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February 18, 2011

The Honorable Donald M. Berwick, M.D., M.P.P.  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**RE: CMS-1350-ANPRM, Medicare Program; Emergency Medical Treatment and Labor Act: Applicability to Hospital and Critical Access Hospital Inpatients and Hospitals With Specialized Capabilities**

Dear Administrator Berwick:

The Healthcare Association of New York State (HANYs), the only statewide hospital and continuing care association in New York, representing more than 550 non-profit and public hospitals, nursing homes, home care agencies, and other health care organizations, submits these comments in response to the Centers for Medicare and Medicaid Services (CMS) advanced notice of proposed rulemaking regarding the possible expansion of responsibilities under the Emergency Medical Treatment and Labor Act (EMTALA).

EMTALA was designed to ensure that all patients who come to the emergency department (ED), regardless of ability to pay, color, race, religion, sex, or national origin, receive an appropriate medical screening examination and necessary stabilizing treatment for an emergency medical condition (EMC). In some cases, an appropriate transfer for specialized treatment may also be required.

HANYs does not believe that EMTALA should be made applicable to hospital inpatients and hospitals with specialized capabilities and opposes any further expansion of EMTALA.

**EMTALA Obligations Should Not Be Extended to Hospital Inpatients**

New York's hospitals fulfill their EMTALA responsibilities and provide stabilizing treatment to all patients who come to the ED with an EMC. In addition, New York's hospitals must meet additional responsibilities to inpatients, through Medicare Conditions of Participation (CoPs).

Current CoPs include specific patient health and safety provisions that provide protection to all patients, including inpatients who are admitted with an unstabilized EMC and those inpatients who have been stabilized but whose condition later deteriorates such that they have an EMC. Significant CoPs that focus on the provision of essential patient care include requirements that:

- all medical staff are held accountable for the quality of care provided to patients (42 CFR 482.12(a)(5));
- a doctor is on duty or on call at all times (42 CFR 482.12(c)(3));
- a doctor is responsible for the care of every patient with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization (42 CFR 482.12(c)(4)(i));
- nursing care is well organized and includes clear delineation of responsibilities for patient care (42 CFR 482.23(a));
- the hospital has an adequate number of nurses to provide nursing care to all patients (42 CFR 482.23(b));
- nursing services are provided 24 hours a day (42 CFR 482.23(b)(1));
- the hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning (42 CFR 482.43(a))—qualified personnel must develop, or supervise the development of, a discharge plan for patients who have been identified as likely to suffer adverse health consequences without discharge planning (42 CFR 482.43(b)(1));
- the hospital must transfer or refer patients, along with necessary medical information to appropriate facilities, agencies, or outpatient services, as needed, for follow-up care (42 CFR 482.43(8)(d)); and
- in the case of a Critical Access Hospital (CAH) that is a member of a rural health network, the CAH has in effect an agreement with at least one hospital that is a member of the network for patient referral and transfer ((42 CFR 485.616(a)(1)).

Medicare CoPs, coupled with traditional theories of medical malpractice and state-enforced legal, licensing, and professional requirements, work together to ensure that hospital inpatients receive proper care and treatment.

### **Hospitals with Specialized Capabilities Should Not Be Compelled Under EMTALA to Accept the Transfer of Inpatients from Other Facilities**

Many of New York's urban and suburban hospitals already have in place transfer agreements similar to those required of CAHs that participate in rural health care networks. Transfer agreements arrange for patient care at another facility when the hospital where the patient first presents does not have the capability to treat the patient.

Hospitals with specialized capabilities should not have an obligation under EMTALA to accept the transfer of patients who have already been admitted as inpatients. It would be an unfortunate unintended consequence if hospitals rethought their properly functioning transfer agreements to avoid potential EMTALA liability.

HANYS therefore respectfully requests that CMS not move forward with its plan to extend EMTALA obligations at this time. If you have questions about our comments, please contact Jeffrey Gold, Vice President, Managed Care and Special Counsel, at (518) 431-7730.

Sincerely,

A handwritten signature in black ink, appearing to read "Daniel Sisto". The signature is fluid and cursive, with the first name "Daniel" being more prominent than the last name "Sisto".

