REPORT NUMBER SEVEN

to the

Secretary

U.S. Department of Health and Human Services

From the

Emergency Medical Treatment and Labor Act

Technical Advisory Group

Wilbur J. Cohen Building

Washington, DC

September 17–18, 2007

EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA)
TECHNICAL ADVISORY GROUP (TAG)
Minutes
September 17–18, 2007

Welcome, Call to Order, and Opening Remarks

Chair David Siegel, M.D., J.D., called the meeting to order and welcomed the members of the TAG and the audience. (See Appendix A for the meeting agenda.) Dr. Siegel reiterated the group's functions, as identified in the charter, and outlined the agenda for the final meeting of the TAG. He noted that some time would be devoted to determining the next steps for the TAG, including the contents and development of the final report to the Secretary.

Summary of Status of TAG Recommendations

Marilyn Dahl, Director of the Division of Acute Care Services for the Survey and Certification Group of the Center for Medicaid and State Operations, provided the responses of the Department of Health and Human Services (HHS) to the 31 TAG recommendations made to date (Appendix 1). Two recommendations (numbers 1 and 4) reaffirm existing policy, so no action was required. A recommendation (number 14) directing HHS staff to place items on a future TAG agenda was completed and removed from the list of recommendations. Five others have been implemented, some with modifications, and one is in the process of implementation. The remaining recommendations are under consideration.

John Kusske, M.D., asked whether recommendation number 15 represented the recommendation made by the TAG as it was originally worded. (It was later confirmed that the recommendation was presented verbatim from the minutes of the May 2006 EMTALA TAG meeting.)

The TAG suggested that HHS revisit recommendation number 17 to "clarify a hospital's obligation under EMTALA to receive a patient who arrives by ambulance" to more thoroughly address EMTALA issues related to triage. Specifically, the TAG suggested HHS provide more guidance about what EMTALA requires in terms of the timeliness of triage and mitigating circumstances. These issues were raised in public testimony at previous meetings.

The TAG agreed to move language out of recommendation number 26 (specifically the second, third, and fourth bullets of sub-recommendation number 2) so that issues related to EMTALA enforcement would appear as a separate recommendation. The following language should be removed and placed into a new recommendation:

> *Recommendation*
> 1. The TAG recommends that the Centers for Medicare and Medicaid Services (CMS) take the following steps to improve understanding about EMTALA among regional offices and state surveyors:
>
> - Establish a system to improve consistency in regional office EMTALA interpretations and enforcement (e.g., assign CMS central office person to monitor deficiency statements for consistency with CMS policy and consistency among jurisdictions and remedy concerns).

- Establish a system to monitor effectiveness of surveyor education.
- Establish a system to demonstrate surveyor competencies.

Ms. Dahl said she could not give a specific timeframe in which HHS would make a final determination on each recommendation. TAG members asked whether the TAG would be notified of the disposition of the recommendations. Terry Kay, Acting Director of the Hospital and Ambulatory Policy Group, said once the EMTALA TAG's charter expires, HHS will no longer have staff time allotted to follow up in that manner. He noted that changes to the regulations could occur through revisions to the inpatient and outpatient prospective payment systems, which are open to public comment. Statutory changes would require Congressional action. Mr. Kay strongly recommended that the TAG prioritize its remaining recommendations to help HHS focus its efforts.

EMTALA and Inpatients

Dr. Kusske, chair of the On-Call Subcommittee, presented the minutes of the On-Call Subcommittee Teleconference on September 11, 2007 (Appendix 2). He summarized a letter forwarded to the EMTALA TAG, written by Edward L. Burr, asking "whether 1395dd(g) and 489.24(f) place any obligation upon a hospital with specialized capabilities or facilities to accept the transfer from another hospital of an inpatient who requires those specialized capabilities or facilities." Dr. Kusske added that a court in Puerto Rico determined that an inpatient who requires the services of a hospital with specialized capabilities should be transferred under EMTALA. The court determined that Interpretive Guidelines are not law and paved the way for a private right of action in the case at hand.

The Interpretive Guidelines state that a hospital's EMTALA obligation ends when a patient is admitted to the hospital, but, as Charlotte Yeh, M.D., pointed out, the Guidelines refer only to the hospital where the patient originally presented at the emergency department (ED) with an emergency medical condition (EMC). The regulation is silent on the obligation of a hospital with specialized capabilities to accept transfers of inpatients. Ms. Dahl agreed and added that the Center for Medicaid and State Operations is not enforcing any obligation on a hospital with specialized capabilities to accept the transfer of an inpatient.

Rachel Seifert, J.D., said a hospital should not admit a patient with an EMC that the hospital does not have the capability to address, and furthermore, hospitals should have transfer agreements in place to address situations in which an inpatient's condition worsens. Dr. Yeh described a case in which an uninsured patient was admitted with chest pain, but his condition subsequently was diagnosed as a very complicated one (unstable angina) that the hospital could not treat. The hospital had great difficulty transferring the patient to a hospital where he could receive the appropriate treatment. Dr. Yeh suggested considering two different scenarios: one in which an inpatient develops an EMC, and one in which the patient is admitted but the hospital is unable to stabilize the patient's EMC.

Julie Mathis Nelson, J.D., said the Action Subcommittee stated in its document "Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers" that such hospitals had no obligation to accept transfers of inpatients. At a previous meeting, the TAG indicated agreement

with the content of the document and suggested some revisions, but the document was not formally accepted as a recommendation by the TAG to the Secretary. The Action Subcommittee also proposed that the Medicare Conditions of Participation include language to protect inpatients with EMCs.

Several members of the TAG argued that requiring hospitals with specialized capabilities to accept inpatient transfers under EMTALA would adversely affect patient care and increase the number of unnecessary patient transfers (Appendices 3 and 4). Dr. Yeh countered that the statute includes a provision for receiving hospitals to seek remittance of the cost of care from the sending hospital if the transfer was inappropriate.

Recommendations

2. The TAG recommends that HHS revise the Interpretive Guidelines, regulations, and statute as needed to clarify that EMTALA does not apply when a patient develops an EMC after being admitted to a hospital.

3. The TAG recommends that HHS revise the Interpretive Guidelines, regulations, and statute as needed to clarify the following: When a patient who is covered by EMTALA is admitted as an inpatient to the hospital and that patient's original EMC remains unstabilized, the obligation of a receiving hospital that has specialized capabilities required to stabilize that patient's EMC under Subsection G of Title 42, U.S.C., 1395dd, is not altered.

The chair pointed out that recommendation number three was controversial among the TAG members and passed with a slim majority. Most physician members and hospital representatives voted against recommendation number three. Dr. Siegel emphasized that until HHS adopts the recommendation or changes its policy, the current enforcement policy stands.

Behavioral Health

Mark Pearlmutter, M.D., presented recommendations on psychiatric issues from the Action Subcommittee. TAG members generally agreed that patients with psychiatric or behavioral health conditions should receive the same level of care and protections under EMTALA as those with medical conditions.

Recommendations

4. The TAG recommends that HHS remove the current separate guidance on psychiatric EMCs so that the remaining rules apply equally to EMCs of either psychiatric or medical origin.

5. The TAG recommends that HHS generate specific examples or vignettes to shed more light on aspects of psychiatric EMCs that are causing confusion.

6. The TAG recommends that HHS describe that a medical screening examination (MSE) should attempt to determine whether an individual is gravely disabled, suicidal, or homicidal. "Gravely disabled" implies a danger to oneself due to extremely poor judgment or inability to care for oneself. If a patient is felt to be gravely disabled, suicidal, or homicidal, this does not

necessarily mean that the patient has an EMC. The TAG supports the use of community protocols, community services, and other supportive resources (e.g., police custody, nursing home settings) to determine whether an EMC exists or to ensure appropriate disposition of the patient to a safe setting.

7. The TAG recommends that HHS explore educational tools, training options, and further education of ED physicians and other clinical staff in general acute care hospitals without psychiatric services about the proper psychiatric medical screening, discharge, and transfer of patients with behavioral health conditions.

8. The TAG recommends that HHS add to the Interpretive Guidelines the following statement: Hospitals shall be allowed to utilize contracted agencies or services to assist with psychiatric MSEs. Hospitals shall ensure that clinicians working for such agencies/services are properly credentialed in accordance with hospital and medical staff bylaws or policies and procedures. (This recommendation replaces the following recommendation made previously: "The TAG recommends that CMS insert the following sentence into the Interpretive Guidelines [489.24(a)] in the paragraph defining qualified medical personnel to perform an MSE (before the last sentence of the paragraph beginning, "The MSE must be conducted..."]: 'For the purpose of screening psychiatric patients, hospitals may utilize contracted agencies or services to assist with the psychiatric MSE if they are properly credentialed in accordance with the above.'")

9. The TAG recommends that receiving hospitals with specialized behavioral health capabilities, including freestanding facilities, should be required to accept the transfer of patients who are gravely disabled or a danger to self or others and who have an EMC if the receiving hospital has the resources and capacity to provide care to these patients and the transferring hospital does not have the capability to provide stabilizing care.

10. The TAG recommends that the following be incorporated into the Interpretive Guidelines: The administration of chemical or physical restraints does not in itself stabilize a psychiatric EMC. It may, however, provide a temporary safe environment by minimizing risk during patient transport. Unless the hospital or physician can demonstrate that a patient is stabilized irrespective of the chemical and physical restraints, EMTALA still applies to the patient's care, any subsequent transfer, and the duty of a hospital with specialized capabilities to accept that patient. For example, a patient presents to the ED actively suicidal with a plan and is determined to have an EMC. The patient is either administered a sedating medication or placed in physical restraints to prevent him/her from harming himself/herself. In this situation, the patient is still considered to have an unstabilized EMC because the patient's underlying suicidal intent persists.

The TAG members discussed situations in which EMTALA requirements conflict with state laws or local policies intended to ensure access to psychiatric care (often for uninsured and indigent patients). Many of these policies, or community protocols, relate to involuntary detainment of patients with psychiatric conditions. Sandra Sands of the Office of the Inspector

General confirmed that transferring psychiatric patients under community protocols can be an EMTALA violation in some cases.

Recommendation

11. The TAG recommends that HHS review its position on community protocols in consultation with state agencies and other stakeholders in the area of mental health.

Minutes from the May 3–4, 2007, TAG Meeting

After discussion about the intent behind the TAG's approval of the document proposed by the Action Subcommittee, "Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers," the TAG approved the minutes of the May 3–4, 2007, meeting of the EMTALA TAG with the following revision:

Action Items

1. The following sentence [in the minutes of the May 3–4, 2007, meeting of the EMTALA TAG] will move from the main text into the subsequent action item: The TAG agreed with the concepts presented in the document "Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers" with specific revisions.

Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers

Ms. Nelson, chair of the Action Subcommittee, summarized comments received from the Catholic Health Initiatives about the proposed document, "Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers," (Appendix 5). The TAG determined that the first item under "Duties of Receiving Hospitals," "No obligation to accept hospital inpatients, consistent with 42 C.F.R. 489.24(d)(2)," should be replaced by the first two recommendations made by the TAG at the current meeting regarding EMTALA and inpatients. Ms. Nelson agreed to make that change and to remove other items from the document on which the TAG did not reach consensus (Appendix 6).

Recommendation

12. The TAG approves the document "Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers" with revisions as discussed and recommends that HHS incorporate it as needed.

Final Papers from the Framework Subcommittee

Dr. Yeh, chair of the Framework Subcommittee, presented the final drafts of the documents prepared for the TAG's final report to the Secretary (Appendices 7–11). Dr. Siegel praised the quality of the documents. The TAG expressed gratitude to the students who drafted and revised the papers: Mary Bing, Won Ki Chae, and Christine Parkins from Harvard University; and Carrie Williams Bullock, Carly Cammarata, Cara Demmerle, Edward Garcia, Shannon Mills, and Maik Schutze from the Johns Hopkins University School of Public Health. Dr. Yeh added that Scott Keays of Boston University's School of Public Health edited the final papers.

Action Items

2. The five papers written by the Framework Subcommittee will be incorporated as is (with minor editorial changes as needed) into the final report submitted to the Secretary by the EMTALA TAG.

3. Dr. Siegel will work with CMS staff to send letters to the schools of the students who developed the Framework Subcommittee papers so the letters will appear in the students' official transcripts.

Stabilization and Follow-Up Treatment

The TAG discussed the various degrees of treatment to stabilize an EMC and the difference between stabilizing and definitive treatment. Members agreed that there were situations in which a condition might be considered temporarily or partially stabilized. In some cases, health care providers use their judgment to determine whether a patient can and will take the required action to receive the next phase of care for the EMC. For example, after screening a patient who arrives at the ED in early labor, it may be appropriate to discharge her with instructions on when to return to the hospital. TAG members generally agreed on the concept but were concerned that revising the language might lead to an expectation that hospitals must ensure that patients receive follow-up treatment or even that the patient's condition is treated definitively.

Recommendations

13. The TAG recommends that HHS clarify that an EMC does not need to be resolved to be considered stabilized for the purpose of discharge home provided that, within reasonable clinical confidence, it is determined that the individual has reached the point where his/her continued care, including diagnostic workup and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, and provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions. The TAG further recommends that HHS add appropriate examples (such as early labor and abdominal pain).

14. The TAG recommends that HHS clarify that EMTALA only applies until a patient is stabilized, and a hospital has no EMTALA obligation to provide definitive treatment to the patient, although other rules (e.g., Medicare Conditions of Participation) may apply.

Documentation of Hospital Requirements for Qualified Medical Personnel (QMP)

Ms. Nelson said some hospitals have complained about the regulation that they document their requirements for QMP in the hospital bylaws or rules and regulations, because some hospitals have different methods of documenting such requirements. The TAG members agreed that the intent of the regulation was to ensure that hospitals have such requirements in place and take them seriously.

Recommendation

15. The TAG recommends that HHS provide the flexibility to permit hospitals to make and document determinations of QMP in accordance with the hospital's and medical staff's usual credentialing procedures. If a hospital typically documents credentialing decisions in

documents other than hospital bylaws or rules and regulations, then such documentation should be permitted.

Deferred Care

Ms. Nelson pointed out that EMTALA only applies to patients with EMCs. The TAG members agreed that there are ethical and policy implications when hospitals deny care to individuals with conditions that are not considered EMCs. Some TAG members believe that the number of patients who defer care or are "triaged out" of the ED is growing and poses a significant problem for the health care system. Dr. Siegel pointed out that some states, including Florida, have developed programs to provide non-emergency care for uninsured individuals. Warren Jones, M.D., emphasized that even though hospitals are not required under EMTALA to provide care for non-emergency conditions, the health care system should consider how deferred care affects the whole system and recognize that access to care is a pressing issue.

Recommendation

16. The TAG recommends that HHS monitor and evaluate the consequences of "triaged out" and deferred care.

Expiration of EMTALA TAG Charter

The charter of the TAG expires on September 30, 2007. However, TAG members felt that many EMTALA issues remain unaddressed, despite the TAG's efforts.

Recommendation

17. The TAG recommends that the Secretary of HHS recognize the ongoing need for continued review of EMTALA legislation and that the mission of the EMTALA TAG be continued. (This recommendation replaces the following recommendation made previously: "The TAG recommends that the Secretary extend the charter of the TAG for one year to allow the TAG to continue its work.")

Final Report to the Secretary

Dr. Siegel suggested the final report include all of the TAG's recommendations and the status of each, as well as an indication of the priority level of each (high, medium, or low). The report should also include all of the papers developed by the Framework Subcommittee and a list of issues considered by the On-Call and Action subcommittees that were not resolved. The TAG members agreed that they would like an opportunity to review a draft of the report and give input before it is finalized.

Mr. Kay said that once the TAG's charter expires, HHS cannot provide information on the status of the TAG's recommendations or report other than what it provides to the public.

Action Item

4. HHS will provide members of the TAG with contact information for an individual at CMS who is responsible for overseeing EMTALA policy issues (currently Eric Ruiz).

HHS will also offer suggestions on how to find out more about the progress of specific recommendations, e.g., though CMS' Open-Door Forums.

Referral from the ED to a Physician's Office

Dr. Kusske noted that while the Interpretive Guidelines state that generally a physician in the ED should not refer patients to his or her own office, the On-Call Subcommittee agreed that in some situations, such referral may be appropriate and even preferable to care in the ED for the patient. In addition, the option to treat some patients in the office setting may encourage more physicians to take ED call. The TAG agreed, as long as referral decisions were not made on the basis of the patient's ability to pay for care. Dr. Yeh thought the current enforcement of the regulations permitted such referrals as long as patients were transported appropriately, but other members said the Interpretive Guidelines seem to restrict transfers to only hospital-owned facilities or to other hospitals.

Recommendation

18. The TAG recommends that HHS revise the Interpretive Guidelines to reflect the following: There are circumstances under which a patient in the ED may be discharged or transferred to a non-hospital-owned physician's office for continuation of the MSE, determination of whether an EMC exists, or stabilization of an EMC.

Definitions of Capability and Capacity

Ms. Nelson said that CMS does not define the terms "capability" and "capacity," and they are used inconsistently throughout CMS documents and in the statute.

Recommendation

19. The TAG recommends that HHS better define the terms "capacity" and "capability" and review regulations and Interpretive Guidelines to ensure that the terms are used appropriately and consistently and that intent is clear throughout.

Effect of EMTALA on Professional Liability Insurance Coverage and On-Call Coverage

Dr. Kusske said the perception that taking ED call increases an individual physician's professional liability risk deters physicians from taking ED call. The TAG members agreed but differed on how the issue could be addressed effectively and fairly. Dr. Kusske pointed out that the Institute of Medicine's report *Hospital-Based Emergency Care: At the Breaking Point* supported providing professional liability coverage to physicians who take ED call and the Framework Subcommittee's paper on the topic offers some examples on how such coverage could be provided.

Richard Perry, M.D., said that EMTALA is an unfunded mandate that requires hospitals to care for patients with EMCs but provides no financial support to do so. He said the lack of funding and increased risk for physicians taking call combine to drive physicians away from taking ED call.

Recommendations

20. The TAG recognizes that professional liability is a concern for providers and that having protections would increase coverage in the ED. The TAG recommends that HHS act to support amending the EMTALA statute to include liability protection for hospitals, physicians, and other licensed independent practitioners who provide services to patients covered by EMTALA.

21. The TAG recognizes that reimbursement is a major factor that impacts hospitals' and physicians' ability to provide emergency care and recommends that HHS act to support amending the EMTALA statute to include a funding mechanism for hospitals and physicians.

EMTALA and Private Right of Action

Ms. Nelson said the Action Subcommittee reviewed details on private rights of action under EMTALA. (The case details were compiled by an intern, Irene Chan.) Ms. Nelson pointed out that 80 percent of the cases were dismissed, which she said suggests that many such cases are inappropriate and may represent abuse of the legal system. She added that only a small fraction of the cases seemed to address EMTALA complaints, such as failure to provide an MSE; many more could have been brought to the court under some avenue other than the EMTALA private right of action. The Action Subcommittee felt that the EMTALA private right of action is being misused and should be limited to patients who were wrongfully refused care. Several members felt the EMTALA private right of action is being used to circumvent state laws that cap damage awards. Others added that it is being used to force hospitals to release protected documents that could then be used in other lawsuits.

Recommendation

22. The TAG recommends that HHS seek revisions that would limit the private right of action for personal harm to only those circumstances in which there is no alternative route to claim damages through professional liability laws.

Discussing the Cost of Hospital Care with Patients

Ms. Nelson said the Action Subcommittee agreed that there are circumstances in which it would be to the patient's advantage to discuss the patient's insurance coverage, the cost of care, and treatment options. TAG members agreed that in no circumstances should such a discussion compromise the appropriate care of the patient's EMC. Ms. Sands said that since 2003, the regulations have stated that hospitals may not contact an insurer for prior authorization until a patient has been screened and stabilization treatment started and suggested that statement might serve as a guideline for when it would be appropriate to discuss insurance issues with patients. Dr. Yeh pointed out that EMTALA enforcement is complaint-driven, so patients only complain about their physicians raising insurance issues when the discussion seems inappropriate. Some TAG members raised concerns about the likelihood of conveying misinformation about insurance coverage and costs to the patient.

Recommendation

23. The TAG recommends that HHS develop guidance on how and when a practitioner may discuss financial matters with a patient presenting with an EMC.

Adjournment

Dr. Siegel thanked the TAG members for taking time out from their very busy schedules to participate in the TAG and commended their passion for working for the benefit of both patients and providers. He said the TAG had covered a lot of ground and made significant contributions to improving EMTALA. Dr. Siegel thanked the CMS and HHS staff for all their hard work, and also thanked audio specialist John O'Leary and meeting reporter Dana Trevas, both from contractor Magnificent Publications, for their assistance.

Mr. Kay said that HHS is grateful to all the TAG members for their input and efforts. He added that HHS appreciated Dr. Siegel's willingness to step forward and lead the TAG.

Dr. Siegel adjourned the meeting at 2:10 P.M. on Tuesday, September 18, 2007. Collected recommendations and approved motions of the TAG are listed in Appendix B.

EMTALA TAG Members Present at the September 17–18, 2007, Meeting

EMTALA Technical Advisory Group Members

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Charlotte S. Yeh, M.D.
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Terry Kay, Acting Director
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Rapporteur
Dana Trevas
Magnificent Publications, Inc.

APPENDICES

Appendix A: Meeting Agenda
Appendix B: Recommendations and Action Items from the September 17–18, 2007, meeting

The following documents were presented at the EMTALA TAG meeting on September 17–18, 2007, and are appended here for the record:

Appendix 1: Department of Health and Human Services, Centers for Medicare and Medicaid Services Response to Recommendations of the EMTALA Technical Advisory Group as of September 14, 2007
Appendix 2. Minutes of the On-Call Subcommittee Teleconference
Appendix 3: Correspondence to the TAG Chair expressing opinions about the TAG recommendation on the EMTALA obligation of hospitals with specialized capabilities
Appendix 4: Correspondence to the TAG Chair expressing dissent regarding the TAG recommendation on the EMTALA obligation of hospitals with specialized capabilities
Appendix 5: Correspondence from the Catholic Health Initiatives about the proposed document "Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers"
Appendix 6: "Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers"
Appendix 7: EMTALA and Disparities in the U.S. Health Care System
Appendix 8: Impact of EMTALA on Inpatient Bed Capacity and the Emergency Department (ED)
Appendix 9: The Liability Environment's Effect on Physician & Hospital Compliance with EMTALA
Appendix 10: Impact of EMTALA on Hospital and Physician Payment for ED Services
Appendix 11: Impact of EMTALA on Workforce Capacity and the Emergency Department (ED)

APPENDIX A

Seventh EMTALA TAG Meeting
September 17-18, 2007
Room 5051 Wilbur J. Cohen Building
200 Independence Avenue, SW
Washington, DC 20001

Day 1 **Monday, September 17, 2007**

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 - 10:00	Summary of Status of TAG Recommendations
10:00 – 10:30	Discussion and Action on On-Call and Action Subcommittee Recommendations, rotating between subcommittees
10:30 – 10:45	Break
10:45 – 12:00	Discussion and Action on On-Call and Action Subcommittee Recommendations, rotating between subcommittees
12:00 – 1:00	Lunch
1:00 – 2:30	Report of Framework Subcommittee/TAG Questions and Discussion of Framework Issues
2:30 - 2:45	Break
2:45 – 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

Day 2	**Tuesday, September 18, 2007**
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	Report of Framework Subcommittee/TAG Questions and Discussion of Framework Issues
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

Recommendations and Action Items
from the
September 17–18, 2007, Meeting
of the
Emergency Medical Treatment and Labor Act (EMTALA)
Technical Advisory Group (TAG)

Recommendations

1. The TAG recommends that the Centers for Medicare and Medicaid Services (CMS) take the following steps to improve understanding about EMTALA among regional offices and state surveyors:

- Establish a system to improve consistency in regional office EMTALA interpretations and enforcement (e.g., assign CMS central office person to monitor deficiency statements for consistency with CMS policy and consistency among jurisdictions and remedy concerns).
- Establish a system to monitor effectiveness of surveyor education.
- Establish a system to demonstrate surveyor competencies.

2. The TAG recommends that the Department of Health and Human Services (HHS) revise the Interpretive Guidelines, regulations, and statute as needed to clarify that EMTALA does not apply when a patient develops an emergency medical condition (EMC) after being admitted to a hospital.

3. The TAG recommends that HHS revise the Interpretive Guidelines, regulations, and statute as needed to clarify the following: When a patient who is covered by EMTALA is admitted as an inpatient to the hospital and that patient's original EMC remains unstabilized, the obligation of a receiving hospital that has specialized capabilities required to stabilize that patient's EMC under Subsection G of Title 42, U.S.C., 1395dd, is not altered.

4. The TAG recommends that HHS remove the current separate guidance on psychiatric EMCs so that the remaining rules apply equally to EMCs of either psychiatric or medical origin.

5. The TAG recommends that HHS generate specific examples or vignettes to shed more light on aspects of psychiatric EMCs that are causing confusion.

6. The TAG recommends that HHS describe that a medical screening examination (MSE) should attempt to determine whether an individual is gravely disabled, suicidal, or homicidal. "Gravely disabled" implies a danger to oneself due to extremely poor judgment or inability to care for oneself. If a patient is felt to be gravely disabled, suicidal, or homicidal, this does not necessarily mean that the

patient has an EMC. The TAG supports the use of community protocols, community services, and other supportive resources (e.g., police custody, nursing home settings) to determine whether an EMC exists or to ensure appropriate disposition of the patient to a safe setting.

7. The TAG recommends that HHS explore educational tools, training options, and further education of emergency department physicians and other clinical staff in general acute care hospitals without psychiatric services about the proper psychiatric medical screening, discharge, and transfer of patients with behavioral health conditions.

8. The TAG recommends that HHS add to the Interpretive Guidelines the following statement: Hospitals shall be allowed to utilize contracted agencies or services to assist with psychiatric MSEs. Hospitals shall ensure that clinicians working for such agencies/services are properly credentialed in accordance with hospital and medical staff bylaws or policies and procedures. (This recommendation replaces the following recommendation made previously: "The TAG recommends that CMS insert the following sentence into the Interpretive Guidelines [489.24(a)] in the paragraph defining qualified medical personnel to perform an MSE (before the last sentence of the paragraph beginning, "The MSE must be conducted..."]: 'For the purpose of screening psychiatric patients, hospitals may utilize contracted agencies or services to assist with the psychiatric MSE if they are properly credentialed in accordance with the above.'")

9. The TAG recommends that receiving hospitals with specialized behavioral health capabilities, including freestanding facilities, should be required to accept the transfer of patients who are gravely disabled or a danger to self or others and who have an EMC if the receiving hospital has the resources and capacity to provide care to these patients and the transferring hospital does not have the capability to provide stabilizing care.

10. The TAG recommends that the following be incorporated into the Interpretive Guidelines: The administration of chemical or physical restraints does not in itself stabilize a psychiatric EMC. It may, however, provide a temporary safe environment by minimizing risk during patient transport. Unless the hospital or physician can demonstrate that a patient is stabilized irrespective of the chemical and physical restraints, EMTALA still applies to the patient's care, any subsequent transfer, and the duty of a hospital with specialized capabilities to accept that patient. For example, a patient presents to the emergency department actively suicidal with a plan and is determined to have an EMC. The patient is either administered a sedating medication or placed in physical restraints to prevent him/her from harming himself/herself. In this situation, the patient is still considered to have an unstabilized EMC because the patient's underlying suicidal intent persists.

11. The TAG recommends that HHS review its position on community protocols in consultation with state agencies and other stakeholders in the area of mental health.

12. The TAG approves the document "Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers" with revisions as discussed and recommends that HHS incorporate it as needed.

13. The TAG recommends that HHS clarify that an EMC does not need to be resolved to be considered stabilized for the purpose of discharge home provided that, within reasonable clinical confidence, it is determined that the individual has reached the point where his/her continued care, including diagnostic workup and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, and provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions. The TAG further recommends that HHS add appropriate examples (such as early labor and abdominal pain).

14. The TAG recommends that HHS clarify that EMTALA only applies until a patient is stabilized, and a hospital has no EMTALA obligation to provide definitive treatment to the patient, although other rules (e.g., Medicare Conditions of Participation) may apply.

15. The TAG recommends that HHS provide the flexibility to permit hospitals to make and document determinations of qualified medical personnel in accordance with the hospital's and medical staff's usual credentialing procedures. If a hospital typically documents credentialing decisions in documents other than hospital bylaws or rules and regulations, then such documentation should be permitted.

16. The TAG recommends that HHS monitor and evaluate the consequences of "triaged out" and deferred care.

17. The TAG recommends that the Secretary of HHS recognize the ongoing need for continued review of EMTALA legislation and that the mission of the EMTALA TAG be continued. (This recommendation replaces the following recommendation made previously: "The TAG recommends that the Secretary extend the charter of the TAG for one year to allow the TAG to continue its work.")

18. The TAG recommends that HHS revise the Interpretive Guidelines to reflect the following: There are circumstances under which a patient in the emergency department may be discharged or transferred to a non-hospital-owned physician's office for continuation of the MSE, determination of whether an EMC exists, or stabilization of an EMC.

19. The TAG recommends that HHS better define the terms "capacity" and "capability" and review regulations and Interpretive Guidelines to ensure that the terms are used appropriately and consistently and that intent is clear throughout.

20. The TAG recognizes that professional liability is a concern for providers and that having protections would increase coverage in the emergency department. The TAG

recommends that HHS act to support amending the EMTALA statute to include liability protection for hospitals, physicians, and other licensed independent practitioners who provide services to patients covered by EMTALA.

21. The TAG recognizes that reimbursement is a major factor that impacts hospitals' and physicians' ability to provide emergency care and recommends that HHS act to support amending the EMTALA statute to include a funding mechanism for hospitals and physicians.

22. The TAG recommends that HHS seek revisions that would limit the private right of action for personal harm to only those circumstances in which there is no alternative route to claim damages through professional liability laws.

23. The TAG recommends that HHS develop guidance on how and when a practitioner may discuss financial matters with a patient presenting with an EMC.

Action Items

1. The minutes of the May 3–4, 2007, meeting of the EMTALA TAG are approved with the following revision:

    - The following sentence will move from the main text into the subsequent action item: The TAG agreed with the concepts presented in the document "Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers" with specific revisions.

2. The five papers written by the Framework Subcommittee will be incorporated as is (with minor editorial changes as needed) into the final report submitted to the Secretary by the EMTALA TAG.

3. Dr. Siegel will work with CMS staff to send letters to the schools of the students who developed the Framework Subcommittee papers so the letters will appear in the students' official transcripts.

4. HHS will provide members of the TAG with contact information for an individual at the Center for Medicare Services who is responsible for overseeing EMTALA policy issues (currently Eric Ruiz). HHS will also offer suggestions on how to find out more about the progress of specific recommendations, e.g., though CMS' Open-Door Forums.

APPENDIX 1

Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Response to Recommendations of the EMTALA Technical Advisory Group (TAG) as of September 14, 2007 - **DRAFT**

Recommendations The TAG recommends that . . .	Status
(1) Hospitals with specialized capabilities not be required to maintain emergency departments.	(1) Not currently required, so any CMS statement would merely reaffirm existing policy.
(2) 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.	(2) Adopted in the 2006 IPPS final rule by adding regulations language that makes explicit the current policy that all Medicare-participating providers with specialized capabilities are required to accept an appropriate transfer if they have the ability to treat the individual Survey and Certification letter issued to implement regulations.
(3) CMS move 42 CFR 489.24(j)(1), the provision dealing with maintaining a list of on-call physicians, to 42 CFR 489.20(r)(2), which relates to the Medicare provider agreement.	(3) Under consideration
(4) CMS not require physicians to take emergency call as a Condition of Participation in Medicare.	(4) No action needed. This reflects the status quo, since physicians are not required to take call in order to participate in Medicare and physicians are not required to participate in order to be paid under Medicare.
(5) 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."	(5) Adopted with modification in the 2006 IPPS final rule. Regulations were revised, to permit, in accordance with state law and hospital bylaws, a qualified non-physician clinician to certify that a woman is experiencing false labor.
(6) CMS revise the regulation at 489.24(d)(4)(iii) to read:	(6) Under consideration

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.	
(7) CMS revise the Interpretive Guidelines for the regulation at 489.24(d)(4)(iii) to read: At any time, the treating physician or qualified medical personnel (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.	(7) Under consideration
(8) CMS interpret 489.20(r)(2) to mean that all hospitals, including specialty hospitals, should maintain a call list in accordance with the statute and provider agreement.	(8) Under consideration

(9) CMSO identify FAQs specific to EMTALA to incorporate into the EMTALA website.	(9) Under consideration
(10) CMS replace the word "certifies" with the phrase "determines and documents" in the definition of labor and as needed in the IGs.	(10) Under consideration
(11) CMS incorporate the following into the IGs 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.	(11) Under consideration
(12) 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	(12) Under consideration

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.	
(13) 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.	(13) Under consideration
(14) 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	(14) Done for November 2006 meeting

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 • 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?	

