Legal/Regulatory Overview
EMTALA Anti-Dumping

The National Congress on the Un and Under Insured
September 23, 2008
Washington, D.C.

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Chief Medical Officer
AARP Services, Inc.
An equal-opportunity, non-discriminatory employer. However, we reserve the right to refuse to treat uninsured patients.
History of EMTALA

- In the early 1980’s, reports of widespread “patient dumping” began to appear in the press and the medical literature.
- Schiff et al. (1) estimated that 250,000 inappropriate transfers of medically unstable patients occurred in 1986, resulting in increased patient morbidity and mortality.
- The story of Eugene “Red” Barnes

Slide courtesy of Cesar Aristeiguieta, M.D., F.A.C.E.P., California Emergency Medical Services Authority
History of EMTALA

- In response to this patient dumping, Congress enacted EMTALA as part of the Consolidated Omnibus Budget Reconciliation Act in 1985 (COBRA).
- EMTALA was created within the Medicare section of this large federal budget legislation.
- EMTALA outlines the legal responsibilities of all hospitals that receive Medicare reimbursement to adequately evaluate, stabilize, and appropriately transfer patients regardless of ability to pay.

Slide courtesy of Cesar Aristeiguieta, M.D., F.A.C.E.P. California Emergency Medical Services Authority
The Basics
Consolidated Omnibus Budget Reconciliation Act

1985
Major Provisions of EMTALA

1. Medical Screening Examination

2. Stabilization

3. Transfer Requirements
**Medical Screening Examination**

If:

1. Individual
2. Comes to ED
3. Request made for examination or treatment of medical condition

Then:

1. MSE is required to determine whether or not EMC exists
2. If no EMC, hospital duty under EMTALA ends
**Definition: Emergency Medical Condition**

Medical condition with acute symptoms of sufficient severity (including severe pain), that without immediate medical attention could result in:

1. Placing patient’s health in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part
Stabilization

• If EMC exists, hospital is required to stabilize:

“no material deterioration of the EMC is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or... woman has delivered (including the placenta)”

*Note: Transfer includes discharge from hospital
Stabilization

- If EMC is stabilized, hospital duty under EMTALA ends.
- If hospital is unable to stabilize within available staff and facilities, may transfer according to specified requirements.
Transfer Requirements

1. Physician has signed certification
   – that benefits outweigh risks
   – (or patient request)

2. Transfer is “appropriate”
**Definition: Appropriate Transfer**

1. Transferring facility has provided stabilizing Rx or minimized risk

2. Receiving facility has space, personnel & agreed to accept patient

3. Transferring facility has provided appropriate medical records

4. Transfer is effected through qualified personnel and equipment
Omnibus Budget Reconciliation Act

1989
Key OBRA 1989 Changes

• Medical Screening Examination:
  – May not be delayed in order to inquire about payment method or insurance status

• On Call:
  – Extended liabilities and penalties to on-call physicians, including name and address of on call physician who referred or failed to appear within a reasonable time. The hospital is required to maintain on-call list.

• Non-discrimination:
  – Hospitals with specialized capabilities cannot refuse to accept transfer if hospital has capacity

• “Whistleblower” protection
Action Under EMTALA Framed By

- Statute
- Regulation
- Interpretive guidelines
- CMS/OIG advisories
- Case law
- (State law)
Enforcement

Regulatory:
- DPH
- CMS
- OIG
- QIO
- OCR

Legal System:
- Federal Court
Complaints trigger an investigation.
No complaints = no investigation.
Enforcement Process Penalties

1. Fines up to $50,000
2. Exclusion from Medicare
Enforcement Process

Penalties

1. Private right to civil suit

2. Receiving hospital’s right to sue to recover costs
So Where are We Today?
# CMS EMTALA Enforcement Data

<table>
<thead>
<tr>
<th>NATIONAL DATA</th>
<th>FY04</th>
<th>FY05</th>
<th>FY06</th>
<th>FY07</th>
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<tr>
<td># Complaints</td>
<td>685</td>
<td>753</td>
<td>780</td>
<td>696</td>
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<td># Surveys of alleged violations</td>
<td>637</td>
<td>661</td>
<td>673</td>
<td>625</td>
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<tr>
<td># Surveys with confirmed violations</td>
<td>197</td>
<td>259</td>
<td>290</td>
<td>216</td>
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<tr>
<td>% Confirmed Alleged Violations</td>
<td>31%</td>
<td>39%</td>
<td>43%</td>
<td>35%</td>
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<tr>
<td># Terminations</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
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## Distribution of FY 06 EMTALA Allegations & Violations

