Health Law: Quality & Liability

Professor Thaddeus M. Pope

Reading Packet for Week 3 (Fall 2018)

Weekly Summary

In week one, we examined when a physician "must" treat someone. We saw that under common law principles, a physician has a duty to treat only when the physician is already in a treatment relationship with the individual. Statutes have modified this rule when the patient seeking treatment arrives at a hospital. While some of these statutes imposing a duty to treat are based in state law, the most important duty arises under the federal Emergency Medical Treatment and Labor Act (EMTALA) law.

Pre-EMTALA. Congress enacted EMTALA in 1986. But the states had already been grappling with healthcare provider duties in emergency situations. We will briefly examine some of the legal landscape before EMTALA.

Statute & Regulations. Most of the legal duties that we cover in this course arise under state law. EMTALA is one of only a few federal statutes that we will examine. You must be thoroughly familiar with both the EMTALA statute and its implementing regulations. It is a significant source of liability and regulatory compliance work. Contrast most of the court cases that we read in this course. They are not famous or significant. Unlike cases in constitutional law or criminal procedure, the court cases in this course are usually just convenient vehicles to illustrate broader, generally applicable doctrines and principles. These doctrines and principles manifest differently in each of the 56 U.S. jurisdictions.

Court Cases. Next time, we will discuss EMTALA administrative sanctions and cases adjudicated by federal trial and appellate courts in specific factual situations.

Reading

All the following materials are collected into this single PDF document:

- Wilmington Gen. Hosp. v. Manlove (Del. 1961) (6 pages) (pre-EMTALA)
- Walling v. Allstate Ins. (Mich. App. 1990) (2 pages) (pre-EMTALA)
- EMTALA statute, 42 U.S.C. § 1395dd (4 pages)
- EMTALA regulations, 42 C.F.R. § 489.24 (8 pages)
- EMTALA regulations, 42 C.F.R. § 489.53 (2 pages)
- EMTALA regulations, 42 C.F.R. § 413.65 (2 pages)
- Lee, Annals Health L. (2004) (34 pages) (overview, skip footnotes)
- Dahl, Testimony to U.S. Commission on Civil Rights (2014) (6 pages) (overview)
- ASHRM, How to Read Statutes & Regulations (2003) (read when you can)

Objectives

By the end of this week, you will be able to:

- Analyze and apply key statutory, regulatory, and caselaw principles regarding EMTALA, including the duty to screen, the duty to stabilize, and the duty to accept transfers (2.1).
- Analyze and apply key principles regarding how EMTALA is enforced by private litigants and how it is enforced by the DHHS (2.2).
- Distinguish EMTALA enforcement against hospitals from enforcement against individual Physicians (2.3).

Live Class

We will not meet on Tuesday, September 4, 2018, one of the two sessions that correspond to this material. We will meet on Thursday, September 6, 2018. Please watch the videos. I will respond to any questions by email or with a podcast. Plus, we will continue examining EMTALA in week 4 (on September 11 and 13).

Assessments

Quiz 2 (on treatment relationship formation) is due by 11:59PM on September 2, 2018.

Quiz 3 (on EMTALA) is due by 11:59PM on September 9, 2018.

Supreme Court of Delaware.
WILMINGTON GENERAL HOSPITAL, a corporation of the State of Delaware, Defendant Below, Appellant,
v.
Darius M. MANLOVE, Administrator of the Estate of Darien E. Manlove, Plaintiff Below, Appellee.
Oct. 2, 1961.

Action for wrongful death of infant who died shortly after treatment was refused at defendant private hospital. The Superior Court of New Castle County, 169 A.2d 18, Terry, P. J., entered an order refusing hospital's motion for summary judgment and it appealed. The Supreme Court, Southerland, C. J., held that a question of fact was presented as to whether child's condition presented an emergency situation, but in absence of an unmistakable emergency situation private hospital was not liable for refusal to treat her.

Order affirmed.

~~West Headnotes~~

***16 **135** Appeal from an order of the Superior Court of New Castle County refusing defendant's motion for summary judgment.
***15** Rodney M. Layton of Richards, Layton & Finger, Wilmington, for appellant.

****136** Joseph T. Walsh, Wilmington, for appellee.

SOUTHERLAND, Chief Justice, WOLCOTT, Justice, and CAREY, Judge, sitting.

SOUTHERLAND, Chief Justice.

This case concerns the liability of a private hospital for the death of an infant who was refused treatment at the emergency ward of the hospital. The facts are these:

On January 4, 1959, Darien E. Manlove, the deceased infant, then four months old, developed diarrhea. The next morning his parents consulted Dr. Hershon. They asked whether the medicine they had for him was all right and the doctor said that it was. In the evening of the same day Mrs. Manlove took the baby's temperature. It was higher than normal. They called Dr. Hershon, and he prescribed additional medication (streptomycin), which he ordered delivered by a pharmacy.

Mrs. Manlove stayed up with the child that night. He did not sleep. On the morning of January 6th the parents took the infant to Dr. Hershon's office. Dr. Thomas examined the child and treated him for sore throat and diarrhea. He prescribed a liquid diet and some medicine.

When Mr. Manlove returned home that night, the baby's condition appeared to be the same. His temperature was still above normal, and again he did not sleep during the night.

On the morning of January 7th (a Wednesday) his temperature was still above normal-102. Mr. and Mrs. Manlove determined to seek additional medical assistance. They knew that Dr. Hershon and Dr. Thomas were not in their offices on Wednesdays, and they took their infant to the emergency ward of the Wilmington General Hospital.

***17** There is no real conflict of fact as to what occurred at the hospital. The parents took the infant into the reception room of the Emergency Ward. A nurse was on duty. They explained to the nurse what was wrong with the child, that is, that he had not slept for two nights, had a continuously high temperature, and that he had diarrhea. Mr. Manlove told the nurse that the child was under the care of Dr. Hershon and Dr. Thomas, and showed the nurse the medicines prescribed. The nurse explained to the parents that the hospital could not give treatment because the child was under the care of a physician and there would be danger that the medication of the hospital might conflict with that of the attending physician. The nurse did not examine the child, take his temperature, feel his forehead, or look down his throat. The child was not in convulsions, and was not coughing or crying. There was no particular area of body tenderness.

The nurse tried to get in touch with Dr. Hershon or Dr. Thomas in the hospital and at their offices, but was unable to do so. She suggested that the parents bring the baby Thursday morning to the pediatric clinic.

Mr. and Mrs. Manlove returned home. Mrs. Manlove made an appointment by telephone to see Dr. Hershon or Dr. Thomas that night at eight o'clock.

At eight minutes past three o'clock in the afternoon the baby died of bronchial pneumonia.

The foregoing facts are taken mainly from the de-

position of the plaintiff.

Plaintiff, as administrator, brought suit against the hospital to recover damages for wrongful death. The complaint charged negligence in failing to render emergency assistance, in failing to examine the baby, in refusing to advise the interne about the child or permit the parents to consult him, and in failing to follow reasonable and humane hospital procedure for the treatment of emergency cases. Defendant ***18** answered denying negligence and averring ****137** that, pursuant to its established rules and community practice, plaintiff was advised by its employee that it was unable to accept the infant for care.

Discovery proceedings were taken by both parties, eliciting the facts set forth above. Defendant then moved for summary judgment, and attached an affidavit from the nurse on duty when the infant was brought to the hospital. Her statement concerning the refusal of treatment is:

'I then told Mr. and Mrs. Manlove that the rules of the hospital provided that in such cases, where a person is under attendance and medication by a private doctor, *and there is no frank indication of emergency*, no treatment or medication may be given by doctors employed by the hospital until the attending doctor has been consulted.' [Emphasis supplied.]

The issues made by the parties below were in effect two:

1. Whether the hospital was under any duty to furnish medical treatment to any applicant for it, even in an emergency;

2. Whether the existence of an apparent emergency was a material fact in dispute.

The holding of the court below may be summarized as follows:

1. The hospital is liable for refusal to furnish medical treatment in an emergency because it is a quasi-public institution, being the recipient of grants of public funds and of tax exemptions.

2. There was some evidence of an apparent emergency because (1) of death following in a few hours, and (2) of the child's symptoms as recited by the nurse.

Hence the court denied the motion. The hospital appeals.

***19** We take a somewhat different view of these questions from that of the learned judge below.

First, as to the status of the defendant hospital.

It was assumed by both parties below that the hospital was a private hospital and not a public one-that is, an institution founded and controlled by private persons and not by public authority. The trial court disagreed, finding a quasi-public status in the receipt of grants of public money and tax exemptions. See, for example, the Act of 1959 (52 Del.L. c. 159) granting certain hospitals, including defendant, the sum of $550 per bed; and the act authorizing the Levy Court of New Castle County to appropriate public funds to certain hospitals, including defendant, for the care of indigent persons. 9 Del.C. §§ 1801-1806. For the exemption of its property from county taxation see 9 Del.C. § 8103.

Hence, the court concluded, liability may be imposed on the defendant in an emergency case.

[1] We are compelled to disagree with the view that the defendant has become a public (or quasi-public) hospital. It is admitted (although the record does not show it) that it is privately owned and operated. We find no dissent from the rule that such a hospital is a private hospital, and may, at least in the absence of control by the legislature, conduct its business largely as it sees fit.

The question of public or private status has frequently arisen in suits by a physician to compel the hospital to admit him to the use of its facilities. See annotation at 24 A.L.R.2d 850, 854. The cases uni-

formly hold that the receipt of public funds and the exemption from taxation do not convert a private hospital into a public one. See the following cases: Levin v. Sinai Hospital, 186 Md. 174, 46 A.2d 298 (supported in part by public funds); Van Campen v. Olean General Hospital, 210 App.Div. 204, 205 N.Y.S. 554, affirmed ***20**239 N.Y. 615, 147 N.E. 219 (although exempted from taxation); West Coast Hospital v. Hoare, Fla., 64 So.2d 293 (grants of public funds); ****138**Edson v. Griffin Hospital, 21 Conn.Sup. 55, 144 A.2d 341 (a private hospital is one founded and maintained by private persons and the granting of state and municipal aid does not make it a public hospital).

The rule has even been applied to a county-owned hospital if leased to and operated by a private corporation. Akopiantz v. Board of County Commissioners, 65 N.Mex. 125, 333 P.2d 611.

Moreover, the holding that the receipt of grants of public money requires the hospital to care for emergency cases, as distinguished from others, is not logical. Why emergency cases? If the holding is sound it must apply to all the hospital services, and that conclusion, as we shall see, is clearly unsound.

Plaintiff attempts to build an argument upon 9 Del.C. § 1806, requiring the Levy Court of New Castle County to appropriate $10,000 to the defendant hospital for medical care for indigent persons suffering from contagious diseases. Subsection (b) provides that the hospital 'shall admit and care for' such persons.

Plaintiff argues that this is a recognition of the status of the defendant as a public hospital. On the contrary, it is no more than a condition attached to the gift; or at most a regulation of certain special cases of disease affecting public health. There is no doubt that medical care is directly related to public health and is therefore an appropriate subject of legislative regulation; but the provision in subsection (b) only emphasizes the absence of any other provision requiring the hospital to admit any one.

We are of opinion that the defendant is a private and not a public hospital, in so far as concerns the right of a member of the public to demand admission or treatment.

***21** What, then, is the liability of a private hospital in this respect?

[2] Since such an institution as the defendant is privately owned and operated, it would follow logically that its trustees or governing board alone have the right to determine who shall be admitted to it as patients. No other rule would be sensible or workable. Such authority as we have found supports this rule.

'A private hospital owes the public no duty to accept any patient not desired by it, and it is not necessary to assign any reason for its refusal to accept a patient for hospital service.' 41 C.J.S. Hospitals § 8, p. 345.

To the same effect is 26 Am.Jur. 'Hospitals and Asylums', p. 593.

In Birmingham Baptist Hospital v. Crews, 229 Ala. 398, 157 So. 224, 225, it appeared that after giving a child emergency treatment for diptheria the hospital refused her admission because its regulations did not permit the admission of patients with contagious diseases. The court said:

'Defendant is a private corporation, and [is] not a public institution, and owes the public no duty to accept any patient not desired by it.'

The Supreme Judicial Court of Massachusetts, in McDonald v. Massachusetts General Hospital, 120 Mass. 432, 21 Am.Rep. 529, 532, discussing the question of the character of a hospital as a public charity, announced the same rule:

'Nor does the fact that the trustees, through their agents, are themselves to determine who are to be the immediate objects of the charity, and that no person has individually a right to demand admission to its benefits, alter its character. All cannot

participate in its benefits; the trustees are those to whom is confided the duty of selecting those who ***22** shall enjoy them, and prescribing the terms upon which they shall do so. If this trust is abused, the trustees are under the superintending power of this court of equity, by virtue of its authority to correct all such abuse, and the interest of the public ****139** therein, that is to say, of the indefinite objects of the charity, may be represented by the Attorney-General.'

In Levin v. Sinai Hospital, above cited, the court said:

'A private hospital is not under a common law duty to serve every one who applies for treatment or permission to serve.' 46 A.2d 301.

Van Campen v. Olean General Hospital, also cited above, is to the same effect.

The above authorities announce a general rule governing the question of admissions to a private hospital. Does that rule apply to the fullest extent to patients applying for treatment at an emergency ward?

Defendant stresses the rule or practice of the hospital to decline to give medical aid to persons already under the care of a physician. This is no doubt entirely reasonable, but we do not think the rule controlling in this case. We are not furnished with a copy of the rule, or with an affidavit explaining it, but it would seem to be applicable to all admissions-not especially to admissions to the emergency ward. Its significance here appears to lie in the fact that it impliedly recognizes that in case of 'frank'-i. e. unmistakable-emergency there is some duty on the part of the hospital to give help.

We return, then, to the important question: Is there any duty on the part of the hospital to give treatment in an emergency case, i. e., one obviously demanding immediate attention?

[3] It may be conceded that a private hospital is under no legal obligation to the public to maintain an emergency ***23** ward, or, for that matter, a public clinic. Cf. Taylor v. Baldwin, Mo., 247 S.W.2d 741, 751.

But the maintenance of such a ward to render first-aid to injured persons has become a well-established adjunct to the main business of a hospital. If a person, seriously hurt, applies for such aid at an emergency ward, relying on the established custom to render it, is it still the right of the hospital to turn him away without any reason? In such a case, it seems to us, such a refusal might well result in worsening the condition of the injured person, because of the time lost in a useless attempt to obtain medical aid.

Such a set of circumstances is analogous to the case of the negligent termination of gratuitous services, which creates a tort liability. Restatement, Law of Torts, 'Negligence', § 323.

It must be admitted that there is a dearth of helpful legal precedent. There are very few cases dealing with the liability of a hospital for negligence in connection with the care and treatment of a patient brought to an emergency ward. See annotation at 72 A.L.R.2d 396. Nearly all the decisions that have been found deal with charges of negligence in the treatment of a patient who has been accepted for treatment. See Bourgeois v. Dade County, Fla., 99 So.2d 575, 72 A.L.R.2d 391 (interne charged with negligent examination of patient); Leavy v. Yates, Sup., 142 N.Y.S.2d 874 (doctor charged with negligent diagnosis of injured patient); Wade v. Ravenswood Hospital Association, 3 Ill.App.2d 102, 120 N.E.2d 345 (charge of lack of competent medical care).

But this is not a case in which the hospital assumed to treat the patient. The claim is that it should have treated him, and that the nurse was negligent in failing to have the infant examined by the interne on duty, because an apparent emergency existed.

***24** This leads to the inquiry: What is the duty of a nurse to one applying for admission as an emer-

gency case? Obviously, if an emergency is claimed, some one on behalf of the hospital must make a *prima facie* decision whether it exists. The hospital cannot reasonably be expected to station an interne at all times in the receiving room. It therefore keeps a nurse on duty. ****140** If the nurse makes an honest decision that there is no unmistakable indication of an emergency, and that decision is not clearly unreasonable in the light of the nurse's training, how can there be any liability on the part of the hospital?

The only case cited to us involving refusal of treatment at an emergency ward is that of O'Neill v. Montefiore Hospital, 11 A.D.2d 132, 202 N.Y.S.2d 436. In that case Mr. and Mrs. John J. O'Neill came early one morning to the hospital emergency ward. O'Neill complained of symptoms of a heart ailment or attack. He was refused admission because he was a member of a Hospital Insurance Plan and the hospital did not take such cases. The nurse called an H I P doctor, and Mr. O'Neill took the telephone and described his symptoms. The nurse then arranged for O'Neill to see that doctor a few hours later. Mrs. O'Neill asked to have a doctor examine him because it was an emergency, but this was not done. The O'Neills returned home, and O'Neill died in a very short time.

In a suit against the doctor and the hospital the trial court found for the defendants. The Appellate Division unanimously reversed as to the doctor. As to the hospital, three judges held there was a question of fact for the jury to decide, that is, whether the nurse's conduct was a personal favor to deceased, or whether her conduct was that of an attaché discharging her duty, and if the latter, whether what she did was adequate. Two judges dissented, pointing out that the doctor called by the nurse did not, after talking to the patient, indicate that any emergency treatment was required, or request***25** that the patient be admitted to the hospital. In these circumstances they found no liability.

The difference of opinion in that case seems to turn on the question whether, by calling a physician for the applicant, the nurse assumed to give him hospital service. The case does not discuss the questions of what constitutes an emergency, and what is the duty of the nurse in such cases.

As to the majority holding that the nurse's telephone call gave rise to liability, we respectfully dissent. We think the minority opinion is the better view.

[4] As above indicated, we are of opinion that liability on the part of a hospital may be predicated on the refusal of service to a patient in case of an unmistakable emergency, if the patient has relied upon a well-established custom of the hospital to render aid in such a case. The hospital rule with respect to applicants already under the care of a physician may be said to be an implied recognition of this duty.

[5] Applying this rule here, we inquire, was there an unmistakable emergency? Certainly the record does not support the view that the infant's condition was so desperate that a layman could reasonably say that he was in immediate danger. The learned judge indicated that the fact that death followed in a few hours showed an emergency; but with this we cannot agree. It is hindsight. And it is to be noted that the attending physician, after prescribing for the child on morning before, did not think another examination that night or the next morning was required. If this case had gone to the jury on the record here made, we would have been required to hold that it was insufficient to establish liability. We cannot agree that the mere recitation of the infant's symptoms was, in itself, evidence of an emergency sufficient to present a question for the jury. Before such an issue could arise there would have to be evidence that an experienced nurse should have known that such symptoms constituted unmistakable evidence of an emergency.

