On-Call Issue Is Focus of EMTALA Panel Meeting

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WASHINGTON — On-call emergency care dominated the agenda at the inaugu-
ral meeting of the Department of Health and Human Services technical ad-
visory group on the Emergency Medical Treatment and Labor Act.

EMTALA, enacted in 1986 to ensure public access to emergency services re-
gardless of ability to pay, requires hospitals to maintain a list of physicians who are on
call to the emergency department. Hos-
pitals 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 re-
quires the Department of Health to en-
ter into an agreement with the technical ad-
visory 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 re-
 sponsibilities, Charlotte Yeh, M.D., an emergency physician and advisory
group member, said in an interview.

Hospitals cannot force physicians to
work on the EMTALA list, 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’s physicians get 
into the EMTALA debate,” she said.

Hospitals testified that their emergency
care was suffering due to physicians’ un-
williness 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 fill-
ing on-call slots,” said Jeff Micklos, vice
president and general counsel for the Fed-
eration 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 de-
 sire 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 hospi-
tals,” Mr. Micklos said.

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 sues related to EMTALA. It includes hos-
pital, physician, and patient representa-
tives, in addition to CMS and state officials
and one representative from a Quality Im-
 provement Organization.

The concept of on-call physicians is not
new, and discussing the appropriate role of
on-call physicians is nothing new, said
Dr. Yeh, who spoke on behalf of the American Association of Orthopaedic Surgeons and the Orthopaedic Trauma Association. “But it is unrealistic to ex-
pect physicians to work to-
gether with hospitals in developing and implement-
ning 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. Yeh said.

Interpretive guidelines developed to
clarify hospitals’ EMTALA responsibili-
ties should be amended to further en-
courage true partnership arrangements between hospitals and physicians, Dr.
Yeh 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 hos-
pitals to provide continuous emergency
on-call coverage,” Alex B. Valadka, M.D.,
who spoke on behalf of the American Association of Orthopaedic Surgeons and the Congress of Neurological Surgeons, testified.

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No recommendations were issued at the
meeting, although a subcommittee was
formed to address on-call concerns.

P O L I C Y & P R A C T I C E

Bill Would Address Medicare Cuts

A bipartisan bill (H.R. 2356) introduced by Reps. Clay Shaw (R-Fla.) and Ben
Cardin (D-Md.) seeks to halt cuts to Medicare physician payments and re-
place the flawed formula that sets those payments. Following up on the recom-
 mendation of the Medicare Payment Advisory Commission, the bill would increase payments by no less than 2.7% in 2006 and would also require the sus-
tainable growth rate adjustment, re-
placing it “with a methodology that as-
sures 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 10% from 2007 and 2012. The bill was referred to the House Ways and Means and Energy and Commerce commit-
tees. A similar bill introduced in the Sen-
ate (S. 1081) would boost Medicare pay-
ments 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 Medic-
aid beneficiaries couldn’t afford to get at
least one prescription filled in the pre-
vious year. Medicaid beneficiaries and the uninsured has similar access problems, but 27% 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 1 Household Survey, a national survey in-
volving 46,600 people in 2003 and 60,000 people in 2001. States have been inten-
sively efforts to control rising Medicaid
drug spending, but the proportion of
Medicaid beneficiaries reporting they
 couldn’t afford prescription drugs re-
mained unchanged from 2001 to 2003.

Vaccine Underinsurance

Having insurance doesn’t mean you’re
covered for immunizations, according to a survey of 995 Americans conduct-
ed 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 im-
munization rates. “Over the past few
years, newly approved vaccines have been
routinely prescribed and insurance
plan costs have been less likely to cov-
er them,” said lead study author Matthew Davis. “New vaccines of the future may be available to many peo-
ple 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 safe (Health Affairs 2005;24:770-9).

Limits to Quality Improvement

Most physicians are not seeing quality improvement measures and are reduc-
tant to make public any information
about the quality of care they provide, a survey of more than 1,800 physicians revealed. Only one-quarter of the re-
spondents said they were using an elec-
tronic medical record routinely or oc-
casionally, 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 doctors said that quality infor-
mation should be shared with leaders of
the health care systems at which they
work, only 35% 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, con-
ducted by the Commonwealth Fund
between March and May 2001, was pub-
lished in the journal Health Affairs.

Depression and Marijuana Use

The evidence for a link between mari-
juana use and depression is getting
stronger, according to the White House Office for National Drug Control Poli-
cy. “There certainly isn’t self-medicating, but the danger we’re talk-
ing about is the growing evidence that use itself may be triggering and may be worsening the onset of mental health problems,” ONDCP Director John Walsh
said at a Washington press briefing. “Now would some of those people have mental health problems anyway? That’s entirely possible that some of those people may not subsequently show these mental health problems, and the evi-
dence 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 per-
sons aged 18 years or older, those who
first used marijuana before age 12 were
twice as likely to have serious mental ill-
ness 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 adver-
sing associated with NCAA events.

“The prevalence of alcohol advertising in college sports sends a damaging mes-
sage about the dangers of drinking and higher education,” AMA President-
elect J. Edward Hill, M.D., said in a state-
mement. “Allowing aggressive alcohol ad-
vertising during the event not only encourages underage consumption of alcohol.” In a national poll sponsored by the
AMA, 62% of adults said the NCAA
should revoke its policy and not let beer companies advertise during college
sporting events. NCAA spokesman Erik
Christenson said the association already
limits alcohol ads to 60 seconds per hour of any broadcast. He said 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 re-
quest from one of its divisions.

—Jennifer Silverman

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