Specialty Hospitals to Take On EMTALA Duties

BY CHRISTINE KILGORE
Contributing Writer

The technical advisory group examining the Emergency Medical Treatment and Labor Act put its efforts to rest in April with a final report that its physician members hope will make on-call service more workable and improve the statute's effects in the trenches.

The report recommends "community call" plans that share resources to fulfill EMTALA responsibilities, and emphasizes the obligations of specialty hospitals in meeting the on-call crisis. The advisory panel met seven times over 3 years to advise the Secretary of the Department of Health and Human Services on how to improve guidance and enforcement of EMTALA. The 19-member advisory group included Centers for Medicare and Medicaid Services (CMS) staff, the inspector general of HHS, various patient and hospital representatives, and physician representation. Several of the panel's recommendations to improve on-call systems already have been implemented.

The CMS has begun to make it clear that specialty hospitals are not exempt from EMTALA obligations. Furthermore, in a draft Inpatient Prospective Payment System regulation for fiscal year 2009, the agency is now proposing that hospitals be allowed to group together and form community call to meet their on-call responsibilities.

The panel "had a fairly circumscribed charge, in that they weren't being asked to tackle the big problems lurking behind EMTALA," said Barbara Tomar, director of federal affairs for the American College of Emergency Physicians. "They did a tremendous job in dealing with some incredibly technical and complex issues … in simplifying and clarifying language, and in refining what [EMTALA] means."

The panel did not let its limited charge—and the broader issues—go unnoticed. It included in its list of recommendations two "high-priority" items: HHS should amend EMTALA to include liability protection, and it should develop a funding mechanism for hospitals and physicians who provide care covered by the statute.

Like other TAG recommendations, the request for CMS to clarify its position on "shared or community call" and permit formal arrangements is a recognition of local variations. It's also a reflection of how the emergency care environment has changed overall since 2003, when EMTALA regulations were revised to allow on-call physicians more flexibility.

The advisory panel's conclusion that participation in community call plans can "satisfy [hospitals'] on-call coverage obligations"—a notion that CMS is now seeking comment on—is "a new option on the table," said Ms. Tomar.

"It's a recognition of the fact that you no longer have full contingents of on-call doctors waiting at every hospital … that if you can get a community to pull together doctors to serve different hospitals on different days and connect that with your EMS system, you've got a potential plan," she said.

It may not always be possible to implement such plans successfully—at least one solid regional effort recently collapsed, Tomar noted. In that light, the panel clearly stated in its recommendation that hospitals must have backup plans, and that a community call arrangement does not negate a hospital's obligation under EMTALA to perform medical screening exams.

The 2006 Inpatient Prospective Payment System final rule adopted another related recommendation: Hospitals with specialized capabilities but no EDs are bound by the same responsibilities under EMTALA as specialty hospitals with dedicated EDs.

The advisory group closed with heated debate, when questions were raised about whether EMTALA should apply to the transfer of inpatients who are never fully stabilized. The panel was presented with several scenarios, such as a patient who comes in with chest pain and is admitted with a probable diagnosis of angina—but who is found with additional testing to have a dissecting thoracic aneurysm or other life-threatening surgical emergency that the admitting hospital is unable to address.

The panel narrowly recommended that EMTALA be extended to cover inpatient transfers, but only if the patient has not been stabilized for the condition requiring admittance. And in the end, the CMS ran with the contentious recommendation. Like the community call recommendation, it made its way into the draft Inpatient Prospective Payment System regulation for fiscal year 2009. ■

POLICY & PRACTICE

Ezetimibe Troubles Hit Home

Schering-Plough reported in its most recent quarterly filing with the Securities and Exchange Commission that its joint venture with Merck & Co. on ezetimibe (Zetia) and ezetimibe/simvastatin (Vytorin) is the subject of multiple lawsuits and legal inquiries. In a May 6 filing, Schering stated that it has received "several subpoenas from state officials, including state attorneys general, and requests for information from U.S. Attorneys," all seeking information on the ENHANCE clinical trial, the sale and promotion of ezetimibe/simvastatin, and stock sales by corporate officer since April 2006, when ENHANCE was completed. Since mid-January, the company has been served with class action lawsuits alleging fraud in conjunction with the sale and marketing of the two products. The company is also looking at several securities-related class action suits, according to the filing.

CMS Covers Artificial Heart

Artificial hearts will be covered by Medicare when they are implanted as part of a study, according to a national coverage decision issued in May. The decision was not a surprise, as CMS telegraphed its intention to do so in a February proposal. According to a statement, the agency "believes there is now sufficient scientific evidence on the use of artificial hearts to allow coverage of these devices for beneficiaries in the carefully controlled clinical environment of an [Food and Drug Administration]–approved study." The devices are for use in severe heart failure, where patients are at imminent risk of death.

Gainsharing Cuts Stent Costs

A study of gainsharing programs sanctioned by CMS at six cardiac catheterization labs has found that costs declined for coronary stent patients relative to nongainsharing hospitals. The gainsharing hospitals reduced costs by 7.4% per patient; 91% of the savings came from lower prices, and 9% from lower utilization, according to authors Jonathan Ketcham, Ph.D., and Michael Furukawa, Ph.D., of Arizona State University, Tempe. Under the programs, savings are shared equally by the hospital and the physician practice. From 2001 to 2006, the average cost per patient increased from $3,338 to $4,644, but the gainsharing hospitals were able to reduce that by $315 per patient, or 7.4%. The study appears in the May/June 2008 issue of Health Affairs.

Self-Referrals Drive Imaging Hike

Physicians who refer patients to their own facilities or machines for scans account for much of the increase in diagnostic imaging ordered for privately insured patients, according to a commentary in the journal Medical Care. The increases in imaging were seen mainly in privately insured patients with fee-for-service plans, according to by Dr. Vivian Ho, professor of medicine at Baylor College of Medicine, Houston. "Physicians seem to choose the self-referral option, meaning they do the imaging in their own office, because they are reimbursed by private insurance companies," Dr. Ho wrote. If they don't have the equipment in their office, she said, they lease an imaging center's facilities and employees for a fixed period each week. This creates revenue for both parties involved, but raises questions about the necessity of the testing conducted, Dr. Ho wrote, adding, "The current reimbursement system lacks incentives to provide high quality imaging in a cost-effective manner."

—Alicia Ault

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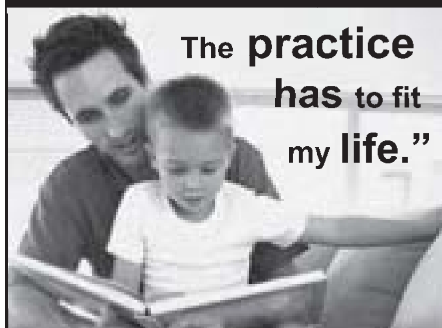

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