EMTALA -- the Uninsured and the Homeless

Legal/ Regulatory Framework

National Congress on the Un and Uninsured
December 11, 2007
Overview

- EMTALA Basics
- How EMTALA Helps the Un/Underinsured
- How EMTALA Does Not Help the Un/Underinsured
- The Un/Underinsured Impact on EMTALA
- The Homeless
  - A Tale of Two Cities
  - Homeless Politics
EMTALA Basics

- Enacted 1986 -- reaction to hospitals turning away emergent indigent patients (especially women in labor)
- Regulations adopted 1994 –
  - Major changes in 2000 and 2003
  - Interpretive Guidelines – 1998, 2001 and 2004
- 20+ years --
  - Changing interpretations
  - Lack of clarity for some obligations
Who is Covered by EMTALA

- Individual presents to “dedicated emergency department” for examination or treatment for a medical condition
- Individual presents elsewhere on hospital property for examination or treatment for potential emergency condition
- Individual in a hospital-owned/operated ambulance not under EMS direction
- Individual in a non-hospital owned/operated ambulance on hospital property
EMTALA Obligations – The Basic Food Groups

- Medical screening examination
- Further examination and stabilizing treatment for a patient with an emergency condition
- On-call coverage
- Transfer/discharge of patients
- Acceptance of unstabilized patients requiring a higher level of care
EMTALA – Core Principles

- Access to Required Emergency Services

- Anti-Discrimination --
  - Emergency services must be provided without regard to financial or insurance status
  - Cannot delay emergency services for insurance or financial reasons
  - Medical screening must be the same examination provided to all patients presenting with similar presenting complaints, signs and symptoms
Stabilization

EMTALA: an emergency condition is “stabilized” when

- No material deterioration is likely, within reasonable probability, to result from or occur during the transfer of the patient to another medical facility, or

- A woman having contractions has delivered the baby and placenta
Outside EMTALA

- Outpatients (i.e., scheduled patients)
- Urgent care/retail clinics
  - EMTALA may apply if billed under hospital provider number and held out as an “dedicated emergency department”
- Private physician offices and other non-hospital providers
- Inpatients – even if have or develop an emergency medical condition
How EMTALA Benefits the Un/Underinsured
Access to Emergency Services

- EMTALA guarantees the un/underinsured access to the E.D. and Labor & Delivery –
  - To determine the presence of an emergency condition (including labor); and
  - Stabilizing treatment if an emergency condition
Access to Emergency Services

- EMTALA guarantees the un/underinsured the right to receive a medical screening and stabilizing treatment (if required) without delay due to financial or insurance status.
- Cannot discriminate in where or how required emergency services are provided.
1011 Funding

- Section 1011 of the MMS provided $250 million each for FYs 2005-2008 for emergency health services provided to undocumented persons
- Hospitals, physicians and ambulance providers are eligible participants (15,766 enrolled as of May 07)
- Expenditures to date (allocated by state):
  - FY 2005: $58 million
  - FY 2006: $192 million

How EMTALA Does Not Benefit the Un/Underinsured
Limits of the EMTALA Obligations

- EMTALA obligations end if the patient’s condition is determined to be non-emergent --
  - Hospital can refuse further care, including medication or other services
  - No obligation to provide primary, urgent or other routine care
Limits of the EMTALA Obligations

- EMTALA obligations are limited to the hospital --
  - EMTALA obligations usually do not apply to off-campus hospital departments (although must appraise conditions and assist in transport to an emergency department)
  - EMTALA obligations do not apply to rural health clinics, retail clinics and most urgent care clinics and physician offices
Limits of the EMTALA Obligations

- Lack of a safety net for the un/under-insured for post-discharge services –
  - Hospitals are required to provide discharge instructions, but are not required to arrange for post-discharge services
  - Many patients cannot access follow-up care from community providers
  - Result is often repeat E.D. visits for follow-up care
EMTALA – the Unfunded Mandate

