REPORT NUMBER THREE

to the

Secretary

U.S. Department of Health and Human Services

From the

Emergency Medical Treatment and Labor Act

Technical Advisory Group

CMS Headquarters, Central Building
Baltimore, MD

October 26–28, 2005

EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA)
TECHNICAL ADVISORY GROUP (TAG)
Minutes
October 26–28, 2005

Welcome, Call to Order, and Opening Remarks

David Siegel, M.D., J.D., called the meeting to order on Wednesday, October 26. (See Appendix A for the meeting agenda). He welcomed the members of the TAG and the audience and introduced new member Rory Scott Jaffe, M.D., M.B.A., Executive Director of Medical Services for the University of California. Dr. Siegel reiterated the group's functions, as identified in the charter, and outlined the agenda for the meeting.

Summary Reports of the Subcommittees

On-Call Subcommittee

John Kusske, M.D., chair of the On-Call Subcommittee, outlined the four major issues the group hoped to address at this meeting. He presented background/rationale statements from the subcommittee for recommendations on 1) using a range of minutes in the requirements for physician response time and 2) the TAG recommendation that CMS not require physicians to take emergency call as a Condition of Participation in Medicare. Julie Mathis Nelson, J.D., asked the subcommittee to stipulate that "response" refers to making contact in response to the initial call. Charlotte Yeh, M.D., asked the subcommittee to consider making recommendations on how CMS could encourage physicians to take emergency call. The subcommittee is also working on clarifying physicians' obligations in light of regulations regarding "selective call" and revising the "best meets the need" regulation.

Action Subcommittee

Ms. Nelson, chair of the Action Subcommittee, presented background/rationales statements from the subcommittee for recommendations on 1) who may certify that a patient is in labor and 2) communication with a patient's personal physician. Three members of the subcommittee have formed a sub-subcommittee to address psychiatric emergency medical conditions (EMCs), screening, and stabilization. The Action Subcommittee is also discussing expanding EMTALA waivers for state and local emergencies (in addition to national emergencies) and the duty of hospitals with specialized capabilities to accept patients transferred under EMTALA guidelines.

> *Action Item*
> The TAG requests that CMS staff identify representatives of hospitals affected by Hurricane Katrina who could provide input on challenges associated with the waiver of EMTALA requirements during national emergencies. The TAG requests that those individuals be invited to provide testimony at the next meeting of the EMTALA TAG. In particular, CMS staff should contact the chair of the National Association of Emergency Medical Service Providers, which is planning to address the issue.

Framework Subcommittee

Dr. Yeh said the goal of the subcommittee is to shed light on critical health care issues that intersect with EMTALA guidelines and how the TAG's recommendations would affect those issues. The subcommittee has identified four areas of interest and will produce a document on

each: professional liability, reimbursement, supply and capacity (e.g., workforce and facilities), and disparities in care. The Framework Subcommittee is being assisted by Won Ki Chae, a medical student and graduate student at the Harvard School of Public Health.

Public Testimony

American Medical Association

Cecil B. Wilson, M.D., said requiring specialty hospitals to maintain emergency departments (EDs) would be "disadvantageous and inequitable" (Appendix 1). He noted that specialty hospitals have not caused the shortage of physicians available for emergency on-call coverage and therefore should not be subject to different or additional on-call requirements. He stressed that states understand the needs of their communities and should have more leeway in regulating emergency coverage than the Federal government.

Tom Gustafson, Ph.D., noted his understanding that EMTALA does not apply to a facility that does not have a dedicated ED. He added that these guidelines are the result of the Secretary's decision to interpret two parts of the EMTALA statute "conjunctively" (i.e., in relation to one another) and would differ if they were read "disjointedly." If the statute were interpreted disjointedly, it would require specialty hospitals without dedicated EDs to accept transfers of patients with EMCs if the sending hospital could not care for the patient and the specialty hospital had the capability to care for that patient.

Note: Following the TAG meeting, Tom Gustafson, wrote to the TAG to express concern that the statement above may not with full accuracy describe CMS policies and practices regarding hospitals with specialized capabilities. He requested that the following replacement language be included in this report:

Although a hospital without a dedicated ED that has specialized capabilities or facilities would have no EMTALA responsibility with respect to an individual who comes to the hospital as his or her initial point of entry into the medical system for emergency care, the issue has arisen as to whether such a hospital would have a separate obligation under section 1867(g) of the Act. CMS has in the past taken enforcement actions which presume that such a hospital does have an EMTALA obligation to accept an appropriate transfer of an unstable individual protected by EMTALA who requires those specialized capabilities or facilities.

American Hospital Association

Charles Hart, M.D., described how specialty hospitals have adversely affected the availability of specialty physicians for emergency on-call coverage in less populous states with fewer tertiary care centers (Appendix 2). He suggested that specialty hospitals should be required to have transfer agreements in place with general/community hospitals that address 1) procedures for appropriate transfer of patients not covered under EMTALA, 2) continuity of care, and 3) support for maintaining full-time emergency capacity at the general/community hospital, including on-call coverage.

Request for Data

The TAG asked the American Hospital Association (AHA) to provide the following data:

- Number of patient transfers before and after EMTALA regulations took effect

- Mortality and morbidity data on patients transferred out to distant facilities

American Surgical Hospital Association

Greg Miner said his organization represents most of the country's physician-owned hospitals, and all of its member hospitals have transfer agreements with their general/community hospitals (Appendix 3). He noted that states should determine requirements based on community needs, and additional Federal rules are not needed for specialty hospitals. The American Surgical Hospital Association (ASHA) advocates collaboration among institutions to facilitate emergency care for patients. Mr. Miner agreed to submit a policy statement from ASHA clearly describing its position on the obligation of specialty hospitals to receive patients under EMTALA.

Request for Data
The TAG asked the ASHA to provide the following data:

- Number of specialty hospitals that mandate that physicians take call at the local community or general hospital
- Source and breakdown of statistic that 42% of ASHA members have an ED
- Number of patients transferred under EMTALA from a specialty hospital to a community or general hospital (if possible, distinguish pediatric from adult patients)
- Number of patients transferred under EMTALA from a community or general hospital to a specialty hospital (if possible, distinguish pediatric from adult patients)

MedCath Corporation/Heart Hospital of New Mexico

Kathleen Blake, M.D., described the care provided by the 12 cardiac specialty hospitals in the MedCath system, all of which have full-time EDs open to the public (Appendix 4). She requested that specialty hospitals not be required to provide on-call coverage to other EDs, as such a requirement might have the unintended consequence of limiting the availability of emergency services.

Request for Data
The TAG asked the MedCath Corporation/Heart Hospital of New Mexico to provide the following data:

- Payer mix on patients transferred from a community or general hospital to a MedCath facility
- Breakdown of insured, underinsured, and uninsured patients with myocardial infarction and S-T segment elevation who present to a MedCath ED (if possible, compared with breakdown for local community hospitals)
- Number of visits per ED bed for all MedCath facilities

Federation of American Hospitals

Jeffrey Micklos said specialty hospitals should not be required to maintain an ED but should be required to accept appropriate transfers of patients with EMCs (Appendix 5). He stated that specialty hospitals have exacerbated the shortage of physicians available for emergency on-call coverage and therefore should be subject to different or additional on-call requirements. Mr. Micklos said his organization continues to believe the TAG should recommend that hospitals require all physicians on staff to take part in emergency call as a Medicare Condition of Participation, which would give hospitals more room to negotiate with physicians to ensure emergency call coverage is available. He added that his organization supports more upfront, collegial discussion about how to create and maintain an on-call emergency coverage list.

Request for Data
The TAG asked the Federation of American Hospitals to provide the following data:

- Support for the contention that physicians moving their practices to specialty hospitals has exacerbated the shortage of specialty physicians available to take call

Maureen Mudron, general counsel for the AHA, added that her organization is exploring the issues of collaborative call agreements and shared call.

American Ambulance Association

Kurt Krumperman explained that when EDs are full, ambulance personnel must wait in the hospital parking lot with the patient, administering care, before the patient is allowed into the ED for triage or treatment (known as "extended offloading") (Appendix 6). The combination of diversion status and extended offloading times affects the ability of the ambulance service to respond to other calls. Mr. Krumperman said his organization recommends that waiting more than 15 minutes to offload a patient be considered a violation of EMTALA by the hospital. Brian Robinson said extended offloading times may hamper access but do not constitute discrimination, which is what EMTALA was designed to prevent. Dr. Yeh said a delay in screening a patient with an EMC may be a violation of EMTALA.

Action Item

The Action Subcommittee would like input from the American Ambulance Association, among others, when it addresses the issue of hospital-owned versus non-hospital-owned ambulances.

Request for Data

The TAG asked the American Ambulance Association to provide the following data:

- Estimated number of hospital-to-hospital ambulance transports caused by lack of capacity, not lack of capability, to care for the patient

Written Testimony

The TAG reviewed written testimony and data provided from the American College of Emergency Physicians (Appendix 7); Horty, Springer, & Mattern, Attorneys at Law (Appendices 8a, 8b); The Schumacher Group (Appendices 9a, 9b); American Society of Plastic Surgeons (Appendix 10); and Protect Health Care Now (Appendix 11).

Discussion of Specialty Hospitals

For the sake of simplicity and clarity, the TAG agreed that specialty hospitals should be considered hospitals with specialized capabilities and referred to as such. Mr. Robinson said he did not think the statute took specialty hospitals into account when it was written, but it would be better for communities if specialty hospitals were considered the same as other hospitals under EMTALA, and TAG members agreed.

Recommendation

The TAG recommends that hospitals with specialized capabilities not be required to maintain EDs.

Recommendation

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

Action Item
The Action Subcommittee will consider whether hospitals without dedicated EDs are experiencing problems, for example, with maintaining on-call lists or effective transfer agreements.

The TAG discussed the utility of transfer agreements and the issue of "de-credentialing," i.e., physicians limiting their practices by dropping their privileges to perform certain procedures.

Ms. Nelson said that the inclusion in EMTALA regulations of 489.24(j)(1), the provision that hospitals must maintain an on-call list of physicians that best meets the needs of the hospitals' patients, leaves hospitals open to private lawsuits on the basis that their on-call list was insufficient. Moving it to the Medicare Conditions of Participation, 489.2(r)(2), would allow only the Federal government to enforce this area of the statute.

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

Ms. Mudron of the AHA asked the TAG to reconsider whether hospitals with specialized capabilities should have unique or additional emergency on-call requirements because simply clarifying these hospitals' duty to accept transfers does not address availability of specialty physicians. Carolyn Steinberg of the AHA added that when specialty physicians are practicing in a specialty hospital, they are not available to the community as a whole.

Action Item
The TAG will consider the impact on patient access in community hospitals of the recommendation that hospitals with specialized capabilities, both with and without dedicated EDs, be bound by the same responsibilities under EMTALA. The issue will be referred to one of the TAG subcommittees for initial discussion.

Dr. Siegel presented three articles from *Health Affairs* on specialty hospitals to the TAG members for their consideration (Appendices 12–14).

Subcommittee Reports

Framework Subcommittee

Dr. Yeh explained the format for the documents her subcommittee planned to produce. Each would have an overview of the topic, with additional background on the effect of EMTALA, followed by ideas to consider that may improve compliance with EMTALA. For the document on reimbursement, for example, the subcommittee may suggest mechanisms for paying for call coverage, such as including call in practice expense relative value units (RVUs) and disproportionate share payments. For the document on liability, for example, it may suggest national tort reform, "good Samaritan" protections, hospital sanctions other than removal from the Medicare program, or Federal peer review protection. For all the topics identified, the Framework Subcommittee seeks input from TAG members, including suggestions on data and

background material. Members provided a number of suggestions for the Framework Subcommittee's consideration.

Action Item
For its report on reimbursement, the Framework Subcommittee should consider:

- Creating incentives through tax relief proposals
- Improving reimbursement for freestanding psychiatric facilities by removing the exclusion for mental health providers, evaluating the Medicaid Fairness Act of 2003 for possible mechanisms, and identifying potential best practices or financial incentives for hospitals without on-site inpatient psychiatric care
- Linking reimbursement to existing American Medical Association Current Procedural Terminology (CPT) codes for providing care on nights, weekends, or holidays
- Prohibiting retrospective denial of reimbursement for EMTALA-mandated care

Action Item
For its report on liability, the Framework Subcommittee should consider:

- Federal health care programs that fall under Federal tort guidelines
- Caps or exemptions for psychiatric care provided under EMTALA regulations in the ED
- Malpractice reform efforts in Florida

On-Call Subcommittee

Dr. Kusske presented the subcommittee's rationale for the recommendation approved in June that CMS not require physicians to take emergency call as a Condition of Participation in Medicare (Appendix 15). It was approved by the TAG with revision of the title.

Recommendation
The TAG approved the rationale submitted by the On-Call Subcommittee for the recommendation that CMS not require physicians to take emergency call as a Condition of Participation in Medicare.

Dr. Kusske presented proposed changes to the Interpretive Guidelines[1] on physician response time, 489.24(j)(1). The TAG members discussed whether a physician's representative may respond on behalf of the physician, whether quality assessment and performance improvement measures should be explicitly described, and how to ensure that individual physicians have a stake in ensuring EMTALA compliance.

[1] * Interpretive guidelines and regulations noted above are from the *State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases* (Rev. 1, 05-21-04) available at http://www.cms.hhs.gov/manuals/107_som/som107ap_v_emerg.pdf

Action Item
The TAG reviewed the proposed revisions to the Interpretive Guidelines submitted by the On-Call Subcommittee on hospital policies for physician response times. The On-Call Subcommittee agreed to consider changes suggested and issues raised by TAG members and present a revised version at the next TAG meeting.

Action Subcommittee
Ms. Nelson provided the subcommittee's list of issues for discussion for the TAG's consideration (Appendix 16).

Action Item
The TAG reviewed Appendix G of the September 19, 2005, Action Subcommittee minutes, "EMTALA TAG Action Subcommittee Issues for Subcommittee Discussion." It will be posted on the CMS web site for public input.

Definition of Labor
Ms. Nelson presented the subcommittee's rationale for the recommendation approved in June that CMS delete the following sentence from the regulation in the definition of labor: "A woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable time of observation, the woman is in false labor." (Appendix 17). The rationale was approved by the TAG with revisions.

Recommendation
The TAG approved the rationale submitted by the Action Subcommittee for the recommendation that that CMS delete the following sentence from the regulation in the definition of labor: "A woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable time of observation, the woman is in false labor," with the following changes:

- In the rationale, the phrase "labor is not imminent" will be revised to "an emergency medical condition does not exist."
- In the corresponding Interpretive Guidelines, references to qualified medical personnel discharging patients will include the phrase, "consistent with state regulations regarding scope of practice."
- In the corresponding proposed change to the Interpretive Guidelines, the phrase, "e.g., Certified Nurse Midwife" will be removed.

Consultation with a Patient's Physician
Ms. Nelson presented proposed changes to the EMTALA regulation and corresponding Interpretive Guidelines on the emergency physician's communication with the patient's physician. The TAG members discussed the purpose and nature of communication and consultation regarding an ED patient. They agreed that communication should be encouraged, that non-physician health care providers may have valuable input, and that the emergency physician ultimately is responsible for determining the care of the patient. They felt the proposed revision needed clear definitions of "nonphysician practitioner," "clinician," and "qualified medical person(nel)."

Action Item
The TAG reviewed the proposed revision to the EMTALA regulation and corresponding Interpretive Guidelines submitted by the Action Subcommittee on emergency physician communication with other clinicians. The Action Subcommittee agreed to consider changes suggested and issues raised by TAG members and present a revised version at the next TAG meeting.

Action Item
The Action Subcommittee will review the Interpretive Guidelines to evaluate the regulations concerning communication between clinicians in a transferring hospital and those in a receiving hospital.

Definitions of Psychiatric Emergency Medical Condition and Stabilization
The sub-subcommittee addressing psychiatric considerations made several recommendations to the Framework Subcommittee for its reimbursement document on the impact that payment disparities for freestanding psychiatric hospitals have on availability of treatment for patients with EMCs. The group is discussing definitions of psychiatric EMCs. It would like to identify best practices and incentives for hospitals without psychiatric services that would encourage them to better screen and stabilize patients. The group is drafting language to address conflicts between EMTALA regulations and State/local protocols that address psychiatric patients with EMCs.

Hospitals with Specialized Capabilities
Ms. Nelson provided the subcommittee's list of discussion issues on hospitals with specialized capabilities for the TAG's consideration (Appendix 18).

Action Item
The TAG reviewed Appendix H of the September 19, 2005, Action Subcommittee minutes, "Hospitals with Specialized Capabilities Discussion Issues." Questions 1–10 of the document will be posted on the CMS web site for public input.

Administrative Items
Dissemination and Communication About EMTALA Regulations and Interpretive Guidelines
Dr. Siegel pointed out that the TAG may recommend ways for CMS to educate health care providers about EMTALA. Many TAG members agreed that more education is needed. Dr. Gustafson said the agency's Provider Communications Group and the Office of the Inspector General have several mechanisms available for such communication and education.

Action Item
EMTALA TAG subcommittees should identify specific areas of common misinterpretation or confusion related to EMTALA and forward them to Molly Smith at the Center for Medicare Management. At the next EMTALA TAG meeting, staff from the Center for Medicare Management will present an overview from the Provider Communications Group and describe the agency's existing methods for communicating with providers.

Scheduling
The TAG members agreed to schedule the next meeting sometime from late March to early April 2006.

Request for CMS Input
The TAG members continue to seek input and reaction from CMS staff regarding their recommendations.

> *Action Item*
> Recommendations from the EMTALA TAG will be presented to key staff of CMS and the Office of the Inspector General after each EMTALA TAG meeting for preliminary input. That input will be incorporated into a report on the status of TAG recommendations at the subsequent meeting.

Logistics
The TAG members agreed that subcommittees should be prepared to present their recommendations and requests to the TAG when they arrive for the TAG meeting. The input of the TAG should then be considered by the subcommittees for future recommendations and revisions. Therefore, the subcommittees should meet at the end of the TAG meeting to prepare for the next meeting.

> *Action Item*
> At the next EMTALA TAG meeting, subcommittees will meet for half a day at the end of the meeting.

Members also agreed that it would be helpful to subcommittees and the TAG to have a designated individual to make suggested revisions to documents (on a digital file) and project the revisions on a screen in real time.

> *Action Item*
> CMS staff will determine whether a projector can be provided for the TAG and its subcommittees to enable them to revise documents on a projected screen during their meetings.

Adjournment
Dr. Siegel adjourned the meeting at noon on Friday, October 28, 2005. Collected recommendations and approved motions of the TAG are listed in Appendix B.

EMTALA TAG Members Present at the October 26–28, 2005 Meeting

EMTALA Technical Advisory Group Members

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

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

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

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

Azzie Conley, R.N.
Assistant Section Chief for Acute Care
North Carolina State Survey Agency
Raleigh, NC

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

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

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

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

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

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

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

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

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

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

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

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

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

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

George Morey, Health Insurance Specialist
Hospital and Ambulatory Policy Group
Center for Medicare Management

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

Frank Sokolik, Director
Division of Acute Care Services

Public Witnesses
Kathleen Blake
MedCath Corporation/Heart Hospital of New Mexico

Charles Hart, M.D.
American Hospital Association

Kurt Krumperman
American Ambulance Association

Jeffrey G. Micklos
Federation of American Hospitals

Greg Miner
American Surgical Hospital Association

Maureen Mudron, General Counsel
American Hospital Association

Carolyn Steinberg
American Hospital Association

Cecil B. Wilson, M.D.
American Medical Association

Rapporteur
Dana Trevas
Magnificent Publications, Inc.

APPENDICES

Appendix A: Meeting Agenda
Appendix B: Recommendations, Actions, and Requests from the October 26–28, 2005, meeting

The following documents were presented at the EMTALA TAG meeting on October 26–28, 2005, and are appended here for the record:

Appendix 1: Statement of the American Medical Association to the Emergency Medical Treatment and Labor Act Technical Advisory Group re: Emergency Medical Services and Specialty Hospitals
Appendix 2: Statement of the American Hospital Association before the EMTALA Technical Advisory Group
Appendix 3: Statement of the American Surgical Hospital Association to the Emergency Medical Treatment and Labor Act Technical Advisory Group
Appendix 4: Statement of MedCath Corporation/Heart Hospital of New Mexico
Appendix 5: Statement of the Federation of American Hospitals
Appendix 6: Correspondence from the American Ambulance Association
Appendix 7: On-Call Specialist Coverage in U.S. Emergency Departments: American College of Emergency Physicians Survey of Emergency Department Directors, September 2004
Appendix 8a: Horty, Springer, & Mattern, Attorneys at Law, Re: EMTALA
Appendix 8b: Horty, Springer, & Mattern, Attorneys at Law, Re: Specialty Hospitals and EMTALA
Appendix 9a: The Schumacher Group: Summary Report, 2005 Hospital Emergency Department Administration Survey
Appendix 9b: The Schumacher Group: Percentages of Transfers: Preliminary Data, 2002–2005
Appendix 10: American Society of Plastic Surgeons: Emergency Department On-Call Survey, August 2005
Appendix 11: The Neurosurgery Crisis in North Carolina, Statement of Dan Albright, M.D., President, Protect Health Care Now
Appendix 12: Physician-Owned Specialty Hospitals: A Market Signal for Medicare Payment Revisions, by Jack Hadley and Stephen Zuckerman, *Health Affairs*
Appendix 13: Effects of Physician-Owned Limited-Service Hospitals: Evidence from Arizona, by Jean M. Mitchell, *Health Affairs*
Appendix 14: The Rise of the Entrepreneurial Physician, by Allen Dobson and Randall Haught, *Health Affairs*
Appendix 15: Recommendation and Rationale: The TAG recommends that CMS not require physicians to take emergency call as a Condition of Participation in Medicare.
Appendix 16: EMTALA TAG Action Subcommittee Issues for Subcommittee Discussion
Appendix 17: Recommendation and Rationale: Definition of Labor
Appendix 18: Hospitals with Specialized Capabilities Discussion Issues, Questions 1–10

APPENDIX A

Agenda*
Third EMTALA TAG Meeting
October 26–28, 2005
CMS Headquarters
Central Bldg
7500 Security Boulevard
Baltimore, MD 21244–1850.

Day 1	**Wednesday, October 26, 2005**
9–9:30	Welcome, call to order, and opening remarks
9:30–10:30	Summary Reports of On-Call and Action Subcommittees
10:30 – 10:45	Break
10:45 – 12:00	Discussion of On-Call Issues
12:00 – 1:00	Lunch
1:00 – 2:30	Public Testimony
2:30 - 2:45	Break
2:45 – 4:00	Discussion of Specialty Hospital Issues
4:00 – 4:30	Summary Report of Framework Subcommittee
4:30 – 5:00	Public comment.
5:00	Adjourn

Day 2	**Thursday, October 27, 2005**
9:00 -11:00	Subcommittee Meetings
11:00 – 12:00	Public Testimony
12:00 – 1:00	Lunch
1:00 – 1:45	Discussion of Framework Subcommittee Issues
1:45 – 2:45	Discussion of On-Call Subcommittee Issues
2:45 – 3:00	Break
3:00 – 4:30	Continued discussion of On-Call/Action Subcommittee Issues
4:30 – 5:00	Public comment
5:00	Adjourn

Day 3	**Friday, October 28, 2005**
9:00 – 10:00	Continued discussion of On-Call/Action Subcommittee Issues
10:00 – 10:15	Break
10:15 – 11:30	Discussion of current business
11:30 – 12:00	Public comment
12:00 p.m.	Adjourn

APPENDIX B

EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP (TAG)
Recommendations, Actions, & Requests
October 26–28, 2005

Recommendations

Hospitals With Specialized Capabilities

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

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

Call Coverage

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

The TAG approved the rationale submitted by the On-Call Subcommittee for the recommendation that CMS not require physicians to take emergency call as a Condition of Participation in Medicare.

Other Issues

The TAG approved the rationale submitted by the Action Subcommittee for the recommendation that that CMS delete the following sentence from the regulation in the definition of labor: "A woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable time of observation, the woman is in false labor," with the following changes:

- In the rationale, the phrase "labor is not imminent" will be revised to "an emergency medical condition does not exist."
- In the corresponding Interpretive Guidelines, references to qualified medical personnel discharging patients will include the phrase, "consistent with state regulations regarding scope of practice."
- In the corresponding proposed change to the Interpretive Guidelines, the phrase, "e.g., Certified Nurse Midwife" will be removed.

Action Items

General

The TAG reviewed Appendix G of the September 19, 2005, Action Subcommittee minutes, "EMTALA TAG Action Subcommittee Issues for Subcommittee Discussion." It will be posted on the CMS web site for public input.

The TAG reviewed Appendix H of the September 19, 2005, Action Subcommittee minutes, "Hospitals with Specialized Capabilities Discussion Issues." Questions 1–10 of the document will be posted on the CMS web site for public input.

The TAG will consider the impact on patient access in community hospitals of the recommendation that hospitals with specialized capabilities, both with and without dedicated emergency departments, be bound by the same responsibilities under EMTALA. The issue will be referred to one of the TAG subcommittees for initial discussion.

CMS staff will determine whether a projector can be provided for the TAG and its subcommittees to enable them to revise documents on a projected screen during their meetings.

Action Subcommittee

The Action Subcommittee would like input from the American Ambulance Associations, among others, when it addresses the issue of hospital-owned versus non-hospital-owned ambulances.

The Action Subcommittee will consider whether hospitals without dedicated emergency departments are experiencing problems, for example, with maintaining on-call lists or effective transfer agreements.

The Action Subcommittee will review the Interpretive Guidelines to evaluate the regulations concerning communication between clinicians in a transferring hospital and those in a receiving hospital.

The TAG reviewed the proposed revision to the EMTALA regulation and corresponding Interpretive Guidelines submitted by the Action Subcommittee on emergency physician communication with other clinicians. The Action Subcommittee agreed to consider changes suggested and issues raised by TAG members and present a revised version at the next TAG meeting.

Framework Subcommittee

For its report on reimbursement, the Framework Subcommittee should consider:

- Creating incentives through tax relief proposals
- Improving reimbursement for freestanding psychiatric facilities by removing the exclusion for mental health providers, evaluating the Medicaid Fairness Act of 2003 for possible mechanisms, and identifying potential best practices or financial incentives for hospitals without on-site inpatient psychiatric care

- Linking reimbursement to existing American Medical Association Current Procedural Terminology (CPT) codes for providing care on nights, weekends, or holidays
- Prohibiting retrospective denial of reimbursement for EMTALA-mandated care

For its report on liability, the Framework Subcommittee should consider:

- Federal health care programs that fall under Federal tort guidelines
- Caps or exemptions for psychiatric care provided under EMTALA regulations in the emergency department
- Malpractice reform efforts in Florida

On-Call Subcommittee

The TAG reviewed the proposed revision to the Interpretive Guidelines submitted by the On-Call Subcommittee on hospital policies for physician response times. The On-Call Subcommittee agreed to consider changes suggested and issues raised by TAG members and present a revised version at the next TAG meeting.

EMTALA TAG Agenda

The TAG requests that CMS staff identify representatives of hospitals affected by Hurricane Katrina who could provide input on challenges associated with the waiver of EMTALA requirements during national emergencies. The TAG requests that those individuals be invited to provide testimony at the next meeting of the EMTALA TAG. In particular, CMS staff should contact the chair of the National Association of Emergency Medical Service Providers, which is planning to address the issue.

EMTALA TAG subcommittees should identify specific areas of common misinterpretation or confusion related to EMTALA and forward them to Molly Smith at the Center for Medicare Management. At the next EMTALA TAG meeting, staff from the Center for Medicare Management will present an overview from the Provider Communications Group and describe the agency's existing methods for communicating with providers.

Recommendations from the EMTALA TAG will be presented to key staff of CMS and the Office of the Inspector General after each EMTALA TAG meeting for preliminary input. That input will be incorporated into a report on the status of TAG recommendations at the subsequent meeting.

At the next EMTALA TAG meeting, subcommittees will meet for half a day at the end of the meeting.

CMS staff will determine whether a projector can be provided for the TAG and its subcommittees to enable them to revise documents on a projected screen during their meetings.

