Don't Hate the Player; Hate the Game

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INTRODUCTION

Significant controversy has surrounded the development of freestanding emergency departments (EDs) in the United States. This controversy is a part of a larger narrative about how the US health care system meets the acute and emergency care needs of patients. Both the absolute number[1,2] and the intensity of ED visits[3] have increased in recent years, placing a significant burden on hospital-based EDs. This increase is certainly due in part to the advances in clinical care that have steadily increased life expectancy in the United States,[4] but it also results from changes in the health care delivery system. Market forces, including the consolidation and closure of hospitals,[5,6] the reduction in inpatient beds, and the transition of many formerly hospital-based procedures and interventions to outpatient practice,[7] have increased the number of patients with complex medical conditions who are living in the community. The outpatient infrastructure has not grown in a manner sufficient to compensate for inpatient closures. In many communities, supply does not meet demand and long wait times for unscheduled care remain the norm. Despite the rhetoric about patient centeredness, the policy community repeatedly uses words such as "inappropriate" or "unnecessary" to describe patients who seek care when they are concerned that something is wrong or seek unscheduled care on their terms.

Solving the acute care crisis will require cooperation across medical specialties, payers, policymakers, and patients. Favored innovations such as patient-centered medical homes, concierge or boutique practices, and open-access primary care initiatives often limit the number of patients in a practice and ultimately include only a small proportion of Americans. Payers are currently testing larger models, including accountable care organizations and comprehensive primary care,[8] that seek to control the cost of care for chronic conditions, but have limited focus on acute conditions or acute exacerbations of chronic conditions. In the end, most mainstream interventions are fundamentally structured around a primary care model, but the reality is that sicker individuals managed as outpatients with specialist care will intermittently require real-time advanced diagnostics and therapeutics.

Newer innovations emerging outside of the dominant policy mind-set—that the outpatient primary care system should manage acute care—have been met with skepticism. In addition to the standing objection to the use of EDs by payers,[9,10] professional societies have articulated concerns about the use of retail clinics and urgent care centers,[11,12] and disruptive innovations, such as direct telemedical consultation with patients, have been stymied by efforts to limit payment to providers who have a preexisting relationship with the patient.[13] Freestanding EDs are the latest lightning rod in this debate.

FREESTANDING EDs

Unlike urgent care centers, which focus on low-acuity injuries and nonemergency illness, freestanding EDs have more sophisticated capabilities and are typically open for extended hours, mostly 24 hours, 7 days a week. In recent years, freestanding EDs have proliferated,[14] mainly in Texas (which had 0 in 2010 and 191 in 2016),[15] Colorado, and Arizona. Freestanding EDs have grown in popularity among the general public, but there is little evidence to determine how they affect cost, quality, and access to care for individual patients, as well as the health care system.

Although freestanding EDs have existed since the 1970s, with the original intent to provide emergency services to more rural areas without access to a hospital,[16] the scant literature that exists about them is outdated, given the rapidly changing landscape. Overall, the most recent data clarify several things about the current status of freestanding EDs. First, they have become increasingly popular among patients and are now seen as convenient and reliable sources of emergency care.[17] Second, most freestanding EDs are capable of handling high-acuity cases, provide quality comparable to that of hospital-based EDs for diagnostic and therapeutic services,[18] and compete with hospital-based EDs for patient share. Third, they can be lucrative and are proliferating wherever state legislation

permits. Finally, consumers of acute care may not yet fully understand the difference between urgent care centers and freestanding EDs, which has associated cost implications.[19]

Not all freestanding EDs are the same. Payment structures allow 2 distinct types to exist: freestanding EDs affiliated with an existing hospital and considered satellite EDs, and those that are truly freestanding and independent. Furthermore, some "hybrid" models of freestanding EDs allow patients to register in urgent care status and convert to an ED patient (and charge fee) only if their diagnostics evaluation requires ED-level resources.[20]

The article by Ho et al[21] is one of the few studies that tries to answer one of the most important questions in this shift in the landscape of emergency services: how do utilization and costs compare across freestanding and hospital-based EDs?* The article by Ho et al had 2 key findings with respect to utilization and costs: the use of freestanding EDs has increased by 236% in a 4-year period, and the average price of a visit to a freestanding ED has increased to nearly the same level as the average visit to a hospital-based ED. As is often the case, the story about cost has gotten greater press than the story about an innovation that is potentially meeting unmet demand; both deserve attention.

