

# Fighting for You, and Too Often Alone

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*Remember: what appears in "From the Editor's Desk" is nothing more than my personal opinion, not an official statement from the American Academy of Emergency Medicine. Whether you think I am a genius or an idiot, I hope you will write a letter to the editor and tell me about it.*

Our Academy's board of directors was in Washington, D.C. on December 10 and 11. One day was spent in a board meeting and the other in meeting with regulators, legislators, and congressional staffers — fighting for you and your ability to take proper care of patients in the emergency department. Three issues were the focus of those meetings.

## Joint Ventures

Over recent years, several hospital chains have launched joint ventures (JVs) with corporate staffing companies — better known as contract management groups (CMGs). Probably the most notable of these is the one between HCA and EmCare, although it doesn't differ in any way I can see from other hospital/CMG joint ventures. But using the HCA/EmCare JV as an example, since HCA was already free to contract with EmCare to staff its emergency departments — and was doing so in a number of hospitals — why would it form a joint venture with EmCare? In my opinion there is only one reason: to conceal a kickback paid by EmCare in return for the contracts to staff HCA emergency departments.

Formerly, the hospital would bill the patient (or insurer) for hospital services and EmCare would bill for physician services, and each party kept what it collected. Now, under the JV, EmCare shares part of its physicians' professional fees with the hospital. Imagine if a hospital administrator went to a local, independent, physician-owned emergency medicine group and said, "I'll let you keep the ED contract if you kick back \$250,000 a year to the hospital." I suspect even the demand would be illegal, much less actually paying the kickback and then billing the federal government (Medicare, Medicaid, etc.) for services rendered. Independent, democratic EM groups cannot — and should not — compete with such bribery, giving hospital/CMG joint ventures the power to drive the private practice of emergency medicine out of existence. Although I cannot go into detail, AAEM continues its effort to stop these JVs.

## Balance Billing

At both national and state levels, there is a movement to ban balance billing by emergency physicians. It has already happened in California, and in D.C., the End Surprise Billing Act of 2015 (HR 3770) would do the same thing. I believe we convinced several legislators — including some of the bill's co-sponsors — that a ban on balance billing is a horrible idea with disastrous consequences they hadn't considered, so this bill is extremely unlikely to advance. However, there is a more dangerous movement against balance billing in the executive branch. In November the Dept. of Health and Human Services, the Dept. of Labor, and the

Internal Revenue Service issued a joint rule under the Affordable Care Act ("Obamacare") that implies they will ban all balance billing in the near future.

What's wrong with prohibiting balance billing by emergency physicians — doesn't that protect emergency department patients from being surprised by high out-of-pocket costs? No, prohibiting balance billing does not protect patients — it protects insurance companies. And judging by the annual compensation of their CEOs, insurance companies are doing just fine, thank you.

For those of you who have never dealt with insurance companies, I'll explain in a slightly more graphic way than we did in Washington. Let's say an imaginary insurance company called Distributed Insurance Companies of Kalamazoo, Houston, Erie, and Detroit (DICKHEAD) comes to your group and says, "Here is a contract to join our network and get paid \$50 every time you see one of our covered patients; take it or leave it." Being in-network usually means accepting a set fee from the insurer and getting little or nothing else. Being out-of-network usually means you can bill whatever you think is fair, and although the insurer will pay more than if you are in-network because you haven't contractually agreed to a discount, the patient bears some of the increased cost too.

There are advantages to being in-network. Your group gets paid faster and more reliably with less paperwork and administrative overhead, and has lower billing costs. And especially in the ED, many patients aren't going to pay any out-of-pocket fees anyway, so trying to collect wastes both time and money. However, at the level of reimbursement offered you can't staff your department with PAs or nurse practitioners 24/7, much less with board-certified emergency physicians. And like all EM groups, yours carries a huge charity burden (Medicaid, Medicare, self-pay, etc.) and needs to charge patients with private insurance enough to make up for some of the free care you render. So, your group decides to "go nonpar" (nonparticipating) and stay out-of-network. Now when a DICKHEAD patient comes to your ED, he has to pay a larger percentage of his bill out-of-pocket than if you were in-network. That is balance billing — billing an insured patient for costs his insurance doesn't cover, rather than taking whatever the insurance company offers and stopping there.

When this happens in the real world, the out-of-network patient goes back to his employer and complains about DICKHEAD insurance being inadequate (or shops for new insurance if he is buying his own). The employer then complains to the insurer, and more often than not DICKHEAD eventually comes back to the bargaining table and finally agrees to a contract that meets the needs of all concerned.