***26** We must keep in mind the fact that this is not the ordinary accident case in which the services of the hospital emergency ward are sought because of a showing of serious physical injury, or of a danger

of such injury. It is a case of disease. This is not to say that an emergency could not arise out of a diseased condition; it is only to say that some degree of experience and knowledge is required to make a *prima* *****141*** *facie* determination of the existence of such an emergency.

We do not think that the record made below satisfactorily developed the pertinent facts. What is standard hospital practice when an applicant for aid seeks medical aid for sickness at the emergency ward? Is it the practice for the nurse to determine whether or not an emergency exists, or is it her duty to call the interne in every case? Assuming (as seems probable) that it is her duty to make such a determination, was her determination in this case within the reasonable limits of judgment of a graduate nurse, even though mistaken, or was she derelict in her duty, as a graduate nurse, in not recognizing an emergency from the symptoms related to her? To resolve these questions additional evidence, probably expert opinion, would seem to be required.

It may be said that it was the duty of the plaintiff below, when confronted with the motion for summary judgment, to offer additional proof by affidavit or otherwise. This is perhaps so, but the defendant also could have submitted evidence on the questions we have referred to. As it was, the defendant pitched its case on the theory that under no circumstances could it be liable. The possibility that the case might turn on additional evidence respecting the matters we have touched upon was not considered either by the court or counsel.

In the circumstances we think the case should go back for further proceedings. We should add, however, that if plaintiff cannot adduce evidence showing some incompetency of the nurse, or some breach of duty or some negligence, his case ***27** must fail. Like the learned judge below, we sympathize with the parents in their loss of a child; but this natural feeling does not permit us to find liability in the absence of satisfactory evidence.

For the reasons above set forth the order denying summary judgment is affirmed, without approving the reasons therefor set forth in the court's opinion.

Del., 1961
Wilmington General Hosp. v. Manlove
4 Storey 15, 54 Del. 15, 174 A.2d 135

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183 Mich.App. 731

Douglas WALLING, Personal Representative of the Estate of Jacklyn Walling, Deceased, Sydney Walling, Douglas Walling and Kathlyn Johnston, Plaintiffs–Appellants,

v.

ALLSTATE INSURANCE COMPANY, a Foreign corporation, Gary Frank, Dianne Dailey, Harold Cripe, Sr., James Cromar and Wynona Cromar, Defendants,

and

Flint Osteopathic Hospital, a Private corporation and Marilyn K. Safa and Riad Safa, d/b/a the Hayloft, Jointly and Severally, Defendants–Appellees.

Docket No. 108277.

Court of Appeals of Michigan.

Submitted March 8, 1990.

Decided May 21, 1990.

Released for Publication June 1, 1990.

Decedent's estate brought action against hospital and liquor store, alleging medical malpractice and violation of dramshop statute. The Circuit Court, Genesee County, Judith A. Fullerton, J., granted summary disposition for defendants and appeal was taken. The Court of Appeals, Brennan, J., held that: (1) private hospital owed no duty to treat decedent, who did not present herself in emergency room in condition which constituted unmistakable medical emergency, and (2) liquor store which sold alcohol to minor was not liable for death of decedent with whom purchaser shared alcohol.

Affirmed.

Griffin, P.J., concurred and filed opinion.

1. Hospitals ⇐7

Private hospital had no common-law duty to treat person who appeared in emergency room absent evidence that person's condition constituted unmistakable medical

Henry M. Hanflik and David Melkus, of counsel, Flint, for plaintiffs-appellants.

Plunkett & Cooney, P.C. by Robert G. Kamenec, Detroit, for Flint Osteopathic Hosp.

Kallas, Lower, Henk & Treado, P.C. by Constantine N. Kallas and Nancy A. Plasterer, Bloomfield Hills, for Marilyn K. Safa and Riad Safa.

Before GRIFFIN, P.J., and WAHLS and BRENNAN, JJ.

BRENNAN, Judge.

In this medical malpractice and dram-shop action, plaintiffs appeal as of right from multiple orders for summary disposition entered in favor of defendants by the Genesee Circuit Court. We affirm.

On the night of January 1, 1984, Jacklyn Walling, Harold Cripe, Jr., Gary Frank and others went to The Hayloft, a Flint-area party store owned by Marilyn and Riad Safa. All of the members of the group were minors. While Walling waited in Frank's car, Cripe and Frank went into the store and purchased a substantial quantity of liquor. Frank made the actual purchase, using a fake driver's license and money given to him by Cripe. There is no question that Walling did not contribute money toward the purchase of the liquor. Frank and Cripe left the store and returned to Frank's car. They drove away and made two stops during which time they proceeded to consume the liquor.

At some time during the evening, Walling became ill, vomiting several times and screaming. Frank drove Walling to Flint Osteopathic Hospital. Frank and Cripe assisted Walling into the emergency room where they sat her in a wheelchair.

An emergency room nurse questioned Walling concerning her ailments. The nurse noted that, although Walling appeared to be in pain, she had no trouble speaking and her speech was clear. The nurse informed Walling that the hospital would need permission from a parent or other responsible adult before the hospital

would treat her. Walling refused to disclose her parents' telephone number. Walling then indicated that she was going to be sick. She vomited into an emetic basin. The nurse noted that the vomitus smelled of alcohol. Cripe admitted to the nurse that Walling had been drinking. Walling refused a second request to disclose her parents' telephone number. The nurse left Walling alone, hoping that she would change her mind. When the nurse went to check on Walling five minutes later, she discovered that Walling had left the hospital.

On the way back to Frank's car, Walling did not complain of any stomach pains and appeared to be sober during the drive to Cripe's home. Walling and Cripe got out of Frank's car at Cripe's home. Walling and Cripe went inside the house. Several hours later, during the early morning of January 2, 1984, a fire broke out inside the Cripe home, killing Walling.

Plaintiffs first argue that the trial court erred by ruling that defendant hospital had no duty to examine and treat plaintiffs' decedent as a matter of law. Plaintiffs contend that the question of the hospital's duty is a mixed question of law and fact which could not be resolved in the context of a motion for summary disposition. Plaintiffs contend that the hospital's admitted violation of federal, state and hospital association standards is evidence of negligence which creates a disputed question of fact for a jury to decide.

[1, 2] The trial court did not err in finding that defendant hospital had no common-law duty to treat plaintiffs' decedent. The question whether a duty exists is one of law to be decided by the court. *Smith v. Allendale Mutual Ins. Co.*, 410 Mich. 685, 713, 303 N.W.2d 702 (1981), reh. den. 411 Mich. 1154 (1981). The trial court ruled that defendant hospital did not owe a duty to treat plaintiffs' decedent because decedent did not present herself in defendant's emergency room in a condition which constituted an unmistakable medical emergency.

No reported case in Michigan has dealt with the issue whether a private hospital has a duty to treat members of the public who appear in its emergency room. The original rule at common law was that a private hospital did not have a duty to treat any patient not accepted by it. See Powers, *Hospital Emergency Service and The Open Door*, 66 Mich L R 1455, 1462–1463 (1968). The modern rule is that liability on the part of a private hospital may be based upon the refusal of service to a patient in a case of unmistakable medical emergency. *Valdez v. Lyman–Roberts Hospital, Inc.*, 638 S.W.2d 111, 114 (Tex.App.1982); Anno: *Liability of hospital for refusal to admit or treat patient*, 35 A.L.R.3d 841, § 4, pp 846–847. An unmistakable emergency exists when a reasonable person would say that the patient's life is in immediate danger. *Wilmington General Hospital v. Manlove*, 54 Del. 15, 174 A.2d 135 (1961). The trial court applied the modern rule.

[3] When dealing with an issue of first impression, a court may rely on precedents from other jurisdictions in deciding such a question. *Dodge v. Blood*, 299 Mich. 364, 371, 300 N.W. 121 (1941). We do not disagree with the rule applied by the trial court in deciding defendant hospital's motion for summary disposition and adopt it here.

The record clearly establishes that, although decedent walked into defendant's emergency room with some difficulty, she did not require medical assistance while there. Decedent was conscious and coherent. The evidence before the trial court was insufficient to create a genuine issue as to whether decedent's condition constituted an unmistakable emergency. Therefore, summary disposition was properly granted on this issue.

[4] Moreover, the trial court correctly ruled that defendant did not owe a statutory duty under M.C.L. § 333.6121; M.S.A. § 14.15(6121) to treat decedent. The statute provides in part:

> The consent to the provision of substance abuse related medical or surgical care, treatment, or services by a hospital, clinic, or health professional authorized by law executed by a minor who is or

42 U.S.C. § 1395dd

(a) Medical screening requirement
In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor
(1) In general
If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—
(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
(B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.
(2) Refusal to consent to treatment
A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.
(3) Refusal to consent to transfer
A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) of this section and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized
(1) Rule
If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless—
(A)
(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1395x (r)(1) of this title) has signed a certification that [1] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or
(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x (r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and
(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.
A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.
(2) Appropriate transfer
An appropriate transfer to a medical facility is a transfer—
(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;
(B) in which the receiving facility—
(i) has available space and qualified personnel for the treatment of the individual, and
(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;
(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;
(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and
(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement
(1) Civil money penalties
(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a–7a (a) of this title.
(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for

the care of such an individual, and who negligently violates a requirement of this section, including a physician who—
(i) signs a certification under subsection (c)(1)(A) of this section that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or
(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,
is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a–7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a–7a (a) of this title.
(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc (a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.
(2) Civil enforcement
(A) Personal harm
Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.
(B) Financial loss to other medical facility
Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.
(C) Limitations on actions
No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.
(3) Consultation with peer review organizations
In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1) or in terminating a hospital's participation under this subchapter, the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of subchapter XI of this chapter) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review. Except in the case in

which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.
(4) Notice upon closing an investigation
The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.

(e) Definitions
In this section:
(1) The term "emergency medical condition" means—
(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—
(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
(ii) serious impairment to bodily functions, or
(iii) serious dysfunction of any bodily organ or part; or
(B) with respect to a pregnant woman who is having contractions—
(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.
(2) The term "participating hospital" means a hospital that has entered into a provider agreement under section 1395cc of this title.
(3)
(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).
(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).
(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who
(A) has been declared dead, or
(B) leaves the facility without the permission of any such person.
(5) The term "hospital" includes a critical access hospital (as defined in section 1395x (mm)(1) of this title).

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

(a) *Applicability of provisions of this section.* (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) ''comes to the emergency department'', as defined in paragraph (b) of this section, the hospital must—

(i) Provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of § 482.55 of this chapter concerning emergency services personnel and direction; and

(ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.

(2)(i) When a waiver has been issued in accordance with section 1135 of the Act that includes a waiver under section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department if the following conditions are met:

(A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period.

(B) The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan.

(C) The hospital does not discriminate on the basis of an individual's source of payment or ability to pay.

(D) The hospital is located in an emergency area during an emergency period, as those terms are defined in section 1135(g)(1) of the Act.

(E) There has been a determination that a waiver of sanctions is necessary.

(ii) A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public

health emergency, as provided under section 1135(e)(1)(B) of the Act.

(b) *Definitions.* As used in this subpart—

Capacity means the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment and the hospital's past practices of accommodating additional patients in excess of its occupancy limits.

Comes to the emergency department means, with respect to an individual who is not a patient (as defined in this section), the individual—

(1) Has presented at a hospital's dedicated emergency department, as defined in this section, and requests examination or treatment for a medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition;

(2) Has presented on hospital property, as defined in this section, other than the dedicated emergency department, and requests examination or treatment for what may be an emergency medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs emergency examination or treatment;

(3) Is in a ground or air ambulance owned and operated by the hospital for purposes of examination and treatment for a medical condition at a hospital's dedicated emergency department, even if the ambulance is not on hospital grounds. However, an individual in an ambulance owned and operated by the hospital is not considered to have ''come to the hospital's emergency department'' if—

(i) The ambulance is operated under communitywide emergency medical service (EMS) protocols that direct it to transport the individual to a hospital other than the hospital that owns the ambulance; for example, to the closest appropriate facility. In this case, the individual is considered to have come to the emergency department of the hospital to which the individual is transported, at the time the individual is brought onto hospital property;

(ii) The ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance; or

(4) Is in a ground or air nonhospital-owned ambulance on hospital property for presentation for examination and treatment for a medical condition at a hospital's dedicated emergency department. However, an individual in a nonhospital-owned ambulance off hospital property is not considered to have come to the hospital's emergency department, even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment. The hospital may direct the ambulance to another facility if it is in ''diversionary status,'' that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the hospital's diversion instructions and transports the individual onto hospital property, the individual is considered to have come to the emergency department.

Dedicated emergency department means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

(1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

(3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

Emergency medical condition means—

(1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part; or

(2) With respect to a pregnant woman who is having contractions—

(i) That there is inadequate time to effect a safe transfer to another hospital before delivery; or

(ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

Hospital includes a critical access hospital as defined in section 1861(mm)(1) of the Act.

Hospital property means the entire main hospital campus as defined in § 413.65(b) of this chapter, including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities.

Hospital with an emergency department means a hospital with a dedicated emergency department as defined in this paragraph (b).

Inpatient means an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services as described in § 409.10(a) of this chapter with the expectation that he or she will remain at least overnight and occupy a bed even though the situation later develops that the individual can be discharged or transferred to another hospital and does not actually use a hospital bed overnight.

Labor means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor.

Participating hospital means (1) a hospital or (2) a critical access hospital as defined in section 1861(mm)(1) of the Act that has entered into a Medicare provider agreement under section 1866 of the Act.

Patient means—

(1) An individual who has begun to receive outpatient services as part of an encounter, as defined in § 410.2 of this chapter, other than an encounter that the hospital is obligated by this section to provide;

(2) An individual who has been admitted as an inpatient, as defined in this section.

Stabilized means, with respect to an ''emergency medical condition'' as defined in this section under paragraph (1) of that definition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to an ''emergency medical condition'' as defined in this section under paragraph (2) of that definition, that the woman has delivered the child and the placenta.

To stabilize means, with respect to an ''emergency medical condition'' as defined in this section under paragraph (1) of that definition, to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the

transfer of the individual from a facility or that, with respect to an ''emergency medical condition'' as defined in this section under paragraph (2) of that definition, the woman has delivered the child and the placenta.

Transfer means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person.

(c) *Use of dedicated emergency department for nonemergency services.* If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

(d) *Necessary stabilizing treatment for emergency medical conditions*—(1) *General.* Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

(i) Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition.

(ii) For transfer of the individual to another medical facility in accordance with paragraph (e) of this section.

(2) *Exception: Application to inpatients.* (i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual.

(ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment.

(iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation.

(3) *Refusal to consent to treatment.* A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both.

(4) *Delay in examination or treatment.* (i) A participating hospital may not delay providing an appropriate medical screening examination required under paragraph (a) of this section or further medical examination and treatment required under paragraph (d)(1) of this section in order to inquire about the individual's method of payment or insurance status.

(ii) A participating hospital may not seek, or direct an individual to seek, authorization from the individual's insurance company for screening or stabilization services to be furnished by a hospital, physician, or nonphysician practitioner to an individual until after the hospital has provided the appropriate medical screening examination required under paragraph (a) of this section, and initiated any further

medical examination and treatment that may be required to stabilize the emergency medical condition under paragraph (d)(1) of this section.

(iii) An emergency physician or nonphysician practitioner is not precluded from contacting the individual's physician at any time to seek advice regarding the individual's medical history and needs that may be relevant to the medical treatment and screening of the patient, as long as this consultation does not inappropriately delay services required under paragraph (a) or paragraphs (d)(1) and (d)(2) of this section.

(iv) Hospitals may follow reasonable registration processes for individuals for whom examination or treatment is required by this section, including asking whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment. Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation.

(5) *Refusal to consent to transfer.* A hospital meets the requirements of paragraph (d)(1)(ii) of this section with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with paragraph (e) of this section and informs the individual (or a person acting on his or her behalf) of the risks and benefits to the individual of the transfer, but the individual (or a person acting on the individual's behalf) does not consent to the transfer. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of a person acting on his or her behalf). The written document must indicate the person has been informed of the risks and benefits of the transfer and state the reasons for the individual's refusal. The medical record must contain a description of the proposed transfer that was refused by or on behalf of the individual.

(e) *Restricting transfer until the individual is stabilized*—(1) *General.* If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless—

(i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and

(ii)(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer;

(B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or

(C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.

(2) A transfer to another medical facility will be appropriate only in those cases in which—

(i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(ii) The receiving facility—

(A) Has available space and qualified personnel for the treatment of the individual; and

(B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and

(iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

(3) A participating hospital may not penalize or take adverse action against a physician or a qualified medical person described in paragraph (e)(1)(ii)(C) of this section because the physician or qualified medical person refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized, or against any hospital employee because the employee reports a violation of a requirement of this section.

(f) *Recipient hospital responsibilities.* A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive case units, or, with respect to rural areas, regional referral centers (which, for purposes of this subpart, mean hospitals meeting the requirements of referral centers found at §412.96 of this chapter)) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

(1) The provisions of this paragraph (f) apply to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.

(2) The provisions of this paragraph (f) do not apply to an individual who has been admitted to a referring hospital under the provisions of paragraph (d)(2)(i) of this section.

(g) *Termination of provider agreement.* If a hospital fails to meet the requirements of paragraph (a) through (f) of this section, CMS may terminate the provider agreement in accordance with §489.53.

(h) *Consultation with Quality Improvement Organizations (QIOs)—*

(j) *Availability of on-call physicians.* In accordance with the on-call list requirements specified in § 489.20(r)(2), a hospital must have written policies and procedures in place—

(1) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control; and

(2) To provide that emergency services are available to meet the needs of individuals with emergency medical conditions if a hospital elects to—

(i) Permit on-call physicians to schedule elective surgery during the time that they are on call;

(ii) Permit on-call physicians to have simultaneous on-call duties; and

(iii) Participate in a formal community call plan. Notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to conduct appropriate transfers. The formal community plan must include the following elements:

(A) A clear delineation of on-call coverage responsibilities; that is, when each hospital participating in the plan is responsible for on-call coverage.

(B) A description of the specific geographic area to which the plan applies.

(C) A signature by an appropriate representative of each hospital participating in the plan.

(D) Assurances that any local and regional EMS system protocol formally includes information on community on-call arrangements.

(E) A statement specifying that even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an obligation under §489.24 to provide a medical screening examination and stabilizing treatment within its capability, and that hospitals participating in the community call plan must abide by the regulations under §489.24 governing appropriate transfers.

(F) An annual assessment of the community call plan by the participating hospitals.

