INDEPENDENT FREESTANDING EMERGENCY CENTERS: THE FACE OF AN ALTERNATIVE MODEL TO HEALTHCARE IN RURAL AMERICA

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I. INTRODUCTION

Stewart-Webster Hospital in Richland, Georgia closed its doors last year, leaving 1,500 anxious residents without care.[1] The critical access hospital in rural Georgia was one of the town's largest employers, serving residents for nearly sixty years until the hospital, riddled with high unemployment, high rates of uninsured and underinsured patients, and declining reimbursements from government payors, could no longer overcome financial obstacles to stay afloat.[2] Richland's residents were forced to travel thirty-five miles to the closest emergency department, which meant that, in situations such as cardiac arrest, car accidents, workplace injuries and other emergencies, lives were lost because residents did not have emergent care in their immediate vicinity.[3] Nationwide, more than two dozen rural hospitals closed between 2013 and 2014 alone, and more hospital closures continue during COVID-19 pandemic.[4]

Health care facilities devoted to emergency department (ED) services but physically separated from hospitals proliferated in the last decade.[5] Urgent care centers and retail clinics lack the specialized equipment and medical specialists available around the clock for patients with serious illnesses and injuries.[6] Thus, the number of these standalone EDs has multiplied since 2010, driven by a need to efficiently expand access to emergency services in communities facing gaps in healthcare delivery, primarily in rural America where hospitals are considered a high financial risk.[7] Rural hospital closures form a void in geographic areas which constrains people to seek care elsewhere, extending travel times and often

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[1] *See* Bob Herman, *When the tiny hospital can't survive: Free-standing EDs with primary care seen as new rural model*, MODERN HEALTHCARE (Sept. 27, 2014). https://www.modernhealthcare.com/article/20140927/MAGAZINE/309279952/when-the-tiny-hospital-can-t-survive-free-standing-eds-with-primary-care-seen-as-new-rural-model.

[2] *Id.*

[3] *Id.*

[4] *Id*.

[5] *See Freestanding Emergency Departments*, AM. C. OF EMERGENCY PHYSICIANS (Apr, 2020), https://www.acep.org/patient-care/policy-statements/freestanding-emergency-departments.

[6] *See The Real Story Behind Freestanding ER Costs*, BLUE CROSS BLUE SHIELD OF TEX. (July 2017), https://www.bcbstx.com/newsroom/category/affordability/freestanding-er-costs.

[7] *See* Zach Smith, *Freestanding Emergency Departments and Micro-Hospitals*, CTR. FOR MISS HEALTH POLICY (July 2019), https://mshealthpolicy.com/policy-points-freestanding-emergency-departments-and-micro-hospitals.

leading to an increase in mortality rate among those with time-sensitive diseases.[8]

Though independent freestanding emergency centers seem like an obvious solution to the issue, CMS's regulatory decisions complicate how these facilities remaining profitable. Independent freestanding emergency centers lack hospital affiliation and do not receive Medicare or Medicaid reimbursement. They are often concentrated in high-income areas with a growing population, a higher proportion of privately-insured patients, and a lower proportion of Medicaid beneficiaries. This is largely because they cannot remain afloat without serving patients who can pay out-of-pocket expenses because they do not receive recognition and reimbursement for services by Medicare and Medicaid.[9]

Standalone ED's provide emergency services, basic imaging, and laboratory services. They come in two forms: off-campus emergency departments (OCEDs), which are affiliated with hospitals and oftentimes reimbursed by Medicare and Medicaid, and independent freestanding emergency centers (IFECs), which are owned in whole or in part by independent groups or individuals not affiliated with hospitals. IFECs are ineligible for Medicare and Medicaid reimbursement. The American Hospital Association (AHA) defines an IFEC as

> ...a facility that provides unscheduled outpatient services to patients whose conditions require immediate care in a setting that is geographically removed from a hospital . . . [IFECs] can be either independently licensed facilities or satellite hospital emergency departments (EDs) that are physically separate and distinct from the conventional hospital ED.[10]

State licensing laws control IFECs. Yet reimbursement, including billing and collection, and thus conditions of participation, are governed at the federal level through federal government regulatory agencies. However, state licensing laws vary.[11]

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[8] *Id.*; *See Free Standing Emergency Departments and Alternatives for Rural Markets*, S.C. Off. of Rural Health (Oct. 2019), https://scorh.net/wp-content/uploads/2018/10/C2-Emerging-Models-in-Rural-Health-Care.pdf.
[9] *See* Zach Budryk, *Freestanding ERs may freeze out poor, minorities*, Fierce Healthcare (Jul. 2016), *https*://www.fiercehealthcare.com/healthcare/freestanding-ers-may-freeze-out-poor-minorities.
[10] *Id.*
[11] *Id.*

As of 2016, IFECs in the United States represented 36% of all standalone EDs, with most of these entities located in Texas, Minnesota, Rhode Island, Delaware, and Colorado.[12] Only four states license independent freestanding EDs to operate without hospital affiliation: Colorado, Delaware, Rhode Island, and Texas.[13]