Requests for Data

American Hospital Association

- Number of patient transfers before and after EMTALA regulations took effect
- Mortality and morbidity data on patients transferred out to distant facilities

American Surgical Hospital Association

- Number of specialty hospitals that mandate that physicians take call at the local community or general hospital
- Source and breakdown of statistic that 42% of American Surgical Hospital Association members have an emergency department
- Number of patients transferred under EMTALA from a specialty hospital to a community or general hospital (if possible, distinguish pediatric from adult patients)
- Number of patients transferred under EMTALA from a community or general hospital to a specialty hospital (if possible, distinguish pediatric from adult patients)

MedCath Corporation/Heart Hospital of New Mexico

- Payer mix on patients transferred from a community or general hospital to a MedCath facility
- Breakdown of insured, underinsured, and uninsured patients with myocardial infarction and S-T segment elevation who present to a MedCath ED (if possible, compared with breakdown for local community hospitals)
- Number of visits per emergency department bed for all MedCath facilities

Federation of American Hospitals

- Support for the contention that physicians moving their practices to specialty hospitals has exacerbated the shortage of specialty physicians available to take call

American Ambulance Association

- Estimated number of hospital-to-hospital ambulance transports caused by lack of capacity, not lack of capability, to care for the patient

APPENDIX 1

Statement

of the

American Medical Association

to the

Emergency Medical Treatment and Active Labor Act (EMTALA) Technical Advisory Group (TAG)

RE: Emergency Medical Services and Specialty Hospitals

Presented by: Cecil B. Wilson, MD

October 26, 2005

The American Medical Association (AMA) appreciates the opportunity to provide input to the Emergency Medical Treatment and Active Labor Act (EMTALA) Technical Advisory Group (TAG). Pursuant to section 945 of the "Medicare Prescription Drug Improvement and Modernization Act of 2003" (MMA), Congress legislated several improvements to EMTALA. Among these, Congress created the TAG to review EMTALA regulations and provide advice and recommendations for their improvement. The AMA strongly supported inclusion of Section 945 establishing the TAG within the MMA. We recognize that the TAG is actively soliciting comments and recommendations regarding the implementation of EMTALA regulations. We appreciate the TAG's efforts and look forward to working with the TAG and CMS to reduce regulatory burdens on physicians while continuing to safeguard the health of Medicare beneficiaries.

The TAG has requested comments on the intersection of EMTALA and specialty hospitals. Specifically, the TAG has asked for comments on whether specialty hospitals should be required to maintain dedicated emergency departments, whether specialty hospitals are subject to the EMTALA requirements, and whether additional or different on-call requirements should be established for specialty hospitals.

Specialty hospitals offer improved, cost-effective care because they are able to concentrate their efforts on the provision of specialized services. As a result of this focus, specialty hospitals have lower infection rates, fewer medical errors, shorter

turnover times, and increased cost efficiencies. Moreover, specialty hospitals encourage competition between and among health facilities, which has led to the delivery of higher quality, more efficient health care in the communities where they are located. By continuing to provide specialized services rather than being forced to deliver services that do not fit their model of care, specialty hospitals are able to offer superior, cost-effective care for patients and introduce important competition into the health care market.

Whether Specialty Hospitals Should be Required to Maintain Emergency Departments

The AMA believes that implementing a federal requirement, applicable only to specialty hospitals, to maintain emergency departments would be disadvantageous and inequitable. As with general hospitals, there are some specialty hospitals that maintain dedicated emergency services and others that do not. Whether a hospital maintains dedicated emergency services is based upon state law and the capabilities of each facility. Absent any indication that there is a national shortage of emergency services, state and local regulations regarding the need for emergency services should not be disturbed. Furthermore, arbitrary application of such a requirement only to specialty surgical hospitals would undermine the very characteristics that make them effective.

Historically state and local governments have established various regulatory standards regarding the establishment of health care services within their borders. This includes determining whether hospitals are required to maintain dedicated emergency departments. Some states require hospitals to have emergency departments as a condition of licensure; others do not. These decisions are made based upon the health care needs of the community. Imposing a federal mandate on specialty hospitals to maintain dedicated emergency services would create oversupply in some communities and exacerbate staff shortages in others. Rather than add unnecessary costs to an already overburdened health care system, the federal government should continue to respect the states' role in evaluating the health care needs of their residents and regulating the hospital industry within their boundaries.

Not only would a federal requirement to provide emergency services amount to the usurpation of a power traditionally reserved for state and local governments, it would unfairly put an onus on specialty hospitals that does not exist for general hospitals. Many specialty hospitals already maintain dedicated emergency departments. Some do so because it is required by state or local law. Others do so because it is consistent with the treatments they provide. Cardiac hospitals, for instance, have emergency departments because of the nature of the diseases they treat. They are likely to offer a broad array of supporting medical services, consistent with the medical needs of their cardiovascular patients. Other types of specialty hospitals that are not required by state or local law to maintain emergency departments, and would not have the capabilities to best treat emergency situations, do not maintain such facilities. This is also true of some general hospitals. There are many general hospitals that do not have dedicated emergency services. These general hospitals, like some specialty hospitals, transfer patients that they

are unable to accommodate to other facilities with the capacity to care for those individuals. Because not all general hospitals maintain dedicated emergency services and not all specialty hospitals lack them, any regulation that forces only specialty hospitals to maintain such services would be arbitrary and discriminatory.

Whether Specialty Hospitals are Subject to EMTALA

All hospitals, regardless of the state in which they are located, and regardless of their designation as a specialty or general hospital, are required to comply with EMTALA. Specialty hospitals located in states that require emergency departments, and specialty hospitals that provide the type of care that requires emergency facilities, maintain dedicated emergency services and are subject to EMTALA. Specialty hospitals with emergency departments will not turn away an EMTALA patient that comes directly to the hospital or is transferred from another facility so long as they have the capacity to treat that patient. In fact, cardiac hospitals often receive and accept transfers from general hospitals and other specialty hospitals that do no have heart programs and are not equipped to treat cardiac patients. Specialty hospitals without dedicated emergency services, like their general hospital counterparts, are subject to EMTALA in that they are required to stabilize and transfer any and all emergency patients that come through their doors. Specialty hospitals across the country understand and comply with these obligations.

Specialty hospitals are uniquely and specially designed and equipped. They focus on providing the highest quality of care in the specialties for which they are designed. It is precisely this specialization that allows these hospitals to deliver myriad benefits to their communities' - high-quality, state-of-the-art care; reduced average lengths-of-stay; high levels of patient satisfaction; and high staff satisfaction. Thus, by their very nature, specialty hospitals can only treat patients whose medical needs can be met by the hospital's resources. Patients with emergency conditions beyond a hospital's capabilities must be transferred to more comprehensive facilities, and patients that require specialty care must be transferred to hospitals that specialize in that care.

It is in the best interests of the patient for every hospital to do those things for which it is best suited and whenever possible transfer other cases to better-equipped establishments. All hospitals vary widely in the types of services they offer, consistent with their staffing, facilities, and the physicians present in the community. To require emergency services, or any other services, without taking into account the relative strengths and weaknesses of a facility, applicable transfer agreements, and the specific needs of the community would be improvident.

Whether Additional or Different, On-call Requirements Should be Established for Specialty Hospitals

The AMA is aware that some general hospitals are having problems with emergency department on-call coverage. The problem, however, was not precipitated by specialty hospitals. On-call coverage problems result from numerous issues, including; medical

liability concerns, extremely high levels of uncompensated care in emergency departments, shortages of certain specialty physicians, unequal payment rates for on-call services, and the generally increasing demands on medical staff. This is evidenced by the fact that the dilemma of on-call shortages existed long before the rise of specialty hospitals, as well as by the fact that the areas in which specialty hospitals are located do not necessarily correlate with the areas suffering the greatest on-call shortages.

In addition, physicians at specialty hospitals maintain privileges at one, and often many, community hospitals, which subjects them to emergency room call and all other requirements hospitals impose on physicians with privileges. Maintaining privileges at community hospitals is not only required by specialty hospitals, it is necessary for physicians from a practical standpoint. The realities of modern health care are such that insurance contracts determine the reason patients go to one hospital or another and physicians must have privileges at multiple facilities if they are to meet the medical and financial needs of their patients.

The only way in which the rise of specialty hospitals has contributed to the shortage of on-call physicians is by prompting general hospitals to engage in the self-destructive practice of revoking or refusing to grant medical staff membership or clinical privileges to physicians who have an indirect or direct financial investment in a specialty hospital. Many general hospitals have removed physicians who have a financial interest in a competing facility from their referral and on-call panels, and removed competing physicians from extra assignments under the control of the hospital, e.g., directors of departments, reading EKGs, ultrasounds, echocardiography, and x-rays. The AMA strongly opposes the use of such criteria to determine an individual physician's qualifications for granting or renewing medical staff membership or privileges. It is difficult to understand why hospitals, claiming to be suffering from staff shortages, would exacerbate the problem by implementing such policies.

There is no doubt that solutions for the longstanding problem of on-call shortages are needed. Indiscriminately requiring additional or different on-call obligations for physicians that perform procedures at specialty hospitals without considering these physicians current on-call responsibilities, and the specific circumstances of areas where specialty hospitals are located, is not the answer. The EMTALA TAG, together with local, multi-organizational task forces, with representation from hospital medical staffs, should work to devise solutions that take into account the varied circumstances that cause specific hospitals and areas of the county to suffer on-call shortages. This, along with the enactment of effective medical liability reform and adequate government funding for emergency medical services, should be the focus of this inquiry, not proposals that would stifle the beneficial competition and improved treatment that specialty hospitals bring to the health care system.

Conclusion

The AMA recognizes that the emergence of specialty hospitals has given rise to a number of concerns by general hospitals. Mandating emergency services, however, rather than

dealing with the problem of cross-subsidization from better-paying service lines, is not the appropriate solution. The proper course of action is to implement changes to the Medicare inpatient prospective payment system to minimize the need for cross-subsidization by more accurately reflecting the relative costs of hospital care, and fixing the flawed methodology for allocating Medicare and Medicaid Disproportionate Share Hospital payments. Hospitals are compensated based upon payments that vary according to patient diagnosis, complications, procedures, and the average resources required to treat comparable cases. This means that relatively lower paid services such as medical admissions, emergency care, trauma care, and burn care are subsidized by relatively better paid procedures.

The recent MedPAC report describes flaws in the hospital payment system that cause payments for some cases to be higher than the average cost of providing services and, conversely, to pay less than would be indicated for other cases. The AMA encourages CMS to adopt MedPAC's recommendation to revise these payment rates to better reflect relative costs. This process should ensure that Medicare payments accurately reflect the relative cost of providing care and that all hospitals are paid appropriately for their services to Medicare patients. Hospital services should be priced such that emergency departments enjoy the same operating margins as cardiac units. Requiring specialty hospitals to maintain services over and above what they are capable of providing is an unfair and inefficient method of leveling the playing field between specialty hospitals and general hospitals. Rather than forcing specialty hospitals to sacrifice the very things that make them valuable, disparities should be corrected by eliminating the need for cross-subsidization, ensuring that hospital payments better compensate historically unprofitable services, and promoting full and fair competition in the market for hospital services.

We again thank the TAG for its diligent attention and work in addressing these important EMTALA issues, and we look forward to working with the TAG and CMS to ensure a successful, common sense approach to the application of EMTALA that ensures the safety of all patients.

APPENDIX 2

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

October 26, 2005

Good morning. I am Dr. Charles Hart, president and CEO of Regional Health, an integrated health care delivery system serving South Dakota, Wyoming and Nebraska. I also am an emergency physician by training. On behalf of the American Hospital Association (AHA) and its 4,800 member hospitals and health systems, I appreciate this opportunity to address the Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group. My remarks will address the requirements that should be placed on physician-owned, limited-service hospitals related to the support of emergency services in the community.

Regional Health, which includes Rapid City Regional Hospital (RCRH) and a network of hospitals, clinics and senior living facilities, employs 4,125 people and has more than $600 million in annual revenue. RCRH, a sole community hospital licensed for 417 beds, serves as a major referral center for about 372,000 people within a 150-mile radius.

RCRH historically has offered a full-range of services, but the entry of physician-owned, limited-service hospitals not only has threatened our financial footing, but has made it increasingly difficult to maintain emergency access to neurosurgical and trauma care. These physician-owned surgical hospitals have created a profitable business in three ways: (1) by targeting healthier patients, (2) focusing on patients with good insurance, and (3) offering only well-reimbursed services with a high margin potential. These practices have siphoned off resources critical to our hospital's continued ability to serve the broader needs of the community.

In 1996, RCRH had a healthy, positive bottom line. In 2003, our bond rating was downgraded, and by 2004, we lost money on operations. In 2003, the Black Hills Surgery Center, a physicianowned orthopedic and neurosurgical hospital in our community, boasted an operating margin of

40.4 percent. We are only now, after considerable effort, able to generate a positive income from
operations.
2
Specialty hospitals generally don't have emergency departments (EDs). Physician-owned,
limited-service hospitals selectively decide which patients to treat. This practice, however,
jeopardizes access to emergency and trauma care for the region. The neurosurgeon-owners of
the Black Hills Surgery Center have abandoned taking call at Rapid City Regional Hospital,
leaving our facility with insufficient capacity to meet the needs of the community. We have the
facilities and the space, but our physician staff simply are stretched too thin. We have attempted
to recruit additional physicians, but there already are enough neurosurgeons practicing in our
community – they are just not available to all who need their care.
Our main hospital is the only tertiary care facility serving the region. We are not in a city where
we can divert patients to other facilities. A transfer to another tertiary care facility requires travel
of 350 miles or more. While we have the facilities to accept transferred patients from other
smaller hospitals in the region, we don't always have the physician capacity to meet their needs.
Therefore, we live under the constant threat of an EMTALA violation.
Physician-owned, limited-service hospitals strain the ability of community hospitals to maintain
on-call coverage and threaten emergency access to care. However, the consequences of these
facilities reach far beyond what can be addressed through EMTALA.

EMTALA AND PHYSICIAN-OWNED LIMITED-SERVICE HOSPITALS[1]

In the notice for today's meeting, the Centers for Medicare & Medicaid Services (CMS) requested information on how EMTALA might be applied to physician-owned, limited-service
hospitals. Specifically, CMS asked:

- whether a federal requirement is needed so that specialty hospitals maintain emergency departments and, if so, whether this is best achieved by amending EMTALA or through some other means;
- whether specialty hospitals, regardless of whether they have emergency departments, are
subject to EMTALA requirements under which a Medicare participating hospital with specialized capabilities or facilities may not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the

capacity to treat the individual; and
• whether additional or different on-call requirements should be established for specialty hospitals (for example, whether specialty hospitals should be required to participate in community protocols).

In response to these questions – and taking them in the order of the most relevance and significance to EMTALA – the AHA believes the third question is most important. Unique and specific requirements should apply to physician-owned, limited-service hospitals to support the provision of emergency services for the community. We also believe physician-owned, limitedservice hospitals should be treated as hospitals with specialized capability regardless of whether they have an emergency department. In general, however, it is unlikely this will result in

[1] CMS refers to hospitals providing primarily cardiac, surgical or orthopedic services, which are under Congress's moratorium, as specialty hospitals. The AHA, however, uses the term "physician-owned limited-service hospital" for more clarity, since children's, rehabilitation, women's and psychiatric hospitals traditionally have been referred to as specialty hospitals and are not the subject of today's discussion.

improved access for patients to the specialty care they need. Finally, the AHA believes requiring physician-owned, limited-service hospitals to operate an ED is not the best approach. Rather, we need existing emergency service requirements enforced.

We elaborate further on these issues below.

Unique and specific requirements should be imposed on physician-owned, limited-service hospitals to support the provision of emergency services for the community. Of the three questions posed, this requirement would have the greatest impact on the ability of community hospitals to meet EMTALA requirements, and ensure communities have access to needed care during medical emergencies. Most physician-owned, limited-service hospitals have withdrawn specialist services from the general community and created incentives for physicians to walk away from participating in on-call coverage for emergency departments and emergency patients.

Some physician investors in limited-service hospitals earn such high incomes that they no longer are interested in providing emergency department on-call service to the community hospital or in the referral base it might generate for them. **Ironically, the patterns and practices of physician-owned, limited-service hospitals in their selection of services to offer and the**

patients to treat raise the kind of disparate treatment concerns that are the reason EMTALA was created.

The AHA recommends the following:

• A physician-owned, limited-service hospital should be required to have a preexisting agreement with the community hospital(s) it intends to rely on for emergency back-up services.

• The Secretary of the Department of Health and Human Services should establish the terms that must be addressed by an agreement, including:

▸ Procedures for an appropriate transfer for patients not covered under EMTALA (e.g., inpatients or outpatients whose condition develops into an emergency beyond the capability of the limited-service hospital).

▸ Continuity of care (e.g., telephone consultation with the receiving hospital and physician, sending the patient's medical records along when transferred, etc.).

▸ Support for maintaining full-time emergency capacity at the community hospital, including on-call coverage (e.g., physician-owned, limited-service hospital physicians serve in on-call panels at the community hospital, or the physician-owned, limited-service hospital provides financial support to the community hospital to maintain on-call coverage).

As physicians are maintaining an increasing amount of their practice at physician-owned, limited-service hospitals or other sites outside the hospital (e.g., ambulatory surgical centers), they are shifting from full medical staff privileges at community hospitals to courtesy privileges.

At the same time, physicians performing surgical and other procedures outside the community hospital presume to rely on the community hospital for back-up in the event of complications requiring round-the-clock access to emergency care and inpatient admissions. Physician-owned, limited-service hospitals are required to meet general Medicare hospital requirements for adequate staff and personnel to meet the emergency needs of their patients. However, they are not required to have full-time EDs nor are they required to have a transfer agreement with the

4

hospital(s) on which they intend to rely for back-up when the emergency needs of their patients require more medical care than they can provide. This is more than hypothetical; at RCRH, we have accepted transferred patients from local physician-owned, limited-service hospitals who required limb amputation due to infection, and we have had transferred patients die on our catheterization lab table.

With the change in physician practice patterns and the increased number of physicians requesting
only courtesy admitting privileges, relying just on the professional obligations attached to admitting privileges is not sufficient to assure appropriate transfer arrangements and the availability of physicians to provide emergency specialty capacity. Every physician-owned,
limited-service provider that relies on the community's emergency services capacity should be
obligated to support it.

**A physician-owned, limited-service hospital should be treated as a hospital "with specialized capability or facilities" under EMTALA without regard to whether it has an
emergency department. It is unlikely, however, to have much of an effect on emergency
access to specialty services. Either the physician-owned, limited-service hospital's capability would only infrequently be adequate to address the needs of the patient at the
community hospital, or it would have very limited time periods during which it would have
the capacity to accept a transfer.**

Although physician-owned, limited-service hospitals hold themselves out as "hospitals," many of
these facilities actually have a range of capabilities more similar to a hospital department or
ambulatory surgical center than a full-service hospital. These hospitals often do not have emergency capabilities; they are geared toward elective cases of minor severity; their capabilities
are limited to a single major diagnostic category; and they staff for minimal inpatient capacity.

Many of these facilities minimize resource consumption by being almost a Monday through
Friday operation. For these reasons, it generally would not be in the best interests of community
hospital patients to be transferred to these facilities.

Specifically:

• CMS found only 4 percent of surgical and orthopedic hospitals have functional EDs (defined as treating more than 5 percent of cases in the ED).

• An analysis of Medicare claims data (MEDPAR 2003) established that 95 percent of the inpatient care provided by physician-owned orthopedic hospitals and 82 percent of the care provided by surgical hospitals is elective. This data reinforces the point these facilities are not designed to handle emergency cases.

• A study by the Moran Company found more than half of the cases at surgical and orthopedic hospitals are of minor severity.

• An analysis of Medicare claims data (MEDPAR 2003) revealed 85 percent of the volume
of orthopedic hospitals and 81 percent of the volume of heart hospitals is in a single

major disease classification. Many patients, particularly those experiencing trauma, need capabilities that go beyond a single specialty area.

• An analysis of Medicare cost report data (HCRIS 2003) found that the average daily census of physician-owned surgical hospitals is 3.4 and 3.3 for orthopedic hospitals, indicating limited inpatient capabilities.
5

• The same analysis pointed out the average length of stay for surgical and orthopedic hospitals was 2.2 days.

In thinking about the duty to accept transfers, it is important to separate the capabilities of the practicing physicians from the capabilities of the facility in which they are practicing. While the physician expertise housed in the physician-owned, limited-service facility could be capable of meeting the needs of community hospital patients, the facility is seldom designed or operated in a manner to support this level of practice.

Current hospital Conditions of Participation (COPs) related to emergencies should be strictly enforced. This does not require every hospital have an ED.

Under the COPs, the hospitals that do not offer emergency services are required, nonetheless, to ensure they have the ability to appraise emergencies, initially treat, and refer when medically appropriate. This requires more than simply dialing 911 and waiting for an ambulance to arrive.

Hospitals that do offer emergency services, whether by choice or state requirement, should be required to fully meet the provisions of 42 CFR 482.55. As identified by MedPAC's March 2005 report, some physician-owned, limited-service hospitals have what they characterize as an ED in order to meet state hospital licensure requirements. However, MedPAC found some of those hospitals cannot possibly be in compliance with Sec. 482.55. For example, MedPAC staff noted one hospital they visited had to "…turn on the lights of its emergency room to show us the space." (MedPAC Meeting Transcript, September 10, 2004) If a hospital represents itself as having emergency services, that proffer must be real or the public's health and safety will be endangered.

ADDITIONAL INPUT ON PSYCHIATRIC SERVICES

At the last meeting, the Technical Advisory Group heard testimony describing a range of

concerns regarding EMTALA and patients needing psychiatric services. Since that meeting, the
AHA has consulted with a cross-section of its members, and will continue to do so, to get their
views on the challenges, potential EMTALA implications, and possible recommendations to
improve the situation.

On an interim basis, we want to share with you some of the themes voiced during those discussions:

• "Emergency medical condition" and "stabilization:" The psychiatric facilities encouraged
that additional guidance be developed in applying those terms specifically to psychiatric conditions and individuals presenting in emergency circumstances.

• State and local government mental health: The psychiatric facilities urged that EMTALA
guidance recognize the role that state laws play in determining: (1) whether an individual might be subject to involuntary admission; and (2) what local clinic staff or professional must be called to assess the need for involuntary admission or provide access to additional public mental health resources.

• Lack of resources: The community hospitals stressed they have insufficient resources overall, lack expertise in particular, and are concerned they might face sanctions from 6
state licensure agencies for keeping a patient who needs psychiatric services that the general community hospital cannot provide.

• Capability: Both general medical and psychiatric facilities urged that additional guidance
be developed on how to determine a facility's capability and who has authority to define that capability. General medical facilities, especially smaller facilities, indicated they often do not have the capability and resources to manage psychiatric emergencies. Many psychiatric facilities expressed concern about their limited ability to treat medical conditions and the need for the patient to be medically stable in order to ensure patient safety.

• Transport: The requirements of those who most often transport psychiatric patients – emergency medical services (EMS) and police – also were raised for consideration in the guidance. We welcome the participation of emergency medical services providers in this round of Technical Advisory Group meetings.

The American Hospital Association members appreciate this opportunity to present testimony
and look forward to continuing to work with the Technical Advisory Group in examining EMTALA implementation issues and potential improvements in guidance.

Thank you.

APPENDIX 3

STATEMENT OF THE AMERICAN SURGICAL HOSPITAL ASSOCIATION TO THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP (TAG)

OCTOBER 26, 2005

Mr. Chairman and Members of the EMTALA TAG:

My name is Greg Miner, Executive Director, Siouxland Surgery Center, Dakota Dunes, SD, one of the very first licensed surgical specialty hospitals in the United States. I am here today representing the American Surgical Hospital Association (ASHA), the national trade association for physician owned hospitals that specialize in the delivery of cardiac and other surgical services. ASHA appreciates the opportunity to provide information to the TAG on the issue of emergency services and specialty hospitals, including the role of EMTALA.

While the debate over specialty hospitals has been going on in Washington for several years, many of you may not be familiar with these facilities. State regulations, such as certificate of need, limit the development of new hospitals in more than half the states, including many represented on this panel. This explains the limited distribution of specialty hospitals.

ASHA represents 78 facilities, the majority of physician owned specialty hospitals functioning today. Estimates vary, but there are probably between 100 and 110 of these facilities in operation. All are for profit and have some degree of physician ownership. Approximately one third are wholly owned by doctors, one third are joint ventures with community hospitals and one third are joint ventures between physicians and a corporate partner. This distribution was first identified by the Government Accountability Office (GAO) in its 2003 studies, and was confirmed by a 2004 membership survey conducted by ASHA. My hospital is a joint venture with Mercy Hospital in Sioux City, IA.

According to our own study, the average specialty hospital has around 20 inpatient beds and at least six surgical specialties are practiced in the facility. Cardiovascular hospitals are usually much larger and focus only on cardiac care.

We found that our members had 30 physician owners on average and 90 physicians with privileges. This confirms the GAO finding that many physicians use these facilities even though they have no financial interest in the venture. According to GAO and the Medicare Payment Advisory Commission (MedPAC), the average ownership share of an individual physician was small, in the two to four percent range. This limited ownership interest combined with the number of non-investors who use these hospitals strongly suggests that physicians are interested in specialty hospitals for many reasons other than the potential return on investment. Also our physicians almost always maintain privileges at community hospitals, thus obligating them to follow the hospitals' privileging rules, include on-call and emergency service. At my hospital, each one of our physician owners participate in trauma call at two of the local hospitals in Sioux City, Iowa, and it is a requirement in our bylaws that physician owners have hospital admitting privileges at our local hospitals for transfer reasons.

Our members accept Medicare, Medicaid and uninsured patients, with the Medicare rates comparable to other hospitals. Medicaid revenue is lower, but Medicaid distribution is affected by many factors, including hospital location and whether or not the state uses managed care in its Medicaid program. Medicaid caseloads vary widely among all types of hospitals, according to MedPAC. The Centers for Medicare and Medicaid Services (CMS) determined that the combination of taxes paid by specialty hospitals and the uncompensated care they provide exceed, as a percent of total revenue, the charity care provided by not-for-profit hospitals.

CMS also found that the quality of care in our facilities was high, as was patient satisfaction. We think this is largely due to the small nurse to patient ratios we maintain. Our average member has one nurse for every three and a half patients. These nurses, like the rest of the staff, specialize in surgical care. We think specialization also breeds better patient quality.

Finally, MedPAC determined that specialty hospitals are not harming community hospitals, as has been alleged. Nor are they responsible for unnecessary increased utilization. Service volume increased at the same rates in areas that had specialty hospitals and in areas that did not.

To the specific issues before this group, we found that 42 percent of our members had emergency departments. Virtually all specialty hospitals are licensed as general acute care hospitals, just like every other community hospital. The state requirements for licensure vary. It is not necessary to have an emergency department to be licensed as a hospital in a number of states. South Dakota and California, for example, do not require that hospitals have emergency departments. We believe that it is appropriate to allow the states to make this determination, based on the needs of the states, and we would oppose a requirement that all Medicare certified hospitals have an emergency room. Unless the federal government can demonstrate a nationwide crisis in access to emergency services, there is no rationale for requiring that every hospital have emergency facilities. Nationally, nearly 10% of all hospitals do not provide emergency services. In California, approximately one third of all licensed hospitals do not have emergency departments. Such a requirement would add greatly to the costs of health care, without improving the health of a single patient. It would place a particularly onerous burden on rural hospitals in those states that do not currently have a requirement for an emergency room.

Physician owned specialty hospitals that have emergency departments are subject to EMTALA. We all operate according to those requirements. Our members that do not have emergency rooms still have obligations under EMTALA to stabilize and transfer patients to the appropriate facility. We are not aware of any EMTALA complaints lodged against specialty hospitals, but would hope than any violations that might occur are punished.

All of our facilities have transfer agreements with other hospitals. The only reason we would not is if the community hospital refuses to make such an arrangement. As required by state law, we will participate in the state and local EMS plans. Specialty hospitals will also accept transfers from community hospitals if they are the appropriate facility for a patient. We believe that this is required by EMTALA and would again encourage enforcement of any violations.

ASHA firmly believes that our members are subject to the requirements of EMTALA, as they apply to all acute care hospitals. There is no reason to write new requirements directed at specialty hospitals that merely duplicate the obligation we already have under this law. Again, we are not aware of any EMTALA complaints against our members, but would urge that any alleged violations be investigated thoroughly and handled appropriately, just as they would be in any other acute care facility.

As noted, the overwhelming majority of physicians practicing at specialty hospitals do maintain privileges at one or more community hospitals and are thereby subject to any on call requirements that the hospital imposes. We do not understand why this panel would recommend new regulations to require us to do what we already do.

