California Hospital Association

Emergency Care Models in California: Freestanding Emergency Departments

With hospitals facing unprecedented financial distress, some hospital leaders have recently expressed interest in the concept of Freestanding Emergency Departments (FSEDs) as a way to address rising emergency department (ED) crowding, seismic compliance pressures, and broader shifts away from inpatient care. This brief outlines the current regulatory landscape and key considerations for this type of service model — including the history of state regulatory barriers, federal Medicare payment constraints, and political opposition — that have prevented adoption in California to date.

An FSED offers emergency services that are physically separate from a traditional acute care hospital. While not currently permitted in California, there are typically two types of FSEDs:

- **Hospital-based FSEDs** — These operate off-campus under a parent hospital's license, must meet emergency department standards (including 24/7 physician coverage), and must maintain transfer agreements for patients requiring inpatient admission.
- **Independent FSEDs** — These are separately licensed facilities that provide emergency services but are not attached to inpatient hospitals; they must stabilize and transfer patients who require admission.

Regulatory Landscape in California

California currently requires EDs to be licensed as part of a general acute care hospital and physically located within hospital buildings that include inpatient and other basic hospital services. In practice, this interpretation has prevented the licensure of FSEDs in California. There is no existing regulatory pathway that allows emergency services to be provided by a non-hospital facility in a freestanding setting in California.[1] Legislative efforts to allow hospitals at risk of closure in rural and urban areas to maintain emergency services under the consolidated license of another hospital — effectively creating a pathway toward ED-only operations — have faced significant political opposition and have not advanced. As a result, California continues to treat emergency services as inseparable from inpatient hospital infrastructure, limiting flexibility to develop standalone ED models or provide an option for struggling hospitals to transition to emergency-only facilities.

Pros and Cons

Key considerations for authorizing or converting to a FSED model in California center on regulatory feasibility, financial sustainability, and alignment with federal payment policy. Current state licensure rules require EDs to be hospital-based; any change to authorize FSEDs would need to address California Department of Public Health (CDPH) oversight, Medi-Cal reimbursement, and supplemental payment implications. At the federal level, Medicare site-neutral payment limits significantly constrain revenue for new off-campus EDs, while independent FSEDs cannot bill in the same manner as hospital EDs. In addition, prior legislative efforts to authorize

[1] Health and Safety Code 1798.175 creates the potential authority for such an arrangement to exist, although this option has never been operationalized through CDPH regulations.

independent FSEDs in California faced opposition from a range of stakeholders, including previous Administrations, physician groups, labor unions, and consumer advocates.

Potential Pros of the FSED Model	Potential Cons of the FSED Model
Preserves Emergency Access: Allows vulnerable hospitals and health systems to maintain critical ambulatory and emergency care for communities, even if financial pressures force closure of acute inpatient beds.	**Severe Medicare Reimbursement Limits:** New off-campus EDs are paid at site-neutral rates under federal law unless they qualify as "excepted" provider-based departments (operating prior to Nov. 2, 2015), significantly reducing facility revenue.
Reduces Main ED Overcrowding: Can alleviate strain on traditional hospital EDs facing rising volumes, boarding, and inpatient bed shortages.	**Strict California Licensing Barriers:** CDPH requires EDs to be located within licensed hospital buildings or on hospital campuses; no clear licensure pathway for independent FSEDs exists at this time.
Potential Relief from Seismic Retrofit Pressures: May reduce exposure to costly inpatient hospital seismic compliance requirements.	
Maintains High-Quality Emergency Care: Fully equipped for emergencies with physician coverage; evidence from other states shows comparable outcomes for stroke, STEMI, and trauma stabilization.	**Untested Non-Hospital Model:** Although California statute that could allow for a FSED references "non-hospital emergency services," no regulatory framework exists, and Medi-Cal reimbursement for such services is unclear.
Lower Inpatient Infrastructure Burden: Avoids maintaining full inpatient units and associated overhead costs.	**Financial Vulnerability in High-Medi-Cal or Uninsured Areas:** FSEDs in areas where payer mixes are dominated by Medicare, Medi-Cal, or uninsured patients may struggle financially due to limited and restricted reimbursement models.
Right-Sizing for Low-Volume Markets: Provides a scaled model for markets unable to sustain full-service hospitals.	**Loss of Inpatient Downstream Revenue:** Eliminating inpatient beds removes admission capture and referrals, which may reduce financial viability.
Potential to Improve Patient Experience: Possibility for shorter wait times, convenient locations, and streamlined care delivery.	**Commercial Contracting Risk:** Without inpatient services, payers may push for site-neutral or urgent-care levels of reimbursement rates.
Operational Focus & Efficiency: A narrower service model may improve throughput and staffing efficiency.	**Supplemental Payment Risk:** Conversion may affect eligibility for Medi-Cal supplemental payments, disproportionate share hospital (DSH) calculations, or directed payments that depend on inpatient metrics.
	EMTALA Obligations Remain: Hospital-affiliated FSEDs must still comply with Emergency Medical Treatment and Labor Act stabilization and transfer requirements without onsite inpatient beds.

Potential Pros of the FSED Model	Potential Cons of the FSED Model
	340B Exposure (if Independent): Independent FSEDs would lose access to 340B drug pricing.
	Transfer & Clinical Risk Management: Higher transfer volume to tertiary centers may create logistical and liability complexities.

Medicare & Medicaid Reimbursement

Medicare. Even if California authorized FSEDs, federal Medicare policy creates significant constraints. The Centers for Medicare & Medicaid Services (CMS) only recognizes an ED as a hospital-based service. FSEDs that are not hospital-based are *not* recognized as EDs under Medicare.

