

**Statement
of the
American Hospital Association
before the
EMTALA Technical Advisory Group**

June 15, 2005

My name is Kathleen DeVine, CEO of Saint Anthony Hospital in Chicago Illinois. I am here on behalf of the American Hospital Association (AHA) and its 4,800 member hospitals, health systems and other health care organizations, and Ascension Health, the nation's largest nonprofit Catholic health system. We appreciate this opportunity to address the Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group on the challenges of providing on-call coverage to the communities we serve.

Since its founding in 1896, Saint Anthony Hospital, a member of Ascension Health, has provided health care to some of Chicago's most impoverished and health-challenged people. Today, Saint Anthony serves a primarily Mexican-American and Mexican immigrant community on Chicago's southwest side. Consistent with the vision of our sister sponsors, Saint Anthony truly lives its mission: "to provide high-quality health care that leaves no one behind."

In the mid-90's, Saint Anthony began to forge partnerships with the Chicago Department of Public Health, the Cook County Bureau of Health Services and Rush University Medical Center to create a "virtual" safety net for the community. Saint Anthony's public private partnership model is being adapted in Los Angeles, San Francisco and other cities around the country.

Today, Saint Anthony is a 170-bed nonprofit community teaching hospital staffed by 650 associates and a medical staff of 300. A network of 13 clinics and outreach locations provide care – Saint Anthony Hospital and clinics treat approximately 96,000 people each year, with 7,500 admissions, 30,000 emergency department (ED) visits, and 2,200 births. Saint Anthony is among Illinois' top 10 Medicaid service providers and one of the largest employers in the community. The total population of the service area is about 1 million, with many of these communities designated Medically Underserved Areas, and some in a Health Professional Shortage Area.



Our hospital, like hospitals across the country, is the health care safety net for our community, and our EDs are the entry point for those in need. Every day hospitals like ours face the many challenges of meeting the health care needs of their community. Providing on-call coverage is one of those challenges. It is a multifaceted issue that does not lend itself to easy solutions, and it is more than an EMTALA issue. I'd like to use our experience at Saint Anthony to illustrate the challenges of providing on-call coverage.

Hospitals respond to everyone who comes to the ED. They make good-faith efforts to provide on-call coverage, but can only provide coverage within the resources reasonably available to them. Hospitals support the key principle of EMTALA, which is to provide a safety net for emergency care, but EMTALA should not be applied in a vacuum ... hospitals are as unique as the communities they serve, and so are the challenges they face in complying with EMTALA.

When EMTALA was enacted it was assumed that the screening and stabilization responsibilities that required the participation of physicians would be met through the relationship between the hospital and its medical staff – what some now refer to as the “volunteer medical staff.” Through the medical staff bylaws or policies, the hospital's medical staff would support the hospital in meeting clinical obligations under EMTALA, including the provision of on-call services as needed.

For a variety of reasons, relying on the volunteer medical staff to fulfill those obligations is no longer viable in many communities. Similarly, relying on the medical staff bylaws to ensure on-call coverage does not work in many communities. Economic, legal, and lifestyle changes have created a very different dynamic in the relationship between a hospital and its voluntary attending physicians.

The AHA's 2004 Survey of Hospital Leaders and preliminary findings of the 2005 survey provide insight into the on-call coverage issue:

- 41 percent of community hospitals responding had experienced a lack of specialty coverage in the ED for some period of time.
- Hospitals that reported a loss of specialty coverage cited several reasons, including:
 - uncompensated care
 - liability concerns
 - retirement
 - loss of specialists to other facilities.

At Saint Anthony, we also have experienced a lack of specialists and other physicians to provide on-call coverage. Our medical staff includes 289 physicians that represent a wide spectrum of specialists. At the same time, the demands on our ED are significant. Of the approximately 7,500 annual admissions to Saint Anthony's, 49 percent enter through the ED. Fifty-six percent of the patients discharged from the hospital are funded by Medicaid (in contrast to a city average of 23 percent and a state average of 12 percent). Approximately 30 percent of the ED visits are uninsured.

The organization and delivery of on-call coverage at the hospital is regulated through the medical staff bylaws, which place with each department the responsibility for establishing on-call coverage. The department has the latitude to provide coverage on a mandatory or voluntary basis. In spite of the bylaws provision and our good faith efforts, Saint Anthony's cannot maintain full time on-call coverage.