Daniel Sisto  
President



Healthcare Association  
of New York State

*Proud to serve New York State's  
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and Continuing Care Providers*

Daniel Sisto, President

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September 17, 2010

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The Honorable Kathleen Sebelius  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

## **Re: OCIO-9992-IFC, Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act**

Dear Secretary Sebelius:

The Healthcare Association of New York State (HANYs), the only statewide hospital and continuing care association in New York, representing more than 550 non-profit and public hospitals, nursing homes, home care agencies, and other health care organizations, submits this letter in response to the Department of Health and Human Services' (HHS) request for comments regarding *Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act*.

The *Interim Final Rules* were published to implement Section 2713 of the Public Health Service Act, which generally prohibits group health plans and health insurance issuers from imposing cost-sharing requirements for preventive services. HANYs believes that coverage for basic preventive services like screening for blood pressure, cholesterol, cancer, sexually transmitted infections, adolescent and adult depression, autism, lead, and oral health; diabetes screening for hypertensive patients; genetic testing for the BRCA gene; and counseling related to aspirin use, tobacco cessation, and obesity is critical to providing early detection and treatment for costly chronic diseases.

HANYs applauds the HHS Secretary for mandating coverage for a broad array of preventive services, including evidence-based items or services rated "A" or "B" by the United States Preventive Services Task Force (45 CFR § 147.130(a)(1)(i)); immunizations for routine use in children, adolescents, and adults by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (45 CFR § 147.130(a)(1)(ii)); preventive care and screenings for infants,

children, and adolescents as recommended by the Health Resources and Services Administration (HRSA) (45 CFR § 147.130(a)(1)(iii)); and preventive care and screenings for women as recommended by HRSA (45 CFR § 147.130(a)(1)(iv)).

However, we note that 45 CFR § 147.130(a)(3) does not require health insurance plans and issuers to cover preventive services when delivered out of network and allows cost-sharing to be imposed if preventive services are delivered by out-of-network providers. We urge you to take further action to ensure that preventive services are covered without cost-sharing requirements, regardless of the network status of the provider.

In addition, HANYS believes that 45 CFR § 147.130(a)(4) should provide additional guidance to help health insurance plans and issuers to determine the frequency, method, treatment, and setting for items or services for which coverage is mandated. The *Interim Final Rule* provides that a health insurance plan or issuer may use “reasonable medical management” to determine the appropriate standards for providing a preventive service. We believe that “reasonable medical management” should be explicitly defined in relation to evidence-informed medicine and not left to the judgment and inclination of payers.

We also respectfully suggest that precise guidelines be developed for value-based insurance designs (VBIDs) which are designed to align patient incentives with the clinical benefit of health services by reducing or eliminating patient cost-sharing requirements for those services that are likely to have the greatest clinical benefit, while requiring a patient fee for access to services judged to have less clinical value. We are concerned that unless the Secretary carefully issues guidance on VBIDs, health insurance plans and issuers may be tempted to steer patients and providers to choose lower-cost care options, without sufficient regard to quality outcomes.

In this regard, the New York Attorney General began an industry-wide investigation into physician ranking systems in 2007 because of concern that consumers were being steered to providers based on faulty data and may have been encouraged to choose physicians primarily based on cost, not quality of care. The Attorney General thereafter developed a *Model for Doctor Rankings* and reached settlements with seven health plans, all of which were required to sign on to the *Model* and revise their physician ranking systems.

*The Model for Doctor Rankings* requires health insurance plans and issuers to:

- ensure that rankings for doctors are not based solely on cost and clearly identify the degree to which any ranking is based on cost;

- use established national standards to measure quality and cost efficiency, including measures endorsed by the National Quality Forum and other generally accepted national standards;
- employ several measures to foster more accurate physician comparisons, including risk adjustment and valid sampling;
- disclose to consumers how the program is designed and how doctors are ranked, and provide a process for consumers to register complaints about the system;
- disclose to physicians how rankings are designed, and provide a process to appeal disputed ratings; and
- nominate and pay for a ratings examiner, subject to the approval of the Attorney General, who oversees compliance with all aspects of the new ranking model and reports to the Attorney General's office every six months.

Thoughtful guidance is necessary to protect consumers from flawed insurance designs that have in the past placed more emphasis on managing cost than on managing quality of care. Therefore, HANYS urges the Secretary to provide additional guidance like the *Model for Doctor Rankings* to help ensure that unbiased and transparent clinical judgment is the cornerstone of the determination process in choosing appropriate medical care for consumers.

If you have questions about our comments, contact Jeffrey Gold, Vice President, Managed Care and Special Counsel, at (518) 431-7730.

Sincerely,



Daniel Sisto  
President

DS:dd