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Administration of Emergency Medicine

CORPORATE AND HOSPITAL PROFITEERING IN EMERGENCY MEDICINE: PROBLEMS OF THE PAST, PRESENT, AND FUTURE

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Abstract—Background: Health care delivery in the United States has evolved in many ways over the past century, including the development of the specialty of Emergency Medicine (EM). With the creation of this specialty, many positive changes have occurred within hospital emergency departments (EDs) to improve access and quality of care of the nation's de facto "safety net." The specialty of EM has been further defined and held to high standards with regard to board certification, sub-specialization, maintenance of skills, and research. Despite these advances, problems remain. **Objective:** This review discusses the history and evolution of for-profit corporate influence on EM, emergency physicians, finance, and demise of democratic group practice. The review also explores federal and state health care financing issues pertinent to EM and discusses potential solutions. **Discussion:** The monopolistic growth of large corporate contract management groups and hospital ownership of vertically integrated physician groups has resulted in the elimination of many local democratic emergency physician groups. Potential downsides of this trend include unfair or unlawful termination of emergency physicians, restrictive covenants, quotas for productivity, admissions, testing, patient satisfaction, and the rising cost of health care. Other problems impact the financial outlook for EM and include falling federal, state, and private insurance reimbursement for emergency care, balance-billing, up-coding, unnecessary testing, and admissions. **Conclusions:** Emergency physicians should be aware of the many changes happening to the

specialty and practice of EM resulting from corporate control, influence, and changing federal and state health care financing issues. © 2016 Elsevier Inc.

Keywords—emergency medicine; corporation; finance; billing; Medicare; contract management group

INTRODUCTION

The evolution of the Emergency Department (ED) and practice of Emergency Medicine (EM) in the United States has changed dramatically over the past 50 years. Prior to the enactment of the Medicare and Medicaid programs in 1965, patient volumes in the ED were small, and office-based physicians took calls and provided much of the emergency care in community hospitals (1). In larger urban or county hospitals, ED care frequently was provided by unsupervised medical students, interns, residents, or foreign medical graduates (2). Often, patients were charged a nominal fee, and physicians or hospitals could easily reduce or waive fees for persons with limited income.

In 1961, Dr. James Mills, Jr., a general practitioner, started a full-time EM practice at Alexandria Hospital in Virginia (3). He developed a shift structure for physicians, charged patients \$5 per visit, and collected a

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hospital subsidy for indigent care. Also at this time, several community physicians began working part-time to staff the ED around the clock at Pontiac General Hospital in Michigan. As ED volumes grew in the 1960s and 1970s, an increasing number of hospitals found it necessary to contract with full-time physicians based in the ED (4,5). It was during this period when EM began to be recognized as a unique niche of medical specialization (6). The establishment of the American College of Emergency Physicians in 1968, introduction of the first EM training program at the University of Cincinnati in 1970, incorporation of the American Board of Emergency Medicine (ABEM) in 1976, and recognition of EM by the American Board of Medical Specialties in 1979 represent important milestones (1,3).

One of the defining characteristics of the ED and the specialty of EM is the concept of a public “safety net,” providing emergency care for all persons, including undocumented immigrants, unemployed, uninsured, and homeless persons. This was further defined in 1986 with the advent of the Emergency Medical Treatment and Active Labor Act (EMTALA). It requires hospitals that accept payments from Medicare to provide a medical screening examination to individuals seeking EM treatment, regardless of citizenship, legal status, or ability to pay. There are no reimbursement provisions. Hospitals may not transfer or discharge ED patients, except with their informed consent, stabilization of their condition, or when their condition requires transfer to a hospital with a higher level of care (7). Prior to EMTALA, patients may have been denied care at certain EDs due to inability to pay or lack of insurance.

Despite this unfunded mandate, 21st-century EDs have become a major epicenter of hospital operations and source of revenue, and billing for ED care by hospitals has grown into a billion-dollar enterprise. Large, publicly traded corporations have acquired many hospitals. “Wall Street”-type contract management groups (CMGs) now control and employ a large number of physicians staffing EDs. For some managers and administrators of these entities, many of whom are not physicians, emergency practitioners may be treated as revenue producers, and the ED viewed as a profit center and gateway to admission for further treatment. The focus on revenue has created an environment that potentially places hospital profit ahead of patient welfare. With government-mandated electronic medical record (EMR) systems, managers and administrators of hospitals and CMGs have discovered a new tool to monitor the productivity, test ordering, and admission practices of their contracted emergency physicians (8). In the wrong hands, this may lead to influencing or even coercing emergency physicians to increase testing, imaging, and admissions for the benefit of the hospital and not the patient. Pressure to increase profit for the

benefit of management and shareholders has the potential to intensify within these corporate entities. An Institute of Medicine report highlighted a crisis in emergency care, with ED crowding, hospital closures, ambulance diversion, lack of inpatient beds resulting in the hallway boarding of admitted patients, unavailability of on-call specialists, and an inconsistent emergency medical system (9). Despite these issues, corporate forces have developed methods to profiteer in the chaotic ED environment.