(15) 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.	(15) Under consideration
(16) 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.	(16) Under consideration
(17) CMS clarify a hospital's obligation under EMTALA to receive a patient who arrives by ambulance.	(17) Adopted and implemented by CMS in S & C Letter 07-20, released 4/27/2007.
(18) CMS expand the current 72 hour waiver from EMTALA enforcement for hospitals and physicians during a national emergency to include state and county and city government emergencies and hospital-specific emergencies and to apply until the government-declared emergency has been terminated or until the hospital is not longer in an emergency.	(18) Under consideration FYI, FY 08 IPPS revised 489.24(a)(2) to reflect statutory changes as follows: "Sanctions under this section for an inappropriate transfer during a national emergency *or for the direction or relocation of an individual to receive medical screening at an alternate location* do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act. *A waiver of these sanctions is limited to a 72 hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect*

	until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1)(B) of the Act."
(19) CMS amend the Interpretative Guidelines, A407, to clarify that once a patient has been stabilized, the hospital and physician have no further follow-up care obligation.	(19) Under consideration
(20) CMS clarify that a hospital may not refuse to accept an individual protected under EMTALA on the grounds that the receiving hospital does not approve the method of transfer arranged by the attending physician at the sending hospital.	(20) Adopted and implemented by CMS in S & C Letter 07-20, released 4/27/2007.
(21) CMS strike the language in the Interpretative Guidelines on telehealth/telemedicine (489.24(j)(1)) and replace it with language that clarifies that the treating physician ultimately determines whether the on-call physician should come to the emergency department and that the treating physician may use a variety of methods to communicate with the on-call physician.	(21) Adopted and implemented by CMS in S & C Letter 07-23, released 6/22/2007.
(22) CMS insert the following sentence into the Interpretive Guidelines (489.24(a)) in the paragraph defining qualified medical personnel to perform and medical screening examination (before the last sentence of the paragraph beginning "The MSE must be conducted"): "For the purpose of screening physiatrist patients, hospitals may utilize contracted agencies or services to assist with the psychiatric MSE if they are properly credentialed in accordance with the above."	(22) Under consideration

(23) CMS move 42 CFR 489.24(j)(1) in accordance with the prior TAG recommendation: *(3)(CMS move 42 CFR 489.24(j)(1), the provision dealing with maintaining a list of on-call physicians, to 42 CFR 489.20(r)(2), which relates to the Medicare provider agreement.)*	(23) Under consideration
(24) CMS change 42 CFR 489.20(r)(2) to read: "Each hospital must maintain an on-call list of physicians on its medical staff who are available to examine and stabilize the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians." [Note--This recommendation assumes that previous recommendations(3) and (23) above will also be adopted.]	(24) Under consideration
(25) CMS change the Interpretive Guidelines to state the following: 1) If a hospital offers a service to the public, this service should be available for emergency care through on-call coverage. 2) To satisfy the requirement for on-call coverage, at least annually, hospital and medical staff must develop a plan for on-call coverage that includes, at a minimum, evaluation of the following factors: • hospital capabilities/services provided (advertised/licensed) • community need for emergency department (ED) services as determined by ED visits • transfers out of hospital for emergency services • physician resources • past call plan performance	(25) Under consideration

3) The hospital must have a backup plan for patient care when it lacks capacity to provide services or on-call physician coverage is not available. The backup plan should consist of viable patient care options, such as the following: • telemedicine • other staff physicians • transfer agreements designed to ensure that the patient will receive care on in a timely manner • regional or community coverage arrangements 4) A hospital may satisfy its on-call coverage obligation by participation in an approved community/regional call coverage program (*CMS to determine appropriate approval process*).	
(26) CMS take the following steps to improve understanding about EMTALA: 1) More comprehensive, prominent, user friendly CMS EMTALA website that includes the following: • Statutes • Regulations • Interpretive Guidance • Current CMS/Office of the Inspector General (OIG) program memoranda/guidance letters • EMTALA questions and answers • Link to Medicare Conditions of Participation • Enforcement statistics • "Top 10" cited EMTALA deficiencies • Special advisories of potential EMTALA violations • Link to OIG website	(26) Related to #2: CMS is working with a contractor to develop a web-based basic EMTALA training module, including an assessment component, that would be available in FY 09 to ROs and SAs on an on-demand basis. To include an assessment component. In-person training would become an advanced/update course. All other elements remain under consideration

• Topical cross-references • EMTALA 101 "basics" • Document downloads 2) Standardized Regional Office/State Surveyor Education • Institute annual EMTALA surveyor education sessions (currently offered every 2 years). • Establish a system to improve consistency in Regional Office EMTALA interpretations and enforcement (e.g., assign CMS central office person to monitor deficiency statements for consistency with CMS policy and consistency among jurisdictions and remedy concerns). • Establish a system to monitor effectiveness of surveyor education. • Establish a system to demonstrate surveyor competencies. • Confirm prompt distribution of CMS EMTALA guidance, including EMTALA opinion letters and program memoranda, to Regional Offices and state agencies. 3) Provider education • Designate/approve specific CMS/OIG personnel to participate in provider education through various educational forums (e.g., American Health Lawyers Association, hospital/physician association meetings). Consider joint presentations by both agencies and establish a process to confirm consistency of information provided. • Ensure timely response to provider queries regarding EMTALA compliance and interpretation questions. • Establish a timely process to address new obstacles to EMTALA compliance and remedy through regulatory or	

interpretive guidance change. • Establish listservs or other mechanism so that interested parties can receive regular updates and information regarding EMTALA from CMS/OIG. • Consider EMTALA training by Quality Improvement Organizations (QIOs). 4) Patient education • Provide information about EMTALA rights and consequences (e.g., EMTALA requires hospitals to provide care irrespective of the patient's ability to pay, however, the hospital may still expect the patient to pay for services rendered). This information should be provided outside of the context of an ED visit.	
(27) CMS reach out to providers to remind them that they can contact their Regional Offices for clarification of the Interpretive Guidelines or any other regulations regarding EMTALA, such as acceptable uses of telehealth for communication under the current Interpretive Guidelines.	(27) Under consideration
(28) CMS establish an appeals process for hospitals/providers before making a termination decision. a. Hospitals should be allowed to request QIO review for medical issues prior to termination. b. Hospitals should be allowed to request an appeal from the CMS Regional Office on factual, policy, and legal issues before submission of a plan of correction or a decision to terminate. For example: • If the Regional Office believes a violation has occurred, a	(28) Under consideration

hospital is first given a draft statement of deficiencies, after which it has 10 days to provide CMS with any objections or additional information. CMS would have 10 days to consider the additional information and issue a final statement of deficiencies that responds to it. An expedited appeals process should be in place for hospitals to be placed on a 23-day termination track. • Region VI process (to be submitted by Dodjie Guioa).	
(29) CMS establish intermediate sanctions, such as an opportunity to correct with follow-up inspection or a system of warnings, for less serious EMTALA violations. Hospitals with technical violations (e.g., signage, log books) should receive lower sanctions.	(29) Under consideration
(30) CMS establish a method for consistent data collection of all EMTALA violations and central evaluation of the information, in a format determined by CMS to improve consistency of enforcement across the regions and that can serve as a resource for providers.	(30) Under consideration
(31) The Secretary extend the charter of the TAG for one year to allow the TAG to continue its work.	(31) No HHS discretion; requires Congressional action.

APPENDIX 2

Report of the
On-Call Subcommittee
of the
Emergency Medical Treatment and Labor Act
Technical Advisory Group

Teleconference: September 11, 2007

ON-CALL SUBCOMMITTEE REPORT
(Emergency Medical Treatment and Labor Act [EMTALA]
Technical Advisory Group [TAG])

Teleconference: September 11, 2007

Introduction

John A. Kusske, M.D., chair of the subcommittee, confirmed that a quorum was present. He introduced Rachel Seifert, J.D., a new member of the subcommittee. The agenda for the teleconference is provided in Appendix A.

New Business

1) Application of EMTALA to Hospital Inpatients

Tag A411 42 CFR §489.24(f) and Interpretive Guideline §489.24(e). Also USC 1395dd(g). See also TAG A406 §489.24(a)(ii) and Interpretive Guideline §489.24(a)(1)(ii) and TAG A407 Interpretive Guideline §489.24(d)(2)(i).

The TAG has been asked whether the statute and the regulation cited place any obligation on a hospital with specialized capabilities or facilities to accept the transfer from another hospital of an inpatient who requires specialized capabilities or facilities. See the letter from Edward L. Burr to Elizabeth Jacobson of CMS Region 4 and the response from Marilyn Dahl of CMS to Mr. Burr in Appendix A.

Subcommittee members discussed at some length whether EMTALA applies to hospital inpatients but came to no firm conclusion.

Historically, once a patient is admitted, the prevailing view has been that the hospital has fulfilled its EMTALA obligation. This view is expressed in the Interpretive Guideline §489.24(a)(1)(ii), which states:

> EMTALA does not apply to hospital inpatients. The existing hospital COPs [conditions of participation] protect individuals who are already patients of a hospital and who experience an EMC (Emergency Medical Condition). Hospitals that fail to provide treatment to these patients may be subject to further enforcement actions.

However, the statute itself does not distinguish between hospitalized and nonhospitalized patients. The statutory endpoint for EMTALA is whether the patient is stabilized.

A majority of the subcommittee believes that a hospital's EMTALA obligation does end with admission.

The subcommittee agreed that applying EMTALA to inpatients would involve a momentous shift and could result in many more patients being transferred, particularly to hospitals that have specialized capabilities, and that more thought is needed.

Action Item

Dr. Aristeiguieta requested more information from attorneys about the basis for the current interpretation.

Old Business

2) On-Call Arrangements and Call Sharing

The subcommittee previously discussed the issue of call sharing and community call arrangements, but the full TAG has not given the topic much attention. Dr. Kusske believes there is still confusion among hospitals about whether CMS will sanction these types of call arrangements, particularly when, by prior arrangement, an ambulance takes a patient with an EMC to a hospital designated by a community call arrangement to receive such patients, bypassing a nearer hospital.

Dr. Kusske contrasted the language in Interpretive Guideline §489.24(d)(1)(i)), which states, "... the hospital must meet its EMTALA obligations (screen, stabilize, and or [sic] appropriately transfer) [the patient] prior to transferring the individual to a community plan hospital," with that of a March 30, 2005, letter from the Division of Survey and Certification, Region VI (see Appendix A), which states:

> …if a hospital is contacted directly by another hospital or ambulance seeking transfer of an emergency patient who falls within the system protocols, it would be appropriate under EMTALA to refer the call to the Regional Trauma Transfer and Referral Center for appropriate referral to the designated hospital.

There was consensus among subcommittee members that the letter is a correct interpretation of the statute and Interpretive Guidelines.

Recommendation:

The TAG should reiterate that community call sharing arrangements are acceptable.

Next Steps

The subcommittee agreed that the TAG has a lot of unfinished business. A full record of the issues discussed should be established for use by a new EMTALA TAG, in the event Congress reauthorizes it.

Action Item:

Dr. Kusske will prepare a complete list of the issues the subcommittee has addressed and its recommendations by Monday, September 17, when the TAG next meets.

EMTALA TAG Members Participating in the
On-Call Subcommittee September 11, 2007, Teleconference

Participants
(Alphabetical Order)

EMTALA TAG Members

John A. Kusske, M.D., *Chair, On-Call Subcommittee*
Neurosurgeon
Chair, Department of Neurological Surgeons
University of California, Irvine Medical Center
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Hospital and Ambulatory Policy Group
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Rapporteur
Martha Romans
Magnificent Publications, Inc.

APPENDIX A
Agenda
On-Call Subcommittee of the EMTALA TAG
September 11, 2007

1) Introductions

2) Old Business

A) TAG recommendations from the May 3-4, 2007 TAG meeting related to On-Call Subcommittee presentations:

The TAG reiterated its previous recommendation that HHS move 42 C.F.R. 489.24(j)(1), the provision dealing with maintaining a call list of physicians that best meets the needs of the hospital's patients to 42 C.F.R. 489.20(r)(2), which relates to the Medicare provider agreement. The TAG further recommended that CMS change 42 C.F.R.(r)(2) to read: "Each hospital must maintain an on-call list of physicians on its medical staff who are available to examine and stabilize the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians." This eliminates the "best meets the needs" phrase that the Subcommittee has discussed extensively.

Further the TAG recommended:
That the Interpretive Guidelines be changed to state that if a hospital offers a service to the public, this service should be available for emergency on-call coverage.

There are several issues that this recommendation raises which need to be reviewed by the On-Call Subcommittee. (See Appendix 11 of Report Number Six to the Secretary of HHS)

B) Previous Topics Discussed by the On-Call Subcommittee

1) At the last subcommittee meeting the topic of call sharing and community call was discussed. In the Sixth Report the topic was given little attention by the TAG. I would like the subcommittee to give further consideration to the following points for their possible open discussion at the TAG for inclusion in the Interpretive Guidelines:

Issues that are proposed to be considered by the TAG and to be addressed in the Interpretive Guidelines.

- CMS should clarify that it does not require shared call arrangements to involve simultaneous call at multiple hospitals.
- Guidelines should describe how a shared call arrangement can be used to reduce a hospital's obligation to ensure backup coverage.

- When a call sharing arrangement is in place the Guidelines should describe who is responsible for performing the medical screening examination—emergency services medical personnel or the transferring hospital.
- The Guidelines should describe the appropriate method for consulting (or informing) the CMS regional offices before shared call arrangements are established.
- The Guidelines should describe the required elements of a formal shared call arrangement.
- CMS should clarify, in the Guidelines, those situations in which transfer of a patient whose condition is not stabilized is considered not to be a violation of EMTALA because a shared call arrangement is in place.
- The On-Call Subcommittee believes that CMS should ensure anti-trust immunity and protection to those coordinating and providing shared call coverage.

The On-Call Subcommittee requests that the TAG review these issues to encourage use of shared call coverage. Part of this discussion will include the use of the Oklahoma State Trauma Plan.

Oklahoma State Department of Health
James M. Crutcher, MD, MPH
Commissioner of Health

March 25, 2005

David Wright
Chief, Long Term Care Branch
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Room 833
Dallas, Texas 75202

Dear Mr. Wright:

As you are aware, Oklahoma is in the process of further developing our trauma systems on both a regional and a statewide basis. Part of these efforts have been directed toward encouraging physicians, hospitals, and emergency medical service providers to participate in an organized system of providing twenty-four hour emergency trauma care according to a regional plan developed within each of the eight trauma regions.

As our planning activities have progressed and our systems begin to be implemented, we continue to generate a significant number of questions, comments, and concerns with regard to the applicability of the Emergency Medical Treatment and Labor Act (EMTALA) to specific aspects of our regional plans.

In an effort to confirm that certain assumptions we have made are true, we would like to present a few of these assumptions to the Centers for Medicare & Medicaid Services (CMS) and ask you to verify or invalidate these statements and to provide any comments you or your colleagues in the Region VI office would like to make:

1. CMS recognizes the development and implementation of community wide call plans within the context of provider's EMTALA obligations. These plans are designed to help meet a community's needs for emergency medical care by helping to ensure the appropriate delivery of emergency medical treatment for people with acute illness and traumatic injury.

2. Patients with emergency conditions may be referred and delivered to a designated hospital based on a predetermined rotational schedule as developed by the region utilizing defined clinical triage criteria according to an established protocol. Such referrals may be facilitated through a Regional Trauma Transfer and Referral Center.

MAG

1000 NE 10th Street
Oklahoma City, OK 73117-1299
www.health.state.ok.us

3. EMTALA regulations are directed toward patients with an emergency medical condition that present to a hospital with a dedicated emergency department. A hospital that participates in an organized community wide system of providing emergency care will need to continue an internal call schedule, consistent with their resources, in order to meet the emergency needs of patients that present to the emergency department outside the community wide system, or those that have a pre-existing relationship with a member of the hospital's medical staff.

4. It is not a violation of EMTALA for hospitals participating in a community wide system of providing emergency care to refer patient transfer requests from a medical provider, including hospitals and ambulance services, to the designated hospital. This transfer must adhere to an established community protocol using defined clinical triage criteria and referral through a Regional Trauma Transfer and Referral Center. This does not apply to patients who are already on a hospital's grounds or are being transported by a hospital-based ambulance service.

If you have questions or need additional information, please feel free to contact Tom Welin of my staff by email at tomw@health.ok.gov or by telephone at 405-271-6576. Thank you for your time and attention, and we look forward to your response.

Sincerely,

James M. Crutcher

James M. Crutcher, M.D., M.P.H.
Commissioner of Health and
State Health Officer

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Room 833
Dallas, Texas 75202

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Division of Survey and Certification, Region VI

March 30, 2005

James M. Crutcher, M.D., M.P.H.
Commissioner of Health and
State Health Officer
Oklahoma State Department of Health
1000 N.E. 10th St.
Oklahoma City, Oklahoma 73117-1299

RECEIVED
MAR
Protective Health Services
Medical Facilities

Fax: 405-271-1308

Dear Dr. Crutcher:

This is in response to your letter of March 25, 2005 requesting a review of certain policies and protocols with regard to the use of a Regional Trauma Transfer and Referral Center and a hospital's obligations under the Emergency Medical Treatment and Labor Act (EMTALA).

CMS recognizes the need and importance of state and regional trauma systems to ensure the rapid and effective transfer of patients to hospitals that have the necessary capabilities to provide definitive care. In doing so, we have determined that hospitals operating within the protocols of such a system are deemed to be in compliance with EMTALA.

Therefore, if a hospital is contacted directly by another hospital or ambulance seeking transfer of an emergency patient who falls within the system protocols, it would be appropriate under EMTALA to refer the call to the Regional Trauma Transfer and Referral Center for appropriate referral to the designated hospital.

Hospitals may continue to maintain their own call schedules for emergency patients who present directly to their facility seeking care, and provide medical screening stabilizing treatment utilizing those resources without incurring an EMTALA obligation for calls that are transferred to the Regional Trauma Transfer and Referral Center.

I hope this resolves any concerns you may have with implementation of the trauma system and EMTALA compliance. If you have any other questions, please do not hesitate to contact our office.

Sincerely,

David R. Wright
Chief, Long Term Care Branch
EMTALA Outreach and Education Coordinator

The Subcommittee believes that CMS should make it clear that Regional Trauma Plans are acceptable and that these plans can include call sharing arrangements among various hospitals and physicians as exists in the Oklahoma system. Examples of successful models such as the Oklahoma plan should be placed on the EMTALA website.

The issue is not clear in the Interpretive Guidelines (Interpretive Guidelines §489.24(d)(1)(i)). "If a community wide plan exists for specific hospitals to treat certain EMCs (e.g., psychiatric, trauma, physical or sexual abuse), the hospital must meet its EMTALA obligations (screen, stabilize, and or appropriately transfer) prior to transferring the individual to the community plan hospital. An example of a community wide plan would be a trauma system hospital."

2) Liability protection for EMTALA mandated services provided by on-call physicians.

The On-Call Subcommittee previously requested that the TAG consider Federal liability protection for physicians and hospitals acting under EMTALA requirements, but this issue did not make it onto the agenda of the last TAG meting. Subcommittee members continue to believe that liability protection will provide incentives for physicians to take calls and thereby assist in alleviating the present on-call shortage of specialist physicians. The specifics of liability protection still need to be worked out. Among the issues to consider are:

- Under most state laws a physician will not be protected if it is determined that the physician was already legally bound to deliver the care in question.

- Also the Good Samaritan statutes typically bar from qualification under the statute persons who accept compensation for the emergency care delivered.

- Under these protections any physician or hospital that provides emergency services pursuant to obligations imposed by state or federal EMTALA requirements would not be liable for civil damages unless they acted with gross negligence.

Dr. Tuggle suggested that the June 2006 IOM Report: *Future of Emergency Care, Hospital-Based Emergency Care at the Breaking Point* supports providing liability protection.
Using Good Samaritan laws as a reference point is somewhat problematic, as they typically don't apply to those who receive payment for their services.

3) Discussion by the On-Call Subcommittee of some strategies used by hospitals to refuse transfers:

a) The hospital does not have the appropriate specialist on call at the time of transfer, although the specialist will, in fact, be on call within an appropriate treatment window for the patient.

b) The specialist will not be available, on call, to provide continued care or to monitor the patient.

c) The hospital will not have other specialists on call that may be needed at some point to assist in the patient's care

Subcommittee members cited a variety of factors that affect call lists, including more doctors dropping off calls lists, the aging of the physician population, and other changes in the medical landscape. Members agreed that medical and hospital associations are the most appropriate groups to develop guidance on call issues, not EMTALA.

It would be useful to collect data on the frequency of transfers to and from hospitals to get a better understanding of how well hospitals are meeting the needs of the community. Often it is the sickest of the sick who are transferred. Members agreed that EMTALA transfer patients should not be included in the overall quality data on hospitals that is reported online.

Recommendation

The On-Call Subcommittee recommends developing a database for EMTALA transfers that will give future evaluators a better understanding of how the system is working.

4) Continuous Call. The question remains whether CMS should prohibit involuntary continuous call. Previous surveys have revealed that about one third of the neurosurgeons across the country are forced to take continuous call, sometimes for weeks at a time.

5) Tag A 404, §489.24(j)(1): Referral of Patients to the Emergency Department to the On-Call Physicians Office.

This issue was discussed at the September 2006 conference call but it did not make it to the TAG agenda. The Interpretive Guidelines (at page 24 of the State Operations Manual) state that it is "generally not acceptable" for a physician on call to have emergency cases referred to his or her office for examination. The On-Call Subcommittee believes there are situations in which a patient in the emergency department is considered by the treating physician to be stable for travel to the specialist physician's office for treatment. Revising the Interpretive Guidelines to allow such referrals, the Committee opines, may encourage more specialists to take call. There clearly are subsets of patients which can be cared for in this manner. The Committee has asserted that the emergency physician must notify the on-call doctor and the referral must be irrespective of the patient's ability to pay.

6) Specialized Capabilities.

The subcommittee's impression is that the situation regarding hospitals and specialized capabilities is becoming untenable. Dr. Kusske was informed of a hospital in Idaho that was facing CMS sanctions because it refused to accept transfers from a hospital well beyond its catchment area with which it had no relationship. It is noted that under present regulations no geographic boundaries are applicable to specialized capabilities requirements. Furthermore regional offices are not required to consider the fairness and appropriateness of a transfer from the perspective of the receiving hospital.
The subcommittee recommended that the TAG discuss:

• Whether geographic limitations should apply to transfers to hospitals with specialized capabilities.

• Whether transferring hospitals should alert recipient hospitals of potential transfers (for a patient who may need specialty care) or of the lack of specialty coverage at the transferring hospital (in case patients come to the transferring hospital in need of that specialty coverage).

• Whether notification should be part of the specialized capabilities requirement.

• Whether other, less punitive mechanism can be used to enforce EMTALA regulations and prevent potential violations.

• Whether CMS should provide more written guidance on the specialized capabilities requirement.

Dr. Tuggle said that this speaks to need for regionalization of emergency services and said that the presumption that services exist in all or most counties is incorrect.

3) New Business

A) Tag A411 42 CFR §489.24(f) and Interpretive Guidelines §489.24(e). Also USC 1395dd(g). See also TAG A406 §489.24(a)(ii) and Interpretive Guideline §489.24(a)(1)(ii) and TAG A407 Interpretive Guidelines §489.24(d)(2)(i).

The TAG has been asked if the statute and the regulation cited place any obligation upon a hospital with specialized capabilities or facilities to accept the transfer from another hospital of an inpatient who requires specialized capabilities or facilities. See Appendix A with letter from Mr. Edward L Burr to Ms. Elizabeth Jacobson, CMS Region 4 and a response from Marilyn Dahl to Mr. Burr.

Mr. Burr in his letter asks:
"My question is whether 1395dd(g) and 489.24(f) place any obligation upon a hospital with specialized capabilities or facilities to accept the transfer from another hospital of an inpatient who requires those specialized capabilities or facilities."
And further:
"The rationale for CMS's conclusion that it was appropriate to interpret a good faith hospital inpatient admission as terminating the obligations of the presenting hospital

under EMTALA clearly is inconsistent with the assertion that an inpatient admission at the presenting hospital eliminates the obligations placed by EMTALA upon hospitals with specialized capabilities or facilities. CMS concluded that inpatient admission was a reasonable termination event for EMTALA obligations because the admitting hospital remained compelled by Medicare COPs to provide appropriate treatment to its inpatients. It seems unlikely that CMS intended the September, 2003 final rule to simply eliminate, without comment or rationale, any obligation, other than a moral one, of specialized hospitals to come to the assistance of those individuals whose treatment needs are beyond the capabilities of the hospitals to which they have been admitted."

The Subcommittee has been asked to formulate guidance regarding this issue.

Interpretive Guideline §489.24(a)(1)(ii) states that: "EMTALA does not apply to hospital inpatients. The existing hospital COPs protect individuals who are already patients of a hospital and who experience an EMC. Hospitals that fail to provide treatment to these patients may be subject to further enforcement actions."

A contrary view has been offered by Bitterman.[1] He states that:

- EMTALA will apply to patients admitted through the emergency department and until the presenting EMC is stabilized.
- EMTALA will apply to admitted patients, regardless of where they are in the hospital and regardless of whether they presented through the emergency department, and until the initial presenting EMC is stabilized. The patient's portal of entry to the hospital will be irrelevant.
- EMTALA will apply to inpatients for at least as long as it takes to stabilize the initial presenting EMC. The establishment of a hospital/physician patient relationship will not shorten this stabilization duty, because to do so would render the federal statute nugatory. The instant a patient is seen by a physician, either in the emergency department or in the inpatient setting, this legal relationship is established. And if EMTALA were to cut off at that point, the stabilization and transfer duties of the law would *never* apply."

He further states: "As the 6th Circuit once stated: "The words of the statute are quite plain, and to interpret them as such does not lead to an absurd result. It leads to a result considerably broader than one might think Congress should've intended, or perhaps than any or all individual members of Congress were cognizant of. However, it is not our place to rewrite statutes to conform with our notions of efficiency or rationality. That is the job of Congress."

And finally on this issue Bitterman states: "Expanding EMTALA stabilization and transfer provisions to inpatients is far beyond anything Congress intended and significantly expands the duties and potential civil and regulatory liability of hospitals."

[1] Bitterman, RA. Providing Emergency Care Under Federal Law: EMTALA. American College of Emergency Physicians, Dallas, Texas, 2000 at p 73.

APPENDIX 3

9/18/07

Dear Mr. Chairman:

On September 18, 2007 the EMTALA TAG voted to recommend that the regulation's "Duty to Accept Patient Transfers" apply to hospital inpatients admitted from the Emergency Department who have not yet been stabilized.

We two physician members of the TAG who voted for the recommendation feel that its implementation should be carefully considered as having potential for abuse (ie. patient dumping). It is our well considered opinion that the intent of the recommendation is to assist in the transfer of patients requiring a higher level of care with no consideration of their ability to pay for services. This we strongly support.

We fear that the potentially unintended consequence may be the transfer of EMTALA patients for reasons other than those related to emergency care of the problem for which the patient was originally admitted when these services could have been provided at the sending hospital.

Mark D. Pearlmutter M

MARK D. PEARLMUTTER

Michael J. Rosenberg MD

MICHAEL J. ROSENBERG

9/18/2007

Dear Mr. Chairman:

On September 1[illegible], 2007 the EMTALA TAG voted to recommend that the regulation's Duty to Accept Patient Transfers apply to hospital inpatients admitted from the Emergency Department who have not yet been stabilized. We are very concerned that this recommendation, if implemented, will adversely affect patient care and potentially increase the number of unnecessary patient transfers.

All of the practicing surgical specialty physician representatives as well as all of the hospital representatives of the TAG are in opposition to this recommendation.

With due consideration to our colleagues on the TAG we respectfully wish to formally record our dissent

James Nepola

Richard Perry

Julie M. Nelson

James L. Biddle

Rory S. Jaffe

Rachel Seifert

DAVID W. Tuggle M.D.
(proxy)

John Kusske

APPENDIX 5

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Via Electronic Transmission

July 30, 2007

David Seigel, M.D
Chairman, EMTALA Technical Advisory Group

Julie Nelson, J.D.
Chair, Action Subcommittee

John A. Kusske, M.D.
Chair, On-Call Subcommittee

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Requirements of Recipient Hospitals

Dear Dr. Siegel, Dr. Kusske and Ms. Nelson:

Thank you for the opportunity to provide comments to the EMTALA TAG. Catholic Health Initiatives is a faith-based, mission-driven health system that includes approximately 70 hospitals, 42 long-term care, assisted-living and residential units, and two community health service organizations in 19 states. The sizes of CHI's hospitals range from multi-campus regional hospitals to extremely small critical access hospitals. CHI's hospitals are located in CMS Regions 3, 4, 5, 6, 7, 8 and 10. EMTALA education and compliance is a priority for CHI hospitals. We have provided prior comments to TAG and very much appreciate the consideration of those comments. Our comments reflect the concern of physicians from the Medical Staffs of hospitals within our system which are experiencing patient care difficulties as a result of recent EMTALA enforcement.

Duty to Accept Transfers

We appreciate the improvements and clarifications to the Duties of the Transferring and Recipient Hospitals as reflected in Appendix 2 of TAG Report No. 6 with the revisions recommended by TAG. However, we continue to have concerns about the lack of clarity regarding the amount of clinical discretion and medical decision making to be exercised by the potential recipient hospital. CMS enforcement actions by some Regional Offices have imposed a standard to "accept all patients, then assess and re-transfer for definitive care if necessary" on some hospitals in our system. These hospitals are larger community hospitals with more resources than the smaller, rural hospitals surrounding them, but without the resources to serve as tertiary care referral centers for large areas of the state or

even from other states. The standard imposed on these hospitals through enforcement by the CMS Regional Offices requires them to accept requests for transfers even when:
(1) the physician (ED or on call specialist) at the recipient hospital believes the patient is stable or that the sending hospital will be able to provide the necessary stabilizing treatment within the appropriate window of time obviating the need for transfer;
(2) the physician at the recipient hospital believes that the patient would be better served clinically by transfer to another facility (i.e., a hospital with a higher level of trauma care or a hospital that can provide the likely follow up care once the EMC is stabilized);
(3) the transfer of the patient would substantially burden a specific specialty at the recipient hospital (e.g., acceptance of the patient would result in cancellation or delay of scheduled surgeries or the unavailability of an on-call physician to patients presenting to the recipient hospital's ED); or
(4) based on the information provided by the transferring hospital, the recipient hospital is unsure whether the hospital has the appropriate resources (including whether the on call physician has the necessary scope of clinical privileges or clinical competence) to treat the patient's condition.

When a request for a transfer is received, the inability of the ED or on-call physician to decline the transfer for the reasons noted above without threat of an investigation for violating sec. 489.24(f) results in delays in the patient receiving definitive care at the most appropriate facility, subsequent transfers of the patient from the receiving hospital to another hospital that can provide appropriate post-stabilizing care, the inability of hospitals to manage their available resources to treat the patients from their own communities who present to the ED, disruption to the care of patients already in the recipient hospital, the dissatisfaction and frustration of on call physicians whose private practices are unreasonably disrupted and who may be called upon to accept a patient for who they are not the most appropriate treating physician. We recognize that in extreme circumstances (e.g., due to very limited capabilities at the sending hospital or an unusual event that has taxed their capacity) it is necessary to accept a patient for the sole purpose of providing stabilizing treatment and then sending that patient on to a higher level of care. However, those circumstances constitute a small percentage of the requests for transfer received by our medium sized to larger community hospitals.

This problem has become particularly acute with regard to orthopaedic cases as smaller hospitals increasingly lack orthopaedic on call coverage (either due to the lack of physicians or the refusal of the orthopaedists on staff to provide adequate call coverage), have fewer orthopaedic physicians accept trauma cases, and have more orthopaedic surgeons choose to subspecialize (e.g., hands, spines, sports medicine) rather than practice general orthopaedics. This last situation has significantly increased the burden on medium sized and somewhat larger community hospitals, because even though the orthopaedic surgeon(s) at the smaller facility have the training to temporize the orthopaedic injury, they refuse to do so based on being sub-specialized beyond their baseline orthopaedic training. The result is a transfer for the physician's convenience, not due to a specific orthopaedic need the physician the physician is unable to provide.

Item 5 of the Duties of the Transferring Hospital provides sole discretion to the treating physician as to whether the receiving hospital has the capability to treat the patient. Furthermore, the Teaching Points in Item 5 ("(1) When in doubt accept patient transfers; and (2) when question [sic] regarding appropriateness of transfer, encourage communication with transferring hospital or EMTALA report, as required by law") reinforce the lack of discretion on the part of the receiving hospital regarding acceptance of the transfer. In many cases, it is this concept of "when in doubt" that becomes the vehicle by which smaller hospitals (and in some cases, equivalent hospitals) directly shift the burden of uninsured trauma patients to the medium and larger community hospital facilities.