[59 FR 32120, June 22, 1994, as amended at 62 FR 46037, Aug. 29, 1997; 65 FR 18548, Apr. 7, 2000; 65 FR 59748, Oct. 6, 2000; 66 FR 1599, Jan. 9, 2001; 66 FR 59923, Nov. 30, 2001; 68 FR 53262, Sept. 9, 2003; 71 FR 48143, Aug. 18, 2006; 72 FR 47413, Aug. 22, 2007; 73 FR 48758, Aug. 19, 2008; 74 FR 44001, Aug. 27, 2009]

EFFECTIVE DATE NOTE: At 59 FR 32120, June 22, 1994, §489.24 was added. Paragraphs (d) and (g) contain information collection and recordkeeping requirements and will not become effective until approval has been given by the Office of Management and Budget.

Subpart E—Termination of Agreement and Reinstatement After Termination

§ 489.53 Termination by CMS.

(a) *Basis for termination of agreement with any provider.* CMS may terminate the agreement with any provider if CMS finds that any of the following failings is attributable to that provider:

(1) It is not complying with the provisions of title XVIII and the applicable regulations of this chapter or with the provisions of the agreement.

(2) It places restrictions on the persons it will accept for treatment and it fails either to exempt Medicare beneficiaries from those restrictions or to apply them to Medicare beneficiaries the same as to all other persons seeking care.

(3) It no longer meets the appropriate conditions of participation or requirements (for SNFs and NFs) set forth elsewhere in this chapter. In the case of an RNHCI no longer meets the conditions for coverage, conditions of participation and requirements set forth elsewhere in this chapter.

(4) It fails to furnish information that CMS finds necessary for a determination as to whether payments are or were due under Medicare and the amounts due.

(5) It refuses to permit examination of its fiscal or other records by, or on behalf of CMS, as necessary for verification of information furnished as a basis for payment under Medicare.

(6) It failed to furnish information on business transactions as required in § 420.205 of this chapter.

(7) It failed at the time the agreement was entered into or renewed to disclose information on convicted individuals as required in § 420.204 of this chapter.

(8) It failed to furnish ownership information as required in § 420.206 of this chapter.

(9) It failed to comply with civil rights requirements set forth in 45 CFR parts 80, 84, and 90.

(10) In the case of a hospital or a critical access hospital as defined in section 1861(mm)(1) of the Act that has reason to believe it may have received an individual transferred by another hospital in violation of § 489.24(d), the

(i) Specify the termination date; and

(ii) Explain to what extent services may continue after that date, in ac-

hospital failed to report the incident to CMS or the State survey agency.

(11) In the case of a hospital requested to furnish inpatient services to CHAMPUS or CHAMPVA beneficiaries or to veterans, it failed to comply with § 489.25 or § 489.26, respectively.

(12) It failed to furnish the notice of discharge rights as required by § 489.27.

(13) It refuses to permit photocopying of any records or other information by, or on behalf of CMS, as necessary to determine or verify compliance with participation requirements.

(14) The hospital knowingly and willfully fails to accept, on a repeated basis, an amount that approximates the Medicare rate established under the inpatient hospital prospective payment system, minus any enrollee deductibles or copayments, as payment in full from a fee-for-service FEHB plan for inpatient hospital services provided to a retired Federal enrollee of a fee-for-service FEHB plan, age 65 or older, who does not have Medicare Part A benefits.

(15) It had its enrollment in the Medicare program revoked in accordance to § 424.535 of this chapter.

(b) *Termination of agreements with cer-*

(3) *Content of notice.* The notice states the reasons for, and the effective date of, the termination, and explains the extent to which services may continue after that date, in accordance with §489.55.

(4) *Notice to public.* CMS concurrently gives notice of the termination to the public.

(e) *Appeal by the provider.* A provider may appeal the termination of its provider agreement by CMS in accordance with part 498 of this chapter.

[51 FR 24492, July 3, 1986, as amended at 52 FR 22454, June 12, 1987; 54 FR 5373, Feb. 2, 1989; 56 FR 48879, Sept. 26, 1991; 59 FR 32123, June 22, 1994; 59 FR 56251, Nov. 10, 1994; 60 FR 45851, Sept. 1, 1995; 60 FR 50119, Sept. 28, 1995; 62 FR 43937, Aug. 18, 1997; 62 FR 46037, Aug. 29, 1997; 62 FR 56111, Oct. 29, 1997; 68 FR 66720, Nov. 28, 2003; 69 FR 49272, Aug. 11, 2004; 71 FR 20781, Apr. 21, 2006; 72 FR 47413, Aug. 22, 2007; 72 FR 53649, Sept. 19, 2007; 73 FR 48758, Aug. 19, 2008]

§ 413.65 Requirements for a determination that a facility or an organization has provider-based status.

(2) *Definitions.* In this subpart E, unless the context indicates otherwise—

Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.

An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement

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SUMMARY

Enacted in 1986, the Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals to provide a medical screening examination to all persons who present to an emergency department. While it has been nearly two decades since EMTALA was enacted, the problems it was meant to solve persist and continue to affect providers and the public. Section I of this article provides a history of the statute. Section II provides an in-depth explanation of the specifics of the statute and its accompanying regulations. Section III details governmental enforcement efforts to date. Section IV identifies the benefits and drawbacks of the statute. Section V of the article provides recommendations for ameliorating EMTALA's weaknesses. Finally, Section VI discusses several factors that may compromise the future effectiveness of EMTALA, including the costs of enforcement and the re-ordering of federal administrative priorities in the wake of September 11th. In order for EMTALA to serve its intended purpose, Congress must grant providers appropriate financial relief so that EMTALA compliance does not become an unfunded mandate. The government must refine its procedures for holding providers accountable for EMTALA violations, including narrowing the prosecutorial discretion of the Office of the Inspector General, and updating federal information systems so that tracking and enforcement are efficient.

I. A HISTORY OF THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT

It is said that poverty's partners are public indignity and perennial

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danger[1]—a truism manifested in modern American medical culture by the practice of patient dumping. Patient dumping occurs when poor or uninsured patients in need of emergency treatment are transferred from hospital to hospital before they are medically stable, solely or primarily because of their inability to afford medical services. The social and medical harms of patient dumping have long been recognized. When patient dumping first became common, states initially sought to forbid the practice by recognizing and enforcing at common law an affirmative duty on the part of public hospitals to provide emergency treatment to patients without regard to ability to pay.[2] In addition, courts often relied upon public policy and custom to ensure that health care providers met this duty.[3] However, the common law duty proved ineffective, as indigent patients still encountered substantial difficulty in obtaining health care. Consequently, states sought to impose on hospitals a statutory duty to treat emergency patients without regard for their ability to pay.[4] However, this approach also proved ineffective because there was often no clear definition of what constituted an emergency, thus allowing providers to abdicate their responsibility to provide care under the guise of confusion. Moreover, many states did not enforce this requirement and there were few sanctions imposed against providers that ignored this responsibility.[5]

Because the states were largely unsuccessful in requiring hospitals to provide emergency care to the poor, the federal government took action. In 1946, Congress enacted the Hill-Burton Act, which required hospitals, as a condition of receiving federal funds for construction or modernization, to treat and stabilize all emergency patients prior to discharge.[6] However, the

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1. *See, e.g.*, Somini Sengupta, *In Bombay, Public Indignity Is Poverty's Partner*, N.Y. TIMES, Feb. 10, 2002, § 1, at 3.

2. *See, e.g.*, Wilmington Gen. Hosp. v. Manlove, 174 A.2d 135, 140 (Del. 1961); Richard v. Adair Hosp. Found. Corp., 566 S.W.2d 791, 793 (Ky. Ct. App. 1978); Mercy Med. Ctr. of Oshkosh, Inc. v. Winnebago County, 206 N.W.2d 198, 200 (Wis. 1973).

3. *See, e.g.*, *Mercy*, 206 N.W.2d at 200 ("Our health conscious society and the government's interest in extensive health care . . . demands that emergency service . . . be promptly rendered to those in need without regard for immediate payment or security therefor.").

4. *See, e.g.*, CAL. HEALTH & SAFETY CODE §1317(b) (West 2001); S.C. CODE ANN. §44-7-260(E) (Law. Co-op. 2000); 210 ILL. COMP. STAT. 70/1 (2002). *See also* Thomas L. Stricker, Jr., *The Emergency Medical Treatment & Active Labor Act: Denial of Emergency Medical Care Because of Improper Economic Motives*, 67 NOTRE DAME L. REV. 1121, 1125 n.16 (1992) (citing various state statutes designed to eliminate patient dumping).

5. *See* Karen I. Treiger, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. REV. 1186, 1202 (1986) (describing the ineffectiveness of the state response to patient dumping).

6. Treiger, *supra* note 5, at 1198; 42 U.S.C. § 291c(e) (2000) (providing that hospitals built with federal funds must be part of a state plan to provide for "adequate hospitals . . . for all persons residing in the State . . . to furnish needed services for persons unable to pay

Hill-Burton requirement proved to be yet another ineffective measure against patient dumping—primarily for the reasons that states failed to stanch the practice. First, the Department of Health and Human Services ("DHHS") failed to enforce the indigent patient care requirement.[7] Second, neither the Hill-Burton Act nor its regulations effectively defined "emergency," thus allowing hospitals to disregard the requirement to provide emergency services to all persons.[8] Third, there were no punitive remedies for violations of the statute.[9] Finally, though some courts recognized an implied private right of action under Hill-Burton, most patients remained unaware of their rights and remedies under the statute.[10]

While the federal government was considering what its next step would be to ensure that all persons had equal access to emergency medical care, the public grew increasingly concerned by vivid news media accounts of severely ill or injured persons being denied emergency care.[11] For example, one instance of patient dumping was reported in gruesome detail:

> In one case a patient who had been on a mechanical breathing device for 5 days, and was comatose, was transferred without the knowledge or consent of the county hospital. The patient had surgical incisions for brain operations on both sides of the head with the brain bulging out of one of the incisions. This patient had a fever of 103 and was paralyzed on the left side of the body.[12]

One group of patients particularly affected by patient dumping was pregnant women, who often found it difficult to find a hospital that would admit them in their time of need:

> [T]he refusal of two private hospitals to treat a desperate, pregnant woman who had no medical insurance resulted in the stillbirth of her

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therefor."). *See also* Stricker, Jr., *supra* note 4, at 1125.

7. Treiger, *supra* note 5, at 1198.

8. *Id.* at 1199.

9. *Id.* at 1199-1200.

10. *Id.* at 1200.

11. 131 CONG. REC. S13,892 (daily ed. Oct. 23, 1985). According to Senator Durenberger:

> [T]he patient dumping issue . . . has gained much public attention over the last year. The CBS News show '60 Minutes' ran a segment exposing the inappropriate transfer of a number of seriously ill patients from the emergency rooms of private hospitals to public hospitals .... The Washington Post [subsequently] chronicled a Dallas case of a badly burned laborer who was turned away from a number of hospitals before he could get the treatment he badly needed.

12. 131 CONG. REC. E5520 (daily ed. Dec. 10, 1985) (statement of Rep. Stark) (citing multiple media reports of patient dumping).

> baby. Even though she was in severe pain when she showed up at the first hospital, the hospital turned her away without letting her even see a doctor. At the second hospital a fetal monitor had detected irregularities in the baby's heart and a doctor at the hospital thought the baby's irregular heartbeat was a sign of fetal distress. Incredible as it may seem, she was told to go to the county hospital for care. By the time she arrived at the third hospital, the baby's heartbeat was barely detectable. Although the county hospital rushed to perform a Ceasarean [sic] section, the baby was stillborn.[13]

As the public became more aware of cases like these, elected representatives gave voice to the growing sense of outrage. Representative Fortney "Pete" Stark deemed the problem of patient dumping "a growing problem with tragic results."[14] Senator David Durenberger stated that "[a]ll Americans, rich or poor, deserve access to quality health care. This question of access should be the government's responsibility at the federal, state, and local levels."[15] The inequity of medical treatment calibrated by socioeconomic circumstance was summed up by Congressman Stark, who stated that "[t]hese cases are medically indefensible. They are ethically indefensible. Clearly, if these patients had been middle class with health insurance they never would have faced the horrors that they encountered."[16]

When Congress began to direct its attention to the issue of patient dumping with an eye toward legislation to prohibit the practice (eventually enacted as EMTALA), hospital administrators reacted strongly. They denied the need for any new requirements because they claimed existing policies and procedures adequately ensured fair access to medical facilities.[17] However, these protestations were belied by the results of several studies showing that patient dumping was indeed an ongoing and serious problem. The Himmelstein research team conducted one of the earliest studies of patient dumping. The study examined 458 patient transfers to a public hospital from private hospitals during a six-month period.[18] The study found that 97% of the patients who were transferred to

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13. *Id.*

14. *Id.*

15. 131 CONG. REC. S13,892.

16. 131 CONG. REC. E5520.

17. *See, e.g.*, OFFICE OF THE INSPECTOR GEN. (OIG), DEP'T OF HEALTH & HUMAN SERVS. (DHHS), THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT: SURVEY OF HOSPITAL EMERGENCY DEPARTMENTS 15 app.A (Jan. 2001) (reporting that forty-one percent of hospital emergency department directors believed that EMTALA has no effect on quality of care and that such hospitals already had policies and procedures in place to ensure that everyone received quality care in the emergency department before EMTALA was implemented) [hereinafter OIG SURVEY].

18. David U. Himmelstein et al., *Patient Transfers: Medical Practice as Social Triage*,

the public hospital either had no insurance or were government-insured through Medicare or Medicaid.[19] Most of these patient transfers were not formally explained or documented in hospital records; only one transfer was explicitly justified as having a medical rationale,[20] but many transfers were blatantly attributed to the patient's "inability to pay."[21]

The Himmelstein study also documented the adverse effects of transfers on clinical outcomes.[22] For example, the researchers found that three patients died of nervous system trauma because of insufficient care at the transferring hospital.[23] The study also reported that several obstetric patients were transferred to a public hospital, despite the fact that they were high-risk patients and had initially presented to a private hospital that served as the state's high-risk obstetrics center.[24] Perhaps foreshadowing the implementation of EMTALA, the authors of the study concluded their research by calling for additional regulatory standards to reduce the problem of economically-motivated patient transfers.[25]

A subsequent study on the issue of patient dumping examined patient transfers to Cook County Hospital in Chicago, Illinois, the region's only public hospital, from private hospitals.[26] Investigators undertook this study after the number of transfers to Cook County Hospital increased nearly six-fold between 1980 and 1983.[27] The authors examined 467 patient transfers that occurred over a six-week period[28] and documented findings similar to Himmelstein's. First, the authors found that in examining transfers for which patient insurance data was available, 95% of patients who were transferred to the public hospital either had no insurance or were government-insured.[29] In addition, the researchers found that in 87% of cases in which the patient was transferred and a rationale for the transfer was given, the official at the transferring hospital explicitly mentioned lack of insurance as the reason for the transfer.[30] The investigators found that

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74 AM. J. PUB. HEALTH 494, 495 (1984).

19. *Id.*
20. *Id.* at 496.
21. *Id.*
22. *Id.* at 495.
23. *Id.*
24. Himmelstein et al., *supra* note 18, at 496.
25. *Id.*
26. *See* Robert L. Schiff et al., *Transfers to a Public Hospital*, 314 NEW ENG. J. MED. 552, 552 (1986).
27. *Id.*
28. *Id.*
29. *Id.* at 553.
30. *Id.*

nearly 25% of patients were unstable at the time of the transfer.[31] Of the patients who were transferred, few had provided informed consent.[32] Furthermore, the investigators found, much as Himmelstein did, that the public hospital receiving the transferred patients suffered major financial losses as a result, incurring nearly $24.1 million annually in uncompensated expenses.[33]

Yet another testament to the extent and effect of the patient dumping phenomenon was the study by Kellermann and Hackman, which examined private-to-public hospital patient transfers.[34] The authors found that in nearly 90% of the cases, the transferring private hospital cited "lack of insurance," "no charity service beds," or "indigent" as the reason for the transfer.[35] In addition, the authors found that 55% of the patients studied were transferred without the requisite advance authorization by the receiving public hospital, and four patients were transferred in spite of the public hospital's express refusal to accept them.[36] Even where transfers were authorized, the authors found that the very practice of transferring indigent emergency patients resulted in significant delays in delivering appropriate medical care, averaging four hours per patient.[37] The authors found that uncompensated care cost the public hospital more than $320,000 over a three-month period.[38]

In response to the finding that patient dumping was endemic in the United States, Congress drafted legislation designed "to send a clear signal to the hospital community, public and private alike, that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress."[39] The legislation

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31. *Id.* at 554-55 (noting specific instances of egregious cases in which the patient was unstable). For example, one patient was transferred with head trauma, confusion, other symptoms and a temperature of only 34.1° C. *Id.* In another example, a person was transferred despite falling from confusion as a result of a fall from the third story of a building. *Id.*

32. Schiff et al., *supra* note 26, at 556, 558 (noting that these transfers were improper since various trade associations in the health care industry—including the American Hospital Association—had instituted guidelines that mandate informed consent of transfer whenever possible).

33. *Id.* at 556 (observing that this amount represented approximately twelve percent of the yearly operating budget for the county hospital).

34. *See* Arthur L. Kellermann & Bela B. Hackman, *Emergency Department Patient 'Dumping': An Analysis of Interhospital Transfers to the Regional Medical Center at Memphis, Tennessee*, 78 AM. J. PUB. HEALTH 1287, 1288 (1988).

35. *Id.*

36. *Id.* at 1289.

37. *Id.*

38. *Id.* at 1290.

39. 131 CONG. REC. S13892 (daily ed. Oct. 23, 1985) (statement of Sen. Durenberger).

became known as the Emergency Medical Treatment and Labor Act and was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1985.[40]

II. THE STATUTE AND REGULATIONS

A. The Emergency Medical Treatment and Active Labor Act ("EMTALA")

The core mandate of EMTALA is the requirement that hospitals that receive federal Medicare funding and have emergency facilities provide a medical screening examination to "any individual regardless of diagnosis (e.g., labor, AIDS), financial status (e.g., uninsured, Medicaid), race, color, national origin (e.g., Hispanic or Native American surnames), handicap, etc."[41] While the statute's applicability is dependent upon a hospital's participation in the Medicare program, its protections are not limited solely to Medicare recipients; they extend to all persons who present to the emergency department of a Medicare-funded hospital.[42] EMTALA provides:

> [I]f any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition . . . exists.[43]

Under the statute, hospitals cannot delay an initial medical screening to inquire about a patient's insurance status.[44] If the person is diagnosed with an "emergency medical condition"[45] during the medical screening, the

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40. Lauren A. Dame, *The Emergency Medical Treatment and Active Labor Act: The Anomalous Right to Health Care*, 8 HEALTH MATRIX 3, 9 (1998).

