REPORT NUMBER FOUR

to the

Secretary

U.S. Department of Health and Human Services

From the

Emergency Medical Treatment and Labor Act

Technical Advisory Group

Hubert H. Humphrey Building

Washington, DC

May 1–2, 2006

EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA)
TECHNICAL ADVISORY GROUP (TAG)
Minutes
May 1–2, 2006

Welcome, Call to Order, and Opening Remarks

David Siegel, M.D., J.D., called the meeting to order on Monday, May 1. (See Appendix A for the meeting agenda). He welcomed the members of the TAG and the audience and introduced two new members: Dodjie Guioa of CMS Region VI Survey and Certifications Operation Branch, and Sul Ross Thorward, M.D., a psychiatrist at Twin Valley Behavioral Health Care in Columbus, OH. Dr. Siegel reiterated the group's functions, as identified in the charter, and outlined the agenda for the meeting.

CMS Response to TAG Recommendations

Thomas Gustafson, Ph.D., deputy director of the Center for Medicare Management, described CMS' response to five TAG recommendations:

Definition of Labor

The TAG recommends that CMS delete the following sentence from the regulation in the definition of labor, "A woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable time of observation, the woman is in false labor."

CMS Response

In the notice of proposed rulemaking for the 2007 Inpatient Prospective Payment System (Appendix 1), CMS proposed modifying the definition of "labor" in section 489.24(b) by revising the second sentence of that definition to state that a woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor. The public comment period for the proposed rule ends June 12, 2006. At that time, CMS will evaluate the comments received and make a final determination on changes to the rule.

Hospitals with Specialized Capabilities

The TAG recommends that hospitals with specialized capabilities (as defined in Section G of the EMTALA regulation) that do not have a dedicated emergency department be bound by the same responsibilities under EMTALA as hospitals with specialized capabilities that do have a dedicated emergency department.

CMS Response

The recommendation is consistent with CMS' current policy and highlights the need to clarify CMS' policy regarding hospitals with specialized capabilities. Therefore, in the proposed rule, CMS proposes modifying the regulations at section 489.24(f) to specifically indicate that any participating hospital with specialized capabilities or facilities, even if it does not have a dedicated emergency department, may not refuse to

accept an appropriate transfer if the hospital has the capacity to treat the individual. The proposed revision does not reflect any change in current CMS policy.

Hospitals with Specialized Capabilities
The TAG recommends that hospitals with specialized capabilities not be required to maintain emergency departments.

CMS Response
The recommendation is consistent with current CMS policy.

Requiring Emergency Department On-Call Coverage as a Condition of Participation in Medicare
The TAG recommends that CMS not require physicians to take emergency call as a Condition of Participation in Medicare.

CMS Response
The recommendation is consistent with current CMS policy.

Call Coverage
The TAG recommends that CMS move 489.24(j)(1), the provision dealing with maintaining a list of on-call physicians, to 489.20(r)(2), which relates to the Medicare provider agreement.

CMS Response
CMS staff is evaluating this recommendation.

Dr. Siegel and the TAG members thanked Dr. Gustafson for his feedback and expressed their appreciation that the Secretary is taking their recommendations into account.

Summary Reports of the Subcommittees
Julie Mathis Nelson, J.D., chair of the Action Subcommittee, and John Kusske, M.D., chair of the On-Call Subcommittee, identified the topics their subcommittees wished the TAG to address at this meeting.

The Framework Subcommittee, chaired by Charlotte Yeh, M.D., seeks the TAG's input on two draft papers: *Reimbursement*, written by Won Ki Chae, a medical student and graduate student at the Harvard School of Public Health, and *Liability*, by Mary Bing, also a graduate student at the Harvard School of Public Health. The Framework Subcommittee will also address capacity and disparities in care in future papers. The papers identify issues related to EMTALA and will be published with the final report to the Secretary. The TAG recognizes that the suggestions offered in the papers are beyond the scope of the TAG but feels it would be remiss if it did not point out the need for larger, systemic changes.

Physician Communication
The TAG reviewed the draft document presented by the Action Subcommittee and suggested changes. Ms. Nelson noted the Interpretive Guidelines do not contain any explanatory text about the physician communication provision in 489.24(d)(4)(iii).

Recommendation
The TAG recommends the statute regarding communication with the patient's physician (489.24[d][4][iii]) be revised as follows:

> At any time, a treating physician or qualified medical person is not precluded from contacting the patient's physician to seek advice regarding the patient's medical history and needs that may be relevant to the medical treatment and screening of the patient.

The following statement represents the consensus of the TAG, which recommends that CMS incorporate the concepts into the Interpretive Guidelines for 489.24(d)(4)(iii):

> At any time, the treating physician or qualified medical person (QMP) may seek advice or clinical information from a clinician or other appropriate source regarding the patient's medical history or needs that may be relevant to the patient's medical screening examination or stabilizing treatment. While the contacted clinician may provide information or render advice, the treating physician or QMP is ultimately responsible for the patient's care. There is no requirement that the treating physician or QMP engage in this contact. The treating physician or QMP determines whether this contact is necessary. While awaiting the clinician's response, the treating physician or QMP shall proceed with the patient's medical screening examination or stabilizing treatment as indicated. In the event that a difference of opinion exists between the treating physician or QMP and the contacted clinician, the medical judgment of the treating physician or QMP shall prevail.

On-Call Physician as Specialized Capability
Dr. Kusske said a CMS administrative law judge found in a 2000 hearing that the presence of a vascular surgeon inferred a specialized capability at the hospital where the surgeon was on call, and the On-Call Subcommittee disagrees with this finding. The TAG raised several concerns in the course of discussion, including the need to prevent discrimination by closing loopholes used by hospitals to transfer uninsured patients and to prevent abuse of transfer provisions, which indirectly penalizes hospitals that maintain a 24-hour call list.

Recommendations
The following statements represent the consensus of the TAG, which recommends that CMS incorporate the concepts into the Interpretive Guidelines for 489.24(f), recipient hospital responsibilities:

- The presence of a specialty physician on the call roster is not, by itself, sufficient to be considered a specialized capability. At the time of the transfer, the receiving

hospital should also have available the necessary equipment, space, staff, etc., to accommodate the patient transfer.

- The presence of a physician who has privileges at the receiving hospital but is not on the call roster or who is not on call at the time of the transfer should *not* be considered a specialized capability.

The TAG recommends that 489.20(r)(2) be interpreted by CMS as meaning that all hospitals, including specialty hospitals, should maintain a call list in accordance with the statute and provider agreement. If necessary, the Interpretive Guidelines at Tag 404A should be revised to clarify this point.

CMS Provider Communications

Gerry Nicholson, director of the Center for Medicare Management's Provider Communications Group, described how CMS communicates with providers and requested input from the TAG on which methods are most successful (Appendix 2). The TAG agreed that CMS can reach physicians through their specialty societies and medical associations. Hospital associations and health care attorneys are also effective in disseminating CMS information. Warren Jones, M.D., stressed the importance of distinguishing EMTALA information from all the other information physicians receive, particularly from the letters sent out by the Center for Medicaid and State Operations to communicate new policies rapidly. Katie Orrico, director of the American Association of Neurological Surgeons, asked that CMS provide one page on its website that includes links to all the EMTALA information located throughout the website and that CMS improve the ease of use of its website.

Recommendation

The TAG recommends that CMS add to its website a list of frequently asked questions (FAQs) specific to EMTALA, categorized into sub-topics.

