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Thomas A. Scully, Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Room 443-G  
Washington, DC 20201

Attention: CMS-1203-P Medicare Program; Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2003 Rates

Dear Mr. Scully,

The American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) appreciate the opportunity to comment on the Emergency Medical Treatment and Labor Act (EMTALA) provisions contained in the above referenced proposed rule. As you are aware, over the years the scope of EMTALA has been expanded well beyond the law's original intent, which was to prevent hospitals from "dumping" patients with emergency medical conditions based on their inability to pay for the emergency medical care. We would therefore like to commend you for moving forward with proposed changes that recognize the need to revise and clarify current EMTALA rules and regulations to ensure that they do indeed conform to the scope of the law. There are several areas of the proposal, however, that we believe need further review. In addition, we continue to be extremely concerned that the proposed rule does not adequately address questions related to EMTALA's on-call requirements. This is the most critical EMTALA issue facing practicing neurosurgeons, and we will focus the majority of our comments on this section of the proposed rule.

### **EMTALA AND ON-CALL REQUIREMENTS**

According to the American Hospital Association, there are 5,810 registered hospitals in the United States. There are approximately 3,900 actively practicing neurosurgeons. Not all hospitals provide neurosurgical services, but neither do all neurosurgeons take call very day, with some arrangements having one neurosurgeon covering for up to 7 or more other neurosurgeons during night hours. Doing the math, it is obvious that there are not enough neurosurgeons to provide full on-call emergency coverage to all the hospitals in this country 24 hours per day, 7 days per week, 365 days per year. The AANS and CNS therefore fully support the proposal to codify in regulations the statement that physicians are not required to be on-call at all times and that it is the hospital's responsibility to maintain an on-call list in a manner that best meets the needs of patients. Explicitly allowing hospitals and physicians this flexibility is absolutely essential, particularly for specialties such as neurosurgery that are in short manpower supply.

We fear, however, that the proposal does not go far enough to protect on-call physicians from nevertheless being required by hospitals to provide continuous emergency on-call coverage. For example, in some instances the hospital medical staff bylaws or other rules and regulations require 24-7-365 call (and/or the hospital administration interprets them as so requiring), so neurosurgeons with privileges at such institutions have no choice but to comply with these hospital requirements to be in compliance with EMTALA. It is not always feasible for the neurosurgeons or others on the medical staff to modify the bylaws or hospital rules, so they are forced to either comply or resign from the medical staff. Given the inescapable fact that there is a shortage of neurosurgeons available to cover hospital emergency departments, it is totally unreasonable for hospitals to force individual neurosurgeons to provide continuous on-call coverage as part of their hospital privileges.

We are also concerned that the proposed rule is internally inconsistent in that it states that while physicians are not required to be on-call at all times, the hospital must maintain an on-call list in a manner that "best meets the needs of the hospital's patients." In an enforcement action, it is conceivable that a hospital may have a difficult time defending itself for not having 24-7-365 coverage, when such coverage could be deemed as best meeting the needs of its patients.

We further believe that the regulation and/or interpretive guidelines need to provide additional guidance and clarification of what constitutes not being available to the hospital emergency department "because of circumstances beyond the physician's control." This is an extremely vague standard and provides little protection for on-call physicians. For example, if a physician's beeper does not operate properly, is this a legitimate reason for not responding to call? If a physician is responding to an emergency at another hospital, is this beyond his or her control? Similarly, if a neurosurgeon is on-call but is performing elective surgery, is this a permissible reason for not responding to an emergency call?

**Finally, the regulation completely fails to address three additional issues that need immediate resolution, that is, whether or not EMTALA (1) permits simultaneous call, (2) permits elective surgery when on-call, and (3) requires physicians to be on-call to evaluate and stabilize patients outside the usual scope of their elective practice.** Despite the fact that CMS has not specifically requested input on these issues in this proposed rule, the AANS and CNS nevertheless offer the following comments on these issues.

- **Simultaneous Call.** As you may be aware, it is customary for neurosurgeons to have hospital privileges at multiple institutions because, as stated above, there are more hospitals than neurosurgeons. This practice allows our citizens to have the broadest access to critical neurosurgical services. It is also typical that as a condition of their privileges neurosurgeons are required to provide on-call emergency services. As a practical matter, this means that most neurosurgeons are on-call at the same time to more than one hospital. Indeed, it is not uncommon for one neurosurgeon to simultaneously provide emergency coverage for 4 or more hospitals.