41. HEALTH CARE FIN. ADMIN. (HCFA), DHHS, INTERPRETIVE GUIDELINES - RESPONSIBILITIES OF MEDICARE PARTICIPATING HOSPITALS IN EMERGENCY CASES app. v at v-19 (May 1998) [hereinafter HCFA INTERPRETATIVE GUIDELINES]. *See also* Dame, *supra* note 40, at 10.

42. Dame, *supra* note 40, at 10.

43. 42 U.S.C. § 1395dd(a) (2000) (internal citation omitted).

44. 42 U.S.C. § 1395dd(h).

45. 42 U.S.C. § 1395dd (e)(1). This provision defines an "emergency medical condition" as:

> (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

statute requires the hospital to stabilize the patient's condition prior to transfer, subject to a few narrowly defined exceptions.[46] Both hospitals and physicians are subject to substantial penalties for violating the provisions of EMTALA. Maximum civil fines for hospitals range from $25,000 to $50,000 for each violation,[47] while physicians who participate in the wrongful transfer of an unstable patient can be fined up to $50,000, and can even be excluded from federal and state medical reimbursement programs for "gross and flagrant" or repeated EMTALA violations.[48] EMTALA also provides for private rights of action against hospitals that violate the statute, both to patients harmed by a wrongful transfer[49] and to hospitals forced to bear the costs of a wrongful transfer.[50]

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant women [woman] who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

46. 42 U.S.C § 1395dd (c)(1) (permitting a hospital to transfer a patient before stabilization where, 1) the patient requests a transfer, or 2) a physician certifies that the medical benefit of the transfer would outweigh the attendant risks).

47. 42 U.S.C. § 1395dd(d)(1)(A) (providing for a maximum civil fine of $25,000 for hospitals with fewer than 100 beds and a maximum fine of $50,000 for larger hospitals).

48. 42 U.S.C. § 1395dd(d)(1)(B). This provision provides that:

Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—

(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is [is] [sic] gross and flagrant or is repeated, to exclusion from participation in this title . . . and State health care programs.

49. 42 U.S.C. § 1395dd(d)(2)(A). This provision provides that:

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

50. *See* 42 U.S.C. § 1395dd(d)(2)(B). This provision provides that:

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil

However, while EMTALA is both broad and ambitious, it nevertheless suffers from some of the same shortcomings as earlier laws intended to curb patient dumping. Much like the overly vague state statutes,[51] EMTALA, too, is vague in several important respects. For example, it is unclear whether EMTALA's duties and potential penalties apply only to hospitals, or also to off-campus hospital facilities, including physician's offices, outpatient departments, and other facilities affiliated with but not physically part of a hospital campus.[52] Because of confusion as to these and other issues, the agencies charged with enforcing the EMTALA statute have made several attempts at clarification.[53] The Health Care Financing Administration[54] issued regulations in 1994[55] and interpretive guidelines in 1998.[56] In 1999, the Office of the Inspector General, a part of DHHS, issued a special advisory bulletin to clarify how EMTALA affects individuals enrolled in managed care organizations.[57] However, in spite of these and other efforts to make the EMTALA requirements more comprehensible and effective, EMTALA is still widely perceived as being complex and confusing and, hence, a difficult law with which to comply.[58]

B. Regulations and Other Clarification

The Department of Health and Human Services first issued regulations to implement EMTALA in 1994.[59] The regulations are codified primarily in

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action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

51. Treiger, *supra* note 5, at 1202.

52. *See* U.S. GEN. ACCOUNTING OFFICE (GAO), EMERGENCY CARE: EMTALA IMPLEMENTATION AND ENFORCEMENT ISSUES, 5-6 (June 2001) [hereinafter EMTALA IMPLEMENTATION AND ENFORCEMENT].

53. *See id.* at 5-6 (reporting the issuance of new regulations making EMTALA applicable to off-campus hospital-based departments).

54. The Health Care Financing Administration, an agency of DHHS, was renamed the Centers for Medicare and Medicaid Services in 2001. Throughout this article, both terms are used interchangeably.

55. *See* 42 C.F.R. § 489.24 (1994) (as amended) (setting forth as a condition for participation in Medicare the hospital emergency care requirement).

56. *See* HFCA INTERPRETATIVE GUIDELINES, *supra* note 41, app. v at v-13.

57. OIG/HCFA Special Advisory Bulletin on the Patient Anti-Dumping Statute, 64 Fed. Reg. 61,353 (Nov. 10, 1999), *available at* http://oig.hhs.gov/fraud/docs/alertsandbulletins/frdump.pdf.

58. Ed Lovern & Jonathan Gardner, *Good News on Fraud: GAO Reports Find Most Providers Don't Set Out to Defraud Medicare, Medicaid*, MODERN HEALTHCARE, July 2, 2001, at 4 (stating that the trade association for hospitals—the American Hospital Association—has asked for additional clarification regarding the responsibilities of providers under EMTALA).

59. GAO IMPLEMENTATION AND ENFORCEMENT, *supra* note 52, at 5.

two sections of Part 489 of 42 C.F.R., which sets forth conditions for Medicare provider agreements and supplier approval. The main EMTALA section, 42 C.F.R. § 489.24, states the general requirement that a medical screening examination be provided to any individual who presents to the emergency room to determine whether an emergency medical condition exists.[60] The section also defines several important terms, including "comes to," "emergency medical condition," "stabilize," and "appropriate transfer."[61]

The Department of Health and Human Services followed the issuance of the regulations with interpretive guidelines in 1998, which provided additional clarification by setting forth the criteria for investigations of EMTALA violations, and detailing the indicia of compliance that DHHS surveyors should look for during an EMTALA investigation.[62] For example, according to the interpretive guidelines for determining if a patient transfer was appropriate, the surveyor will look through the medical record and the emergency department log to find evidence that:

> [T]he [receiving] hospital had agreed in advance to accept the transfers; the [receiving] hospital had received appropriate medical records; all transfers had been effected through qualified personnel, transportation equipment and medically appropriate life support measures; and the [receiving] hospital had available space and qualified personnel to treat the patients.[63]

The interpretive guidelines also detail the requirements for compliance with 42 C.F.R. § 489.20, which sets out the administrative requirements for EMTALA compliance. For example, one provision of 42 C.F.R. § 489.20 requires hospitals to post signs in hospital emergency departments informing patients of their rights to emergency treatment and examination.[64] The interpretive guidelines provide details to assist hospitals in precisely complying with this regulation:

> At a minimum: the sign must specify the rights of individuals with emergency conditions and women in labor who come to the emergency department for health care services; it must indicate whether the facility participates in the Medicaid program; the wording of the sign must be clear and in simple terms and language that are understandable by the population served by the hospital; and the sign must be posted in a place

60. 42 C.F.R. § 489.24(a) (2003).
61. 42 C.F.R. § 489.24(b) (2003).
62. *See* HFCA INTERPRETATIVE GUIDELINES., *supra* note 41, app. v at v-13.
63. *Id.*
64. 42 C.F.R. § 489.20(q) (2003).

> or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment (e.g., entrance, admitting area, waiting room, treatment area).[65]

The interpretive guidelines have also addressed the responsibilities of hospitals in a managed care environment. As will be discussed,[66] hospitals often face a serious dilemma when treating managed care patients in the emergency room, since managed care organizations can retrospectively deny claims for such treatment if they determine that "emergency" care was not truly necessary. Thus, a conflict arises: when a managed care patient presents to an emergency room, the hospital can either comply with the EMTALA mandate by immediately treating the presenting patient regardless of the prospects for reimbursement, or comply with the conditions attached to the patient's insurance coverage and (unlawfully) delay emergency treatment by first evaluating the severity of the purported emergency. The interpretive guidelines provide clarification of the hospital's responsibility, informing hospitals that regardless of the participating provider agreements that they may have with managed care organizations, providers must treat any person who presents to the emergency department without delaying treatment to consider reimbursement issues.[67]

Because the EMTALA statute has existed for nearly two decades, hospitals have learned how to skirt the outer bounds of the statute.[68] The interpretive guidelines attempt to prevent some of this "gaming" of the system.[69] For example, to discourage private hospitals from suggesting that indigent patients go to a public hospital for "free care," the interpretive guidelines state that "[h]ospitals may not attempt to coerce individuals into making judgments against their best interest by informing them that they will have to pay for their care if they remain, but that their care will be free

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65. HFCA INTERPRETATIVE GUIDELINES, *supra* note 41, app. v, at v-14.

66. *See* discussion *infra*, Section IV, Subsection B: "The Drawbacks of EMTALA."

67. *See* HFCA INTERPRETATIVE GUIDELINES, *supra* note 41, app. v at v-20, v-23, v-24:

> A hospital may not refuse to screen an enrollee of a managed care plan because the plan refuses to authorize treatment or to pay for such screening and treatment . . . A managed health care plan cannot deny a hospital permission to treat its enrollees. It may only state what it will or will not pay for. Regardless of whether a hospital will be paid, it is obligated to provide the services specified in the statute and this regulation . . . If the individual seeking care is a member [sic] an HMO or CMP, the hospital's obligation to comply with the requirements of § 489.24 is not affected.

68. *See generally* OIG/HCFA Special Advisory Bulletin on the Patient Anti-Dumping Statute, 64 Fed. Reg. 61,353.

69. *See id.*

or at low cost if they transfer to another hospital."[70]

Though the guidelines were issued to clarify existing ambiguities, providers still claim that they are unsure about their responsibilities under the statute and have asked the Centers for Medicare and Medicaid Services ("CMS") for additional clarification.[71]

III. ENFORCEMENT

A. Generally

The OIG and the CMS are both charged with EMTALA enforcement.[72] Each agency performs a distinct function: CMS has the power to terminate the Medicare participation of a noncompliant hospital or physician, while the OIG's punitive "stick" is its authority to assess civil monetary penalties.[73]

The CMS receives complaints at its regional offices;[74] the complaints from each state are then directed to the state agency responsible for investigating EMTALA violations.[75] The state agency gathers pertinent information[76] and returns the information to the regional CMS office. The regional office must then determine whether there was an EMTALA violation. If the regional office finds an EMTALA violation, it notifies the hospital that the hospital will be terminated from participation in federally-funded programs unless the hospital proposes and undertakes appropriate corrective measures.[77] The regional office provides the hospital with a notice of termination as well as a statement of deficiencies, indicating the problems to be corrected to bring the hospital into compliance with the statute.[78] If a violation is found to involve a medical issue, for example whether a patient was properly stabilized prior to transfer, a peer review

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70. HFCA INTERPRETATIVE GUIDELINES, *supra* note 41, at v-26.

71. OIG SURVEY, *supra* note 17, at 13 (staff citing the need for more precise definitions for "emergency medical condition," "medical screening exam," and "stable for discharge"); Lovern & Gardner, *supra* note 58, at 4.

72. Dame, *supra* note 40, at 11.

73. *Id.*

74. OIG, DHHS, THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT: THE ENFORCEMENT PROCESS 7 (2001) [hereinafter OIG ENFORCEMENT PROCESS]. *See also* the CMS website, *at* http://www.cms.hhs.gov/medicaid/survey-cert/rodir.pdf (listing the ten CMS regional offices).

75. OIG ENFORCEMENT PROCESS, *supra* note 74, at 7.

76. *Id.* at 7.

77. *Id.* at 8; Dame, *supra* note 40, at 12.

78. Dame, *supra* note 40, at 12. It is important to note that most hospitals submit a plan of correction in a timely manner and thus are not subsequently terminated from the Medicare program. GAO IMPLEMENTATION AND ENFORCEMENT, *supra* note 52, at 17.

organization ("PRO") reviews the medical issue from a physician's perspective.[79] After the PRO has reviewed the case, the regional CMS office notifies the OIG so that the OIG can determine whether to assess fines against the provider.[80]

B. Department of Health and Human Services Office of the Inspector General

The OIG has been fairly active in assessing the impact of EMTALA on various providers within the health care system, as the agency has authored several reports on EMTALA enforcement.[81] These studies illustrate the scope of awareness of and compliance with the EMTALA statute and its accompanying regulations. Accordingly, these studies are briefly summarized below.

The OIG recently conducted a random survey ("Survey") of emergency department personnel to determine the level of awareness of EMTALA.[82] The Survey was conducted via a telephone and mail survey of more than 100 randomly selected hospitals.[83] The findings suggest that most emergency department physicians and staff are familiar with many of EMTALA's requirements.[84] Most providers believe that they comply with EMTALA's mandates; only 4% of staff believe that an inappropriate transfer has occurred at their facility in the last year.[85] Forty-one percent of emergency department directors say patient care at their hospital has not been affected by EMTALA, claiming that their hospital has always ensured appropriate screening and stabilization procedures were in place without regard to a patient's ability to pay.[86] Simply put, many emergency department administrators believe that their hospital's internal policies and procedures alone effectively ensure that all patients are appropriately cared

79. OIG ENFORCEMENT PROCESS, *supra* note 74, at 16.

80. EMTALA IMPLEMENTATION AND ENFORCEMENT, *supra* note 52, at 23 (stating that the OIG will consider various factors in determining whether or not to impose a fine, including whether the hospital took corrective action; the financial condition of the hospital; and the potential impact of the fine on a hospital's ability to provide care). *See also* 42 C.F.R. § 1003.106(a)(1) (2003).

81. *See generally* OIG SURVEY, *supra* note 17; OIG ENFORCEMENT PROCESS, *supra* note 74.

82. OIG SURVEY, *supra* note 17, at 1.

83. *Id.* at 8-9 (stating that the OIG attempted to select an approximately equal number of small, medium, and large hospitals, as determined by bed size). Because the agency received what it considered a fairly representative response rate, it believes the results can be extrapolated to emergency departments in general. *Id.*

84. *Id.* at 10.

85. *Id.* at 13.

86. *Id.* at 15.

for in the absence of governmental intervention.

The OIG also recently studied the effectiveness of the EMTALA enforcement process, yielding valuable information about the strengths and weaknesses of the process.[87] For example, the study ("Enforcement Study") noted that, in contrast to the state agencies charged with EMTALA investigation which are required to turn around complaints in fifteen to twenty days,[88] regional CMS offices took nearly sixty-five days after the state's investigation to determine whether a complaint was substantiated.[89] The Enforcement Study found that the time between investigation and the issuance of findings has increased substantially between fiscal years 1994 and 1998.[90] The OIG also cited as problematic the significant variance from region to region of the EMTALA-related workload.[91] The Enforcement Study cited examples of extreme variation from year to year.[92]

Finally, the OIG cited poor tracking systems for complaints and resolution of EMTALA cases as impeding enforcement efforts.[93] Because each region uses its own methodology for reporting monthly EMTALA violations, data collection and management is inconsistent and incomplete, which limits CMS's ability to track and improve its efforts.[94] Officials at the regional offices attribute the data collection problems to a lack of guidance from the central office.[95] A recent report by the General Accounting Office supports the contention that tracking civil monetary penalty collection is a growing problem for CMS.[96]

Although EMTALA grants the OIG the power to impose civil monetary penalties against noncompliant providers, the OIG also has the discretion *not* to fine providers.[97] Thus, most EMTALA violations do not result in fines.[98] One estimate by an OIG official found that, although 180 to 210

87. OIG ENFORCEMENT PROCESS, *supra* note 74, at 1-2.

88. *Id.* at 12.

89. *Id.* (noting that seven regional offices sometimes took a year or more to determine whether a complaint was substantiated, and that such lengthy delays defeated the primary purpose of EMTALA: "to address immediate threats to patient health and safety.").

90. *Id.* at 13.

91. *Id.*

92. *Id.* (finding that in 1994, for example, one of the largest regions handled 119 EMTALA cases compared to only three EMTALA cases in 1998 while another region registered forty-two cases in 1996 and only seven in 1998).

93. OIG ENFORCEMENT PROCESS, *supra* note 74, at 15.

94. *Id.*

95. *Id.*

96. *See generally* GAO, CIVIL FINES AND PENALTIES DEBT: REVIEW OF CMS' MANAGEMENT AND COLLECTION PROCESSES 2-3 (2001) (finding that civil monetary penalty receivables for CMS stood at $260 million as of Sept. 30, 2000).

97. *See* EMTALA IMPLEMENTATION AND ENFORCEMENT, *supra* note 52, at 17.

98. OIG ENFORCEMENT PROCESS, *supra* note 74, at 8.

violations are typically identified each year, only nineteen fines were assessed to hospitals in 2001.[99]

In recent years, the government appears to have increased its commitment to pursuing noncompliant providers. The number of settlements in EMTALA cases, as well as the amount of such settlements, has increased sharply.[100] In fiscal year 1997, the OIG fined fourteen hospitals a total of $500,000.[101] By the end of fiscal year 2000, the OIG fined forty-eight hospitals $1.2 million.[102] Still, the number of EMTALA cases in which the OIG imposes a civil monetary penalty represents a small fraction of the total number of confirmed violations.[103] Between January 1, 1995, and March 20, 2001, the OIG declined to impose a civil monetary penalty in 61% of cases forwarded to the office by CMS.[104]

IV. BENEFITS AND DRAWBACKS OF EMTALA

A. The Benefits of EMTALA

EMTALA has the potential to become an effective means of ensuring that each person receives adequate emergency medical care as and when needed. While no statute can guarantee the best possible medical outcome in every case, the law can at least hold providers to an acceptable minimum standard in making available quality emergency care. In this regard, EMTALA has already shown itself to be effective in establishing an acceptable level of care.

For example, many providers may be motivated to comply with EMTALA simply out of fear of its investigatory mechanisms. Additionally, EMTALA's vague language assures that providers work harder to comply with its intent. It is noteworthy that providers have gained a better understanding of the statute due to increasing guidance from federal agencies. Finally, case law is evolving to clarify some of EMTALA's ambiguities, which also improves providers' understanding of the statute and provides additional guidance on the scope of EMTALA.[105]

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99. *Small Share of Patient Dumping Nets Fines: Mitigating Factors Get Hospitals Off Hook*, HEALTH CARE POL'Y, Oct. 2, 2001, at 1502 [hereinafter *Patient Dumping Nets Fines*].

100. OIG ENFORCEMENT PROCESS, *supra* note 74, at 9 (attributing at least some of the recent increase to the OIG's clearing its backlog of older cases).

101. *Patient Dumping Nets Fines*, *supra* note 99, at 1502.

102. *Id.*

103. EMTALA IMPLEMENTATION AND ENFORCEMENT, *supra* note 52, at 17.

104. *Id.* at 24.

105. *See, e.g.*, Roberts v. Galen of Va., Inc., 525 U.S. 249, 253 (1999); Baber v. Hosp. Corp. of Am., 977 F.2d 872, 883 (4th Cir. 1992); Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 272 (6th Cir. 1990).

