EMTALA

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Disclosures

None

EMTALA
Emergency Medical Treatment & Active Labor Act

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"Access should be the government's responsibility at the federal, state, and local levels. We cannot and should not expect hospitals to be this nation's National Health Service."

Speaking on EMTALA (1985):
Senator David Durenberger (Minnesota)

Presentation Goals:

- What is the Emergency Medical Treatment & Active Labor Act (EMTALA)?
- What does EMTALA mandate?
- Patient anti-dumping laws?
- What are the EMTALA requirements, exceptions & violations?

Case #1

- 22 year old black male
- Hx: IDDM
- Presented with DKA
- He was admitted to a hospital floor bed
- Escorted out of hospital by administrator

Case #1 cont'd:

- Next day
- Found dead at home

Case #1: In Congress

- Mrs. Zettie Mae Hill testified before congress
- She stated: Patient refused care because of insurance
- He was dumped in the hospital parking lot by a hospital administrator

House of Representatives, One Hundredth Congress. Equal Access to Healthcare. Patient Dumping: Hearing before a Subcommittee of the Committee on Governmental Operations, July 22, 1987, Washington, DC. CGPO SUDOCS #Y4, G74/7:H34/5

Case #1

- 22 year old black male
- Hx: IDDM
- Presented with DKA
- He was admitted to a hospital floor bed
- Qualified for medical care
- Refused to fill out forms for coverage
- Left AMA

Case #1: More Hx

- 8 admissions over 3 yrs
- Never refused care
- Qualified for medical care
- Repeatedly refused to complete forms for coverage

Case of Terry Takewell

- Poster boy for: Patient Dumping
- 1980s research:
  - Unstable uninsured patients often transferred to public hospitals with high death rate
  - 87% of transfers to public hospitals were for economic reasons
  - Only 6% of these transfers were consented
  - 24% were transferred unstable
  - 250,000 occurring yearly in 1980s

1986 Schiff: NEJM
1988 Kellerman: Am J Pub Health

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What is EMTALA

- The Emergency Medical Treatment and Active Labor Act: 42 CFR § 489.24
- AKA Emergency Transfer law
- AKA Patient Anti-Dumping law

- Applies to any hospital with an Emergency Department that participates in Medicare

Reason for EMTALA:

- Passed by congress
- Upheld by Supreme Court
- To combat patient dumping
- The refusal of hospitals and physicians to provide emergency care to the medically indigent

Reason for EMTALA cont'd:

- Congress knew why hospitals and physicians turned away uninsured patients
- Who will pay for uncompensated care
- "Unfunded Mandate"
- "Healthcare Safety Net"

"Access should be the government's responsibility at the federal, state, and local levels. We cannot and should not expect hospitals to be this nation's National Health Service."

Speaking on EMTALA (1985):
Senator David Durenberger (Minnesota)

"There's a federal law right now that if you show up at a hospital, you get coverage"

Referring to EMTALA and speaking against Universal Health Coverage (2017):
Congressman Mark Meadows (N. Carolina)

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What Does EMTALA Mandate?

- EMTALA requires participating hospitals to perform a *medical screening examination* (MSE) on all ED patients
- Regardless of patient's ability to pay
- To determine if an *emergency medical condition* (EMC) exists

MSE & EMC:

- MSE: Medical Screening Examination:
  - To determine if an EMC exists
- EMC: Emergency Medical Condition:
  - A condition that without immediate medical attention can reasonably be expected to result in:
    - Placing the health of individual in serious jeopardy
    - Serious impairment to bodily functions
    - Serious dysfunction of any bodily organ or part

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- What is the Emergency Medical Treatment & Active Labor Act (EMTALA)?
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- *What are the EMTALA requirements, exceptions & violations?*

EMTALA Requirements:

- Provide MSE
- If EMC exists, hospital must either:
  - Provide stabilizing treatment within the capabilities of its staff and facilities
  - If patient cannot be stabilized: Hospital must arrange for an appropriate transfer (accounting for risks/benefits of transfer)

When Is A Patient Stabilized?

