate freestanding emergency departments. It could: (1) allow them to operate under the same license as parent hospitals; (2) officially define freestanding departments and their licensing requirements, similar to the way regulations for Frontier Extended Stay Clinics have been established (Report to Congress, 2014); (3) indirectly affect their development, through strict definition of terms such as "emergency department," or through construction requirements (California HealthCare Foundation, 2009); (4) not establish any criteria, as Texas has done. Texas's lack of regulation has led to rapid growth in the construction of freestanding emergency departments (California HealthCare Foundation, 2009).*

WHY OPEN A FREESTANDING EMERGENCY DEPARTMENT?

- *For owners of hospitals, it's less expensive per square foot to build a freestanding emergency department than to build an emergency department in a hospital* (New York State Department of Health, 2013). Construction costs per square foot for hospital emergency departments are higher because they have to be constructed and equipped to handle the highest levels of emergency care.
- *Freestanding departments that comply with federal regulations can bill as dedicated emergency departments, which are reimbursed at higher rates than outpatient or urgent-care facilities.* Under the Centers for Medicare and Medicaid Services (CMS) billing for Type A dedicated emergency departments and urgent care centers, dedicated emergency departments are reimbursed between 25% and 100% more per visit than outpatient clinics. This reimbursement differential does not include additional procedural or other miscellaneous charges (California HealthCare Foundation, 2009). See Table 2 on page 6 for details of cost comparisons.
- *Insurance pays freestanding emergency departments the same as it does standard hospital emergency departments, including co-pays, separate facility, and professional fees charged* (Ayers and Nawalaniec, 2013). Hospitals have historically charged a facility fee to cover the higher overhead costs inherent in being prepared to handle any situation (including 24-hour staffing, administration, and equipment), serving chronically ill patients, and subsidizing charity and indigent care for uninsured patients (Galewitz, 2013).
- *As of 2013, the owner of Alaska Regional Hospital, Health Corporation of America, was operating at least seven freestanding emergency departments nationwide, according to Kaiser Health News, which reported that the corporation sees these freestanding facilities as “a way to expand into new markets, generate admissions to their hospitals, and reduce crowding at their hospital-based ERs”* (Galewitz, 2013).

HOW MIGHT FREESTANDING DEPARTMENTS AFFECT HEALTH-CARE COSTS?

A number of analysts have found that freestanding emergency departments could potentially increase costs of health care, for several reasons.

- *Analysts in New York report that many patients at freestanding emergency departments are walk-ins who are less acutely ill or injured and who might otherwise have been seen by primary-care physicians or urgent-care clinics at significantly lower cost* (California HealthCare Foundation, 2009). As noted above, freestanding emergency departments are paid at significantly higher rates than doctor's offices or urgent-care clinics.
- *Insurers have little power to stop patients from using emergency facilities because by state law, they must pay for emergency-room coverage any time patients believe they have an emergency, regardless of whether that turns out to be the case.* Analysts say that insured patients have little incentive to drive past the more expensive emergency departments—whether standard or freestanding—because their co-payment may be only \$50 or \$100, just modestly more than what it might be for a visit to an urgent-care center or a doctor's office. So a number of patients use emergency departments for routine care that could be provided in less costly settings (Galewitz, 2013).

- *Independently owned freestanding emergency departments can potentially “balance bill” patients, for amounts over what insurance companies will pay.* Most hospital-affiliated freestanding emergency departments contract with insurers as in-network facilities, which means the facilities agree to accept specific payment levels. But because insurers are required to pay for emergency care, independently owned emergency departments can choose not to contract with insurance companies and bill the insurers at higher out-of-network rates—and then bill patients for the balance (Ayers and Nawalaniec, 2013).

- *Insurers may charge patients a separate fee for transportation to a hospital, depending on billing requirements, licensing arrangements, and transfer agreements between facilities.* If freestanding emergency departments receive a patient via emergency transport and then determine the patient needs a higher level of care and must be transferred to a hospital, there is the possibility that the patient will be charged for two emergency transports for one event—resulting in higher costs for patients (Ayers and Nawalaniec, 2013; Galewitz, 2013).

Perhaps the most important policy consideration is that freestanding emergency departments could potentially increase the systemic costs of health care in Alaska.

