REPORT NUMBER FIVE

to the

Secretary

U.S. Department of Health and Human Services

From the

Emergency Medical Treatment and Labor Act

Technical Advisory Group

Hubert H. Humphrey Building

Washington, DC

November 2–3, 2006

EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA)
TECHNICAL ADVISORY GROUP (TAG)
Minutes
November 2–3, 2006

Welcome, Call to Order, and Opening Remarks

Chair David Siegel, M.D., J.D., called the meeting to order on Thursday, November 2, and welcomed the members of the TAG and the audience. (See Appendix A for the meeting agenda). Dr. Siegel reiterated the group's functions, as identified in the charter, and outlined the agenda for the meeting. He added that CMS has recruited several graduate students to assist the Framework Subcommittee with preparing their background documents. Thomas Gustafson, Ph.D., deputy director of the Center for Medicare Management, welcomed the TAG members and apologized on behalf of the agency for the problems some members had faced with travel arrangements.

Action Item
The TAG requests that CMS update the TAG on the status of all of the TAG's current and pending recommendations at the next meeting.

Summary Reports of the Subcommittees

Julie Mathis Nelson, J.D., chair of the Action Subcommittee, and John Kusske, M.D., chair of the On-Call Subcommittee, summarized the proceedings of their fall subcommittee meetings and identified the topics they wished the TAG to address at this meeting (Appendices 1 and 2). Charlotte Yeh, M.D., chair of the Framework Subcommittee, said graduate student Mary Bing had graduated but still took the time to revise her paper, *Liability*. The revised document was distributed to the TAG at the meeting for review.

Ambulance "Parking" of Emergency Patients

The TAG reviewed background information and a letter from member Dodjie Guioa describing a potential violation of EMTALA regarding ambulance "parking," i.e., the practice of refusing to admit patients transported via ambulance on the basis of the notion that as long as the patient remains on the ambulance stretcher, the hospital does not have an EMTALA obligation to that patient (Appendix 3). The TAG discussed the history of the issue and the intent behind letters written by CMS Regional Office VI to clarify the issue.

Recommendation
To clarify the intent of CMS regulations regarding obligations under EMTALA to receive patients who arrive by ambulance, the TAG recommends that CMS/HHS promulgate the letter written by TAG member and representative of CMS Region VI Dodjie Guioa with the following changes:

- In the first paragraph, revise the sentence as follows: "The specific concern was that hospital ED staff deliberately delay the transfer of individuals from the EMS provider's stretcher to an ED bed with the impression that the ED staff is relieved of their EMTALA obligation by doing so. This practice constitutes a potential violation of EMTALA."

- Delete the sentence, "When individuals arriving via EMS providers are required to wait several hours with only EMS provider staff attending to them, then this practice may be viewed as a violation of the EMTALA requirements."
- Revise the last paragraph as follows: "It was not the intent of the guidance in the Letters that there should be enforcement action against any hospital when the delay in the immediate provision of an appropriate [medical screening examination] and/or stabilizing treatment is due to circumstances beyond the hospital's control (e.g., the hospital does not have the capacity or capability at the time of presentation)."

Emergency Waiver of EMTALA Obligations

The Action Subcommittee presented a draft document, "Application of EMTALA in a State of Emergency," describing a rationale and proposed recommendation for waiving hospitals' EMTALA obligations in certain emergency conditions (Appendix 4). The proposed change would require revising the statute. CMS staff indicated they do look at emergency situations when investigating potential EMTALA violations, and the Office of the Inspector General (OIG) takes such conditions under consideration when determining civil penalties. Ms. Nelson indicated that formalizing the emergency waiver in the statute would allow hospitals to determine what is in the best interest of patients during an emergency without fear of CMS or OIG enforcement or private rights of action regarding potential EMTALA violations, particularly in the case of localized or hospital-specific emergencies.

Recommendation

The TAG recommends that HHS pursue statutory and regulatory changes, as well as changes to the Interpretive Guidelines, addressing waiving EMTALA obligations in an emergency as declared by a Federal, State, county, or city government or by an individual hospital (consistent with the Action Subcommittee's document, "Application of EMTALA in a State of Emergency").

Duty to Provide or Arrange for Follow-Up Care

The Action Subcommittee presented a draft document, "Follow-Up Care," describing a rationale and proposed recommendation for clarifying that a provider's EMTALA obligation ends once the patient is stabilized (Appendix 5). The document also suggests actions providers *may* take to aid patients in getting needed follow-up care. Members agreed that as long as the Medicare Conditions of Participation addresses follow-up care, it is appropriate to clarify where the EMTALA obligation ends.

Recommendations

The TAG recommends that HHS amend the Interpretive Guidelines with respect to follow-up care to clarify that once a patient has been stabilized, the hospital and physician have no further follow-up care obligation under EMTALA. The hospital must, however, comply with applicable Medicare Conditions of Participation. The TAG believes this interpretation is more consistent with the EMTALA statute and regulations, which no longer apply once the patient is stabilized, and current CMS interpretation.

The TAG recommends that HHS incorporate into the Interpretive Guidelines the educational issues identified by the Action Subcommittee's document, "Follow-Up Care," with the following changes:

- For bullet two, replace "For insured patients" with "For patients with a personal physician."
- For bullet 5, delete the parentheses but retain the text in the parentheses.

EMTALA Education Efforts

The Action Subcommittee presented a draft document, "EMTALA Education Recommendations," describing specific efforts CMS can undertake to better educate providers and the public about EMTALA (Appendix 6). TAG members and members of the audience (Katie Orrico of the American Association of Neurological Surgeons; Angela Foehl, deputy director of the American Psychiatric Association; Diane Godfrey of Florida Hospital; Kathleen McCann of the National Association of Psychiatric Health Systems; and Clifford Beyler of Hall, Render, Killian, Heath & Lyman) offered suggestions.

Action Item

The Action Subcommittee will take into consideration the following changes and suggestions made by the TAG as it revises its document, "EMTALA Education Recommendations:"

<u>More Comprehensive CMS Website</u>

- Enhance access to an EMTALA-specific website.
- Link to the website of the OIG.
- Provide user-friendly descriptors for attached or linked documents.
- Investigate the use of e-mail, listserves, or other technology to update facilities on EMTALA changes and clarifications.
- Improve the search mechanisms so that results are grouped by topic.

<u>Standardized Regional Office/State Surveyor Education</u>

- Assess the quality of the education process for new surveyors.
- Require surveyors to demonstrate competency following education.

<u>Provider Education</u>

- Investigate the use of e-mail, listserves, or other technology to update providers with specific education.
- Include EMTALA training in the next statement of work for quality improvement organizations (QIOs) as part of the QIOs' technical assistance to the hospital.
- Include the OIG in provider education efforts whenever possible.
- Organize the information on the CMS EMTALA website into a basic tutorial format.

<u>Patient Education</u>

- Delete the bullet "Health care destination options and appropriate level of care rendered by each destination."
- Consider the potential chilling effect of notifying patients that they may be asked to provide documentation of citizenship.
- Clarify that patient education should be provided by CMS through its website or other vehicles, not through hospitals.

Air Medical Service

Seth Myers of Air Evac Lifeteam said some hospitals refuse to accept transfers of patients from other institutions unless the sending hospital agrees to use the receiving hospital's air medical services (Appendix 7; see Appendix 8 for additional, anonymous testimony). In a written response to Mr. Myers' request for clarification of CMS policy, Dr. Gustafson wrote:

> A hospital may only refuse an appropriate transfer of an individual [protected under EMTALA] with an unstabilized emergency medical condition if it does not have the capability or capacity to treat the individual. Therefore, if a hospital refuses to accept an appropriate transfer of an individual protected by EMTALA solely because the sending hospital does not utilize the recipient hospital's air transport services, the recipient hospital may be in violation of EMTALA.

The members agreed that Dr. Gustafson's clarification should be communicated more widely. Maureen Mudron of the American Hospital Association suggested that CMS evaluate whether the issue occurs with sufficient frequency to require widespread communication efforts.

> *Recommendation*
> The TAG recommends that HHS clarify that a hospital may not refuse to accept an individual protected under EMTALA on the grounds that it (the receiving hospital) does not approve the method of transfer arranged by the attending physician at the sending hospital (e.g., a receiving hospital may not require the sending hospital to use an ambulance transport designated by the receiving hospital). In addition, HHS should improve its communication of such clarifications with its Regional Offices.

On-Call Physician as Specialized Capability

Dr. Kusske asked the TAG to reconsider its recommendation from the previous meeting that CMS incorporate into the Interpretive Guidelines for 489.24(f), recipient hospital responsibilities, that "the presence of a specialty physician on the call roster is not, by itself, sufficient to be considered a specialized capability. At the time of the transfer, the receiving hospital should also have available the necessary equipment, space, staff, etc., to accommodate the patient transfer."

The TAG was asked to consider how the recommendation would apply to the following situation: Two hospitals in the same area have equivalent capacity and capability. One has a specialist on call, the other has the same type of specialist on its staff but that specialist does not wish to take call. Therefore, when a patient needs the services of a particular specialty, the

specialist on call must accept that patient, while the specialist who does not wish to take call avoids any EMTALA obligation.

Members agreed that better definitions are needed of what constitutes an adequate and appropriate call list and what constitutes specialized capability. It was noted that in the past, hospitals were obligated to establish a call roster that mirrored the services it provided during normal business hours. Ms. Godfrey of Florida Hospital described a situation in which a hospital with 11 urologists on staff did not have any urologists on call and so transferred emergency patients out. She said CMS investigated the situation and determined that no EMTALA violation occurred. Alan Steinberg of Horty, Springer, & Mattern suggested encouraging more hospitals to report such potential abuses but added that physicians who feel overburdened will eventually quit taking call. Dr. Kusske said the On-Call Subcommittee would discuss the issue further.

Notification of Potential Transfer

Dr. Kusske asked the TAG to discuss whether a hospital should alert another hospital to which it transfers patients if the first hospital anticipates that it might need to transfer patients, e.g., when the first hospital lacks coverage for a certain specialty on a given night. It was noted that intensive care units sometimes alert each other of diversions and other such issues. Dr. Kusske said the On-Call Subcommittee would discuss the issue further.

Telehealth

Bob Waters of the Center for Telehealth and E-Health Law said the current language of the Interpretive Guidelines inappropriately limits the amount and format of information that can be transmitted to an on-call physician and inappropriately limits the use of emergency telehealth services (Appendix 9). Marilyn Dahl, Director of the Division of Acute Care Services, said the language was never intended to preclude consultation with the on-call physician via electronic methods.

> *Recommendation*
> The TAG recommends that HHS strike the language in the Interpretive Guidelines on telehealth/telemedicine (489.24(j)(1)) and replace it with language that clarifies that the treating physician ultimately determines whether the on-call physician should come to the emergency department (ED) and that the treating physician may use a variety of methods to communicate with the on-call physician. A potential violation occurs only if the treating physician requests that the on-call physician come to the ED and the on-call physician refuses.

Definition of Psychiatric Emergency Medical Conditions

Mark Pearlmutter, M.D., presented proposed revisions to the Interpretive Guidelines' definition of a psychiatric emergency medical condition that would include the term "gravely disabled," which is widely used in psychiatric circles to describe a patient who may be a danger to him- or herself and who may die without emergency medical care provided within 48 hours.

> *Action Item*
> The Action Subcommittee will seek input from interested specialty societies on the proposed language to further define what constitutes a psychiatric emergency medical

condition. The Action Subcommittee will consider the input and present proposed language to the TAG at the TAG's spring 2007 meeting. The Action Subcommittee will work with CMS staff to get input from outside organizations in a timely manner.

Qualified Medical Personnel for Screening Psychiatric Patients

Dr. Pearlmutter proposed revising the Interpretive Guidelines on qualified medical personnel for screening psychiatric patients to recognize the fact that many hospitals rely on contractors to screen such patients.

Recommendation

The TAG recommends that HHS insert the following sentence into the Interpretive Guidelines (489.24(a)) in the paragraph defining qualified medical personnel to perform a medical screening examination (MSE, before the last sentence of the paragraph beginning "The MSE must be conducted by an individual(s) who is determined qualified..."): "For the purpose of screening psychiatric patients, hospitals may utilize contracted agencies or services to assist with the psychiatric MSE if they are properly credentialed in accordance with the above."

Time Frame for Screening Psychiatric Patients

Dr. Pearlmutter asked the TAG to consider whether the Interpretive Guidelines should impose a time frame in which psychiatric patients should be screened, because such patients may wait in the ED a very long time (up to 12 hours) for screening. The TAG agreed that the current time frame that applies to obtaining a consultation with an on-call physician also applies to consultants who provide psychiatric screening. Therefore, the TAG agreed that CMS need not define time frames for psychiatric screening and that hospitals should determine their own policies on the matter.

Screening in Psychiatric Emergency Departments

Dr. Pearlmutter noted that the TAG received testimony alleging that patients who are sent to a psychiatric ED may not receive the same MSE as patients who are seen in the conventional ED. The TAG agreed that hospitals are responsible for ensuring that qualified medical personnel perform screening consistent with EMTALA obligations.

EMTALA Enforcement Efforts

The TAG discussed concerns about the consistency of the interpretation of EMTALA regulations and enforcement efforts across the country. The process does not distinguish minor technical violations from more substantial ones in terms of investigating or assessing penalties, and there is no effective process for hospitals to respond to deficiencies cited by CMS. Mr. Beyler of Hall, Render, et al. suggested that before investigating a complaint, CMS should quickly determine whether the alleged violation falls under EMTALA or the Medicare Conditions of Participation.

Action Item

The TAG requests that CMS staff gather the following information from each Regional Office and present the results to the TAG at its next meeting:

- Total number of EMTALA complaints received, classified by allegation type

- Whether the complaint triggered an investigation
- Whether investigation resulted in termination from the Medicare program
- What type of remediation was required
- How long it took to bring the hospital into compliance when either termination or remediation was required

In addition, CMS staff should identify which enforcement actions are governed by statutory authority and which are governed by regulatory authority.

Barbara Marone of the American College of Emergency Physicians supported the TAG's suggestion that QIOs be involved in the complaint process earlier but raised concerns that some QIOs are confused about the difference between EMTALA violations and medical malpractice complaints. Mr. Guioa said his region has pilot-tested a new tool for training physician reviewers in assessing EMTALA complaints.

Action Item
The TAG requests that CMS staff present an overview of the process of QIO physician review of EMTALA complaints at the spring 2007 EMTALA TAG meeting. The current tool for training physician reviewers that is posted on the CMS website and the new tool that is being pilot-tested should be provided with the presentation for the TAG's consideration. The CMS staff may wish to get input from the American Health Quality Association to inform its presentation.

Institute of Medicine Report: *The Future of Emergency Care in the United States Health System*
Brian Robinson presented his summary of issues raised in the Institute of Medicine's (IOM's) report on emergency care that may relate to EMTALA (To download the report brief, go to http://www.iom.edu/CMS/3809/16107/35007/35014.aspx). Many issues raised in the report are beyond the scope of EMTALA but should be addressed in the Framework Subcommittee's papers.

Action Item
Dr. Siegel and Warren Jones, M.D., agreed to work with the American Medical Association to coordinate a review of the IOM report by various medical specialty societies to determine the physician-related EMTALA issues identified in the report.

Regional, Shared, or Community Call
Ms. Orrico of the American Association of Neurological Surgeons said the IOM report suggests that EMTALA be reviewed to ensure it does not pose barriers to regional call-sharing arrangements. The TAG members identified successful and unsuccessful shared-call arrangements in California and Florida.

Framework Subcommittee Papers
Dr. Yeh noted that Ms. Bing and Won Ki Chae, the graduate students who drafted the reports on liability and reimbursement, both graduated. However, CMS staff and Dr. Siegel identified a

group of master's-degree candidates in the Johns Hopkins University School of Public Health who have volunteered to assist with completing the papers:

- Carrie Williams Bullock
- Carly Cammarata
- Cara Demmerle
- Edward Garcia
- Shannon Mills
- Maik Schutze

Dr. Yeh presented a revised version of *Liability* produced by Ms. Bing for this meeting and asked for supporting research for some specific issues in the report. She emphasized the need for more data for all the reports. The Framework Subcommittee plans to have drafts for all four papers, *Reimbursement*, *Liability*, *Capacity*, and *Disparities in Care*, ready for review by the TAG in the spring and final approval at the fall 2007 meeting. Dr. Yeh asked members of the public who represent specialty societies or other organizations to provide their contact information if they have data that may be useful for the papers.

Liability

The TAG reviewed the draft document. Dr. Yeh said she is particularly interested in providing a state-by-state analysis of disincentives to taking call, specifically looking at states where insurers offer reduced liability insurance premiums for physicians who do not take call.

Capacity

For the paper's discussion of workforce capacity, the TAG asked that the writer take into consideration Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements that force hospitals to tighten their criteria for recredentialing physicians, making fewer physicians eligible for ED call. Mr. Robinson cited the example of a surgeon who had specialized in breast cancer surgery for 5 years and thus was no longer considered eligible to take ED call as a general surgeon. The TAG members suggested that the writers seek input from specialty societies who have evaluated workforce capacity issues. Writers should also look into the Florida model of community call and efforts to encourage telehealth to determine whether they should be mentioned as approaches to address workforce capacity concerns.

"Best Meets the Needs" Language

Dr. Kusske presented proposed language to replace the current requirement that hospitals maintain a list of on-call physicians that "best meets the needs of the hospital's patients who are receiving services...." The TAG felt the phrase "best meets the needs" should be retained but better defined. The TAG has already recommended that the language be moved from the EMTALA regulations into the Medicare Conditions of Participation.

> *Action Item*
>
> Dr. Kusske will summarize the On-Call Subcommittee's rationale for revising the "best meets the needs" language and its suggestions for revisions to the Interpretive Guidelines that clarify hospitals' obligations to maintain an on-call list. The summary will be posted by CMS for public comment. TAG members who wish to solicit comments from

particular specialty societies or organizations should provide specific contact information to Dr. Siegel and CMS staff.

Duty to Accept Transfers

Ms. Nelson presented for comment the Action Subcommittee's draft document "Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers" that outlines the responsibilities of both transferring and receiving hospitals in cases of a transfer under EMTALA regulations (Appendix 10). The TAG members generally supported the concepts presented in the draft and gave specific suggestions to assist the subcommittee in further revision. Among other changes, the TAG agreed to drop the duties for transferring hospitals that would have required them to 1) take a patient back (upon request of the receiving hospital) after the receiving hospital determines the patient no longer needs a higher level of medical care and 2) pay for transfers if the cost was not reimbursed by any other entity.

Action Items

The Action Subcommittee will revise the document "Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers," taking into account the suggestions of the TAG, and present a revised version at the spring 2007 EMTALA TAG meeting.

The TAG requests that CMS clarify whether hospitals are never, in fact, obligated to accept the transfer of an inpatient, even if that patient was stabilized under EMTALA but now needs a higher level of care. The Action Subcommittee will evaluate how the Medicare Conditions of Participation apply in such cases, recognizing that the TAG does not wish to expand EMTALA to include inpatient transfers.

Issues for Future Discussion

At the spring 2007 meeting, the TAG will review the language in the Interpretive Guidelines on pages 24 and 25 that discusses whether the on-call physician responds in person and the role of telemedicine.

Written Testimony

The TAG reviewed written testimony from Catholic Health Initiative (Appendix 11); Horty, Springer, & Mattern (Appendix 12); and the Florida Hospital Association (Appendix 13).

Plan of Action

The TAG's charter expires October 1, 2007. At the spring 2007 meeting, the TAG will finalize its recommendations and the Framework Subcommittee's papers and begin developing its final report to the Secretary. All of the documents will be finalized at the TAG's last meeting in fall 2007. It is anticipated that the next TAG meeting will be scheduled for March or April of 2007.

Administrative Items

The TAG thanked the CMS staff for sending the agenda to the members electronically.

Action Items

The TAG members particularly appreciate having an electronic version in addition to a print version of the agenda and request that the agenda be provided as far in advance of the meeting as possible.

The TAG members request that CMS staff determine the feasibility of starting meetings at 8 A.M.

Adjournment

Dr. Siegel adjourned the meeting at 3:45 P.M. on Tuesday, November 3, 2006. Collected recommendations and approved motions of the TAG are listed in Appendix B.

EMTALA TAG Members Present at the November 2–3, 2006 Meeting

EMTALA Technical Advisory Group Members

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Marilyn Dahl, Director
Division of Acute Care Services
Survey and Certification Group
Center for Medicaid and State Operations

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

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

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

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

Public Witnesses
Seth Myers, R.N., B.A., M.B.A., C.M.T.E.
Air Evac Lifeteam

Bob Waters
Center for Telehealth and E-Health Law

Rapporteur
Dana Trevas
Magnificent Publications, Inc.

APPENDICES

Appendix A: Meeting Agenda
Appendix B: Recommendations and Action Items from the November 2–3, 2006, meeting

The following documents were presented at the EMTALA TAG meeting on November 2–3, 2006, and are appended here for the record:

Appendix 1: Minutes of the On-Call Subcommittee
Appendix 2: Minutes of the Action Subcommittee
Appendix 3: Correspondence about ambulance "parking"
Appendix 4: Application of EMTALA in a State of Emergency
Appendix 5: Follow-Up Care
Appendix 6: EMTALA Education Recommendations
Appendix 7: Statement of Air Evac Lifeteam
Appendix 8: Anonymous Testimony on Requirements for Air Medical Services
Appendix 9: Testimony on Behalf of the Center for Telehealth and E-Health Law
Appendix 10: Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers
Appendix 11: Testimony from the Catholic Health Initiative
Appendix 12: Testimony from Horty, Springer, & Mattern
Appendix 13: Testimony from the Florida Hospital Association

APPENDIX A

Fifth EMTALA TAG Meeting
November 2 - 3, 2006
HHS Headquarters
705A Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20001

Day 1 **Thursday, November 2, 2006**

9 – 9:15	Welcome, call to order, and opening remarks
9:15 – 9:45	Summary Reports of On-Call and Action Subcommittees [TABS 7 and 8]
9:45 – 10:30	Discussion and Action on On-Call and Action Subcommittee recommendations, rotating between subcommittees
10:30 – 10:45	Break
10:45 – 12:00	Continued Discussion and Action on On-Call and Action Subcommittee Recommendations, rotating between subcommittees
12:00 – 1:00	Lunch
1:00 – 1:40	Report of Framework Subcommittee/TAG Questions and Discussion of Framework Issues [TAB 9]
1:40 – 2:30	Discussion of Enforcement Issues [TAB 10]
2:30 - 2:45	Break
2:45 – 3:45	Continued Discussion and Action on On-Call and Action Subcommittee Recommendations, rotating between subcommittees
3:45 – 4:30	Scheduled Public Testimony by Registered Speakers [TAB 5]
4:30 – 5:00	Public comment (unscheduled, time permitting).
5:00	Adjourn

Day 2	**Friday, November 3, 2006**
9 – 9:45	Continuation of Scheduled Public Testimony by Registered Speakers (if necessary)
9:45 – 10:30	Discussion and Action on On-Call and Action Subcommittee recommendations, rotating between subcommittees.
10:30 – 10:45	Break
10:45 – 12:00	Continued Discussion and Action on On-Call and Action Subcommittee Recommendations, rotating between subcommittees
12:00 – 1:00	Lunch
1:00 – 2:45	Continued Discussion and Action on On-Call and Action Subcommittee Recommendations, rotating between subcommittees
2:45 – 3:00	Break
3:00 – 4:30	Continued Discussion and Action on On-Call and Action Subcommittee Recommendations, rotating between subcommittees
4:30 – 5:00	Public comment (unscheduled, time permitting)
5:00	Adjourn

APPENDIX B

EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP (TAG) Recommendations and Action Items November 2–3, 2006

Recommendations to CMS

Ambulance "Parking" of Emergency Patients
To clarify the intent of CMS regulations regarding obligations under EMTALA to receive patients who arrive by ambulance, the TAG recommends that CMS/HHS promulgate the letter written by TAG member and representative of CMS Region VI Dodjie Guioa with the following changes:

- In the first paragraph, revise the sentence as follows: "The specific concern was that hospital ED staff deliberately delay the transfer of individuals from the EMS provider's stretcher to an ED bed with the impression that the ED staff is relieved of their EMTALA obligation by doing so. This practice constitutes a potential violation of EMTALA."
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- Revise the last paragraph as follows: "It was not the intent of the guidance in the Letters that there should be enforcement action against any hospital when the delay in the immediate provision of an appropriate [medical screening examination] and/or stabilizing treatment is due to circumstances beyond the hospital's control (e.g., the hospital does not have the capacity or capability at the time of presentation)."

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The TAG recommends that HHS pursue statutory and regulatory changes, as well as changes to the Interpretive Guidelines, addressing waiving EMTALA obligations in an emergency as declared by a Federal, State, county, or city government or by an individual hospital (consistent with the Action Subcommittee's document, "Application of EMTALA in a State of Emergency").

Duty to Provide or Arrange for Follow-Up Care
The TAG recommends that HHS amend the Interpretive Guidelines with respect to follow-up care to clarify that once a patient has been stabilized, the hospital and physician have no further follow-up care obligation under EMTALA. The hospital must, however, comply with applicable Medicare Conditions of Participation. The TAG believes this interpretation is more consistent with the EMTALA statute and regulations, which no longer apply once the patient is stabilized, and current CMS interpretation.