COST, CHARGES, AND PRICE

One of the main challenges in making sense of any study discussing costs, charges, or prices is to clearly understand the definitions used because these terms are often conflated and can be misconstrued by academics, the media, and the public. A "charge," which can be understood as the "sticker price," or retail price, of a service, is not—as some might expect—the same as the "price." Charges can generally be found on a hospital's charge master, in which the hospital lists the services and the amount they have decided to bill for them.[22] Outside of health care, the charge and price of an item are the same. In health care, however, because of the complex arrangements between providers and payers, the price (or what one is expected to pay for the service) can differ, depending on numerous factors. In this article, Ho et al define price as the "amount the provider should be paid by the insurer and patient together." This price differs if a facility or provider is "in network" with a health plan. Facilities and health plans negotiate insurance payments ahead of time, with facilities often granting health plan discounts from the charge master rate. Patients are often left to pay the difference between the price (total allowed amount) and either the negotiated payment for an in-network facility or the difference between the price and the amount that the health plan decides to pay after the service is rendered for out-of-network facilities. For uninsured patients, the price is often the charge master rate, which can be many times the price charged to a health plan. Finally, price is not the same as the economist's definition of cost, which is the amount of resources required to produce a certain commodity or service (because no one in health care really knows the cost of services).

In addition to understanding the distinction between charges and prices, it is essential to understand that ED visits generate 2 charges, one for the facility and one for the provider. Although provider fees are relatively comparable for ED visits and other outpatient visits,[23] facility fees are specific to hospital-based services, including ED visits, and have been used to improve health system revenue.[24] As shown by Ho et al, these fees can be costly and are the major contributor to the higher cost frequently associated with ED care. Facility fees exist to offset the fixed costs (ie, overhead) associated with running a hospital continuously. Although rarely framed as such, they essentially represent a cost shift, a means by which to distribute the cost of ensuring that a hospital's facilities, equipment, and staff are ready at all times.

CONTRIBUTIONS TO CURRENT KNOWLEDGE

How does understanding these very cumbersome terms help us distill the lessons from the article by Ho et al? These definitional differences are not simply semantics. Price in this article is defined as the price that the patient sees and, from that perspective, is a significant contribution to the national conversation of how freestanding EDs affect patient cost. Had the article by Ho et al reported charges, we could easily dismiss them as fairly useless because insurers negotiate with providers to determine their reimbursement rates and, after all, the study examined claims of insured individuals. Had the article by Ho et al reported true costs (which is almost impossible to do in the US health care system), that also would have mattered little to the patient because our system of payment is not based on true costs. Instead, Ho et al used total allowed amount, which enables the patient to see the effect of the visit to a freestanding ED compared with a hospital-based ED in a very direct way: what is the amount that both my insurer and I are required to pay for this service? In essence, then, this choice of a price term also provides a societal framework for which to study the relative value of freestanding EDs because even though the amount the insurer pays is not directly related to the patient for this specific instance, in the long run, higher outlays by the

*The authors purport to include an additional comparator—urgent care centers—but for reasons explained in the accompanying editorial by Dr. Callaham, they are not suitable for direct comparison.

insurer will inevitably lead to higher premiums for the patient.

Given the policy community's interest in simply denying claims for some types of "nonemergency" visits,[9,10] no dialogue on this subject would be complete without addressing the reality that a diagnosis can't always be used to determine the intensity of service (and the related total allowed amount) required. Any comparisons across acute care settings require adjustment by patient severity so that, for example, a 70-year-old with a history of aortic dissection, gastrointestinal bleeding, and metastatic colon cancer who eventually receives a diagnosis of abdominal pain after a negative evaluation result in the ED is not classified the same way as a 16-year-old who ate some bad chicken. Although some work has been done to develop a chief complaint–based framework by which to benchmark resource intensity in diagnostic evaluations,[25] the predominant model remains diagnosis codes, a method so fraught with challenges that it verges on useless. In past work, 13% of patients with nonemergency diagnoses were demonstrated to require hospital admission (of whom 11% required ICU care and 3% were taken to the operating room).[26]

MEETING AN UNMET DEMAND: THE PATIENT'S PERSPECTIVE

Lost in much of the payer-based discussion on the relative costs of care at a freestanding ED compared with other settings is the inherently patient-centered reality that these facilities may be meeting a need. Access to acute care has become a national crisis during the last 2 decades, and cost concerns have driven payers to divert patients from EDs into the overwhelmed primary care system and discourage ED use through co-payment and other disincentives. The Centers for Medicare & Medicaid Services (CMS) developed quality-reporting measures to provide incentive for rapid ED throughput. These quality-reporting measures put pressure on many EDs to discharge or admit patients quickly or be penalized.

Faced with public shaming through star ratings or financial penalties, the acute care community did what the private sector does in response to incentives: they innovated. Favored programs focused on the management of chronic conditions, such as hospital at home, identification of superusers, and Project Extension for Community Healthcare Outcomes, have been warmly received.[27,28] Acute care–focused solutions, including community paramedicine, retail clinics, urgent care centers, direct-to-consumer telemedicine, and now freestanding EDs, however, have been met with mixed reception.

The question of whether these innovative delivery models are equally distributed has been particularly sensitive. Profitable services, such as cardiac catheterization and percutaneous coronary intervention, have been systematically located—like urgent care centers[29] and freestanding EDs[30]—in areas with better patient payer mix and more affluence.[31,32] For example, although there was a 44% relative increase in the number of percutaneous coronary intervention laboratories in the United States from 2001 to 2006, it increased relative access to less than 1% of the population.[33] These studies provide evidence of what we already know to be true: locations for new health care service providers are chosen according to business feasibility rather than solely patient need. These decisions, although financially sound and business savvy, risk systematic duplication of services in affluent areas with health care services until the market saturates and do not address the significant access gaps for low-income, high-need communities.