The purpose of EMTALA is to provide access to emergency treatment to patients regardless of payer source. Allowing a hospital to exercise discretion about accepting transfers based on operational and clinical factors, but obviously not payer source, fulfills the intent of the statute.

We think these recommendations address the need of smaller hospitals (of which we have many in our system) to have available hospitals to take in transfer patients whom they cannot treat while allowing potential recipient hospitals, in conjunction with the members of the Medical Staff providing on-call services, to efficiently manage the available resources of the hospital and meet the clinical needs of all patients.

Recommendations

Item 5 of the Duties of the Transferring Hospital should be revised as follows:

> The determination of whether the patient is unstable, requires a higher level of care, the transferring hospital has the capability to provide stabilizing treatment, and whether the intended recipient hospital has the appropriate capabilities and capacity to provide definitive care to the patient shall be made only after consultation with and concurrence by the physicians (ED or on call physician) at the recipient hospital. Transfers made without the concurrence of the recipient hospital may be subject to report by the recipient hospital and review by CMS surveyors.

Item 7 of the Duties of the Transferring Hospital should be revised to include the following:

> "The transferring physician should seek to arrange transfer to a hospital with a high enough level of care to or specialized capabilities to provide definitive care to the patient to minimize subsequent transfers of the patient."

Item 4 of the Duties of Receiving Hospitals should be revised to include the following:

> "Except in circumstances in which the sending hospital completely lacks the capacity to provide the necessary stabilizing care and the window of

opportunity for stabilizing a patient's condition precludes a transfer to a hospital that can provide both stabilizing and definitive care, a recipient hospital has an obligation to accept only those patients in transfer to whom it can provide definitive care. A recipient hospital is not obligated to accept a patient if, in the clinical judgment of the ED physician or available on-call physician, the patient will require a subsequent transfer to a hospital with a higher level of care or specialized capabilities which can provide definitive care to the patient."

Item 8 of the Duties of Receiving Hospitals should be revised to include the following:

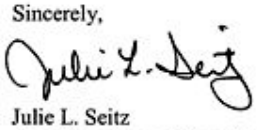
"Specialized capabilities include the privileges of the available on-call physicians. Although on-call physicians are generally expected to provide services within the scope of their privileges, professional judgment based on the patient's potential clinical needs may be exercised by the on call physician in consultation with the ED physicians/staff and the transferring hospital physicians/staff in determining whether to accept a patient in transfer."

The definition of "capacity" should be revised to read:

"A potential recipient hospital with specialized capabilities is not deemed to have the capacity to accept a patient in transfer when receipt of the patient would cause the hospital to operate beyond its licensed capacity, violate other legal requirements, or cause substantial disruption to the hospital's overall ability to provide care to its current inpatients, outpatients, or ED patients or cause substantial disruption to the patients currently in need of the specialized capability requested. Recipient hospitals with specialized capabilities are not required to accept in transfer for admission patients who would not otherwise meet admission criteria for the specialized services needed."

Again, thank you for the opportunity to provide comments. If you have any questions or would like to discuss further, please feel free to contact me.

Sincerely,



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APPENDIX 6
DUTIES OF HOSPITALS WITH SPECIALIZED CAPABILITIES TO ACCEPT PATIENT TRANSFERS

CURRENT RULE:

42 U.S.C. § 1395dd(g); 42 C.F.R. § 489.24(f)
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) 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.

EMTALA Interpretive Guidelines, Tag A411 (see Interpretive Guidelines, page 53-54)

NEED FOR CHANGE:

Hospitals and physicians have expressed confusion with respect to their duty to accept patient transfers and there has been relatively little guidance on this subject. The term "specialized capabilities" is not clearly defined. In addition, the current interpretation is subject to abuse, which has resulted in improper transfers.

RECOMMENDATION:

The Action Subcommittee recommends that the Interpretive Guidelines with respect to a hospital's duty to accept patient transfers if it has specialized capabilities be replaced with language that more clearly reflect the responsibilities of both the transferring and receiving hospital, as follows:

DUTIES OF TRANSFERRING HOSPITAL*
1. Maintain a call list that best meets the needs of hospital patients. While the duty to maintain an on call list is a Medicare Provider Agreement requirement, transfers based on lack of on-call coverage in a specialty may trigger a review of the transferring hospital's compliance with this provider agreement requirement. For example, transfers out for conditions hospital normally capable of handling may suggest inadequate call list, as will an increased number of transfers on weekends, vs. weekdays.
2. Provide appropriate medical screening examination and stabilizing care within the transferring hospital's capabilities prior to transfer, in accordance with 42 C.F.R. 489.24(d)(1) and (e)(2)(i). The extent of the medical screening examination and stabilization will depend on the patient's needs and the hospital's capabilities. When determining a hospital's capabilities, the critical question is whether the hospital has the capabilities to provide the services that are necessary to stabilize the patient's emergency medical condition. It would not be acceptable for a hospital to transfer a

DUTIES OF TRANSFERRING HOSPITAL*
patient solely because it does not have certain capabilities that the patient requires for definitive care, but are not essential to stabilize the patient's emergency medical condition. When the hospital does not have the capability to completely stabilize the patient's emergency medical condition, the hospital must complete necessary stabilizing steps within its capability unless doing so would cause harm to the patient in the best judgment of the physician. The treating physician at the transferring hospital determines the stabilizing steps necessary within the hospital's capability given the patient's medical condition.
3. The physician's decision as to whether or not to transfer may not be based on insurance status/financial means (number of transfers of patients without insurance evidences possible abusive transfers.). Patients may request transfer based upon insurance/financial reasons, but the hospital should not present financial information to the patient in a manner that would discourage the patient from receiving stabilizing care from the hospital. If a patient requests transfer, the hospital must comply with the EMTALA requirements for patient requests for transfer set forth in 42 C.F.R. § 489.24, which includes a requirement to inform the patient of the risks and benefits of the transfer decision. *[The EMTALA TAG recommends that CMS review its position on transfers based on state and community protocols (e.g., psychiatric patients who are a part of a state-wide psychiatric program based on indigent status).]*
4. The transfer must be an appropriate transfer, *i.e.*, the transferring hospital lacks the capacity or capability to stabilize the patient's unstable emergency medical condition (EMC) or to perform a complete medical screening examination (MSE).
5. The determination of whether patient is unstable, requires a higher level of care, and whether the transferring hospital has the capability to provide stabilizing treatment, the treating physician's judgment rules, but may be questioned later by receiving hospital and reviewed by CMS surveyors for potential abusive transfer decisions. *[Teaching points:* *(1) when in doubt, accept patient transfers;* *(2) when question regarding appropriateness of transfer, encourage communication with transferring hospital or EMTALA report, as required by law.]*
6. In determining whether the transferring hospital has the capabilities to provide stabilizing care to the patient, surveyors look at whether the hospital has the capability to treat the individual patient within the patient's "window" for required emergency care. Availability of additional care that will be or may be required once the patient's emergency medical condition is stabilized is not a basis for determining that the hospital lacked the capability to stabilize the patient's EMC. This recommendation is intended to prevent hospitals that typically have the capability to stabilize a particular emergency medical condition (*e.g.*, appendectomy) from transferring patients to another hospital simply because the hospital currently does not have the on-call physician resources or equipment to stabilize the patient's medical condition, but when the hospital's resources are likely to be available within the timeframe necessary to stabilize the patient's emergency medical condition. This recommendation is not intended to delay the care and treatment for patients who must be treated immediately, when the hospital does not have the capability to stabilize the

DUTIES OF TRANSFERRING HOSPITAL*
patient's medical condition immediately.
7. The transferring physician must take into account the distance that the patient will travel in his/her certification that the benefits of the transfer outweigh the risks. If the transfer destination is outside of the hospital's local region, the transferring hospital must attempt to transfer patients to the nearest appropriate hospital with the specialized capabilities to stabilize the patient's emergency medical condition, consistent with the patient's health care needs. Transfers over great distances in which closer, appropriate hospitals are bypassed may violate EMTALA. This provision does not apply to established pre-determined transfer arrangements designed to meet patient care needs. In determining the appropriateness of the transfer, surveyors will take into account the distance, hospital availability, and patient's needs.

DUTIES OF RECEIVING HOSPITAL
1. No obligation to accept hospital inpatients that were not admitted through the emergency department. An emergency medical condition arising after admission does not trigger EMTALA obligations. The TAG recommends that the duty to accept apply to hospital inpatients admitted from the emergency department if the initial emergency medical condition has not yet been stabilized. *[Note: This recommendation was controversial, narrowly passing 10-8.]* *[Consider imposing a requirement in the Medicare Conditions of Participation to protect inpatients with emergency medical conditions.]*
2. Only required to accept emergency department patient transfers when the transferring hospital does not have the capability to stabilize the patient's emergency medical condition. In other words, a hospital is not required to accept a patient transfer simply because the patient would like to be transferred to the receiving hospital. The physician must certify that the transfer is necessary because the transferring hospital does not have the capability to stabilize the patient's emergency medical condition and the benefits of the transfer outweigh the risks, consistent with the physician certification requirements set forth in 42 C.F.R. § 489.24(e)(1)(B).
3. No obligation to accept if the only basis for the transfer is patient request (must be physician certified of higher level of care).
4. In determining whether the receiving hospital has the capacity to accept the transfer, surveyors look at whether the hospital has the capacity to treat the individual patient within the patient's "window" for required emergency care. If a receiving hospital has demonstrated the ability to accommodate additional patients by whatever means (*e.g.*, moving patients to other units, calling in additional staff, borrowing equipment from other facilities), it has demonstrated the ability to operate in an overcapacity situation and the receiving hospital would be obligated to accept the patient transfer. However, if receipt of the additional patient would cause

DUTIES OF RECEIVING HOSPITAL
the hospital to operate beyond its licensed capacity or otherwise violate law or regulation, it does not have capacity to accept the individual patient. This requirement is consistent with the current EMTALA Interpretive Guidelines, Tag A411.
5. Receiving hospital may provide advice regarding stabilizing care or transport options, as long as these communications do not unduly discourage patient care, but the transferring hospital is not required to accept the receiving hospital's recommendation. *[possible medical liability impact, depending on state law.]*
6. Receiving hospitals should have systems in place to communicate with admissions staff and on call physicians to confirm that they have the capacity and capability to provide stabilizing care to the patient before accepting a patient. Receiving hospital must make the decision as to whether it will accept/reject transfer within a "timely" manner, based on the patient's condition as reported by the transferring hospital.
7. Duty to report improper transfers, which includes abuses of this provision, in accordance with 42 C.F.R. § 489.20(m).
8. "Specialized capabilities" includes dedicated units, specialized equipment and personnel (including on call physicians) available at the time of transfer or that will be available within the patient's treatment "window." Specialized capabilities do not include medical staff members who are not on call. This duty does not exclude the duty to maintain a list of on-call physicians. *[Subject to TAG recommendations regarding whether an on-call physician is a specialized capability.]*
9. Failure to accept an unstable patient who requires the hospital's specialized capabilities available at the time of transfer may be an EMTALA violation if the hospital has the capacity to accept the transfer.

APPENDIX 7

EMTALA and Disparities in the U.S. Health Care System

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EMTALA and Disparities in the U.S. Health Care System

ABSTRACT

This paper examines how disparities in health care affect hospitals' and providers' ability to comply with the Emergency Medical Treatment and Active Labor Act and provide universal access to emergency care. First, we examine the characteristics of the uninsured as well as the social/political climate surrounding EMTALA. We next examine the causes of disparities in emergency care, paying particular attention to the issues affecting ED utilization, capacity, and provider reimbursement. Third, we look at factors contributing to healthcare disparities experienced by different uninsured populations, such as provider/patient biases and stereotyping, patient preferences, system and organizational level factors, communication barriers, and cultural sensitivity/competence and social constructs. Finally, we identify areas for further study to inform key stakeholders about changes that may be helpful in ensuring health care institutions and clinicians can continue to provide care under EMTALA.

INTRODUCTION

From its inception in 1985, the Emergency Medical Treatment and Labor Act (EMTALA) was intended to protect the indigent and uninsured from unequal or indifferent emergency medical practices.[1] The literature examined for this report will demonstrate that disparities in health care persist across many medical specialties, including emergency care. Designed to diminish these disparities, this statute provides access to emergency medical care through mandatory screening and by requiring any treatment necessary to stabilize treatment for every emergency medical patient in need of such services, regardless of insurance status. The question begs to be answered, how far have we come in decreasing disparities in the quality of emergency decreasing disparities in quality of emergency medical care since the passage of EMTALA was enacted?

In addressing this question, we explore social and ethical considerations pertaining to the continued existence of disparities in health care. We also show that the statute established legal obligations for the provision of a minimum standard of services for emergency healthcare to every patient regardless of gender, insurance status, income, citizenship, legal status, and race/ethnicity. The report delineates in great detail the population of concern and how the changes in insurance status and emergency department (ED) utilization as well as capacity exacerbate disparities in health care.

EMTALA seeks to expand has access to care for all patients regardless of insurance and health status but our literature review establishes that limited access is only one of many factors that contribute to the differences in provision of health care and treatment outcome. Patient and provider stereotypes as well as training and practice constraints are significant factors in the perpetuation of disparities. Other culprits include shortcomings in the organization and delivery of health care. We discuss a myriad of

[1] Hubler, J. (2001). Guidelines, developments, and recent court opinions. *ED Legal Letter*, 12(11): 125.

underlying causes for disparate treatment that affect the delivery of EMTALA-related services. This report provides evidence that EMTALA's scope should be increased to alleviate a much broader spectrum of disparities beyond access to care that continue to plague the delivery of healthcare. Finally, the report provides recommendations to increase EMTALA's potential to eliminate disparities in emergency medical treatment.

SOCIAL/POLITICAL CLIMATE SURROUNDING EMTALA

Many health services researchers have suggested that racial and ethnic minorities receive lower quality care than non-minorities. These trends continue even when controlling for socioeconomic indicators, such as access to healthcare services and income. Various sources of scientific literature have also sought to define this problem of unequal treatment but recent surveys have found that a majority of respondents continue to believe that blacks receive the same quality of care as non-minorities.[2] The existence of disparities in the delivery of health services and in health outcomes presents an ethical problem of great social significance.

Ethical theorist Norman Daniels believes that health is in fact central to every person's right of equal opportunity, and society is thus obliged to cultivate a communal structure that eschews inequalities of health and treatment.[3] Madison Powers and Ruth Faden have also examined in great detail the moral implications for physicians and the healthcare system.[4] They discuss ethical and moral reasoning to outline an agreement across several ethical theories that inequalities in health services received and health outcomes along racial lines are unjust. An Institute of Medicine (IOM) report, *Unequal*

[2] Lillie-Blanton M, Brodie M, Rowland D, Altman D, McIntosh M (2000). Race, Ethnicity, and the Health Care System: Public Perceptions and Experiences. Medical Care Research and Review. Volume 57 (Supplement 1), p. 218-235.
[3] Smedley BD, Stith AY, Nelson AR (eds). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academy Press, 2003, p 764; recommendation 8-1, pp 242–243.
[4] Ibid.

Treatment, concurs and concludes that race and ethnicity are morally irrelevant in the distribution of health care services and their outcomes.[5]

Projections by the U.S. Census Bureau predict that demographic changes over the coming decades will fundamentally affect the American healthcare landscape. According to the census data, if current trends continue, then almost half the population will be members of minority groups.[6] The changes in the composition of our nation draw even greater attention to current healthcare disparities and the need for providing equal quality healthcare to all Americans.[7] Minority populations are of particular interest due to their disproportionate representation among the poor and uninsured.[8]

In response to social concerns, Medicare and Medicaid were created in 1965 under the Social Security Act to provide healthcare to the most vulnerable populations: the indigent, the uninsured, and the elderly. The programs have undergone many regulatory changes to provide more people with necessary healthcare.[9] Yet even as nearly ninety-eight percent of all healthcare providers participate in these programs, the federal and state governments' importance and scope in providing healthcare to those in need continues to expand (e.g., the creation of the State Children's Health Insurance

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[5] Ibid.
[6] Lavizzo-Mourey R, Mackenzie ER (1996). Cultural Competence: essential Measurements of Quality for Managed Care Organizations. Annals of Internal Medicine. Volume 124. Issue 10, p. 919-921.
[7] Mitchell DA, Lassiter SL (2006). Addressing Health Care Disparities and Increasing Workforce Diversity; The Next Step for the Dental, Medical, and Public Health Profession. American Journal of Public Health. Volume 96, p. 2093-2097.
[8] Ibid Lavizzo-Mourey, et. al., 1996; Ibid Smedley, et. al. 2003.
[9] Rosenbaum S (2003). Racial and Ethnic Disparities in Healthcare: Issues in the Design, Structure, and Administration of Federal Health Financing Program Supported Through Direct Public Funding. Institute of Medicine: Unequal Treatment, p. 664-698.

Program (SCHIP), which extends coverage to low-income children, mothers, and even childless women in some states).[10]

Similarly, hospital emergency departments are not immune from these demographic trends. Aware of these trends, Congress passed the Emergency Medical Treatment and Labor Act (EMTALA) in 1986. While EMTALA was enacted to attempt to mitigate treatment and outcome disparities in healthcare, Congress also became concerned with an increasing number of reports that hospital emergency departments were refusing to accept or treat individuals without health insurance coverage. Correspondingly, EMTALA has appeared to have its greatest emphasis centered on overcoming disparities for the uninsured over other vulnerable populations.

The EMTALA statute requires all Medicare-participating hospitals that make emergency medical services available to provide medical examinations and stabilizing services to *all* patients that present themselves to their emergency department. EMTALA specifically prohibits a delay in providing required screening to determine if a medical emergency exists or a delay in stabilization services for a detected emergency in order to inquire about the individual's payment method or insurance status (section 1867h).[11] Further, Congress included specific provisions of the law to combat concerns that medically unstable patients were not being treated appropriately due to reports of situations where treatment was simply not provided and others where patients in unstable condition were transferred improperly, sometimes without the consent of the receiving hospital.[12]

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[10] Government Accounting Office. 2007. *Children's Health Insurance: State Experiences in Implementing SCHIP and Considerations for Reauthorization*. GAO-07-447T (Washington, D.C.: February 2007).
[11] Federal Register/ Vol. 68, No. 174/ Tuesday, September 9, 2003/ Rules and Regulations. 53223.
[12] Ibid. Federal Register, 2003.

Thus, EMTALA was created to protect uninsured and low-income individuals from unequal treatment practices and to ensure a minimum standard of emergency medical treatment.[13] This was to have an effect on racial and ethnic minorities because of their disproportionate representation among the indigent and uninsured. Similarly, this probably would affect HIV/AIDS patients as they are primarily covered by Medicaid, which provides care for roughly 50 percent of adults with AIDS and 90 percent of children with HIV at a cost of about $4 billion annually.[14] Also, EMTALA probably would have an affect on a mental health patient's access to care as it is estimated that these patients make up 6.5 to 8.1 percent of all ED visits, with 70 percent of all ED physicians noting an increase in the number of patients boarding in the ED.[15]

EXPANDING ACCESS – ADDRESSING THE UNINSURED

The need for the "safety net" of care that EMTALA provides uninsured populations is supported by staggering figures of a health insurance coverage crisis in the U.S. In 2006, over 46 million American's lacked health insurance coverage – an over eight million person increase since 2000.[16] And some suggest that an additional 29 million (1999 figure) Americans are underinsured, lacking sufficient coverage for essential medical care.[17]

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[13] Ibid. Hubler, 2001.
[14] Office of the Inspector General. 1998. Work Plan: Health Care Financing Administration Projects Fiscal Year 1998. U.S. Dept. Health and Human Services: Washington, DC. Retrieved March 16, 2007 from http://oig.hhs.gov/reading/workplan/1998/98wpl2.pdf.
[15] IOM. 2006. Hospital-Based Emergency Care: At the Breaking Point. Washington, DC: National Academy Press. 33-34.
[16] Kaiser Family Foundation. 2006. The Uninsured: A Primer. The Kaiser Commission on Medicaid and the Uninsured Issue Brief. November 2006.
[17] O'Brien GM, Stein MD, Fagan MJ, Shapiro MJ, Nasta A. 1999. Enhanced emergency department referral improves primary care access. American Journal of Managed Care 5(10): 1265-1269.

Given this increase, national surveys[18] consistently show the need to base policies on a realistic, data-based analysis of the uninsured. For instance, surveys show that due to public programs such as Medicaid and the State Children's Health Insurance Program (SCHIP), only 17-19% of the uninsured are children.[19] Because low-income adults under age 65 qualify for Medicaid only if they are disabled, pregnant, or have dependent children, adults are disproportionately represented among the uninsured and constitute the large majority, with those 18 to 44 years old making up roughly 60% of the uninsured.[20]

Among working-age low-income adults (less than 200% of the poverty level or $37,620 for a family of four in 2003), three major national surveys estimate that at least two-thirds of non-elderly uninsured adults are employed.[21] Employers are the most common source of health coverage for non-elderly Americans, but many uninsured workers either work for employers who do not offer coverage, cannot afford the coverage that they are offered or choose not to purchase insurance. In 2005, only 60% of employers offered health insurance to their workers, compared to 69% in 2000.[22] About two-thirds of uninsured adults in all three surveys have no college education and more than one-quarter of the uninsured did not graduate from high school. These groups tend to be less able to get high-skill jobs that come with health benefits, and those with less education are also more likely to be uninsured for longer periods.

The uninsured tend to be in worse health than the privately insured. Ten percent

[18] Current Population Survey, the Medical Expenditure Panel Survey, and the National Health Interview Survey
[19] Kaiser Family Foundation. Who are the uninsured? A consistent profile across national surveys. August 2006.
[20].Ibid. KFF, August 2006.
[21] Ibid. KFF, August 2006.
[22] Kaiser Family Foundation. *National Health Interview Survey*. 2006.

of the uninsured are in fair or poor health, compared to 5% of those with private coverage. Almost half of all uninsured non-elderly adults have a chronic condition.[23] Those with such conditions and others who are not in good health may find non-group coverage to be unavailable or unaffordable if they do not have job-based coverage.[24]

These surveys show that half of the uninsured are white (non-Hispanic) and half are racial and ethnic minorities.[25] Minorities are more likely to have lower family incomes, which raises the risk of being uninsured, yet income disparities do not account for all of the racial and ethnic differences in health coverage.[26] Minorities at both lower and higher income levels are more likely to be uninsured than their white counterparts. Uninsured rates are highest among low-income Hispanics who make up about 16% of the non-elderly population, but about 30% of the uninsured.[27]

Similarly, immigration status (whether non-citizen immigrants, naturalized citizens,

or native-born citizens) shows a similar trend in uninsurance rates, with illegal immigrants being the greatest disproportionately represented group among the uninsured. About 90% of illegal immigrants, or about 10 million out of 11.5 million people, do not have medical insurance and routinely use emergency rooms for medical problems, but not at significantly greater rates than uninsured citizens.[28] Yet, illegal immigrant Latino

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[23] Kaiser Commission on Medicaid and the Uninsured. 2003. *Access to Care for the Uninsured*. March 2003

[24]Kaiser Family Foundation. The Uninsured: A Primer. 5. November 2006.

[25] Ibid. KFF. November 2006.

[26] LaVeist TA. Beyond dummy variables and sample selection: what health services researchers ought to know about race as a variable. Health Serv Res. 1994; 29(1):1–16.

[27] Kaiser. Who are the uninsured? A consistent profile across national surveys. August 2006.

[28] Ku, L., Matani, S. 2001. Left Out: Immigrants' Access to Health Care and Insurance. Health Affairs. January/February 2001.

adults use fewer physician services than all adults nationally despite reporting worse health, even regardless of insurance status.[29]

Yet, evidence has accumulated that racial and ethnic minorities experience differential treatment and a lower quality of clinical services even when *presence* in the health system has been achieved.[30] Much of the published literature has been conducted in cardiovascular disease and treatment and scientists concluded that differences are not simply due to different clinical factors associated with disease.[31, 32] Unfortunately, the differences in health continue to exist even after the patient has entered the healthcare system. Socioeconomic status has often been thought to explain many disparities, but work by Peterson and Mayberry has shown that racial and ethnic disparities still remain even after controlling for income, education, and other socioeconomic factors.[33, 34]

ADDITIONAL CAUSES OF DISPARITIES IN EMERGENCY CARE

Beyond the issues affecting ED utilization, capacity, and provider reimbursement, several other issues might also contribute to disparities in the emergency department setting. Provider/patient biases and stereotyping, patient preferences, system and organizational level factors, communication barriers, and cultural sensitivity/competence and social constructs are all factors that may contribute to the healthcare disparities experienced by different uninsured populations.

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[29] Ibid. Ku, L., Matani, S. 2001

[30] Ayanian JZ, Weissman JS, Chasan-Taber S, Epstein AM (1999). Quality of care by race and gender for congestive heart failure and pneumonia. Medical Care. Volume 37, p. 1260-1269.

[31] Peterson ED, Shaw LK, DeLong ER, Pryor DB, Califf RM, Mark DB (1997). Racial Variation in the Use of Coronary-Revascularization Procedures. *The New England Journal of Medicine,* (336): 480-486.

[32] Canto JG, Allison JJ, Kiefe CI, Fincher C, Farmer R, Sekar P, Person S, Weissman NW (2000). Relation of race and Sex to the Use of reperfusion Therapy in Medicare Beneficiaries with Acute Myocardial Infarction. *The New England Journal of Medicine,* (342):1094-1100

[33] Mayberry RM, Mili F, Ofili E (2000). Racial and Ethnic Differences in Access to Medical Care. Medical Care Research and Review. Volume 57 (Supplement 1), p. 108-145.

[34] Peterson ED, Shaw LK, DeLong ER, Pryor DB, Califf RM, Mark DB (1997). Racial Variation in the Use of Coronary-Revascularization Procedures. The New England Journal of Medicine. Volume 336, p. 480-486.

Decline in Hospital ED Capacity/Increased ED Utilization

Between 1993 and 2003, the U.S healthcare system lost 703 hospitals (a decline of nearly 11 percent). Similarly, the number of emergency departments declined by 425 units (9 percent decrease) during the same period.[35] This decline in capacity has been attributed to cost cutting measures, lower reimbursements by managed care, Medicare, and other insurers, and the rise in uncompensated care for uninsured patients.[36] At the same time, emergency department visits increased from 90.3 million to 113.9 million (26% increase), or an average increase of more than 2 million visits per year.[37] With limited access to community-based alternatives to the emergency system (e.g., public clinics, specialists, psychiatric facilities, and other services), many of the uninsured patients have no regular source of care and must turn to emergency departments as a primary source of care or often because conditions have worsened due to lack of care.[38]

Disparities among chest pain patients, including delays in seeking care, emergency department (ED) treatment, hospital admission rates, and subsequent in-hospital therapy, have been well described.[39] [40] [41] [42] [43] Disparities in the administration of

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[35] AHA. 2005. TrendWatch Chartbook 2005. [Online]. Available: http://www.ahapolicyforum.org /ahapolicyforum/trendwatch/chartbook2005.html [accessed January 26, 2007].

[36] Although the numbers of emergency departments and hospitals have declined nationwide, a study by the California Healthcare Foundation found that the total number of beds actually increased in California despite closures.

[37] McCaig LF, Burt CS. 2005. National Hospital Ambulatory Medical Care Survey: 2003 Emergency Department Summary. Hyattsville, MD: National Center for Health Statistics.

[38] Ibid. IOM, 2006.

[39] Ayanian JZ, Udvarhelyi IS, Gatsonis CA, Pashos CL, Epstein AM. 1993. Racial differences in the use of revascularization procedures after coronary angiography. J*AMA,* (269):2642–6

[40] Sheifer SE, Escarce JJ, Schulman KA. Race and sex differences in the management of coronary artery disease. Am Heart J. 2000; 139:848–57.

[41] Bell PD, Hudson S. Equity in the diagnosis of chest pain: race and gender. Am J Health Behav. 2001; 25(1):60–71.

[42] Johnson PA, Lee TH, Cook EF, Rouan GW, Goldman L. Effect of race on the presentation and management of patients with acute chest pain. Ann Intern Med. 1993; 118:593–601.

[43] Ell K, Haywood LJ, deGuzman M, et al. Differential perceptions, behaviors, and motivations among African Americans, Latinos, and whites suspected of heart attacks in two hospital populations. J Assoc Acad Minor Phys. 1995; 6(2):60–9

analgesia in the ED among various ethnic groups have been studied showing that African American and Hispanic patients often are less likely to have received appropriate analgesia than are whites.[44] Access to care is also a factor for African American and Hispanic patients who are more likely to receive their regular care in EDs and less likely to have a primary care physician than white patients.[45] As minorities make up a disproportionate share of the uninsured, consistent differences in access and quality of care received by minorities in many medical specialties have resulted in overall greater mortality.[46]

Carol Hogue and colleagues speculate in their book *Minority Health in America* that the healthcare needs of minority populations are not sufficiently met. They argue that minorities should in fact consume healthcare services in *excess* of non-minorities in accord with their generally lower health status.[47] But survey data does not support that premise and Hogue and associates surmise that this may be due to the barrier of not having a regular care provider.[48] Following this hypothetical framework, it could be inferred that the improved access to emergency medical care by EMTALA might lead minorities to utilize the emergency department as a substitute for primary care. In fact, a study conducted in 2005 found that just over half of care provided in hospital emergency departments was categorized as urgent or emergent (requiring needed care within 15

[44] Todd KH, Deaton C, D'Adamo AP, Goe L. Ethnicity and analgesic practice. Ann Emerg Med. 2000; 35(1):11–6; Todd KH. Pain assessment and ethnicity. Ann Emerg Med. 1996; 27:421–3; Fuentes EF, Kohn MA, Neighbor ML. Lack of association between patient ethnicity or race and fracture analgesia. Acad Emerg Med. 2002; 9:910–5

[45] Hogue CJR, Hargraves MA, Collins KS (eds). Minority Health in America: Findings and Policy Implications from the Commonwealth Fund Minority Health Survey. Baltimore, MD: Johns Hopkins University Press, 2000, p 326.

[46] Ibid. Peterson, et. al., 1997.

[47] Ibid. Hogue, et. al., 2000.

[48] Ibid. Hogue, et. al., 2000.

minutes to one hour of ED arrival).[49] A 2006 IOM report, *Hospital-Based Emergency Care: At the Breaking Point*, notes that "without the ED to fall back on, other community safety net services would be equally overwhelmed. Thus, the emergency care system truly has become the "*safety net of the safety net.*"

This crossroads of trends of lowered emergency department capacity and increased utilization by minority uninsured populations have resulted in 60% of U.S. hospitals reporting operating *at* or *over* capacity.[50] One study found that 91% of emergency departments found overcrowding as a significant problem – with 40% reporting overcrowding occurring daily.[51] The result of this imbalance is overcrowded emergency departments, frequent "boarding" of patients waiting for inpatient beds, diversion of ambulances, and patients who leave without being seen or leave against medical advice.[52]

Similarly, border states such as California and Texas claim that unpaid medical bills---due to EMTALA compliance---that resulted from providing emergency care to uninsured illegal immigrants has contributed to the closure of several hospitals. For example, between 1993 and 2003, 60 hospitals in California alone reportedly were forced to close because of unpaid emergency medical bills. Several other hospitals throughout the state reportedly reduced their staff or the level of service they could provide. These closures and reductions of staff and services occurred even after the 1994 passage of

[49] Ibid. McCaig, et al, 2005.
[50] Lewin Group. 2002. Emergency Department Overload: Growing Crisis. The results of the AHA Survey of Emergency Department (ED) and Hospital Capacity. Washington, DC: AHA.
[51] Derlet R, Richards J, Kravitz R. 2001. Frequent overcrowding in U.S. emergency departments. Academic Emergency Medicine 8(2):151-155.
[52] IOM. 2006.

