MAY/JUNE 2025

The Value Examiner®

A PROFESSIONAL DEVELOPMENT JOURNAL *for the* CONSULTING DISCIPLINES

Valuation of Freestanding Emergency Departments (Part I of II)

By Todd Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, and Jessica Bailey-Wheaton, Esq.

The U.S. faces a significant need for robust primary care services. Demand is driven by an aging population and the increasing prevalence of chronic diseases. Traditional primary care providers are often unable to meet this escalating demand, leading to access challenges and strain on the broader healthcare system. As a result, freestanding emergency departments (FSEDs) are increasingly important in the healthcare delivery system. This two-part series examines the environment in which FSEDs operate and its valuation implications.

While not traditional primary care providers, FSEDs offer crucial access, particularly for higher-acuity patients. They help alleviate the strain on hospital emergency departments (EDs) and provide services such as diagnostic imaging and laboratory services. Unlike urgent care centers, FSEDs are equipped to handle more serious conditions and are open 24/7. Some FSEDs even offer primary care services, addressing the rising demand for accessible healthcare. Their growth reflects a need for more convenient and efficient medical services, supplementing traditional healthcare models.

FSEDs represent entry points into the healthcare system, and typically see and treat higher-acuity patients compared to retail clinics and primary care offices, but do not usually treat trauma cases (e.g., gunshot wounds, car accidents) as hospital EDs would. FSEDs, also known as stand-alone EDs, are facilities that provide emergency services and are not located on a hospital's campus. There are two types of FSEDs: those that are affiliated with a hospital and those that are independent.[1] Like hospital EDs, FSEDs are typically open 24/7 and offer basic diagnostic imaging (e.g., x-ray, CT, ultrasound) and laboratory services.[2] Larger FSEDs may also offer additional diagnostic services (e.g., MRIs), as well as primary care services.[3] As discussed further below, while hospital-affiliated FSEDs are typically located within five to 10 miles from their affiliated hospitals, they must be located within 35 miles to receive the higher reimbursement associated with hospital outpatient departments (HOPDs).[4]

FSEDs have been touted as a way to alleviate the stress experienced by current hospital EDs. However, because they are typically located in more affluent areas that have a greater number of potential patients with higher-reimbursing commercial insurance coverage,[5] FSEDs may not be fulfilling one of their original goals—increasing healthcare access to underserved populations.

1 "Stand-Alone Emergency Departments," chap. 8 in *June 2017 Report to the Congress: Medicare and the Health Care Delivery System*, Medicare Payment Advisory Commission, June 2017, 248, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun17_ch8.pdf.
2 Ibid., 248.
3 Ibid., 248.
4 Ibid., 248.
5 Ibid., 256.

Competitive Environment

The number of FSEDs has increased exponentially over the last 15 years.[6] Currently, over 5,600 EDs operate across the U.S., approximately 841 of which are FSEDs.[7] Of that total, approximately 564 FSEDs are hospital-affiliated and approximately 277 are independent.[8] These facilities are largely based in more urban and suburban areas, where potential patients have higher incomes and private insurance.[9]

Demand for FSEDs has generally increased over the past decade. Between 2017 and 2022, FSED visits increased 52.7 percent even while overall ED visits decreased 5.66 percent during the same time frame.[10] Although overall ED visits decreased, the rate of these visits has remained steady over the past 25 years, with one in five adults visiting the ED at least once per year.[11] While the reasons for increased FSED utilization are not completely clear, it is hypothesized that it may be due to lack of access to other providers (e.g., overcrowded ERs that result in long wait times), a desire for faster access to care, or provider practice pattern changes (perhaps motivated by the relative profitability of ED services).[12] FSEDs typically boast much shorter wait times than traditional ERs, and tend to be more accessible, as they are freestanding facilities that are typically located within the community, close to patients.[13]

FSEDs compete with each other for patients, as well as with other hospitals with EDs and providers serving lower-acuity patients, such as urgent care centers, retail clinics, and primary care physicians. These providers overlap in the most prevalent conditions treated, e.g., upper respiratory infection, bronchitis, cough, urinary tract infection, and sinus infection.[14] However, FSED payment rates are generally higher relative to competing providers,[15] which may serve as a deterrent to patients.

