Freestanding Emergency Department
Preliminary financial models

Prepared for the Rural Hospital Stabilization Committee
by
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November 20, 2014
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Modeling process

• Analyzed financial and statistical data
  – 53 hospitals in counties with population <35,000
• Formulated assumptions through data analyses and input from hospital and industry leaders
• Developed a preliminary financial model for a freestanding emergency department based on specific assumptions
Modeling process

• The preliminary model is not representative of a particular FED in any specific location.
• The model is built using aggregated data and the results are entirely dependent upon the assumptions used in the model.
  • There will usually be differences between the preliminary and actual results, because events and circumstances frequently do not occur as expected, and those differences may be material.
Data used in developing assumptions

• Number of visits- GHA Hermes database
  – Emergency visits that did not result in admission

• Payer mix – GHA Hermes database
  – Average of selected hospitals

• Staffing
  – Provided by input from hospital management

• Expenses
  – Analyses of Medicare cost reports and financial data
Number of visits in models

• Cross-section 10 hospitals (14.1 avg. daily visits)
  – 8 CAH, 2 PPS
  – 4 affiliated with larger hospital system
  – 5 in counties <15,000 population
  – 5 in counties with population 15,001 – 35,000

• Average of 53 hospitals in counties with population <35,000 (22.5 avg. daily visits)
  – <15,000 population – 15 hospitals - 11.2 visits
  – 15,001 – 35,000 population – 38 hospitals - 27.2 visits
Physician staffing in model

• Model considerations
  – ED staffed with physicians 24/7 ($115/hour)*
  – ED staffed with mix of mid-level providers and physicians ($80/hour)**

*Based on hospital input
**Based on analyses of Medicare cost reports
Model expenses

- Staffing
- Ancillary costs
- Plant costs
- Administrative costs
- No costs in model related to capital costs of property and equipment
Scenario 1 – 10 hospitals

<table>
<thead>
<tr>
<th>Visits per day (1)</th>
<th>14.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician costs per hour</td>
<td>$115</td>
</tr>
<tr>
<td>Net profit/(loss)</td>
<td>$(1,200,000)</td>
</tr>
</tbody>
</table>

(1) Based on cross-section of hospitals
*Assuming insignificant variable costs
No costs included for capital costs of building and equipment
# Scenario 3 - Average volume ED

<table>
<thead>
<tr>
<th>Visits per day (1)</th>
<th>22.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/mid-level costs per hour</td>
<td>$115</td>
</tr>
<tr>
<td>Net profit/(loss)</td>
<td>$(700,000)</td>
</tr>
</tbody>
</table>

(1) Average for 53 hospitals in counties <35000 population
*Assuming insignificant variable costs
*No costs included for capital costs of building and equipment
## Scenario 4 – Average volume ED

<table>
<thead>
<tr>
<th><strong>Visits per day (1)</strong></th>
<th>22.5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician/mid-level costs per hour</strong></td>
<td>$ 80</td>
</tr>
<tr>
<td><strong>Net profit/(loss)</strong></td>
<td>$(400,000)$</td>
</tr>
</tbody>
</table>

(1) Average for 53 hospitals in counties <35000 population

*Assuming insignificant variable costs

No costs included for capital costs of building and equipment
Contributing factors

Why is the FED not profitable?
Low volume

Visits

35 to 40 patients per day to breakeven*

<table>
<thead>
<tr>
<th>Industry*</th>
<th>&lt;15000</th>
<th>15001-35000</th>
<th>Model</th>
<th>Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>11.2</td>
<td>27.2</td>
<td>14.1</td>
<td>22.5</td>
</tr>
</tbody>
</table>

*Source: Urgent Care Association of America
Unfavorable payer mix
(based on primary payer)

In models, self pay Reimbursement is same as Medicaid.

- **Commercial**: 24%
- **Medicare**: 18%
- **Medicaid**: 27%
- **Self Pay**: 31%

Commercial includes patient portion

Source: GHA Hermes database  2011-2013  Cross-section of 10 facilities
Poor reimbursement

- Medicare – will pay same as physician office
- Medicaid – will pay same as physician office
- Commercial - ? Will not spend more than current total spend
- Self-pay – in model at Medicaid payment rate

- Physician office reimbursement is not designed to cover a 24/7 operation with few patients and high overhead.
- Most physician offices do not have advanced radiology or full lab services as required in an ED.
- Profitable physician offices typically see more than 20 patients per day.
Low ED patient acuity

Source: GHA Hermes database  2011-2013  Cross-section of 10 facilities

Could 74% of patients be treated in a lower level setting (urgent care or physician practice)?
Clinical classifications to 25 highest volume ED visits.

Source: GHA Hermes database 2011-2013 Cross-section of 10 facilities
Timing of visits

Source: GHA Hermes database 2011-2013 Cross-section of 10 facilities
Few admissions

Source: GHA Hermes database  2011-2013  Cross-section of ten facilities
Quality

- Industry literature and research focuses on the need for high quality in the FED in order to attract patients.
“...while free-standing EDs could help rural residents in states such as Georgia, they don't address the underlying socio-economic issues. The demographics will still be the same, with many people lacking health insurance or having bare-bones coverage and thus unable to pay the high bills associated with free-standing EDs.”

Modern Healthcare, September 27, 2014