

CHAPTER

8

**Stand-alone
emergency departments**

Stand-alone emergency departments

Chapter summary

The number of health care facilities devoted primarily to emergency department (ED) services and located apart from hospitals—referred to as stand-alone EDs—has grown rapidly in recent years. The majority of stand-alone EDs have opened since 2010. This growth has been driven by payment systems that reward treating lower severity cases in the higher paying ED setting, competition for patient market share, and an exemption in law that allows stand-alone EDs to receive higher hospital outpatient payments for non-ED services. Despite being a potentially efficient way to expand access to ED services in underserved areas, very few stand-alone EDs are located in rural areas. In 2016, almost all of the 566 stand-alone EDs were located in metropolitan areas that have existing ED capacity and were often located in more affluent ZIP codes with higher household incomes and higher shares of privately insured patients.

Stand-alone EDs, which provide ED services and basic imaging and laboratory services, come in two forms: off-campus emergency departments (OCEDs), which are affiliated with a hospital and therefore reimbursed by Medicare; and independent freestanding emergency centers (IFECs), which, until recently, typically were not affiliated with a hospital and therefore not eligible for Medicare reimbursement. However, in recent years, many IFECs have chosen to affiliate with hospitals to enable them to bill Medicare.

In this chapter

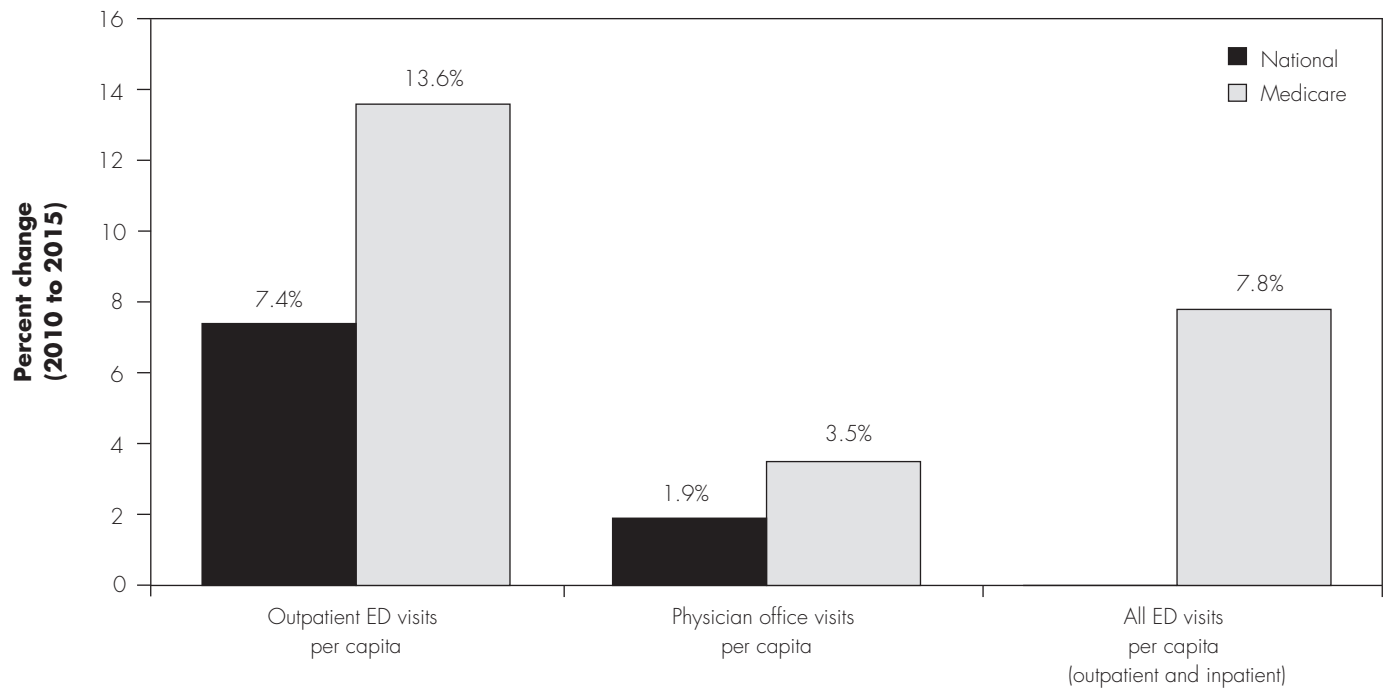
- Medicare payments promote expansion of stand-alone EDs
- Out-of-network payment rates from private insurers are higher
- Stand-alone EDs are concentrated in certain markets and positioned to grow rapidly
- ED services use grew faster in some MSAs where stand-alone EDs were more common
- More stand-alone EDs may begin billing Medicare soon
- In two states, patients served at stand-alone EDs were lower acuity
- Policy options for aligning payments to stand-alone EDs with the acuity of their patients
- Conclusion

Concern exists about whether Medicare pays OCEDs appropriately because, while they are paid the same rates as on-campus hospital EDs, available data suggest that stand-alone EDs may serve lower acuity (severity of illness) patients, more like the mix of patients treated at urgent care centers than at on-campus hospital EDs.

Policymakers may wish to consider the suggestions, recommendations, and policy options derived from the Commission's discussions about stand-alone EDs. In our June 2016 report to the Congress, the Commission discussed stand-alone EDs in the context of rural areas and suggested that rural stand-alone EDs could have a role in the Medicare program (Medicare Payment Advisory Commission 2016). In our March 2017 report, in response to the concern about a lack of Medicare claims data specific to stand-alone EDs, the Commission recommended that the Secretary of Health and Human Services require hospitals to add a modifier on claims for all services provided at stand-alone EDs (Medicare Payment Advisory Commission 2017). Based on our findings to date, policymakers could consider realigning payment rates for OCEDs to reduce payment disparities between settings where low-acuity patients receive services; encourage the development of stand-alone EDs in areas with inadequate access to ED services; and eliminate policy exceptions to site-neutral payment for ambulatory (i.e., hospital outpatient and physician) services. ■

FIGURE 8-1

Emergency department visits increased at a faster rate than physician office visits, nationally and within Medicare, 2010–2015



Note: ED (emergency department). “Outpatient ED visits” refers to ED visits that do not result in an inpatient hospital admission. The “national” category for all ED visits per capita is not shown because the data across all payers are not currently available.

Source: American Hospital Association, National Center for Health Statistics’ National Health Interview Survey, and Medicare claims data.

Background

Emergency departments (EDs) play a growing role in the U.S. health care system, and in recent years the number of facilities providing ED services that are located apart from a hospital campus has also grown. Some researchers believe the volume of ED visits has increased because patients lack access to other providers, providers have changed their practice patterns, or patients desire more immediate access to care (Gindi et al. 2016, Morganti et al. 2013, Pines et al. 2013). Others believe the growth in ED visits is linked to the profitability of ED services (Wilson and Cutler 2014). A contributing factor to the increase in ED visits may include the recent proliferation of facilities providing ED services located apart from the hospital campus, which we refer to as stand-alone EDs.¹

Emergency department visits have increased

Between 2010 and 2015, the number of hospital outpatient ED visits nationally increased by more than 7 percent per

capita compared with an increase of just under 2 percent per capita for physician office visits (Figure 8-1). Among Medicare beneficiaries over the same period, outpatient ED visits increased nearly 14 percent per beneficiary and physician office visits increased approximately 4 percent per beneficiary. In addition, the number of total Medicare ED visits, combining outpatient ED visits that did not result in an inpatient hospital admission and those that did, increased nearly 8 percent per beneficiary. In 2015, Medicare beneficiaries accounted for approximately 28 million total ED visits (data not shown).