As of 2015, over four hundred IFECs are in Texas, accounting for 90% of IFECs in the United States.[14] Texas's growth in IFECs came about as a response to the passage of the Texas Freestanding Emergency Medical Care Facility Licensing Act in 2009, allowing the licensure of facilities providing emergency care that are "structurally separate and distinct" from hospitals.[15] According to the Texas Department of State Health services, the number of IFECs increased from forty facilities to nearly two hundred fifty, with thirty-six new facilities licensed in 2016 alone.[16] However, many other states have not passed similar legislation. Therefore, the number of IFECs, types of services, quality and costs that IFECs offer patients may vary, impacting a patient's options for care.[17]

Another avenue to standardize requirements of IFECs is at the federal level.[18] The Centers for Medicare and Medicaid Services (CMS), a federal regulatory government agency for OCEDs affiliated with hospitals, fails to recognize "emergency services hospitals" like IFECs. As a result, CMS does not reimburse IFECs for services provided to patients with Medicare or Medicaid insurance because these IFECs do not provide inpatient services. This general rule notwithstanding, during the COVID-19 pandemic CMS waived their conditions of participation and reimbursed IFECs for care provided to Medicare and Medicaid patients.[19] CMS recognizes that IFECs provide a "critical resource to assist in expanding capacity for inpatient and outpatient hospital services for patients requiring a higher level of care," and that the expansion of

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[12] *See Guidance for Licensed Independent Freestanding Emergency Departments to Participate in Medicare and Medicaid During the COVID-19 Public Health Emergency*, CMS (Apr. 2020), https://www.cms.gov/files/document/qso-20-27-hospital.pdf at 1.
[13] *Id.* at 2.
[14] COLIN MCDERMOTT & VIC SCHERMERBECK, *Introduction to Freestanding Emergency Rooms and Microhospitals*, https://vmghealth.com/wp-content/uploads/2018/01/Introduction-to-Freestanding-Emergency-Rooms-and-Microhospitals_McDermott-AICPA.pdf.
[15] BLUE CROSS BLUE SHIELD OF TEX., *supra* note 6.
[16] *Id*.
[17] Budryk, *supra* note 9.
[18] *Id.*
[19] CMS, s*upra* note 12.

Medicare and Medicaid to IFECs is necessary to compensate for the influx of patients seeking emergency services.[20]

Therefore, standardizing requirements for IFECs at the federal level through CMS is potentially the easiest route to improve access to care issues by assisting patients in selecting the acute care site most appropriate for them, thereby avoiding unnecessary costs and treatment delays.[21] CMS must consider recognizing IFECs to standardize requirements for these entities even after the COVID-19 pandemic. As a result, CMS's recognition of these entities will require all IFECs to meet emergency regulations similar to EMTALA, so that any individual may receive medical screening exams or a transfer of care, if needed, regardless of their insurance status.

This Note will attempt to provide a background of rural healthcare disparities and the issues facing these regions. This Note will also explore the history of IFECs in the United States to better understand the context of the issues and reasons as to why emergency regulations such as EMTALA do not already extend to IFECs. Part 1 of this Note will examine the origin of IFECs and their role in the healthcare landscape today. Part II will discuss EMTALA and the challenges associated with IFECs during a public health emergency. Lastly, Part III of this Note will highlight the advantages and disadvantages of the current system to assess whether CMS should continue to recognize IFECs even after the COVID-19 pandemic as a potential solution to individuals' inability to access healthcare in rural areas of the United States. This Note will argue that expanding Medicare and Medicaid coverage to IFECs beyond a public health emergency will standardize regulatory concerns and allow these entities to provide emergency services to individuals living in rural areas with little to no healthcare access.

II. Background

A. An Overview of Healthcare in Rural America

More than forty-six million Americans, or 15% of the U.S. population, live in rural areas as defined by the U.S. Census Bureau. These rural Americans face numerous health disparities as compared to their urban counterparts.[22] Rural poverty stems from challenges associated with health disparities, such as unemployment, poor education, and lack of opportunities, arising

[20] *Id*.
[21] Budryk, *supra* note 9.
[22] *See About Rural Health*, CDC (last reviewed August 2, 2017) https://www.cdc.gov/ruralhealth/about.html.

from rural individuals' inability to access health care.[23] Rural Americans have a greater likelihood of dying from heart disease, cancer, unintentional injuries such as vehicular crashes, chronic lower respiratory disease, and stroke when compared to Americans living in urban areas.[24] The CDC states that some characteristics such as longer traveling distances to specialty and emergency care facilities place rural residents at higher risk of death than urban residents.[25]

Further, since 2010, eighty-three rural hospitals nationwide have closed due to the lack of Medicaid revenue because rural hospitals are particularly dependent on government health care program revenue to remain afloat since many patients are not privately insured.[26] Twenty-three of the fifty-one rural hospitals that closed from 2013 through 2017 were over twenty miles from the nearest hospital, reducing access to healthcare.[27] A 2016 study identified over six hundred fifty rural hospitals that are vulnerable to closure in forty-two states. Moreover, less than half of Critical Access Hospitals are rural hospitals, operating at a financial loss due to their rural location and size.[28] Every year, these rural hospitals continue to apply for federal government designation and financial support to keep their doors open.[29] Studies show that hospital closure is partially attributed to low admission volumes, contributing to financial and organizational hardship in rural hospitals.[30] Some hospitals achieved an average daily census of four inpatients a day, causing third-party insurance pays to reduce their reimbursement rates for these facilities.[31] Local residents fear health and economic ramifications since hospitals are major employers and business drivers within their communities. Thus, many advocates encourage pursuing a health care model with an outpatient delivery of care like Freestanding Emergency Departments.[32]

