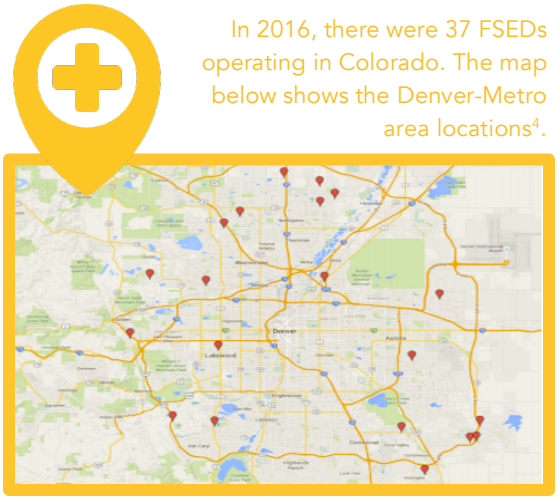
Freestanding Emergency Departments

aka... FSEDs

The Problem. Freestanding emergency departments (FSEDs) have proliferated across Colorado's Front Range in recent years, where traditional emergency departments are plentiful. Unlike traditional hospital emergency departments, FSEDs are physically separate from hospital buildings. While they can provide some emergency medical care, FSEDs sometimes do not provide services for critical conditions such as trauma, stroke, and heart attacks, and most do not receive ambulances or have an operating room on site[1]. In Colorado, FSEDs are licensed as 'community clinics and emergency centers' (CCECs). The CCEC license was originally developed to serve rural and underserved areas in Colorado that could otherwise not afford to develop inpatient hospitals. Instead, FSEDs have exploded in urban and suburban areas, and have not grown in rural areas[2]. Evidence indicates that FSEDs disproportionately serve relatively affluent communities and those that have access to other providers, rather than increasing access to emergency services for underserved communities[2,3].

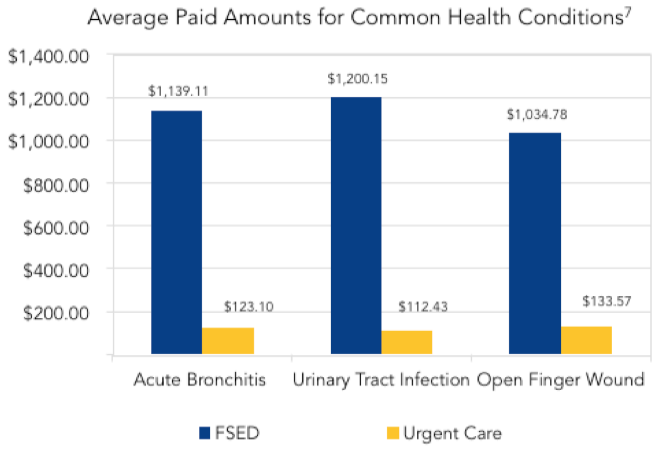
In 2016, there were 37 FSEDs operating in Colorado. The map below shows the Denver-Metro area locations[4].



The Impact. What does this mean for health care consumers?

- **Consumers confuse FSEDs with urgent care facilities** that offer less expensive care for many illnesses that do not require emergency care. For example, at one **FSED** in 2014, the amount paid for an open finger wound was **$1,034 compared to $133.57** at an **urgent care facility**[7].
- The **need for emergency care in rural areas is not being addressed**, as FSEDs are located largely in populated, urban, and suburban areas where they are more profitable.
- Consumers may incur **costly and unnecessary charges,** often times related to facility fees. Facility fees are generally charged by hospitals to cover operational expenses, separate from professional fees or charges for health care services (MRI's, medications, etc.)

The Numbers. Colorado has the **3rd highest** number of FSEDs in the country, with a total of **37 separate locations in 2016**[3,4]. Based on limited available data, between 2015 and 2016 the Colorado Department of Public Health and Environment found that **over 75% of transfers from CCECs** (which include FSEDs) **took more than 2 hours,** and at least **38%** of the **urban transfers bypassed** the **closest** appropriate trauma center[2]. Facility fees at FSEDs can reach more than $6,000, even for non-emergent courses of treatment[5]. Furthermore, data from the All Payers Claims Database shows that **7 of the top 10 reasons** for FSED visits were for **non-life threatening events**, including the common cold, sore throat, and sprained ankle[4]. In Texas, United Health Group found that the average cost of treating strep throat at FSEDs is **21 times higher than at a physician office**, and **17 times higher than at an urgent care center**[6]. In Colorado, most FSEDs are owned by or affiliated with hospitals, which makes it difficult to collect cost data because the claims are billed under the same health system, rather than by individual locations.