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Action Items

TAG Recommendations
The TAG requests that CMS update the TAG on the status of all of the TAG's current and pending recommendations at the next meeting.

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The Action Subcommittee will take into consideration the following changes and suggestions made by the TAG as it revises its document, "EMTALA Education Recommendations:"

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- Assess the quality of the education process for new surveyors.
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Provider Education

- Investigate the use of e-mail, listserves, or other technology to update providers with specific education.
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- Include the Office of the Inspector General in provider education efforts whenever possible.
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- Delete the bullet "Health care destination options and appropriate level of care rendered by each destination."
- Consider the potential chilling effect of notifying patients that they may be asked to provide documentation of citizenship.
- Clarify that patient education should be provided by CMS through its website or other vehicles, not through hospitals.

Definition of Psychiatric Emergency Medical Conditions

The Action Subcommittee will seek input from interested specialty societies on the proposed language to further define what constitutes a psychiatric emergency medical condition. The Action Subcommittee will consider the input and present proposed language to the TAG at the TAG's spring 2007 meeting. The Action Subcommittee will work with CMS staff to get input from outside organizations in a timely manner.

EMTALA Enforcement Efforts

The TAG requests that CMS staff gather the following information from each Regional Office and present the results to the TAG at its next meeting:

- Total number of EMTALA complaints received, classified by allegation type
- Whether the complaint triggered an investigation

- Whether investigation resulted in termination from the Medicare program
- What type of remediation was required
- How long it took to bring the hospital into compliance when either termination or remediation was required

In addition, CMS staff should identify which enforcement actions are governed by statutory authority and which are governed by regulatory authority.

The TAG requests that CMS staff present an overview of the process of QIO physician review of EMTALA complaints at the spring 2007 EMTALA TAG meeting. The current tool for training physician reviewers that is posted on the CMS website and the new tool that is being pilot-tested should be provided with the presentation for the TAG's consideration. The CMS staff may wish to get input from the American Health Quality Association to inform its presentation.

Institute of Medicine Report: The Future of Emergency Care in the United States Health System
Dr. Siegel and Warren Jones, M.D., agreed to work with the American Medical Association to coordinate a review of the Institute of Medicine report by various medical specialty societies to determine the physician-related EMTALA issues identified in the report.

"Best Meets the Needs" Language
Dr. Kusske will summarize the On-Call Subcommittee's rationale for revising the "best meets the needs" language and its suggestions for revisions to the Interpretive Guidelines that clarify hospitals' obligations to maintain an on-call list. The summary will be posted by CMS for public comment. TAG members who wish to solicit comments from particular specialty societies or organizations should provide specific contact information to Dr. Siegel and CMS staff.

Duty to Accept Transfers
The Action Subcommittee will revise the document "Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers," taking into account the suggestions of the TAG, and present a revised version at the spring 2007 EMTALA TAG meeting.

The TAG requests that CMS clarify whether hospitals are never, in fact, obligated to accept the transfer of an inpatient, even if that patient was stabilized under EMTALA but now needs a higher level of care. The Action Subcommittee will evaluate how the Medicare Conditions of Participation apply in such cases, recognizing that the TAG does not wish to expand EMTALA to include inpatient transfers.

Administrative Items
The TAG members particularly appreciate having an electronic version in addition to a print version of the agenda and request that the agenda be provided as far in advance of the meeting as possible.

The TAG members request that CMS staff determine the feasibility of starting meetings at 8 A.M.

APPENDIX 1

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

Teleconference: September 26, 2006

ON-CALL SUBCOMMITTEE REPORT
(Emergency Medical Treatment and Labor Act [EMTALA]
Technical Advisory Group [TAG])
Teleconference: September 26, 2006

Introduction

John A. Kusske, M.D., chair of the subcommittee, welcomed one member of the subcommittee and CMS representatives to the teleconference. Because the subcommittee did not have a quorum, it was agreed that the subcommittee members on the teleconference would frame the issues they would like discussed by the TAG at its November 2006 meeting. The agenda for the teleconference is provided in Appendix A. Dr. Kusske also provided an agenda with additional comments and information (Item 1).

Old Business

On-Call Physician as "Specialized Capability," Tag A411 §489.24(f) and Interpretive Guidelines §489.24(e)

Julie Mathis Nelson, J.D., chair of the Action Subcommittee, asked the On-Call Subcommittee to reconsider the following recommendation made by the TAG to CMS at the May 2006 meeting:

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

Ms. Nelson noted that when two hospitals have equivalent facilities, staff, and capacity, the hospital with the relevant specialist physician on call is obligated to accept a transfer. She believes the recommendation allows hospitals that want to avoid accepting transfers under EMTALA to do so by not having specialists on call. Physicians who do take call feel they are being forced to take on the additional burden of accepting patients from outside the community whose local physicians do not want to take call, Ms. Nelson said.

> *Action Item*
> The On-Call Subcommittee requests that the TAG reconsider the wording of the recommendation to CMS.

Call Sharing/Community Call

The subcommittee enthusiastically supports call sharing as a potential mechanism to enable more specialists to take call and to facilitate better use of scarce resources. The subcommittee identified issues related to call sharing that should be considered by the TAG and addressed in the Interpretive Guidelines:

- CMS should clarify that it does not require shared call arrangements to involve simultaneous call at multiple hospitals.

- Can a shared call arrangement be used to reduce a hospital's obligation to ensure backup coverage?
- When a shared call arrangement is in place, who should be responsible for performing the medical screening examination—emergency medical services personnel or the transferring hospital?
- Should regional CMS offices be consulted about shared call arrangements?
- What are the required elements of a formal shared call agreement?
- CMS should clarify those situations in which transfer of a patient whose condition is not stabilized is not considered a violation of EMTALA because a shared call arrangement is in place.

Dr. Kusske reiterated the American Medical Association's (AMA's) testimony at the May 2006 meeting that CMS should ensure anti-trust immunity and protection to those coordinating and providing shared call coverage (Item 2).

> *Action Item*
> The On-Call Subcommittee requests that the TAG further consider the issues to be addressed to encourage use of shared call arrangements.

Continuous Call
Dr. Kusske reported that about one third of neurosurgeons say they are forced to take continuous call.

> *Action Item*
> The On-Call Subcommittee requests that the TAG revisit the question of whether CMS should explicitly prohibit involuntary continuous call.

New Business

Availability of On-Call Physicians, Tag A404 §489.24(j)(1)
The subcommittee proposes revising the Interpretive Guidelines to remove the controversial phrase, "best meets the needs of the hospital's patients," while maintaining accountability among hospitals. The following language would replace the sentence at §489.24(j)(1):

> Each hospital must maintain an on-call list of physicians on its medical staff who are available to examine and stabilize the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians.

The subcommittee believes the consequences for failing to have sufficient on-call coverage should include regulatory discipline and/or civil monetary penalties but not civil liability. Dr. Kusske noted that the TAG has received a great deal of testimony about the ambiguity of the phrase "best meets the needs of the hospital's patients."

> *Action Item*

The On-Call Subcommittee requests that the TAG consider the proposed revision of the Interpretive Guidelines.

Telemedicine, Tag A404 §489.24(j)(1)

The subcommittee supports allowing on-call mental health professionals to evaluate patients with psychiatric disorders using telemedicine wherever such technology is available. The subcommittee believes CMS should fully reimburse providers for such care. Dr. Kusske provided a resource document and a position statement from the American Psychiatric Association supporting telemedicine (Items 3 and 4).

Action Item

The On-Call Subcommittee requests that the TAG consider expanded use of telemedicine by mental health professionals, as well as appropriate CMS reimbursement.

Referring Emergency Patients to the Physician's Office, Tag A404 §489.24(j)(1)

The Interpretive Guidelines state that it is "generally not acceptable" for a physician on call to have emergency cases referred to his or her office for examination. The subcommittee believes there are situations in which a patient in the emergency department is considered by the treating physician to be stable enough to travel to the specialist physician's office for treatment. Revising the Interpretive Guidelines to allow such referrals may encourage more specialists to take call.

Action Item

The On-Call Subcommittee requests that the TAG consider revising the Interpretive Guidelines to support referral of patients to a physician's office when appropriate.

Medical Liability Protection

The subcommittee supports the concept of Federal protections for physicians who provide emergency care because such protections may encourage more physicians to take call. It was noted that most State laws do not offer protection to physicians who are already legally bound to deliver care to the patient. Also, Good Samaritan statutes generally do not cover those who accept compensation for delivering emergency care. The subcommittee believes that physicians or hospitals delivering care under EMTALA obligations should be protected from civil liability suits unless they act with gross negligence. Dr. Kusske referred to the AMA's testimony at the May 2006 meeting supporting protection for physicians similar to the Good Samaritan laws (Item 2).

Action Item

The On-Call Subcommittee requests that the TAG consider Federal liability protection for physicians and hospitals acting under EMTALA requirements.

Specialized Capabilities

The subcommittee believes EMTALA regulations regarding hospitals with specialized capabilities are creating an untenable situation. Dr. Kusske was informed of a hospital in Idaho that is facing CMS sanctions because it refused to accept transfers from hospitals well beyond its catchment area with which it had no relationship (Items 5 and 6). It was noted that, from the legal perspective, no geographic boundaries are applicable to the specialized capabilities

requirement. Furthermore, regional offices are not obligated to consider the fairness and appropriate of a transfer from the perspective of the receiving hospital, nor are transferring hospitals required to notify the receiving hospital of a potential transfer.

Action Item
The subcommittee requests the TAG discuss:

- whether the TAG should recommend geographic limitations to the specialized capability requirement;
- whether transferring hospitals should alert receiving hospitals of potential transfers (for a patient who *may* need specialty care) or of the lack of specialty coverage at the transferring hospital (in case patients come to the transferring hospital in need of that specialty coverage);
- whether notification should be part of the specialized capabilities requirement;
- whether other, less punitive mechanisms can be used to enforce EMTALA regulations and prevent potential violations; and
- whether CMS should provide more written guidance on the specialized capabilities requirement.

Ms. Nelson presented the Action Subcommittee's document outlining the duties of transferring and receiving hospitals (Item 7). Although the statute states that EMTALA obligations end when a patient is admitted to the hospital, Dr. Kusske said the American College of Emergency Physicians believes that if a patient cannot receive appropriate treatment in the hospital to which he or she is admitted, a hospital with higher treatment capability should accept that patient. It was noted that inpatient transfers are beyond the scope of EMTALA.

Dr. Aristeiguieta said that when a hospital admits a patient as a temporary mechanism for the benefit of the patient (and to enable the flow of patients through the emergency department) while seeking to transfer the patient, the hospital should not be penalized.

Action Item
The On-Call Subcommittee will discuss at a later meeting situations in which it would be appropriate to apply EMTALA regulations to inpatients.

Dr. Nelson indicated that some hospitals are refusing to accept EMTALA transfers on the basis that 1) the hospital does not have the appropriate specialist on call *at the time of the transfer*, although the specialist will, in fact, be on call within an appropriate treatment window for the patient; 2) the specialist will not be available on call to provide continued care or monitor the patient; or 3) the hospital will not have other specialists on call who may be needed at some point to assist in the patient's care.

Action Item
Members of the On-Call Subcommittee will provide input at the next TAG meeting on the Action Subcommittee's proposed guidelines on the duties of hospitals with specialized capabilities to accept patient transfers under EMTALA.

Limits of EMTALA

Dr. Kusske said the American College of Emergency Physicians would like to CMS to clarify that follow-up care by the on-call physician following treatment in the emergency department is not governed by EMTALA. He added that the AMA believes that CMS language is ambiguous regarding when a hospital's EMTALA obligation is complete (see Item 2). Ms. Nelson noted that the Action Subcommittee will make a recommendation to TAG on this topic.

> *Action Item*
> The subcommittee requests the TAG consider whether CMS guidance should clearly state that once a patient is stabilized, EMTALA no longer applies.

Emergency EMTALA Waiver

Dr. Aristeiguieta raised the need for a mechanism that exempts hospitals from EMTALA regulations during disasters. The current waiver only applies to a Federal disaster declaration, and only lasts 72 hours.

> *Action Item*
> The On-Call Subcommittee requests the TAG discuss the need to expand waivers of EMTALA requirements during emergencies.

Adjournment

The teleconference was adjourned at 2:30 p.m. The collected action items of the subcommittee are listed in Appendix B.

Note: 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

EMTALA TAG Members Participating in the On-Call Subcommittee September 26, 2006 Teleconference

On-Call Subcommittee Members
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Other EMTALA TAG Members
Julie Mathis Nelson, J.D.
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Rapporteur
Dana Trevas
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APPENDIX A

Agenda
On-Call Subcommittee of the EMTALA TAG
September 26, 2006

1) Introductions

2) Old Business

1. **Tag A411 §489.24(f) and Interpretive Guidelines §489.24(e).** On-call specialists considered as a "Specialized Capability." Request by Julie Nelson of the Action Subcommittee to reconsider some aspects of the recent recommendation by the TAG that the presence of a specialty physician on the call roster is not, by itself, sufficient to be considered a specialized capability. At the time of transfer, the receiving hospital should also have available the necessary equipment, space, staff, etc., to accommodate patient transfer. There is further discussion of the Specialized Capabilities problems later in the agenda.
2. **Call Sharing.** The On-Call Subcommittee recommends to the TAG that it alert CMS to the urgent need to provide additional guidance for call sharing. The On-Call Subcommittee recommends that guidelines should be inserted into the Interpretive Guidelines which explicitly allow for call-sharing and/or other regional coverage arrangements. Guidelines should explicitly allow for call sharing and/or other regional coverage arrangements.
3. **Continuous Call.** The On-Call Subcommittee recommends that the TAG considering recommending to CMS an affirmative resolution prohibiting forced, continuous call over extended periods of time.

3) New Business

1. **Tag A404 §489.24(j) (1) Availability of On-Call Physicians.** "Each hospital must maintain an on-call list of physicians on its medical 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 physicians."
2. The On-Call Subcommittee proposes that the language "best meets the needs" be eliminated and further proposes that another approach be established which still holds hospitals accountable for providing a complement of on-call specialty physician services within its capabilities and resources. This should be done so that there are only regulatory consequences or civil monetary penalties applicable, but not including civil liability.

3. **Tag A404 Interpretive Guidelines §489.24(j)(1)** Telemedicine. Requests have been made for the utilization of telemedicine techniques for evaluating patients with psychiatric disorders by on-call mental health professionals. The on-call subcommittee recommends to the TAG that these techniques, where available, be permitted for evaluating patients with mental health disorders. Further we recommend that these services be fully reimbursed by CMS.

4. **Tag A404 Interpretive Guidelines §489.24(j)(1)** "When a physician is on call for the hospital and seeing patients with scheduled appointments in his private office, it is generally not acceptable to refer emergency cases to his or her office for examination and treatment of the EMC." The on-call subcommittee recommends to the TAG that CMS should not require that on-call physicians come to the ED to treat all patients with EMCs. In many instances the patient's EMC can be stabilized and the patient moved to the office for definitive treatment, which conforms to the statutory language of the law. Requiring physicians to come to the ED in all instances simply makes them less willing to provide on-call services to the hospital ED.

5. **Medical Liability Protection.** The On-Call Subcommittee believes the TAG should explore means of encouraging physicians to take call in order to alleviate the present on-call crisis. To that end the On-Call Subcommittee recommends to the TAG that providing on-call physicians with federal liability protections similar to the Good Samaritan laws available to others who respond to emergencies under other circumstances would incentivize physicians to take call. These laws typically shield from civil liability a person who provides emergency assistance. Issues to consider in the recommendation:

    1) Under most state laws a physician will not be protected if it is determined that the physician was already legally bound to deliver the care in question.
    2) Also the Good Samaritan statutes typically bar from qualification under the statute persons who accept compensation for the emergency care delivered.
    3) Under these protections any physician or hospital that provides emergency services pursuant to obligations imposed by state of federal EMTALA requirements would not be liable for civil damages unless they acted with gross negligence.

6. **Further Discussion of the issue of Specialized Capabilities.** Many physicians, and hospitals, do not understand the way in which the enforcement of EMTALA has expanded the specialized capabilities requirement. The way in which the specialized capabilities provision is being enforced appears to set hospitals against hospitals as well as

physicians against physicians and physicians against hospitals. The On-Call Subcommittee submits that there must be a better way to make this work.

1) Are there no geographic limits within the specialized capabilities requirement? Should the On-Call Subcommittee, along with the Action Committee recommend that some be established?
2) For the purposes of planning and practice management should hospitals alert potential receiving hospitals in advance if they will need to transfer patients?
3) For purposes of planning and practice management, shouldn't hospitals be expected to alert potential receiving hospitals in advance if they do not have particular specialty coverage available? Should the On-Call Subcommittee along with the Action Subcommittee recommend to the TAG that the notification process should be a part of the specialized capabilities requirement?
4) All the solutions to this problem are punishment based. The requirement to "report the other hospital" which does not address preventing concerns from turning into EMTALA problems. Should the CMS establish other mechanisms which are less punitive in attempts to enforce the regulations?
5) Except for some short provisions concerning specialized capabilities in the EMTALA CMS Guidelines, there are no CMS written rules on specialized capabilities. Should the On-Call Subcommittee recommend to the TAG that CMS provide reasonable advance guidance?
6) According to written communication describing the manner in which ROs typically enforce the specialized capabilities provision the legal answers are:
    a. There are no geographic limits to the provisions
    b. ROs have no obligation to consider the "fairness and appropriateness" from the perspective of the receiving hospital and physician
    c. There is no absolute requirement of advance notification of possible patient transfers coming.

7. **42 CFR §489.24(b)** defines stabilized to mean "that no material deterioration
of the condition is likely, with reasonable medical probability, to result from, or occur during, the transfer of an individual from a facility, or with respect to an "emergency medical condition" as defined in this section under paragraph (1) of that definition, that a woman has delivered the child and the placenta."
    1) The question arises as to whether this language is ambiguous with regard to follow up care and additional unrelated treatment.

2) Should the On-Call Subcommittee recommend to the TAG that a specific statement should be added to the Interpretive Guidelines asserting that once a patient is stabilized for discharge, EMTALA no longer applies?

APPENDIX B

Emergency Medical Treatment And Labor Act (EMTALA)
Technical Advisory Group (TAG)
On-Call Subcommittee
Teleconference: September 26, 2006

Action Items

On-Call Physician as "Specialized Capability"
The On-Call Subcommittee requests that the TAG reconsider the wording of the following recommendation to CMS:

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

Continuous Call
The On-Call Subcommittee requests that the TAG revisit the question of whether CMS should explicitly prohibit involuntary continuous call.

Availability of On-Call Physicians
The On-Call Subcommittee requests that the TAG consider the proposed revision of the Interpretive Guidelines. The following language would replace the sentence at §489.24(j)(1):

> Each hospital must maintain an on-call list of physicians on its medical staff who are available to examine and stabilize the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians.

Telemedicine
The On-Call Subcommittee requests that the TAG consider expanded use of telemedicine by mental health professionals, as well as appropriate CMS reimbursement.

Referring Emergency Patients to the Physician's Office
The On-Call Subcommittee requests that the TAG consider revising the Interpretive Guidelines to support referral of patients to a physician's office when appropriate.

Medical Liability Protection
The On-Call Subcommittee requests that the TAG consider Federal liability protection for physicians and hospitals acting under EMTALA requirements.

Specialized Capabilities

The On-Call Subcommittee requests the TAG discuss:

- whether the TAG should recommend geographic limitations to the specialized capability requirement;
- whether transferring hospitals should alert receiving hospitals of potential transfers (for a patient who *may* need specialty care) or of the lack of specialty coverage at the transferring hospital (in case patients come to the transferring hospital in need of that specialty coverage);
- whether notification should be part of the specialized capabilities requirement;
- whether other, less punitive mechanisms can be used to enforce EMTALA regulations and prevent potential violations; and
- whether CMS should provide more written guidance on the specialized capabilities requirement.

The On-Call Subcommittee will discuss at a later meeting situations in which it would be appropriate to apply EMTALA regulations to inpatients.

Members of the On-Call Subcommittee will provide input at the next TAG meeting on the Action Subcommittee's proposed guidelines on the duties of hospitals with specialized capabilities to accept patient transfers under EMTALA.

Limits of EMTALA

The On-Call Subcommittee requests the TAG consider whether CMS guidance should clearly state that once a patient is stabilized, EMTALA no longer applies.

Emergency EMTALA Waiver

The On-Call Subcommittee requests the TAG discuss the need to expand waivers of EMTALA requirements during emergencies.

Additional Items

Item 1: American Medical Association testimony to the EMTALA TAG, May 1, 2006
Item 2: American Psychiatric Association: Telepsychiatry via Teleconferencing
Item 3: American Psychiatric Association: The Ethical Use of Telemedicine
Item 4: Correspondence dated October 12, 2005, from the law firm of Horty, Springer, and Mattern
Item 5: Correspondence dated August 9, 2006, from the law firm of Horty, Springer, and Mattern
Item 6: Duties of Transferring and Receiving Hospitals, draft document from the Action Subcommittee

Item 1: American Medical Association testimony to the EMTALA TAG, May 1, 2006

Statement

of the

American Medical Association

to the

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

Re: Emergency Medical Services and Specialty Hospitals

May 1, 2006

Division of Legislative Counsel
202 789-7426

Statement

of the

American Medical Association

to the

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

May 1, 2006

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 continuing to work with the TAG and CMS to reduce regulatory burdens on physicians while continuing to safeguard the health of Medicare beneficiaries.

Complying with EMTALA has been a critical and vexing task for physicians. And the AMA commends the TAG and the Centers for Medicare and Medicaid Services (CMS) for recommending and proposing changes to the EMTALA regulations that have provided much needed clarification and guidance. Removing much of the uncertainty and providing additional flexibility for hospitals and physicians so that they can comply with the law will undoubtedly benefit patients and the broader health care system. While the AMA is appreciative of the work the TAG has done to date, we have certain comments and suggestions related to some important and outstanding issues.

On-Call

One of the most significant provisions of EMTALA requires hospitals to maintain a roster of physicians who are "on call" to provide specialized treatment. If a patient needs the services of a specialist, that physician must respond to the call from the emergency room or face sanctions along with the hospital for violation of the Act. As a result, on-call procedures became significantly more rigid and formalized, and physicians became less willing to voluntarily provide emergency room call coverage. The EMTALA on-call

requirement together with the potential for greater exposure to medical liability resulting from treating patients in an emergency room setting, extremely high levels of uncompensated care in emergency departments, unequal payment rates for on-call services, and the generally increasing demands on medical staff, has further strained an already stretched system.

While the AMA believes that CMS should continue to take a flexible approach to implementing EMTALA that allows physicians and hospitals to work in a cooperative, non-punitive partnership to establish call arrangement, we believe there are certain recommendations the TAG could make that would help to alleviate the worsening shortages.

One of the major reasons for physician reluctance to accept on-call coverage is rising medical liability insurance premiums and increasing pressure from medical liability insurers for physicians not to provide emergency room coverage. In fact, several liability insurers have simply stopped providing medical liability coverage for certain physician specialties. One way to counter this trend would be to develop a federal Good Samaritan law that would protect physicians treating EMTALA patients.

Medical Liability Protection

The AMA strongly believes the TAG should explore ways of encouraging physicians to take call in order to alleviate the impending on-call crisis. Physicians on call who treat patients in the emergency room are frequently put in an untenable position whereby they must deliver care for patients with whom they have had no prior relationship and thus have no knowledge of the patient's medical history. We believe that enacting federal liability protection for on-call emergency physicians akin to Good Samaritan laws would strongly resonate within the physician community and would help to persuade more physicians to take call. Good Samaritan laws, which have been enacted in every state and District of Columbia, were passed in order to induce physicians to render emergency care under circumstances in which they have no legal obligation to do so. This includes medical emergencies that occur in areas outside of the health care setting or inside a health care facility at a time or place where the responsible physician is not available. They were designed to provide protection for those offering services in emergency situations by shielding them from liability.

Although these statutes vary from state to state, they typically shield from civil liability a person who provides emergency assistance, as long as that person was neither grossly negligent in providing the emergency care, nor found to have delivered such care in bad faith. Under most state laws, however, a physician rendering emergency care will not be protected under a Good Samaritan statute if it is determined that the physician was already legally obligated to deliver the care in question. Similarly, state Good Samaritan statutes typically bar from qualification under the statute persons who accept compensation for the emergency care delivered.

Given that provision of emergency on-call services is required under EMTALA, the AMA feels that the TAG should recommend providing on-call physicians with federal liability protections analogous to the Good Samaritan protections available to individuals who respond to emergencies under other circumstances. Under these protections, any physician or hospital that provides emergency services pursuant to obligations imposed by federal or state EMTALA requirements would not be held liable for civil damages resulting from such medical care unless they acted with gross negligence. Such a law would limit liability for emergency care and would protect those physicians and hospitals that provide such care. We are confident that extending Good Samaritan protections to emergency physicians would go a long toward alleviating the shortage of physicians willing to take call.

Call Sharing

The AMA thinks that the TAG should recommend that CMS provide additional guidance regarding the practice of call sharing and regional call arrangements. Although the final rule clarifies that hospitals can maintain a certain amount of flexibility in determining their level of on-call coverage and that hospitals have the discretion to maintain coverage "in a manner to best meet the needs" of its patients, the AMA believes that these guidelines should explicitly allow for call-sharing and/or other regional coverage arrangements. Such arrangements are designed to provide an organized, pre-planned response to patient needs to assure the best patient care and efficient use of limited health care resources. And will undoubtedly assist in greater access to on-call specialists.

