The EMTALA Paradox

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Although the Emergency Medical Treatment and Labor Act (EMTALA) was enacted in 1986, it is only in the past 4 years that it has been an enforcement priority for the US Department of Health and Human Services (HHS). The agency’s own figures are striking: during the first 10 years of the statute’s existence, approximately $1.8 million in settlements and judgments were collected. However, beginning in 1998, the government began its aggressive enforcement of the law, imposing $1.83 million in fines in 54 cases, including 4 against physicians. The pace has continued unabated; during the 1999 fiscal year, approximately $2.7 million in judgments and settlements were collected from 95 hospitals and 2 physicians. In 2000, although the total dipped to $1.17 million in 54 cases, 5 penalties were imposed on physicians, 2 of whom were emergency physicians. These figures alone do not tell the complete story; between 1997 and 1999, it has been estimated that 527 hospitals were determined by HHS to be out of compliance with EMTALA’s requirements. Few determinations result in adverse action because most deficiencies are resolved through plans of correction adopted by a hospital under the threat of having its Medicare provider agreement terminated.

As the scope and intensity of the government’s application and enforcement of EMTALA expand, 2 important questions arise. First, is the expansion of the law’s application meeting its policy objectives? Second, is it easier for the government to enforce the law? The answer to both questions is yes and no. This paradox can be explained by acknowledging that, all other things in the health care system being equal, as the scope of EMTALA enforcement widens in an effort to make the law more effective, this exacerbates existing weaknesses in delivery of care and creates new problems. The net impact of these changes has acted to decrease the availability of the services that the law was intended to promote. Because hospitals and physicians are in the center of this controversy, understanding the contradictions in the law can be a useful tool for them to understand their respective obligations under EMTALA, particularly given the rapid expansion of those obligations.

The rapid increase in EMTALA enforcement is a logical outgrowth of the increased funding Congress appropriated for the HHS Office of...
Inspector General (OIG) in the Health Insurance Portability and Accountability Act of 1996, which now exceeds $140 million in the 2002 federal fiscal year. Moreover, that act and the Balanced Budget Act of 1997 also expanded the enforcement authority delegated to the OIG. In addition, EMTALA enforcement has also become a priority for the Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration [HCFA]), which acts through its Medicare certification and reimbursement functions.

A N O V E R V I E W O F E M T A L A

Under EMTALA, a hospital participating in the Medicare program must offer an appropriate medical screening examination to any patient seeking emergency services to determine whether or not an emergency medical condition exists. If an emergency medical condition is found, the hospital must either (1) provide stabilizing treatment within the capabilities of its staff and facilities or, (2) if the patient cannot be stabilized, the hospital must arrange for an appropriate transfer of the patient after considering the patient’s condition and the risks and benefits of the transfer. Neither the screening examination nor any necessary stabilizing treatment may be delayed to inquire into the patient’s method of payment or insurance status. If a hospital fails to meet these obligations, it is subject to a civil monetary penalty of up to $50,000 for each violation and may be excluded from participating in the Medicare and Medicaid programs for repeated violations or for even a single violation that is gross and flagrant.

THE EMTALA ENFORCEMENT PROCESS

The CMS and the OIG are jointly responsible for enforcing EMTALA. CMS regional offices can initiate inquiries in response to reports or complaints of alleged violations from several sources, including patients, another hospital, or a report from the subject hospital itself. In addition, a surveyor may identify a potential EMTALA violation while performing a hospital licensing or recertification survey.

The CMS regional offices screen complaints and potential EMTALA violations identified by surveyors to determine whether to authorize an investigation. If an investigation is warranted, it authorizes a state survey agency to perform an unannounced, on-site investigation of the hospital to assess potential violations. The investigation can include reviews of hospital logs and patient records, as well as interviews with hospital staff and physicians involved in the incident. The survey agency is required to complete the investigation in 5 working days and report the results to the regional office within 10 days. If there appears to be no violation, the report can be made within 15 working days after the investigation is complete. The survey agency can also express to the CMS its view as to whether or not a violation occurred. If a medical judgment or physician action is in question, the survey agency can recommend that the CMS regional office have the matter reviewed by a physician.

