

Ethical Issues in Emergency Department Practices to Obtain Patient Payment During Episodes of Care *An Information Paper*

Emergency departments are the gateway to the acute health care system and stand at the crossroads of tensions within that system on appropriate utilization of resources.¹ As the location available to all patients at all times, emergency departments are the one setting in health care where access is not defined by socioeconomic status. While emergency physicians rightly state that their clinical practice is the health care safety net, they have the ongoing challenges of ensuring that emergency care is financially sustainable and that they are appropriate stewards of scarce resources.²

The financial stresses related to hospital-based emergency department care are clear. Patients present based on their prudent understanding of their underlying symptoms.³ Under federal law, they are entitled to a medical screening examination for the presence of an emergency medical condition which in practicality means they receive care to the extent of the capabilities of that facility.⁴ Emergency physicians have ready access to expensive lab and imaging modalities to assess for acute conditions. Unlike other settings, payers cannot easily limit or pre-authorize the use of these diagnostics. Together, these factors defining emergency care give rise to economic calculations and political rhetoric that suggest there should be opportunities to reduce perceived inappropriate utilization of the emergency department.^{5,6}

As health insurance shifts to place greater financial responsibility on patients, there is increased recognition that emergency departments and hospitals need to collect the portion of payment that is the obligation of the patient. When patient copayments are not collected, emergency departments and hospitals encounter significant budgetary shortfalls that threaten their viability.⁷ In response, hospitals and emergency departments have developed protocols for seeking payment from patients during their episode of care. These protocols create an ethical tension between the role of the emergency department as the ultimate health care safety net and the imperative to maintain financial viability as an underlying requirement to provide acute care.

This information paper will provide an overview of the current practices to obtain patient payment during emergency department episodes of care. The paper will then analyze the ethical implications of these protocols and suggest recommendations for ACEP to consider in developing positions on this important issue.

Scope of Point-of-Care Collection of Payments Prior to and During Emergency Department Care

In evaluating point-of-care collection of payments during emergency department care, it is important to define the practice. While it is likely common at the end of an emergency department visit to approach patients with a request for co-payments or other fees, what is less clear is the prevalence of requests for payment at the point-of-care—eg, in triage prior to ED evaluation or during the ED stay prior to discharge. One challenge in examining this issue is the lack of peer-reviewed systematic data on the breadth of these approaches. Instead, much of the data on this practice comes from lay media coverage.

Media reports reveal that various upfront collection practices have developed in emergency departments across the country, mostly concentrated on collection after an initial evaluation by a qualified medical professional for the presence of an emergent medical condition. As many as half of all emergency departments nationwide, per the Healthcare Financial Management Association, may charge up-front fees.⁸ Two motivations for these practices are commonly cited: 1) to encourage more “appropriate” use of the ED in order to decrease cost and combat overcrowding, and 2) to reduce the heavy financial losses to institutions caused by uncompensated care so that they may remain viable. The most common practice is for the emergency department to provide an upfront medical screening exam as required by EMTALA. If this rules out an urgent or emergent medical need, the patient is required to pay a fee (anywhere from \$40 to \$350) or their insurance co-payment before receiving further evaluation or treatment (including discharge prescriptions). This practice is distinct from the request for co-payment by emergency department administrative staff apart from and after the medical episode of care is completed.⁸ In a less prevalent or at least less publicized practice, some centers have implemented such fees on the back end of an ED encounter, requiring the patient pay prior to receiving any prescriptions.⁸

These practices are not isolated to for-profit facilities. Non-profit academic centers⁹ and community hospitals⁸ have also implemented at-triage assessments and requests for payment from patients deemed not to have an emergent condition. Emergency Departments that have implemented these financial practices note that their obligation under EMTALA ends once an emergent medical condition is ruled out.^{8,10}

Point-of-care collection of co-payment or other fee prior to treatment is not limited to the emergency department. Recent press coverage notes that this practice also extends to subsequent acute care (e.g., surgical treatment of emergency department diagnosed appendicitis) and elective procedures and surgeries.¹¹

There is little empirical evidence on the impact of point-of-care collections on emergency department utilization or operational or financial metrics. One center that implemented this policy and concomitantly started a 24-hour nurse triage phone service reported the following findings¹⁰:

- A 24 percent reduction in lower-acuity ED patients
- A decrease in bad debt from \$8.1 million in 2008 to \$5.5 million in 2009
- A reduction in the left-without-being-seen rate from 4.9 percent in 2007 to 1.7 percent in 2012
- A 40-minute decrease in door-to-physician time—from 67 minutes in 2007 to 27 minutes in 2012
- Shorter decision-to-admit times (the time from when a physician decides to admit an ED patient until the patient is in an inpatient bed)—from 158 minutes in 2007 to 84 minutes in 2012
- A 35-minute decrease in average total ED length of stay (including for patients who are discharged), from 248 minutes in 2007 to 213 minutes in 2012

Another for-profit hospital chain reported that in 2011 approximately 1.3% of patients (80,000 of 6 million ED visits) left due to the request for payment at triage after being deemed to have a non-emergent complaint.⁸