DISCUSSION

Corporate Emergency Medicine

In 1992, Dr. James Keaney published, “The Rape of Emergency Medicine,” which detailed corruption in EM (10). He described exploitation of emergency physicians by managers of CMGs, including the siphoning of profits through unfair business tactics, hiring unqualified physicians for less pay, and termination for any reason. Since this publication, these unethical corporate practices continue and have even expanded in scope to maximize revenue. There has been a steady rise in the number of large CMGs acquiring emergency physician contracts. Approximately one-third of all practicing emergency physicians work for a CMG, and the prevalence of this corporatization is the highest among medical specialties (11).

Emergency physicians may be encouraged or even required by management to follow ad hoc protocols and guidelines for laboratory testing, imaging, consultation, and hospital admission that may not represent the treating physician’s clinical judgment or uniformly benefit the patient (12–14). Corporate forces at the hospital and CMG level can influence emergency physicians’ medical decision-making with impunity and without immediate fear of legal ramifications. This managerial interference potentially results in patients receiving unnecessary and more expensive treatment. Conversely, for health maintenance organizations attempting to control ED costs, this influence could be the opposite and negatively impact physicians who order more tests than average or have higher admission rates. Patients have become more aware of their ED and hospital charges since the enactment of the 2010 Affordable Care Act (ACA), as many experienced changes in their health insurance policies with out-of-pocket deductibles as high as \$6,000/year (15). Patients and third-party payers ultimately foot the bill for unnecessary testing and admissions. Caught in the middle are emergency physicians focused on providing appropriate, high-quality care, without regard to corporate profit or loss.

Hospital managers have been enticed by large for-profit CMGs to cancel their contracts with small local

physician-owned ED groups. In most states, the corporate practice of medicine is prohibited to protect the public from undue influence on the physician–patient relationship (16). However, these laws are rarely enforced, as there is no one responsible for their oversight. Individual physicians or physician groups do not have the financial or time resources to mount a legal challenge against these large corporations. To protect themselves, the CMGs typically construct a shell professional or limited liability corporation to serve as the vehicle to employ the physicians. Despite this corporate veil, the practice is fully controlled by the CMG, and emergency physician professional fees flow to a lay entity (17). This violates the prohibitions on the corporate practice of medicine.

Siphoning of Physician Professional Fees

Emergency physicians' professional fees are billed separately from hospital charges for services incurred in the ED. In the setting of a physician-owned and -managed group, there are overhead costs related to the submission and collection of charges and other administrative functions. The remaining funds are directed to the physicians who provided the actual patient care. In this classic model, the physicians are in a partnership where each has a say in the business affairs of the practice. The revenues from the practice largely stay in the community served, as the ownership is local. In contrast, the large CMGs operate in a "Wall Street" manner in which they seek profit by controlling the economics of the practice, which includes the billing and collection for physician services. The business model of these groups is to actually employ or subcontract emergency physicians while shielding them from the amounts billed and collected in their name.

Emergency physicians first took wide notice of this with the publication of "The Rape of Emergency Medicine" (10). If a CMG goal is to maximize profits, this can be accomplished in ways that may not benefit the patient or taxpayer. The CMG may inflate physician charges as much as possible to realize a higher profit. Patients and third-party payers, including the government, are thus saddled with a higher bill. The largest expense of an ED group practice is what is paid to the physicians. A CMG may seek to extract as much of the fee intended for the physician as circumstances will allow. The percentage will vary depending on physician supply and demand and other local factors. This is known commonly as "fee-splitting," where a large fraction of the professional fee collected for physicians' services is taken by the CMG, beyond costs needed for overhead expenses of the practice. The amount taken to compensate CMG administrators and profit for shareholders may be greater than 30% (18). Nonphysician employees of large

CMGs may also be subjected to this practice in the form of wage withholding (19).

