Understanding the latest changes in

EMTALA:

Our country's emergency care safety net

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On April 7, 1986, President Ronald Reagan signed into law the Consolidated Omnibus Budget Reconciliation Act of 1985, which incorporated legislation known as the Emergency Medical Treatment and Active Labor Act (EMTALA) to address the problem of "patient dumping" by hospital emergency departments. While EMTALA was originally intended to serve as a safety net for emergency patients, the statute grew in both scope and complexity during the following two decades, leaving physicians and hospital administrators confused about their respective responsibilities under the law.

During the 1990s, this confusion, particularly with respect to physician on-call requirements, grew to such mammoth proportions that the affected parties began petitioning Congress and the Health Care Financing Administration, now known as the Centers for Medicare & Medicaid Services (CMS), for clear and understandable guidance about EMTALA mandates. As part of this effort, physician and hospital groups also urged Congress and the agency to revise the regulations to better reflect the statute's original intent.

These efforts paid off when CMS finally issued new EMTALA regulations that went into effect November 10, 2003. The new rules provide guidance that better clarifies physician and Medicare-participating hospital responsibilities under the law.

This article examines the main tenets of the revised EMTALA regulations and their positive impact on the future of surgical practice and emergency surgical care and highlights lingering issues that need to be addressed. Finally, the article considers new trends in the delivery of care that are influencing emergency care.

Obligations for hospitals

In January 1985, San Francisco General Hospital became the final destination for the triage and treatment of Eugene "Red" Barnes, a 32 year-old unemployed mechanic who had been fatally wounded when he was stabbed in an altercation outside an abandoned hotel in Richmond, CA. An investigation into the emergency care that Mr. Barnes received before arriving at San Francisco General revealed a number of weaknesses in our country's emergency care safety net for the uninsured—primarily the lack of a federally mandated obligation for hospitals to examine, treat, and stabilize all patients with an emergency condition regardless of the patient's insurance coverage.

Under EMTALA, this mandate is triggered when an individual comes to a hospital's dedicated emergency department or presents on hospital property and requests an examination or treatment for a medical condition or a request is made on the individuals' behalf. (The interpretation of what constitutes a "hospital emergency department" has expanded and contracted over the years. The current regulations state that a dedicated emergency department is defined as any department of the hospital, located on or off the main hospital campus, that is licensed by the state as an emergency department, is presented to the public as providing emergency services, or has provided at least one-third of its outpatient visits for treatment on an urgent basis during the previous year.[1]) In the absence of such a patient request, EMTALA would also apply if a prudent layperson would believe that an individual needs examination or treatment for a medical condition. Exceptions to this rule are individuals who come to off-campus outpatient clinics that do not routinely provide emergency services or to those patients who have begun to receive scheduled, nonemergency outpatient services at the main campus of the hospital.

Once the hospital determines that the individual does indeed have an emergency medical condition, that hospital must stabilize the patient or, if it is unable to do so, must transfer the patient to a hospital that is capable of providing such treatment. The latter aspect of this requirement was included to ensure that patients with severe injuries or very complex medical conditions are examined and triaged to the appropriate acute care center as quickly as possible.

Physician obligations

Many surgeons complain about the numerous EMTALA obligations that the federal government has imposed on the physician community. In truth, the statute does not place any direct obligations or liabilities on physicians. EMTALA focuses its mandates on hospitals or "agents of the hospital" (for example, hospital medical staff or on-call physicians). It is when they fall into the latter group

that physicians come under the scrutiny of the law.

Close examination of EMTALA reveals that the statute maintains that the hospital, not its medical staff or individual physicians, is responsible for maintaining an on-call roster for the emergency department. However, when physicians join the medical staff of a hospital or agree to take call, they become a "responsible physician" under EMTALA by virtue of entering into a contract with the hospital to examine, treat, and/or transfer individuals who are covered by the law.[2] In doing so, they become agents of the hospital and therefore share responsibility and liability with the hospital for providing EMTALA-related services, regardless of whether the contract references EMTALA responsibilities.

Because the final responsibility for maintaining on-call coverage falls on the hospitals, the medical staff bylaws for these institutions usually include language that requires physicians to comply with hospital policies and procedures as a condition of maintaining their clinical privileges at the hospital.[3] This language, which is congruent with standards issued in the Joint Commission on Accreditation of Healthcare Organizations' manual, encompasses the hospital's policy for on-call coverage.

