REPORT NUMBER TWO

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
June 15–17, 2005

EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA)
TECHNICAL ADVISORY GROUP (TAG)
Minutes
June 15–17, 2005

Opening

Call to Order, Opening Remarks

David Siegel, M.D., J.D., called the meeting to order at 11 a.m., Wednesday, June 15. (See Appendix A for the meeting agenda). He welcomed the members of the TAG and the audience and reiterated the group's functions, as identified in the charter. Carlos Perez will no longer serve on the TAG because he has stepped down from his position at South Manhattan Healthcare Network. Dr. Siegel noted that the TAG subcommittees would provide reports and recommendations to the TAG but that any member may raise issues of concern at any time.

Background Information

Overview of EMTALA Legislation and Regulations

George Morey, Health Insurance Specialist for the Center for Medicare Management, presented the concepts in Sections 1866 and 1867 of the Social Security Act, which serve as the basis for EMTALA (Appendix 1). He suggested TAG members use the following guidelines for deliberation: 1) Begin with the law (the statutory language); 2) Know the different levels of regulation that apply; 3) Know the players involved and their roles; 4) Listen to all sides but verify all information.

> *Action Item*
> At the next TAG meeting, the TAG will consider whether it should solicit public comment for changes even when it is not required.

Overview of EMTALA Investigation by the Center for Medicare and Medicaid Services (CMS), State Agencies

Frank Sokolik, Director of the Division of Acute Care Services, described how his office enforces EMTALA regulations and collects data (Appendix 2). He explained the process of receiving, screening, and investigating allegations, noting that whenever termination of a provider is a possible outcome, a Quality Improvement Organization must review the case. The average time to reach a conclusion on an allegation is about 60 days from the end of the investigation.

Shonte Carter of the Division of Acute Care Services outlined how allegations are tracked (Appendix 3). She noted that CMS, Regional Offices, and hospitals are making a transition from the Aspen Complaints/Incidents Tracking System (ACTS) to the EMTALA Access system. The data are publicly available through the Freedom of Information Act.

Donna Smith of the Division of Acute Care Services presented specific data on allegations and violations (Appendix 4). The highest number of allegations filed came from Florida and Texas, but both states had relatively low percentages of violations. In contrast, California had a low number of allegations but a very high proportion of violations. Mr. Sokolik said his office is analyzing the data to understand these variations.

Overview of Civil Enforcement by the Office of the Inspector General (OIG)
Sandra Sands, J.D., OIG Senior Counsel, said when CMS determines a violation has occurred, the case is forwarded to OIG to determine whether evidence is sufficient to pursue a legal action (Appendix 5). She described the process of deliberation, enforcement, and appeals. She clarified that the OIG has no authority to penalize hospitals or individual physicians for failure to meet Medicare coverage requirements.

Public Testimony

American Hospital Association
Maureen Mudron, general counsel for the American Hospital Association, outlined reasons why hospitals are having difficulty finding physicians to take emergency call and what actions they are taking to address the problem (Appendices 6a, 6b). She said CMS should not attempt to micromanage the provision of on-call coverage in hospitals and 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.

American College of Emergency Physicians
Sandra M. Schneider, M.D., F.A.C.E.P., cited various sources and the American College of Emergency Physicians' survey supporting the contention that EMTALA has resulted in the decreased availability of emergency specialty coverage (Appendices 7a, 7b). She also outlined concerns about the definition of a psychiatric emergency medical condition, who is qualified to screen patients for possible psychiatric conditions, when hospitals are obligated to accept patients with psychiatric disorders, the decline in psychiatric care facilities, and the increasing number of children presenting with mental illness.

American Medical Association
John Van Etta, M.D., F.A.C.P., offered several recommendations for the TAG's consideration, including the following (Appendix 8): 1) CMS should ensure adequate funding to reimburse physicians for providing emergency services, including on-call time; 2) CMS should prohibit hospitals from requiring physicians to be on call and from requiring physicians to take continuous call; 3) The interpretive guidelines should clearly define the phrase "best meets the needs of the hospital's patients"; and 4) The interpretive guidelines should prohibit hospitals from determining when a physician on call may perform elective surgery. Dr. Van Etta asked for further clarification of "selective call."

CMS: Specialty Hospital Issues
Donald Romano, Director or the Division of Technical Payment Policy for the Center for Medicare Management, asked the TAG to consider how EMTALA should relate to specialty hospitals (Appendices 9a, 9b). Specifically, he asked the TAG to explore whether Federal regulations should require that specialty hospitals have emergency departments (EDs) and, if so, how this measure would best be achieved. He also asked the TAG to explore whether specialty hospitals, irrespective of whether they have EDs, can and should be subject to EMTALA requirements for receiving hospitals.