The issue of call is a nationwide one, not limited to communities with specialty hospitals. In fact this problem predates the recent growth of specialty hospitals, and is the result of many factors, including the crisis in professional liability insurance, EMTALA requirements, and the availability of certain specialties in a community. Outlawing specialty hospitals, or setting new requirements on them, will not solve the call problem anywhere.

Opponents of physician owned specialty hospitals have made allegation after allegation in an effort to put us out of business. These allegations have not stood up to careful scrutiny. The allegations about emergency services are equally baseless. Our hospitals are obligated to follow the dictates of EMTALA. Our physicians continue to participate in community hospitals, including taking call. The issues that face our health care system today—high cost, uneven access and inconsistent quality—will not be addressed by imposing new Medicare regulations on physician owned specialty hospitals. The problems of hospital emergency coverage will not magically be resolved if specialty hospitals disappear. Poorly managed, unprofitable community hospitals will not suddenly become successful if our members are outlawed.

State licensure, Medicare conditions of participation and EMTALA all impose obligations on specialty hospitals. If a hospital fails to meet those requirements, then it should be penalized. However, the federal government has more than adequate rules and laws to do this. This panel does not need to recommend the addition of further regulations targeted at specialty hospitals, which are guilty of nothing more than providing an alternative to the general hospital for the elective surgical patient and the surgeon.

Thank you for the opportunity to present this statement. I would be pleased to answer any questions.

APPENDIX 4

STATEMENT OF

DR. KATHLEEN BLAKE
HEART HOSPITAL OF NEW MEXICO

OCTOBER 26, 2005

My name is Dr. Kathleen Blake and I am a cardiologist with the New Mexico Heart Institute. Additionally, I am an investor and partner in MedCath Corporation's (MedCath) Heart Hospital of New Mexico, located in Albuquerque, New Mexico. Thank you for the opportunity to speak today on behalf of MedCath and the Heart Hospital of New Mexico.

MedCath is based in Charlotte, North Carolina and is a national provider of cardiovascular services. The company builds and operates fully licensed acute care hospitals, and other clinics and centers focusing on cardiovascular care. All of MedCath's 12 hospitals are owned in partnership with physicians and, in certain instances, a local community hospital. For example, the largest shareholder of the Heart Hospital of New Mexico at its founding was a local not-for profit community hospital, St. Joseph's, owned at that time by Catholic Healthcare Initiatives. My ownership share in the hospital is approximately 1.2%. My share, although small, guarantees me a say in the hospital where I work; I liken it to the difference between owning a home after years of renting. I share the risks, responsibilities, and the benefits of ownership. This is vastly different from the situation in the late 1990s when my colleagues and I had become increasingly concerned about the resistance we encountered from community hospital administrators to the introduction of new therapies for cardiac patients, including stents and Reopro. Both therapies, while costly, had been proven to reduce the rate of complications for patients undergoing coronary interventional procedures to open blocked arteries. The largest hospital where we practiced received substantial revenue from the care of cardiac patients, but was at that time focused on the purchase of primary practices. Austerity in the cardiac catheterization laboratory provided revenue for those non-cardiac initiatives, but threatened our ability to provide state of the art care to our patients. Access to budget data and contracting options, necessary to our participation in cost-containment programs, was denied. We embarked on a shared ownership model when we founded our hospital, using a strategy still in use today. Information about cost, quality and value is shared by physicians and administrators. We face the challenges of complex patient care, staffing, and prudent purchasing together. We are proud to say that we are a focused organization, physicians and administrators and staff all focused together, on delivering the highest quality and most cost-effective care to our patients.

Each of the MedCath hospitals operates an emergency department that is open 24 hours a day, 7 days a week. We appreciate this opportunity to address this technical advisory group to describe how the MedCath hospitals operate these emergency departments.

Given my background, I believe I have a unique perspective on this issue. In addition to my responsibilities as the President of a 40 plus physician cardiovascular group with

offices throughout the state of New Mexico, I am the immediate past President of the New Mexico Medical Society, have served on Governor Richardson's Taskforce on Healthcare Reform and presently serve on a Senate Memorial taskforce to address concerns about access to medical liability coverage for non-physician providers including New Mexico's 43 hospitals and many allied health professionals.

HHNM is licensed as a general acute care hospital, and while it focuses on treating patients with cardiovascular disease, we have physicians on our medical staff from many different specialties that allow us to treat patients with a variety of conditions. Since its opening in 1999, our Hospital has operated a 7 bed full-service emergency department capable of screening and stabilizing nearly every patient that presents to the Hospital. Like all other MedCath affiliated hospitals, HHNM 's emergency department is staffed by board-certified emergency medicine physicians and other personnel 24 hours a day /7 days a week /365 days a year. In Fiscal Year 2005, the HHNM saw 2,938 patients in the emergency department. During the same period, more than 60,000 people presented to the emergency rooms of MedCath's hospitals. Our emergency departments treat patients who are very sick. In Fiscal Year 2005 at the HHNM Emergency Room the average acuity level of our patients was 4.1. We believe that this is significantly higher than the average at other general hospitals. This high acuity level is evidence that our emergency departments provide an important service for the severely ill patients in our community.

The emergency department has always been part of the MedCath hospital model. Even though HHNM and the other MedCath hospitals focus on cardiology and cardiovascular surgical care, the emergency departments in these hospitals are capable of accepting, screening and stabilizing almost every patient that presents, regardless of whether the patient has a heart problem or not. We believe our hospitals are able to do this because each has a medical staff of 175-300 specialists, sub-specialists, and primary care physicians who can be called upon to provide the care needed by most patients. The physicians on the medical staff, who are available to emergency room patients, have chosen to practice at our facilities, regardless of whether they are investors.

Patient visits to the MedCath heart hospital emergency department, actual admissions, and outpatient visits are for a wide range of non-cardiac conditions. At the HHNM in Fiscal Year 2005 approximately 35% of ER visits were for conditions that are not classified as diseases of the circulatory system. For all MedCath hospitals in Fiscal Year 2005, 62.6% of total ED visits were for non-cardiac illnesses. Attached to my written testimony is a list of the non-cardiac conditions treated at MedCath hospitals.

An example of the responsiveness of a MedCath hospital emergency department to community need was seen during the recent hurricanes in the Gulf region. Two MedCath hospitals in Louisiana, including a MedCath facility just north of New Orleans, made major contributions to the community in the aftermath of the storms. In particular, the Louisiana Heart Hospital was one of only a few hospitals close to New Orleans that remained open during and after Hurricane Katrina. This hospital served as a primary triage center for the people evacuated from New Orleans and consequently cared for a wide variety of medical conditions (many non-cardiac) in the ED and in the hospital.

From this tragic experience, we understand the tremendous impact our hospitals can have in a community, especially when other links in the EMS chain are broken or separated.

In our hospitals, once an ED patient is screened and stabilized, they are treated as necessary and either discharged, admitted to the heart Hospital, or in a minority of cases, transferred to another, more appropriate facility, all in a manner compliant with EMTALA requirements. The need to transfer patients is fortunately rare. In Fiscal Year 2005, the Heart Hospital of New Mexico transferred only 4.6% of the ED patients to other facilities. MedCath hospitals overall transferred on average approximately 2% of their ED patients in Fiscal Year 2005. An example of patients that we might transfer are those with neurosurgical emergencies. These indications for transfer are similar to the reasons why other general acute care hospitals would transfer a patient. We and others know that it is not possible for our patients and their doctors to always know what facility is appropriate until the initial ER evaluation is completed, and that there will always be a need for a small number of patients to be transferred to another facility.

The HHNM's transfer percentage, while quite low, is higher than that of other MedCath facilities. We attribute this to the presence in the Albuquerque market of two heavily populated managed care plans (for commercial and Medicare patients). These plans are owned by nearby hospitals. Consequently, patients covered by those plans who come to our hospital to receive treatment must be transferred to one of the facilities owned by that plan. We believe that absent this unique factor in the Albuquerque market, the transfer rate at HHNM would be comparable to the average at other MedCath facilities.

We believe that the existence of our emergency department has a positive impact in the communities that we serve. Since we are able to care for the great majority of patients that present, our emergency departments provide additional general emergency care capacity in our markets. Additionally, our EDs provide our communities with very specialized cardiac emergency care at a service level and with response times that we believe are the best in class. In the heart business, there is a basic principle that time means heart muscle, which means that access to emergent care with a strong cardiac focus is critical to survival.

Across the United States, only approximately 18% of hospitals have an open-heart surgical program. Approximately 20% of MedCath's cases in Fiscal Year 2005 were referred from other facilities. We believe that our specialized capabilities and facilities are therefore a very necessary resource for patients in our regions. At the HHNM, our patients come from our entire state, as well as southern Colorado and eastern Arizona. Many hospitals located in rural New Mexico are not equipped to handle an emergency cardiovascular case. It is essential that our facility support rural hospitals and to provide them rapid access to cardiac care for the patients they serve. We have set up a CV Stat program to quickly connect the referring physician in the rural hospital with a HHNM accepting physician. We arrange the bed at our facility. On rare occasion, when no bed is available at HHNM, we get that patient a bed at another Albuquerque hospital with the needed services.

As part of the operation of HHNM's emergency department, the hospital has implemented policies and procedures to comply with EMTALA, and maintains a call list of physicians on its emergency department staff to be available to provide on call services.

HHNM, like many hospitals nationwide, experiences from time to time difficulties in obtaining physician specialty call coverage. In particular, it is extremely difficult for us to obtain physician call coverage for urology, GI and neurology services. We note that a number of the representatives of the organizations who have testified previously before the TAG, such as the American Hospital Association, The Schumacher Group, the American College of Physicians, and the Federation of American Hospitals, have provided information concerning the shortage of physician specialists that exists nationwide. The shortage of physicians in particular specialties is due to multiple reasons. On the supply side, we attribute it to the decisions made in the early 1990s to reduce the number of training slots for the specialties, and the resultant aging the specialty physician population. On the demand side, we identify increasing longevity, advances in technology and the aging of the baby boomers as causes for the shortage of specialty coverage for hospitals in general and emergency rooms specifically. It is therefore difficult for ALL hospitals to obtain physician on call emergency coverage. In Albuquerque, for example, our community hospitals have had times when no neurosurgical coverage was available to their patients and ERs. Solutions will be found, but these will take time. As the problem is widespread and affects all hospitals in different ways and for variable periods of time, there is no basis or fairness to the application of different and additional on call coverage requirements on specialty hospitals.

Local emergency services teams are familiar with the capabilities of the hospitals and use this knowledge in deciding on the facility that will receive a patient in their care. This has been accomplished effectively in our community with the transport of ST-elevation acute myocardial infarction patients to hospitals with a cardiac catheterization laboratory. The trauma network requires similar decisions on a patient's behalf.

CMS EMTALA Interpretive Guidelines at section 489.24(j) provide that each hospital should "maintain an on call list of physicians on its departmental staff in a manner that best meets the needs of 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 services." We believe that this continues to be the proper approach. It allows hospitals the flexibility to maintain physician on call arrangements that reflect the services rendered by their particular hospital, as well as the resources available in their particular community. Given the nationwide difficulties that exist regarding physician on call emergency coverage, we do not feel that specialty hospitals should be subject to any additional on call requirements, but rather that all hospitals with emergency departments should provide emergency services within the capability of the hospital consistent with the needs of the communities they serve, as MedCath hospitals do currently.

In conclusion, we believe that our focus on cardiovascular disease provides an essential service to the people in the communities we serve. An integral component of that service is delivered in the emergency rooms of our hospitals. The volume of patients, the range of conditions treated, and the small number of patients requiring transfer to another facility attest to that service. The MedCath hospitals are already a vital link in the emergency services network, dramatically demonstrated recently at our hospitals in Louisiana. We strongly urge this group to continue to allow ALL hospitals to determine the composition of their medical staffs based on the needs of their patients and the resources available in their respective communities. *N*ew requirements for specialty physician emergency room call coverage, requirements which can sometimes not even be met by the general hospitals, may have the unintended consequence of limiting emergency services in the communities where MedCath hospitals are located. We are committed to our communities and want to remain a vital link in the provision of emergency care.

Thank you again for the opportunity to testify and I will be glad to answer any questions.

Emergency Room Discharge Diagnosis

Abdominal Pain
Active Lupus
Acute Ideation
Allergic Reaction
Anemia
Angioedema
Anxiety
Asthma
Back Pain
Body Fluid Exposure
Bronchitis
Bursitis
Cellulitis
Constipation
Contusion
COPD
Costrochondritis
Cough
Dehydration
Dementia
Dental Caries
Diarrhea
Diverticulitis
dizziness
Dog Bite
Dressing Change
Drug Reaction
Ecchymosis

Edema
Electrical Shock from Outlet
Electrolyte Imbalance
Epigastric Pain
Episodic Flushing
Epistaxis
Esophageal Spasm
Esophagitis
ETOH Abuse
Factitous Lab Results
Fatigue
Fever
Finger Laceration
Floaters in R Eye

Emergency Room Discharge Diagnosis

Flu
Fluid Overload
Fracture
Gallbladder Disease
Gastritis
Gastroenteritis
Generalized Weakness
Gerd
GI Bleed
Gout
Groin Echimosis
Groin Pain
Groin Strain
Headache
Heartburn
Hematoma
Hemorroid
Hemotoma
Infected Tooth
Kidney Stone
Knee Pain
Labyrynthitis
Laceration
Laceration/Contusion, Facial
Leg Pain
Medical Evaluation
Medication Reaction
Migraine
Muscle Pain
Muscle Strain
Muscle Tear
MVA

Myalgia
Nausea
Neck Injury
Needle Stick
Neuropathy
Non Specific Chest Pain
Normal Incision
Normal Sinus Rhythm
Numbness
Ovarian Cyst
Pedal Edema
Peripheral Radiculapathy
Perscription Fill
Pharyngitis

Emergency Room Discharge Diagnosis

Picc Line Evaluation
Pleural Effusion
pleurisy
Pleuritic Chest Pain
Pneumonia
Post Blood Exposure
Reflux
Rheumatoid Arthritis
Sciatica
Seizures
Shingles
Shoulder pain
Sinus Infection
Sore Throat
Sprain
Stress Response
Surgical Site
Suture Removal
Tear, Rotator cuff
Tia
Tooth Abcess
Trapezius Trigger Point
URI
Urinary Retention
UTI
Vertigo
Viral Syndrome
Volume Depletion
Volume Overload
Vomiting
Weakness
Wound Care

APPENDIX 5

October 12, 2005

Beverly J. Parker
Division of Acute Care
Centers for Medicare and Medicaid Services
Mail Stop C4-08-06
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: EMTALA TAG Meeting

Ms. Parker:
Attached is testimony to be submitted by the Federation of American Hospitals (FAH) for the EMTALA TAG meeting on October 26-28, 2005. FAH appreciates the opportunity to submit testimony. Another copy was sent electronically this afternoon to EMTALATAG(cms.hhs.gov. If you have any questions, please contact me at (202) 624-1521 or jmicklos(fah.org.
Respectfully submitted,
effrey G. Micklos
Vice President and General Counsel

EMTALA TECHNICAL ADVISORY GROUP MEETING

OCTOBER 26-28, 2005

STATEMENT OF FEDERATION OF AMERICAN HOSPITALS

Hello, my name is Jeff Micklos, and I am the Vice President & General Counsel for the Federation of American Hospitals. The Federation is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Our members include urban and rural community-based full service general hospitals, including both teaching and non-teaching facilities, as well as other hospital providers such as rehabilitation, long term acute care, and psychiatric hospitals.

We appreciate the opportunity to present testimony today to the EMTALA Technical Advisory Group. For this meeting, the EMTALA TAG requested testimony on three issues related to the application of EMTALA to specialty hospitals. The Federation's testimony will respond to these questions and address other important issues that are still under consideration by the TAG.

First, to clarify, our comments today apply only to specialty hospitals as that term is defined in section 1 877(h)(7) of the Social Security Act. This definition includes limited service facilities that are primarily or exclusively engaged in the care and treatment of one of the following categories: (1) patients with a cardiac condition; (2) patients with an orthopedic condition; or (3) patients receiving a surgical procedure. Often, the term specialty hospitals is interpreted to include, among others, rehabilitation, long term acute care, and psychiatric hospitals. However, in keeping with the scope of the Centers for Medicare & Medicaid Services request to the EMTALA TAG at its last meeting, we focus our response on whether EMTALA should apply to the limited service facilities identified in section 1 877(h)(7).

The first question posed by the TAG is whether there should be a federal requirement for specialty hospitals to maintain an emergency department. It is clear that specialty hospitals are not shouldering their burden to provide critical community health care services, such as emergent care or caring for those least able to pay, but instead are exacerbating an existing problem. However, the Federation does not believe that the best way to address this deficiency is through a federal requirement that specialty hospitals maintain an emergency department.

As you are aware, EMTALA makes clear that each and every patient that comes to an emergency department will receive a medical screening examination and, if an emergency medical condition is present, appropriate treatment to stabilize the condition. To provide a comprehensive and meaningful service to the community, an emergency department must be able to draw upon the clinical expertise of a wide range of medical specialties to treat varying types of patients and medical conditions. In general, full-service community hospitals are well suited to provide care to patients with a broad range of emergency medical conditions.

On the other hand, requiring specialty hospitals to furnish emergency services would expose their clinical limitations due to the limited range of services they may otherwise provide. Their limited service mix means that their panel of available physician specialties is also limited. It is critical for the public policy focus to be on the quality of care furnished to patients, which means being able to draw upon a wide range of medical specialties that are available to a community hospital's emergency department.

While community hospitals are extremely concerned that specialty hospitals contribute virtually nothing to the burden of uncompensated care and Medicaid, much of which comes from operating an emergency department, we believe the ultimate policy consideration must be the ability to provide high quality and diverse services to patients. In our view, this can be best achieved by receiving emergency services at a full-service community hospital. Regrettably, in most cases, specialty hospitals, by their very nature, are just not well suited to provide this service to the community. Therefore, the Federation urges the EMTALA TAG not to recommend to CMS that all specialty hospitals be required to operate an emergency department because it is likely to have the unintended and undesirable outcome of lowering quality of care.

The TAG's second question is whether specialty hospitals are subject to the EMTALA requirement under which Medicare participating hospitals with specialized capabilities or facilities may not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the patient. On this question, the Federation believes strongly that all Medicare-participating specialty hospitals are obligated by the EMTALA statute and regulations to accept appropriate transfers of patients that require such specialized capabilities or facilities. This special obligation under EMTALA applies regardless of whether or not the specialty hospital operates a dedicated emergency department, because the requirement to accept a transfer is separate and distinct from the requirements to provide a medical screening examination and any necessary stabilizing treatment.

The EMTALA statute requires a receiving facility to accept an appropriate transfer if it has "available space and qualified personnel for the treatment of the individual." The current EMTALA regulation requires receiving facilities to accept transfers if the facilities have the "capacity to treat the individual." Many specialty hospitals have limited hours of operation, due in large part to their focus on outpatient services. In the interest of best serving patients, we believe that specialty hospitals should not be allowed to refuse to accept transfers on the basis that they lack capacity to treat the individual simply because they are closed.

Therefore, we strongly urge the EMTALA TAG to recommend to CMS that all applicable EMTALA transfer requirements pertaining to receiving facilities be applied uniformly to specialty hospitals, regardless of whether they operate an emergency department. Further, we recommend that the TAG advise CMS that specialty hospitals should be required to provide those specialized services around the clock. If limited service facilities contend they are in fact hospitals, then they should be required to provide non-stop services within their capabilities that are the hallmark of full-service community hospitals. If they do not provide sufficient inpatient services to meet this requirement, then they should not be certified as a hospital for Medicare purposes. Again, being "closed for the day" should not be an acceptable reason to reject an appropriate transfer under current EMTALA law and regulations.

The EMTALA TAG's third question is whether additional or different on-call requirements should be established for specialty hospitals. Given the on-call crisis in this country, we strongly believe the TAG must consider all possible avenues to increase the availability of specialists to

hospital emergency departments. We also remind the TAG of the American Medical Association's ("AMA") on-call physician policy, which states that "[t]he hospital and physicians should jointly share the responsibility for the provision of care to emergency department patients." *(See* AMA H-130.948(1)(a), On-Call Physicians.) Medicare policy should reflect this common goal.

Several physician-specialty groups have testified at previous EMTALA TAG meetings regarding the burdens that on-call coverage places on their members. While certain specialties are in limited supply in particular regions of the country, the issue of specialists transitioning their practices to specialty hospitals has exacerbated significantly, and will continue to exacerbate, this problem.

While one could argue that a physician who transitions his or her practice from a community hospital to a specialty hospital has just switched locations for purposes of treating patients, the impact is very different, especially for emergency department patients. For example, several recent studies have shown that many specialty hospitals do not operate an emergency department. In those cases, physicians who have transitioned their practices to those limited service facilities are often no longer available to the community for purposes of providing on-call coverage to the community hospital's emergency department. The reality is that a physician- specialty which may have already been in short supply now loses even more capacity to treat patients in the community, with one or more physicians effectively disappearing from the on-call landscape. Patients in these communities still have emergency medical conditions, and the ever- decreasing on-call coverage means those needs are not being met.

Specialty hospital advocates have publicized the purported reasons why physicians may transition their practices to specialty hospitals. However, these explanations do not adequately address the impact on the many patients who seek emergency care at community hospitals. The reality is that the lack of availability of specialists to treat patients in the emergency department leads to a number of concerns, including emergency department overcrowding and longer wait times for treatment, which could lead to patient complications or other adverse health outcomes.

For these reasons, the TAG should recommend that CMS impose special requirements under EMTALA to ensure that physicians practicing in specialty hospitals are available to provide on-call services to emergency patients in their communities. There are different possible models for accomplishing this. For future meetings, we recommend that the TAG seek testimony from individuals that have helped develop community-call arrangements in Florida and California. The Federation looks forward to working with the TAG to evaluate particular models that may be presented to it.

On a separate matter, the Federation continues to urge the TAG to recommend to CMS that a new medical staff requirement be added to the Hospital Conditions of Participation that requires the voluntary medical staff as a whole to accept the responsibility of providing on-call services. Also, the new standard should provide that an individual medical staff member's acceptance of on-call coverage and related performance will be evaluated when considering medical staff reappointment or privilege renewal. Again, for EMTALA to work, both hospitals and physicians must recognize their responsibilities and act in a compatible matter. In a separate letter recently provided to the On-Call Subcommittee, the Federation has suggested specific text to effectuate this regulatory change.

Alternatively, if greater physician responsibility cannot be generated to assist hospitals with their EMTALA obligations, then the TAG should recommend that CMS modify hospital obligations to

reflect the level of control that hospitals can exert over their medical staff physicians. To this end, CMS could deem EMTALA obligations fulfilled when patients receive appropriate medical screening and the hospitals work in good faith either to: (1) stabilize the patient with available resources at the time, or (2) transfer the patient to another hospital that has the appropriate resources available.

Thanks again for the opportunity to present the Federation's views to you today. I am available to answer any questions you may have.

APPENDIX 6

September 30, 2005

Elizabeth Richter
Director
Hospital and Ambulatory Policy Group
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

David Siegel, MD, JD
Chair
EMTALA TAG
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Richter and Dr. Siegel:

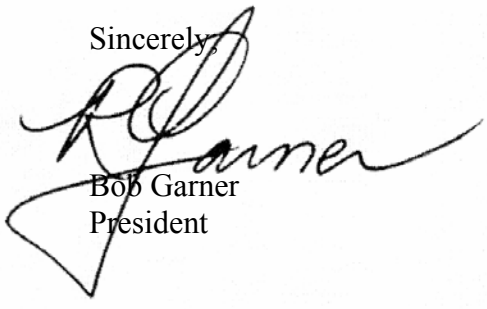
The American Ambulance Association (AAA) very much appreciates the opportunity to have input on the issues under consideration by the EMTALA TAG. Founded in 1979, the AAA's Mission is: "To promote health care policies that ensure excellence in the ambulance services industry and provide research, education and communications programs to enable its members to effectively address the needs of the communities they serve." The American Ambulance Association represents ambulance services across the United States that participate in serving more than 75% of the U.S. population with emergency and non-emergency care and medical transportation services. The AAA was formed in response to the need for improvements in medical transportation and emergency medical services. The Association services as a voice and clearinghouse for ambulance services across the nation. The Association views pre-hospital care not only as a public service, but also as an essential part of the total public health care system.

To respond to your specific question regarding hospital and ambulance communications related to patient destination, we would agree that EMTALA regulations should not interfere with good decision-making that is in the best interest of the patient we are caring for and transporting to a hospital. The communication should enable ambulance service providers to make good decisions regarding what hospital would best care for the patient given 1) the patient's condition, 2) hospital capabilities, 3) patient census in the emergency department (ED) and 4) distance to travel. Although some emergency services systems employ patient transport guidelines and diversion programs effectively, others have chosen to prohibit diversion programs with good results as well. At its core, this remains a local issue where all the stakeholders need to cooperate to come up with the solution unique to their community.

The AAA believes there is a much more significant issue related to EMTALA and ED overcrowding that has a profound negative impact on ambulance services and our patients. Patient care may be compromised due to time waiting for hospital admission, as well as time traveling due to an ED diversion. The excessive time patients stay on our gurneys in the hospital ED with our staff tending to the patients was identified as one of the 7 most significant issues facing ambulance services in the nation in the AAA's letter to the Institute of Medicine expert panel drafting the "Study on the Future of Emergency Care in the United States Health System." In that letter we write regarding ambulance diversions and long ambulance wait-times: "Due to financial pressures on hospitals, two thirds of emergency departments in a recent federal study reported diverting ambulances to other facilities. In addition, ambulance crews, with their patients still on the gurney, often wait to transfer care to the hospital emergency department staff for as long as two to four hours in the most serious cases. Ambulance diversion and long off-load times place a severe financial strain on ambulance resources. Diversion and long wait times cause longer ambulance transport times and delayed turn-around times at hospitals. In turn, ambulance providers experience reduced productivity and increased costs while potentially impacting ambulance response-time reliability. In many cases, ambulance providers are forced to add ambulance resources, without any increase in funding or reimbursement, to offset the affects of emergency department saturation and hospital bed shortages." The AAA recommended the following approach to a solution: "Implement local strategies to reduce ambulance diversions and long ambulance wait times. Implement local hospital emergency department and EMS strategies to assure every request for service is answered in a timely manner. Develop effective diversion policy and off-load time guidelines. For example, require hospital staff to release ambulance personnel within 15 minutes of arrival at the hospital. Encourage hospitals to adopt the productivity and call demand analyses tools used by ambulance providers to assure the number of on-duty staff meets the demand for service during both off-peak and peak periods." Specifically, we suggest adding to EMTALA regulations that make it an EMTALA violation if a patient is not transferred off the ambulance service gurney and into the care of the hospital staff in less than 15 minutes depending on the patient's condition.

Again, we thank you for the opportunity to participate in this important discussion regarding EMTALA. We would certainly be available for more comment including testifying before the EMTALA TAG.

Sincerely,



Bob Garner
President

APPENDIX 7

On-Call Specialist Coverage in U.S. Emergency Departments

ACEP Survey of Emergency Department Directors

September 2004

American College of Emergency Physicians®

Executive Summary

The American College of Emergency Physicians' (ACEP) Emergency Medicine Foundation received a grant from The Robert Wood Johnson Foundation to survey medical directors of hospital emergency departments to assess the effects of current regulations and the practice climate on the availability of medical specialists who provide care in the nation's emergency departments. The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to medically screen every person who comes to an emergency department to determine whether an emergency medical condition exists, and if it does, to stabilize the patient. A patient may only be transferred to another hospital if — after all possible stabilizing efforts have been made — the patient's condition requires a "higher level of care" not available at the original hospital. EMTALA is essentially a non-discrimination law to ensure that every emergency patient is medically screened, regardless of ability to pay. Since its passage in 1986, EMTALA has been subject to regulatory and judicial interpretations that have expanded it into an extensive safety net program in the nation's emergency departments, which have more than 110 million visits annually. [1]

In November 2003, the Centers for Medicare & Medicaid Services (CMS) implemented revised regulations for hospitals and physicians to comply with EMTALA. The new regulations acknowledged the need to balance hospital and physician legal duties with the practical realities of today's crowded emergency departments and the concerns of on-call specialists and their practice demands. Specifically, while hospitals must continue to maintain a list of on-call physician specialists, physicians are permitted to be on call at more than one hospital at the same time and may limit the amounts of call time they are willing to take. While the EMTALA regulations took a more practical approach, recognizing physician specialists' time constraints and willingness to make additional on-call commitments, ACEP was concerned the rules would unwittingly make hospital and emergency physician services more difficult and compound an already growing problem in obtaining specialist care in a timely fashion. In addition to the recent regulatory changes, other factors — reduced payment to physicians by Medicare and other payors, the growing number of uninsured patients in America, and the increasing costs of medical liability insurance — may be affecting patients' access to timely specialty care in the nation's emergency departments.