Specifically, these arrangements envision hospitals reaching formal agreements with other hospitals with which they plan to "share" coverage responsibilities. These arrangements can include agreements whereby hospitals rotate the lead responsibility for providing particular services; a common group of specialists rotates among hospitals, or a particular hospital is recognized as a regional referral center for a particular specialty. The agreements are specific as to the services to be covered and the period of time in which each hospital will assume responsibility. For the period of time each hospital has responsibility, it agrees to accept all patients transferred from the other hospital(s) that are party to the arrangement. Once such an arrangement is in place these hospitals can transfer patients, once stabilized, who require specialized treatment that is part of the call-sharing arrangement to each other when the other has back-up responsibility without violating the emergency transfer laws. Such transfers would be considered "higher level of care" transfers, which are permissible under EMTALA, provided the other requirements for transfer are met.

To further facilitate adoption of these arrangements, the TAG should consider recommending anti-trust immunity and protection to coordinate on-call schedules or sharing of on-call specialists. Physicians, physician groups, and hospitals should be given such immunity in order to form independent practice associations or other physician organizations devoted to providing emergency on-call services on a regional or local basis.

Funding and Payment

Lack of access to on-call services also results from the worsening financial burdens of providing such services. Problems with lack of payment, underpayment, and delinquent payment for on-call emergency care extends to all payers—private health plans, Medicare, Medicaid, and other safety net programs for the uninsured—and acts cumulatively to reduce the willingness of physicians to provide on-call services.

While there are programs that provide funding that can be used to reimburse hospitals and physicians for emergency and on-call services for uninsured patients, limits on who may access them and under what circumstances restricts their availability to physicians as a source of reimbursement. These limitations include funds generally being available only to those hospitals that serve relatively high numbers of uninsured patients; funds going to hospitals rather than to physicians, prohibiting physicians from billing against them directly; and competition from other hospital priorities for use of the funds. Therefore, the AMA strongly supports direct reimbursement to physicians who provide on-call services.

In addition, many health plans deny coverage and delay payments for emergency care services. For example, a health plan may refuse to pay physicians who provide emergency care to patients who are "out of network" (i.e., outside the health plan contract). If a medical specialist employed by a patient's health plan is not available, hospitals are obligated under EMTALA to provide a specialist. However, health plans are not always required to pay for such services, and even in states where payments are required health plans often deny emergency care claims based on physician contracts and prior authorization. Moreover, insurance plans, with the benefit of hindsight, often determine that the patient did not have an emergency condition and refuses payment. While hospitals and physicians have absorbed these costs in the past by shifting them to patients who could pay, it has become increasingly difficult to recover these costs with the flat fees provided by many health plans. The AMA, therefore, recommends that all health plans be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act without regard to prior authorization or the emergency care physician's contractual relationship with the payer.

EMTALA Obligations

Under EMTALA, where it is determined, after an examination, that a patient has an "emergency medical condition" the staff and facilities must stabilize or transfer the patient. The term stabilize is defined by the Act as to provide, "such medical treatment … necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to [a pregnant woman having contractions] to deliver (including the placenta)." Similarly, the term "stabilized" is defined as, "with respect to an emergency medical condition … that no material deterioration of the

condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to [a pregnant woman], that the woman has delivered (including the placenta)."

The AMA believes that this language should be clarified, as it is ambiguous with regard to follow-up care and additional unrelated treatment. CMS should add a bright line rule to the final regulations explaining that once a patient is stabilized for discharge, EMTALA no longer applies. It should be clear that this is the case even where an on-call specialist is called into the emergency department to stabilize or treat a patient and the patient requires relatively immediate follow-up care. We believe that this can be easily accomplished by adding clarifying language that would state that EMTALA does not require medical care or treatment that occurs after the patient is stabilized and is capable of receiving medical treatment as a non-emergency patient or care that is unrelated to the original medical emergency. In addition, it would also be helpful if CMS could include in the guidelines, illustrative examples to demonstrate the point of stabilization associated with common emergency medical conditions. Hospitals and physicians need to know exactly where their EMTALA responsibilities end in order to rein in costs and avoid penalties.

Lastly, the AMA requests that CMS clearly state that on-call physicians do not constitute a "specialized capability" as described in section 1867(g) of the Social Security Act, for the purposes of meeting EMTALA requirements. Interpreting the term "specialized capability" to include on-call physician specialists expands the scope of EMTALA, exceeds the intent of the law, and could be perceived as requiring a specialist to be on-call at all times, which is clearly contrary to CMS' current Interpretive Guidelines.

Conclusion

The AMA appreciates the TAG's 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.

Item 2: American Psychiatric Association: Telepsychiatry via Teleconferencing

APA Document Reference No. 980021

Telepsychiatry Via Videoconferencing
RESOURCE DOCUMENT

Approved by the Board of Trustees, July 1998

"The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. The views expressed are those of the author(s)". -- *APA Operations Manual*.

The widening scope and role of telepsychiatry as a product of the Digital revolution, technologic advance and market forces, and the need for guidelines

I. INTRODUCTION

Telemedicine is an enabling technology, originally conceived to enhance access to health care for the geographically hard-to-reach and the underserved. Widening experience with the technology, in combination with the Digital Revolution and market forces, demonstrates that the thrust of telemedicine is much broader and that it will become the way we are all served -whether underserved or not - with greater efficiency, continuity and timeliness.

Telemedicine -and, by extension, telepsychiatry -is becoming more widespread, less costly, and new applications are emerging. Over the last decade the technology has moved from expensive room-sized systems to the desktop personal computer, now extending to the Internet as well. In recent years telemedicine programs have increased in number as hospitals, academic departments, managed care organizations, home health care, schools, prisons and individual providers are migrating the technology to where the patient happens to be electronically. The widening scope of applications now includes hospice care, cancer support groups, substance abuse and depression screening, teleconsultation to maintain military troops at the front, remote consultation to obviate language or cultural barriers at the local site, and telepsychiatric care of deaf mentally ill via American sign language. Economies of scale can be achieved by providing telehealth care to capitated populations, such as in correctional and managed care, with the potential for cost containment and quality management as well as for increasing competition for patients nationally and internationally. Widening "internetization" of health care implies that the computerized patient record, patient access to vast amounts of health information, and provider access to patients anywhere on the World Wide Web will be commingled in ways that will likely modify the practice of psychiatry and the doctor-patient relation as we have known it. Psychiatry is now confronted with new opportunities and challenges; how will it respond in the "information era"?

Clinical guidelines are urgently needed to assist physicians in using the technology and to safeguard quality of care, confidentiality, ethical practices and risk management. At this time, when communications technology is changing rapidly and when data from ongoing demonstration projects to determine cost, quality and effectiveness are incomplete, it is too early to establish clear standards. Nevertheless American psychiatry must begin to address the issues. While we await more data (e.g., validation studies using telepsychiatry in differing diagnostic conditions, age groups and treatment situations), the following practices are proposed, mindful that this work in progress will be modified by the telepsychiatry of the future.

II. DEFINITION

Telemedicine has been variously defined. To paraphrase the National Library of Medicine definition of telemedicine as it applies to psychiatry, telepsychiatry is the use of electronic communication and information technologies to provide or support clinical psychiatric care at a distance. This definition includes many communication modalities such as phone, Fax, email, the Internet, still imaging and live interactive 2-way audio-video communication.

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Live interactive 2-way audio-video communication - videoconferencing -is the modality addressed in the following report. Videoconferencing has become synonymous with telemedicine involving patient care, distant education, and administration.

III. APPLICATIONS

The technology supports clinical, educational, administrative and research applications. These will be discussed in turn.

A. CLINICAL APPLICATIONS USING VIDEOCONFERENCING

1. Scope

Clinical applications encompass diagnostic, therapeutic, and forensic modalities across the age span. The technology appears applicable to a broad range of diagnoses, although suitability for a specific patient may depend on the needs of the patient at hand. Points of delivery may include hospitals and their emergency rooms, clinics, offices, homes, nursing homes, schools and prisons. ommon applications include pre-hospitalization assessment and post-hospital follow-up care, medication management and consultation. Psychotherapy, including supportive, cognitive-behavioral, brief interpersonal, psychodynamically-oriented, psychoanalytic, group and family therapy, is feasible. Commitment hearings, evaluation of competence and forensic evaluations are feasible.

2. Clinical Interviews

Telepsychiatry may be conducted between physicians in consultation, between a physician and another health care provider (e.g., a case manager, clinical nurse practitioner or physician assistant), or between mental health professionals and a patient. Other persons, such as another health care provider or family member, may also be present in a patient interview. The telepsychiatric interview may be an adjunct to periodic face-to-face contact or it may be the only contact; it may be supported by additional communications technologies such as Faxed consultation information or transmission of a computerized patient record. The consulting physician should request face-to-face consultation if the patient's condition does not lend itself to a telemedical consultation or if visual or sound quality is inadequate. Referring and consulting physicians should clarify who will be responsible for communicating results to the patient.

The consulting clinician's role must be clearly defined, and the patient needs to be clear as to who is responsible for his/her care. If the psychiatrist is to be the treating clinician for a patient at a distance it is helpful for the psychiatrist to have a working relationship with local mental health professionals and psychiatric services; in this way the patient then has available a full continuum of care which can be directed by the psychiatrist even though the patient may reside a substantial distance away. When a patient is in ongoing treatment via telepsychiatry, availability of the physician at times other than those scheduled should be addressed as in any practice setting. Physician availability should be clearly understood by all parties involved, and documented.

There is little information concerning the human factors in telepsychiatry: in what ways it may differ experientially from face-to-face contacts, how distance and telecommunications equipment influence interactional and dynamic issues such as transference and countertransference. Anecdotally it has been observed that, given good technical quality, people tend to accommodate to communicating via television equipment "as if I were in the same room as the doctor." Physicians report that consultation tends to be more focused and briefer than when conducted face-to-face, with less time devoted to the usual social rituals of opening and closing a face-to-face interview. There is an impression that the interposition of telemedical equipment places the patient and provider on a more equal footing, thereby altering the power differential that can arise in office interviews. It is likely that telecommunications technology in general, with its potential for greater patient empowerment, can influence the doctor-patient relationship (Alessi, Huang and Quinlan). This is an area vitally in need of more information.

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3. Emergency Evaluations
While the presence of another person raises issues of confidentiality, certain psychiatric emergencies may require it if, for instance, a patient is suicidal, homicidal, dissociated, demented or acutely psychotic. In general such patients should not be managed via telepsychiatry without support staff or responsible family members present at the remote site unless there are no adequate alternatives and immediate intervention is deemed essential for patient safety. In such instances telepsychiatric assessment and intervention can be considered while other options are aggressively pursued. The possibility of equipment failure (see below) further dictates availability of responsible individuals at the remote site. A psychiatrist who provides direct patient care through telepsychiatry is responsible for considering options if acute hospitalization of the patient is indicated; at a minimum, resources available in the patient's immediate area should be identified and documented and the patient so informed.

4. Case Management
In large distributed systems where multiprovider case management is needed, teleconferencing allows collaboration between all the involved clinical participants regardless of distance. Clinical treatment plans can be developed with input by experts not otherwise available. These plans can be recorded and shared with other clinicians who might care for the patient, or with the patient himself.

5. Forensic Psychiatry
Telepsychiatry is appropriate for a variety of forensic uses, including patient assessment for involuntary commitment (Bear) and for conducting commitment hearings. Indeed, in the latter case it may enable family members to give testimony and emotional support who might be unable to attend otherwise. The physician should determine if a state's commitment laws will allow a telepsychiatric evaluation for the purpose of involuntary commitment. Similarly, if evaluating a patient who is physically located in another state and who is deemed to need involuntary commitment, the physician must determine that state's legal code and its policy for accepting out-of-state evaluations. The physician or psychologist doing the involuntary commitment evaluation may require a license in the state where the involuntary commitment will occur.

6. Procedures
Telepsychiatry-assisted psychiatric procedures (hypnosis, electroconvulsive therapy, and amytal interviews) may be considered appropriate if there is direct physician-to-physician consultation, and if the physician attending the patient has appropriate credentialing, licensure, and malpractice coverage to perform the procedure in a given state. Physician-to-other health care provider consultation for the performance of these procedures is not appropriate.

7. Clinical Supervision
Supervision of a psychiatry resident at a distant site can facilitate both training and patient care. It may be done either in real time with the supervisor present via videoconferencing, or, when appropriate, by store and forward technology. Licensure (particularly if services are across state lines), liability coverage and financial factors must be considered in determining the feasibility of such an application.

Physician extenders are helpful and appropriate in the use of telepsychiatry. Adequate supervision must be maintained, and credentialing, licensure and malpractice must be appropriate for the services rendered for the extenders as well as the physicians involved.

B. OTHER APPLICATIONS IN TELEPSYCHIATRY

1. Distance Learning
Teleconferencing technologies for education encompass a broad range of applications including but not limited to point to point applications, such as a physician to physician teaching session, or physician to patient session, or point-to-multipoint sessions such as would occur in a classroom setting where the teacher is at one site and the "pupils" at the others. The latter represents a more traditional model of broadcasting as we know it except that it can be interactive in real time, allowing the establishment of a real time dialogue and teaching experience unlike traditional broadcasting. Distance learning supports patient education about medications, off-site mentoring to teach

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new techniques, and multi-site transmission of "Grand Rounds" conferences and Continuing Medical Education (CME). The debut of "cybercourses," already a reality on the World Wide Web, promise further alterations in education as we have known it.

2. Research
Telepsychiatry appears promising as an effective and reliable means of gathering research data from certain clinical populations (Baer, Jones, Zarate). It enables multisite acquisition of information for large clinical databases (Stamm). Validation studies are needed, however, to address the use of telepsychiatry in specific populations designated by diagnosis, age, sex and other variables; it is too early to generalize findings from one diagnosis to another. Studies on cost, efficacy and patient satisfaction are just now appearing.
Patients who refuse participation in research studies via telepsychiatry should be made aware that refusal to do so will in no way jeopardize their right to appropriate care (although this may be the only vehicle for care in some instances).

3. Administration
Interactive 2-way audio-visual communication between distant hospitals, clinics, schools, and justice centers is effective for administrative services and support. It may achieve cost savings in large systems. It is inappropriate for nonclinical administrators of health care systems to use the technology to make clinical decisions.

IV. PRIVACY, CONFIDENTIALITY AND INFORMED CONSENT

Patients have a right to privacy and confidentiality of communication, and many states recognize a higher confidentiality standard for psychiatric records. Evaluation or treatment must be performed in an environment where there is a reasonable expectation of absence from intrusion by individuals not involved in the patient's direct care. However, strict privacy may be difficult to maintain in all circumstances (Gilbert). Hospital or clinic staff involved in the patient's care, family members and telemedical technical staff may at times be present in interviews. Patients should be informed about others present in the room at a distant site if such persons are off camera. On occasion telepsychiatric interviews will be audio-or video-taped, although this practice is often avoided to prevent lapses of confidentiality. Informed consent involving these issues should be obtained either verbally or in writing from the patient, next of kin or guardian. If a consent form is used, it should adequately reflect that it may not always be possible to assure privacy.

As with any procedure, the patient must be made aware of the potential risks and consequences as well as the likely benefits of telemedical consultation, and must be given the option of not participating. Patients should be informed that care will not be withheld if the telepsychiatric encounter is refused, although such care could depend on availability of alternative resources.

Assuring the integrity of the analog/digital stream may warrant the use of encryption and of confidentiality clauses in service agreements, supplemented by monitoring and quality control.

V. MEDICAL RECORDS

Medical records of telepsychiatric interventions are to be maintained as with psychiatric interventions in general. If the quality of a transmission was poor, this should be documented in the patient record. Telepsychiatric care is subject to Quality Assurance monitoring as with other forms of medical care; procedures should be systematically monitored and evaluated as part of overall quality improvement of a facility.

The progress note for an interview by videoconference may include the following information:

1. The location of the clinician providing the service (this may be different from the clinician's office);
2. The location of the patient (town, facility where seen);
3. Type of equipment used and any malfunction that may affect clinical care;
4. Who was present during the office visit, and what their role was.

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Who owns the medical record and where the original record is to be kept should be clear. If the record is kept at the site where the patient is being seen, arrangements should be made to have a copy of the record as well at the site of the treating clinician not only for routine care but in case of emergencies.

VI. TRAINING, LICENSURE AND LIABILITY

Training for clinical applications should include familiarity with the equipment, its operation and limitations, and means of safeguarding confidentiality and security. Psychiatrists have an obligation to stay current with the technology and its uses through continuing education.

Physician licensing requirements vary from state to state. If a physician is providing consultation to another physician, supervising a health care professional, or providing direct patient care across state lines, the physician must establish with the state medical board in that patient's state whether a medical license from that state is required in order to provide telepsychiatric services. Interstate use of telepsychiatry may require multi-state licensing unless a national telemedical license is developed.

The physician should establish with his malpractice carrier whether coverage is provided for interstate use of telepsychiatry. As yet there are few guidelines for jurisdictional liabilities of physicians providing or receiving consultation in another state; nor has jurisdictional liability been established for a vendor of telemedical equipment which fails while in use across state lines. When equipment failure prevents adequate diagnosis or treatment, this should be documented in the patient record.

VII. EQUIPMENT FOR VIDEOCONFERENCING

Selection should be based on ease of use, image and sound quality, cost, and suitability to given applications. For instance, simple cognitive screening is not likely to require the resolution needed to detect extrapyramidal signs; an interview with an active youngster is likely to require more sophisticated equipment than one with a demented geriatric patient who moves and speaks little.

The major components include monitors, cameras, CODEC, a desktop computer, microphones, speakers and other audiovisual interactive technologies such as videophones.

Monitor

The monitor, or screen, shows the image of the people at the distant site(s); it may show a picture of the local site too. Room-based units are often 33" or larger. Desk top screens are usually 17" and are adequate for routine interviews where no more than 3 or 4 persons are at the distant site. Monitor size only allows for a bigger picture. Clarity of picture and motion handling are primarily a function of bandwidth.

Camera

The camera captures images at the local site to send to other sites. There is a wide range of cameras available. There is little difference in the quality of the picture from camera to camera as the clarity of the image and the motion handling is primarily a function of the bandwidth and the algorithm used to compress the image prior to transmission to another site. Factors to weigh include lens quality, whether the lens is fixed or can "pan" about a room, and whether it can "zoom" in (for closeup) or out (for distant) views; a wide angle lens is useful if more than 1 or 2 people are to be viewed. It is helpful but not mandatory for the provider to have control over remote camera zoom and scan. A document camera for transmission of graphic material is helpful but not essential.

CODEC

The CODEC (coder -decoder) is the heart of the teleconferencing device. It transforms the analog signal (the picture) picked up by a video camera to a digital signal and compresses it for transmission to the distant site; there, another CODEC transforms the digital signal back to an analog one for viewing on the video monitor. The

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compression algorithms used are responsible for the quality of the signal ultimately received. There are industry standards for video and sound compression and for inter-network compatibility with other teleconferencing systems.

Bandwidth
Bandwidth refers to the amount of data that can be transmitted electronically. To put this in perspective, regular analog phone lines operate at 56-64 Kbps. This is enough bandwidth to handle voice communication, though if one is also transmitting video signals then more bandwidth is needed to avoid motion and image distortion. For this reason digital ISDN lines (128 Kbps) are commonly used. Only a few years ago it was thought that high bandwidths (T1-384 Kbs) were essential for adequate resolution to assure clinical accuracy. With subsequent technologic advances it now appears that a bandwidth of 384 -128 Kbs is acceptable in most situations. The lower bandwidth (128 Kbps) appears suitable for many clinical applications and for administering questionnaires and rating scales (Baer, Bear, Jones, Ermer, Zaylor, Zarate). The higher bandwidth (384 Kbps) enhances recognition of negative symptoms of schizophrenia (Zarate), recognition of manual tremors and pupillary reflexes, and it may enhance patient and provider satisfaction. However, experimentation with very low bandwidth transmissions over ordinary telephone lines suggests that, with improvements in compression algorithms, consultation with certain patient populations such as demented nursing home patients who move little may be feasible. Indeed, future technologic advances may render bandwidth a non-issue.

PC
A desktop computer can be used in conjunction with hardware and software packages to provide interactive videoconferencing. Currently a microprocessor with a speed of at least 166 Mhz is recommended for optimal performance.

Videophones
These are self-contained units which run off analog telephone lines and allow interactive videoconferencing at a low bandwidth.

Other equipment
High quality microphones and speakers assure aural communication.

The capacity to store audio and video information, such as VHS cassettes, optical or hard discs, may be useful for medicolegal, teaching or research purposes, though for most clinical situations it is unnecessary and only increases the burden of securing information.

When Equipment Fails
Procedures for dealing with equipment failure should be anticipated. If the physician initiates the conference, s/he is responsible for attempting to reestablish an adequate 2-way audio-video link, or else for phoning the patient. In emergency situations it is essential that there be adequate personnel at the remote site in the event of equipment failure.

VIII. REIMBURSEMENT

Reimbursement for telepsychiatry services should follow customary charges for the delivery of the appropriate CPT code(s). A structure for reimbursement of collateral charges, e.g. technician and line time, should be identified. At present, reimbursement is obtained either from individual contracts, from managed care, from third party payors in a few states, and from Medicaid and Medicare in limited situations; reimbursement possibilities will likely broaden in the future.

IX. SUMMARY

Not only is telepsychiatry a potentially appropriate technology for the delivery of clinical psychiatric services, distant learning, administration and research; it is likely to change psychiatry as it has been practiced. Much

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information is still needed, particularly in psychiatry where questions for the future include: how is telepsychiatric health care delivery the same as or different from that delivered face-to-face; are there certain conditions or treatments best handled telemedically; does the technology alter the patient-provider relationship? However, given the many clinical, ethical, legal and liability issues in its use, minimum standards for care are critical. To quote Hoover, this is not an occasion for panic but a time for speed.

ACKNOWLEDGEMENT:
The Committee is indebted to Frank W Brown, MD, who set forth many of the above principles in an earlier unpublished paper, "Standards for the Application of Telepsychiatry."

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GLOSSARY

Analog signal
A continuous electrical signal in the form of waves that vary as the source of the information varies (e.g., as the contrast in an image varies from light to dark).

Asynchronous communication
Two-way communication in which there can be a time delay between when a message is sent and when it is received.

Bandwidth
A measure of the information carrying capacity of a communications channel; a practical limit to the size, cost, and capability of a telemedicine service, It is usually described in Bps.

Baud
A unit of digital transmission signaling speed of information transmission; the highest number of single information elements (bits) transferred between two devices (such as modems or fax machines) in one second.

Bit
Binary digit, the smallest possible unit of information making up a character or a word in digital code processed by computers.

Bps
The number of binary digits transmitted per second in a data communication system.

Codec
A "code/decode" electrical device that coverts an analog electrical signal into a digital form for transmission purposes and then coverts it back at the other end.

Compatibility
The ability for computer programs and computer readable data to be transferred from one hardware system to another without losses, changes, or extra programming.

Compressed video
Video images that have been processed to reduce the amount of bandwidth needed to capture the necessary information so that the information can be sent over a telephone network.

Computer conferencing
Group communications through computers, or the use of shared computer files, remote terminal equipment, and telecommunications channels for two-way, real-time communication.

Data compression
Processing data to reduce storage and bandwidth requirements. Some compression methods result in the loss of some information, which may or may not be clinically important,

Dedicated line
Permanent connection between two telephones or PBXs (see private branch exchange, below); the signal does not need to be switched.

Digital
Discrete signals such as those represented by bits as opposed to continuously variable analog signals. Digital technology allows communications signals to be compressed for more efficient transmission.

Digitizing
Conversion of analog into digital information.

DSI
A digital carrier capable of transmitting 1.544 Mpbs of electronic information. Also known as T1; the general term for a digital carrier available for high-value voice, data, or compressed video traffic.

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Encryption
The rearrangement of the 'bit' stream of a previously digitally encoded signal in a systematic fashion to make it unrecognizable until restored by the necessary authorization key. This technique is used for securing information transmitted over a communication channel with the intent of excluding all other than the authorized receivers from interpreting the message.

Firewall
Computer hardware and software that block unauthorized communications between an institution's computer network and external networks.

Hardware
Physical equipment used in data processing, as opposed to computer programs and associated documentation.

Integrated Services Digital Network (ISDN)
A digital telecommunications technology that allows for the integrated transmission of voice, data, and video; a protocol for high-speed digital transmission.

Leased lines (Dedicated lines)
Lines rented from a telephone company for the exclusive use of a customer.

Local Access Transport Area (LATA)
Local telephone service areas created by the divestiture of the Regional Bell Operating Companies formerly associated with AT&T.

Modem
A modulator/demodulator, this device converts digital information into analog form for transmission over a telecommunications channel and reconverts it to digital form at the point of reception.

Peripheral equipment
In a data processing unit, that may provide the system with outside channel communication or additional facilities.

Store-and-forward
Transmission of static images or audio-video clips to a remote data storage device, from which they can be retrieved by a medical practitioner for review and consultation at any time, obviating the need for the simultaneous availability of the consulting parties and reducing transmission costs due to low bandwidth requirements.

Telemedicine
The use of audio, video, and other telecommunications and electronic information processing technologies to provide health services or assist health care personnel at distant sites.