Going forward, as the aging baby boomer population continues to require more healthcare services, it is anticipated that these patients will disproportionately utilize EDs, including FSEDs.[16] Further, more adults are living with chronic conditions, and the number of Americans with one or more chronic conditions has been rising over the past decade.[17] This indicates that the demand for FSED services will continue to rise in the future.

Reimbursement Environment

The U.S. government is the largest payor of medical costs, through Medicare and Medicaid, and has a strong influence on reimbursement to hospitals. In 2023, Medicare and Medicaid accounted for an estimated $1.03 trillion and $871.8 billion in healthcare spending, respectively.[18] The prevalence of these public payors in the healthcare marketplace often results in their acting as price setters and being used as a benchmark for private reimbursement rates.[19]

An FSED encounter generates two separate claims: a physician claim, which is reimbursed under the Medicare Physician Fee Schedule (MPFS), and a hospital outpatient claim, which is reimbursed under the Outpatient Prospective Payment System (OPPS). Within these payment systems,

6 Darya M. Herscovici et al., "What is a Freestanding Emergency Department? Definitions Differ Across Major United States Data Sources," *Western Journal of Emergency Medicine* 21, no. 3 (May 2020): 660–64, https://westjem.com/wp-content/uploads/2020/05/21.3-Issue_compressed.pdf.

7 "2022 FSED Statistics," Emergency Medicine Network, accessed April 24, 2025, https://www.emnet-usa.org/research/studies/nedi/nedi2022/freestanding-eds/.

8 "USA," Emergency Medicine Network, accessed April 24, 2025, https://www.emnet-usa.org/research/studies/nedi/nedi2022/usa/; "2022 FSED Statistics."

9 "Stand-Alone Emergency Departments," 248, 256.

10 "2017 FSED Statistics," Emergency Medicine Network, accessed April 24, 2025, https://www.emnet-usa.org/research/studies/nedi/nedi2017/freestanding-eds/; "2022 FSED Statistics."

11 "Table EDAd. Emergency Department Visits Within the Past 12 Months Among Adults Aged 18 and Over, by Selected Characteristics: United States, Selected Years 1997–2019," Health, United States, 2020–2021, U.S. Centers for Disease Control and Prevention, https://www.cdc.gov/nchs/data/hus/2020-2021/EdAd.pdf.

12 "Stand-alone emergency departments," 247.

13 Paul Olzak, "Exploring Freestanding Emergency Departments (FSEDs): Benefits and Challenges in Today's Healthcare Landscape," PracticeMatch, accessed April 27, 2025, https://www.practicematch.com/physicians/articles/exploring-freestanding-emergency-departments-fseds-benefits-and-challenges-in-today-s-healthcare-landscape.cfm.

14 "Options for Slowing the Growth of Medicare Fee-for-Service Spending for Emergency Department Services," chap. 11 in *June 2019 Report to the Congress: Medicare and the Health Care Delivery System*, 388, Medicare Payment Advisory Commission, June 2019, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch11_medpac_reporttocongress_sec.pdf.

15 Ibid.

16 Cheryl Alkon, "What's Behind the Growth of Urgent Care Clinics?," *Medical Economics* 95, no. 17 (September 10, 2018), https://www.medicaleconomics.com/view/whats-behind-growth-urgent-care-clinics.

17 "About Chronic Diseases," National Health Council, Revised July 29, 2014, https://nationalhealthcouncil.org/wp-content/uploads/2019/12/AboutChronicDisease.pdf; Christina Farr, "Billions of Dollars Are Pouring into Digital Health, but Americans Are Still Getting Sicker and Dying Younger," CNBC, updated January 24, 2019, https://www.cnbc.com/2019/01/04/billions-are-pouring-into-digital-health-but-people-are-dying-younger.html.