Although surgeons "voluntarily" accept their role as agents of the hospital when they secure privileges, many of them receive little training regarding the EMTALA guidelines and, thus, are often unsure of their responsibilities under the statute. This fact was illustrated in a past survey of hospital emergency departments conducted by the Department of Health and Human Services (HHS) Office of Inspector General (OIG). In a 2001 report, the OIG found that "training increases EMTALA awareness, and nearly two-thirds of emergency physicians, nurses, and registration staff receive training. However, only one-quarter of on-call specialists are trained in EMTALA guidelines."[4]

Since the inception of EMTALA, surgeons have found it difficult to distinguish between their responsibilities under the law versus "policy" developed by hospitals to comply with EMTALA. The following sections of this article examine the various issues that surgeons should be aware of when serving as an agent of the hospital, either on its medical staff or on an on-call panel.

Penalties, enforcement, and resolution of EMTALA violations

When CMS receives a report of an alleged EMTALA violation, the agency's regional office sends state surveyors to conduct an investigation. Generally, in determining ETMALA compliance CMS will consider all relevant factors and look for specific patterns of care that could point to EMTALA infractions.

Hospitals that fail to comply with EMTALA-mandated responsibilities may have their Medicare participation terminated and may be subject to civil penalties of up to $50,000 per violation. If a physician serving as "an agent of the hospital" on its on-call panel is called by the hospital to provide emergency screening or treatment and either fails or refuses to appear within a reasonable period of time, that physician may be in violation of EMTALA and could also face fines of up to $50,000 per violation. Patients who have suffered physical harm and hospitals that believe they have incurred a financial loss due to an inappropriate transfer also have a private right of action against hospitals that violate EMTALA.

In its January 2001 report, *The Emergency Medical Treatment and Labor Act: The Enforcement Process* (available at *http://oig.hhs.gov/oei/reports/oei-09-98-00221.pdf*), the HHS OIG recommended that CMS make certain that providers will not be terminated from the Medicare program for an EMTALA violation without peer review. Congress implemented that recommendation in the Medicare Prescription Drug, Improvement, and Modernization Act by requiring HHS to request a quality improvement organization review before making a compliance determination that would terminate a hospital's Medicare privileges. An exception to this rule would be in the case when a delay would jeopardize the health and safety of the individual. Also, in response to complaints from hospitals and physicians that they are kept in the dark as to whether an EMTALA investigation, once opened, is ongoing or has been resolved, the act also requires that a procedure be established to notify hospitals and physicians when an EMTALA investigation is closed.

On-call requirements

EMTALA requires that Medicare-participating hospitals maintain an on-call list of physicians to provide services to patients who seek care in hospital emergency departments. CMS has provided several memoranda and guidance documents since the original EMTALA regulations were released to help clarify various provisions of the act, including the on-call provisions. Despite the agency's attempts to alleviate the ambiguity, it has remained a challenge for physicians to know what EMTALA mandates, whether hospital bylaws relating to emergency care are actually required by EMTALA, and how the law should be interpreted in specific circumstances.

The most onerous and perhaps most confusing aspect of EMTALA for surgeons and other physicians are the on-call requirements. Hospitals, often for fear of violating EMTALA, impose unrealistic on-call requirements on their physicians. It is not uncommon for a single specialist who covers multiple hospitals to be required, as a condition of joining a hospital's staff, to be on-call 24 hours a day, seven days a week. In some cases, surgeons have been expected to leave their office practice activities, or even an operation, in order to respond to emergency department calls at the hospitals for which they have privileges. A "24-7" demand for on-call services creates such unrealistic schedules and unreasonable demands for surgeons and other specialists that a number of these physicians have altered their practices, often dropping privileges at a number of hospitals, in an effort to maintain viable practices and some semblance of quality of life.

Many areas of the country have an insufficient population base to support a large number of specialists in certain fields such as neurosurgery, cardiovascular services, pediatric surgery, obstetrics/gynecology, and orthopaedics. This situation is especially true in rural areas and in areas that have small hospitals providing care to populations spread out over a great distance. Being selective about the day or circumstance for providing on-call services in these areas is usually not an option for these high-risk specialties.

