# On-Call Issue Dominates EMTALA Panel Meeting

BY JENNIFER SILVERMAN
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WASHINGTON — On-call emergency care dominated the agenda at the first meeting of the Department of Health and Human Services technical advisory group on the Emergency Medical Treatment and Labor Act.

EMTALA, enacted in 1986 to ensure public access to emergency services regardless of ability to pay, requires hospitals to maintain a list of physicians who are on call to the emergency department. Hospitals have the discretion to maintain these lists in a way that "best meets the needs" of the hospital's patients.

The Medicare Modernization Act of 2003 required HHS to establish a technical advisory group to review EMTALA regulation.

While the obligation to provide the on-call list falls on the hospital, physicians assume new liability and other obligations once they agree to take on-call responsibilities, Charlotte Yeh, M.D., an emergency physician and advisory group member, said in an interview.

Hospitals cannot force physicians to be on call, although individual hospital policies may require on-call services as a condition for having privileges, she said. "Factor in issues such as reimbursement, and the physician is asking himself: Why should I do this? And that's how physicians get into the EMTALA debate."

Hospital groups who testified before the advisory group said their emergency care was suffering due to physicians' unwillingness to provide on-call services.

"It has become increasingly difficult for hospitals to manage their on-call rosters in a manner that best meets the needs of their patients because of their trouble filling on-call slots," said Jeff Micklos, vice president and general counsel for the Federation of American Hospitals.

"Also, there no longer is any certainty that an on-call physician will report for duty when called," he said. Physicians say that economic, medical practice, and lifestyle considerations affect their desire and ability to provide on-call coverage. As a result, they'll either refuse to be on call, or want to be paid ever-increasing fees, "which adds to EMTALA's practical effect as an unfunded mandate for hospitals," Mr. Micklos said.

Physician-owned specialty hospitals, already a volatile issue, have exacerbated the on-call issue, said Mary Beth Savary Taylor, who spoke on behalf of the American Hospital Association. "Physicians who own limited-service hospitals often refuse to participate in emergency on-call duty at community hospitals, leaving them struggling to maintain [emergency department] specialty coverage."

Hospitals are at a disadvantage, as they can be terminated from Medicare and Medicaid for any kind of noncompliance under EMTALA, whereas physicians are terminated only in cases where the violation is "gross, flagrant, and repeated," Ms. Taylor said. To provide hospitals with some type of due process, the Centers for Medicare and Medicaid Services should revise its regulations to establish an administrator-level appeals process—before a CMS regional office issues a finding of noncompliance and public notice of termination, she said.

Leslie Norwalk, CMS deputy administrator, said that the agency could issue guidelines to hospitals on how they could protect themselves from lawsuits. "We'd like to help so courts will not punish [hospitals] for doing the right thing."

Mr. Micklos asserted that the statute's obligations should apply equally to hospitals and physicians, noting that a hospital "can only can be as good as the physicians on its medical staff."

**Physicians will refuse to be on call or demand ever-increasing fees, adding 'to EMTALA's practical effect as an unfunded mandate for hospitals.'**

EMTALA states that on-call coverage is a joint decision between hospital administrators and physicians who provide on-call coverage, said Jason W. Nascone, M.D., who testified on behalf of the American Association of Orthopaedic Surgeons and the Orthopaedic Trauma Association.

"But it is unrealistic to expect physicians to work together with hospitals in developing and implementing on-call plans if physicians aren't included as equal partners with more authority, oversight, and control in the development and implementation of these plans," he said.

Interpretive guidelines developed to clarify hospitals' EMTALA responsibilities should be amended to further encourage true partnership arrangements between hospitals and physicians, Dr. Nascone said.

Physician groups urged CMS to adopt an affirmative rule prohibiting hospitals from requiring physicians to provide 24-7 emergency call coverage.

"We support the rule that physicians are not required to be on call at all times, but we fear that this provision doesn't go far enough to protect on-call physicians from nevertheless being required by hospitals to provide continuous emergency on-call coverage," Alex B. Valadka, M.D., who spoke on behalf of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons, testified.

Physicians also had concerns about a provision requiring response time to be stated in "minutes." The advisory group should recommend modifications that such response times could be stated in a range of minutes, Dr. Valadka said. "Exceptions should be explicitly permitted in situations when the on-call physician cannot respond within the stated time frame because of circumstances beyond his or her control."

