Urgent Care Centers and Free-Standing Emergency Rooms:

A Necessary Alternative under the ACA

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I. URGENT CARE CENTERS ("UCCs")

a. Definition:
   i. Generally accepted definition: a stand-alone center encompassing attributes of the primary care physician's office and the Emergency Department.
   ii. Urgent Care Association of America definition: "The delivery of ambulatory medical care outside of a hospital emergency department on a walk-in basis, without a scheduled appointment."
   iii. Agreed upon services within the definition: episodic, acute care rather than long-term management of chronic illness or preventative care

b. Common Characteristics:
   i. Walk in, unscheduled care
      1. Call ahead and on line wait list options
   ii. Extended hours, including weekends and evenings
   iii. Provision of services beyond primary care which may include:
      1. radiology
      2. wound treatment/suturing/casting
      3. intravenous hydration
      4. on site lab testing
      5. medications
      6. Occupational Medicine and Workers Compensation
      7. Travel Medicine

c. Presence in the Community:
   i. Approximately 9,200 UCCs exist nationwide as of 2013
   ii. 150 million patient visits annually

iii. Increase in growth since mid-1990's

1. 2008-09: +330 new UCCs nationwide
2. 2010-2011: +304 new UCCs nationwide

d. Causative Factors in Growth

i. Public acceptance and control; high deductible plans causing patients to shop for care based on cost and convenience

ii. Lack of access or delayed access to Primary Care

iii. Overcrowding and/or long wait times in Emergency Departments

iv. High quality care

e. Ownership Models

i. Hospitals

ii. Multi-Specialty Physician Practice Groups

iii. Private Equity/Joint Ventures

f. Key Legal Considerations

i. Certificate of Need

1. Determine whether or not a CON is required to operate an Urgent Care Center

ii. Corporate Practice of Medicine

1. Prohibits employment of physicians by corporations
2. Protects the integrity of medical profession by keeping it separate from corporate (financial) interests
3. Prohibition varies by state, e.g.:
    a. Texas: Strict prohibition (Very Narrow Exceptions)
        i. Results in loss of licensure for physician
    b. Illinois: Intermediate prohibition (Narrow Exceptions)
        i. Permits hospital employment of physicians
    c. Indiana: Relaxed prohibition (Broad Exceptions)
        i. Permitted employment as long as entity does not control independent medical acts/clinical judgment
4. Alternatives in CPOE States:
    a. Physician ownership

b. Medical holding company
c. Foundation model
d. Friendly PC model
i. Physician forms a PC and provides the physicians to the UCC; non-physician owned company opens UCC and contracts with PC to provide administrative services

iii. State Licensure
1. Facility licensing: varies by state; check with Department of Health
a. Arizona only state that specifically requires licensing of UCCs
b. In some states (Florida) UCCs may be required to license as a health care clinic
2. CLIA Certificate of Waiver
a. Necessary if UCC offers certain laboratory testing
3. Radiology permits
4. Pharmacy license

iv. Accreditation
1. Joint Commission accreditation available
a. Useful for managed care negotiations
2. 2010 published standards for Urgent Care (collaboration between Joint and the Urgent Care Association of America)
3. Accreditation Standards Include:
a. Environment of Care
b. Emergency management
c. Human Resources
d. Infection prevention and Control
e. Information Management
f. Leadership

g. Life Safety
h. Medication Management
i. National Patient Safety Goals
j. Provision of Care, Treatment and Services
k. Performance Improvement
l. Record of Care, Treatment and Services
m. Rights and Responsibilities of the Individual
n. Transplant Safety
o. Waived Testing

v. EMTALA
    1. Requirements:
        a. Medical Screening Exam (MSE), and
        b. Treatment/stabilization before transfer or discharge, regardless of
        c. Patient's ability to pay
    2. Application to UCCs
        a. Does NOT apply unless the UCC is hospital-owned OR in a joint venture with a hospital and services provided are billed as a hospital department
            i. No obligation to treat patients who arrive at the center
            ii. Triage: stabilize and transport

vi. Reimbursement
    1. Types:
        a. Provider based
        b. Hospital based
        c. Discounted services
        d. Percent of Medicare
    2. Contracting with government and private payors crucial to financial success

a. Private Payors
    i. Determine list of payors (early, process can be prolonged)
    ii. Contact payor's contracting department ASAP
b. Government Payors
    i. Medicare, Medicaid, TRICARE
    ii. Typically lower reimbursement rates than private payors
    iii. Patient population will dictate need
    iv. Expect protracted negotiation
    v. Must enroll in Medicare as "Clinic/Group Practice"
    vi. Physicians will enroll in Medicare using CMS form 8551

g. Key Operational Considerations
    i. Coding and Billing
        1. Payor contracts will specify reimbursement amounts and payment codes
        2. CMS has designated to HCPS codes for UCCs
            a. S9083 – global fees (does not take into account the treatment provided)
            b. S9088 – add on code (for reimbursement of expenses unique to UCCs)
        3. Note: some managed care organizations will only reimburse freestanding UCCs for professional procedure codes
    ii. Malpractice/Liability Insurance
        1. Risk will generally be that of a primary care physician; potentially higher, but not as high as risk of emergency medicine physician
        2. Risk factors:
            a. Lack of established patient relationship
            b. Drug seekers
            c. Robbery

d. Discharge management/follow up
e. Potential for under-diagnosing

iii. OSHA Standards for Medical Office
1. Published guidelines applicable to all medical offices regardless of size:
a. Blood Borne Pathogens Standard
b. Hazard Communication
c. Ionizing Radiation
d. Exit Routes
e. Electrical Reporting Occupational Injuries and Illnesses