- When no deterioration of condition is likely, within reasonable medical probability
  - Hospitals not required to provide services beyond what is needed to determine EMC
  - Hospitals not required to resolve the underlying medical condition(s) to achieve stabilization

Case #2 cont'd

- Patient arrives to the ED
- No ENT or anesthesia in hospital
- Receiving ENT refuses to accept until airway secured

When Is A Patient Stabilized?

- When no deterioration of condition is likely, within reasonable medical probability
  - Hospitals not required to provide services beyond what is needed to determine EMC
  - Hospitals not required to resolve the underlying medical condition(s) to achieve stabilization

Stabilization of Patient:

- Sending site:
  - » Stabilize prior to transfer within "Capability & Capacity"
- Can not send "unstable" patient
  - » Exception: Sending physician determines: "Benefits Outweigh Risks"
  - » Ongoing care must continue (to capability)

Transfer Process:

- Physician has signed certification:
  - Benefits outweigh risks
  - Or patient request
- Transfer is "appropriate"
  - Transferring facility provided stabilizing Rx or minimized risk
  - Receiving facility has space, personnel & agreed to accept patient
  - Transferring facility has provided appropriate medical records
  - Transfer effected through qualified personnel & equipment

EMTALA Requirements cont'd:

- MSE nor stabilizing treatment may be delayed to inquire patient's method of payment or insurance status
- If hospital fails to meet these obligations
  - Civil monetary penalty up to $50,000 per violation
  - And may have Medicare agreement terminated

EMTALA Requirements cont'd:

- Hospital may also be fined for failure to accept an appropriate transfer if it has the staff and equipment to treat the patient
- Physicians who negligently violate the law:
  - Subject to civil monetary penalty up to $50,000 per violation
  - May be excluded from Medicare & Medicaid

Physician Civil Penalty:

- Civil penalties for ordinary negligence comes close to criminalizing the everyday practice of hospital-based medicine
- Decisions such as:
  - When does an EMC exist?
  - Whether a patient is stable enough for transfer?
  - When a transfer should be accepted?
- Unlike malpractice: Monetary fines are not covered by malpractice insurance

Case #3

- April 2014
- US Virgin Island hospital ED
- CC: Sharp chest pain & SOB
- Diagnosed with a ruptured aortic valve
- No hospital on island can handle
- Called the nearest medical center that can: Jackson Memorial, Miami

Case #3 cont'd:

- Does Jackson Memorial have to accept this patient?

2002 EMTALA case:

- Hospital must accept an unstable patient if it has the capacity and has personnel or equipment that the patient's condition requires and that the transferring hospital lacks
- Disproportionately expands the obligations of EDs with more sophisticated capabilities and obligations placed on on-call physicians

"Capability & Capacity"

Capability & Capacity

- Capability:
  - »Personnel
  - »Equipment
- Capacity:
  - »Open OR = Capacity
  - »"If you have ever before" principle
  - »Physician capacity not considered

Capability & Capacity

- Best policy:

  Accept patient & sort it out later

Hospital Diversions:

- Hospital overwhelmed
- May not be enough to avoid EMTALA liability
- Federal appeals court ruling:
  - A patient "comes to the emergency department" and triggers EMTALA obligations not only when the patient is on hospital property, but even while traveling toward the hospital

Other Implications:

- Some have interpreted:
  - Neurosurgeon on call
  - If on-call for one hospital, may be on for entire country
  - If another hospital, anywhere, without an on-call neurosurgeon calls and asks to transfer a patient with a neurosurgical emergency, they have a legal duty to accept that patient in transfer???
- Consequences:
  - Specialty physicians curtail hospital privileges
  - Some physicians resign from hospitals
  - Physicians open specialty hospitals

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- Called the nearest medical center that can: Jackson Memorial, Miami

Case #3 cont'd:

- Patient not cleared for immediate transfer to Miami by helicopter
- Jackson Memorial doctors & administrators waited while they verified insurance coverage and method of payment
- Patient waited 12 hours for transfer before passing away

Case #3 cont'd:

- CMS report:
  - Jackson Memorial doctors and administrators made the man wait more than 12 hours after the initial call until health officials in the U.S. Virgin Islands could guarantee payment, he had Medicaid
  - Even after receiving a letter of guarantee, which described the man's condition as "life-threatening," Jackson Memorial made him wait more — stating that the administrator in charge of approving international patient transfers did not work on weekends

How Is EMTALA Enforced?

- CMS & OIG jointly enforce EMTALA
- CMS regional offices can initiate inquiries in response to reports or complaints
  - In addition, a surveyor may identify a potential EMTALA violation while performing a hospital licensing or recertification survey
- CMS screens these reports/complaints

EMTALA Enforcement cont'd:

- If investigation is felt to be warranted:
  - CMS authorizes a state survey agency
    - Unannounced, on-site investigation of hospital
    - 5 working days to complete investigation
    - 10 days for written report to regional office
    - Can express view if violation(s) have occurred
    - If a physician issue is in question: Can recommend to CMS for physician review
- CMS regional office makes initial determination of any violations

EMTALA Enforcement cont'd:

- If a violation is confirmed:
- CMS begins process of terminating hospital's Medicare provider agreement
- It also forwards case to OIG for possible civil penalties
  - OIG focuses on compliance with the specific EMTALA statutory requirements:
    - Failure to provide a MSE
    - Authorizing an inappropriate transfer

EMTALA Enforcement cont'd:

- OIG acts independently of CMS
- OIG has declined to impose civil monetary penalties (~50% of cases)
- If OIG imposes a civil monetary penalty, that action is subject to administrative & judicial review

EMTALA Expansion & Evolution

- 1985 - EMTALA enacted
- 1989 – Statutory enhancements
- 1990 - More statutory enhancements
- 1994 – Interim Final Regulations
- 1998 - Interpretive Guidelines
- 1999 - Special Advisory Bulletin
- 2000 - Medicare Outpatient Prospective Payment System (OPPS) Regulations
- 2002 - CMS Guidance Letters, Proposed Regulations
- 2003 - EMTALA Final Rule
- 2003 - Medicare Modernization Act
- 2004 - Revised Interpretive Guidelines
- 2005 - EMTALA TAG
- 2006 - EMTALA Expanded exemptions
- 2009-Hospital Emergency Services Under EMTALA

EMTALA Expansion & Evolution

- 1999 Special Advisory Bulletin
  - About refusal of care

Refusal Of Care, AMA:

- Despite best efforts to perform MSE, some patients may elect to leave premises before all of law's requirements have been met
- If this occurs, HHS has taken the position that a voluntary withdrawal may form the basis for an EMTALA violation

Refusal Of Care cont'd:

- Offer MSE
- Inform patient benefits of MSE and risks of withdrawal
- Document written informed consent to refuse any examination and treatment
  - Include description of risks discussed
  - Equivalent information should be entered by hospital staff in patient's record

EMTALA Evolution:

- Original intention: To prevent financially motivated denial of medical care in emergency situation
- Has expanded to many other areas: QI
  - Meant to protect poor: Why does it also cover well insured?
  - Meant to cover unstable patients: Why does it include stable patients?
  - ED safety net concept???

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ED Safety Net?

- Open 24/7
- Able to provide full range of medical services for acutely ill
- EDs usage: Massive increases
  - 1997 93 million
  - 2003 114 million
  - 2016 145 million
  - Hospital ED closures in last decade: 14%
  - Most EDs running at or above capacity

ED Safety Net cont'd:

- Legally: EMTALA obligates MSE to identify an EMC
- In practice: EMTALA provides definitive hospital care for severe medical illness or injury to all who enter a hospital

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