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[23] *Id.*; *see also* Elizabeth Weeks, *The Medicalization of Poverty: Medicalization of Rural Poverty: Challenges for Access*, 46 J.L. Med. & Ethics 651 (2018).
[24] CDC, s*upra* note 22.
[25] *Id.*
[26] Elizabeth Weeks, *The Medicalization of Poverty: Medicalization of Rural Poverty: Challenges for Access*, 46 J.L. Med. & Ethics 651 (2018).
[27] S.C. OFF. OF RURAL HEALTH, *supra* note 8.
[28] *See* Erika Rogan & Joy Lewis, *Rural health care: Big challenges require big solutions*, AMERICAN HOSPITAL ASSOCIATION (Jan. 28, 2020, 07:59 AM), https://www.aha.org/news/insights-and-analysis/2020-01-28-rural-health-care-big-challenges-require-big-solutions.
[29] *Id.*
[30] *See* Erika Rogan & Joy Lewis, *Rural health care: Big challenges require big solutions*, AMERICAN HOSPITAL ASSOCIATION (Jan. 28, 2020, 07:59 AM), https://www.aha.org/news/insights-and-analysis/2020-01-28-rural-health-care-big-challenges-require-big-solutions.
[31] CDC, *supra* note 22.
[32] Rogan & Lewis, *supra* note 29.

B. History and Origin of IFECs

The concept of freestanding emergency rooms that operate independent of hospitals began at the Newark Emergency Center, Inc. in Delaware in 1973.[33] Equipped to handle trauma and life-threatening situations, freestanding emergency rooms formed to provide comparable services while avoiding high costs and long delays associated with hospital ERs.[34] Serving as a historical offshoot of the emergency room, hospital ER visits increased steadily after WWII, creating a greater need for an alternative venue for emergency visits, especially in times of natural disasters such as hurricanes or pandemics.[35] Ultimately, freestanding EDs were designed to increase access to emergency care in rural and underserved regions as a response to a 2004 Medicare reimbursement policy change that allowed payment for services provided in IFECs. This policy only applied to OCEDs and not IFECs, thus differentiating the two types of freestanding EDs. However, only approximately fifty IFECs existed in the country at the time.[36] Today, IFECs are growing but are often confused by consumers for urgent care clinics.

IFECs are available to the public twenty-four hours a day, seven days a week, three-hundred sixty-five days per year. They have IV fluids and medications on-hand, are managed by experienced ED-trained medical professionals including physicians, are always staffed by a registered nurse certified in advanced cardiac life support and pediatric advanced life support, have policies and procedures to transfer patients in need of a higher level of care to appropriate facilities; and contain in-house lab test capabilities.[37] In comparison, urgent care clinics have set hourly days, have access to x-ray imaging, only some in-house lab testing, and no capability to transfer an individual to an ED or hospital.[38]

Most states have not adopted IFECs due to individual state licensure requirements regarding a Certificate of Need (CON), which requires approval for any new hospital or IFEC by a state CON board.[39] Currently, thirty-five states have CON regulations

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[33] Barba Rylko-Bauer, *The Development and Use of Freestanding Emergency Centers: A Review of the Literature*, 45 Med. Care Rev. 129, 129 (1988).
[34] *Id.*
[35] *Id.* at 131.
[36] *Id.* at 132.
[37] Alexander J. Alexander & Cedric Dark, *Freestanding Emergency Departments: What Is Their Role in Emergency Care?* 74 Annals of Emergency Med. J. 325, 326 (2019).
[38] *Id*.
[39] Herman, *supra* note 1.

which are difficult to overcome, as many boards have hospital representatives who utilize CON to control competition by voting to deny new approvals. Further, the IFECs current client base does not reach rural or underserved communities in need of care.

As IFECs continue to increase in the United States, they will require funding and a consumer base to utilize the entities' services. IFEC patients are most likely privately insured, non-Hispanic white, employed patients with a higher education level between the ages of twenty-four and forty-four years old.[40] IFECs in Texas are likely located in areas with residents of higher incomes and higher private insurance coverage. In contrast, in Ohio, freestanding emergency departments affiliated with hospitals are located in zip codes with fewer hospitals, which increases patient access to emergency care.[41] Though IFECs provide emergency services in populations of need, critics argue that the entities' services are too costly.