Patient wait times in emergency departments have decreased

Between 2013 and 2016, patient wait times in hospital EDs declined, reversing a trend from prior years. CMS’s Hospital Compare data for this period show that the median number of minutes patients waited in hospital EDs to be seen by a clinician declined from 28 minutes to 22 minutes. This decline represents a reversal of a trend from

a decade earlier, when several studies established long and increasing ED wait times as a concern (Government Accountability Office 2009, Horwitz and Bradley 2009, Wilper et al. 2008). The most recent of these studies concluded that, between 1997 and 2006, median ED wait times increased from 22 minutes to 33 minutes (Horwitz and Bradley 2009). The authors found that the source of the increase was growth in patient demand stemming from population growth and reduced primary care access as well as a decline in the number of ED facilities. ED wait times remain a focus of the hospital industry, and hospitals commonly advertise their current ED wait times.

Proliferation of facilities providing ED services

A growing number of ED facilities are located apart from a hospital campus. In 2016, no fewer than 566 stand-alone EDs were in operation. There are two types of these facilities: hospital-affiliated off-campus emergency departments (OCEDs) and independent freestanding emergency centers (IFECs). The regulation of EDs largely occurs at the state level. Other providers such as urgent care centers and physicians' offices compete with stand-alone EDs for low-acuity (severity of illness) patients.

Hospital-affiliated off-campus emergency departments

In 2016, 363 OCEDs operated in 35 states and were affiliated with roughly 300 hospitals. These facilities represented 64 percent of all stand-alone EDs. About 6 percent of hospitals had at least one OCED; these hospitals have tended to be urban, relatively large facilities that are affiliated with a health system. Most of these hospitals operate a single OCED, but about 30 hospitals operate multiple OCEDs. Between 2008 and 2016, the number of hospitals with an OCED increased 97 percent.

OCEDs are paid by Medicare if they are deemed off-campus provider-based departments. OCEDs can bill Medicare under the outpatient prospective payment system (OPPS) for a beneficiary's ED visit and any ancillary services (e.g., imaging and lab services), while clinicians can bill under the Medicare fee schedule for physicians and other health professionals just as in an on-campus ED. Most other payers pay OCEDs a facility fee and generally consider OCEDs in-network facilities. To be deemed a Medicare provider-based department, an OCED must be in compliance with the standard Medicare and state hospital ED requirements, be financially and clinically integrated with the hospital, be publicized as an affiliate of

the hospital, and be located within 35 miles of the hospital (Centers for Medicare & Medicaid Services 2008).²

The majority of OCEDs offer ED services 24 hours per day; basic imaging services such as X-ray, computed tomography (CT) scans, and ultrasound; and on-site lab services for basic diagnostic analysis. They do not typically provide trauma services (e.g., for patients coming from car accidents or having gunshot wounds), and most receive ambulance transports less frequently than do hospital EDs.³ OCEDs range in size, with larger facilities serving as many as 100 patients per day and the smallest facilities serving 20 or fewer patients per day. Larger OCEDs can also offer MRI and primary care, house physician specialists' offices, and tend to take more ambulance transports than smaller OCEDs. OCEDs have one or more physicians on-site at all times, and physicians are typically contracted. OCEDs are often marketed as open longer (24 hours per day) than urgent care centers and as serving higher acuity medical conditions, such as respiratory distress, head injuries, dehydration, infection, orthopedic injuries and fractures, and abdominal pain.

Where OCEDs choose to locate depends on several factors related to the general characteristics of the immediate health care marketplace. According to industry representatives, the purpose of stand-alone EDs can include expanding access in areas that lack ED services, relieving overcrowding in on-campus hospital EDs, and offering patients greater convenience to ED services. The industry typically uses data-driven market real estate-analysis methods to identify "voids in community healthcare delivery systems" (Adeptus Health Inc. 2016). Developers focus on variables such as the location of other EDs, population growth, household income, and insurance coverage in the target area's population. In the absence of Medicare claims data for these facilities, we cannot identify the socioeconomic characteristics of the Medicare patients served by stand-alone EDs. However, anecdotally, we know that OCEDs are typically located where there has been recent population growth and where developers estimate that patient business will be sufficient to support their enterprise. Representatives of the industry asserted that OCEDs are typically developed within 5 to 10 miles of their affiliated hospital. We also observed that sometimes these facilities are located in urban areas close to other hospital EDs or stand-alone EDs, and sometimes they are located in areas where there are few providers offering ED services. In cases where these facilities are located close to other ED providers, it appears the developers' intention is to capture market share from

competitors. In cases where OCEDs are located in areas lacking ED services, the communities appear relatively new and may not include many other providers, or the community has recently lost a provider of ED services. In many of these cases, the OCEDs are owned by hospitals affiliated with large regional health systems and located in areas where residents tend to have health insurance.

According to industry representatives, stand-alone EDs are a mechanism that hospitals and health systems can use to capture patient market share and control patient service use. Spokespeople assert that stand-alone EDs offer hospitals and health systems a way to extend their service areas into their competitors' service areas. They also assert that as hospitals and health systems consolidate in several markets, and in some cases develop their own insurance plans, providers are transitioning to a population health strategy in which they benefit from controlling a patient's overall service use. Stand-alone EDs also allow these systems to maintain more control of their patients' services use.

Independent freestanding emergency centers

In 2016, 203 IFECs operated in the United States, representing about 36 percent of all stand-alone EDs. The majority of IFECs are in Texas, where the number increased from none in June 2010 (when state licensure of IFECs began) to 191 facilities in 2016. Colorado, Minnesota, and Rhode Island also have IFECs. More than 50 unique entities own IFECs, most of which are for-profit entities. The largest is Adeptus Health Inc., which owns 52 IFECs. The business model of IFECs is similar to OCEDs in terms of the services they offer and where they choose to locate. They offer ED services, imaging services (X-rays and CT scans), and basic laboratory services. Similar to OCEDs, developers of IFECs use data-driven market real estate-analysis methods to identify gaps in community delivery systems. Therefore, developers decide to place IFECs based on the following variables: the location of other EDs, population growth, household income, and insurance coverage of the target areas' population. What we observe is that IFECs are almost always in urban and suburban communities and very often are located close to other ED providers.

Currently, IFECs are not defined in Medicare law or regulation. As a result, IFECs cannot bill Medicare, and they do not have to meet any of Medicare's provider-based requirements or conditions of participation. However, 70 percent of states with stand-alone EDs have state licensure

requirements for stand-alone EDs that closely follow the intent of the federal requirements for Medicare and Medicaid providers to screen and stabilize all patients requiring care under the Emergency Medical Treatment and Labor Act of 1986 (Gutierrez et al. 2016).⁴

Representatives of IFECs assert that the patient mix at their facilities consists of higher shares of privately insured patients because IFECs cannot bill for treating Medicare patients. A smaller share of their patient mix consists of Medicare, Medicaid, or uninsured patients. Private insurers do not typically contract with IFECs, instead treating them as out-of-network providers. According to several news reports, private insurers are charged significantly higher rates when IFECs are out-of-network facilities, and patients are often left to pay the balance of these charges when claims are denied in part or in full (Rice 2016).

Regulation of stand-alone EDs

The regulation of stand-alone EDs occurs largely on the state level, but a few provisions of Medicare statute and regulation impact these facilities. A recent study of state-level regulation of stand-alone EDs concluded that states vary widely in their standards and regulation regarding these facilities' location, staffing, and clinical capabilities (Gutierrez et al. 2016). Gutierrez and colleagues found 21 states with policies regulating stand-alone EDs, 29 states without regulations for stand-alone EDs, and 1 state (California) with specific hospital regulations that prohibit these facilities. The net effect of this variation is that most states (e.g., Florida and Ohio) allow OCEDs but not IFECs, and these states view OCEDs as an extension of the hospital. A few states (Colorado, Minnesota, Rhode Island, and Texas) permit both OCEDs and IFECs.

The presence of certificate of need (CON) laws in some states may limit the growth of stand-alone EDs to a degree, but the presence or absence of stand-alone EDs does not vary consistently with state CON laws. A recent study of CON laws concluded that states with CON requirements had fewer stand-alone EDs per capita than states without CONs laws (Gutierrez et al. 2016). However, the presence of CON laws is not a predictor of stand-alone ED growth in some key states. For example, both California and Texas lack CON laws, but only Texas has stand-alone EDs (National Conference of State Legislatures 2016).