Any physician review must occur within 5 days and may be performed under contract with a state peer review organization (PRO) by board-certified physician reviewers. At least one of the physician-reviewers must be drawn from the same specialty as the physician whose care is under review. In some areas, this may be complicated by the regulatory requirement that a panel of PRO reviewers cannot include a physician who is in direct economic competition with the practitioner being considered for a sanction otherwise has a substantial bias for or against that practitioner. The CMS regional office retains the authority to make an initial determination as to whether or not the law has been violated; of the approximately 400 investigations conducted annually, approximately half result in confirmed violations. If a violation is confirmed, the only remedy available to a CMS regional office is to initiate the process to terminate the hospital’s Medicare provider agreement. It can place the hospital on either a 23-day termination track for violations that represent an immediate and serious threat to patient health and safety or a 90-day termination track for other violations. In all but the rarest cases, if the facility submits a plan of correction and the CMS accepts it within these time frames, the termination process ends. The threat of termination is so powerful that to date only 4 hospitals have had their Medicare provider agreements terminated as a result of EMTALA violations, and 2 were subsequently surveyed and recertified.

When the CMS determines that an EMTALA violation has occurred, it also forwards the case to the OIG for a possible assessment of civil monetary penalties. If an alleged violation requires the opinion of a medical expert, the CMS must send the case
to a PRO within 60 days to obtain a medical opinion, and the PRO’s report is also sent to the OIG. The OIG focuses on compliance with the specific EMTALA statutory requirements, such as a failure to provide a screening examination or authorizing an inappropriate transfer, and has the authority to assess civil monetary penalties only for these statutory violations.

The OIG can impose a civil monetary penalty of up to $50,000 per violation, or $25,000 for a hospital with fewer than 100 beds. In addition, any physician who negligently violates his or her responsibility for examining, treating, or transferring an individual in a participating hospital, including an on-call physician, may be fined a maximum of $50,000 and excluded from the Medicare program by the OIG.

The OIG acts independently of the CMS and has declined to impose civil monetary penalties in just more than half of the cases referred by the CMS. If the OIG does impose a civil monetary penalty, that action is subject to administrative and judicial review.

THE REGULATORY EXPANSION OF EMTALA

The scope of EMTALA enforcement has been dramatically broadened by a confluence of case law, regulations, and informal agency policies. The regulatory expansion of EMTALA has occurred in 5 phases since 1986. The first phase was incorporated into the binding regulations published in 1994, which applied the law’s basic screening and stabilization requirements to patients anywhere on hospital property (including ambulances owned and operated by the hospital) and obligated hospitals to report inappropriate transfers.

The next phase in the expansion of EMTALA’s reach was accomplished when the HCFA published interpretive guidelines for surveyors. These guidelines, which do not have the force of law, stated the agency’s position that EMTALA obligations include (1) distinct responsibilities for on-call physicians, (2) an obligation to provide screening and treatment of patients with psychiatric emergencies, (3) approaching the medical screening examination as a dynamic process, and (4) a distinction between patients who are stable, stable for transfer, or stable for discharge. The discussion in the interpretive guidelines of the various forms of stabilization can be difficult concepts to apply in practice, even though they do reflect the professional judgment of the attending physician. A patient can be stable for transfer if the attending physician reasonably believes that the patient’s condition will not materially deteriorate as a result of a transfer to a facility with the capability to handle that patient and any foreseeable complications. By contrast, a patient is stable for discharge if the attending physician reasonably believes that the patient has reached the point where any needed diagnostic tests or treatment can be performed safely on an outpatient or inpatient basis if the outpatient is given a plan of care along with discharge instructions. The concept is different for psychiatric emergencies. A patient is stable for discharge if he or she is protected and prevented from any self-inflicted injury or from injuring others and is stable for discharge when the attending physician reasonably believes that the patient is no longer a threat to himself/herself or to others.

The third event was the 1999 publication of a Special Advisory Bulletin authored jointly by HCFA and the OIG. The bulletin explains that, despite the best efforts of a hospital staff to properly screen and treat all patients, some patients may elect to leave the premises before all of the law’s requirements have been met. If this occurs, HHS has taken the position that a voluntary withdrawal may form the basis for an EMTALA violation. The Special Advisory Bulletin leaves little doubt in such cases that the government’s position is that it is the hospital’s responsibility to (1) offer the patient an examination to determine whether an emergency medical condition exists and treatment to stabilize any such condition; (2) inform the patient of the benefits of receiving an examination and treatment and of the risks of withdrawal; and (3) take all reasonable steps to obtain and document the patient’s written informed consent to refuse any examination and treatment, which should contain a description of risks discussed and of the examination, treatment, or both, if applicable, that was refused. Whenever this is not possible, the equivalent information should be entered by hospital staff in the patient’s record. In cases of voluntary withdrawal, the CMS and the OIG will concentrate their review on the steps that the hospital and its staff took to give the patient a thorough explanation of the risks of leaving the hospital and to discourage the patient from leaving without receiving a medical screening examination. This bulletin underscores the influence that the CMS and the OIG have over the conduct of any encounter in which EMTALA may be triggered, particularly when the survey and certification or accreditation process is involved.
The fourth phase of EMTALA’s regulatory expansion was accomplished through the traditional regulatory authority of the CMS over Medicare reimbursement methodologies. As part of the Medicare Outpatient Prospective Payment System regulations, in 2000 the CMS codified its informal interpretation of the law as applicable to inpatient areas, hospital buildings that are within 250 yards of the hospital’s main campus, and off-campus facilities that are considered part of the hospital for Medicare cost reimbursement purposes. This has increased the regulatory burden of EMTALA without necessarily increasing access to the health care system. Although all of EMTALA’s obligations may not apply to settings outside the emergency department, the regulations do retain the screening and stabilization requirement for all facilities staffed by qualified medical persons and do require close coordination among the ED, other parts of the hospital system, and even with neighboring hospitals. The confusion over this addition to the regulations has led CMS to propose that the scope of EMTALA in the off-campus setting be narrowed to those facilities that have “dedicated emergency departments” that are specially equipped and staffed and that are used for “a significant portion of the time” for evaluation and treatment of emergency medical conditions.