<table>
<thead>
<tr>
<th></th>
<th>Allegations (N=1349)</th>
<th>Violations (N=473)</th>
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<tbody>
<tr>
<td>Overall</td>
<td>11.0%</td>
<td>14.8%</td>
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<tr>
<td>On-call</td>
<td>6.2%</td>
<td>6.3%</td>
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<tr>
<td>Screening</td>
<td>26.2%</td>
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<tr>
<td>Delay</td>
<td>5.5%</td>
<td>3.0%</td>
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<tr>
<td>Stabilization</td>
<td>20.0%</td>
<td>13.3%</td>
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<tr>
<td>Transfer/dis.</td>
<td>17.9%</td>
<td>16.1%</td>
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<tr>
<td>Recipient Hospital</td>
<td>8.2%</td>
<td>8.7%</td>
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<td>Signage</td>
<td>0.9%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Log</td>
<td>2.3%</td>
<td>3.6%</td>
</tr>
</tbody>
</table>
CMS Enforcement Data

- Since inception of EMTALA 19 hospitals have been terminated from Medicare.
OIG Enforcement

- From 1995 through 2000, the OIG imposed fines totaling over $5.6 million on 194 hospitals and 19 physicians. The majority of hospitals fines were $25,000 or less.
- By 2001, the total number of physicians fined by the OIG for EMTALA violations was 28.
- In the years 2002-2006, OIG pursued 110 cases, recovering over $3.1 million.
Number and Percent Uninsured 1985 - 2007

Number of Community Hospitals
1985 vs. 2006

Sources: Health Forum, AHA Annual Survey of Hospitals 1990-2006 total emergency visits includes estimated data
Number of Hospital Admissions by Route of Admission

![Bar chart showing number of hospital admissions by route of admission and year: United States, 1996 and 2006.](chart)

**Figure 4.** Number of hospital admissions by route of admission and year: United States, 1996 and 2006

**NOTE:** Numbers in parentheses are the percentage of hospital admissions via the emergency department (ED).

**SOURCES:** Admissions from the ED are from NHAMCS. Total admissions include nonobstetric hospitalizations obtained from the National Hospital Discharge Survey (29,30). Newborns are also excluded from the denominator. Other admissions represent the difference between total admissions and those coming from the ED.
Number of Beds in 1985 vs. 2006

Sources: Health Forum, AHA Annual Survey of Hospitals 1990-2006 total emergency visits includes estimated data
September 10, 2001

Crisis in the ER

Turnaways and huge delays are a surefire recipe for disaster. What you can do
Most EDs are “at” or “over” capacity…

Percent of Hospitals Reporting ED Capacity Issues by Type of Hospital 2006

- Urban Hospitals: 29% ED at capacity, 39% ED over capacity
- Rural Hospitals: 21% ED at capacity, 10% ED over capacity
- Teaching Hospitals: 28% ED at capacity, 31% ED over capacity
- Non-teaching Hospitals: 25% ED at capacity, 20% ED over capacity
- All Hospitals: 25% ED at capacity, 25% ED over capacity

Source: AHA 2006 Survey of Hospital Leaders
Key Problems

- **Overcrowding**: 40 percent of hospitals report ED overcrowding on a daily basis
- **Boarding**: patients waiting 48 hours or more for an inpatient bed
- **Ambulance Diversion**: Half a million ambulance diversions in 2003
- **Uncompensated Care**: results in financial losses and closures for EDs and trauma centers
Time Spent in the Emergency Department

![Bar chart showing the average ED length of stay from 2003 to 2007](chart.png)

- **2003**: Average ED Length of Stay
- **2006**: Average ED Length of Stay
- **2007**: Average ED Length of Stay

*Press Ganey Associates, Emergency Department Pulse Report 2008*
“This is a symptom of an entire health care system under extreme stress”

– Dr. Howard Koh, Former Massachusetts Commissioner of Public Health
EMTALA Case

• Headline: Los Angeles woman dies on emergency room floor

June 14, 2007

LOS ANGELES — In the 40 minutes before a woman's death last month at Martin Luther King Jr.-Harbor Hospital, two separate callers pleaded with 911 dispatchers to send help because the hospital staff was ignoring her as she writhed on the floor, according to audio recordings of the calls.

"My wife is dying and the nurses don't want to help her out," Jose Prado, the woman's boyfriend, told the 911 dispatcher through an interpreter.

