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

Tiana Mayere Lee*

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—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. In addition, courts often relied upon public policy and custom to ensure that health care providers met this duty. 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. 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.

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. However, the

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).
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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7. Treiger, supra note 5, at 1198.
8. Id. at 1199.
9. Id. at 1199-1200.
10. Id. at 1200.

[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.

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 Caesarean [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

13. Id.
14. Id.
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. 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, but many transfers were blatantly attributed to the patient’s "inability to pay."

The Himmelstein study also documented the adverse effects of transfers on clinical outcomes. For example, the researchers found that three patients died of nervous system trauma because of insufficient care at the transferring hospital. 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. 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.

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. Investigators undertook this study after the number of transfers to Cook County Hospital increased nearly six-fold between 1980 and 1983. The authors examined 467 patient transfers that occurred over a six-week period 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. 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. The investigators found that

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

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 34.10 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

35. Id.

36. Id. at 1289.

37. Id.

38. Id. at 1290.

became known as the Emergency Medical Treatment and Labor Act and was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1985.\textsuperscript{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."\textsuperscript{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.\textsuperscript{42} EMTALA provides:

\begin{quote}

[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 . . . exists.\textsuperscript{43}

\end{quote}

Under the statute, hospitals cannot delay an initial medical screening to inquire about a patient’s insurance status.\textsuperscript{44} If the person is diagnosed with an “emergency medical condition”\textsuperscript{45} during the medical screening, the

\begin{quote}


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]. \textit{See also} Dame, \textit{supra} note 40, at 10.

42. Dame, \textit{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—

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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 transfer49 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 woman who is having contractions—
   (i) that there is inadequate time to effect a safe transfer to another hospital before delivery,
   (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,\(^5\) 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.\(^5\) Because of confusion as to these and other issues, the agencies charged with enforcing the EMTALA statute have made several attempts at clarification.\(^5\) The Health Care Financing Administration\(^5\) issued regulations in 1994\(^5\) and interpretive guidelines in 1998.\(^5\) 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.\(^5\) 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.\(^5\)

**B. Regulations and Other Clarification**

The Department of Health and Human Services first issued regulations to implement EMTALA in 1994.\(^5\) The regulations are codified primarily in

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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).
58. Ed Lovem & 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. The section also defines several important terms, including "comes to," "emergency medical condition," "stabilize," and "appropriate transfer."

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. 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:

- The [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.

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. 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).
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

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.
69. See id.
or at low cost if they transfer to another hospital.  

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.  

III. ENFORCEMENT  

A. Generally  

The OIG and the CMS are both charged with EMTALA enforcement. 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.  

The CMS receives complaints at its regional offices, the complaints from each state are then directed to the state agency responsible for investigating EMTALA violations. The state agency gathers pertinent information 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. 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. If a violation is found to involve a medical issue, for example whether a patient was properly stabilized prior to transfer, a peer review

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.  
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. 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.

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. 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. The Survey was conducted via a telephone and mail survey of more than 100 randomly selected hospitals. The findings suggest that most emergency department physicians and staff are familiar with many of EMTALA’s requirements. 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. 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. Simply put, many emergency department administrators believe that their hospital’s internal policies and procedures alone effectively ensure that all patients are appropriately cared for.

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

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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.
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.\textsuperscript{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.\textsuperscript{100} In fiscal year 1997, the OIG fined fourteen hospitals a total of $500,000.\textsuperscript{101} By the end of fiscal year 2000, the OIG fined forty-eight hospitals $1.2 million.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{105}

\textsuperscript{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).
\textsuperscript{101} Patient Dumping Nets Fines, supra note 99, at 1502.
\textsuperscript{102} Id.
\textsuperscript{103} EMTALA IMPLEMENTATION AND ENFORCEMENT, supra note 52, at 17.
\textsuperscript{104} Id. at 24.
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

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

The impetus for the improper motive requirement was the landmark Sixth Circuit case *Cleland v. Bronson Health Care Group, Inc.* In *Cleland*, the plaintiffs’ fifteen-year-old child died after an emergency department physician misdiagnosed the symptoms of vomiting and cramping as the flu. Shortly thereafter, the child suffered cardiac arrest and died. 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. 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. 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.

The Sixth Circuit stated that inadequate screening rests upon what was “appropriate.” 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.” A hospital’s improper motive for screening patients is not appropriate and may give rise to liability under

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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. One reason the decision received negative treatment was because EMTALA does not explicitly mention an improper motive requirement. 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. 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.


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").

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

127. Id.
130. Id. at 469.
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

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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...


137. KING, supra note 136, at 1.


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."\textsuperscript{140} Virginia adopted a prudent layperson standard, which provides that emergency services are:

\begin{quote}
[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 . . . .\textsuperscript{141}
\end{quote}

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.\textsuperscript{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."\textsuperscript{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.\textsuperscript{144}

\begin{footnotes}
\item[140] MD. CODE ANN. HEALTH-GEN. § 19-701(e) (2001).
\item[141] VA. CODE ANN. § 38.2-4300 (Michie 2001).
\item[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).
\item[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").
\end{footnotes}
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. 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. Though there has been some relief from the BBA through the passage of subsequent legislation, 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. In 1999, the average margin for the not-for-profit hospital sector was 4.7%.

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. In 1979, 29 million people were without insurance. By 2002, this number had risen to nearly 43.6 million. Emergency departments are feeling the financial impact of providing uncompensated care; in Los Angeles, ten of eighteen trauma centers have

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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).


149. Id. at 7.

150. Id. at 2.

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

closed, in part, due to the heavy burden of providing such care. 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. 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. Statistics support the notion that, while the number of visits to emergency departments has increased, the number of hospitals with emergency departments has decreased. 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

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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. 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. 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. 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.  

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.
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

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.
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. 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. 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, most often involving stabbings and gunshot wounds.

166. See Olson, supra note 129, at 478.
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.\textsuperscript{169} Trauma units in such hospitals often are responsible for a disproportionate amount of uncompensated care.\textsuperscript{170} At yet another hospital, the trauma unit is responsible for 44% of the hospital’s uncompensated care.\textsuperscript{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.”\textsuperscript{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

\textsuperscript{169} Id.
\textsuperscript{170} Id.
\textsuperscript{171} Id. (referring to the MedStar trauma unit at Washington Hospital Center).
\textsuperscript{172} Id.
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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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,\textsuperscript{176} suggesting that CMS and its subcontractor state agencies may need to examine their respective hiring needs.

\textsuperscript{173} See supra Section IV for a discussion on the increase in EMTALA complaints and violations.

\textsuperscript{174} OIG ENFORCEMENT, supra note 74, at 8.

\textsuperscript{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).

\textsuperscript{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, 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, however, in crafting EMTALA, Congress decided, as a matter of public policy, that access to emergency services was a right of all persons. 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, 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.
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.\textsuperscript{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."\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{185} To


\textsuperscript{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).

\textsuperscript{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.

\textsuperscript{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 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.

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

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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, 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


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. 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. 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. For example, the revised regulations create new terminology, including the term

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191. See supra Section III for discussion of prosecutorial discretion.
193. Id.
"dedicated emergency department" to indicate when an EMTALA obligation will arise for a hospital provider.\textsuperscript{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, \textit{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."\textsuperscript{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.\textsuperscript{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."\textsuperscript{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.\textsuperscript{198}

\begin{itemize}
  \item[194.] Id. at 53,263.
  \item[195.] Id. at 53,262.
  \item[196.] Id. at 53,225 (stating that CMS will address this issue in future policy guidance).
  \item[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").
  \item[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.
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