THE GAME AND THE PLAYERS

The problem here is with the game, not the players. Like all players, health care providers respond to the rules and incentives of the game they are playing in self-interested ways. Although current knowledge specifically about freestanding ED behavior is limited, an overwhelming amount of evidence from health care in general suggests that although providers in the United States continue to exist in a market-based system, they will continue to respond to market-based incentives to earn profits, if not profit maximize. For-profit environments, and nonprofit environments that resemble for-profit environments (ie, many nonprofit hospitals), tend to accelerate more economic and profit-driven behavior.[34,35] Existing literature shows that for-profit institutions are less likely to offer safety-net services,[36] more likely than their nonprofit or government counterparts to close their EDs,[37] and more likely to have higher markups on services (aka cost-to-charge ratios).[38] Without substantial incentives or regulations to encourage health care entities to open clinics in underserved areas or to charge less than the distorted market will bear, we will continue to see current prices and disparities in the allocation of resources.

Said differently, choosing to locate new freestanding EDs in areas in which an insured population with acute care needs lives was, and is, a sound business decision. Freestanding ED growth in these areas may not solve the access crisis among the lower-income or uninsured populations, nor does it reflect the safety-net component of emergency care's mission, but in a dispassionate manner,

the proliferation of freestanding EDs and other acute care innovations is simply expected market behavior. If not for their costs, the narrative on freestanding EDs might be that they are a welcome release valve for struggling hospital-based EDs charged with absorbing the acute care needs of a population that is aging and fragile. Rather than condemning freestanding EDs for failing to control costs, the challenge might be to better understand how to blend them into the health care system.

POTENTIAL POLICY TOOLS TO CREATE A BETTER GAME

For the emergence of innovation in acute care to be properly analyzed, it is important to examine the context of the system in which it exists. Subspecialty reimbursement has driven medical students away from primary care. Limited providers and full schedules have decreased access to the primary care system. Payer incentives have moved health care to an outpatient model. And fragile patients living at home, along with generally healthy people with a medical concern, need care and often struggle to access the existing system. Given this context, freestanding EDs offer a potential alternative to the overburdened status quo of hospital-based EDs.

But in a policy debate focused on cost, freestanding EDs' potential role in health care delivery is often lost. As we pivot from cost to value (outcome divided by cost), determining what we expect to get for our money becomes essential. If the priority is access to health care in underserved and at-risk communities, policymakers and payers can design incentives to promote those goals. If the goal is to create competition in the acute care marketplace—whether to decrease wait times, transform the patient experience, or decrease costs relative to hospital-based EDs—market forces, payment structures, and regulatory incentives can be developed to get us there. However, it is critical to clearly identify the policy goals we want to achieve before taking any particular action. Although states may have different goals because of differing environments (eg, care in rural areas, additional competition in highly monopolistic or concentrated markets), articulating an absolute choice about what an ideal acute care system in the state would look like, and how much the citizens are willing to pay for it, should be the primary goal of any policymaker attempting to improve the system. Those who create the rules of the game must understand cost, but their motivation must arise from the needs of the patient and the population. Below we describe approaches to addressing 2 of the most common (and sometimes conflicting) priorities in the acute care policy debate.

Providing Care to Underserved Areas

The social justice, or safety net, role of the emergency care system has been well described, legislatively secured, and largely embraced by the emergency care community. Simultaneously, because approximately half of all emergency services are uncompensated in the United States,[39] tension exists between this role and more traditional interests of delivering high-quality emergency care under traditional payment structures. Over the years, several policy tools have been used by states to promote care in underserved areas and prevent duplication of services. To promote access to care in underserved populations, states could require new freestanding EDs to receive previous approval through certificate-of-need programs or licensing requirements. Alternatively, state, federal, or private payers could create incentives to encourage freestanding ED or other actors to meet the acute care needs of these communities in very specific and targeted ways. The following policy options can be used independently or in combination, depending on the goals of the regulating entity.