This survey was designed to estimate, in the early months of the new regulations, the extent of problems related to on-call emergency department coverage by specialists. The survey asked emergency department medical directors whether they were experiencing problems with inadequate on-call coverage, given the needs of the patient populations at their hospitals. It asked about changes in the number of patient transfers to other hospitals and whether physicians and staff were experiencing significant increases in the time spent locating specialists willing to come to the emergency department.

The study findings, coupled with the growing demands for emergency services, show further strain on an already frayed system. Policymakers and physicians must work together to ensure that emergency care remains accessible to all. To that end, the new government-sponsored EMTALA Technical Advisory Group should include this issue in its deliberations.

APPENDIX 8a

HORTY, SPRINGER & MATTERN ATTORNEYS AT LAW
A PROFESSIONAL CORPORATION
4614 Fnm AvENUE, PITrSBURGH, PA 15213
TELEPHONE: (412) **687-7677**
FACSIMILE: (412) **687-7692**
www.hortyspringer.com

JOHN HORTY
LINDA HADDAD
BARBARA **A. BLACKMOND**
DANIEL M. MUUIOLLANL) III
CHARLOTI'E S. JEFFERIES
HENRY M. CASALE
PAULA. VERARDI
ALAN 3. **STEINBERG**
SUSAN M. LAFENTA
LAUREN M. MASSUCCI
NICHOLAS J. CALABRESE
LEEANNE MITCHELL O'BRIEN
MONICA J. HANSLOVAN
RACHEL **E.** REMALEY
PHiLIP W. ZARONE

ERIC W. SPRINGER (OF COUNSEL)

CLARA L. MATI'ERN (I93I-I9I)

October 12, 2005
Beverly J. Parker
Division of Acute Care
Centers for Medicare & Medicaid Services
Mail Stop C4-08-06
7500 Security Boulevard
Baltimore, MD 2 1244-1850
Dear Ms. Parker:

Re: The Emergency Medical Treatment
and Active Labor Act (EMTALA)

The law firm of Horty, Springer & Mattern, P.C. (www.hortyspringer.com) devotes its practice exclusively to hospital and health care law. We consult with hospital boards, hospital medical staff leaders and hospital attorneys throughout the country. We work closely with medical staff Credentials, Executive and Bylaws Committees. Unlike most law firms, we focus much of our efforts on education, through seminars for medical staff leaders on how to conduct effective peer review and credentialing and through our publications. While we represent primarily nonprofit hospitals, in submitting these comments we are not acting on behalf of any client.

Hospitals and their medical staff leaders all across the country are facing a crisis with respect to on-call coverage. Many physicians are resigning from hospital staffs and shifting their practices to freestanding outpatient surgery centers, which do not have emergency departments or require call. The issues surrounding call have become among the most contentious and divisive facing hospitals and physicians.

We recognize and appreciate the more flexible approach that the Centers for Medicare & Medicaid Services ("CMS") has taken in the past couple of years regarding EMTALA's requirements. However, some of these difficult on-call issues are related to strict interpretations by CMS that are having the unintended consequence of driving physicians out of practice in acute care hospitals, into freestanding facilities that do not have 24-hour emergency services. Strife over efforts to implement equitable call coverage is increasing, as are demands for payment.

We have identified a few issues that might help ameliorate or at least not further exacerbate these problems. While our primary focus is upon on-call issues, we will also provide our comments regarding other areas of EMTALA concerns.

I. ON-CALL COMMENTS

1. EMTALA's "non-discrimination" provision has been too broadly interpreted and has created a burden upon on-call physician specialists at hospitals who are forced to receive patient transfers from outside their community.

EMTALA's non-discrimination provision, 42 U.S.C. § 1395dd(g), states that a participating hospital that has specialized capabilities or facilities cannot refuse to accept an appropriate transfer of an individual who requires such specialized capabilities if the hospital has the capacity to treat the individual. The provision cites burn units, shock units, trauma units and neonatal intensive care units as examples of specialized capabilities.

The position taken by CMS in St. *Anthony Hosp ital v. the Inspector General,* HHS Departmental Appeals Board, Appellate Division, Doc. No. A-2000-12, Dec. No. 1728, June 5, 2000 broadened "specialized capabilities" far beyond such unique and specialized units of the hospital. In *St. Anthony's,* CMS/HHS determined that a vascular surgeon constituted a "specialized capability." (There was no vascular surgeon at the hospital to which the patient had been brought, but there was a vascular surgeon at several hospitals that were contacted in an attempt to transfer the patient. In its ruling, CMS stated that having a vascular surgeon at a hospital to which a transfer is attempted constituted having a specialized capability in comparison to the transferring hospital.)

It is true that the patient in the St. *Anthony's* case urgently needed vascular care. The problem, however, with expanding the interpretation of "specialized capabilities" is that every specialist and subspecialist on call (i.e., an orthopedic surgeon, vascular surgeon or neurosurgeon) now has to be on call not just for his or her own hospital, but for an entire region (and possibly beyond, as discussed below). That discourages specialists and subspecialists from wanting to take call, and many shift their practices to ambulatory surgery facilities or drop off the staff at more than one hospital.

It has not been uncommon for midsized community hospitals to have one or more specialists on staff, while smaller community hospitals in the region do not. Under the CMS ruling in St. *Anthony's,* the specialist on call at the midsized hospital would be required to take a patient from

any smaller hospital that does not have a similar specialist on its own staff. Most physicians understand that a responsibility of medical staff appointment is being on call at that hospital for that community. From a fairness perspective, outside of a designated regional referral center, physicians should not be expected to be on call for an entire region.

This problem is further exacerbated by the fact that the smaller hospital can choose any larger hospital to which to send the patient needing the specialty in question. We often hear from hospitals that they receive transfer requests from far away, even from other states.

Patients must be cared for, but it is simply unfair to require physician specialists to fulfill on-call responsibilities for patients who come from beyond the hospital's actual service area (as determined by data). Accepting a proposed patient transfer should be discretionary, as EMTALA otherwise states, with the requirements that come with specialized capabilities being limited to truly specialized and unique units of the hospital.

A variation of the same unfair theme: the sole orthopedic surgeon at Hospital A is not on call; the sole orthopedic surgeon at Hospital B is. Hospital A tells Hospital B that because of those circumstances, Hospital B has specialized capabilities compared to Hospital A. That means Hospital B must accept the patient so long as Hospital B has the capacity to treat the individual or otherwise face an EMTALA noncompliance reporting.

Should the interpretation of the "specialized capabilities" provision continue to include physician specialists, if Hospital A has a specialist on its staff, CMS should view Hospital A as always having this specialized capability for purposes ofEMTALA's non-discrimination provision. We recommend that CMS take this position even for those days on which the specialist is not on call at Hospital A.

2. Community call should be recognized as satisfying EMTALA obligations.

Hospitals in many communities today want to develop community call plans but have been told that CMS permits only "simultaneous" call, with each hospital having to meet its EMTALA obligation individually. This approach places a burden on specialists, and the hospitals where they practice are left trying to coerce physicians to take call so that the hospitals do not violate EMTALA. Not surprisingly, this drives specialists away.

The concept of community call could work well for psychiatric services, yet hospitals understand that if a patient presents to a hospital having a psychiatrist on its staff, but no psychiatric unit, it cannot transfer a patient to a regional psychiatric unit without violating EMTALA, even when it would be in the patient's best interests.

More and more community hospitals are losing neurosurgeons, orthopedic surgeons and other subspecialists as these physicians decide to limit their practices to one or two hospitals. That outcome is further hastened when a subspecialist is faced with having to provide ongoing on-call services at a hospital where he or she performs fewer procedures (better to resign his or her staff appointment there than be required to take on-call responsibilities). In situations such as these, the loss of the subspecialist can mean that these services are no longer available in a smaller community.

Community call would reverse this trend. It would allow hospitals to divide up subspecialty services, and thus on-call responsibilities (as agreed upon by the hospitals in the area, perhaps in

consultation with the CMS Regional Office). It would allow patients to receive excellent on-call care at the optimal treatment location and, at the same time, not place unreasonable call requirements upon each community hospital and its staff physicians. Community call would allow a hospital to provide the neurosurgery on-call services for an area. Under such an approach, subspecialists could maintain a presence in other hospitals, making elective subspecialty services available in each of those communities.

3. Consideration should be given to providing "Good Samaritan" legal protections to on-call physician specialists.

Good Samaritan laws in all states encourage individuals to directly provide emergency assistance to people they do not know. The care provided by an on-call physician specialist can be much like the care provided in a Good Samaritan situation. That is particularly the case for the on-call physician who comes to the hospital and provides emergency care to a patient with whom the physician has no relationship.

It is in that patient's interest to be cared for by the on-call physician specialist. It is in the community's interest that on-call physicians provide emergency on-call care. Given that EMTALA requires these on-call services, consideration should be given to providing on-call physicians with federal protections akin to the Good Samaritan protections which are available to other individuals who respond to an emergency. Such protection could help alleviate the shortage of specialists willing to take call and help those hospitals that simply do not have the resources to pay specialists to take call.

4. CMS should offer some guidance on the level of on-call coverage that would satisfy EMTALA obligations.

In the narrative discussion preceding the 2003 regulations, CMS expressly disavowed the existence of the "three physician" rule which had provided hospitals and their medical staffs with a "rule of thumb" for appropriate on-call coverage. We understand that CMS was trying to provide hospitals with greater flexibility. We also appreciate that a numerical standard can be difficult to define because the composition of every medical staff is different and the obligations of the physicians on those staffs vary widely, as well.

However, regardless of how well-intentioned CMS' flexibility was, it now threatens EMTALA compliance and, more importantly, patient safety.

Defining an appropriate on-call schedule is one of the most contentious issues hospitals face today. We are constantly asked by hospitals and their medical staff leaders some variation of the question: "if we have one neurosurgeon (or two orthopedic surgeons, or three general surgeons) on our staff, how many days do we have to cover the on-call schedule in this specialty area?"

Understandably, physicians often pressure hospitals for fewer on-call days. However, if CMS' flexibility is seen by some as an opportunity to reduce on-call obligations, it will not take long for this to translate into much less coverage, many more transfers, and greater risk to patients.

In fact, a survey conducted by the American College of Emergency Physicians in 2004 (a copy of which is enclosed) supports this conclusion. According to the survey, two-thirds of the emergency departments reported inadequate on-call specialist coverage and a third of the

respondents cited increasing levels of patients being transferred from one hospital to another. The survey also confirms the anecdotal concerns we have been hearing from hospitals.

Some guidance from CMS in this area would be tremendously helpfhl. For example, CMS might say that if there was a single specialist on a hospital's medical staff and that physician practiced at the hospital full-time, the hospital would be expected to provide on-call coverage in that specialty approximately five or six (or more) days a month. Additionally, it would be helpful for CMS to state specifically that a reasonable on-call schedule would have to include some weekends and holidays. (Some physicians who are not good on-call citizens try to create an on- call schedule that is convenient for them but does not reflect when the service is most needed.)

With some guidance from CMS, hospitals and their medical staffs would be better able to design an on-call schedule that satisfies EMTALA and meets the needs of patients in the community. Without any guidance, hospitals will continue to face pressure from physicians to reduce the on-call burden, not to mention growing demands for payment for call. Unfortunately, this constellation of competing interests leaves the most vulnerable patient populations at increasing risk.

5. CMS should permit physician groups to be designated on the on-call list, instead of having a strict requirement that an individual physician name be listed.

Perhaps CMS is worried about the potential for delay or confusion in being able to enforce an OIG penalty for a violation (which physician would come within the OIG's monetary penalty power if a physician is not named?). We recommend that there are effective ways for a physician group to address timely call requirements and still maintain flexibility to provide call. Further, enforcement can be brought against the group as a whole or upon the physician identified on the group's on-call list as the responsible physician.

The statutory provisions immediately preceding EMTALA, the Medicare provider agreement provisions at 42 U.S.C. § 1395cc, do not require that a specific name be listed:

1395cc. Agreements with Providers of Services

(a) Filing of agreement; eligibility for payment; charges with respect to items and services

(1) Any provider of services... shall be qualified to participate under this subchapter and shall be eligible for payments under this subchapter if it files with the Secretary an agreement –

(I) in the case of a hospital or rural primary care hospital –

(i) to adopt and enforce a policy to ensure compliance with the requirements of section 1 *395dd* of this title [EMTALA] and to meet the requirements of such section,

> (iii) to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an "emergency medical condition," and... (Emphasis added.)

The Interpretive Guidelines, Tag A404, §489.20 (r)(2), refer to:

> A list of physicians who are on call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition; and...
>
> Interpretive Guidelines: §489.20 (r)(2). Physicians' groups names are not acceptable for identifying the on call physician. Individual physician names are to be identified on the list.

Several CMS regional offices have in the past confirmed that the EMTALA rules do require the name of a specific physician who will be on call. However, we understand from discussions with some regional offices that the most important thing is that there is a physician who will respond on call when needed. Accordingly, if a particular individual is on call on a particular day and is so listed, but when the hospital calls the group's phone number for that physician, the hospital is told that a different group member is now on call, it is fine if the physician on call for the group responds. The key is that the response time is not different from what it would have been.

We certainly understand that CMS wants to make sure that an on-call specialist comes to treat the patient. But, we have also been told by at least one regional office that it is acceptable for the group to reshuffle the on-call list of physicians such that a different physician is on call than the one originally listed on the on-call list for the day, so long as the hospital is calling the same phone number for any member of the group. We recommend that CMS confirm this approach in revised Guidelines.

6. CMS should be more flexible on the format for Board approval of designation of which "qualified medical personnel" (QMPs) are authorized to perform medical screening exams.

The Board of a hospital client of ours adopted a formal Board resolution setting forth the QMPs authorized to perform medical screening exams. A few months later, it was informed in a "Notice of Termination" that the language had to be in either hospital bylaws or medical staff rules and regulations, that a Board resolution was insufficient.

The actual regulatory language that covers "qualified medical person" indicates that it must be determined by "the hospital in its bylaws or rules and regulations." (See, e.g., 42 C.F.R. §489.24(e)(1)(ii)(C).) However, the Interpretive Guidelines contain the following additional "guidance" (which is unfortunately confusing and inconsistent in places):

> A hospital must formally determine who is qualified to perform the initial medical screening examinations, i.e., qualified medical

person. While it is permissible for a hospital to designate a non-physician practitioner as the qualified medical person, the designated non-physician practitioners must be set forth in a document that is approved by the governing body of the hospital. Those health practitioners designated to perform medical screening examinations are to be identified in the hospital by-laws or in the rules and regulations governing the medical staff following governing body approval. It is not acceptable for the hospital to allow the medical director of the emergency department to make what may be informal personnel appointments that could frequently change.

The MSE must be conducted by an individual(s) who is determined qualified by hospital by-laws or rules and regulations and who meets the requirements *of482.55* concerning emergency services personnel and direction. The designation of the qualified medical personnel (QMP) should be set forth in a document approved by the governing body of the hospital. If the rules and regulations of the hospital are approved by the board of trustees or other governing body, those personnel qualified to perform the medical screening examinations may be set forth in the rules and regulations, or the hospital bylaws. It is not acceptable for the hospital to allow informal persormel appointments that could frequently change.

(Interpretive Guidelines to §489.24(a) and to §489.24(d)(1)(i).)

In today's world, policies are the most common approach to EMTALA issues specifically, and many other issues generally. Therefore, we suggest that hospital Boards be permitted to designate QMPs through a "document" other than bylaws, rules and regulations.

(It is worth noting that hospital Boards themselves may need to implement EMTALA-based policies for compliance purposes. For example, if the medical staff votes against changes to be made to bylaws or rules and regulations in order to make them EMTALA-compliant (as sometimes happens, even when the changes are recommended by the Medical Executive Committee), Boards have no way to comply other than to adopt a policy or a resolution.)

7. CMS should strive to reduce regional office variation.

CMS has previously acknowledged the concern that its different regional offices took different approaches to EMTALA enforcement. We understand that CMS intended that its Interpretative Guidelines would in part help to achieve more uniformity. Still, we encounter different interpretations regarding EMTALA in enforcement actions by different regional offices or in direct communications when we inquire about policy issues or try to resolve concerns. For example, as to our preceding QMP comments, we have a number of hospital clients that have made their QMP designations by written policy and they have never been cited for using a noncompliant approach. CMS should continue to strive to encourage uniformity.

II. COMMENTS ON OTHER AREAS OF CONCERN

1. Many emergency rooms are overwhelmed by providing services for individuals who do not need emergency care. We urge CMS to consider ways to address this concern within EMTALA's rules.

We have had a number of hospital clients ask if there was some way to get those non-urgent patients out of their ED before a full EMTALA medical screening examination is performed. That would not only reduce the ED patient load, it could help speed services to true emergent patients, as well as allow non-urgent patients to be seen sooner at the hospital's non-ED outpatient setting.

CMS has never wavered from the position that any patient who presents to the ED must be provided a medical screening examination. While that position is understandable in the ideal, from a practical perspective, it clogs ED operations and makes timely attention to ED patients more difficult. (An additional difficulty and irony: CMS then finds EMTALA violations for when patients are not seen quickly enough in the ED.) Some flexibility in this area for patients who are really looking for non-urgent care would help lighten the increasingly onerous patient load in the ED.

2. Patients should be advised if the hospital to which they present is not a participating provider in their health plan.

It is not uncommon for a patient who presents to a hospital's ED not to know whether the hospital and the on-call specialist participate in the patient's health plan. It is likely that there is a nearby hospital and an on-call specialist who are participating providers in that plan. It can be in the patient's interest to know this information. CMS prohibits this information-sharing, as CMS is concerned that the hospital will use it to "economically coerce" the patient to choose to go elsewhere. The patient may then be billed tens of thousands of dollars for care by the hospital to which he or she presented. Being provided care at the other hospital would have required the patient to pay only the required deductible.

CMS' position seems to presume that hospitals are more concerned with economic considerations than the well-being of their patients. If anything, hospitals deserve the presumption of doing well by their patients; that is the mission and duty of every nonprofit hospital.

Patients, as consumers, want to know this kind of meaningful payment information. They are upset with hospitals when they are billed for out-of-network services when they could easily have gone to or been transferred to a hospital network provider, particularly when the time delay involved would not result in any material medical risk or deterioration to the patient.

If there is still a concern that patients would make pocketbook rather than good medical decisions, providing this information to the patient could be limited to those situations in which the physician determines that the patient's medical condition should not materially deteriorate by the patient's transfer.

3. Patient transfer choices should be guided by common sense criteria, and not simply at the discretion of the sending hospital.

Under the existing interpretation of the nondiscrimination/specialized capabilities provision, a hospital can choose to contact another hospital hundreds of miles away for a proposed transfer, even though another capable hospital is much closer to the sending hospital. We are aware of such occurrences.

In some cases, it appears that a hospital transfers insured patients to one hospital, but it contacts other hospitals (which have the same specialized capabilities) when the patients involved are uninsured, on Medicaid, etc.

Distance, transfer time involved, and perhaps even patterns of patient transfers (and hospital relationships) should be factors that weigh on hospital transfer decisions.

4. EMTALA compliance by CMS regional offices should take into account actions by local authorities.

We are aware of at least two situations in which local police took a patient from a hospital's ED to another hospital's ED upon their own authority. In one of these situations, the first hospital was found to have violated EMTALA based at least in part upon what appeared to be the actions of the police officers.

ED staff and physicians have enough work on their hands to manage busy emergency departments. They should not be responsible, under EMTALA, for confronting and challenging police officers who, on their own authority, remove a patient to be brought to another facility.

(Why would the police act in this manner? From our experience, it could be for any of a number of reasons. The police officers could be from another area and want the patient to be cared for in a hospital in their "jurisdiction." Or, the hospital in another area may be the one that has a contract with the State to provide specialty services to a Medicaid population (mental health care being one example).

Hospitals can get caught in any number of ways by decisions made by police or the State (the latter in terms of contractual relationships). In the mental health care arena, it is common – even required – for certain patients to be transferred from one facility to another in a police vehicle (this is particularly the case with a patient transferred from a private community hospital to a state hospital, for reasons of physical control and security). EMTALA compliance is not part of the decision-making, even though the decision is put upon the hospital but not made by the hospital.

Thank you for your consideration of these comments.
Sincerely,
Barbara Blackmond

Alan Steinberg

Susan Lapenta

APPENDIX 8b

HORTY, SPRINGER & MATTERN
A PROFESSIONAL CORPORATION
ATTORNEYS AT LAW

JOHN HORTY
LINDA HADDAD
BARBARA A. BLACKMOND
DANIEL M. MULHOLLAND III
CHARLOTTE S. JEFFERIES
HENRY M. CASALE
PAUL A. VERARDI
ALAN J. STEINBERG
SUSAN M. LAPENTA
LAUREN M. MASSUCCI
NICHOLAS J. CALABRESE
LEEANNE MITCHELL O'BRIEN
MONICA J. HANSLOVAN
RACHEL E. REMALEY
PHILIP W. ZARONE

TO: David M. Siegel, M.D., J.D., FACEP, FACP, FCLM
Chair, CMS EMTALA Technical Advisory Group
FROM: Barbara Blackmond and Alan Steinberg

DATE: October 14, 2005

RE: Specialty Hospitals and EMTALA

Thank you for the opportunity to supplement the general comments we submitted on October 12. This memo will specifically address EMTALA and specialty hospitals.

Our firm primarily works with nonprofit full-service community hospitals. The fact that most specialty hospitals are now able to avoid EMTALA is unfair to full-service community hospitals and to patients. One of the attractions for some physicians of practicing at a specialty hospital (in addition to the opportunity to invest) is that they do not face the burden of emergency call obligations. We agree with the comments of the American Hospital Association, but we wanted to add two other points that we believe have emerged recently that may not be obvious.

1. A growing rift between physicians who invest in specialty hospitals and other physicians is exacerbating call coverage problems.

On community hospital medical staffs, we are seeing a growing rift between physicians who invest in specialty hospitals (and other outside facilities) and those who do not. Demands for payment for call coverage are increasing. Specialty hospitals siphon off less severely ill patients and those with better insurance coverage, depleting already limited funds available in full service hospitals to pay for call coverage. (Funds that could be used to pay for call coverage are limited because there are so many other pressing needs,

for services, facilities and equipment. Most hospitals that now are forced to pay for call, in our experience, limit such payments to services that are above a baseline level of call that is expected as part of the basic citizenship obligation of medical staff membership.) Physicians who are not investors in such facilities increasingly are voicing their resentment and asking for payment for what they see as an increased call burden due to the fact that specialty hospitals and ambulatory surgery centers are not obligated to provide any emergency care. The policy issues that relate to specialty hospitals are beyond the TAG's charge, but we wanted to illustrate one more growing problem that community hospitals face.

2. Practical consequences of specialty hospitals' limitations - dumping of inpatients and continuity of care problems flowing from lack of after hours emergency services.

Full service hospitals experience "dumping" in the sense of transfers of more seriously ill inpatients from specialty hospitals, because the limited service hospitals cannot – or do not want to – take care of seriously ill patients. Even if the issue of inpatient transfers is not an EMTALA issue, improper transfers from specialty hospitals contributes to the overall impact on the resources of full services hospitals and burden on physicians who are willing to take call. (In many hospitals, patients who are transferred who don't have an attending physician on that medical staff are seen by the on-call physician.)

Lack of any requirement for speciality hospitals to offer after hours emergency services is risky for patients who develop complications post-discharge. We understand that in 2003, when CMS amended the EMTALA regulations, CMS made it clear that only hospitals that have dedicated emergency departments ("DEDs") come under EMTALA, perhaps because of concerns that EMTALA was being interpreted too broadly. However, perhaps CME did not anticipate the growth of specialty hospitals or the effect on patients and communities of effectively exempting most specialty hospitals from any emergency services requirement.

Under the regulations now in effect, 42 C.F.R. §489.24(a) and (b), hospitals that have DEDs are subject to EMTALA if they meet one of the following three prongs:

> 1. licensed by the state as a emergency department;
> 2. held out to the public as a place providing care for emergency medical conditions
> ("EMCs"); or
> 3. during the preceding calendar year, at least 30% of outpatients' visits constitute treatments for EMCs on an urgent basis without previously scheduled appointments.

In our experience, we do not believe that most specialty hospitals fall under any of these prongs and thus, they are effectively exempt from EMTALA.

This effective exemption may have been an unintended consequence of the laudable goal of making EMTALA enforcement more reasonable. We suggest that CMS consider requiring specialty hospitals to provide some mechanism for handling patients who develop emergency medical conditions related to the procedures performed at the specialty hospital. Otherwise, patients needing evening or weekend care as a result of a post-discharge complication from the care received in a specialty hospital come to full-service hospital emergency departments, increasing the burden on specialists who are still willing to provide call.

If a patient develops a complication post-discharge from a specialty hospital, the physician who actually performed the patient's surgery or cardiac procedure should generally be contacted. For continuity of care purposes, that is better care than having the patient seen by the on-call specialist in an emergency department of another hospital. Patients records from a speciality hospital are typically not available for the benefit of the emergency physician or the on-call specialist at the general hospital.

Specialty hospitals could be required to provide post-discharge instructions to patients to come back to the specialty hospital even if after hours, in the event of a complication. CMS could also require specialty hospitals to have agreements with full service hospitals. The agreements should address transfers, provision of patient records and at least telephone availability of a practitioner knowledgeable about the patient, regardless of the hour at which the patient presents to the DED of a full service hospital. CMS should also consider requiring speciality hospitals to have a roster for call coverage by specialists who could be contacted by the emergency physician in the full service hospitals, at least sufficient to handle patients previously treated in the specialty hospital who are either transferred or who choose to come to the full service hospital DED.

APPENDIX 9a

Summary Report

2005 Hospital Emergency Department Administration Survey

Overview

The Schumacher Group is a national hospital emergency department management firm responsible for the clinical staffing and operation of over 100 acute care hospital emergency departments located throughout the United States.

In an effort to monitor strategic, operational, and staffing trends of importance to emergency medicine delivery, we conduct a continuing survey of hospital emergency department administrators nationwide. This report summarizes the fourth such survey that we have conducted. Previous surveys were conducted in 1999, 2000, 2001 and 2004.

The survey is offered as a benchmark that health care professionals may use in setting emergency department staffing policies, evaluating current operational procedures, and tracking emergency medicine trends.

Methodology

The 2005 Survey of Emergency Department Administrators was mailed to 4,000 emergency department managers/administrators at 4000 non-federal, acute care hospitals located in all 50 states. The survey was mailed in late February, 2005. A total of 716 completed surveys were received by The Schumacher Group by March 7, 2005, for a response rate of 17.9%. The summary of responses was completed and released in April, 2005.

The methodology employed in completing the 2005 survey was similar to that used in 1999, 2000, and 2001. However, the questions asked in 2004 and 2005 were substantially different from those asked in 1999 and 2000, and different in some cases from those asked in 2001. Therefore, only relevant responses from the 2001, 2004 and 2005 surveys are referenced in this report.

Number of Surveys Mailed

2005	2004	2001
4,000	4,000	4,000

Responses Received

2005	2004	2001
716	681	635

Response Rate

2005	2004	2001
17.9%	17%	16%

Questions Asked And Responses Received

1. How many patients do you see in your Emergency Department per year?

	2005	2004	2001
0 – 9,000	25%	27%	23%
9,001 – 16,000	21%	21%	19%
16,001 – 20,000	8%	10%	10%
Greater than 20,000	46%	41%	45%
N/A	0%	1%	3%

2. In the last 12 months, has patient volume in your ED:

	2005	2004	2001
Increased	51%	68%	78%

If increased, by how much?

	2005	2004	2001
1-10%	70%	78%	65%
11-20%	9%	16%	12%
21-30%	2%	3%	18%
31-40%	0%	1%	4%
41-50%	0%	0%	1%
50% or more	0%	0%	0%
N/A	19%	2%	0%

	2005	2004	2001
Decreased	15%	13%	8%

If so, by how much?