Proposition 187 - a piece of legislation which requires "publicly-funded health care facilities" to deny care to illegal immigrants and to report them to government officials.[53]

Inadequate Reimbursement

Over a third (35%) of the costs of care received by the full-year uninsured are paid for out-of-pocket.[54] The uninsured are increasingly paying "up front" before services will be rendered. When the uninsured are unable to pay the full medical bill in cash at the time of service, they can sometimes negotiate a payment schedule with a provider, pay with credit cards (typically with high interest rates), or can be turned away in settings outside of the emergency room.[55]

Most of the uninsured who present to hospitals do not receive health services for free or at reduced charge. Instead, some hospitals may charge uninsured patients two to four times what health insurers and public programs actually pay for hospital services.[56] Only about one quarter of low-income uninsured adults (those with incomes under 200% of the poverty line) report they have received care for free or at reduced rates in the past year.[57] As a result, among the non-elderly in 2004, the costs of medical care received by those uninsured for the full year were just over half that of those with insurance - $1,629 compared to $2,975 for the insured.[58]

Although a direct number is hard to calculate, the actual rate of reimbursement for

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[53] Ziv, Tal Ann, Lo, Bernard. Denial of Care to Illegal Immigrants -- Proposition 187 in California. *New England Journal of Medicine*. 1995 332: 1095-1098.
[54] Hadley J and J Holahan. 2004. The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? Kaiser Commission on Medicaid and the Uninsured.Issue Update (# 7084; May).
[55] Asplin B, et al. 2005. Insurance Status and Access to Urgent Ambulatory Care Follow-up Appointments. *Journal of the American Medical Association* 294**(10)**:1248-1254.
[56] Kasper J, T Giovannini, C Hoffman. 2000. Gaining and Losing Health Insurance: Strengthening the Evidence for Efforts on Access to Care and Health Outcomes. *Medical Care Research and Review* 57**(3)**: 298-318.
[57] Ibid. Hadley and Holahan, 2004.
[58] Ibid. Kasper, et. al., (2000).

services provided to these patients is quite low, and they account for a large portion of the losses associated with hospital ED and trauma care.[59] For instance, the Medical Expenditures Panel Survey (MEPS) reveals an increasing divide between charges and payments for emergency services. The survey finds that in 2001 the combined charge for physician and hospital/facility services was $943 (43% increase from 1996), but the average payment was $492 (a 29% increase from 1996).[60]

In 2003, 36% of ED patients had private insurance, 21% were enrolled in Medicaid or SCHIP, and 16% were covered by Medicare – leaving just over 14% either uninsured or self-paying.[61] As some hospitals treat a large number of uninsured patients unable to pay for care, the Centers for Medicare and Medicaid Services (CMS) provides Disproportionate Share Hospitals (DSH) payments to help offset these costs to qualifying hospitals. Similarly, some states provide additional support to emergency and trauma systems through general revenues or special taxes.[62]

Currently, government spending on uncompensated care has not correlated to growth in the number of uninsured. Although financial support for community health centers increased by more than 50% between 2001 and 2004 (from $430 million to $670 million), these expenditures account for less than 3% of total federal spending for uncompensated care.[63] As the number of uninsured increased by 11% between 2001 and 2004, total federal spending on the health care safety net increased by only 1%, leading to a decline in federal spending per uninsured person from an average of $546 in 2001 to

[59] Ibid. IOM, 2006.
[60] Tsai AC, Tamayo-Sarver JH, Cydulka RK, Baker DW. 2003. Characterizing payments for emergency department visits: do the uninsured pay their way? Academic Emergency Medicine 10(5):523-a.
[61] McCaig and Burt, 2005.
[62] Ibid. IOM, 2006.
[63] Ibid. Hadley J, et. al., 2004.

$498 in 2004.[64]

Further, the cost of uncompensated care provided by physicians (estimated at $5 billion in 2001) is neither directly nor indirectly reimbursed by public dollars.[65] Given the fact that EMTALA does not have its own established funding, this pressure and angst experienced by hospitals and physicians has not decreased since EMTALA was passed, but only increased. Financial pressures and time constraints, coupled with changing physician practice patterns, have reportedly contributed to a decline in charity care provided by physicians. The percent that provide charity care fell to 68% in 2004-2005 from 76% in 1996-1997.[66] Regardless, EMTALA prohibits ED physicians from transferring the *charity care* patients from non-economically viable to economically viable hospitals simply for economic reasons.

Provider/Patient Biases and Stereotyping

The eligibility expansions of Medicaid and Medicare, as well as the stipulations under EMTALA, have contributed to improved access to healthcare for the poor and minorities.[67] It was hoped that improved access to healthcare would improve health status. However, studies in other nations with universal coverage have shown that race and socioeconomic status continue to influence outcomes for minorities and the poor even with reduced financial barriers in access to healthcare.[68] As many scholars have noted, it is not enough to simply lower the barriers of access to healthcare - ensuring an

[64] Ibid. Hadley J, et. al., 2004.
[65] Ibid. Hadley J, et. al., 2005.
[66] Cunningham PJ and JH May. 2006. "A Growing Hole in the Safety Net: Physician Charity Care Declines Again." Center for Studying Health Systems Change. Tracking Report.
[67] Ibid. Smedley, et. al., 2003.
[68] Ibid. Smedley, et. al., 2003.

equally effective process of care is paramount. Therefore, continued moral responsibilities exist for health care providers to become culturally competent.[69]

The convergence of two previously mentioned problem streams: emergency department over-utilization/crowding and low reimbursement rates have lead to additional financial pressures and time constraints on hospital emergency departments. These variables have lead to a reported increased reliance on biases and stereotyping in clinical decision-making, and an exacerbation of issues already contributing to reported disparate care including provider cultural competencies, communication barriers, and system wide discriminatory practices.

Health services researchers have developed several theories attempting to explain healthcare disparities along racial and ethnic lines. The IOM's report, *Unequal Treatment*, suggests two levels of discriminatory treatment: intra/interpersonal and system factors. The report defines discrimination as "differences in healthcare that result from biases, prejudices, stereotyping, and uncertainty in clinical communication and decision-making."[70] System factors, such as availability of services, geography, language barriers, and the time and resource constraints of medical services that further add to disparities in access and treatment outcome of healthcare services.

Providers have a role in the creation and propagation of disparities in health care is clear. A 1999 *New England Journal of Medicine* study found that physicians were less likely to refer women and African Americans to cardiac catheterization.[71] This research found that to understand clinical decision-making heuristics, one must understand

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[69] Richardson L (1999). Patients' Rights and Professional Responsibilities: The Moral Case for Cultural Competence. The Mount Sinai Journal of Medicine. Volume 66, p. 267-270.
[70] Ibid. Smedley, et. al., 2003.
[71] Schulman KA, Berlin JA, Harless W, et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. N Engl J Med. 1999; 340:618–26

provider bias, stereotyping, and uncertainty as they relate to decision-making. This article also notes that when they are part of rational pattern recognition, they can contribute to efficient and effective patient care.[72]

Similarly, the results from a recent Harvard study suggests that unconscious biases held by physicians may contribute to racial and ethnic disparities in health care. In this study, trainee doctors in Boston and Atlanta took a computer survey designed to detect implicit and explicit race biases. Participants were also presented with narratives describing the hypothetical case of a 50 year old male experiencing the symptoms of a heart attack. In some instances, the man was white and in others, he was black. Researchers found that doctors whose ratings of blacks were the most negative were also less likely to administer clot busting drugs to black patients.[73] Dr. Alexander Green, the lead author of this study noted that, "It's not a matter of you being a racist. It's really a matter of the way your brain processes information is influenced by things that you've seen, things you've experienced, the way media has presented things."[74]

One explanation for physician behavior is that physicians acquire stereotypes over time to categorize and process information about others. Stereotypes are tools that simplify and explain complex situations and affect interpersonal communication.[75] Uncertainty is inherent in the clinical interaction, and physicians must make decisions based on patient feedback and observations of the patient (e.g., race). Time constraints and prior beliefs influence this clinical decision making process – especially in

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[72] Schulman, et al, 1999.
[73] Green AR, et al. Implicit Bias among Physicians and its Prediction of Thrombolysis Decisions for Black and White Patients. Journal of Internal Medicine. 27 June 2007
[74] Kaiser Family Foundation. "Unconscious Bias Against Blacks Can Contribute to Inferior Care, Study Finds." July 20, 2007. Available at: http://www.kaisernetwork.org/Daily_reports/print_report.cfm?DR_ID=46380&dr_ cat=5
[75] Mackie, DM, et. al. 1996. Social psychological foundations of stereotype formation. In Macraen, et. al. (Eds), Stereotypes and stereotyping (pp.41-78). New York: Guilford Press.

emergency medicine – therefore treatment decisions are influenced by race and ethnicity.[76]

As American social and economic life continues to be ordered by race and ethnicity, these experiences will affect perceptions in the healthcare setting.[77] Physicians do not differ from others in our society as they are also subjected to the multitude of cultures and may be affected by notions of negative stereotypes - many scholarly works indicate that patient race and ethnicity influence physicians' beliefs and expectations.[78,79] Thus, negative stereotypes of disadvantaged social groups also might affect the way doctors interact with these patients.[80]

Similar to providers, patients utilize related heuristics in seeking the care they need.[81] These practices are bidirectional as both patient and physician respond to race and ethnicity and accordingly change (or do not change) the way in which they communicate. The physician's beliefs and attitudes towards the patient as well as the patient's expectations and judgments about the physician are critical components of this interaction. In fact, patient's views and expectations of the healthcare system differ across race, ethnicity and social class. Due to these issues, previous studies have shown

[76] Van Ryn M, Burke J (2000). The effect of patient race and socio-economic status on physicians' perception of patients. Social Science and Medicine. Volume 50, p. 813-828
[77] Williams DR, Braboy Jackson P (2005). Social Sources of Racial Disparities in Health. Health Affairs. Volume 24, p. 325-334.
[78] Schulman KA, et. al. (1999). The Effect of Race and Sex on Physicians' Recommendation for Cardiac Catheterization. The New England Journal of Medicine. Volume 340, p.618-626.
[79] Ibid. Van Ryn and Burke, 2000.
[80] Cooper L, Roter DL (2003). Patient-Provider Communication: The Effect of Race and Ethnicity on Process of Outcomes of Healthcare. The Institute of Medicine: Unequal Treatment, p. 552-593.
[81] Richards C, Lowe R. 2003. Researching Racial and Ethnic Disparities in Emergency Medicine. *Academic Emergency Medicine* 10(11): 1169-1175.

that patients seek out providers of their own race and perceive the quality of care as higher if they receive care from a racially concordant provider.[82]

A 1999 *Social Science and Medicine* study demonstrates that patient behavior could moderate physician's beliefs. This study found that assertive behavior by African American patients resulted in higher standards of care.[83] Because clinical decisions are made with input from both patient and providers, a better understanding of patient-level influences on care also is needed. The 2003 IOM report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, states that "access to care is more than simply achieving patient presence; it also involves enabling their engagement in the process of care."[84]

Patient Preferences

Differences in services received by patients may be due to refusal of care and a lack of adherence and healthcare seeking behavior.[85] A number of reasons for these occurrences may be due to poor cultural matching, mistrust, misunderstandings, poor prior experience, and a lack of knowledge of how to best utilize the healthcare system. Researchers have found that refusal rates are generally small and that differences in patient preferences and care-seeking behavior are unlikely determinants of healthcare disparities. Some literature points to possible pathophysiological differences---functional

[82] Saha S, Komaromy M, Koepsell TD, Bindman AB. Patient–physician racial concordance and the perceived quality and use of health care. Arch Intern Med. 1999; 159:997–1004; Saha S, Taggart SH, Komaromy M, Bindman AB. Do patients choose physicians of their own race? Health Aff (Millwood). 2000; 19(4):76–83.
[83] Krupat E, Irish JT, Kasten LE, Freund KM, Burns RB, Moskowitz MA, McKinlay JB (1999). Patient Assertiveness and physician decision-making among older breast cancer patients. *Social Science and Medicine.* (4):449-457.
[84] Smedley BD, Stith AY, Nelson AR (eds). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academy Press, 2003.
[85] Sedlis SP, Fisher VJ, Tice D, Esposito R, Madmon L, Steinberg EH (1997). Racial differences in performance of invasive cardiac procedures in a Department of Veteran Affairs Medical Center. Journal of Clinical Epidemiology. Volume 50, p. 899-901.

changes that are either related to or result from disease or injury---that may explain the differences in utilization and treatment outcome.[86] The value of this hypothesis is however believed to be insignificant since studies were conducted with equally effective interventions and resulted in clear findings of underutilization patterns that were not explained by clinical features of the disease.[87]

System and Organizational Causes

Further research purports that system and organizational level factors may contribute to healthcare disparities. Financial constraints and an environment of cost containment threatens that "cultural competence as a priority will be subordinated to economic and market incentives."[88] Culturally competent care is sensitive to the many issues related to culture, race, and gender.[89]

The managed care revolution changed the point of service for many minorities from community based organizations specializing in culturally competent care to other provider groups that are less able to handle their specific population needs.[90] Medicaid and Medicare "have literally remade the American healthcare system for minority Americans."[91] Access to healthcare has become easier but disparities persist. The lack of appropriate training and experience with culturally diverse patients limits the effectiveness of the healthcare system. As Andrew Epstein noted in his paper on "the

[86] Dries DL, Exner DV, Gersh BJ, Cooper HA, Carson PE, Domanski MJ (1999). Racial Differences in the Outcome of Left Ventricular Dysfunction. *The New England Journal of Medicine*, (340):609-616.
[87] Ibid. Peterson, et. al., 1997.
[88] Chin JL (2000). Culturally Competent Health Care. Public Health Reports. Volume 115, p. 25-33.
[89] Labun E (1999). Shared Brokering: The Development of a Nurse/Interpreter Partnership. Journal of Immigrant Health. Volume 1, p. 215-222.
[90] Ibid. Lavizzo-Mourey, 1996; Ibid. Chin, 2000.
[91] Ibid. Rosenbaum, 2003.

inevitability of narrow diagnostic focus", physicians and healthcare providers are limited by their knowledge based on their educational and work experience.[92]

Language barriers and the inability of the provider to offer services to facilitate the medical dialogue may severely hamper the process. A *Journal of Immigrant Health* article also stresses the importance of working with "interpreters who are able to interpret both language and culture."[93] In order for the communication to be effective, the complexities of healthcare and culture demand that interpreters understand western medicine and cross-cultural dynamics.[94] Knowledge of language is not enough.

Geographical location and provider type also have an impact on the quality of care received by minorities.[95] How one enters a healthcare institution---whether via an emergency room or via controlled appointment process---may influence the type and scope of care provided.[96] Most research to date has focused on the physician–patient relationship. However, other health care professionals may have a profound influence on patients' behavior and on their perception of the acceptance, or lack of acceptance, that the medical care system offers to them. Not only will the behavior of nurses and social workers affect patients, but also the behavior of support staff such as registration clerks and billing staff may have a profound influence on our patients' perception of the medical

[92] Epstein A (1997). The Inevitability of Narrow Diagnostic Focus and Trust. Risk Management Foundation of the Harvard Medical Institutions Inc. Winter Forum.
[93] Ibid. Labun, 1999.
[94] Ibid. Labun, 1999.
[95] Khan KL, Peterson ML, Harrison ER, Desmond KA, Rogers WH, Rubenstein LV, Brook RH, Keeler EB (1994). Health care for black and poor hospitalized Medicare patients. Journal of the American Medical Association. Volume 271, p. 1169-1174.
[96] DelVecchio-Good M, James C, Good B, Becker AE (2003). The Culture of Medicine and Racial, Ethnic, and Class Disparities in Healthcare. Institute of Medicine: Unequal Treatment. National Academies of Science. Pages: 594-625.

care system.[97] Further research into the role of non-physician healthcare professionals, including nurses, physician assistants, occupational and rehabilitation therapists, mental health professionals (including psychologists, social workers, and marital and family therapists), pharmacists, allied health professionals, as well as non-professional staff in contributing to healthcare disparities should be studied.[98] Ameliorating health disparities must therefore begin with improving the health system.[99]

Communication Barriers and Cultural Sensitivity/Competence

Health beliefs in the clinical care setting may threaten clinical outcomes as well as patient satisfaction. Arthur Kleinman[100] noted the importance of culture in healthcare in the late 1970's. And the racial and ethnic mosaic that is the United States characterizes the great cultural complexity of our society. Thus different cultural perceptions of health and healthcare must be heeded in an attempt to provide equally proficient healthcare to all. The "failure to address the very real issues of cross-cultural communication and variations in health beliefs in the clinical setting certainly threatens patient satisfaction and potentially threatens clinical outcomes."[101] The cultural differences are of particular importance for ethnic minorities that often find themselves in

[97] Richards C, Lowe R. 2003. Researching Racial and Ethnic Disparities in Emergency Medicine. *Academic Emergency Medicine* 10(11): 1169-1175.
[98] Smedley BD, Stith AY, Nelson AR (eds). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academy Press, 2003, p 764; recommendation 8-1, 242–243.
[99] Bell J, Standish M (2005). Communities and Health Policy: A Pathway for Change. Health Affairs. Volume 24, p. 339-342.
[100] Arthur Kleinman is a prominent psychiatrist and professor of medical anthropology and cross-cultural psychiatry at Harvard University.
[101] Ibid. Lavizzo-Mourey, 1996.

race-discordant relationships with physician.[102] The impact of race-discordant relationships was however questioned by findings in which the use of cardiac catheterization was found to be "independent of the race of the physician."[103] However, the preponderance of evidence suggests that race alters physician behavior.[104, 105]

Difficulty understanding the patient may further exacerbate an already difficult interpretive situation. Studies indicate that type and intent of the physician and patient communication differ by race and ethnicity. Conflicting physician-patient communications have shown to contribute to the differences in health outcomes experienced by the patient. Interpreter services in emergency departments have the potential to improve communication. Neither EMTALA nor anyone else currently pays for these language services for uninsured populations. This dilemma may lead to reliance on decisions based that may include preconceived notions about the patient and prior attitudes/beliefs about race and ethnic heritage.[106]

Social differences between provider and patient can lead to communication difficulties. The physician and patient may have completely different expectations from the medical engagement. According to a *Journal of Social Justice* article, a patient's interpretation and expectation of pain differed greatly across ethnic groups and thus completely differed in their presentation of symptoms.[107] Ethnic origin and cultural background contribute not only to the definition of what symptoms are noteworthy, but

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[102] Ibid. Cooper, 2003.
[103] Chen J, Rathore SS, Radford MJ, Wang Y, Krumholz HM (2001). Racial Differences in the use of Cardiac Catherization After Acute Myocardial Infarction. The New England Medical Journal. Volume 344, p. 1443-1449.
[104] Ibid. Schulman, 1999; Ibid. Peterson, 1997.
[105] Canto JG, Allison JJ, Kiefe CI, Fincher C, Farmer R, Sekar P, Person S, Weissman NW (2000). Relation of race and Sex to the Use of reperfusion Therapy in Medicare Beneficiaries with Acute Myocardial Infarction. The New England Journal of Medicine. Volume 342, p. 1094-1100
[106] Ibid. van Ryn, 2000.
[107] Zborowski M (1952). Cultural Components in responses to pain. *Journal of Social Issues, (4):*16-30.

may also be responsible for how symptoms will be presented to the physician.[108] Although appropriate treatment can be tied to the way in which patients presented their pain, non-solicited information is often not offered, and reticence may be taken as an indication of disinterest.[109] Also, the fact that minority status is associated with lower report of participatory visits further diminishes the quality of care received by racial and ethnic populations.

Similarly, sociolinguistic differences among classes may interfere in communication - or aid in encounters where both physician and patient are of congruent social class origin.[110] It has also been found that social upbringing was strongly associated with how physicians related to patients and on therapeutic orientation.[111] The correlation between social class and ethnicity has lead to the evidence that non-minorities have received greater technical and interpersonal quality of care than Hispanics.[112]

An article in *Medical Education* notes that communication regarding drugs with patients of lower social class was less successful as recall of diagnosis, drugs prescribed, advice regarding how often drugs should be taken, and duration of treatment was less than other patients.[113] Unfortunately, most of current medical training does not include any formal training in communication skills.[114] And cultural competence continues to be largely ignored and has not been integral to health profession training.[115] As has been

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[108] Ibid. Cooper, 2003.
[109] Ibid. Zborowski 1952.
[110] Waitzkin H, Waterman B. 1974. The exploitation of illness in capitalist society. New York: Bobbs-Merril.
[111] Hollingshead AB, Redlich FC. 1958. Social class and mental illness. New York: John Wiley & Sons.
[112] Hall JA, Dornan MC. 1988. Meta-analysis of satisfaction with medical care: Description of research domain and analysis of overall satisfaction levels. Social Science & Medicine, (27):637-644
[113] Bain DJ. 1976. Patient knowledge and the content of the consultation in general practice. Medical Education, (11):347-350.
[114] Ibid. Epstein, 1997.
[115] Chin JL (2000). Culturally Competent Health Care. Public Health Reports. Volume 115, p. 25-33.

highlighted here, this lack of skill and awareness diminishes the effectiveness of the medical encounter. Developing culturally competent skills, best understood as the ability to form effective relationships that disregard cultural differences, are critical to improving the quality of care for all Americans. Andrew Epstein exhorts medical care organizations to "support their clinicians with training, systems, and supportive structures."[116]

Medical care has begun to adapt to these new challenges, but initiatives and commitments must become measurable standards and quality indicators to assist in the abatement of disparate treatment.[117] A lack of effort through organizational quality improvement initiatives and race/ethnicity data collection represents a significant problem.[118, 119] Transforming the healthcare system and implementing quality standards that focus on improving the quality of care delivered to the individual patient can mitigate healthcare disparities.[120]

Social Constructs

It has been stated that racial and ethnic minorities receive "less care and poorer quality than their middle-class and educated" counterparts.[121] Healthcare disparities arise out of the social constructs in which they present themselves. The existence of racial and ethnic disparities in health services received and health outcomes is not merely a product

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[116] Ibid. Epstein, 1997.
[117] Green Ar, Betancourt JR, Carillo JE (2002). Integrating Social Factors into Cross-Cultural Medical Education. Academic Medicine. Volume 77, p. 193-197.
[118] Fiscella, K., et. al. 2000. Inequality in Quality: Addressing Socioeconomic, Racial, and Ethnic Disparities in Health Care. *Journal of American Medical Association*, 283(19):2579-2584.
[119] Bierman AS, Lurie N, Scott Collins K, Eisenberg J (2002). Addressing Racial and Ethnic Barriers to Effective Health Care: The Need For Better Data. Health Affairs. Volume 21, p 91-102
[120] Frist W (2005). Overcoming Disparities in U.S. health Care: A broad view of the causes of health disparities can lead to better, more appropriate solutions. Health Affairs. Volume 24, p. 445-451.
[121] Ibid. DelVecchio, 2003.

of the very complex and modern healthcare system but also of the social structure.[122] The United States has a well-documented history of racial and ethnic segregation and the disparate provision of healthcare and its consequences on the health of racial and ethnic minorities is an extension of these social practices in the historical development of the nation. Thus our efforts to eradicate disparities in access to health services and health outcomes through efforts like EMTALA show our conflicting beliefs that these disparities should not exist versus the reality that they continue to linger. [123]

Numerous social sources of racial disparities in health exist. Community-based research has been conducted to study social characteristics that initiate and perpetuate racial disparities in health. Policy initiatives that address socioeconomic status and community dynamics are critical in "ameliorating the underlying forces at the heart of the determinants of health."[124] EMTALA, Medicaid, and Medicare have begun this transformation but there is a need for continued discussion and collaborative action to better understand the factors in the delivery of healthcare.[125]

Psychological Issues

Although EMTALA has contributed to the reduction of disparities in care by requiring non discrimination processes for screening and stabilization at emergency departments, it may also be worth exploring the more subtle contributors behind the actual access to these emergency services. For example, typical EMS point of entry

[122] Ibid. Frist, 2005.
[123] Ibid. Smedley, et. al., 2003.
[124] Ibid. Bell, 2005.
[125] Van Ryn M, Burgess D, Malat J, Griffin J (2006). Physicians' Perceptions of Patients' Social and Behavioral Characteristics and Race Disparities in Treatment Recommendations for Men with Coronary Artery Disease. American Journal of Public Health. Volume 96, p. 351-357.

protocols determine the "most appropriate" hospital based on a patient's clinical presentation alone (e.g. suspected acute MI to cardiac facilities, major trauma to trauma centers, and critically ill children to pediatric hospitals). However, individuals with mental health or behavioral emergencies, may be directed to particular facilities not only on a basis of clinical presentation, but also insurance coverage by local or state guidance, which determines what facilities are available for screening and placement for psychiatric emergencies.

Before a psychiatric evaluation can be conducted, an individual's insurance influences the level of medical screening that they must receive. Although medical screenings are an important way of ensuring that psychiatric patients do not have an underlying cause for there presenting symptoms, such screenings can delay the psychiatric evaluation of individuals who are low medical risks.[126] Individuals who lack insurance (or with state sponsored insurance) who require inpatient level care are often sent to 'contracted' hospitals where intake coordinators mandate a comprehensive batter of predetermined test (and images) regardless of a patients clinical presentation. These tests are not always obtained if an individual with insurance presents a health or behavioral emergency to an emergency department that has an inpatient psychiatric unit.

An individual's insurance coverage as well as whether or not there are on-site psychiatric evaluators available might also affect how long it takes for an individual with a mental health or behavioral emergency to be evaluated. Some EDs outsource all of their psychiatric evaluations to mobile crisis teams. In this case, disparities in treatment may or may not occur as it could take equally as long for a mobile clinician to arrive at a

[126] See MACEP's and ACEP's clinical guidelines on low medical risk and medical screening exam

hospital in order to conduct an evaluation as it would for the on-site evaluator if the hospital has limited mental health staffing. Some hospitals use a combination of both on-site and mobile crisis clinicians. An individuals' type of insurance coverage determines by whom they are evaluated. As a result, a two tiered system exists where patients could experience delays in evaluation, treatment recommendations, and assessment methodologies. Ultimately, these factors could have negative affects on individuals' access to services that they need to treat their condition.

After being evaluated, a mental health patient's insurance might cause disparities in regards to the patient's treatment plan and in what type of setting this will occur. If the patient has insurance, there is a greater likelihood that an inpatient bed will be more immediately available. In addition, for those patients who lack insurance coverage, lower cost treatment alternatives may be considered. This patient might be admitted to a free patient bed, an outpatient facility, or a Crisis Stabilization Unit (CSU). Whether or not the treatment and care that these patients receive at these facilities is better or worse than the care received at an inpatient facility is unclear. Thus, a more comprehensive review may be warranted for how the treatment of mental health patients in emergency departments contributes to disparity of care.[127]

FURTHER IDEAS FOR CONSIDERATION

The challenges presented herein for overcoming disparities in healthcare are inherent to social change, but the exact mechanisms to ameliorate their contributions remain elusive. EMTALA presents a substantive health policy attempt to alleviate the historical and social injustices that continue to befall the indigent and uninsured and form

[127] Pearlmutter, Mark. Email Response to EMTALA TAG Inquiry. August, 24, 2007.

the basis of disparate or indifferent emergency medical practices. Although studies have shown ED refusals to screen or stabilize still occur despite EMTALA regulation and enforcement, a substantial number of violations reviewed contained no evidence of deliberate denial of care.[128]

A *Patient Education and Counseling* report notes that a patient-centered approach must be adopted if healthcare disparities are to be eliminated.[129] Similarly, this report outlines the importance of institutional and social changes as hallmarks for improved emergency medical services. Access barriers must continue to be lowered while standards of institutionally cultural competent care must be implemented. The implication that differences in treatment and outcome are attributed to unconscious biases in the medical decision-making process does not diminish the moral obligation to identify and neutralize those biases.

The report further outlined an unequal utilization of emergency medical services by the indigent, uninsured, severely ill, and racial/ethnic minorities. This particular emphasis on a culturally and socioeconomically diverse population places a particular burden on EMTALA related services. Emergency departments thus find themselves at the vanguard of an effort to operationalize culturally competent care in the protection of the indigent and uninsured from disparate or indifferent emergency medical practices. Other ideas for overcoming disparities in ED care while helping to sustain the original purpose of EMTALA include:

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[128] Ballard, W., Rich, B., Derlet, R. EMTALA: Two decades later. *Academic Emergency Medicine*. 2004 11: 458. Retrieved March 16, 2007 from http://www.aemj.org/cgi/citmgr?gca=aemj;11/5/458.
[129] Krupat E, et. al. 2000. The practice orientations of physicians and patients: the effect of doctor-patient congruence on satisfaction. *Patient Education and Counseling*, (39):49-59.

1. Raising public and provider awareness of racial/ethnic disparities in care; especially through increased cultural competency training for healthcare providers.
2. Expanding health insurance coverage and access to emergency medical services
3. Improving emergency medical services data collection and monitoring efforts
4. Further investigating causes and possible interventions to reduce disparities
5. Providing for adequate resources to both patients and providers for better communication (e.g., funding mechanism for interpreter services)
6. Improving the quality of care by implementing quality indicators/standards
7. Improving administrative/institutional mechanisms to provide an environment more conducive to sympathetic patient-provider relationships

APPENDIX 8

Impact of EMTALA on Inpatient Bed Capacity and the Emergency Department (ED)

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Impact of EMTALA on Inpatient Bed Capacity and the Emergency Department (ED)

ABSTRACT

This paper examines how the current inpatient bed capacity affects hospitals' and providers' ability to comply with the Emergency Medical Treatment and Labor Act (EMTALA) and provide universal access to emergency care. First, we examine recent trends in ED utilization as well as the effects of ambulance diversion and patient boarding. We next assess how inpatient bed capacity poses particular problems for bed turnover and ambulatory care sensitive conditions. Third, we examine the implications of ED crowding on patients, hospitals, and EMTALA obligations. Finally, we identify areas for further study to identify changes that may be helpful to ensure that health care institutions and clinicians can continue to provide care under EMTALA.

INTRODUCTION

In 1986, the Emergency Medical Treatment and Labor Act (EMTALA) legally established a hospital's duty to provide a medical screening examination to any patient who "comes to the emergency department," to determine if an emergency medical condition is present, and then to stabilize such a condition if it were discovered. Recognizing the burden this additional care could place on hospitals, the regulation stated that each hospital was required to provide screening exams and stabilization care only within the bounds of its capabilities (absolute capacity mediated by occupancy rate, workforce supply and current technical resources).[1] Since EMTALA's enactment, trends in hospital use such as increased reliance on outpatient surgery and care in the home and changes in the manner in which emergency care is delivered have prompted concerns that capacity, or a hospital's ability to accept new patients, has been limited and hospitals' abilities to meet their EMTALA obligations may be compromised. While inpatient capacity is not the sole cause of emergency department crowding, it has been argued that it contributes significantly and merits examination.

One burden on the emergency care system is the increased complexity of illnesses facing hospitals and physicians. According to the Centers for Disease Control (CDC), chronic disease affects 90 million Americans.[2] Chronic disease is disproportionately found in older populations, which has implications for healthcare delivery as the population ages. Americans' life expectancy has increased significantly since 1986 due to improvements in medical technology and care: the Administration on Aging estimated that there were 25.7 million older Americans in 1980; this number has since grown to 35

[1] Emergency Medical Treatment and Active Labor Act, Section 1867a-b, 42 U.S.C. 1395dd.
[2] Centers for Disease Control and Prevention. Chronic Disease Prevention. Available from: http://www.cdc.gov/nccdphp/index.htm

million.[3] Access to primary health services has declined, and the number of uninsured persons has risen steadily since 1986, reaching approximately 46.6 million today.[4] The uninsured may be more likely to present with complex illness when they do seek care.

Changes in medical care itself have placed unanticipated burdens on hospital systems and emergency departments. Innovative technologies such as same-day surgeries and the migration of procedures to outpatient or ambulatory surgery centers have created financial and operational difficulties for managers and have increased the complexity of measuring capacity. Sensitive diagnostic procedures predict diseases earlier and with greater reliability, and "new procedures are increasing the range of treatment options"[5] allowing patients to receive unprecedented levels of care.

The medical system today is significantly different than it was in 1986; changes in medical technology, patient care practices, delivery of services, and the patient population itself demand an evaluation of how these shifts have constrained hospitals' abilities to fulfill their EMTALA obligations. This paper will attempt first to quantify the problem of ED crowding, and then to assess whether hospitals have the ability to absorb the changes described above.

RECENT TRENDS IN EMERGENCY DEPARTMENT (ED) CAPACITY

Emergency department crowding is a readily observable phenomenon; the American College of Emergency Physicians (ACEP) has defined emergency department crowding as a situation where:

> …the identified need for emergency services exceeds available resources for patient care in the emergency department (ED), hospital, or both. Crowding manifests itself in significant delay in evaluation and treatment of emergency patients, boarding of admitted patients in the ED, treating patients in non-treatment areas such as hallways, and patients leaving prior to completion of medical treatment[6]

Emergency department crowding has gained notoriety in the popular media, clinical community, and academic medical literature. Crowding raises serious questions about

[3] Administration on Aging: A profile of older Americans, 2030. Available from http://www.aoa.gov/prof/Statistics/profile/2003/4.asp#figure1
[4] Center on Budget and Policy Priorities. The Number of Uninsured Americans is at an all-time high. August 29 2006. Available from: http://www.cbpp.org/8-29-06health.htm
[5] American Hospital Association. Trendwatch Report. 2001 Nov 3(3): 2-8.
[6] American College of Emergency Physicians. Policy statement: crowding. Available from: http://www.acep.org/webportal/PracticeResources/PolicyStatements/hosp/crowding.htm

hospitals' abilities to treat large numbers of patients, for the quality of patient care, and for the efficiency of hospital use.[7,8]

Despite the widespread perception that crowding is a nationally significant threat to timely emergency care, quantification of the problem has been elusive. National surveys of hospitals have attempted to measure crowding. According to findings from the 2007 American Hospital Association (AHA) Survey of Hospital Leaders, nearly half of emergency departments (EDs) are "at" or "over" capacity[9], and 91% of ED directors identified crowding and patient boarding as a significant problem at their facilities.[10] In an attempt to verify these perceptions, it is important to evaluate the primary indicators of emergency department crowding: ambulance diversion and patient boarding.