Transmission speed
The speed at which information passes over the line; defined in either bits per second (bps) or baud. Plain old telephone service (POTS) runs at 56Kbps. An ISDN line can run at between 128-384Kbps.

Video conferencing
Real-time, usually two-way transmission of digitized video images between two or more locations.

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Item 3: American Psychiatric Association: The Ethical Use of Telemedicine

APA Document Reference No. 950015

The Ethical Use of Telemedicine
POSITION STATEMENT

Approved by the Board of Trustees, December 1995

"Policy documents are approved by the APA Assembly and Board of Trustees…These are … position statements that define APA official policy on specific subjects…" -- *APA Operations Manual*.

The American Psychiatric Association supports the use of telemedicine as a legitimate component of a mental health delivery system to the extent that its use is in the best interest of the patient and is in compliance with the APA policies on medical ethics and confidentiality.

The American Psychiatric Association is a national medical specialty society, founded in 1844, whose 40,000 physician members specialize in the diagnosis and treatment of mental and emotional illnesses and substance use disorders.

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Item 4: Correspondence dated October 12, 2005, from the law firm of Horty, Springer, and Mattern

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VIA E-MAIL
AND FEDERAL EXPRESS

October 12, 2005

Beverly J. Parker
Division of Acute Care
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Mail Stop C4-08-06
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Ms. Parker:

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 Hospital 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 of EMTALA'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 helpful. 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 1395dd 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 of §482.55 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 personnel 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

BB/AS/SL/djm

Enclosure

Item 5: Correspondence dated August 9, 2006, from the law firm of Horty, Springer, and Mattern

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August 9, 2006

John A. Kusske, M.D.
EMTALA Technical Advisory Group
c/o Beverly J. Parker
Division of Acute Care
Centers for Medicare & Medicaid Services
Mail Stop C4-08-06
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Re: The Emergency Medical Treatment and Active Labor Act ("EMTALA") – Examples of Continued Hardship by the "Specialized Capabilities" Provision

Dear Dr. Kusske:

Susan Lapenta and I had the pleasure of speaking with you this past April in connection with your work with the EMTALA Technical Advisory Group ("TAG"). You had called our office to discuss our October 12, 2005 letter sent to the TAG. For reminder purposes, a copy of that October 12 letter is enclosed.

For Susan and myself, a highlight of our conversation was how much of it focused on the real and practical difficulties EMTALA places upon hospitals and physicians. That includes the difficulties oftentimes created by EMTALA's "non-discrimination" or "specialized capabilities" provision, the first-described item in the on-call comments of the enclosed October 12 letter.

Our office recently assisted Kootenai Medical Center ("KMC") located in Coeur d'Alene, Idaho, in responding to an EMTALA deficiency determination made by the Seattle CMS Regional Office ("RO") based upon the specialized capabilities provision. That work, once again, showed

us just how badly this provision can hit community hospitals and specialists who are trying to do right by their community.

Given the nature of our April phone call, I thought it could be helpful to the TAG to see just how EMTALA enforcement continues to pose hardships and unfairness. There continues to be uncertainties as to EMTALA's reach, and, in important situations, little advance written guidance.

(We are not sending you this letter on behalf of KMC, but to illustrate problems the specialized capabilities provision presents. KMC has permitted us to identify it for this purpose. If you would like, we would be happy to send you the full packet that KMC sent the RO, if that will be helpful to you.)

Some quick background: KMC has historically served the five northern counties in the State of Idaho, and has a long history of accepting transfers from the four surrounding county hospitals to its own. The EMTALA deficiencies found by the RO concerned four instances in which neurosurgeons on KMC's staff declined to accept proposed patient transfers from hospitals outside of this five-county region. In each of these situations, the RO determined that KMC had to accept the patients because a neurosurgeon constituted a "specialized capability," and KMC had the capability and capacity to accept the patient.

1. The Difficulties Caused by the Specialized Capabilities Requirement

The KMC physicians involved (both ED and the neurosurgeons) did not understand the way in which the enforcement of EMTALA has expanded the specialized capabilities requirements. We have subsequently provided on-site EMTALA education to everyone involved, particularly about the specialized capabilities requirements.

The physicians' questions to us – all of them quite fair and reasonable – show the burdens placed on physicians and hospitals by the current interpretation and enforcement of the specialized capabilities provision:

(a) KMC already serves a full five-county area. These four patient transfers all originated from outside that five-county area. Are there no geographic limits within the specialized capabilities requirement? Would KMC have to accept a patient transferred from anywhere in Idaho?

(b) The hospitals and physicians involved in the proposed patient transfers typically transfer neurosurgery patients to a hospital in Spokane. These proposed patient

transfers were entirely unexpected. Shouldn't that have some bearing in a finding of an EMTALA deficiency?

(c) When the hospitals outside of the surrounding four counties do not have a neurosurgeon on call, they never let KMC know this in advance (although this has been repeatedly requested). Again, for purposes of planning and practice management, shouldn't hospitals be expected to alert potential receiving hospitals in advance? Shouldn't that be a part of the specialized capabilities requirements? And of whether to make a finding of an EMTALA deficiency?

Based upon our experience with the manner in which ROs typically enforce the specialized capabilities provision, our legal answers were (a) there are no geographic limits to the provision, (b) ROs have no obligation to consider the "fairness and appropriateness" from the perspective of the proposed receiving hospital and physician, and (c) there is no absolute requirement of advance notification of possible patient transfers upcoming.

While legally correct, these answers pose significant hardships on all hospitals and on-call specialists. There must be better answers than the pure legal ones.

In the KMC area, there is a physician-owned hospital that does not have an ED. Physicians on KMC's medical staff are threatening to abandon the full-service hospital. If that is the case, KMC may no longer have specialized capabilities in any number of patient care areas. Perversely, rigid EMTALA interpretations could result in a diminution in services. That would serve neither KMC nor, more importantly, the larger community which it serves.

2. The Sending Hospital's Responsibilities

Under EMTALA, when a hospital is not able to provide on-call services, it is to have a policy in place as to how it will manage patients who present to its ED the need of such services. It is our understanding that for these situations it is best for each hospital to alert other hospitals in the area that it will have to be transferring patients because of an uncovered ED. That is particularly the case when this information has been specifically requested by another hospital in the area, for its own planning purposes.

In its explanation letter to the Seattle RO, KMC asked for guidance as to the responsibilities of the transferring hospital in this situation. In a follow-up conversation, the RO told KMC that if it had any concerns with other hospitals' actions in this area, KMC's sole "remedy" was to report that hospital for a potential EMTALA violation.

There has to be a better answer for situations such as this than "report the other hospital." That answer is all punishment based, with no consideration given to preventing concerns from turning into EMTALA problems.

Other than some short provisions concerning specialized capabilities in the EMTALA CMS Guidelines, there are no CMS written rules on specialized capabilities. Hospitals should be able to expect CMS to provide reasonable advance guidance. Would each RO have managed this EMTALA matter in the same way? Are the limits on the RO's discretion?

The way in which the specialized capabilities provision is being enforced sets hospitals against hospitals as well as physicians against hospitals. There must be a better way to make this work.

3. Difficult Time Requirements Put Upon KMC by the RO

These final concerns are much less important on a policy level than the ones just raised.

KMC received its EMTALA deficiency letter from the RO on Thursday, June 29, with a response due date of Monday, July 10. That time period, basically a little over a week, included the July 4 holiday within it. (The RO contact was gone on vacation for a day or two within that ten-day period.)

While the RO granted KMC a two-day extension on the due date, the RO said that KMC had to be re-surveyed and approved by CMS before the July 20 public notice date. Otherwise, the public notice would go forward and KMC would receive its Medicare termination letter on July 22.

This extreme inflexibility is harsher than every other "fast track" deficiency case on which we have worked. With all those other cases, the submission of the corrective action plan stopped everything else from happening while the RO reviewed the hospital's materials.

In our experience, the follow-up survey has never had to take place within the initial "Medicare termination letter" fast track time frame. Quite frankly, those time frames taken together (submission and follow-up survey) were an exceptional hardship on KMC.

There must be a better way to use the specialized capabilities provision to protect patients but also to be fundamentally fair to the hospitals and physicians involved. We are hopeful that the TAG can assist CMS in finding that better balance. As before, we would be very happy to talk

about this situation further and provide more information, if that would be helpful to you and to the TAG.

Very truly yours,

Alan Steinberg

AS/pam

Enclosure

Item 6: Duties of Transferring and Receiving Hospitals, draft document from the Action Subcommittee

DUTIES OF HOSPITALS WITH SPECIALIZED CAPABILITIES TO ACCEPT PATIENT TRANSFERS

DUTIES OF TRANSFERRING HOSPITAL	DUTIES OF RECEIVING HOSPITAL
1. Maintain a call list that best meets the needs of hospital patients. (Transfers out for conditions hospital normally capable of handling may suggest inadequate call list.)	1. No obligation to accept hospital in-patients.
2. Hospital to provide stabilizing care within its capabilities prior to transfer.	2. Only required to accept unstable emergency department patients when transferring hospital does not have the capability to provide stabilizing care.
3. Transfer decision not based on insurance status/financial means (Number of transfers of patients without insurance evidences possible abusive transfer.)	3. No obligation to accept if basis for the transfer is patient request (must be physician certified of higher level of care).
4. Appropriate transfer, as defined in 42 C.F.R. § 489.24(e)(2).	4. No obligation to accept if the basis for the transfer is lack of capacity.
5. Encourage transfer agreements with other hospitals where patients routinely transferred.	5. Encourage transfer agreements with hospitals that typically transfer patients to receiving hospital.
6. In determination of whether patient is unstable, treating physician judgment rules (and re: transferring hospital capabilities), but may be questioned later by receiving hospital.	6. Receiving hospital may recommend alternative stabilizing care options, but transferring hospital is not required to accept recommendation.

DUTIES OF TRANSFERRING HOSPITAL	DUTIES OF RECEIVING HOSPITAL
7. In determining whether hospital has the capabilities to provide stabilizing care to the patient, surveyors look at capabilities of hospital at the time of the transfer and period thereafter consistent with the patient's "window" for required emergency care. Availability of additional care that will be or may be required once the patient's emergency medical condition is stabilized is not a basis for determining that the hospital lacked the capability to stabilize the patient's EMC.	7. Receiving hospital must accept/reject transfer within a "timely" manner.
8. The transferring physician must take into account the distance that the patient will travel in his/her certification that the benefits of the transfer outweigh the risks.	8. Duty to report improper transfers, which includes abuses of this provision, in accordance with 42 C.F.R. § 489.20(m).
9. Consider: If requested by the receiving hospital must take patients back once the patients' EMC has been stabilized and no longer needs higher level of care.	9. "Specialized capabilities" includes dedicated units, specialized equipment and personnel (including on call physicians) available at the time of transfer or that will be available within the patient's treatment "window." Specialized capabilities do not include medical staff members who are not on call.
10. Consider: contact nearest appropriate hospital first.	10. Receiving hospitals should have systems in place to communicate with admissions staff and on call physicians to confirm that they have the capacity and capability to provide stabilizing care to the patient before accepting a patient.
	11. Receiving hospitals are not required to accept patient transfer if they lack the capacity to do so.

DUTIES OF TRANSFERRING HOSPITAL	DUTIES OF RECEIVING HOSPITAL
	12. Failure to accept an unstable patient who requires the hospital's specialized capabilities available at the time of transfer is an EMTALA violation if the hospital has the capacity to accept the transfer.

APPENDIX 2

AGENDA
EMTALA TAG ACTION SUBCOMMITTEE
September 21, 2006

1. Administrative Issues: EMTALA TAG meeting

   A. Legal Extern

2. Substantive Issues

   A. Follow-Up Care
   B. EMTALA in Surge Capacity/Disasters
   C. Hospitals with Specialized Capabilities (Duty to Accept)
   D. EMTALA Education Recommendations
   E. EMTALA Enforcement Recommendations – CMS/OIG
   F. EMTALA Psychiatric Care Update
   G. Non-Hospital Owned Ambulances

3. Next Steps

4. Adjourn

APPENDIX 2
(continued)

EMTALA TAG
Action Subcommittee Telephone Conference

Date: Thursday, October 5, 2006

Time: 4:00 p.m. EST

Members Present: Julie Nelson; Brian Robinson; Rory Jaffe, M.D.; Richard Perry, M.D.; Mark Pearlmutter, M.D.; Mike Rosenberg, M.D.

Others Present: George Morey, CMS; Donna Smith, CMS; Camille Blake, CMS; Heather Boysel, Extern

MINUTES:

1. Administrative Issues

   - No meeting next week due to lack of participant availability.

2. Substantive Issues: Hospitals with Specialized Capabilities

   - Discussion:

     - Current Rule:

       - A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

         - There is a problem with hospitals transferring patients to other hospitals with on-call specialists when the transferring hospital had the capability to take care of patients.

         - Sometimes these transfers are really improper transfers under the guise of requiring "specialized hospitals."

     - Duties of Transferring Hospital

- On-call Lists

- Initial recommendation for transferring hospitals: Maintain a call list that best meets the needs of hospital patients. (Transfers out for conditions hospital normally capable of handling may suggest inadequate call list.)

- Transferring hospitals should have the duty to improve on-call coverage to reduce the number of patients transferred due to lack of on-call coverage.

- Comments/Questions

  - Does the hospital have enough patients with a particular condition to warrant having on-call for a particular specialty?

  - What about a patient with a condition so rare that there isn't an on-call physician for the condition?

  - What about when doctor is on-call for an entire region?

  - Issue of on-call physician capabilities: Example: Inpatient gynecology v. outpatient gynecology.

    - Need to have education on what "specialty" encompasses for purposes of establishing the on-call list.

    - Clarify hospital capabilities with respect to inpatient/outpatient services.

  - Should hospitals just be required to have a more comprehensive back-up plan?

- Refer on-call issue to the on-call subcommittee.

- Stabilization Within Capabilities

- Initial recommendation for transferring hospitals: Hospital to provide stabilizing care within its capabilities prior to transfer. This is already a requirement, but could be expanded upon.

- An example of where this would be an issue is in a small rural hospital where a bad motor vehicle accident occurs and the

hospital does not have the capability to truly stabilize and has to transfer patient, but can open airways, etc.

- Is it better for the patient to be transferred immediately or have further diagnostics when the hospital knows that it doesn't have capabilities to stabilize?

- Stabilization efforts and medical screening examinations should continue within the hospital's capabilities until time of transfer rather than as soon as the receiving hospital accepts.

▪ Transfer Decisions

- Initial suggestion: Transfer decision not based on insurance status/financial means (Number of transfers of patients without insurance evidences possible violation.)

- Can transfer for financial reasons with patient's consent.

- Psychiatric patients generally get transferred based upon financial means.

- Decision to transfer vs. decision where to transfer.

  - Recommendation: Change "transfer decision" to "Decision whether or not to transfer a particular patient may not…"; address where to transfer issue in separate sentence.

- Send issue of after-hours and weekends being treated differently to on-call subcommittee.

  - Have surveyors look at the number of patients transferred on weekends vs. weekdays in determining whether there is an EMTALA violation.

  - One problem is hospitals not wanting to pay for on-call services.

▪ Appropriate Transfer

- Initial recommendation for transferring hospital: Must effect an appropriate transfer, as defined in 42 C.F.R. § 489.24(e)(2).

- Medical treatment within its "capacity" should be changed to "capability."

- Need to distinguish between capacity and capability and need to have consistent language.

- Transfer Agreements

- Initial recommendation for transferring hospitals: Encourage transfer agreements with other hospitals where patients routinely transferred.

- This is one of the ways to get hospitals to work better together and prevent animosity.

- Suggested Change: "Transfer agreements may be useful to…."

- Some question the usefulness of transfer agreements and whether this should even fall under EMTALA.

- Consensus is to not require or encourage transfer agreements – remove statement from recommendation.

- One way of discouraging excessive transfers would be to make the transferring hospital pay for the transfer.

- Travel Distance Considered in Transfer Decision

- Initial recommendation: The transferring physician must take into account the distance that the patient will travel in his/her certification that the benefits of the transfer outweigh the risks.

- Distance requirement: could have a 50 mile limit; anything outside the limit would have to be the closest hospital with capabilities.

- Suggestions/Comments:

  - Hospital could have list to let staff know which hospitals are closest.

  - Could have rule where receiving hospital would not have to accept patient if there was a closer hospital. This would put the burden back on the receiving hospital. However, a specialized hospital probably has a better idea of where other specialized physicians are located. There are concerns as to how this would play out, such as whether the specialized

hospital would be required to call the closer hospital and whether this would actually delay patient care more than a longer transfer distance.

- Could have a rule that if a hospital was 50 miles closer, the receiving hospital could make a recommendation to go to the closer hospital.

- Return of Patient After Stabilization by Receiving Hospital

- Initial recommendation: If requested by the receiving hospital must take patients back once the patients' EMC has been stabilized and no longer needs higher level of care.

- This is the law in Florida.

- Question of whether the original hospital would have to pay cost of transferring patient back. Transfer agreements could be useful in this scenario.

- Concern that physicians do not want to take on complications after treatment by another hospital and whether the physicians at the specialized hospital would want to return the patient to the initial hospital. Could leave this to the discretion of the receiving hospital and could be used as an additional reason to not dump patients.

- Need information from Florida on how this works in Florida.

- Requiring original hospital to take back patient once EMC has been stabilized makes sense if the patient was really only transferred because of specialized capabilities.

- Could also require the original hospital to pay for both transfers in order to discourage dumping.

- Consideration of Patient's "Window" for Emergency Care

- Initial recommendation: In determining whether hospital has the capabilities to provide stabilizing care to the patient, surveyors look at capabilities of hospital at the time of the transfer and period thereafter consistent with the patient's "window" for required emergency care. Availability of additional care that will be or may be required once the patient's emergency medical

condition is stabilized is not a basis for determining that the hospital lacked the capability to stabilize the patient's EMC.

- Comments

  - Issue of best care versus necessity.

  - Need to research when lack of capacity is the only reason for transfer whether a hospital has a duty to accept – there may be an old memorandum on the CMS website regarding this issue.

  - Donna Smith will research and forward on to committee.

  - Specialized hospitals can't take every transfer or won't be able to take on more patients in need.

  - Reimbursement considerations.

    - Could reimburse hospitals for admitting patients in order to move patients through ER faster.

    - Problem of patients remaining in ER for multiple days because they need to be admitted and the hospital lacks bed space.

- Consensus:

  - Interpretive Guidelines need to provide more guidance regarding the duties of transferring and receiving hospitals.

  - Suggested Revisions to the EMTALA Interpretive Guidelines:

    - Stabilization efforts and medical screening examinations should continue within the hospital's capabilities until time of transfer rather than as soon as the receiving hospital accepts the transfer.

    - Decision *whether or not* to transfer a particular patient may not be based on insurance status/financial means. Decision *where* to transfer may be based on insurance status/financial means. (Number of transfers of patients without insurance evidences possible abusive transfers).

    - Appropriate transfer, as defined in 42 C.F.R. § 489.24(e)(2) should be modified to require medical treatment within the hospital's "capability" rather than "capacity."

- No recommendation regarding promoting use of transfer agreements. This should be left to the discretion of the hospitals. Many members believe that transfer agreements are ineffective.

- The transferring physician must take into account the distance that the patient will travel in his/her certification that the benefits of the transfer outweigh the risks. If the transfer distance will exceed 50 miles, the transferring hospital must attempt to transfer patients to the nearest appropriate hospital. Receiving hospital may question transferring hospital with respect to other hospitals contacted to confirm that nearest appropriate hospital contacted when the transfer exceeds 50 miles.

- If requested by the receiving hospital, the transferring hospital must take patients back once the patient's emergency medical condition has been stabilized and no longer needs higher level of care.

- Duties of transferring and receiving hospitals need to be better defined.

- Next Steps:

  - Send issue of transferring hospital's duty to maintain on-call list that best meets needs of hospital patients to on-call subcommittee.

  - Send issue of differences in transfers during weekdays vs. weeknights and weekends to on-call subcommittee.

  - Research how Florida law requiring transferring hospital to take patient back once receiving hospital has stabilized is working.

  - Donna Smith will research whether a hospital has a duty to accept a patient when the only reason for the transfer is the transferee hospital's lack of bed space.

3. Next Steps

- Julie Nelson will revise "Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers" document to reflect comments from meeting and e-mail to subcommittee members.

- Revised document should be reviewed by the rest of the committee and any comments submitted to Julie Nelson.

- Although next week's call is cancelled, will use e-mail to get through some of the issues that were to be discussed.

4. Adjourn: 5:06 p.m. EST

APPENDIX 2
(continued)

EMTALA TAG MEETING

Date: Thursday, October 19, 2006

Time: 4:00 p.m. EST

Members Present: Julie Nelson; Azzie Conley; S.R. Thorwards, M.D.; Mike Rosenberg, M.D.; Richard Perry, M.D.

Others Present: George Morey, CMS; Donna Smith, CMS; Marilyn Dahl, CMS; Edith Hambrick, CMS, Heather Boysel, Extern

Minutes:

1. Administrative Issues

    - Deadline for attachments at TAG meeting is 10/25

2. Substantive Issues: Hospitals with Specialized Capabilities

    A. EMTALA Education Recommendations

        - Standardized Regional Office/State Surveyor Education

            - Discussion Items:
                - Recommend CMS monitoring function.
                - Central office is currently looking at ways to make surveyor interpretation/enforcement more consistent.
                - There may be less resource-intensive ways to flag trends among regions; CMS should have flexibility.
                - Since 2000, surveyor education has taken place every two years.
                - Right now it is not possible to do annual education sessions due to lack of resources.
                - Annual education is important because of problem with inconsistent regional application.
                - Hospitals are expected to educate their personnel annually on compliance issues .
            - Consensus:
                - New Recommendation: CMS central office to establish a system to enhance the consistency of the standards within the regions.

- Next Step:
  - Julie Nelson will update EMTALA Education Recommendations to reflect consensus.

- Patient Education

  - Discussion Items:
    - Who would be responsible for patient education?
    - Should this be put on CMS website for Medicare beneficiaries?
      - Point out that there are different levels of care and explain what each level does.
    - Important to educate patients that hospital requests for social security numbers and citizenship documentation as part of §1011 do not constitute violations of EMTALA.
  - Consensus:
    - Keep patient education recommendations as stated, but we may need to explore § 1011 requirements in more detail.
  - Next Step:
    - Send recommendations to rest of committee to confirm consensus on this issue.

B. Duty of Hospitals w/ Specialized Capabilities – Duties of Transferring Hospitals

- Duty to maintain on-call lists.
  - Discussion Items:
    - The present concern is that there are excessive transfers due to insufficient on-call list.
  - Consensus:
    - None.
  - Next Steps:
    - Send this issue to on-call subcommittee.
- Duty to provide appropriate MSE and care within capabilities until patient is transferred.
  - Discussion Items:
    - Example: Severe head trauma patient may require at least open airways.
    - Some patients require some stabilization services prior to transfer and transferring hospital should do as many of these things as they can to stabilize the patient before transferring.
    - The language of the recommendation should identify what is emergently germane at the moment and what is not.
    - The goal of this recommendation is to reduce the need to transfer patients and the amount of stabilizing care the receiving hospital is responsible to provide.

- Suggestion: Hospital is expected to complete all reasonable stabilization steps as long as it does not delay necessary life-saving care.
    - Would this create a problem of jeopardizing patient care because the transfer is delayed?
    - The decision to transfer is based upon medical judgment.
    - Is "life threatening" condition a new standard that would be created by this?
- The main concern here is that a hospital will neglect necessary services because it has an excuse to transfer. An example is when x-ray machine down. Sometimes the x-ray is not the most germane issue and outcome could be that x-ray showed everything to be fine.

▪ Consensus:
- Hospital is expected to complete all reasonable stabilization steps as long as it does not delay necessary life-saving care.
- The language should state that the physician still has the ability to make a medical judgment.

▪ Next Steps:
- See if TAG and CMS like this concept and the language can be worked out at a later date.

o Decision as to whether or not to transfer may not be based on insurance status/financial means (number of transfers of patients without insurance evidences possible abusive transfers.)

▪ Discussion Items:
- One of the issues here is psychiatric programs where decision to transfer can be based on financial issues.
- Don't want to unintentionally place patient's family under financial duress by not explaining financial consequences of different facilities.
- Should share financial issues with family in allowing them to make decision of where to transfer when it is a patient request transfer, rather than a certified transfer.
- Will the need to explain the financials of transfers lead to a delay in services overall?
- This is generally a psychiatric patient issue and comes up often.
- Once patient is "stabilized," financial information would be very important when considering where to have next procedures done.
- Do managed care contracts make difference in price to patient?
- Is it hospital's responsibility to know where cheapest place is for patient to go?

- Suggestion: Don't require hospitals to discuss financial impact of where to transfer, but permit hospitals to discuss this with patients without violating EMTALA.
    - At what point can you have that conversation? Can discuss this once the patient "stable for transfer." However, definition of "stable" is very murky.
    - Compromise could be to state that treatment is not contingent on ability to pay.
- Explore concept of community protocols as an exception to the rule.
- Could make this rule only apply to certified transfers and not patient request transfers.
- Sometimes patient doesn't want to be at the hospital they are taken to and may want to be transferred.
- Does receiving hospital have an obligation to accept patient request transfers?