Certificate-of-need laws generally prohibit new or existing health care providers from creating a new provider entity or expanding facilities or services without demonstrating a genuine public need in the relevant geographic market.[40] In states with certificate-of-need laws, private entities typically must receive a certificate of need from the state health department before proceeding with any development that meets the state's designated threshold for expansion review. Although at one point every state had a certificate-of-need program, certificate-of-need laws have fallen out of favor in many states and federal agencies because of criticisms that they failed to control costs and they decreased quality. After extensive study, the Federal Trade Commission and Department of Justice concluded that certificate-of-need laws created a barrier to market entry by firms that could provide higher-quality care or innovative care methods. In some instances, existing providers had exploited the certificate-of-need process to prevent or delay entry by competitors to protect their supracompetitive rates.[41] In the case of freestanding EDs, hospital systems have reportedly lobbied during the certificate-of-need process to prevent freestanding ED construction near their facilities to avoid competitor entry.[42] In the 24 states with certificate-of-need programs, certificate-of-need laws have been a large deterrent of freestanding ED growth[43]; the majority of freestanding EDs are in Texas, Colorado, and Arizona, which are non–certificate-of-need states.[44]

Rather than instituting a regulatory process subject to influence by competitors, states could consider creating a

licensing program that clearly establishes criteria that coincide with the state's health care needs and patient population. To date, states have instituted 3 types of licensing schemes related to freestanding EDs. First, states have permitted freestanding EDs to operate under the license of an affiliated parent hospital. After an initial pilot program, Florida chose to require freestanding EDs to meet the same criteria as onsite EDs and allow them to operate only under their parent-hospital state license.[41] Second, states have created specific licenses for freestanding EDs, which are typically similar to hospital ED requirements, including acceptance of all patients arriving at the facility, stabilization, and provision for transport when necessary.[45,46] Third, a state that wanted to avoid freestanding EDs could narrow its ED definition and requirements significantly to prohibit licensure of freestanding EDs, as California has done.[47] Again, policymakers should establish a clear set of priorities and apply them equally to existing and novel entrants into the acute care marketplace. Reactive regulation risks losing any potential benefits that could arise from freestanding EDs (eg, limiting licenses to existing hospitals) and an overly permissive approach might fail to balance the interests of the public with the interests of the firm.

In addition to regulatory and licensing policies, payment incentives can also promote policy goals. For instance, a state with highly competitive urban and suburban health care markets, but underserved rural communities, could provide incentive to freestanding EDs (or other health care models) to locate and operate in areas with the greatest need rather than communities with the highest proportion of privately insured individuals.[48] For example, policymakers could enable all freestanding EDs that open in underserved areas to collect hospital facility fees or other incentive payment. Two forms of freestanding EDs currently exist: satellite branches of a parent hospital, and independent freestanding EDs that are unaffiliated with any other hospital. Only satellite freestanding EDs are currently eligible for Medicare reimbursement for their facility fee because they operate under the hospital license, which enables them to bill CMS for their services. Currently, independent freestanding EDs do not qualify for facility fee reimbursement because CMS permits hospital outpatient departments to operate under the license of their parent hospital only if they are within a 35-mile radius.[49] CMS could consider relaxing its 35-mile distance rule in certain instances if the freestanding ED demonstrated that it increased access to emergency care in an underserved area.

Alternatively, Congress can also provide incentive for freestanding EDs to provide care in rural areas with targeted payment structures. Senate Bill 1130, for instance, the Rural Emergency Acute Care Hospital, would allow CMS to reimburse facility fees to freestanding EDs in rural areas where the fixed costs of operating a hospital are more expensive, given the lower volume. Specifically, the bill officially recognizes "rural emergency hospitals" as a new facility type with specific qualifications and benefits, and proposes reimbursing services at 110% of reasonable cost.[50] This payment adjustment is especially important because current Medicare payments use cost of living, as defined by the geographic practice cost index, to adjust payments, which unfortunately ignores the challenges of attracting physicians to live in rural areas. Several states, including Georgia and Mississippi, have either already approved rules to govern rural emergency hospitals or are piloting these programs.[51] In a similar vein, many rural hospitals currently qualify for lower payment rates (type B Hospital Outpatient Prospective Payment System) because they are not open 24 hours a day.[15] Allowing them to receive payment rates equivalent to type A rates could provide incentive for more service providers to locate there, or at least support the current provision of service in these areas.

Finally, a number of novel payment structures currently being tested by payers, including accountable care organizations and global budgets, may help to inform how to best meet the acute care needs of a community. Aligning payment structures with a focus on community and population health and an eye toward meeting acute care needs offers promise if done correctly (ie, ensuring that "communities" or "populations" are defined in an inclusive manner rather than simply as within health system networks). The Pennsylvania Department of Health has partnered with CMS to develop a rural health payment model that will give hospitals some freedom to deliver care not available under traditional payment structures. Although the focus is on preventive services, a natural extension to include new acute care models exists.[52]

Promoting Competition in Acute Care Markets

The acute care delivery system in the United States has been widely criticized for being expensive, crowded, fragmented, and low value. Given this, policymakers (eg, states, payers) may want to provide incentive for freestanding ED entry into a market that already has a dominant hospital-based ED to promote competition over access, price, and quality. Allowing institutions with new innovative models of care the opportunity to enter a market and compete has the potential to change existing norms within our health care markets and drive change across all providers. Without proper oversight, however, this approach can easily backfire. First, freestanding ED entry into a market dominated by a hospital-based ED can result in shadow pricing, in which the freestanding ED entry fails

to decrease prices and instead charges only slightly less than the hospital-based ED. Second, freestanding ED presence in a market could result in cost competition that paradoxically worsens quality. There are inadequate data at present to determine whether quality of care is superior at freestanding EDs or hospital-based EDs. On one hand, locating freestanding EDs in areas already served by hospital-based EDs, which generally have more specialty services (eg, cardiac catheterization, surgical services), could result in delayed care as a result of transfers.[17] Hospital-based EDs, however, compete for resources (eg, computed tomography scan, laboratory, pharmacy, consultants) with other components of the hospital. If subspecialty services are made to compete for business from freestanding EDs, a buyer's market could emerge that might improve service.