Ambulance Diversion

During a typical ambulance diversion, the hospital instructs area ambulances to deliver patients to other nearby hospitals for treatment. Ambulance diversion, labeled by some investigators as the "most useful operational definition and proxy measure of ED crowding[11]," occurs when a hospital determines that its emergency department is operating above its functional capacity or capability; the hospital instructs area ambulances to deliver patients to nearby hospitals for treatment. In some regions of the country hospital emergency departments may be on diversion status 20-50% of the

[7] New York Times "Emergency in the Emergency Rooms" Wednesday, June 21 2006.
[8] Derlet R, Richards J. Overcrowding in Academic Emergency Departments: Complex Causes and Disturbing Effects. Annals of Emergency Medicine, 2000 Jan 35(1): 63-8.
[9] American Hospital Association. "The 2007 State of America's Hospitals – Taking the Pulse." July 2007. Available at: http://www.aha.org/aha/content/2007/PowerPoint/StateofHospitalsChartPack2007.ppt
[10] Schneider S, Zwemer F, Doniger A, Dick R, Czapranski T, and Davis E. Rochester, New York: A Decade of Emergency Department Crowding. Academic Emergency Medicine, 2001 Nov, 8(11): 1044-50.
[11] Asplin B, Magid D, Rhodes K, Solberg L, Lurie N, Camargo C. A Conceptual Model of Emergency Department Crowding. Annals of Emergency Medicine, 2003 Aug 42 (2): 173-80.

time.[12] Moreover, in a recent survey of hospitals in Metropolitan Statistical Areas (MSA), which the US Census Bureau defines as highly integrated population nuclei[13], two thirds of these facilities reported being on diversion status at some point during the previous year, with 10% of responding hospitals indicating that their EDs were on diversion status at least 20% of the time.[14] Finally, according to the AHA's 2007 Survey of Hospital Leaders, of urban hospitals reporting diversion, almost one in eight was on diversion for more than 20% of the time.[15]

Diversion status has serious implications for emergency patients and the community. When ambulances drive farther to deliver emergency patients, the availability of these ambulances to respond to other potential patients decreases, potentially placing all members of the community at risk. Diverting seriously ill patients (patients accessing care via ambulance are likely to be seriously ill) to area hospitals consumes precious time and some have argued places these patients at higher risk for poor outcomes. Diverted patients ultimately receive care, but the practice of diversion raises questions under EMTALA. Establishing how many hours of diversion are acceptable would be impossible; however, the number of hours spent on diversion may provide evidence that ED capacity is significantly compromised. It is important to note that there may be other reasons that EDs are on diversion that are unrelated to ED capacity, such as hospital issues.

Patient Boarding

[12] Ibid. Trzeciak S, Rivers E. 2003.
[13] United Status Census Bureau: Metropolitan statistical areas. Available from: http://quickfacts.census.gov/qfd/meta/long_metro.htm
[14] DeLia D. Emergency Department Utilization and Surge Capacity in New Jersey, 1998-2003. A report to the New Jersey Department of Health and Senior Services. Rutgers Center for State Health Policy, March 2005.
[15] Ibid. American Hospital Association. July 2007.

Once patients arrive at a hospital ED, they may encounter long wait times or may be assessed in non-treatment areas such as hallways due to a lack of available inpatient emergency beds, a practice referred to as "patient boarding." In a 2002 survey, 90% of New Jersey hospitals reported some patient boarding in the previous year, which was defined as an average wait time greater than two hours per patient between initial triage and treatment.[16] In many hospital EDs, patients encounter waiting times that far exceed ACEP's definition of "reasonable period of time." The same survey found that 20% of hospitals reported average wait times of greater than eight hours per patient.[17] Boarding patients in non-treatment areas may compromise a physician's and nursing staff's ability to provide appropriate care as well as the privacy of patients. Consequently, patients may choose to leave a hospital without treatment.

RECENT TRENDS IN ED UTILIZATION

Before attempts to alleviate emergency department crowding can be successful, a more thorough understanding of the problem's causes is needed. The simplest explanation is that emergency department crowding has worsened with increasing utilization of emergency services in the past 25 years. While the demand for emergency services has risen steadily, the actual number of functioning emergency departments has declined nationwide. From 1988 to 1999, the number of EDs decreased 9%[18], which, coupled with an increased need for emergency treatment, has greatly burdened the EDs that remain open.

Absolute Capacity: Number of Inpatient beds

[16] Ibid. DeLia D, March 2005.
[17] Ibid. DeLia D. March 2005.
[18] Ibid.

Inpatient bed capacity is the most frequently cited cause of ED crowding. In his presentation to the Institutes of Medicine (IOM), Eugene Litvak demonstrated notes that the "correlation between the average number of ED patients waiting for hospital beds and divert status was substantially higher than all other tested hypotheses.[19] Moreover, a 2001 Issue Brief for the Massachusetts Health Policy Forum notes that "the frequency of ambulance diversion is better correlated with total hospital occupancy than with the number of ED visits."[20] In their comprehensive assessment of national emergency care, the Institutes of Medicine (IOM) notes that "ED crowding is a hospital-wide problem – patients back up in the ED because they can not get admitted to inpatient beds." [21] Hospital capacity is also limited by each institution's ability to staff available beds. The shortage of clinicians at all levels is a potential threat to patient care.

Inpatient bed capacity, like ED space, has declined in recent years. The American Hospital Association (AHA) reported that the number of inpatient beds nationwide declined by 39% between 1981 and 1999.[22] New Jersey alone experienced a 17% decrease in twenty years.[23] Bed capacity may be particularly constrained in certain areas of the hospital: intensive care, critical care, telemetry, pediatric, cardiac, and psychiatric beds as those least likely to be available.[24] Patients admitted to these departments are likely to require intensive care in the ED while they await transfer, further burdening staff and resources. The General Accounting Office found that hospital officials reported

[19] Litvak E. Managing Patient Flow is the Key to Improving Access to Care, Nursing Staffing, Quality of Care, and Reducing its Cost. Presentation to the Institutes of Medicine, June 24, 2004.
[20] McManus M. Emergency department overcrowding in Massachusetts: Making room in our hospitals. Issue Brief for the Massachusetts Health Policy Forum, June 2001.
[21] Institutes of Medicine: The Future of Emergency Care: Key Findings and Recommendations. Fact sheet, June 2006. From Arizona Emergency Medical Services Task Force, August 16 2006.
[22] American Hospital Association. Trendwatch Report. 2001 Nov 3(3): 2-8.
[23] Ibid. DeLia D, March 2005.
[24] Ibid. DeLia D, July 2006.

inability to transfer emergency patients to inpatient spaces once admissions decision had been reached as the primary contributor to crowding and boarding.[25]

Puzzling reports of low occupancy rates have provoked further examination of inpatient bed capacity. A 2001 Issue Brief for the Massachusetts Health Policy Forum notes that hospital-wide occupancy rates in Massachusetts may be as low as 60-70%; a statistic that suggests hospitals are actually operating below capacity.[26] This Issue Brief and others persuasively argue, however, that significant flaws plague the current census system. The current practice of "midnight sampling" may yield grossly unrepresentative occupancy rates; for example, hospitals in Massachusetts EMS Region IV reported an increase of 19% when occupancy rates were measured at noon (96%) versus midnight (77%).[27] These data support providers' and managers' perception that hospitals are saturated.

Additionally, new forms of health care delivery affect inpatient capacity but evade measurement. Same-day or outpatient surgeries, which account for approximately 50% of surgeries (compared to 16% in 1980)[28], are not included in traditional measures of capacity but may place significant restrictions on the number of beds available to emergency patients. The Issue Brief for the Massachusetts Health Policy Forum uses an illustrative example: in a fictional 20 bed hospital, if length of stay is consistent at 5 days, 1,460 patients can receive care if they are able to wait. If patients become unable to wait, as many emergency patients are, this report estimates that caring for even 1,000 patients

[25] United States General Accounting Office. Hospital Emergency Departments: Crowded Conditions Vary by Hospitals and Communities, March 2003.
[26] McManus M. Emergency department overcrowding in Massachusetts: Making room in our hospitals. Issue Brief for the Massachusetts Health Policy Forum, June 2001.
[27] Ibid.
[28] American Hospital Association. Trendwatch Report. 2001 Nov 3(3): 2-8.

will become problematic, and states emphatically that "when arrivals are random, higher occupancy rates are always accompanied by higher rejection rates.[29] Given that rejection of emergency patients is not permissible under EMTALA, absolute hospital capacity warrants critical evaluation.

RECENT TRENDS IN AVAILABLE CAPACITY

Inpatient Psychiatric Capacity

Treating individuals with mental disorders has also played a significant role in ED crowding. Not only do psychiatric patients normally remain in the ED twice as long as non-psychiatric patients, it also usually takes twice as long to find these patients beds.[30] Data from a cross-sectional study of EDs also indicates that mental health-related visits to the ED have increased 75% between 1992 and 2003.[31] Consequently, according to an American Psychiatric Association survey, 60% of ED physicians believe that this increase in ED visits from individuals with mental illness is negatively affecting access to ED care for all patients, increasing wait times, causing patient dissatisfaction, reducing the availability of hospital staff, and decreasing the number of ED beds available.[32]

One possible driver behind increasing mental health visits to the ED is the decreasing availability of in-patient psychiatric beds. Cut-backs by state- and county-operated mental hospitals have often been cited as the main reason for the decrease in the

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[29] Ibid. McManus M, June 2001.
[30] American Psychiatric Association, "Emergency Departments See Dramatic Increase in People with Mental Illness Seeking Care," press release, June 2, 2004; available at www.psych.org/news_room/press_releases/emergencystudy06032004.pdf.
[31] Salinsky E, Loftis C. "Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern?," Issue Brief, August 1, 2007; available at http://www.nhpf.org/pdfs_ib/IB823_InpatientPsych_08-01-07.pdf
[32] American Psychiatric Association, "Emergency Departments See Dramatic Increase in People with Mental Illness Seeking Care," press release, June 2, 2004; available at www.psych.org/news_room/press_releases/emergencystudy06032004.pdf.

total number of dedicated inpatient psychiatric beds. For example, in 1970, of the approximately 524,878 psychiatric beds in the U.S., 80% of these beds were provided by state or county mental hospitals. In contrast, by 2002, the total number of psychiatric beds in the U.S. had fallen to 211,199. Of these beds, 68% were provided by the private sector. Although private sector inpatient capacity growth between 1970 and the 1990's helped to offset the beds lost in the private sector, recent private sector closures have led to inpatient psychiatric capacity levels that are now significantly lower than those of previous decades.[33]

Bed Turnover

Lack of actual physical beds clearly limits inpatient capacity, but hospitals may experience difficulty in moving patients in and out of staffed beds. For example, isolation precautions that prevent new patients from being moved into available beds, delays in cleaning rooms after patient discharge, over-reliance on certain types of beds (such as those in intensive care or telemetry units), inefficient or delayed diagnostic procedures for admitted patients, and delays in discharging patients may slow movement through inpatient units.[34,35] The AHA specifically notes that lack of available home care services, a factor over which hospitals have no control, services stalls discharges. [36]

Ambulatory Care Sensitive Conditions

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[33] Daniel J. Foley *et al.*, "Highlights of Organized Mental Health Services in 2002 and Major National and State Trends," in Center for Mental Health Services, *Mental Health, United States 2004*, Ronald W. Manderscheid and Joyce T. Berry, Eds., DHHS pub. no. (SMA)-06-4195 (Rockville, MD:. Substance Abuse and Mental Health Services Administration, 2006), table 19.2, chap. 19, p. 203; available at http://download.nca.di.samhsa.gov/ken/pdf/ SMA06-4195/CMHS_MHUS_2004.pdf.
[34] American Hospital Association. Trendwatch Report. 2001 Nov 3(3): 2-8.
[35] Asplin B, Magid D, Rhodes K, Solberg L, Lurie N, Camargo C. A Conceptual Model of Emergency Department Crowding. Annals of Emergency Medicine, 2003 Aug 42 (2): 173-80.
[36] Ibid. American Hospital Association, Nov 2001.

Ambulatory care sensitive (ACS) conditions such as diabetes, coronary heart disease, and asthma, which may become acute if left untreated but can be successfully managed in non-acute settings, represent a significant portion of hospital admissions – in one New Jersey study, 31% of admissions that originated in an emergency department were for ACS conditions.[37] Decreasing the number of individuals presenting to EDs with ACS conditions will require primary care interventions, including communication with area providers or use of supervised EMS workers for treatment in the field.[38]

THE EFFECTS OF CAPACITY ON PATIENT CARE

While the stress that emergency department crowding places on hospitals and clinicians is a public health problem in and of itself, the driving force for change is patient care. Limited inpatient capacity and ED crowding may result in insufficient or no treatment, return visits to the emergency department, pain and suffering, and even morbidity and mortality. ED crowding and limited inpatient capacity "reduce healthcare quality by increasing the potential for medical errors, prolonging pain and suffering, and reducing patient satisfaction with services."[39] Emergency departments are not designed to provide long-term care, and patient outcomes may be compromised when wait times are long.

Particularly troubling is the tendency of patients to leave emergency departments without being treated when wait times are long. Approximately 1.4% of patients in a recent New Jersey survey left the hospital after entering triage but before receiving treatment, and 7% of hospitals reported that up to 5% of triaged patients left before

[37] Ibid. DeLia D, July 2006.
[38] Arizona Department of Health Services Overcapacity/Surge Subcommittee Recommendations, September 2006.
[39] Derlet R, Richards J. Overcrowding in Academic Emergency Departments: Complex Causes and Disturbing Effects. Annals of Emergency Medicine, 2000 Jan 35(1): 63-8.

receiving needed care.[40] Individuals who choose to leave the ED without treatment are at increased risk for return visits: 11% of patients who left the ED during a first visit were admitted within one week.[41]

Patients who choose to wait and receive care in crowded EDs may not be exempt from the health consequences of crowding. A 2003 *Emergency Medicine Journal* article reports that over half of "sentinel cases" of morbidity and mortality were "secondary to delays" in ED treatment, and in 31% of these cases emergency department crowding was identified as a contributing factor.[42] Solutions for emergency department crowding and limited inpatient bed capacity are necessary to allow hospitals to fulfill their duty to care for all patients who seek emergency care.

FURTHER IDEAS FOR CONSIDERATION

Many possible ideas have been proffered to address inpatient bed capacity to allow more hospitals to fulfill their EMTALA obligations. These ideas fall broadly into four categories: reduce demand for inpatient bed capacity; improving patient throughput within the hospital; rethinking hospital operational management; reducing and restructuring system-wide practices, specifically reimbursement and primary care access.

1. Reduce Demand for Inpatient Capacity

Several strategies have been recommended in order to address the problem of undue reliance on inpatient bed capacity; including improved chronic care management, better access to and availability of patient care, and basic preventive care (i.e. wearing a seat belt or helmet and reducing exposure to alcohol and cigarette smoke). These

[40] Ibid. DeLia D, March 2005.
[41] Asplin B, Magid D, Rhodes K, Solberg L, Lurie N, Camargo C. A Conceptual Model of Emergency Department Crowding. Annals of Emergency Medicine, 2003 Aug 42 (2): 173-80.
[42] Ibid. Trzeciak S, Rivers E. 2003.

strategies not only have the potential to reduce undue reliance on inpatient capacity, but also have the promise of enabling hospitals and providers to improve management of out-patient care as well as reduce the need for emergency services and acute care admissions.

2. Patient Throughput

Throughput---the efficiency with which patients are moved from the ED to inpatient areas and eventually to the community---has been identified as a chief obstacle to timely admission as well as patient flow within individual hospitals.

Several strategies for improving patient flow within an individual hospital have been suggested. Standardization of triage systems in EDs could prioritize patients for admission and reduce confusion leading to long wait times. One hospital achieved a significant reduction time on diversion status after it created an ED-staffed and controlled acute care unit where patients with serious but non-urgent conditions such as chest pain were treated and monitored.[43] Capitalizing on flexible staffing, such as "float teams" of RNs, would be compatible with satellite ED treatment areas and could improve efficiency throughout the hospital. Given the shortage of health care workers, creative management of available forces is essential.[44]

3. Operations Management

A 2002 report submitted by the Boston University Program for the Management of Variability in Health Care Delivery proposed simple management strategies as solutions to throughput issues. Recognizing the burden that same-day-surgeries place on inpatient space, the authors of this report argue for a division of scheduled and

[43] Kelen GD, Scheulen JJ, and Hill PM. Effect of and Emergency Department (ED) Managed Acute Care Unit on ED Overcrowding and Emergency Medical Services Diversion. Academic Emergency Medicine, 2001 Nov, 8(11): 1095-1100.
[44] Schneider S, Zwemer F, Doniger A, Dick R, Czapranski T, and Davis E. Rochester, New York: A Decade of Emergency Department Crowding. Academic Emergency Medicine, 2001 Nov, 8(11): 1044-50.

unscheduled services.[45] Using surgical suites as an illustrative example, the authors of this report also argue that patient throughput can be improved if surgical rooms are designated and managed as separate entities, allowing elective surgeries to continue without compromising the availability of surgical services to emergency patients. Utilizing a computerized model of crowding called "ED Divert," the authors of this report demonstrate that large variability in scheduled admissions, in contrast with a relatively consistent demand in the ED, creates artificial changes in capacity, and that using the model, "adjustments of ED capacity or process time have less impact than smaller adjustments in critical bottlenecks elsewhere."[46] The authors of this report demonstrated that expanding inpatient capacity had greater effects on time spent on diversion than did alterations to the ED department itself in his program. Although this report focuses on surgical facilities, this model could be adopted in other areas of the hospital by designating a small portion of high demand beds (in areas such as the ICU) specifically for emergency purposes.

An Issue Brief for the Massachusetts Health Policy Forum provides further evidentiary support for separate management of emergency and non-emergency beds. Beds are committed for scheduled surgery based on statistical assumptions about the rate of patient discharge; even if these models prove incorrect, beds cannot be made available.[47] While designating certain inpatient beds as "emergency use only" may not be financially optimal for hospitals, ensuring emergency patients' at least minimal access to

[45] Litvak E, McManus M, Cooper A. Root cause analysis of emergency department crowding and ambulance diversion in Massachusetts. Report submitted by the Boston University Program for the Management of Variability in Health Care Delivery. Sponsored by the Massachusetts Department of Public Health. October 2002.
[46] Litvak E. Managing Patient Flow is the Key to Improving Access to Care, Nursing Staffing, Quality of Care, and Reducing its Cost. Presentation to the Institutes of Medicine, June 24 2004.
[47] Ibid. McManus M, June 2001.

these spaces may be necessary for hospitals to meet their legal responsibilities under EMTALA. Additionally, reevaluating scheduled surgeries or admissions may become necessary when hospitals reach capacity.[48]

4. System-targeted Initiatives

If the problem of emergency department crowding is to be fully attenuated, solutions will need to address treatment access and the regulatory climate in which hospitals operate. Restructuring Medicare and Medicaid requirements either to cover home care provided by nurse practitioners or relaxing inpatient guidelines such as the three-day rule for skilled nursing facility admission has been proffered as ways to reduce the number of non-critical patients clogging the hospital system.[49,50] Updating the current statutory or regulatory scheme may improve hospitals' ability to increase their capacity; reevaluating staffing ratios or allowing patients to be boarded in inpatient hallways when hospitals have reached capacity would allow hospitals to maximize use of physical space and open up ED treatment areas.[51] More broadly, restrictions on hospital expansion such as Certificate of Need regulation may restrict hospitals' ability to respond to emerging patient needs.[52] Creating regional communication headquarters would allow hospitals to advise one another of their capacity status, possibly allowing patient transfer to within-system hospitals or reallocating staff within a region.[53] Health information technology may aid hospitals in communicating among inpatient units or regional hospitals, and

[48] Ibid. Arizona Department of Health Services, September 2006.
[49] Institutes of Medicine: The Future of Emergency Care: Key Findings and Recommendations. Fact sheet, June 2006. From Arizona Emergency Medical Services Task Force, August 16 2006.
[50] Florida Hospital Association Task Force Report, December 2005. In Arizona Emergency Medical Services Task Force Report, August 16 2006.
[51] Ibid. Arizona Department of Health Services, September 2006.
[52] Popescu I, Vaughan-Sarrazin M,
[53] Schneider S, Zwemer F, Doniger A, Dick R, Czapranski T, and Davis E. Rochester, New York: A Decade of Emergency Department Crowding. Academic Emergency Medicine, 2001 Nov, 8(11): 1044-50.

early examinations of management software have demonstrated success.[54] The costs of such software and associated training may be prohibitive for hospitals, and increased funding for HIT may be necessary; the Institutes of Medicine proposed in 2006 that hospitals be appropriated an additional $50 million for such initiatives.[55]

CONCLUSIONS

To successfully address the problem of limited capacity and to expand hospitals' ability to provide EMTALA-mandated care, research must identify the primary causes of crowding. Given the flawed tools currently used to measure inpatient bed capacity, more sophisticated indicators that include multiple time points and discharge models should be used to gauge inpatient occupancy rates. If census data indicate room for construction of additional facilities, hospitals with chronically high volume may need to consider expanding, possibly with the aid of federal monies.

Operations management research may alleviate crowding more rapidly; further study in this area should emphasize patient throughput improvements designed to accelerate admission through the emergency department. While some "smoothing" programs, such as the "ED Divert" program, have demonstrated results, replication of these findings and practical applications are imperative. The challenge going forward is to evaluate more specifically what improvements can be achieved through pure expansion of hospital facilities and what improvements will result from improved throughput. While the causes of emergency department crowding span the healthcare system, hospital capability is a critical bottleneck, and exhausting strategies to expand it

[54] Barthell EN, Foldy SL, Pemble KR, Felton CW, Greischar PJ, Pirrallo RG, and Bazan WJ. Assuring Community Emergency Care Capacity with Collaborative Internet Tools: The Milwaukee Experience. Journal of Public Health Management Practice, 2003 MONTH, 9(1): 35-42.
[55] Ibid. IOM, 2006.

must be a priority if emergency care is to be delivered according not only to the regulations but also the intent of EMTALA.

APPENDIX 9

The Liability Environment's Effect on Physician & Hospital Compliance with EMTALA

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The Liability Environment's Effect on Physician & Hospital Compliance with EMTALA

ABSTRACT

This paper examines how the current liability environment affects hospitals' and providers' ability to comply with the Emergency Medical Treatment and Active Labor Act (EMTALA) and provide universal access to emergency care. First, we examine the nature of emergency medicine and assess how compliance with EMTALA has created difficulties within the emergency department (ED). Next, we examine the liability crisis and its effects on the ED environment. In addition, we assess the impact of the liability crisis on physicians, evaluate their response, and examine how this liability crisis has created an on-call specialist shortage. Similarly, we assess the impact of the liability crisis on hospitals, evaluate their response, and examine how hospitals' are responding to the on-call specialist shortage. We also look at Nevada's trauma crisis and response as well as other state liability reform initiatives. Finally, we identify areas for further study to inform key stakeholders about changes that may be helpful in ensuring health care institutions and clinicians can continue to provide care under EMTALA.

INTRODUCTION

By requiring that all patients be screened and stabilized regardless of their ability to pay, the 1986 Emergency Medical Treatment and Labor Act (EMTALA) addressed the rise of "patient dumping." Under this practice, less profitable patients, such as the indigent and uninsured, were refused care based on their ability to pay. While this federal mandate requires that all hospitals participating in Medicare are required to provide medical screening and stabilization services or appropriate transfer to all patients who present to an emergency department (ED), the question at hand is: Does the greater healthcare liability environment affect compliance with EMTALA? This paper highlights some of the barriers in the current healthcare system that impedes physician and hospital compliance with EMTALA. Specifically, this paper focuses on the current medical liability environment through the "lens" of EMTALA.

THE EMERGENCY DEPARTMENT (ED) ENVIRONMENT

It has been argued that the nature of emergency medicine may place ED physicians at a higher risk for medical malpractice. In this setting, physicians evaluate

higher acuity patients with whom they have neither a pre-established relationship nor a provision for follow-up care. As claims are easier to levy against a physician who is a "stranger," the threat of litigation may block effective communication between patients and physicians. Similarly, it may be difficult to establish strong doctor-patient relationships in the ED environment. This doctor-patient disconnect may make patients more likely to sue when adverse outcomes occur.[1]

Within the medical community, it is a common perception is that the poor and uninsured are the predominant users of ED services. However, a recent study conducted by the Robert Wood Johnson Foundation and UC San Francisco researchers found the uninsured account for 15% of ED visits, which is roughly equivalent to the proportion of uninsured Americans (45.8 million of 298 million).[2] Moreover, the Center for Disease Control and Prevention's 2004 Emergency Department Summary noted that private insurance was the foremost source of payment (35.7%), followed by Medicaid (22.2%), self-payment (16%), and Medicare (15.3%).[3]

The medical community may also perceive the indigent and uninsured as more litigious. In reality, studies show the poor, uninsured, and Medicaid patients are less likely to take legal action and are more likely to suffer from substandard health care.[4]

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[1] Beckman, HB., Markakis, KM., Suchman, AL., and Frankel, RM. "The Doctor-Patient Relationship and Malpractice: Lessons from Plaintiff Depositions." *Arch Intern Med*. June 1994 27; 154(12): 1365-70.
[2] Yi, Daniel. *Los Angeles Times*, March 29, 2006. Home Edition, Business; Business Desk; Part C; Pg 1.
[3] McCaig, Linda F. and Nawar, Eric W. "National Hospital Ambulatory Medical Care Survey 2004 Emergency Department Summary." *Advance Data from Vital and Health Statistics*. June 2006. Available at: http://www.cdc.gov/nchs/data/ad/ad372.pdf.
[4]McNulty, M. "Are Poor Patients Likely To Sue For Malpractice?" *JAMA*. 1989;262:1391-1392.
See also: Mussman, MG, Zawistowich, L, Weisman, CS, Malitz, FE, and Morlock, LL. "Medical Malpractice Claims Filed By Medicaid and Non-Medicaid Recipients in Maryland." *JAMA*. 1991;265:2992-2994.
See also: Baldwin, LM, Greer, T, Wu R, Hart, G, Lloyd, M, Rosenblatt, RA. "Differences in the Obstetric Malpractice Claims Filed by Medicaid and Non-Medicaid patients.
See also: Burstin, HR, Johnson, WG, Lipsitz, SR, Brennan TA. "Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status." *JAMA* 1993;270: 1697-1701.

With smaller contingency fee based settlements, smaller jury awards, and smaller future earnings, malpractice cases are becoming less attractive for attorneys.[5] Nevertheless, anxiety and fear produced by the perception that the poor and uninsured are more litigious may affect some physicians' behavior. Physicians' perceptions of malpractice may be influenced by these misperceptions.[6]

Physician On-call Hours & Frequency of Professional Liability Lawsuits			
		Some On-Call Hours	
	No On-Call Hours	**Not Called to the Emergency Room**	**Called to the Emergency Room**
% of physicians in each "call category"	55.10%	17.20%	27.70%
% of physicians sued in last 12 months	6.80%	8.00%	12.70%
# of suits per 100 physicians	17.3	21	27.4

Source: 2001 Patient Care Physician Survey, American Medical Association.
Note: Questions about on-call hours pertain to the physician's most recent complete week of practice. Estimates exclude emergency medicine physicians.

COMPLIANCE WITH EMTALA AND THE EMERGENCY DEPARTMENT (ED)

A contributing factor to the stress of the ED environment may be compliance with EMTALA. The Centers for Medicare & Medicaid Services (CMS) and the Office of the Inspector General (OIG) are charged with investigation and enforcement of potential EMTALA violations. CMS can terminate a hospital's participation in Medicare for

[5] Burstin, HR, Lipsitz, SR, Brennan, TA. "Socioeconomic Status and Risk for Substandard Medical Care." *JAMA*. November 1992. 4;268(17):2383–2387.
[6] Mello, MM, Brennan, TA. "Deterrence of Medical Error Theory and Evidence for Malpractice Reform." *Texas Law Review* 2002; 80: 1595-1637.

EMTALA violations, while the OIG may subject hospitals to civil monetary penalties and can terminate an individual physician's Medicare participation.

In addition, the potential for peer review/quality assessment (PR/QA) record use in federal courts may provide further deterrence for specialists to be forthright in disclosing ED experiences.[7] EMTALA is a federal statute, which allows civil suits against hospitals to go to federal court, while most malpractice claims are relegated to state court. PR/QA records, though protected from discovery in a state court, are discoverable in federal court.[8] Survey documents resulting from EMTALA investigation are also discoverable through the federal Freedom of Information Act (FOIA) and its state-law equivalents.

Although EMTALA sanctions against physicians are rare, some physicians may equate EMTALA violations with malpractice liability without necessarily realizing that fines for EMTALA are separate from tort liability. By not making this distinction clear, physicians may have an unfounded fear of EMTALA and view it as a burden in terms of liability. According to a 2001 study at the Yale University School of Medicine, "Many on-call specialists are not aware of their legal responsibilities under EMTALA."[9] A 2003 study at a large tertiary care hospital in Texas found that only 29.3% of the emergency staff had ever heard of EMTALA.[10] Finally, a 2006 study of hospital-based pediatric

[7] Peer review/quality-assurance (PR/QA) privilege is a state law doctrine designed to protect the PR/QA assessment of providers from being discovered during litigation.
[8] During the discovery process, one party in a lawsuit may force another to bring forth all relevant information not protected by a legal privilege.
[9] Cone, David C., Alexander, Victor, and Myint, Wynne. "EMTALA Knowledge among On-Call Specialists at an Academic Medical Center." *Academic Emergency Medicine*. Yale University School of Medicine: New Haven, CT. 2001. Available at: http://www.aemj.org/cgi/content/abstract/8/5/572
[10]Zibulewsky, J. "Medical Staff Knowledge of EMTALA At A Large, Tertiary Care Hospital." *American Journal of Emergency Medicine*. January 2003; 21(1)8-13. Available at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12563572&dopt=Abstract

physicians in Colorado concluded physicians were "strikingly unaware of their EMTALA obligations and potential liabilities."[11] Although each of these studies differed by time, population, study size, hospital type, and geographic location, a common thread is that physicians as well as emergency staff are unaware of their obligations under EMTALA.

THE LIABILITY CRISIS

Liability crises are often cyclical events which lead to some aspect of tort reform. For example, during the 1970's, the tort crisis was characterized by the decreased availability of professional liability insurance (PLI) for purchase. Insurers quickly left the PLI market when premium rates soared. This trend continued into the 1980's as some exorbitant premium rates led to declining affordability.[12] Since 1975, medical liability costs rose on average 11.8% per year, outpacing increases in overall U.S. tort costs (9.2%).[13]

The most recent liability crisis included both decreasing availability and declining affordability of PLI.[14] As managed care gradually replaced fee-for-service healthcare and Medicare and private insurers started to set more stringent price controls to prevent payers from bearing the burden of increased premiums, the healthcare system is less able

[11]McDonnell, WM., Roosevelt, GE., Bothner, JP. "Deficits in EMTALA Knowledge Among Pediatric Emergency Physicians." *Pediatric Emergency Care*. 2006 Augst;22(8):555-61. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=16912622&dopt=Abstract

[12] Erol, A. and Winn, H. "Review of the Professional Medical Liability Insurance Crisis: Lessons from Missouri." *American Journal of Obstetrics and Gynecology.* 2004. 190:1534-1540.

[13] Towers and Perrin. "U.S. Tort Costs: 2004 Update: Trends and Findings on the Cost of the U.S. Tort System." 2004. Available at: http://www.towersperrin.com/tillinghast/publications/report/Tort_2004/Tort.pdf

[14] Erol, A. and Winn, H. "Review of the Professional Medical Liability Insurance Crisis: Lessons from Missouri." *American Journal of Obstetrics and Gynecology.* 2004. 190:1534-1540

to absorb increased PLI costs.[15] According to a 2004 *New England Journal of Medicine* article, the main driving forces for the current liability crisis include:

(1) Significant increases in payouts to plaintiffs since 1999;[16]

(2) Moderate increases in the frequency of claims in some states;[17]

(3) The downturn of the economy reflected in lower stock values and bond rates, affecting insurers' investment returns;[18]

(4) Rapid expansion of the subscriber base by insurers in the 1990s leading to under-

priced insurance policies, which were unable to completely cover the losses experienced by the insurers.[19]

Determining a State's Medical Liability Situation

The American Medical Association (AMA) decides whether a state is in a "liability crisis" by determining if patients have less access to care from doctors in certain specialties because high PLI premiums have driven physicians to retire earlier, move to other jurisdictions, change their specialization, or otherwise withdraw their services.[20] The AMA considered a variety of factors when categorizing a state's medical liability situation including: (1) loss of patients' access to health care; (2)

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[15] Studdert, D., Mello, M., and Brennan, T. "Health Policy Report: Medical Malpractice." *NEJM.* January 2004.

[16] Statement by the Physician Insurers Association of America. Rockville, Md. Physician Insurers Association of America. January 2003. Available at: http://www.thepiaa.org/pdf_files/january_29_piaa_statement.pdf.