To hire physicians at a competitive rate and also have money left over for shareholder profit and administrator salaries, CMGs may charge excessively high professional fees to patients. A CMG may also seek to maximize individual physician productivity by establishment of patient per hour and critical care note quotas. Pushing their physicians to see more patients per hour could lead to compromised care. Other profit-maximizing measures include hiring non-ABEM-certified physicians at a lower rate, and replacing physicians with nurse practitioners and physician assistants. The individual physician who wishes to work at an ED controlled by a CMG has no option other than to accept this extortion of some of their fee. These entities control the majority of EDs throughout the country; if an emergency physician wants to work in a specific community, they may have no alternative employment options.

Falsely Inflating ED Charges

The potential problem of up-coding, or billing a level higher than appropriate for ED services rendered, was recognized many years prior to the advent of EMRs (20–22). Emergency physicians were usually not the root of this problem; rather, it was the managerial and administrative staff responsible for coding and billing (21). Prior to EMR, many ED charts were hand-written and had poor documentation, leaving two options for billing: 1) coding based on documentation, or 2) coding based on the service provided without regard for documentation, or "presumptive" coding. Both physician and billing service were liable for any fraudulent claims. If found guilty, either may be required to pay between \$5,500 and \$11,000, plus treble damages paid for each false claim under the False Claims Act, or "Lincoln Law" (23). The False Claims Act also requires that these claims were submitted "knowingly," which includes conduct beyond acting with actual knowledge of a situation such as "deliberate ignorance" or "reckless indifference" for the falsity of the claim. The Health Insurance Portability and Accountability Act (HIPAA) resulted in the revision of the False Claims Act to "any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or *should have known* will result in greater payment than service actually provided" (24). Emergency physicians can fall under the "should have known" category without proof of any intent to defraud (22). Another pitfall is emergency physicians may be excluded from participating in Medicare, Medicaid, and all federal health care programs for a period of years, effectively ending their career.

The Office of Inspector General of the Department of Health and Human Services (DHHS) determined that between 2001 and 2010, the proportion of higher-paid ED visits, especially level 5 (Current Procedural Technology code 99285), increased significantly (25). During this time, EMR systems were becoming more widespread in use by emergency physicians. Both the Department of Justice (DOJ) and DHHS issued warnings to hospital leaders regarding fraud specifically tied to the use of EMRs (26). Clicking check-boxes on a computer screen for review of systems and physical examination elements that may not have been performed is an example of this type of potential fraud. Other examples include the use of templates and phrases specifically created to ensure billing at the highest level. One giant hospital chain was able to increase its adjusted earnings from ED billing by 7% immediately after implementation of new EMR and coding procedures, while triaging patients with pre-determined nonemergency conditions who were unwilling to provide a co-payment up front (27).

Although up-coding may have been responsible for some of this increase, it is important to note that during this period there was increasing availability and use of technology such as magnetic resonance imaging (MRI), computed tomography (CT), ultrasound, and laboratory tests in the ED (28). Lack of access to primary care, increasing number of ED visits, and ED crowding also may have contributed to this trend. Aggressive, interventional ED care with initiation of intravenous fluids, imaging, and laboratory testing translates into increased medical decision-making complexity, a major component in determining billing level.

Unnecessary Laboratory, Imaging Tests, and Admissions

Emergency patients may be subjected to thousands of dollars of unnecessary laboratory and imaging tests based on a chief complaint prior to being seen by any physician. Some hospital administrators may consider these additional tests as revenue sources. A small number of these administrators, with collusion from corporate medical directors, have allegedly imposed ED protocols designed to increase testing (27,29). Some ED software programs are designed to automatically recommend a panel of tests based only on a patient's chief complaint at triage (8). Once the nurse enters the chief complaint, recommended tests are ordered before the patient is seen by an emergency physician. In many cases, the emergency physician would not have ordered a full panel of tests, and in some cases, would not have ordered any tests. Nonetheless, the emergency physician is required to sign and approve the order for the tests after the fact.

Certain hospital administrators may see financial incentive in admitting a higher-than-average percentage

of patients presenting to the ED, rather than treating and discharging them home. This includes insured patients who do not require admission. Some hospital corporate entities have been accused of establishing quotas for admissions and expecting their emergency physicians to admit a certain percentage of patients (27,29). Physicians who do not meet their quotas may be pressured with threat of termination by hospital administration. This also includes emergency CMGs interested in retaining their hospital partnership contract (30). The pressure on emergency physicians to comply with these quotas may be intense, particularly in small communities where alternative employment is limited. Patients may suffer as a result. Not only is their total charge significantly higher, but their hospital stay may be extended as well once admitted to increase reimbursement under the "Two-Midnight Rule" (31). Hospital stays of any length of time increase the risk of infection and medical mishaps. In a recent case, Community Health Systems, Inc. paid more than \$89 million to settle allegations that it billed government health care programs for full admissions that should have been billed as outpatient or observation ED services (32).

