AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
SCIENTIFIC ASSEMBLY
1999

COBRA/EMTALA Roundtable: Directly from the Experts

Thirteen years after enactment, federal COBRA/EMTALA legislation continues to strike fear into the hearts of practicing clinicians. This panel includes representatives from the federal government, as well as a physician who has experienced the bite of COBRA. Participants will have the chance to raise questions.

- Discuss the COBRA/managed care conflict in light of current legal interpretation.
- Discuss the ramifications of "non-compliance."

MO-26
Monday, October 11, 1999
12:30 PM - 2:25 PM
Room # N250
Las Vegas Convention Center

FACULTY

Robert A Bitterman, MD, JD, FACEP (Moderator)

Clinical Assistant Professor, Emergency Medicine, University of North Carolina Medical School, Chapel Hill; Director, Risk Management and Managed Care, Department of Emergency Medicine, Carolinas Medical Center, Charlotte, North Carolina; Editorial Board Member, *Annals of Emergency Medicine;* Chair ACEP EMTALA Task Force

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Director, Emergency Services, Anaheim Memorial Medical Center, Anaheim, California; Clinical Attending Faculty, Department of Emergency Medicine, University of California, Irvine Medical Center, Irvine, California; Chair, ACEP Emergency Medicine Practice Committee

Sandra Sands

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Assistant Professor, Department of Emergency Medicine, Tufts University Medical School, Boston, Massachusetts; Carrier Medical Director, Medicare, Part B, National Heritage Insurance Company, New England

ACEP Scientific Assembly
October 11, 1999

COBRA/EMTALA Roundtable: Directly From the Experts

Panel:
Gloria Frank, JD, Coordinator, EMTALA Enforcement, HCFA
Sandra Sands, JD, Senior Counsel, Office of Inspector General
Stephen Groth, MD, Chair, ACEP Emergency Medicine Practice Committee
Charlotte Yeh, MD, Chair, ACEP Federal Government Affairs Committee

Moderator:
Robert Bitterman, MD, JD, Chair, ACEP EMTALA Task Force

Objectives:

1. Update emergency physicians on the interpretations and enforcement activities of EMTALA by the governmental regulating bodies.
2. Allow our membership to question leaders of the government's policy and enforcement divisions on issues pertinent to emergency physicians and the practice of emergency medicine.
3. Address the uncharted areas of the ever-expanding reach of the law.

Plan:

Members of the panel will present a ten-minute update on topics relevant to the practice of emergency medicine. In between presentations, and after the last presentation, the audience will be asked to question the panel regarding their specific concerns related to EMTALA. Your participation is strongly encouraged.

EMTALA Roundtable
Specific Topics to be covered:

1. What areas of EMTALA are currently under policy review by HCFA?

    a. Application of EMTALA to off-campus hospital-owned facilities? Does the law apply to Urgent Care centers? If so, what do these centers need to do differently? Must hospitals now provide on-call physicians for Urgent Care facilities?
    b. Does EMTALA apply to in-patients? If so, for how long? Only if are admitted via the ED or even if a direct-admit?
    c. Does EMTALA apply to persons presenting to the ED for tests or treatments ordered by their private physician?

2. What's new regarding the screening, stabilization, and transfer of psychiatric patients?

3. What has been the effect of HCFA's new interpretive guidelines?

4. How has the law impacted the care of managed care patients? (See the enclosed HCFA/OIG Advisory Bulletin on Managed Care under EMTALA.)

5. Any ramifications from the OIG survey on compliance with EMTALA?

6. What have been the enforcement actions taken by the OIG, and where is the OIG headed?

    a. What actions have been taken against on-call physicians or emergency physicians?
    b. What parameters does the OIG consider when deciding whether to impose civil monetary penalties against physicians?
    c. How does the OIG intend to enforce the law, under a 'disparate process' standard or an ordinary malpractice standard? How does the OIG's interpretation compare to the interpretation of the federal courts?

7. Issues raised by members of the audience.

OIG/HCFA Special Advisory Bulletin on the Patient Anti-Dumping Statute Related to Managed Care Plans.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Inspector General and Health Care Financing Administration
December 3, 1998

Solicitation of Comments on the OIG/HCFA Special Advisory Bulletin on the Patient Anti-Dumping Statute

AGENCY: Office of Inspector General (OIG) and Health Care Financing Administration (HCFA), HHS.

