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The Abaris Group

The TAG Line

The Abaris Group | *Innovative Solutions for the Emergency Care Field*
700 Ygnacio Valley Rd, Ste. 270 | Walnut Creek, CA 94596
888.EMS.0911 | www.abarisgroup.com

Pending EMTALA Changes Could Ease/Hurt Hospital On-Call Coverage

The Centers for Medicare and Medicaid Services (CMS) has proposed two changes to EMTALA or the Emergency Medical treatment and Active Labor Act. One would be to permit community call schedules for on-call ED physician specialists and another would extend the EMTALA responsibility to include some hospital inpatients. These proposed changes were issued April 30, 2008.

With the first proposed change, neighboring hospitals will be allowed to create "community-call plans" in order to fulfill their EMTALA on-call physician requirement on a regional level rather than an individual hospital level. Specifically, the recommendation is that community call arrangements should be acceptable if the hospitals involved have formal agreements recognized in their policies and procedures, and the plans meet the minimum criteria outlined below. CMS has included this recommendation in its Proposed Rules for Fiscal Year 2009. CMS regulations currently require each hospital to maintain on-call physician coverage in order to be compliant with EMTALA.

The Abaris Group is holding an urgent Webinar on these new proposed EMTALA changes. Join experts Stephen Frew and Mike Williams for a 90-minute web conference to learn how these changes may effect your organization.

Click **here** for more information

The response to this proposed regulation change is expected to be favorable, as throughout the country hospitals are increasingly facing difficulties maintaining adequate on-call coverage in a number of specialties.

A community-call plan will essentially reorganize patient services. Groups of hospitals located within the same region will be able to collaborate with one another to determine which facility will be the "on-call facility" for various medical and surgical specialties. Within each region, a specific hospital would be designated as the "on-call facility" for a specified period of time or for a specified service, or both.

The hospitals will have to coordinate with EMS, so that ambulance crews always know the most appropriate hospitals to which to transport certain types of patients.

A community call plan must, at a minimum, include the following:

- A clear definition of the responsibilities of on-call coverage
- A clearly defined description of the geographical area to which the plan applies
- An authorized representative of each hospital included in the plan must sign the community call plan
- Information about the community call plans

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Proposed Ban on "Balance Billing" in California

In the past two years in California, more than 1.75 million insured residents have received bills for payments in addition to their co-pays and deductibles after visiting emergency departments (ED) as a result of balance billing.

Balance billing is the practice billing patients for the portion of the bill not paid by insurance (in addition to their co-pays). This typically happens when an individual visits an ED outside of his or her insurance network, or when the physicians who treated the individual do not have the same contracts with insurance providers as do the hospitals in which they are providing care. These physicians may feel that the payers are not providing adequate reimbursement, and so they send bills to the patients to collect the difference. While this practice typically applies to EDs, it can happen with other hospital-based physicians as well.

Since 2006, the Department of Managed Care has been negotiating with insurers and providers trying to reach an agreement on the issue of balance billing. However, after no agreement could be reached, the Department of Managed Care has decided to ban the practice altogether. This proposed regulation would prohibit hospitals and physicians from billing patients for any amount owed to them by the health care service plan. This ban would apply only to members of HMOs, as other types of insurance plans are not regulated by the Department. However, some feel that this draft regulation is inadequate, as it does not provide any provisions for independent dispute resolution or any method for calculating fair charges that the HMOs should pay.

California legislators are also considering a bill to end this practice. S.B. 981, introduced by Senator Perata, relates to claims payments for healthcare services to non-contracting hospital-based physicians. Specifically, the bill would prohibit non-contracting hospital-based physicians from seeking additional payment from individual patients for any medically necessary services that are covered by that patient's insurance plan. Instead the physician may only seek payment from the patient's health care service plan or the health care service plan's risk-bearing organization. The bill explicitly states that patients will not be responsible

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Study Finds Communities Lack Capacity to Handle Mass-Casualty Event

A recent House committee investigation found that nationwide hospitals lack the capacity to handle a terrorist attack or other mass-casualty event, even of a modest level.

For the study, researchers looked at the ability of hospitals in seven major US cities to handle a sudden influx of patients, as would result from a terrorist attack or other large-scale disaster. The seven cities, New York City, Washington, Los Angeles, Chicago, Houston, Denver, and Minneapolis, were selected for the study because they are considered to be at highest risk for a terrorist attack.

Researchers found that hospitals in these cities do not have the capacity to accommodate a sudden influx of patients. Specifically, the emergency rooms have no open treatment spaces and the ICU and other inpatient units have little or no capacity to take on additional patients. The study looked at conditions in each of the hospitals in these cities on March 25 at 4:30 pm (local time), to get an understanding of how well these hospitals would be able to care for additional patients on a random day at a non-peak time.

