

# The EMTALA Community Call Plan and Implications for On-Call Requirements

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The Hospital Inpatient Prospective Payment System final rule for fiscal year 2009 (the Final 2009 IPPS Rule), recently published by the Centers for Medicare and Medicaid Services (CMS), finalizes provisions relating to the Emergency Medical Treatment and Labor Act (EMTALA) on-call obligations and community call plan requirements.<sup>1</sup> These provisions took effect on October 1, 2008. This article summarizes those finalized provisions and discusses their implications for hospitals.<sup>2</sup>

## Background on EMTALA

EMTALA, also known as the patient anti-dumping statute, was passed by Congress in 1986 with the goal of ensuring that individuals with emergency medical conditions are provided essential medical treatment regardless of their ability to pay. In general terms, EMTALA requires that hospitals stabilize individuals who come to the emergency department with emergency medical conditions (including active labor) by either providing treatment or by arranging for an appropriate transfer to another more capable hospital.<sup>3</sup> "Stabilize," "emergency medical condition," and "transfer" all have very particular meanings under EMTALA.<sup>4</sup> The statute also sets forth the obligation of hospitals to receive appropriate transfers from other hospitals. Further, EMTALA states that a participating hospital that has specialized capabilities or facilities (such as burn units and shock-trauma units) shall not refuse to accept an appropriate transfer of an individual who requires the specialized capabilities or facilities, if the hospital has the capacity to treat the individual.<sup>5</sup> Participating hospitals and physicians that violate EMTALA face stiff civil penalties, and expose themselves to substantial civil liability and/or termination of their Medicare provider agreement.<sup>6</sup>

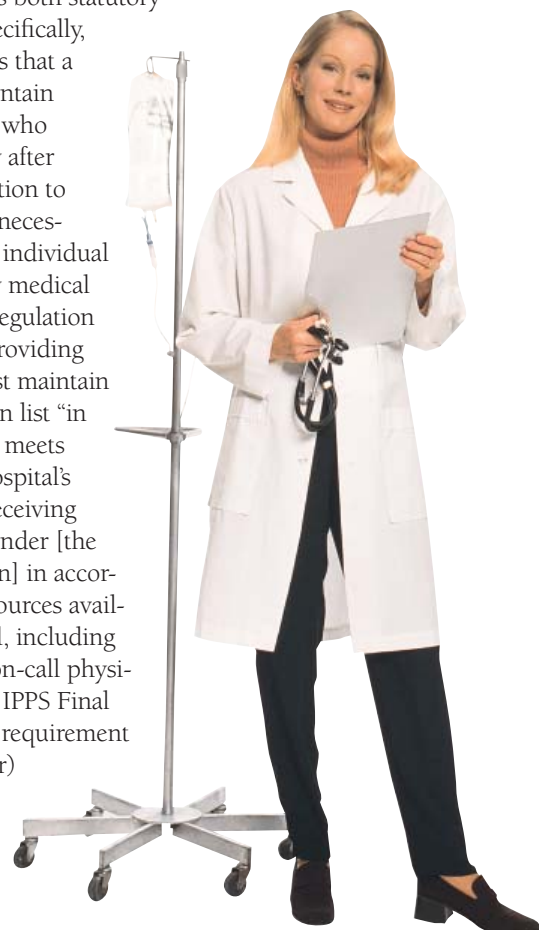
Beyond the statute itself, regulations, interpretive guidelines, and CMS Survey & Certification letters provide further guidance for hospitals.<sup>7</sup> In addition, a Technical Advisory Group (known as the EMTALA TAG) was established to advise the Secretary of the Department of Health and Human Services (HHS) concerning issues related to the regulations and implementation of EMTALA.<sup>8</sup> Generally, the EMTALA TAG's mandate was to: (1) review the EMTALA regulations and provide advice and recommendations to the Secretary of HHS concerning these regulations and their application to hospitals and physicians; (2) solicit comments and recommendations from hospitals, physicians, and the public regarding implementation of such regulations; and (3) disseminate information concerning the application of these regulations to hospitals, physicians, and the public. The EMTALA TAG's term ended September 30, 2007, and resulted in a total of fifty-five recommendations to the Secretary.<sup>9</sup> The community call plan provisions discussed later in this article stem from recommendations made by the EMTALA TAG.

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## EMTALA On-Call Obligations

A hospital's on-call obligations under EMTALA have long been a source of difficulty and debate. In CMS' own words, "[w]e are aware that providing specialty on-call coverage can be challenging for a hospital because of the limited availability of specialty physicians who are willing or able to take call."<sup>10</sup> Many specialty physicians who feel overburdened by the requirements—particularly those physicians belonging to more than one hospital medical staff—have chosen to seek compensation from hospitals or to sever their relationships with hospitals altogether. In one instance, trauma surgeons in Broward County, FL, boycotted a hospital district in an effort to force the district to pay them for taking call at two area trauma centers. The Federal Trade Commission ultimately intervened and issued a consent order requiring the surgeons to cease and desist the boycott.<sup>11</sup> Nevertheless, the case is an example of how hospitals are often struggling to provide adequate on-call coverage and may find themselves with no specialty-physician coverage for their patients.