1. Many Providers Are Motivated to Comply with EMTALA Simply Out of Fear of Its Investigatory Mechanisms

The EMTALA statute has been somewhat effective in guaranteeing access to all who present to emergency departments. The prospect of an EMTALA investigation has resulted in behavioral modifications on the part of many providers: nearly 50% of hospitals changed some policy or procedure because of the initiation of an EMTALA investigation by CMS.[106]

2. EMTALA's Vague Language Assures That Providers Work Harder to Comply with Its Intent, and Guidance from Federal Agencies Has Given Providers a Better Understanding of the Statute

EMTALA's intentionally vague language has eliminated potential loopholes that providers may have used to deny poor persons emergency care. However, many critics in the provider community argue that they have been unable to fully comply with EMTALA because it is overly vague.[107] However, while it may be true that EMTALA is vague in aspects, one CMS administrator recently noted that the statute is purposefully vague since not all conduct can be anticipated by the statute and regulations.[108]While a morass of regulation in the face of vagueness can be problematic, CMS has attempted to provide guidance on several levels for providers.[109] CMS continues to generate useful guidelines; for example, a 1999 special advisory bulletin recommended a number of "best practices" to aid hospitals with EMTALA compliance.[110] Further, the attempts by the agency in 1998 to clarify the statute through regulations and interpretive guidelines are laudable.[111] However, despite the increased guidance, the OIG found that many providers are not aware that guidelines have been issued.[112]

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106. OIG SURVEY, *supra* note 17, at 19.

107. *See, e.g.*, David A. Ansell & Robert L. Schiff, *Patient Dumping: Status, Implications, and Policy Recommendations*, 257 JAMA 1500, 1502 (1987) (stating that "stabilization" is a vague term that needs clarification).

108. Barry R. Furrow, *An Overview and Analysis of the Impact of the Emergency Medical Treatment and Active Labor Act*, 16 J. LEGAL MED. 325, 329 (1995) (citing 39 Fed. Reg. 32,099 (1994)).

109. Provider Agreements and Supplier Approval, 42 C.F.R. § 489 (2003) (codification of EMTALA regulations); OIG/HCFA Special Advisory Bulletin on the Patient Anti-Dumping Statute, 64 Fed. Reg. 61,353 (Nov. 10, 1999).

110. OIG ENFORCEMENT, *supra* note 74, at 9. *See also* News Release, OIG, Special Advisory Bulletin Outlines Hospitals' Obligations to Provide Emergency Services to Managed Care Enrollees (Nov. 9, 1999).

111. *See* HCFA INTERPRETATIVE GUIDELINES, *supra* note 41.

112. *See* OIG SURVEY, *supra* note 17, at 10.

3. Case Law Is Clarifying Ambiguities, Improving Providers' Understanding of the Statute, and Providing Additional Guidance on EMTALA's Scope

Prior to 1999, there was a split of opinion among the judicial circuits as to whether an improper motive was required for an EMTALA violation to exist. The United States Supreme Court, in *Roberts v. Galen*, settled this dispute. The court held that no showing of improper motive on part of the hospital was required to sustain a violation of EMTALA.[113] However, before *Galen*, circuits, such as the Sixth Circuit, required proof of an improper economic motive in order to sustain a cause of action against a provider under EMTALA.[114]

The impetus for the improper motive requirement was the landmark Sixth Circuit case *Cleland v. Bronson Health Care Group, Inc.*[115] In *Cleland*, the plaintiffs' fifteen-year-old child died after an emergency department physician misdiagnosed the symptoms of vomiting and cramping as the flu.[116] Shortly thereafter, the child suffered cardiac arrest and died.[117] The plaintiffs brought an EMTALA claim, alleging that the defendant hospital and physicians did not provide an appropriate medical screening examination, failed to treat their son's condition, and failed to stabilize him, as required by the statute.[118] The Sixth Circuit held that the plaintiffs failed to prove that the hospital improperly screened patients based on their ability to pay. When the hospital discharged the child he was in a stable condition, not in acute distress, and neither the doctors nor the parents indicated that the child's condition was worsening.[119] The Sixth Circuit relied on the legislative history of the statute, which demonstrated that Congress did not intend to provide a guarantee of the result of emergency room treatment.[120]

The Sixth Circuit stated that inadequate screening rests upon what was "appropriate."[121] If the hospital acts "in the same manner as it would have for the usual paying patient, then the screening provided is 'appropriate' within the meaning of the statute." [122] A hospital's improper motive for screening patients is not appropriate and may give rise to liability under

113. Roberts v. Galen of Va., Inc., 525 U.S. 249, 253 (1999).
114. Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266 (6th Cir. 1990).
115. *Id.*
116. *Id.* at 269.
117. *Id.*
118. *Id.* at 269.
119. *Id.* at 271.
120. *Cleland*, 917 F.2d at 271.
121. *Id.* at 272.
122. *Id.* at 272.

EMTALA. Improper motives include a hospital's economic motive based on the patient's ability to pay, as argued in *Cleland*; prejudice against the race, sex or ethnicity of a patient; and the personal dislike of a patient or his occupation or the distaste for a patient's medical condition, as if a patient was improperly screened because he or she has AIDS.

Though *Cleland* became the rule in the Sixth Circuit, it clearly reflected a minority view, as its decision received negative treatment by several circuits.[123] One reason the decision received negative treatment was because EMTALA does not explicitly mention an improper motive requirement.[124] Courts that follow the *Cleland* holding arguably bypass the plain meaning requirement of statutory interpretation.

Curing the split of opinions in the circuits over the improper motive requirement, the Supreme Court, in *Roberts v. Galen*, held that improper motive is not required under the statute when stabilization is at issue.[125] The *Galen* case is illustrative of how the evolution of case law provides guidance to hospitals on what is required by the EMTALA statute.

B. The Drawbacks of EMTALA

Though EMTALA is a potentially useful tool to ensure adequate emergency medical care, it has several drawbacks. First, EMTALA can be misused by managed care organizations to effectively eliminate insurers' responsibility to reimburse providers for services rendered in the emergency department. Second, because EMTALA represents an unfunded mandate, it has exacerbated existing financial problems that hospitals face. Third, there are inadequate systems in place to assess the effectiveness of the statute and related enforcement efforts. Fourth, the statute disproportionately impacts inner-city, rural, and public hospitals. Fifth, EMTALA can be misused by the plaintiffs' bar when EMTALA complaints are simply appended to state medical malpractice claims to remove cases to federal court.

123. The decision received negative treatment by the First, Fourth, Eighth, and District of Columbia Circuits. *See* Summers v. Baptist Med. Ctr. Arkadelphia, 91 F.3d 1132, 1138 (8th Cir. 1996); Correa v. Hosp. San Francisco, 69 F.3d 1184, 1194 n.9 (1st Cir. 1995); Power v. Arlington Hosp. Ass'n, 42 F.3d 851, 857 (4th Cir. 1994); Gatewood v. Wash. Healthcare Corp., 933 F.2d 1037, 1041 n.3 (D.C. Cir. 1991).

124. *Arlington Hosp. Ass'n*, 42 F.3d at 857 (rejecting the improper motive requirement, stating "there is nothing in the statute itself that requires proof of indigence, inability to pay, or any other improper motive on the part of a hospital as a prerequisite to recovery").

125. *Galen*, 525 U.S. at 253.

1. The EMTALA Statute Can Be Misused by Managed Care Organizations to Effectively Eliminate Insurers' Responsibility to Reimburse Providers for Services That Are Rendered in the Emergency Department

Today, managed care is the dominant means by which most Americans receive health insurance.[126] In 2002, 76.1 million Americans were enrolled in health maintenance organizations.[127] Historically, hospitals were reimbursed under a fee-for-service system in which they were reimbursed fully for their costs.[128] Prior to the growth in managed care, hospitals were able to shift costs of bad debt, charity, and uncompensated care to privately insured patients.[129] However, as managed care became more pervasive, these insurance entities would not allow cost-shifting to occur.[130]

Under most managed care plans, some type of pre-authorization is required before a patient can receive treatment that is reimbursable.[131] Many hospital administrators claim that managed care organizations deny reimbursement claims submitted by providers or hospitals based on retrospective review of charts.[132] Providers assert that the insurance industry practice of ensuring coverage without paying for it leaves emergency departments with costly bills.[133] As a result, physicians and hospital administrators have asked for assistance from the CMS, as well as from the OIG, to correct this alleged bias.[134] CMS has responded by indicating that it is powerless to remedy this problem since CMS can only regulate health insurers where it has the leverage of Medicare and Medicaid participation (i.e., federally-funded programs).[135] Since many managed

126. CTRS. FOR DISEASE CONTROL & PREVENTION, COMPREHENSIVE DATA ON HEALTH MAINTENANCE ORGANIZATIONS COVERAGE, *available at* http://www.cdc.gov/nchs/data/hus/tables/2003/03hus132.pdf (last visited Oct. 18, 2003).

127. *Id.*

128. Lisa M. Enfield & David P. Sklar, *Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem*, 13 AM. J.L. & MED. 561, 563 (1988).

129. Erik J. Olson, *No Room at the Inn: A Snapshot of an American Emergency Room*, 46 STAN. L. REV. 449, 469 (1994) (stating that in 1994 hospitals charged insured patients over 154% of emergency department expenses to offset losses from uncompensated care).

130. *Id.* at 469.

131. OIG/HCFA Special Advisory Bulletin on the Patient Anti-Dumping Statute, 64 Fed. Reg. at 61,354.

132. OIG SURVEY, *supra* note 17, at 16.

133. *Id.*

134. OIG/HCFA Special Advisory Bulletin on the Patient Anti-Dumping Statute, 64 Fed. Reg. at 61,354 (stating that commentators "indicated that unless prior authorization requirements are abandoned or prohibited altogether, huge bills could result for patients whose care had not been authorized in advance").

135. *Id.* (stating that CMS "do[es] not have the authority under the patient anti-dumping statute to mandate reimbursement for emergency services or to regulate non-Medicare and

care organizations do not offer managed care products on behalf of Medicare and Medicaid and solely function in the private sector, the federal government has little authority to regulate such plans.

While federal authorities have indicated that there is little that they can do to correct the one-sided benefit that managed care organizations receive relative to hospitals, some state officials have attempted to correct this problem. The GAO reports that thirty-six states and the District of Columbia have laws related to standards that managed care organizations must adhere to in order to ensure that hospitals are not retrospectively denied payment for services provided in the emergency department.[136] Many states have adopted a "prudent layperson" standard to distinguish an emergency situation from a non-emergency situation.[137] Under such a standard, "emergency services" are often defined as "those health care services provided to evaluate and treat medical conditions of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that urgent and/or unscheduled medical care is required."[138] The prudent layperson standard recognizes that the average layperson without medical training is not necessarily equipped to determine whether a true medical emergency exists.[139]

There is no single objective definition of emergency services in the prudent layperson context. Maryland, for example, defines "emergency services" as "those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be

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non-Medicaid managed care plans").

136. *See* EMTALA IMPLEMENTATION AND ENFORCEMENT, *supra* note 52, at 13 (citing reports from the American College of Emergency Physicians). *See also* KEN KING, AM. COLL. OF EMERGENCY PHYSICIANS, ISSUE PAPER TOPIC: PRUDENT LAYPERSON STATUS (Mar. 2002) (stating that the following thirty-two states and the District of Columbia have enacted a prudent layperson or similar standard for access to emergency medical services: Alabama, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin), *available at* http://www.acep.org/library/pdf/issue_pl_status.pdf (last visited Oct. 27, 2003).

137. KING, *supra* note 136, at 1.

138. Am. Coll. of Emergency Physicians Reimbursement Comm., *Fighting Managed Care Denials in the Emergency Department*, at 5 (1999), *available at* http://www.acep.org/library/pdf/mgd_care_denial.pdf (last visited Oct. 27, 2003).

139. *See, e.g.*, 215 ILL. COMP. STAT. 5/370g(h) (2002) (defining a "prudent layperson" as one "who possesses an average knowledge of health and medicine").

expected by a prudent layperson."[140] Virginia adopted a prudent layperson standard, which provides that emergency services are:

> [T]hose health care services that are rendered by affiliated or nonaffiliated providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine . . . .[141]

Therefore, by granting "emergency services" a more expansive meaning using the prudent layperson standard, states have attempted to decrease the likelihood that managed care organizations will retrospectively deny payment on the basis that no emergency condition existed at the time the patient went to the emergency department. Though several states have introduced and subsequently enacted legislation encompassing the prudent layperson standard, there has been no significant progress in developing similar legislation on the federal level with regard to private sector health plans.

At the same time, managed care organizations have softened their stance against providing payment for emergency services.[142] In 1997, the major trade association for managed care plans—the American Association of Health Plans ("AAHP")—announced a customer service and patient's rights initiative designed to improve the public image of managed care organizations. Through this initiative, the AAHP indicated that "health plans should cover emergency-room screening and stabilization as needed for conditions that reasonably appear to constitute an emergency, based on the patient's presenting symptoms."[143] However, because of the lack of dominion by the federal government over managed care organizations, health care providers continue to insist that they are left to cover emergency claims that managed care organizations retrospectively deny.[144]

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140. MD. CODE ANN. HEALTH-GEN. § 19-701(e) (2001).

141. VA. CODE ANN. § 38.2-4300 (Michie 2001).

142. *See* AM. ASS'N OF HEALTH PLANS (AAHP), CODE OF CONDUCT (stating the philosophy that member plans should cover the cost of emergency services), *available at* http://www.aahp.org/Content/NavigationMenu/About_AAHP/What_We_Stand_For/Code_of_Conduct/Code_of_Conduct.htm (last visited Oct. 27, 2003).

143. *Id. See also* Joan M. Stieber & Linda J. Spar, *EMTALA in the '90s – Enforcement Challenges*, 8 HEALTH MATRIX 57, 79-80 n.72 (1998) (citing a press release from the AAHP that urges managed care organizations to provide appropriate reimbursement to providers when enrollee has sought care in an emergency situation).

144. OIG SURVEY, *supra* note 17, at 16 (stating "private managed care organizations deny or reduce payment for mandated medical screening exams when the patient is found not to have an emergency condition").

2. Because EMTALA Represents an Unfunded Mandate, It Has Exacerbated Existing Financial Problems That Hospitals Are Facing

Hospital administrators cite cost concerns on several different levels.[145] Despite the fact that not-for-profit hospitals already face a delicate financial situation, recently enacted legislation has worsened their financial position. For example, the Balanced Budget Act of 1997 ("BBA") reduced Medicare spending growth $115 billion over five years.[146] Though there has been some relief from the BBA through the passage of subsequent legislation,[147] the hospital industry is facing a fiscal crisis, hospitals face a growing number of financial constraints that make it difficult for them to operate cost centers that lose money.[148] In 1999, the average margin for the not-for-profit hospital sector was 4.7%.[149]

Increased misuse of the emergency department by managed care enrollees exacerbates hospitals' cost concerns. Uninsured persons and Medicaid enrollees often seek care in the emergency department, rather than in a physician's office.[150] In 1979, 29 million people were without insurance.[151] By 2002, this number had risen to nearly 43.6 million.[152] Emergency departments are feeling the financial impact of providing uncompensated care; in Los Angeles, ten of eighteen trauma centers have

145. *See, e.g.*, News Release, Am. Hosp. Ass'n, Hospital Employment Cost Increases Accelerate (Jan. 1, 2002) (describing the increase in employment-related costs for hospitals). *See also* AM. HOSP. ASS'N & THE LEWIN GROUP, TREND WATCH, HOSPITAL FINANCIAL PERFORMANCE 1 (Jan. 1999) (citing a decrease in cost shifting and a decrease in revenues from private payors).

146. Karen Pallarito, *Plugging the Holes: CFOs Work to Offset Cutbacks Under Balanced-Budget Law*, MODERN HEALTHCARE, May 11, 1998, at 84.

147. *See, e.g.*, 146 CONG. REC. H11209, H11217 (daily ed. Oct. 26, 2000) (statement of Rep. Linder, who provided a letter from the Federation of American Hospitals that pledged support for the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000, which would address "some of the excesses in the BBA, and restor[e] stability to our health care delivery system"). *See also* Jonathan Gardner, *Rate Increases Likely to Gain Approval*, MODERN HEALTHCARE, Sept. 11, 2000, at 46 (stating that the Balanced Budget Refinement Act is likely to provide $2.1 billion in relief for providers participating in Medicare+Choice).

148. AM. HOSP. ASS'N & THE LEWIN GROUP, TREND WATCH, EMERGENCY DEPARTMENTS - AN ESSENTIAL ACCESS POINT TO CARE 1, 7 (Mar. 2001) [hereinafter TREND WATCH EMERGENCY DEPARTMENTS], *available at* http://www.hospitalconnect.com/ahapolicyforum/trendwatch/content/twmarch2001.pdf (last visited Oct. 27, 2003).

149. *Id.* at 7.

150. *Id.* at 2.

151. *See* Treiger, *supra* note 5, at 1193.

152. U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN UNITED STATES: 2002 (Sept. 2003), *available at* http://www.census.gov/prod/2003pubs/p60-223.pdf (last visited Oct. 27, 2003).

closed, in part, due to the heavy burden of providing such care.[153] In light of the increasing number of uninsured, the demand on emergency department resources is likely to continue.

3. Inadequate Systems Are in Place to Assess the Effectiveness of the Statute and Related Enforcement Efforts

As described in Section III, the number of EMTALA violations over the last decade has increased substantially. However, this increase may be the result of causes other than that of just patient dumping for economic considerations. Currently, DHHS and CMS do not have the appropriate information systems in place to determine what factors are actually driving the increase in EMTALA violations. The increase may be due simply to an increase in the number of emergency department visits, which makes it more likely that violations will occur.[154]Alternatively, the increase may be attributable to the financial situations of hospitals. Certain hospitals are being forced to shoulder more of the burden of providing care to indigents.[155] Statistics support the notion that, while the number of visits to emergency departments has increased, the number of hospitals with emergency departments has decreased.[156] Where hospitals are attempting to remain financially viable, they may not be as receptive to providing charity and uncompensated care as they have been historically.

Accordingly, improved methods of separating out the various causes of EMTALA violations may assist the government in determining where its focus should lie in EMTALA enforcement. Without improvements in information systems, it is impossible to apportion the increase in the number of EMTALA violations to the appropriate cause. Such an inability to measure the impact of EMTALA is a drawback to the statute, as policymakers are unable to quantitatively ascertain whether the statute is serving its intended purpose of ensuring access to all persons to quality health care services.

4. The EMTALA Statute Disproportionately Impacts Inner City, Rural, and Public Hospitals

Hospitals that treat a large number of indigent patients often receive a

153. *See* Olson, *supra* note 129, at 476.