Recognizing this burden, CMS revised the on-call language to state that a hospital's on-call list must be maintained in a manner that best meets the needs of the hospital's patients who are receiving services required under EMTALA *in accordance with the capability of the hospital, including the availability of on-call physicians*. CMS intended this modification to provide more flexibility for hospitals and their medical staffs to determine how best to provide emergency medical care and respond to on-call needs. The agency states that these decisions can be made reasonably only at the individual hospital level through coordination between the hospitals and their staffs of physicians.[1]

CMS issued this clarification in the latest regulations because of confusion over one of the most heavily perpetuated myths about EMTALA—the existence of the "rule of three," which states that if a hospital has more than three physicians within a specialty, it must provide continuous emergency department coverage for that specialty. CMS makes it clear that no such rule exists; however, many hospitals have developed policies based on this principle, and physicians historically have been led to believe that it is mandated by EMTALA.

Some people have argued that EMTALA should require a minimum number of hours for individual physicians to be on call, the times for which physicians should be on call, or the number of physicians needed to fulfill on-call responsibilities at particular hospitals. CMS has rejected these proposals from a practical standpoint. The agency maintains that the wide variations with regard to medical staff size, specialty mix, and general capabilities that exist among institutions that participate in the Medicare program make it infeasible to mandate a particular minimum level of on-call coverage that must be maintained by all hospitals.

The latest changes to EMTALA provide other specific clarifications regarding on-call requirements that are aimed at allowing hospitals and their medical staffs to develop more realistic policies and procedures to achieve the goals of EMTALA and to address critical issues that have long concerned surgeons and other physicians with regard to the regulations.

Of course, many surgeons hold privileges at several hospitals, particularly in areas where shortages of certain specialties exist. CMS has only recently established that it is in the best interests of patients and hospital emergency departments that physicians be permitted to be on-call at more than one hospital simultaneously.[5] In updating its policy,

the agency recommends that hospitals notify each other when a physician is on-call at more than one hospital simultaneously and that each facility be aware of the physician's on-call schedule. Furthermore, hospitals must have in place written policies and procedures for when a physician is on-call at another hospital and is unable to respond. Such policies and procedures could include arranging for a back-up on-call physician or executing an appropriate transfer.[1]

Performing elective surgery while on call has become another issue that surgeons struggle with in order to maintain their regular busy practice while fulfilling EMTALA requirements. In the past, CMS has made conflicting statements in guidelines regarding whether physicians who cannot respond to an emergency call because they are performing elective surgery have violated EMTALA. In the current regulations, the agency states that EMTALA does not prohibit surgeons from performing elective surgery while on call. This is welcome news to many surgeons who are on call for days or weeks at a time.

Scope of privilege

"Many physicians limit their scope of practice to well-defined subspecialty areas, even though they are often credentialed by their hospitals to perform all surgery for the broader specialty for which they are board-certified."[1] For example, a neurosurgeon with limited privileges for spine surgery would argue that he or she is not required to take call for head trauma. Surgeons should be aware that CMS addresses this issue in the current regulations, and hospitals may soon begin to move toward defining core privileges for a number of specialties.

CMS states that "a physician who is in a narrow specialty may, in fact, be medically competent in his or her general specialty, and in particular may be able to promptly contribute to the individual's care by bringing to bear skills and expertise that are not available to the emergency physician or other qualified medical personnel at the hospital."[1] CMS also stresses that while the emergency physician and the on-call specialist may need to discuss the patient's best treatment options, the agency believes any disagreement between the two regarding the need for the on-call physician to come to the hospital and examine the individual must be resolved by deferring to the medical judgment of the emergency physician or other practitioner who has personally examined the individual.[1]

Although the new EMTALA regulations clarify that on-call coverage determinations are to be made jointly by the hospital and the physicians on its on-call roster, the hospitals are in the position of ensuring that policies and procedures are in place to provide coverage of emergency department services. In turn, physicians practice at hospitals under privileges extended to them by those institutions. If a physician refuses to assume on-call responsibilities or to carry out the responsibilities he or she has assumed, the hospital could suspend, curtail, or even revoke the offending physician's privileges.

Hence, hospitals retain a tremendous amount of leverage in the development of on-call policies and schedules. Despite this fact, surgeons should take solace in knowing that they now have more concrete knowledge of EMTALA's requirements—an invaluable asset when negotiating privileges with hospitals, working to maintain a viable practice, and striving to provide comprehensive emergency care in their communities.

