

CASE AND COMMENTARY

Should Hospital Emergency Departments Be Used as Revenue Streams Despite Needs to Curb Overutilization?

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Abstract

This case asks how a hospital should balance patients' health needs with its financial bottom line regarding emergency department utilization. Should hospitals engage in proactive population health initiatives if they result in decreased revenue from their emergency departments? Which values should guide their thinking about this question? Drawing upon emerging legal and moral consensus about hospitals' obligations to their surrounding communities, this commentary argues that treating emergency departments purely as revenue streams violates both legal and moral standards.

Case

General Hospital, located in a downtown urban center, serves a wide variety of patients from its immediate neighborhood and surrounding suburbs and counties. A significant percentage of the patient population is drawn from General's adjacent blocks, where the community has high rates of poverty and crime and many residents tend to have poor health status. Traditionally, General's programs offer charity care to local, underserved patients.

Dr Z, a health professional and senior executive, meets quarterly with each department to discuss successes, challenges, and plans moving forward. One particular area of concern has been emergency department overutilization. During this meeting, Dr X, director of emergency medicine, and Dr Y, a third-year emergency medicine resident, propose a plan to address overutilization. Dr Y presents data on asthma-related emergency department visits, which illustrates that most patients with asthma-related complaints have lower-than-average household incomes and come from demographically similar neighborhoods within 3 miles of General's campus.

Drs X and Y propose a plan to send physicians and community health workers to patients' homes to try to help reduce asthma triggers; this plan would likely improve health outcomes over the long term but would be costly to implement.

Dr Z reiterates General's commitment to treating any patient who presents to the emergency room (ER), regardless of ability to pay. Dr Z expresses concern that shifting charity efforts from emergency service provision to community outreach could compromise an important current revenue stream for General, as the hospital collected millions in revenue for asthma-related emergencies over the past 2 years. The physicians wonder what they should do to balance their competing obligations—to address emergency department overutilization and build community programs that improve health outcomes.

Commentary

How should hospitals improve community health without compromising the quality of emergency care or their bottom line? Ultimately, we argue, treating emergency departments as a major revenue source violates legal standards and core values. However, hospitals are obligated to try to reduce ER utilization not by erecting barriers but by improving communities so that local residents rely less on emergency care to meet their acute health care needs in the first place.

Hospitals' Legal Obligations to Communities

We assume that General Hospital is, like most US hospitals, a nonprofit hospital that receives funding from Medicare. As such, it is bound by 3 major legal obligations. First, the Emergency Medical Treatment and Labor Act ([EMTALA](#)) requires that emergency departments accept walk-in patients regardless of ability to pay and provides them (at a minimum) with direct medical services to a point of stabilization.¹ Second, Section 501(r)(3) of the Internal Revenue Code requires that nonprofit hospitals provide [community benefit](#) under the Affordable Care Act (ACA), with the aim of improving the health of their communities.² Accordingly, they must undertake community health needs assessments every 3 years and develop an accompanying implementation strategy to address those needs.³ Third, a requirement found in Section 501(r) of the Internal Revenue Code has long mandated that nonprofits provide charity care to patients who need it, particularly by ensuring that patients who qualify for assistance get it.⁴ The ACA expanded these requirements, ensuring that hospitals make public their financial assistance policy and provide services either for free or at a reduced rate to patients who qualify.⁵ Hospitals also must make an effort to determine patient eligibility for financial assistance and, if patients meet these criteria, forego extensive collection practices.⁶

General Hospital's nonprofit status potentially tells us a great deal about how this dilemma should be resolved. While we do not know any details about General Hospital's financial status, we can assume that the institution receives a variety of tax benefits as a nonprofit. These benefits include not only the direct benefits of not having to pay numerous federal and state income taxes but also indirect benefits, such as being exempt from taxation on donations and opportunities to invest in tax-free bonds.⁷ Although we do not know the scope or depth of General Hospital's community benefit

work, we can assume that, as required by law, the hospital has a financial assistance program in place and provides charity care as a primary source of its community benefit activities.⁸ Like all nonprofit hospitals, General has an ethical obligation to its ER patients to provide them the best possible care, whether in the acute setting or through community-building initiatives that reduce the need for emergency care.

General Hospital's Deliberation About Values

In her aim to provide the best possible care to the surrounding community, Dr Y, an ER resident (hereafter "the resident"), represents ideals for which physicians should strive. A widely cited 1964 interpretation of the Hippocratic Oath, a foundation of medical ethics, makes a critical distinction between prevention and treatment: "I will apply, for the benefit of the sick, all measures [that] are required.... I will prevent disease whenever I can, for prevention is preferable to cure."⁹ The Hippocratic Oath is taken by just about every medical professional at some point in his or her training, and it delivers an ethical blueprint for medical practice. Nevertheless, health care systems have responsibilities that transcend ethical patient care, including administrative and financial responsibilities. Given the multifaceted nature of hospitals as both businesses and sites for medical care, how should these institutions weigh their various responsibilities?

Enter Dr Z, the hospital administrator (hereafter "the administrator"). The case characterizes the administrator as concerned about both patients and the hospital's financial viability. Looking more closely, the administrator casts the hospital as a business in which asthma-related emergencies are viewed in one light as an "important current revenue stream." "Charity care," however, only serves to hurt hospital margins. Asthma control, in this context, becomes a commodity. Framing the administrator's outlook in this way is not to say that she lacks regard for the health of patients; she very well may, or at least may have convinced herself that she does. But how can the administrator promote health in the organization if she does not meet the bottom line? The administrator's main concern appears to be that shifting General Hospital's charity care program from emergency service provision to community outreach would compromise an important revenue stream. General would not only sacrifice current monies generated from patients with asthma in the emergency room but also lose all potential revenue from now-healthier community members who would no longer visit the ER at the same rate.