Medicare's regulation of stand-alone EDs is defined in statute and regulation related to provider-based facilities and hospital conditions of participation. Two components of the provider-based definition have a significant impact

on stand-alone EDs. First, Medicare's 35-mile limit on provider-based facilities is a significant provision because it prevents hospitals and health systems from developing OCEDs in isolated rural areas or beyond their existing service areas. Second, Section 603 of the Bipartisan Budget Act of 2015 altered the provider-based definition to exempt both emergency and nonemergency services provided in "dedicated EDs" from the law prohibiting certain off-campus provider-based departments from billing Medicare under the OPPS. Section 603 defines dedicated EDs as facilities where at least one-third of a facility's outpatient visits for the treatment of emergency medical conditions are on an urgent basis without requiring a previously scheduled appointment.⁵ Under this exemption for EDs, both ED and non-ED services provided in off-campus facilities are paid the higher hospital OPPS rates (as opposed to rates paid in the physician office setting). Therefore, a new provider-based physician office that might otherwise be prohibited from billing at higher hospital OPPS rates as a stand-alone office could instead receive those higher rates by locating inside the OCED and satisfying enrollment and compliance requirements. Moreover, because Medicare claims data cannot currently distinguish OCED claims from on-campus hospital ED claims, CMS cannot automatically verify what services are being delivered in these facilities.

Facilities competing with stand-alone EDs for low-acuity patients

Stand-alone EDs generally have two types of competitors: providers offering ED services and providers serving generally lower acuity patients. More than 4,400 hospital EDs submit claims for ED services annually, by far the most common type of ED facility (American Hospital Association 2015). These facilities are located within a hospital, or on a hospital campus. A relatively new type of hospital ED is the micro-hospital. These facilities are smaller than full-service hospitals and offer a limited range of services but maintain full hospital status. They typically maintain a small number of inpatient beds (e.g., 10 beds) and their focus is primarily on ED services. Some micro-hospitals also offer limited surgical and rehabilitation services, while others house primary care practices, specialty practices, and labor and delivery rooms (Andrews 2016). Most micro-hospitals do not offer higher intensity services such as trauma care in the ED, intensive care units, cancer services, and transplant services. Representatives of micro-hospitals stated that patients requiring prolonged care are regularly transferred to

larger facilities (Rudavsky 2016). There are currently very few micro-hospitals, but several are being developed by hospital systems such as SCL Health in Colorado; Dignity Health in Las Vegas; Baylor Scott & White in Texas; and Emerus, a for-profit entity that also owns stand-alone EDs.

Urgent care centers, retail clinics, and primary care physician practices serve lower acuity patients who are similar to the low-acuity patients served by hospital EDs. More than 7,000 urgent care centers, 2,800 retail clinics, and more than 200,000 practicing primary care physicians may compete for lower acuity patients.⁶ Urgent care centers come in two forms: those affiliated with a hospital (i.e., "provider based") and those not affiliated with a hospital. These facilities provide a broad range of nonemergency services but generally maintain somewhat less service capacity than on-campus hospital EDs. They are typically open fewer than 24 hours per day; are staffed by physicians, nurses, and physicians' assistants; and offer relatively limited lab and imaging services. Retail clinics consist of pharmacy- or retailer-based health clinics such as CVS Minute Clinic and Target Clinic. These facilities offer brief medical visits with an advanced practice provider such as a physician assistant or nurse practitioner, are open fewer than 24 hours per day, and are designed to provide immunizations and core services for simple illnesses (Thygeson et al. 2008). They do not offer diagnostic services. Primary care physicians who deliver direct patient care generally are in group practices rather than individual physician practices. Physicians' offices are generally open during standard business hours; are staffed with physicians, registered nurses, and physicians' assistants; and may offer lab or imaging services.

Urgent care centers, retail clinics, physician offices, and EDs provide overlapping access to care for patients with lower severity health needs, but research suggests that the cost of providing care is higher when lower acuity patients are treated in emergency departments. A variety of sources confirm this overlap, and a 2010 study estimated that between 13 percent and 27 percent of cases served in hospital EDs could be served similarly at urgent care centers or retail clinics (Ashwood et al. 2016, Weinick et al. 2010). In addition, several studies have documented that the cost of treating lower acuity patients in on-campus hospital EDs exceeds the cost of treating these patients in non-ED settings (Baker and Baker 1994, Mehrotra et al. 2009, Thygeson et al. 2008). To date, cost data are not available to enable a comparison of costs at these settings with stand-alone EDs.

The Commission's recent activity related to stand-alone EDs

In our June 2016 report to the Congress, the Commission discussed stand-alone EDs in the context of rural areas and suggested there may be a role for rural stand-alone EDs in the Medicare program (Medicare Payment Advisory Commission 2016). At our November 2016 public meeting, the Commission revisited stand-alone EDs as a separate topic, discussing these facilities in the context of both rural and urban areas. As a part of this discussion, the Commission voiced concern about (1) the inability to differentiate between Medicare ED claims at on-campus hospital EDs and stand-alone EDs and (2) the inability to determine the appropriateness of payment for ED services in the two different settings. As a result, the Commission recommended in its March 2017 report to the Congress that the Secretary of the Department of Health and Human Services require hospitals to add a modifier on claims for all services provided at off-campus stand-alone ED facilities (Medicare Payment Advisory Commission 2017).

Research methods

A variety of sources were used to obtain information for this analysis. The universe of stand-alone EDs was identified using data from the American Hospital Association, various stand-alone ED companies, and online research. To understand where stand-alone EDs locate, these data were paired with population data from the U.S. Census Bureau to calculate the density of stand-alone EDs in each metropolitan statistical area (MSA). To determine whether stand-alone EDs induce demand for ED services, the Commission analyzed Medicare and private-payer ED claims data in the 7 MSAs with the highest concentration of stand-alone EDs (and at least 1 million residents) and compared this data with the change in ED claim volume in the 11 MSAs with more than 1 million residents and no stand-alone EDs. In the absence of distinguishable Medicare claims data for stand-alone EDs, we used information from Colorado's Center for Improving Value in Health Care (CIVHC) and the Maryland Health Care Commission to assess possible differences in patient mix and payment amounts between stand-alone EDs and competing facilities. The small number of stand-alone EDs in these two states may not be representative of all stand-alone EDs. However, these data are the only available information that shed light on the practices of stand-alone EDs. Our findings were also based on interviews with representatives of stand-alone EDs, hospitals, and the ambulance industry, as well as visits to stand-alone EDs in New York and Virginia.

Medicare payments promote expansion of stand-alone EDs

Medicare pays for ED services using three payment systems—an arrangement largely mirrored by private payers. Medicare beneficiaries who receive ED services generate a physician claim and a hospital outpatient ED claim. Physician claims for ED visits are paid through the Medicare physician fee schedule (PFS). Hospital claims for ED visits that do not result in an admission are paid through the hospital OPPS. ED claims that result in a hospital admission are bundled into a diagnosis related group and paid through the inpatient prospective payment system (IPPS).

The PFS and OPPS both use a five-tiered scale to pay for ED visits. The five levels of PFS and OPPS ED visits are based on the same standard set of Current Procedural Terminology codes and general descriptions of the service. Level 1 visits represent the lowest acuity, and Level 5 visits represent the highest acuity. The two systems maintain separate sets of fixed payment rates for each of the five levels (Table 8-1, p. 252). The OPPS maintains two sets of rates: Type A ED rates for hospital EDs open 24 hours per day and Type B ED rates for EDs open fewer than 24 hours per day. Type B rates are generally lower than Type A rates because Type B facilities do not need to maintain ED staff 24 hours per day. OCEDs receive the higher Type A ED rates, similar to on-campus hospital EDs. The volume of visits paid at Type B ED rates is low, accounting for approximately 1 percent of all Medicare ED claims in 2015.