Licensing regulations can be used to achieve goals of promoting competition, decreasing costs, and improving quality. For a hospital to participate in the Medicare program, CMS requires that "[i]f emergency services are provided at the hospital…policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff."[53] Currently, however, CMS does not set standards for what defines emergency care. In fact, although a clear articulation of what services and staff are required for some specialty designations (eg, trauma center, stroke center) exists, a clear standard of resources and capabilities, a tiered structure of levels of an "ED," or a panel of outcomes that are used to benchmark emergency care, does not. The introduction of freestanding EDs into markets has in some cases required that these standards be defined[54]; the degree to which similar standards exist for hospital-based EDs is variable but, to date, not uniform. The introduction of a novel acute and emergency care delivery model may provide a compelling reason to define what is desired or required from any acute care setting.

Payers, including government entities, can also intervene financially to promote their policy goals with respect to freestanding EDs with the use of facility fee eligibility. As described earlier, facility fees are often a major driver of price and are at the heart of the controversy in constraining the market for emergency care. Some insurers argue that because freestanding EDs do not bear the same overhead costs as a hospital-based ED, they should be ineligible for facility fees[55]; in fact, a 2014 senate bill in Colorado sought to prohibit facility fees from independent freestanding EDs, based on the rationale that they did not provide the same on-site specialty services and consults.[56] This type of universal measure risks providing disincentive for freestanding EDs to offer services in areas of true need, such as more rural communities. A more reasonable and implementable policy at the state level would be to limit balance billing for facility fees, also briefly mentioned in the article by Ho et al.

States and the federal government (because states do not have the authority over health plans that are in self-funded employer plans because of the Employee Retirement Income Security Act[57] of 1974) can attempt to decrease disparity between hospital-based EDs, satellite freestanding EDs, and independent freestanding EDs by a combination of requiring adequate coverage of emergency care by insurance companies and regulating ED payments. Although most of the current discussions about solutions for the high costs of emergency care focus on regulating physicians, it is critical to recognize that insurance companies can refuse to contract with emergency groups, which force beneficiaries into out-of-network care and then shift the blame to emergency providers for being out of network. States could more closely regulate insurers and also set a minimum benefit standard that carriers are required to pay for emergency care.

The crux of rate regulation is defining what "usual, customary, and reasonable" charges are. Earlier this year, the Nevada legislature passed legislation,[58] subsequently vetoed by the governor, that would have required certain hospitals, freestanding EDs, and physicians to accept certain rates as payment in full for the provision of emergency services. All Nevada EDs would have to accept as payment either the average amount that the insurer has negotiated with other hospitals in Nevada or 125% of the average amount paid by Medicare for the same or similar services in the same geographic area. The American College of Emergency Physicians agrees with the idea in principle, although they advocate a standard of the 80th percentile of FAIR Health charges,[59] similar to Connecticut's Surprise Bill, which went into effect July 1, 2016.[60] Texas introduced but did not successfully pass legislation granting the Texas attorney general the authority and discretion to seek penalties and injunctions against a hospital-based ED or freestanding ED for unconscionable pricing.[61] Instead, the Texas legislature passed SB 507, which allows mediation of balance bills for emergency care from any provider or facility of emergency care services, including freestanding EDs.[62] Although this mediation process has allowed dispute resolution and agreement between health plans and providers, it has also significantly increased the burden on the Texas Department of Insurance, which currently mediates these disputes, and requires the patient to be balanced billed and file a complaint (personal communication, Brad Shields, National Association of Freestanding Emergency Centers, July 2017). Ultimately, rate regulation across all types of providers, along with adequate insurance coverage for emergency care, may

enable freestanding EDs to compete and help control costs. However, this is a significant deviation from how health care is currently financed, and would likely have ramifications for how we pay all health care providers.

FINAL THOUGHTS

What are the potential consequences of inaction? Most likely, freestanding EDs will continue to proliferate in areas in which there are few restrictions, potentially creating more supply than demand. Health services research demonstrates that geographic proximity to an ED can induce demand and suggests that freestanding EDs may not be pure substitutes for emergency care at a hospital-based ED because patients may be more likely to seek care at a conveniently located freestanding ED. To the extent that freestanding EDs increase utilization without improving outcomes, their presence can drive up costs for insurers and, ultimately, patients who pay those premiums. Claims that freestanding EDs can decrease ED crowding have not yet been substantiated and certainly merit investigation.