New York State Department of Health

Vicki Ventresca expressed concern that evaluations of facility compliance with EMTALA requirements are measured and reported differently around the country, which affects the accuracy of national data (Appendix 10). She asked that CMS determine whether to authorize an investigation of an allegation based on the information received, without requiring the state agency to conduct a survey first. She suggested that when an allegation is made about a provider that operates several sites, the investigation be conducted only at the site that was the source of the allegation. Finally, Ms. Ventresca recommended that the definition of stabilization be revised to ensure community hospitals do not routinely transfer patients to tertiary care facilities that are already overwhelmed.

American Psychiatric Association

Sul Ross Thorward, M.D., described barriers to appropriate psychiatric care and asked the TAG to create a subcommittee to look at psychiatric care (Appendix 11). The subcommittee could address the definitions of a psychiatric emergency medical condition, stabilization, and comorbid conditions; who is qualified to determine the patient's status; and who determines when and where to transfer the patient.

American College of Nurse Midwives

Deanne Williams, C.N.M., M.S., Executive Director of the American College of Nurse-Midwives, asked the TAG to consider modifying the regulation that states a physician must certify whether a woman is in false labor to include certified nurse-midwives and certified midwives (Appendix 12). Ms. Williams said the determination and assessment of labor is well with the legal scope of practice for certified nurse-midwives and certified midwives. When asked, she agreed that removing the sentence on physician certification altogether would be an appropriate resolution.

National Association of Public Hospitals and Health Systems

Johnese Spisso, Chief Operating Officer of Harborview Medical Center, said some hospitals craft their on-call coverage policies to get around their EMTALA obligations and asked that the TAG consider a minimum threshold for call coverage (Appendix 13). She requested that the interpretive guidelines include more frequently asked questions and guidance on the application of EMTALA to patients with psychiatric emergency medical conditions; she also asked that such guidance be reviewed to determine whether it can be consistently applied by various states. At the request of the TAG, Ms. Spisso agreed to provide data on the following topics:

- Increase in number of transfers received by the Harborview ED since the 2003 interpretive guidelines were published, particularly transfers for specialized care
- Number of uninsured or underinsured patients received as transfers by the Harborview ED, compared with the number of insured patients
- Evidence that outlying hospitals apply a different standard of care in stabilizing ED patients who are uninsured or underinsured than for those who are insured
- *American Journal of Trauma* article showing payer status was the top reason for transfers
- Number of transfers by insurance status and time of day comparing daytime hours vs. evenings and weekends
- On-call policies that are designed to circumvent EMTALA requirements

- Questionable transfers resulting from hospitals that claim to have insufficient specialty physicians to determine whether an emergency medical condition exists
- Hospitals transferring insured patients to affiliated hospitals and uninsured or underinsured patients to safety-net hospitals
- EMTALA regulations that prevent hospitals from directing nonemergency patients away from emergency resources

American College of Surgeons

TAG member David Tuggle, M.D., presented data from a survey by the American College of Surgeons on perceived changes in transfers and availability of specialty physicians for emergency call from 15 trauma centers (Appendices 14a, 14b). All of those surveyed agreed that the increased number of transfers received is related to a lack of specialty physician coverage at the sending hospital. Dr. Tuggle said the findings imply that the nature of transfers has changed since the interpretive guidelines were published in 2003.

California Medical Association

John Hill, M.D., said CMS should not require physicians to take emergency call as a Condition of Participation in Medicare because it would drive physicians away from Medicare (Appendix 15). He stated that emergency call coverage poses a liability concern and drives up the cost of professional liability insurance. The TAG asked the California Medical Association to provide data on the relationship of emergency call coverage to insurance premiums and welcomed such data from other groups as well.

University of California Academic Medical Centers

Peter Sokolove, M.D., F.A.C.E.P., said academic centers are treating a disproportionate share of indigent patients, while community hospitals have focused on profitable services and reduced the amount of charity care they provide (Appendix 16). He suggested the TAG consider 1) a mechanism that allows the receiving hospital to transfer a patient back to the sending hospital once the patient is stabilized; 2) recommending that emergency patients be taken to the closest hospital with the capacity to provide appropriate care, regardless of the patient's insurance status; and 3) guidelines to ensure that care for indigent patients is equitably distributed among hospitals capable of providing care. The TAG asked Dr. Sokolove to provide data from his system similar to that requested from the National Association of Public Hospitals and Health Systems, as well as data on liability insurance premiums for physicians who take emergency call.

