

**EXCERPTS FROM JUNE 9, 2008 AHA COMMENT LETTER TO CMS  
REGARDING PROPOSED CHANGES TO THE  
PHYSICIAN SELF-REFERRAL RULES**

**EMTALA, PHYSICIAN SELF-REFERRAL AND  
PATIENT DISCLOSURE ISSUES**

**HOSPITAL EMERGENCY SERVICES UNDER EMTALA**

In the fiscal year (FY) 2009 proposed rule for the inpatient prospective payment system (PPS), the Centers for Medicare & Medicaid Services (CMS) proposes a number of changes to the *Emergency Medical Treatment and Labor Act* (EMTALA) regulations, most of which derive from recommendations made by the EMTALA Technical Advisory Group (TAG).

Applicability of EMTALA Requirements to Hospital Inpatients. CMS proposes to revise EMTALA so that when an individual covered by EMTALA is admitted as an inpatient and remains unstabilized with an emergency medical condition, a receiving hospital with specialized capabilities has an EMTALA obligation to accept that individual, assuming that the transfer of the individual is an appropriate transfer and the participating hospital with specialized capabilities has the capacity to treat the individual.

**We urge CMS not to finalize this proposal.** We believe that this proposal represents a substantial change in policy, not merely a clarification of current regulation as CMS suggests. Specifically, this policy change contradicts the current regulation regarding the non-applicability of EMTALA to inpatients that was finalized in September 2003. The regulation at 42 CFR 489.24 (d)(2)(i) clearly sets out that once an individual presenting to the hospital's emergency department has been screened and admitted as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its EMTALA obligations for that individual. CMS' proposed "clarification" contradicts the regulation in that it re-opens EMTALA. The hospital to which the patient has been admitted is again subject to EMTALA (obligations for conducting an "appropriate transfer" (42 CFR 489.24 (e)(2)); and other hospitals take on an EMTALA obligation unrelated to a patient who is presenting to a hospital for emergency care. As CMS explained in its 2003 rule, once an individual becomes an inpatient, they have the same legal protections as all other patients.

Further, such a change in policy is simply unnecessary. We do not know why a hospital would knowingly admit a patient with an unstabilized emergency medical condition to an inpatient unit if it did not have the capacity or capability to medically stabilize the patient's condition. However, even if a hospital were to do so, once admitted as a patient to an inpatient unit, current regulations and state law already impose a legal and clinical responsibility on the hospital to provide appropriate care to the patient. As 42 CFR 489.24 (d)(2)(iii) indicates, the following hospital conditions of participation (CoPs) regulations, as well as the associated CMS interpretive guidelines, provide an appropriate foundation for safe care of all inpatients, including inpatients who have an unstabilized emergency medical condition:

- *Physician On Duty or On Call* (42 CFR 482.12(c)(3))
- *A Responsible Physician for Each Patient* (42 CFR 482.12(c)(4))
- *RN Supervision & Availability 24/7* (42 CFR 482.23(b))
- *Right to Care in a Safe Setting* (42 CFR 482.13(c)(2))
- *Governing Body Ensures Accountability* (42 CFR 482.12(a)(5))
- *Medical Staff - Organized & Accountable* (42 CFR 482.22(b))
- *Quality Assessment and Performance Improvement (QAPI)* (42 CFR 482.21(e))
- *Discharge Planning* (42 CFR 482.43 and 42 CFR 482.43(a))

We also do not believe that CMS has adequately demonstrated that its current policy needs to be reversed. The discussion in the proposed rule's preamble does not establish that a problem exists with regard to the inability of hospitals to transfer unstable inpatients. Nor does it address why the existing CoPs are not sufficient to protect hospital inpatients. Instead, CMS states it is relying on the recommendation of the EMTALA TAG, which offers no compelling description of an existing problem in this area, to justify the need for a change in policy.

