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Statement of the American Hospital Association to the
EMTALA Technical Advisory Group
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On behalf of our nearly 4,700 member hospitals and health care systems, and 31,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to provide our views to the Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group. We applaud the advisory group's creation; it will provide a valuable forum for the discussion of important issues hospitals face as they strive to meet EMTALA's regulatory requirements and get patients the care they need.

Community hospitals are the medical safety net for this country. AHA members support the underlying intent of EMTALA – to ensure that people who need emergency services get them. In 2002, former Health and Human Services Secretary Thompson's Advisory Committee on Regulatory Reform proposed useful regulatory changes to EMTALA, many of which were incorporated into the revised regulations the Centers for Medicare and Medicaid Services (CMS) issued in September 2003. Overall, the regulations moved closer to the original intent of EMTALA, and removed regulatory impediments that had gotten in the way of meeting the clinical needs of patients. The changes streamlined some processes for responding to people in need of care, and focused EMTALA procedures on those parts of a hospital truly designed to treat emergency cases.

This statement focuses on several challenges hospitals continue to face under EMTALA. There are two overarching themes: hospitals cannot do it alone…they must depend on physicians to provide the medical services necessary to screen and stabilize patients under EMTALA; and hospital emergency departments (EDs) do not operate in a vacuum…they are part of the larger health system of a community with related legal and clinical responsibilities.

ON CALL COVERAGE

EMTALA is a nondiscrimination statute, created to ensure that ED services are available to all patients without regard to financial circumstance. The statute requires that a hospital maintain a list of physicians who are on-call to the ED to provide stabilizing treatment; know in advance who can be called when specialty services are needed; and make services uniformly available regardless of a patient's ability to pay.

The ability of community hospitals to provide on-call coverage has weakened as the number of specialists willing to provide ED coverage has faded. This was an area in which confusion and difficulty had been sowed by the ad hoc development of guidance among CMS regional offices. We appreciate the regulation's emphasis on flexibility in this area to enable hospitals to deal with a limited presence of specialists in a community.

Unfortunately, specialists are using that flexibility as grounds for ending or limiting their ED service. CMS's approach places hospitals in an increasingly untenable position: they are being held accountable for ensuring the availability of on-call physicians, yet they have virtually no control over those

physicians. While patients are expected to receive the benefits of on-call coverage, there is no obligation for specialists to agree to serve on call. The result is that patient access to specialty physician services in emergency, often life-threatening, circumstances is being limited. The AHA raised this concern during CMS' most recent EMTALA rulemaking; the continued withdrawal of specialists from call panels has intensified our concern.

As an increasing amount of their practice can be maintained at sites outside the community hospital, physicians are shifting from full medical staff privileges to courtesy privileges. Hospitals have much less influence over these physicians, and relying only on the professional obligations attached to admitting privileges is not sufficient to assure coverage for on-call panels. If CMS intends to regulate on-call services, it must deal directly with physicians. The AHA suggests that CMS review all of its existing authority, such as its discretionary authority under Medicare's enrollment provisions, to address physician on-call responsibilities. CMS also should examine options to address the liability, financial and other concerns raised by physicians as reasons to limit their on-call service. Hospitals can ensure that on-call resources are provided in a nondiscriminatory manner. They cannot, however, guarantee that individual specialists will provide on-call services.

PHYSICIAN-OWNED LIMITED-SERVICE HOSPITALS

Physician-owned limited-service hospitals are having a serious impact on patients' access to emergency specialty care. Some physicians are exploiting a loophole in federal law that allows them to own limited-service hospitals to which they refer carefully selected patients for highly reimbursed procedures. This raises serious concerns: conflict of interest, fair competition, and whether the best interests of patients are being served.

Self-referral is dangerous for patient care. When physicians own, even in part, a facility to which they refer patients, their decisions are subject to competing interests – the clinical interest of the patient and the financial interest of the physician. Studies demonstrate that self-referral leads to increased use of services and higher spending.