American Association of Emergency Psychiatry

Jon Berlin, M.D., President of the American Association of Emergency Psychiatry, supported the recommendation that TAG develop a subcommittee on psychiatric issues (Appendix 17). He made several recommendations for the TAG's consideration, including the following: 1) Require EDs with a certain volume of psychiatric patients to have someone available for consultation, such as a nurse or social worker with psychiatric training; 2) Require consultation with someone who has at least master's-level training in psychiatry to admit involuntary patients; 3) Establish a mechanism to prevent dumping of patients to facilities with psychiatric emergency services; 4) Evaluate the financial effect of EMTALA on psychiatric emergency services; and 5) Support reintroduction of the Medicaid Psychiatric Hospital Fairness Act, which would allow

freestanding psychiatric hospitals to be reimbursed for care provided to Medicaid patients over 21 years old.

National Association of Psychiatric Health Systems
Kathleen McCann, R.N., D.N.Sc., Director of Clinical Services for the National Association of Psychiatric Health Systems, supported the recommendation that TAG develop a subcommittee on psychiatric issues (Appendix 18). She echoed the comments of previous presenters, requesting better definitions of terms and more detailed interpretive guidelines related to psychiatric care.

American Association of Neurological Surgeons and Congress of Neurological Surgeons
Katie Orrico, Director of the Washington office of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons, said a survey by her organization found about one third of neurosurgeons are forced by hospitals to provide continuous call, and she asked that the interpretive guidelines explicitly prohibit hospitals from doing so (Appendix 19). She asked that CMS consider instituting a grievance process for physicians required to provide an unreasonable amount of call coverage. About 45% of respondents said the number of transfers has increased, at least some of which are unnecessary. The survey found that 12% of neurosurgeons saw a decrease in their premiums when they limited their emergency practice, and 35% have been sued by an ED patient. Ms. Orrico offered to provide more data from the survey and to perform additional surveys as needed.

The TAG reviewed the written testimony of The Schumacher Group (Appendix 20), the American Academy of Family Physicians (Appendix 21), the American College of Obstetricians and Gynecologists (Appendix 22), and Robert Pedersen, M.D., of Austin Heart (Appendix 23).

Subcommittee Reports
On-Call Subcommittee
John Kusske, M.D., Chair of the On-Call Subcommittee, presented the Subcommittee's proposals and described the rationale for them (Appendices 24, 25).

Interpretive Guidelines and Physician Response Times in Minutes
Some TAG members felt hospitals should specify appropriate response time within a range of minutes to give surveyors a measure by which to judge on-call physician response while allowing for local flexibility. Others felt it was neither necessary nor feasible to document such response times in minutes. Diane Godfrey of Florida Hospital in Orlando said she felt the concern about specifying the number of minutes for response time stemmed from surveyors enforcing the time too strictly. TAG members agreed that the existing statement on physician response time should be replaced with one that requires hospitals to have a policy in place and emphasizes the need for patient safety. Charlotte Yeh, M.D., said facilities should be educated that if they don't specify response time in minutes, the determination of appropriateness will be left to the judgment of the surveyors and the Quality Improvement Organization in an investigation.

Action Item
The On-Call Subcommittee will address the issue of hospital policies for physician response times, drafting language to present to the TAG at its next meeting that takes into account the consensus reached during the June 15–17, 2005 meeting. The proposed language will also include a rationale. The language will be forwarded to CMS staff for comment at the next TAG meeting. The following statement was suggested, which the Subcommittee may wish to consider: "Hospitals should establish a policy that outlines when a physician on call should respond to the ED when called."

Moving Language About an Institution's Duty to Maintain an On-Call List from Part 489.24(j) to Part 489.20
Gregory Demske said the OIG would not pursue a violation of this nature because it does not fall within Section 1867 of the Social Security Act. However, it could be a source of private rights of actions (lawsuits). Julie Mathis Nelson, J.D., said moving the language as suggested would place the requirement with the Medicare Conditions of Participation, decreasing the potential for substantial fines if it were enforced. The TAG agreed to table the discussion until further Action Subcommittee review and input from CMS' Office of General Counsel.

Action Item
The On-Call Subcommittee will review the issue and propose language and a rationale for its recommendation that reflects input from CMS' Office of General Counsel.