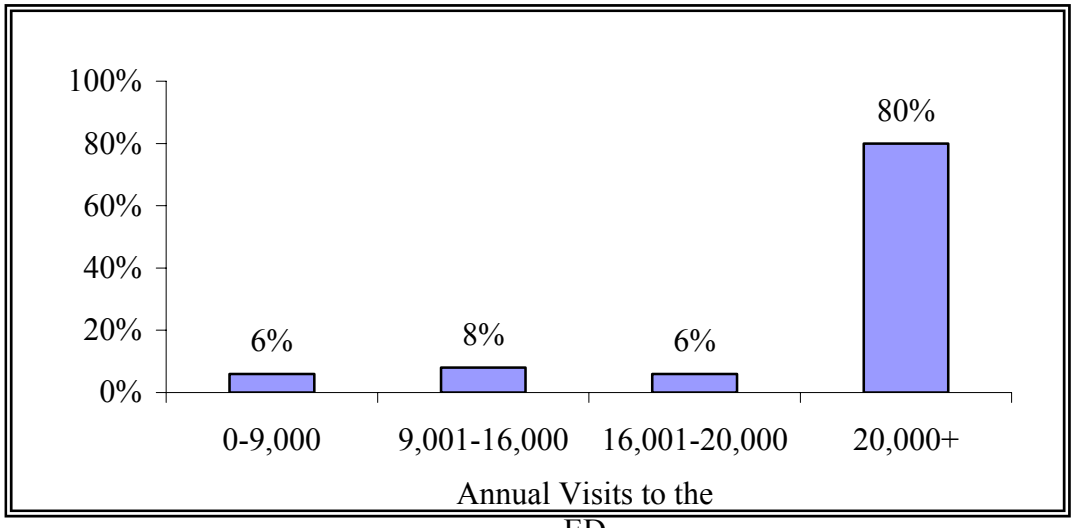
	2005	2004	2001
1-10%	72%	95%	79%
11-20%	5%	4%	7%
21-30%	0%	1%	4%
31-40%	0%	0%	0%
41-50%	0%	0%	0%
50% or more	0%	0%	0%
N/A	23%	0%	10%

	2005	2004	2001
Stayed the same	34%	19%	14%

3. In the last 12 months, has overcrowding in your ED caused you to divert patients to other hospitals?

	2005	2004	2001
Yes	35%	18%	36%
No	65%	82%	62%
N/A	0%	0%	2%

% of Hospitals that Diverted Patients Due to ED Overcrowding in the Last 12 Months by Number of ED visits



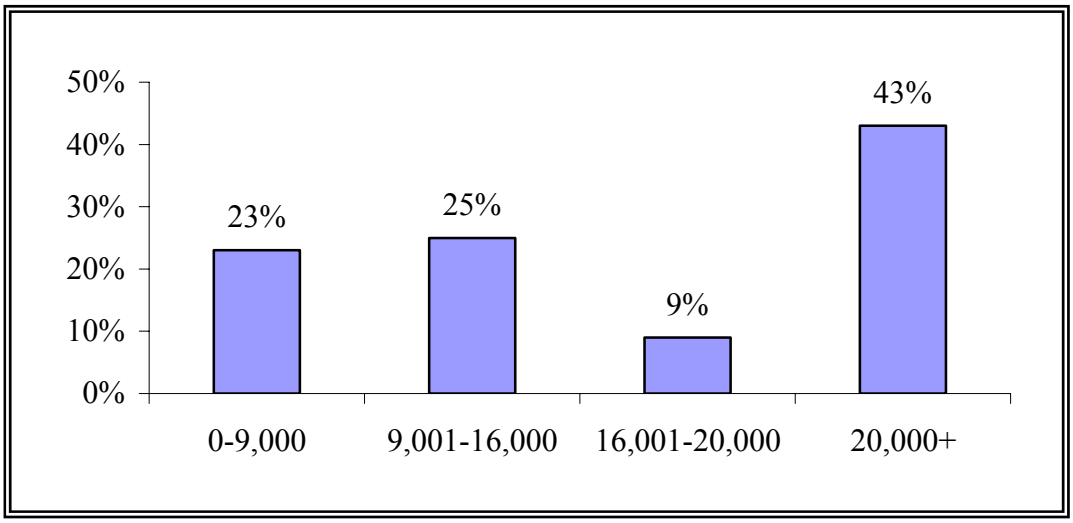
4. If yes, how often?

	2005	2004	2001
Once every few months	45%	43%	%
1-2 times a month	17%	19%	%
3-5 times a month	14%	22%	%
6 or more times a month	24%	11%	%
N/A	0%	5%	%

5. In the last 12 months, has lack of physician specialty coverage caused you to divert patients to other hospitals?

	2005	2004	2001
Yes	57%	76%	65%
No	43%	24%	33%
N/A	0%	0%	2%

% of Hospitals that Diverted Patients Due to Lack of Specialty Coverage in the Last 12 Months by Number of ED visits



6. If yes, how often:

	2005	2004	2001
Once every few months	27%	17%	22%
1-2 times a month	25%	21%	19%
3-5 times a month	20%	28%	25%
6 or more times a month	28%	33%	34%
N/A	0%	1%	0%

7. In the last 12 months has your ED lost any specialty coverage?

	2005	2004	2001
Yes	33%	31%	N/A
No	67%	68%	N/A
N/A	0%	1%	N/A

8. If yes, why did you lose specialty coverage? (choose all that apply)

	2005	2004	2001
Malpractice concerns have discouraged specialists from providing ED coverage	34%	26%	N/A
Physicians have left for military service	1%	9%	N/A
Uncompensated care has discouraged specialists from providing ED coverage	10%	33%	N/A
EMTALA obligations have discouraged specialists from providing ED coverage	4%	12%	N/A
Competition has attracted specialists away from our facility	18%	31%	N/A
Not sure of reason for loss of specialty coverage	12%	18%	N/A
Other	21%	23%	N/A

9. If competition has been a factor in loss of specialty coverage, please specify what type of competition:

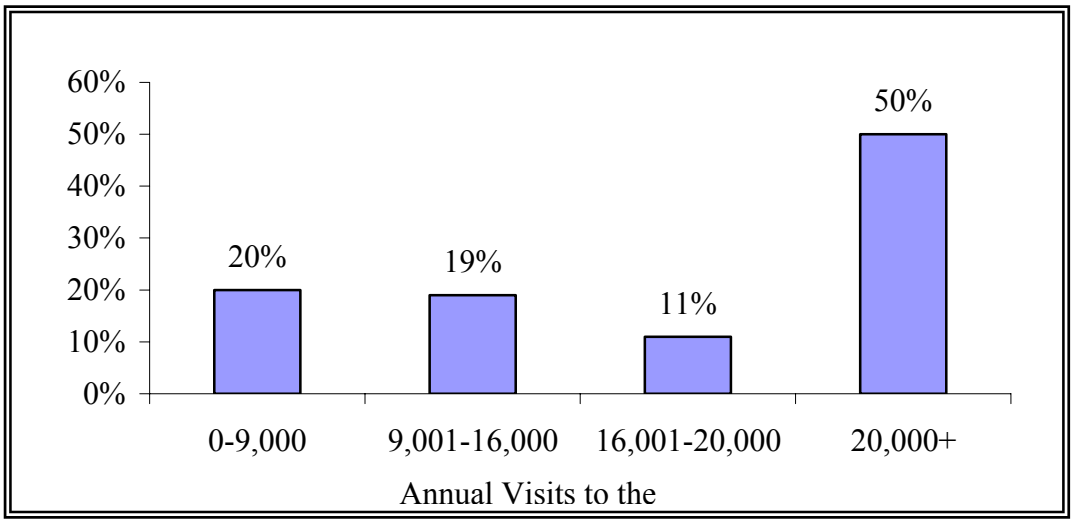
	2005	2004	2001
Specialty hospital	18%	14%	N/A
Surgery center	31%	12%	N/A
Competing acute care hospital	51%	51%	N/A
Other	N/A	23%	N/A

10. Does lack of specialty coverage in your ED pose a significant risk to patients?

	2005	2004	2001
Yes	42%	23%	20%

No	58%	69%	76%
N/A	0%	8%	4%

Does lack of specialty coverage in your ED pose a significant risk to patients? ("yes" responses by number of ED visits)



11. In the last 12 months, have patient wait times in your ED:

	2005	**2004**	**2001**
Grown longer	34%	40%	42%
Grown shorter	16%	10%	11%
Stayed the same	50%	50%	44%
N/A	N/A	0%	3%

12. What is the average wait time for patients in your ED?

	2005	**2004**	**2001**

Less than one hour	47%	N/A	N/A
1-2 hours	22%	N/A	N/A
2-3 hours	21%	N/A	N/A
3-4 hours	7%	N/A	N/A
4-5 hours	2%	N/A	N/A
5 hours or more	1%	N/A	N/A

13. Please rate how the following factors contribute to wait times in your ED:

	Strong Effect	Moderate Effect	Little Effect
Delays in triage	17%	81%	2%
Overcrowding	35%	37%	28%
ER bed availability	43%	38%	19%
Ancillary (x-ray, lab) service delays	20%	46%	34%
Admitted or transfer patient boarding in the ED	40%	28%	32%
ED physician over-utilization of services	14%	33%	53%
Local Physicians using ED for non-emergent patients	20%	33%	47%

14. In the last 12 months, has the number of uninsured patients in your ED:

	2005	2004	2001
Increased	54%	49%	43%
Decreased	1%	0%	2%
Stayed the same	45%	48%	52%
N/A	N/A	3%	3%

15. Does your medical community have access to countywide or citywide indigent care programs?

	2005	2004	2001
Yes	75%	54%	53%
No	25%	44%	47%
N/A	N/A	2%	0%

16. Is your ED a major provider of primary care for the indigent/uninsured in your community?

	2005	2004	2001
Yes	80%	77%	74%
No	20%	23%	24%
N/A	N/A	0%	2%

17. Does your ED have policies and procedures to actively identify and document non-emergency patients in the medical screening process?

	2005	2004	2001
Yes	60%	N/A	N/A
No	40%	N/A	N/A

18. Has your hospital ever been subject to an EMTALA-related investigation?

	2005	2004	2001
Yes	36%	32%	32%
No	64%	67%	66%
N/A	0%	1%	2%

19. How would you rank the top three concerns/priorities facing your Emergency Department in the next 12 months? Please number three items below 1, 2, & 3 in order of priority/concern.

	2005 Most Important	2005 Somewhat Important	2005 Least Important
Uncompensated care	35%	37%	28%
Overcrowding of the department	45%	30%	25%
Lack of specialty physician coverage	26%	37%	37%
Shortage of physicians in the ED	12%	32%	56%
HIPAA compliance	8%	34%	58%
Shortage of nurses in the ED	34%	41%	25%
Length of patient stay in the ED	40%	38%	22%
EMTALA compliance/investigation	10%	28%	62%
Reimbursement for services	40%	41%	19%

ED Physician competence	21%	30%	49%
Poor public image of the department	34%	33%	33%
Other	29%	26%	45%

20. If you were seriously hurt and had a variety of options to choose from, would you go to your own hospital's ED, or would you choose to go elsewhere in hopes of obtaining better care?

	2005	**2004**	**2001**
Would choose my hospital's ED	88%	84%	84%
Would go elsewhere	12%	15%	16%
N/A	0%	1%	0%

21. If you would choose to go elsewhere, please indicate why (check all that apply):

	2005	**2004**	**2001**
Lack of confidence in ED physician skills/competence	23%	32%	12%
Lack of equipment	1%	8%	6%
Lack of specialty backup	74%	73%	63%
Lack of nurses	1%	8%	3%
Too crowded	N/A	3%	3%
Other	1%	20%	13%

TRENDS AND OBSERVATIONS

A number of demographic, medical, and socio-economic trends have led to greater patient volumes in hospital emergency departments in recent years. As a result, emergency medicine has become an increasingly important part of overall health care delivery in the United States.

The Schumacher Group regularly conducts surveys to track trends in this rapidly evolving area of medicine. The 2005 Survey of Hospital Emergency Department Administrators reflects current strategic, staffing, and operational concerns facing ED managers at 716 different acute care hospitals nationwide. The survey both examines ongoing issues facing hospital ED managers and indicates what their concerns are for the next 12 months.

The 2005 Survey confirms a continuing trend toward greater utilization of hospital emergency departments. Fifty-one percent of those surveyed indicated that patient volumes in their EDs had increased in the last 12 months, while 34% said volumes remained the same, and 15% said they had decreased. This represents a decrease over the last several years among ED managers who indicate patient volumes are rising. In the 2004 survey, 68% of ED managers indicated patient volumes had risen in the previous year, while in the 2001 survey, 78% of ED managers indicated that patient volumes had risen.

Meanwhile, 15% of those surveyed indicated that patient volume in their EDs had decreased in the last year, compared to 13% who saw decreases in 2004 and 8% who saw decreases in 2001. The 2005 Survey therefore suggests that while patient volumes are increasing for a slim majority of hospital EDs, volumes are flat or actually decreasing for a growing number of facilities.

Though patient volumes are not rising for some facilities, overcrowding in the ED continues to be a concern and a cause for patient diversions to other facilities. Over one third (35%) of ED managers surveyed in 2005 indicated that overcrowding in the ED caused them to divert patients to other hospitals in the last 12 months. By contrast, in the 2004 survey, 18% of ED managers indicated that overcrowding in the ED had caused them to divert patients to other hospitals in the previous 12 months. In addition, in the 2005 survey, 24% of those facilities that had diverted patients to other hospitals due to overcrowding did so six or more times per month, compared to just 11% in the 2004 survey. The incidence of multiple patient diversions due to overcrowding therefore more than doubled from 2004 to 2005. Though in recent years concerted efforts have been made by many hospitals to reduce ED patient crowding through retooled patient flow standards and other methods, overcrowding remains a significant challenge.

Not surprisingly, hospitals with a high volume of annual ED patient visits were more likely to indicate they had diverted patients due to overcrowding than hospitals with a low volume of ED patients. Eighty percent of hospitals with 20,000 or more annual ED visits indicated they had diverted patients due to overcrowding in the last 12 months, compared to just six percent of hospitals with 9,000 or fewer annual ED visits. It can be inferred that for larger hospitals with many ED patient visits, ED overcrowding is a common problem – less so for smaller hospitals with fewer ED visits.

Though overcrowding is a concern, the 2005 survey indicates that ED patient diversions are more likely to be caused by lack of physician specialty coverage in the ED than by overcrowding. Fifty-seven percent of ED managers surveyed in 2005 indicated that lack of physician specialty coverage caused them to divert patients to other hospitals during the last 12 months, considerably more than the number who diverted patients due to overcrowding in the ED. Of those who diverted due to lack of specialty coverage, 28% did so six or more times per month.

Quality of care can be a vital issue in such diversions, since patients needing critical neurological, orthopedic or other specialty services may have to be shuttled from hospital to hospital in search of specialty services. In a potentially positive trend, the number of ED managers reporting patient diversions due to lack of specialty coverage dropped in 2005 relative to 2004 and 2001.

However, the 2005 survey indicates that lack of specialty coverage will continue to be a concern in the future. About one-third (33%) of ED managers indicated their ED's had lost specialty coverage in the last 12 months, up from 31% in the 2004 survey. Those that lost specialty coverage cited malpractice concerns among specialty doctors as a major contributing reason. The fact that specialists often are not compensated for ED care was cited considerably less frequently as a factor leading to loss of specialty coverage than was malpractice concerns among

physicians. Many medical specialists today are reluctant to treat patients in an emergency setting because malpractice liability tends to be higher in the ED than in more controlled settings. ED managers surveyed also indicated that competition, mostly from other acute care hospitals, has attracted some specialists away from their hospitals.

The risk to patients

In one of the most telling results of the 2005 survey, 42% of ED managers indicated that lack of specialty coverage in their emergency departments poses a significant risk to patients at their facilities. This was a dramatic increase over 2004, when 23% of ED managers indicated lack of specialty coverage posed a significant risk to patients, and 2001, when 20% of those surveyed indicated lack of specialty coverage posed a significant risk to patients.

It is disturbing to consider that patients may be at significant risk in over four in ten hospital emergency departments in the United States due to lack of specialty coverage. Many other factors affecting patient safety in the hospital have received focus in recent years, but no standards have been set for the number or type of specialists required to be on call. In addition to establishing such standards, the overall shortage of medical specialists, and the liability issues that make many specialists reluctant to provide care in the ED, must be addressed if quality of care in the nation's hospital emergency departments is going to be maintained.

Indeed, 12 percent of ED managers surveyed indicated they would not choose to go to their own facility's emergency department for treatment should they be seriously hurt. Of these, about three-quarters (74%) indicated that lack of medical specialty coverage at their facilities would cause them to go elsewhere.

Patient wait times in the ED also continue to be a cause for concern. Over one third (34%) of ED managers indicated that patient wait times in their ED's had grown longer in the last 12 months, compared to 40% in 2004 and 42% in 2001. Sixteen percent indicated that patient wait times had decreased, compared to 10% in 2004 and 11% in 2001, suggesting that some hospitals have taken steps to enhance the rate of patient through-put.

Nevertheless, 53% of ED managers surveyed indicated that average wait times for treatment in their departments was over one hour. About one-third (31%) indicated average patient wait times in their EDs was two hours or more. This is disturbing in light of the fact that 27 minutes is considered a standard favorable average wait time for physician treatment in the emergency department. ED managers identified lack of bed availability in the ED as a major contributing factor to patient wait times. In many cases, ED beds are being taken by patients who have been admitted to the hospital but for whom no regular hospital beds are available. In the past, slow lab and x-ray turnaround times often were cited as causes for treatment delays in the ED, but these concerns have been replaced to some extent by bed availability issues.

Providing primary care to the indigent

Over one half (53%) of ED managers surveyed indicated that the number of uninsured patients visiting their facilities had increased in the last 12 months, up from 49% in 2004 and 43% in

2001. The great majority of ED managers surveyed (80%) indicated that their facilities are a major provider of primary care for the indigent/uninsured in their communities.

While the majority of ED managers surveyed (60%) indicated that their facilities have policies in place to identify non-emergency patients in the medical screening process, a large minority (40%) do not have such policies in place. This leaves them relatively ill-equipped to triage patients in a timely manner and to reduce problems of overcrowding and long wait times in the ED.

Looking ahead, more ED managers (45%) identified overcrowding in the ED as a most important concern in the next 12 months than any other issue or concern listed in the survey. Length of patient stay in the ED, reimbursement for services, and uncompensated care also were listed as top concerns.

For more information about this survey or about related emergency department management issues, please contact:

Lafayette, Louisiana
800-893-9698
www.tsged.com

APPENDIX 9b

Percentages of Transfers---PRELIMINARY DATA

Combined

Count of Cases	Month												
Year-Transferred Patients	January	February	March	April	May	June	July	August	September	October	November	December	Grand Total
2002	1505	1354	1474	1371	1433	1418	1379	1524	1467	1531	1494	1799	17749
2003	2105	2234	2682	3006	3024	2941	3080	3048	3056	3205	3340	3703	35424
2004	3524	3621	4013	3774	4016	3779	3982	4114	4043	4217	3865	3960	46908
2005	4037	3651	3939	3769	0	0	0	0	0	0	0	0	15396
Grand Total	11171	10860	12108	11920	8473	8138	8441	8686	8566	8953	8699	9462	115477

Total Patient Visits													
2002	173058	162886	170051	164782	173660	168434	174585	177254	175419	167165	161747	183733	2052774
2003	215431	208778	241010	247565	261332	251282	260904	274019	271909	274418	282412	306071	3095131
2004	274376	268217	287174	278502	293168	281472	290563	292208	289214	284934	273171	274624	3399674
2005	295349	288563	298871	279056	0	0	0	0	0	0	0	0	1161839
Grand Total	958214	928444	997106	969905	728160	701188	726052	743481	736542	726517	717330	764428	9709418

Percentages of Transfers

Year	January	February	March	April	May	June	July	August	September	October	November	December	Grand Total
2002	0.870%	0.831%	0.867%	0.832%	0.825%	0.842%	0.790%	0.860%	0.836%	0.916%	0.924%	0.979%	0.865%
2003	0.977%	1.070%	1.113%	1.214%	1.157%	1.170%	1.181%	1.112%	1.124%	1.168%	1.183%	1.210%	1.145%
2004	1.284%	1.350%	1.397%	1.355%	1.370%	1.343%	1.370%	1.408%	1.398%	1.480%	1.415%	1.442%	1.380%
2005	1.367%	1.265%	1.318%	1.351%									1.325%
Grand Total	1.166%	1.170%	1.214%	1.229%	1.164%	1.161%	1.163%	1.168%	1.163%	1.232%	1.213%	1.238%	1.189%

APPENDIX 10

Survey Summary

The American Society of Plastic Surgeons (ASPS) and its affiliated Plastic Surgery Educational Foundation (PSEF) conducted an online membership survey in August 2005 regarding the current status of emergency department (ED) on-call services. Various concerns had been raised among the membership regarding the demands imposed by on-call schedules and associated interpretation of the regulatory framework, as well as their desire to best meet the needs of their patients and practice obligations.

The survey was emailed to approximately twenty-five hundred members (2,500). A total of seven hundred seventy-three (773) plastic surgeons throughout the United States took the confidential survey over the course of a three-week period, with a response rate of approximately 31%.

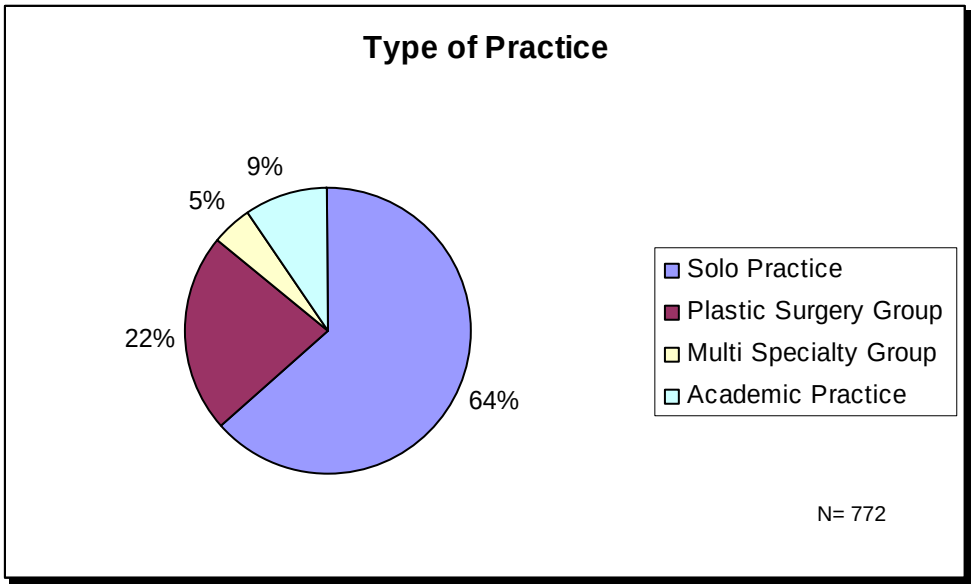
The survey set out a breadth of questions, including ED coverage requirements associated with hospital privileges, on-call days per month, difficulty with ED scheduling, types of coverage being provided, availability of a stipend, ability to schedule other patients while on-call, and liability concerns. Plastic surgeons were also asked about the adequacy of ED coverage and contributing factors when ED coverage was not viewed as adequate. Of particular note, while the majority (55%) indicated ED call coverage was adequate at the hospital where they take ED call, top concerns by the remainder included inadequate or absent reimbursement, inadequate number of plastic surgeons available, too demanding of an on-call schedule, and liability concerns.

The survey findings offer information about significant issues surrounding on-call emergency department coverage. These concerns are compounded in an already strained climate of declining and inadequate reimbursement, liability concerns, and increasing demands for specialty care. Survey questions focused on potential obstacles in the provision of on-call services and the intrinsic relationship of ED call coverage with hospital privileges.

Results

Practice Setting

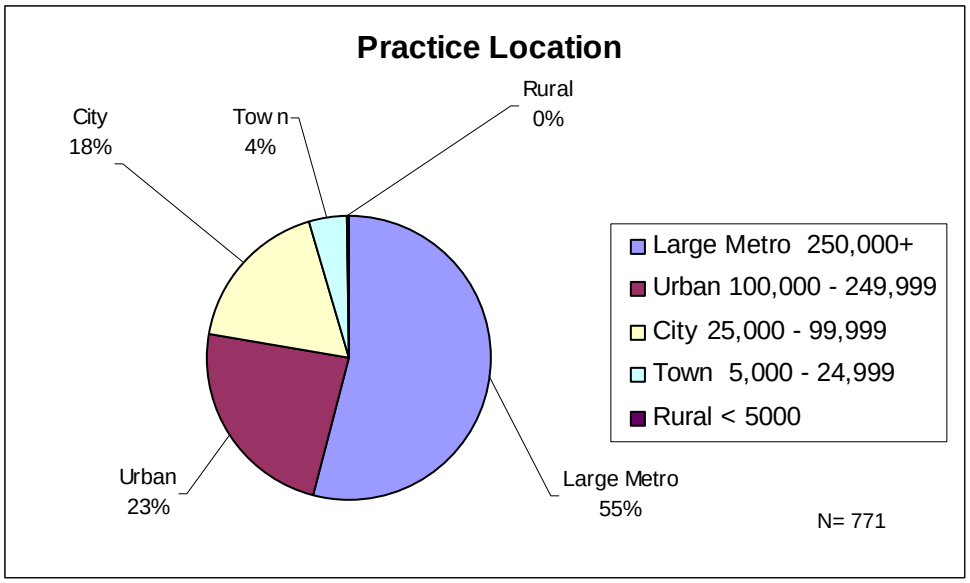
Question: Which one of the following best describes your type of practice?



The plastic surgeons who responded to the survey represent a cross-section of the membership from varied practice settings. The majority work in a solo practice (64%), and nearly one-quarter (22%) work in a plastic surgery specialty group. Less than ten percent (9%) were in academic practice and the remainder (5%) was in a multi-specialty group.

Practice Location/Population

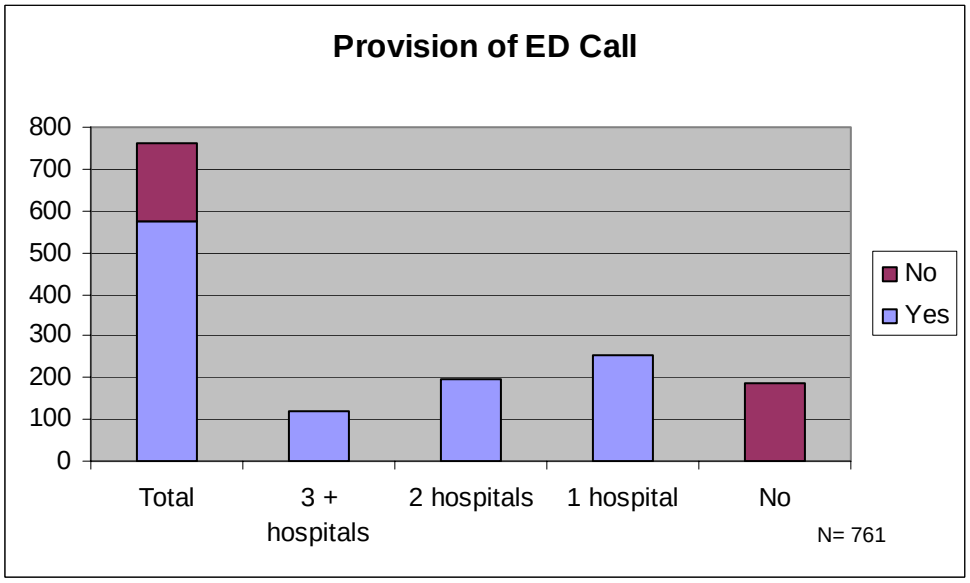
Question: Which one population description best defines your current location?



Over half (55%) of plastic surgeons who participated in the survey practice in a large metropolitan area. Nearly a quarter (23%) practice in an urban area, 18% in a city, and 4% in a town. Less than 1% practice in a rural area (2 total respondents).