Until recent pronouncements by CMS officials, neurosurgeons were under the impression that EMTALA permitted simultaneous call. Although there is no specific guideline directly on this point, we can find nothing in the law, regulations or interpretive guidelines specifically prohibiting such practice. Take the following scenario, for example: Dr. Neurosurgeon is on-call to Hospital A and Hospital B at the same time. There are no other neurosurgeons in the community available to provide back-up emergency call coverage. Hospital A calls Dr. Neurosurgeon to evaluate and treat a neurosurgical emergency, and the patient ends up requiring emergency surgery. While he is in surgery, Dr. Neurosurgeon is called by Hospital B to treat an emergency there as well. He is

obviously not available since he is currently treating emergency number one. Our reading of the current interpretive guidelines and the provisions of this proposed rule arguably would render his unavailability as “beyond his control,” and hence no EMTALA violation.

When we sought clarification of this scenario from CMS, we were informed that indeed current EMTALA policy **prohibits** simultaneous call. Apparently CMS believes that this policy is justified because Dr. Neurosurgeon placed himself in a position of possibly not being able to respond to Hospital B, and since there was no back-up plan for coverage and Hospital B held itself out to the public to have neurosurgical emergency coverage, Dr. Neurosurgeon’s failure to respond would not be beyond his control and he would therefore be in violation of EMTALA. CMS officials have suggested that if neurosurgeons are going to provide simultaneous call, that the neurosurgeon and all the hospitals involved must have a coordinated back-up plan in advance to ensure neurosurgical coverage if they are going to hold themselves out to the public to be available to provide emergency neurosurgical services.

There are several problems with this policy. First, as with the 24-7-365 issue, neurosurgeons are in short manpower supply relative to the number of hospitals, so it is not always possible to have back-up neurosurgical coverage. Second, it is not necessarily feasible for multiple hospitals to get together and devise a global neurosurgical emergency system, particularly where there is no official regional trauma/EMS system in place. Indeed, antitrust laws may actually prohibit competing hospitals from dividing the market for emergency neurosurgical services unless such negotiations are conducted under the auspices of a government agency. Third, and most important, if neurosurgeons are not permitted to take call at more than one hospital at a time, access to emergency neurosurgical services is going to be severely restricted and patients will likely find themselves having to travel greater distances to find available neurosurgeons. We are already hearing that neurosurgeons who have privileges at multiple institutions are now rethinking this and restricting their practices to one hospital because they fear EMTALA prosecution. Not only will this limit patient access to emergency neurosurgical services, but it will affect patient access to elective neurosurgical services as well. Clearly, EMTALA was enacted to improve and expand access to emergency medical services, and prohibiting simultaneous call runs counter to this goal.

- Elective Surgery When On-Call. Typically, neurosurgeons continue to perform elective surgery when on-call to the emergency department. As with the simultaneous call issue, from time-to-time, neurosurgeons may not be able to respond to an emergency if they are performing elective surgery. When we reviewed the interpretive guidelines for clarification on this issue, they seem to contradict themselves. On the one hand, the 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.” On the other hand, the guidelines go on to indicate, “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.” This is highly confusing and so we sought clarification by CMS. According to CMS officials, unlike the simultaneous call issue, EMTALA does not prohibit scheduling elective surgery when the surgeon is also on call. However, if the on-call surgeon is in elective surgery and therefore cannot respond to an emergency he could be in violation of EMTALA. This seems a bit schizophrenic to us. Of course, if there is a back-up plan in place, and another neurosurgeon is able to respond to the emergency, then there will not likely be an EMTALA problem. In manpower shortage areas like neurosurgery, however, this is not always possible.

This is a very big problem, since neurosurgeons are often on-call for a week or more at a time. If, as a practical matter, they are not permitted to schedule elective surgery when they are on-call it will seriously limit their ability to provide timely care to their regular patients. It will also have a serious detrimental effect on their ability to generate income to maintain their practices. With decreases in Medicare and other reimbursement and significant increases in professional liability insurance premiums and other practice expenses, neurosurgeons can ill afford to eliminate elective surgery for weeks at a time when they are on-call to the emergency department.

- **Limiting On-Call Coverage to Physician's Scope of Practice.** Many physicians limit their medical practices to certain well-defined subspecialty practice areas. For example, a limited number of neurosurgeons subspecialize in pediatric neurosurgery, whereby they treat only children and perform no surgical procedures on adults. Many neurosurgeons also limit the scope of their practice to spine procedures, performing no cranial procedures at all. In practice, however, it is customary for neurosurgeons to be credentialed by their hospitals to perform all neurosurgical procedures, notwithstanding the fact that they may limit the scope of their actual practice. Recently, questions have arisen as to whether subspecialty neurosurgeons are obligated to be on-call for emergencies that are outside the scope of their usual practice. Because these surgeons are credentialed to perform neurosurgical services generally, when they are on-call most hospitals are requiring these neurosurgeons to evaluate and treat all neurosurgical emergencies, even if they are beyond the scope of their practice. When these neurosurgeons inform the hospital that a particular emergency is beyond the scope of their practice, they are met with threats of potential EMTALA violations if they do not respond when called.

