On-Call Issue Is Focus of EMTALA Panel Meeting

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WASHINGTON — On-call emergency care dominated the agenda at the inaugural 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 manner 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.

Although 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.

It's unrealistic to expect physicians to work with hospitals in developing and implementing on-call plans if physicians aren't equal partners.

Hospitals cannot force physicians to be on call, although individual hospital policies may require on-call services as a condition for having privileges, Dr. Yeh 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."

Hospitals testified that 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. "There no longer is any certainty that an on-call physician will report for duty when called," he said.

Physicians say that economic, 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, told advisory group members 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," she said.

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."

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," Dr. Nascone 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.

The group will be advising HHS 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, although a subcommittee was formed to address on-call concerns. ■

POLICY & PRACTICE

Bill Would Address Medicare Cuts

A bipartisan bill (H.R. 2356) introduced by Rep. Clay Shaw (R-Fla.) and Rep. Ben Cardin (D-Md.) seeks to halt cuts to Medicare physician payments and replace the flawed formula that sets those payments. Following up on a recommendation of the Medicare Payment Advisory Commission, the bill would increase payments by no less than 2.7% in 2006. It would also repeal the sustainable growth rate adjustment, replacing it "with a methodology that assures adequate and appropriate payments as well as stable updates for Medicare providers," Rep. Cardin said in a statement. If the formula isn't fixed, physicians face a 4.3% cut in Medicare payments in 2006 and later cuts totaling 30% from 2007 and 2012. The bill was referred to the House Ways and Means and Energy and Commerce committees. A similar bill introduced in the Senate (S. 1081) would boost Medicare payments for 2 years.

Medicaid Patients and Drug Access

Medicaid patients are finding it just as difficult as the uninsured to get access to prescription drugs. Researchers from the Center for Studying Health System Change found that 22% of adult Medicaid beneficiaries couldn't afford to get at least one prescription filled in the previous year. Medicaid beneficiaries and the uninsured has similar access problems, but only 9% of adults with employer-sponsored health coverage said they couldn't afford a prescribed drug in the previous year. The findings were drawn from HSC's Community Tracking Study Household Survey, a national survey involving 46,600 people in 2003 and 60,000 people in 2001. States have been intensifying efforts to control rising Medicaid drug spending, but the proportion of Medicaid beneficiaries reporting they couldn't afford prescription drugs remained unchanged from 2001 to 2003.

Vaccine Underinsurance

Having insurance doesn't mean you're covered for immunizations, according to a survey of 995 Americans conducted by researchers at the University of Michigan, Ann Arbor. As many as 36 million privately insured adults and 5 million privately insured children are not covered for immunizations, a factor that may be contributing to low immunization rates. "Over the past few years, newly approved vaccines have been increasingly expensive, so insurance plans have been less likely to cover them," said lead study author Matthew Davis. "New vaccines of the future may be available to many people only if they can pay out of pocket." Most respondents said they'd be willing to pay higher premiums for vaccine coverage, and most strongly believed that vaccines were effective and generally safe (Health Affairs 2005;24:770-9).

Limits to Quality Improvement

Most physicians are not using quality improvement measures and are reluctant to make public any information about the quality of care they provide, a survey of more than 1,800 physicians revealed. Only one-fourth of the respondents said they were using an electronic medical record routinely or occasionally, and one-third said they were redesigning their systems to improve care. Just one-third said they had access to any data about the quality of their own clinical performance. Although 7 out of 10 thought physicians' clinical information should be shared with leaders of the health care systems at which they work, only 55% thought patients should have access to quality-related data about their own doctors, and only 29% thought the general public should have access to such data. The survey, conducted by the Commonwealth Fund between March and May 2003, was published in the journal Health Affairs.

Depression and Marijuana Use

The evidence for a link between marijuana use and depression is getting stronger, according to the White House Office for National Drug Control Policy. "There certainly are people who self-medicate, but the danger we're talking about is the growing evidence that use itself may be triggering and may be worsening the onset of mental health problems," ONDCP Director John Walters said at a Washington press briefing. "Now would some of those people have mental health problems anyway? That's entirely possible. But it's also entirely possible that some of these people may not subsequently show these mental health problems, and the evidence suggests that the use of marijuana may trigger the onset of problems that would not otherwise be there." The office's National Survey on Drug Use and Health shows that, among persons aged 18 years or older, those who first used marijuana before age 12 were twice as likely to have serious mental illness in the past year as those who first used marijuana at age 18 or older.

AMA: Ban Booze Ads at NCAA Events

The American Medical Association has asked the National Collegiate Athletic Association to eliminate alcohol advertising associated with NCAA events. "The prevalence of alcohol advertising in college sports sends a damaging message about the core values of the NCAA and higher education," AMA President-elect J. Edward Hill, M.D., said in a statement. "Allowing aggressive alcohol advertising during its events only encourages underage consumption of alcohol." In a national poll sponsored by the AMA, 62% of adults said the NCAA should reverse its policy and not let beer companies advertise during college sporting events. NCAA spokesman Erik Christianson said the association already limits alcohol ads to 60 seconds per hour of any broadcast NCAA event, and noted that the NCAA executive committee was already planning to discuss, at an upcoming meeting, the idea of banning the ads completely, in response to a request from one of its divisions.

—Jennifer Silverman