Panel Decides Not to Link On Call to Medicare

Hospital associations had floated the proposal to address the shortage of on-call physicians.

BY JENNIFER SILVERMAN
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WASHINGTON — On-call services should not be a condition for participating in Medicare, a federal advisory panel on the Emergency Medical Treatment and Labor Act has recommended.

While most panel members panned the idea of an on-call/Medicare link, they were divided over whether to turn their disapproval into a formal recommendation to the Centers for Medicare & Medicaid Services.

The measure to recommend that CMS not link on-call participation with Medicare participation was approved in a close vote (7-6 with one abstention). The technical advisory group advises the Department of Health and Human Services and the CMS administrator on issues related to the Emergency Medical Treatment and Labor Act (EMTALA).

Hospitals cannot force physicians to be on call, although individual hospital policies may require on-call services as a condition of privileges. To address the shortage of on-call physicians, hospital associations had floated a proposal to the technical advisory group to link on-call participation to Medicare participation or hospital privileges.

Technical advisory group members who voted against making a formal recommendation to CMS at this point said they "were concerned about angering or offending the hospital associations who brought the idea to begin with," said Carol Bayer, M.D., a panel member and vice president for medical affairs at East Jefferson General Hospital in Metairie, La.

If such a link were enacted, however, "physicians would quit Medicare in droves," Dr. Bayer told this newspaper. Participating in Medicare "has never been linked to anything like this before."

Some panel members, such as Charlotte Yeh, M.D., an emergency physician and CMS regional administrator for Region I in Boston, thought the issue deserved further review by the technical advisory group's on-call subcommittee before making a recommendation to CMS.

While most panel members panned the idea of an on-call/Medicare link, they were divided over whether to state their disapproval in a formal recommendation.

"Given the multiple factors affecting availability of on call, and the importance of solutions that both meet patient care needs and yet are practical enough for both hospitals and physicians, taking the time for analysis will result in a stronger position," she said.

But James Nepola, M.D., an orthopedic trauma surgeon in Iowa City, and author of the recommendation, thought there was enough evidence to oppose the on-call/Medicare link. "We've had testimony, we've had studies, and we've had surveys on both sides of this issue. Cultural changes are taking place in medicine right now that don't bode well for emergency medicine," Dr. Nepola said. "Young physicians are moving as quickly as they can to study fields that do not require emergency work at all. They are moving toward boutique practices, which I abhor."

For that reason, the technical advisory group should take affirmative actions "so that physicians can go in without this problem before them," Dr. Nepola said. The panel should also be addressing physician concerns such as liability reform and adequate resources and compensation for on-call services. "We need to move toward solutions like warnings for hospitals, not big penalties, and get rid of things that are not going to work."

Physician and hospital groups offered their own views about the Medicare/on-call link at the technical advisory group's June meeting. Requiring on-call services as a condition of participating in Medicare "would far exceed the scope of the EMTALA statute," the American College of Surgeons argued in written testimony.

It is also contrary to the regulations and the interpretive guidelines, which state that 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, the ACS stated.

Many neurosurgeons are already being required to provide continuous call 24 hours a day, 7 days a week, 365 days per year, the American Association of Neurological Surgeons and the Congress of Neurological Surgeons testified, reporting from a survey of more than 1,000 members.

"Despite the fact that EMTALA does not mandate continuous emergency call, hospitals are nevertheless imposing this requirement on nearly one-third of neurosurgeons," the groups testified.

Going beyond Medicare, the neurosurgeons requested that CMS adopt a rule that would prohibit hospitals from requiring around-the-clock call of physicians.

In its own surveys, the American Hospital Association illustrated a continued struggle to recruit specialists for on-call services. Nearly one-third of the hospitals surveyed reported paying physicians for specialty coverage, and 40% of the community hospitals had to place their emergency departments on diversion for some period of time, said Kathleen DeVine, chief executive officer of Saint Anthony Hospital in Chicago, who testified on behalf of the AHA.