18 "NHE Fact Sheet," Centers for Medicare & Medicaid Services, last modified December 18, 2024, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.

19 Roger Feldman, Bryan Dowd, and Robert Coulam, "Medicare's Role in Determining Prices Throughout the Health Care System," Mercatus Working Paper (Mercatus Center, George Mason University, October 2015), 3–5, https://www.mercatus.org/research/working-papers/medicares-role-determining-prices-throughout-health-care-system.

Medicare pays for physician services through the MPFS, which calculates payments according to its Resource Based Relative Value Scales (RBRVS) system.

providers are reimbursed for ED visits pursuant to a five-tier scale, commensurate with the acuity level of the patient. Level 1—Current Procedural Terminology (CPT) code 99281—represents the lowest acuity (and thus the least resource intensive), and Level 5 (CPT code 99285) represents the highest acuity (most resource intensive).[20]

Medicare Reimbursement of Physician Services

Medicare pays for physician services through the MPFS, which calculates payments according to its Resource Based Relative Value Scales (RBRVS) system, which assigns relative value units (RVUs) to individual procedures based on the resources required to perform them. Under this system, each procedure in the MPFS is assigned RVUs for three categories of resources: (1) physician work (wRVUs), (2) practice expense (PE RVUs), and (3) malpractice expense (MP RVUs). Further, each procedure's RVUs are adjusted for local geographic differences using Geographic Practice Cost Indexes (GPCIs) for each RVU component. Once a procedure's RVUs have been modified for geographic variance, they are summed, and the total is multiplied by a conversion factor (CF) to obtain the dollar amount of governmental reimbursement.

The formula for calculating the Medicare physician reimbursement amount for a specific procedure and location is as follows:[21]

Payment = [(wRVU x GPCI work) + (PE RVU x GPCI PE) + (MP RVU × GPCI MP)] × CF

The wRVU component represents the physician's contribution of time and effort to the completion of a procedure. The higher the value of the code, the more skill, time, and work it takes to complete.

The PE RVU is based on direct and indirect physician practice expenses involved in providing healthcare services. Direct expense categories include clinical labor, medical supplies, and medical equipment. Indirect expenses include administrative labor, office expenses, and all other expenses.

MP RVUs correspond to the relative malpractice expenses for medical procedures.[22] These values are updated at least every five years and typically represent the smallest component of the RVU.[23] Due to the variation in malpractice costs among states and specialties, the malpractice component must be weighted geographically and across specialties.[24]

The GPCI accounts for the geographic differences in the costs of maintaining a practice. Every Medicare payment locality has a GPCI for the work, practice, and malpractice component.[25] A locality's GPCI is determined by taking into consideration median hourly earnings of workers in the area, office rents, medical equipment and supplies, and other miscellaneous expenses.[26] There are currently 109 GPCI payment localities.[27]

The CF is a monetary amount that is multiplied by the RVU from a locality to determine the payment amount for a given service.[28] It is updated yearly by a formula that takes into account: (1) the previous year's CF, (2) the estimated