While the problem is obvious, the solution is not. Researchers note that there is no practical way to ensure that hospitals are prepared for such a sudden influx of patients. It would not be financially practical to build adequate facilities to handle such an emergency when the facility would remain idle until a catastrophic event necessitates its use, a situation which may never come. The costs of building and maintaining emergency and trauma care facilities are enormous.

Some cities do have plans in place for how to deal with a sudden surge of patients during a mass-casualty event. These plans typically involve setting up make-shift hospitals in large, public spaces and re-opening previously closed hospitals for temporary use. However, the effectiveness of such plans may be limited by the fact that emergency resources are already operating beyond their capacity.

For more information on the results of this investigation, please click here.

EMTALA Changes, *continued*

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must be formally included in local and regional EMS protocols
- An analysis of the specialty on-call needs of the community conducted by all hospitals included in the plan
- A statement that a hospital still has an EMTALA obligation to provide a medical screening exam and stabilizing treatment for any patient arriving at a hospital that is not the on-call hospital for the specific patient's needs, and that all hospitals participating in the community call plans must still comply with EMTALA regulations regarding patient transfers
- An annual reassessment of the community call plan by all hospitals participating in the plan

The second change extends EMTALA to inpatients that have not yet been "stabilized." Specifically, for a patient whose condition is unstable because he needs specialty treatment not available in the hospital to which he has been admitted, EMTALA remains in effect until that patient is transferred to a specialty facility and stabilized at that facility. Under EMTALA, any hospital that has the specialty capability required to stabilize the patient MUST accept that patient as a transfer.

More information can be found here. The CMS Proposed Rules for FY 2009 can be found here.

On Thursday, June 19, 2008, The Abaris Group will be hosting a Webinar addressing a number of issues associated with this proposed EMTALA change. Join Stephen Frew, national EMTALA expert, and Mike Williams, President of The Abaris Group, for this important 90-minute Webinar to learn how these changes will affect you and your hospital. For $295, your organization can learn what the proposed rule says, how the community call plan will impact the burden on each hospital in a region, the minimum requirements of a community call plan, EMTALA obligations regarding the community call plan, the potential impact of the extension of EMTALA to inpatients, and more. For more information or to register, please call (888) 367-0911 or register online.

Uninsured Not Driving Increase in ED Visits, Study Finds

A study published in the April 2008 issue of *Annals of Emergency Medicine* addressed the question of whether increases in emergency department visits can be attributed to the uninsured. The study's authors noted that although the uninsured are often cited as a major cause of the rise in ED visits, previous studies have shown that the uninsured do not make up a disproportionate share of ED visits, and ED visits are increasing even in places with universal health coverage.

For the study, researchers examined data from the Center for Studying Health System Change's Community Tracking Study Household Surveys for the years 1996-1997, 1998-1999, 2000-2001, and 2003-2004. They looked at the breakdown of adult ED visits by insurance status, family income, usual source of care, general health status, and outpatient visits (non-ED).

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Proposed Ban on "Balance Billing," *continued*

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for any bills that they receive in violation of this ban.

Physicians who feel that they are receiving inadequate reimbursement for the non-contracted services they provide may request a review of the claim dispute by the Independent Dispute Resolution Process. The independent dispute resolution organization and the process which that organization shall follow to resolve disputes are outlined in the text of the bill.

Eight states currently regulate the practice of balance billing. California lawmakers have previously made several attempts to pass such legislation, but each of these attempts has failed.

More information on balance billing and attempts to ban it can be found here. To read the Department of Managed Care's draft regulation banning the practice of balance billing, click here. To read to text of S.B. 981 and check its status, please click here.

Court Rules Diverting Non-Hospital Ambulance is EMTALA Violation

On April 18, the United States Court of Appeals for the First Circuit ruled that a hospital that is not on formal diversion status that diverts a non-hospital ambulance away from its ED is violating EMTALA, even if the ambulance has not yet arrived on hospital property. The ruling was regarding a case in which a hospital inquired about the insurance status of a patient en route to its ED, and terminated the call with the ambulance staff after receiving no definite assurance that the patient did have medical insurance. The ambulance crew was thus forced to bring the patient to a different hospital.

For any patient that has "come to" the ED, EMTALA requires the hospital to provide a medical screening to determine whether or not the patient's condition is emergent and provide any treatment necessary to stabilize the patient's condition. The ruling of this case says that a patient has "come to" the ED as long as the patient is en route to the hospital, and the ED has been notified of the patient's arrival, even if the patient has not yet physically arrived at the hospital. Thus a hospital cannot inquire about a patient's insurance status upon receiving notification of the pending patient arrival and use that information to determine whether or not to accept the patient.