▪ Consensus:
- Don't require hospitals to discuss financial impact of where to transfer, but permit hospitals to discuss this with patients without violating EMTALA.

▪ Next steps:
- Send to rest of committee for review.

o Appropriate Transfer

▪ Discussion Items:
- It is difficult for a hospital to be found to lack capacity, but there are certain things that make lateral transfers appropriate transfer.
- Need to distinguish between appropriate transfer and duty to accept.
- This issue is being looked at by CMS.
- If a hospital is truly not capable of dealing with an EMC, lateral transfer should be mandatory on receiving hospital.
- However, there is a concern of abuses by transferring hospitals.
- The test for lack of capacity is a stringent standard, so receiving hospitals should have duty to accept.
- The program memo and current interpretive guidelines on this issue are confusing, should be reviewed to better explain appropriate transfers.
- Test could be that transfer is appropriate if there is an "insurmountable barrier."
- The problem here could be just that language is not clear, but policy is okay.

▪ Consensus:

        - Program memo and current interpretive guidelines on this issue are confusing.
    - Next Steps:
        - Program memo and current interpretive guidelines should be reviewed to better explain appropriate transfers.

3. Next Steps

- Julie Nelson will make changes consistent with consensus from this meeting and re-circulate through email to committee.

5. Adjourn: 5:06 p.m. EST

APPENDIX 2
(continued)

EMTALA TAG
ACTION SUBCOMMITTEE TELEPHONE CONFERENCE

Date: Thursday, October 26, 2006

Time: 4:00 p.m. EST

Members Present: Julie Nelson; S.R. Thorwards, M.D.; Dodjie Guioa; Richard Perry, M.D.; Mark Pearlmutter, M.D.

Others Present: George Morey, CMS; Edith Hambrick, CMS; Heather Boysel, Extern

MINUTES:

1. Administrative Issues

- All documents must be completed and sent to CMS by close of business Friday, October 27, 2006 in order to be included in the TAG binders. Alternatively, members may present materials as handouts at the TAG meeting (30 copies, and CD format for CMS).

2. Substantive Issues:

A. Patient Parking Program Memorandum

- Issue: The TAG received public testimony opposing the memorandum, therefore the subcommittee needs to review this concern.
- Discussion Items:
  - Technically, the program memorandum reflects a correct interpretation of EMTALA, but places burdens on hospitals that are overcapacity.
  - The memorandum was originally developed in 2003 by Region VI with hospital association and provider input.
  - Initial intent was not to place burdens on hospitals that lacked the capability to offload patients immediately. To apply, the patient must have an EMC and the hospital must have the capability to promptly off-load patients. It was not designed for the situation where multiple ambulances arrive at the same time or the hospital is experiencing an ED overcrowding situation.
  - Arizona has an issue with hospital overcapacity and it is often hard to promptly off-load ambulances.

    - It would be helpful to provide guidance to clearly state the exceptions to CMS' general rule, including overcapacity constraints.
    - How can surveyors tell the difference between legitimate waiting and illegitimate waiting? Surveyor will look to see if all available resources were being used.
- Consensus:
    - Action subcommittee agrees with the program memorandum, provided that there are adequate exceptions for situations where hospitals cannot comply. Recommend that CMS revise the program memorandum to clearly state these exceptions.
- Next Steps:
    - Dodjie will put together bullet points to incorporate into the existing program memorandum to further explain the intent behind the rule and exceptions.

B. Duty of Hospitals to Accept Patient Transfers

- Determining Capabilities of Transferring Hospital
    - Discussion Items:
        - Recommendation: In determining whether hospital has the capabilities to provide stabilizing care to the patient, surveyors look at capabilities of hospital at the time of the transfer and period thereafter consistent with the patient's "window" for required emergency care. Availability of additional care that will be or may be required once the patient's emergency medical condition is stabilized is not a basis for determining that the hospital lacked the capability to stabilize the patient's EMC.
        - The old interpretive guidelines state that the receiving hospital has a duty to treat reasonably foreseeable complications of the EMC.
        - Concern over a patient who requires appendectomy, and surgeon can't be there for two hours, so hospital decides to transfer, even though the patient could have been stabilized two hours later (condition not require immediate surgery).
        - Want to avoid every patient being sent to level one trauma centers because one aspect of care is not available at the transferring hospital.
        - This recommendation would be the flip side of the old interpretive guidelines in requiring transferring hospital to treat what they can treat to prevent an abuse without hampering patient care. Hospital should look to see if they have the capability to treat patient within the patient's window of time for treatment.
        - Don't want to extend duties beyond stabilization.
        - The transferring physician must make a medical judgment that patient should be transferred because EMC requires more immediate treatment.

        - Could tie back to treating physician's judgment. Want hospitals to keep patients if they will have the capabilities within the patient's treatment window.
        - Could be tied into following transferring hospital duty:
            - Provide appropriate medical screening examination and stabilizing care within the transferring hospital's capabilities prior to transfer, in accordance with 42 C.F.R. 489.24(d)(1) and (e)(2)(i). [Note: recommend revising (e)(2)(i) to state that the "transferring hospital provides medical treatment within its *capability*" (instead of "capacity).]

              The extent of the medical screening examination and stabilization will depend on the patient's needs and the hospital's capabilities. When determining a hospital's capabilities, the critical question is whether the hospital has the capabilities to provide the services that are necessary to stabilize the patient's emergency medical condition. It would not be acceptable for a hospital to transfer a patient solely because it does not have capabilities that the patient requires, but are not essential to stabilize the patient's emergency medical condition. When the hospital does not have the capability to completely stabilize the patient's emergency medical condition, the hospital must complete all necessary stabilizing steps within its capability unless doing so would cause an undue delay in the patient's care and transfer (*e.g.*, severe head trauma patients that do not present to a trauma center may require basic stabilization, then transfer).
        - The above recommended duty, however, does not address the timing issue. If a hospital believes that it has been dumped on, this can be explored in the survey process.
        - Some examples, such as appendectomy example, would be helpful. Hospitals shouldn't use the excuse to transfer that a physician is not currently there or that MRI will be back up in 45 minutes.
    - Consensus:
        - When looking at hospital's capabilities, take into consideration time frame for patient's needs.
    - Next Steps:
        - Julie Nelson will revise this section of the document to reflect the subcommittee's consensus.
- Taking Distance into Consideration for Transfers
    - Discussion Items:
        - Recommendation: The transferring physician must take into account the distance that the patient will travel in his/her certification that the benefits of the transfer outweigh the risks. If

the transfer distance will exceed 50 miles, the transferring hospital must attempt to transfer patients to the nearest appropriate hospital. Receiving hospital may question transferring hospital with respect to other hospitals contacted to confirm that nearest appropriate hospital contacted when the transfer exceeds 50 miles.
        - This could give receiving hospitals reason to delay patient care because receiving hospital can question transferring hospital.
        - This is more of an issue in the Southwest. This is concerning truly long-distance referrals.
        - Recommendation: Change last sentence to say "Surveyors may look into . . ."
        - Recommendation: Delete the last sentence.
    - Consensus:
        - Will bracket to show that this is under discussion and defer to TAG.
    - Next Steps:
        - Julie Nelson will incorporate this change into document for TAG.

- Duty to accept unstable patients.
    - Discussion Items:
        - Initial Recommendation: Only required to accept unstable emergency department patients when transferring hospital does not have the capability to provide stabilizing care.
        - Not talking about patients who are truly stable.
        - Suggestion: Change to "patients who cannot be stabilized at the transferring hospital."
    - Consensus:
        - Only required to accept patients that the transferring hospital is not capable of stabilizing.
    - Next Steps:
        - Julie Nelson will incorporate this change into document for TAG.

- Patient Request Transfers
    - Discussion Items:
        - Recommendation: No obligation to accept if SOLE basis for the transfer is patient request (must be physician certified of higher level of care).
    - Consensus:
        - No obligation to accept if only basis for the transfer is patient request (must be physician certified of higher level of care).
    - Next Steps:
        - Accept recommendation.

- Basis for Transfer is Lack of Capacity
    - Discussion Items:

        - Recommendation: No obligation to accept if the basis for the transfer is lack of capacity, with the exception of when the transferring hospital faces an insurmountable barrier to providing care (*e.g.*, surge capacity, disaster, lack of critical equipment because equipment is down).
        - Capacity is different than capability.
        - When a hospital experiences typical lack of capacity, it is required to just make do.
        - What about when your hospital is at inpatient capacity and another is not? This will not prevent a transfer, but will not impose a duty on receiving hospital.
        - Ex. Cardiac patient for whom hospital has done everything they can and have no beds? Concern here is that everyone is already over capacity. Don't want hospitals to be too quick to transfer patients to other hospitals at capacity.
        - Surveyor can look to see whether hospital has done everything possible. If not, the transfer would not be appropriate.
        - Whether or not hospital truly lacked capacity is handled by the "insurmountable barrier" exception outlined in the proposal.
        - Problem with requiring a receiving hospital to go above its capacity in order to comply with duty to accept.
        - Don't want critical patients to remain in ER and receive sub-optimal care. Want these patients to be transferred to the appropriate care setting.
        - Provide more examples to clarify recommendation.
        - Concern is that receiving hospitals will be looked at taking into consideration what they have done previously to deal with.
        - Hospitals should not have an obligation to accept a patient when only have one bed and need to account for the receiving hospital's own needs.
        - Don't want hospitals to transfer solely based on capacity issues – the patient must have an EMC as well.
    - Consensus:
        - Revise recommendation to clarify intent.
    - Next Steps:
        - Julie Nelson will revise document to reflect intent.
- Time Frame to Accept/Reject
    - Discussion Items:
        - Recommendation: Receiving hospital must accept/reject transfer within a "timely" manner.
        - Problem is that hospitals are not refusing transfers, but are accepting or rejecting within a timely manner (passive refusal).
        - Hospitals should have communication systems in place to determine whether can accept in a timely manner.
        - Should be a very short timeframe.

        - Acceptable timeframe would be 20 minutes – 1 hour. One hour should be enough time.
        - Need to specify that this is the decision whether to accept.
    - Consensus:
        - Agree with recommendation, but further clarify timeframe and that this is regarding the decision whether or not to accept, not timeframe for when receiving hospital actually accepts the patient.
    - Next Steps:
        - Julie Nelson will revise document to reflect clarifications.
- Cost of Transfer
    - Discussion Items:
        - Recommendation: Consider: Transferring hospital must pay for the cost of the transfer to the receiving hospital if the cost of transfer is not reimbursed by the patient's insurance carrier, a federal or state health care program, or the patient.
        - This is already addressed in statute - § 1395dd(d)(2)(B).
    - Consensus:
        - None.
    - Next Steps:
        - Include in final report for TAG consideration.

C. Psychiatric Issues

- Discussion Items:
    - Definition of EMC as it relates to psychiatry
        - Current regulations provide what is considered is a psychiatric EMC
        - Want to add term "gravely disabled" to the current definition
        - "Gravely disabled" is relatively common term – means danger to oneself due to extremely poor judgment or inability to care for self.
        - Also include a definition of gravely disabled.
        - This would be in the interpretive guidelines.
    - Community protocol concept
        - There are some cases where psychiatric patients are transferred based on insurance participation in state program.
        - Several states have a single point of entry system as a protocol. If the single point of entry is not a hospital, would not be a problem.
        - This is meant to deal with situation where hospital does have psychiatric facility, but want to move patient based on financial issues consistent with the state protocol.
        - Some places patient cannot go to state facility without going through state hospital. This is a common paradigm.
        - Don't want EMTALA to prevent hospitals from doing what they are supposed to do under state law in transferring to state facility.
    - Hospitals bylaws should be allowed to define who can perform MSE for psychiatric issues.

        - Governing body has the responsibility for determining who are QMP's.
        - As long as permitted under license, this is allowed.
        - Prevents requiring law to account for who is QMP, which may vary from state to state
- Consensus:
    - Change definition of EMC pertaining to psychiatric patients to include "gravely disabled" and a definition of "gravely disabled."
    - Community protocol concept: EMTALA does not prevent hospitals from transferring psychiatric patients based on insurance participation in state program.
    - Hospitals bylaws may define who can perform MSE for psychiatric issues consistent with state licensing scheme.
- Next Steps:
    - Mark Pearlmutter will put together a document that outlines these recommendations for the TAG's consideration.

3. Next Steps

- Dodjie Guioa will put together Patient Parking Program Memorandum with bullet points to explain intent of and exceptions to rule.
- Julie Nelson will update TAG Action Subcommittee recommendations.
- Mark Pearlmutter will put together document outlining psychiatric recommendations for TAG's consideration.

6. Adjourn: 5:05 p.m. EST

APPENDIX 3

The following memo from Dodjie Guioa, Hospital/EMTALA Lead for CMS Region VI, was drafted by an EMTALA TAG member to assist the EMTALA TAG in deliberation. It does not represent official CMS policy.

APPENDIX 3

DRAFT: FOR EMTALA TAG DELIBERATION ONLY

Date: October 27, 2006

To: EMTALA TAG Members

From: Dodjie B. Guioa
Hospital/EMTALA Lead
CMS Regional VI

Subject: EMTALA – "Parking" of EMS patients in hospitals

BACKGROUND

My office issued the original letter (Attachment 1) on March 20, 2002 to address specific concerns from EMS and hospital providers voiced during the TX Governor's Trauma Advisory Committee that CMS Region VI was invited to participate. The specific concern was that hospital ED staff deliberately delay the transfer of individuals from the EMS provider's stretcher to an ED bed with the impression that the ED staff is relieved of their EMTALA obligation by doing so. It was reported that there were ED staff (physicians and/or nurses) available for patient care in majority of the occasions where the delay of transfer was done. The letter was mailed to all the hospital associations in Region VI.

The letter was published on a couple of national EMS publication after it was released, and my office fielded questions for clarification from various States across the nation, including graduate students from New Jersey, New York and Washington.

My office forwarded a copy of that letter to CMS Region IV in late 2005 at their request and the letter was subsequently mailed out to CMS Region IV hospitals (Attachment 2) in December 2005.

That letter was brought up during a Hospital Open Door Forum. CMS Central Office subsequently released a revised version of the above letters as an S & C Letter (06-21) (Attachment 3) in July 2006.

DRAFT: FOR EMTALA TAG DELIBERATION ONLY

ENFORCEMENT

The intent of our March 20, 2002 letter and the S & C Letter 06-21 (Letters) is to ensure that any individual presenting to the dedicated ED of a hospital receives, in a timely manner, an appropriate medical screening examination (MSE) and/or stabilizing treatment of an emergency medical condition in accordance with the individual's presenting symptomatologies depending on the hospital's capacity and capability at the time of presentation.

It was not the intent of the Letters to obligate hospitals to take immediate possession of an individual from EMS provider staff when the hospitals do not have the capacity or the capability at the time of presentation. However, the individual should be seen in accordance with the hospital's triage policy, as should any individual who presents in the ED. For example, if the EMS provider brought an individual to the dedicated ED at a time when the ED staff were occupied dealing with a trauma case, it is reasonable that the EMS provider staff has to stay with the individual and wait until such time that there are ED staff available to care for that individual. However, an ED staff still needs to examine the individual to ensure that the individual's condition does not require an emergent intervention and assure that the EMS provider staff can appropriately monitor the individual's condition.

The Letters were intended to clarify that a hospital practice of deliberately delaying the provision of an appropriate MSE and/or stabilizing treatment by refusing to take responsibility for the patient upon presentation and a request for examination and/or treatment of a medical condition was made. When individuals arriving via EMS providers are required to wait several hours with only EMS provider staff attending to them, then this practice maybe viewed as a violation of the EMTALA requirements. The practice in question, in addition to raising patient safety and quality care concerns, also could create community concern about the availability of EMS services, due to the ambulance units being forced to stay at the hospital for a prolonged period of time.

It was not the intent of the guidance in the Letters that there should be enforcement action against any hospital when the delay in the immediate provision of an appropriate MSE and/or stabilizing treatment is due to circumstances beyond the hospital's control.

APPENDIX 4

APPLICATION OF EMTALA IN A STATE OF EMERGENCY

DRAFT

CURRENT RULE:

42 C.F.R. 489.24(A)(2)
Sanctions under this section for inappropriate transfer during a national emergency do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act.

42 U.S.C. § 1320b-5 (SSA § 1135)
Sanctions under section 1395dd [EMTALA] for a transfer of an individual who has not been stabilized in violation of subsection (c) of such section [may be waived] if the transfer arises out of the circumstances of the emergency. The waiver is limited to a 72 hour period.

NEED FOR CHANGE:

EMTALA currently exempts hospitals and physicians from EMTALA enforcement for violations of the EMTALA provisions governing appropriate transfers in a national emergency. This provision does not exempt EMTALA enforcement in a state or city government emergency, or hospital-specific emergency, that may similarly impact a hospital's or physician's ability to comply with the EMTALA requirements. Disasters or other emergency situations that may impact a hospital's ability to comply with EMTALA may occur at various levels, and not all disasters give rise to a national emergency.

The provision is likewise limited to CMS/OIG enforcement, not private right of actions against hospitals, and is limited in the EMTALA requirements that may be waived (transfers) and duration (72 hours). As we have learned from Katrina and other types of disasters, a hospital's or physician's ability to comply with EMTALA may extend beyond the EMTALA transfer requirements and exceed 72 hours.

The same concerns that prompted CMS to exempt hospitals and physicians from EMTALA compliance in national emergencies apply equally in state or state of city government emergencies when hospitals cannot comply with the EMTALA provisions as a result of the state of emergency. The Action Subcommittee therefore recommends significant expansion of the EMTALA waiver provisions to provide protection to hospitals and physicians who are in an emergency situation or emergency area and whose ability to comply with EMTALA is compromised by the emergency situation. The Action Subcommittee's specific recommendations are set forth below.

ACTION SUBCOMMITTEE RECOMMENDATIONS:

1. Emergency Situations Eligible for Waiver. The Action Subcommittee recommends expansion of the existing waiver provisions to include: (1) declared national, state, and county and city government emergencies, and (2) hospital-specific emergencies as determined by CMS/OIG on a case-by-case basis. Hospital-specific emergencies may include, for example, hazardous material spills, utility failures, bomb threats, surge capacity, localized flu epidemic. The Action Subcommittee recommends that the waiver be a complete and automatic waiver for hospitals located in government declared national, state, and city government emergencies that impact a hospital's ability to comply with EMTALA (and when the hospital is located in the national, state, and city emergency area). For individual hospital emergencies, CMS may grant waivers concurrently or retrospectively on a case-by-case basis.

2. Application to Hospitals and Physicians. The Action Subcommittee recommends that the waiver apply to both hospitals and physicians, for purposes of both CMS/OIG enforcement and private right of actions.

3. EMTALA Provisions Eligible for Waiver. The specific provisions of EMTALA that may be waived include:

A. Medical screening examination. Hospitals are still required to provide a medical screening examination in an emergency situation, but the determination of whether the medical screening examination was "appropriate" is based on the hospital's resources at the time of the emergency and the care provided to other patients during the emergency situation. A hospital cannot discriminate against patients based on their ability to pay during an emergency situation.

B. Qualified Medical Personnel. The hospital should be permitted to use persons not normally deemed to be qualified medical personnel to provide medical screening and stabilization services (*e.g.*, RN medical screening examinations, consistent with state scope of practice). [Alternative: provided that hospitals state in their "emergency" or "disaster" plans the additional categories of personnel capable of providing a medical screening examination in an emergency situation.]

C. Stabilization. In an emergency situation, it may be in the patient's best interest for the patient to be promptly transferred to another hospital, even though the hospital might be technically capable of providing stabilizing care (*e.g.*, need to prioritize who receives patient beds based on patient acuity when there is an expected/unexpected surge).

D. Transfers. In an emergency situation, it may not be possible for hospitals and physicians to complete transfer documentation (*e.g.*, physician certification form) or obtain/send the necessary transfer documentation or ensure that the patient is transferred (appropriately). In extreme situations, ambulances may not be available, for example. Hospitals and physicians should not risk EMTALA sanctions in this situation.

E. Duty to accept transfers. A hospital in an emergency situation is not required to accept patients from other hospitals even though the hospital may have the "specialized capabilities" that the patient requires and the capacity to provide care.

4. Patient Safety Protections. The Action Subcommittee recommends that patient safety protections be part of any waiver provision. These protections may include, for example:

A. The hospital/physician must be experiencing the emergency or located in the emergency area;

B. The emergency must interfere with the hospital's/physician's ability to comply with EMTALA.

C. The waiver is limited only to those specific EMTALA provisions with which the hospital/physician is unable to comply due to the emergency situation;

D. The hospital/physician applies the same criteria for providing care to all patients presenting with an emergency medical condition during the emergency;

E. The hospital/physician develops criteria for care based upon providing the best response reasonably practicable in the emergency situation;

F. The hospital/physician takes reasonably practicable steps to assure that patients receive appropriate screening and stabilization services at another facility;

5. Term of Waiver. The Action Subcommittee recommends that the waiver continue until the hospital is no longer in an emergency situation or the government-declared emergency has been terminated.

APPENDIX 5

FOLLOW-UP CARE

DRAFT

CURRENT RULE:

Interpretive Guidelines, Tag A407

"For those individuals whose EMCs have been resolved the physician or QMP has several options:

- Discharge home with follow-up instructions. An individual is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the individual has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions. The EMC that caused the individual to present to the dedicated ED must be resolved, but he underlying medical condition may persist. Hospitals are expected within reason to assist/provide discharged information with the necessary information to secure the necessary follow-up care to prevent relapse or worsening of the medical condition upon release from the hospital; or
- Inpatient admission for continued care."

NEED FOR CHANGE:

The current guidance with respect to a hospital's and physician's obligation to provide follow-up care to patients is not entirely clear. The interpretive guideline's reference to patients whose emergency medical conditions have been resolved seems to refer to stable patients, in which case EMTALA would no longer apply, yet seems to impose additional EMTALA obligations with respect to these patients' follow up care. The Action Subcommittee believes that hospitals and physicians need better guidance with respect to their obligations with respect to follow up care.

RECOMMENDATION:

The Action Subcommittee recommends that the EMTALA Interpretive Guidelines be amended with respect to follow-up care to clarify that once a patient has been stabilized, the hospital and physician have no further follow-up care obligation under EMTALA. The hospital must, however, comply with applicable Medicare Conditions of Participation. We believe that this interpretation is more consistent with the EMTALA statute and regulations, which no longer apply once the patient is stabilized and current CMS interpretation.

EDUCATION:

Although the Action Subcommittee believes that EMTALA does not impose any hospital or physician follow-up care obligations once a patient has been stabilized, the Subcommittee believes that hospitals nevertheless need additional education on follow-up care options and best practices with respect to patients whose medical conditions, although stable, may require follow-up care. Accordingly, for education purposes, the subcommittee provides the following list of potential follow-up care options.

- Provide the patient with a list of physicians or facilities known to provide care to the patient given the patient's insurance status (together with a plan of care and recommended timeframe to receive follow-up care);

- For insured patients, instruct the patient to contact their personal physician or health plan for a list of physicians who can provide the necessary care within the desired timeframe;

- Arrange an appointment for the patient;

- Obtain on-call physician consent to provide follow-up care and instruct patient to follow-up with on-call physician (may be done on a case-by-case basis or through a bylaw requirement);

- Notify the patient of the recommended plan of care and timeframe, and instruct the patient that if they cannot receive care within the timeframe to return to the hospital emergency department (or other hospital department or clinic) for definitive care; OR

- Any other action reasonably designed to prevent relapse or worsening of the patient’s medical condition upon release from the hospital.

APPENDIX 6

EMTALA EDUCATION RECOMMENDATIONS

DRAFT

1. More Comprehensive CMS Website That Includes:

   A. Statutes
   B. Regulations
   C. Interpretive Guidance
   D. Current CMS/OIG Program Memoranda/Guidance Letters
   E. EMTALA Questions and Answers
   F. Link to Medicare Conditions of Participation
   G. Enforcement Statistics
   H. "Top 10" Cited EMTALA Deficiencies
   J. Special Advisories of Potential EMTALA Violations

2. Standardized Regional Office/State Surveyor Education

   A. Annual EMTALA surveyor education sessions (currently offered every two years)
   B. Establish a system to improve consistency in regional office EMTALA interpretations and enforcement (*e.g.*, assign CMS central office person to monitor deficiency statements for consistency with CMS policy and consistency among jurisdictions and remedy concerns).

3. Provider Education

   A. Designate/approve specific CMS personnel to participate in provider education through various educational forums (*e.g.*, AHLA, hospital/physician association meetings). Establish process to ensure consistency of information provided.

   B. Timely response to provider queries regarding EMTALA compliance and interpretation questions.

   C. Establish a process to address new obstacles to EMTALA compliance and remedy through regulatory or interpretive guidance change.

4. Patient Education

   A. Health care destination options and appropriate level of care rendered each designation (*e.g.*, emergency department, urgent care center; clinic; physician office).

B. EMTALA rights and consequences (*e.g.*, EMTALA requires hospitals to provide care irrespective of the patient's ability to pay, however, the hospital may still expect the patient to pay for services rendered).

C. Hospitals may request social security numbers and citizenship documentation in order to receive payment for care rendered to undocumented patients (Section 1011 requirements).