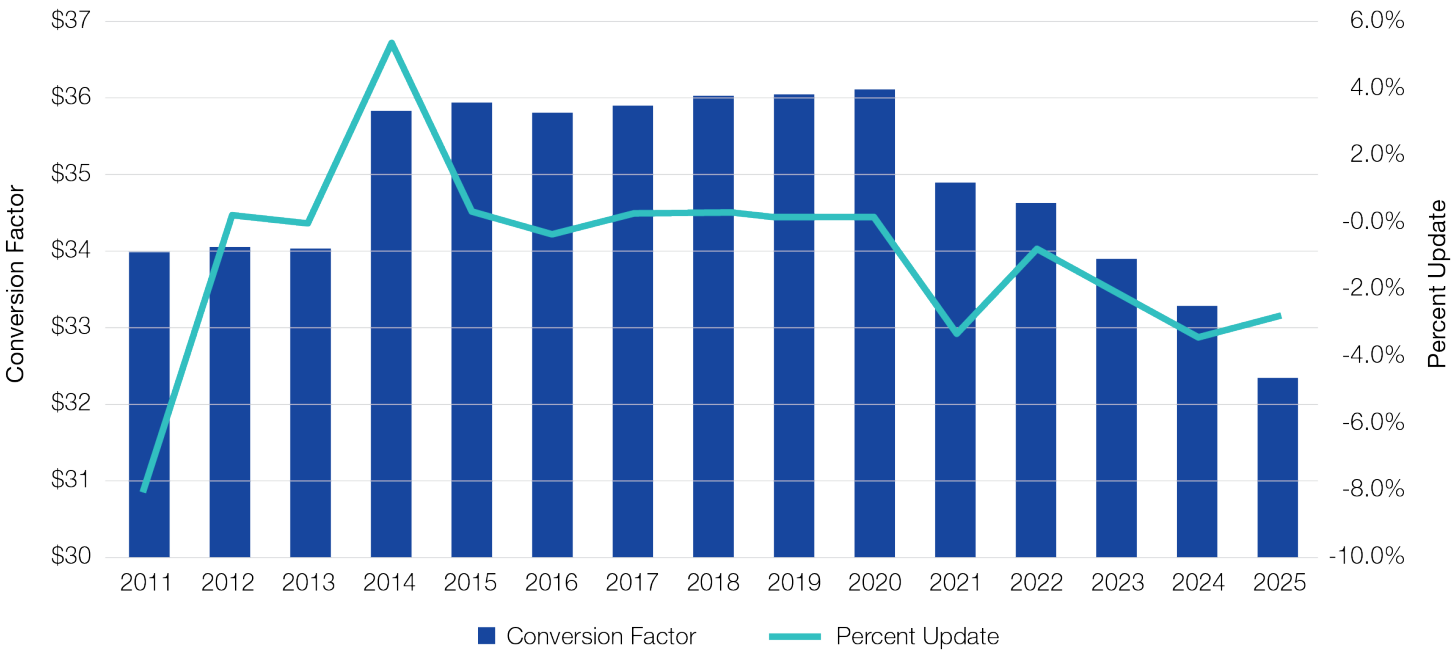
20 "Stand-Alone Emergency Departments," 251.
21 Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Final Rule, 80 Fed. Reg. 70890 (November 16, 2015).
22 Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Final Rule, 75 Fed. Reg. 73208 (November 29, 2010).
23 Ibid.; Alesa Lightbourne, "What Independent Practices Need to Know About RVUs," *The Intake*, October 18, 2023 (last updated Februrary 2, 2025), https://www.tebra.com/theintake/getting-paid/independent-practices/what-independent-practices-need-to-know-about-rvus.
24 Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Final Rule.
25 "Documentation and Files: National Physician Fee Schedule and Relative Value Files," Centers for Medicare & Medicaid Services, last modified April 11, 2025, https://www.cms.gov/medicare/physician-fee-schedule/search/documentation.
26 Alan M. Scarrow, "Physician Reimbursement Under Medicare," *Neurosurgical Focus* 12, no. 4 (April 2002): 2.
27 "Medicare PFS Locality Configuration," Centers for Medicare & Medicaid Services, last modified September 10, 2024, https://www.cms.gov/medicare/payment/fee-schedules/physician/locality-configuration.
28 Scarrow, "Physician Reimbursement Under Medicare," 2.

percentage increase in the Medicare Economic Index (MEI) for the year (which accounts for inflationary changes in office expenses and physician earnings), and (3) an update adjustment factor.[29] All physician services, except anesthesia services, use a single CF.[30]

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) contains a predetermined schedule of updates to the CF. However, these annual updates have been 0 percent since 2020, and will continue through 2025.[31] Note that, although the annual updates to the MPFS have been stagnant at best, MACRA includes several provisions related to financial rewards for providers who furnish efficient, high quality healthcare services.