"If CMS wants to deal with any more specificity around on-call coverage, then physicians, those whom hospitals rely on to provide on-call care, must be brought to the table," she said. "Hospitals cannot do it alone."

EMTALA was enacted in 1986 to ensure public access to emergency services regardless of ability to pay. The Medicare Modernization Act of 2003 required that HHS establish a technical advisory group to review EMTALA regulations. The advisory group is required by law to meet at least twice a year. ■

Specialists Paid to Take Emergency Call in 47% of Hospitals

BY MARY ELLEN SCHNEIDER
Senior Writer

Most hospital officials are having trouble getting specialists to take emergency department call, according to a national survey of physician executives.

About 64% of physician executives surveyed reported having a problem getting specialists to take call at their hospitals. Many of them—about 47%—report that their hospitals are coping with this problem by paying specialists to take call.

Of those whose hospitals were not offering payments, 46.4% said the idea has been considered.

The survey, conducted by the American College of Physician Executives, was sent to 3,000 physician executives in hospitals and group practices around the country. The poll had 814 responses, or a 27% response rate.

The results of the survey are consistent with previous studies over the last several years, said Alex Valadka, M.D., chairman of the Joint Section of Neurotrauma and Critical Care for the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons.

Dr. Valadka said he sees taking emergency call as part of his responsibility as a physician, but said many of his colleagues just can't afford to do it anymore.

With the high cost of professional liability insurance, physicians are stopping or cutting back on emergency call because certain insurance carriers offer discounts to physicians who cut back on these services, he said.

In the past, physicians may have had enough of a profit margin to cover the cost to them of taking emergency call, he said, but declining reimbursements have mostly eliminated that margin.

"Like any other service, nothing is for free," said Dr. Valadka, who also is a professor of neurosurgery at Baylor College of Medicine in Houston.

But even with stipends for taking call, some physicians still won't do it, he said. "I think the money will help, but it's not going to solve all the problems," he said.

These financial incentives need to be coupled with federal medical liability reform to ease the strain of the high cost of premiums, Dr. Valadka said.

Paying stipends to specialist physicians to take emergency department call is taking away from other services and also reducing funding for uncompensated care.

Paying specialists to take call helps to offset their costs, but it's only a stopgap solution, said James Bean, M.D., AANS treasurer and a neurosurgeon in private practice in Lexington, Ky.

In the short term, hospitals should create more incentives for physicians to take call. "You've got to create a carrot, not a stick," Dr. Bean said.

Over the long term, physicians and hospitals should consider the idea of a regional trauma system with a large staff of rotating specialists to handle cases.

"Clearly the community needs physicians to take call," said Andrew Pollak, M.D., associate professor of orthopedics at the University of Maryland in Baltimore and a member of the board of directors of the American Academy of Orthopaedic Surgeons.

Hospitals and physicians need to work together to provide reasonable ways to manage call, he said.

For example, hospitals should provide stipends to help offset physician costs. In addition, hospitals need to provide physicians with the right resources to work in the emergency department, such as having an adequate level of ancillary staff to assist physicians, Dr. Pollak said.

Emergency physicians have a different take on the issue, however. It's often the hospitals with the highest number of uninsured patients that face shortages in specialist care in the emergency department, said Wesley Fields, M.D., immediate past president of the California chapter of the American College of Emergency Physicians and an emergency physician in Laguna Hills, Calif. But those are also the hospitals that are least able to provide stipends to physicians.

"This really just reflects the weakness of the hospital safety net," Dr. Fields said. And money diverted to pay for physician stipends often means that less money is available to cover emergency department costs, he said.

Paying stipends to physicians to take emergency department call is taking away from other services and the funding for uncompensated care, said Jeff Micklos, general counsel for the Federation of American Hospitals.

The federation is concerned that more hospitals will need to offer stipends for taking call, Mr. Micklos added. Otherwise, they will be creating an incentive for physicians to invest in local specialty hospitals. ■