[17] General Accounting Office. "Medical Malpractice Insurance: Multiple Factors Have Contributed To Increased Premium Rates." June 2003. GAO-03-702.
See also "Implications of Rising Premiums on Access to Health Care: Medical Malpractice and Access to Health Care," Government Accounting Office: GAO-03-836, at http://www.gao.gov/atext/d0386.txt 41 pages.

[18] Ibid. Erol. and Winn, 2004.

[19] Studdard, D., Mello, M., and Brennan T. "Health Policy Report: Medical Malpractice." *NEJM*. January 2004.

[20] Richmond, J. and Fein, R. "The Health Care Mess: How we got into it and what it will take to get out." 209-214.

affordability/availability of professional liability insurance; and, (3) legislative, legal, and judicial climates of the state.

After gathering data in each of these three areas, the AMA collaborates with state medical associations to determine how a state should be classified. The categories are currently crisis, caution, and stable. In 2006, The AMA listed twenty-one states in the crisis category (up from twelve in 2002[21]), and only six stable states in the stable category (California, Colorado, New Mexico, Louisiana, Wisconsin, and Indiana).[22] It is worth noting that medical malpractice coverage is not based on the national market. Instead, it is dependent on the insurance, legal, and healthcare structure of each state. Thus, losses and other insurance factors influencing premium rates vary from state to state.[23]

The stability of these six states is probably due to a combination of factors unique to each state, most notably tort reform efforts. The 2003 American Tort Reform Association (ATRA) Tort Reform Record indicated that among these six stable states, punitive damages and joint and several liability reforms were the most common.[24] Joint and several liability is based on the idea that each defendant is responsible for the entire amount of damages a plaintiff seeks regardless of the defendant's degree of responsibility for the damages.[25] A pitfall of this "deep pocket" rule is that lawsuits can turn into searches to find the most financially profitable defendant. The ATRA encourages states

[21] AMA. "Medical Liability Crisis Map." March 2006. Available at: http://www.ama-assn.org/ama/noindex/category/11871.html.
[22] AMA. "AMA's Medical Liability Reform – Now! A compendium of facts supporting medical liability reform and debunking arguments against reform." October 2005. Available at: http://www.ama-assn.org/ama/pub/category/7861.html.pdf.
[23] Miller, R. "Problems in Health Care Law." 2006. Ninth ed. Jones and Bartlett Publishers.
[24] American Tort Reform Association (ATRA). "Tort Reform Record." December 2003. Available at: http://www.atra.org/files.cgi/7668_Record12-03.pdf.
[25] National Association of Mutual Insurance Companies. "Tort Reform: An Overview of State Legislative Efforts to Improve the Legal System" NAMIC Report on State Laws and Legislative Trends. 2005. Available at: http://www.namic.org/reports/tortReform/overview.asp

to adopt a proportionate liability rule, which holds defendants responsible only for their relative share of the damages.[24] Many states also instituted punitive damage reforms. Punitive damages seek to punish defendants who act maliciously under the theory that it deters future malicious, irresponsible, and harmful actions.[26]

As of March 2007, uncertainty exists as to whether a tort crisis persists. For the first time in several years, the number of malpractice claims has decreased and professional liability insurance premiums have remained level or decreased. The AMA affirmed several states' liability environments have improved, as the number of states in crisis fell from twenty-one in 2006 to seventeen in 2007.[27] From a physician perspective, however, many believe this crisis continues. The American College of Emergency Physicians (ACEP) has noted the crisis is not as severe as it was a few years ago, yet the proportion of physician revenue devoted to PLI payments is still high. Certain specialty groups, such as surgeons and obstetrics/gynecologists (OB/GYNs), also argue the crisis persists. For instance, medical liability premiums for an OB/GYN in Miami-Dade County are almost $300,000/year versus a Chicago general surgeon's $100,000/year.[28]

IMPACT OF LIABILITY ON PHYSICIANS

According to the Insurance Information Institute, medical liability insurance is the second riskiest types of insurance in the world.[29] The cost of medical liability insurance is typically experience-rated for hospitals based on retrospective claims data. For physicians, the premium is usually priced according to specialty and geographic location.

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[26] Ibid.
[27] Sorrel, Amy Lynn. "Tort Reform Boost Some States' Liability Outlook." *American Medical News.* March 2007.
[28] Johnson, Mari. AMA Email Response to EMTALA TAG Inquiry. February 28, 2007.
[29] Alliance of Specialty Medicine. "Federal Medical Liability Reform, Addressing a National Crisis." July 2005.

According to the U.S. General Accounting Office (GAO), specialties with an increased risk of large or frequent losses from liability claims will have higher premium rates. High-risk specialties, such as emergency medicine, general surgery, neurosurgery, obstetrics/gynecology, orthopedic surgery, and radiology tend to have higher costs for liability insurance with regional variation. According to a 2006 Institute of Medicine (IOM) Emergency Medicine brief, a comparison of insurance premiums paid by specialists in Palm Beach County Florida found that orthopedists who take call in the ED pay $75,000 more than their counterparts who do not take call.[30]

Solo and small-group practitioners (compared to group and hospital-based practices) are more likely to change their scope of practice and patient mix to limit their liability exposure. Strategies include deselecting high-risk patients or eliminating high-risk services/procedures. In order to examine the effects of liability issues on specialist supply, a 2005 *Annals of Surgery* report surveyed physicians in high-risk clinical practices in Pennsylvania (an AMA deemed crisis state). The report found that, due to liability concerns, high-risk specialty care is concentrated on a smaller number of providers, shifting the burden from community hospitals to academic medical centers. Solo and small-group practitioners are also joining larger practices and hospitals in order to obtain liability coverage. The study concludes that the supply of high-risk specialists in Pennsylvania is decreasing due to the tort crisis and may affect patient access to care.[31]

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[30] "IOM: The Future of Emergency Medicine in the United States Health." from Taheri PA, Butz DA. 2004. *Specialists On-call Coverage of Palm Beach County Emergency Departments,* Palm Beach County, FL: Palm Beach County Medical Society Services.

[31] Mello MM, Studdert DM, DesRoches CM, Peugh J, Zapert K, Brennana TA, Sage WM. "Effects of a Malpractice Crisis on Specialist Supply and Patient Access to Care." *Annals of Surgery.* November 2005. Vol 242 No. 5.

Some physician groups view the EMTALA as an unfunded mandate amidst a climate of stringent healthcare cost control by third-party payers. From their viewpoint, physicians and hospitals are exposing themselves to liability risk while receiving minimal or no reimbursement for providing these mandated ED services. The increased number and severity of medical malpractice claims has resulted in a defensive approach to medicine in the ED. The fear of potential litigation may cause ED physicians and on-call specialists to order additional tests and/or prolong monitoring. Primary care providers are increasingly referring their patients to emergency departments for diagnostic workups. This shifts responsibility and, by extension, liability to ED physicians.[32] These kinds of strategic moves may slow the ED process and might restrict access to care. An environment of mismatched incentives may cause physicians to insulate themselves from liability by limiting their scope of practice, or leaving the practice of medicine altogether.

On-Call Specialty Services

In response to the tort crisis, some specialty physicians are taking selective call, decreasing the amount of call, or refusing to take call altogether. The Blue-Cross Blue-Shield Association (BCBS), which insures approximately one-third of the U.S population, conducted a survey of its member health plans in all 50 states and Washington, D.C. According to the 2003 BCBS Malpractice Insurance Crisis survey, medical malpractice premiums may decrease patient access to high-risk specialties. In fact, 56% of physicians in crisis states refuse some "high-risk" procedures compared to

[32] Berenson RA, Kuo S, May JH. 2003. "Medical Malpractice Liability Crisis Meets Markets: Stress in Unexpected Places." *Issues Brief: Center for Studying Health System Change.* (68):1-7.

32% in non-crisis states.[33] However, a majority of respondents indicated rising malpractice premiums affect all doctors, not merely specialists.[33]

A 2004 study by the Schumacher Group, an emergency management organization, found three out of four emergency rooms diverted ambulances because of specialist shortages. In addition, over 25% of hospitals reported loss of specialist coverage because of medical liability.[34] Similarly, according to a 2006 ACEP survey, three-quarters of emergency departments report a shortage of specialists, up from two-thirds in 2004. Almost half of Oregon's hospitals cannot provide twenty-four-hour emergency on-call treatment in at least one specialty. As a result, several hospitals have been forced to downgrade their trauma designation.[35] In the Southeast states, an ED survey confirmed 54% diverted patients because they did not have the appropriate specialist.[36] The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) cited "lack of specialists" as the reason for 21% of ED sentinel events, defined by JCAHO as an "unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof."[37]

A Harvard Medical Practice Study found that among physicians in certain Pennsylvania counties, 81% agree that, "because of concerns about malpractice liability, I

[33] Blue Cross Blue Shield Association, "The Malpractice Insurance Crisis: The Impact on Healthcare Cost and Access." 2003.
[34] The Schumacher Group, "2004 Hospital Emergency Department Administration Survey." cited in "Federal Medical Liability Reform," Alliance of Specialty Medicine. July 2005.
[35] Lloyd, Julie. "On-Call Specialist Crisis Downgrades Statewide Trauma System." January 2007. American College of Emergency Physicians. Available at: http://www.acep.org/webportal/Newsroom/NR/annals/2007/010907.htm
[36] Fischman, Josh. "Get Me a Neurosurgeon, Stat!" *US News and World Report*. January 21, 2007. Available at: http://www.usnews.com/usnews/health/articles/070121/29er_2.htm
[37] Joint Commission on Accreditation for Healthcare Organizations. "The Sentinel Event Alert." Issue 26 – June 17, 2002. Available at: http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_26.htm

view every patient as a potential malpractice lawsuit."[38] In addition, these physicians admitted to limiting certain "high-risk" procedures to reduce the probability of litigation and the cost of PLI. However, one aspect of the study found only 13% of negligent injuries and 4% of all medical injuries resulted in malpractice claims. Whether by diverting patients or reducing rendered services, each of these studies emphasizes the fear of liability in "high-risk" procedures.

IMPACT OF THE LIABILITY CRISIS ON HOSPITALS

Hospitals are required under Medicare Conditions of Participation to ensure on-call staff availability. With the current liability crisis, some emergency departments find it increasingly difficult to fulfill the on-call requirement, especially for high-risk specialties. In 2005, the AHA surveyed hospital leaders and found 41% of community hospitals reported having lost specialty coverage in the ED for a period (any period in the last 24 months from when the survey was administered).[39]

The 2003 GAO report summarized findings from a study which compared the effects of liability premiums on emergency and trauma specialists between five tort crisis states (PA, FL, NV, MS and WV) and four non-crisis states (CA, CO, MN, and MO).[40] The study found that EDs in "crisis states" had fewer on-call specialists as compared to non-crisis states, especially in the areas of orthopedics and neurosurgery.[41] In 2003, the American Hospital Association (AHA) surveyed more than 1,000 hospitals and found that 45% reported that liability concerns resulted in the loss of physicians and/or reduced

[38] David Studdert, Michelle Mello, et al., "Caring for Patients In A Malpractice Crisis: Physician Satisfaction And Quality of Care," 23 *HEALTH AFFAIRS*, 2004 at 42-53.
[39] American Hospital Association. "AHA Report Details Challenges Facing America's Community Hospitals." October 2005. Available at: http://www.aha.org/aha/press-release/2005/051020-pr-report.html.
[40] It may appear the GAO and AMA studies are inconsistent in assigning the crisis label to states. The GAO clarified they examined five states on the AMA's tort crisis list and four states not on the list.
[41] GAO. "Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates." Report to Congressional Requesters. June 2003.

coverage in emergency departments.[42] The Schumacher Group also reported that the majority of hospital administrators cite malpractice concerns as the number one reason for lack of specialist coverage of ED services.[43]

A 2004 ACEP survey assessed the impact of the 2003 EMTALA regulation changes and found that two-thirds of ED medical directors reported shortages of on-call specialist coverage. The top three consequences from the shortage were increased risk of harm to patients, delay in patient care, and increase in the number of transfers of patients between emergency departments. ACEP also found that specialists are negotiating for less on-call coverage hours and ED physicians and staffs are spending more time locating specialists for on-call coverage.[44]

The Center for Studying Health System Change (HSC) illustrates a few reasons for lack of interest in providing on-call services include:

(1) Perceived liability risk;

(2) Lack of reimbursement from the uninsured;

(3) Opportunity costs of providing on-call coverage; and,

(4) Lifestyle choices.

Similarly, a 2005 *Physician Executive* article noted that other reasons for the on-call shortage include: growth of ambulatory centers for some surgical procedures and the ability to gain a patient base through managed care networks make the tradition of

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[42] American Hospital Association. "Professional Liability Insurance: A Growing Crisis." AHA News Center. June 2003. Available at: http://www.aha.org/aha/press_room-info/releasedisplay.jsp?dcrpath=AHA/Press_Release/data/PR_030428_Liability&domain=AHA.
[43] Schumacher Group, "The. Summary Report: 2005 Hospital emergency department administration survey." 2005. Available at: http://www.tsged.com.
[44] American College of Emergency Physicians. "On-Call Specialist Coverage in U.S. Emergency Departments, American College of Emergency Physicians Survey of Emergency Department Directors" September 2004. Available at http://www.acep.org/NR/rdonlyres/A3D31508-1462-4314-B13E-ED3AECE924F6/0/RWJfinal.pdf.

providing on-call services in the ED to gain experience unnecessary; and loosened EMTALA regulations by CMS in 2003 allow physicians to schedule elective surgeries during call and to take call for multiple hospitals concurrently. [45]

Hospital Response to On-Call Specialist Shortage

With escalating PLI rates in many states, physicians appear to limit their practice of high-risk and complex services, opting for services that are more limited. Preferred lifestyles, the growth of ambulatory surgical centers, and the rise in specialty hospitals, leaves general hospitals scrambling to fill the ED on-call list for specialists. In response to this shortage, hospitals are providing incentives to retain or attract on-call specialists. A 2005 AHA survey found that approximately one-third of hospitals now pay physicians for some specialty coverage.

According to an ACEP report, 36% of ED directors responded that they pay stipends for any specialists to provide on-call coverage compared to 8% in 2004. Eighteen percent answered that specialists negotiated for less call in 2004 compared to 42% in 2005. Thus, in response to the on-call specialist shortage, some hospitals pay physicians stipends to be on-call, including a guaranteed payment for services and a form of professional liability coverage for providing on-call services.

THE NEVADA TRAUMA CRISIS

The trauma crisis in Nevada illustrates one hospital's response to an on-call specialty shortage. University Medical Center (UMC), a county hospital, is the only level-one trauma center in Nevada. In July 2002, UMC closed for ten days when 56 of 58 on-call orthopedic surgeons resigned to protest exorbitant liability premiums caused

[45] Glabman, M. "Specialist Shortage Shakes Emergency Rooms; More Hospitals Forced to Pay for Specialist Care." *Physician Executive*. May-June, 2005. Available at:http://www.hschange.com/CONTENT/799/.

by insurers exiting the Nevada market.[46] At the time, Nevada did not have any malpractice caps in place. The trauma closure severely limited patient access to care; some patients reportedly died from delays in treatment. In response, UMC urged physicians to become temporary employees of the hospital, limited their liability to $50,000, and encouraged the governor to file tort reform legislation. As a result, Nevada voters passed a ballot measure which:

(1) Capped non-economic damages at $350,000;

(2) Capped attorney fees;

(3) Required the actual monetary amount the plaintiff would receive to be disclosed to the jury; and,

(4) Eliminated joint-and-several liability, so defendants are responsible for only the percentage of harm attributable to them.[47]

A 2007 Protect Patients Now article indicated the Nevada reforms have been successful. Professional liability insurance premiums have lowered. However, some trial lawyers claim malpractice victims find difficulty in taking their cases to court.[48] Nevada's Insurance Commissioner, Alice Molasky-Arman, noted it is too early to draw conclusions; however, PLI rates have stabilized since the sudden increases that occurred in 2002. Furthermore, two insurance companies recently filed for lower rates.[48]

OTHER STATE LIABILTY REFORM INITIATIVES

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[46] Romano, M., "Nevada's Only Trauma Center Closes; Docs Leave Rather Than Rely on UMC's Malpractice Insurance." *Modern Healthcare*. July 2002.
See also Managed Healthcare.info via NewsRx.com and NewsRx.net. August 19, 2002.
[47] Med Mal News. *Medical Malpractice Law and Strategy*; Jan 10, 2005. Vol.22; No. 3; p. 8.
[48] Protect Patients Now. "Med-mal Changes Help Doctors." February 26, 2007. Available at: http://www.protectpatientsnow.org/site/c.8oIDJLNnHlE/b.2536363/k.89AD/Medmal_changes_help_doctors.htm.

In 2003, Texas instituted a constitutional amendment and cap on non-economic damages. Many Texas counties are experiencing premium rate cuts, fewer lawsuits filed, and more physicians have come to the state.[49] The State of Michigan has enacted tort reforms in 1994, but these reportedly had minimal impact. The statutes included a compulsory six month pre-suit notice requirement, two-tiered cap on non-economic recovery, stricter qualifications for expert testimony, and an affidavit of merit to support any "Complaint and Answer to Complaint filed." However, some argue that these changes affected the system minimally.

In 2001, the University of Michigan Health System adopted a new approach to medical malpractice. The approach is defined by three principles: (1) quick and fair compensation for improper care that causes injury; (2) vigorous defense of appropriate care; and (3) reduction of patient injuries through retrospective learning. As a result, the health system reported that the number of claims fell by two-thirds, legal expenses dropped by one-half, and processing times dropped from 21 months (average) to less than 10 months. Surveys indicate physicians, attorneys, and patients are supportive and benefit from the new approach.[50]

FURTHER IDEAS FOR CONSIDERATION

The goals of malpractice litigation are to act as a deterrent of unsafe practices by physicians, compensate persons injured through negligence, and to exact corrective justice.[51] In the current malpractice environment, most patients that suffer negligence do

[49] Johnson, Mari. AMA Email Response to EMTALA TAG Inquiry. February 28, 2007.
[50] Boothman, Richard C. "Medical Justice: Making the System Work Better for Patients and Doctors." *Testimony to the U.S. Senate Committee on Health, Education, Labor, and Pensions.* June 22, 2006. Available at: http://www.senate.gov/comm/labor/general/Hearings/2006_06_22/boothman.pdf
[51] Keeton, WP., Dobbs, DB., Keeton, RE., and Owens, DG. *Prosser and Keeton on the Law of Torts*. 5th ed. St. Paul, Minn.: West Publishing, 1984.

not sue, while many patients file claims that are not due to negligence. This mismatch indicates tort system goals are not being met. A study examining physician supply (using annual data from 1985 through 2001) found that direct tort reforms increased physician supply by 2.4% relative to non-reform states. Additionally, they found the impact on a number of high-risk specialties was as large as 11.5%.[52] The following list of statutory and regulatory proposals and other ideas should be examined in order to help sustain the original purpose of EMTALA while improving the malpractice environment without negatively impacting the health care system:

1. Enactment of the proposed Access to Emergency Medical Services Act of 2005 (H.R. 3875) which would claim hospitals, emergency rooms, and physicians, providing emergency care to uninsured individuals as employees of the Public Health Service. This approach would enable the federal government to defend these groups in civil action.[53]
2. Adoption of the AMA policy stance (D-375.999) on Confidentiality of Physician Peer Review, which advocates for legislation to amend the Freedom of Information Act to exempt confidential peer review information from disclosure under the Act; and the Health Care Quality Improvement Act to prohibit discovery of information obtained in the course of peer review proceedings. (BOT Rep. 22, A-01)

See also: Studdert, D., Mello, M., and Brennan, T. "Health Policy Report: Medical Malpractice." *NEJM* January 2004.

[52] Kessler, Daniel P., Sage, William M., and Becker, David J. "Impact of Malpractice Reforms on the Supply of Physician Services." *JAMA* 2005. 293:2618-2625.

[53] Library of Congress. *H.R. 3875*. September 2005. Available at: http://thomas.loc.gov/cgi-bin/bdquery/z?d109:HR03875:@@@D&summ2=m&.

3. Encouragement of providers and insurers to collaborate to provide malpractice premium credits to physicians using the EHR (Connecticut Medical Insurance Company and Massachusetts eHealth Collaborative, Massachusetts Medical Society, and Physicians Insurance Agency of Massachusetts collaborate to provide malpractice premium credits to physicians using HER).[54]
4. Regionalize critical on-call services. Hospitals would pool their on-call doctors to ensure a specialist is always available. Hospitals would pay liability insurance for the on-call cases.
5. Increase of Medicare reimbursements. Representatives Gordon (D-TN) and Sessions (R-TX) reintroduced a bill that would increase Medicare reimbursements by 10%, to physicians providing care in EDs or post-stabilization care related to emergency medical conditions. The legislation would establish a commission to examine ED overcrowding, on-call specialist availability, and medical liability issues related to emergency care.[55]
6. Promotion of state reform. For example, California's Medical Injury Compensation Reform Act of 1975 (MICRA) includes:

    (1) Unlimited economic damages, reasonable limits on non-economic damages up to $250,000;

    (2) Admission of evidence on collateral source benefits to prevent double recovery, prohibits subrogation of patient damage awards;

[54] "PIAMM and CMIC Launch EHR Malpractice Credit," *PIAM Medical Malpractice Bulletin.* Vol. 8 Issue 1. Winter 2007. Available at: http://www.piam.com/News_and_Information/18855.pdf
[55] Kaiser Family Foundation. "Emergency Department Physicians Ask Congress To Pass Legislation That Would Address Cost of Treating Uninsured, ED Overcrowding, Lack of On-Call Specialists." *Daily Health Policy Report*. February 08, 2007.

(3) "Fair share" rule allocates damage awards fairly and in proportion to fault; and

(4) A sliding scale for plaintiff attorney contingency fees, maximizing patient recovery.

This approach is supported by the AMA.

7. Creation of charitable immunity for EMTALA-rendered services.
8. Implementation of intermediate sanctions.
9 Establishment of stark relief to pay liability insurance (legislation to curb referral abuses for self-gain).
10. Creation of medical courts.
11. Initiation of a no-fault system similar to worker's compensation.
12. Promotion of efforts surrounding patient safety and quality measures.
13. Improvement of patient/provider interactions.
14. Improvement in the aggressiveness of state medical associations.
15. Indemnification, amelioration of premiums, tax write-offs.

CONCLUSIONS

Emergency departments are reported to be increasingly stressed, more so in states experiencing a medical liability crisis. Demands on the ED include lack of ED on-call coverage by specialists and increased utilization of the ED for primary care purposes. The liability environment, unfunded mandates, low managed care reimbursement rates, and strained ED capacity may hinder physician and hospital compliance with EMTALA as reported by providers. Recall that EMTALA was created to prevent patient dumping and improve equity. General healthcare issues, such as the liability crisis, may affect

EMTALA compliance by physicians and hospitals. In order to improve adherence to the current regulations, change may be necessary. Conclusions regarding proper solutions are beyond the scope of this paper. Some areas to consider include federal peer review protection, tort reform, charitable immunity, and more. Other areas, such as hospital and physician payment and capacity of ED/hospitals should be explored as well.

APPENDIX 10

Impact of EMTALA on Hospital and Physician Payment for ED Services

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Impact of EMTALA on Hospital and Physician Payment for ED Services

ABSTRACT

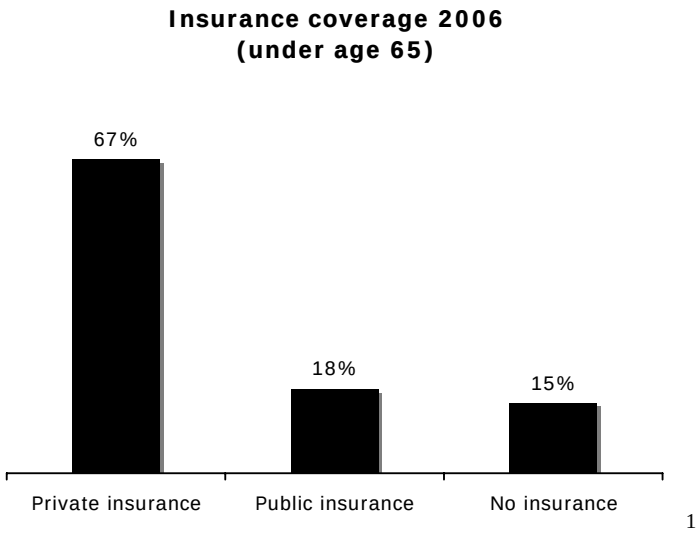
This paper examines how the current reimbursement environment affects hospitals' and providers' ability to comply with the Emergency Medical Treatment and Labor Act (EMTALA) and provide universal access to emergency care. First, we examine recent trends in health care spending and insurance. Next, we look at recent trends in hospital spending, the costs of providing care in the hospital setting, the effect of specialty hospitals, and the costs of emergency care that physicians bear. Third, we assess how pediatric emergencies, rural location, and mental health and substance abuse patients pose particular reimbursement difficulties, and analyze the current payment structures for emergency care. Fourth, we analyze the current payment structures for emergency care (i.e., Medicare, Medicaid, and Outpatient Prospective Payment System). Next, we look at initiatives that states are employing to increase insurance coverage. Finally, we identify areas for further study to identify changes that may be helpful to ensure that health care institutions and clinicians can continue to provide care under EMTALA.

INTRODUCTION

By requiring that all patients be screened and stabilized regardless of their ability to pay, the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA) created a health care safety net in hospital emergency departments. However, reimbursement for health care has changed in the twenty years since Congress enacted EMTALA, leading some stakeholders to conclude that it has become more difficult for hospitals and clinicians to comply with the regulation. By examining what aspects of reimbursement may need refinement, we may strengthen physicians' and hospitals' willingness to provide emergency care under EMTALA.

RECENT TRENDS IN HEALTH CARE SPENDING

Although a substantial proportion of the U.S. population has some type of health insurance, EMTALA provides an important source of health access to the growing segment of the population who lacks health insurance.



[1]

From 1987 to 2006, the number of individuals without insurance rose 40%, reaching 42.6 million people throughout the United States (U.S.).[2, 3, 4] As health care spending in the United States grows at a faster rate than the overall economy, health care has become increasingly less affordable to U.S. residents.[5,6] Some evidence indicates that drivers of health care costs include the rapid development of high-cost technologies and the market power of pharmaceutical companies, physicians, and hospitals.[7] Despite a three-year

[1] Income Stable, Poverty Rate Increases, Percentage of Americans Without Health Insurance Unchanged. http://www.census.gov/Press-Release/www/releases/archives/income_wealth/005647.html. Accessed March 13, 2007.
[2] Ibid.
[3] Income, Poverty, and Health Insurance Coverage in the United States: 2004. http://www.census.gov/prod/2005pubs/p60-229.pdf. Accessed March 13, 2007.
[4] National Center for Health Statistics. Early Release of Selected Estimates Based on Date from the January-June 2006. http://www.cdc.gov/nchs/data/nhis/earlyrelease/200612_01.pdf. Accessed February 21, 2007.
[5] Strunk BC, Ginsburg PB. Tracking Health Care Costs: Trends Turn Downward in 2003. *Health Affairs.* 2004;W4:354-362.
[6] The acceleration in the growth of health care spending, which peaked in 2001 at 10.0 %, has declined slightly and is currently stable at 8.2% in 2004. But the growth of health care spending still outpaces the growth of the U.S. economy.
[7] Bodenhiemer T. High and rising health care costs. *Ann Intern Med*. 2005;143:26-31

slowdown in spending growth from 2002 to 2005, U.S. health spending was still 16% ($2.0 trillion) of the gross domestic product in 2005.[8]

According to projections published in a 2005 *Health Affairs* article, more than one in four American workers under age 65—nearly 56 million people—could have no health insurance by 2013 because they will be unable to pay the high cost of coverage.[9] If these projections are correct, almost 11 million more individuals will lack coverage in 2013 than in 2003.[10] If the growth rate of uncompensated care continues to be greater than the growth of hospital revenues, uncompensated care will continue to strain hospital bottom lines and emergency departments (EDs). Consequently, the EMTALA safety net could unravel, leaving all patients with diminished access to quality emergency medical services.

RECENT TRENDS IN INSURANCE

The rising percentage of individuals who receive uncompensated or low-compensated care in EDs may be the result of recent trends in insurance. As insurance premiums and out-of-pocket costs increase, an individual's ability to afford higher rates falls. Over time, this often leads to individuals dropping their coverage and relying on public programs in order to receive medical care.

Premium Increases

The majority of ED patients have insurance, with the largest proportion of payment coming from private insurance.

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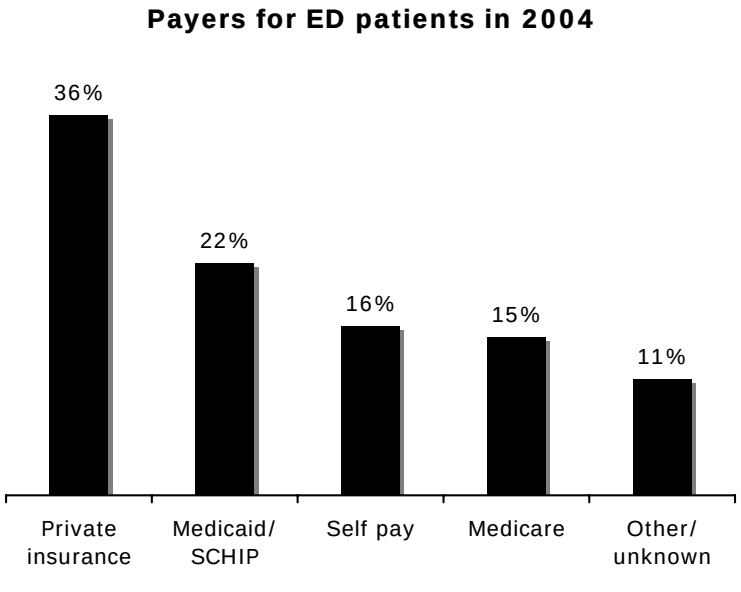
[8] Catlin A, Cowan C, Heffler S, Washington B, and the National Health Expenditure Accounts Team. National Health Spending in 2005: The Slowdown Continues. *Health Affairs.* 2007; 26:142-153.
[9] Gilmer T, Kronick R. It's the premiums, stupid: projections of the uninsured through 2013. *Health Affairs.* 2005; 24:143-151.
[10] Ibid.



[11]

Although premium growth in private health insurance exhibited a slowdown from 2002 to 2005, it still rose 6.6% in 2005. Rising health care costs may cause insurance premiums to rise, which may drive down private coverage and increase uninsurance.[12] As health insurance premiums rise and consumers spend a greater proportion of their incomes on insurance, their ability to buy other goods may become more constrained.[13] When the portion of an individual's income devoted to insurance becomes too large, he or she will often discontinue their enrollment in insurance (See Figure A). As the number of uninsured individuals increases, the need for public programs to fill in the gaps increases as well.

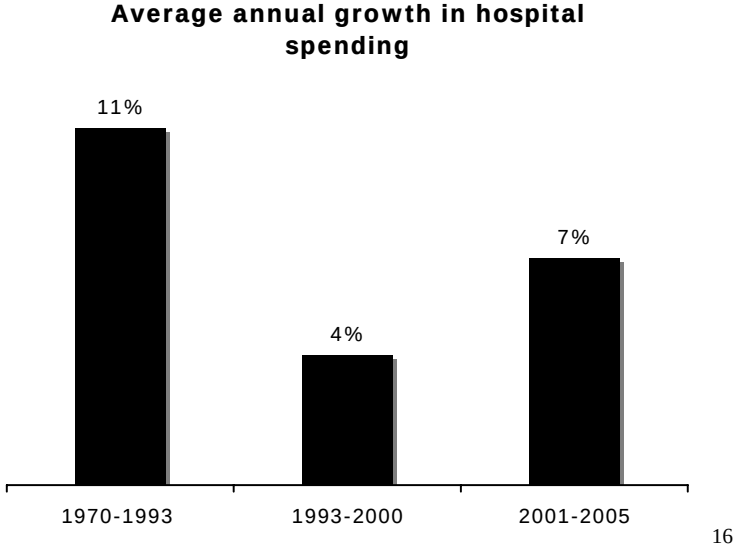
[11] McCraig LF, Nawar EW. National Hospital Ambulatory Medical Care Survey: 2004 Emergency Department Summary. Advance Data from Vital and Health Statistics. 2006; 372. http://www.cdc.gov/nchs/data/ad/ad372.pdf. Accessed February 21, 2007.
[12] Keenan PS, Cutler DM, Chernew M. The Graying' Of Group Health Insurance. *Health Affairs.* 2006;11:1497-1506.
[13] Ibid. Gilmer T, Kronick R. 2005.

Out-of-Pocket Increases

A 2006 *Health Affairs* article predicts that health care costs and insurance premiums will "continue to grow faster than workers' earnings," resulting in increasing uninsurance.[14] Many employees' out-of-pocket costs are growing because of employer cost saving through "increasing the use of coinsurance, adding deductibles, and eliminating coverage for specific treatments or prescription drugs." Thus, even if the growth in premiums begins to slow, the growth in the percentage of income devoted to health care may continue to affect insurance affordability.