The advisory group will be advising HHS and the administrator of the CMS on issues related to EMTALA. It includes hospital, physician, and patient representatives, in addition to CMS and state officials and one representative from a Quality Improvement Organization.

No recommendations were issued at the meeting. The advisory group decided to form a subcommittee that would address the large volume of concerns about on-call issues. ■

# *Coalition Defines Set of 26 Clinical Care Measures*

BY MARY ELLEN SCHNEIDER
*Senior Writer*

Taking a crucial first step in an effort to make pay for performance work for office-based physicians, a coalition of physician groups, insurers, and the federal government has endorsed a set of 26 clinical-performance measures for the ambulatory care setting.

The coalition—the Ambulatory Care Quality Alliance (AQA)—was formed last year by the American Academy of Family Physicians, the American College of Physicians, America's Health Insurance Plans, and the federal Agency for Healthcare Research and Quality.

The starter set of 26 measures focuses on prevention, chronic care, and the overuse and misuse of certain treatments. The set could be implemented as early as next year

"This is a watershed event," said William E. Golden, M.D., professor of medicine and public health at the University of Arkansas in Little Rock.

The announcement of the 26-measure starter set signals the beginning of an era in which physician performance in the aggregate will be monitored and assessed, he said.

Creating a single set of measures that can be used across health plans is key, Dr. Golden said. It means that physicians won't need to gather different types of data from each patient, he said, and it will allow for increase comparability of patient care.

"The ultimate goal is to improve the quality of care," said John Tooker, M.D., CEO and executive vice president of the American College of Physicians. AQA's starter set of measures was assembled from existing measures developed by either the Physician Consortium for Performance Improvement or the National Committee for Quality Assurance. Most of the measures are now under review by the National Quality Forum.

AQA compiled the set in part to reduce the administrative burden on physicians, Dr. Tooker said. Most physicians deal with multiple health plans and having a single set of uniform measures used across all plans would lessen the hassle factor for physicians, he said.

In addition to being less of an administrative burden, the measures are evidence-based and were developed with physician input, he said.

But this is just the beginning of the process. The measures still need to be validated in the field, Dr. Tooker said. He expects that the measures will be adopted as they are ready to be implemented, possibly as early as next year.

AQA will also work this year on setting standards for data aggregation and reporting.

And in the future, AQA plans to expand the measure set to include subspecialties outside of primary care.

The measures in the starter set were selected based on their clinical importance and scientific validity, feasibility, and their relevance to consumers, purchasers, and physician performance.

The starter set includes measures of preventive care related to breast cancer screening, colorectal cancer screening, cervical cancer screening, tobacco use and cessation, and vaccination for influenza and pneumonia. Other measures address chronic care of coronary artery disease, heart failure, diabetes, asthma, depression, and prenatal care.

The starter set also contains measures related to appropriate treatment for children with upper respiratory infections and appropriate treatment and testing for children with pharyngitis.

This movement toward performance measures and pay for performance programs is already happening in many parts of the country, said Alan Nelson, M.D., a member of the Medicare Payment Advisory Commission (MedPAC) and a special advisor to Dr. Tooker.

"The pressure is coming from the purchasers of care who are insisting on buying value," he said. "Medicare is taking the same approach."

Mark McClellan, M.D., administrator for the Centers for Medicare and Medicaid Services said his agency support the AQA's efforts to implement valid, reliable measures.

In a statement, Dr. McClellan called the initial set of measures a "milestone" in the area of ambulatory care. But Dr. Nelson said he is concerned that most solo and small group practices are not equipped to gather and document the data needed to show compliance with the measures. As this effort moves forward, physicians will need to create patient registries and create some easy and efficient way of collecting the data needed for pay for performance.

MedPAC has acknowledged that difficulty and recommended that under Medicare pay for performance initiatives, only information that can be collected through claims data should be used, he said.

Many of the performance measures that are being pushed by AQA are already in use within the Department of Veterans Affairs, said Rowen Zetterman, M.D., chief of staff at the VA Nebraska–Western Iowa Healthcare System in Omaha.

That bodes well for the success of programs that use the measures going forward since the VA has been able to significantly improve quality through its use of performance measures, Dr. Zetterman said. ■

*The starter-set measures are online at www.ahrq.gov/qual/aqastart.htm.*