Termination without Cause and Noncompetition

The typical CMG contract includes provisions for termination without cause or if requested by the hospital administration. Surveys of emergency physicians reveal that many have been terminated without due process or have been threatened when complaining or speaking up about the quality of care (12,13). Emergency physicians who complain directly to hospital administration regarding a lack of resources compromising patient care have been terminated for raising these issues (33). Furthermore, terminated physicians often have noncompete or restrictive covenants in their original contracts that preclude them from working at another ED in their home area. Even certain academic medical centers have these covenants in their employment contracts (34). Restrictive covenants have been criticized by the Council on Ethical and Judicial Affairs of the American Medical Association (35).

Variability of ED Facility Fees

Hospitals charge patients a basic fee to be treated in the ED in a licensed bed, the facility fee. This provides revenue to cover the expense of nursing care, supplies, support, and maintenance. A recent study of California EDs found that facility fees for level 4 service (level 5 is highest) ranged from \$275 to \$6,662 (36). Licensed ED beds, in theory, provide visual and auditory privacy for HIPAA compliance, either with walls or thick curtains between

beds. However, increasing numbers of patients receive ED care in noisy, congested ED hallways, and not licensed beds (37). In the hallway, patients are fully visible to ED staff, patients, and visitors, and may receive compromised care as a complete history and physical examination is usually impossible. These patients or their insurance carriers may be billed the full facility fee, even though they were never evaluated in a licensed ED bed.

Some hospital billing departments include other miscellaneous charges in addition to the facility fee. In the past, many of these extra charges were accepted as part of the facility fee. Examples include “lab draw,” “i.v. start fees,” and charges for basic supplies and drugs such as a packet of gauze pads or an acetaminophen tablet. These charges are usually significantly marked up, as much as 10,000% (38,39). Billing departments of hospitals designated as “Trauma Centers,” “Heart Centers,” or “Stroke Centers” have used these designations to justify additional charges, even though care may not be more comprehensive than in a hospital without these credentials (40). For example, trauma activation occurs when paramedics in the field communicate that an injured patient is being brought in so a trauma team can be ready to deliver care. Trauma activation charges may add additional thousands of dollars to the facility fee. Certain states have addressed this variability: Maryland sets uniform facility fees regardless of the insurance status of the patient, and New Jersey has passed a law mandating that uninsured patients are not responsible for 15% greater than the Medicare reimbursement for the same service (41,42).

Balance-Billing

Insurance companies may require their enrolled patients to receive care at in-network hospitals, or the insurers will cover only a limited percent of the cost or none at all. The ACA requires that insurance companies cover emergency care (43). However, insurance companies may cover only a “usual, customary, and reasonable” (UCR) portion of the emergency care bill at an out-of-network hospital. The out-of-network hospital and emergency care providers are then forced to balance-bill the patient, because insurance companies’ interpretation of “UCR” often results in severely underpaying these out-of-network claims. Participating Medicare and in-network providers are generally forbidden from balance-billing patients, having agreed to accept the Medicare or private insurance fees as payment in full (44). Although the ACA includes caps on consumers’ out-of-pocket costs, this does not include out-of-network charges. In addition, the law does not prohibit out-of-network emergency care providers from engaging

in balance-billing. Unfortunately, patients have less control in their choice of ED, especially when travelling outside their home state.

In many states, balance-billing is allowed, but in states in which it is banned, such as California, physicians attempting to balance-bills for emergency care have been prosecuted (45,46). This is a loophole in the ACA, and consumer protection is not uniform in all states for emergency care. These excessive additional charges potentially force patients into financial hardship, loss of assets, and bankruptcy. However, a total ban on balance-billing could benefit insurers, allowing them to arbitrarily set payment rates for emergency physicians and on-call specialists. One solution would be for legislators, insurers, and emergency providers to develop fair payment methodologies and rates, and develop reasonable ways to review disputed claims for all parties. Some states, such as Maryland, have banned balance-billing but also established out-of-network reimbursement rates that are standardized (47). In Section 2719A of the Public Health Service Act, regulations require the patient’s insurance company to reimburse out-of-network emergency service by paying “the greatest of three possible amounts: 1) the average amount negotiated with in-network providers for the service furnished; 2) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as UCR charges); or 3) the amount that would be paid under Medicare for the emergency service.”