RECENT TRENDS IN HOSPITAL SPENDING

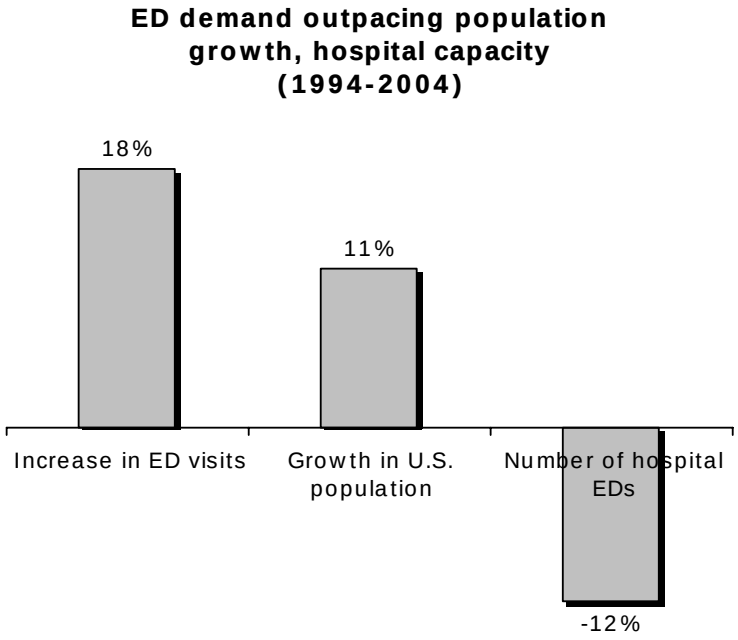
Since 2001, hospital spending has risen substantially and is now the largest segment of overall U.S. health spending. In 2005 hospital spending was responsible for 31% of health care, and it continues to be a stable, key driver of health costs. [15]



[16]

[14] Holahan J, Cook A. Changes in Economic Conditions and Health Insurance Coverage, 2000-2004. Health Affairs. 2005;24:w498-w508.
[15] Ibid. Catlin A, et al. 2007.
[16] Ibid. Catlin A, et al. 2007.

This trend in rising hospital spending is a result of the rise "in the underlying cost of providing care."[17] Such costs include "increased compensation and malpractice costs combined with hospitals' improved ability to pass these costs on to private payers as a result of their stronger negotiating position."[18] In addition, some postulate that as a result of the national shift away from tightly controlled hospital use by managed care companies in the 1990s, the United States has seen increased utilization of and demand for hospital services.



19,20, 21

Costs of Providing Care in the Hospital Setting

The cost of providing uncompensated or low-compensated care may affect the financial viability of a hospital. The associated expenses of uncompensated care make

[17] Ibid. Catlin A, et al. 2007.
[18] Ibid. Catlin A, et al. 2007.
[19] Ibid. McCraig LF, Nawar EW. 2006.
[20] Historical Health Insurance Tables. http://www.census.gov/hhes/www/hlthins/historic/hihistt1.html. Accessed March 13, 2007.
[21] Ibid. McCraig LF, Nawar EW. 2006.

cost shifting difficult. In addition, the growth of specialty hospitals and bad debt require hospitals to make difficult budgetary choices, often leading to reductions in services and staff.[22]

Cost Shifting

Some health care economists believe that hospitals try to shift the cost of providing uncompensated or low-compensated care by charging higher prices to individuals with private health insurance.[23] They argue that reimbursement rates for public health insurance programs require hospitals to shift costs in order to make up for any financial losses incurred in the treatment of publicly insured patients. A study of California hospitals from the 1980's to the 1990's concluded that cost shifting was occurring, but that only hospitals with substantial market power can shift costs and that an institution's ability to do so declined over time. A 2006 *Health Affairs* article concluded that, "states with low public payments relative to costs and high degrees of charity care are associated with high private payment-to-cost ratios." However, reimbursement rates from private insurance companies have also declined, making it difficult for hospitals to shift costs.[24] Consequently, cuts in Medicare and Medicaid reimbursement combined with reduced private payer reimbursement levels could constrain hospitals' abilities to provide quality care.[25]

In the past some managed care organizations have tried to reduce physician payments through downcoding—coding a less severe diagnosis with a lower rate of

[22] Kaiser Commission on Medicaid and the Uninsured: Stresses to the Safety Net: The Public Hospital Perspective. http://www.kff.org/medicaid/upload/Stresses-to-the-Safety-Net.pdf. Accessed June 19, 2007
[23] Dobson A, Davanzo J, Sen N. The Cost-Shift Pyament 'Hydraulic': Foundation History, and Implications. *Health Affairs*. 2006;25: 22-33.
[24] Tsai A, Tamayo-Sarver JH, Chydulka JH, Baker DW. Declining Payments for Emergency Department Care, 1996-1998. *Ann Emerg Med*. 2003;41:299-308.
[25] Ibid. Dobson A, et al. 2006.

reimbursement—or by refusing to reimburse for a service where the patient's visit did not turn out to be an actual emergency. A 2002 *Annals of Emergency Medicine* study showed that almost two-thirds of all ED claims were initially denied while "reimbursed claims were uniformly downcoded."[26] In recent years, denials and downcoding have decreased since the passage of "prudent layperson" laws that require ED visits to be reimbursed based on presenting symptoms rather than the patient's final diagnosis.[27]

Specialty Hospitals

Hospitals may strategically offset uncompensated care losses by limiting their caseload to profitable procedures, such as orthopedic, cardiac or general surgical cases, or operating without an emergency room. These types of hospitals are referred to as "specialty hospitals" because of their niche services. From 2002 to 2004, the number of these specialty hospitals doubled, with the majority established in regions without certificate-of-need (CON) laws.[28] The rising number of specialty hospitals had a direct impact on the provision of emergency medical services and increasing uncompensated care rates. Some health care experts believe these hospitals "cherry-pick" the most profitable procedures from general acute-care community hospitals.[29] In a 2006 report to Congress, the Medicare Payment Advisory Commission (MedPAC) concluded that Medicaid patients make up only 3% of discharged individuals at physician-owned

[26] Young GP, Ellis J, Becher J, Yeh C, Kovar J, Levitt, MA. Managed care gatekeeping, emergency medicine coding, insurance reimbursement outcomes for 980 emergency department visits from four states nationwide. *Ann Emerg Med*. 2002;39:24-30.
[27] Hall MA. The impact and enforcement of prudent layperson laws. *Ann Emerg Med*. 2004:43:558-566.
[28] Report to Congress: Physician-Owned Specialty Hospitals Revisited. http://www.medpac.gov/publications/congressional_reports/Aug06_specialtyhospital_mandated_report.pdf . Accessed March 1, 2007.
[29] Recommendations Regarding Physician-Owned Specialty Hospitals. http://www.cms.hhs.gov/reports/downloads/RTCPhysSpecHospPt2.pdf. Accessed March 1, 2007.

specialty hospitals, compared with 13% of patients at community hospitals.[30] The overhead at specialty hospitals is also lower since many of them do not have an emergency department, so they do not have uncompensated care costs, bad debt, or the same administrative burdens of hospitals with EDs.[31]

Included in CMS' hospital inpatient prospective payment system (IPPS) final rule for fiscal year (FY) 2007 was a requirement that all Medicare-participating hospitals with specialized capabilities be required to accept the transfer of unstable individuals, regardless of whether the hospital with specialized capabilities has an ED. Previously, CMS had taken enforcement actions based on its policy that all Medicare-participating hospitals with specialized capabilities have an EMTALA obligation to accept the transfer of an unstable individual protected by EMTALA. This rule could result in an increase in the number of specialty hospitals accepting transfers of emergency patients during nights and weekends.

Bad Debt

According to a 2003 American Medical Association (AMA) study, the financial impact of EMTALA on physicians' practices is reflected in the amount of bad debt incurred from providing EMTALA-mandated care.[32] The AMA defines bad debt as related to the "provision of services for which payment was expected but not received."[33] The study estimated that emergency physicians incurred on average $138,300 per year of

[30] Ibid. Report to Congress: Physician-Owned Specialty Hospitals Revisited.
[31] Mitchell JM. Effects of Physician-Owned Limited-Service Hospitals: Evidence From Arizona. *Health Affairs*. 10.1377/hlthaff.w5.481
[32] Physician Marketplace Report. http://www.ama-assn.org/ama1/pub/upload/mm/363/pmr2003-02.pdf. Accessed March 13, 2007.
[33] Ibid.

bad debt due, in part, to EMTALA. In contrast, physicians from other specialties incur an average of $25,000 of EMTALA-related bad debt.

THE COSTS OF PROVIDING EMERGENCY CARE

Beyond the issues directly affecting the financial viability of hospitals, several issues unique to the emergency department setting also place a burden on hospital financing. For example, the impact of uncompensated and low-compensated care has reduced specialists' willingness to take call. In addition, the case-mix in emergency departments—which includes a higher number of complex pediatric, mental health, and substance abuse cases—may impact not only the hospital's bottom line, but also the sustainability of the ED. Finally, emergency departments in rural areas are particularly susceptible to the potential burdens of uncompensated and low-compensated care.

On Call Issues

One of the most critical issues in emergency care is the hospital's ability to ensure adequate on-call specialist coverage. According to a 2005 survey, 73% of ED medical directors surveyed reported insufficient on-call specialist coverage.[34] A 2005 survey of hospital emergency department administrators found that uncompensated care was the second most commonly reported reason for the shortage of specialists providing ED coverage (the first reason was malpractice concerns).[35]

Some health care researchers believe that the shortage of specialists is related to inadequate reimbursement for on-call services. For example, many specialists do not want to take call in EDs with high volumes of pediatric Medicaid cases because

[34] On-Call Specialist Coverage in U.S. Emergency Departments. http://www.acep.org/webportal/Newsroom/NewsMediaResources/PK/oncallspecshortage. Accessed January 9, 2007.
[35] Hospital emergency department administration survey. http://www.tsged.com. Accessed March 13, 2007.

physicians say they say they have difficulty obtaining Medicaid reimbursement.[36,37] Although more studies of national trends are needed, the situation in California provides some insight to the issue. In California approximately eight out of 10 doctors report difficulties obtaining reimbursement for on-call services from private and public payers.[38] In addition, providers contend that reimbursement rates are so low that collection efforts are often not worth the time and administrative expense. California has funding sources to supplement the cost of care provided to uninsured or underinsured patients, but physicians also report problems collecting these payments. A recent study of California emergency departments revealed that where a hospital was located "had a significant impact on how long it took the specialist to respond" to a call; 23% of specialists paged by EDs in low-income areas failed to respond to the call within the required 30 minutes.[39]

In order to encourage specialists to take call, many hospitals are now offering stipends---a costly and unsustainable solution for most institutions. According to a 2005 survey by the American College of Emergency Physicians (ACEP), 36% of hospitals report paying stipends to specialists to take call (compared with 8% in 2004).[40] This growth might be attributable to physicians in other areas of the United States, especially the West Coast, becoming more aware of this practice.[41] Of the hospitals that offer on-call stipends to specialists, general surgeons receive these monies the most frequently.[42]

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[36] Institute of Medicine. *Emergency Care for Children: Growing Pains.* The National Academies Press, Washington, D.C. 2006. P 68.
[37] For more on this topic, please see the discussion about pediatric cases and Medicaid.
[38] Ibid. On-Call Specialist Coverage in U.S. Emergency Departments.
[39] Mohanty SA, Washington DL, Lambe S, Fink A, Asch SM. Predictors of On-call Specialist Response Times in California Emergency Departments. *Acad Emerg Med.* 2006;13:505-512.
[40] On-Call Specialist Coverage in U.S. Emergency Departments. http://www.acep.org/webportal/Newsroom/NewsMediaResources/PK/oncallspecshortage. Accessed January 9, 2007.
[41] Ibid.
[42] Ibid.

Pediatric Issues

Despite the rising number of uninsured people, 92.3% of children had insurance in 2005 (29.9% with public insurance and 62.4% with private insurance).[43] Pediatric emergency visits, however, result in a different payer mix than adult visits because they have a high proportion of Medicaid or State Children's Health Insurance Program (SCHIP) patients.[44] In addition, pediatric Medicaid recipients have disproportionately high ED usage rates; putting pressure on hospital EDs. Pediatric Medicaid patients often must seek care outside of regular business hours due to their guardians' work schedules. Research suggests that difficulty accessing primary care and some providers' refusal to accept Medicaid patients because of low reimbursement levels account for Medicaid patients' high ED usage rates. Medicaid and SCHIP reimburse at lower rates than other payers, approximately 60% of what Medicare pays, and 35% to 40% of what private insurance reimburses.

In addition, the complexity of the state Medicaid programs often make it difficult for providers to collect Medicaid payment, making specialists particularly reluctant to be on-call at pediatric EDs or EDs with high pediatric volume. Because Medicaid programs are crafted by each state, some choose not to reimburse for certain services provided to pediatric Medicaid patients in the ED. In addition, many private insurers model their payment structure on Medicare's Resource Based Relative Value Scale (RBRVS), which

[43] Early Release of Selected Estimates Based on Date from the January-June 2006 National Health Interview Survey. <http://www.cdc.gov/nchs/fastats/hinsure.htm>. Accessed February 21, 2007.
[44] Institute of Medicine. *Emergency Care for Children: Growing Pains.* The National Academies Press, Washington, D.C. 2006. P 56-65.

does not provide payment for certain common services provided to children in the ED, such as sedations.[45]

Mental Health and Substance Abuse Reimbursement

Mental health and substance abuse patients comprise a relatively small portion of ED cases, but their complex illnesses present providers with numerous complications. Many of these patients are uninsured or cannot afford to go elsewhere for care. Lack of access to care is due in large part to reductions in mental health and substance abuse expenditures, which have decreased by 13% in the past 10 years.[46] In addition, in real dollars, funding for community-based social services has decreased over the past two decades. These funding cuts have limited access to treatment for mental health and substance abuse individuals.[47]

A 2001 IOM report found that mental health-related ED visits grew from 6.5% in 1992 to 8.1% in 2001.[48] This is a small, but substantial jump because patients with mental illnesses can be resource-intensive.[49] These individuals receive "urgent" status and are more likely to be transported to the hospital in an ambulance than other patients. Patients with a mental illness likely need the consultation of a psychiatric specialist, resulting in longer and more expensive stays as they wait for a psychiatric consultation.[50]

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[45] IOM. *Emergency Care for Children: Growing Pains.* The National Academies Press, Washington, D.C. 2006. P 69.
[46] U.S. Department of Health and Human Services. National Expenditures for Mental Health and Substance Abuse Treatment 1997, 2000.
[47] Judge David L. Bazelon Center for Mental Health Law 2001
[48] Institute of Medicine. *Hospital Based Emergency Care: At the Breaking Point.* The National Academies Press, Washington, D.C. 2006. P 5.
[49] Larkin GL, Claassen CA, Emond JA, Camargo CA Jr. Trends in U.S. emergency department visits for mental health, 1992.2001. *Acad Emerg Med*. 2004;11:486-a.
[50] Emergency Departments See Dramatic Increase in People with Mental Illness. www.acep.org/1,33706,0.html. Accessed March 13, 2007.

Substance abuse cases are also costly and receive low reimbursement from private and public insurance payers. From 1992 to 2000, 8% of emergency room cases each year were attributed to alcohol.[51] In the second half of 2003, the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that 628,000 ED visits that were drug-related (Of those visits, 33% were for an adverse reaction, 17% for overmedication, 10% for detoxification, and 6% for drug-related suicide attempts).[52] Screening and on-site counseling could reduce these growing numbers, but research shows that ED physicians rarely perform these tasks, in part because some payers will not provide reimbursement for patients who test positive for drugs or alcohol.[53,54]

Rural and Critical Access Hospitals

Twenty-one percent of the United States' population lives in rural areas and it is this population is served by approximately 2,200 rural and critical access hospitals.[55] Rural hospitals face substantial obstacles providing emergency care. Rural hospitals tend to be smaller than their urban counterparts and often face shortages of emergency and trauma physicians, on-call specialists, and equipment. Rural hospitals paid under IPPS also tend to have lower margins. Patients at rural hospitals tend to be poorer, and are

[51] McDonald A, Wang N, Camago C. U.S. emergency department visits for alcohol-related diseases and injuries between 1992 and 2000. *Arch Intern Med.* 2004;164:531-537 [from within Institute of Medicine. *Hospital Based Emergency Care: At the Breaking Point.* The National Academies Press, Washington, D.C. 2006. P 5.]
[52] SAMHSA (Substance Abuse and Mental Health Services Administration). 2004. *2003 National Survey on Drug Use and Health.* Rockville, MD: Office of Applied Studies [from within Institute of Medicine. *Hospital Based Emergency Care: At the Breaking Point.* The National Academies Press, Washington, D.C. 2006. P 5.]
[53] Williams JM, Chinnis AC, Gutman D. 2000. Health promotion practices of emergency physicians. *American Journal of Emergency Medicine* 18(1):17.21 [from within Institute of Medicine. *Hospital Based Emergency Care: At the Breaking Point.* The National Academies Press, Washington, D.C. 2006. P 5.]
[54] Gentilello L. 2003. *Effectiveness and Influence of Insurance Statutes and Policies on Reimbursement for EmergencyCare*. Presentation at Crossing Barriers in the Emergency Care of the Alcohol-Impaired Patient meeting, Washington, DC. [from within Institute of Medicine. *Hospital Based Emergency Care: At the Breaking Point.* The National Academies Press, Washington, D.C. 2006. P 5.]
[55] Institute of Medicine. *Hospital Based Emergency Care: At the Breaking Point.* The National Academies Press, Washington, D.C. 2006. P 2.

more likely to be uninsured or publicly insured. In 2003, public programs, such as Medicaid and the SCHIP, insured 16% of people in rural areas compared with 10% to 11% in other areas.[56]

The Balanced Budget Act (BBA) of 1997 made substantial cuts to Medicare reimbursement payments that had a substantial effect on rural hospitals' margins. The BBA mandated that Medicare outpatient payments shift from a fee-for-service to a prospective-based system, reducing payments $118.9 billion (11.7%) from 1998 to 2004. Medicare payments to rural hospitals were also reduced by $14.7 billion (9.9%) from 1998 to 2004. The Balanced Budget Refinement Act (BBRA) of 1999 restored cost-based reimbursement for some services in rural hospitals and raised payments for hospitals dependent on Medicare revenues. The rule for CY 2007 included a provision to compensate rural hospitals with retroactive payments for low reimbursement rates between 2000 and 2006.[57] Nevertheless, given many rural hospitals' payer mix, the cuts have affected rural hospitals' ability to provide emergency services.

The critical access hospital (CAH) program, created by the BBA, exempts small rural hospitals from the outpatient prospective payment system. Instead, Medicare reimburses small rural hospitals designated as CAHs on a fee-for-service basis. These payments are 101% of the reasonable costs; however, private insurers who contract with Medicare do not have to adhere to the 101% payment rule.[58] More research is needed

[56] Kaiser Commission on Medicaid and the Uninsured. The Uninsured in Rural America. April 2003. Available at: http://www.kff.org/uninsured/loader.cfm?url=/commonspot/secuity/getfile.cfm&PageID=22146

[57] Final OPPS Rule. <http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/CMS1506FC.pdf>. Accessed February 28, 2007.

[58] Haugh, R. "A Rural Crossroad." *H&HN*. 2005; 79.

about how the CAH program has protected the provision of emergency care in these rural areas.

ANALYSIS OF THE CURRENT PAYMENT STRUCTURES FOR EMERGENCY CARE

Medicare

Currently, Medicare pays approximately 38% of all hospital revenues.[59] According to a 2000 AHA survey, 58.1% of hospitals reported negative total Medicare margins, which continues to grow due to a rising Medicare population. Hospitals have received Medicare payment updates below the inflation rate for 13 of the last 15 years. The BBA of 1997 led to the largest cut in Medicare payments in the history of the program. Medicare spending on hospitals continues to grow, but, in recent years, this growth has slowed. In 2004, Medicare spent 8.4% of its budget on hospitals, and in 2005, that number slightly decreased to 8.1%.[60]

Medicaid

Although the largest volume of ED utilization is attributable to privately insured and Medicare patients[61], Medicaid beneficiaries visit the ED at the highest rates of any patient population: 81 visits per 100 enrollees. This number is double the rate of the

[59] AHA (American Hospital Association). 2002. *Hospitals Face a Challenging Operating Environment: Statement of the American Hospital Association Before the Federal Trade Commission Health Care Competition Law and Policy Workshop*. Chicago, IL: AHA. < http://www.aha.org/aha/testimony/2002/020909-tes-aha-ftc.html>.
[60] Ibid. Catlin A, et al. 2007.
[61] DeLia D. Potentially Avoidable Use of Hospital Emergency Departments in New Jersey. New Jersey Department of Health and Senior Services. Rutgers Center for State Health Policy, July 2006.

uninsured population, and four times the rate of privately insured patients.[62] Research suggests that because many primary care providers refuse to take Medicaid patients, the patients use the ED as their source of primary care. In 2000, 73% of hospitals reported negative Medicaid margins, receiving 82 cents per dollar spent on Medicaid and charity care patients.[63] Hospital care represents the largest share of Medicaid spending, with 9.2% of the Medicaid budget going to hospitals in 2005, up from 7.2% in 2004.[64]

Outpatient Prospective Payment System (OPPS)

Enacted by the BBA of 1997, the Outpatient Prospective Payment System (OPPS) sought to slow the growth of Medicare costs and create incentives for hospitals to increase efficiency.[65, 66] Before OPPS, CMS used a cost-based reimbursement system for outpatient services, which gave hospitals an incentive to shift inpatient costs—paid on the flat rate DRG system—to outpatient units where they could receive increased payments.[67] Between 1984 and 1994, Medicare payments rose 13.4% annually to $11.9 billion.[68] Under OPPS, reimbursement for services varies based on the ambulatory payment classification (APC) group to which the service is assigned.[69] APCs are updated annually and are based on regionally adjusted, national average historical costs.[70]

Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA)

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[62] Institute of Medicine. *Hospital Based Emergency Care: At the Breaking Point.* The National Academies Press, Washington, D.C. 2006. P 2.
[63] AHA (American Hospital Association). 2002. *Hospitals Face a Challenging Operating Environment: Statement of the American Hospital Association Before the Federal Trade Commission Health Care Competition Law and*
Policy Workshop. Chicago, IL: AHA. < http://www.aha.org/aha/testimony/2002/020909-tes-aha-ftc.html>.
[64] Ibid. Catlin A, et al. 2007.
[65] Weissenstein E. Showdown at PPS Gap. *Modern Healthcare.* 1998; 28.
[66] Saphir A. New PPS brings mixed blessings. *Modern Healthcare.* 2006; 30.
[67] Ibid. Weissenstein E. 1998.
[68] Ibid. Saphir A. 2006.
[69] Final OPPS Rule. <http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/CMS1506FC.pdf>. Accessed February 28, 2007.
[70] Ibid. Saphir A. 2006.

The 2003 MMA appropriated $250 million per year for fiscal years 2005-2008 for payments for emergency health services furnished to undocumented aliens.[71] Two-thirds of the funds are divided among all 50 states and the District of Columbia based on their relative percentages of undocumented aliens. One-third is to be divided among the six states with the largest number of undocumented alien apprehensions (in FY 2005-2007 Arizona, California, Florida, New Mexico, New York, and Texas). Some health care experts argue that the allocated money will cover only a fraction of each state's uncompensated care costs for undocumented aliens. Estimates show that the cost for emergency services provided to undocumented aliens is $1.45 billion annually.[72] From a national perspective, $250 million represents 1% of the estimated $26.9 billion in hospital reported financial losses from uncompensated care in 2004. Section 1011 of the MMA has set a precedent by recognizing the amount of uncompensated care hospitals provide as a result of EMTALA-mandated services. However, many hospitals and physician groups have declined to participate in the reimbursement program, citing burdensome rules to qualify for payment.

Disproportionate Share Hospital (DSH) payments

The uninsured compose 14.1% of all ED visits.[73] Hospital groups' claim that reimbursement for these visits is low, creating sustainability problems for public and tertiary medical centers that bear a large share of these high-risk, complex patients. In 2001, the average emergency room charge was $943, while the average payment was

[71] Section 1011. https://www.trailblazerhealth.com/section1011/Default.aspx. Accessed March 1, 2005.
[72] Institute of Medicine. *Hospital Based Emergency Care: At the Breaking Point.* The National Academies Press, Washington, D.C. 2006.
[73] Ibid. McCaig LF, Burt CW. 2005.

$492.[74] Although public payers have steadily increased reimbursement, it has not kept pace with rising hospital costs. As a result, large public hospitals say that they may not be able to keep their EDs open.

To alleviate some of this burden, in 1985, Congress authorized supplemental payments known as the Disproportionate Share Hospital (DSH) adjustment to compensate hospitals that serve a disproportionately higher share of low-income patients.[75] Any hospital that provides at least 15% of their care to indigent populations qualifies to receive these payments.[76] For providers that qualify as a Medicare DSH, payments include a percentage add-on to the Diagnosis Related Group (DRG) base payment rate.[77] This add-on depends on the volume of low-income individuals that are treated in the particular hospital. In addition, if a hospital qualifies as a Medicaid DSH, add-on payments are determined by the state. Each state considers the situations of all disproportionate share hospitals and determines how much additional money they will receive for the services provided to indigent populations. In FY 2002, CMS estimated that combined federal and state Medicaid DSH payments were $15.9 billion, a major portion ($12.5 billion) of which was delegated to acute care hospitals.[78] Some states have also redirected their DSH payments to increase access to health insurance.[79, 80]

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[74] MEPS Data, 2001.
[75] Consolidated Omnibus Budget Reconciliation Act of 1985, Pub.L. 99-272, 100 Stat. 82.
[76] MedPAC. *Hospital Acute Inpatient Payment Services System*. October 2006. http://www.medpac.gov/search/searchframes.cfm
[77] Acute Inpatient PPS. http://www.cms.hhs.gov/AcuteInpatientPPS/. Accessed March 1, 2007.
[78] FFY 2002 Form CMS-64 Expenditure Reports. Unadjusted amounts by CMS. April 14, 2003.
[79] Silow-Carroll S, Alteras T. *Stretching State Health Care Dollars: Innovative Use of Uncompensated Care Funds.* The Commonwealth Fund. October 2004.
[80] For more on this topic, see "Creative use of DSH, Medicaid, and CHIP."

STATE INITIATIVES TO IMPROVE COVERAGE AND FINANCING

States are employing many approaches to increase insurance coverage and to help residents pay for care, including coverage of ED visits and preventive care.

Universal coverage initiatives

Some states have tried to ensure insurance coverage for all residents. In 2003, the Maine legislature passed the Dirigo Health Reform Act, which sought to make health care affordable to all citizens within five years.[81] The Act includes a health insurance product for small businesses and self-employed or unemployed citizens, with subsidies for low-income residents. The insurance—Dirigo Choice—is a public-private health insurance program in partnership with Anthem Blue Cross and Blue Shield of Maine. Maine is also expanding Medicaid to increase insurance coverage. The state believes that by expanding coverage it will avoid approximately $10 million in charity care and bad debt from uninsured patients.

In 2006 Massachusetts followed Maine by passing a universal coverage initiative that includes a requirement that all residents obtain health insurance and a "pay-or-play" mandate for employers.[82] To help low income residents obtain care, Massachusetts converted its uncompensated care pool into a premium-support program. This legislation also transforms the private insurance system into a single market structure, which has uniform rules and a central clearinghouse for administering coverage.

Creative use of Disproportionate Share Hospital (DSH) Funds, Medicaid, and SCHIP

[81] Innovations by State. <http://www.cmwf.org/tools/tools_show.htm?doc_id=305357>. Accessed February 28, 2007.
[82] Haislmaier EF, Owcharenko N. The Massachusetts Approach: A New Way to Restructure State Health Insurance Markets and Public Programs. *Health Affairs*. 2006;25:1580-1590.

Other states are using their uncompensated care and DSH funds "to finance primary and preventive care programs that could ultimately reduce emergency and inpatient hospital care costs."[83] For instance, Georgia created the Indigent Care Trust Fund in 1990 to expand Medicaid eligibility and benefits and support hospitals, nursing homes, and primary care programs that serve medically indigent citizens. To finance this fund, the state collects fees from providers and uses these revenues for its share of the Medicaid DSH payment. The state then uses the matching funds from CMS to finance the Indigent Care Trust Fund. Similarly, Maine is using DSH funds to finance a Medicaid expansion for indigent adults without dependent children.[84] In 1999, Michigan instituted Access Health--a subsidized health care program for uninsured residents working for small and medium-sized businesses. Access Health uses a "three-way share model": Employers pay 30%, employees pay 30%, and the state pays 40% of the health insurance premium. Federal funds match each dollar of the state's share.

Alternatively, other states are leveraging Medicaid or SCHIP funds to provide premium assistance. Rhode Island has attempted to use RIte Care funds—Rhode Island's combination Medicaid/SCHIP program—to pay for employer-sponsored insurance premiums.[85] In an effort to avoid cutting eligibility to RIte Care, the state is enrolling eligible families into RIte Share, the state's premium assistance program. Under RIte Share, the state pays the employee's share of employer-sponsored insurance premiums.

[83] Ibid. Innovations by State. 2005.
[84] Ibid. Silow-Carroll S, Alteras T. 2004.
[85] Ibid. Innovations by State. 2005.

Currently, no minimum or maximum employer premium contributions exist, although most employers contribute half of the costs.[86]

Similarly, by leveraging employer-sponsored health care, Pennsylvania has saved money while still helping low-income residents obtain health insurance. The Health Insurance Premium Assistance Program (HIPP), which was implemented in 1994, pays for employer-sponsored insurance for Medicaid enrollees when it is offered. Compared with providing direct Medicaid coverage, Pennsylvania saved $76.3 million in FY 2003 with the HIPP program. Finally, New Mexico created a public-private partnership that subsidizes premiums for indigent uninsured adults with unspent SCHIP funds. Three commercial managed care organizations are offering low-cost insurance through the New Mexico State Coverage Insurance program, which offers premium assistance.

Creating options for small business and the self-employed

Other states are trying to help small businesses and self-employed workers obtain insurance. Wisconsin established a law allowing farmers to pool their purchasing power to increase insurance affordability. The law allows farmers to form five health care cooperatives that will negotiate and contract with insurers to create health care plans for members, allowing individual farmers to buy into a group plan. In 2005, West Virginia implemented the Small Business Plan--a public-private partnership between the Public Employees Insurance Agency (PEIA) and Mountain State Blue Cross Blue Shield, which offers a health plan to uninsured small businesses. Although the state does not provide subsidies, the plan still benefits from the state's purchasing power because the insurance

[86] RIte Share: Premium Assistance in Rhode Island. http://www.commonwealthfund.org/innovations/innovations_show.htm?doc_id=235058. Accessed June 20, 2007

uses the provider reimbursement rates and prescription drug prices negotiated through PEIA's multiple state-purchasing plan.

In addition, Oregon has created the Children's Group Plan, which allows small businesses to provide coverage for children of workers, even if the business cannot afford to cover employees. Employers must contribute at least $50 while the family pays the rest of the premium, although lower-income employees may qualify for a subsidy from the state. To create an adequate risk pool, in a firm 75% of eligible families with children must participate. Arizona has created the Healthcare Group of Arizona, which is a public-private partnership of the state's Medicaid agency and two private health plans, which offers an HMO plan for small businesses. Employers and employees share the cost of premiums but the state subsidizes the program to make up for adverse selection and purchases catastrophic reinsurance for claims above $100,000.

FURTHER IDEAS FOR CONSIDERATION

Providers and policy makers generally agree that the health care safety net provided by EMTALA is essential, but they have little agreement about how to fund EMTALA. If health care spending and costs continue to rise, and reimbursements for EMTALA-mandated emergency services will not cover the cost of services-provided, EMTALA compliance may place increasing strain on the health care system. The following list of ideas, some of which would require statutory changes, should be examined in order to help sustain the original purpose of EMTALA without crippling the health care system:

1. Enact the equivalent of a "disproportionate share" adjustment for physician services.

2. Establishment of dedicated funding separate from DSH payments to reimburse hospitals that provide a significant volume of uncompensated emergency and trauma care.[87]

3. Revision of the Relative Value Units (RVUs) in the Medicare physician fee schedule to recognize uncompensated care in the practice expense portion of the payment.

4. Expansion of the allowable costs on Medicare cost reports to account for costs such as physician stipends for on-call services for cost reimbursement hospitals.

5. Increase payments to hospitals (via ED payments or other funds) for hospitals when full breadth of specialty on-call coverage is present 24/7.

6. Adoption of a state model for EMTALA service similar to Medicaid: A system where state provides half of the funding while the federal side would match each dollar.