Over time, our greatest difficulty has been in providing coverage for neurosurgery, orthopedics, ear, nose and throat, and general and pediatric surgery. The reasons mirror the AHA survey results: Uncompensated care for on-call patients and increased medical liability exposure, along with the rise in premiums, are the two most significant factors for us. As I described, Saint Anthony's community is largely uninsured or covered only by the state Medicaid program. Typically, the on-call physician has never seen the patient before. From the physician's perspective, they are assuming all of the liability and bearing the costs of providing services. In addition, their medical liability premiums are actually increased for providing on-call services to the ED, and further increased for each additional hospital at which they provide on-call services. As a result, specialists and other physicians are withdrawing from the medical staff, leaving the community, or agreeing to serve only limited amounts of time on-call.

Hospitals are responding to the on-call coverage challenge in a variety of ways. In the AHA surveys we found that:

- Nearly one-third of hospitals reported paying some physicians for specialty coverage, a practice that has become more common over the last few years.
- 40 percent of community hospitals responding had to place their EDs on diversion for some period of time.
- Lack of specialty physician coverage is one of the top five reasons for ED diversion.

In some areas, certain specialty coverage is available only through a physician who is simultaneously covering more than one hospital. In others, coverage is available only if the specialist is given the option to schedule elective procedures while on-call.

At Saint Anthony's we are paying some physicians to be on-call. Transfers to other hospitals for patients requiring neurosurgical services are routine. In other specialties, patients are transferred on an as-needed basis. Some of our physicians also provide on-call services to other hospitals. Our efforts to recruit physicians to our community are also limited by the circumstances of our community. New graduates faced with significant debt from medical training, and the cost of medical liability coverage, are reluctant to establish practices where there is such a high proportion of patients who have no health care coverage or only Medicaid coverage. The result of the combination of uncompensated care, medical liability exposure and costly premiums, is that new and experienced physicians are often not attracted to our community.

The steps Saint Anthony's has taken to provide physician specialty services are only stopgap measures. There are complex underlying issues that need to be addressed: specialist shortages and distribution; uncompensated care; medical liability exposure and increasing premiums; physicians retiring from practice and new physicians expecting a different lifestyle.

EMTALA requires screening and stabilization – hospitals must have the discretion to determine how best to meet that responsibility. Since EMTALA does not create a mandate for physicians to serve on-call, it is unfair and unworkable for the Centers for Medicare & Medicaid Services (CMS) to attempt to micromanage the provision of on-call services in hospitals. CMS should declare that when a hospital acts in good faith to provide on-call coverage within the resources reasonably available, it has met its on-call obligations.

Further, if CMS wants to deal with any more specificity around on-call coverage, then physicians, those whom hospitals rely on to provide on-call care, must be brought to the table. Hospitals cannot do it alone.

Physician-Owned Limited-Service Hospitals

Challenges in maintaining specialty physician on-call coverage are exacerbated by another new disturbing trend --- physician-owned limited-service hospitals.

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. Physician-owned limited-service hospitals are having a serious impact on health care access, use and cost across the country. Congress and CMS are currently working to address the broader set of issues brought on by the inherent conflict of interest involved with physician ownership and self-referral. Strain on ED on-call obligations is just one of the many consequences these facilities impose on our communities. The consequences reach far beyond EMTALA and jeopardize communities' health care safety net.

“Self-referral” – the practice of physicians referring patients to a facility they own – has been of concern to Congress for many years. Federal laws to regulate these referrals grew out of a rapidly changing health care environment and increased concern about the potential for conflict of interest and inappropriate use of services. Research by the Department of Health and Human Services' Office of the Inspector General found that physicians ordered more services when they owned the facility that provided the service.

As a result, this practice was limited by a new law, the Ethics in Patient Referrals Act of 1989, which created a strict prohibition on physician conflicts of interest and self-referral to clinical laboratories – the field that was studied in 1989. Additional research found that self-referral increases the use and cost of imaging services, physical therapy, and services covered by workers' compensation. In 1993, Congress expanded the law to apply to inpatient and outpatient hospital services; physical, occupational and radiation therapy services; most imaging services; and home health services.

