



## EMTALA TAG Holds First Meeting

by Kathleen Ream, Director of Government Affairs

## Washington Watch

Two clear themes emerged from the inaugural meeting of the EMTALA Technical Advisory Group (TAG) in Washington, DC, on March 30-31, 2005. It was overwhelmingly apparent that a fractured relationship exists between hospitals and their medical staffs, as evidenced by discussion on the issue of on-call specialist coverage. In addition, federal regulators were challenged with regard to the “unfunded mandate” created by the Emergency Medical Treatment and Active Labor Act (EMTALA), passed by Congress in 1986, amid growing concern over the availability of emergency health care services to the poor and uninsured. Committee members utilized the opportunity to acknowledge the role of EMTALA in a few key issues: ED overcrowding, primary care for the uninsured, and access to specialists. Attendees reminded CMS that EDs are the only element of the health care safety net whose function has been defined by federal law, which mandates that all EDs provide screening, stabilization, and/or appropriate transfer to all patients with any medical condition.

Under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, the Secretary of Health and Human Services was mandated to establish a Technical Advisory Group to review issues related to EMTALA and its implementation. The MMA also defined the composition for the EMTALA TAG – 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services or their designees.

Members appointed by the Secretary include:

- Four representatives of hospitals, including at least one public hospital representative having experience with the application of EMTALA, and at least two representatives from hospitals that have not been cited for EMTALA violations;
- Seven practicing physicians drawn from the fields of emergency medicine, cardiology or cardio-thoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;
- Two representatives of patients;
- Two staff involved in EMTALA investigations from different CMS regional offices;
- One representative from a state survey agency involved in EMTALA investigations; and
- One representative from a Quality Improvement Organization, both from areas different from that of the two CMS regional staff members.

All members are required to have technical expertise that will enable them to participate fully in the work of the EMTALA TAG. David Siegel, MD JD, an emergency and internal medicine physician from Florida Medical Quality Assurance, was appointed Chair of the group.

The majority of public testimony centered on the issue of on-call specialists with tense positions being presented from hospital and physician specialty groups. The points of contention focused on revised regulations that provide each hospital the discretion to maintain the on-call list in a manner that “best meets the needs of the hospital’s patients.” Hospital groups maintained that the revised regulations are reducing the willingness of physicians to take calls. One physician specialty organization said the “best meets the needs” terminology was too vague and requested that CMS adopt an affirmative rule **prohibiting** hospitals from requiring physicians to provide continuous on call coverage.

Other issues created by the revisions include a provision that permits hospitals to have internal policies prohibiting elective surgery by on-call physicians. Commentary was also provided on hospitals that invoke EMTALA by permitting physicians to “selectively take call” (of patients with whom they’ve established a physician-patient relationship while refusing to see other patients) and the hospital’s coverage for that particular service is not adequate.

In an attempt to help resolve the multitude of issues surrounding on-call specialists, the American Hospital Association agreed to provide information from its membership with the regard to the number of hospitals who have been forced to reduce or eliminate patient services due to forced cutbacks by on call specialists. In addition to specific suggestions for language in the regulations and interpretive guidelines, discussion also included appropriateness of patient transfers, civil lawsuits arising from EMTALA, conditions of participation (Medicare), and coding modifiers to the physician fee schedule that target specific services.

Leslie Norwalk, Acting Deputy Administrator and Chief Operating Officer of CMS, clarified the role of the EMTALA TAG as an advisory group to the Secretary and CMS through its charter (see [www.cms.hhs.gov/faca/emtalatag/emtalachrt.asp](http://www.cms.hhs.gov/faca/emtalatag/emtalachrt.asp)). She indicated that recommendations related to the enforcement of EMTALA as it pertains to the regulations or interpretive guidelines were within the reach of the group but that changes to the law that would affect the intent or requirements of the statute would require an act of Congress.

AAEM will keep you apprised of the developments from this Advisory Group as they arise.

### Congress Renews Debate on Medical Malpractice AAEM Endorses Bills

On February 10, 2005, Senate Budget Committee Chairman Judd Gregg (R-NH) and Senate Health, Education, Labor, and Pensions Committee Chairman Mike Enzi (R-WY) introduced S.354, the *HEALTH (Help Efficient Accessible, Low-Cost, Timely Health Care) Act of 2005*, which would impose a \$250,000 cap on non-economic damages. The legislation would apply to “all health care providers, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product.” S.354 is similar to legislation introduced in the last Congress, except that the new bill has a provision requiring experts called to testify in medical malpractice cases to be appropriately credentialed and experienced with standard of care in the case.

Judging from comments made upon introduction of the bill, it appears there will be few breaks in the partisan sniping that has dominated the issue in Congress in the last several years. Democrats say that Republican bills are too narrowly focused on medical litigation, fail to address patient safety problems, and fail to impose additional requirements on medical malpractice insurance carriers. While Republicans contend that the Democrats are under the thumbs of the trial lawyers.

The House companion bill – H.R.534 – was introduced on February 2, 2005, by Representative Christopher Cox (R-CA). The Small Business Committee held a hearing on the bill on February 17.

In letters dated, March 30, 2005, AAEM endorsed both the House and Senate *HEALTH* bills. AAEM President Antoine Kazzi stated, “Skyrocketing medical liability premiums . . . are debilitating the nation’s health care delivery system forcing physicians to limit services, retire early, or move to a state with reforms where premiums are more stable. Many emergency physicians find themselves unable to obtain needed specialty consultation for victims of trauma. Without federal legislation, the crisis in our nation’s emergency departments will continue to grow, and patients will find it increasingly difficult to obtain needed health care.”

While the House is likely to pass medical malpractice legislation, the outlook in the Senate is less clear. Enzi told reporters at a briefing on S.354 that public opinion is beginning to turn in the direction of favoring limits on malpractice awards, which may push the Senate to act this year. ❏