As I said, there are huge advantages to being in-network for an EM group, and the pressure to participate with a particular insurer is especially severe if the group's hospital is already in-network. A legal ban on balance billing isn't necessary. However, if it is impossible for emergency physicians to balance bill, if we can't even threaten to go nonpar with an

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insurer, every emergency department in the country will be completely at the mercy of insurance companies. Because of EMTALA, insurers know we have to see their patients. Unlike private offices or clinics, EDs can't screen out and turn away patients from out-of-network insurance plans. If emergency physicians can't threaten to go nonpar and balance bill, insurers will decide entirely on their own what they will pay us for taking care of their clients — knowing that we will take care of those patients regardless. Insurers will choose to pay very little for emergency services, often not even enough to keep the EM group alive or the doors of the ED open. That is just what happened in California — hospitals closed and the state lost EDs after the ban on balance billing, especially in poor areas that were already medically under-served. As so often happens when government intervenes, the Law of Unintended Consequences reared its ugly head. An effort to protect patients and improve access to care actually protects insurance companies and reduces access to emergency care. Government would do well to remember that nothing is free. If it is easy for insurers to pay next to nothing for emergency medical care, next to nothing is just what patients will get.

### Due Process

If you are a partner in a democratic EM group or faculty in an academic ED, it is extremely unlikely that you will be fired “without cause” (except during some probationary period that follows being hired). If you are accused of incompetence or some kind of wrong-doing, you will be given a chance to respond to the charges against you. In a democratic EM group, your partners will then vote on whether or not to retain you in the group, according to the group's bylaws. In an academic hospital your department chair, and maybe even a dean, will review the facts and decide your fate. In any case, you are assured some kind of peer review and due process rather than arbitrary termination based on the whim of a single person who may have no medical training at all.

That is not the case if you work for a CMG. Whether you are an employee or an independent contractor, if you work for a CMG you can not only be fired “for cause,” with some degree of advance notice you can be fired “without cause.” And if the hospital administrator requests that you be taken off the schedule, termination can be immediate and without any notice at all. Read your contract. I can just about guarantee that somewhere in it are clauses saying what I just described, and that you have waived your right to due process — meaning you can be fired for no reason at all and that you automatically resign your medical staff privileges when that happens. Think about that for a minute. You can be fired immediately and “without cause” at the request of a non-physician hospital administrator. Now, how secure do you feel twisting the arm of that cranky cardiologist who doesn't want to take your STEMI patient to the cath lab at 0300; or refusing to transfer the indigent alcoholic patient with cirrhosis and upper GI bleeding that your gastroenterologist doesn't want to take care of, and your hospital administrator doesn't want lingering in the ICU for a few weeks before he dies, running up huge bills that will never be paid?

Let's face it: emergency physicians care for some of the most undesirable patients imaginable — undesirable to hospital administrators who only care about hitting their corporate metrics and getting their bonuses, and sometimes even to other physicians too. We take pride in taking care of patients others shun, and in standing up for those patients and fighting for

them when we have to. But what if you knew you might be fired just for doing the right thing, for taking good care of your patient or for complying with EMTALA? Your right to due process and peer review doesn't just protect you, it protects your ability to be a good doctor. It protects your patients.

There is one other reason emergency physicians should be guaranteed due process. In theory, if you go to the CMG you work for and ask to see how the CMG codes your professional services, what it has billed for those services, and how much it has collected — it is legally bound to give you that information. However, this is a sure way to get yourself fired. Not because you asked to see the books — of course not — but “without cause.” As long as you can be fired without cause, without peer review and due process, it is impossible to protect yourself against accusations of billing fraud or to protect the federal government, the usual victim of that fraud. As we argued in Washington, protecting the right of emergency physicians to due process protects both patients and those who pay the bills.

### Too Often Alone

Our Academy is not alone in the effort to protect the ability of emergency physicians to balance bill. This is one of the few things that AAEM, ACEP, democratic groups, academic medical centers, and even CMGs agree on. No one wants to be left completely at the mercy of insurance companies. And although I know of no organization as passionate or active on the due process issue as AAEM, we do have allies. The AAEM/RSA, ACEP, EMRA, CORD, the American Society of Anesthesiologists, the American College of Legal Medicine, and the Society of General Internal Medicine all cosigned a letter on this topic written by AAEM for various government recipients, and the American Academy of Family Physicians sent its own letter on the issue.

On joint ventures however, AAEM is alone — despite my widely shared opinion that hospital/CMG joint ventures violate both federal and state laws and, as I said, threaten the private practice of emergency medicine with extinction. So, where is ACEP? Where is ACEP? ACEP is where it always seems to be when there is a conflict between individual emergency physicians (and their democratic groups) and the corporations that exploit us, prey on us, and enrich their owners and managers with our hard-earned professional fees. ACEP is with the CMGs, in the corporations' corner. In future columns I'll take a closer look at this consistent pattern of behavior, and try to explain it.

I think I had better make the disclaimer under the title of this column a permanent part of “From the Editor's Desk.” To quote Bette Davis in *All About Eve*, “Fasten your seat belts, it's going to be a bumpy night.”

If you want to help AAEM fight for your ability to control your own practice, take good care of patients, and be fairly compensated for your work — do something! The link below is an easy place to start.

<http://www.aaem.org/calendar/current-news&item=4400>. ■

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