D. [other]

APPENDIX 7

This appendix contains testimony and supporting materials from Air Evac Lifeteam that includes correspondence with Thomas A. Gustafson, Ph.D., Deputy Director of the Center for Medicare Management, and Colleen Sandman, RN, Acting Manager of the Survey and Certification Branch. Dr. Gustafson's and Ms. Sandman's responses to individual letters do not constitute the kinds of statements of national policy that are made by Federal regulations, interpretive guidelines, or Survey and Certification letters.

APPENDIX 7

EMTALA TECHNICAL ADVISORY GROUP MEETING
NOVEMBER 2-3, 2006

STATEMENT OF AIR EVAC LIFETEAM

Hello, my name is Seth Myers, RN, BA, MBA, CMTE, and I am the Vice President of Operations for Air Evac Lifeteam ("Air Evac"). Air Evac is an independent provider of air ambulance services. Air Evac was founded in 1985 in West Plains, Missouri by a group of private citizens who were interested in providing the people in their community better access to emergency medical care. Since its inception, it has been Air Evac's mission to provide affordable and quality air ambulance services to rural communities, closest to people who are great distances from cities with definitive care, where air ambulance transport is often needed the most.

Air Evac EMS, Inc. was incorporated in June of 1985 and placed its first helicopter into service at Ozarks Medical Center. Air Evac has since expanded its operations to multiple rural areas that benefit from air ambulance care. Currently, we have 69 bases in 12 states throughout the central United States. Air Evac is a licensed air ambulance provider in Missouri, Arkansas, Oklahoma, Virginia, Tennessee, Mississippi, Illinois, Kentucky, Iowa, Alabama, Indiana, and Texas.

We appreciate the opportunity to present testimony today to the EMTALA Technical Advisory Group ("TAG"). We are present today to discuss an issue that we have been facing for the past several years regarding the appropriate transfer of patients from one hospital to another. Over the past two years, we have seen the troubling practices we will describe continue to occur, and on a more frequent basis and in more locations. We have contacted the appropriate Centers for Medicare & Medicaid Services ("CMS") Regional Office, as well as the Deputy Director of the Centers for Medicare Management ("CMM"), Thomas A. Gustafson, Ph.D. Our correspondence with CMS is attached to this testimony for your information. Our testimony will illustrate for the TAG what we consider to be inappropriate practices on the part of recipient hospitals with regard to the appropriate transfer of patients under the EMTALA statute at section 1867(c)(2) of the Social Security Act and regulations at 42 C.F.R. § 489.24(e)(2), and will make recommendations for clarifying providers' obligations under these circumstances.

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, the hospital must provide either appropriate treatment to stabilize the condition or for the appropriate transfer of the patient to another medical facility. To appropriately transfer a patient to another facility, EMTALA requires that the recipient hospital has the capacity and qualified personnel for the treatment of the patient and that the recipient hospital agrees to accept the transfer of the patient and provide such appropriate medical care.

The EMTALA Interpretive Guidelines ("IGs") further expand on this requirement.[1] Under Tag A409, the sending hospital is responsible for ensuring that the transfer is completed appropriately.[2] More specifically, "[t]he physician at the sending hospital (and not the receiving hospital) has the responsibility to determine the appropriate mode of equipment, and attendants for transfer."[3] Although the IGs do not expressly state whether or not the designation of a particular ambulance provider is within the discretion of the attending physician and/or the sending hospital, "a recipient hospital may not refuse to accept a patient protected under EMTALA if it does not approve of the method of transfer approved by the attending physician at the sending hospital."[4] The discretion under which the recipient hospital may refuse a patient protected under EMTALA is based on whether or not the facility does not have the capacity or the capability to appropriately treat the patient. As such, if a hospital engages in the practice of refusing to accept an appropriate transfer based solely on the patient's mode of transportation, the recipient hospital should be in violation of EMTALA.

Today, we want to bring to the TAG's attention instances of such practices that are having a detrimental impact on patient care and should be considered violations under EMTALA. Over the past several years, in several of our service regions throughout the country, receiving hospitals have begun refusing to accept transfers of patients from other institutions unless the sending hospital agrees to use the receiving hospital's air medical services ("AMS") provider to transfer the patient. Our anecdotal evidence is that this occurs twice a week, on average, in our service area.[5] On many occasions, this has occurred after Air Evac is already on route to or has arrived at the sending hospital. Consequently, if the sending hospital yields to the receiving hospital's demand, the patient's transport is then delayed for the length of time it takes the receiving hospital's helicopter to leave its base and fly to the sending hospital. In nearly all examples of these situations, the sending hospital yields to the demands of the receiving hospital, thereby, resulting in a delay in transport and of necessary medical care for the patient.

This practice quite clearly implicates EMTALA, in addition to raising a number of serious concerns about patient care. By requiring that the sending hospital use only the recipient hospital's helicopter, the sending hospital is placed in the difficult position of having to decide whether the patient's condition will allow for a delay in the transport and, if not, finding another receiving hospital, which also causes delay. Furthermore, if the receiving hospital as a policy conditions all transfers of emergency patients on the use of its own helicopter for the transport, sending hospitals are then required to use the receiving hospital's helicopter even if there is another helicopter in closer proximity to the sending hospital. Such a policy is unreasonable at best and impedes on the sending

[1] State Operations Manual, Appendix V – Responsibilities of Medicare Participating Hospitals in Emergency Cases.
[2] Id.
[3] Id.
[4] Letter from Deputy Director, Center for Medicare Management, Thomas A. Gustafson, Ph.D, to Seth Myers, Vice President of Operations, Air Evac EMS, Inc. (Aug. 2, 2006).
[5] If it would be helpful to the TAG, we would be happy to make available specific examples of the scenarios that we have experienced.

hospital's ability to comply with the requirements for arranging an appropriate transfer – an obligation that the sending hospital must satisfy under the EMTALA statute and regulations. Although there are circumstances where specialized AMS of the receiving hospital may be necessary, such as with pediatric hospitals, in most instances there is no valid reason for a hospital to insist on using its own transport service.

In essence, the actions of the recipient hospital implicate EMTALA and are an EMTALA violation because there has been a refusal by the recipient hospital to accept the patient not based on capacity or capability. While the sending hospital "cures" the refusal by acceding to the recipient hospital's demands, it does not change the fact that there was an EMTALA violation – a prohibited refusal of a transfer request. Such a refusal is aggravated by the fact that it appears to be financially motivated and not based on medical judgment or patient medical condition. Such a conditional acceptance is essentially a constructive transfer denial and a forced reformation of the transferring hospital's request for transfer.

In effect, what is occurring is that the care of the patient is being determined based on the receiving hospital's financial interests, even though a duly-qualified and licensed AMS provider in closer proximity to the sending hospital is available to transport the patient and has been called. Given that patient care decisions, especially in emergency situations, must be based on the best medical interests of the patient and not the financial interests of the hospital, we believe it is inappropriate medically, ethically, and legally for a receiving hospital to condition acceptance of a patient on the use of their own transportation. This is particularly true when this decision could delay emergency treatment for the patient. Under certain circumstances, the delay in treating the patient could be a violation of EMTALA, in addition to being generally inconsistent with providing high quality patient care.

These practices contradict the intent of EMTALA, which is to ensure that any patient in an emergency situation is provided appropriate medical care by facilities that have the capacity and personnel to provide such care without delay and without regard for financial interests. Because the practice of these receiving hospitals goes against the underlying anti-discrimination and anti-financial incentive principles of the EMTALA statute and regulations and seems to have become routine practice for some receiving hospitals, we believe that this matter should be addressed by both the TAG and CMS.

We urge the TAG to review the EMTALA statute and regulations in light of the issues that we have presented and to advise CMS on how to curb these practices by receiving hospitals. We believe that CMS should take steps to provide guidance to participating providers about their obligations under these circumstances as either a published Frequently Asked Question ("FAQ") or other type of guidance document made available to providers, as well as through revisions to the IGs and the regulations. CMS must clarify that receiving hospitals may not arbitrarily deny appropriate transfers of patients protected under EMTALA simply because the sending hospital is using an AMS provider other than the receiving hospital's AMS provider. We believe these practices, which

result in a delay of necessary medical care for patients, are precisely what Congress intended EMTALA to protect against.

Thank you again for the opportunity to present our concerns at today's meeting. We would be happy to take questions at this time or in the future. If we can provide any further information regarding these issues, please do not hesitate to contact us.

AIR EVAC LIFETEAM

Office Of the Corporate Counsel 417.255.9913

November 12, 2004

COPY

Colleen Sandmann
Acting Branch Chief
Centers for Medicare & Medicaid Services (CMS)
Region IV
Atlanta Federal Center
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303-8909

Dear Ms. Sandmann,

Air Evac EMS, Inc. is an independent provider of Air Medical Services (AMS) from 40+ locations in 10 states. Air Evac is sensitive to the competitive and aggressive nature of AMS and strives to work cooperatively with other providers and institutions. Air Evac's primary purpose is to provide access to healthcare for rural patients. Recently Air Evac and patient's we have been requested to transfer, have experienced a disturbing and discriminatory practice.

On October 22, 2004, Air Evac received a report from a Registered Nurse at Baptist Hospital in Forrest City, AR that an emergency department physician had attempted to transfer a patient to the Regional Medical Center, (The Med) in Memphis, TN, about noon on this date. According to the sending and responsible physician, his patient had been accepted by a Dr. Hodges, who then reportedly stated to the sending physician, "if you are sending the patient by Air Evac, you can just turn them around because I won't accept them." The Wing AMS, based at The Med, reportedly did transfer this patient.

On October 22, 2004, at approximately 1326, Air Evac's team at Lake City, AR received a direct request call from the Ambulance Director of Arkansas Methodist Medical Center (AMCC) requesting a patient flight from AMCC to The Med in Memphis, TN. Simultaneously, it was reported to Air Evac, that the sending ED physician was arranging care for the patient at The Med with a Dr. Hodges, and Air Evac was requested to respond by the Ambulance Director of AMCC. Prior to Air Evac's team launching on the 13.7 nautical mile flight to AMCC, the team received a second call from the Ambulance Director canceling the flight request. Reportedly, according to the AMCC Ambulance Director, Dr. Hodges accepted

306 Davis Dr.,
P.O. Box 768
West Plains Mo 65775

facsimile 417.257.9125

the patient and then when informed that Air Evac was enroute to transport the patient, Dr. Hodges stated "I will not accept this patient unless The Wing does the transport." The Wing then performed the transport of this patient after arriving at the patient's bedside around 1350, after a flight of 59.1 nautical miles.

Air Evac's Director of Base Operations (West), Mr. Steve Bassett contacted Ms. Pam Castleman, Director, Emergency Trauma Center at Regional Medical Center at 1407 October 22, 2004, about this situation and was informed that she was aware of one instance and had counseled Dr. Hodges. Air Evac then spoke with the sending physician at AMCC, who stated that he was concerned about voicing any complaint as his concern was in upsetting The Med and having his patients being denied acceptance because of The Med's being upset with his transport preference.

Air Evac wishes to file a complaint that in these specific instances, and in other instances yet to be brought to light, The Med has discriminated against patients and interfered with the access to care of patients being referred to its facilities. In these two instances there was acceptance of patients solely conditioned on the receiving facilities being the transporting team. This responsibility is clearly that of the sending facility and physician. The report of the sending physician at AMCC, implies that there is a pattern of conditional acceptance of patients at The Med that demonstrates discriminatory and illegal behavior.

Air Evac is available to answer any questions and provide materials at your request.

Sincerely,

Tim Pickering
Corporate Counsel

Cc: Mr. Bruce W. Steinhauer, President, The Regional Medical Center at Memphis
Ms. Roselyn Miller, Risk Manager, The Regional Medical Center at Memphis
Mr. Steve Bassett, Director Base Operations (West) Air Evac
Mr. Seth Myers, V.P. Operations, Air Evac

File

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite. 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Ref. P..corres..air amb recip hos.

November 30, 2004

Tim Pickering
Corporate Counsel
Air Evac Life Team
306 Davis Drive
PO Box 768
West Plains, Mo 65775

Dear Mr. Pickering:

I am responding to your letter of November 12, 2004, in which you complain about The Regional Medical Center's (The Med) refusal to accept patients being transferred via Air Evac to their hospital.

The regulation under the Emergency Medical Treatment And Labor Act (EMTALA) for recipient hospital responsibilities at 42 CFR 489.24(f) states *a hospital that has specialized capabilities or facilities may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.* If the patient required the specialized capabilities of the intended receiving hospital, and the hospital has the capability and capacity to accept the transfer, but refused, this requirement has been violated.

In the cases you describe, the hospital made a statement placing a stipulation on the transfer of requiring a certain air medical service to do the transport. They didn't refuse the patient.. When this occurs, the sending hospital does not have to honor such request or demand. In your examples, the hospital did receive the patients, because the sending hospital gave in to the demand. The regulation would not have been violated in this instance. If the sending hospital tells the receiving hospital, we request to send a patient with an emergency medical condition to your hospital and the hospital (having the capability and capacity) refuses the patient, EMTALA has been violated. The sending hospital does not have to discuss the sending mode of transportation with the receiving hospital. We agree the responsibility is with the sending hospital and physician.

If you can provide instances where The Med did not accept a patient at all, please let us know. The scenarios you describe do not reflect EMTALA violations, but disagreement with the mode of transport. We encourage the hospitals to communicate to resolve such

disagreements with the consideration of promoting the highest quality of patient care in mind.

If the patient has been stabilized and has no emergency medical condition, the receiving hospital does not have to accept the patient. Thank you for your inquiry and if you have additional questions, please contact me at 404-562-7458.

Sincerely,

Colleen Sandmann

Colleen Sandmann, RN
Acting Manager, Survey and Certification Branch
Health Quality Review Specialist
Region IV EMTALA Coordinator

June 7, 2006

Mr. Thomas Gustafson, Deputy Director
Center for Medicare Management
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Mail Stop C5-01-14
Baltimore, MD 21244-1850

Re: Requirements for Air Medical Services Provided to Medicare Beneficiaries

Dear Mr. Gustafson:

We are writing to express our concern about a business practice in the air medical services industry that could affect the quality of care provided to Medicare beneficiaries and, in some cases, beneficiaries' access to care. Air Evac EMS, Inc. is an independent provider of air medical services ("AMS") from over 63 locations in 12 states. Air Evac's primary purpose is to provide access to health care for rural patients. Air Evac is sensitive to the competitive and aggressive nature of the AMS industry and strives to work cooperatively with other providers and institutions.

Recently, Air Evac and patients we have been requested to transfer have experienced a troubling practice in several service regions throughout the country. As explained further below, some hospitals are refusing to accept transfers of patients from other institutions unless the sending institution agrees to use the receiving institution's AMS provider to transfer the patient. This practice raises a number of concerns about patient care and may implicate the Emergency Medical Treatment and Labor Act ("EMTALA"). We urge the Centers for Medicare and Medicaid Services ("CMS") to investigate these concerns and address them through the Technical Advisory Group ("TAG") and the Interpretive Guidelines that surveyors must follow in investigating and evaluating EMTALA violations, including providing specific and appropriate training to surveyors about this issue. In addition, we are requesting that CMS develop a Frequently Asked Question ("FAQ") that addresses this issue, and publish the FAQ on the CMS website as soon as possible to prevent further disruption to patient care.

As you know, when a patient presents at a hospital with an emergency medical condition, the hospital is responsible for providing further medical examination and treatment as required to stabilize the medical condition, or arranging for appropriate transfer of the patient to a facility that can provide the necessary services. *See* 42 C.F.R. § 489.24(d)(2). When the hospital has determined that it is not capable of providing the type or level of service required by the patient and therefore decides to seek a transfer, it is the sending hospital that must ensure that the method of transfer is appropriate. *See* 42 C.F.R. § 489.24(e). Air Evac provides this type of inter-facility transport upon request by sending hospitals in its service areas. However, in several regions where Air Evac operates, including some areas in Tennessee, Indiana, Oklahoma, and Texas, Air Evac has encountered a problem in attempting to provide these transports, which we believe implicates and, in some cases, may violate EMTALA. Sending hospitals in these areas have been told by the receiving hospital that the receiving hospital will not accept the patient unless the receiving hospital is able to use its own helicopter for the transport. At times, this has occurred when the Air Evac helicopter is already on route to or has arrived at the sending hospital. If the sending hospital yields to the receiving hospital's demand, the result is that the patient's transport is delayed for the length of time it takes the receiving hospital's helicopter to leave its base, and fly to the sending hospital.

This type of demand puts the sending hospital in the difficult position of having to decide whether the patient's condition will allow for a delay in the transport and, if not, finding another receiving hospital. Furthermore, if the receiving hospital as a policy conditions all transfers of emergency patients on the use of their own helicopter, sending hospitals must use the receiving hospital's helicopter even if there is another helicopter in closer proximity to the sending hospital. Such a policy impedes the sending hospital's ability to comply with the requirements for arranging an appropriate transfer, an obligation it must satisfy under the EMTALA regulations. While there are certain limited circumstances where the use of the receiving hospital's specialty transport staff is important (e.g., with pediatric hospitals), in most cases, there is no reason for a hospital to insist on using its transport service.

In essence, what is occurring is that the care of the patient is being determined based on the receiving hospital's financial interests, even though a duly-qualified and licensed air transport service in closer proximity to the sending hospital may already be available to transport the patient. We understand that hospitals may be facing increasing financial pressure on their AMS programs with full conversion to the ambulance fee schedule, but this is an inappropriate way to deal with such financial pressure. Patient care decisions, especially in an emergency, must be based on the best medical interests of the patient, not the financial interests of the hospital.

In addition, as you know, 42 C.F.R. § 489.24(f) requires that a participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers) may not refuse to accept from a referring

hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

Consistent with this requirement, we believe it is inappropriate for a receiving hospital to condition acceptance of a patient on the use of their own transportation, especially when this decision could delay treatment of the patient. Delay in treating a patient could be a violation of EMTALA, under certain circumstances, in addition to being generally inconsistent with high quality patient care. Given that this troubling practice seems to be routine for some receiving hospitals, we believe that CMS should take steps to provide guidance to participating providers about their obligations under these circumstances. Specifically, we recommend that CMS refer this issue to the Technical Advisory Group for further discussion and resolution, including clarification of the Interpretive Guidelines to specify that the behavior described above is inappropriate and could possibly violate the legal obligations of institutions providing emergency care.

We would be happy to provide more information to CMS and the TAG on the issues raised above, including specific scenarios that we have encountered, and to work with the agency to develop additional guidance to ensure that Medicare beneficiaries receive the high quality AMS services to which they are entitled under the Medicare program. Thank you for your time and attention to these issues; we will be following up with you soon.

Sincerely,

Seth Myers, RN, BA, MBA, CMTE
Vice President Operations
Air Evac EMS, Inc.

cc: David Siegel, M.D., J.D., Chair
EMTALA Technical Advisory Group

WDC01/243327v1

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

AUG - 2 2006

Seth Myers, RN, BA, MBA, CMTE
Vice President Operations
Air Evac EMS, Inc.
PO Box 768
West Plains, Missouri 65775

Dear Mr. Myers:

Thank you for your letter concerning the problems Air Evac EMS, Inc. has encountered with hospitals refusing to accept transfers of patients from other hospitals via air transport unless the sending hospital agrees to use the receiving institution's air transport services. You believe this practice may be in violation of the Emergency Medical Treatment and Active Labor Act (EMTALA) and have requested that the Centers for Medicare & Medicaid Services (CMS) develop a Frequently Asked Question (FAQ) to address this issue. You also suggested that CMS submit this issue to the EMTALA Technical Advisory Group (TAG) for review.

Section 1867(c)(2)(D) of the Social Security Act (the Act) and the regulations at 42 CFR 489.24(e)(2)(iv) require that an appropriate transfer under EMTALA be effected through qualified personnel and transportation equipment. The Interpretive Guidelines (IGs) further expand on this requirement. Under Tag A409, we state that the physician at the sending hospital (and not the receiving hospital) has the responsibility to determine the appropriate mode, equipment, and attendants for transfer. The IGs do not explicitly state whether or not the designation of a particular transport company is considered to be in the jurisdiction of the attending physician at the sending hospital. However, a recipient hospital may not refuse to accept an individual protected under EMTALA if it does not approve of the method of transfer approved by the attending physician at the sending hospital. A hospital may only refuse an appropriate transfer of an individual with an unstabilized emergency medical condition if it does not have the capability or capacity to treat the individual. Therefore, if a hospital refuses to accept an appropriate transfer of an individual protected by EMTALA solely because the sending hospital does not utilize the recipient hospital's air transport services, the recipient hospital may be in violation of EMTALA.

You suggested that CMS submit this issue to the EMTALA TAG for review. We agree that this is something that should be brought to the TAG's attention. We will submit a copy of your letter and this response to all members of the TAG. Should the TAG be interested in further information from you, they will contact you. In the meantime, we will consider your request that we publish an FAQ on the CMS Web site regarding this issue and consider whether any other actions may be needed on this issue.

Please note that while the paragraphs above state general Medicare policy regarding EMTALA requirements, as set forth in 42 CFR 489.24, EMTALA enforcement is a complaint-driven process. Any decision as to whether or not a violation has occurred in a specific case will be made by the appropriate regional office only after there has been a full investigation including consideration of all the facts and circumstances of the individual complaint.

Thank you for bringing this issue to our attention.

Sincerely,

Thomas A. Gustafson, Ph.D
Deputy Director
Center for Medicare Management

APPENDIX 8

June 7, 2006

Mr. Thomas Gustafson, Deputy Director
Center for Medicare Management
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Mail Stop C5-01-14
Baltimore, MD 21244-1850

Re: Requirements for Air Medical Services Provided (AMS) to Medicare Beneficiaries

Dear Mr. Gustafson:

We are writing to express our concern about a business practice in the air medical services industry that could affect the quality of care provided to Medicare beneficiaries and, in some cases, beneficiaries' access to care.

Recently, and patients we have been requested to transfer have experienced a troubling practice in several service regions throughout the country. As explained further below, some hospitals are refusing to accept transfers of patients from other institutions unless the sending institution agrees to use the receiving institution's AMS provider to transfer the patient. This practice raises a number of concerns about patient care and may implicate the Emergency Medical Treatment and Labor Act ("EMTALA"). We urge the Centers for Medicare and Medicaid Services ("CMS") to investigate these concerns and address them through the Technical Advisory Group ("TAG") and the Interpretive Guidelines that surveyors must follow in investigating and evaluating EMTALA violations, including providing specific and appropriate training to surveyors about this issue. In addition, we are requesting that CMS develop a Frequently Asked Question ("FAQ") that addresses this issue, and publish the FAQ on the CMS website as soon as possible to prevent further disruption to patient care.

As you know, when a patient presents at a hospital with an emergency medical condition, the hospital is responsible for providing further medical examination and treatment as required to stabilize the medical condition, or arranging for appropriate transfer of the patient to a facility that can provide the necessary services. *See* 42 C.F.R. § 489.24(d)(2). When the hospital has determined that it is not capable of providing the type or level of service required by the patient and therefore decides to seek a transfer, it is the sending hospital that must ensure that the method of transfer is appropriate. *See* 42 C.F.R. § 489.24(e). provides this type of inter-facility transport upon request by sending hospitals in its service areas. However, in several regions where operates, including some areas in , has encountered a problem in attempting to provide these transports, which we believe implicates and, in some cases, may violate EMTALA. Sending hospitals in these areas have been told by the receiving hospital that the receiving hospital will not accept the

patient unless the receiving hospital is able to use its own helicopter for the transport. At times, this has occurred when the helicopter is already on route to or has arrived at the sending hospital. If the sending hospital yields to the receiving hospital's demand, the result is that the patient's transport is delayed for the length of time it takes the receiving hospital's helicopter to leave its base, and fly to the sending hospital.

This type of demand puts the sending hospital in the difficult position of having to decide whether the patient's condition will allow for a delay in the transport and, if not, finding another receiving hospital. Furthermore, if the receiving hospital as a policy conditions all transfers of emergency patients on the use of their own helicopter, sending hospitals must use the receiving hospital's helicopter even if there is another helicopter in closer proximity to the sending hospital. Such a policy impedes the sending hospital's ability to comply with the requirements for arranging an appropriate transfer, an obligation it must satisfy under the EMTALA regulations. While there are certain limited circumstances where the use of the receiving hospital's specialty transport staff is important (e.g., with pediatric hospitals), in most cases, there is no reason for a hospital to insist on using its transport service.

In essence, what is occurring is that the care of the patient is being determined based on the receiving hospital's financial interests, even though a duly-qualified and licensed air transport service in closer proximity to the sending hospital may already be available to transport the patient. We understand that hospitals may be facing increasing financial pressure on their AMS programs with full conversion to the ambulance fee schedule, but this is an inappropriate way to deal with such financial pressure. Patient care decisions, especially in an emergency, must be based on the best medical interests of the patient, not the financial interests of the hospital.

In addition, as you know, 42 C.F.R. § 489.24(f) requires that a participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

Consistent with this requirement, we believe it is inappropriate for a receiving hospital to condition acceptance of a patient on the use of their own transportation, especially when this decision could delay treatment of the patient. Delay in treating a patient could be a violation of EMTALA, under certain circumstances, in addition to being generally inconsistent with high quality patient care. Given that this troubling practice seems to be routine for some receiving hospitals, we believe that CMS should take steps to provide guidance to participating providers about their obligations under these circumstances. Specifically, we recommend that CMS refer this issue to the Technical Advisory Group for further discussion and resolution, including clarification of

the Interpretive Guidelines to specify that the behavior described above is inappropriate and could possibly violate the legal obligations of institutions providing emergency care.

