May 8, 2002

To Members of the HHS Advisory Committee on Regulatory Reform

On behalf of the undersigned organizations, we would like to thank the Secretary's Advisory Committee on Regulatory Reform (the Committee) for convening its Miami meeting in which it heard how the Emergency Medical Treatment and Active Labor Act (EMTALA) is having a deleterious effect on patient care and physician practices. We have reviewed the initial draft of recommendations released by the Committee and believe that it fails to address several issues that must be resolved as they relate to EMTALA and physicians. While we understand that the Administration is in the process of finalizing regulations on certain EMTALA issues, we believe that the Committee should carefully study other issues that will not be addressed in these regulations. The following issues have become increasingly confusing and counterintuitive as more regulations and guidelines have been issued.

- Continuous Call - For certain specialties that have a limited number of physicians in the area, hospitals are claiming that EMTALA requires the physicians to be on call 24 hours a day, 7 days a week, 365 days a year. The Interpretative Guidelines issued in 1998 by the Center for Medicare and Medicaid Services (CMS) state that this continuous call schedule is not required under EMTALA, yet hospitals are pressuring physicians by claiming that continuous call is mandated by EMTALA. **We urge the Advisory Committee and CMS to issue an announcement to clearly state that continuous call is not required by EMTALA.**

- Simultaneous Call – The Center for Medicare and Medicaid Services (CMS), through a regional administrator, has stated that EMTALA prohibits simultaneous call. This prohibition is not stated in law, regulation, or Interpretative Guidelines. This pronouncement is especially troublesome, as it precludes physicians from servicing several hospitals on the same days. This prohibition would ensure that patients at other hospitals do not have access to the physician's services unless the patient travels to that particular hospital. **This limitation is contrary to the goals of EMTALA and should be reversed by CMS.**

- Surgery when On-Call – Many specialists perform other surgeries when they are on-call to the emergency department. As with simultaneous call, there may be times that if the physician is performing surgery, he or she would not be able respond to the emergency call. CMS has been very unclear in this area. Its 1998 Interpretative Guidelines state, "Physicians are not required to be on call in their specialty or subspecialty for emergencies whenever they are visiting their own patients in a hospital." The Guidelines then state, "If a staff physician is on-call to provide emergency services or to consult with an emergency room physician in the area of his or her expertise, that physician would be considered to be available at the hospital." A CMS Regional Administrator recently opined that EMTALA does not prohibit

scheduling surgery when the surgeon is on call but if the on-call physician is performing surgery and cannot respond to an emergency, he or she could be in violation of EMTALA.

This lack of clear CMS policy is very frustrating to physicians who are attempting to comply with EMTALA. We cannot urge you strongly enough to clarify this policy to ensure that physicians can perform other surgeries (elective and otherwise) while on-call. Physicians are often on-call for simultaneous days or even up to a week in certain areas (not to mention the continuous call issue cited above). If physicians are unable to perform surgery when they are on call, we will soon have a very significant access problem for patients seeking medical treatment. **We strongly urge the Committee to clarify that physicians can perform other surgeries when on-call**.

- Follow Up Care – We strongly urge the Committee to review, update and clarify the Interpretive Guidelines as they relate to follow-up care. We believe that the guidelines are unclear regarding medical care that falls outside the realm of emergency, the actual point of stabilization, and the obligation of the on-call physician to provide follow-up care. The "stable for discharge" definition set forth in the Interpretive Guidelines indicates that a patient is stable for discharge if the care can be reasonably performed on an outpatient basis and the patient is given a plan for appropriate follow-up care. The guidelines also describe several cases as "stabilized but requiring *immediate* treatment," such as the temporary splinting of a fracture. The immediacy component of the Guidelines may intimate some responsibility on the part of the physician to provide the immediate follow-up care, but this seems to exceed the intent of EMTALA to mandate immediate *emergency* care. The Guidelines also require the hospital to have a "reasonable" plan for follow-up care, which may suggest an obligation to provide this care. **The Committee should examine to what extent the Guidelines create an expectation that follow-up care is required and under what circumstances.**

- Non-Provider Based Facilities – The undersigned organizations would like to remind the Committee that EMTALA applies only to hospitals and provider-based entities. As such, Number 4 under "Immediate Reform" should be revised to exclude urgent care centers as they are not subject to EMTALA requirements unless they are provider-based entities, which the vast majority are not. Likewise, the term "urgent care centers" should be deleted from "Who would be Affected?" This terminology could be clarified to state "provider-based urgent care centers." These requirements would also only apply to medical and surgical specialist who provide care for emergencies in hospitals or provider-based entities. Once again, the non-provider based urgent care centers and the physicians working in these settings are not subject to EMTALA requirements.

In closing, we hope that you will consider these extremely serious EMTALA concerns. We will be commenting on the EMTALA regulations that are released by CMS this week, but these are specific, immediate concerns that we believe the Committee should address in the near term. For your information, we have also attached a letter sent by

Representative John Shadegg (R-AZ) to CMS Administrator Tom Scully which raises some of the same issues, and which demonstrates the belief that these specific EMTALA concerns can be addressed expeditiously by CMS.

We appreciate your attention to the EMTALA issue, and we are happy to assist the Advisory Committee with further information related to this or to other issues.

Sincerely,

American Academy of Facial, Plastic and Reconstructive Surgery
American Academy of Neurology
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Chest Physicians
American College of Osteopathic Emergency Physicians
American College of Physicians-American Society of Internal Medicine
American College of Surgeons
American Medical Association
American Osteopathic Association
American Psychiatric Association
American Society of Anesthesiologists
American Society of General Surgeons
Congress of Neurological Surgeons