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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. All rights reserved.**

☐ **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