WHAT ARE POTENTIAL BENEFITS AND DISADVANTAGES OF FREESTANDING DEPARTMENTS?

Aside from cost considerations, freestanding emergency departments offer potential benefits and disadvantages for patients.

- *Freestanding emergency departments can make emergency care more readily accessible.* The risk is that ease of access to facilities near home may encourage more people who could use lower-cost alternatives to instead use the more convenient but also more expensive emergency facilities (Cunningham, 2011).

- *Freestanding departments can relieve overcrowding and shorten waiting times from those in hospital-based departments.* On the other hand, they are not equipped to handle all trauma care, and patients who require hospital admission and, in some instances, surgery or specialist care, must be transferred to hospitals—which could delay care (New York State Department of Health, 2013).

- *Freestanding departments can potentially get critically ill patients into hospitals faster, if they have agreements with more than one hospital.* But there is a risk to patients, if it takes longer for the freestanding facility to get authorization for a patient to be admitted to a hospital (California HealthCare Foundation, 2009).

An important policy consideration is that patients simply may not understand the cost difference between freestanding emergency departments and urgent-care clinics. If freestanding emergency departments open in Alaska, they will be a new part of an already complex and often fragmented health-care system. The State of Alaska will need to raise awareness and educate patients, to help them understand the difference in types of health-care facilities—and choose the type of facility they need.

DETAILED TABLES

Table 1. Characteristics of Freestanding Emergency Departments, 2008

Characteristics	Description
Hospital-affiliated freestanding emergency departments. Most were associated with regional hospitals or large health-care organizations.	Approximate 191 (86.0%)
Owned and managed by physicians or other private groups – mostly in Texas	Approximate 31 (14.0%)
Average Size	Approximately 14,000 sq. ft.
Staff	Emergency MDs, PAs, NPs, RNs
Hours of Operation	Approximately 91% are open 24/7
Services Offered	Urgent/emergency care, lab, x-ray, CT
The Joint Commission Accreditation	Hospital - 174; Ambulatory Care -24
Regulation**	Centers for Medicare and Medicaid Services (CMS) ⁱ , Emergency Medical Treatment and Labor Act (EMTALA), State licensing
Billing***	Type A/B dedicated emergency department or outpatient clinic

*Due to the lack of data on freestanding departments, most numbers are estimated.

** Some freestanding departments are not Medicare or Medicaid providers and are not restricted by the Emergency Medical Treatment and Active Labor Act (EMTALA)

***DED: Dedicated Emergency Department, as defined by Centers for Medicare and Medicaid Services (CMS)

Source: California HealthCare Foundation, 2009. *Freestanding Emergency Departments: Do They Have a Role in California?*

Table 2. Differences Between Urgent-Care Providers and Freestanding Emergency Departments Nationwide

Characteristic	Urgent Care (Ayers A. A., February) (New York State Department of Health, 2013)	Freestanding Emergency Department (New York State Department of Health, 2013) (Ayers A. A., February)	Data from Providence and Alaska Regional Hospital Certificate of Need Applications
Net Revenue per Patient	\$105 to \$135	\$350 to \$500	
Average Patient Revenue per patient Day last 5 years actual – 2009 to 2013			<p>Providence Emergency Dept. Revenue per Patient Day 2009 – \$591 2010 – \$898 2011 – \$945 2012 – \$1,153 1013 – \$1,175 (Providence Emergency Department Expansion Certificate of Need Application October 2014)</p> <p>Alaska Regional Hospital Revenue per Patient Day 2009 – \$8,014 2010 – \$8,426 2011 – \$9,082 2012 – \$9,031 1013 – \$8,567 (Alaska Regional Hospital Certificate of Need Application Proposing the Establishment of Two Freestanding Emergency Departments December 2014)</p>
Co-Pay Charged	Typically \$35 to \$50	Typically \$75 to \$100	
Facility Fee Charged	Typically no facility fee is charged, except in certain instances in which the center is part of a hospital complex. Typically one invoice for all services on site.	A facility fee is charged in addition to a professional fee for the providers. Patient is often billed separately by the facility and physician group.	