As set forth in Figure 1, MPFS payment amounts have been cut for the last five consecutive years, with the MPFS conversion factor decreasing by 2.93 percent for 2025.[32]

Figure 1: Historical MPFS Payment Update Adjustments[33]

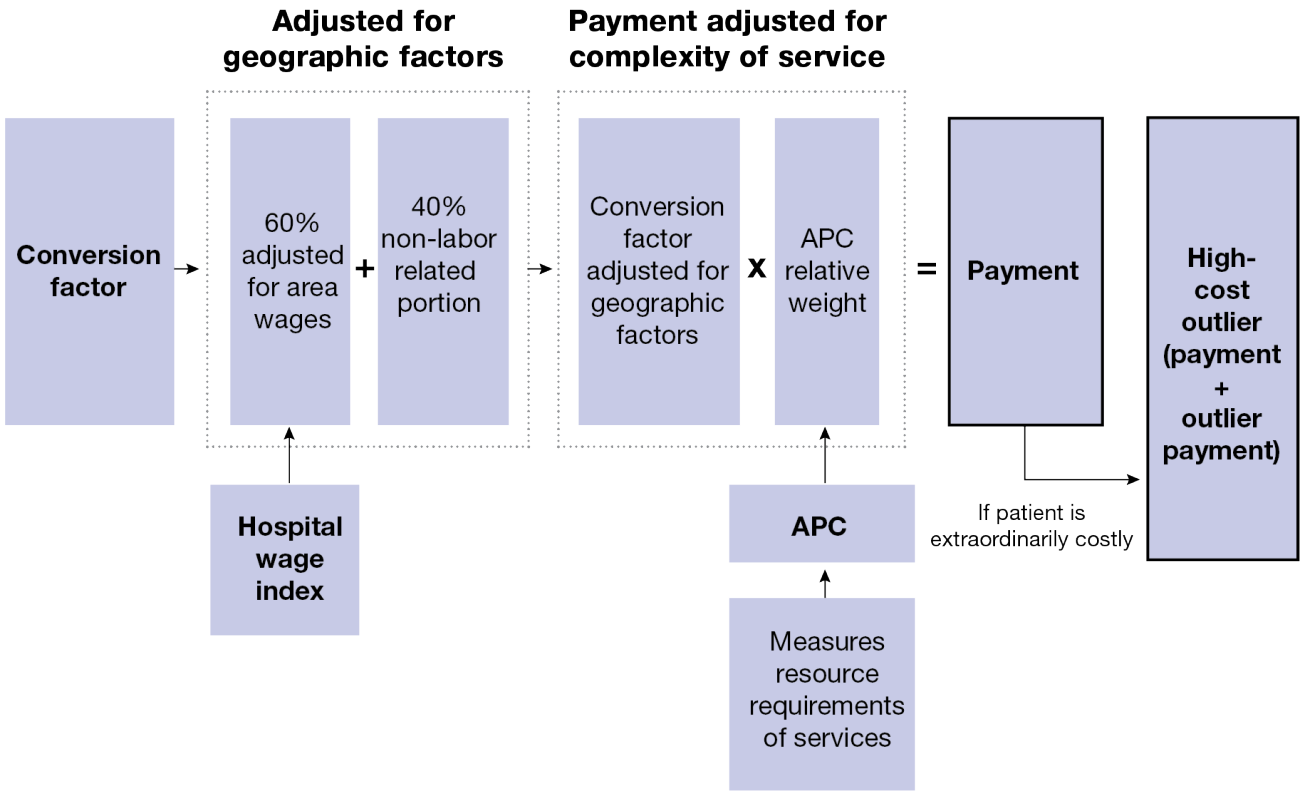


Medicare Reimbursement of Outpatient Services

Medicare pays for outpatient services through the OPPS, which aims to reimburse the facility's portion of the medical service provided, separate and apart from the physician services. Under the OPPS, HOPDs bill for individual medical services defined by Healthcare Common Procedure Coding System (HCPCS) codes, which are grouped to an ambulatory payment classification (APC) by similar clinical characteristics and costs.[34] That APC is then scaled by the relative weight, which "measures the resource use requirements of the service relative to a clinic visit and is based on the geometric mean cost of services in that APC."[35] The scaled APC is then multiplied by a CF, which is derived from the hospital market basket, to arrive at a payment rate for a service.[36] That rate is then adjusted based on the geographic location of the services by adjusting the labor portion of the service by the local hospital wage index.[37] Figure 2 illustrates a general, high-level breakdown of OPPS payment rate determination.