The development of freestanding EDs can be seen as a microcosm of the US health care system, in which health care is largely considered like any other industry and assumed to function as a market good. On some level, market forces will likely act to force some freestanding EDs to close if there is excessive redundancy. Simultaneously, empiric evidence demonstrates that the market for health care fails to meet many of the conditions required for a free market to function. The complete lack of information on the cost, charges, or price of care, and their relationship to quality, for example—all of which are unknown to the patient, who cannot be expected to act as a rational customer even in the best of circumstances, much less when ill—are not singular to patients presenting to EDs, whether they be freestanding or hospital based. Rather than simply casting blame on the players who are providing emergency care within the current structure, the debate over freestanding ED represents an important call to action for policymakers, payers, and patients; it is time to identify our priorities and to create incentives that drive innovation to meet the population's needs.

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Representatives of BCBS were asked to attest to the completeness and validity of the data they provided to Dr. Ho. The Senior Director for Media and Public Relations for BCBS Texas sent a description of the methods and the multiple academic organizations who supported the research. We interpreted the following statement as their attestation:

"Blue Cross and Blue Shield of Texas firmly supports the work done by the non-biased researchers led by Dr. Vivian Ho at Rice University's Baker Institute. We stand by the accuracy of the data used in the study."

Additionally two other separate requests were sent to executives of national BCBS asking if they would be willing to have the data reviewed for completeness and accuracy by an impartial third party (the only intervention that could convincingly confirm or rebut the concerns about data manipulation). Neither request received any reply from BCBS.

The views expressed here do not necessarily reflect those of the US government.

REFERENCES

1. Healthcare Cost and Utilization Project. Trends in Emergency Departent Visits, 2006-2011. 2014. Available at: https://www.hcup-us.ahrq.gov/reports/statbriefs/sb179-Emergency-Department-Trends.pdf. Accessed August 30, 2017.
2. Chow JL, Niedzwiecki MJ, Hsia RY. Trends in the supply of California's emergency departments and inpatient services, 2005–2014: a retrospective analysis. *BMJ Open*. 2017;7:e014721.
3. Hsia RY. Increasing care intensity at emergency department visits in California, 2002–2009. *Health Aff (Millwood)*. 2013;32:1811-1819.
4. Centers for Disease Control and Prevention. Life Expectancy. Available at: https://www.cdc.gov/nchs/fastats/life-expectancy.htm. Accessed August 30, 2017.
5. Ellison A. A state-by-state breakdown of 80 rural hospital closures. December 13, 2016. Available at: http://www.beckershospitalreview.com/finance/a-state-by-state-breakdown-of-80-rural-hospital-closures.html. Accessed August 30, 2017.
6. Ginsburg PB. Health care market consolidations: Impacts on costs, quality and access. March 16, 2016. Available at: https://www.brookings.edu/testimonies/health-care-market-consolidations-impacts-on-costs-quality-and-access/. Accessed August 30, 2017.
7. Evans M. Hospitals face closures as 'a new day in healthcare' dawns. February 21, 2015. Available at: http://www.modernhealthcare.com/article/20150221/MAGAZINE/302219988.

