

Thinking Outside the Hospital Box: Freestanding Emergency Facilities

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Introduction and Background

There is a subtle, yet increasingly noticeable trend in the delivery of emergency care. In the past several years there has been substantial growth in the use of freestanding emergency rooms. This provision of emergency care outside the four walls of a hospital represents an opportunity not only for hospitals but for other providers as well.

The number of freestanding emergency rooms (FERs) has grown significantly in the past decade. It should be noted that the freestanding emergency room concept is not new. These facilities have existed since the early 1970's when they were used as a means of extending emergency care to rural and other underserved areas. Recent growth has been prompted by the increased demand for emergency care at the same time that hospitals are cutting back on emergency departments, down 27% from 1990 to 2009 in non-rural areas according to *The Journal of the American Medical Association*. This helps explain the growth of FERs as they allow extended geographic coverage of emergency services without the need to build an entire hospital at each location.

Regulation of Freestanding ERs

In the strictest sense of the word, a FER is merely a location providing emergency services outside the four walls of a hospital. However, there is no single definition for freestanding emergency rooms (FERs), and there are different requirements as well as different names for FERs depending on which state they are located in.

FERs vary widely in character. The main distinction among FERs is whether the facility is organizationally part of a hospital (an off-site location) or an independent health care facility. This distinction has significant implications from a legal and reimbursement perspective. Irrespective of who runs a FER, however, the facility should offer essentially all of the capabilities of an ER located within a hospital. It is understood that there will be a need to admit patients to a hospital in some instances, but this should not be affected by whether the FER is organizationally part of a hospital.

The FER is not a separate facility type recognized by Medicare. If it is part of a hospital it will be reimbursed as such and receive a facility fee. If it is not, the facility itself would not receive payment - only physician services under Part B would be reimbursed. Likewise, if the FER is not organized as the off-site location of a hospital, then the Emergency Medical Treatment and Labor Act (EMTALA) will not apply. This law requires Medicare-certified *hospitals* to treat anyone needing emergency care or in labor, at least in order to stabilize and transfer to a more appropriate facility. Non-hospital FERs are neither hospitals, nor are they Medicare certified. As a practical matter, however, most will at least stabilize anyone requiring treatment.

Some states have a specific licensure category for FERs, but these vary so widely that a viable FER business model in one state could be wholly useless in another. Some states do not allow FERs at all, requiring any emergency medical care to be delivered within the four walls of a hospital. Further complicating this is the fact that many states have not really decided how they would license such facilities, if at all. Therefore, the particular business model under which a FER operates is largely determined by state law.

Reimbursement

The legal framework under which FERs operate speaks directly to what is probably the most important factor in the viability of this care model – **reimbursement**. It is essential for FERs that they receive a facility fee from payers, whether governmental or private. This seldom presents an issue when the FER is an off-site location of a hospital, as payers will recognize care provided there as hospital services. It is more problematic when the FER is not part of a hospital, even when it provides precisely the same service at precisely the same standard.

When a FER is not part of a hospital, patients and payers do not always have a firm grasp of precisely what the facility is supposed to be. For some, the terms “emergency room” and “hospital” go hand in hand. When FERs that are not part of a hospital charge a facility fee, this can, in some cases, incur greater charges or out-of-pocket costs than what the patient expected or what an insurer is willing to pay.

It should also be noted that payment for emergency services has undergone some very important changes. Under the Affordable Care Act, insurance plans cannot require higher copayments or coinsurance for emergency services provided at an out-of-network hospital. Furthermore, insurers can no longer require patients to get prior approval before getting emergency room services from a provider or hospital outside their plan’s network. It should be noted that most states have very broad restrictions against “prior authorization” as well. The Affordable Care Act also defines emergency care as an “essential health benefit” required to be included in individual and small group health plans.

Another, potentially important change to reimbursement for emergency services is CMS’ proposed modification to the Outpatient Prospective Payment System (OPPS). The proposed rule would modify CMS’ longstanding policies related to hospital outpatient clinic and ED visits. Specifically, it wishes to create three new codes: one for clinics, one for Type A Emergency Departments (open 24 hours), and one for Type B Emergency Departments (not open 24 hours).

This would replace the current structure which uses five levels of billing for emergency services based on the intensity of services. The goal of this proposed change is to address the practice of upcoding, in which hospitals code services at a higher level of intensity than they deserve. It is anticipated that this rule change will affect different emergency rooms in different ways, depending on the acuity of patients they tend to treat.

Emergency room reimbursement is likely to undergo a number of other important changes with the expansion of health insurance. The expansion of Medicaid is anticipated to significantly increase ER utilization as these patients often use ERs for lack of any alternatives. It is less clear what role the health insurance exchanges will play. Theoretically, insurance provided

through the exchanges, in conjunction with the expansion of Medicaid, should reduce the amount of uncompensated care an ER provides, but it remains to be seen precisely how this will unfold.

Concerns about the FER Model

The FER model is not, per se, controversial. Some states require emergency services to be provided within the four walls of a hospital, but most recognize the efficacy and usefulness of facilities that provide emergency services even if not located in a hospital. Indeed, many non-hospital organizations are entering the FER market because it offers significant business opportunities. Herein lies the source of controversy.

Some hospitals object that these non-hospital ERs siphon off the patients with the best insurance reimbursement. These hospitals, as well as insurers, further argue that many non-hospital ERs act as glorified urgent care centers and merely call themselves ERs in order to charge for the facility fee.

The problem with these arguments is that the non-hospital ERs can and do offer essentially all of the same services as their hospital-owned counterparts. Indeed, there is considerably more capability, for example CT scanners, than one would find in a typical physician's office. In some cases, patients will have to be transported for admission to a hospital, but this is a function of the facility being freestanding and has nothing to do with the structure of ownership. Likewise, the types of cases and conditions presenting at the ER will be the same, irrespective of whether it is under a hospital's license or not. Many of these patients could be treated at urgent care centers, but this is true of all ERs and is most certainly not particular to those operating independently of hospitals.

Still, non-hospital FERs should be careful to ensure that they are truly acting as ERs rather than physician offices or urgent care centers. This will help avoid compliance issues with licensure authorities and payment issues with insurers. Aetna, the nation's third-largest private Medicare insurer, has sued several FERs, claiming that they wrongfully submitted for facility fees. It alleged that the facilities, which were not licensed as FERs, were operating essentially as urgent care clinics. It must be reiterated, however, that this was an atypical situation and that independent FERs can and do offer all the capabilities of their hospital-owned counterparts, including being open 24 hours a day.

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