Historically, CMS failed to recognize IFECs as EDs and, therefore, does not reimburse for IFECs providing services to Medicare or Medicaid patients. CMS states that "'emergency services hospital' is not a recognized separate category of a Medicare-participating hospital."[42] Instead, a hospital attempting to apply for Medicare and Medicaid funds must satisfy the statutory definition of a hospital found in section 1861 of the Social Security Act, which requires hospital providers to engage in inpatient services."[43]

CMS interprets section 1861 of the Social Security Act and defines inpatient services as a "provider devoting 51% or more of its beds to inpatient care."[44] CMS recognizes that a "'51%' test" is not dispositive in all cases.[45] Therefore, the agency will consider the burden of proof to assess inpatient care as the primary health care service, and consider the burden to increase substantially as the ratio of inpatient to other beds decrease. At the request of the applicant, CMS may consider additional factors. For example, if an applicant solely specializes in emergency services, CMS will "pay particular attention to the size of the applicant's ED compared to its inpatient capacity" followed by a detailed analysis of the facts of the applicant's operations.[46]Further, IFECs cannot bill to Medicare or Medicaid and, thus, are not required to meet Medicare's conditions

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[40] *Id.*
[41] *Id.*
[42] CMS S&C Memo 08-08, 2008 Requirements for Provider-based Off-campus Emergency Departments and Hospitals that Specialize in the Provision of Emergency Services, January 11, 2008, at 5.
[43] *Id.*
[44] *Id.* at 2; *see also* 42 C.F.R. § 482.
[45] CMS, *supra* note 42 at 5.
[46] *Id.*

of participation or provider-based requirements. As a consequence, IFECs are ineligible for Medicaid and Medicare funds, unlike most hospital EDs.

As a response, health insurance providers claim that IFECs increase the cost of healthcare because insurance providers consider them "out of network." Consequently, insurance providers lowered FSED reimbursement rates, placings substantial costs for care on the medical care provider and the patient.[47] Subsequently, care is considered out-of-network and patients are responsible for all charges not covered by their insurance, including their copayment, deductible, or coinsurance, a practice termed "balance-billing".[48] Studies claim that the total price of an IFEC averaged $2,199 in 2015 vs. $168 for an urgent care clinic visit.[49] This includes a "facility fee" that an IFEC may charge for treatment that ranges "between five hundred dollars and one hundred thousand dollars" and an "observation fee" which ranges from "one thousand to one hundred thousand dollars."[50] Costs for the same diagnosis on average were nearly ten times higher for patients at IFECs than for patients treated at urgent care centers, where fifteen of the twenty most common diagnoses treated at the IFEC could have been treated at the urgent care center.[51] For example, the most common diagnosis at IFECs was "other upper-respiratory infections" and the average price was $1,351, compared to an average price of $165 at the urgent care center.[52] As a result, there is substantial overlap in services delivered.

Texas IFEC employers saw significant increases in their emergency services costs, particularly for groups with generous ER benefits.[53] While reimbursement to hospital EDs remained the same with overall increases in reimbursement, member data showed that there was an increase in ER costs directly related to more freestanding IFECs opening across the state, and that more individuals chose to use these centers for non-emergency services. Emergency service costs increased during the COVID-19 pandemic with patients complaining of a $2,479 charge for a drive-thru

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[47] *Id.*
[48] Marshall Allen, *How a $175 COVID-19 test led to $2,479 in charges*, The Tex. Tribune, (Aug. 1, 2020, 4:00 AM CST), https://www.texastribune.org/2020/08/01/coronavirus-texas-COVID-test-charges-emergency-room/
[49] Blue Cross Blue Shield of Tex., *supra* note 6.
[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] Rogan & Lewis, *supra* note 29.

COIVD-19 test, after the IFEC charged a facility fee of $1,784 and a physician fee of $486.[54]

Further, in 2013, Davis Hospital and Medical Center in Layton, Utah opened a freestanding ER about eight miles away in the town of Weber.[55] The decision to open an IFEC here was prompted by the fact that freight trains passing through railroad crossings in the Weber area slow down traffic, causing a trip to the hospital to take longer. [56] The 16,000-square-foot facility has fourteen treatment rooms, a trauma bay, an orthopedic room, a negative pressure room with a separate bathroom for dealing with infectious diseases, and two overflow rooms[57]. It also boasts a full-service laboratory and x-ray capability; and soon it will perform MRIs.[58] Though visits are quick, the cost is considered astronomical per service and in terms of operation costs.[59]

In addition, the annual total costs to operate an IFEC also vary.[60] The annual total cost to operate a low, medium, and high volume IFEC is estimated to cost $5.5, $8.8, and $12.5 million, respectively.[61] The average cost of visit per patient declines with greater volume ($600, $380, and $347 for low, medium, and high volume IFECs, respectively).[62] IFECs must also consider low patient volumes, high rates of uninsured patients, minimum staffing requirements, provider shortages, federal reimbursement policies, and other factors when assessing the financial viability of IFEC in rural America.[63] These facilities may face very high fixed standby costs of coverage compared to the volume of services provided and, generally, a much less favorable payor mix compared to services provided by hospitals.[64] There are also issues in the provision of care from a regulatory standpoint.