Providers have the financial incentive to treat patients in the ED because Medicare's total ED payment (facility payment plus physician payment) is higher than its total payment made to other settings for a comparable case. For ED services provided in a hospital ED open 24 hours per day, the facility bills Medicare for the ED visit and other outpatient services (e.g., imaging and lab services) under the OPPS and the physician bills Medicare under the PFS. Under a hypothetical example of a non-life-threatening medical condition—that is, a Level 3 ED visit—Medicare pays the hospital EDs and OCEDs that are open 24 hours per day \$196 (not including other outpatient services) and the physician \$63, for a total Medicare payment of \$259 (Figure 8-2, p. 252). If the same patient were treated at a hospital ED or OCED open fewer than 24 hours per day (that is, the Type B rate), Medicare would pay the facility \$115 and the physician \$63, for a total payment of \$178.⁷

TABLE 8-1

Medicare payment rates for emergency department visits under the Medicare physician fee schedule and hospital outpatient prospective payment system, 2016

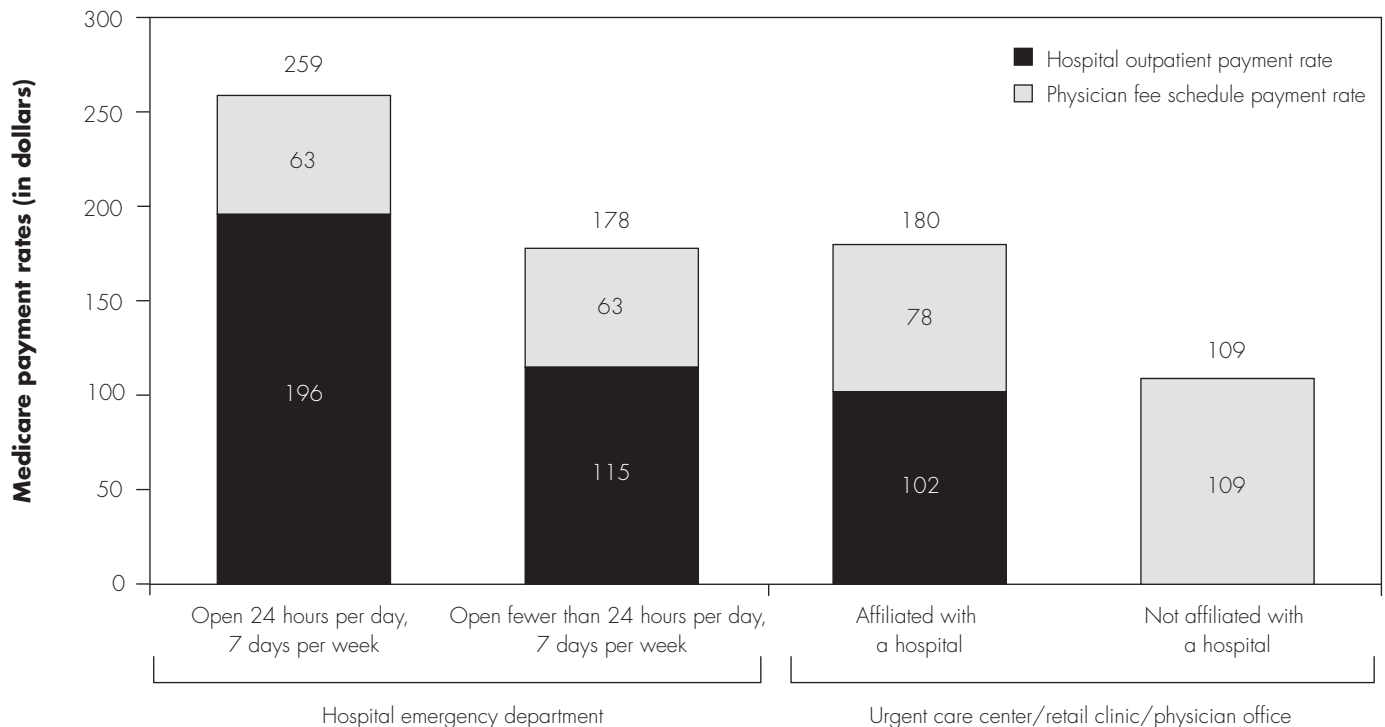
Emergency department payment level	Physician fee schedule payment for emergency department visits	OPPS payment amount	
		Type A emergency department visit (facility open 24 hours per day)	Type B emergency department visit (facility open fewer than 24 hours per day)
Level 1	\$21.48	\$59.30	\$79.22
Level 2	41.89	109.51	76.17
Level 3	62.66	195.98	115.20
Level 4	118.87	326.99	196.25
Level 5	175.44	486.04	315.88

Note: OPSS (outpatient prospective payment system). The data reflect 2016 Medicare payment rates under the physician fee schedule and OPSS and do not include patient cost sharing or payments for ancillary services that might be incurred at the time of treatment. Level 1 visits represent the lowest acuity, and Level 5 visits represent the highest acuity.

Source: Centers for Medicare & Medicaid Services, calendar year 2016 hospital OPSS final rule.

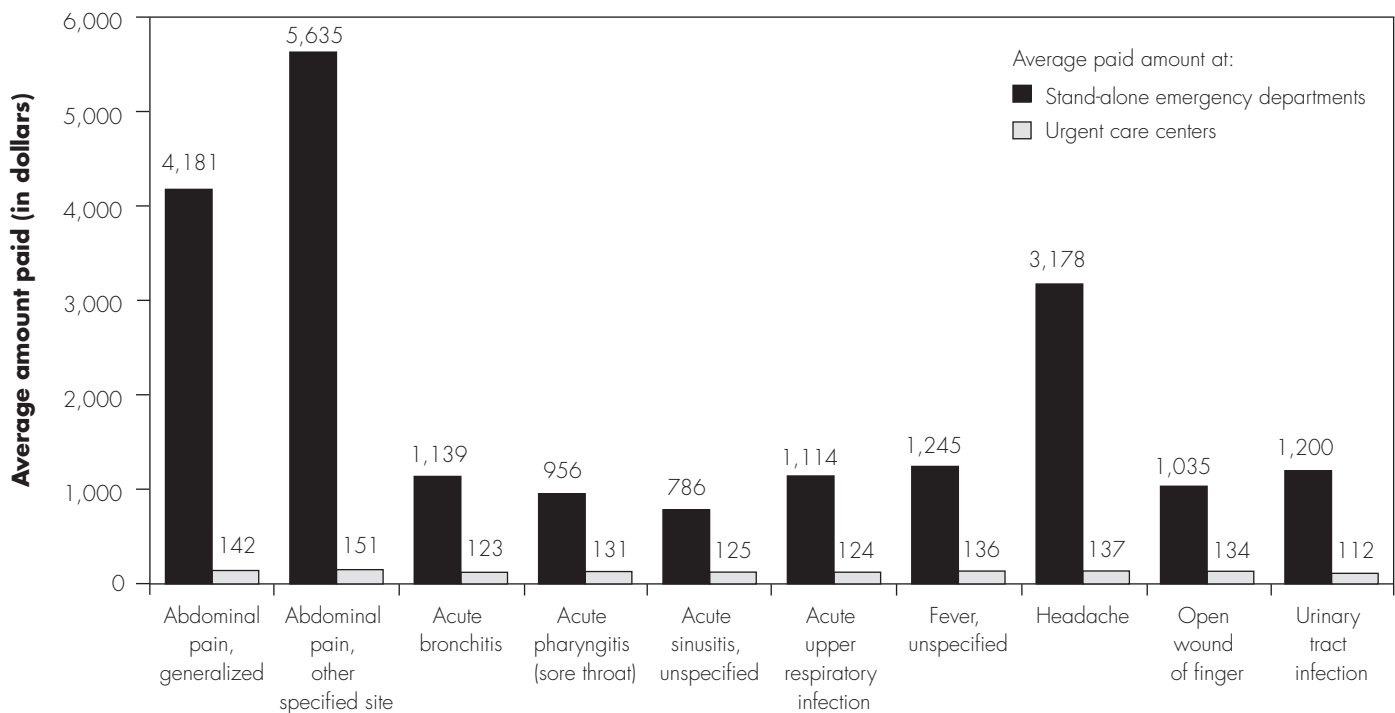
FIGURE 8-2

Hypothetical example of differences in 2016 Medicare payment rates for similar services delivered at hospital emergency departments and other providers



Note: The physician fee schedule payment rates for services delivered in hospital emergency departments (EDs) reflect Level 3 physician ED services; payment rates for services delivered in urgent care centers and physician offices reflect Level 3 evaluation and management codes for new patients. The hospital outpatient payment rates for services delivered in hospital EDs reflect Level 3 ED services; payment rates for services delivered in urgent care centers and physician offices reflect the hospital outpatient clinic visits code.