- The Center for Medicaid and State Operations' Survey and Certification staff members will identify FAQs.
- Ms. Nelson will provide a list of FAQs that she has already developed.

Action Item

Dr. Siegel will work with the CMS staff and the TAG subcommittees to identify specific topics that should be addressed by CMS provider outreach efforts and the appropriate communication vehicles and methods to use.

Framework Subcommittee Papers

Reimbursement

The TAG reviewed the draft, with Mr. Chae participating by phone. Dr. Yeh emphasized that the potential solutions in the paper are meant to represent a range of ideas without regard for which would be most effective or how they would be implemented. Some members felt the paper does not sufficiently capture the severity of the situation. Drs. Siegel and Yeh reiterated that data are needed to support contentions, e.g., that reimbursement levels are driving hospitals to close their emergency departments.

Action Items
Mr. Chae will incorporate the specific edits and general suggestions made by TAG members into the document. The paper will include a brief section on special considerations that discusses mental health care, among other areas with unique issues.

For the draft paper *Reimbursement*, TAG members are asked to send information or suggest sources on the expenses incurred by and costs associated with on-call specialty physicians. TAG members are also asked to provide any additional references or resources related to the topic.

- Dr. Kusske will forward to Dr. Yeh data from the California Health Care Foundation and the California Medical Association on physician costs in the emergency department. He will also identify a reference to information from the American College of Emergency Physicians on the average amount of payment physicians are unable to collect each year (i.e., bad debt).
- Mark Pearlmutter, M.D., will identify a reference to information from the American College of Physician Executives on bad debt.
- Rory Scott Jaffe, M.D., will provide California data on reimbursement to hospitals that provide a disproportionate share of care to uninsured patients (i.e., disproportionate share hospital [DSH] payments).

Liability
The TAG reviewed the draft, with Ms. Bing participating by phone. Ms. Nelson suggested looking more closely at data from states where liability reform has had some success (e.g., California, Texas, and Florida). She also suggested addressing how physicians' perceptions and fear of liability lawsuits affects their practices.

Action Items
Ms. Bing will incorporate the clarifications and general suggestions made by TAG members into the document.

Dr. Kusske will provide data supporting the assertion that neurosurgeons are more likely to face a malpractice lawsuit as a result of elective surgery than as a result of surgery performed in the emergency department.

Capacity
The subcommittee is finalizing the outline for this paper. Dr. Yeh asked TAG members to provide information on how capacity affects hospitals' ability to comply with EMTALA, including examples, case studies, and newspaper articles. Dr. Siegel asked that any workforce studies on specialties be forwarded to Dr. Yeh.

Disparities in Care
The subcommittee is finalizing the outline for this paper. While the other three papers discuss issues that prevent providers from complying with EMTALA, *Disparities in Care* will address whether EMTALA is achieving its goal of providing uniform access to care. Dr. Yeh noted that

if cultural sensitivity is the root of the problem of disparate care, addressing access to care does not resolve it.

Action Item
Dr. Jaffe will identify the reference for the Centers for Disease Control and Prevention's study on wait times in the emergency department for patients by race and acuity.

Definition of Labor
Ms. Nelson suggested that in the proposed, revised definition, the word "certifies" suggests a regulatory procedure, and "determines" would be more appropriate for clinicians. The determination of false labor should also be documented.

Recommendation
The TAG recommends that CMS replace the word "certifies" with the phrase "determines and documents" in the definition of labor and as needed in the Interpretive Guidelines.

Physician Response Time
The TAG reviewed the recommendation and rationale presented by the On-Call Subcommittee. Currently, hospitals are required to state expected physician on-call response time in minutes, which could be defined very narrowly (e.g., 30 minutes).

Recommendation
The following statements represent the consensus of the TAG, which recommends that CMS incorporate these concepts into the Interpretive Guidelines for 489.24(j), availability of on-call physicians:

- Response times should be defined in a range of minutes, not a single number of minutes.
- Response time should refer to the initial response by the physician on call.
- Through their medical staff bylaws, hospitals may define who may respond on behalf of the on-call physician (i.e., physician's designated representative).
- The initial response may occur by phone (or other means).
- Hospitals should develop policies and procedures to address the response time and appropriate exemptions.
- A physician's failure to respond when called or failure to arrive at the hospital when requested may be a violation of EMTALA.

Selective Call
The TAG reviewed the recommendation and rationale presented by the On-Call Subcommittee. Dr. Kusske said the Interpretive Guidelines could be interpreted as requiring any physician in the hospital to see a patient even when the physician is not on the call list. Dr. Yeh said the goal of enforcement efforts is to identify informal call patterns by specialists that bypass EMTALA and favor private patients.

Recommendations

The TAG recommends that CMS delete the following paragraph in the Interpretive Guidelines for 489.24(j), availability of on-call physicians:

> Physicians that refuse to be included on a hospital's on-call list but take calls selectively for patients with whom they or a colleague at the hospital have established a doctor-patient relationship while at the same time refusing to see other patients (including those individuals whose ability to pay is questionable) may violate EMTALA. If a hospital permits physicians to selectively take call while the hospital's coverage for that particular service is not adequate, the hospital would be in violation of its EMTALA obligation by encouraging disparate treatment.

The following statements represent the consensus of the TAG, which recommends that CMS incorporate these concepts into the Interpretive Guidelines for 489.24(j), availability of on-call physicians:

- When a physician takes call for patients with whom he/she has a preexisting medical relationship, that is *not* considered "selective call."
- When a physician is not on the call roster, he/she is not obligated to provide call coverage (e.g., when he/she is in the hospital seeing patients).
- If the EMTALA-related call list is adequate and meets the requirements of the statute, physicians may see patients in the hospital as they see fit.
- A physician on call must see patients without regard for any patient's ability to pay.
- If a physician volunteers to see patients in the emergency department while not participating in the call list, the physician must agree to see patients regardless of any patient's ability to pay.
- If a surveyor identifies a discriminatory or disparate pattern of selective referral for specialty care on the basis of patients' ability to pay, that is potentially a violation of EMTALA.
- Hospitals should be reminded of their obligation to fulfill call coverage duties, e.g., they should not permit discrimination to occur.

EMTALA Enforcement

The TAG identified enforcement issues to be addressed at a future meeting.

Action Item

Dr. Siegel will work with the CMS staff and the TAG subcommittees to place the following enforcement-related issues on the agenda for the next TAG meeting:

- Consistency of enforcement nationally
- A variety of procedures to evaluate complaints and/or conduct surveys, e.g., a procedure to substantiate a complaint before undertaking a full investigation
- Disincentives to report violations, consideration of self-reporting as a mitigating factor

- Clarification of the private right of action; preventing attorneys from using EMTALA investigations as method to make confidential, protected information public; clarification of hospitals' responsibility when court interpretation differs from that of the Office of the Inspector General
- Development of standardized reporting tools, e.g., for transfers; using information technology to gather information for auditing and identifying patterns
- National dissemination of methods for electronically transmitting notices from the regional offices to hospitals and hospitals' responses to provide a plan of correction
- Sanctions or penalties that vary according to the nature of the violation and that address remediation

Emergency EMTALA Waiver

The Action Subcommittee proposes the TAG recommend expanding emergency waivers to cover both state and local government-declared emergencies and also hospital-specific emergencies. It also suggests increasing the duration of the waiver beyond 72 hours. Some members described models in which a retrospective review is undertaken to determine whether a hospital acted appropriately given the circumstances of a localized emergency.