- EMTALA mandates emergency services, but does not mandate payment
  - CMS: close to half of emergency services are uncompensated
  - AMA (2003): $4.2 billion physician shortfall
  - ACEP: E.D. physicians have the most unreimbursed care -- $138,000 per year
  - ACEP: specialists – $25,000 per year

Source: ACEP “Costs of Emergency Care” www.acep.org
EMTALA - the Unfunded Mandate

California --

- 65 EDs closed in California in past 10 years (20% of EDs have closed in Los Angeles in same period)
- Increased ED saturation and ambulance diversions (CDC – 40-50% of EDs nationally experienced overcrowding in 2003-4)
- Boarding of inpatients in the ED – (NAS: 73% of hospitals board 2-3 inpatients a day)

Sources: California Medical Association: The ER Crisis: Impact of the Uninsured on Emergency Care (2004)
State of California, “Fixing our Broken Health Care System”
http://www.fixourhealthcare.ca.gov/index.php/facts/more/6771/
EMTALA – the Unfunded Mandate

California (cont.) --

- 40% of ED patients are Medicaid or uninsured
- 80% of Medicaid and uninsured ED visits could be treated in non-emergent location
- Uninsured are 5 times more likely to use the ED for primary care (Kaiser Family Foundation, 2006)

Sources: California Medical Association: The ER Crisis: Impact of the Uninsured on Emergency Care (2004)
State of California, “Fixing our Broken Health Care System”
http://www.fixourhealthcare.ca.gov/index.php/facts/more/6771/
Unintended Consequences - EMTALA Transfers
Unintended Consequences

- EMTALA requires on-call specialty coverage, but does not require physicians to serve on call panels

- Influx of un and underinsured has led many physicians to decline coverage obligations

- One result is increasing number of transfers to access routine inpatient services

- Is the lack of on-call coverage driving the current crisis in patient transfers?
Unintended Consequences
On-Call -- Physicians

- Physicians believe that they are not required to take call…
  - without being paid for it…
  - and may refuse to accept call obligations even if offered coverage stipends

- Many medical staffs are not helpful in encouraging or enforcing call coverage
Unintended Consequences

Hospitals

- Many hospitals have huge gaps in call coverage
  - Cannot force physicians to accept call
  - Cannot afford to pay physicians what they want (or are receiving from other hospitals) for call coverage
- Wide variation between hospitals in the same community as to call coverage
- Race to the bottom in some communities to see who has less call
Unintended Consequences
ED Physicians

- Some emergency physicians feel like they practice with one hand behind the back because they lack sufficient on-call coverage to provide specialty care
  - Have to call staff members to accept cases on voluntary basis, or
  - Transfer patients
- Many transfer cases are not specialty/tertiary care, but are being transferred due to the lack of on-call coverage
Unintended Consequences
Receiving Hospitals

- Receiving hospitals are seeing transfers of routine cases from hundreds of miles:
  - Believe that most cases could be handled by the sending hospital by staff physicians
  - Believe that most cases could be transferred to hospitals closer to the sending hospital
  - Believe that transfers are often Medicaid and indigent (defying the law of averages)

- Some tertiary/quaternary hospitals are seeing a crimping of their mission or threat to financial stability
Unintended Consequences
Receiving Physicians

- On-call physicians at receiving hospitals are tired of accepting emergency patients from other hospitals that have qualified specialists who refuse call obligations.
The Homeless Discharge Crisis
A Tale of Two Cities
A Tale of Two Cities
Los Angeles
Los Angeles

- Hospitals treat 18,000 homeless patients per year
- On average, homeless patients spend 4 days longer in a hospital than medical necessary
- Los Angeles County – USC Medical Center averages up to 50 homeless patients who are ready for discharge

Source: Hospital Association of Southern California
Los Angeles

- Los Angeles County has only 45 recuperative care beds (45 more under development)
- County spending for the homeless is substantially below other communities
- Severe lack of shelter beds permanent supportive housing

Source: Hospital Association of Southern California
December 22, 2005 --

Office of the Los Angeles City Attorney sends letters regarding the treatment and discharge of homeless patients to selected hospitals asking for voluntary responses to a series of questions and information requests.
Los Angeles – Legal Action