Emergency Department On-Call Coverage Requirement as a Condition for Participation in Medicare for Physicians
While most of the TAG members agreed that physicians should not be required to take emergency call coverage, discussion centered around whether the TAG should make such a recommendation and, if it did, whether the TAG would be limited in its capacity to recommend or respond to other proposals that may involve some form of mandatory call coverage.

Recommendation
The TAG recommends that CMS not require physicians to take emergency call as a Condition of Participation in Medicare. (Dr. Kusske will prepare a rationale to accompany the recommendation.)

Action
The On-Call Subcommittee will look at the hospital Conditions of Participation in Medicare, specifically the medical staff section, and consider possible changes to address call coverage. The On-Call Subcommittee asks that specialty groups and others with an interest in this topic provide their input to the Subcommittee as soon as possible.

Because of time constraints, the remaining issues identified by the On-Call Subcommittee were tabled for discussion at the next TAG meeting.

<u>Action Subcommittee</u>
Ms. Nelson, Chair of the Action Subcommittee, presented the Subcommittee's proposals and described the rationale for them (Appendices 26–29). She asked members of the public to submit

issues for consideration or specific suggestions to the Subcommittee before the next TAG meeting.

Definitions of Psychiatric Emergency Medical Condition and Stabilization
Ms. Nelson asked specialty societies and others to offer to the Subcommittee suggestions for specific language defining these terms. The TAG members agreed that the rationale for any recommendation should clearly spell out the intent of the recommendation for CMS. In addition, rationales should identify areas in which providers should receive clear education about the recommendation (should it become a permanent change) and its intent.

> *Action Item*
> The Action Subcommittee will further examine the definitions of psychiatric emergency medical condition and stabilization, taking into consideration public testimony and input from other interested parties. It will then propose some language for consideration at the next TAG meeting.

Consultation with a Patient's Physician
The Action Subcommittee proposed deleting language that seems to encourage needed consultation but has been interpreted in a way that makes physicians overly concerned that such consultation will delay patient care. Dr. Yeh said the intent of the language was to allow emergency physicians to treat a patient even when the patient's physician did not respond to a call for consultation. Members felt the original intent of the language should be restored through revision, not deletion, of the language.

> *Action Item*
> The Action Subcommittee will further examine whether the language identified in italics should be revised or deleted from the following statement in the regulation [489.24(d)(4)(iii)]: "An emergency physician or nonphysician practitioner is not precluded from contacting the patient's physician at any time to seek advice regarding that patient's medical history and needs that may be relevant to the medical treatment and screening of this patient, *as long as consultation does not inappropriately delay services required under paragraph (a) or paragraphs d1 and d2 of this section.*"

Refusal to Accept Patient from a Non-Hospital-Owned Ambulance Off Hospital Property
Ms. Nelson described how CMS' interpretation of the guidelines contradicts that of some courts regarding when a hospital can discourage an ambulance from bringing a patient to its ED. Dr. Yeh said the language was intended to clarify that contact between ambulance and hospital personnel is not the same as "coming to the ED" and that there are legitimate reasons for bypassing one hospital in favor of another. Members agreed that the guidelines should ensure patients are well served and hospitals are not avoiding their EMTALA obligation but also should not prevent hospital and ambulance personnel from discussing where a patient would best be treated at a given time.

> *Action Items*
> The Action Subcommittee will further examine regulation 489.24(b)(4) regarding non-hospital-owned ambulances to clarify whether a hospital that refuses to accept a patient

who is in an ambulance but not on the hospital grounds, even though the hospital is not on formal diversionary status, is in violation of EMTALA.

The TAG requests that CMS staff identify national associations related to emergency transport and formally request their input on this issue.

Definition of Labor
Members generally agreed that hospitals should determine who is qualified to assess the condition of a woman who appears to be in labor, in keeping with hospital and state policies, as they do for other emergency conditions. Tzvi Hefter, Director of the Division of Acute Care, said labor is addressed elsewhere in the regulation and agreed to check with CMS' Office of General Counsel to determine the ramifications of the suggested change.

Recommendation
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." (Ms. Nelson will prepare a rationale to accompany the recommendation.)

Hospitals with Specialized Capabilities
Ms. Nelson noted the Subcommittee is considering various questions about what constitutes "specialized capabilities" and when EMTALA applies. She asked that the On-Call Subcommittee address whether the availability of a specialty physician on call who is on site (as opposed to off site) constitutes a specialized capability.

Administrative Items
Scheduling
The TAG members agreed to schedule the next meeting sometime from September to early November 2005.