Action Item

The Action Subcommittee will further discuss the need to expand waivers of EMTALA requirements during emergencies. TAG members agreed that it is appropriate to expand waivers to include emergencies declared by a state government; the Action Subcommittee will bring to the TAG the considerations for expanding waivers to locally-declared or hospital-specific emergencies.

Shared or Community Call

The TAG agreed that community call arrangements, also known as shared or regional call, may be an appropriate and helpful method for some hospitals to meet the need for on-call specialty physicians. Molly Smith of CMS explained the agency's current position on community call. The TAG felt CMS' position should be better communicated.

Recommendation

The TAG recommends that CMS clarify its position regarding shared or community call: that such community call arrangements are acceptable if the hospitals involved have formal agreements recognized in their policies and procedures, as well as backup plans. It should also be clarified that a community call arrangement does not remove a hospital's obligation to perform a medical screening examination.

Obligations Beyond EMTALA

Dr. Yeh said the Anti-Dumping Task Force addressed this issue in depth, focusing on when an emergency medical condition is resolved. She emphasized that EMTALA has never guaranteed follow-up care and that hospitals have no EMTALA obligation beyond discharge. Questions have been raised about what constitutes appropriate discharge instructions and how to handle patients who need follow-up treatment for definitive care of their condition.

Action Item
Dr. Siegel will work with the CMS staff and the TAG subcommittees to place the following discussion points on the agenda for the next TAG meeting:

- Should the TAG recommend changes to the statute on the definition of stabilization?
- Does the current EMTALA statute infer an obligation to provide follow-up care or take steps to ensure the patient can access follow-up care? If it does not, should it?
- Should the Interpretive Guidelines describe a range of appropriate discharge plans (as suggested in the draft document presented by the Action Subcommittee)? Should appropriate discharge planning instead be communicated through provider education?
- Should the Interpretive Guidelines better describe what constitutes discrimination under EMTALA in terms of discharge/follow-up instructions?
- How do the Medicare Conditions of Participation relate to follow-up care for EMTALA patients?

Duty to Accept Transfers
Ms. Nelson presented concepts from the Action Subcommittee on clarifying the duty to accept transfers in the Interpretive Guidelines for 489.24(f), recipient hospital responsibilities. She said CMS should clarify the patient population to which the statute applies and the responsibilities of both the transferring and receiving hospitals. Brian Robinson said some hospitals avoid violating EMTALA by refusing to decide whether to accept a patient; the Texas Department of Health requires that a decision be made within 1 hour of the request. Dr. Siegel noted that Florida has addressed the issue of geography/proximity in its transfer guidelines.

Recommendation
The following statement represents the consensus of the TAG, which recommends that CMS incorporate the concept into the Interpretive Guidelines for 489.24(f), recipient hospital responsibilities:

- Physician to physician communication, i.e., between the sending physician (or designated representative) at the transferring hospital and the receiving physician (or designated representative) at the receiving hospital, should be permitted and encouraged.

Action Items
The Action Subcommittee will further discuss clarifying the responsibilities of both the transferring and receiving hospitals, specifically elaborating on the following points:

- Should distance limits be imposed (e.g., transfer to the closest hospital when possible)?
- Should hospitals be bound to accommodate patients after they have reached capacity if they have ever demonstrated the ability to do so before?

Issues for Future Discussion
Dr. Siegel solicited suggestions from the TAG for future discussion, and the following issues were identified:

- Is it acceptable to ask patients about copays at registration if it does not affect the medical screening examination?
- Should CMS revisit its guidelines on EMTALA and hospital diversion status, taking into account rapid population growth in some areas?
- Should the TAG recommend continuing education for providers, hospitals, CMS staff, and state surveyors on EMTALA, and if so, what should be addressed and how?

Written Testimony
The TAG reviewed written testimony and data from the Emergency Nurses Association (Appendix 3); Patty Gray, J.D., L.L.M., and Merle Lenihan, M.D., director of the Women's Wellness Clinic at St. Vincent's Episcopal House in Galveston, TX (Appendix 4); and the American College of Emergency Physicians (Appendix 5).

Administrative Items
The next TAG meeting is tentatively set to take place in September or October 2006.

Adjournment
Dr. Siegel adjourned the meeting at 5 P.M. on Tuesday, May 2, 2006. Collected recommendations and approved motions of the TAG are listed in Appendix B.

EMTALA TAG Members Present at the May 1–2, 2006 Meeting

EMTALA Technical Advisory Group Members

David Siegel M.D., J.D., *Chair*
Emergency and Internal Medicine Physician
Senior Physician Consultant and Clinical Coordinator
Florida Medical Quality Assurance (Quality Improvement Organization)
Tampa, FL

James Nepola, M.D., *Vice Chair*
Orthopedic Trauma Surgeon
Chair, Orthopedic Trauma Association
Iowa City, IA

James L. Biddle, M.D.
Obstetrician-Gynecologist
McAllen, TX

Gregory E. Demske
Chief, Administrative & Civil Remedies Branch, Office of the Inspector General, Department of Health and Human Services
Washington, DC

Dodjie B. Guioa
Centers for Medicare and Medicaid Services, Region VI Survey & Certification Operations Branch Division of Survey & Certification
Dallas, TX

Rory Scott Jaffe, M.D., M.B.A.
Executive Director, Medical Services
University of California
Office of the President
Oakland, CA

Warren A. Jones, M.D.
Physician, Executive Director
Mississippi State Medicaid Director
Jackson, MS

John A. Kusske, M.D.
Neurosurgeon
Chair, Department of Neurological Surgeons
University of California, Irvine Medical Center
Orange, CA

Julie Mathis Nelson, J.D.
Attorney and Partner
Coppersmith, Gordon, Schermer, Owens, & Nelson, P.L.C.
Phoenix, AZ

Mark Pearlmutter, M.D.
Emergency and Internal Medicine Physician
Chief, Department of Emergency Medicine
St. Elizabeth's Medical Center
Boston, MA

Richard Perry, M.D.
Surgeon and Physician
Phoenix, AZ

Brian Robinson
President, Chief Executive Officer
HCA Las Vegas Market
Las Vegas, NV

Michael J. Rosenberg, M.D.
Cardiologist and Interventional Cardiologist
Assistant Professor of Medicine
University of Chicago Pritzker School of Medicine
Park Ridge, IL

Sul Ross Thorward, M.D.
Twin Valley Behavioral Health Care
Columbus, OH

David W. Tuggle, M.D.
Pediatric Surgeon, Vice Chair, Department of Surgery
University of Oklahoma College of Medicine
Oklahoma City, OK

Charlotte S. Yeh, M.D.
Emergency Physician
CMS Regional Administrator, Region I
Boston, MA

CMS Staff
Shonte Carter
Division of Acute Care Services
Survey and Certification Group
Center for Medicaid and State Operations

Tom Gustafson, Ph.D., Deputy Director
Center for Medicare Management

Edith Hambrick, M.D., Medical Officer
Hospital and Ambulatory Policy Group
Center for Medicare Management

Kathryn Lindstromberg
Division of Acute Care Services
Survey and Certification Group
Center for Medicaid and State Operations

George Morey, Health Insurance Specialist
Division of Acute Care
Hospital and Ambulatory Policy Group
Center for Medicare Management

Gerry Nicholson, Director
Provider Communications Group
CMS/CMM

Beverly Parker
Division of Acute Care
Hospital and Ambulatory Policy Group
Center for Medicare Management

Eric Ruiz
Division of Acute Care
Hospital and Ambulatory Policy Group
Center for Medicare Management

Sandra Sands, J.D., Senior Attorney
Office of the Inspector General

Donna Smith
Division of Acute Care Services
Survey and Certification Group
Center for Medicaid and State Operations

Molly Smith
Division of Acute Care
Hospital and Ambulatory Policy Group
Center for Medicare Management

Helaine Jeffers, Acting Director
Division of Acute Care Services
Survey and Certification Group
Center for Medicaid and State Operations

Public Witnesses
Katie Orrico, Director
American Association of Neurological Surgeons

Rapporteur
Dana Trevas
Magnificent Publications, Inc.

