Comparing Freestanding Emergency Departments, Hospital-Based Emergency Departments, and Urgent Care in Texas: Apples, Oranges, or Lemons?

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0196-0644/$-see front matter

http://dx.doi.org/10.1016/j.annemergmed.2017.04.019

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[Ann Emerg Med. 2017;■:1-4.]

The hospital-based emergency department (ED) holds a special place in the US health care system: anyone can get care, anytime, for almost any complaint, with access mandated by the federal government. Now, other options for unscheduled acute care have emerged, including urgent care centers and freestanding EDs. The latter range from large facilities that accept ambulances, are closely affiliated with acute care hospitals, and have visit volumes of midsized community hospital EDs (>20,000 visits per year) to small facilities with several treatment spaces and no formal affiliation with an acute care hospital.

In this issue of *Annals*, Ho et al[1] analyze the administrative billing data of a single, large, commercially insured population in Texas, the state with the most freestanding EDs, and describe the diagnoses, billing codes, and prices of care at freestanding EDs from 2012 to 2015. They found rapid growth in the number of freestanding EDs submitting bills, with the number of visits to freestanding EDs more than tripling and the proportion of total ED visits occurring at freestanding EDs increasing from 5.7% in 2012 to 17.6% in 2015. Additionally, they found that the total charges for freestanding ED visits and the charges that patients are responsible for out of pocket are similar to those for hospital-based EDs. However, the authors also compared the ED data for a subset of these patients with similar discharge billing codes who were treated in urgent care centers; unsurprisingly, they found the urgent care bills and payments much cheaper. Many in the media and those affiliated with payer groups are using these observations to decry the payments to freestanding EDs, with claims of "overpayment" and that freestanding EDs are "misleading patients."[2-4] Are these concerns legitimate? How should we compare the services, costs, and value of urgent care centers and freestanding and hospital-based EDs?

The data for the commercially insured population in the study by Ho et al showed that freestanding EDs appear to care for a patient population with higher disease severity than urgent care centers, but care for a population with lower disease severity than hospital-based EDs. Compared with hospital-based EDs, freestanding EDs care for a larger proportion of patients with diagnoses codes of low-acuity conditions that are frequently seen at urgent care centers, such as upper respiratory infections and bronchitis. Similarly, freestanding EDs treated fewer patients with codes for potentially time-sensitive diagnoses such as chest pain, abdominal pain, and headache than hospital-based EDs. Thus, patients treated in all 3 settings overlap but are distinct, with a skew toward more severe illness and higher resource need in EDs than in urgent care centers; given this, a cost difference isn't unwarranted.

Even when subsets of urgent care and ED populations *seemingly* are the same (as defined by administrative billing codes), we still wonder whether this is an apples-to-apples comparison. Diagnosis codes cannot fully measure illness burden at patient arrival,[5] casting doubt on those comparisons. It is implausible that patients with chest pain see an urgent care center and an ED as equivalent places to seek care, no matter what the final diagnosis code; it is likely those perceiving a higher self-threat more frequently choose the ED (or are transferred there). Ho et al did not analyze clinical measures of comorbidity or severity such as age, comorbid conditions, or vital signs. They report that freestanding EDs perform procedures, including diagnostic testing and treatments, at rates lower than those for hospital-based EDs but higher than those for urgent care centers. However, without analysis accounting for patient severity, it is impossible to determine whether this reflects the patient population or practice patterns and does not allow meaningful comparison to other treatment venues.

Perhaps more is done because of differing potential for morbidity.