Subcommittees
The TAG members agreed to create a subcommittee that would develop a document describing the TAG's philosophical approach to its recommendations by addressing general health care issues with which EMTALA intersects. Dr. Yeh will serve as chair of the Framework Subcommittee, with Warren Jones, M.D., and James Biddle, M.D., (to be confirmed) as members.

Recommendation
The TAG recommends establishing a Framework Subcommittee to develop a document to be submitted to the Secretary describing the TAG's conceptual approach to recommendations and policy suggestions.

Request for CMS Input
The TAG requests that a senior representative from CMS' Office of General Counsel with expertise on EMTALA issues be available for some portion of the TAG meeting to offer insight on legal interpretations of EMTALA.

Adjournment

Dr. Siegel adjourned the meeting at 11:40 a.m. on Friday, June 17, 2005. Collected recommendations and approved motions of the TAG are listed in Appendix B.

EMTALA TAG Members Present at the June 15–17, 2005 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

Cesar A. Aristeiguieta, M.D.
Emergency Physician, Medical Director
Los Angeles County Paramedic Training Institute
Los Angeles, CA

Carol L. Bayer, M.D.
Psychiatrist, Vice President for Medical Affairs
East Jefferson General Hospital
Metairie, LA

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, EC

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

Gretchen A. Kane
Health Quality Review Specialist and EMTALA Coordinator
CMS Region IX
San Francisco, CA

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

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

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

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

Tzvi Hefter, Director
Division of Acute Care
Hospital and Ambulatory Policy Group
Center for Medicare Management

George Morey, Health Insurance Specialist
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

Frank Sokolik, Director
Division of Acute Care Services

Donald Romano, Director
Division of Technical Payment Policy
Center for Medicare Management

Public Witnesses
Jon Berlin, M.D.
American Association of Emergency Psychiatry

John Van Etta, M.D., F.A.C.P.
American Medical Association

Diane Godfrey
Florida Hospital, Orlando

John Hill, M.D.
California Medical Association

Kathleen McCann
National Association of Psychiatric Health Systems

Maureen Mudron, General Counsel
American Hospital Association

Katie Orrico, Director
Washington Office
American Association of Neurological Surgeons

Sandy Schneider, M.D., F.A.C.E.P.
American College of Emergency Physicians

Peter Sokolove, M.D.
University of California Academic Medical Centers

Johnese Spisso
National Association of Public Hospitals and Health Systems

Sul Ross Thorward, M.D.
American Psychiatric Association

Vicki Ventresca
New York State Department of Health

Deanne Williams, C.N.M., M.S.,
American College of Nurse Midwives

Robert Wilson, Esq.
Attorney for James Nepola, M.D.

Rapporteur
Dana Trevas
Magnificent Publications, Inc.

APPENDICES

Appendix A: Meeting Agenda
Appendix B: Recommendations, Action Items from the June 15–17, 2005, meeting

The following documents were presented at the EMTALA TAG meeting on June 15–17, 2005, and are appended here for the record (to be posted separately):

Appendix 1: Overview of EMTALA Law, Regulations, and Enforcement
Appendix 2: Understanding EMTALA: The Investigation
Appendix 3: EMTALA Data Tracking Process
Appendix 4: EMTALA Data Review
Appendix 5: EMTALA Enforcement, Office of the Inspector General
Appendix 6a: Statement of the American Hospital Association before the EMTALA Technical Advisory Group
Appendix 6b: Letter from the American Hospital Association and Data from the 2004 and 2005 Survey of Hospital Leaders
Appendix 7a: Statement of the American College of Emergency Physicians to the EMTALA TAG
Appendix 7b: On-Call Specialist Coverage: ACEP Survey of Emergency Department Directors, September 2004
Appendix 8: Statement of the American Medical Association to the Emergency Medical Treatment and Labor Act Technical Advisory Group re: EMTALA Regulations
Appendix 9a: EMTALA TAG Specialty Hospital Agenda Item (from the Center for Medicare Management)
Appendix 9b: EMTALA TAG Specialty Hospital Agenda Item Submitted by CMS
Appendix 10: Statement of the New York State Department of Health
Appendix 11: Testimony of Sul Ross Thorward, M.D. on Behalf of the American Psychiatric Association
Appendix 12: Statement of the American College of Nurse-Midwives
Appendix 13: Statement of the National Association of Public Hospitals and Health Systems
Appendix 14a: Survey Data from the American College of Surgeons
Appendix 14b: American College of Surgeons Comments for the EMTALA Technical Advisory Group
Appendix 15: Statement of the California Medical Association
Appendix 16: Statement of the University of California Academic Medical Centers
Appendix 17: Statement of the American Association of Emergency Psychiatry
Appendix 18: Statement of the National Association of Psychiatric Health Systems
Appendix 19: Comments of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons
Appendix 20: Summary Report, 2005 Hospital Emergency Department Administration Survey. from The Schumacher Group
Appendix 21: Statement from the American Academy of Family Physicians
Appendix 22: Statement from the American College of Obstetricians and Gynecologists
Appendix 23: Correspondence from Robert Pedersen, M.D., of Austin Heart, to Congresswoman Nancy Johnson