Given concerns associated with quality of care, public understanding of IFEC capabilities, protecting the physician-hospital relationship, and financial resources, some states implemented regulatory laws to govern IFECs.[65] However, since

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[54] Allen, *supra* note 48.
[55] Weber Campus – Roy, Utah, DAVIS HOSPITAL AND MED. CTR. https://www.davishospital.org/weber-campus-roy-utah (last visited Jan 8, 2022).
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *Id.*
[60] NAT'L ADVISORY COMM. ON RURAL HEALTH AND HUMAN SERVS., ALTERNATIVE MODELS TO PRESERVING ACCESS TO EMERGENCY CARE: POLICY BRIEF (July 2016) at 5.
[61] *Id*.
[62] *Id*
[63] *Id*.
[64] *Id*.
[65] Rylko-Bauer, *supra* note 33 at 131.

very few states have IFECs, there are currently no federal regulations.[66] Therefore, states created their own regulations, reducing uniformity amongst IFECs in different states..[67] Some states, such as Rhode Island, Georgia, Florida, and Minnesota, implemented licensure requirements, whereas other states, including Ohio, Tennessee, and New York, created CON requirements.[68] In contrast, states such as Louisiana completely banned freestanding EDs with the intention of protecting rural hospitals from the encroachment of freestanding EDs. Lawmakers fear that rural patients will visit freestanding EDs instead of rural hospitals in an attempt to access medical care quickly, believing that their private or government insurance will cover the cost of care or that the out-of-pocket costs are insignificant With lawmakers arguing that IFECs select services that generate the most money, IFECs have bad reputation in Louisiana, which has a large rupral population. [69]

Researchers conducting a study at Harvard Medical School examined data on four hundred freestanding ERs located in the US as of December 2014.[70] These facilities were located across thirty-two states, of which seventeen must comply with state-specific regulations on staffing, licensing, and operation for their facilities.[71] The majority of these states had policies on freestanding ERs that were either associated with hospitals or operating independently. For example, states like New York and Washington regulate freestanding ERs on a case-by-case basis, while California's hospital regulations bar IFECs in the state.[72] Further, several states apply regulations similar to the Emergency Medical Treatment and Labor Act (EMTALA) to IFECs, and other states list specific equipment and services that such facilities must offer.[73] State-level regulation of IFECs vary widely in their standards. These regulations vary by the facilities' locations, staffing, and clinical capabilities, which result in a negative impact on a patient's option for care. This is especially true if a patient is in dire need of care but provisions like EMTALA are unavailable.

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[66] *Id.*
[67] *Id.* at 130.
[68] *Id.*
[69] *See* Steven Porter, *Louisiana Passes Bill to Ban Freestanding Emergency Departments*, HEALTHLEADERS (June 7, 2019), https://www.healthleadersmedia.com/strategy/louisiana-passes-bill-ban-freestanding-emergency-departments.
[70] Catherine Gutierrez et al., *State Regulation Of Freestanding Emergency Departments Varies Widely, Affecting Location, Growth, And Services Provided*, 35 Health Affairs 1857, 1859-1865 (2016).
[71] *Id.*
[72] *Id.*
[73] *Id.*

Ultimately, state licensing criteria governing IFECs which follow the intent of the Emergency Medical Treatment and Labor Act (EMTALA) vary by state and lack federal oversight.[74] Most states do not address licensing rules for IFECs and, thus, do not have laws requiring IFECs to follow the intent of the federal requirements for Medicare and Medicaid to screen and stabilize all patients requiring care under the Emergency Medical Treatment and Labor Act (EMTALA).

C. EMTALA

Under EMTALA, all hospitals that participate in Medicare and have an ED are required to provide a medical screening to all patients who present to the hospital campus, within the capability of the hospital's ED, to determine if a medical issue exists.[75] EMTALA provides individuals who are deemed to have an emergency medical condition with either stabilizing treatment or, if the facility is unable to provide care, an appropriate transfer to another hospital.[76] To abide by the provisions of EMTALA, the patient must first be screened for an "emergency medical condition."[77] This includes, but is not limited to, a condition that entails a serious impairment of bodily functions, organs, or acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably place the health of the individual (or for a pregnant woman, her unborn child) in serious jeopardy.[78] In the case of pregnant women having contractions, an emergency medical condition entails the prospect of inadequate time for a safe transfer to another hospital before delivery or the prospect that a transfer may pose a threat to the health or safety of the woman or the unborn child.[79] In essence, a priority of EMTALA was to create a set of categories where people facing certain dire conditions are not turned away.

Second, EMTALA requires hospitals to stabilize patients with identified emergency conditions before transferring them to other institutions.[80] This stabilization requirement entails the provision of medical treatment "as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency

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[74] *Id.*
[75] 42 C.F.R. § 489.24(a).
[76] 42 C.F.R. § 489.24(d).
[77] 42 C.F.R. § 489.24(a).
[78] 42 C.F.R. § 489.24(b).
[79] *Id.*
[80] 42 C.F.R. § 489.24(d).

medical condition."[81] A non-stabilized patient may only be transferred in two instances: if a physician certified that the benefits of the transfer would outweigh the risks, or if the patient (or surrogate) requested a transfer after being informed of the potential risks.[82] EMTALA allows for patient transfers to prevent hospitals from relocating patients whose condition may worsen during the transfer.