8. Centers for Medicare and Medicaid Services. Comprehensive Primary Care Initiative. Available at: https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/. Accessed August 30, 2017.
9. Ostrom CM. State Medicaid program to stop paying for unneeded ER visits. February 9, 2012. Available at: http://www.seattletimes.com/seattle-news/state-medicaid-program-to-stop-paying-for-unneeded-er-visits/. Accessed August 30, 2017.
10. Hiltzik M. A big health insurer is planning to punish patients for 'unnecessary' ER visits. June 2, 2017. Available at: http://www.latimes.com/business/hiltzik/la-fi-hiltzik-insurance-er-20170602-story.html. Accessed August 30, 2017.
11. American Academy of Pediatrics. The AAP Advises Parents Against Using Retail-Based Clinics. February 24, 2014. Available at: https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/The-AAP-Advises-Parents-Against-Using-Retail-Based-Clinics.aspx. Accessed August 30, 2017.
12. American Academy of Family Physicians. Retail Clinics. Available at: http://www.aafp.org/about/policies/all/retail-clinics.html. Accessed August 30, 2017.
13. American Medical Association. 50-state survey: Establishment of a patient-physician relationship via telemedicine. Available at: https://www.ama-assn.org/sites/default/files/media-browser/specialty%20group/arc/ama-chart-telemedicine-patient-physician-relationship.pdf. Accessed August 30, 2017.
14. Medicare Payment Advisory Commission. Report to the Congress: Medicare and the Health Care Delivery System. June 2016. Available at: http://www.medpac.gov/docs/default-source/reports/june-2016-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0. Accessed August 30, 2017.
15. Medicare Payment Advisory Commission. Report to the Congress: Medicare and the Health Care Delivery System. June 2017. Available at: http://www.medpac.gov/docs/default-source/reports/jun17_reporttocongress_sec.pdf?sfvrsn=0. Accessed August 30, 2017.
16. Bucciarelli C, Payton T, Weeks E, et al. Survey of patient knowledge and expectations about a free-standing emergency department. *Adv Emerg Med*. 2015. http://dx.doi.org/10.1155/2015/867094.
17. Kuehner-Herbert K. Mistaking freestanding ERs for urgent care carries expensive consequences. April 27, 2017. Available at: http://www.benefitspro.com/2017/04/27/mistaking-freestanding-ers-for-urgent-care-carries. Accessed August 30, 2017.
18. Simon EL, Griffin P, Medepalli K, et al. Door-to-balloon times from freestanding emergency departments meet ST-segment elevation myocardial infarction reperfusion guidelines. *J Emerg Med*. 2014;46:734-740.
19. Dewberry D. Freestanding Emergency Rooms Can Be Confusing, Costly. April 27, 2017. Available at: http://www.nbcdfw.com/investigations/Freestanding-Emergency-Rooms-Can-Be-Confusing-Costly-301476201.html. Accessed August 30, 2017.
20. Spectrum Emergency Room. Spectrum Healthcare. Available at: http://spectrum-er.herokuapp.com/. Accessed August 30, 2017.
21. Ho V, Metcalfe L, Dark C, et al. Comparing utilization and costs of care in freestanding emergency departments, hospital emergency departments, and urgent care centers. *Ann Emerg Med*. 2017;70:846-857.
22. Reinhardt UE. The pricing Of US hospital services: chaos behind a veil of secrecy. *Health Aff (Millwood)*. 2006;25:57-69.
23. Smulowitz P, Honigman L, Landon BE. A novel approach to identifying targets for cost reduction. *Ann Emerg Med*. 2013;61:293-300.
24. Thomas Hertz B. Facility fees can change the economic equation. January 10, 2013. Available at: http://medicaleconomics.modernmedicine.com/medical-economics/news/user-defined-tags/facility-fees/facility-fees-can-change-economic-equation. Accessed August 30, 2017.
25. Griffey RT, Pines JM, Farley HL, et al. Chief complaint-based performance measures: a new focus for acute care quality measurement. *Ann Emerg Med*. 2015;65:387-395.
26. Raven MC, Lowe RA, Maselli J, et al. Comparison of presenting complaint vs discharge diagnosis for identifying "nonemergency" emergency department visits. *JAMA*. 2013;309:1145-1153.
27. Centers for Medicare and Medicaid Services. First Release of the Overall Hospital Quality Star Rating on Hospital Compare. July 27, 2016. Available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-27.html. Accessed August 30, 2017.
28. The University of New Mexico School of Medicine. Project ECHO. Available at: https://echo.unm.edu/. Accessed August 30, 2017.
29. Le ST, Hsia RY. Community characteristics associated with where urgent care centers are located: a cross-sectional analysis. *BMJ Open*. 2016;6:e010663.
30. Schuur JD, Baker O, Freshman J, et al. Where do freestanding emergency departments choose to locate? A national inventory and geographic analysis in three states. *Ann Emerg Med*. 2017;69:383-392.e5.
31. Concannon TW, Nelson J, Kent DM, et al. Evidence of systematic duplication by new percutaneous coronary intervention programs. *Circ Cardiovasc Qual Outcomes*. 2013;6:400-408.
32. Hsia RY, Shen YC. Percutaneous coronary intervention in the United States: risk factors for untimely access. *Helath Serv Res*. 2016;51:592-609.
33. Concannon TW, Nelson J, Goetz J, et al. A percutaneous coronary intervention lab in every hospital? *Circ Cardiovasc Qual Outcomes*. 2013;5:14-20.
34. Shen YC. Do HMO and its for-profit expansion jeopardize the survival of hospital safety net services? *Health Econ*. 2009;18:305-320.
35. Horowitz JR. Does Corporate Ownership Matter? Service Provision in the Hospital Industry. May 2005. Available at: http://www.nber.org/papers/w11376.pdf. Accessed August 30, 2017.
36. Horowitz JR. Making profits and providing care: comparing nonprofit, for-profit, and government hospitals. *Health Aff (Millwood)*. 2005;24:790-801.
37. Hsia RY, Kellermann AL, Shen YC. Factors associated with closures of emergency departments in the United States. *JAMA*. 2011;305:1978-1985.
38. Bai G, Anderson GF. US hospitals are still using Chargemaster markups to maximize revenues. *Health Aff (Millwood)*. 2016;35:1658-1664.
39. American College of Emergency Physicans. The Impact of Unreimbursed Care on the Emergency Physician. Available at: https://www.acep.org/Clinical—Practice-Management/The-Impact-of-Unreimbursed-Care-on-the-Emergency-Physician/. Accessed August 30, 2017.
40. Sznol E. Issue Brief: Certificate of Need. Available at: http://sourceonhealthcare.org/legislative-topics-certificates-need/. Accessed August 30, 2017.
41. US Department of Justice, Federal Trade Commission. Competition in health care and certificates of need: joint statement of the Antitrust Division of the Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform - September 15, 2008. Available at: https://www.justice.gov/atr/competition-health-care-and-certificates-need-joint-statement-antitrust-division-us-department. Accessed August 30, 2017.
42. California Health Care Foundation. Freestanding emergency departments: do they have a role in California? July 2009. Available at: http://www.chcf.org/publications/2009/07/freestanding-emergency-departments-do-they-have-a-role-in-california. Accessed August 30, 2017.
43. Gutierrez C, Lindor RA, Baker O, et al. State regulation of freestanding emergency departments varies widely, affecting location, growth, and services provided. *Health Affairs*. 2016;35:1857-1866.
44. Harish N. How the freestanding emergency department boom can help patients. October 24, 2016. Available at: http://catalyst.nejm.org/how-the-freestanding-emergency-department-boom-can-help-patients/. Accessed August 30, 2017.