To address this issue, neurosurgeons are now attempting to specifically limit their hospital credentials to a defined scope of practice. Some hospitals are permitting this practice. However, we are also hearing about neurosurgeons who are having great difficulty in negotiating such arrangements with their hospitals. The AANS and CNS believe that the goal of EMTALA is not only to ensure that patients with emergency medical conditions get treatment for their emergencies, but also that they get quality patient care from the health care provider most capable of tending to their medical needs. It therefore seems reasonable to us that EMTALA regulations should recognize that physicians should only be required to be on-call to emergency departments to provide evaluation and stabilization services within the scope of their actual practice.

**AANS/CNS Recommendations.** At this time, the only apparent remedy available to physicians is for them to protect themselves through the medical staff bylaws and/or hospital policymaking processes or through direct contracts with the hospitals. However, there are numerous reasons why relying on hospital processes to protect physicians from EMTALA problems is not always possible. For example, if the neurosurgeon is unable to obtain the consensus of the medical staff to implement bylaws that provide the necessary protections, he or she will continue to face potential EMTALA violations. In addition, in some institutions, the hospital administration or board has the final say in any bylaws changes. Therefore, even if the medical staff adopts provisions to protect on-call physicians, the administration may refuse to implement such changes. Finally, many hospitals simply refuse to "deal" with neurosurgeons when approached with specific contract proposals.

While we recognize that CMS is attempting to be helpful by providing hospitals and their medical staffs with some flexibility to comply with EMTALA's on-call requirements, and that CMS does not want to get in the middle of contract negotiations between hospitals and their physicians, we nevertheless believe that CMS must provide physicians, especially those who are in short manpower supply, with some additional protections that are not included in the proposed rule. To this end, the AANS and CNS recommend the following:

- Amend the proposal and adopt an affirmative rule *prohibiting* hospitals from requiring physicians to provide 24-7-365 emergency coverage. The language could be amended to read: "Hospitals are prohibited from requiring physicians, including specialists and subspecialists, to be on call at all times." At the very least, CMS must establish some sort of grievance process whereby physicians can appeal unreasonable hospital on-call requirements.
- Recognize that hospitals are not always capable of providing on-call coverage and that the failure to do so is not contrary to the "best meets the needs of the hospital's patients" standard proposed in the rule. To recognize this fact, CMS could amend the language to state: "Each hospital must maintain an on-call list of physicians on its medical staff that best meets the needs of the hospital's patients *in accordance with the resources available to the hospital, including the availability of on-call physicians.*"
- Further clarify through interpretive guidelines and/or illustrative examples what constitutes "circumstances beyond the physician's control" when an on-call physician cannot respond to emergency call.
- Create EMTALA "safe harbors" that recognize some exceptions to strict EMTALA compliance. Safe harbors could be created that would:
  - Permit simultaneous call at multiple hospitals, particularly for those manpower shortage specialties like neurosurgery.
  - Permit the transfer of patients to the hospital where the on-call physician is physically located when, in the judgment of the treating or on-call physician, transfer would ensure the fastest or most effective treatment.
  - Permit physicians to schedule and perform elective surgery when they are on-call, especially for manpower shortage specialties like neurosurgery.
  - Recognize that physicians are only required to be on-call to perform emergency services that are within the scope of their usual practice.

### **SCOPE OF EMTALA APPLICABILITY TO HOSPITAL INPATIENTS.**

The AANS and CNS have long been proponents of the proposition that EMTALA does not apply to hospital inpatients, and therefore we are encouraged that CMS is moving in the right direction by proposing to apply EMTALA to the inpatient setting in only certain limited circumstances. Unfortunately, however, we believe that the proposed rule confuses, rather than clarifies, the scope of EMTALA vis-à-vis the inpatient setting. According to the proposal, EMTALA essentially would only apply to inpatients who are admitted with an unstabilized emergency medical condition that was determined pursuant to an EMTALA mandated medical screening examination. Once the individual's condition is stabilized, EMTALA no longer applies. The rule sets forth criteria that attempt to distinguish what constitutes stable for EMTALA purposes versus what constitutes stable for discharge purposes, noting that the two criteria differ and a patient can be stable for EMTALA purposes, but yet not stable for discharge. We believe this creates a perilous gray area and can foresee circumstances where physicians and hospitals will be caught in a battle over the definition of "stable".