He was calling from a pay phone outside the hospital, his tone increasingly desperate as he described how his 43-year-old girlfriend was spitting up blood.

Slide courtesy of Cesar Aristeiguieta, M.D., F.A.C.E.P., California Emergency Medical Services Authority
Press Coverage

- **Headline:**
  “Kaiser Permanente is accused of leaving a homeless woman to wander on skid row.”

  November 16, 2006

  The Los Angeles city attorney's office filed false-imprisonment and dependent-care-endangerment charges against hospital giant Kaiser Permanente on Wednesday, the first criminal prosecution of a medical center accused of "dumping" patients on skid row.

Slide courtesy of Cesar Aristeiguieta, M.D., F.A.C.E.P., California Emergency Medical Services Authority
US Healthcare in Trouble

- Hospital, ED and trauma center closures
- Increased patient volumes and waiting times
- Increased ambulance diversion practices
- An exodus of physician specialists from hospital emergency call panels, and even the profession as a whole
August 6, 2008, 10:52 am

**Emergency Room Visits Hit Record High**

Posted by Jacob Goldstein

There were 119 million emergency room visits in 2006, the **feds are reporting this morning**. That’s the most ever, and an increase of 36% in the course of a decade.

During the same period, the number of emergency rooms fell from 4,019 to 3,833.

The authors, from the government’s division of health care statistics, duly note that the increase is driving longer wait times for minor and serious problems as well as boarding of patients in hallways.

The results are from an ongoing federal survey, give lots of data about who’s most likely to go to the emergency room (infants, the elderly) and what the most common issues are (injury is a hit...

But they don’t say much about what’s causing the rise in ER visits. It’s not the rate of ER visits per 100 people rose from 34.2 to 40.5 between 2003 and 2006.

While conventional wisdom suggests that the uninsured, what’s going on. The uninsured (come down) accounted for between 17.6 and 23.2%.

A recent study in the Annals of Internal Medicine found that many ER visits came from well-off people who would’ve preferred to go to the doctor’s office.

**Specialists shun emergency rooms**

Los Angeles Times  California | Local

**Campaigns to the ER**

USA Today

California | Local

**Financial Crisis at Atlanta’s Grady Hospital**

by Helena Cavendish de Moura

Immigrants Facing Deportation by U.S. Hospitals

Arlington hospitals fined after patients were turned away
The slowing economy hurt both companies, said analyst Robert R. Hawkins of Stifel Nicolaus & Co. in Baltimore. Increasing unemployment causes the number of uninsured patients to grow. Hospitals are skilled at steering those patients elsewhere, although that means the number of patients being treated declines, he said. Also, many insurers have raised the amount of money patients must pay out of pocket, discouraging people from seeking treatment, he said. …..
MMA Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens

- HHS must pay for otherwise unreimbursed costs on EMTALA services to:
  - Hospitals
  - Physicians
  - Ambulance providers
  - Indian Health and Tribal organizations

- Authorized $250 million each for FYs 2005-2008
  - 2/3 ($167m) to all 50 states plus DC
  - 1/3 ($83m) to 6 states with highest number of undocumented alien apprehensions (AZ, CA, FL, NM, NY, TX)

- Expenditures to date (allocated by state):
  - FY 2005: $58 million
  - FY 2006: $192 million
  - FY 2007: $214 million
Notable Changes from 2008 Final IPPS Rule

• Community Call permissible

• Specialized rec’g hospitals no longer required to accept requests for in-patient transfers
Summary: EP Perspective & EMTALA

OVERALL – GOOD LAW

- Access to care preserved
- Level playing field

BUT: Uninsured Still at Risk
But we don't have a doctor!

That's alright... I don't have insurance either!
Evolution of EMTALA

- 1985 - EMTALA enacted (42 U.S.C. §1395 dd)
- 1989 - Statutory “enhancements”
- 1990 - More statutory “enhancements”
- 1994 - Interim final Regulations
- 1998 - Interpretive Guidelines
- 1999 - Special Advisory Bulletin
- 2000 - OPPS Regulations
- 2001 - OPPS Q&A
- 2002 - CMS Guidance Letters, Proposed Regulations
- 2003 - Final Regulations
- 2003 - Medicare Modernization Act
- 2004 - Revised Interpretive Guidelines
- 2005 – EMTALA TAG
- 2009 – IPPS regulations
Okay, okay, okay . . . everyone just calm down and we'll try this thing one more time."
QUESTIONS?