Urgent Care Centers and Free-Standing Emergency Rooms: A Necessary Alternative Under the ACA

Kim Harvey Looney
Kim.Looney@wallerlaw.com
615.850.8722

Mollie K. O’Brien
MOBrien@ebglaw.com
973.639.8297

Jon Sundock
jonsundock@carespot.com
615.600.4060

Why the Proliferation of Urgent Care Centers?

- Growth spurt began in mid-1990s and has continued
  - 2008-2009: added 330 new urgent care centers
  - 2010-2011: added 304 new urgent care centers

- Why the continued growth?
  - Acceptance by the public
  - Lack of access to primary care (no access or delayed access)
  - Overcrowding in Emergency Departments (ED)
  - Long wait times at other providers (EDs especially)
  - Convenience of longer hours and walk-ins
  - Emphasis on high-quality care
  - Increased healthcare consumerism spurred by high-deductible plans
Current State of Urgent Care Centers

- Approximately 600 new urgent care centers added in 2011
- Approximately 9,200 urgent care centers exist today
  - An increase of 1,200 in just three years
- 150 million patient visits to urgent care centers each year in the United States

Current Distribution of UCCs

Source: 2011 Urgent Care Association of America data
What Is an Urgent Care Center?

- No universal definition
  - Provide services that fall in between primary care and emergency department
  - Can also include some primary care services and could branch into other areas, e.g., weight loss, allergy care, wellness, etc.

- Urgent Care Association of America:
  - The delivery of ambulatory medical care outside of a hospital emergency department on a walk-in basis, without a scheduled appointment

- Generally focused on episodic, acute care rather than on long-term management of chronic illness or preventive care

Common Characteristics of Urgent Care

- Walk-in or unscheduled care
  - Many urgent care centers also offer call-ahead options and online appointment-making

- Extended hours, including weekends and evenings

- Provide an array of services beyond primary care

- Customer service approach to providing care

- Occupational health services often provided
Services Provided by Urgent Care Centers

- Primary Care
- Onsite radiology
- Simple fractures and lacerations
- Intravenous hydration
- On-site lab testing
- Medications—prepackaged pharmaceuticals and pain management
- Occupational Medicine and Worker’s Compensation
- Other services may include immunizations, travel medicine, and sports and school physicals

Formation of Urgent Care Centers

- Ownership Models
  - Hospitals
  - Multi-Specialty Physician Practice Groups
  - Private Equity/Joint Ventures
Key Legal Considerations

- Certificate of Need
- Corporate Practice of Medicine
- State Licensure
- Accreditation
- EMTALA
- Reimbursement
- Other Issues

Corporate Practice of Medicine

- The corporate practice of medicine doctrine prohibits employment of physicians by corporations
- Purpose is to protect the integrity of medical profession by keeping it separate from corporate interests
- State laws vary on the doctrine
  - Strict prohibitions
  - Some Limitations
  - No prohibitions
Strict Prohibition Against Corporate Practice of Medicine: Texas

- Any corporation employing a licensed physician to treat patients and receive fees for those services is unlawfully engaged in the practice of medicine
- Employee-physician subject to disciplinary action or license revocation

Narrow exceptions
- Professional corporations formed by physicians
- Independent contractor relationships under certain circumstances
- Critical access hospitals if (1) only facility in community and (2) population of 50,000 or less

Exceptions do not include most physician-entity relationships in Texas
Intermediate Prohibition Against Corporate Practice of Medicine: Illinois

- Permits hospital employment of physicians
- Employment by entities other than hospitals prohibited
- Illinois courts have construed the term “hospital” strictly
  - Covered entities: hospitals or entities directly or indirectly controlled by or under the common control of a hospital
  - Entities must meet the precise terms set forth in the statute
  - Illinois Supreme Court refused to recognize a non-profit health institute and voided a physician employment contract for not meeting the terms