APPENDIX A

Agenda*
Second EMTALA TAG Meeting
June 15-17, 2005
Hubert Humphrey Bldg, Room 705A
200 Independence Avenue, S.W.
Washington, D.C. 20201

Day 1 -	Wednesday, June 15, 2005
9:00 a.m.	Subcommittee Meetings
11:00 a.m.	Overview of EMTALA Legislation and Regulations (George Morey, CMS); Overview of EMTALA investigation by CMS/State Agencies (Frank Sokolik--CMS)
12:00 p.m.	Lunch
1:00 p.m.	Overview of OIG civil enforcement (Sandra Sands, Esq. – OIG)
1:45 p.m.	Break
2:00 p.m.	Public Testimony
5:00 p.m.	Adjourn

Day 2 -	Thursday, June 16, 2005
9:00 a.m.	Public Testimony – continued
12:00 p.m.	Lunch
1:00 p.m.	Subcommittee Reports
2:30 p.m.	Break
3:00 p.m.	General Meeting • Action Items • Data Requests from CMS
5:00 p.m.	Adjourn

Day 3 -	Friday, June 17, 2005
9:00 a.m.	General Meeting • Administrative Items • Recommendations • Dates for next meeting • Agenda for next meeting
12:00 p.m.	Adjourn

APPENDIX B

EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP (TAG)
Recommendations
June 15–17, 2005

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. (Dr. Kusske will prepare a rationale to accompany the recommendation.)

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." (Ms. Nelson will prepare a rationale to accompany the recommendation.)

New Subcommittee
The TAG recommends establishing a Framework Subcommittee to develop a document to be submitted to the Secretary describing the TAG's conceptual approach to recommendations and policy suggestions.

Action Items

Requirement for Public Comment
At the next TAG meeting, the TAG will consider whether it should solicit public comment for changes even when it is not required.

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The On-Call Subcommittee will address the issue of hospital policies for physician response times, drafting language to present to the TAG at its next meeting that takes into account the consensus reached during the June 15–17, 2005 meeting. The proposed language will also include a rationale. The language will be forwarded to CMS staff for comment at the next TAG meeting. The following statement was suggested, which the Subcommittee may wish to consider: "Hospitals should establish a policy that outlines when a physician on call should respond to the ED when called."

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The Action Subcommittee will review the issue and propose language and a rationale for its recommendation that reflects input from CMS' Office of General Counsel.

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The On-Call Subcommittee will look at the hospital Conditions of Participation in Medicare, specifically the medical staff section, and consider possible changes to address call coverage. The On-Call Subcommittee asks that specialty groups and others with an interest in this topic provide their input to the Subcommittee as soon as possible.

Definitions of Psychiatric Emergency Medical Condition and Stabilization

The Action Subcommittee will further examine the definitions of psychiatric emergency medical condition and stabilization, taking into consideration public testimony and input from other interested parties. It will then propose some language for consideration at the next TAG meeting.

Consultation with a Patient's Physician

The Action Subcommittee will further examine whether the language identified in italics should be revised or deleted from the following statement in the regulation [489.24(d)(4)(iii)]: "An emergency physician or nonphysician practitioner is not precluded from contacting the patient's physician at any time to seek advice regarding that patient's medical history and needs that may be relevant to the medical treatment and screening of this patient, *as long as consultation does not inappropriately delay services required under paragraph (a) or paragraphs d1 and d2 of this section.*"

Refusal to Accept Patient from a Non-Hospital-Owned Ambulance Off Hospital Property

The Action Subcommittee will further examine regulation 489.24(b)(4) regarding non-hospital-owned ambulances to clarify whether a hospital that refuses to accept a patient who is in an ambulance but not on the hospital grounds, even though the hospital is not on formal diversionary status, is in violation of EMTALA.

The TAG requests that CMS staff identify national associations related to emergency transport and formally request their input on this issue.