Source: MedPAC description of Medicare 2016 hospital outpatient prospective payment system payment rates and physician fee schedule payment rates.

FIGURE 8-3**Average amounts paid for commercial insurance claims for various health conditions were higher at stand-alone emergency departments in Colorado than at urgent care centers, 2014**

Source: Colorado Center for Improving Value in Health Care 2016.

Total Medicare payments for urgent care centers, retail clinics, and physicians' offices are generally lower than rates paid to hospital EDs and OCEDs for the same types of patients. Urgent care centers, retail clinics, and physicians' offices owned by a hospital and deemed provider based are paid under the OPSS and PFS; they are not permitted to bill for ED services. Using the same hypothetical example, at one of these hospital-affiliated providers, Medicare would pay a total of \$180: \$102 for a hospital outpatient clinic visit plus \$78 for a Level 3 facility-based evaluation and management (non-ED) visit (Figure 8-2).

Non-hospital-affiliated urgent care centers, retail clinics, and physician offices are paid only under the PFS and are not permitted to bill for ED services. Using the same hypothetical example, at one of these non-hospital-affiliated providers, Medicare would pay the physician \$109 for a Level 3 nonfacility evaluation and management (non-ED) visit.

Medicare claims data do not allow us to demonstrate actual payment differences for similar patients treated at stand-alone EDs compared with urgent care centers, but we were able to construct an example using data from Colorado's CIVHC. Claims data for privately insured patients in Colorado in 2014 demonstrate that patients with similar conditions incur higher payments when served at stand-alone EDs relative to urgent care centers.⁸ In an analysis isolating payments made to a small sample of stand-alone EDs in Colorado only, CIVHC found that, in 2014, privately insured patients paid higher amounts—exceeding 10 times the amount—for treatment at stand-alone EDs compared with treatment at urgent care centers. For example, in 2014, the average payment amount for an acute upper respiratory infection (a non-life-threatening condition) at stand-alone EDs was \$1,114, compared with \$124 at urgent care centers. Similar differences existed for other conditions (Figure 8-3).⁹

**TABLE
8-2****Medicare Type B ED visits consisted of a higher share of low-acuity claims and were less common than Type A ED visits, 2015**

Emergency department payment level	Type A ED visits (facility open 24 hours per day)		Type B ED visits (facility open fewer than 24 hours per day)	
	Number of visits	Share of visits	Number of visits	Share of visits
Level 1	644,482	3.6%	33,945	16.6%
Level 2	1,332,648	7.4	57,446	28.1
Level 3	5,211,454	28.9	81,315	39.8
Level 4	6,254,606	34.7	26,625	13.0
Level 5	4,559,691	25.3	4,927	2.4
Total	18,002,881	100.0	204,258	100.0

Note: ED (emergency department). Components may not sum to stated totals due to rounding. Level 1 visits represent the lowest acuity, and Level 5 visits represent the highest acuity.

Source: Centers for Medicare & Medicaid Services, calendar year 2016 hospital outpatient prospective payment system final rule.

Shifting services to higher cost settings increases patients' financial liability. In recent years, articles in the popular press have documented how patients with minor medical conditions chose an OCED instead of an urgent care center and ended up with higher than expected medical bills because the care was billed as an ED visit rather than an urgent care center visit (Schlachter 2014). The same is true under Medicare, for which beneficiaries (without supplemental insurance) must pay a 20 percent coinsurance for services received at either an urgent care center or an OCED. Using the same hypothetical example discussed earlier, this distinction could mean the beneficiary's copayment at an on-campus hospital ED or OCED would be 20 percent of \$259 (\$52); at an urgent care center affiliated with a hospital, 20 percent of \$180 (\$36); or at a non-hospital-affiliated physician office, 20 percent of \$109 (\$22).

Medicare Type B ED claims were lower acuity and less common than Type A ED claims in 2015

Although Medicare claims data do not allow us to demonstrate differences in the severity level of Medicare beneficiaries served at stand-alone EDs relative to on-campus hospital EDs, claims data do display differences between Type B ED visits and Type A ED visits. In 2015, about 85 percent of the Medicare Type B ED visits were for one of the three lowest ED acuity levels (Table 8-2). By contrast, approximately 40 percent of all Type A ED visits were in one of the three lowest ED acuity levels. Overall,

Type B visits accounted for approximately 1.1 percent of all Medicare ED claims and 2.4 percent of Medicare ED claims in one of the three lowest ED acuity levels.

Out-of-network payment rates from private insurers are higher

Stand-alone EDs can receive higher payment rates when they bill private insurers as out-of-network providers rather than in-network providers. For example, according to representatives of stand-alone EDs, in-network ED visit rates are about \$1,000 per visit compared with out-of-network ED visit rates that are about \$1,800. This payment difference may lead stand-alone EDs to operate without directly contracting with private insurers to establish prices. Under a provision in the Public Health Service Act, effective 2015, plans are required to cover ED services and maintain the same cost-sharing requirements whether the services are delivered by in-network or out-of-network providers.¹⁰ However, the patient may be required to pay the amount the out-of-network provider charges over the amount insurers are required to pay. This practice is commonly referred to as balance billing, and patients are shielded from balance billing by law in some states.

The out-of-network payment strategy may be more common at IFECs than OCEDs, but we cannot quantify how often it is used. IFECs may be more likely to use this strategy because they are not affiliated with a hospital or

system that is likely to have a contract in place with private insurers. Anecdotally, we have heard that some insurers have contracted with IFECs for lower than standard ED payment rates. OCEDs are more likely to bill in-network payment rates because they are affiliated with hospitals. However, it is also conceivable that OCEDs bill out-of-network payment rates for patients without insurance or patients with insurance through private insurers that the OCEDs choose not to contract with.

Concerns about patients being billed by providers for services they receive out of network (i.e., balance billing) apply to patients with commercial insurance but not to Medicare fee-for-service or Medicare Advantage beneficiaries. Medicare beneficiaries are protected from balance billing, and several states have acted to prohibit providers from balance billing commercially insured patients (Hoadley and Lucia 2009, Pollitz 2016).

Stand-alone EDs are concentrated in certain markets and positioned to grow rapidly

Further analysis of stand-alone EDs suggests that the payment policies of Medicare and private payers promote expansion of stand-alone EDs in a manner that does not represent good value. Stand-alone EDs are concentrated in certain markets, notably in Texas and Colorado, and they tend to locate in areas where patients have above-average incomes. At the same time, ED service use has increased in some markets where stand-alone EDs are more common. In addition, IFECs appear to be taking steps to affiliate with hospitals, which would give them provider-based status and the opportunity to bill Medicare. Our analysis of detailed data from two states shows that patients served by stand-alone EDs tend to be lower acuity compared with patients served by on-campus EDs, making the stand-alone facilities similar to urgent care centers. However, for treating similar patients—as our previous hypothetical example shows—these facilities receive higher payment rates relative to urgent care centers.