Relaxed Prohibition Against Corporate Practice of Medicine: Indiana

- Permits physician employment as long as the terms of relationship do not violate statutory requirements:
  - “Entity does not direct or control independent medical acts, decisions, or judgment of the licensed physician”
- Most physician-entity employment relationships permitted as long as physician’s professional medical discretion is preserved
- Overall
  - Preserves purpose of corporate practice doctrine, but
  - Allows maximum flexibility of physician-entity employment relationships
Comparison of State Prohibitions Against Corporate Practice of Medicine

<table>
<thead>
<tr>
<th></th>
<th>Strict (Texas)</th>
<th>Intermediate (Illinois)</th>
<th>Relaxed (Indiana)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prohibits any corporation from employing a licensed physician</td>
<td>Prohibits any entity from employing physicians other than a hospital</td>
<td>Prohibits any entity from directing or controlling physician’s medical discretion</td>
<td></td>
</tr>
<tr>
<td>Very Narrow Exceptions</td>
<td>Narrow Exceptions</td>
<td>Broad Exceptions</td>
<td></td>
</tr>
<tr>
<td>Severe restriction—vast majority of physician-entity relationships do not meet exceptions</td>
<td>Fairly severe restriction—permits physician employment, but must meet very specific requirements</td>
<td>Flexible—allows a range of physician-entity relationships</td>
<td></td>
</tr>
</tbody>
</table>

Alternatives in States that Prohibit Corporate Practice of Medicine

- Physician ownership
- Forming a medical holding company
- Foundation model
- Friendly PC model
  - Physician forms a professional corporation (PC) and provides the physicians for the center
  - Non-physician owned company that opens the center contracts with the PC to provide management services
State Licensure

- Facility licensing varies greatly from state to state
  - Arizona is the only state that specifically requires licensing of urgent care centers
  - Urgent care centers may fall under licensing requirements for healthcare clinics
- CLIA Certificate of Waiver
  - Necessary if the center offers certain clinical laboratory testing
- X-ray permit

State Licensure (continued)

- Pharmacy license
  - In some states, highly restrictive pharmacy provisions have led urgent care centers to forego offering prescription medications
- Other licenses depending on state
- Check Department of Health or similar state agency for licensing requirements
Accreditation

- Although accreditation by the Joint Commission is not required for urgent care centers, managed care payors in markets with numerous urgent care centers may look to accredited centers for their networks and exclude those centers that are not accredited.

- 2010 publication of Standards for Urgent Care
  
  □ Offered by the Joint Commission in collaboration with the Urgent Care Association of America

15 Categories of Accreditation Standards

1. Environment of Care
2. Emergency Management
3. Human Resources
4. Infection Prevention and Control
5. Information Management
6. Leadership
7. Life Safety
8. Medication Management
9. National Patient Safety Goals
10. Provision of Care, Treatment, and Services
11. Performance Improvement
12. Record of Care, Treatment, and Services
13. Rights and Responsibilities of the Individual
14. Transplant Safety
15. Waived Testing
EMTALA Requirements

- Medical Screening Exam (MSE); and
- Treatment or necessary stabilization before transfer or discharge
- An MSE and treatment or stabilization must be provided regardless of the patient’s ability to pay
- Regulations contain specific EMTALA requirements

Application of EMTALA

- Treatment obligations of EMTALA do not apply unless the urgent care center is owned by a hospital or in a joint venture with a hospital and services provided are billed as a department of the hospital
  - No obligation to treat patients who arrive at the center
  - Triage policy – stabilize and transport
Operation of Urgent Care Centers

- Reimbursement
  - Provider based
  - Hospital based
  - Discounted services
  - Percent of Medicare

- Staffing and Supervision

- Liability

Reimbursement

- Contracting and credentialing with payors for reimbursement is critical for financial success

- Insurance companies

- Government payors
  - Medicare
  - Medicaid
  - TRICARE
Reimbursement
(Insurance Companies)