Provision of Emergency Department On-Call

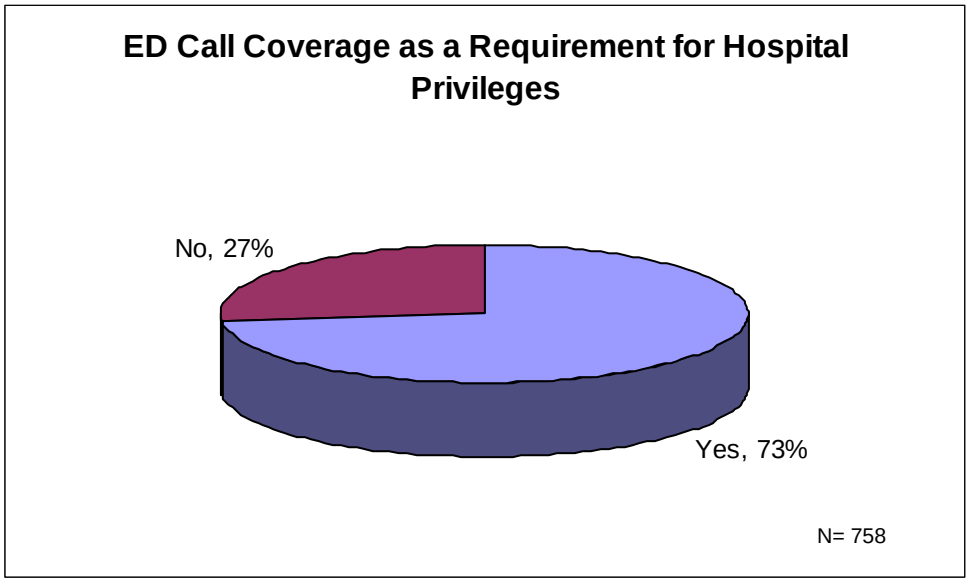
Question: Do you provide ED call?



Three out of four plastic surgeons (575 respondents or 76%) taking the survey provide ED call, of which 34% provide it at one hospital, 26% at two hospitals, and 16% at three or more hospitals

Emergency Department On-Call/Hospital Privileges

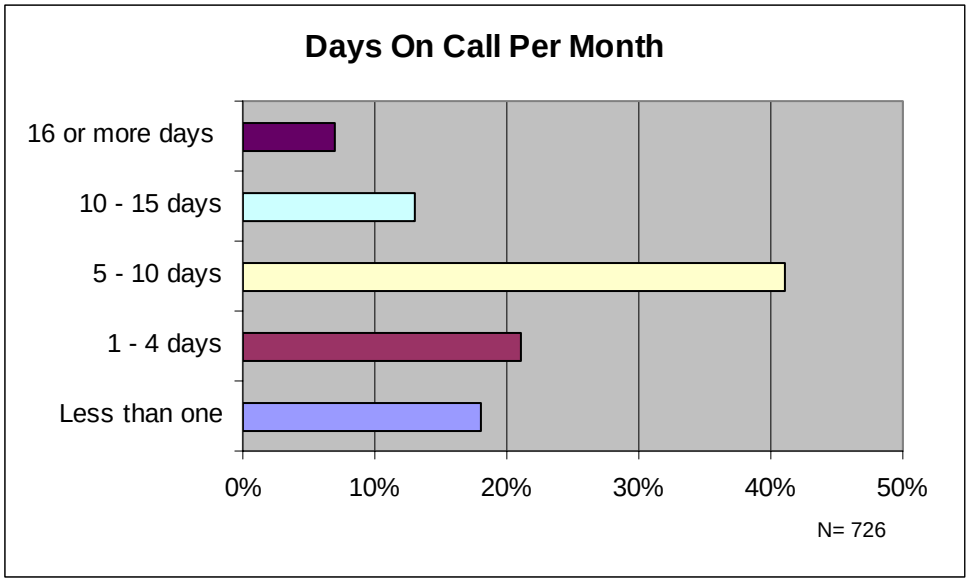
Question: Is ED call coverage a requirement to maintain hospital privileges?



The majority (73%) indicated ED coverage is a requirement to maintain hospital privileges.

Provision of Emergency Department On-Call/Length of Call

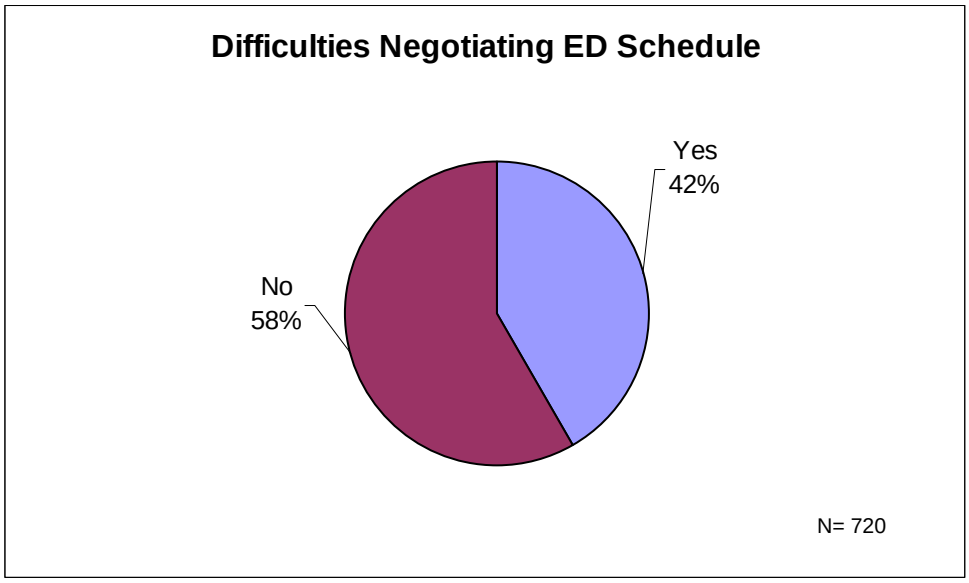
Question: If you provide ED call, how many days are you on-call per month?



As to the majority of plastic surgeons who provide ED call, 41% indicated they take call 5-10 days per month while 21% are on-call 1-4 days per month, 13% for 10-15 days per month, and 7% for 16 or more days per month. The remaining 18% take call less than one day per month.

Challenges Negotiating Emergency Department Schedule

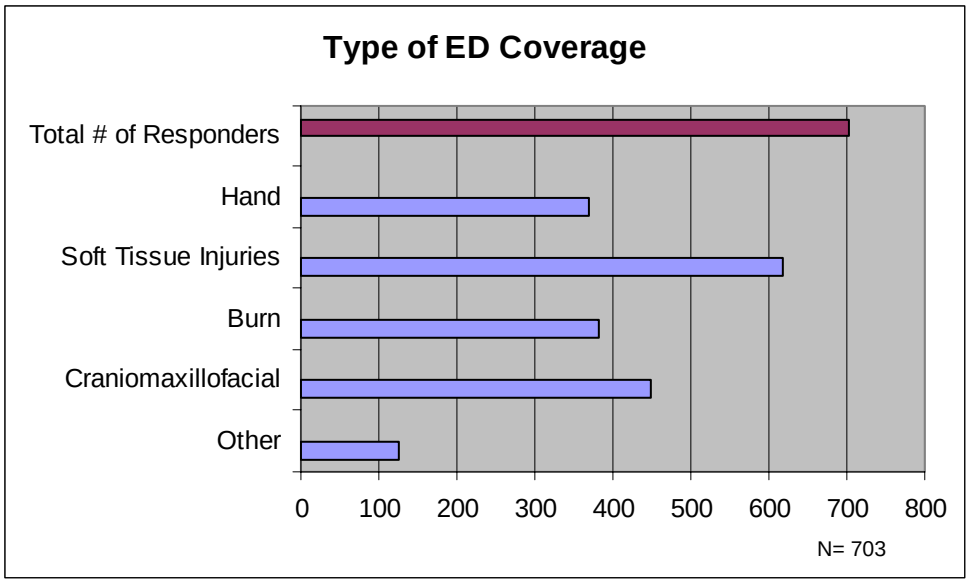
Question: Are you currently having difficulties negotiating your emergency call schedule with the hospital(s)?



A significant portion of plastic surgeons surveyed (42%) indicate that they are currently having difficulties negotiating ED schedule. While respondents were not asked about past difficulties, inclusion of that information might raise additional concerns among this pool.

Spectrum of Emergency Department Coverage

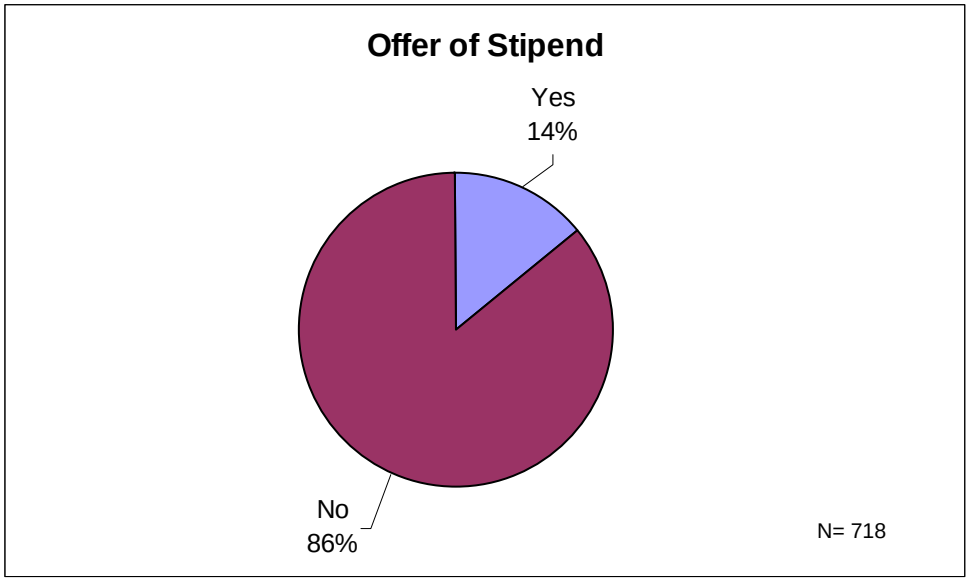
Question: Indicate the type of ED coverage you provide. (Select all that apply)



Of the plastic surgeons respondents who indicated they provide ED call, 88% (618 responses) covered soft tissue injury, 64% (448 respondents) craniomaxillofacial, 55% (383 respondents) burn, 52% (368 responses) hand, and 17.8% (125 responses) other.

Emergency Department Call/Stipend

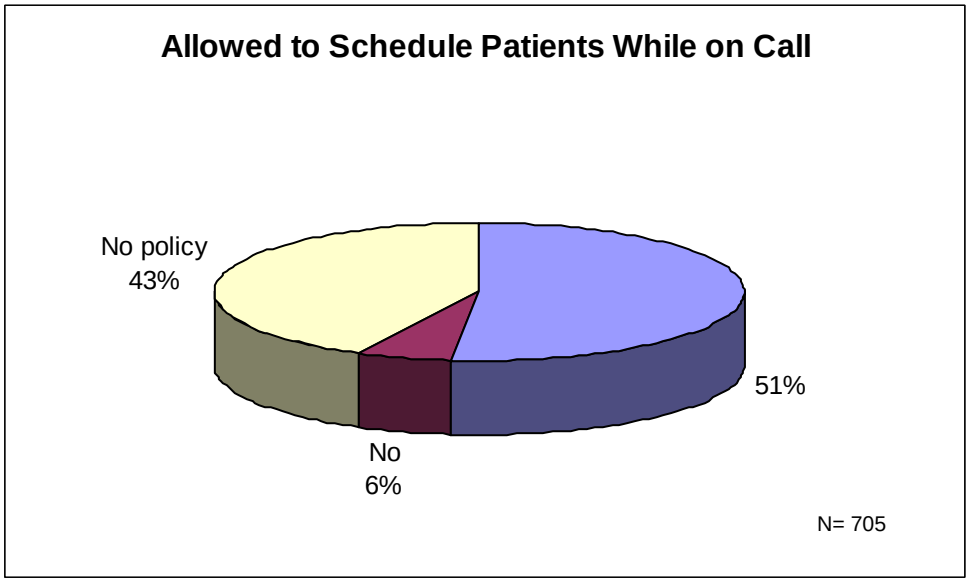
Question: If you provide call, does the hospital(s) where you take call provide an on-call stipend?



A large majority (86%) of the plastic surgeons surveyed do not receive a stipend from a hospital for providing on-call services.

Ability to Schedule Other Patients/Operating Room Cases

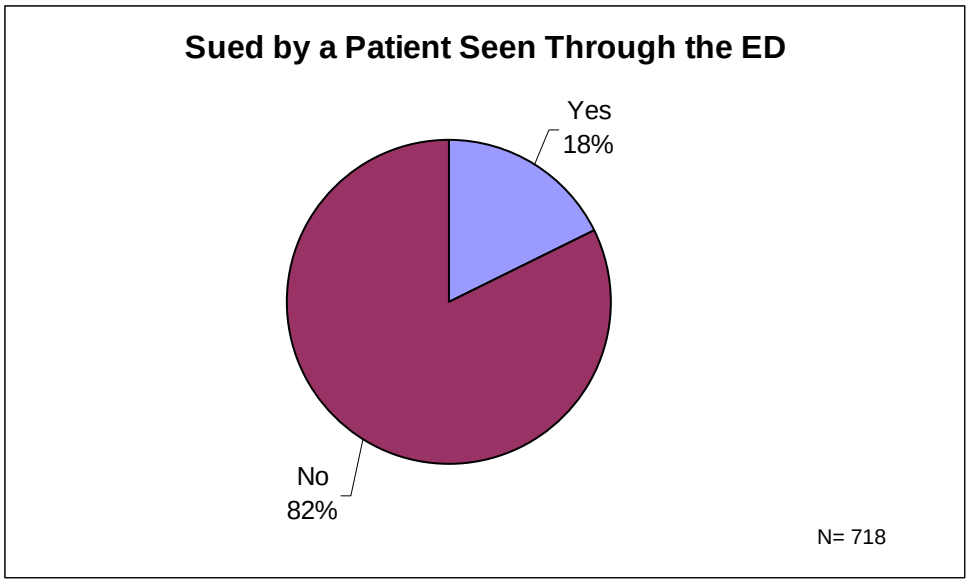
Question: Does your hospital's on-call program allow you to see your scheduled patients and perform your scheduled operating room (OR) cases while serving on call?



When asked whether the on-call program of the hospital(s) allowed them to see their scheduled patients and perform OR cases while on-call, only about half (51%) indicated that they were permitted to do so. The remaining half (49%) selected no or that the hospital does not have a specific policy on the issue.

Emergency Department Call/Lawsuits Brought

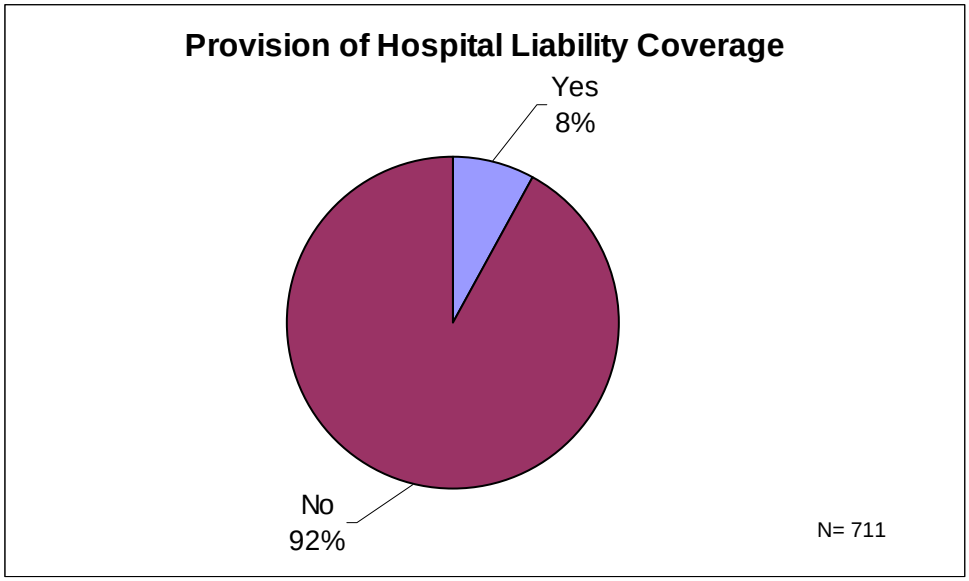
Question: Have you ever been sued by a patient(s) seen through the hospital ED?



Eighty-two percent (82%) of plastic surgeons surveyed revealed that they have not been sued by a patient seen through the ED.

Hospital Provision of Professional Liability Coverage

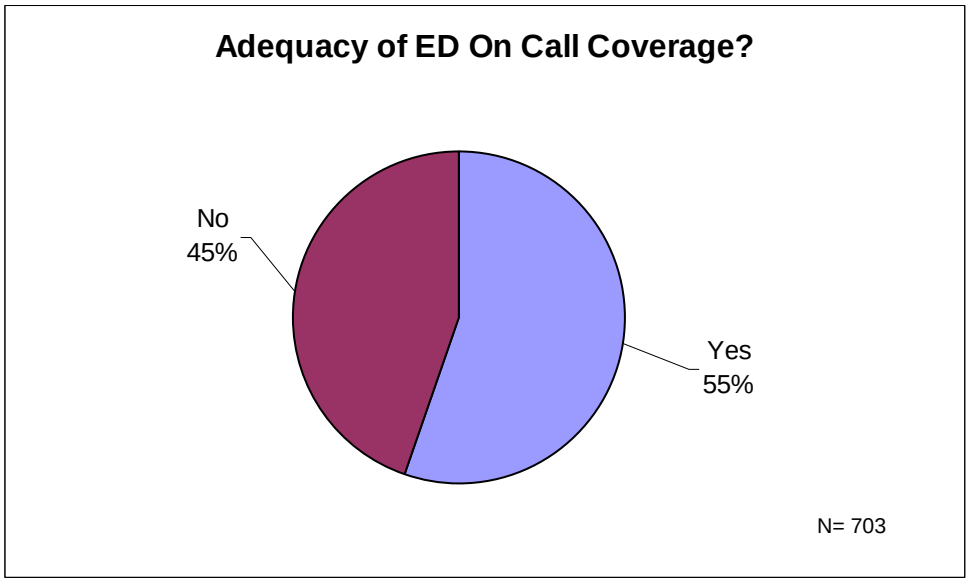
Question: Does the hospital(s) offer professional liability coverage for the procedures you provide in the ED?



The overwhelming majority surveyed (92%) are not offered professional liability coverage for procedures performed in the ED.

Adequacy of Plastic Surgery On-Call Coverage

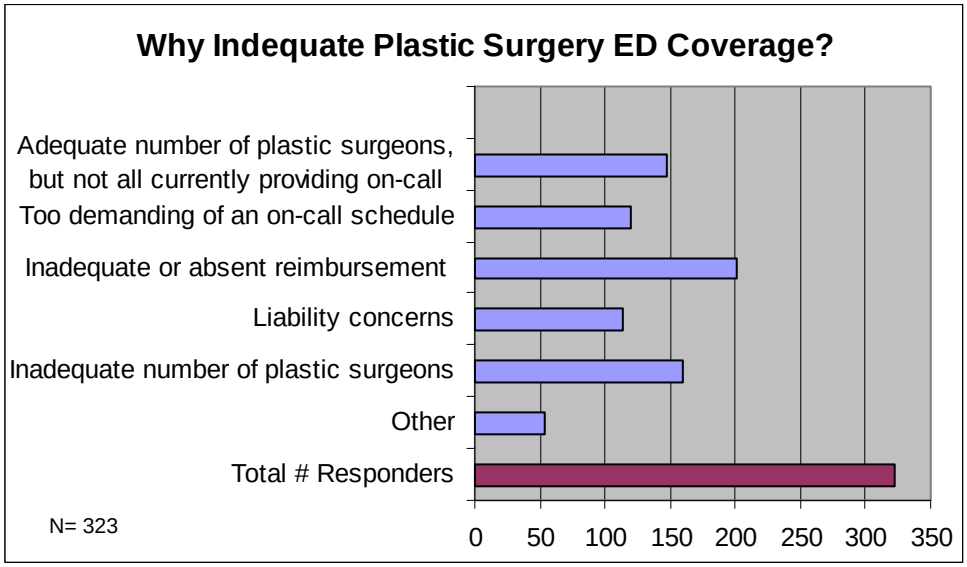
Question: To your knowledge, does the hospital(s) where you take ED call have adequate plastic surgery on-call coverage?



Over half of plastic surgeons surveyed (55%) feel that plastic surgery on-call coverage is adequate, with forty-five percent (45%) indicating inadequacy of such coverage.

Inadequacy of Plastic Surgery On-Call Coverage/Factors

Question: If you indicated that plastic surgery coverage was inadequate at the hospital(s) where you take ED call, to what do you attribute the inadequate plastic surgery ED call? (Select all that apply)



For the forty-five percent (45%) of respondents who indicated that plastic surgery coverage was inadequate at the hospital(s) where they take ED call, opportunity was given to select specified reasons as well as list 'other' attributing reasons. The top three reasons identified were 'inadequate or absent reimbursement' (62%, 201 responses), followed by 'inadequate number of plastic surgeons available to provide on-call' (49%, 159 responses) and 'adequate number of plastic surgeons, but not all currently providing on-call' (46%, 147 responses). Further key responses that garnered high percentages were 'too demanding of an on-call schedule' (37%, 119 responses) and 'liability concerns' (35%, 114 responses). 'Other' was least selected (16%, 53 responses), where a host of issues were identified ranging from inappropriate consult with specialists to required call for procedures outside of the surgeon's practice pattern to inability to see other patients while on-call.

About the American Society of Plastic Surgeons (ASPS)

The ASPS, founded in 1931, is the largest organization of board-certified plastic surgeons in the world and represents the broad spectrum of the specialty of plastic surgery — both reconstructive surgery and cosmetic surgery. It represents more than 6,000 physicians certified by the American Board of Plastic Surgery or the Royal College of Physicians and Surgeons of Canada. The ASPS works closely with the Plastic Surgery Educational Foundation, which serves as the education, research, and service arm of the Society.

APPENDIX 11

1

The Neurosurgery Crisis in North Carolina

Robert Walters, Jr., is a healthy 79 year old man who likes to build furniture and tinker with computers. In the spring of 2004, Mr. Walters hit his head during a car accident. Some time later, he was dragging his leg and couldn't move around normally. His pupils were not right either. An emergency head CT scan at Rex Hospital showed a subdural hematoma (bleeding inside of his skull). Within a few short hours of completing his CT scan, Mr. Walters had the life-threatening blood removed from his brain by neurosurgeon Dr. Russell Margraf. Mr. Walters is normal again, building furniture and tinkering with
computers again. Mr. Walters' story represents a classic neurosurgery miracle. He is fortunate to live in Wake County where neurosurgeons usually can be found for emergency brain problems.

Howard Baylor was not as fortunate. Mr. Baylor was a 63 year old active husband, father and grandfather who liked to mow his yard and work around the house. He developed some vomiting and headaches at 3 p.m. on November 4, 2004, and walked into his local emergency room in Jacksonville, North Carolina, at 4 p.m. that day. He spoke to the nurses and answered questions. An hour later he lost
consciousness. A head CT scan showed a subdural hematoma. Mr. Baylor needed emergency surgery to remove the hematoma and save as much brain function as possible.

Mrs. Baylor says the Jacksonville emergency room staff made many telephone calls trying to find a neurosurgeon anywhere nearby. None were found. Mrs. Baylor thinks a neurosurgeon works in Jacksonville but was not available. Many hours passed by. Portions of Mr. Baylor's brain were crushed by the dangerous bleeding. Finally, Mr. Baylor was transported by ambulance about 120 miles away to Raleigh and WakeMed Hospital.

At 3 a.m., November 5 (eleven hours after Mr. Baylor arrived at the Jacksonville emergency room), neurosurgeon Dr. Ken Rich surgically removed the subdural hematoma in Raleigh. Unfortunately, Mr. Baylor's surgery had been delayed too long. Portions of his brain were permanently damaged. Dr. Rich says if Mr. Baylor had found a neurosurgeon earlier near his home and had surgery many hours earlier,
he likely could have been saved.

Mrs. Baylor says her husband now lives in a nursing home in Jacksonville, mostly paralyzed in his right arm and leg. He can't stand or walk. His right eye doesn't work and he can't remember anything except the distant past. He is crippled with severe brain damage. Mr. Baylor's story represents a tragic neurosurgical disaster where surgery was performed too late, says Dr. Rich.

This is a true story. The patient's real name is changed to Mr. Baylor to protect his privacy. Mr. Baylor is a real person with a real tragedy that could have been prevented…if a nearby neurosurgeon had been willing or available to take emergency calls. No medical malpractice occurred here. The problem was that nobody could find the right kind of doctor in a timely manner. If Mr. Baylor had lived in Wake

County, rather than Onslow County, he likely would have had much more prompt surgery for his brain hemorrhage and a far better outcome.

Mr. Baylor's tragedy is not unusual. Compared to several years ago, Dr. Rich and all of his seasoned fellow neurosurgeons at WakeMed, say they now see more head injury patients travel much longer distances because many local neurosurgeons at the smaller hospitals don't take head injuries anymore. "Just ask any small hospital emergency room physician how many telephone calls it takes to find a neurosurgeon," says Dr. Rich. That E.R. physician often makes between five and ten telephone calls before he finds a neurosurgeon able to take a head injury patient.

Dr. Craig VanDerVeer, a neurosurgeon in Charlotte, says that tragedies like Mr. Baylor's happen all the time in Charlotte. In recent years, he has noticed a dramatic increase in head-injured patients referred to Charlotte from the North and South Carolina coastline, because the local neurosurgeons on the coast (outside of Wilmington) have stopped doing brain surgery. Dr. VanDerVeer regularly sees patients dying or suffering severe brain damage because it often takes too long to transport a patient from the Carolina coast to a Charlotte hospital. These patients with serious head injuries on the Carolina coastline need quick, emergency craniotomy surgery at a hospital on the coast, not many hours inland in Charlotte, Dr. VanDerVeer says.

Dr. John Wilson is president of the North Carolina Neurosurgical Society and an associate professor at Wake Forest University Baptist Medical Center. He sees the exact same trend in Winston-Salem that has been identified in Raleigh and in Charlotte. Compared to several years ago, Dr. Wilson has more head-injured patients traveling greater distances to Baptist Medical Center because local neurosurgeons are not available for head injuries. Patients are being harmed by the substantial delays in receiving emergency neurosurgical care.

Dr. Rebekah Austin is a neurosurgeon who finished her neurosurgical training at Wake Forest University this year. During her more than five years at Baptist Medical Center, she saw about two to three head-injured patients per month transported at least 60-100 miles to her medical center oftentimes because the local neurosurgeons no longer took care of brain injuries. Even more amazing is that she saw emergency head injury patients regularly transporting hundreds of miles inland from the Carolina coast. Many neurosurgeons practice medicine between the Carolina coast and Winston-Salem. The fact that patients who suffer head injuries on the coast sometimes have to go to Winston-Salem in order to find a neurosurgeon is a powerful testament to the crisis in neurosurgery in North Carolina.

Many of those head-injured patients transported in from far away arrived dead or dramatically braindamaged. Dr. Austin says that many of those patients could have been saved with quicker brain surgery done closer to their home.

Fayetteville is another well-known crisis area without consistent emergency neurosurgical care for the last several years. Just ask the state legislators from Fayetteville about the neurosurgery crisis and ask the local newspaper that has reported on it. The neurosurgeons at WakeMed frequently see emergency head injuries sent in from Fayetteville because the local neurosurgeons are unavailable to take emergency call everyday.

Many parts of rural North Carolina, particularly in the west, simply don't have any neurosurgeons. Patient access to neurosurgical care is poorer because no physicians live nearby. However, many parts of North Carolina, such as eastern and central North Carolina, do have practicing neurosurgeons who could take care of head-injury victims but have stopped doing brain surgery because of the increased legal liability and financial risks.

Dr. Rich reports that numerous towns in eastern, central and southern North Carolina that have local neurosurgeons regularly send head injury patients to WakeMed in Raleigh.

The neurosurgeons are disappearing in North Carolina. Here are a few examples. Wake Forest University neurosurgery graduate Dr. Austin grew up in North Carolina and loves her home. Just a few months ago, she chose to start her private neurosurgery practice in Tennessee rather than in her home state. The neurosurgery department at UNC in Chapel Hill has become alarmingly small in recent years,
losing over half of its academic neurosurgeons. Mrs. Baylor says: "We had a real good neurosurgeon here a few years ago in Jacksonville. He couldn't afford to stay here. His insurance went up and he moved to Memphis, Tennessee." Many other examples exist of neurosurgeons retiring early or moving out of North Carolina often due to the high cost of malpractice insurance and the threat of unfounded
lawsuits.

Dr. VanDerVeer calculates that 147 neurosurgeons practiced in North Carolina four years ago. Now, 110 neurosurgeons practice in our state. Less than 60 of those 110 neurosurgeons do full service work like taking care of emergency head injuries. Since our total population in North Carolina continues to increase, the substantial decrease in neurosurgeons becomes even more alarming. This year for the first time ever for his neurosurgery group, Dr. VanDerVeer lost an excellent prospective neurosurgeon
looking for a job with them. That young neurosurgeon, even though he wanted to live in Charlotte and work with Dr. VanDerVeer, chose to practice neurosurgery in Georgia specifically because the medical malpractice climate is better in Georgia than in North Carolina.