APPENDICES

Appendix A: Meeting Agenda
Appendix B: Recommendations and Action Items from the May 1–2, 2006, meeting

The following documents were presented at the EMTALA TAG meeting on May 1–2, 2006, and are appended here for the record:

Appendix 1: FY 2007 IPPS proposed rule (selected pages)
Appendix 2: Fee-for-Service Provider Communications
Appendix 3: Testimony of the Emergency Nurses Association
Appendix 4: Comment Regarding the Potential Impact of EMTALA Final Rules on Emergency Care Provided in Hospitals Where Denials, Deferrals, and Upfront Payment of Care Deemed Nonemergency is Initiated, from Patty Gray, J.D., L.L.M., and Merle Lenihan, M.D., Director, Women's Wellness Clinic, St. Vincent's Episcopal House, Galveston, TX
Appendix 5: On-Call Specialist Coverage in U.S. Emergency Departments: American College of Emergency Physicians Survey of Emergency Department Directors, April 2006

APPENDIX A

Fourth EMTALA TAG Meeting
May 1 – 2, 2006
HHS Headquarters
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20001

Day 1	**Monday, May 1, 2006**
9:00 – 9:15	Welcome, call to order, and opening remarks
9:15 – 9:45	Summary Reports of On-Call and Action Subcommittees
9:45 – 10:30	Discussion and Action on On-Call and Action Subcommittee recommendations, rotating between subcommittees.
10:30 – 10:45	Break
10:45 – 12:00	Continued Discussion and Action on On-Call and Action Subcommittee Recommendations, rotating between subcommittees
12:00 – 1:00	Lunch
1:00 – 1:20	CMS Provider Education Staff Presentation
1:20 - 2:00	Report of Framework Subcommittee/TAG Questions and Discussion of Framework Issues
2:00 – 2:30	Continued Discussion and Action on On-Call and Action Subcommittee Recommendations, rotating between subcommittees
2:30 - 2:45	Break
2:45 – 3:45	Continued Discussion and Action on On-Call and Action Subcommittee Recommendations, rotating between subcommittees
3:45 – 4:30	Scheduled Public Testimony by Registered Speakers
4:30 – 5:00	Public comment (unscheduled), time permitting.
5:00	Adjourn

Day 2	**Tuesday, May 2, 2006**
9:00 –- 10:30	Discussion and Action on On-Call and Action Subcommittee recommendations, rotating between subcommittees.
10:30 – 10:45	Break
10:45 – 12:00	Continued Discussion and Action on On-Call and Action Subcommittee Recommendations, rotating between subcommittees
12:00 – 1:00	Lunch
1:00 – 2:45	Continued Discussion and Action on On-Call and Action Subcommittee Recommendations, rotating between subcommittees
2:45 – 3:00	Break
3:00 – 4:30	Continued Discussion and Action on On-Call and Action Subcommittee Recommendations, rotating between subcommittees
4:30 – 5:00	Public comment (unscheduled, time permitting)
5:00	Adjourn

APPENDIX B

EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP (TAG)
Recommendations and Action Items
May 1–2, 2006

Recommendations to CMS

Physician Communication

The TAG recommends the statute regarding communication with the patient's physician (489.24[d][4][iii]) be revised as follows:

> At any time, a treating physician or qualified medical person is not precluded from contacting the patient's physician to seek advice regarding the patient's medical history and needs that may be relevant to the medical treatment and screening of the patient.

The following statement represents the consensus of the TAG, which recommends that CMS incorporate the concepts into the Interpretive Guidelines for 489.24(d)(4)(iii) on communication with the patient's physician:

> At any time, the treating physician or qualified medical person (QMP) may seek advice or clinical information from a clinician or other appropriate source regarding the patient's medical history or needs that may be relevant to the patient's medical screening examination or stabilizing treatment. While the contacted clinician may provide information or render advice, the treating physician or QMP is ultimately responsible for the patient's care. There is no requirement that the treating physician or QMP engage in this contact. The treating physician or QMP determines whether this contact is necessary. While awaiting the clinician's response, the treating physician or QMP shall proceed with the patient's medical screening examination or stabilizing treatment as indicated. In the event that a difference of opinion exists between the treating physician or QMP and the contacted clinician, the medical judgment of the treating physician or QMP shall prevail.

On-Call Physician as Specialized Capability

The following statements represent the consensus of the TAG, which recommends that CMS incorporate the concepts into Interpretive Guidelines for 489.24(f), recipient hospital responsibilities:

- The presence of a specialty physician on the call roster is not, by itself, sufficient to be considered a specialized capability. At the time of the transfer, the receiving hospital should also have available the necessary equipment, space, staff, etc. to accommodate the patient transfer.

- The presence of a physician who has privileges at the receiving hospital but is not on the call roster or who is not on call at the time of the transfer should *not* be considered a specialized capability.

The TAG recommends that 489.20(r)(2) be interpreted by CMS as meaning that all hospitals, including specialty hospitals, should maintain a call list in accordance with the statute and provider agreement. If necessary, the Interpretive Guidelines at Tag 404A should be revised to clarify this point.

Provider Outreach and Education
The TAG recommends that CMS add to its website a list of frequently asked questions (FAQs) specific to EMTALA, categorized into sub-topics.

- The Center for Medicaid and State Operations' Survey and Certification staff members will identify FAQs
- Ms. Nelson will provide a list of FAQs that she has already developed

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The TAG recommends that CMS replace the word "certifies" with the phrase "determines and documents" in the definition of labor and as needed in the Interpretive Guidelines.

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The following statements represent the consensus of the TAG, which recommends that CMS incorporate these concepts into the Interpretive Guidelines for 489.24(j), availability of on-call physicians:

- Response times should be defined in a range of minutes, not a single number of minutes.
- Response time should refer to the initial response by the physician on call.
- Through their medical staff bylaws, hospitals may define who may respond on behalf of the on-call physician (i.e., physician's designated representative).
- The initial response may occur by phone (or other means).
- Hospitals should develop policies and procedures to address the response time and appropriate exemptions.
- A physician's failure to respond when called or failure to arrive at the hospital when requested may be a violation of EMTALA.

Selective Call
The TAG recommends that CMS delete the following paragraph in the Interpretive Guidelines for 489.24(j), availability of on-call physicians:

> Physicians that refuse to be included on a hospital's on-call list but take calls selectively for patients with whom they or a colleague at the hospital have established a doctor-patient relationship while at the same time refusing to see other patients (including those individuals whose ability to pay is questionable)

may violate EMTALA. If a hospital permits physicians to selectively take call while the hospital's coverage for that particular service is not adequate, the hospital would be in violation of its EMTALA obligation by encouraging disparate treatment.