154. *See* TREND WATCH EMERGENCY DEPARTMENTS, *supra* note 148, at 1 (providing that the average number of emergency department visits per hospital in 1999 was over 20,000, an increase of nearly 4000 since 1990).

155. *Id.* (citing a growing number of emergency visits at fewer hospitals).

156. *Id.* (providing that by 1999 approximately 4700 hospitals had emergency department visits, down from over 5100 in 1990).

subsidy from the federal government for providing a disproportionate share of care to such populations in the form of a disproportionate share hospital ("DSH") payment.[157] However, the DSH subsidy is often inadequate because it does not appropriately compensate the hospitals that treat a disproportionate share of indigents. Additionally, states do not provide adequate guidance as to which hospitals should receive the subsidy.[158] Because of the lack of clarity as to how subsidies are calculated, poor hospitals languish in their inability to secure appropriate relief necessary to subsidize the care of disproportionately indigent patients while other hospitals that are not treating significant numbers of uninsured or underinsured patients receive a subsidy that they do not necessarily deserve.[159] Such an inequity disproportionately impacts the financial health of urban and rural hospitals, and could potentially force the closure of such hospitals, thereby making them unable to offer health care services to their communities.

5. The EMTALA Statute Is Misused by the Plaintiffs' Bar When EMTALA Complaints Are Simply Appended to State Medical Malpractice Claims to Remove Cases to Federal Court

Many critics of the statute have complained that EMTALA is used to supplant state malpractice statutes, contrary to the legislative intent of the statute. Commentators contend that the legislative history of the statute demonstrates that EMTALA was not intended to function as a federal malpractice statute regulating the quality of care received.[160]

V. SOLUTIONS AND RECOMMENDATIONS

Patient dumping remains a problem despite the continued existence of EMTALA and an increasing amount of federal guidance. However, there are several means available to address some of the problems identified

157. *See generally* 42 U.S.C. § 1395ww(d)(5)(F) (2000). *See also* 42 U.S.C.A. § 1395ww(d)(5)(F) (West 2003).

158. *See Teaching Hospitals and Medicare Disproportionate Share Hospital Payments: Hearing before the House Subcomm. on Ways and Means*, 105th Cong. 16 (1997) (statement of Rep. Stark) (stating the need for a "new formula to figure out which hospitals really are under pressure from the uninsured and the underinsured and what kind of a proxy to use to recalculate that").

159. *See* Letter from Michael Hash, HFCA Deputy Adm'r, to Senator William Roth, Chairman of the Senate Fin. Comm. (Oct. 15, 1999) (explaining that where hospitals receive additional DSH payments, HCFA will not hold them liable because guidance on how to claim DSH payments was not sufficiently clear), *available at* http://www.cms.hhs.gov/states/letters/smd11499.asp (last visited Oct. 27, 2003).

160. OIG SURVEY, *supra* 17, at 14. *See also* Furrow, *supra* note 108, at 326.

above.

A. The OIG and CMS Should Provide Additional Clarification Through Guidance and New Interpretive Guidelines to Assist Providers in Understanding Their Responsibilities Under the Statute

A General Accounting Office report found that many providers are not out to defraud the federal government; they are simply unclear about their responsibilities under the statute.[161] In fact, more than 40% of physicians and 60% of emergency department directors assert that some part of the statute is unclear.[162] CMS has admitted that some of its guidance and regulations have been unclear.[163] However, continued clarification is important, as the provider community has expressed frustration over its inability to understand EMTALA and its related regulations

B. Congress Should Address the Superior Position That Managed Care Organizations Possess by Enacting Federal Legislation That Includes a "Prudent Layperson" Standard for All Insurance Determinations

Various legislative initiatives that have been introduced would mandate managed care organizations to pay for emergency services where "emergency" is determined from a reasonable patient or prudent layperson standard.[164] This is fairly synonymous with the "prudent layperson" standard.[165] As previously mentioned, managed care organizations that participate in federally-funded programs already must make reimbursement decisions from a prudent layperson perspective under the BBA. However, many plans are exempt from this standard because they do not offer a Medicare or Medicaid managed care product.

C. Congress Should Grant Financial Relief to Providers So That They Can Remain Viable in the Current Competitive Landscape

If Congress decides that public policy requires the provision of emergency services to all persons regardless of ability to pay, Congress must be prepared to pay to support the provision of such services. There

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161. EMTALA IMPLEMENTATION AND ENFORCEMENT, *supra* note 52, at 15.

162. *See* Lovern & Gardner, *supra* note 58, at 4.

163. *See* EMTALA IMPLEMENTATION AND ENFORCEMENT, *supra* note 52, at 15.

164. *See, e.g.*, Quality Health Care and Consumer Protection Act, H.R. 1222, 105th Cong. (1997); S. 373, 105th Cong. (1997); Managed Care Bill of Rights for Consumers Act of 2001, H.R. 2947, 107th Cong. (2001).

165. *See supra* Section IV, discussion describing the benefits and drawbacks of the statute.

are several means to ensure payment for emergency services.

First, the disproportionate share hospital payment could be increased. This would ensure the continued existence of poor hospitals that treat a disproportionate share of the uninsured and underinsured. However, if this route is taken, government officials should consider revising the complicated formula that determines which hospitals receive the DSH payments. The current formula benefits many hospitals which are not committed to treating a disproportionately indigent patient population; this is patently unfair.

Alternatively, the federal government could provide a subsidy to all hospitals to fund the EMTALA mandate. One vehicle by which this might be accomplished is by improving Medicaid reimbursement by reimbursing physicians at or above the cost that they incur to treat patients. Increasing reimbursement might improve general access to primary care services, which would allow emergency departments to function as places of last resort instead of as primary care treatment centers. Additionally, because reimbursement levels for Medicaid are often low, many physicians in private practice do not accept patients insured by Medicaid.[166] If Medicaid funding were improved, there would be several related benefits: ensuring primary care services outside of emergency departments; and ensuring reimbursements for emergency and general medical care for those in greatest need.

D. Hospitals Should Educate Patients About Prevention and the Proper Use of the Emergency Department and Social Policy Must be Addressed in Arenas Other Than Health Care

Forcing the health care system to affect change in social policy is an inefficient use of the already insufficient resources that exist for the health care industry. One report from the New York Academy of Medicine suggested that $100 million is spent annually in emergency departments treating victims of violence and an additional $100 million is spent on "violence-related" hospitalizations.[167] In 1990, a physician at Cook County Hospital in Chicago, Illinois suggested that Chicago's seven trauma centers combined lose about $10 to $12 million annually, primarily from "penetrating trauma" cases,[168] most often involving stabbings and gunshot wounds.

166. *See* Olson, *supra* note 129, at 478.

167. Karen Pallarito, *Health Pros Ally Against Violence*, MODERN HEALTHCARE, May 2, 1994, at 40.

168. Lynn Wagner, *Hospitals Feeling Trauma of Violence*, MODERN HEALTHCARE, Feb. 5, 1990, at 23.

Trauma units for inner-city hospitals are particularly susceptible to losses associated with social problems. One such hospital reported a 204% increase in patients treated as a result of gunshot wounds.[169] Trauma units in such hospitals often are responsible for a disproportionate amount of uncompensated care.[170] At yet another hospital, the trauma unit is responsible for 44% of the hospital's uncompensated care.[171]

If the nation continues to force the health care industry to take responsibility for social ills, such as drug abuse and gang violence, there may be severe consequences, including the closure of several hospitals. Illustratively, by 1990 Chicago had lost three Level I trauma centers (i.e., those equipped to handle the most severe emergencies), as they were forced to close due to "unsustainable losses."[172] Though a discussion of creating and funding social programs and other such alternatives is beyond the scope of this paper, the availability and funding of such programs should be addressed. To those who suggest that such alternatives are too costly, the short-term cost of establishing such programs is likely much less than the number of dollars per episode that must be spent (and may not be reimbursed) in the emergency department. Particularly salient is the fact that while one emergency department encounter as a result of penetrating trauma may cost thousands of dollars in the treatment of the victim, such victims who are involved in drug abuse and violence may end up making several trips to the emergency department if the destructive underlying behaviors are not addressed.

It should also be noted that prevention and the provision of social alternatives becomes an important issue with regard to ensuring that people know how to make proper use of the emergency department. Hospitals should make patients aware of the increased cost of receiving care from the emergency department versus through a primary care physician. This would particularly be useful for patients who have a primary care physician (i.e., managed care enrollees) but are simply too impatient to wait for an appointment. Because of third-party insurance, such patients are often insensitive to medical costs. Managed care organizations could consider denying payment or instituting a more substantial co-payment that the patient incurs when using the emergency room for primary care. As for most uninsured persons who receive primary care services through the emergency room, the establishment of neighborhood clinics and other alternatives to care may prove useful in ensuring receipt of prompt

169. *Id.*
170. *Id.*
171. *Id.* (referring to the MedStar trauma unit at Washington Hospital Center).
172. *Id.*

treatment.

E. The Government Must Examine Its Role in EMTALA Enforcement and Address Existing Problems

Both the OIG and the CMS must re-examine their roles in EMTALA enforcement. Recent reports from the OIG suggest that problems still exist: the number of EMTALA complaints and confirmed violations is on the rise.[173] These agencies must continuously re-evaluate their roles in ensuring that patients have access to emergency departments without regard to the patient's ability to pay. For example, the prosecutorial discretion that the OIG enjoys may contribute to the impotence of the statute. In addition, the inability of the government to communicate with providers is problematic. Differential enforcement across the country also weakens the statute. While the OIG has recognized some of these problems, it must implement the appropriate system and policies to ensure that such problems are corrected.

The prosecutorial discretion that the OIG has in imposing civil monetary penalties should be reduced or eliminated because the OIG imposes civil monetary penalties in so few cases with confirmed violations that there is a perceived lack of force behind the statute. The alternate remedy—termination of participation in federally-funded programs—is also rarely carried out because hospitals almost always submit a timely plan of correction before the termination deadline.[174] Thus, the OIG must become more involved in holding facilities accountable for complying with the statute using civil monetary penalties that force providers to be attentive to their conduct in the emergency department.

Another problem that weakens the statute is the government's perceived inability to communicate with providers. Many providers complain, for example, that they are not informed when an EMTALA investigation has been completed.[175] The time it takes between investigating an EMTALA complaint and the regional office to make a determination has increased substantially between fiscal year 1994 and fiscal year 1998,[176] suggesting that CMS and its subcontractor state agencies may need to examine their respective hiring needs.

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173. *See supra* Section IV for a discussion on the increase in EMTALA complaints and violations.

174. OIG ENFORCEMENT, *supra* note 74, at 8.

175. *Id.* at 12 (suggesting that the enforcement process is compromised by delays and inadequate feedback after the OIG found that CMS regional offices take nearly sixty-five days after the State's investigation to determine whether a violation had occurred and that seventy percent of the regional offices took up to a year to determine whether a hospital violated EMTALA).

176. *Id.* at 13.

Finally, variance in the level of enforcement across regions and over time compromises the effectiveness of the statute. Such variance in enforcement is problematic. For example, when the number of EMTALA violations in a region decreases from more than 100 cases in one year to three cases the next year,[177] one questions the consistency of enforcement.

VI. FOLLOW-UP ISSUES

A. Cost Considerations

Americans must determine whether they are willing to continue to subsidize care for the uninsured. In the United States, health care is not a right;[178] however, in crafting EMTALA, Congress decided, as a matter of public policy, that access to emergency services was a right of all persons.[179] Thus, in order to continue to provide emergency services to all persons who present to an emergency department, Americans must pay for these services.

No matter how this is done, payment must be made for services that are rendered. It is irresponsible to mandate that hospitals must provide emergency services and leave them with the entire financial burden of treatment. Health care is a competitive business and facilities cannot operate unless they produce revenue sufficient to cover their costs. This will not occur if the current environment continues in which EMTALA represents an unfunded mandate.

B. The Future of EMTALA Post-September 11, 2001

Though federal and state governments have approved various legislative initiatives that represent commitments to improved funding for the health care industry and relief from previous budgetary cuts,[180] those priorities seem to have changed after the tragic events of September 11, 2001. Post-

177. *Id.*

178. Though health care is not a right in the generic sense of the term "right," so-called "Patients' Bill of Rights" legislation has been introduced that would purportedly guarantee consumers explicit rights with regard to health care. *See, e.g.*, H.R.J. Res. 30, 108th Cong. (2003) (proposing a constitutional amendment to provide that all citizens have the right to health care of "equal high quality"); H.R. 2315, 107th Cong. (2001) (seeking to protect patient-provider interactions, access to obstetrics and gynecological care, and access to pediatric care from interference by managed health care bureaucrats); S. 6, 107th Cong. (2001) (seeking to improve access to specialist care; seeking to protect the physician-patient relationship from interference by managed health care executives; and seeking to improve access to appeals when care is denied by the managed care organization).

179. *See supra* Section I for a discussion of the origins of EMTALA.

180. *See, e.g.*, Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, 113 Stat. 1501 (1999).

September 11, there are new priorities that require funding; for example, the Food and Drug Administration has claimed that it needs additional funds to ensure that food remains protected from terrorist acts.[181]

Hospital officials must continue to use their trade associations to lobby for funds to improve their capabilities at addressing the threat of bioterrorism. For instance, recent legislation appropriated $135 million for "grants to improve hospital capacity to respond to bioterrorism."[182] In addition, hospital officials must find creative ways of securing funding for their facilities. For example, hospitals may need to raise more funds through philanthropic programs, as some New York hospitals are doing.[183]

The federal government realizes that various sectors of the economy have financial needs that must be addressed and is determining how it will address those needs in the face of diminished resources. One means by which the federal government recently proposed to alleviate some of the financial constraints of providers came in the form of a proposal to decrease health care-related regulation.[184] These proposals, however, could have disastrous consequences. Though providers would be granted relief from extensive paperwork and from frequent surveys by state and federal investigators, the effort would harm the public, as state and federal compliance oversight would be diminished. Because the public is not fully knowledgeable about its statutory health care rights, citizens are at a disadvantage relative to providers. The intent of EMTALA was to protect the public, and such proposals for deregulation must not impact EMTALA enforcement. This would be contrary to the legislative intent of the statute.

C. The Need for Continuous Assessment of Progress

Although concerns over patient dumping were voiced when Congress drafted EMTALA there was little data on the scope of the problem.[185] To

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181. *Hearing Before the Comm. on Governmental Affairs Subcomm. on Oversight of Gov't Mgmt., Restructuring, and the District of Columbia*, 107th Cong. (Oct. 10, 2001) (statement of Bernard A. Schwetz, D.V.M., Ph.D., Acting Principal Deputy Comm'r, FDA), *available at* http://www.fda.gov/ola/2001/foodsafety1010.html (last visited Oct. 27, 2003).

182. Dep't of Defense and Emergency Supplemental Appropriations for Recovery from and Response to Terrorists Attacks on the U.S. Act, Division A - Dep't of Defense Appropriations Act, Pub. L. No. 107-117, 115 Stat. 2230, 2314 (2002).

183. Cinda Becker, *Hanging on: NYC Hospitals Begin to Recoup Losses*, MODERN HEALTHCARE, Nov. 26, 2001, at 24 (finding that one New York area system reported $12 million in losses associated with the Sept. 11, 2001 attacks, even though the system expected to raise greater than average charitable donations).

184. Jonathan Gardner & Mark Taylor, *Relief on a Shoestring; Amid Fiscal Pressure, Feds Look at Medicare Deregulation as Way to Help Providers*, MODERN HEALTHCARE, Nov. 12, 2001, at 4.

185. H.R. REP. 99-241, pt. 3, at 6 (1986), *reprinted in* 1986 U.S.C.C.A.N. 727-8 ("There was little evidence available to the Committee during its consideration of H.R. 3128 as to the

remedy this, the legislative history of the statute indicates that the General Accounting Office was to:

> [T]horoughly review the issue [of patient dumping]... [to] give Congress sufficient information to objectively assess this problem. Whatever additional steps General Accounting Office recommends, whether further Medicare action or refinements in Medicaid, the aim of the Congress should be to encourage states to take definite action to guard against "dumping" at the local level....[186]

Despite Congressional recommendations that the General Accounting Office perform these studies, there were no GAO studies until relatively recently.[187]

These studies are important because they highlight problems that exist with EMTALA's structure. For example, the problem of improper motives for transfers between emergency departments came to the attention of legislators as a result of several scientific studies in the 1980's that documented the magnitude of the problem.[188] The EMTALA statute, however, has been in place for more than fifteen years and additional studies are needed. While the OIG has documented trends in EMTALA enforcement and has surveyed providers about their comfort level with the statute, additional investigations by health services researchers, trade associations, provider groups, and other stakeholders are essential in understanding the effectiveness of the statute. Continuous assessment is key to understanding how EMTALA affects the industry and the public.

While the reports of the OIG are instructive in ascertaining the effectiveness of the statute, there are several drawbacks to leaving this responsibility solely to governmental investigators. For example, providers may not be as candid with their remarks as they would be with a non-governmental health services researcher. Providers have an incentive to spin the data that they furnish to government officials to serve their own interests and insulate themselves against possible civil or criminal liability. If the OIG developed a partnership with a not-for-profit think tank or similar organization, the level of candor may be increased, as the partner agency could presumably survey providers.[189] With any means the

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scope of the problem addressed... since there have been no hearings in either the House or the Senate on this issue or on the language recommended by the Ways and Means Committee.").

186. 131 CONG. REC. S13892 (daily ed. Oct. 23, 1985) (statement of Sen. Durenberger).

187. EMTALA IMPLEMENTATION AND ENFORCEMENT, *supra* note 52.

188. *See* Kellermann & Hackman, *supra* note 34, at 1288. *See also* Schiff et al., *supra* note 26, at 495.

189. One possible not-for-profit investigative group that could be used is the RAND

government uses, systems should be developed to monitor the progress of hospitals in complying with the statute. There is evidence, for example, that there are several "repeat violators" of EMTALA,[190] having been found to be in noncompliance with the statute during two consecutive periods. If systems were improved, more appropriate action could be taken to make certain that repeat violations do not occur.

VII. CONCLUSION

For EMTALA to work as intended, three things must occur: (1) appropriate financial relief must be made available to providers; (2) the government must refine its procedures for holding providers accountable for violations of EMTALA; and (3) governmental information systems must be upgraded so that continuous assessment of the effectiveness of the statute can be achieved.