Under Medicare, ED services are payable at hospital outpatient rates only if two conditions are met. They must be:

- A department of a hospital (provider-based under 42 CFR § 413.65), **AND**
- Either: on the main campus **OR** an excepted off-campus provider-based department (PBD)

To obtain "excepted" status, a facility must have been operating and billing as a provider-based hospital outpatient department before Nov. 2, 2015. If an FSED does not meet this criterion, CMS would treat it as a clinic for the purpose of Medicare reimbursement. In this scenario, Medicare pays clinic or physician fee schedule (PFS) rates, which are significantly lower than hospital-based rates, often between 40-60% of the outpatient prospective payment system (OPPS) hospital rate. This significantly limits the financial viability of new hospital-affiliated FSEDs under current Medicare rules unless the payer mix is predominately commercial and commercial payers agree to reimburse at hospital rates.

When CMS does recognize an off-site, hospital-based FSED, it categorizes it into one of two types for reimbursement purposes:

- **Type A:** Dedicated EDs that are open 24 hours a day, which generally receive a higher reimbursement rate
- **Type B:** Dedicated EDs that do not meet the Type A definition (e.g., they are open less than 24/7)

Medicare Treatment of Emergency Department Services

Scenario	CMS Recognizes as Hospital Dept (PBD)?	Eligible for Full OPPS Payment?	Paid at Site-Neutral (PFS-Equivalent) Rate?	ED Type A/B Classification?	EMTALA Applies?	Financial Viability for Medicare Volume
On-Campus Hospital ED	Yes	Yes	No	Yes	Yes	High
Off-Campus ED – Excepted (Pre-Nov. 2, 2015)	Yes	Yes	No	Yes	Yes	High
Off-Campus ED – Non-Excepted (Post-Nov. 2, 2015)	Yes (if provider-based compliant)	No	Yes	Yes (operationally classified)	Yes (if meets dedicated ED definition)	Lower

Scenario	CMS Recognizes as Hospital Dept (PBD)?	Eligible for Full OPPS Payment?	Paid at Site-Neutral (PFS-Equivalent) Rate?	ED Type A/B Classification?	EMTALA Applies?	Financial Viability for Medicare Volume
Independent (Non-Hospital) FSED	No	No	N/A	No	Generally No (not hospital-based)	Very limited (cannot bill Medicare as ED)

Medicaid. As there are no FSEDs in California, it is unclear how Medi-Cal would treat freestanding EDs that are not part of a hospital for reimbursement purposes.

Other State Models

A number of states —notably Texas, Colorado, and Ohio — license FSEDs either as hospital-based off-campus departments or as independent facilities. Nationally, there are more than 800 FSEDs operating across the United States in more than 30 states. This number has nearly doubled in the past decade, reflecting their expanding role in addressing the growing need for emergency care. Texas has the largest concentration and permits both hospital-affiliated and independent models while other states limit FSEDs to hospital-operated models. While there are various models, many independent FSEDs in other states often pursue additional accreditation from organizations such as the Joint Commission, which can accredit FSEDs under the ambulatory care accreditation program.

As a result of the Medicare reimbursement constraints described above, in many states, FSEDs are concentrated in suburban areas with strong commercial insurance penetration where payer reimbursement supports emergency-level hospital billing. Medicaid treatment varies by state, with some programs reimbursing independent FSEDs similarly to hospital EDs and others limiting payment. States that adopted FSED models often did so to expand geographic access and relieve pressure on crowded hospital EDs, though critics argue that independent FSED growth has tended to cluster in commercially insured communities rather than underserved areas.

Comparison With the Rural Emergency Hospital Model

FSEDs and the federal Rural Emergency Hospital (REH) designation both reflect efforts to preserve emergency access in communities that cannot financially sustain full inpatient hospitals, but they operate under entirely separate legal and payment frameworks. An FSED is generally a state-licensed emergency facility that may be hospital-affiliated or independent and typically does not receive enhanced federal support. By contrast, the REH model (click here to see CHA's analysis of the REH model) — created by Congress and implemented by CMS in 2023 — allows certain rural hospitals to eliminate inpatient beds while retaining emergency and outpatient services in exchange for enhanced Medicare reimbursement, including a monthly facility payment and a 5% outpatient add-on. While both models involve ED-centered care without traditional inpatient operations, REH is a federally defined Medicare provider type with built-in payment stabilization, whereas FSEDs rely on state licensure and standard reimbursement structures.

Comparison of FSED and REH Models

Feature	FSED	REH
Pathway Existence	Does not currently exist in California	Currently exists as federal model
Legal Basis	State licensure model	Federal Medicare provider designation
Created By	State law/regulation	Congress (Consolidated Appropriations Act of 2021)
Inpatient Beds	None	None (must eliminate acute inpatient beds)
Emergency Services Required	Yes	Yes (24/7 ED required)
Outpatient Services	Typically limited to ED + ancillary	Must provide emergency + outpatient services
Medicare Payment	Independent FSEDs cannot bill Medicare as hospital EDs. If new hospital-based off-campus site created after Nov. 2, 2015, can bill Medicare site-neutral payment rate	OPPS + 5% add-on + fixed monthly facility payment
Enhanced Federal Support	No	Yes (monthly facility payment)
Eligibility Limits	Depends on state law	Limited to eligible rural hospitals (CAH or small rural hospitals)
340B Eligibility	Only if hospital-affiliated and hospital qualifies	No
EMTALA Applicability	Applies if hospital-affiliated (provider-based department of a Medicare-participating hospital); independent FSEDs generally not subject	Applies fully; REH is a Medicare-participating hospital-type provider and must comply with EMTALA

Disclaimer: This document provides general considerations for various emergency service models. The transition to an FSED or REH model involves complex financial, operational, and regulatory shifts. Each organization must conduct its own independent, site-specific financial and legal analysis to determine if these models are a viable strategic fit for their facility and community.