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- If the EMTALA-related call list is adequate and meets the requirements of the statute, physicians may see patients in the hospital as they see fit.
- A physician on call must see patients without regard for any patient's ability to pay.
- If a physician volunteers to see patients in the emergency department while not participating in the call list, the physician must agree to see patients regardless of any patient's ability to pay.
- If a surveyor identifies a discriminatory or disparate pattern of selective referral for specialty care on the basis of patients' ability to pay, that is potentially a violation of EMTALA.
- Hospitals should be reminded of their obligation to fulfill call coverage duties, e.g., they should not permit discrimination to occur.

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The TAG recommends that CMS clarify its position regarding shared or community call: that such community call arrangements are acceptable if the hospitals involved have formal agreements recognized in their policies and procedures, as well as backup plans. It should also be clarified that a community call arrangement does not remove a hospital's obligation to perform a medical screening examination.

Duty to Accept Transfers
The following statement represents the consensus of the TAG, which recommends that CMS incorporate the concept into the Interpretive Guidelines for 489.24(f), recipient hospital responsibilities:

- Physician to physician communication, i.e., between the sending physician (or designated representative) at the transferring hospital and the receiving physician (or designated representative) at the receiving hospital, should be permitted and encouraged.

Action Items
Provider Outreach

Dr. Siegel will work with the CMS staff and the TAG subcommittees to identify specific topics that should be addressed by CMS provider outreach efforts and the appropriate communication vehicles and methods to use.

Framework Subcommittee Paper: Reimbursement
Mr. Chae will incorporate the specific edits and general suggestions made by TAG members into the document. The paper will include a brief section on special considerations that discusses mental health care, among other areas with unique issues.

For the draft paper *Reimbursement*, TAG members are asked to send information or suggest sources on the expenses incurred by and costs associated with on-call specialty physicians. TAG members are also asked to provide any additional references or resources related to the topic.

- Dr. Kusske will forward to Dr. Yeh data from the California Health Care Foundation and the California Medical Association on physician costs in the emergency department. He will also identify a reference to information from the American College of Emergency Physicians on the average amount of payment physicians are unable to collect each year (i.e., bad debt).
- Dr. Pearlmutter will identify a reference to information from the American College of Physician Executives on bad debt.
- Dr. Jaffe will provide California data on reimbursement to hospitals that provide a disproportionate share of care to uninsured patients (i.e., disproportionate share hospital [DSH] payments).

Framework Subcommittee Paper: Liability
Ms. Bing will incorporate the clarifications and general suggestions made by TAG members into the document.

Dr. Kusske will provide data supporting the assertion that neurosurgeons are more likely to face a malpractice lawsuit as a result of elective surgery than as a result of surgery performed in the emergency department.

Framework Subcommittee Paper: Disparities in Care
Dr. Jaffe will identify the reference for the Centers for Disease Control and Prevention's study on wait times in the emergency department for patients by race and acuity.

EMTALA Enforcement
Dr. Siegel will work with the CMS staff and the TAG subcommittees to place the following enforcement-related issues on the agenda for the next TAG meeting:

- Consistency of enforcement nationally
- A variety of procedures to evaluate complaints and/or conduct surveys, e.g., a procedure to substantiate a complaint before undertaking a full investigation
- Disincentives to report violations, consideration of self-reporting as a mitigating factor

- Clarification of the private right of action; preventing attorneys from using EMTALA investigations as method to make confidential, protected information public; clarification of hospitals' responsibility when court interpretation differs from that of the Office of the Inspector General
- Development of standardized reporting tools, e.g., for transfers; using information technology to gather information for auditing and identifying patterns
- National dissemination of methods for electronically transmitting notices from the regional offices to hospitals and hospitals' responses to provide a plan of correction
- Sanctions or penalties that vary according to the nature of the violation and that address remediation

Emergency Waivers
The Action Subcommittee will further discuss the need to expand waivers of EMTALA requirements during emergencies. TAG members agreed that it is appropriate to expand waivers to include emergencies declared by a state government; the Action Subcommittee will bring to the TAG the considerations for expanding waivers to locally-declared or hospital-specific emergencies.

Obligations Beyond EMTALA
Dr. Siegel will work with the CMS staff and the TAG subcommittees to place the following discussion points on the agenda for the next TAG meeting:

- Should the TAG recommend changes to the statute on the definition of stabilization?
- Does the current EMTALA statute infer an obligation to provide follow-up care or take steps to ensure the patient can access follow-up care? If it does not, should it?
- Should the Interpretive Guidelines describe a range of appropriate discharge plans (as suggested in the draft document presented by the Action Subcommittee)? Should appropriate discharge planning instead be communicated through provider education?
- Should the Interpretive Guidelines better describe what constitutes discrimination under EMTALA in terms of discharge/follow-up instructions?
- How do the Medicare Conditions of Participation relate to follow-up care for EMTALA patients?

Duty to Accept Transfers
The Action Subcommittee will further discuss clarifying the responsibilities of both the transferring and receiving hospitals, specifically elaborating on the following points:

- Should distance limits be imposed (e.g., transfer to the closest hospital when possible)?
- Should hospitals be bound to accommodate patients after they have reached capacity if they have ever demonstrated the ability to do so before?

APPENDIX 1

FY 2007 IPPS proposed rule

The following pages came from the Office of the Federal Register (OFR) display copy of CMS-1488-P, http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/cms1488p.pdf

Premable
Pages 431-439

J. Hospital Emergency Services under EMTALA (§489.24)
(If you choose to comment on issues in this section, please include the caption "EMTALA" at the beginning of your comment.)
1. Background
Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act impose specific obligations on certain Medicare-participating hospitals and CAHs. (Throughout this section of this proposed rule, when we reference the obligation of a "hospital" under these sections of the Act and in our regulations, we mean to include CAHs as well.) These obligations concern individuals who come to a hospital emergency department and request examination or treatment for medical conditions, and apply to all of these individuals, regardless of whether they are beneficiaries of any program under the Act. The statutory provisions cited above are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA), also known as the patient antidumping statute. EMTALA was passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272. Congress enacted these antidumping provisions in the Social Security Act to ensure that individuals with emergency medical conditions are not denied essential lifesaving services because of a perceived inability to pay.
Under section 1866(a)(1)(I)(i) of the Act, a hospital that fails to fulfill its EMTALA obligations under these provisions may be liable for termination of its
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Medicare provider agreement, which would result in loss of all Medicare and Medicaid payments.
In general, section 1867 of the Act sets forth requirements for medical screening examinations for individuals who come to the hospital and request examination or treatment for a medical condition. The section further provides that if a hospital finds that such an individual has an emergency condition, it is obligated to provide that individual with either necessary stabilizing treatment or an appropriate transfer to another medical facility where stabilization can occur.
The EMTALA statute also outlines the obligation of hospitals to receive appropriate transfers from other hospitals. Section 1867(g) of the Act states that a participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units or (with respect to rural areas) regional

referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires these specialized capabilities or facilities if the hospital has the capacity to treat the individual.
The regulations implementing section 1867 of the Act are found at 42 CFR 489.24.
2. Role of the EMTALA Technical Advisory Group (TAG)
Section 945 of Pub. L. 108-173 (MMA) required the Secretary to establish a Technical Advisory Group (TAG) to provide the Secretary with advice concerning issues related to EMTALA regulations and implementation. Section 945 of Pub. L. 108-173 further requires that the EMTALA TAG be composed of 19 members, including the
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Administrator of CMS, the Inspector General of HHS, hospital representatives and physicians representing various specialties, patient representatives, and representatives of organizations involved in EMTALA enforcement.
The EMTALA TAG was first established in 2005 and held three meetings during that year. At each of its meetings, the EMTALA TAG heard testimony from representatives of physician groups, hospital associations, and others regarding EMTALA issues and concerns. As explained more fully below in sections IV.K.3. and 4. of this preamble, we are proposing to revise the EMTALA regulations at §489.24 based on the recommendations adopted and forwarded to the Secretary by the EMTALA TAG.
3. Definition of "Labor"
As noted in the background portion of this section, the EMTALA statute and regulations require that if an individual comes to a hospital emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital is obligated to provide that individual with an appropriate medical screening examination within the capability of the hospital. If the individual is found to have an emergency medical condition, the hospital is obligated by EMTALA to provide either necessary stabilizing treatment or an appropriate transfer to another medical facility where stabilization can occur.
Section 489.24(b) of the regulations defines the key terms used in the section.
The term "emergency medical condition" is defined as--
"A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance
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abuse) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery; or that transfer may pose a threat to the health and safety of the woman or the unborn child."
This definition is identical to the definition of "emergency medical condition" in section 1867(e)(1) of the Act. In recognition of the fact that this definition gives special consideration to women in labor, the term "labor" is itself defined, in paragraph (b) of §489.24, to mean "the process of childbirth beginning with the latent or early phases of labor and continuing through the delivery of the placenta." The definition further states:

"A woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable period of observation, the woman is in false labor." A woman found to be in false labor is considered not to have an emergency medical condition and that finding thus means that the hospital has no further EMTALA obligation to her.
The CMS interpretative guidelines used by State surveyors in EMTALA investigations provide that once an individual has presented to a hospital seeking emergency care, the determination as to whether an emergency medical condition exists is made by the examining physician(s) or other qualified medical person actually caring for the individual at the treating facility. The guidelines further provide that the medical screening examination must be conducted by one or more individuals who are determined
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to be qualified by the hospital bylaws or rules and regulations and who meet the hospital condition of participation in 42 CFR 482.55 regarding emergency services personnel and direction. (Of course, these individuals would not be expected or permitted to perform any screening functions other than those which they are allowed to perform under State scope of practice laws.) However, consistent with the definition of "labor" at §489.24(b), the guidelines also state that if a qualified medical person other than a physician determines that a woman is in false labor, a physician must certify the diagnosis. The guidelines permit this certification to be made based either on actual examination of the patient or on a telephone consultation with the qualified medical person who actually examined the patient. (Medicare State Operations Manual, Appendix V—Interpretive Guidelines—Responsibility of Participating Hospitals in Emergency Cases, TAG A-406.)
At its meeting held on June 15-17, 2005, the EMTALA TAG heard testimony from representatives of both physician and nonphysician professional societies regarding the competence of practitioners other than physicians to certify false labor. In particular, a representative of the American College of Nurse-Midwives stated that the current requirement that allows only a physician to certify false labor is overly restrictive and does not adequately recognize the training and competence of certified nurse-midwives. Testimony was also presented by the American College of Obstetricians and Gynecologists, which recommended amending the EMTALA regulations to allow certified nurse-midwives and other qualified medical persons to determine whether a woman is in false labor.
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After extensive consideration of the issue, the members of the EMTALA TAG voted to recommend to the Secretary that the definition of "labor" at §489.24(b) be amended to permit certified nurse-midwives and other qualified medical personnel to certify false labor. The TAG recommended deleting the second sentence, which states that a woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable time of observation, the woman is in false labor.
We agree with the TAG's recommendation that other health care practitioners besides physicians should be allowed to certify false labor, and believe that the recommendation is consistent with CMS' current policy regarding who may conduct medical screening examinations. However, we do not believe such a change can be best accomplished by simply deleting the second sentence of the current definition of "labor" in the existing regulations because doing so would also remove the explicit statement that a woman experiencing contractions is in labor unless she has been found to be in false

labor. To achieve the principal objective of the EMTALA TAG recommendation without compromising the protections of EMTALA for women having contractions, we are proposing to modify the definition of "labor" in §489.24(b) by revising the second sentence of that definition to state that a woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor. The effect of this change would be to have a single, uniform policy on the personnel who
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are authorized to make a determination as to whether an individual has an emergency medical condition.

4. Application of EMTALA Requirements to Hospitals Without Dedicated Emergency Departments

Section 489.24(b) of the regulations outlines when a hospital will be considered to be a hospital with a "dedicated emergency department" and makes it clear that only a hospital with a dedicated emergency department has an EMTALA responsibility with respect to an individual for whom no appropriate transfer is sought but who comes to the hospital seeking examination or treatment for a medical condition. However, it has come to CMS' attention that our policy regarding the application of EMTALA to hospitals that have specialized capabilities but are without dedicated emergency departments may be less well understood as it relates to individuals for whom an appropriate transfer is sought.

It has been CMS' longstanding policy that any Medicare-participating hospital with a specialized capability must, in accordance with section 1867(g) of the Act, accept, within the capacity of the hospital, an appropriate transfer from a requesting hospital. This policy has been applied to hospitals without regard to whether they have dedicated emergency departments. In fact, in the past, CMS has taken enforcement actions against hospitals with specialized capabilities that failed to accept appropriate transfers under EMTALA when the hospitals had the capacity to treat the transferred individuals.

At its meeting held on October 26-28, 2005, the EMTALA TAG heard testimony from representatives of physician groups, hospital associations, and others regarding
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EMTALA compliance by specialty hospitals that typically do not have dedicated emergency departments. After extensive consideration and discussion of the issues raised and views presented, the members of the EMTALA TAG voted to recommend to the Secretary that hospitals with specialized capabilities (as defined in §489.24(f) of the regulation) that do not have a dedicated emergency department be bound by the same responsibility to accept an appropriate transfer under EMTALA as hospitals with a dedicated emergency department.

We agree with the EMTALA TAG's assessment. We believe that the recommendation is consistent with CMS' current policy and highlights the need to clarify CMS' policy regarding hospitals with specialized capabilities. Therefore, in this proposed rule, we are proposing to modify the regulations at §489.24(f) to specifically indicate that any participating hospital with specialized capabilities or facilities, even if it does not have a dedicated emergency department, may not refuse to accept an appropriate transfer if the hospital has the capacity to treat the individual. We note that this proposed

revision does not reflect any change in current CMS policy. We further note that the revision would not require hospitals without dedicated emergency departments to open dedicated emergency departments nor would it impose any EMTALA obligation on those hospitals with respect to individuals who come to the hospital as their initial point of entry into the medical system seeking a medical screening examination or treatment for a medical condition. Although this proposed revision seeks only to clarify, rather than change, current policy, we nevertheless, welcome comments on what effect, if any,
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commenters believe this proposed clarification may have on EMTALA compliance and patient health and safety.
5. Clarification of Reference to "Referral Centers"
The language of the existing regulations at §489.24(f) duplicates the language of section 1867(g) of the Act in that it identifies, as an example of a hospital with specialized capabilities, "(with respect to rural areas) regional referral centers identified by the Secretary in regulation)". Because the term "regional referral centers" is not used elsewhere in the Medicare regulations, it is unclear whether the reference is to referral centers as defined in 42 CFR 412.96, which must be located in rural areas and meet other criteria spelled out in that section, or to any facilities that are located in rural areas and accept patients on referral. To maintain consistency in the Medicare regulations and avoid confusion as to which facilities are considered to have specialized capabilities for purposes of EMTALA, we are proposing to amend §489.24 by clarifying that "regional referral centers" are those centers meeting the requirements of §412.96.