Some individuals may argue that CMS's most recent actions "relax" EMTALA standards and endanger the safety net established by the law. Physicians believe that the EMTALA clarifications promise to have a positive effect on a situation that has been, up to now, increasingly unsustainable.

Managed care reimbursement

Managed care plans often require preauthorization for services delivered in the emergency room. Under EMTALA, though, Medicare-participating hospitals or physicians are barred from seeking preauthorization before providing medical treatment unless such activities do not delay required screening and stabilization services. Thus, hospitals and physicians often wind up in a financial quandary when treating managed care patients in the emergency room—either forgoing payment or risking the imposition of EMTALA fines.

A key provision in the new Medicare Prescription Drug, Improvement, and Modernization Act (MPDIMA), which was signed into law December 8, 2003, addresses the issue of managed care plans making retrospective denials for emergency screen-

ing and stabilization services. Under MPDIMA, medical necessity determinations for EMTALA services must be made "on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis)."[1]

Many experts in the medical community and in Congress have long advocated requiring managed care plans to pay for justifiable screening and treatment services provided under EMTALA. Hopefully, this key reform in the Medicare prescription drug law will resolve many of the disputes that hospitals and physicians often encounter with the managed care community's approach to reimbursement for emergency care services.

General responsibilities of EMTALA Technical Advisory Group

1. Review EMTALA regulations.
2. Provide advice and recommendations to the HHS Secretary with respect to those regulations and their application to hospitals and physicians.
3. Solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations.
4. Disseminate information on the application of such regulations to hospitals, physicians, and the public.

Technical Advisory Group

Another key provision of MPDIMA establishes a new EMTALA Technical Advisory Group "to review issues related to EMTALA and its implementation." Membership in the advisory group will consist of 19 individuals, including the Administrator of CMS and the OIG. Seven slots on the advisory group are reserved for representatives from the physician community in the areas of emergency medicine, cardiology or cardiothoracic surgery, orthopaedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry.[1] The physician and hospital communities are optimistic that this new group will help CMS in its future deliberations on implementing changes in EMTALA regulations.

Issues remain

While the federal government has come a long way in addressing the concerns of the medical community regarding the scope of EMTALA, a number of issues remain that will continue to affect access to emergency surgical care. These issues include: managed care reimbursement policies and emergency room overcrowding; proliferation of single-specialty hospitals; lack of liability protections for EMTALA-related services; and growing burdens on trauma centers and community hospitals.

While Congress has now addressed the issue of managed care reimbursement for EMTALA-related services, a number of other practices used by this industry continue to place stress on the emergency care safety net. One such pressure revolves around patients' inability to receive timely access to specialty care in the nonhospital setting. More often than not, managed care plan enrollees, some of whom are knowledgeable about EMTALA requirements, may use the emergency room when they cannot get an appointment with their regular specialist or primary care physician. Add to this number the more than 40 million uninsured who view the ER as their primary source of health care, and the result is massive overcrowding. This kind of nonemergent saturation of emergency room departments across the country, particularly in urban areas, is resulting in numerous injured patients being unnecessarily diverted—causing critical delays for individuals requiring acute care.

Furthermore, while many physicians are heralding the recent changes in EMTALA's on-call requirements, others, particularly in the trauma community, are worried that these changes will further exacerbate the financial difficulties facing trauma centers and community hospitals. Under EMTALA, hospitals are now only required to maintain an on-call list "in a manner that best meets the needs of the hospital's patients in accordance with the capability of the hospital, including the availability of on-call physicians."[1]

Many trauma professionals believe that this change in the regulation will provide hospitals, particularly for-profit entities, with the ability to shield themselves from caring for severely injured patients by limiting on-call schedules. For example, some hospitals may only provide on-call coverage until 9:00 pm every night—leaving the local trauma center as the provider of last resort.

One trend that will likely grow as a result of this change will be the increased demands by specialists for hospitals to provide on-call compensation or stipends for emergency room coverage. The trauma community views this situation as yet another financial burden that trauma centers and community hospitals will have to bear in order to maintain their trauma designation or keep the doors of their emergency room open.