III. CHALLENGES REGARDING EMTALA

EMTALA does not apply to IFECs because they do not receive federal funding through Medicare. Consequently, without federal regulatory oversight, IFECs are currently not required by federal law to accept all patients for emergency screening and stabilizing treatment regardless of a patient's ability to pay. Only some states' laws require this.

Although CMS has not recognized IFECs in the past, during the COVID-19 pandemic, CMS acknowledged these facilities and provided financial reimbursement to patients under the Medicare or Medicaid programs to address the surge in patients fueled by COVID-19 hospitalizations.[83] By increasing hospital capacity and extending reimbursement to IFECs, CMS aimed to effectively establish care for its vulnerable citizens by waiving the conditions of Medicare and Medicaid participation. During the public health emergency, these entities were "temporarily certified as a hospital to increase healthcare system capacity" if certain conditions were met.[84] IFECs could participate in Medicare and Medicaid in one of three ways: (1) becoming affiliated with a Medicare/Medicaid-certified hospital under the temporary expansion 1135 emergency waiver; (2) participating in Medicaid under the clinic benefit, if permitted by the state; or (3) enrolling temporarily as a Medicare- or Medicaid-certified hospital to provide hospital services.[85] To qualify for CMS reimbursement, IFECs opted for either of these options and followed an urgent care fee schedule to appropriately reimburse physicians, ambulance services, clinical laboratory services, durable medical equipment, prosthetics, orthotics, and other supplies for the services they provide.[86]

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[81] *Id.*
[82] *Id.*
[83] David R. Wright, *Guidance for Licensed Independent Freestanding Emergency Departments (EDs) to Participate in Medicare and Medicaid during the COVID-19 Public Health Emergency*, CMS (April 21, 2020),https://www.cms.gov/files/document/qso-20-27-hospital.pdf.
[84] *Id.*
[85] *Id.*
[86] *Id.*

Further, CMS waived certain elements of EMTALA to allow for more flexibility if an IFEC temporarily enrolled as a or became affiliated with a Medicare or Medicaid-certified hospital. In particular, CMS loosened the in-person medical screening examination component of EMTALA. For example, if an IFEC qualified as a hospital under the public health emergency guidance, then patients could receive a medical screening exam via telehealth or offsite, if necessary, instead of traveling in-person for the exam like EMTALA requires.[87] Thus, CMS waived the enforcement section of EMTALA, allowing hospitals, psychiatric hospitals, and critical access hospitals to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19, if not inconsistent with the state's emergency preparedness plan.[88]

Once approved through CMS, IFECs may provide and receive reimbursement for inpatient and outpatient services provided to Medicare beneficiaries. To maintain participating in Medicare and Medicaid, the IFEC must meet all of Medicare's Conditions of Participation and provide a Medicare Outpatient Observation Notice to all Medicare beneficiaries informing them that they are receiving outpatient observation services and are not considered an inpatient of the facility.[89] IFECs' temporary participation is terminated at the conclusion of the public health emergency.

Through the waiver, CMS acknowledges that "expanding the number of providers available to Medicare and Medicaid beneficiaries eases some of the burden shouldered by traditional hospitals and allows the healthcare system to treat more patients at a time when capacity is often limited."[90]

IV. CMS RECOGNITION OF IFECS IS THE APPROPRIATE ROUTE FOR RELIEF

Given the inefficient role IFECs serve in the rural healthcare industry due to differing state licensure requirements, high pricing, and lack of uniform EMTALA-like provisions, the most appropriate remedy for the ongoing issue of accessing healthcare in rural America requires CMS to recognize and reimburse care for services provided to Medicare and Medicaid patients at IFECs. In determining the components of this argument, it is most beneficial

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[87] *Id.*
[88] *Id.*
[89] *Id.*
[90] Ayla Ellison, *CMS Lifts Freestanding ER Billing Restrictions During Pandemic*, BECKER'S HOSPITAL REVIEW (April 22, 2020), https://www.beckershospitalreview.com/finance/cms-lifts-freestanding-er-billing-restrictions-during-pandemic.html.

to analyze each aspect of the barriers IFECs currently face in the healthcare landscape.

First, lack of federal oversight and licensure regulation led to states enacting their own laws to regulate IFECs. Without any consistency and uniformity, IFECs fail to serve its true purpose: providing emergency services to those located in rural populations. In response to this issue, federal oversight and standardized regulations provided by CMS may best enforce uniform regulations to apply to IFECs. These federal licensure requirements will allow for greater adoption of IFECs in states where rural hospitals are unable to financially stay afloat.

Second, because IFECs lack CMS recognition and are not reimbursed for care provided to Medicare and Medicaid patients, IFECs must strategically place themselves in more affluent areas instead of rural communities in need of greater access to healthcare services. With CMS recognition, IFECs may receive reimbursement for services provided to Medicare and Medicaid patients, alleviating high facility costs placed upon patients. Finally, recognition of IFECs by CMS will require IFECs to act in accordance with EMTALA, ensuring that all individuals entering the IFEC will receive a screening for an emergency medical condition and stabilization, regardless of the patient's insurance status or ability to pay. In order for these changes to occur, CMS and the federal government must define "underserved" to narrow down which entities CMS qualifies as IFECs. A rural-specific definition under federal regulations is ultimately required to address the ongoing healthcare issue. Studies indicate that there is a discrepancy in the definition of IFECs among major US data sources. Therefore, a universal, standardized definition will allow IFECs to be identified and listed in national ED databases to carefully characterize ED care. Therefore, IFECs may provide high-quality emergency care to people in medically underserved areas, relieve the burden on overwhelmed hospital EDs, and provide convenient services with shorter wait times for treatment.