Proposed regulations text
Pages 566 to 567

CMS-1488-P 566
PART 489--PROVIDER AGREEMENTS AND SUPPLIER APPROVAL
42. The authority citation for part 489 continues to read as follows:
Authority: Secs. 1102, 1819, 1861, 1864(m), 1866, 1869, and 187l of the Social Security Act (42 U.S.C. 1302, 1395i-3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).
43. Section 489.24 is amended by--
a. Revising the definition of "Labor" under paragraph (b).
CMS-1488-P 567
b. Revising paragraph (f).
The revisions read as follows:
§489.24 Special responsibilities of Medicare hospitals in emergency cases.
* * * * *
(b) * * *
Labor means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor.

* * * * *

(f) Recipient hospital responsibilities. A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers, which, for purposes of this subpart, means hospitals meeting the requirements of referral centers found at §412.96 of this chapter) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual. This requirement applies to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.

APPENDIX 2

APPENDIX 3

APPENDIX 4

Comment Regarding the Potential Impact of EMTALA Final Rules on Emergency Care Provided in Hospitals Where Denials, Deferrals, and Upfront Payment of Care Deemed Nonemergency is Initiated

Legislating Health Policy
Patty Gray, J.D., L.L.M.
Spring, 2006

Merle Lenihan, M.D.
Director, Women's Wellness Clinic
St. Vincent's Episcopal House
2817 Postoffice
Galveston, Texas 77550
Email: msleniha@utmb.edu
Phone:409-621-1895

The following comment is respectfully submitted to the Centers for Medicare & Medicaid Services (CMS) Technical Advisory Group (TAG) meeting occurring May 1st and 2nd, 2006.

Brief summary of comment: CMS issued final rules clarifying the responsibilities of hospitals under EMTALA in September, 2003. This clarification included identifying the limits of EMTALA obligations to people whose medical conditions are deemed to be nonemergent. As a result, a variety of hospitals across the nation have implemented new policies and procedures that defer or deny care, or require upfront payment for care once a nonemergency medical condition is diagnosed. While EMTALA has always been a statute pertaining to emergency medical conditions, there is the potential for these new hospital policies on nonemergency care to create institutionalized bias that affects all care, including emergency care. In addition, these new policies may lessen people's willingness to seek care for conditions that would be considered emergent. At the present time it is unknown whether such policies may allow the provision of disparate care for the uninsured and racial and ethnic minorities. I ask the Technical Advisory Group to consider that these policies may affect emergency care in precisely the ways that the original statute was intended to counter. In order to begin to assess this possibility, CMS could require hospitals to report whether such policies are in place and to report the health insurance status, income, and race or ethnicity of those people whose condition was labeled nonemergent and who had their care denied or deferred or were required to pay first. The question to consider is whether such policies, perhaps unintentionally endorsed by the final rules, are affecting emergency care.

I would like to begin my comment with a true account of events that occurred about two months ago, although I have been involved in several similar situations.

At about 10:00 in the morning I was called over by the receptionist to talk on the phone to a woman who was crying uncontrollably, saying she needed a doctor. The receptionist at our free and somewhat bare-bones clinic had urged the woman to go to the emergency room, but the woman said she couldn't do that. I told the woman I was a doctor and asked her to tell me about the problem. She said she had "the worst headache of her life, not like anything she had ever experienced before." That statement is a red flag to doctors because it is the classic way patients who are about to have a subarachnoid, or brain, hemorrhage describe how they feel. She then told me she was calling from the waiting area of the local Federally Qualified Health Care Center where, although she had arrived at 7:30, she had just learned she would not be seen because all the same day appointments had already been filled. I explained that it was possible she had a very serious condition and asked if she would go to the emergency department at the local academic medical center. She said that two weeks before she had gone to the emergency department with a painful, abscessed tooth and had not been treated because she did not have the $150 dollars required for treatment of a nonemergency condition. She believed that she simply could not afford to go back even when I explained that it was likely that her current symptoms would trigger a fuller evaluation without an upfront payment. I then asked her to come to our clinic where I treated her high blood pressure and gave her Tylenol. She stayed at our clinic a few hours, and although I was still

uncertain that she had received an appropriate medical evaluation, she would not go to the emergency department.

In the case of this woman, she clearly did not seek care at the emergency department for a condition that most all physicians would categorize as emergent. Her prior experience in the emergency department where she was denied care unless she could pay first was the direct cause of her unwillingness to return. It is unknown whether her lack of health insurance or whether being identified as black or African American affected the judgment that her tooth abscess was a nonemergent condition. As a practical matter, if she had had health insurance, she would have been offered the option to make a copayment and then be treated. It may be difficult to sort out the potential role for bias in a single encounter, so it becomes of greatest concern to ascertain whether policies that require the denial of treatment for nonemergency conditions, even when not overtly aimed at the uninsured or racial and ethnic minority persons, may alter care throughout the emergency department such that the potential for bias is increased. In other words, do policies that change emergency departments from places where all who request care receive it to places where some people who request care will be denied such care, fundamentally alter the interactions and care given?

I will take this question up after I explore the evidence that the clarification of the limits of treatment for nonemergencies presented in the September, 2003 final rules has been a significant factor in the implementation of new processes to deny, defer, or require upfront payment for nonemergencies.[1] One noteworthy example of recent changes is Hospital Corporation of America (HCA) who announced in April, 2004 that it would begin to direct patients with nonemergency medical conditions to other sites for

treatment.[2] HCA is the largest for-profit hospital chain in America; in 2004 HCA operated 189 hospitals in twenty-three states.[3] Hospitals such as HCA appear to be well aware of the greater legal clarity with which denial or upfront payments can be undertaken. HCA President Richard Bracken said in 2004, regarding the new policy, "We are obviously very, very sensitive to (patient-dumping) regulations and don't want to – in any way, shape, or form—run afoul of those."[4] Such statements regarding new procedures for limiting care in nonemergency conditions are not only occurring in for-profit hospitals, though. Academic medical centers and nonprofit hospitals in California, Colorado, and Texas have announced similar changes.[5]

In the case I cited and in other instances in my community, people are reluctant to seek care in the emergency department after policies allowing the denial or requiring upfront payment for nonemergent care are implemented. Even people who have not sought care in emergency departments seem to know of such policies from friends or family. In fact, to some degree, this is the intent of such policies.[6] However, do people reliably know when their symptoms would be considered a possible medical emergency?

In a different context, this question was addressed by CMS in 1999 when it published a Special Advisory Bulletin that included attention to rules governing managed care plans requiring prior authorization for services at the emergency department. CMS recognized that managed care plans had a "legitimate interest in deterring their enrollees from over-utilizing emergency services,"[7] just as hospitals may now believe they have a legitimate interest in deterring visits for nonemergencies. At the same time, CMS stated that "the 'prudent layperson' standard…means that the need for emergency services should be determined from a reasonable patient's perspective at the time of presentation

of the symptoms."[8] Furthermore, when an individual seeks care at an emergency department CMS understood that the "circumstances surrounding the need for such services, and the individual's limited information about his or her medical condition, may not permit an individual to make a rational, informed consumer decision."[9]
CMS seemed to understand that it is not reasonable to expect people to know, prior to a screening examination, if their condition is an emergency. In addition, CMS was particularly concerned that knowledge of "potential financial liability for medical services provided by a hospital that offers emergency services, could unduly influence patients,"[10] precluding an appropriate exam or treatment. Again, as in the case I cited, it appears that entire communities might be unduly influenced to not seek care due to the possibility of financial risk.