Some other factors that will likely influence the viability of trauma centers in the future include lack of medical liability protections for EMTALA-related services and the exploding growth of specialty hospitals in areas such as cardiac and orthopaedic care. Congress is examining both of these issues. In terms of medical liability protection, some legislators are calling for a narrow approach to medical liability reform that would focus solely on providing caps on noneconomic damages for EMTALA and ob-gyn services. With regard to the growth of specialty hospitals, Congress has imposed an 18-month moratorium on physician investments in specialty hospitals through mid-2005 in order to study the impact of this growing trend in care delivery on patient access to specialty services, particularly in the emergency room environment.

Suggestions from surgeons

In drafting this article, I reached out to a broad array of surgeons from all parts of the country—physicians who are on the frontlines of providing emergency surgical care. Without exception, all of them applauded the recent changes in EMTALA. Some of them also had very good suggestions regarding aspects of the law that should be addressed to better enhance timely patient access to specialized emergency care. These suggestions include better hospital triage and transfer policies, more flexibility regarding on-call response time, and evaluation of hospital staff cutbacks and recent implementation of the 80-hour resident workweek on hospital capacity.

While greatly abbreviated, the preceding comments were all presented to me with one goal in mind—improving care for the emergency patient. Surgical schedules and caseloads are increasing, reimbursement is declining, and liability insurance premiums are skyrocketing. In the twenty-first century, these trends have led many surgeons to alter their practices in ways that would have seemed unimaginable a decade ago—limiting scope of privileges, dropping participation in hospital medical staffs, and requesting stipends for providing on-call coverage.

While many individuals outside the profession mistakenly view these changes in surgical practice as selfish and self-serving, surgeons know that these modifications have often become necessary to maintain a viable practice where they may continue treating patients, albeit for a reduced range of services. Despite this fact, surgeons with whom I have spoken say that they still view the provision of charity care as an integral part of why they became physicians and that they anticipate being able to continue to provide these services to the local community.

It is a shame that the last 20 years of government involvement in strengthening the emergency care safety net may have inadvertently weakened it to the breaking point. Surgeons, in general, say that to mend this safety net our country and government must recognize the public good that emergency medical and trauma systems provide to

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ACS Insurance Program: Update on major medical products

The Trustees of the American College of Surgeons Insurance Program approved a rate increase for participants under age 65 and their dependents on the conventional major medical product and on the cost advantage major medical product of 25 percent and 30 percent, respectively, effective October 1, 2003, and 5 percent effective April 1, 2004. There will be no increase for members age 65 and over at this time. The premium rates for these products are based primarily on the actual claim experience of the ACS risk pool, which recently has not been favorable.

The Trustees feel that New York Life Insurance Co., the insurer, and CBCA administrators, the plan administrator, provide quality services to our members. However, the approximate 850 plan participants is a relatively small risk pool and, as a result, the College's products may not always be cost-competitive when compared to other products that have a much larger risk pool as a basis for their rate setting. If premium cost on your major medical coverage is a concern, the Trustees encourage you to compare the American College of Surgeons Insurance Program major medical cost with other products available to you in the market. Our members should make the appropriate decision that best suits their insurance needs.

If you have any questions, please contact the plan administrator at 1-800/433-1672.

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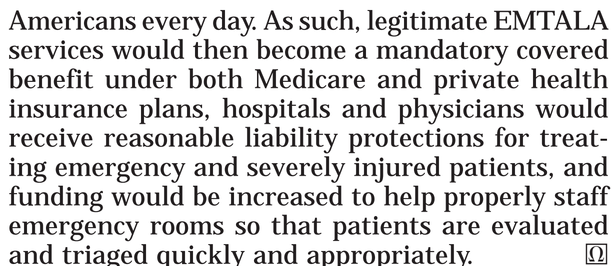

Americans every day. As such, legitimate EMTALA services would then become a mandatory covered benefit under both Medicare and private health insurance plans, hospitals and physicians would receive reasonable liability protections for treating emergency and severely injured patients, and funding would be increased to help properly staff emergency rooms so that patients are evaluated and triaged quickly and appropriately. Ω

Acknowledgement

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Correction

The January issue of the *Bulletin* featured an article titled "The Swedish Patient Compensation System: A viable alternative to the U.S. tort system?" by Susan Hershberg Adelman, MD, FACS, and Li Westerlund, JD. The academic titles for Dr. Westerlund should have read "JD, LLM, PhD." The editors regret the omission.