However, exceptions were created in the law to allow what Congress thought, at the time, to be a narrow set of arrangements that would be free from conflict of interest. One is the so-called “whole hospital” exception for self-referrals for inpatient and outpatient hospital services when a physician has an ownership stake in a “whole hospital.” This exception was created based on the reasoning that a single physician's ownership in and referral to a whole hospital was diffused across so many different departments in the hospital that it would limit any financial gain that

might result to the physician. Congress expressly prohibited physician self-referral to individual departments or subdivisions within a hospital to protect against conflicts of interest.

But when the self-referral laws were passed, policy makers did not foresee that specific departments or specialties within a hospital (e.g., cardiac care, orthopedics, surgery) would become stand-alone hospitals. Because of concerns with this practice, the Medicare Modernization Act of 2003 (MMA) imposed a temporary moratorium on physician self-referral to new limited-service providers.

The Facts

According to CMS, 59 physician-owned, limited-service cardiac, orthopedic and surgical hospitals were open and operating at the end of 2003 as a result of this federal loophole. Many more have opened since then and many more are waiting to open their doors.

These physician-owned, limited-service hospitals raise concerns about conflict of interest and fair competition in the health care market place. In October of 2003, the Government Accountability Office found that, when compared to full-service hospitals, physician-owned limited-service hospitals:

- treat patients that tended to be less sick;
- treat smaller percentages of Medicaid patients;
- are much less likely to have EDs;
- derive a smaller share of their revenue from inpatient services;
- have higher margins; and
- have physician ownership that averaged slightly more than 50 percent.

In March 2005, the Medicare Payment Advisory Commission (MedPAC) issued its report to Congress on the topic. MedPAC found that, when compared to full service hospitals, physician-owned limited-service hospitals:

- tend to treat lower shares of Medicaid patients;
- concentrate on certain diagnoses (diagnostic related groups (DRGs))
- treat relatively low-severity patients within those DRGs; and
- do not have lower Medicare costs per case.

In March 2005, CMS shared with the Congress its preliminary findings on the topic. CMS' work showed that, when compared to full-service hospitals, physician-owned limited service hospitals:

- generally treat less severe cases; and
- provide less uncompensated care.

These findings, from all three sources, describe some of the ways in which physician ownership creates unfair competition in the health care market place. But all of these advantages accrue to physician-owned limited-service hospitals because of procedure, service and patient selection – all driven by self-referral.

Patient Care Impact

As physician-owned limited-service hospitals pull out profitable services and healthy elective patients from community hospitals, full-service community hospitals are challenged to:

- Maintain specialty “on-call” coverage in their EDs, as physician-owners of limited-service hospitals no longer want to participate in this broader community commitment. Lack of specialty coverage in our nation’s EDs can jeopardize a hospital’s trauma level status and cause emergency patients to be transported much farther to access needed specialty care.
- Continue providing essential services that are seldom self-supporting, such as emergency departments, burn units, trauma care, and care for the uninsured.
- Overcome growing inefficiencies, such as more downtime and less predictable staffing needs, that result from a higher proportion of emergency admissions at full-service hospitals. These result as physician-owners move more and more elective admissions to their own limited-service hospitals.
- Coordinate care for patients in their community when more and more are being treated for a single condition by a limited-service hospital. Also, complications unrelated to the condition being treated (for example, a heart attack or a blood clot during or following surgery) result in last-minute emergency transfers to full-service hospitals, increasing the risk to patients.

These are serious implications for all patients – for everyone who relies on an ED when they are in need of urgent care or a hospital to be there to meet a wide range of health care community needs.

While maintaining ED on-call coverage is one disturbing consequence of physician-owned limited-service hospitals, it is just one of many. Congress and CMS are moving forward to address the myriad of issues surrounding physician ownership and self-referral. Physician ownership and self-referral generate very serious concerns about the health and economic interests of a community, including higher health care costs, duplication of services, patient and service selection, inappropriate use of procedures, and more.

We strongly urge Congress and CMS to close the loophole in federal law by permanently banning physician self-referral to new limited-service hospitals. By doing so, the Congress and CMS will help prevent conflict of interest between physicians and patients, preserve care for everyone’s emergent and urgent health care needs, and promote fair competition in today’s market place.