A 2014 CMS Bulletin on this practice noted that it would be considered legal to charge triage fees and cost-sharing once the EMTALA obligation has been met. They do note, however, that alternative care options should be available, and referrals provided. The CMS Bulletin specifically states that they expect EDs implementing such protocols to demonstrate sufficient access to non-urgent services for these patients. They note that this payment or cost-sharing practice should be implemented after the EMTALA obligation has been fulfilled.⁵

Ethical Considerations in Evaluating Emergency Department Practices to Obtain Patient Payment During Episodes of Care

The primary concern with point-of-care fee collection is the discouraging of ED presentation by patients with emergent medical conditions out of anticipation of potential fees.⁸ An additional reservation is the availability of truly accessible alternatives to ED care when patients are referred elsewhere. Whether patients suffer a measurable delay in care for emergent medical conditions remains to be seen, as data measuring the impact of these practices are lacking.

A number of empirical questions should be explored prior to making ethical and policy judgments. For all of these, there is limited or no data to allow definitive conclusions, highlighting the need for further study:

1. What is the prevalence of point-of-care collections, and where exactly do they occur—in triage before physician evaluation, in triage after physician evaluation or in the ED after evaluation but before treatment (e.g., prescriptions) is provided?
2. What is accuracy of at-triage assessment for ruling-in or ruling-out an emergency condition?
3. What access do uninsured or underinsured patients have to acute care in venues other than the emergency department?
4. What is the financial impact of point-of-care collections on patients, on institutions (private vs. public), and on the health care system as a whole?
5. What impact does the practice have on ED overcrowding and related metrics, including time-to-physician, ED length-of-stay, and left-without-being seen?
6. How does the practice influence patient behavior, e.g., the likelihood of presenting to the ED for a low-risk complaint vs. a high-risk complaint?
7. What are the downstream effects to the health system of shifting uncompensated care from one ED to another, or to non-ED care locations?

Even with these unknowns, there are a number of ethical and practical implications to these practices that deserve the attention of ACEP.

Violating the Spirit of Universal Access to Emergency Care

The ACEP Code of Ethics elucidates the ethical principle of justice as it applies to emergency care in the United States. To quote:

“In a broad sense, acting justly can be understood as acting with impartiality or fairness. In this sense, emergency physicians have a duty of justice to provide care to patients regardless of race, color, creed, gender, nationality, or other irrelevant properties. In a more specific sense, justice refers to the equitable distribution of benefits and burdens within a community or society. In the United States, public policy has established a limited right of patients to receive evaluation and stabilizing treatment for emergency medical conditions in hospital emergency departments. This policy indirectly ascribes to emergency physicians a social responsibility to provide necessary emergency care to all patients, regardless of ability to pay.”¹²

When a particular ED requires payment that the patient cannot provide, the patient leaves to seek care elsewhere. If the patient then goes to an alternative facility without this practice, the cost of the uncompensated care is now shifted to the stakeholders of that hospital. This is counter to one of the aims of EMTALA, to reduce the ability of hospitals to shift the burden of uncompensated care. The real financial benefit to the first hospital is not simply avoiding the cost of the non-emergent visit in which the patient is essentially turned away. It is also avoiding the cost of subsequent visits, as the patient now knows upfront to seek care elsewhere in the future. The most expensive visits are the true emergencies, where patients

require treatment and admission, in some cases to intensive care units. By turning impoverished or uninsured or underinsured patients away for non-emergent visits, fee-collecting hospitals send the message that they should “go elsewhere.” This message is sent in anticipation of future visits that are true emergencies, requiring expensive, uncompensated care. In essence, this practice allows particular hospitals to ‘dump’ patients in advance, before ‘dumping’ would be considered an EMTALA violation. If the patient has to travel farther to the alternative hospital and the increased time to presentation leads to additional harm, the practice truly would have run afoul of the spirit of EMTALA.

Medicaid rules require hospitals to identify an alternative care source for patients before imposing cost-sharing; however, it is doubtful that many patients can access the alternative in a way that allows them to receive equivalent care. For example, if the recommended treatment is antibiotics for a non-emergent condition, the patient is likely to suffer some harm, even if not life-threatening, prior to reaching another provider. A privately-insured patient with the same condition will not suffer the same harm. Though the consequences are less severe than the cases from the 1980s that motivated EMTALA, the basic injustice of inequitable care is manifest in this cost-sharing practice. Practices to obtain payment before the episode of care may not only burden the individual patient’s ability to receive necessary, if not emergent, acute care but also put undue stress upon the structure of emergency care.