7. Conduct a comprehensive MEDPAC review of cost related to EMTALA with payment options.

8. Creation of tax credits or tax incentives for physicians who provide EMTALA-related services; CPT codes for after hours.

9. Reimbursement for and encouragement of the use of telemedicine. Studies of telemedicine have demonstrated that it is effective in delivering acute care to trauma victims in remote locations.[88] Video conferencing has facilitated specialty consultation in a number of critical areas, including trauma, radiology, cardiology, and orthopedics. In addition, telemedicine has allowed specialist consultation before patient transfer; in one study a majority of both referring doctors and consulting specialists felt that it resulted in improved patient care.[89] Telemedicine could provide a way for hospitals to share specialists, relieving the on-call burden.

10. Revision of reimbursement regulations for Type-B EDs to include full reimbursement for fast-track systems and for EDs providing EMTALA-related care (even if not open 24 hours a day) to uninsured and under-insured patients.
11. Collaborate to regionalize critical specialty care on-call services. This would ensure coverage at key tertiary and secondary locations and alleviate the burden of every hospital having to maintain on-call services for every specialty.

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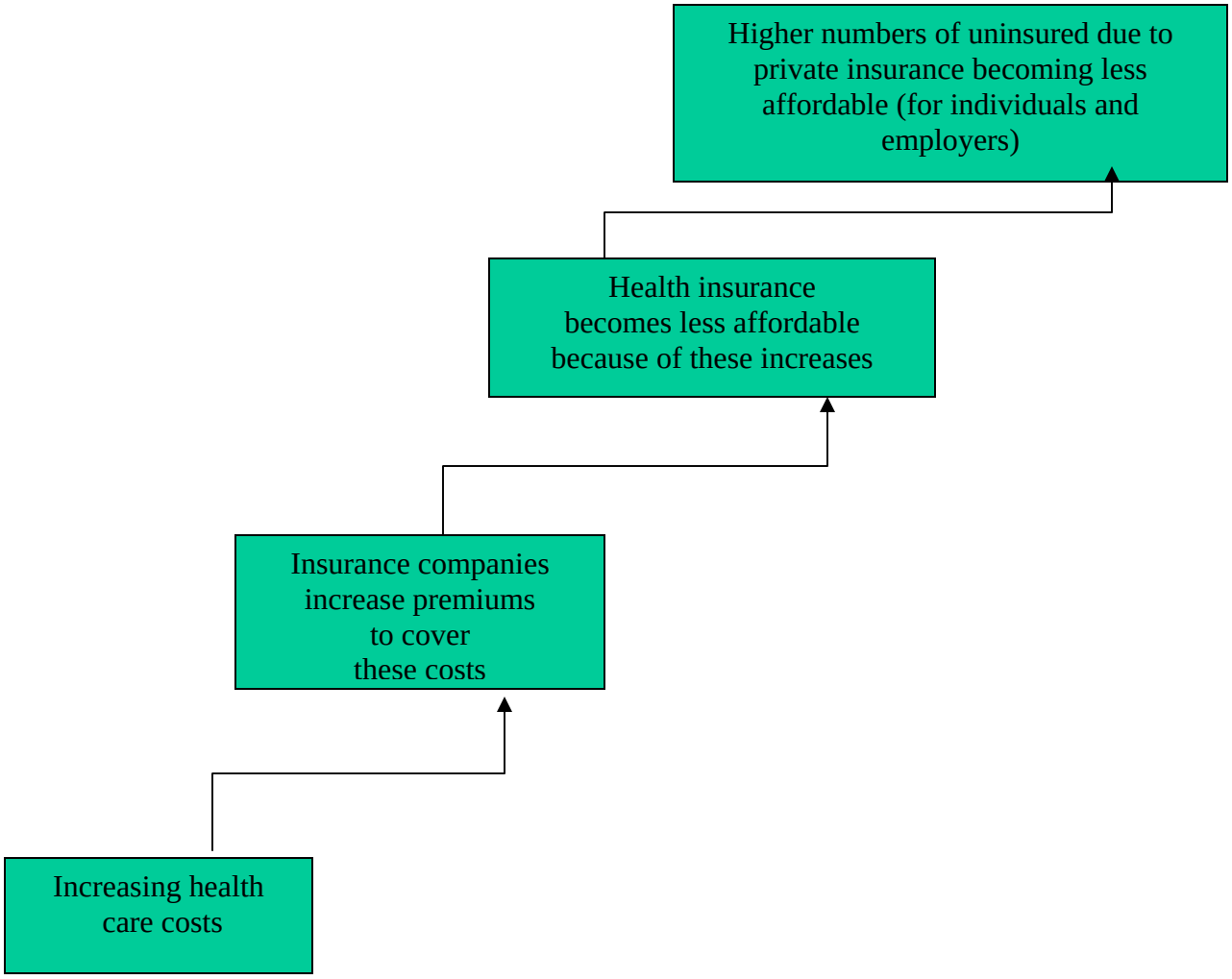
[87] Institute of Medicine. *Hospital Based Emergency Care: At the Breaking Point.* The National Academies Press, Washington, D.C. 2006. P 6.
[88] Institute of Medicine. *Hospital Based Emergency Care: At the Breaking Point.* The National Academies Press, Washington, D.C. 2006. P 139.
[89] Rogers F, Ricci M, Shackford S, Caputo L, Sartorelli K Dwell J, Days S The use of telemedicine for real time video consultation between trauma center and community hospital in a rural setting improves early trauma care: preliminary results. *J Trauma.* 2001: 51; 1037–1041

12. Increase of public reporting of hospitals on-call panels, waiting times, and access.

13. Coverage of the uninsured. This could solve all problems, but an estimate by the Urban Institute indicates that it would cost nearly $48 billion ($33.9-$68.7 billion), which would increase the current health spending per GDP by 0.4%.[90]

[90] Ibid. Hadley J, Holahan J. 2003.

Figure A


Higher numbers of uninsured due to private insurance becoming less affordable (for individuals and employers)
Health insurance becomes less affordable because of these increases
Insurance companies increase premiums to cover these costs
Increasing health care costs

APPENDIX 11

Impact of EMTALA on Workforce Capacity and the Emergency Department (ED)

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Impact of EMTALA on Workforce Capacity and the Emergency Department (ED)

ABSTRACT

This paper examines how the current emergency department (ED) workforce capacity affects hospitals' and providers' ability to comply with the Emergency Medical Treatment and Active Labor Act and provide universal access to emergency care. First, we assess overall physician capacity. We next assess the impact of physician workforce capacity on the ED. Similarly, we examine the impact of nursing workforce capacity on the ED. Third, we examine the implications of workforce capacity issues for ED care. Finally, we identify areas for further study to inform key stakeholders about changes that may be helpful in ensuring health care institutions and clinicians can continue to provide care under EMTALA.

INTRODUCTION

Historically, physician and nurse workforce capacity has been a source of concern for the American health care system. Throughout the 1950s and 1960s, concerns of an impending shortage of physicians emerged and prompted policy actions to expand the physician workforce.[1] Similarly, reports of an insufficient number of nurses to meet patient demand date back over 30 years.[2] More recently, in 1990, researchers began to note a shortage of health professionals in the emergency department (ED) in particular.[3]

The adequacy of the supply of healthcare professionals in the ED setting continues to be a source of concern expressed by some, particularly in light of recent growth in the utilization of ED services and a decline in the number of EDs. From 1993 to 2003, the number of ED visits increased by 26% (from 90.3 to 113.9 million visits), while the population grew by 12.3%.[4] Meanwhile, the number of EDs and inpatient beds decreased (425 fewer EDs and 198,000 fewer inpatient beds) across the country.[5] As a result, the Institute of Medicine (IOM), the Center for Health Workforce Studies, the Health Resources and Services Administration (HRSA), and many provider advocacy organizations have brought to light issues surrounding the emergency care workforce in recent years. The general consensus from the resultant literature is that workforce

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[1] U.S. Department of Health and Human Services. Health Resources and Services Administration. Physician Supply and Demand: Projections to 2020. October 2006.

[2] Schwarz E. The Nursing Shortage: A Call To Action. Topics in Advanced Practice Nursing eJournal, 2003 3(2).

[3] Gallagher EJ, Lynn SG. The Etiology of Medical Gridlock: Causes of Emergency Department Crowding in New York City. Journal of Emergency Medicine, 1990 8: 785-790.

[4] CDC. "National Hospital Ambulatory Medical Care Survey: 2003 ED Summary." 2003. Available at: www.cdc.gov/nchs/data/ad/ad358.pdf

[5] IOM. "IOM: The Future of Emergency Medicine in the United States Health System." June 2006.

capacity issues are one of several stresses threatening the ED, or what is also known as America's "safety net."

The sufficiency of the ED workforce has direct implications on the capacity of an ED to care for all individuals, regardless of ability to pay, as mandated by the Emergency Medical Treatment and Labor Act (EMTALA). EMTALA requires that when an individual presents to an ED and requests examination or treatment of a medical condition, "the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department." [6] If the hospital finds that an emergency medical condition exists, the hospital must provide for further medical examination and treatment as required to stabilize the individual to the extent possible given the hospital's available capacity.[7] This paper will examine the current and future state of ED staffing, and will explore how workforce capacity issues influence the ability of hospitals to fulfill EMTALA obligations.

OVERALL PHYSICIAN CAPACITY

The adequacy of the physician workforce both now and in the future is a source of considerable debate. Recent estimates from HRSA indicate that the U.S. is likely to face a shortage of physicians in the coming years. According to HRSA, if the US population continues to use services in the future as they have in the past, and if physicians practice medicine in the future as they have in the past, then the US likely will face a shortage of between 85,000 and 96,000 physicians in 2020. These estimates are based on assumptions that new physicians may work fewer hours than their predecessors; that those over age 45 and the baby-boom generation will continue to increase their rate of physician utilization compared to prior generations; and that growth in the nation's wealth will contribute to increased utilization of medical services. HRSA notes that other factors may contribute further to future physician shortages, including growth in non-patient care activities among physicians; potential changes in practice patterns among physicians over age 50; departures from practice due to liability concerns; decreases in hours worked by physicians in training; decreases in immigration of

[6] Emergency Medical Treatment and Active Labor Act, Section 1867a, 42 U.S.C. 1395dd.
[7] Emergency Medical Treatment and Active Labor Act, Section 1867b, 42 U.S.C. 1395dd.

graduates of foreign medical schools; increases in the practice of "boutique medicine"; advances in genetic testing that lead to increases in service utilization; and medical advances likely to keep individuals with chronic illnesses alive longer.[8],[9] Baseline projections from HRSA on primary care physicians in particular indicate that supply and demand will grow at about the same rate over the next 15 years, at which time demand will begin to outpace supply. Between 2005 and 2020, HRSA projects that the need for specialists will grow faster than supply, although other researchers forecast an excess of specialists.[10]

IMPACT OF PHYSICIAN WORKFORCE CAPACITY ON THE ED

Physician capacity issues may be felt more acutely in the ED setting, than in other settings of care, and may negatively affect hospitals' ability to fulfill EMTALA obligations, due to a convergence of two factors: (1) the number of physicians who practice primarily in the ED setting may be insufficient to meet current and future demand; and (2) the availability of specialists to take ED call is reported to be diminishing. Physician supply shortages impact the ED both directly, when there are not enough physicians to provide care in the ED, and indirectly, when there are not enough specialists to respond to calls from the ED. A detailed discussion of these factors and their effects on hospitals' ability to provide EMTALA-mandated care is presented below.

Emergency Physicians and Generalists

[8] U.S. Department of Health and Human Services. Health Resources and Services Administration. Physician Supply and Demand: Projections to 2020. October 2006.
[9] U.S. Department of Health and Human Services, Health Resources and Services Administration. Physician Workforce Guidelines for the United States, 2000-2020, January 2005.
[10] Ibid. U.S. Department of Health and Human Services, October 2006.

In 1999, approximately 32,000 physicians provided care in the ED setting, 62% of whom were either residency-trained or board-certified in emergency medicine.[11] In addition to board-certified emergency physicians, a significant amount of care in the ED is provided by generalists (e.g., family practitioners and internists), particularly in rural settings.

According to the Center for Health Workforce Studies, which cites 2004 data from the American Medical Association (AMA), the field of emergency medicine is experiencing significant growth. Since 1990, the number of emergency physicians in the U.S. has increased by 79%, while the number of total physicians increased by only 39%.[12] HRSA projects that by 2020, the number of emergency physicians will grow an additional 29%.[13] Despite these positive trends, a Center for Health Workforce Studies report suggests that the supply of board-certified emergency physicians will not be adequate to meet demand over the long-term.[14] The Massachusetts Medical Society also reports that, based on physician survey data, the field of emergency medicine is less than 1% away from being categorized as "severe" in terms of labor market tightness in that state.[15]

While the data on emergency physician availability in the U.S. are mixed, it is reasonable to suggest that emergency medicine will not be exempt from the pressures that many suggest are leading to an overall physician shortage nationwide. In fact, HRSA predicts these negative effects of an overall shortage likely will spill over to the

[11] Moorhead et al. A Study of the Workforce in Emergency Medicine: 1999. Annals of Emergency Medicine, July 2002 40(1).
[12] McGinnis S, Moore J, Armstrong D. The Emergency Care Workforce in the United States. Center for Health Workforce Studies, August 2006.
[13] Ibid. U.S. Department of Health and Human Services, October 2006.
[14] McGinnis S, et al., August 2006.
[15] Massachusetts Medical Society. Physician Workforce Study, June 2006.

emergency setting as well. When this occurs, and an individual hospital's emergency physicians and generalists reach capacity, it may become increasingly difficult for hospitals to fulfill the legislative intent of the EMTALA mandate to provide necessary stabilizing treatment within the hospital's capability and capacity.

On-Call Issues

In its 2006 report titled *Hospital-Based Emergency Care: At the Breaking Point,* the IOM characterized the lack of available specialists to provide on-call services as "one of the most troubling aspects" of a growing national crisis.[16] A survey published in 2006 by the American College of Emergency Physicians (ACEP) found that nearly 75% of ED medical directors reported inadequate on-call specialist coverage, compared with two-thirds in 2004.[17] Data from the American Hospital Association (AHA) paint a less bleak picture, but one that is troubling nonetheless: their 2006 survey data indicate that 42% of hospitals experienced gaps in specialty coverage in the ED.[18]

The Centers for Disease Control (CDC) estimates that hospitals have the most difficulty securing on-call surgeons, including plastic surgeons, hand surgeons, neurosurgeons, orthopedists, and cardio/thoracic surgeons. Difficulties also were reported for the specialties of psychiatry, otolaryngology, neurology, and ophthalmology, among others.[19] Regional studies of on-call specialist availability, for example in California and Oregon, support the findings of the CDC and advance the notion that on-

[16] Institute of Medicine. Hospital-Based Emergency Care: At the Breaking Point. The National Academies Press, 2006, Washington, DC.
[17] American College of Emergency Physicians. On-Call Specialist Coverage in U.S. Emergency Departments: ACEP Survey of Emergency Department Directors, April 2006.
[18] American Hospital Association. The State of America's Hospitals—Taking the Pulse, 2006.
[19] Burt CW, McCaig LF. Staffing, Capacity, and Ambulance Diversion in Emergency Departments: United States, 2003-04. Advance Data from Vital and Health Statistics, Centers for Disease Control and Prevention, September 27, 2006, 376.

call specialist shortages might contribute to the difficulties hospitals face in delivering emergency services.

The diminishing availability of specialists to take call in the ED can be attributed to both a decrease in the absolute *number* of specialists and a decrease in the *willingness* of specialists to participate in on-call panels. The AMA indicates that the number of resident physicians in specialties that provide surgical care in emergency situations has not, in general, increased.[20] Projections of a specialist surplus in the 1990s may have resulted in medical schools and hospitals scaling back specialist training opportunities, thereby reducing current and future specialist supply. For example, states such as Arizona have attributed on-call shortages to limited graduate medical education programs and resident training opportunities in the state.[21] The AMA also notes that about one-third of surgeons in specialties that commonly provide ED services are age 55 and older, and are often allowed by hospital bylaws to reduce or opt out of ED on-call responsibilities.[22] Finally, a 2003 mandated cap on the number of hours physicians may work during their residency may affect specialists' willingness to work as many hours as their predecessors when they leave their residency, thereby further reducing specialist "manpower" in the future.[23] As is the case when the supply of generalists and emergency physicians is not adequate, it becomes increasingly difficult for hospitals to fulfill the legislative intent of EMTALA to provide necessary stabilizing treatment within the

[20] Wilson C. The Future of Emergency and Trauma Care, Report of the Board of Trustees of the American Medical Association, 2006.
[21] Arizona Emergency Medical Services Task Force Report, December 13, 2006.
[22] Wilson C. The Future of Emergency and Trauma Care, Report of the Board of Trustees of the American Medical Association, 2006.
[23] Hutter MM, Kellogg KC, Ferguson CM, Abbott WM, Warshaw AL. The Impact of the 80-Hour Resident Workweek on Surgical Residents and Attending Surgeons. Annals of Surgery. June 2006 243(6):864-71; discussion 871-5.

hospital's capability and capacity when a shortage of specialists to take call in the ED exists.

The issue of specialists' *willingness* to take call has been characterized as "complex" and "highly politically and economically charged."[24] Inadequate reimbursement, financial losses due to uncompensated care, and liability concerns are frequently cited in the literature as important contributing factors to the on-call shortage. Other reasons cited in the literature include lifestyle issues, opportunities for specialists to build practices outside the traditional, acute hospital setting, and EMTALA regulations pertaining to hospital on-call requirements.

Lifestyle Issues

Potential disruptions of specialists' personal and professional lives are inherent when providing on-call services for EDs. Late-night telephone calls and weekend emergencies are unappealing for many specialists who seek a more balanced lifestyle with more time devoted to family and personal interests, or greater practice flexibility.[25,26,27] On-call disruptions are particularly problematic for specialists who state they are already coping with excessive professional demands, such as busy office and surgery schedules.[28]

Alternatives to Practice in the Acute-Care Hospital Setting

[24] Bitterman RA. EMTALA and the Ethical Delivery of Hospital Emergency Services. Emergency Medicine Clinics of North America, 2006.
[25] Ibid. Arizona Emergency Medical Services, December 2006.
[26] Wilson C. The Future of Emergency and Trauma Care, Report of the Board of Trustees of the American Medical Association, 2006.
[27] McConnell KJ et al. The On-Call Crisis: A Statewide Assessment of the Costs of Providing On-Call Specialist Coverage. Annals of Emergency Medicine, 2006.
[28] Johnson, LA et al. The Emergency Department On-Call Backup Crisis: Finding Remedies for a Serious Public Health Problem. Annals of Emergency Medicine, May 2001 37(5).

As a result of the lifestyle factors discussed above, along with changes in how specialist care may be delivered, many specialists are practicing medicine away from the traditional, acute-care hospital setting. Until recently, hospital bylaws frequently required specialists to take ED call in exchange for operating room and admitting privileges. Often, young specialists also relied on the ED to build their practices. With the advent of managed care and large, multi-specialty practices, many specialists no longer need ED call to build their practices. Additionally, ambulatory surgical centers and specialty hospitals, which frequently do not have EDs, provide alternative facilities for specialists to perform procedures that do not require specialists to be on-call.[29] Specialists also may choose to sub-specialize in procedures they can perform in their offices. Consequently, hospitals have lost most of their leverage to require specialists to participate in on-call panels.[30] According to findings from the 2007 American Hospital Association (AMA) Survey of Hospital Leaders, over one-third of hospitals now pay for some physician specialty emergency department call coverage.[31] Some hospitals may be forced to offer physicians less demanding on-call coverage schedules as a way to keep them from withdrawing their services altogether.[32] In California, as few as one-third of hospitals require on-call coverage in their bylaws as a condition of medical staff privileges, because doing so may prompt physicians to leave the hospital for a competing hospital.[33]

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[29] Ibid. McConnell KJ et al. 2006.
[30] Ibid. IOM, 2006.
[31] American Hospital Association. "The 2007 State of America's Hospitals – Taking the Pulse." July 2007. Available at: http://www.aha.org/aha/content/2007/PowerPoint/StateofHospitalsChartPack2007.ppt
[32] Ibid. Arizona Emergency Medical Services, December 2006.
[33] California Healthcare Foundation. On-Call Physicians at California Emergency Departments: Problems and Potential Solutions. Issue Brief, January 2005.

Given the ability of some specialists to build lucrative practices with little or no utilization of the hospital, few incentives exist for specialists to provide care to patients under EMTALA. A 2005 Rutgers Center for State Health Policy study of ED utilization and surge capacity in New Jersey notes that, "on-call work has become increasingly unattractive to specialists as on-call time is often uncompensated and specialists have more attractive options working in private practice and in specialty hospitals dealing with well-insured patients during normal business hours."[34] A 2002 *Annals of Emergency Medicine* article, "The EMTALA Paradox," describes the cumulative effect as "a spiraling situation in which physicians become less dependent on hospital-based work as a source of revenue, which further diminishes the incentives for physicians to provide the services required under EMTALA."[35]

EMTALA Regulations

Finally, it has been suggested that some hospitals have interpreted clarifying language provided by CMS in the September 2003 final EMTALA regulations surrounding hospital on-call obligations as allowing them to reduce the number of specialists they have on their on-call rosters. In response to this debate and the seriousness surrounding the issue, the EMTALA TAG has convened a sub-committee to evaluate on-call issues; their analysis will be issued in a separate paper. A further challenge faced by hospitals is that EMTALA does not *require* specialists to participate in ED on-call panels. Many have observed that this creates tension between hospitals

[34] DeLia D. Emergency Department Utilization and Surge Capacity in New Jersey, 1998-2003. Rutgers Center for State Health Policy, March 2005.
[35] Wanerman R. The EMTALA Paradox. Annals of Emergency Medicine, November 2002) 40(5).

who are mandated by law to provide specialist care and specialists who are under no legal obligation to do so.

Whether due to lacking numbers or willingness, a shortage of on-call specialists to provide care in the ED is a potential barrier to hospitals' fulfillment of EMTALA obligations. Hospitals must maintain a list of on-call physicians who are available to provide specialty services if required by the ED patient upon initial examination. If the needed specialist does not come to the hospital to provide care or if the specialist does not arrive in a timely manner, both the hospital and specialist may be liable under EMTALA.[36] Anecdotally, emergency physicians and other ED staff report they spend a great deal of time on the telephone trying to secure specialists to provide on-call services.

IMPACT OF NURSING WORKFORCE CAPACITY ON THE ED

According to the Emergency Nurses Association, there are approximately 100,000 emergency nurses in the U.S.[37] Between 1992 and 2000, growth in the number of emergency registered nurses (RNs) exceeded growth in the number of nurses generally—16.9% compared to 14.1% between 1992 and 1996, and 6.3% compared to 4% between 1996 and 2000.[38]

Despite recent positive trends in the supply of ED nurses, a current shortage exists and is expected to worsen in the absence of reform. Approximately 12% of RN positions for which hospitals are recruiting are for the ED—making the ED the third most common source of RN openings in hospitals.[39] The availability of nurses to staff the ED may be

[36] Kamoie, B. EMTALA: Dedicating an Emergency Department Near You. Journal of Health Law, Winter 2004 37(1).
[37] Emergency Nurses Association. Emergency Nursing Fact Sheet. Available: http://www.ena.org/EN-Week/BackgroundInfo.pdf.
[38] Ibid. McGinnis S, et al. , August 2006.
[39] Ibid.

exacerbated by an overall nursing shortage—HRSA characterizes the current shortage of RNs across all clinical areas as "moderate" and projects that by 2020, the shortage will be "severe" if current trends prevail.[40] Recent findings from the AHA estimate that, as of December 2006, there are 116,000 registered nurse vacancies.[41] Similar to physician shortages, nursing shortages may affect EDs' capacity and capability to fulfill EMTALA obligations both directly, when EDs struggle to procure adequate ED nursing staffs, and indirectly, when other areas of the hospitals become back-logged as a result of insufficient nursing capacity and patients cannot be moved out of the ED.

A 2006 report from the Center for Health Workforce Studies observes that the evolution of the present nursing shortage in the ED closely parallels that of ED crowding:

> "…managed care penetration, declining admissions, falling average daily censuses, and the need to staff below peak occupancy led to downsizing and a disappointing job market for nurses during the middle nineties. Nursing school enrollment declined and the average age of nurses in the United States rose to 44.3 years. Today, as practicing nurses retire, hospitals are forced to compete for, and then fight to retain, a decreasing number of new graduates. Yet new graduates are unable to function in high-acuity, critical care units (such as EDs and ICUs) and require mentoring from more experienced nurses. Unfortunately, non-patient care activities (such as mentoring) are economically difficult to support." [42]

Fewer nurses in the ED results in fewer staffed beds and limits the ED's ability to diagnose and stabilize new patients as mandated by EMTALA. A 2001 Issue Brief for the Massachusetts Health Policy Forum notes that, "hospital beds are of little use if there is no one to attend them."

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[40] Health Resources and Services Administration. What is Behind HRSA's Projected Supply, Demand, and Shortage of Registered Nurses? September 2004.
[41] Ibid. American Hospital Association. July 2007.
[42] McManus M. Emergency department overcrowding in Massachusetts: Making room in our hospitals. Issue Brief for the Massachusetts Health Policy Forum, June 2001.

Insufficient nursing supply in the inpatient setting may also influence the ED's capacity to provide EMTALA mandated care: un-staffed or under-staffed beds in the intensive care unit, critical care unit, or other inpatient settings prevent EDs from admitting patients. When these patients cannot be moved, the ED's ability to make room for new patients may be hampered. Hospitals may divert ambulances, and their capacity to provide EMTALA-mandated care may be diminished.

IMPLICATIONS OF WORKFORCE CAPACITY ISSUES ON ED CARE

Workforce capacity issues converge with other factors, such as facility capacity issues, to threaten the role of the ED as America's "safety net," a significant component of which is providing EMTALA-mandated care. As a result, patients may experience long waits or be transported to a distant hospital, particularly if they are in need of highly-skilled specialties such as neurosurgery, interventional cardiology, and orthopedic surgery.[43] While non-emergent patients may be better served in their physician's office, many choose to come to the ED because they would have to wait a very long time for an appointment with their physician, do not have a regular source of care, or because they are seeking tests not available in the office setting (e.g., magnetic resonance imaging). Uninsured patients in particular are unlikely to have primary care providers. When alternative care sites, such as free care clinics and community health centers, do not exist in their communities, uninsured patients rely on the ED as "both their first entry point into the healthcare system and their healthcare source of last resort.[44]

Noting national data demonstrating a rapidly rising trend in the use of the ED for primary care, treatable, and non-emergent medical problems, researchers at the Rutgers

[43] Ibid. IOM, 2006.
[44] Ibid. McManus M., June 2001.

Center for State Health Policy designed a study to measure the rate of ED admissions due to ambulatory care sensitive (ACS) conditions—those conditions that, while emergent, are usually preventable when individuals have access to timely and effective primary care (e.g., asthma and bladder infections). ACS admissions are representative of the importance of the ED for patients who lack adequate access to primary care in other settings, and perhaps could be avoided if medical care services were organized and delivered in a way that addressed primary care needs more effectively. The study found that ACS admissions comprised 24% of all hospital admissions through the ED for non-elderly adults, an increase of 25.6% between 1998 and 2003. Among children, ACS admissions are even more common—45% in 2003. ACS conditions also make up a significantly higher percentage of ED admissions for hospitals with high concentrations of Medicaid and uninsured/self-pay patients.[45]

FURTHER IDEAS FOR CONSIDERATION

Many possible ideas have been proposed to alleviate pressures of emergency workforce shortages that range from global reforms of the health care system, such as reducing the number of uninsured Americans, improving access to primary care, or increasing the overall number of nurses, to specific hospital-level or regional innovations in how emergency services are provided. The following list of ideas should be examined as possible means to help sustain the original purpose of EMTALA while improving workforce capacity without crippling the health care system.

1. Regionalization of ED Services

[45] Ibid. DeLia D., March 2005.

One of the most commonly referenced strategies to overcome ED workforce issues is the regionalization of emergency medicine services. The Institute of Medicine (IOM) supports the overall regionalization of trauma services as a means to improve outcomes and reduce costs across a range of high-risk conditions and procedures. The regionalization of on-call specialty services would direct patients to the hospitals with optimal capabilities for any given type of illness or injury.[46] The AMA describes an ideal regionalization plan as one that designates specific hospitals as referral centers in order to ease on-call staffing difficulties and remove the burden from all hospitals to provide identical services.[47] It is important to note that the 2006 IOM report cites concerns that EMTALA regulations may present barriers to regionalization plans, claiming that "the statute is not clearly adaptable to a highly integrated regional emergency care system in which the optimal care of patients may diverge from conventional patterns of emergency medicine and transport."[48] The IOM urges the EMTALA TAG to adopt regulatory changes or clarifications that preserve the original intent of the law while providing for the regionalization of emergency medical care. The TAG recommendations regarding this important concept will be included in the recommendation section of the final TAG report.

2. Increased Utilization of Telehealth/Telemedicine Practices

An additional strategy that may be used in conjunction with regionalization is the enhancement of telemedicine capabilities, particularly in rural areas. The AMA notes

[46] Ibid. IOM, 2006.
[47] Ibid. Wilson C. 2006.
[48] Ibid. IOM, 2006.

that telemedicine could facilitate specialist consultations across institutions.[49] A study conducted at the Baylor College of Medicine and the Ben Taub General Hospital suggests that "the desirability of remote evaluation of trauma victims is based on the potential benefit to trauma victims that present at hospitals without a defined trauma system or with limited trauma related resources and may not be limited to rural environments."[50]

3. Stipends

One of the most common strategies employed by hospitals to overcome on-call specialist shortages is the provision of stipends as a guaranteed rate of pay. Independent surveys conducted by both the AHA and ACEP found that more than one-third of hospitals now pay some physicians for specialty coverage.[51,52] An additional survey conducted in Oregon found that the largest stipends were paid to trauma surgeons, neurosurgeons, and orthopedists, with a median per-diem stipend of approximately $1,000.[53] Hospitals also may combine stipends with a system that provides for productivity based payments.[54] While this may ease on-call specialist shortages for some hospitals in the short-term, many doubt the viability of this strategy as a long-term solution due to its high costs for hospitals.[55]

4. Increased Utilization of Mid-level Professionals and Hospitalists

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[49] Ibid. Wilson C. 2006.
[50] Aucar J et al. Is Regionalization of Trauma Care Using Telemedicine Feasible and Desirable? The American Journal of Surgery, December 2000 180.
[51] Ibid. American College of Emergency Physicians, April 2006.
[52] Ibid. American Hospital Association. 2006.
[53] McConnell KJ et al. The On-Call Crisis: A Statewide Assessment of the Costs of Providing On-Call Specialist Coverage. Annals of Emergency Medicine, 2006.
[54] Ibid. Wilson C. 2006.
[55] Ibid. California Healthcare Foundation, January 2005.

It has been suggested that mid-level practitioners, including advanced practice nurses, physician assistants, and hospitalists can relieve doctors of some on-call responsibilities and alleviate pressure on emergency physicians. The California Healthcare Foundation describes a hospital in central California that uses physician assistants as first responders to assess patients and coordinate care.[56] The Department of Medicine at the University of Rochester found that a "transition team" composed of one mid-level professional and one nurse can relieve some ED physician workload.[57]

Hospitalists are physicians who focus exclusively on managing hospital inpatients. They may be more willing to accept emergency admissions after hours or at night than other physicians, which helps maintain patient flow and reduces the risks of crowding and ambulance diversion. Hospitalists also may help with shortages of on-call specialists by reducing the number of calls placed when patients' conditions do not necessitate specialist care. It is important to note, however, that hospitalists are generally best-suited for medical cases and are not likely to alleviate surgical specialist shortages.[58]

CONCLUSIONS

Workforce capacity issues affect the providers on the front lines of emergency services and the patients who seek care in the ED. The IOM found that the emergency physicians and generalists who remain on the front lines of emergency care are "increasingly exhausted, stressed out, and frustrated by the deteriorating state of emergency care and the safety net that it supports."[59] Insufficient workforce capacity

[56] Ibid.
[57] Ganapathy S, Zwemer FL. Coping with a Crowded ED: An Expanded Unique Role for Midlevel Providers. American Journal of Emergency Medicine, March 2003 21(1).
[58] Ibid. IOM, 2006.
[59] Ibid.

may make it increasingly difficult for hospitals to fulfill their obligation under EMTALA to screen and stabilize all patients who come to the ED. The supply of emergency physicians and on-call specialists may not be adequate at times, due either to decreasing absolute numbers or diminished willingness to practice in the ED. Nursing shortages—both in EDs and in hospital inpatient departments—may lead to a backlog of patients in the ED and prevent new patients from being seen. No simple solution exists to solve ED workforce capacity issues and strategies to alleviate the pressure range from broad-scale reform measures (e.g., regionalization of emergency medical services) to facility-specific measures (e.g., increased utilization of telemedicine). It is likely that solutions of both scopes will need to be implemented in order to maintain the integrity of America's safety net, both now and in the future.