To ensure that hospitals remain able to comply with EMTALA and remain financially viable, the government must provide appropriate financial relief to providers, including clarification on their responsibilities under the statute as well as financial relief. Investigations by both the OIG and CMS demonstrate that many providers who violate EMTALA do not intend to do so. Instead, many ambiguous areas within the statute are subject to multiple interpretations. Thus, the OIG and CMS must continue to provide appropriate guidance to providers to ensure that providers are penalized fairly in accordance with the statute. Additionally, the Balanced Budget Act and other legislative initiatives have drastically decreased Medicare funding for health care providers and Congress must continue to improve funding for health care providers.

The legislative history of EMTALA suggests that Congress decided, as a matter of public policy, that all persons had the right to receive emergency medical care without regard to socioeconomic circumstance. Congress' intent is clear and unambiguous. Thus, the governmental agencies charged with enforcement of the statute must continue to be vigilant in enforcing the letter of the law. As discussed, the OIG's prosecutorial discretion in

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organization and its health care component, RAND HEALTH, which distributes health care related books, briefings and conference proceedings. *See* RAND INST., A BIBLIOGRAPHY OF SELECTED RAND PUBLICATION - HEALTH-RELATED RESEARCH, *available at* http://www.rand.org/publications/bib/SB4027.pdf (last visited Oct. 27, 2003).

190. KAIJA BLALOCK & SIDNEY M. WOLFE, PUB. CITIZEN HEALTH RESEARCH GROUP, QUESTIONABLE HOSPITALS: 527 HOSPITALS THAT VIOLATED THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT: A DETAILED LOOK AT "PATIENT DUMPING" (July 2001) (publishing a report on EMTALA enforcement, which found 527 hospitals with EMTALA violations between 1996 and 2000, 12.9% of which were repeat violators that had recorded EMTALA violations in other periods), *available at* http://www.citizen.org/questionablehospitals/qhcompletereport.pdf (last visited Oct. 27, 2003).

imposing civil monetary penalties against providers has been exercised in a haphazard manner.[191] By holding the OIG responsible for enforcing the letter of the law, the OIG's inconsistent use of prosecutorial discretion could be eliminated or drastically reduced. Literal enforcement of the penalties provided in EMTALA will ensure that the statute remains consequential enough to compel compliance on the part of providers. Until Congress decides that public policy no longer demands that all persons have a right to emergency care, providers must continue to provide emergency care to all who present to the emergency department, despite the harsh economic environment that providers currently face.

Finally, Congress must refine the means of data collection on EMTALA. An agency or not-for-profit organization should be appointed to provide regular reports to Congress on the state of EMTALA. These reports should be given annually so that year-to-year comparisons can be made to establish data on the effectiveness of the statute. The regular reports provided to Congress should include input from essential stakeholders. Thus, hospital administrators, emergency department physicians, CMS, and DHHS personnel should all be involved in workgroups designed to provide the government with information on the effectiveness of EMTALA.

Though hospital administrators face economic constraints due to cuts in Medicare reimbursement, the mandate of EMTALA remains clear and unchanged. Providers simply must ensure that all persons receive emergency care without regard to their ability to pay. Hospitals' claims of financial hardship warrant heightened federal financial assistance, but cannot be used as an excuse for noncompliance with EMTALA.

VIII. POSTSCRIPT: NEW EMTALA REGULATIONS

The CMS issued new EMTALA regulations that were published in the *Federal Register* on September 9, 2003, and are effective November 10, 2003.[192] Though a comprehensive review of the new regulations is beyond the scope of this narrative, the newly available guidance will be briefly addressed.

The new regulations represent yet another attempt by the government to clarify the responsibilities of providers under EMTALA, addressing situations in which EMTALA obligations arise for hospitals.[193] For example, the revised regulations create new terminology, including the term

191. *See supra* Section III for discussion of prosecutorial discretion.

192. Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions, 68 Fed. Reg. 53,222 (Sept. 9, 2003) (to be codified at 42 C.F.R. pts. 413, 482 and 489).

193. *Id.*

"dedicated emergency department" to indicate when an EMTALA obligation will arise for a hospital provider.[194]

The new regulations also incorporate a "prudent layperson" standard; however, the standard is used to determine whether EMTALA obligations arise as a result of a patient having come to the emergency department. Thus, a patient "comes to the emergency department" when, *inter alia*, "a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition."[195]

Though the new regulations do provide additional guidance to providers as to the scope of their EMTALA obligations, many questions remain unanswered. For example, the post-stabilization responsibilities of hospitals with regard to Medicare+Choice enrollees have not been fully delineated.[196] In addition, there is some confusion as to what sampling techniques should be used to determine whether a hospital operates a "dedicated emergency department."[197] Accordingly, CMS has indicated that it will issue additional guidance so that providers may achieve a better understanding of their obligations under EMTALA.

Notwithstanding the additional clarification provided by the revised regulations, the regulations do not address most of the commentary provided in this narrative. Crucial issues such as funding for EMTALA and the increased demand on emergency departments for services still remain, and should be addressed by both CMS and DHHS.[198]

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194. *Id.* at 53,263.

195. *Id.* at 53,262.

196. *Id.* at 53,225 (stating that CMS will address this issue in future policy guidance).

197. *Id.* at 53,229 (stating that CMS "may develop a series of questions and answers for posting on [its] website that will provide further clarification and guidance to providers").

198. Since the completion of this article, Congress has also passed the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 108th Cong. (2003). Here again, the specifics of the legislation are beyond the scope of this article. Note, however, that the legislation does incorporate another suggestion that the author has made in this article. The statute amends EMTALA to require the Secretary of DHHS to establish a process by which he will notify providers when an EMTALA investigation has been closed. The legislation also establishes a Technical Advisory Group to review issues related to EMTALA and its implementation. The Advisory Group is comprised of various industry stakeholders, including hospitals, physicians, patient representatives, and regional office personnel who are involved with the oversight of EMTALA investigations.

Statement of Marilyn Dahl
Briefing for the U.S. Commission on Civil Rights
On
CMS Enforcement of EMTALA
March 14, 2014

Good morning. My name is Marilyn Dahl and I am the Director of the Division of Acute Care Services within the Survey & Certification Group at the Centers for Medicare & Medicaid Services (CMS). The Survey & Certification Group is charged with enforcing the compliance of Medicare-participating providers and institutional suppliers of health care services with Medicare Conditions of Participation, Conditions for Coverage, and, in the case of hospitals and critical access hospitals, the Emergency Medical Treatment and Labor Act, commonly referred to as EMTALA.

Section 1867 of the Social Security Act, entitled "Examination and Treatment for Emergency Medical Conditions and Women in Labor," establishes certain requirements for Medicare-participating hospitals and for Medicare-participating critical access hospitals , which are small, rural acute care facilities. (Throughout the remainder of this statement, when I refer to hospitals I am also referring to critical access hospitals.) It also establishes requirements for on-call physicians. There are also some provisions of Section 1866 of the Social Security Act governing the provider agreement between Medicare and a provider which are related to EMTALA and its enforcement.

Enforcement mechanisms established under Sections 1866 and 1867 of the Social Security Act pertain to enforcement actions that CMS may take with respect to a hospital's Medicare provider agreement, as well as actions the U.S. Department of Health and Human Services Office of Inspector General may take with respect to hospitals and physicians. Section 1867 of the Act also provides for a private right of action by individuals or medical facilities; CMS has no role in such civil litigation.

Hospital Obligations under EMTALA

Depending on their characteristics, hospitals may be subject to either or both of two different types of EMTALA obligations: (1) obligations of hospitals with an emergency department towards individuals who come to the emergency department; and (2) obligations of hospitals with specialized capabilities. One misconception about EMTALA is that there are no EMTALA obligations for hospitals that do not have emergency departments. However, this is not always the case.

Obligations of Hospitals with Emergency Departments

If an individual comes to the emergency department of a Medicare-participating hospital and a request is made for examination or treatment for a medical condition, the hospital is required to conduct an appropriate medical screening examination, within the capabilities of that hospital, to determine if the individual has an emergency medical condition. Although the EMTALA provisions in Section 1867 are found in the Medicare portion of the statute, EMTALA protections apply to any individual who comes to a hospital's emergency department, regardless of his or her insurance or payment status.

If the individual is found to have an emergency medical condition, the hospital must provide further examination and treatment, within its capabilities and capacity, to stabilize the emergency medical condition. Or, the hospital must transfer the individual to another facility if the hospital lacks the capability to stabilize and if the medical benefits reasonably expected from provision of appropriate treatment at another facility outweigh the increased risks from being transferred. Hospitals are not permitted to delay screening for an emergency medical condition or stabilizing treatment in order to inquire about an individual's method of payment or insurance status. Hospitals are required to provide screening and stabilizing treatment regardless of the individual's ability to pay. In addition, the EMTALA regulations provide that if a hospital admits an individual as an inpatient in good faith in order to stabilize his or her emergency medical condition, then that hospital has fulfilled its obligations under EMTALA.

The law and regulations also specify definitions for an "emergency medical condition," "to stabilize" and "stabilized," and "transfer." The regulations also define additional terms, including what it means to "come to the emergency department," and what a "dedicated emergency department" is.

The statutory definition of an "emergency medical condition" contains provisions focusing on pregnant women in labor as well as provisions for all other cases. For the latter, an "emergency medical condition" is one that is manifested by acute, severe symptoms (including severe pain) that lead to a reasonable expectation that absence of immediate medical care would result in serious jeopardy to the individual's health, serious impairment of one or more bodily functions, or serious dysfunction of a bodily organ or part.

The EMTALA definition of "stabilized" is not the same as what clinicians typically mean when they refer to a patient as being stabilized. In addition to provisions specific to women in labor, the EMTALA statutory definition of "stabilized" means that one can reasonably expect that the individual's emergency medical condition will not materially deteriorate during or as a result of the individual's "transfer." "Transfer" is also specifically defined to mean the movement, including discharge, of an individual out of a hospital at the direction of hospital staff. To "stabilize" an individual's emergency medical condition, hospitals are expected to provide treatment that mitigates the severity of the acute episode so that when the individual leaves the hospital, his or her condition no longer meets the definition of an emergency medical condition when he or she is discharged or transferred. If a hospital lacks the capability to stabilize the emergency medical condition, then it is not only allowed but expected to transfer an unstabilized individual to a hospital that has the required stabilization capabilities. There are additional EMTALA requirements to assure that the transfer of an unstabilized individual is carried out appropriately.

In some cases, the required stabilizing treatment could also be definitive treatment, as, for example, when an individual who presents with symptoms of acute appendicitis undergoes surgery for removal of the appendix. In other cases, particularly with individuals who have underlying chronic diseases, such as asthma, diabetes, or congestive heart failure, hospitals are required under EMTALA to address the acute episode, but are not required to provide ongoing treatment of the underlying disease.

Individuals who come to a hospital's emergency department with symptoms of severe psychiatric disturbances present particular challenges for hospitals and their staffs, both in terms of determining whether these individuals have an "emergency medical condition" under EMTALA and, if so, when they are "stabilized" under EMTALA. Notably, the regulatory definition of an emergency medical condition includes psychiatric disturbances among the acute, severe symptoms suggesting there is a medical emergency. In CMS interpretive guidance on how to assess compliance with the EMTALA regulations with respect to individuals with psychiatric disturbances, CMS has elaborated on the definition of an emergency medical condition to clarify that an individual is considered to have a psychiatric emergency medical condition if he or she is expressing homicidal or suicidal thoughts or gestures and is determined to be a threat to self or others.

Between 2004 and 2007, a technical expert panel mandated by Congress met to consider many aspects of EMTALA regulations and enforcement. The published minutes of this panel note that it deliberated at length on whether there was another way to describe a psychiatric emergency medical condition, but the panel did not offer an alternative definition.

CMS has issued guidance in order to help hospital staff determine if a psychiatric emergency medical condition has been "stabilized" per the EMTALA definition, particularly if the individual's acute symptoms have been mitigated through the use of physical or chemical restraints. CMS guidance on determining whether a psychiatric emergency medical condition has been stabilized says, "Psychiatric patients are considered stable when they are protected and prevented from injuring or harming [themselves] or others. The administration of chemical or physical restraints for purposes of transferring an individual from one facility to another may stabilize a psychiatric patient for a period of time and remove the immediate [emergency medical condition] but the underlying medical condition may persist and if not treated for longevity the patient may experience exacerbation of the [emergency medical condition]. Therefore, practitioners should use great care when determining if the medical condition is in fact stable after administering chemical or physical restraints." It is also important to note that any use of physical or chemical restraints must be utilized in accordance with the CMS conditions of participation (COPs) for hospitals (42 CFR 482).

Importantly, although psychiatric hospitals are not typically thought of as having an emergency department in the same way that general acute care hospitals frequently do, they may, in fact, meet the definition under the EMTALA regulations for having a "dedicated emergency department," and therefore would have to meet the EMTALA requirements for hospitals with emergency departments. The CMS regulatory definition of a "dedicated emergency department" considers how the unit of a hospital *functions*, paying particular attention to whether it is handling unscheduled, walk-in patients, with a significant number having emergency medical conditions for which the patients are then admitted. Labor and delivery units of hospitals are one example. Likewise, a psychiatric hospital that has a walk-in clinic from which a significant volume of patients are directly admitted as inpatients is considered to have a "dedicated emergency department." In these cases, the "dedicated emergency department" is not expected to have the same capability to provide a broad range of medical screening or treatment that a more typical emergency department furnishes, so that a transfer to a more appropriate hospital might be in order. For example, if an individual came to a psychiatric hospital's "dedicated emergency

department" with serious self-inflicted wounds as well as other symptoms of psychiatric disturbances, the psychiatric hospital would not be expected or required to have the capability to treat the wounds, but would instead be expected to arrange an appropriate transfer to another hospital that could.

Additionally, EMTALA's focus is on assuring that *every* individual who comes to the emergency department, as defined in regulations, of a Medicare-participating hospital is screened appropriately for an emergency medical condition, and stabilized if found to have an emergency medical condition. Accordingly, CMS's assessment of compliance with EMTALA requirements makes no distinctions with respect to whether or not an individual coming to an emergency department has a disability of any sort, including a psychiatric disability. CMS's focus is on whether the individual was appropriately screened, whether he or she had an emergency medical condition, and, if so, whether he or she received appropriate stabilizing treatment or an appropriate transfer.

Obligations of Hospitals with Specialized Capabilities

Regardless of whether or not a hospital has a dedicated emergency department, if it has the specialized capabilities that are needed to stabilize the emergency medical condition of an individual who presented to another hospital's emergency department that lacks the required capability to stabilize the individual, then it must accept transfer of the individual, assuming it also has the capacity to treat the individual at the time of transfer. For example, psychiatric hospitals that have a bed available are required under EMTALA to accept an appropriate transfer of an individual who presented to the sending hospital with a psychiatric emergency medical condition. The EMTALA obligations of hospitals with specialized capabilities are governed by Section 1867(g) of the EMTALA statute. Additionally, CMS adopted regulations at 42 CFR 489.24(f)(1), which explicitly state that recipient hospital responsibilities apply to any Medicare-participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.

CMS EMTALA Enforcement Process

The potential for termination of their Medicare provider agreement highly motivates hospitals to comply with EMTALA obligations and proactively prevent violations from occurring. Despite this motivation, EMTALA complaints do arise. Complaints can come from a variety of sources, including affected individuals and their families, hospital staff, and other hospitals. Further, if CMS learns through media reports of potential EMTALA violations, it may treat them as a complaint and authorize an investigation.

Between 2006 and 2012, CMS received approximately 500 EMTALA complaints on average per year, and investigated the vast majority of these complaints. Of those complaints investigated, on average, approximately 40 percent resulted in hospitals being cited for EMTALA deficiencies. In most cases the hospitals corrected their deficiencies and came back into compliance, which is the goal of CMS's enforcement actions. Termination of a hospital's Medicare provider agreement due to violations of EMTALA is a rare occurrence.

EMTALA investigations are generally conducted on behalf of CMS by State surveyors who make an unannounced visit to the hospital. In accordance with Section 1864 of the Social

Security Act, CMS has entered into agreements with all of the States to have qualified staff conduct on-site inspections, or surveys, to assess the compliance of Medicare-participating hospitals with their respective Medicare Conditions of Participation and with the EMTALA requirements. In some cases, CMS employees or contractors may conduct part or all of a survey, or participate in a State's Federal survey team, but the overwhelming majority of EMTALA surveys are conducted by State surveyors.

CMS provides regular training to State surveyors and provides guidance on EMTALA via the State Operations Manual, which articulates the policy and processes surveyors are to follow when assessing compliance. Surveyors conducting an EMTALA complaint look not only at the complaint case, but also at a sample of other cases, and assess the hospital's compliance with all of the EMTALA regulations in 42 CFR 489.24 as well as the EMTALA-related provisions of 42 CFR 489.20, such as the hospital's obligation to maintain a list of physicians on-call to come to the hospital in an EMTALA case and the requirement for a log of all individuals who come to the emergency department, among others.

The State surveyors complete their investigation and forward to their CMS Regional Office not only their survey report, but also copies they have made of any medical records or other documents that the surveyors believe provide evidence of EMTALA noncompliance. There are ten CMS Regional Offices around the country, and based on the survey findings and the supporting documents, survey and certification staff in those offices make the determination as to whether the hospital is in compliance with all EMTALA requirements.

CMS focuses on the hospital's compliance with EMTALA at the time of the survey. For example, if the survey finds evidence that the deficient practices alleged in a complaint did occur, but that the hospital identified the noncompliance and took effective corrective action prior to the survey, CMS will not pursue an EMTALA enforcement action against that hospital. However, that case may be referred to the Office of Inspector General for consideration of whether it will pursue its own, separate enforcement action under its Section 1867 authority. In some instances, CMS may also refer a case to the Office for Civil Rights for consideration under its Hill-Burton Act authority.

If, after reviewing the case file from the State, the CMS Regional Office finds evidence of current EMTALA noncompliance *and* where there are clinical issues related to the types of noncompliance, the statute requires CMS to send the case file to the appropriate CMS-contracted Quality Improvement Organization (QIO). The QIO arranges to have a physician review the case and answer a standard series of questions for CMS. Applying accepted standards of practice, the QIO physician reviewer is expected to answer questions such as: given the individual's presenting signs and symptoms, did the hospital provide an appropriate medical screening examination; did the individual have an emergency medical condition; was the individual's emergency medical condition "stabilized" per the statutory definition, before he or she was transferred or discharged; and did the hospital have the capability to provide stabilizing treatment.

After considering both the State survey report and the QIO physician review, the CMS Regional Office issues the final survey report to the hospital, which is known as the Statement of Deficiencies. If the report identifies EMTALA deficiencies, the hospital must correct those

deficiencies in a timely manner and the State must conduct another survey to confirm that compliance has been achieved. Failure to correct deficiencies may result in CMS terminating the hospital's Medicare provider agreement, no longer enabling it to participate in the program and receive Federal funds. CMS' main focus is ensuring hospitals correct deficient practices while maintaining access to care, so termination of the provider agreement only rarely occurs.