Ethical Implications of the Burden of Uncompensated Care

The ACEP Code of Ethics also recognizes that the principle of justice as applied to emergency care places an obligation on emergency physicians to be appropriate stewards of finite resources. In the quote above, there is a specific acknowledgment of providing ‘necessary’ emergency care. More explicitly, the Code of Ethics states:

“Emergency physicians also have a duty in justice to act as responsible stewards of the health care resources entrusted to them. In carrying out this duty, as, for example, in making triage decisions, emergency physicians must make careful judgments about the appropriate allocation of resources to maximize benefits, minimize harms, and respect the rights of their patients.”¹²

There is little doubt that uncompensated care places a burden on emergency departments, hospitals and society as a whole to maintain the infrastructure of high-quality emergency care. Available data, albeit limited, suggest that triage screening and requests for payment can improve financial and operational metrics for emergency departments. Deferral of non-acute care from the emergency department may therefore meet the justice principle as articulated in the ACEP Code of Ethics.

However, as a practical matter, the ability of uninsured and underinsured patients to receive acute care in a timely fashion in venues aside from the emergency department is debatable. Medicaid beneficiaries, as an example, present to the ED at twice the rate of privately insured patient.^{5,13} The ethical permissibility of charging such patients for non-urgent visits to the ED at triage rests on the assumption that their decision to seek care in the ED is “inappropriate” or “an abuse of the system,” that they have a moral obligation to “use the health care system more responsibly.” But studies demonstrate that only about 10 percent of ED visits by Medicaid patients are actually non-urgent.⁵

Another significant problem is that there is no reliable way for patients to determine a priori whether a visit to the ED would be “appropriate.” Raven et al. examined nearly 35,000 ED visits reported in the National Hospital Ambulatory Medical Care Survey and found that only 6.3% of patients were found to have primary care-treatable diagnoses; the vast majority of patients judge correctly that they should seek care in the ED. Further they found poor correlation between chief complaint and primary care-treatable diagnoses, meaning that it would generally be difficult for patients to determine in advance based on their symptoms that they did not require ED care and could instead have been treated appropriately by their primary doctor. 11.1%

of patients with symptoms that suggested primary care-treatable diagnoses needed immediate emergency care or hospital admission.¹⁴ Patients evaluated in the ED and charged for presenting with “non-urgent complaints” are penalized for failing to make a judgement that the data suggest is generally difficult for them to make. Since there is no reliable correlation between symptoms and discharge diagnoses, it is appropriate for patients to present to the ED if *they* believe they are having an emergency, whether or not this judgment ultimately turns out to be correct. The idea that an ED visit can be determined, a priori, to be “inappropriate” is not supported by the data and risks discouraging vulnerable patients from coming immediately to the ED when they do in fact require emergency care. It is important to note that ACEP has consistently fought for the prudent layperson standard to determine when emergency care should be accessible and advocated against attempts to prevent patients from seeking emergency care based on post-hoc evaluations of diagnosis.¹⁵ There is a danger that implementation of practices to obtain payment during episodes of care at triage prior to full emergency department treatment may conflict with the efforts of emergency physicians and ACEP in particular to ensure ready access to emergency care.

The Obligation to the Patient

Ultimately, the medical and ethical obligations to the patient are what should define the actions of emergency physicians and emergency departments in evaluating practices to obtain payment during episodes of care. As shown above, the issue is complex, given the challenges in assessing for the presence of a non-emergency condition in a limited time period, the need to consider the access to alternative venues for acute care and the burden placed on the emergency care system by potentially shifting the burden of uncompensated care to other centers. Theoretically, a robust system to connect non-emergent patients with timely care could allow emergency physicians to meet their ethical obligations in the circumstance of triage assessment of the need for emergency treatment.^{5, 16}

There also needs to be an acknowledgment of the difference in position and power among emergency physician and facility and the patient. While the letter of the law might be appropriately met by providing a medical screening exam and identifying the condition as non-emergent with referral, there is an ethical concern in shifting the burden of finding an alternative venue of care to a vulnerable patient when the condition might be readily and rapidly treatable in a setting put forward as a universal access point within the health care system such as the emergency department.^{5, 16}

However, once an episode of emergency department care is undertaken by an emergency physician, the practice of requiring payment to complete the episode of care, as opposed to explaining at triage that the complaint is non-emergent after a thorough medical-screening exam and ensuring that a robust follow-up process is available to the patient in real time, is fraught with ethical concern. We contend that for emergency physicians to meet the ethical obligations of beneficence and non-maleficence there can be no requirement that patients provide payment to receive medically-indicated discharge prescriptions or follow-up at the end of an emergency department episode of care. The provision of such discharge instructions and treatment is integral to the health care needs of the patient given the episodic nature of emergency department care. Furthermore, withholding a prescription at discharge for payment after the evaluation is completed is close to abandonment and not in keeping with the motivations for this payment practice since no additional cost would be incurred. In this way, this particular practices’ goal must be to discourage future visits. To use financial obligation in this regard is to place an undue burden on patients whom we have noted above have significant barriers to otherwise receiving timely, quality acute care. There is the practical matter also that if the goal is to reduce non-emergent care, lack of completion of appropriate discharge planning will likely result in the patient returning to the emergency department either for worsening of their condition from lack of treatment/appropriate follow-up or again due to lack of access to other venues for care. While individual hospitals may hope that such follow-up care will be elsewhere, the burden placed on other facilities providing emergency care also has an adverse impact that point against this practice.

Created by the Ethics Committee

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