CMS already recognized the need for IFECs within healthcare by expanding Medicare and Medicaid recognition and reimbursement for services rendered during the COVID-19 pandemic. By issuing guidance and recommendations for IFECs to receive Medicare and Medicaid funding during the pandemic, the regulatory agency acknowledges that Medicare and Medicaid patients see IFECs as a source of care, especially in rural areas where access to COVID-19 care is scarce. Further, IFECs are one of several models proposed to aid rural communities affected by or at-risk of hospital closure. The Medicare Payment Advisory Committee (MedPAC) proposed altering regulations to provide

funding to failing Critical Access Hospitals to convert to IFECs.[91] With fixed stipends or grants to cover standby costs, IFECs can begin providing care.

Critics voice concerns stating that IFECs encourage the increased use of emergency services for nonemergency complaints, lead to an increase in the costs of health services, and compete with hospitals for ED services, which ultimately threatens access to services that are mainly provided by only hospital EDs, such as trauma care.[92] However, these threats are warrantless. Though many IFECs are placed in densely populated communities to generate higher volumes and revenues, this is of less concern in rural areas without OCEDs or with poor access to primary care. IFECs in rural areas are likely the only health care provider for hundreds of miles, providing both emergent and non-emergent services to patients in need in areas where rural hospitals closed due to their low inpatient volume. Yet, CMS will need to incentivize independent groups to open rural IFECs. These incentives could derive from critical access hospitals that have closed. The federal government should instead decide to shift current fund allocation from closed critical care access hospitals to IFECs.[93]

Nonetheless, many IFECs purposely locate their entities in affluent suburbs, targeting privately insured patients who visit EDs out of convenience.[94] For example, First Choice Emergency Room, a for-profit chain that is publicly traded as Adeptus Health, announced a dozen new freestanding ED openings within high income, suburban areas of Texas and Colorado.[95] Perhaps, not all IFECs aim to expand services to rural populations.[96] Thus, CMS may consider carefully defining "underserved" communities and IFECs eligible for reimbursement for services provided to Medicare and Medicaid patients.

To address concerns related to IFECs practice of charging facility fees to mitigate high costs associated with maintaining technologically advanced equipment and upholding the facility and its staff, research is necessary before investing into IFECs.[97] Researchers propose a hybrid model, separating IFECs and urgent

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[91] *See* Jenn Lukens, *Freestanding Emergency Departments: An Alternative Model for Rural Communities*, RURAL MONITOR (Nov. 30, 2016), https://www.ruralhealthinfo.org/rural-monitor/freestanding-emergency-departments/.
[92] Rogan & Lewis, *supra* note 29
[93] Rylko-Bauer, *supra* note 33
[94] Herman, *supra* note 1.
[95] *Id.*
[96] *Id.*
[97] Rylko-Bauer, *supra* note 33

care capabilities within the same facility.[98] Patients with acute care injuries would be triaged to the urgent care area of the IFEC and reimbursed using the lower-cost CMS urgent care fee schedule. In contrast, more severe injuries would be treated on the IFEC side and reimbursed under CMS's hospital facility fee.[99] Further, CMS could create a new IFEC fee structure for the hybrid IFEC model to economically support greater access to different types of care.[100] A new fee structure could take into account low patient volumes, high rates of uninsured patients, difficulty meeting minimum staffing requirements, and provider shortages, all of which are common occurrences in rural areas.[101]

An example of a hybrid IFEC-urgent care facility can be found in Wadesboro, North Carolina, a town of less than six thousand individuals. In 2012, Carolina HealthCare System, a large health system based in Charlotte, purchased the hybrid IFEC-urgent care facility that was staffed with one hundred twenty-five acute-care and nursing beds. Spending twenty million dollars, the hospital downsized the rural hospital's inpatient capacity from thirty beds to fifteen. This new facility provides "24/7 emergency care" with a limited number of acute beds, and it uses a patient-centered medical home model, offering residents access to primary-care providers with the assistance of a patient navigator.[102] By molding primary care and emergent care services together, this hybrid model is better able to remain afloat while tackling major healthcare issues in rural America.