“This Office has been investigating allegations regarding the treatment of homeless patients by area hospitals and their post-treatment discharge of homeless patients to Skid Row near downtown Los Angeles. We are contemplating possible action against medical service providers that fail to provide the level of post-discharge care and oversight that is standard among medical providers in the Los Angeles area. As part of this investigation, we are attempting to determine the extent to which the Emergency Medical Transfer and Active Labor Act (“EMTALA”) and with the patient discharge requirements of ... 42 CFR 482.43 ... in cases involving homeless patients.”
Los Angeles - Legal Action

- Primary focus of the investigation: patient consent
  - Are hospitals obtaining consent from homeless patients (some with limited capacity to consent) who are provided transportation to Skid Row?
- What are the clinical conditions and medical needs of patients, especially those who arrive at rescue missions and shelters without advance notice or prior relationships with downtown facilities?
- Why are patients transported at a considerable distance (20+ miles) to downtown Los Angeles?
Los Angeles - Legal Action

November 2006:

- City Attorney files criminal and civil charges against a Kaiser Hospital in the dumping of a homeless patient
- Allegations that Kaiser discharged a homeless woman who was found “wandering in a daze and wearing little more than a hospital gown, sweatshirt and socks, after being dropped off by a taxi…” in Skid Row
- Allegations that no prior relationship of patient and any skid row shelters or providers
Los Angeles - Legal Action

Complaint against Kaiser --

- Criminal counts of false imprisonment and dependent adult endangerment
- Civil complaints of unlawful and unfair business practices and failure to follow state law on discharge planning
Kaiser Settlement (May 2007)

- Applicable to all L.A. County Kaiser Hospitals
- Detailed protocols for discharge of homeless patients
  - Former District Judge to monitor compliance
- $5,000 civil penalties and $50,000 for investigative costs
- $500,000 to charitable foundation to development database on shelter availability, free legal clinic and additional recuperative beds
- Three-year agreement
Kaiser Settlement Discharge Protocols

- Identification of homeless patients
  - Must be entered in a homeless patient log
- Documentation of patient belongings
  - Must provide clothing if inadequate
  - Patients must be discharged with appropriate clothing
- Must assess and document the mental status of all homeless patients during the course of stay; treat and refer as appropriate
Kaiser Settlement
Discharge Protocols

Discharge plans must include assessment of cognitive intactment, including patient’s ability to understand the discharge plan

- Cognitive assessment includes living conditions, support systems, complexity of discharge plan, orientation to person/time/place, ability for self-care and access to medical care, food and shelter

- If any discharge team, member questions the patient’s cognitive intactment, discharge is delayed until concern addressed and resolved
Kaiser Settlement Discharge Protocols

- Treating physician – determine clinical stability and post-hospital needs
- Social worker – needs assessments for inpatients
- Emergency patients – must request a social services consult “when indicated for social services needs” --
  - need for food, shelter
  - treatment for substance abuse or domestic violence
  - Vocational assistance
  - Medi-Cal enrollment or DMH mental health services or other application for financial assistance
Kaiser Settlement
Discharge Protocols

- Discharge plans will meet patient’s medical and social needs
  - Transfers as medical and legally appropriate
  - Assistive and/or outpatient care -- assist with referral options
  - Social service needs – referrals to service providers and governmental agencies
  - Medical equipment or drugs – review eligibility for KFH Medical Financial Assistance Program and assist patient in obtaining equipment or drugs
Kaiser Settlement Discharge Protocols

Referral to shelters – social worker must

- Assist all homeless patients who request post-discharge shelter referral
- Review patient’s wishes and current and preferred geographical residence, and locate available options
- Assure patient meets shelter’s criteria for acceptance
- Document patient’s consent and shelter acceptance
Kaiser Settlement
Discharge Protocols