Dr X, the emergency medicine director (hereafter "the director"), attempts to provide a solution to this conflict. The director, as a physician, aims for the same ideals of health as the resident by virtue of the core professional ethics principles he has vowed to uphold. As the emergency medicine point of contact for the administrator, however, he is also tasked with making sure these ideals fit within a successful business model. More succinctly, the director represents the middle ground between the goals of improving health outcomes and maintaining financial viability within the hospital. This middle

ground reflects a more general tension within the US health care system today, as financial realities constrain health care decision making and subsequent health outcomes. And this middle ground too often becomes necessary to navigate for physicians such as the director, who are stuck between administrators' concerns about the bottom line and their own commitment to the health of their patients.

Ultimately, the above conflict requires that a choice be made that weighs moral responsibilities to ensure optimal health outcomes and protect the financial viability of the institution. Clearly both must be addressed in this scenario; however, the moral path aligns significantly better with the core values of health care professionals and the interests of patients alike. Thus, it becomes necessary to examine the current health care system and to explore meaningful changes that would both protect patient care and population health while promoting a successful business model for health care institutions.

Exploring Solutions to General Hospital's Dilemma

While EMTALA is a long-established federal law, true community outreach requires more of hospitals. Just as medicine itself is increasingly shifting to models of active (eg, preventive) engagement, community-building activities can be considered "active" while charity care is mostly "reactive." Charity care is, at the end of the day, aimed not at improving health conditions in communities but rather at swallowing the bill for care—either entirely or by delivering it at a reduced rate. Yet, as enforcement and oversight of charity care is weak, it is likely that General Hospital will face no consequences if it meets even bare minimum standards. Only a handful of hospitals have lost their nonprofit status under community benefit laws.¹⁰

This reality raises the question of whether new incentives are needed to push hospitals toward a more active approach to community health. Innovative models used by hospitals across the country demonstrate many ways that General could improve the quality of life for the surrounding community. One way would be implementing public health programs, such as the one presented by the resident. By shifting to preventive medicine, General Hospital would spend more time educating the community and providing tools to promote wellness. The hope is that such a shift would result in patients coming to the ER only when they truly need emergent care while the hospital would still benefit both morally and financially by keeping its patients. One consideration with regard to ER use and reimbursement is that, while Medicaid and the Medicaid expansion have greatly reduced uncompensated care provided by US hospitals,¹¹ the only truly profitable patients are those who have private insurance. And, even here, a sobering fact underpins this profitability: regardless of their payer (Medicare, Medicaid, private insurance), patients not experiencing a true emergency—meaning that their care could have been managed in an outpatient setting—are rarely profitable.¹² By implementing preventive measures, General Hospital would shift nonemergent care to

its more appropriate outpatient setting while allowing emergency department resources to be utilized more as they were intended.

Another possible solution is to zoom out on the presented case and look at how this situation might be different within value-based payment structures that are currently being tested in the US health care system. Coverage is undoubtedly one of the core issues that helps to drive General Hospital's conflict, as those who depend on Medicaid or self-pay account for 48% of [nonurgent emergency room visits](#).¹³ Universal health care proposals such as Medicare for All have gained significant traction among lawmakers, health care practitioners, and the public at large,¹⁴ and such proposals would ensure that coverage is not a prohibitive factor in meeting basic health needs. In the near future, however, the move away from fee-for-service payment models toward systems that pay for value and demonstrated outcomes will force hospitals such as General to think more comprehensively about the relationship between patient care and financial considerations. Avoidable emergency department visits, in particular, jeopardize hospital profitability. Indeed, if these trends toward value-based payment continue, hospitals will no longer be paid for services provided that do not have enduring positive effects on patients—including through prevention.

Yet another option is increasing the focus on preventative social services in hospitals and having that focus reflected in compensation, a possibility discussed by Stuart Butler and Carmen Diaz of the Brookings Institution with regard to hospitals and schools as community "hubs."¹⁵ Shifting health care further into a central role in the community could feasibly shift perception of disease from an emergent issue needing a quick fix to a preventable entity. Developing hospital-based programs to promote access to affordable, healthy food and safe housing provides an opportunity to strengthen moral commitments to local communities and develop new revenue streams for hospitals.

Conclusion

This case raises a number of difficult questions for hospitals operating in a fast-changing health care environment. The different perspectives that comprise the case's ethical core—those of Drs X, Y, and Z—represent ideal types and possibly even stereotypes of positions that certainly do exist within US hospitals. At the same time, we assume that all clinicians, be they emergency room physicians or hospital leadership, care (albeit to potentially different degrees) about health outcomes, patient needs, and ethics. Yet, this case makes clear that ethics may not always be enough to force different actors, driven by divergent roles and interests, to provide patient-centered care. Rather, legal structures such as those put in place by EMTALA, nonprofit tax code, and the Affordable Care Act serve as a guardrail for ethical lapse. Indeed, in an age of mergers, consolidation, and system competition, when patient-centricity risks being reduced to a buzzword or branding campaign, the case of General Hospital illustrates the need for

strong legal requirements, backed up by enforcement, to ensure that medical professionals put their obligations to patients first.

In recent years, innovations have arisen both in the way health care is delivered and in methods of payment. It is therefore important, as well, to consider the fast-changing nature of medicine itself in assessing this case. Promising models such as accountable care organizations, medical homes, and payment reforms emphasizing value over volume—especially those receiving strong financial and logistic support from the Centers for Medicare and Medicaid Services—are likely to both force and incentivize hospitals to take more responsibility for the well-being of the populations surrounding their campuses.

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