Essentially, EMTALA requires hospitals to maintain a list of on-call physicians who are available to provide the necessary call coverage. This requirement is both statutory and regulatory. Specifically, the statute provides that a hospital must "maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition."<sup>12</sup> The regulation expands on this, providing that a hospital must maintain an on-call physician list "in a manner that best meets the needs of the hospital's patients who are receiving services required under [the EMTALA regulation] in accordance with the resources available to the hospital, including the availability of on-call physicians."<sup>13</sup> The 2009 IPPS Final Rule relocates that requirement to Section 489.20(r) (where language setting forth a general obligation to maintain





an on-call list already exists). It also broadens the language of the requirement consistent with the new community call plan requirements (discussed below). Thus, effective October 1, 2008, Section 489.20(r)(2) will require hospitals to maintain:

[An] on-call list of physicians who are on the hospital's medical staff, or who have privileges at the hospital, or who are on staff or who have privileges at another hospital participating in a formal community call plan in accordance with § 489.24(j)(2)(iii) available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services required under section § 489.24 in accordance with the resources available to the hospital.

It also is noteworthy that CMS dropped the language "in a manner that best meets the needs of the hospital's patients" from this requirement. CMS points out that the dropped language had caused confusion in the provider community and that leaving it at "in accordance with the resources available to the hospital" provides clarification. According to CMS commentary in the preamble to the 2009 IPPS Final Rule, a hospital should ultimately "strive to provide adequate specialty on-call coverage consistent with the services provided at the hospital and the resources the hospital has available."<sup>14</sup>

## Community Call Plan Requirements

EMTALA regulations also require hospitals to have written policies and procedures in place to: (a) respond to situations in which the on-call physician cannot respond because of circumstances beyond his/her control or if a particular specialty is not available, and (b) provide for the availability of needed emergency services if the hospital permits on-call physicians to schedule elective surgery during on-call periods or permits on-call physicians to have simultaneous call duties.<sup>15</sup> CMS intended these provisions to provide hospitals with some flexibility in meeting on-call obligations.

In the 2009 IPPS Final Rule, in furtherance of recommendations made by the EMTALA TAG, CMS adds the community call plan option to provide additional flexibility to hospitals. The community call plan permits two or more hospitals to develop and implement a plan to coordinate on-call coverage in a specific geographic area. In effect, hospitals participating in a call plan could divide responsibilities for a specific time period or specific service, or some combination thereof. CMS provides examples of how a community call plan might work. For instance, two hospitals could agree that one hospital would be designated as the on-call facility for cases requiring specialized, interventional cardiac care, while the other hospital could be designated as on-call for neurological cases. Alternatively, one hospital could be designated as the on-call facility for the first fifteen days of the month, with the other hospital designated as on-call for the remaining days of the month. That being said, if a patient presents to a hospital that participates in a call plan, that hospital still has an EMTALA duty to conduct a medical screening examination and administer stabilizing treatment within its capability before a transfer is made under the plan. CMS reminds hospitals that even if participating in a community call plan, they must implement written policies and procedures in order to respond to scenarios in which an on-call physician cannot respond for reasons beyond his or her control (i.e., a pre-existing EMTALA requirement).

In the finalized regulatory text, CMS sets forth the minimum requirements for a community call plan, which include the following elements:

- Precise delineation of a hospital's on-call coverage responsibilities (i.e., when is each hospital responsible for on-call coverage and what services will the on-call hospital be able to provide);
- Definition of the specific geographic area to which the call plan applies;
- Signatures from appropriate representatives of each hospital participating in the plan;
- Provision that all local and regional EMS system protocols formally include information on the community on-call arrangements;
- A statement in the call plan specifying the hospital's obligation that even if an individual presents with an emergency medical condition to a hospital that is not designated as the on-call hospital, that hospital has an EMTALA duty to conduct a medical screening examination and administer stabilizing treatment within its capability; and
- Reassessment of the community call plan on an annual basis.

A community call plan must be a formal plan, but does not require preapproval from CMS. Participation in a community call plan is strictly voluntary. Notwithstanding participation in a call plan, hospitals are still required to perform medical screening examinations and provide for a transfer when appropriate. The revised regulatory text capturing these concepts will appear at 42 C.F.R. § 489.24(j)(2).

Hospitals should be aware, however, that because such collaboration and information exchanges among competing hospitals can facilitate collusion or otherwise have the effect of reducing competition, a community call plan may invite antitrust scrutiny if implemented by hospitals. Collusion can be illegal, even within the framework of regulatory proceedings.<sup>16</sup> While the Noerr-Pennington doctrine protects legitimate efforts to petition the government and to express views concerning government decisions, the doctrine does not protect conduct that does not amount to petitioning, even if such conduct is encouraged by the government.<sup>17</sup> Thus, while the new community call plan provisions under EMTALA highlight serious challenges arising from the on-call requirements—and while legitimate collaboration to address those problems can be appropriate—such collaboration must proceed with caution. Apparently, CMS received many comments about the potential antitrust risk, to which CMS responded that “antitrust concerns should be directed to the U.S. Department of Justice Antitrust Division for further review.”<sup>18</sup> Thus, hospitals are strongly encouraged to consult antitrust counsel before proceeding.