Thank you for the opportunity to discuss hospitals' obligations under EMTALA and CMS's role in enforcing those obligations. I would now be happy to answer questions you might have.

MONOGRAPH

PREPARED BY THE MONOGRAPHS TASK FORCE OF THE AMERICAN SOCIETY FOR HEALTHCARE RISK MANAGEMENT

How to use & understand

statutes, regulations, guidelines, interpretations & model guidance

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INTRODUCTION

The health care field is the subject of a host of federal statutes, regulations, guidelines, interpretive information, and model guidance. At the state level there is also a considerable number of statutes and regulations that have an impact on the delivery of health care services.

This monograph puts in perspective these federal and state materials. Learning how to read such legal information can facilitate the design and implementation of risk management systems. A flow chart is incorporated here to depict the spectrum of laws and other tools that guide the delivery of health care. In the end, rather than be an imposing and daunting challenge to understand, the outcome can be development of risk management systems that use this information as a blueprint for success.

UNDERSTANDING THE SYSTEM BEHIND STATUTES

Legislative assemblies enact statutes before they become laws. Such laws do not take effect upon the passage of a legislative bill that generates new legislation. Rather, in most democracies there is a system of checks and balances that provides for a "second look" at legislation. At the federal level in the United States, this role is fulfilled by the President. The President "signs" the law to give it full effect. At the state level, this role is fulfilled by the governor. In other countries, a parliamentary system might include a prime minister who signs into law a piece of legislation passed by an assembly.

In a constitutional system, the authority to enact legislation is described in the constitution. In the United States, the Constitution delineates the authority vested in the federal government and the powers reserved to the states. Congress is empowered to enact legislation at the federal level. Each state has its own constitution that describes the scope of authority vested in a state legislature.

WHAT IS A STATUTE?

A statute is legislative enactment that has been signed into law. A statute either directs someone to take action, grants authority to act in certain situations, or to refrain from doing so. Statutes are not self-enforcing. Someone must be authorized to do so to take action. A statute may authorize the Department of Health and Human Services to take action, and it is up to the department to implement the law.

HOW TO READ A STATUTE

Reading or "interpreting" a statute is something of an art. Judges spend years interpreting or construing the "meaning" or application of a law. Getting to the true meaning may come down to a turn of a phrase, the use of a particular verb, or reference back to the written proceedings of Congress or a legislative committee. The same is true at the state level and in other democratic countries.

Notwithstanding what transpires at the appellate court level, each individual is expected to act within the scope of the law. This is the practical side of statutory interpretation. If an environmental law prohibits the dumping of chemical wastes in protected areas, it is axiomatic that such behavior is acting "against" the law. It does not require someone to interpret the fine points of a statute.

Even where the law is less than straightforward, there are certain practical steps that can help risk management professionals understand how to read a statute. These steps include:

1. Look at the title of the statute. The body of the law should reflect what is encapsulated in the title of the legislation. For example, if the title reads "Licensure of Nurse Midwives," the body of the law should describe what is involved in licensing nurse midwives.

2. Look at the preamble. Legislature often will provide a statement that describes the purpose for the law. This is very useful, especially in trying to understand how to give effect to the law.

3. Look at the definitions. Many statutes begin with a section of definitions. Caution should be exercised, however, especially if the law reads*, "For purposes of Sections 1.1.0 through 1.1.8, the definition of 'authorization' means … ."* Such statutory construction is a warning that the definition has limited application. It does not apply to Sections 1.1.9 through the end of the statute. Whether on purpose or as a result of an oversight, sometimes the legislation does not include definitions for the sections that have been carved out from the application of the overarching explanation of the terms. At other times, the definitions are intended to apply to all the sections of the statute. In reading through a statute, however, one may find a section that reads, *"For purposes of this section the term 'authorization' means*" or it may read "*Notwithstanding the provision [definition] in 1.1, the term 'authorization' means… .*" When this type of statutory construction is used, the intent is to provide a section-specific definition or exception to the overall use of the term.

4. Look at the "action" statement in the statutory section. Determine if the statutory provision requires you to *take action, refrain from a particular action* or *authorizes you to embark upon a particular activity*. For example, a provision in a nurse practice act may state, "Only those who have successfully passed the state licensure examination and who possess the prerequisite educational background may use the title "RN" after his or her surname." Another version might state, "It is an offense for anyone to use the title "RN" in this state who is not duly licensed to do so." Some protective legislation offers an example of the requirement to take action: "All physicians shall report known or suspected cases of elder abuse to the Department of Social Services." In some instances, a statute grants a caregiver discretionary authority. For example, in some parental notification provisions, a section might state that, "The attending physician may notify the minor's parents of the care provided to the patient, giving due regard to the circumstances of the case."

5. Read statutory provisions in context. Be careful not to read one section of a statute as being applicable to a circumstance that is addressed in another provision. Many times, statutory craftsmanship provides signals to avoid such misinterpretation. For example, a statutory provision may read, "For purposes of this section" or it may state, "This section is applicable to the following."

6. Look for exceptions. Be aware of statutory provisions that create limited application exceptions. For example, the language may read, "*This provision is applicable in all circumstances with the exception of the following ... ."* When this type of statutory construction is used, it in effect creates a number of "carve out" situations in which the provisions of the law do not apply.

7. Look for effective dates of statutory provisions. Determine "when" a statutory or statutory section takes effect. Sometimes this information is found at the end of the statute or statutory section. Note, too, that in some states, statutes have built-in expiration dates. This is a form of design that is used to compel state assemblies to evaluate the law with a view to re-enactment or refinement.

8. Look for severability clauses. To guard against a court ruling nullifying an entire statute when only one provision is deemed unconstitutional, many statutes include a severability clause. This means that if even if one or more provisions of a statute or ruled unconstitutional, the remainder of the law remains in effect.

UPDATING STATUTORY INFORMATION

Federal and state statutes can be dynamic documents. Legislative changes occur that change the statute, sometimes repealing or amending specific provisions. In some instances, changes occur as the result of judicial interpretations. A court may rule that a certain provision within a long statute is unconstitutional.

Most risk management professionals do not have the time or resources to track down statutory changes. This can be done by legal counsel. General counsel or panel counsel usually have the resources to provide rapid information to update statutory law.

Statutory change is a signal that careful review is in order for institutional policies, procedures, and practice routines. For example, if a state assembly enacts a new law dealing with psychiatric advance directives, it is important to look at the *application* of the law in operational terms. By the same token, if the highest court in the jurisdiction overturns a provision dealing with the administration of psychotropic medication, applicable policies and procedures must be modified accordingly.

From a practical perspective, there are several strategies to consider:

1. Establish a process for regular updates. Develop a service agreement with outside counsel or a practice routine with in-house counsel to provide ongoing statutory updates. Included in this service should be legislative changes and judicial rulings that affect statutory provisions.

2. Obtain copies of statutory changes. Many states and the federal government provide online access to statutory changes. This service might also be obtained from in-house or outside counsel.

3. Update the statutory file book. Make certain that resource material is current. Rather than have the "old" version behind one tab and the update behind another section, retool the Statutory File Book to reflect only current provisions. This might involve something as simple as cutting and pasting or obtaining a current version of the law.

4. Evaluate existing policies and procedure. All policies and procedures should be reviewed to make certain that the content is consistent with any legislative or judicial decisions that resulted in a change in applicable statutory provisions. Working with relevant departments or units, a new policy or procedure may be needed or an existing document may need to be reworked to make it consistent with the revised statutory requirements.

5. Provide inservice education for staff. Work with department and unit leaders to provide practice inservice education programs on legislative changes for health care personnel. Thus, if a consent policy and procedure was modified to reflect statutory changes, the core content of the inservice program should be geared to what the caregivers need to know. This sometimes may mean the use of new forms or tools.

6. Provide updates for leadership. Many statutory changes have a direct impact on the stewardship of a health care organization. Work with legal counsel to provide a "legislative update" program for the board, senior management and members of health professional staff who are independent contractors such as physicians and licensed independent practitioners. Included in this process should be updates relevant to judicial interpretation of statutory law.

REGULATORY LAW

Regulations, or rules, are promulgated by administrative personnel to whom legislatures have delegated such responsibilities. At the federal level, the Department of Health and Human Services promulgates regulations/rules that address day-to-day operations of federal health care requirements. The department takes this action based on the authority delegated in enabling legislation.

The federal government and each of the states follow a prescribed course for promulgating regulations. At the federal level, the requirements are set forth in the Administrative Procedures Act (APA). Similar laws are found in each of the states. In essence, the APA maps out how to propose a regulation, or "rulemaking" (Notice of Proposed Rule Making, NPRM), how to solicit public commentary, and how to issue a final rule or regulation. Provision is also made for interim rulemaking and modifications or repeal of regulations.

As in the case of statutory law, rules and regulations are subject to judicial interpretation. Sometimes the judicial intervention is based on procedural considerations. For example, a court might determine that the administrative agency or department failed to adhere to the process required for promulgating a rule under the APA. The result might be a nullification of the rule. In other instances, the legal intervention may be more substantive. A court might determine that, given the scope of enabling legislation, the agency or department exceeded its authority in promulgating a rule or regulation. The net effect would be to nullify the rule or regulation.

HOW TO READ A REGULATION

As with statutes, there are several practical considerations to keep in mind when reading a regulation:

1. Read the preamble. The preamble to an NPRM is a useful tool in understanding the context for a department or an agency promulgating a regulation. The same is true of the preamble that accompanies the final version of the rule or regulation. In the latter situation, the agency or department often provides responses to public commentaries.

2. Look at the definitions. Take notice of any definitions that are limited to specific regulations or subsets of a regulation.

3. Look at the operative terms. Understand if the regulation requires specific actions, prohibits certain actions, or provides latitude in implementation of the content of the regulation.

4. Look for exceptions. Sometimes a regulation has a general application and then a subsequent subsection or provision carves out an exception.

5. Look for effective dates. Make certain that it is clear "when" the regulation takes effect for your health care organization.

6. Look for cross-references. Beware of sections or subsections that cross-reference to another provision in the regulations.

USING REGULATORY INFORMATION

At the federal level, regulatory information first appears in a public document called the Federal Register. Similar registers or bulletins are found at the state level. Important preamble information can be found in this document. Once a regulation or rule is final, it is incorporated into the federal or state code of regulations.

It is sometimes easier to read amendments to an existing regulation in the Federal Register than it is to see it ensconced in the Code of Regulations. The reason is that the changes are highlighted in the Federal Register. The same is true of a state register or bulletin. Therefore, it is useful to retain a copy of the Federal Register version of the amended rule to read alongside the final Code of Regulations.

For risk management professionals, there are some practical steps to consider in reading a regulation:

1. Obtain updates of regulations. The Federal Register and the Code of Federal Regulations are easily accessed on the Internet. Bookmark the Web site and browse the site daily or weekly for changes. One way of obtaining this information is to go to http://www.access.gpo.gov/su_docs/aces/aces140.html

2. Compare operational policies and procedures with revised regulations. If a regulation is modified, consider how it will impact the policies and procedures of the health care organization. If a change is needed in policy and procedure, use institutional processes to make necessary refinements.

3. Obtain legal guidance. Many times, a regulation necessitates legal interpretation. Use legal guidance at the outset to make certain that policies, procedures and practice routines will be consistent with the regulation.

4. Obtain legal updates. As with statutory changes, seek legal updates for judicial interpretations of regulations. This update may reflect a decision nullifying the regulation or interpreting the application of it.

5. Provide in-service education. Offer inservice education for health care personnel with respect to new or modified regulations that affect daily operations. If policies and procedures are modified to reflect regulatory change, the inservice program should emphasize these modifications.

6. Provide updates for leadership. If a regulation is promulgated or modified, provide leadership with an education program regarding what they need to know about the new requirements.

7. Be prepared to address regulatory-accreditation inconsistencies. Sometimes, an accreditation body may issue a standard that is inconsistent with a regulation promulgated by a department or agency. If the health care organization is using accreditation as a means for obtaining Medicare or Medicaid certification, a choice must be made whether to accede to the regulatory or to the accreditation standard. If the choice is made to follow Medicare or Medicaid, the health care organization might be noncompliant with the accreditation provision. Health care organizations must make a deliberate choice. Since federal funding often provides a large amount of money to a health care organization, the choice is apt to be one in which compliance with the Conditions of Participation for Hospitals in Medicare and Medicaid will take precedence over the position embraced by the accreditation organization. Documenting the rationale for this position may be useful in convincing the accreditation organization to reconsider its perspective.

GUIDELINES AND MODEL GUIDANCE

From time to time, a government agency or department will issue guidelines to explain the meaning or application of a regulation. On occasion, these guidelines are geared to regulatory personnel to assist them in applying the rule to a given situation. Termed "interpretive guidelines," the content gives the health care organization an excellent vantage point in understanding how the government views the regulation.

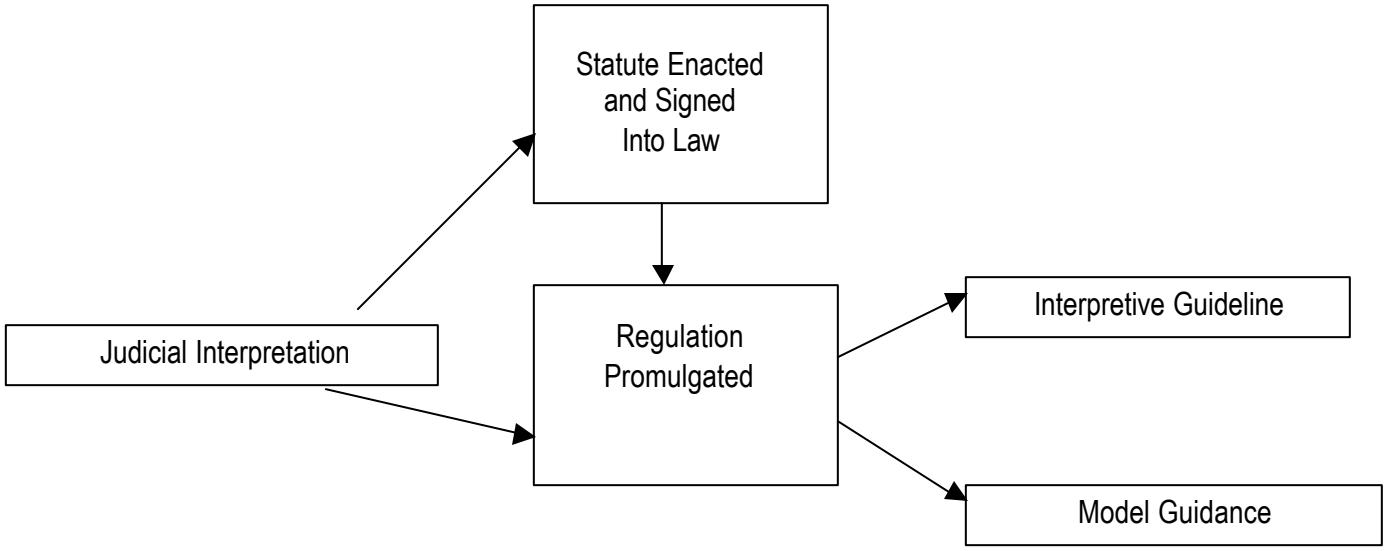
The interpretive guidelines do not have the effect of law. Rather it is like a portal that illuminates how a regulatory body intends to enforce the regulatory requirement.

A difference set of materials – model guidance – is sometimes issued by a regulatory body. It is designed to assist the subject of a regulatory framework in achieving compliance with the requirements. In the health care field, there are examples of such model guidance for corporate compliance. Often published on the Web site of the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services or in the Federal Register, this federal guidance represents the basic expectations to be met in achieving regulatory compliance. Indeed, the model guidance often will encourage the user to do more in terms of being a compliant organization.

The OIG is not the only regulatory body to issue model guidance. The Food and Drug Administration (FDA) also issues model guidance. Like the interpretive guidelines, the model guidance does not have the effect of a statute or regulation. Rather, it is a template for action. It is a tool for developing policies, procedures, and practice routines that track the expectations of regulatory agencies and departments.

A PROCESS MODEL

The schematic below depicts the process from legislation through regulation to interpretive guidelines and model guidance. The statutory and regulatory requirements are subject to judicial interpretation. It is plausible that a plaintiff may use the model guidance as a tool in establishing a standard of care. The same is true in terms of statutes and regulations. Health care organizations should position themselves to use these requirements, guidelines and guidance in a proactive way to establish practical policies and procedures with a view to avoiding liability or regulatory challenges.



CONCLUSION

There is an art to the interpretation and application of statutes and regulations. Because these provisions are written in a stylistic manner, it is sometimes difficult to understand the meaning or application of these requirements. To avoid confusion or misunderstandings, it is prudent to obtain legal advice in using these legal tools. Recognizing this fact is an important attribute of the risk management professional.

WHERE TO FIND THE TOOLS

Many federal agencies and departments provide statutory, regulatory and model guidance on their Web sites. Others also include interpretive guidelines. Similarly, at the state level, there are useful Web sites to explore for such information.

Below are some frequently accessed federal Web sites to utilize in finding statutes, regulations, interpretive guidelines, and model guidance:

Federal Register: http://www.access.gpo.gov/su_docs/aces/aces140.html
Code of Federal Regulations: http://www.gpo.gov/nara/cfr/index.html
U.S. Government Official Web Portal: http://www.firstgov.gov/
Legislative Information on the Internet: http://thomas.loc.gov/
Food and Drug Administration: http://www.fda.gov/
Centers for Disease Control and Prevention: http://www.cdc.gov/
U.S. Department of Health and Human Services: http://www.dhhs.gov/
HHS Office of the Inspector General: http://www.oig.hhs.gov/
HHS Office of Civil Rights (OCR): http://www.hhs.gov/ocr/

RELATED RESOURCES

Risk Management Handbook for Health Care Organizations - 3rd Edition (See Part I – Framework for Health Care Risk Management). 2001. Available from www.ashrm.org or at (800) AHA-2626. Catalog # 178160.

Health Care Fraud Enforcement and Compliance. R. Fabrikan, P.E. Kalb, M.D. Hopson and P.H. Bucy. Law Journal Press, New York. 2002.

United States Health Care Laws & Rules. P. Pavarini, editor. American Health Lawyers Association - West Group, Washington, D.C. 2002.

Health Law and Compliance Update. J. Steiner, editor. Aspen Publishers, New York. 2003.

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