Characteristic	Urgent Care (Ayers A. A., February) (New York State Department of Health, 2013)	Freestanding Emergency Department (New York State Department of Health, 2013) (Ayers A. A., February)	Hospital Emergency Departments
Cases Treated – Number and Acuity	Typically low- to-moderate acuity, with the bulk of patients presenting with minor infections, flu symptoms, allergies, rash, lacerations, sprains/strains, and fractures. Ambulatory patients.	Typically non-emergent with greater emphasis on musculoskeletal injury and lacerations. Patients’ self-triage for acutely rising conditions including high fever, automobile accidents, and asthma attack. Ambulatory patients. FSED can break even at 35-40 patients per day (Ayers A. A., February)	Higher acuity at hospital EDs due to trauma center certification, surgical and intensive care capabilities, and ambulance diversion and transfer. (Ayers A. A., February) Average metropolitan hospital ED sees 100-150 patients per day (Ayers A. A., February)
Operating Hours	Typically 10-12 hours a day, seven days a week.	Most are open 24-hours a day, 365 days a year although some privately held centers may operate 10-12 hours/day, seven days a week.	
Square Footage	Typically 2,500 to 4,500 sq. ft.	5,000 to 20,000 sq. ft. depending on whether the center is independent or hospital-affiliated.	Providence ED current 21,551 sq. ft. to 24,279 sq. ft. (Providence Emergency Department Expansion Certificate of Need Application October 2014)
Provider Staffing	May be any combination of physicians, physician assistants, or nurse practitioners supported by medical assistants and technicians.	Emergency medicine physician on staff during all operating hours typically supported by an emergency medicine nurse. Ancillaries like lab and imaging supported by cross-trained technicians.	
Provider Specialty	Typically family practice or emergency medicine with representation from internal medicine, pediatrics and other specialties. May or may not be certified by an ABMS-recognized board.	Typically board-certified in emergency medicine.	
Receipt of Patients via Ambulance or EMS Transport (Ayers A. A., February)	EMS does not serve	Typically EMS or Ambulance does not service	16% of all hospital emergency department patients arrive via ambulance
Capital costs and institutional commitment (Carrier, 2012)		Lower for FSED vs hospital much lower than the costs of building a hospital because operating rooms and inpatient areas are not needed in a freestanding facility. (Carrier, 2012)	

Characteristic	Urgent Care (Ayers A. A., February) (New York State Department of Health, 2013)	Freestanding Emergency Department (New York State Department of Health, 2013) (Ayers A. A., February)	Hospital Emergency Departments
Hospital Admission		<p>If a patient in a freestanding emergency department requires hospital admission or emergent evaluation by a specialist, the patient must be transferred to a full-service hospital. (Carrier, 2012)</p> <p>Average hospital admission rate 3%-5%. (California HealthCare Foundation, 2009) (Ayers A. A., February)</p>	<p>Average hospital admission rate of 12.8% (California HealthCare Foundation, 2009)</p> <p>15-20% in hospital EDs (Ayers A. A., February)</p>
Patient Transfer to a Higher Level of Care		Freestanding emergency departments that are part of larger systems can provide stabilizing care and then transfer patients safely to their own affiliated hospitals, even if a competitor's hospital is closer. In this way, freestanding emergency departments can effectively siphon off the emergent care business as well as inpatient admissions from a nearby competitor. (Carrier, 2012)	
Length of Stay – Throughput – Amount of time from door to door to door to discharge a patient spends in a facility		<p>Estimated Door to Door time 30 minutes. (California HealthCare Foundation, 2009)</p> <p>Door to discharge times of less than 90 minutes. (California HealthCare Foundation, 2009)</p>	<p>Estimated Door to Door time 55.8 minutes</p> <p>Door to Discharge [Door] time 180 minutes (California HealthCare Foundation, 2009)</p>
Patients Leave without being seen – register & leave before being treated			Providence 2011 to 2013 average 1,713 patients – primarily due to long waits and overcrowding. (Providence Emergency Department Expansion Certificate of Need Application October 2014)

Sources: Reproduction from the Urgent Care Association, A. Ayers, 2012. *Emerging Business Models: Freestanding Emergency Departments*; New York State Department of Health, 2013. Retrieved April 22, 2015, from www.health.ny.gov/.../meetings/2013-09-13/docs/feds_background.pdf; Providence Alaska Medical Center and Alaska Regional Hospital, Anchorage Certificate of Need Applications

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