Disclosure of Charges for ED Services

Most patients who are treated in EDs do not arrive by ambulance, but by private auto, public transportation, or ambulation. In 2011 there were 136 million ED visits, and only 15.7% of patients arrived by ambulance (48). As such, patients in urban areas likely can choose from one of several EDs to receive care. But prices for ED services, including the facility fee, laboratory tests, imaging, and procedures are not posted or disclosed up front to patients. In addition to for-profit hospitals, many nonprofit and academic institutions are also guilty of this practice. There have been many publicized examples of very high charges for what should be considered straightforward ED care. One article describes a patient presenting to an ED with chest pain and diagnosed 3 hours later with esophagitis. She was billed \$21,000, with itemization (38). A laboratory test, for which Medicare pays \$11, was billed to the patient for \$158. Another patient who had minor injuries from a slip and fall received a bill of \$9,400. Included in that bill were CT scans charged at \$6,538, with Medicare reimbursement at \$825. It is rare or unheard of for

EDs to post charges for their services visible to the public seeking emergency care. Knowing the prices charged by various EDs or urgent care centers to treat common problems would provide consumers with important information in their decision to seek emergency care. Posting of charges would also likely stimulate competition among health care institutions. Conversely, it may result in discouraging patients from seeking care of easily treated medical conditions such as cystitis, lacerations, or abscesses, which have potential for significant morbidity if not treated early. In theory, ED charges should be the same for everyone receiving the same service. Medicare and Medicaid have established a precedent by setting limits it will pay hospitals and physicians for services. This is a double-edged sword, as EDs provide an essential public service 24 hours a day, no matter how full or empty the waiting room. The differential in pricing of ED services enables the staffing and equipment required to maintain the readiness of an ED and cover the cost of uncompensated care. It is doubtful any ED could remain open if Medicare and Medicaid reimbursement rates, which routinely decline each year, were standardized for all patients. This could force further closures of EDs, resulting in a shrinking safety net and worsening ED crowding.

Medicare and Medicaid Fraud

Fraudulent billing of Medicare and Medicaid from EDs became headline news with a *60 Minutes* report broadcast December 11, 2010 describing alleged fraud and corruption at several hospitals owned by Hospital Corporation of America (29). This continues to be a problem, with the DOJ reporting recovery of \$3.8 billion from False Act Claims in 2013 alone (49). As noted in the unnecessary testing section of this article, many of these fraudulent practices were identified through *qui tam*, or whistleblower, lawsuits. In addition to corporate for-profit hospital chains, academic medical centers have also been found guilty of fraud (50–55). The Racketeer Influenced Corrupt Organizations Act, the Anti-Kickback Statute, and the Stark Law governing physician self-referral have all been used in the prosecution of alleged ED billing and management misconduct. The advent in 2009 of the Health Care Fraud Prevention and Enforcement Action Team, and creation of the Self-Referral Disclosure Protocol by the Centers for Medicare & Medicaid Services in 2010 have resulted in even further investigations, penalties, and settlements (56). For some managers, board directors, and investors of certain large hospital chains and CMGs, the constant threat of Medicare and Medicaid fraud allegations, DOJ investigations, and *qui tam* lawsuits are considered to simply be a cost of doing business (50).

CONCLUSION

Profiteering from excessive billing of our sick and injured who seek treatment in EDs should be prohibited. On a national level, the corporate practice of medicine should be outlawed and enforced. For-profit corporations with nonphysician administrators should not be allowed to dictate how physicians practice medicine and siphon their fees for the benefit of stockholders and executives. Hospitals should be required to make fees and charges for ED care publicly available. State and federal prosecutors should continue to enforce civil and criminal laws against corporate economic misconduct, as well as prohibiting nonphysician corporate managers from practicing medicine through quotas or threats. Hospital or CMG administrators who attempt to practice medicine by mandating test ordering and higher admissions risk being prosecuted for practicing medicine without a license. State laws should be modified to define the practice of medicine in a clear fashion to prevent nonmedically trained individuals from attempting to make medical decisions that are essentially profit driven and not in the interest of the patient. Emergency physicians should be able to practice in democratic groups with financial transparency without fear of retaliation for expressing their opinion on practice management rules and hospital resources for ED care.

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