Further, the preamble includes no reference to or summary of the TAG's lengthy and heated discussion on this recommendation. CMS fails to note that this recommendation was strongly contested within the TAG and that the recommendation passed with only a slim majority, with most of the physician and hospital representatives voting against the proposal. The support for this recommendation came largely from the TAG's government representatives. During TAG discussions, a brief description of a single relevant patient case, provided by one of the government representatives, was entered into the record. After the meeting ended, letters to the chairman of the TAG from groups of its members were sent indicating concern that this recommendation, if implemented, would adversely affect patient care and potentially increase the number of unnecessary patient transfers. In addition, two of the physicians who voted in favor of the recommendation subsequently sent a letter expressing concern that its implementation could have "potential for abuse (i.e., patient dumping)" and that they "...fear that the potentially unintended consequence may be the transfer of EMTALA patients for reasons other than those related to emergency care of the problem for which the patient was originally admitted when these services could have been provided at the sending hospitals."

Most importantly, this proposal is simply poor public policy. Through its 30-month term, the TAG heard a great deal about the larger issues affecting the emergency department related to overcrowding, patient boarding, ambulance diversion and the precarious operational and financial situation in which many trauma centers and psychiatric hospitals find themselves. In fact, the TAG dedicated an entire chapter of its final report to acknowledging the many issues that impinge on emergency department operation. Trauma center and psychiatric hospital representatives testifying before the TAG stressed the difficulties that their facilities faced due to the increasing numbers of EMTALA transfers from other hospitals, many of which were felt to be of questionable added value ("over-triage"). Over-triaging of patients and related transfers have adverse consequences; they limit access for patients who truly require the level of care provided at trauma centers, and result in financial strain that limits trauma centers' ability to meet the needs of their communities. Individuals testifying and TAG members noted insufficient attention paid to unnecessary transfers in the enforcement of EMTALA. From many recent

reports, ranging from the Institute of Medicine's report, *Hospital-Based Emergency Care at the Breaking Point*, to the recently released House of Representatives Oversight and Government Reform report, *Hospital Emergency Surge Capacity: Not Ready for the Predictable Surprise*, the public has heard the message of the crisis in emergency care loud and clear.

Therefore, it is all the more troubling that CMS has decided to move forward with the most controversial recommendation of the TAG; one that TAG members indicate has potential to worsen this situation facing the nation's emergency departments. The minutes of the September 2007 TAG meeting reflect these concerns, stating that "[s]everal members of the TAG argued that requiring hospitals with specialized capabilities to accept inpatient transfers under EMTALA would adversely affect patient care and increase the number of unnecessary patient transfers."

**For these reasons, the AHA urges CMS not to finalize this proposed policy.**

Shared/Community Call. CMS proposes that, as part of the obligation to have an on-call list, hospitals may choose to participate in a community call plan to provide on-call coverage for an area. A community call plan must be a formal plan among the participating hospitals and include, at a minimum, a number of specific elements outlined in the proposed regulations.

**The AHA supports CMS' proposal to allow hospitals to meet their on-call list obligations through a shared or community call plan.** Such an approach would allow communities to provide for access to specialty care in a more reasoned, expedited and efficient manner. However, we caution CMS against being too prescriptive in the requirements imposed on hospitals in such a plan. In particular, we believe that the element located at the proposed new 489.24 (j)(2)(iii)(E) requiring "evidence of engagement of the hospitals participating in the community call plan in an analysis of the specialty on-call needs of the community for which the plan is effective" is overly prescriptive and is likely already subsumed under the element (G), the "annual assessment of the community call plan by the participating hospitals." Therefore, we recommend that CMS delete this element (E) from the regulation.

Relocation of Regulatory Provisions for On-Call List Requirements. CMS proposes to move the regulation discussing the obligation of a hospital to maintain an on-call list from the EMTALA regulations to the hospital provider agreement regulations and amends the language to be more consistent with the EMTALA statute. We support this change but note that in the process of moving and amending the on-call list language, CMS has removed the "in a manner that best meets the needs of the hospital's patients" language from the current paragraph (j)(1) without explicitly describing its rationale for doing so. Given that this language was controversial when it was originally proposed in 2002 and remained so during the TAG deliberations, we recommend that CMS explain why it has removed this language from the regulation. The AHA believes that an explanation is important so that the change is not misconstrued as undermining the ability of hospitals to set expectations for physicians agreeing to serve on-call to the hospital emergency department.

Non-applicability of EMTALA Provisions in an Emergency. CMS proposes to make technical corrections regarding the non-applicability of EMTALA provisions in an emergency area during an emergency period. We support this change because it makes the regulations consistent with

the requirements of the statute and will allow hospitals to provide timely and appropriate care to patients in disaster situations without fear of sanction under EMTALA.