## Conclusion

Ultimately, it is the treating emergency department physician that determines whether an on-call physician should come to the emergency department. A physician’s failure to respond to a call or refusal to appear in a reasonable amount of time could constitute an EMTALA violation for both the physician and the hospital. If antitrust hurdles are surmounted, however, the new community call plan requirements should provide some additional flexibility and relief to hospitals and physicians who have struggled to meet on-call coverage obligations. The community call plan provisions will allow hospitals to develop a plan that best leverages local resources and relieves some of the strain on specialty physicians.

That being said, however, the new provisions are deceptively simple and leave many unanswered questions that will pose practical challenges to hospitals in implementing a community call plan. A hospital that is interested in developing and implementing a call plan will need to consider which other hospitals and what geographic area should be included. With the guidance of antitrust counsel, the hospital will have to think through how to memorialize the community call plan responsibilities in a formal written contract with the other hospitals participating in the call plan. Further, since CMS does not appear to put any parameters on the geographic area over which a plan may be implemented, hospitals (and physicians) must give due consideration to the impact on patient care of transfers between hospitals in a community call plan that may be set apart by lengthy distances. It also is unclear how physicians should be included in the community call plan discussions and what impact the community call plan will have on a hospital’s financial arrangements with physicians who provide call coverage. Thus, the true implications and impact of the new community call plan provisions will be fully understood only when hospitals begin to attempt to develop and implement call plans.

In any case, the community call plan provisions are likely not the last word on a hospital’s on-call obligations under EMTALA. Since the community call plan provisions that were finalized stemmed from recommendations of the EMTALA TAG, it would be reasonable to assume that future modifications to the on-call obligations would stem from those recommendations as well. In fact, CMS states, “[we] also note that the TAG made additional recommendations on the topic of on-call requirements which remain under consideration by CMS. We may, in the future, in response to these recommendations, engage in additional rulemaking or revise our interpretative guidelines to the EMTALA and related regulations in 42 CFR part 489.” Thus, it is likely that there is still more to come on this topic.

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- 1 See generally 73 Fed. Reg. 48654 (Aug. 19, 2008).
- 2 We note that the Final 2009 IPPS Rule also provides some clarification regarding the application of EMTALA to hospital inpatients, and certain technical changes relating to emergency situations. We do not discuss those items here.
- 3 See generally 42 U.S.C. §1395dd.
- 4 42 U.S.C. § 1395dd(e).
- 5 42 U.S.C. § 1395dd(g). EMTALA regulations clarify that this requirement is applicable to all Medicare-participating hospitals with specialized capabilities (regardless of whether they have a dedicated emergency department). 42 C.F.R. § 489.24(f).
- 6 See 42 U.S.C. § 1395dd(d)(1-2) (outlining penalties of up to \$50,000 for each violation).
- 7 The regulations implementing the EMTALA statute are found at 42 C.F.R. § 489.24 and 42 C.F.R. § 489.20(l), (m), (q), and (r). The Interpretative Guidelines are found at Appendix V of the CMS State Operations Manual. The survey and certification letters can be found at the CMS website, [www.cms.hhs.gov](http://www.cms.hhs.gov).
- 8 Establishment of the EMTALA TAG was a requirement of Section 945 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
- 9 The EMTALA TAG compiled a final report, including a comprehensive list of all of its recommendations, which is available online at the CMS website.
- 10 73 Fed. Reg. at 48662.
- 11 *In re Trauma Associates of North Broward, Inc.*, Dkt. No. C-3541 (F.T.C. Nov. 1, 1994) (consent order), 59 Fed. Reg. 63,805 (1994).
- 12 42 U.S.C. § 1395cc(1)(I)(iii).
- 13 42 C.F.R. § 489.24(j)(1).
- 14 73 Fed. Reg. 48662.
- 15 42 C.F.R. § 489.24(j)(2).
- 16 See *U.S. v. Bluefield Reg’l Med. Ctr, Inc.*, 2005-2 Trade Cas. 74, 916 (S.D. W. Va. 2005) (final judgment) (striking down a market allocation agreement between two hospitals and noting that West Virginia’s Certificate of Need authority does not shield agreements from federal antitrust review).
- 17 The Noerr-Pennington doctrine is a doctrine of United States antitrust law set forth by the United States Supreme Court through case law. *In Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961) and *United Mine Workers v. Pennington*, 381 U.S. 657 (1965), the Court held that actions that amount to petitioning the government are not subject to antitrust liability. The Court later expanded the doctrine to adjudicative proceedings in *California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508 (1972).
- 18 73 Fed. Reg. at 48665.