For the privately insured individuals seeking care, in an effort to increase price transparency in IFECs for patient's ineligible for Medicare or Medicaid, CMS could implement a regulation requiring provisions similar to Senate Bill 425 in Texas. This bill requires all patients visiting IFECs to submit and sign documentation regarding the IFECs billing practices.[103] This documentation generally states that the facility will submit its bill to the insurance provider, but that the IFEC lacks a "contractual relationship" with the insurance provider, so that the insurance company is not obligated to cover any medical expenses incurred at the IFEC .[104] The law further requires the facility to post a notice in all rooms, stating the facility is a "freestanding emergency medical care facility", that the entity charges rates comparable to a hospital

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[98] *Id.*
[99] *Id.*
[100] *Id.*
[101] *Id.*
[102] Herman, *supra* note 1.
[103] TEX. HEALTH & SAFETY CODE ANN. § 241.251 et seq.; *see also* McDermott & Schermerbeck, *supra* note 14; *see also* Allen, *supra* note 48.
[104] McDermott & Schermerbeck, *supra* note 14; *see also* Allen, *supra* note 48.

emergency room including a facility fee, that the facility and/or physician providing medical care at the facility may not be a participating provider in the patient's health benefit provider network, and the physician providing medical care at the facility may bill separately from the facility for the medical care provided to a patient." [105]

Further, IFECs may be financially viable in different communities facing different situations, thus requiring the IFEC to find additional financial supports like grants, taxes, or the creation of other services in order to succeed. However, a successful IFEC may rely on designing services to meet patient needs within its specific population. Rural locations for IFECs will pose their own challenges in relation to staffing, higher fixed costs per patient, and longer transfer times. Therefore, even with new reimbursement methods, these factors may not be adequately compensated.

Strategies to remain financially viable include potentially staffing the IFECs with nurse practitioners and physician assistants, with fewer physicians a part of the facility. The entity may function as a satellite center and utilize telemedicine technology, an aspect that was allowed and encouraged during the COVID-19 pandemic. Further, community services may also be offered at the IFEC, forming a one-stop-shop model. Thus, patients may receive social and economic services to alleviate healthcare disparities in relation to their emergency.

In contrast to the proposed solution, states may independently adopt EMTALA-like regulations to apply to all IFECs within the state. However, these regulations will vary by state and not all state legislatures have adopted regulations following the intent of EMTALA. In order to insure IFECs meet EMTALA-like requirements, these entities must also receive adequate funding to compensate for this increased provision of care. Further, the proliferation of IFECs in rural states in America is necessary to increase access to care for residents living in these areas.

Critics may also state that with the establishment of IFECs, hospitals should also consider expanding their emergency departments to rural areas. With the ability to already access Medicare and Medicaid reimbursements for services provided to patients under either insurance program, many of these hospitals will have the ability to stay afloat and the capital to initiate a freestanding ED. However, larger health systems have become pickier about which rural facilities to absorb.[106] Hospitals want to build networks of providers to demonstrate a strong measure of

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[105] TEX. HEALTH & SAFETY CODE ANN. § 241.252.
[106] Herman, *supra* note 1.

quality of care that rural providers cannot provide.[107] Often Critical Access Hospitals and other rural providers exhibit below-average quality scores.[108] To become more marketable, rural hospitals and communities need to show that they have the capability to provide high-quality health care at a low cost.

Lastly, critics may argue that potential fraud issues may rise with the increase in IFECs in rural areas. Physicians and other providers may falsely claim payment for services that did not occur or are unnecessary, leading to issues with the Anti-Kickback Statute, Stark Law, and the False Claims Act. However, like other hospital EDs, IFECs are also subject to the same federal oversight to prevent any fraud or abuse issues. IFECs can help alleviate the stress that the current emergency care system faces and provide care to individuals with limited access to traditional hospital EDs. By implementing state-by-state regulations, uniform licensing criteria created on a federal level, encouraging freestanding EDs to operate in more rural and underserved areas, and increasing price transparency, IFECs can dramatically alter the rural healthcare landscape.

V. CONCLUSION

A broad solution should be for CMS to establish an Innovation Center pilot to test the solutions mentioned above and collect data on IFECs around the country. The Innovation Center supports the development and testing of innovative health care payment and service delivery models.

It is important to recognize that there is little research to support whether IFECs are viable in rural areas across the country. Most research addresses issues within each state and forms a potential solution. Therefore, CMS should first establish a definition for IFECs to further focus its research efforts on facilities that may qualify for Medicare or Medicaid reimbursement. Through a pilot test or routinely collecting data from IFECs during the COVID-19 pandemic, CMS may learn whether IFECs are a reliable and affordable source of care for individuals in rural America that qualify for Medicare and Medicaid reimbursement. By participating in Medicare and Medicaid, researchers with CMS may find whether IFECs are viable in all rural areas and what type of model will best suit each population. Further, CMS may explore whether to expand reimbursement to IFECs as well as provide federal regulatory oversight to these entities. Ultimately, CMS will continue to lend a

[107] *Id.*
[108] *Id.*

heavy hand in federal oversight to provide uniform and standardized regulations.

There are several potential solutions to increase access to care in rural areas in America. These may include establishing more urgent care centers or micro-hospitals. In Colorado, Arizona, and other non-CON states, IFECs established micro-hospitals recognized by CMS. These facilities encompass eight to ten inpatient beds where subsidiary IFECs are placed in underserved areas or hospitals continue to establish their own freestanding EDs under the hospital's license. However, these entities must still meet Medicare's conditions of participation, requiring that the freestanding ED remain within a thirty-five-mile distance from the main hospital campus. In an effort to further increase services in rural America, more research and conversation amongst lawmakers and rural communities must continue to discover an appropriate healthcare model.