We would be happy to provide more information to CMS and the TAG on the issues raised above, including specific scenarios that we have encountered, and to work with the agency to develop additional guidance to ensure that Medicare beneficiaries receive the high quality AMS services to which they are entitled under the Medicare program. Thank you for your time and attention to these issues; we will be following up with you soon.

Sincerely,

cc: David Siegel, M.D., J.D., Chair
EMTALA Technical Advisory Group

APPENDIX 9

TESTIMONY ON BEHALF OF
THE CENTER FOR TELEHEALTH & E-HEALTH LAW

TO THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA)
TECHNICAL ADVISORY GROUP (TAG)

Presented by:

Robert J. Waters
Gardner Carton & Douglas

November 2, 2006

TESTIMONY ON BEHALF OF
THE CENTER FOR TELEHEALTH & E-HEALTH LAW

TO THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA)
TECHNICAL ADVISORY GROUP (TAG)

My name is Robert Waters. I serve as Counsel for the Center for Telehealth & E-Health Law (CTeL). CTeL is a non-profit organization created to examine legal and regulatory barriers to telehealth and related e-health services. CTeL's founding members included the Mayo Clinic, Cleveland Clinic Foundation, Texas Children's Hospital, and the Midwest Rural Telemedicine Association. Our membership today includes leading medical centers from across the United States, both urban and rural. We appreciate the opportunity to testify before the EMTALA Technical Advisory Group (TAG) on the issue of on-call physicians and emergency room telehealth services.

CTeL has carefully reviewed the two paragraphs referencing telemedicine under the Center for Medicare and Medicaid's (CMS) Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases Section 489.24(j)(1) (hereinafter, the "Interpretive Guidelines"). Two paragraphs involving Medicare requirements for telemedicine reimbursement appear to have been inserted into EMTALA guidelines. We have serious concerns that these two paragraphs that reference Medicare reimbursement policies may actually limit the care provided to patients presenting at an emergency department. Therefore, we propose eliminating these two paragraphs from the Interpretative Guidelines.

The two paragraphs referencing telemedicine state the following:

> On-call physicians may utilize telemedicine (telehealth) services for individuals in need of further evaluation and/or treatment necessary to stabilize an EMC. Individuals are eligible for telemedicine services only when, because of the individual's geographic location, it is not possible for the on-call physician to physically assess the patient. Permissible situations under which on-call physicians may access telemedicine include the case of an individual who presents to an originating hospital located in a rural health professional shortage area (HPSA) or in a county outside of a metropolitan statistical area (MSA). The RO is to consult with Health Resources Service Administration (HRSA) personnel...or RO staff working with rural health issues to determine if a hospital is located in a rural HPSA or MSA to be eligible for telemedicine services and therefore not be in violation of EMTALA on-call requirements.
>
> Reimbursement for such telemedicine services are limited, therefore it is in the best interest of the provider to be knowledgeable concerning

coverage and payment for Medicare telehealth services (see Medicare Benefit Policy Manual, Pub. 100-2, Chapter 18 [sic], Section 270).[6]

The insertion of these two paragraphs will unintentionally undermine the objectives of EMTALA for the following reasons:

1. The language inappropriately limits the amount and format of information that can be transmitted to on-call physicians.

   Modern communications technology permits emergency departments to have almost instantaneous contact with on-call physicians. Information on a patient's condition can be transmitted to on-call physicians via a phone call, pager, computer link, the Internet, or a video link. All of these forms of communication are telemedicine. The Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services defines telehealth broadly, stating on their website that telehealth is "the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration."[7]

   Communications technologies are extremely important to convey information and instructions needed to appropriately treat the patient while the on-call physician is in-transit to the emergency department. If a patient presents at an emergency room, the hospital has a professional and legal obligation to take those actions necessary to stabilize the patient.

   Minutes can save lives. Information is critical to appropriate decision-making. Telemedicine reduces the time to the Emergency Department (ED) and enhances the information available to the on-call physician. EMTALA should fully support the use of this technology as determined necessary by the emergency and on-call physicians. We need to enhance rather than limit the responsiveness of on-call physicians.

   If the current guideline is not modified the only action an on-call physician can take in response to call from the emergency room is to report to emergency room without asking additional questions or receiving additional information critical to the patient's care.

2. The language inappropriately limits emergency telehealth services to only those areas currently covered by the Medicare program.

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[6] Centers for Medicare and Medicaid Services, *States Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases (Rev. 1, 05-21-04)*, Part II, § 489.24(j)(1) - Availability of On-Call Physicians, (*hereinafter* Interpretive Guidelines). As noted, there appear to be two typographical errors in various published versions of this section.

[7] Health Resources and Service Administration, *What is Telehealth, at* http://www.hrsa.gov/telehealth.

EMTALA applies to all individuals, regardless of whether or not they are beneficiaries of any program under the Social Security Act Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867.[8] Furthermore, according to EMTALA, the scope or nature of the emergency care rendered should not be constrained by the patient's ability to pay, such as whether they have Medicare, Medicaid, or private insurance.[9]

It is our understanding that CMS's objective in issuing these Interpretive Guidelines for EMTALA was to ensure that a patient presenting at an emergency department with an emergency medical condition would be stabilized by the emergency department and any on-call physicians or appropriately transferred to another facility.[10] The current language of the Interpretive Guidelines, however, permits an on-call physician to only access telemedicine based upon the geographic location of the patient, such as a patient who presents to an originating hospital located in a rural HPSA or in a county outside of an MSA. This language is based upon Medicare reimbursement rules for telehealth that were created and defined by Congress.[11] The reimbursement rules do not reflect any form of professional judgment regarding appropriate care. They are simply situations where Congress and the Executive Branch have authorized Medicare payment.

In our discussions with CMS staff, we have been unable to identify any other situation where the EMTALA guidelines are constrained by Medicare reimbursement rules.

3. Even in areas covered by Medicare payment policy, the EMTALA interpretative guideline could constrain appropriate care.

Medicare reimbursement is available for certain telehealth services in rural health professional shortage areas and non-metropolitan statistical areas. The payment is further constrained based on the originating site of the patient and the type of procedure. For example, Medicare does not pay for "store and forward" telehealth encounters outside of Alaska and Hawaii.

The store and forward situation would include any time that information or images are transmitted electronically to a physician for review. If there is not two-way interaction between the physician and patient, this activity is not reimbursable by Medicare. If this reimbursement rule were applied to EMTALA, an on-call physician would be prohibited from reviewing a patient record, an x-ray, CT scan, or an EKG unless he is engaged in a two-way video interaction with the patient.

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8 68 Fed. Reg. 53,223 (Sept. 9, 2003) (codified at 42 C.F.R. pts. 413, 482, and 489).

9 Centers for Medicare and Medicaid Services, EMTALA OVERVIEW, *available at*, http://www.cms.hhs.gov/EMTALA, stating, "In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay."

10 42 C.F.R. § 489.24(a) (2005).

11 *See* Medicare Benefit Policy Manual, Pub. 100-2, Chapter 15, Section 270.

4. Telemedicine is a valuable tool in urban as well as rural areas.

Communications tools may be particularly important in urban areas. The response time for an on-call physician in urban area could actually be greater than in rural area due to congestion and traffic patterns. In rural area, two miles may be two minutes. In an urban area at rush hour, two miles might be an eternity.

5. An on-call physician may not be able to utilize the same telemedicine tools available to a physician who is not on-call at the hospital.

If an emergency room physician needs to consult immediately with a specialist, they will have contact a physician who is not "on-call" if they would like to have a meaningful interaction or discussion regarding the patient's care or transmit any information to the remote specialist. This undermines the whole objective of establishing and maintaining on-call providers.

The language in the Interpretive Guidelines allows a physician who is not on-call at the hospital to use telemedicine services without restrictions. The inconsistent language within the Interpretive Guidelines is contrary to current practice and to physician professional responsibilities in handling emergency situations.[12]

Telemedicine is used extensively as part of emergency care. There are many examples throughout the country. Three illustrative examples have been provided by Lehigh Valley Hospital and Health Network. They are set out below:

1. An ED without an open heart surgery program transmits, via a telecommunications system, an EKG strip and echocardiogram ahead of sending a patient to a larger center for a balloon angioplasty procedure. The receiving ED is better prepared to care for the patient.

2. A stroke patient in an ED who receives Tissue Plasminogen Activator (tPA) within the three-hour window of opportunity and then transported to a certified stroke center is better off, because telehealth technologies were used to connect that patient to a neurologist and stroke team that was not otherwise available in the remote ED. In many cases the 3-hour window of opportunity to receive tPA often closes on a patient, because of the transport time

[12] American College of Emergency Physicians, *Policy Statement: Availability of Hospital Diagnostic and Therapeutic Services*, stating, "The American College of Emergency Physicians supports policies that endorse consistent 7-days a week availability of hospital diagnostic and therapeutic services in order to facilitate timely disposition of emergency department patients and to minimize hospital crowding," *available at*, http://www.acep.org/webportal/PracticeResources/PolicyStatements/hosp/availhospdiagthersvs.htm.

needed for the patient to get to a center capable of administering that agent.

3. A pediatric cardiology patient in an ED without a pediatric cardiologist is much better off if a pediatric cardiologist were made available via an interactive video link to a larger center that has that level of expertise available.

In closing, we believe that the EMTALA Interpretive Guidelines on On-Call Physicians, Section 489.24(j)(1), are appropriate as long as the two paragraphs referencing telemedicine are eliminated. Emergency department physicians should be able to avail themselves of all information and tools necessary to assist them in treating patients. Telemedicine is one of these critical tools.

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

October 17, 2006

APPENDIX 10

DUTIES OF HOSPITALS WITH SPECIALIZED CAPABILITIES TO ACCEPT PATIENT TRANSFERS

DRAFT

CURRENT RULE:

42 U.S.C. § 1395dd(g); 42 C.F.R. § 489.24(f)
A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

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

NEED FOR CHANGE:

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

RECOMMENDATION:

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

DUTIES OF TRANSFERRING HOSPITAL	DUTIES OF RECEIVING HOSPITAL
1. Maintain a call list that best meets the needs of hospital patients. (Transfers out for conditions hospital normally capable of handling may suggest inadequate call list, as will an increased number of transfers on weekends, vs. weekdays.) [*Refer to on-call sub-committee; hospitals and physicians need more guidance regarding whether a hospital's on-call list is adequate. Some members urged that the on-call*	1. No obligation to accept hospital in-patients, consistent with 42 C.F.R. 489.24(d)(2) and CMS interpretation.

DUTIES OF TRANSFERRING HOSPITAL	DUTIES OF RECEIVING HOSPITAL
list reflect a hospital's <u>inpatient and outpatient</u> services routinely offered at the hospital.]	
2. Provide appropriate medical screening examination and stabilizing care within the transferring hospital's capabilities prior to transfer, in accordance with 42 C.F.R. 489.24(d)(1) and (e)(2)(i). [Note: recommend revising (e)(2)(i) to state that the "transferring hospital provides medical treatment within its *capability*" (instead of "capacity).] The extent of the medical screening examination and stabilization will depend on the patient's needs and the hospital's capabilities. When determining a hospital's capabilities, the critical question is whether the hospital has the capabilities to provide the services that are necessary to stabilize the patient's emergency medical condition. It would not be acceptable for a hospital to transfer a patient solely because it does not have capabilities that the patient requires, but are not essential to stabilize the patient's emergency medical condition. When the hospital does not have the capability to completely stabilize the patient's emergency medical condition, the hospital must complete all necessary stabilizing steps within its capability unless doing so would cause an undue delay in the patient's care and transfer (*e.g.*, severe head trauma patients that do not present to a trauma center may require basic stabilization, then transfer).	2. Only required to accept emergency department patient transfers when the transferring hospital does not have the capability to stabilize the patient's emergency medical condition. In other words, a hospital is not required to accept a patient transfer simply because the patient would like to be transferred to the receiving hospital. The physician must certify that the transfer is necessary because the transferring hospital does not have the capability to stabilize the patient's emergency medical condition and the benefits of the transfer outweigh the risks, consistent with the physician certification requirements set forth in 42 C.F.R. § 489.24(e)(1)(B).
3. The physician's decision as to whether or not to transfer may not be based on insurance status/financial means (number of transfers of patients without insurance evidences possible abusive	3. No obligation to accept if the only basis for the transfer is patient request (must be physician certified of higher level of care).

DUTIES OF TRANSFERRING HOSPITAL	DUTIES OF RECEIVING HOSPITAL
transfers.). The Action Subcommittee supports an exception for community protocols (*e.g.*, psychiatric patients who are a part of a state-wide psychiatric program based on indigent status). Patients may request transfer based upon insurance/financial concern, but the hospital should not present financial information to the patient in a manner that would discourage the patient from receiving stabilizing care from the hospital. If a patient requests transfer, the hospital must comply with the EMTALA requirements for patient requests for transfer set forth in 42 C.F.R. § 489.24, which includes a requirement to inform the patient of the risks and benefits of the transfer decision.	
4. The transfer must be an appropriate transfer, as defined in 42 C.F.R. § 489.24(e)(2).	4. Receiving hospitals are not obligated to accept a patient transfer if the basis for the transfer is lack of capacity, except in unusual circumstances. Likewise, receiving hospitals are not required to accept patient transfer if they lack the capacity to do so. For example, the transferring hospital is experiencing surge capacity, a disaster situation, or lacks critical equipment or space due to an equipment or physical plant failure. A receiving hospital may also have an obligation to accept a patient if, despite taking all reasonable actions to maintain adequate capacity, the transferring hospital cannot stabilize the patient's care due to overcapacity, assuming the receiving hospital has capacity to accept the patient. If a transferring hospital has demonstrated the ability to accommodate additional patients by whatever means (*e.g.*, moving patients to other units, calling in additional

DUTIES OF TRANSFERRING HOSPITAL	DUTIES OF RECEIVING HOSPITAL
	staff, borrowing equipment from other facilities), it has demonstrated the ability to operate in an overcapacity situation and the receiving hospital would not be obligated to accept this patient transfer. This requirement is consistent with the current EMTALA Interpretive Guidelines, Tag A411. The receiving hospital, however, is under no such duty to expand its existing capacity to accept patient transfers in this manner. This is a recommended departure from the current EMTALA Interpretive Guidelines, which appear to require such efforts on behalf of a receiving hospital. Finally, a receiving hospital is under no EMTALA obligation to accept transfers of patients who do not require stabilization services for an emergency medical condition, even if the transferring hospital lacks capacity, irrespective of extenuating circumstances.
5. The determination of whether patient is unstable, requires a higher level of care, and whether the transferring hospital has the capability to provide stabilizing treatment, the treating physician's judgment rules, but may be questioned later by receiving hospital and reviewed by CMS surveyors for potential abusive transfer decisions.	5. Receiving hospital may serve as a resource for alternative stabilizing care options, but transferring hospital is not required to accept recommendation. *[possible medical liability impact, depending on state law.]*

DUTIES OF TRANSFERRING HOSPITAL	DUTIES OF RECEIVING HOSPITAL
6. In determining whether hospital has the capabilities to provide stabilizing care to the patient, surveyors look at capabilities of hospital at the time of the transfer and period thereafter consistent with the patient's "window" for required emergency care. Availability of additional care that will be or may be required once the patient's emergency medical condition is stabilized is not a basis for determining that the hospital lacked the capability to stabilize the patient's EMC. This recommendation is intended to prevent hospitals that typically have the capability to stabilize a particular emergency medical condition (*e.g.*, appendectomy) from transferring patients to another hospital simply because the hospital currently have the on-call physician resources or equipment to stabilize the patient's medical condition, but when the hospital's resources are likely to be available within the timeframe necessary to stabilize the patient's emergency medical condition. This recommendation is not intended to delay the care and treatment for patients who must be treated immediately, when the hospital does not have the capability to stabilize the patient's medical condition immediately.	6. Receiving hospitals should have systems in place to communicate with admissions staff and on call physicians to confirm that they have the capacity and capability to provide stabilizing care to the patient before accepting a patient. Receiving hospital must make the decision as to whether it will accept/reject transfer within a "timely" manner. "Timely" means within an hour.
7. The transferring physician must take into account the distance that the patient will travel in his/her certification that the benefits of the transfer outweigh the risks. If the transfer distance will exceed 50 miles, the transferring hospital must attempt to transfer patients to the nearest appropriate hospital. *[Consider: Receiving hospital may question*	7. Duty to report improper transfers, which includes abuses of this provision, in accordance with 42 C.F.R. § 489.20(m).

DUTIES OF TRANSFERRING HOSPITAL	DUTIES OF RECEIVING HOSPITAL
transferring hospital with respect to other hospitals contacted to confirm that nearest appropriate hospital contacted when the transfer exceeds 50 miles.]	
8. If requested by the receiving hospital, the transferring hospital must take transferred patient back once the patients' EMC has been stabilized and no longer needs higher level of care and the remaining care is within capabilities of the transferring hospital, irrespective of the transferring hospital's capacity.	8. "Specialized capabilities" includes dedicated units, specialized equipment and personnel (including on call physicians) available at the time of transfer or that will be available within the patient's treatment "window." Specialized capabilities do not include medical staff members who are not on call.
9. Consider: Transferring hospital must pay for the cost of the transfer to the receiving hospital if the cost of transfer is not reimbursed by the patient's insurance carrier, a federal or state health care program, or the patient.	9. Failure to accept an unstable patient who requires the hospital's specialized capabilities available at the time of transfer may be an EMTALA violation if the hospital has the capacity to accept the transfer.

APPENDIX 11

CATHOLIC HEALTH INITIATIVES

A spirit of innovation, a legacy of care

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October 18, 2006

Eric Ruiz
Division of Acute Care
Centers for Medicare & Medicaid Services
Mail Stop C4-08-06
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Comments for the November 3-4, 2006 EMTALA TAG Meeting

Dear Mr. Ruiz:

Thank you for the opportunity to provide comments to the EMTALA TAG. Catholic Health Initiatives is a faith-based, mission-driven health system that includes 70 hospitals, 42 long-term care, assisted-living and residential units, and two community health service organizations in 19 states. The sizes of CHI's hospitals range from multi-campus regional hospitals to extremely small critical access hospitals. CHI's hospitals are located in CMS Regions 3, 4, 5, 6, 7, 8 and 10. EMTALA education and compliance is a priority for CHI hospitals.

Obligations to patients after discharge from the ED

In Report Number Four of the TAG, the Anti-Dumping Task Force indicated that there were several issues to be placed on the November agenda related to obligations to patients after discharge from the Emergency Department. The definition of "stabilized" to mean that …"no material deterioration of the condition is likely, within reasonable medical probability, to result from, or occur during, the transfer of the individual from a facility, or with respect to "emergency medical condition" as defined in this section under paragraph (1) of that definition, that a woman has delivered the child and the placenta," when read in conjunction with the Interpretive Guidelines infers that ensuring access to follow up care after discharge is an EMTALA obligation. In particular, the use of the word "transfer" in the statute, without reference to "discharge" results in a lack of clarity about when the hospital's EMTALA obligation ends for a patient who can be released from the hospital, but is still in need of significant follow up treatment.

The Interpretive Guidelines provision that "Hospitals are expected within reason to assist/provide discharged individuals the necessary information to secure the necessary follow-up care to prevent relapse of worsening of the medical condition upon release from the hospital" places hospitals in an untenable position. For example, assume that a patient

has a fracture that may need surgical intervention, but that determination cannot be made until the swelling subsides. The ED physician splints or casts the broken limb. The ED physician knows that no orthopedic surgeon in the immediate geographic area accepts the patient's health coverage. If the ED physician discharges the patient with instructions to seek orthopedic care in the next 48 hours knowing that the patient will probably not be able to obtain access to an orthopedic surgeon in that timeframe, has the hospital acted "within reason" and has the hospital provided the "necessary information to secure the necessary follow-up care"?

In the absence of a Medical Staff Bylaws provision or hospital policy/procedure requiring otherwise, ED physicians must sometimes require on call physicians to come to the hospital to evaluate and/or treat a patient even when that patient could probably be discharged and treated in an outpatient setting simply because it is unlikely that the patient would be able to access the on call physician after discharge due to health coverage issues. Likewise, patients who are unable to access follow up care in the community end up back in the ED for non-emergency services such as wound checks, suture removal, or medication refills because they have been unable to access a physician. These circumstances are an inefficient use of the ED.

Recommendations:

--Revise the Interpretive Guidelines to clarify that a hospital's EMTALA obligation ends when a physician or qualified medical personnel has made a decision that an emergency medical condition exists but that, within reasonable clinical confidence, the individual has reached the point at which his/her continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient and the patient has been given discharge instructions regarding follow-up care and information regarding resources in the community that may be available for the necessary follow-up care.

--Clarify in the Interpretive Guidelines that a physician who is on call to the ED for EMTALA purposes may satisfy his or her EMTALA obligations by (a) responding to a request from the ED physician to come to the ED to assess and/or treat the patient; (b) consulting by phone with the ED physician within the on call physician's areas of expertise; (c) accepting a patient for follow-up care in the outpatient setting for the purpose of resolving or providing additional stabilizing treatment of the emergency medical condition for which the patient has sought evaluation in the ED.

Recipient and transferring hospital responsibilities

The Action SubCommittee also solicited comments on the responsibilities of the transferring and accepting hospitals. Given the variance of the size and capabilities of hospitals within the CHI system, we have experience in the impact of the EMTALA on both transferring and receiving facilities.

Recommendations:

--Imposing a distance limit such as "transfer to the closest hospital when possible" is too proscriptive and interferes with the judgment of the ED physicians at the transferring facility and physicians at the potential recipient facilities to determine the best transfer for the patient's clinical condition.

--The Interpretive Guidelines should be revised to reflect that "The capacity and capability of a recipient facility includes the availability of on-call physicians. Although on-call physicians are generally expected to provide services within the scope of their privileges, professional judgment based on the patient's potential clinical needs may be exercised by the on call physician in consultation with the ED physicians/staff and the transferring hospital physicians/staff in determining whether to accept a patient in transfer from another facility."

--The Interpretive Guidelines should be further revised to clarify that "Transferring hospitals should seek to arrange transfer to a hospital with a high enough level of care or specialized capabilities to provide definitive care to a patient. A recipient hospital has an obligation to accept only those patients in transfer to whom it can provide definitive care. A recipient hospital is not obligated to accept a patient if, in the clinical judgment of the ED physician or available on-call physician, the patient will require a subsequent transfer to a hospital with a higher level of care or specialized capabilities which can provide definitive care to the patient."

--The Interpretive Guidelines should be revised to include a provision that "Recipient hospitals may not condition acceptance of a patient to whom EMTALA applies on the agreement of the transferring hospital to assume financial responsibility for the patient's care or the agreement of the transferring hospital to arrange for any subsequent transfers of the patient from the recipient facility."

--The following language in the Interpretive Guidelines should be deleted: "Capacity includes whatever a hospital customarily does to accommodate patients in excess of its occupancy limits sec.489.24(b). If a hospital has customarily accommodated patients in excess of its occupancy limits by whatever means (e.g., moving patients to other units, calling in additional staff, borrowing equipment form other facilities) it has, in fact, demonstrated the ability to provide services to patient in excess of its occupancy limits."

Hospitals should be free to manage their resources to accommodate patients on a daily basis without fear that they will be held to a same accommodation standard in the future. Likewise, physicians and hospital should be free to exercise discretion as to the acceptance of a particular patient at that point in time based on the totality of circumstances. Decisions by recipient hospitals based on the patient's clinical condition and the judgment of the hospital and physician about the ability to accommodate that patient at that point in time should be allowed.

--The decision to accept patients once the hospital has reached capacity is a complex one based on a multitude of rapidly changing factors (e.g., current patient acuity, staffing

levels, distribution of patients and staff, even the weather). Requiring hospitals to accept transfers once they have reached capacity interferes with the hospital and physician's ability to accommodate the patients in an expeditious, safe and effective manner. Obviously, decisions made on discriminatory factors would be impermissible. In order to carry out the intent of EMTALA, the Interpretive Guidelines could be revised to state: "A hospital is expected to accommodate patient in excess of its occupancy limits when it can reasonably do so based on the totality of the circumstances. When a hospital is operating in excess of its occupancy limits, the capacity of the hospital to admit a patient through its dedicated emergency department or in transfer from another hospital shall be based on the patient's clinical needs and the available resources at the hospital and not on the patient's payor status or any other discriminatory basis."

--The Interpretive Guidelines should be revised to clarify that "Recipient hospitals with specialized capabilities are not required to accept in transfer for admission patients who would not otherwise meet admission criteria for the specialized services needed."

Thank you for the opportunity to provide comments. If you have questions or would like to discuss further, please contact me using the information below.

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Sincerely,

Julie L. Seitz
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APPENDIX 12

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August 9, 2006

John A. Kusske, M.D.
EMTALA Technical Advisory Group
c/o Beverly J. Parker
Division of Acute Care
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Mail Stop C4-08-06
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: The Emergency Medical Treatment and Active Labor Act ("EMTALA") – Examples of Continued Hardship by the "Specialized Capabilities" Provision

Dear Dr. Kusske:

Susan Lapenta and I had the pleasure of speaking with you this past April in connection with your work with the EMTALA Technical Advisory Group ("TAG"). You had called our office to discuss our October 12, 2005 letter sent to the TAG. For reminder purposes, a copy of that October 12 letter is enclosed.