Stand-alone EDs are concentrated in certain markets

Stand-alone EDs operate in many MSAs and the majority of states, but are concentrated in a few dozen MSAs. In 2016, the 566 stand-alone EDs were located in 39 percent of MSAs.¹¹ About 64 percent of stand-alone EDs were OCEDs (363 facilities), and about 36 percent were

IFECs (203 facilities). In 2016, the number of stand-alone EDs per resident ranged from zero facilities per million residents to more than 20 facilities per million residents. Across all markets, 37 MSAs had more than 5 stand-alone EDs per million residents. This group of MSAs included relatively small MSAs with only a couple of stand-alone EDs as well as large MSAs with numerous stand-alone EDs.¹²

In 2016, 20 large MSAs (500,000 or more residents) accounted for over 60 percent of all stand-alone EDs. Five of these MSAs (Austin, Dallas, El Paso, Houston, and San Antonio) had more than 10 stand-alone EDs per million residents, including both OCEDs and IFECs (Table 8-3, p. 256).¹³ Two MSAs in Colorado were also in the top 20, Denver and Colorado Springs. These MSAs had 8.5 and 7.2 stand-alone EDs per million residents, respectively, and both contained OCEDs and IFECs. Several MSAs in Ohio were in the top 20, but these MSAs included only OCEDs. By contrast, many large MSAs did not have stand-alone EDs, including Atlanta, Las Vegas, Los Angeles, Pittsburgh, and San Francisco.

Stand-alone EDs were concentrated in several smaller MSAs (fewer than 500,000 residents) in Colorado, Connecticut, and Texas. Smaller MSAs in Texas include Tyler (22.4 stand-alone EDs per million residents), Corpus Christi (19.9), Midland (18.0), and Beaumont (14.7). Smaller MSAs in Colorado and Connecticut include Greeley, CO (14.0); Pueblo, CO (12.2); and Norwich, CT (11.0).

Nineteen stand-alone EDs were located in rural areas, defined as being outside the boundary of an MSA. Most of these facilities were OCEDs, and most were located in Colorado, Michigan, Minnesota, and Ohio. The only three rural IFECs were located in Texas.

The distribution of OCEDs and IFECs varies by MSA, and markets with more OCEDs per million residents are more likely to impact the Medicare program. MSAs with the highest overall levels of stand-alone EDs per capita had both OCEDs and IFECs. For example, Houston had about 16 stand-alone EDs per million residents, of which approximately half were OCEDs (Table 8-3, p. 256). By contrast, all of the stand-alone EDs in Cleveland were OCEDs. This distinction is relevant to our analysis of ED utilization within MSAs because Medicare beneficiaries are treated only at OCEDs. Therefore, to measure the growth of Medicare ED utilization, we focused on MSAs with high rates of OCEDs; to measure the growth of private-payer ED utilization, we focused on MSAs with high rates of both OCEDs and IFECs.

**TABLE
8-3**

Stand-alone emergency departments were concentrated in 20 large MSAs, and the type of facility varies by market, 2016

Rank	MSA Name	Number of:			2015 population	Number per million residents		
		All stand-alone EDs	OCEDs	IFECs		Stand-alone EDs	OCEDs	IFECs
1	Houston, TX	104	44	60	6,656,947	15.6	6.6	9.8
2	El Paso, TX	10	4	6	838,972	11.9	4.8	7.2
3	Dallas-Fort Worth, TX	79	31	48	7,102,796	11.1	4.4	6.5
4	Austin, TX	22	9	13	2,000,860	11.0	4.5	6.5
5	San Antonio, TX	26	6	20	2,384,075	10.9	2.5	8.0
6	Denver, CO	24	19	5	2,814,330	8.5	6.8	1.8
7	Akron, OH	6	6	0	704,243	8.5	8.5	0.0
8	Colorado Springs, CO	5	4	1	697,856	7.2	5.7	1.4
9	Dayton, OH	5	5	0	800,909	6.2	6.2	0.0
10	Cleveland, OH	12	12	0	2,060,810	5.8	5.8	0.0
11	Portland, ME	3	3	0	526,295	5.7	5.7	0.0
12	Youngstown, OH	3	3	0	549,885	5.5	5.5	0.0
13	Wichita, KS	3	3	0	644,610	4.7	4.7	0.0
14	Jacksonville, FL	6	6	0	1,449,481	4.1	4.1	0.0
15	Richmond, VA	5	5	0	1,271,334	3.9	3.9	0.0
16	Oklahoma City, OK	5	5	0	1,358,452	3.7	3.7	0.0
17	Charlotte, NC	8	8	0	2,426,363	3.3	3.3	0.0
18	Cincinnati, OH	7	7	0	2,157,719	3.2	3.2	0.0
19	Raleigh, NC	4	4	0	1,273,568	3.1	3.1	0.0
20	Toledo, OH	2	2	0	646,833	3.1	3.1	0.0
	Rural non-MSAs	19	16	3	46,064,445	0.4	0.4	0.1
	All MSAs	547	347	200	275,354,375	2.0	1.3	0.7
	United States	566	363	203	321,418,820	1.8	1.1	0.6

Note: MSA (metropolitan statistical area), ED (emergency department), OCED (off-campus emergency department), IFEC (independent freestanding emergency center). The Census Bureau's most recent MSA-level data are for 2015.

Source: MedPAC count of stand-alone emergency department facilities from various sources and population data from the Census Bureau.

Stand-alone EDs locate in areas where patients have higher incomes and are better insured

Recent data suggest stand-alone EDs tend to locate in ZIP codes with higher than average incomes and higher shares of patients with private insurance coverage. In a 2016 study, Schuur and colleagues concluded that, in the three states where stand-alone EDs were most common (Colorado, Ohio, and Texas), stand-alone EDs tended to locate in ZIP codes where the median household income was higher than in ZIP codes without stand-alone EDs (Schuur et al. 2016). For example, in Texas, ZIP codes with stand-alone EDs had a median household income

of \$73,003, compared with a median household income of \$49,267 in ZIP codes without stand-alone EDs (Table 8-4). The same trend was identified in Colorado and Ohio.

This study also found that ZIP codes with stand-alone EDs tended to have patients who were better insured. In Ohio, ZIP codes with stand-alone EDs had higher shares of patients with private insurance (77 percent) than ZIP codes without stand-alone EDs (71 percent), lower shares of patients with Medicaid (12 percent) than ZIP codes without stand-alone EDs (16 percent), and lower shares of patients without any insurance (9 percent) than ZIP codes without stand-alone EDs (11 percent). Similar trends existed in Texas and, to a lesser extent, Colorado.

**TABLE
8-4**

Median household incomes and patient payer mix for ZIP codes in Texas, Ohio, and Colorado with and without stand-alone emergency departments, 2015

Characteristic	Texas ZIP codes		Ohio ZIP codes		Colorado ZIP codes	
	With stand-alone EDs	Without stand-alone EDs	With stand-alone EDs	Without stand-alone EDs	With stand-alone EDs	Without stand-alone EDs
Median household income	\$73,003	\$49,267	\$58,482	\$49,646	\$70,604	\$59,831
Share of patients:						
With private insurance	72%	54%	77%	71%	76%	71%
With Medicaid insurance	10	19	12	16	9	13
Without insurance	16	25	9	11	14	14

Note: ED (emergency department). The authors' list of stand-alone EDs in Texas, Ohio, and Colorado was compiled as of March 31, 2015; median income data were drawn from the Environmental Systems Research Institute Demographics files at the Center for Geographic Analysis at Harvard University; and patient payer-mix data were drawn from the 2013 American Community Survey.

Source: Schuur et al. 2016.

In addition, the authors of the study found that Ohio's stand-alone EDs located in ZIP codes where hospital EDs were absent, while Texas's stand-alone EDs located in ZIP codes where hospital EDs were present (data not shown).

Similarly, our own analysis of stand-alone-ED location in 2016 found that within MSAs, stand-alone EDs disproportionately located in ZIP codes with higher incomes. Including both types of stand-alone EDs, 64 percent in the Houston MSA were located in ZIP codes with an average household income above \$90,000, but these ZIP codes made up only 31 percent of the total in the Houston MSA (Table 8-5, p. 258).¹⁴ In the Denver MSA, 65 percent of stand-alone EDs were located in ZIP codes with an average household income above \$90,000, which made up 39 percent of ZIP codes in the Denver MSA. (See online Appendix 8-A, available at <http://www.medpac.gov>, for further detail.)