Georgia recently passed into law substantial reforms, including caps on non-economic damages and immunity from lawsuits for ordinary negligence occurring in emergency rooms. States all around North Carolina have undergone serious medical liability reform. North Carolina is now the only state from West Virginia through Florida on the east coast without significant reforms. Not only does this fact create problems in attracting and retaining good doctors, but it will also begin to hurt tourism and the state's ability to attract and retain good business. Lack of access to quality healthcare is an economic
development issue.

Dr. Robin Koeleveld, neurosurgeon and president of the medical staff at WakeMed in Raleigh, wonders how long the bigger medical centers and universities can meet the increased need for caring for high risk neurosurgical patients. With the departure of over half of the UNC-Chapel Hill neurosurgeons, that concern intensifies. Years ago, many of the higher risk neurosurgical patients were treated by local neurosurgeons closer to the patients' homes, say both Dr. Koeleveld and Dr. Wilson.

The neurosurgery crisis has worsened not only in the less populated counties but even in popular Wake County. A few months ago, neurosurgery emergency call coverage changed in Raleigh. WakeMed in Raleigh is now the only hospital in Wake County with local neurosurgeons available every day of the year.

Dr. Tim Garner, Raleigh neurosurgeon, explains the subtle dangers of this situation: "If you have a heart attack or stroke and if you need a blood thinner medicine, then you are at risk for bleeding into your brain". Dr. Garner and his fellow neurosurgeons are occasionally called to remove hematomas from the brains of cardiac and stroke patients who have bled as a result of their medicines. Of the four hospitals in Wake County, only one hospital can now provide constant or 24/7 emergency neurosurgical care. That is the scary reality of healthcare in our capital city.

So remember, if you are at risk for a head injury (like if you drive a car or play sports or if you have ever fallen down), it would be best to stay away from the coast of North Carolina (except Wilmington), stay away from Fayetteville, and stay away from the smaller communities. Most importantly, be near a major medical center that has neurosurgeons taking emergency call for all head injuries 365 days per
year.

Does that sound ridiculous? This notion is not ridiculous if you are Mr. Howard Baylor who now cannot walk at all or think much because he lived near Jacksonville and his brain hemorrhage was treated too late. There are many patients like Mr. Baylor in North Carolina, many of whom have died or suffered severe brain damage because a nearby neurosurgeon stopped doing brain surgery. This lack of timely access to appropriate medical care must be improved.

Neurosurgeons are being driven out of the brain surgery business…by the trial lawyers. By stopping emergency and high risk brain surgery, a neurosurgeon usually is sued less and may save substantial money on his malpractice insurance policy. His life is less stressful and his quality of life improves. Many neurosurgeons simply can't afford the legal and financial risk of taking care of head-injured patients. Ask any busy practicing neurosurgeon around North Carolina, particularly those neurosurgeons in private group practices, and you'll hear the same concerns. It's downright scary.

The crisis in neurosurgery is just the tip of the liability iceberg in medicine. Almost all surgical subspecialties and many of the medical specialties feel similar, though sometimes less intense, ongoing threats from trial lawyers and pressure from increasing malpractice insurance costs. Ask your local obstetrician or any surgical specialist. You'll usually hear these same concerns.

Patients in need of neurosurgical, obstetrical or emergency medical care are harmed or substantially inconvenienced because many doctors can't afford to take on the tough cases, the risky patients with the complicated problems. Doctors are afraid of unjustified, frivolous lawsuits, *out of court settlements*, and higher malpractice insurance costs. People suffer because many doctors are not practicing the full scope of medicine that they were trained to do. Trial lawyers slowly and steadily are changing the very face of

medicine.

The threat of unjustified, expensive lawsuits and settlements from trial lawyers and the high cost of malpractice insurance are killing the practice of medicine and harming patients. There is no doubt about this. Look around our country and around our state for further proof. The objective evidence is overwhelming.

North Carolina has a true crisis in neurosurgery…and in most of medicine. Patients are being harmed by the worsening access to an appropriate doctor. "People need to realize that people's lives are in jeopardy," says Dr. Rich. The over 8,400,000 people in North Carolina deserve more timely access to the right doctor who practices nearby. Even the couple hundred medical malpractice trial lawyers in North Carolina deserve better access to doctors for their own emergency neurosurgical care. We all need the crisis improved. We are all at risk as the medical liability crisis worsens.

We need real, not token, medical liability reform in North Carolina. Our North Carolina General Assembly needs to pass powerful, effective medical liability reform, just as many other state legislatures have already done around the U.S. The time is now. Our health depends on it.

Dan Albright, M.D.
Orthopaedic Surgeon in Raleigh
President of the Wake County Medical Society
President of Protect Health Care Now

APPENDIX 12

Perspective

Physician-Owned Specialty Hospitals: A Market Signal For Medicare Payment Revisions

Policymakers should view the growth in these hospitals as a signal that the hospital payment system is out of balance.

by Jack Hadley and Stephen Zuckerman

ABSTRACT: Jean Mitchell's findings show that physician-entrepreneurs respond to financial incentives and take advantage of variations in profitability within Medicare's hospital payment system. The growth of physician-owned specialty hospitals can be seen as the reflection of parallel growth in profit opportunities. As Medicare plans to do, payments should be revised to squeeze out excess profits. Prohibiting physicians' use of hospitals they own might be unnecessary and could make it harder to identify future distortions in Medicare prices. If squeezing out excess profits threatens general hospitals' social missions, then new and explicit ways of identifying and funding social missions must be found.

Jean mitchell's analysis of physicianowners and nonowners of cardiac specialty hospitals in Arizona finds that owners treat more cases and that the cases they treat in their own hospital are less severely ill and are much less likely to be either health maintenance organization (HMO) or Medicaid (AHCCCS) patients compared with nonowners. Her findings are consistent with those recently reported by the Medicare Payment Advisory Commission (MedPAC), the U.S. Government Accountability Office (GAO), and the Centers for Medicare and Medicaid Services (CMS).[1]

Mitchell's findings should come as no surprise. Physician-entrepreneurs respond to financial incentives and will take advantage of profit opportunities as they arise. MedPAC has shown that the relative profitability of hospital care can vary greatly both across diagnosis-related groups (DRGs) and by patient severity within a DRG.[2] Thus, the growth of physician-owned specialty hospitals can be seen as the visible reflection of parallel growth in profit opportunities.

As a result of these studies, the CMS is considering revisions to the DRG payment methodology to better account for differences in severity across patients aswell as the underlying cost structures of specialty and community hospitals. Congress is also considering legislation to make permanent the prohibition on physician referral of Medicare patients to specialty hospitals in which they have an ownership interest.

We address three questions in this commentary: (1) What prompted the recent growth of physician-owned specialty hospitals? (2)Why should we care about their existence? (3)What should be done, if anything, as a policy response?

_ Why the growth now? Although there is no way of knowing definitively, several factors were probably at play in the recent rise in the number of physician-owned specialty hospitals.

First, consolidation of hospital administrators' managerial authority as a result of both the inpatient prospective payment system (IPPS) and the growth of managed care probably eroded physicians' implicit share of hospital profits through salaries and practice subsidies (for example, free office space). MedPAC site visits indicated that physicians formed specialty hospitals to gain more control of hospital operations.[3] Second, the IPPS

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HEALTH A F FA I R S ~ *We b Ex c l u s i v e* W5-49 1
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JackHadley and Stephen Zuckerman (szuckerm@ui.urban.org) are principal research associates at theUrban Institute inWashington,D.C.

has probably not kept pace with technical changes that have lowered the costs of providing certain types of surgical services.[4] Third, theMedicare physician fee schedule as well as possibly some private physician fee arrangements have constrained physicians' payment rates and increased incentives to seek new money-making opportunities.[5] It might be coincidence, but concerns over physicianowned specialty hospitals emerged as Medicare policies were beginning to produce negative updates in the fee schedule conversion factor.

_ Why should we care? What does it matter whether patients are treated in physician-owned specialty hospitals rather than general hospitals? Physicians who have a financial conflict of interest could have an incentive to hospitalize patients unnecessarily or, at least, could be unduly influenced to use the facility in which they have an ownership interest. In addition, if the physician-owners of specialty hospitals capture profits that otherwise would accrue to general hospitals, these hospitals' ability to cross-subsidize charity care or emergency and trauma services could be jeopardized.

There is little evidence to suggest either overuse of services by Medicare beneficiaries or general hospitals' financial stress.[6] This suggests that physician-owners are redistributing "profitable" cases to their hospitals, rather than increasing overall admissions, and that general hospitals are either becoming more efficient or cutting back on unprofitable patients and services.[7] Unfortunately, there is too little good evidence to confirm these responses.

_ What should be done? What, if anything, should policymakers do? The CMS's plan to improve the accuracy of DRG payments is an appropriate first step. However, proponents of this strategy have to recognize that the CMS will have to invest more than it has historically in datacollection resources and staff to monitor and evaluate future developments. Although these actions are needed, it is unlikely that an administered price system will ever be perfect. The best we can hope for is that major imbalances in the profitability of different types of patients will be less likely to occur. In addition to using the IPPS to create market signals, policymakers should bewatching themarket for signals that the IPPS could have problems. Thus, policymakers should view the growth of physicianowned specialty hospitals as a short-term signal that the IPPS is out of balance.

Critics of administered pricing often suggest that Medicare should rely on competing health plans to negotiate provider rates. At best, this strategy is likely to result in a reallocation of profits from specialty hospital investors to managed care companies, with no net savings for the government.[8] Moreover, a recently released GAO report indicates that private health plans are less able to negotiate favorable rates in areas with highly concentrated hospitals.[9] Medicare's administered prices might have an advantage in this situation.

If adjusting DRG payments squeezes out the excess profit for certain types of patients, then we have to presume that cross-subsidies within community hospitals will also be curtailed. This raises the question ofwhether relying on inaccuracies in price setting is an effective way of paying for hospitals' social mission. There seems to be no reason to perpetuate historical cross-subsidies, especially since there is no guarantee that hospital profits are fully applied to achieving socially desired objectives. A system that funds hospitals' social missions

"In the absence of better evidence on overuse or poorer quality, prohibiting physicians' use of hospitals they own could make it harder to identify distortions in Medicare prices."

more directly would require hospitals to be explicit about activities that provide community benefit and about their costs and funding sources. Greater transparency will lead to greater accountability, equity, and efficiency. Policymakers can use the activities of forprofit medical care providers to identifywhere excess profit opportunities exist. In the absence of better evidence on overuse or poorer quality in physician-owned specialty hospitals, prohibiting physicians' use of hospitals they own might be unnecessary and could make it harder to identify distortions inMedicare prices. Policymakers must make sure that the CMS has the resources to monitor and evaluate market activities and to develop payment
methods that capture excess profits and redirect them to socially beneficial services that the for-profit sector should not be expected to provide.

The views expressed are those of the authors and not the
Urban Institute or its trustees or sponsors.

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APPENDIX 13

MarketWatch

Effects Of Physician-Owned Limited-Service Hospitals: Evidence From Arizona

An examination of cardiac care provided in single-specialty hospitals and community hospitals in two Arizona cities.

by Jean M. Mitchell

ABSTRACT: In recent years physician ownership of so-called limited-service hospitals has become commonplace in many states lacking certificate-of-need regulations. Empirical evidence documenting the effects of these facilities is sparse. This study compares practice patterns of physician-owners of limited-service cardiac hospitals and physician-nonowners who treat cardiac patients at competing full-service community hospitals. Analyses of six years of Arizona inpatient discharge data show that physician-owners treat higher volumes of profitable cardiac surgical diagnosis-related groups (DRGs), higher percentages of lowseverity cases, and higher percentages of cases with generous insurance compared with physician-nonowners who treat cardiac patients in community hospitals.

Prohibitions on physician self-referral were enacted during the early 1990s in response to several empirical studies' findings that the financial incentives inherent in physician self-referral arrangements resulted in increased use of services and higher third-party reimbursements.[1] Federal and most state laws, however, exempt "whole hospitals" and ambulatory surgery centers (ASCs).[2] The basis for the formerwas that any referral made by a physician-investor would yield only small financial gains for each physician because hospitals typically provide a wide range of services. Although classified as whole hospitals, physician-owned "limitedservice" hospitals are more akin to a specialized hospital department.[3]

Much of the concern about the recent growth of limited-service hospitals focuses on physician ownership issues.[4] Hospitals are typically paid a facility fee for each patient treated; physicians bill patients separately for professional services. A referring physician with ownership interest in a limited-service hospital is compensated for professional services but also shares in any profit generated from facility fees. Thus, physician ownership of limited-service hospitals creates financial incentives that could influence physicians' referral behavior. Second, under the diagnosisrelated group (DRG) case-based payment approach, physician-owners of limited-service hospitals could have incentives to treat primarily low-acuity patients within DRGs that are more profitable but send clinically complex cases to full-service community hospitals. A third concern is whether physician-investors refer patients with generous insurance coverage to their own facilities and send those with limited or no coverage to community hospitals. If this is the case, then full-service community hospitals will have limited revenues to subsidize the costs of money-losing services (such as trauma and indigent care). Proponents counter that physician ownership enables limited-service hospitals to secure high volume through referrals made by physician-investors.[5] Advocates further contend that such arrangements result in better patient care and outcomes because physicianowners have direct control over the management decisions. Because care in such facilities is organized along product lines or by type of

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HEALTH A F FA I R S ~ *We b Ex c l u s i v e* W5-48 1
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JeanMitchell (mitchejm@georgetown.edu) is a professor of public policy in the Georgetown Public Policy Institute, Georgetown University, inWashington,D.C.

illness, economies of scale could occur and result
in lower production costs.
Despite concerns regarding the increasing number of physician-owned limited-service hospitals, empirical evidence to date consists primarily of case studies.[6] Comparisons of hospital
types, however, do not focus on the individual physicians who make the decisions to admit patients. This study addresses this gap in knowledge by comparing practice patterns of physician-owners of limited-service cardiac hospitals and physician-nonowners who treat cardiac patients at competing full-service community hospitals. Much of the literature documenting the effects of physician selfreferral arrangements compares physicianowners with nonowners.[7]

Study Data And Methods

The data for this study come from two sources: (1) inpatient discharge data from Arizona
hospitals, spanning the years 1998–2003, obtained from the Arizona Department of Health Services, and (2) physician directory information obtained from the Arizona Medical Board. The discharge database contains detailed
information on each patient discharge, including the name and state license number of the attending or operating physician responsible.
For surgical DRGs, the identified physician is the person who performed the procedure, whereas for medical DRGs, the identified physician is the person who monitored the patient in the hospital. The Arizona Medical Board maintains a database that contains
detailed information (such as specialty and medical school graduation date) on all physicians (active and retired) and residents practicing in the state.
With assistance from the Arizona Department of Health Services, the study team identified two physician-owned limited-service hospitals that specialize in the delivery of cardiac
care services. The Tucson Heart Hospital began treating patients in October 1997. The Arizona Heart Hospital in Phoenix became operational in June 1998. We also identified four full-service community hospitals with substantial cardiac care programs that were operational before the Tucson Heart Hospital entered the market and that submitted valid inpatient discharge data to the state during 1997–2003. In the Phoenix market area, we identified seven hospitals that had substantial cardiac care programs before the Arizona Heart Hospital entered the market and two competing facilities that entered later.

_ Construction of physician-level analytical file. For each year (1998–2003) we selected all inpatient discharges with either a cardiac surgical or medical DRG code that were treated at either of the two heart hospitals or one of the competing full-service community hospitals in either city.[8] We identified 236,590 inpatient discharges that met these criteria. Our first series of exclusions resulted in a sample of 215,435 cases (91 percent of the original sample). This sample included 33,060 cardiac cases treated at one of the heart hospitals
and 182,375 cardiac DRG cases treated at one of the competing hospitals.[9]
The next step was to aggregate across cardiac DRG cases by physician license number and hospital provider number to construct an analytical file in which the physician-year is the unit of observation and the volume counts for each physician reflect the number of DRG cardiac cases (total, surgical, and medical) treated at each hospital where the physician practices. For physicians who treated cases at both a heart hospital and the community hospitals,
we calculated two indicators of supply: the annual volume of cardiac DRG cases treated at the heart hospital, and the number of cardiac DRG cases treated in competing hospitals. For physicians who only treated patients
in the community hospitals,we summed

across facilities to calculate the volume of inpatient
cardiac DRG cases treated at community hospitals in the market area.

_ Defining physician-owners and nonowners. Because physician ownership of health care facilities is not reported to the state, it was necessary to establish a set of criteria
to define “owners” and “nonowners.” Considerable evidence indicates that ownership of limited-service hospitals is offered only to physicians who can both refer and treat patients

at the facility.[10] We used this information to define “owners” and “nonowners.” A physician-year observation is included in the sample of owners if (1) the physician treated at least six cardiac DRG cases in a given year across all hospitals in the market area, and (2) the physician treated at least 10 percent of his or her cardiac DRG cases at the heart hospital. Recognizing that this definition of *owners* could include some physicians who are nonowners,
we conducted sensitivity analyses to evaluate the robustness of the results to more stringent definitions of *ownership.* Specifically, we increased the share of cardiac DRG cases that a physician-owner treated in a given year at the heart hospital to 20 percent, 30 percent, 40 percent, and 50 percent and then used higher minimum caseload volumes (11 and 21). We then replicated the statistical analyses using these more stringent definitions.
A physician was classified as a nonowner if he or she treated at least six cardiac DRGcases in one or more of the community hospitals and no such cases at the heart hospital in a given year. The volume counts of inpatient cardiac DRG cases that each physician-owner treated in competing full-service community hospitals were excluded from the primary comparisons butwere analyzed later; 17,424 discharges (7.36 percent of the original sample of 236,590) met this criterion. The rationale for this exclusion was to create a pure control group comprising physicians who only treated patients
at competing full-service community hospitals. Physicians who treated low volumes resulted in the exclusion of another 10 percent of the original sample.[11] The final sample used in constructing the indicators of physician supply contained 174,133 discharges (73.6 percent of the original sample); 32,032 cases treated at the heart hospitals; and 142,101 cases treated at
the community hospitals.
_ Indicators of case-mix. We used the 3M APR-DRG software to assign a severity of illness class (minor, moderate, major) to each cardiac DRG case. Based on these results, we constructed a series of mutually exhaustive indicator
(0–1) variables to identify the severity of each case. Next we summed the severity indicator
variables to create, for each physicianyear observation, a count of the number of cases treated in each severity class. Finally, we calculated the percentage of cardiac DRG cases in each severity-of-illness class (minor, moderate, major) treated by each physician in a given year.
More complicated case-mix can also be measured by identifying the presence of multiple comorbid conditions.We used the comorbidity software developed by Anne Elixhauser and colleagues to construct a series of comorbidity
variables from secondary diagnosis codes reported on each discharge.[12] Based on the results, we assigned a count of the number of comorbid conditions to each case. Next we constructed a series of mutually exhaustive indicator
variables to identify whether each case has zero, one, two, three, four, five, or six-plus comorbid conditions. Following the approach outlined for severity-of-illness class, we summed the comorbidity indicator variables across each physician in a given year to calculate
the number of cases treated in each comorbidity category. The last step was to calculate the percentage of cases in each comorbidity category treated by each physician in a given year.
_ Indicators of payer mix. For each physician-year observation, we constructed several indicators of payer mix. Thesemeasure the percentage of cardiac DRG cases treated by eachphysician in a given year, by type of insurance
coverage. For each physician, we calculated the percentages of cardiac DRG cases treated each year with the following types of insurance coverage: Medicare fee-for-service (FFS); commercial indemnity or preferred

provider organization (PPO);Medicare health maintenance organization (HMO); Medicaid HMO; commercial HMO; and AHCCCS Health Care Group (a state-sponsored HMO available to self-employed people and small businesses). Arizona providers regard Medicare FFS and commercial indemnity/PPO plans as “generous” insurance coverage because
each reimburses on either a FFS or discounted FFS basis. Conversely, providers consider Medicare HMO, Medicaid HMO,
commercial HMO, and the state-sponsored AHCCCS plans as less generous because each pays lower rates than either Medicare FFS or

commercial PPO/indemnity plans.[13]

_ Analyses comparing physicianowners and nonowners. Assuming that patients are randomly distributed, there should be no difference in the volume of cases treated, case-mix, and payer mix between owners and nonowners. The null hypothesis assumes that the financial incentives linked to physician ownership do not affect referral behavior.We first compared the annual volume of inpatient cardiac DRG cases (total, surgical, and medical) treated by owners versus nonowners using a two-tailed test for differences between the means, with a null hypothesis of no difference.

We next evaluated the effects of physician ownership on case-mix by comparing the mean percentage of cardiac DRG cases within each severity-of-illness class treated by owners relative to nonowners.We also conducted t-tests to compare the mean percentages of cases treated within each comorbidity category by physician ownership status. Finally, we performed t-tests to compare the mean percentage of cardiac DRG cases with each type of insurance coverage treated by owners relative to nonowners, again to test the null hypothesis of no difference. We replicated these four sets of analyses controlling for market area and year.

Study Results

_ Sample sizes. The sample of physicianowners used in the volume and payer-mix analyses includes 426 physician-year observations (210 from Phoenix and 216 from Tucson). The sample of physician-nonowners used in the volume and payer-mix comparisons comprises 3,197 physician-year observations (2,164 from Phoenix and 1,033 from Tucson). The analyses comparing severity-of-illness class and comorbidity counts controlling for DRG type (surgical versus medical) are based on the subsamples of owners and nonowners who treated one or more surgical (medical) cases. The analyses of case-mix for surgical cases are based on a sample of 388 owner and 2,762nonowner physician-year observations. The corresponding set of analyses for cardiac medical cases is based on a sample of 395 owner and 3,101 nonowner physician-year observations.

_ Physician supply comparisons. Physician-owners in Phoenix treated nearly twice as many cardiac DRG cases as nonowners in the study period; the annual volume was eighty-nine for owners in Phoenix compared with forty-five for nonowners ($p < .01$) (Exhibit 1). This difference in total cardiac DRG arises because owners treated close to 3.8 times as many surgical DRG cases as nonowners.

The mean was seventy-two for owners compared with nineteen for nonowners ($p < .01$). The reverse pattern emerges for cardiac medical DRGs. Physician-owners in Tucson treated 47 percent more cardiac DRG cases per year than nonowners; the mean was 62 for owners compared with 42 for nonowners ($p < .01$). Comparisons of cardiac surgical DRG caseloads reveal that physician-owners treated more than double the number of surgical cases that nonowners treated (Exhibit 1). The average was 26.5 for owners and 12.2 for nonowners ($p < .01$). Results controlling for year and market area are similar to the pooled findings.[14]

_ Severity-of-illness comparisons. Exhibit 2 compares the severity-of-illness classes assigned to cardiac surgical DRG cases treated by owners and nonowners, stratified by market area. Physician-owners treated proportionately more surgical cases classified as “minor” in comparison with nonowners. The reverse holds true for surgical cases assigned either a “moderate” or “major” severity class. Although not depicted graphically, similar

patterns are evident for cardiac medical DRG cases classified as either “minor” or “moderate” ($p < .01$). Also, the results comparing severity by ownership status controlling for both market area and year are similar.

_ Comorbidity comparisons. Exhibit 3 shows a comparison of comorbidity counts for cardiac surgical DRGs, controlling for physician ownership status. Physician-owners treated significantly higher percentages of surgical DRG cases with one or two comorbid conditions. For example, surgical DRG cases with one comorbidity account for nearly 21 percent of the cases treated by owners compared with about 10 percent of similar cases treated by nonowners ($p < .01$). The reverse pattern characterizes surgical DRG cases with four, five, or six-plus comorbid conditions. It is interesting to note that the distribution of surgical cases classified by comorbidity counts is

EXHIBIT 1
Comparison Of Cardiac Diagnosis-Related Group (DRG) Volumes By Physician Ownership Status, Phoenix And Tucson, Arizona, 1998–2003
SOURCE: Arizona Inpatient Discharge Data, 1998–2003.
90
75
Mean number of cases
Phoenix Phoenix Phoenix Tucson
60
45
30
15
Physician-owners
Physician-nonowners
Tucson Tucson
0
Total cardiac DRGs Cardiac surgical DRGs Cardiac medical DRGs
EXHIBIT 2
Comparison Of Severity-Of-Illness Classification By Physician Ownership Status, For Cardiac DRGs, Phoenix And Tucson, Arizona, 1998–2003
SOURCE: Arizona Inpatient Discharge Data, 1998–2003.
Percent of cases
Phoenix Phoenix Phoenix Tucson
60
45
30
15
Physician-owners
Physician-nonowners
Tucson Tucson
0
Minor Major Moderate

normally distributed for nonowners. In contrast, the distribution of cases treated by owners is highly skewed toward low-severity cases. The results controlling for both market area and year are nearly identical.

Although not displayed graphically, examination of the comorbidity status of cardiac medical DRGs reveals a similar pattern. Compared to physician-nonowners, physicianowners treated significantly higher percentages of cardiac medical DRG cases with zero, one, or two comorbidities ($p < .01$). Physicianowners treated significantly lower percentages of medical DRG cases with three or more comorbidities than did nonowners ($p < .01$). Analogous comorbidity comparisons stratified by market area and year mirror the results for both market areas combined.

_ Payer-mix comparisons. Exhibit 4 shows the mean percentage of cardiac DRG cases treated under specific types of insurance coverage by physician ownership status. Physician-owners treated higher percentages of patients with generous insurance coverage (Medicare FFS and commercial PPO) but lower percentages of cases enrolled in HMOtype plans ($p < .01$). A similar comparison of payer mix controlling for market area reveals that two-thirds of the cardiac DRG cases treated by owners in Phoenix had Medicare FFS coverage, compared with 48 percent of such cases in Tucson. In contrast, Medicare FFS patients accounted for similar percentages of the cardiac DRG caseloads of nonowners: 36 percent in Phoenix and 39 percent in Tucson. On the other hand, commercially insured patients inTucson accounted for 24 percent of cardiac cases treated by owners, comparedwith 4.5 percent of such cases treated by nonowners ($p < .01$). In Phoenix, nearly 20 percent of cardiac cases treated by physicianowners and 15 percent of such cases treated by nonowners were commercially insured ($p < .01$).

Discussion And Policy Implications

This study reports empirical evidence comparing the practice patterns of physician-owners of limited-service cardiac hospitals and nonowners who treat cardiac patients at competing full-service community hospitals. The analyses suggest that physician self-referral arrangements have major effects on physician practice patterns.

First, physician-owners of limited-service

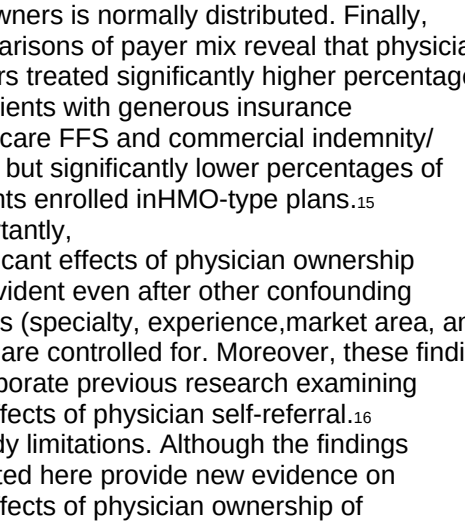
EXHIBIT 3
Comparison Of Comorbidity Status Of Cardiac Surgical Diagnosis-Related Groups (DRGs) By Physician Ownership Status, Phoenix And Tucson, Arizona, 1998–2003
SOURCE: Arizona Inpatient Discharge Data, 1998–2003.
30
25
Percent of cases
One Five Three Four
20
15
10
5
Physician-owners
Physician-nonowners
Two Six-plus

0
Number of comorbid conditions
cardiac hospitals treated significantly higher volumes of the profitable cardiac surgical DRG cases than did nonowners treating patients at competing full-service community hospitals. Second, owners treated a less severe case-mix of both cardiac surgical andmedical DRGs relative
to nonowners. Irrespective of whether one measures case-mix by severity-of-illness class or a count of comorbid conditions, the results
consistently show that the caseloads of physician-owners are low-acuity patients. In contrast, the case-mix of patients treated by nonowners is normally distributed. Finally, comparisons of payer mix reveal that physician-owners treated significantly higher percentages of patients with generous insurance (Medicare FFS and commercial indemnity/ PPO) but significantly lower percentages of patients enrolled inHMO-type plans.[15] Importantly,
significant effects of physician ownership are evident even after other confounding factors (specialty, experience,market area, and year) are controlled for. Moreover, these findings corroborate previous research examining the effects of physician self-referral.[16]

_ Study limitations. Although the findings reported here provide new evidence on the effects of physician ownership of limitedservice
cardiac hospitals, the study has some limitations. First, because Arizona does not require
physicians to disclose ownership interests in limited-service hospitals, it was necessary to establish criteria to identify physicianowners and physician-nonowners. We recognized that the sample of owners might include some nonowner observations and thus tested the sensitivity of the results to alternative definitions
of *ownership.* Although the analyses based on more stringent definitions reduced the number of physicians who qualified as owners, the differences in volume, case-mix, and payer mix by ownership were larger than those based on the 10 percent share criterion. Only 10 percent of the 426 physician-year observations
were eliminated from the analyses when we increased the share treated by a physician-owner at the heart hospital from 10 percent to 20 percent. Furthermore, almost three-quarters of the 426 physician-year observations
in the owner sample treated 50 percent or more of their cases at the heart hospital. Based on the sensitivity analyses, we

EXHIBIT 4
Sources Of Payment For Cardiac Diagnosis-Related Group (DRG) Cases By Physician Ownership Status, Phoenix And Tucson, Arizona, 1998–2003

SOURCE: Arizona Inpatient Discharge Data, 1998–2003.
NOTES: FFS is fee-for-service. PPO is preferred provider organization. HMO is health maintenance organization. AHCCCS is Arizona Health Care Cost Containment System (see text).



contend the 10 percent threshold is conservative and thus biases downward the differences that exist between owners and nonowners.