For Susan and myself, a highlight of our conversation was how much of it focused on the real and practical difficulties EMTALA places upon hospitals and physicians. That includes the difficulties oftentimes created by EMTALA's "non-discrimination" or "specialized capabilities" provision, the first-described item in the on-call comments of the enclosed October 12 letter.

Our office recently assisted Kootenai Medical Center ("KMC") located in Coeur d'Alene, Idaho, in responding to an EMTALA deficiency determination made by the Seattle CMS Regional Office ("RO") based upon the specialized capabilities provision. That work, once again, showed

us just how badly this provision can hit community hospitals and specialists who are trying to do right by their community.

Given the nature of our April phone call, I thought it could be helpful to the TAG to see just how EMTALA enforcement continues to pose hardships and unfairness. There continues to be uncertainties as to EMTALA's reach, and, in important situations, little advance written guidance.

(We are not sending you this letter on behalf of KMC, but to illustrate problems the specialized capabilities provision presents. KMC has permitted us to identify it for this purpose. If you would like, we would be happy to send you the full packet that KMC sent the RO, if that will be helpful to you.)

Some quick background: KMC has historically served the five northern counties in the State of Idaho, and has a long history of accepting transfers from the four surrounding county hospitals to its own. The EMTALA deficiencies found by the RO concerned four instances in which neurosurgeons on KMC's staff declined to accept proposed patient transfers from hospitals outside of this five-county region. In each of these situations, the RO determined that KMC had to accept the patients because a neurosurgeon constituted a "specialized capability," and KMC had the capability and capacity to accept the patient.

1. The Difficulties Caused by the Specialized Capabilities Requirement

The KMC physicians involved (both ED and the neurosurgeons) did not understand the way in which the enforcement of EMTALA has expanded the specialized capabilities requirements. We have subsequently provided on-site EMTALA education to everyone involved, particularly about the specialized capabilities requirements.

The physicians' questions to us – all of them quite fair and reasonable – show the burdens placed on physicians and hospitals by the current interpretation and enforcement of the specialized capabilities provision:

(a) KMC already serves a full five-county area. These four patient transfers all originated from outside that five-county area. Are there no geographic limits within the specialized capabilities requirement? Would KMC have to accept a patient transferred from anywhere in Idaho?

(b) The hospitals and physicians involved in the proposed patient transfers typically transfer neurosurgery patients to a hospital in Spokane. These proposed patient

transfers were entirely unexpected. Shouldn't that have some bearing in a finding of an EMTALA deficiency?

(c) When the hospitals outside of the surrounding four counties do not have a neurosurgeon on call, they never let KMC know this in advance (although this has been repeatedly requested). Again, for purposes of planning and practice management, shouldn't hospitals be expected to alert potential receiving hospitals in advance? Shouldn't that be a part of the specialized capabilities requirements? And of whether to make a finding of an EMTALA deficiency?

Based upon our experience with the manner in which ROs typically enforce the specialized capabilities provision, our legal answers were (a) there are no geographic limits to the provision, (b) ROs have no obligation to consider the "fairness and appropriateness" from the perspective of the proposed receiving hospital and physician, and (c) there is no absolute requirement of advance notification of possible patient transfers upcoming.

While legally correct, these answers pose significant hardships on all hospitals and on-call specialists. There must be better answers than the pure legal ones.

In the KMC area, there is a physician-owned hospital that does not have an ED. Physicians on KMC's medical staff are threatening to abandon the full-service hospital. If that is the case, KMC may no longer have specialized capabilities in any number of patient care areas. Perversely, rigid EMTALA interpretations could result in a diminution in services. That would serve neither KMC nor, more importantly, the larger community which it serves.

2. The Sending Hospital's Responsibilities

Under EMTALA, when a hospital is not able to provide on-call services, it is to have a policy in place as to how it will manage patients who present to its ED the need of such services. It is our understanding that for these situations it is best for each hospital to alert other hospitals in the area that it will have to be transferring patients because of an uncovered ED. That is particularly the case when this information has been specifically requested by another hospital in the area, for its own planning purposes.

In its explanation letter to the Seattle RO, KMC asked for guidance as to the responsibilities of the transferring hospital in this situation. In a follow-up conversation, the RO told KMC that if it had any concerns with other hospitals' actions in this area, KMC's sole "remedy" was to report that hospital for a potential EMTALA violation.

There has to be a better answer for situations such as this than "report the other hospital." That answer is all punishment based, with no consideration given to preventing concerns from turning into EMTALA problems.

Other than some short provisions concerning specialized capabilities in the EMTALA CMS Guidelines, there are no CMS written rules on specialized capabilities. Hospitals should be able to expect CMS to provide reasonable advance guidance. Would each RO have managed this EMTALA matter in the same way? Are the limits on the RO's discretion?

The way in which the specialized capabilities provision is being enforced sets hospitals against hospitals as well as physicians against hospitals. There must be a better way to make this work.

3. Difficult Time Requirements Put Upon KMC by the RO

These final concerns are much less important on a policy level than the ones just raised.

KMC received its EMTALA deficiency letter from the RO on Thursday, June 29, with a response due date of Monday, July 10. That time period, basically a little over a week, included the July 4 holiday within it. (The RO contact was gone on vacation for a day or two within that ten-day period.)

While the RO granted KMC a two-day extension on the due date, the RO said that KMC had to be re-surveyed and approved by CMS before the July 20 public notice date. Otherwise, the public notice would go forward and KMC would receive its Medicare termination letter on July 22.

This extreme inflexibility is harsher than every other "fast track" deficiency case on which we have worked. With all those other cases, the submission of the corrective action plan stopped everything else from happening while the RO reviewed the hospital's materials.

In our experience, the follow-up survey has never had to take place within the initial "Medicare termination letter" fast track time frame. Quite frankly, those time frames taken together (submission and follow-up survey) were an exceptional hardship on KMC.

There must be a better way to use the specialized capabilities provision to protect patients but also to be fundamentally fair to the hospitals and physicians involved. We are hopeful that the TAG can assist CMS in finding that better balance. As before, we would be very happy to talk

about this situation further and provide more information, if that would be helpful to you and to the TAG.

Very truly yours,

Alan Steinberg

AS/pam

Enclosure

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VIA E-MAIL
AND FEDERAL EXPRESS

October 12, 2005

Beverly J. Parker
Division of Acute Care
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Re: The Emergency Medical Treatment and Active Labor Act (EMTALA)

Dear Ms. Parker:

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 Hospital 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 of EMTALA'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 helpful. 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 1395dd 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 of §482.55 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 personnel 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

BB/AS/SL/djm

Enclosure

APPENDIX 13

June 7, 2006

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

Dear Dr. Siegel,

The Florida Hospital Association appreciates the opportunity to address an issue before the TAG. Last year, the American Ambulance Association in a September 30, 2005 letter to the TAG and again at the October 2005 meeting of the TAG, raised the problem of wait-times before off-loading patients at hospital emergency departments. It is certainly a concern for hospitals as well and in a recent Florida Hospital Association Task Force Report, this issue was highlighted along with numerous recommendations for easing the overcrowding situation. (Report enclosed)

I am also enclosing a CMS Memo that was issued on December 14, 2005 by the Atlanta office and which apparently was also published in 2002 by the CMS Dallas office. This Memo has caused a lot of confusion among hospitals and on June 2, 2006 both the Florida Hospital Association and Alabama Hospital Association sent the enclosed reply asking that the Memo be retracted.

We would urge CMS headquarters to be cautious about expanding this Memo to the rest of the United States. The Memo is sending the wrong message on a very complicated situation caused by an overtaxed health care system.

Thank you for considering this request and we look forward to working with you on this and other EMTALA issues.

Sincerely,

William A. Bell
General Counsel

WAB/jm
Enclosure
cc: George Morey

June 2, 2006

Ann Pfeiffer, RN, MSN, FNP
Region IV EMTALA Team
Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, GA 30303-8909

Re: Memorandum Regarding "Parking" of EMS Patients in Hospitals

Dear Ms. Pfeiffer:

On behalf of our hospital members in the states of Florida and Alabama, the Florida Hospital Association (FHA) and the Alabama Hospital Association (AHA) are writing to respond to a Memorandum issued by your office regarding the length of time it takes to transfer patient care from EMS personnel to hospital Emergency Department personnel. Your Memorandum suggests that transition times which are deemed too long by EMS could be a violation of EMTALA or the hospital Medicare Conditions of Participation and could result in an enforcement action by your office.

The FHA and the AHA strongly disagree with your interpretation of EMTALA. There is no basis in law that supports the contention that hospitals violate EMTALA or the Conditions of Participation whenever a transfer of care takes longer than EMS personnel would like. EMTALA governs how a hospital must respond to an individual's request for medical treatment to determine if the patient has an emergency medical condition. It further provides that a medical screening and any required stabilizing treatment may not be delayed to inquire about the patient's financial status. EMTALA does not mandate specific response times or the order in which a hospital is obligated to accept or treat its patients nor should it. The time it takes to transition patient care from one provider to another is a function of numerous factors, including patient volume, hospital capacity, the availability of ED physician coverage, and the use of the ED for non-emergencies. See Florida Hospital Association, 911: FHA Task Force on Addressing the Crisis in Emergency Care, December 2005.

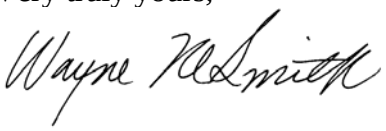
Further, we take exception to the suggestion that, as a matter of federal enforcement, long EMS transfer times are somehow the responsibility of hospitals alone. Your position is especially frustrating given that EMS is permitted to ignore a hospital's diversion status – a status which is not taken lightly and is undertaken only when the hospital's resources are overtaxed. EMS units arriving at a hospital on diversion should be aware that such hospital's resources are already at or above capacity and may result in patient care transitions taking longer than if the hospital was not overburdened.

EMTALA is a federal statute designed to address financial discrimination in providing emergency care. It was not designed to solve the problems of an overtaxed health care system nor is it amenable to be used in such a manner. The issues described in your Memorandum are reflective of a lack of resources both at the ambulance and hospital level. Hospitals alone cannot make these issues disappear. Hospitals cannot control how many ambulances show up at their doors or how many people walk through their doors. Despite best efforts to use a medical control system, hospitals' medical control directions may be ignored by EMS, thus compounding the problem.

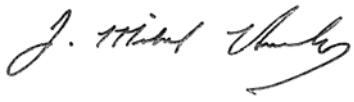
FHA is committed to working cooperatively with other interested stakeholders in resolving the ED crisis in Florida in a manner which places patient care first. The FHA Task Force is working together with many agencies and organizations in Florida, including several EMS organizations, to study the issues critically and to develop recommendations on how to address these issues. Similarly, the Alabama Hospital Association is working to address EMS and hospital coordination and capacity issues. However, we believe the "Parking" Memorandum clouds the real issues and implies that hospitals could be punished for circumstances over which they have little control. Accordingly, we request the "Parking" Memorandum to be retracted.

If you wish to discuss this matter further, please call us. Thank you for your attention to this matter.

Very truly yours,



Wayne NeSmith
President
Florida Hospital Association



J. Michael Horsley
President
Alabama Hospital Association

WN:jm

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Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

Date: December 14, 2005

To: Region IV Hospitals

From: Ann M. Pfeiffer, RN, MSN, FNP
Region IV EMTALA Team

Subject: "Parking" of EMS Patients in Hospitals

The Centers for Medicare and Medicaid Services (CMS) has learned that several hospitals routinely prevent Emergency Medical Service (EMS) staff from transferring patients from their ambulance stretchers to a hospital bed or gurney. Reports include patients being left on an EMS stretcher (with EMS staff in attendance) for extended periods of time. Many of the hospital staff engaged in such practice believe that unless the hospital "takes responsibility" for the patient, the hospital is not obligated to provide care or accommodate the patient. Therefore, they will refuse EMS requests to transfer the patient to hospital units.

This practice may result in a violation of the Emergency Medical Treatment and Labor Act (EMTALA) and raises serious concerns for patient care and the provision of emergency services in a community. Additionally, this practice may also result in violation of the Conditions of Participation for Hospitals.

Under EMTALA, a patient is considered to have "presented" to a hospital when a patient arrives on hospital grounds (defined as the main hospital building and any hospital owned property within 250 yards of the main hospital building) and a request is made on the individual's behalf for examination or treatment of an emergency medical condition. A patient who arrives via EMS meets this requirement when EMS personnel request treatment from hospital staff. Therefore, the hospital must provide a screening examination and stabilizing treatment, if necessary, to resolve the patient's emergency medical condition. CMS does not recognize the distinction some hospital staff are trying to make in identifying EMS versus Hospital responsibility for a patient already in the facility.

This applies to patients transferred to a receiving facility under EMTALA as well. A hospital that delays the screening examination or stabilizing treatment of a patient who arrives via transfer from another facility by not allowing EMS to leave the patient could also be in violation of EMTALA.

Our office recognizes the enormous strain and crowding many hospital emergency departments face every day. However, this practice is not a solution. "Parking" patients in hospitals and refusing to release EMS equipment or personnel jeopardizes patient health and impacts the ability of the EMS personnel to provide emergency services to the rest of the community.

The Atlanta Regional Office welcomes the opportunity to work with provider organizations to develop a legal and effective way to manage the larger issues raised by this practice.

FHA Task Force on

Addressing the Crisis in Emergency Care Services

December 2005

EXECUTIVE SUMMARY

Florida is facing a crisis in providing emergency care to the citizens of Florida. Multiple challenges face our hospital emergency departments (EDs) on a daily, if not hourly, basis. These include providing on-call specialty care coverage, increased volumes and backlogs of patients requiring care, overcrowding that causes delays in patient care delivery, providing emergency obstetrical care, use of the ED for routine care, and the delays in care for emergency medical services (EMS) due to ambulance diversion and/or transfers.

To address the crisis in emergency care services, the Florida Hospital Association (FHA) convened a task force to explore the problems in the delivery of emergency care services and develop recommendations on how to solve those problems. Based on the task force findings, Florida's emergency care challenges stem from several things:

- **Increased patient volumes** both in the ED and the inpatient setting fueled by Florida's growing and aging population, significant number of tourists and retired, seasonal residents. Additionally, lack of community mental health services is placing an additional burden on Florida's acute care hospitals and EDs.

- **Lack of hospital capacity,** impacted by fewer hospital beds, sicker patients requiring specialized beds, fewer hospital EDs, and shortages of nurses and other health professionals to care for patients.

- **Shortages of physicians taking ED on-call coverage** due to physician supply not keeping up with demand, physicians no longer providing clinical care, physicians practicing in outpatient settings and no longer needing hospital privileges, stagnant medical school enrollment, medical students leaving the state for their residency programs, challenges in obtaining licenses, hospital privileges, and contracts with health plans. Shortages of specialists, such as ENT, neurosurgery, hand surgery, and orthopedic surgery, have reduced the supply of those willing to cover the ED.

- **Medical liability issues** impact the reluctance of physicians to take on-call coverage because of the increased risk of litigation.

- **Florida's growing uninsured and under-insured population** who rely on the ED as their "safety net" or source of primary care.

- **Use of the ED for non-emergencies** because of convenience, delays in getting appointments with physicians, and lack of alternative sites for after-hours, non-emergency care.

- **Effective use of EMS** constrained by state laws that require all patients be taken to the hospital ED if they request it, even if the patient might need minor treatment or could be treated in an alternative care site. The EMS community is also facing shortages of paramedics and emergency medical technicians (EMTs) as demand for their services increases.

- **Antiquated regulations at the state level,** which include lack of clarity in the hospital ED licensure laws for requirements for both service capability and a state exemption; EMS laws requiring transport of patients regardless of whether the patient actually requires emergency care and limiting the type of care paramedics may provide in the field; Baker Act receiving facilities being ineligible for reimbursement from the Department of Children and Families (DCF); and a lengthy process to file for a Limited License for those physicians interested in volunteering in clinics that serve the uninsured.

- **Regulatory ambiguity at the federal level** in the Emergency Medical Treatment and Active Labor Act (EMTALA) which discourages innovative ways to treat the patient. Hospitals are fearful of EMTALA violations despite data that show there are very few complaints and only a fraction of those are violations, most of which are documentation issues.

Recommendations

After several meetings and conference calls, the FHA Task Force agreed upon the following recommendations as potential strategies for easing the problems in Florida's emergency care system.

1. Ease overcrowding in hospital EDs:
   a. Maximize the effective use of the hospital ED.
      1) Expand chapter 401, F.S., the EMS Scope of Practice, to permit EMTs and paramedics to treat patients not requiring hospital emergency care in the field.
      2) Modify chapter 401, F.S., to allow EMS to transport patients, under the supervision of the EMS medical director, to the most appropriate licensed setting for the patients' needs. These facilities must agree to treat all patients regardless of their ability to pay. Hospital-based ambulances would continue to comply with EMTALA regulations.
      3) Consider using physician assistants (PAs) or Advanced Registered Nurse Practitioners (ARNPs) in conjunction with EMS to treat patients not requiring emergency care.
      4) Encourage physicians, county health departments, and federally qualified community health centers (FQHCs) to offer extended office hours to their patients.
      5) Increase the availability of alternative sites for non-emergency care.
      6) Offer "bridge" antibiotic programs to avoid ED visits for medications.
      7) Educate the public and provide information regarding alternatives to the ED and the potential out-of-pocket cost differences.
      8) Educate physicians as to the availability of other care sites and incentivize them not to inappropriately use the ED.
      9) Work with health plans to educate their members on alternative sites of care for non-emergency conditions.
      10) Explore community case management programs through county health departments, hospitals, and EMS to better manage patients frequently using the hospital ED for nonemergent care.
      11) Identify a master list of urgent care centers.

2. Reduce backlogs in the ED:
   a. Ensure that EMS patients are off-loaded to the hospital ED as quickly as possible.
      1) Encourage prompt off-load of EMS patients by designating a person in the ED to be responsible for ambulance receiving.
      2) Change the scope of practice to allow EMS to help with off-loading patients in the hospital ED subject to each hospital's protocol.
      3) Develop regional dispatch programs to better coordinate patient transportation.

4) Implement a real-time communication system which allows EMS, hospitals, and emergency physicians to know the availability of services, current capacity, and on-call specialties at each hospital.

b. Explore ways of improving the medical screening process.
   1) Educate hospitals on how registered nurses and other personnel could be used to provide medical screening exams in the ED.

c. Promote innovative strategies to increase patient throughput in the ED.
   1) Implement programs such as a hospital "bed czar" to oversee the demand and resource needs for the entire hospital.
   2) Identify processes to minimize ED patient wait times for admission to hospital or a critical care bed.
   3) Identify best practices for defining patients requiring critical care plans.
   4) Encourage each hospital to develop an "ED overcapacity crisis plan."
   5) Use hospitalists, internists, and PAs to manage the inpatient stay.
   6) Work with medical staff to ensure timely patient discharge or transfers.
   7) Explore creating alternative areas in which to discharge patients no longer needing acute care.
   8) Evaluate standing orders for consults to determine appropriateness.

d. Ensure there is an adequate supply of nurses, paramedics, and allied health professionals to take care of Florida's growing and aging population.
   1) Develop and implement equivalency measures to allow Florida to streamline the licensure process between states for nurses, paramedics, and other allied health professionals.
   2) Expand funding of Florida nursing school programs, nurse faculty positions, and allied health training programs such as radiology and ultrasound technologists.

3. Ease shortage of physicians willing to take ED call:
   a. Increase the supply of physicians.
      1) Require the medical licensure boards to expand and enhance data on physicians to allow assessment of physician characteristics, medical specialty, and practice settings.
      2) Mandate that the Board of Medicine monitor gaps in the availability of specialties.
      3) Increase state funding for residency programs.
      4) Develop strategies, such as incentives or grants, to encourage Florida medical school graduates to stay in Florida.
      5) Consider using physicians with medical degrees without a Florida license as a "house" physician.
      6) Modify requirements for limited licenses to permit a more expedited application and licensure process for physicians wanting to volunteer to help the uninsured.
      7) Streamline hospital and health plan credentialing processes to expedite granting of privileges to newly licensed and out-of-state physicians interested in practicing in Florida.
   b. Encourage licensed physicians to take ED call.
      1) Explore the option of community-based ED call coverage to determine the feasibility and whether antitrust exemptions are necessary to implement.
      2) Explore potential revenue sources to provide funding to those hospitals and physicians treating uninsured patients in the ED.
      3) Develop data to create a litigation immunity zone for emergency services to protect EMS, EMS medical directors, hospitals, and physicians.

4. Modernize regulations to reflect the changing dynamics of healthcare:
   a. Maintain state laws but modify to reduce some of the confusion with the Florida Access to Care laws.

1) Educate hospitals on the current capability, exemption, and complaint requirements under state law.
2) Modify the Agency for Health Care Administration (AHCA) form for exemptions to change the requirement to seek local community transfer agreements from hospitals in a 50-mile radius to either the five closest hospitals or all hospitals within a 10-mile range.
3) Analyze the state's inpatient database to determine the extent of hospitals' problems with providing services on an emergency basis.
4) Evaluate the impact of the current public policy that encourages more specialties to function outside the hospital and not be available for ED coverage.
5) Expand the Baker Act to allow private hospitals to be eligible for reimbursement from DCF.
6) Develop guidelines for crisis stabilization units (CSUs) to require a mental health and medical screening exam prior to leaving the CSU and to call ahead to the ED to make arrangements prior to transfer to a hospital ED.
7) Increase funding of community mental health services to minimize the reliance on acute care hospitals to treat these patients.

b. EMTALA Interpretative Guidelines should be modified to reflect the current healthcare environment.
   1) Modify the EMTALA Interpretative Guidelines to either encourage, or at least not discourage, hospitals that want to create innovative on-call coverage.
   2) Reevaluate the original intent of the law and allow more flexibility in where patients are treated, including facilities outside the hospital.
   3) Change the 23/90-day termination process to permit more due process before threatening to publicize the alleged violation or withdrawing Medicare certification based on the alleged violation.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-06-21

DATE: **July 13, 2006**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: **EMTALA -** "Parking" of Emergency Medical Service Patients in Hospitals

Letter Summary

- The Centers for Medicare & Medicaid Services (CMS) has received reports from hospital emergency departments concerning patients being left on stretchers for extended periods of time with emergency medical service personnel in attendance, possibly in violation of the Emergency Medical Treatment and Labor Act.
- CMS recognizes the enormous strain and crowding many hospital emergency departments face every day; however, this practice is not a solution.
- "Parking" patients in hospitals impacts the ability of the emergency medical service personnel to provide emergency services to the rest of the community.

The Centers for Medicare & Medicaid Services (CMS) has learned that several hospitals routinely prevent Emergency Medical Service (EMS) staff from transferring patients from their ambulance stretchers to a hospital bed or gurney. Reports include patients being left on an EMS stretcher (with EMS staff in attendance) for extended periods of time. Many of the hospital staff engaged in such practice believe that unless the hospital "takes responsibility" for the patient, the hospital is not obligated to provide care or accommodate the patient. Therefore, they will refuse EMS requests to transfer the patient to hospital units.

This practice may result in a violation of the Emergency Medical Treatment and Labor Act (EMTALA) and raises serious concerns for patient care and the provision of emergency services in a community. Additionally, this practice may also result in a violation of 42 CFR 482.55, the Conditions of Participation for Hospitals for Emergency Services, which requires that a hospital meet the emergency needs of patients in accordance with acceptable standards of practice.

A hospital has an EMTALA obligation as soon as a patient "presents" at a hospital's dedicated emergency department, or on hospital property (as defined at 42 CFR 489.24(b)) other than the dedicated emergency department, and a request is made on the individual's behalf for examination or treatment of an emergency medical condition. A patient who arrives via EMS meets this requirement when EMS personnel request treatment from hospital staff. Therefore, the hospital must provide a screening examination to determine if an emergency medical condition exists and, if so, provide stabilizing treatment to resolve the patient's emergency medical condition. Once a patient presents to the dedicated emergency department of the hospital, whether by EMS or otherwise, the hospital has an obligation to see the patient, as determined by the hospital under the circumstances and in accordance with acceptable standards of care.

EMTALA obligations would also apply to a hospital that has accepted transfer of a patient from another facility, as long as it is an "appropriate transfer" under EMTALA. An appropriate transfer is one in which the transferring hospital provides medical treatment that minimizes risks to an individual's health and the receiving hospital has the capability and capacity to provide appropriate medical treatment and has agreed to accept transfer (42 CFR 489.24(e)(2)). Therefore, the expectation is that the receiving facility has the capacity to accept the patient at the time the transfer is effectuated. A hospital that delays the medical screening examination or stabilizing treatment of a patient who arrives via transfer from another facility, by not allowing EMS to leave the patient, could also be in violation of EMTALA.

CMS recognizes the enormous strain and crowding many hospital emergency departments face every day. However, this practice is not a solution. "Parking" patients in hospitals and refusing to release EMS equipment or personnel jeopardizes patient health and impacts the ability of the EMS personnel to provide emergency services to the rest of the community.

For questions on this memo, please contact Donna Smith at (410) 786-3255 or by email at Donna.Smith@cms.hhs.gov.

Effective Date: Immediately. The State agencies should disseminate this information within 30 days of the date of this memorandum.

Training: The information contained in this announcement should be shared with all survey and certification staff, surveyors, their managers, and with managers who have responsibility for processing EMTALA complaints.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)