- Determine the payors from which the center will accept payment
- Payors’ approved list
  - Start early as this can be an extended process
- Practitioners must be credentialed with the insurance company
- Contact the insurance company’s contracting department early in the process

Government Payors

- Medicare, Medicaid, and TRICARE
- Typically lower reimbursement rates than private insurers
- Analyze patient population with respect to government payors
- Contracting is an extended process—start early
- Usually covers services retroactive to a requested date
- Must enroll in Medicare as a “Clinic/Group Practice”
- Physicians must enroll in Medicare using CMS Form 8551
Other Issues

- Coding and Billing
- Malpractice Insurance
- OSHA Standards for Medical Offices
- Physician Supervision Requirements
- Prescription Writing Authority
- Breath Alcohol Testing
- Employer Drug Testing/Screening

Coding and Billing

- Specify reimbursement amounts and payment codes in the contract
- CMS has designated two HCPS codes for UCCs
  - S9083—global fees; does not take into account the treatment provided
  - S9088—“add on code” for reimbursement of expenses unique to UCCs
- Some managed care organizations will only reimburse freestanding UCCs for professional procedure codes
Liability

- Malpractice risk for UCCs generally falls between that of primary care practitioners and EDs
- Risk factors for UCCs
  - Lack of long-term, well established patient relationships
  - Target for drug seekers
  - Target for robbery if UCC stocks medications
  - Discharge management—patient follow-up plan
  - Potential for underdiagnosing patients—rely on patients to correctly self-triage and select appropriate facility for care

OSHA Standards for Medical Offices

- OSHA has issued guidance on the following areas:
  - Bloodborne Pathogens Standard
  - Hazard Communication
  - Ionizing Radiation
  - Exit Routes
  - Electrical
  - Reporting Occupational Injuries and Illnesses
- Requirements apply to all medical offices—whether there are 2 or 200 employees
Physician Supervision Requirements

- State laws vary and can significantly impacting staffing and operations
- Certified Nurse Practitioners and Physician Assistants
  - Continuous and constant supervision or intermittent
  - Availability of supervising physician for consultation—generally must be at all times
  - Arrangements for a substitute physician to be available
- Registered Nurses and Licensed Nurse Practitioners
  - Frequency and length of time that physician must be “on-site”
  - Availability of supervising physician for communication and consultation—at all times

Prescription Writing Authority

- State laws vary as do requirements for Nurse Practitioners and Physician Assistants
- Nurse Practitioners (TN)
  - Must hold a certificate of fitness
  - Joint adoption of physician supervisory rules concerning controlled substances required
  - Can prescribe and/or issue controlled substances listed in Schedules II, III, IV and V
Prescription Writing Authority *(continued)*

- **Physician Assistants (TN)**
  - Written protocols required—developed and agreed upon by physician and PA
  - Supervising physician may delegate authority to issue prescriptions or medication orders for legend drugs and controlled substances listed in Schedules II, III, IV, and V

---

**Breath Alcohol Testing**

- Policy setting forth the UCC’s procedure for Breath Alcohol Testing
- Use of U.S. Department of Transportation (DOT) procedures for modeling alcohol testing policies increasing
Breath Alcohol Testing (continued)

- DOT Procedures:
  - Initial tests for alcohol concentration:
    - Approved Saliva Screening Device operated by a trained Screening Test Technician (STT); or
    - Approved evidential breath testing device (EBT) operated by a trained Breath Alcohol Technician (BAT).
  - Alcohol concentration of 0.02 or greater—Second EBT test to confirm
  - An alcohol concentration of 0.02 or greater considered a positive alcohol test

Employer Drug Testing & Screening

- Policies for setting forth the UCC’s procedure for drug testing
  - Employer provided forms for listing medications
  - Collection procedures
  - Chain of custody procedures
  - Security of the collection site
  - Privacy of individual
  - Retention and transportation of the specimen