The most recent expansion of EMTALA’s scope was incorporated into a set of regulatory clarifications and technical corrections published by the OIG in early 2002. This revision broadened the OIG’s civil monetary penalty authority by permitting it to consider any other instances in which the individual or entity may have violated EMTALA as an aggravating factor when determining the amount of a civil monetary penalty. This can include the underlying event that triggered the investigation, as well as any other prior or subsequent instances, even if there has been no formal finding or administrative or judicial decision. The revised regulation does not mention any relevant mitigating factors.

**REGULATORY STRESS AND FAULT LINES: CAN ENFORCEMENT UNDERCUT THE LAW’S OBJECTIVES IN THE LONG TERM?**

The expansion of EMTALA enforcement has been a contributing factor in the increase in ED patient volume, which has slightly exceeded the overall increase in the US population. A component of this increase has been the number of uninsured individuals, which has remained above 38 million throughout the past decade. However, during the same period the number of hospital EDs has declined. As a result, fewer resources are available at the ED level to meet an increasing legal obligation.

The net effect of the policy efforts to improve the law are acting to weaken it in practice. Although enforcement actions are an inescapable part of the regulatory framework, they are also sentinels of significant weaknesses in the ad hoc expansion of EMTALA. In *St. Anthony Hospital v The Inspector General*, the HHS Departmental Appeals Board concluded that a hospital had violated the law when it refused to accept the transfer of a patient from a hospital that lacked a vascular surgeon when the injury to the patient’s abdominal aorta required those services, even though the same services were available at other local hospitals. Although the law has always required hospitals to maintain a list of on-call specialists, the availability of a particular specialist had not been considered previously to be a “specialized capability” of a hospital that stands on the same footing as a burn unit or neonatal intensive care unit (NICU) and creates a rebuttable presumption that the transfer must be accepted. The Board concluded that the provision of the law obligating a hospital to accept all transfers if it has “specialized capabilities” included dedicated units, such as trauma units or NICUs, and also encompassed the availability of staff with special training, such as vascular surgeons.

The *St. Anthony* decision has emboldened the CMS to interpret the law in some cases as obligating a hospital to accept an unstable patient if it has the capacity and has any personnel or equipment that the patient’s condition requires and that the transferring hospital lacks. This interpretation disproportionately expands the obligations of EDs with more sophisticated capabilities and, in particular, increases the obligations placed on many on-call physicians. The threats posed by the possibility of EMTALA sanctions and of overwhelming the hospital’s existing ED capacity may lead some hospitals to divert time and resources away from treatment and toward inquiring about the transferring hospital’s capabilities before agreeing to accept some transfers.

The problem framed by the *St. Anthony* case is particularly acute in areas where EDs regularly close their doors and go on diversionary status. Yet, even when the decision to close the ED is reasonable, this may not be enough to avoid EMTALA liability. A recent decision by a federal appeals court concluded that a patient “comes to the emergency department” and triggers EMTALA obligations not only when the patient...
is on hospital property, but even while traveling toward the hospital. This decision suggests that before a hospital intentionally diverts ambulances, it bears the responsibility to show that the appropriate staff or equipment to treat the patient are either unavailable or nonexistent. Therefore, to balance the demands of an ED operating at or near capacity while still satisfying its EMTALA obligations, the staff may have to engage in extended exchanges with potential transferring hospitals to determine whether they can or must accept the transfer. The paradoxical effect may be that some necessary transfers are delayed pending some objective proof that the transfer must be accepted.