A second limitation is that analyses reflect inpatient cardiac DRG cases treated. No data are available on outpatient surgeries and ancillary
services rendered to cardiac patients at each hospital.However, the GAO report found that limited-service cardiac hospitals derived about 85 percent of their revenues from inpatient cases.[17]

Third, the analyses were based on limited-service cardiac hospitals located in two
market areas in Arizona. The findings, therefore, might not be applicable to other types of physician-owned limitedservice hospitals—in particular, those that specialize in the provision of orthopedic, spinal, or general surgical procedures. On the other hand, the findings

are probably applicable to cardiac limitedservice hospitals in other states. Both cardiac hospitals in Arizona are joint ventures between referring physician investors and a forprofit corporation that has established similar facilities in other states, including California, Arkansas, South Dakota, Ohio, and Texas.

A fourth limitation is that the findings provide no insights as to the benefits that could arise from high-volume specialization: namely, lower production costs and improved outcomes. A report by theMedicare Payment Advisory Commission (MedPAC), however, found that specialty hospitals do not have lower costs for Medicare patients than community hospitals, even though lengths-of-stay are shorter at specialty hospitals.[18] Moreover, there is no evidence indicating that limitedservice hospitals have better outcomes. Peter Cram and colleagues found that differences between specialty and general hospitals in mortality rates after cardiac revascularization were not significant after differences in patient characteristics and procedural volume were adjusted for.[19] The Centers for Medicare and Medicaid Services (CMS) also analyzed specific mortality rates for four procedures and two conditions performed in heart hospitals and competing facilities. It found that both types of facilities performed better than expected, given the hospitals' case-mix.[20]

A final limitation is that because source of payment is not accurately reported for people without insurance, it was impossible to ascertain if physician-owned limited-service hospitals treat uninsured patients.

_ Other comparisons.We also compared cases that physician-owners treated in the heart hospitals versus the community hospitals, but for at least two reasons, we contend that such comparisons are less informative than comparisons of physician-owners and nonowners. First, a large percentage of owners did not treat any cases at the community hospitals. In Phoenix, almost 62 percent of physician-owner observations treated no patients at the community hospitals; 83 percent of such observations treated 80 percent or more of their cases at the heart hospital. In Tucson, more than 20 percent of the physicianowner observations treated no cases at the community hospitals. Since physician-owner observations who did not treat any patients at the community hospitals would be excluded from the analysis, such exclusions raise concerns about selection bias. Second, for those owners who treated patients at both types of facilities, a large percentage treated so few cases that these comparisons are hampered by selection bias. Physician-owners in Phoenix treated a mean of 3.5 surgical and 3.2 medical cases per year in community hospitals. Further analyses of the cases they treated in community hospitals show that the payer mix is similar to that of cases treated by physician-nonowners. Irrespective of whether physicians are owners or nonowners, the severity of the caseloads they treated at community hospitals is normally distributed. In contrast, the cases physician-owners treated in the heart hospital are highly skewed toward low-severity cases.

"Our comparisons suggest that patient characteristics, not physician reputation, determine where physician-owners treat each patient."

These comparisons suggest that patient characteristics, not physician reputation, determine where physician-owners treat each patient.

_ Policy implications. TheMedicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 imposed an eighteen-month moratorium on physician selfreferral of Medicare and Medicaid patients to new limited-service hospitals. The moratorium expired 8 June 2005.[21] By administrative rule, the CMS extended the moratorium until January 2006 while it reviews whether physician-owned specialty facilitiesmeet the definition of a *whole hospital.*[22] In May 2005 Senators Charles Grassley (R-IA) and Max Baucus (DMT) introduced legislation known as theHospital Fair Competition Act of 2005, which would close the loophole and prohibit physicians from making referrals to limited-service

hospitals in which they have an investment interest.

The findings reported here provide evidence in support of these legislative actions. Nevertheless, if such a prohibition is to be effective,
it should require that physicianowners divest their investments in existing limited-service hospitals within eighteen to twenty-four months.

The Grassley bill also requires that DRG weights be calculated at the hospital level rather than nationally, and that these weights be recalibrated on the basis of costs at least once every five years. Tying payment to patient severitywithin a givenDRGclass (that is, riskadjusting)
should help mitigate the financial incentives to treat low-acuity patients with specific DRG categories. Nonetheless, even if the DRG payment were risk-adjusted, physicians
could compensate for the lower payment by recommending that the patient undergo more outpatient procedures and ancillary tests that are not covered by the DRG payment. Evidence documenting physicians' responses to fee changes implemented under the Medicare fee schedule shows that cutting fees for profitable surgical procedures has spillover effects and causes physicians to increase the supply of services whose payments have not been reduced.[23] A prohibition on self-referral to the limited-service hospitals in conjunction with the payment adjustment should help mitigate
undesirable spillover effects. It is important to recognize that the Grassley bill does not apply to nonelderly patients with private insurance coverage. Thus, the findings reported here should be of interest to state policymakers as well as insurance companies who are concerned about the conflict of interest associated with physicians' self-referral arrangements.

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1. For a comprehensive review of the physician selfreferral
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9. Supplemental Exhibit 2 provides details; ibid.

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and Iglehart, “The Emergence of Physician-Owned Specialty Hospitals.”
11. See Note 9.
12. A. Elixhauser et al., “Comorbidity Measures for Use with Administrative Data,” *Medical Care* 36, no. 1 (1998): 8–27.
13. We based this classification on extensive discussions
with staff at the Arizona Department of Health Services and people employed by community hospitals with cardiac care programs, who are responsible for negotiating contracts with the insurers in either the Phoenix or Tucson markets.
14. Physician-owners in Phoenix seem to differ from owners in Tucson. One explanation is that owners in Tucson could have academic affiliations with University Medical Center, which has training programs in both cardiology and vascular surgery. There are no such training programs in the Phoenixmarket.Another contributing factor could be differences in ownership structure. The Tucson Heart Hospital is a joint venture among referring physicians, a community hospital, and a for-profit corporation,whereas the Arizona Heart Hospital does not involve a community hospital partner.
15. Several sources in Arizona confirmed that the heart hospitals opted not to contract with some of the HMOs because they pay lower rates than Medicare FFS and the commercial PPO plans.
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APPENDIX 14

From The Field

The Rise Of The Entrepreneurial Physican

Physicians' demands for more clinical and economic autonomy will not go away if specialty hospitals are "banned."

by Allen Dobson and Randall Haught

ABSTRACT: The policy issues surrounding physician-owned specialty hospitals are highly controversial. Central to the controversy is the trade-off between the role these hospitals might play in increasing competition and the impact they might have on community hospitals' ability to cross-subsidize unfunded missions. Key policy questions relate to quality, efficiency, and the degree to which specialty hospitals are fairly paid for their services. This commentary reviews Jean Mitchell's basic thesis in relation to both the emerging specialty hospital literature and earlier work performed by the Lewin Group for MedCath, a corporation that owns and manages heart specialty hospitals.

The paper by Jean Mitchell contributes to the growing body of evidence on physician-owned specialty hospitals.[1] It notes that physician-owners and nonowners of these hospitals behave differently, presumably because of ownership incentives. Key to Mitchell's presentation is the description of owners versus nonowners. She states that "considerable evidence indicates that ownership of limited-service hospitals is only offered to physicians who can both refer and treat patients at the facility." She then defines a physician as a "nonowner" if "he or she treated at least six cardiac [diagnosis-related group] cases in one or more of the community hospitals and no cardiac DRG cases at the [physician-owned] heart hospital in a given year." Similarly, a physician is defined as an "owner" if "the physician treated at least six cardiac DRG cases in a given year across all hospitals in the market area, and…treated at least 10 percent of his or her cardiac DRG cases at the heart hospital." The hypothesis that these assumptions reflect actual ownership was never verified.

We present relevant data from heart hospitals. MedCath, a corporation that owns and manages heart specialty hospitals, reports that of the 262 credentialed physicians at the Arizona Heart Hospital (one of the two limitedservice hospitals Mitchell studied), only 17 were investors with true ownership interest; thus, many key admitters are not investors. In addition, MedCath reports fifty-two ownerinvestors at the Tucson Heart Hospital, which is very different from the number of physicianowners estimated in Mitchell's report. Even if physician-owners could be identified, Mitchell's study data indicate the attending physician and not the referring physician. There is no credible way to positively identify selfreferrals.

MedCath data show that more than 40 percent of patients are admitted through the emergency department or as transfers.[2] Although these patients might have been treated by physician-owners, they are not selfreferrals.

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AllenDobson (al.dobson@lewin.com) is senior vice president of the LewinGroup in FallsChurch,Virginia.
RandallHaught is a senior scientist there.

Interpreting The Data

Given the difficulty of defining "owners" versus "nonowners" by assumption, the conclusions that owners' self-referral patterns based on economic interests led to (1) a higher proportion of surgical cases, (2) a less severe case-mix, and (3) a higher proportion of patients with generous insurance are open to alternative interpretation.

First, the premise that cardiac specialty

hospitals treat more surgical cases is an inevitable result of their design and intent. These hospitals were designed to specialize in highly technical procedural cases. To find that theirphysician-owners did not treat a higher proportion of procedural cases than nonowners would be counterintuitive.

Second, the finding that cardiac specialty hospital physicians (and presumably owners) treat less severely ill patients is by now well documented.[3] The explanation of this finding is likelymore complex than physician ownership alone. The Centers for Medicare and Medicaid Services (CMS), for instance, was "unable to conclude that referrals were driven primarily based on incentives for financial gain." It also noted that owners are "constrained in where they refer patients by several factors including a) patient preferences, b) presence of managed care networks, c) specialty care hospital location and d) taking emergency room 'calls' in local competitor hospitals."[4] Similarly, we believe that referrals to cardiac specialty hospitals likely reflect community physicians' preferences to send more complex patients to hospitals that offer a wider range of specialty services and that the primary care physicians "owning" these patients refer them to those hospitalswhere they practice.

Third, the conclusion that physicianowners refer patients with more "generous" insurance coverage to their own hospitals can perhaps be partially explained by the fact that many specialty hospitals are locked out of health maintenance organization (HMO) contracts.

Thus, in the case of the Arizona Heart Hospital, half of patients came from rural areas not supported by HMOs. Given the lack of HMO referrals, the preponderance of Medicare patients is not surprising. More telling is the issue of Medicaid patients,who tend to be underrepresented in cardiac specialty hospitals. Finally, Mitchell does not document actual generosity by payer, so it is difficult to assess the effect of the various payers.

Discussion

The early evidence on quality suggests that cardiac specialty hospitals have quality of care that is at least as good as, if not better than, that of "peer hospitals."[5] Lewin Group studies have consistently found lower case-mix-adjusted mortality rates and higher quality on numerous dimensions for cardiac specialty hospitals. A study by Peter Cram and colleagues shows that outcomes of such hospitals are as good as those of other high-volume hospitals.[6]

Evidence on efficiency is mixed. Results from a Medicare Payment Advisory Commission (MedPAC) study indicate higher case costs for cardiac specialty hospitals than for community hospitals providing community care, while Lewin estimates for cardiac hospitals show lower case costs after adjusting for start-up capital and interest expenses. Med-PAC did not find evidence that specialty hospitals affect community hospitals financially.[7]

The evidence on patient severity is more consistent. Recent studies collectively point to the fact that patients at specialty hospitals are less severely ill than patients at comparable nonspecialty community hospitals.[8] However, the causes are less certain. Mitchell contends that the primary cause is the economic incentives associated with physician self-referral. The CMS is careful in not ascribing economic intent as the primary cause of favorable patient selection. The MedPAC commissioners are "concerned with the issue of self-referral" but are also intrigued with the potential competitive effects of specialty hospitals.[9] As noted above, physician referral patterns are complex, and plausible market reasons exist as to why specialty hospitals do not treat the sickest patients. In addition, the majority of cardiac specialty hospitals have round-the-clock emergency departments,which serve as an important

From The Field
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"Physician referral patterns are complex, and plausible market reasons exist as to why specialty hospitals do not treat the sickest patients."

patient referral service.
The role of specialty hospitals in promoting competition is widely discussed as a counterbalance to possible effects of physician self-referral. MedPAC noted recently that it does "not want to unnecessarily inhibit the development of organizational arrangements that may bring innovations to care delivery."[10] Similarly, the Federal Trade Commission and Department of Justice concluded that barriers to entry should be removed, and the existing players should not be allowed to block the entry of new competitors. They note that competition can be "quite unpleasant for competitors" and that the ultimate goal of competition is to allow winners and losers to emerge, so that providers can improve quality and efficiency, thus doing a "better job for consumers."[11]
Although the role of competition in health care is controversial, its merits as applied to specialty hospitals are worth considering. If patients' preferences were the only guide, specialty hospitals are more than holding their own in the competitive process. The CMS found that "patients responded very favorably to specialty hospitals" and "value very highly the amenities and services" they provide, as well as their "greater predictability in scheduling and services." However, the CMS also found high levels of patient loyalty to community hospitals.[12]
Mitchell notes that her findings support the moratorium in the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 on physician self-referral of Medicare and Medicaid patients to "limitedservice" hospitals. MedPAC commissioners weremoremeasured in that they extended the moratorium on specialty hospitals until January 2007 on the grounds that such hospitals might eventually "increase their efficiency and improve quality."[13] TheCMS has taken a different approach, in that it recommends "closer scrutiny of whether entities meet the definition of a hospital" from the perspective of the CMS's conditions of participation.
Advocacy groups have taken many positions on the moratorium; however, federal policymakers thus far seem torn between protecting both the positive benefits of competition and community hospitals' ability to crosssubsidize their missions.

Concluding Comments

The views of the benefits and costs of specialty hospitals are extreme, ranging from competitive theorists claiming these hospitals provide health care with a much-needed "wake-up call" to those who contend that specialty hospitals are undermining community hospitals' financial stability. The literature at this point is not supportive of either extreme. Mitchell's study shows how difficult it is to produce definitive evidence either way. She uses information from only two cardiac specialty hospitals for which the key distinction between physician-owners and nonowners has not been verified, and it draws conclusions about physician self-referral that other studies are hesitant to agree with.
Policymakers continue to be perplexed by the range of contentions and allegations in light of the emerging literature. Thus far, however, policy responses have been measured and appropriate, given the limited number of facts at hand. Given the finding that cardiac specialty hospitals draw a less-severe patient caseload, the CMS's call for cardiology pay-ments that track both patient severity and comorbidities is a sensible first step, with more powerful payment adjustments certain to follow.

"Given the finding that cardiac specialty hospitals draw a lesssevere patient caseload, the CMS's call for cardiology payments that track patient severity and comorbidities is sensible."

The CMS decision to more carefully consider which entities should be certified as Medicare providers goes right to the heart of the matter. If the CMS can decide what levels of care hospitals should provide, much of the policy debate would be resolved. Should hospitals
provide a given percentage of inpatient care? Should hospitals have round-the-clock emergency departments? If we can answer these types of questions and get the payments right, the competitive playing field will be more balanced.

Finally, after reviewing the evidence, we note that physicians' demands for more clinical autonomy and control over their incomes will not go away if specialty hospitals are "banned." The emergence of specialty hospitals is a manifestation of a larger issue: the rise of the entrepreneurial physician. In response, community hospitals are partneringwith physicians
in numerous creative ways. Thus, the future outlets for physician demand for clinical and economic control may go beyond specialty hospitals to include variants of partnering between community hospitals and physicians, and perhaps gain-sharing arrangements
or pay-for-performance systems as advocated by the CMS andMedPAC. This might suggest that the marketplace is already adapting to the competitive "threat" of physicianowned specialty hospitals and emerging government regulation in this area is probably adequate.

The views expressed here are those of theauthors and
do not reflect the views of the LewinGroup or its clients.

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6. Cram et al., "Cardiac Revascularization."
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8. Ibid.; GAO, *Specialty Hospitals: Information on National*
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APPENDIX 15

RECOMMENDATION

The TAG recommends that CMS not require physicians to take emergency call as a Condition of Participation in Medicare.

RATIONALE

The TAG considered multiple issues when it recommended that physicians not be required to participate in emergency on-call coverage as a condition of participation in Medicare. Hospital organizations argued that physicians should be required to take part in on-call coverage, for their hospital emergency departments, as a condition of participation in the Medicare program.

First there is no statutory language to mandate such a requirement. The process would require a regulatory change to require physicians to take call as a Condition for Medicare Participation. Early analysis suggested that such a regulation would not be consistent with the language and the purpose of the EMTALA statute. Statutory language in 1395cc(a)(1)(l)(iii) requires hospitals to maintain a list of physicians who are available to the emergency department as a hospital condition of participation in Medicare. Since this is expressly required by statute with respect to hospitals, any extension of this requirement to physicians would also have to be enacted by statute.

Ample testimony was received by the TAG regarding the multiple factors which are inhibiting the participation of physicians in Emergency Department on-call panels.
These include:

1. Lack of adequate reimbursement for time spent on-call and for delivering care in the emergency department setting.
2. The perception of increased risk of malpractice suits arising from providing care to patients in the emergency department.
3. Workforce issues including a reduction in the number of applicants for critical specialties related to emergency department including orthopedics and surgery.
4. Decreases in the numbers of certain funded residency positions.
5. The increase in the number of subspecialists (e.g., spine surgeons, hand surgeons,) practicing in focused disciplines rather than being familiar with the current state of medical practice for the care of severely ill or injured patients.
6. The growth in the number of specialty hospitals and ambulatory surgery centers allowing physicians to drop their privileges in general care hospitals in order to practice in environments which are said to be more efficient and patient friendly.
7. The graying of the physician population with large numbers of physicians nearing retirement age and, therefore, not wanting or caring to participate in emergency room coverage.
8. The demand for an altered life style by young physicians and women physicians which often reduces their enthusiasm or desire to participate in prolonged periods of being on-call and responding to emergency rooms.

The complexities of the reasons for the apparent decline in the number of physicians who are willing to take Emergency Department call for the hospitals with which they are associated are apparent. The TAG does not believe that mandating physicians to participate in ED call is a solution to this multifaceted issue. It seems, to the contrary, as some testimony indicated that forcing physicians to carry this burden, by taking away the ability to participate in Medicare will only exacerbate the problem, further reducing physicians available to Emergency Departments. More ominously, such a requirement would undoubtedly lead to significant access to care problems for the Nation's senior and disabled, as physicians would likely reconsider their Medicare participation as a result of such a mandate.

APPENDIX 16
EMTALA TAG
ACTION SUBCOMMITTEE
Issues for Subcommittee Discussion

APPLICATION OF EMTALA

A. Special hospitals/hospitals that do not have a dedicated emergency department *(under discussion)*
B. Hospital-based urgent care centers
C. Other providers (e.g., freestanding urgent care centers, outpatient psychiatric treatment centers)
D. Ambulances not owned/operated by the hospital *(under discussion/presented to TAG, June 2005)*
E. Application during state/local emergencies, vs. national emergencies (emergency physician licensing)

DEFINITIONS

A. Capacity
B. Capability
C. Comes to the emergency department (prudent layperson standard)
D. Hospital property (250 yard rule)
E. Labor *(presented to TAG, June 2005, report pending)*
F. Emergency medical condition *(under discussion for possible interpretive guideline revisions)*
G. Patient (patient encounter vs. waiting area)

MEDICAL SCREENING EXAMINATION

A. "Appropriate" medical screening examination
B. Non-discriminatory medical screening examination
C. Triage
D. Qualified medical personnel
E. Fast-track MSEs
F. Psychiatric patients *(under discussion)*
G. OB MSEs
H. Location/processes (off-site triaging)
I. Persons with non-emergency conditions
G. Physician communications *(taken to TAG, June 2005, report pending)*

STABILIZING TREATMENT

A. Definition *(under discussion)*

B. Need for more specific definitions (e.g., stabilization of psychiatric patients)
C. Stable vs. stable for transport/discharge/impact on other EMTALA provisions
D. Women in labor (clarification/requirements for discharge while labor progresses) *(under discussion)*

TRANSFER

A. Application to "stable for transfer" patients
B. Facility vs. physician acceptance
C. Medical record requirement for transfers/scope
D. Community standards/protocols *(under discussion)*
E. Lateral transfers for insurance reasons
F. Physician certification

REPORTING/RECORDKEEPING REQUIREMENTS

A. Duty to report hospital transfers in violation of EMTALA *(under discussion)*
B. EMTALA signage/location
C. Central log content

SURVEY/ENFORCEMENT ISSUES

A. Non-substantive violations/documentation errors
B. Appeal rights prior to termination
C. Survey procedures/number of records reviewed when complaint is not substantiated
D. QIO process/referral
E. Bases for termination/provision for discretionary termination
F. Consistent interpretations/enforcement across CMS regions
G. Survey process for determining whether a hospital has a dedicated emergency department
H. Deficiency statements/content/timeline

LIABILITY ISSUES

A. Level of intent/non-discrimination
B. Private cause of action against hospitals (patients who are not screened vs. patients who have been screened)
C. EMTALA fines/considerations

OTHER

A. Refusals to consent to treatment vs. patients who leave without treatment or prior to MSE

B. Registration procedures
C. Informing patients of financial liability during emergency department stay or prior to inpatient admission/transfer
D. Duty of hospitals with specialized capabilities to accept patient transfer
(under discussion, issue raised with TAG June 2005)
E. Follow-up care *(under discussion)*
F. Prior notice vs. authorization

***** Underlined issues reflect current Action Subcommittee priorities.

APPENDIX 17

DEFINITION OF LABOR

CURRENT RULE:

42 C.F.R. 489.24(b)
Labor means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable time of observation, the woman is in false labor.

PROPOSED CHANGE:

42 C.F.R. 489.24(b)
Labor means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta.

REASON FOR CHANGE:

The current regulation implies that a physician must observe a woman having contractions to determine whether the woman is in true or false labor. Even when the observation may be delegated to nonphysician practitioners, the physician must "certify" that the woman is in false labor, which implies a heightened documentation standard that is not required for any other type of emergency medical condition. This provision has generated confusion regarding when it acceptable to discharge a woman having contractions. In addition, this provision is outdated because there are nonphysician practitioners who, consistent with their states' scope of practice, are qualified to determine whether a woman having contractions is having true or false labor.

The EMTALA TAG recommends deletion of the physician certification requirement for women having contractions. Hospitals should be given flexibility to determine who is qualified at their hospital to conduct medical screening examinations of women experiencing contractions and determine whether a woman is experiencing true or false labor, consistent with state scope of practice laws.

In addition, the Action Subcommittee believes that hospitals need clarification on when a woman in false labor, or the early stages of labor, may be discharged to wait for labor to progress or transferred to another hospital where the woman would prefer to receive further services (or deliver). While women experiencing contractions may report to the nearest hospital when they believe that they are in labor, once it is determined that an emergency medical condition does not exist, some women prefer to receive services (or deliver) elsewhere (e.g., where their obstetrician practices or that has a contract with their insurance plan). The Action Subcommittee believes that EMTALA does not apply to these discharges or transfers once a qualified medical person (QMP) has determined that the patient does not have an emergency medical condition and recommends revisions to the EMTALA Interpretive Guidelines need to be revised to clearly state this point.

INTERPRETIVE GUIDELINE:

TAG A406
A QMP other than the physician may determine that a woman is in false labor, subject to hospital policies and procedures governing designated QMPs and state scope of practice laws. Once a QMP determines that the patient is in false labor and does not otherwise have an emergency medical condition, then the hospital's EMTALA obligation ends with respect to that patient. The QMP may discharge the patient home, discharge the patient with follow-up instructions to return to the hospital or another hospital, or discharge the patient to report to another hospital preferred by the patient, consistent with state regulations regarding scope of practice, without having to comply with the EMTALA stabilization or transfer requirements. The EMTALA stabilization and transfer requirements likewise do not apply if a QMP determines that a patient is in the early stages of labor, but the patient does not have an emergency medical condition (i.e., there is adequate time to effect a safe transfer and the transfer will not pose a threat to the patient's or unborn child's health or safety). The QMP may discharge the patient home to wait for labor to progress and either instruct the patient to return to the hospital or another facility appropriate for delivery, consistent with state regulations regarding scope of practice, at the patient's option.

TEACHING POINTS:

- Hospitals may designate nonphysician personnel as qualified medical personnel capable of conducting the medical screening examination and determining whether a woman experiencing contractions is in true or false labor, consistent with state scope of practice laws. This designation should be set forth in hospital bylaws, rules and regulations, or policies approved by the hospital's governing board.

- EMTALA no longer applies once it is determined that a woman that is experiencing contractions is in false labor (assuming the woman does not otherwise have an emergency medical condition). If a woman presents to a hospital because she believes that she may be in labor, and it is determined by the hospital's QMP that the patient is in false labor and does not otherwise have an emergency medical condition, then EMTALA no longer applies to that patient. The QMP may freely discharge the patient, or even discharge the patient directly into the care of another hospital, without violating EMTALA. The purpose of this provision is to permit hospitals to discharge women who do not have emergency medical conditions home or to permit them to go to the hospital or other facility of their preference (e.g., where their obstetrician practices, where they plan to deliver, or that is contracted with their insurance plan), without having to comply with the EMTALA stabilization or transfer requirements.

- EMTALA no longer applies once it is determined that a woman who is in the early stages of labor does not have an emergency medical condition, as that term is defined by the EMTALA statute. The purpose of this provision is to expressly permit hospitals to discharge women who do not have emergency medical conditions home or to permit them to go to their preferred facility for delivery (e.g., where their obstetrician practices, where they plan to deliver, or that is contracted with their insurance plan), without having

to comply with the EMTALA stabilization or transfer requirements. This provision grants patients freedom of choice and protects hospitals when they make transfer decisions based on the patient's preferences when the patient does not have an emergency medical condition.

APPENDIX 18

HOSPITALS WITH SPECIALIZED CAPABILITIES
DISCUSSION ISSUES

1. Is the availability of other staff members a "specialized capability" (e.g., social worker, technician)?

2. Is the availability of specialized equipment, when the hospital would not have the ability to provide definitive care a "specialized capability" (e.g., diagnostic cath lab, but no interventional capabilities)?

3. Does this provision apply to hospitals that participate in the Medicare program, but do not have emergency departments (e.g., psychiatric and specialty hospitals)?

4. Does this provision apply to both stable and unstable patients?

5. Does this provision apply to hospital inpatients or inpatient transfers?

6. Should there be a requirement for hospitals to treat patients within their own hospital system (including sister hospitals) before unrelated hospitals are asked to accept the patient transfer?

7. Should there be a requirement to transfer patients to the closest hospital with specialized capabilities?

8. Should CMS implement detailed guidelines on when a hospital may or may not transfer a patient to a hospital with specialized capabilities?

9. Should the receiving hospital have any input in the sending hospital's decision to transfer the patient (e.g., request that the sending hospital perform designated diagnostic tests to confirm the existence of an emergency medical condition before transfer?).

10. Should the availability of an on-call physician be considered a "specialized capability" for purposes of this EMTALA requirement?