- State-approved procedures can be used as a model for drafting UCC drug testing policies and procedures
### Overview of Issues

<table>
<thead>
<tr>
<th>Reimbursement</th>
<th>Insurance Companies—start process early Medicare enrollment required for reimbursement—both the UCC and physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Licensure</td>
<td>No License Required. Except in AZ.</td>
</tr>
<tr>
<td>CLIA Certification</td>
<td>CLIA Certificate Of Provider-Performed Microscopy Procedures Is Required.</td>
</tr>
<tr>
<td>Other Licenses</td>
<td>X-Ray Licensure, Pharmacy Licensure, and Others</td>
</tr>
<tr>
<td>OSHA Standards for Medical Offices</td>
<td>OSHA Standards Applicable</td>
</tr>
<tr>
<td>Physician Supervision Requirements</td>
<td>Certified Nurse Practitioners and Physician Assistants Registered Nurses and Licensed Nurse Practitioners</td>
</tr>
<tr>
<td>Prescription Writing Authority</td>
<td>Nurse Practitioners v. Physician Assistant Written protocol requirements</td>
</tr>
<tr>
<td>Alcohol and Drug Screening</td>
<td>Alcohol policies based on DOT increasing Drug policies based on state-approved standards if available</td>
</tr>
</tbody>
</table>

### Key Business Considerations

- Location, management, and services
- Issues in buying or selling an Urgent Care Center
- Partnering with hospitals and investors
Location

- Volume key to financial success
  - One study showed that a population of 20,000 to 30,000 was needed to sustain a UCC
- Currently, UCCs are concentrated in urban areas
- Convenience for patients
- Population demographics, e.g., age, average income
- Free-standing v. hospital-associated

Management of UCCs

- How will the UCC be managed?
  - Physician managed
  - Management company
- Customer service oriented management improves financial success of UCCs
- Leadership with a healthcare background is key
Services Provided

- Target population
  - Know the community’s demographic in order to tailor services to community’s needs
- Specialty v. General
  - For example, some UCCs focus specifically on pediatric care
- One stop shop
  - All services within the UCC or nearby referral locations
  - Goes back to the convenience factor

Buying or Selling an Urgent Care Center

- Buying an existing Urgent Care Center
  - Location
  - Competition
  - Reputation
  - Property—leased or owned
- Valuation
- Due Diligence
- Non-Disclosure Agreements
- Employment & Non-Compete Agreements
Buying or Selling an Urgent Care Center (continued)

- Governing and Ownership Agreements
  - Voting
  - Officers
  - Compensation
  - Decision making—Management and Control
- Retirement
- Sale of Ownership Interest
- Tax Considerations

Partnering with Hospitals and Investors

- Possible Ownership Models
  - Physician or group of physicians – 50%
  - Hospital – 27.9%
  - Corporation - 13.5%
  - Non-physician individual – 7.6%
  - Franchise – 1.0%
- With the wide range of services offered and extended service hours, integration is key to the successful growth of an urgent care center
Different Integration Models

- Group Practice Model
- Physician-Hospital Organization
- Management Company Model
- Accountable Care Organization

Group Practice Model

- Multiple physicians practicing under one form of entity at one location
- Multi-specialty group practices advantageous for UCCs
- Supergroup Model
  - A new practice entity formed by and among existing group practices
  - Owned by individual physician members or existing group practices
  - Higher volume of patients typically
Group Practice Model

- Advantages
  - Increased revenue
  - Greater input and control over range of care and treatment

- Criticism
  - Concerns over abusive arrangements and overutilization

Physician-Hospital Organization

- Provides healthcare services through a network of collaborating physicians and hospitals

- Characteristics
  - Clinical and economic efficiency and effectiveness are central to the design
  - Provides a wide range of services
  - Goal is seamless integration that greatly reduces or eliminates referrals to entities outside the system
Management Company Model