ED services use grew faster in some MSAs where stand-alone EDs were more common

The use of ED services within Medicare and private-payer populations grew somewhat more rapidly in recent years in a few large MSAs with higher rates of stand-alone EDs per capita. However, the growth in ED service use was not consistent across all MSAs with higher rates of stand-alone EDs, suggesting that stand-alone EDs may

not maintain significant enough market share to drive MSA-wide service use and that other factors contribute to service use trends.

Medicare ED service use grew faster in some MSAs where OCEDs are more common

Among the seven MSAs with the highest shares of OCEDs, Denver and Oklahoma City saw particularly high growth in ED service use. Between 2010 and 2014, the number of ED visits per 1,000 Medicare beneficiaries in Denver and Oklahoma City grew 17.7 percent and 14.4 percent, respectively (see online Appendix 8-A, available at <http://www.medpac.gov>). By contrast, growth in ED visits in the five other MSAs ranged from -2.8 percent to 8.2 percent. Collectively, during this period, ED service use in all 7 of the MSAs with highest rates of OCEDs increased 5.5 percent, compared with 0.4 percent among 11 comparably sized MSAs without any OCEDs.

Privately insured patients' ED service use grew faster in some MSAs where stand-alone EDs are more common

Among the seven MSAs with the highest shares of all stand-alone EDs, Denver and San Antonio saw particularly high growth in ED service use by privately insured patients. Between 2012 and 2014, the growth in the number of ED visits per 1,000 privately insured patients was 7.0 in Denver and 17.2 in San Antonio (see online Appendix 8-A, available at <http://www.medpac.gov>). By contrast, growth in ED visits in the other five MSAs

**TABLE
8-5**

Larger share of stand-alone EDs in Denver and Houston were located in ZIP codes with higher average household incomes, 2016

Average household income, by quintile	Denver MSA		Houston MSA	
	Share of ZIP codes	Share of stand-alone EDs	Share of ZIP codes	Share of stand-alone EDs
\$120,000 to \$285,000	12%	26%	12%	29%
\$90,000 to \$119,999	27	39	19	35
\$65,000 to \$89,999	35	22	27	24
\$40,000 to \$64,999	25	13	37	12
\$0 to \$39,999	2	0	6	0
Total	100	100	100	100

Note: ED (emergency department). One stand-alone emergency department in Denver and one in Houston were excluded from this analysis because they were located in ZIP codes without income data. ZIP codes devoted to schools, corporations, or other large entities often do not possess residents from whom to collect income data. Column totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of stand-alone ED industry and population data from the Census Bureau.

ranged from -6.1 percent to 1.8 percent. Collectively, during this period, the 7 MSAs with the highest rates of stand-alone EDs increased 1.0 percent, compared with a 1.3 percent decline across 11 comparably sized MSAs without any stand-alone EDs.

More stand-alone EDs may begin billing Medicare soon

In 2016, 363 stand-alone EDs were OCEDs and permitted to bill Medicare, but we estimate another 203 stand-alone EDs were IFECs that may become OCEDs and begin billing Medicare in the near future. The 363 OCEDs billing Medicare were defined as provider-based facilities and submitted claims to Medicare through their affiliated hospital's provider ID number. However, because CMS does not separately track claims from these off-campus facilities, we do not know exactly which ones are billing Medicare or for what services they are billing.

Many of the 203 IFECs appear to be taking steps to affiliate with hospitals to gain Medicare provider-based status and begin billing Medicare, effectively converting to new OCEDs. For example, in recent years, the largest owner of IFECs, Adeptus, modified its business model to partner with hospitals to enable its IFECs to bill Medicare and Medicaid. In Arizona and Ohio, Adeptus partnered with large health systems to build new stand-alone EDs.

In Colorado, Adeptus partnered with the University of Colorado Health (UCHealth) to build new hospitals with which its existing IFECs could then affiliate. In Texas, Adeptus built its own new hospitals (without partnering with a hospital system) and partnered with the hospital system Texas Health Resources to enable 31 of their IFECs in Dallas to begin billing Medicare.

In two states, patients served at stand-alone EDs were lower acuity

Colorado

Claims data for privately insured patients in Colorado in 2014 suggest that most patients served by stand-alone EDs were treated for non-life-threatening conditions, similar to conditions treated at urgent care centers. These data also suggest that the patients served by stand-alone EDs are somewhat different from those served at hospital EDs. In July 2016, Colorado's CIVHC used claims data from nine stand-alone EDs to compare with claims from urgent care centers and hospital EDs. CIVHC concluded that among the top 10 conditions for which privately insured patients sought care at stand-alone EDs, 7 were for non-life-threatening conditions (Table 8-6). At urgent care centers, all 10 of the top 10 conditions were non-life-threatening, whereas at on-campus hospital EDs, 3 of the top 10 were for non-life-threatening conditions. Between

**TABLE
8-6**

Ten most common conditions treated at stand-alone emergency departments, urgent care centers, and hospital emergency departments in Colorado, by facility type and condition type, 2014

Conditions	Stand-alone emergency departments	Urgent care centers	Hospital emergency departments
Number of non-life-threatening conditions	7	10	3
Number of life-threatening conditions	3	0	7
Non-life threatening			
Common cold	✓	✓	✓
Urinary tract infection	✓	✓	✓
Open wound (finger)	✓	✓	✓
Sore throat	✓	✓	
Bronchitis	✓	✓	
Ear infection	✓	✓	
Ankle sprain	✓		
Cough		✓	
Strep throat		✓	
Sinus infection		✓	
Pain in limb		✓	
Life threatening			
Fever	✓		
Viral infection	✓		
Abdominal pain	✓		✓
Loss of consciousness			✓
Head injury			✓
Headache			✓
Chest pain			✓
Chest pain, other			✓
Abdominal pain, other			✓

Note: The definitions of non-life-threatening and life-threatening conditions were determined using the National Institutes of Health's guidelines for emergency care. Data for stand-alone emergency departments (EDs) are from eight facilities in Colorado for which the Colorado Center for Improving Value in Health Care could specifically identify claims. Data for urgent care centers and hospital EDs are for all facilities in Colorado.

Source: Colorado Center for Improving Value in Health Care.

stand-alone EDs and urgent care centers, six of the most common conditions overlapped, and none of them were life threatening. Between stand-alone EDs and hospital EDs, four of the most common conditions overlapped, and three were non-life threatening.

Maryland

A 2015 report from the Maryland Health Care Commission (MHCC) about the three stand-alone EDs in the state concluded that the patients they serve were generally of lower acuity (Maryland Health Care Commission 2015). MHCC reported that between 68 percent and 80 percent of patients served by the three

stand-alone EDs in 2014 were in one of the three lowest ED payment levels (out of five levels) compared with between 46 percent and 64 percent of patients served at the nearest competing hospital-based ED. Between 3 percent and 6 percent of patients served by the three stand-alone EDs in 2014 were later admitted as inpatients to a hospital compared with between 15 percent and 19 percent of patients served at the nearest competing hospital EDs. In addition, at the Maryland stand-alone EDs in Bowie and Germantown, 97 percent and 95 percent of patients, respectively, arrived as walk-ins rather than by ambulance. By contrast, the Emergency Department Benchmarking Alliance and the American College of Emergency

Physicians reported that, in 2013, 17 percent of all ED patients nationally arrived at the ED by ambulance (Augustine 2014).

MHCC also concluded that patients served by the three Maryland stand-alone EDs in 2014 were younger, more likely to have private insurance coverage, and had treatment options other than the ED available to them. Compared with all EDs in Maryland, the stand-alone EDs tended to treat a larger share of children and a smaller share of patients older than age 41, tended to serve a slightly larger share of privately insured patients, and tended to serve a lower share of Medicare and Medicaid patients. In addition, the vast majority of patient visits at the three stand-alone EDs occurred during hours when a viable alternative for treating lower acuity conditions was likely available.