29 CCH Health Editorial, "Part B Payments: General Limits and Payment Rules," in *2009 Master Medicare Guide*, (Wolters Kluwer, 2009), 901.
30 Ibid., 900.
31 Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 101, 129 Stat. 87, 89–90.
32 "Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule," Fact Sheet, Centers for Medicare & Medicaid Services, November 1, 2024, https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-final-rule.
33 Medicare Physician Fee Schedule Final Rules, 2011–2025.
34 "Outpatient Hospital Services Payment System," Medicare Payment Advisory Commission, Payment Basics, revised October 2024, 1, https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_OPD_FINAL_SEC.pdf.
35 Ibid., 2.
36 Ibid., 2.
37 Ibid., 2.

Figure 2: Determination of OPPS Payment Rates[38]



Some medical services are paid for separately (i.e., not grouped into an APC), including:

- Many surgical, diagnostic, and nonsurgical therapeutic procedures
- Blood and blood products
- Most clinic and ED visits
- Some drugs, biologicals, and radiopharmaceuticals
- Brachytherapy sources
- Corneal tissue acquisition costs
- Certain preventive services[39]

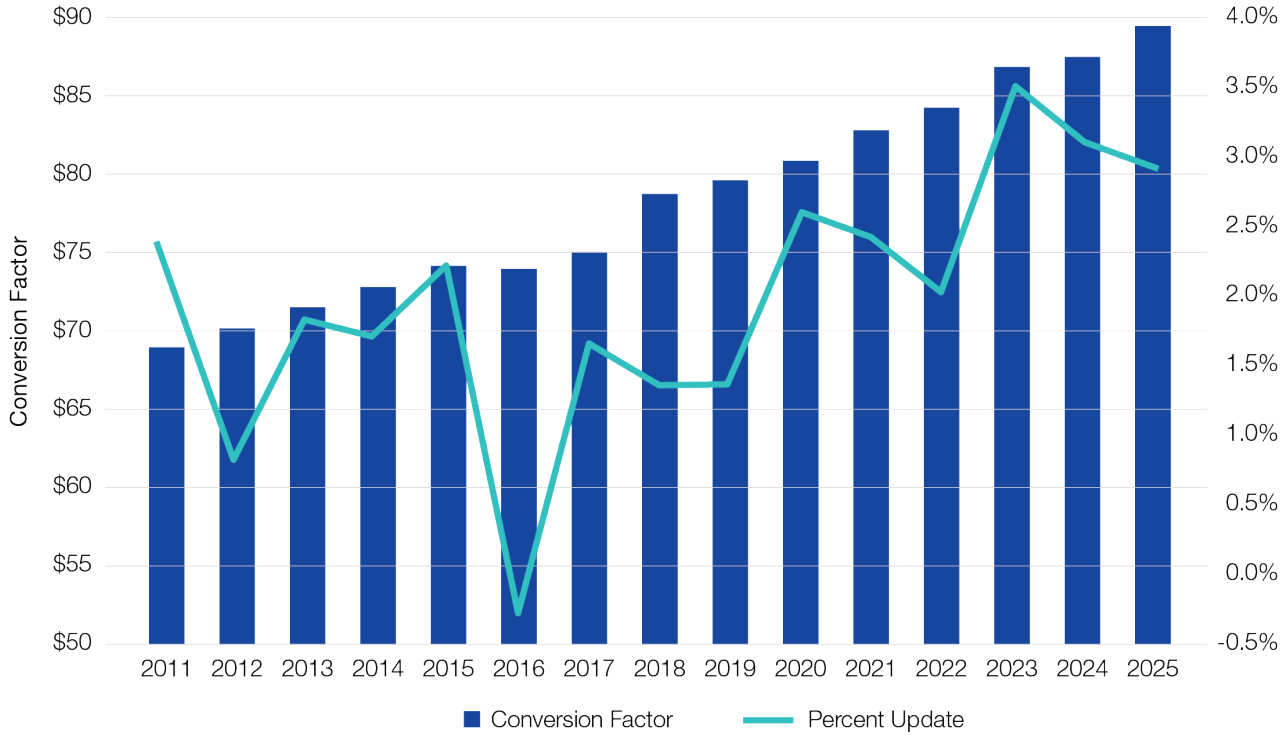
FSEDs may be reimbursed an additional amount (i.e., receive an "add on") for any of the following:

- Pass-through payments for specific drugs, biologicals, and devices in delivering services that meet the criteria for pass-through status (these items are generally too new to have the data needed to set payment rates)
- Outlier payments for individual services that cost hospitals much more than the services' APC group payment rates (CMHCs get a separate capped outlier threshold from hospitals)
- Transitional outpatient payments for certain cancer hospitals and children's hospitals
- An adjustment for certain cancer hospitals
- A rural adjustment (currently an increased payment of 7.1 percent) for most services by Sole Community Hospitals (SCHs), including Essential Access Community Hospitals (EACH) located in rural areas[40]

As shown in Figure 3, the OPPS payment rate for HOPDs has increased annually by an average of 2.8 percent over the past five years.[41]

38 Ibid., 2.
39 "Hospital Outpatient Prospective Payment System," Centers for Medicare & Medicaid Services, MLN Booklet, 5, March 2020, available at: https://corneagen.com/wp-content/uploads/2022/02/Hospital-Outpatient-Prospective.pdf.
40 "Hospital Outpatient Prospective Payment System," 7.
41 "CY 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1717-FC)," Centers for Medicare & Medicaid Services, November 1, 2019, https://www.cms.gov/newsroom/fact-sheets/cy-2020-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0 (Accessed 5/7/20).

Figure 3: Historical OPPS Payment Update Adjustments[42]



Conclusion

FSEDs have emerged as a significant component of the evolving U.S. healthcare landscape, driven by increasing demand for accessible and efficient medical services and the strain on traditional hospital EDs. While offering benefits, such as shorter wait times and convenient locations, their role in truly expanding access to underserved populations remains a point of discussion. The reimbursement environment, which has been characterized by increasing uncertainty in recent years due to decreasing Medicare payments for physician services, significantly influences the financial viability of FSEDs. Understanding these dynamics is crucial for stakeholders navigating this growing sector. Part II of this series will delve into the regulatory environment shaping FSED operations, the technological innovations impacting their service delivery, and the overall industry outlook, ultimately exploring the implications for their valuation. VE

Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, is president of Health Capital Consultants, where he focuses on the areas of valuation and financial analysis for hospitals and other healthcare enterprises. Mr. Zigrang has significant physician integration and financial analysis experience, and has participated in the development of a physician-owned, multispecialty management service organization and networks involving a wide range of specialties, physician-owned hospitals, as well as several limited liability companies for acquiring acute care and specialty hospitals, ASCs, and other ancillary facilities. Email: tzigrang@healthcapital.com.

Jessica L. Bailey-Wheaton, Esq., serves as senior vice president and general counsel of Health Capital Consultants. Her work focuses on the areas of Certificate of Need (CON) preparation and consulting, as well as project management and consulting services related to the impact of both federal and state regulations on healthcare transactions. In that role, Ms. Bailey-Wheaton provides research services necessary to support certified opinions of value related to the fair market value and commercial reasonableness of transactions related to healthcare enterprises, assets, and services. Email: jbailey@healthcapital.com.

42 Medicare Hospital Outpatient Prospective Payment System Final Rules, 2011–2025.