Furthermore, when people seek care in the emergency department, "while the problem may not turn out to be a true medical emergency in a clinical sense, it may be prudent behavior."[11] Rather than expecting people to seek emergency care for situations in which even medical professionals may differ in perceptions about what constitutes a medical emergency, it may make more sense to acknowledge "that common sense dictates their behavior to seek emergency care."[12] In one study of over 10,000 patients, more patients understated rather that overstated their need for emergency care. Even though the prudent layperson standard attempts to account for how "average knowledge" should be viewed, it does not provide "guidance on how factors such as age, education, literacy, insurance status, access to primary care, time of visit, experience with the health care system…relate to a person's average knowledge or reasonable expectations."[13] For the people who have been denied care or for those in the community who know of such

denials, it may be relevant that the experience of previously negative interactions in getting health care does jeopardize care for those people who actually need it.[14]

It is not only patients who may be affected generally by policies denying care for nonemergencies, it is also a possibility that institutions and health care providers may be influenced, however unintentionally, by such policies. For example, when the Office of the Inspector General (OIG) surveyed hospital emergency departments, eight percent of respondents, and in hospitals with a large proportion of Medicaid patients, almost eighteen percent, reported that decisions about medical screening examinations were at least sometimes influenced by a patient's ability to pay.[15] The literature on disparities in care given to racial and ethnic minority patients is, for the most part, no longer disputed. This in part stems from the report published in 2002 by the Institute of Medicine (IOM), *Unequal Treatment*.[16] Several studies have documented that disparities in providing health care occur specifically in the emergency department. Some examples of disparate care for racial and ethnic minority patients include care for mild traumatic brain injury, management of pediatric appendicitis, pain management, treatment for childhood asthma, and diagnoses of schizophrenia.[17]

The emergency department's role as a safety net provider requires giving care to a diverse group of people who are disproportionately from racial and ethnic minorities. Emergency departments are inherently fast-paced, complex, and demanding places to receive care, often in the context of considerable clinical uncertainty. The IOM report noted the relationship between these factors and the potential for bias and stereotyping in the following passage:

> Even highly educated and socially conscious individuals, such as doctors, are susceptible to these biases. Moreover, the types of situations that

> promote these biases –time pressure, incomplete information, high demand on attention and cognitive resources- are those that frequently occur in the context of doctor-patient interactions.[18]

In addition to these factors, one author has noted that attitudes among physicians toward the appropriateness of the emergency room visit may adversely affect care that is given.[19] Anecdotal evidence sometimes provides powerful suggestions that health care providers are not immune to biases held by the wider community. For example, the following story is from the *Los Angeles Times:* "When Althea Alexander broke her arm, the attending resident at Los Angeles County—USC Medical Center told her to 'hold your arm like you usually hold your can of beer on Saturday night.' Alexander who is Black, exploded. 'What are you talking about? Do you think I'm a welfare mother?' The White resident shrugged: 'Well aren't you?' Turned out she was an administrator at USC medical school."[20]

Case law regarding EMTALA has made it clear that the standard for medical screening examinations and treatment encompasses an anti-discrimination or disparate care application. Regarding this standard, the Sixth Circuit provided the following analysis: "We can think of many reasons other than indigency that might lead a hospital to give less than standard attention to a person who arrives at the emergency room. These might include: prejudice against the race, sex, or ethnic group of the patient; distaste for the patient's condition (*e.g.* AID's patient); personal dislike or antagonism between the medical personnel and the patient; disapproval of the patient' occupation; or political or cultural opposition. If a hospital refused treatment to persons for any of these reasons, or gave cursory treatment, the evil inflicted would be quite akin to that discussed

by Congress in the legislative history, and the patient would fall squarely within the statutory language."[21]

None of the data on disparities in care due to inability to pay, insurance status, or racial and ethnic minority status prove that such disparities are created or sustained by policies that deny care for nonemergencies. Further, the scope of EMTALA does not include mandating care for nonemergencies. Yet there is some reason to believe that the denial of treatment for nonemergencies affects the willingness of people to seek care for emergency conditions and that such policies may institutionalize bias.

Hospitals are required to keep a log of all patients presenting for emergency care.[22] In order to address the concerns related to the affect of policies that deny care for nonemergencies on the care given for emergency conditions, CMS could require hospitals to report to CMS, and therefore publicly, whether there are policies in place to deny, defer, or require upfront payment for care. When such policies are in place, reporting the insurance status, race and ethnicity of patients not treated would begin to allow an assessment of the possibility of bias. I urge the CMS TAG committee members to consider this requirement.

Notes

1. Federal Register, September 9, 2003, Part II, Department of Health and Human Services, Center for Medicare & Medicaid Services, 42 CFR Parts 413, 482, and 489. Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals Treating Individuals with Emergency Medical Conditions; Final Rule.
2. V. Gallero, "Screen Test: HCA Tries to Move Nonemergency Patient Out of ER," *Modern Healthcare* 34 (2004): 12.

3. "Health Care Giant had Beginnings in Tennessee Hospital," *Business Insurance (*April 18, 2005).
4. Gallero, 12.
5. Editorial, "Turning Away Patients: Hospitals, County Need Stronger Safety Net," *Sacramento Bee* (February 10, 2005). Editorial, "ER Screening Plan at CU Very Troubling," *Rocky Mountain News* (*June* 14, 2003). B. Zachariah, "The Right Medical Care at the Right Place," *Galveston County Daily News* (February 1, 2005). J. Manning, "St. Joseph Hopes Fee Will Reduce Minor ER Visits," *Milwaukee Journal Sentinel* (October 24, 2003).
6. Zachariah.
7. Federal Register, November 10, 1999, 61356.
8. Ibid, 61357.
9. Ibid, 61358.
10. Ibid.
11. M. Solloway, "EMTALA and the Prudent Layperson in Emergency Medical Services for Children," *EMCS White Paper Series*, (December, 2000).
12. Ibid, 7.
13. Ibid.
14. R-E-S-P-E-C-T: Patient Reports of Disrespect in the Health Care Setting and Its Impact on Care," *Journal of Family Practice*, 53 (2004): 721-30.
15. Department of Health and Human Services Office of the Inspector General. The Emergency Medical Treatment and Labor Act : Survey of Hospital Emergency Departments, OEI-09-98-00220, January, 2001.
16. B. Smedley, A. Stith, A. Nelson, Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* (Washington, DS: National Academy Press, 2002).
17. J. Bazarian, et al, "Ethnic and Racial Disparities in Emergency Department Care for Mild Traumatic Brain Injury," *Academic Emergency Medicine* 11 (2003):1209-17. M. Guagliardo, et al, "Racial and Ethnic Disparities in Pediatric Appendicitis Rupture Rate," *Academic Emergency Medicine* 11 (2003):1218-27. L. Richardson, C. Irvin, J. Tamayo-Sarver, "Racial and Ethnic Disparities in the Clinical Practice of Emergency Medicine," *Academic Emergency Medicine* 11 (2003):1184-88.
18. Smedley, 10.
19. Richardson, 1186.
20. V. Gamble, "Under the Shadow of Tuskegee: African Americans and Health Care," *American Journal of Public Health* 87 (1997): 1776.
21. Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 268-71 (6th Cir. 1990).
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APPENDIX 5