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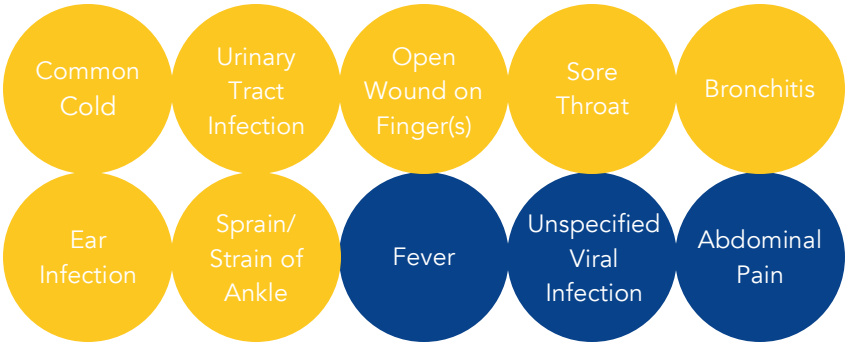

> *I searched for "Urgent Care" on Yelp and this facility is the first place that appeared because they are using those keywords to place ads. Let's be clear—this IS NOT AN URGENT CARE. DO NOT COME HERE UNLESS YOU HAVE A LIFE THREATENING INJURY. It is an ER (even though it is not attached to a hospital), and there is a big difference.* ***The bill will prove that to you.***
>
> *—FSED consumer on Yelp*

The Landscape. At the end of 2015, there were 32 states that had FSEDs, with the highest numbers found in Texas, Ohio, and Colorado. California is the only state that has (indirectly) barred FSEDs through hospital regulations, requiring all health facilities providing emergency medicine to have comprehensive medical services like radiology, laboratory, and surgical services. Additionally, 4 states have regulations for FSEDs but do not have any yet, and 24 states require a Certificate of Need (CON) before an FSED can be opened[8]. Evidence indicates that states with CON requirements that apply to FSEDs have fewer FSEDS per capita than states without[8]. Other state efforts that address issues with FSEDs include increased transparency about FSED charges and insurance network coverage. For example, in 2015, Texas passed SB-425 requiring FSEDs to be more transparent about FSED practices[10]. The bill requires FSEDs to provide notice to patients (1) that the facility is a freestanding emergency medical care facility, (2) that the facility charges rates comparable to a hospital emergency room and may charge a facility fee, (3) that doctors at the facility may be out-of-network with insurance companies, and (4) that the doctor may bill separately from the FSED for some services. This information must be posted at the primary entrance to the facility, in each treatment room, at each location within the facility at which a person can pay for services, and on each facility's website.

When FSEDs bill under the same National Provider Identifier (NPI) as an affiliated hospital, they are recognized by Medicare as an emergency department. In contrast, Medicare does not recognize independently owned and operated FSEDs as emergency departments. While providers at an independent FSED may still get paid by Medicare for a 'general office visit', **patients may get left with the remainder of the charges, including the facility fee[8]**. Additionally, independent FSEDs are not bound by EMTALA and have no *federal* obligation to provide care to all patients, although Colorado "look-a-like" rules do provide for patients needing emergency services to receive a medical screening before the facility may inquire about payment or insurance[9].

The Solution. CCHI supports policies that:

1) Hold all emergency rooms accountable to the **same standards**. This may include creating a new license type for FSEDs, distinct from CCECs.
2) **Increase transparency** of the costs associated with receiving care at an FSED, including the facility fees incurred.
3) Establish policies and procedures at FSEDs that ensure all consumers get the **appropriate care at the appropriate price.**
4) Work to **ensure appropriate claims data is collected** in order to track and analyze costs associated with FSEDs.

1 http://www.unitedhealthgroup.com/~/media/UHG/PDF/2017/Freestanding-ER-Cost-Analysis.ashx?la=en

2 https://www.colorado.gov/pacific/sites/default/files/CCECs_Final_091316.pdf

3 https://www.ncbi.nlm.nih.gov/pubmed/27421814

4 http://www.civhc.org/getmedia/7c90a844-ae3f-4566-bd0a-953c02f8309b/Spot-Analysis-FSED-July-2016.pdf.aspx/

5 CCHI analysis, 2017.

6 http://www.unitedhealthgroup.com/~/media/UHG/PDF/2017/Freestanding-ER-Common-Conditions-Emergency-Prices.ashx?la=en

7 Average paid amounts based on claims data from the Colorado All Payer Claims Database in 2014 from one FSED and all common health conditions are considered non-life threatening by the National Institutes of Health guidelines for emergency care; http://www.civhc.org/getmedia/7799d663-953b-43a8-83a1-6813d5505ab3/averagepaidamounts.PNG.aspx/

8 https://www.colorado.gov/pacific/sites/default/files/Health%20Aff-2016-Gutierrez-1857-66.pdf

9 2017 6 CCR 1011-1 Chapter 9 18.102(2)(c)

10 https://legiscan.com/TX/text/SB425/id/1231572