The expansion of EMTALA enforcement is also evident through 2 administrative actions by the CMS. Through its enforcement of the Medicare conditions of participation, the CMS has investigated several hospitals and concluded that their screening or transfer policies fell short of the EMTALA standard. Because a hospital that is out of compliance with the Medicare conditions of participation faces the termination from the program, there are powerful incentives to avert such draconian measures. However, under the circumstances, the hospital’s short-term response to the government can be equally draconian and produce long-term problems within the hospital. For example, hospitals that represent to the government that they will pour more resources into providing responses often do so well before they have verified that they have the capability to do so and may have to unilaterally increase the burdens on ED staff and on specialists. This can create friction between hospital administration and medical staffs, many of whom are not currently reimbursed for their call coverage.

Even as the scope of EMTALA enforcement widens, it may be more difficult for the OIG to impose sanctions, especially on individual physicians. In a recent decision, the US Court of Appeals for the Sixth Circuit reversed an agency decision to impose a civil monetary penalty of $100,000 on a general surgeon who elected to transfer 2 patients who had suffered head trauma and abdominal bleeding because his hospital lacked the equipment to safely monitor the administration of anesthesia under such circumstances. The court found that the scope of the stabilization requirement demanded under EMTALA only requires that the hospital stabilize the patient within the capacity of the staff and equipment available and that a review of the attending physician’s decision to either treat or transfer an unstable patient must be based on the circumstances and available diagnostic information at the moment that the physician makes that decision. Under this standard, the court rejected the agency’s view that Dr. Cherukuri was obligated to perform the abdominal surgery before attempting a transfer. The court refused to go beyond the scope of EMTALA’s legislative history, which observed that “all participating hospitals must … provide further examination and treatment within their competence to stabilize the medical condition or provide treatment for the labor.” Yet, this is the same language that can be cited by proponents of an expanded EMTALA obligation.

The increased attention to EMTALA by both the OIG and the CMS must also be viewed from the perspective of whether or not the law is meeting its public policy objectives. Through publicizing its efforts in its annual work plan and through reports of individual settlements, the OIG and the CMS have increased the overall awareness of the law and the risks that hospitals and physicians face. At the same time, the public’s awareness of EMTALA may be a contributing factor in the overall increase in the number of annual visits to EDs. As a result, as providers grapple with their new burdens, they confront additional challenges that are a logical consequence of those new responsibilities. For example, although EMTALA obligates hospitals to have a roster of on-call physicians who can complete medical screening examinations and provide stabilizing treatment for those services that the hospital offers to its community, some hospitals are not able to fill their on-call rosters. The OIG has recently noted that shortages are most common in such specialties as neurosurgery, cardiovascular surgery, pediatrics, and orthopedics. This problem is more severe in areas with high managed care penetration rates. The most commonly cited disincentive for the lack of participation is the risk of not being paid for work performed. In some cases, the pressure to enhance a hospital’s on-call coverage may have the unintended effect of creating an impetus for physicians to either demand some form of compensation for providing on-call coverage and services or drop their active staff privileges, regardless of compensation. In extreme cases, some on-call physicians have knowingly risked penalties under the law by not responding to calls from EDs when there is little or no chance of being compensated for their work. The net effect of increasing burdens, the lack of compensation, and the growth of alternate practice settings such as ambulatory surgical centers may create a spiraling situation in which physicians become less dependent on hospital-based work as a source of revenue, which further diminishes...
the incentives for physicians to provide the services required under EMTALA.\(^4\) As this process continues, overall access to emergency medical services can decline, thus undercutting the public policy objectives of EMTALA. As a result, the efforts to improve the law only sabotage it in the long run.

The meandering path of EMTALA enforcement and the unintended consequences of enforcement policies may not be fully remedied in the near future, although Congress has recognized the problem. At the end of 2000, Congress directed the General Accounting Office (GAO) to prepare a report on the impact of EMTALA on hospitals, emergency physicians, and physicians providing on-call coverage. In particular, the report is to examine such factors as the extent of the services provided in meeting the law’s requirements, the total cost of EMTALA-related care to hospitals and physicians, the extent to which the law now exceeds its original intent, and the possible funding sources to cover the uncompensated costs incurred as a result of EMTALA.\(^27\) Although the GAO produced a report in 2001 that described the current problems with implementing EMTALA, it deferred to the future any analysis of whether or not the law has created an unfunded mandate and how any remedies might be structured. Although the nature and extent of any remedial action cannot be predicted, the past history and accumulated data suggest that hospitals, physicians, and policymakers must be more sensitive to EMTALA concerns and must work cooperatively to prevent the burdens imposed by the law from undermining its core policy goals.

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