- Provides the facilities, office space, equipment, non-physician personnel, and non-professional services to an existing practice or other healthcare services provider
- Must be commercially reasonable and reflect fair market value payment for the goods and services
- Physician’s return on investment is limited to a reasonable return
- Must ensure the joint venture is a management company and not a healthcare provider

Accountable Care Organization

- Entity willing to become accountable for the quality, cost and overall care of Medicare FFS beneficiaries assigned to it
- Expected to meet specific organizational and quality performance standards
- If standards met, eligible to receive cost sharings
- UCCs can be an important intermediary in any ACO
  - Increased savings by reducing ED visits when primary care physicians are unavailable
  - Increased continuity of care
Future Role of Urgent Care Centers

- Primary care access problems to continue
  - A projected shortage of 45,000 primary care physicians by 2020
  - Increased insurance coverage under PPACA will add to the shortfall already predicted
- Increased use of EDs for non-emergency care
  - 2008-2011: Approximately 27% of visits for non-emergencies
  - Average wait times risen to over 4 hours
- Rising healthcare costs

Future Role of Urgent Care Centers

- Utilization projected to continue growing
- Current and future areas of growth include
  - Primary care
  - Non-emergent care
  - ACOs—urgent care centers could be an integral part of the organization in order to reduce visits to ACO’s ED
- Advantages
  - Reduce healthcare costs
  - Reduce overcrowding in EDs
  - Increased access to primary and urgent healthcare
Free-Standing Emergency Departments

- Concept developed during late 1970s
- Hospital Affiliated
- Private Facilities

Growth in FEDs

- 400 (more than double number four years ago: AHA)
CMS Categories

- Type A
  - Licensed by State
  - Advertised to public as providing emergency services
  - Open 24/7

- Type B
  - Dedicated emergency department
  - Operating less than 24 hours per day

CMS Requirements

- Organized and supervised by qualified medical staff member
- Integrated with other hospital departments
- Governed by medical staff-approved policies
- Adequate numbers of medical personnel
- Policies and procedures for transfer process for patients requiring hospital admission
Improve Access to Care

- Health system may use to establish footprint in particular area – may include imaging center
- FEDs in more rural areas can assist EMS personnel in stabilizing critically ill patients
- Suburban locations with rapid population growth feed inpatient volume and procedures to a central facility

Proponents of FEDs

- Ability to expand hospital footprint and brand or serve underserved population without significant capital expenditure and CON requirements associated with a new hospital
- Ability to expand incremental use of hospital-based resources
- Mitigates threats from UCC business lines and other competitors
Opponents to FEDs

- Creating and Distorting Demand
- Driving up Cost of Medical Care
- Siphoning patients with insurance from urban hospitals that need money to subsidize charity care
- Location, Location, Location
  - High traffic, high visibility retail strip serving well-established, high-income, high density residential areas

Hospital Systems and FEDs

- Increased demand for hospital emergency services
- Dysfunction in hospital FEDs
  - Inadequate number of beds and treatment areas
  - Poor space configuration
  - Inefficient operations leading to long ED wait times
- Ability to expand hospitals’ brand and physical footprint without capital costs and CON requirements of new hospital or outpatient campus
- Ability to expand incremental use of hospital-based services, capture referrals, differentiate itself from competitors, mitigate threats from urgent care centers, retail clinics and other on-demand providers
Hospital Systems and FEDs

- HCA
- Wake Med Health and Hospitals

Challenges for FEDs

- Respiratory Therapy
- Radiology
- Laboratory
- Pharmacy
- Insurance
FEDs and State Licensure

- Differs by state:
  - Some states have laws that prohibit or restrict the freestanding ER, e.g. Alabama
  - Some states require licensure of FEDs and regulate hours, facilities, e.g. Texas, Illinois