Prices charged by freestanding EDs closely parallel those of hospital-based EDs[1]; all ED prices are much higher (up to 10-fold) than at urgent care centers. The majority of this price difference is from the facility fee, which accounts for at least 80% of the total ED price. Historically, hospital-based ED facility fee pricing reflects the direct costs of ED care and the indirect costs associated with the broad mandate to comprehensively care for all patients. State regulations of freestanding EDs vary widely; 24 states have a certificate-of-need process, placing a burden of proof on freestanding EDs to demonstrate medical need for the facility before they are licensed.[6] Texas does not have a need assessment but does have licensing requirements, including being open 24 hours per day, 7 days per week, with a physician and registered nurse with emergency training present at all times; on-site diagnostics, including laboratory tests, computed tomography, and ultrasonography; a licensed pharmacy for treating all medical emergencies; and transfer plans for patients needing higher or ongoing care.[7] In contrast, urgent care centers are not open around the clock, can be staffed by a wide range of licensed independent practitioners, have limited diagnostic tests and treatment options, and are not mandated by the Emergency Medical Treatment and Labor Act to provide uncompensated care. Thus, their operating costs are inherently much lower than at a freestanding ED.

Professional fees paid to physicians and advanced practice providers make up just one fifth of the overall cost of emergency care in the analysis by Ho et al and deserve separate discussion from ED facility fees. In 2015, freestanding ED average and median professional fees payments were similar, but lower than average hospital-based ED professional fees payments (average $388 versus $435, median $200 versus $242; their Table E1). The median amount paid to providers at freestanding EDs rose more rapidly from 2012 to 2015 than it did at hospital-based EDs (88% versus 16%). It is not clear whether this increase is due increased prices from providers or changing payment practices from the insurer. There are insufficient data to accurately determine the appropriateness or comparability of professional fees at freestanding versus hospital-based EDs, but from the limited description provided by Ho et al, the lower professional fees payments at freestanding EDs appear to be in alignment with lower patient illness severity, as judged by diagnosis codes and admission rates. The more rapid increase in professional payments at freestanding EDs from 2012 to 2015 is in alignment with a more rapid increase in high severity CPT E&M codes (level 4 & 5) at freestanding EDs than at hospital-based EDs (14.7% increase versus 6.9% increase; their Figure 4). Further work would be needed to determine the appropriateness of professional fees coding by both hospital-based and freestanding EDs, and the effect of network participation.

Given the differences in capabilities, staffing, and societal mandate, it is reasonable that freestanding EDs charge higher prices than urgent care centers, but should they get the same price opportunity as their hospital-based ED counterparts, who have an overlapping but even broader mandate? In Texas, freestanding EDs enter the market with the same positional market advantages as hospital-based EDs, which protect their prices, yet they do not bear the same costs. ED positional advantages include the ability to charge a facility fee, and reimbursement protections such as the prudent layperson standard and mandated usual and customary rates from out-of-network insurance. Although freestanding EDs have higher costs than urgent care centers, they have lower costs than hospital-based EDs, including materials (eg, real estate location, equipment such as magnetic resonance imaging machines) and labor (eg, on-call services), and lower costs of uncompensated care. In Texas, freestanding EDs are required to screen all patients for an emergency medical condition and stabilize or transfer if the ED does not have the capability to treat such a condition, resulting in a modest uncompensated care risk for the cost of ED visits. In comparison, hospitals with EDs are at risk for large uncompensated care losses associated with the emergency treatment of uninsured patients after an emergency condition is identified, including services such as dialysis, surgery, and hospitalization. Additionally, freestanding EDs can more easily target patients with better reimbursement by locating near populations with fewer uninsured patients or those with government insurance and by not receiving ambulances.[8]

Ho et al argue that "freestanding EDs potentially waste societal resources because they represent a high-cost provider for services that could be delivered in lower-cost settings." This argument is not new and has been made for years about all types of ED care, and this study is not generalizable enough to settle this question. Perceived care inefficiencies must be balanced against the comprehensive, accessible, high-quality care EDs provide, which society wants and consumers demand. To limit patient out-of-pocket costs, Ho et al advocate "limiting the amount for which freestanding EDs can balance bill patients for out-of-network care, particularly for facility fees." We agree that a dialogue about freestanding ED facility payments is timely, but from the