Referral to Skid Row Shelters

- Skid Row will be a destination of last resort
- Patient must reside in or request Skid Row shelter
- Assessment of cognitive intactness
- Must confirm shelter acceptance
- Provide patient with information on resources
- Transport by van
- Hospital administrator/designee approve the discharge plan if transported to Skid Row
Kaiser Settlement
Discharge Protocols

Training --

- Initial and periodic training for physicians, clinical staff, social services, discharge planning personnel and other staff
- Training in eleven areas – including the Protocol; homelessness in LA County; problems faced by the homeless; assessment of cognitive intactness; post-discharge issues; communication; location of shelters and services; referral sources; hazards of Skid Row; use of surrogate decision-makers
Kaiser Settlement Discharge Protocols

Training Program –

- Must be developed and approved within 90 days
- Must be completed within 90 days of approval
- Must be completed for all new applicable hires within 90 days of employment
Kaiser Settlement Monitoring

- Hon. Lourdes Baird appointed by the Court to oversee implementation
  - Approve the training program
  - Review certification of compliance (submitted every 90 days)
  - Recommend contempt actions for violation of the settlement
A Tale of Two Cities
Sacramento
Sacramento

Interim Care Program (ICP) created in 2005 and funded by –

- Local nonprofit hospital systems
- County of Sacramento
- Salvation Army
- MAAP, Inc. (community health center clinic)

Source: www.tsatoday.org
Sacramento

ICP Components:

- 24-hour respite care shelter
- Required daily services (meals, housekeeping, laundry and bathrooms)
- Case management services
- Access to primary care services
- Access to social services
Sacramento

ICP Components:

- Mutually agreed criteria for placement
- Coordinated patient flow process
- Program budgeting/cost-sharing
- Oversight board from partner agencies
- Clinical review team for troubleshooting barriers to admission
Sacramento

Outcome Measurement:

- Number of referrals
- Reduction in length of hospital stays
- Reduction in inappropriate use of emergency departments
- Reduction in hospital admissions
- Referrals to community services, health coverage and follow-up care
Homeless Politics
Homeless Politics

Publicity—

- Video camera capture of patients transported to Skid Row
- LAPD are watching skid row for hospital vans/ambulances
- Local and national coverage
  - 60 Minutes (May 20, 2007)
  - “Sicko”
Homeless Politics

- Extensive media coverage – legislative interest
- Visual imagery – especially patients in gowns with medical equipment
- Repeated incidents
- Not easily resolved due to lack of resources in most communities
- Hard to engage politicians to oppose legislation
Homeless Politics

2006 California Legislation:

- Cannot transport discharged homeless patients across county lines without consent of a receiving shelter/mission.

- Regional hospital associations are required to hold meetings with stakeholders to develop recommendations for post-hospital transition of homeless patients; all hospitals must participate; recommendations are due January 1, 2008.
2007 Legislation - SB 275

Hospital may not cause the transport of a patient to a location other than his/her residence or another health facility without the patient’s knowing and voluntary consent. Violations by a hospital are subject to fines—

- **1st Violation:** Administrative penalty by Licensing
- **2nd Violation:** Civil penalty of $150,000
- **3rd Violation:** Civil penalty of not less than $300,000
Legislation - SB 275

VETO
Homeless Politics

Regional Association Findings:

- Common problems for all community hospitals
- Most communities lack centralized coordination for post-hospital services
  - Difficult to manage follow-up care
- Lack of public commitment and funding
- Acute lack of substance abuse and behavioral health services

Source: Hospital Council of Northern and Central California
Homeless Politics

Regional Association Findings:

- County 211 systems or other resources are used inconsistently, not available or both.
- All stakeholders agree that lack of respite care beds is the most serious deficiency in the post-discharge network for homeless services.

Source: Hospital Council of Northern and Central California
Homeless Politics

Regional Association Findings:

- Need better knowledge and use of resources that are already available
- Identify multi-community resources
- Identify and replicate best practices from other communities
  - Some counties have frequent user programs
  - Development of respite care centers
What Comes Next?

Be Prepared
Questions and Answers
EMTALA -- the Uninsured and the Homeless

Legal/Regulatory Framework

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