- All states licensing FEDs will address EMTALA responsibilities

Differences: UCCs & FEDs

<table>
<thead>
<tr>
<th>Urgent Care Center</th>
<th>Freestanding Emergency Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Contracting</td>
<td>Typically as an urgent care facility, reimbursing either a flat fee per patient (with carve-out for high-value procedures) or fee-for-service. May also be contracted as a primary care office.</td>
</tr>
<tr>
<td>Net Revenue per Patient</td>
<td>$400 to $1195</td>
</tr>
<tr>
<td>Co-Pay Charged</td>
<td>Urgent care co-pay—typically $55 to $150</td>
</tr>
<tr>
<td>Facility Fee Charged</td>
<td>Typically no facility fee is charged, except in certain instances in which the center is part of a hospital campus. Typically one invoice for all services on site.</td>
</tr>
<tr>
<td>Costs Treated</td>
<td>Typically low to moderate acuity, with the bulk of patients presenting with minor infections, flu symptoms, allergies, rash, lacerations, sprains/strains, and fractures.</td>
</tr>
<tr>
<td>Operating Hours</td>
<td>Typically 10-12 hours a day, seven days a week.</td>
</tr>
<tr>
<td>Square Footage</td>
<td>Typically 2,500 to 4,500 sq. ft.</td>
</tr>
<tr>
<td>Trauma and Resuscitation</td>
<td>Providers typically certified in Basic Life Support although many have advanced life support certification. Center typically equipped with EKG, defibrillator and drug cart. Process is to stabilize patient, call 911, and then EMS transfers patient to hospital emergency room.</td>
</tr>
<tr>
<td>Source: Urgent Care Association of America</td>
<td></td>
</tr>
</tbody>
</table>

| Freestanding Emergency Center | Typically as an emergency facility with physicians contracted as separate, independent providers. |
| Co-Pay Charged | Emergency room co-pay—typically $275 to $500 |
| Facility Fee Charged | A facility fee is charged in addition to a professional fee for the providers. Patient is often billed separately by the facility and physician group. |
| Costs Treated | Typically non-emergent with greater emphasis on musculoskeletal injury and lacerations. Patients self-triage for acuterising conditions including high fever, automobile accidents, and asthma attack. |
| Operating Hours | Most are open 24-hours a day, 365 days a year although some privately held centers may operate 10-12 hours/day, seven days a week. |
| Square Footage | 5,000 to 30,000 sq. ft. depending on whether the center is independent or hospital affiliated. |
| Trauma and Resuscitation | Providers certified in Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS). Capabilities to administer IV medications and perform cardiac enzyme and BMP labs. Process is to stabilize patient and admit to hospital (using contracted paramedics transport) under direct referral agreement. |

Source: Urgent Care Association of America
### Differences: UCCs & FEDs

<table>
<thead>
<tr>
<th>Urgent Care Center</th>
<th>Freestanding Emergency Center</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider Staffing</strong></td>
<td>May be any combination of physicians, physician assistants, or nurse practitioners supported by medical assistants and technicians.</td>
</tr>
<tr>
<td><strong>Provider Specialty</strong></td>
<td>Typically family practice or emergency medicine with representation from internal medicine, pediatrics and other specialties. May or may not be certified by an ABMS-recognized board.</td>
</tr>
<tr>
<td><strong>Laboratory</strong></td>
<td>Varies by location. Typically lab accredited for point-of-care testing. Labs performed by medical assistants. Collection and send-out to reference laboratory for more advanced labs. Ultrasound screening as a revenue center.</td>
</tr>
<tr>
<td><strong>Imaging</strong></td>
<td>Typically basic x-ray performed (depending on state law) by trained medical assistant or radiology technician. Consulting radiologist over-reads to validate diagnosis.</td>
</tr>
</tbody>
</table>

Source: Urgent Care Association of America

---

### Questions?

**Kim Harvey Looney**  
Kim.Looney@wallerlaw.com  
615.850.8722

**Mollie K. O’Brien**  
MOBrien@ebglaw.com  
973.639.8297

**Jon Sundock**  
jonsundock@carespot.com  
615.600.4060