**AANS/CNS Recommendations.** The AANS and CNS recommend that CMS establish a bright-line rule that simply states that once a patient has been admitted to the hospital as an inpatient, EMTALA ceases to apply. While we are sensitive to CMS's concern that hospitals not evade their EMTALA obligations by simply admitting patients to the hospital, we believe that our proposal is supported for

all the reasons CMS enumerates as justifications for not applying EMTALA's requirements to nearly all other inpatient situations. Whether the patient is admitted to the hospital via the emergency department or through the regular elective admissions process is immaterial. As CMS recognizes, there are numerous other safeguards in place to protect patients from premature discharge, including various health and safety obligations under the Medicare program (i.e., the hospital conditions of participation rules). In addition, hospitals are already subject to numerous other legal, licensing and professional obligations with respect to the continued proper care and treatment of its patients. When enacted, EMTALA was intended to fill a gap that did not then exist in current law. To expand its reach to the inpatient setting not only will create confusion but will also add a redundant layer of rules, regulations and remedies that are not necessary to protect patients with emergency medical conditions.

### **APPLICABILITY OF EMTALA TO PROVIDER-BASED ENTITIES**

The AANS and CNS are extremely pleased that the proposed rule significantly scales back the applicability of EMTALA requirements on provider-based entities. We wholeheartedly agree that EMTALA requirements should not be triggered at off-site locations (such as hospital owned physician practices or ambulatory surgery centers) that do not routinely provide emergency services, and therefore support your proposal to narrow the applicability of EMTALA to only those off-campus departments that are "dedicated emergency departments" (e.g., hospital owned urgent care centers). In general, we further agree with your proposal to limit the applicability of EMTALA to only those on-campus entities that are "provider-based." Under the proposed revised definitions, if a patient with an emergency medical condition presents to an independent entity that is on the hospital's campus, but is not part of the hospital, EMTALA would not apply.

We do have one concern with this newly limited definition, however. Prior to the implementation of the April 7, 2000 final EMTALA rule on provider-based entities, there was some question as to whether or not any "movement" of a patient from the hospital's main building to other buildings on the hospital campus (whether owned by the hospital or independently operated) constituted a "transfer" under EMTALA. For example, in some instances, there are imaging centers that are not physically located or connected to the main hospital building, but who nevertheless provide radiology services to the hospital. Prior to the April 7<sup>th</sup> rule, the widely held view was that moving emergency patients to the imaging center to obtain necessary radiology services for screening and evaluation of an emergency medical condition constituted a transfer, and if the patient's medical condition deteriorated during this "transfer" it could be considered an EMTALA violation. The April 7<sup>th</sup> rule made it fairly clear that such movement did not constitute a transfer and hence provided hospitals and physicians with some protection from potential EMTALA violations.

**AANS/CNS Recommendation.** We are concerned that the proposed definition will once again raise these past concerns and the AANS and CNS therefore recommend that CMS specifically acknowledge that the movement of patients to on-campus entities that may not be physically attached (or owned by the hospital) to the main hospital building do not constitute a "transfer" when such movement is for the purposes of performing EMTALA mandated screening and stabilization services.

### **CONCLUDING THOUGHTS**

The Emergency Medical Services (EMS) system is in the midst of a growing crisis, in part because of overcrowding, but also because of a recognized shortage of on-call specialists. Recent press accounts and new studies demonstrate that hospitals are increasingly operating on "diversion status" because they either lack the capacity to treat additional patients or because there are no on-call

physicians available to treat these patients. When this occurs, individuals with emergency medical conditions are often forced to travel great distances in order to find a hospital that is available to receive them. Individuals are also not always sent to the hospital that is the most appropriate for treating the emergency. Some of the contributing factors to these problems are the onerous burdens, inefficiencies and confusion related to the current EMTALA rules. EMTALA was meant to enhance access to emergency medical treatment. We fear, however, that if the current interpretations of the on-call requirements, in particular, stand, this laudable goal will not be achieved and patients will find themselves without access to many specialty services, especially neurosurgery. Making these reasonable changes to these rules will therefore indeed benefit patients.

The AANS and CNS want to again thank CMS for making EMTALA reform one of the agency's highest priorities. We do believe that progress is being made and that by issuing this proposed regulation CMS has clearly demonstrated that it is willing to revisit the intent and purpose of EMTALA and take the necessary steps to ensure that the rules more closely align with this purpose. Thank you very much for considering our comments and recommendations. We look forward to continuing to work with you and your staff on this and other important health care issues.

Sincerely,



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President  
American Association of Neurological Surgeons



Stephen M. Papadopoulos, MD  
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cc: The Honorable Tommy G. Thompson  
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