Both this ruling and a similar 2001 ruling in the Ninth Circuit seem inconsistent with EMTALA, because EMTALA says that a non-hospital owned ambulance is not subject to EMTALA requirements until it arrives at the hospital; however the exact language is ambiguous. To address the ambiguity, the court considered Congress' intent for EMTALA – to ensure that no patient is turned away from an emergency room based on a lack of health insurance.

Many EMTALA experts disagree with this ruling, and do not believe that there will be any enforcement from the Centers for Medicare and Medicaid Services (CMS). However, in order to avoid any potential EMTALA violations, hospitals in the First and Ninth Circuits, where these rulings are binding, as well as those throughout the country, should be sure careful to document all diversions. If a hospital must divert a patient when not officially on diversion status, it should make sure that such a diversion is appropriate and follows all laws and protocols.

More information about this ruling can be found here.

Special thanks to Michael Scarano, Healthcare Law Practice at Foley & Lardner, for providing information for this article.

The Abaris Group Continues its 2008 Webinar Series

Still to come in this exciting series:

1. *How to Use the New EMTALA Rules to Ease the On-Call Crisis—But Guard Against New Risks.* June 19, 2008, 10:30am-12:00 Pacific Time
2. *Optimizing ED and Trauma Center Payments: Enhancing Fee Schedules, Optimizing Co-Pays, and Billing all Unique Payer Sources.* July 22, 2008, 10:00-11:30 am Pacific Time
3. *Choosing the Right ED Information System*. September 10, 2008, 10:00-11:30 am Pacific Time
4. *Optimizing an Emergency Department's Design for the Future*. October 22, 2008, 10:00-11:30 am Pacific Time
5. *Medicare's New Rules for EDs and Trauma Centers for 2009.* November 2008, date and time to be announced
6. *So You Want to be a Consultant?* December 16, 2008, 10:00-11:30 am Pacific Time

For more details and to register, visit: www.abarisgroup.com. Educate your entire staff for one low cost. Pay only **$295** per site for one Webinar or learn about our special discounts when you purchase two or more Webinars.

If you've missed any of our previous Webinars, you may purchase a recording from The Abaris Group website. Previous topics have included product lines for improved patient throughput, solving the ED on-call crisis, retail health centers and freestanding EDs, and many more.

Uninsured Not Driving Increased ED Visits, *continued*

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The researchers found that the proportion of ED visits made by the uninsured remained relatively constant throughout each year of the study. Instead, factors found to contribute to the rise in ED visits included increased visits by non-poor and both individuals whose usual source of care is a physician's office. Specifically, in each year of the study, individuals from the highest income bracket made up a greater proportion of total ED visits.

The study's authors discussed factors that have been found to contribute to increasing ED visits. In addition to a growing an aging population demanding more healthcare services, a key reason for the increase in ED visits is difficulty in obtaining appointments with one's usual source of care in a timely manner.

The authors concluded by stating the problems with incorrectly attributing the uninsured with causing increased crowding in the ED. They feel that this over-simplifies the problem, and without fully understanding all of the factors contributing to increased ED use, it will not be possible to solve the problem of overcrowding in the ED.

An abstract from this study can be found at the *Annals of Emergency Medicine* website.

TAG Line Clarification

In our last edition of *The TAG Line*, we published an article regarding survival rates at Level I vs. Level II trauma centers, which unfortunately has led to some confusion. The article discusses a study which found that survival rates for severely injured patients were significantly higher at Level I vs. Level II facilities.

In our article, we did not mean to imply that the only differences between Level II and Level I centers were academic in nature. The study clearly found a difference in mortality with Level I trauma centers having a lower mortality rate. We apologize for any confusion.

ABARIS GROUP

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About Us

The Abaris Group is a consulting firm that specializes in emergency and outpatient services. We provide clients with help on a wide range of topics, including strategic planning, operational improvement, and financial enhancement, to help them achieve their goals.

We pride ourselves on delivering value to our clients in the form of quality recommendations and strategies that work. To achieve this, we conduct detailed analyses, blending insight and experience from all spectrums of the healthcare and emergency care fields to meet our client's unique needs.

Whether it is evaluation of new programs, studies of existing ones or assistance with implementation, we will extend this superior level of service to you and your organization.

For more information, visit www.abarisgroup.com or email subscriptions@abarisgroup.com.

Contact Us

The Abaris Group
700 Ygnacio Valley Rd, Ste 270
Walnut Creek, CA 94596
Phone: (888) EMS-0911
Fax: (925) 946-0911
Email: subscriptions@abarisgroup.com

www.abarisgroup.com

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