iv. Physician Supervision Requirements
1. Laws vary by state, some onerous
2. Certified Nurse Practitioners (CNPs) and Physician Assistants (PAs)
a. Continuous or Intermittent Supervision required?
b. Physician availability for consultation or substitution
c. Concurrent work requirements

v. Prescription Writing Authority
1. Laws vary by state for CNPs and Pas
2. State pharmacy laws for UCCs may be onerous

vi. Breath and Blood Alcohol Testing
1. UCC should have written policy
2. Use of U.S. Department of Transportation (DOT) procedures for alcohol testing polices increasing

vii. Employer Drug Testing/Screening
1. UCC should have written policy including collection procedures, chain of custody, security of collection site, privacy of patient, retention and transport of specimen
2. States may have published approved procedures for incorporation into written policy

h. Key Business Considerations
    i. Location
        1. Patient volume key factor
        2. At least one study has shown a population of 20,000-30,000 necessary to sustain one UCC
        3. Typically concentrated in urban areas
        4. Must be convenient for patients
    ii. Management
        1. Physician managed vs. Management Company
        2. Philosophy
            a. Customer service oriented management improves financial success
    iii. Services
        1. Target population
            a. Know community demographic
        2. Specialty vs. General
            a. Pediatrics and Adult services
            b. Radiology and Intravenous Hydration
        3. Ability for ease of referral
    iv. Buying and Selling
        1. Location – Location – Location
        2. Competition
        3. Reputation
        4. Real property – lease or own
        5. Valuation
        6. Due Diligence
        7. NDAs
        8. Governing/Ownership documents
        9. Employment considerations
            a. Restrictive Covenants/Non Competes
            b. Retirement benefits

c. Ownership interest

d. Taxes

v. Partnering with Hospitals or Investors

1. Possible Ownership Models

a. Physician owned – 50%

b. Hospital owned – 27.9%

c. Corporate owned – 13.5%

d. Non-physician individual owned – 7.6%

e. Franchise – 1.0%

2. Integration – key to successful growth

a. Group Practice Model

i. Multiple physicians practicing under one form of entity at one location

1. Multiple specialty group practices advantageous for UCCs

ii. "Super Group" Model

1. New practice entity formed by and among existing group practices

2. Owned by individual physician members or existing group practices

3. Higher volume of patients typically

iii. Risks/Benefits:

1. Increased revenue

2. Greater input and control over range of care and treatment

3. Concerns over abusive arrangements and overutilization

b. Physician-Hospital Organization

i. Services provided through a network of collaborating physicians and hospitals

ii. Clinical and economic efficiency central to design

iii. Provides wide range of clinical services
iv. Goal of seamless integration that reduces or eliminates referrals outside system

c. Management Company Model
    i. Provides facility, office space, equipment, non-physician personnel, and non-clinical services to existing practice
    ii. Must be commercial reasonable and reflect fair market value payment for the goods and services
    iii. Physician's return on investment must be limited to reasonable return
    iv. Joint venture must be management company and not a healthcare provider

d. Accountable Care Organization
    i. Entity is accountable for the quality, cost and overall care of Medicare FFS beneficiaries
    ii. Will agree to specific organizational and quality performance standards
    iii. Eligible for cost sharing/saving
    iv. Could see UCC as important intermediary
        1. Reduction in ER visits
        2. Increase in continuity of care

i. Future for UCCs
    i. Primary care access / shortages continue
        1. Projected shortage of 45,000 primary care physicians by 2020
        2. Projected increase to that number based on increased insurance coverage under PPACA
    ii. Increased use of EDs for non-emergent care
        1. 2008-2011, approximately 27% of ED visits for non-emergencies
        2. Average wait times > 4 hours
    iii. Rising health care costs and rising utilization

iv. Advantages:

1. Reduction of health care costs
2. Reduce overcrowding in ERs
3. Increasing access for primary care services

II. FREE STANDING EMERGENCY DEPARTMENTS ("FEDS")

a. Concept developed in late 1970's

b. Hospital Affiliated

c. Private Facilities

d. Growth

i. Has doubled in last four years *American Hospital Association

e. Categories

i. Type A

1. Licensed by State
2. Advertised to public as providing ER services
3. Open 24/7

ii. Type B

1. Dedicated emergency department
2. Operating less than 24 hours per day

f. CMS Requirements

i. Organized and supervised by qualified medical staff

ii. Integrated with other hospital departments

iii. Governed by medical staff approved policies

iv. Adequate numbers of medical personnel

v. Policies and procedures for transfer process for patients requiring hospital admission

g. Provides improvement in access to care

i. Health system may use to widen footprint in particular area

ii. FEDs in rural areas can assist EMS personnel in stabilizing critically ill patients

iii. Suburban locations with rapid population grown feed inpatient volume and procedures to a central facility

h. Proponents of FEDs
    i. Ability to expand hospital footprint and brand without capital costs and CON requirements of new hospital or outpatient campus
    ii. Ability to expand incremental use of hospital-based resources, capture referrals, differential from competitors, mitigate threats from UCCs/retail clinics

i. Opponents of FEDs
    i. Creating and distorting demand
    ii. Driving up cost of care
    iii. Siphoning patients with insurance from urban hospitals that need those paying patients to subsidize charity care
    iv. Feeds increased demand for hospital emergency services
    v. Inadequate number of feds and treatment areas
    vi. Poor space configuration
    vii. Inefficient operations lead to long wait times

j. Challenges for FEDs
    i. Respiratory Therapy
    ii. Radiology
    iii. Laboratory
    iv. Pharmacy
    v. Insurance
    vi. Medical Record Keeping (aligned with hospital)