Physician-owned limited-service hospitals have exacerbated the on-call issue. Physicians who own limited-service hospitals often refuse to participate in emergency on-call duty at community hospitals, leaving them struggling to maintain ED specialty coverage.

The adverse effects of physician-owned limited-service hospitals goes well beyond on-call issues. The conflicts of interest that create patient selection, service selection and on-call concerns are jeopardizing America's health care safety net. Community hospitals serve all patients, regardless of their health status or ability to pay. Physician-owned limited-service hospitals, to be blunt, don't.

The solution is beyond the reach of EMTALA. The loophole in federal law must be closed, and physicians must be permanently banned from referring patients to new limited-service hospitals they own. Congress has already stepped in on this problem.

FAIR PROCESS FOR HOSPITALS BEFORE TERMINATION

Hospitals currently have no recourse if they are found by the CMS regional office (RO) to be noncompliant with EMTALA. There is no due process or administrator-level review before the RO issues public notice of termination and a subsequent termination letter. Because there is not adequate time to respond, no hospital can risk publication of the notice or ultimate termination by trying to convince its regional CMS office that a violation did not occur. The combination of the severe time constraints and the amount of time required of clinical staff to make the case means caregivers have less time for patient care. An appeals process would allow caregivers to exercise and defend their

professional judgments without the threat of a prematurely published newspaper notice announcing the government's intent to terminate the facility from Medicare.

Without any means of review, an RO can impose requirements beyond the statute or regulation, misinterpret the agency's policy, or simply get the facts wrong. The hospital must simultaneously argue that the RO is incorrect while also attempting to satisfy the RO that the hospital has developed a plan of correction that satisfies the RO's version of events. While the statute grants the Secretary authority to terminate providers from participation in Medicare for failure to comply *substantially* with the terms of participation (which includes compliance with EMTALA), under the regulations a hospital may be terminated for *any* type of noncompliance and any *single incident* of noncompliance. In contrast, a physician who violates EMTALA may be excluded from the program only if the violation is gross and flagrant or repeated. Before exercising a sanction as fatal as termination, CMS should ensure that it is merited and appropriate.

The AHA recommends that CMS revise its regulations to establish an administrator-level appeal process prior to an RO's issuance of a finding of noncompliance and public notice of termination. The provision in the Medicare Modernization Act requiring review by a Quality Improvement Organization (QIO) before making a compliance determination as part of a termination process is a step in the right direction. It should enable patient care and QIO professionals to review the clinical soundness of the care provided. Adding administrator-level review would not slow the process. There is a significant lapse in time between the alleged noncompliance and the RO decision. Changing the process so the RO issues a tentative decision with an option for the hospital to seek review could occur within the same period. These are unique situations that can bring differing views. Thoughtful reviews and decisions will better serve caregivers and patients.

PSYCHIATRIC PATIENTS

EMTALA is one of many regulatory obligations a hospital must comply with in the ED. Other services, such as public health, rape treatment, and EMS, clearly have the patient in mind, yet may conflict with EMTALA and the hospital's ability to comply.

For example, when a patient in need of psychiatric hospitalization presents to a community hospital ED, state law controls the process and standards for admission to psychiatric facilities. At the same time, community hospitals with very limited psychiatric inpatient capabilities are obligated under EMTALA to "stabilize" patients with a psychiatric emergency. Yet the state surveyors and ROs evaluate the community ED in an EMTALA vacuum. ROs may require a different process than the state, or may expect more from the community inpatient facility than that facility can provide the psychiatric patient. Consideration needs to be given to the variety of regulatory obligations that could greatly impact patient care; in particular the intersection between EMTALA and state-controlled procedures for accessing inpatient psychiatric services.

To close, we again thank you for the opportunity to bring our concerns to you, and the AHA looks forward to working with the advisory group to help hospitals balance compliance with EMTALA and the need to provide patient-focused emergency care.