45. 16 Delaware Administrative Code §4404 (2017).
46. 77 Illinois Administrative Code §1110.3230 (2017).
47. California Health & Safety Code §1798.175 (2017).
48. Patidar N, Weech-Maldonado R, O'Connor SJ, et al. Impact of the presence of freestanding emergency departments in market on the healthcare cost. Available at: http://proceedings.aom.org/content/2016/1/17888.short. Accessed August 30, 2017.
49. 42 Code of Federal Regulations §413.65 (2011).
50. Library of Congress. S.1130-Rural Emergency Acute Care Hospital Act. Available at: https://www.congress.gov/bill/115th-congress/senate-bill/1130/text. Access August 30, 2017.
51. Rural Health Research Gateway. Estimated costs of rural freestanding emergency departments. November 2015. Available at: https://www.ruralhealthresearch.org/publications/995. Access August 30, 2017.
52. Centers for Medicare and Medicaid Services. Pennsylvania rural health model. Available at: https://innovation.cms.gov/initiatives/pa-rural-health-model/. Accessed August 30, 2017.
53. Centers for Medicare and Medicaid Services. Center for Medicaid and State Operations/survey and certification group. January 11, 2008. Available at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/scletter08-08.pdf. Accessed August 30, 2017.
54. Department of State Health Services Regulatory Licensing Unit Facility Licensing Group. Freestanding emergency medical care facilities licensing rules. June 1, 2010. Available at: http://www.dshs.texas.gov/facilities/pdf/Freestanding/Chapter_131_FEC_Rules.pdf. Accessed August 30, 2017.
55. Overland D. Aetna sues freestanding ERs over facility fees. April 5, 2013. Available at: http://www.fiercehealthcare.com/payer/aetna-sues-freestanding-ers-over-facility-fees. Accessed August 30, 2017.
56. Draper E. Free-standing ERs draw patients, critics and legislation. March 14, 2014. Available at: http://www.denverpost.com/2014/03/14/free-standing-ers-draw-patients-critics-and-legislation/. Accessed March 14, 2014.
57. 29 USC §;1001-1461.
58. Nevada State Legislature AB382 (2017). Available at: https://www.leg.state.nv.us/Session/79th2017/Bills/AB/AB382_EN.pdf.
59. Berger E. Finding a balance on balance billing. *Ann Emerg Med*. 2017;70:15A-18A.
60. State of Connecticut. An act concerning hospitals, insurers and health care consumers. Available at: http://www.ct.gov/dss/lib/dss/hit/PA15-146.pdf. Accessed August 30, 2017.
61. Texas State Legislature, HB 3867 and SB 2064 (2017).
62. Texas State Legislature, SB 507 (2017). Available at: http://www.capitol.state.tx.us/Search/DocViewer.aspx?ID=85RSB005074A&QueryText=%22507%22&DocType=A.

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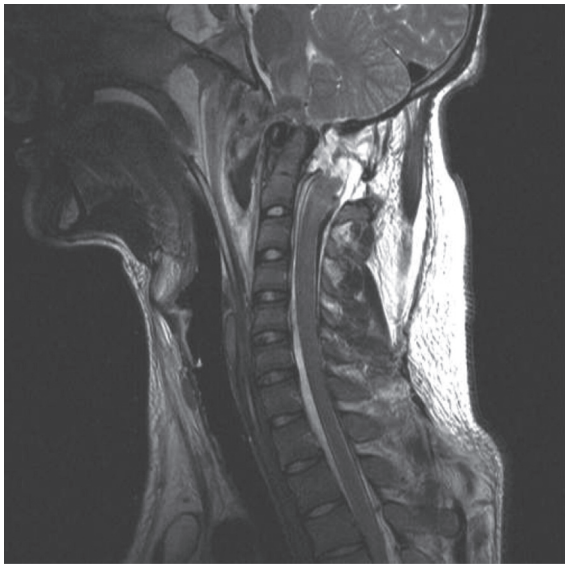

"Long-Term Survival Following Complete Medulla/Cervical Spinal Cord Transection" by Gautschi and Zellweger, April 2007, Volume 49, #1, pp. 540, 545.