Policy options for aligning payments to stand-alone EDs with the acuity of their patients

The growth in stand-alone EDs in recent years appears to signal that existing Medicare and private-insurer payment policies encourage providers to shift services from lower paying settings such as urgent care centers and physicians' office to higher paying settings such as EDs. The Commission's position on aligning payment rates across settings is that Medicare should ensure that patients have access to settings that provide the appropriate levels of care and that Medicare should strive to base payment rates on the resources needed to treat patients in the most efficient setting. For example, under Medicare payment policy, payments are higher for services delivered in the hospital outpatient department compared with payments for the same service delivered in the physician office setting. To capitalize on this contrast, some hospitals are acquiring physician practices and can bill higher hospital OPPS rates for those physician-provided services. The concern in the case of stand-alone EDs is that providers seek to gain market share for low-severity conditions that could be treated more efficiently in other settings. For example, some hospitals are building ED facilities or partnering with IFECs to enable them to bill for services for low-acuity conditions at higher ED rates.

Several policy options could be considered to ensure that payments to stand-alone EDs are aligned with the acuity of their patients and designed to address access concerns.

Policymakers could consider paying OCEDs the lower Type B ED payment rates. Paying OCEDs Type B ED rates would reduce providers' incentive to serve lower acuity cases in the higher paying ED setting by more closely aligning payment rates for stand-alone EDs with both urgent care centers and physicians' offices. Moreover, Type B ED rates appear to be a good match for OCEDs because lower acuity cases account for the majority of Medicare claims receiving Type B ED rates and lower acuity cases account for the majority of cases served by the stand-alone EDs for which claims data exist. Policymakers could also consider allowing OCEDs in isolated rural areas to receive the higher Type A ED payment rates. Paying higher ED rates may enable stand-alone EDs to open in isolated areas that lack access to ED services, or it may enable an isolated rural community with a full-service hospital on the verge of closing to maintain ED services. Finally, policymakers could consider amending Section 603 of the Bipartisan Budget Act of 2015 so that services provided at physician offices connected to stand-alone EDs do not receive higher hospital outpatient department payment rates. The exemption given to "dedicated EDs" under Section 603 encourages the development of stand-alone EDs and encourages hospitals and health systems to expand medical office space inside stand-alone EDs.

Conclusion

The stand-alone ED industry has grown significantly over a short period of time, and the role these facilities play in the Medicare program is growing. Today, there are 363 OCEDs billing Medicare and potentially another 203 facilities that may begin billing Medicare in the near future. In March 2017, the Commission recommended the Secretary of Health and Human Services begin collecting claims data for these facilities because it is unclear what types of Medicare beneficiaries are served at stand-alone EDs versus on-campus hospital EDs. Using information gathered from alternative sources, we found that many more stand-alone EDs could begin billing Medicare in the near future, stand-alone EDs tend to locate in ZIP codes with higher incomes and better insurance coverage, and stand-alone EDs serve lower acuity patients. Policymakers could consider amending the existing Medicare payment rates for stand-alone EDs by aligning payments more closely with patient severity and accounting for the costs of stand-by capacity. ■

Endnotes

- 1 Stand-alone EDs are also commonly referred to—in the media or in research literature—as freestanding EDs. We purposely chose not to use the term *freestanding EDs* because it may cause confusion for readers when we begin to draw the important distinctions between the two different types of stand-alone EDs, those affiliated with a hospital and those not affiliated with a hospital.
- 2 Under the Medicare program, provider-based ED facilities are eligible for payment if they are in compliance with Medicare’s provider-based department regulations, Medicare’s conditions of participation, and the requirements of the Emergency Medical Treatment and Active Labor Act of 1986.
- 3 Representatives of ambulance suppliers in markets with OCEDs stated in interviews that they are aware of the limited set of medical services offered by OCEDs, and they exercise their own judgment in determining where to direct their transports. These suppliers stated that they generally do not transport patients to OCEDs. They specified that they typically transport patients to an OCED only when (1) the patient is not a candidate for inpatient care, (2) the OCED is the nearest provider, and (3) the patient requests the OCED for his or her own convenience.
- 4 The American College of Emergency Physicians summarizes the basic regulatory requirements of IFECs relative to OCEDs in a brief on their website (<https://www.acep.org/Clinical---Practice-Management/Freestanding-Emergency-Departments/>).
- 5 Section 603 of the Bipartisan Budget Act of 2015 defines dedicated EDs as any department or facility of a hospital that meets at least one of the following criteria: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.
- 6 The number of urgent care centers was obtained from the Urgent Care Association of America’s website on September 22, 2016, at <http://www.ucaa.org/?page=IndustryFAQs#Size%20of%20Industry>. The number of retail clinics was obtained from a study by Accenture, as commissioned by America’s Health Insurance Plans (AHIP), and downloaded from the AHIP website on September 22, 2016, at <https://www.ahip.org/wp-content/uploads/2016/06/accenture-retail-health-clinics-pov.pdf>. The number of primary care physicians in patient care in 2010 was obtained from the Agency for Healthcare Research and Quality website at <http://www.ahrq.gov/sites/default/files/publications/files/pcwork1.pdf> on September 22, 2016.
- 7 The OPSS is more likely than the PFS to combine the costs of primary services with ancillary services and supplies into a single payment, a concept referred to as packaging. Under the PFS, services are largely paid for separately. By contrast, the Commission has estimated in previous years that packaged items account for a small share of the total payment of evaluation and management services under the OPSS. The degree to which items and services are packaged into OPSS payments for ED services is likely to be higher than for evaluation and management services in either the OPSS or PFS setting.
- 8 In September 2016, CIVHC provided the Commission with an analysis it conducted in 2015 of the average paid amounts for similar cases at eight stand-alone EDs in Colorado compared with urgent care centers. In 2015, CIVHC published these data on its website under the title “Average Paid Amount for Common Health Conditions, Freestanding Emergency Rooms Versus Urgent Care Facilities” (Colorado All-Payer Claims Database, 2014 Commercial Claims, www.comedprice.org). In 2017, these data are not available on the CIVHC website. CIVHC used commercial claims data from 2014 for this analysis, and at that time, these eight stand-alone EDs were IFECs. In 2017, these eight stand-alone EDs are OCEDs because they are now affiliated with a hospital.
- 9 Private insurers in Colorado pay stand-alone EDs more for other services associated with non-life-threatening conditions compared with the same services at urgent care centers, including abdominal pain—other specified site (\$5,635 vs. \$151), acute bronchitis (\$1,139 vs. \$123), acute sinusitis—unspecified (\$786 vs. \$125), and open finger wounds (\$1,035 vs. \$134) (see Figure 8-3, p. 253).
- 10 Section 2719a of the Public Health Service Act was amended by the Patient Protection and Affordable Care Act of 2010 to require group health plans to cover emergency services without requiring any prior authorizations, regardless of whether the health care provider is a participating network provider (if the service is provided out of network); without imposing any administrative requirements or limitations on coverage that is more restrictive than the requirements that apply to in-network services (if the service is provided out of network); and without imposing any cost-sharing or coinsurance requirements that exceed the member’s in-network requirements. However, the plan member may be required to pay the amount the out-of-network provider charges over the amount the plan requires them to pay. These requirements were effective for plan year 2015.

- 11 Stand-alone EDs are present in 35 states.
- 12 We defined large MSAs as those with 500,000 or more residents in 2015.
- 13 The two types of stand-alone EDs—OCEDs and IFECs—tend to locate in certain markets and not others. The 363 OCEDs (stand-alone EDs affiliated with hospitals) were located in 96 MSAs and 34 states. The 203 IFECs (stand-alone EDs independent of a hospital) were located in 26 markets in 4 states (Colorado, Minnesota, Rhode Island, and Texas).
- 14 The median household income for Houston in 2014 was \$57,000. The median household income for Denver in 2015 was \$58,000. Household income data are from the U.S. Census Bureau’s Fact Finder tool (<https://factfinder.census.gov>).

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