ACTION: Notice of Proposed Special Advisory Bulletin.

SUMMARY: This Federal Register notice seeks the input and comments of interested parties on a Special Advisory Bulletin being developed by the OIG and HCFA designed to address requirements of the patient anti-dumping statute and the obligations of hospitals to screen all patients seeking emergency services and provide stabilizing medical treatment to enrollees of managed care plans if their condition warrants it. In developing this proposed issuance and soliciting public comment, it is our goal to provide clear and meaningful advice with regard to the application of the anti-dumping provisions, and ensure greater public awareness of the hospitals' obligations in providing emergency medical services to those individuals insured by managed care plans.

DATES: To assure consideration, comments must be delivered to the address provided below by no later than 5 p.m. on [30 days after publication in the Federal Register.]

ADDRESSES: Please mail or deliver your written comments and recommendations to the following address:

> Office of Inspector General
> Department of Health and Human Services
> Attention: OIG-33-SFA; Room 5246, Cohen Building
> 330 Independence Avenue, S.W.
> Washington, D.C. 20201

We do not accept comments by facsimile (FAX) transmission. In commenting, please refer to file code OIG-33-SFA. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 5541 of the Office of Inspector General at 330 Independence Avenue, S.W., Washington, D.C., on Monday - Friday of each week from 8:00 a.m. to 4:30 p.m.

FOR FURTHER INFORMATION CONTACT:
Joel Schaer, Office of Counsel to the Inspector General, (202) 619-0089

SUPPLEMENTARY INFORMATION:

In an effort to identify and eliminate fraud, waste and abuse in the Department's health care programs, the OIG periodically develops and issues Special Fraud Alerts and, with the cooperation of HCFA, Advisory Bulletins to alert health care providers and program beneficiaries about potential problems. This proposed bulletin is being developed by the OIG and HCFA to address the principal requirements of the patient anti-dumping statute (section 1867 of the Social Security Act) and to discuss how the requirements of that statutory provision apply to individuals insured by managed care plans that require "prior authorization" for emergency services. We have attempted to conform this proposed bulletin with policies set forth in the HCFA State Operations Manual on Provider Certification (Transmittal No. 2, May 1998) which provides guidelines and investigative procedures for reviewing the responsibilities of Medicare participating hospitals.

Section 1867 of the Act imposes specific obligations on Medicare-participating hospitals that offer emergency services with respect to individuals coming to the hospital and seeking treatment of possible emergency medical conditions. Specifically, the draft Special Advisory Bulletin proposes to address: (1) the obligations of these hospitals in providing screening to all patients seeking emergency services and stabilizing emergency treatment to individuals seeking such care; (2) the special concerns in the provision of emergency services to enrollees of managed care plans; (3) the rules governing Medicare and Medicaid managed care plans with respect to prior authorization requirements and payment for emergency services; and (4) what types of practices will serve to promote compliance by hospitals with the patient anti-dumping statute when managed care enrollees seek emergency services. We would appreciate receiving specific comments, recommendations and suggestions on the issues discussed in this proposed bulletin.

Set forth below for comment is the proposed OIG/HCFA Special Advisory Bulletin addressing the patient dumping statute.

OBLIGATIONS OF HOSPITALS TO RENDER EMERGENCY CARE TO ENROLLEES OF MANAGED CARE PLANS

What are the Obligations of Medicare-Participating Hospitals That Offer Emergency Services to Individuals Seeking Such Services?

- The anti-dumping statute (section 1867 of the Social Security Act; 42 U.S.C. 1395dd) sets forth the federally mandated responsibilities of Medicare-participating hospitals to individuals with potential emergency medical conditions.

- Under the anti-dumping statute, a hospital must provide to any person who comes seeking emergency services an appropriate medical screening examination sufficient to determine whether he or she has an emergency medical condition, as defined by statute. When appropriate, ancillary services routinely available at the hospital must be provided as part of the medical screening examination.

- If the person is determined to have an emergency medical condition, the hospital is required to stabilize the medical condition of the individual, within the staff and facilities available at the hospital, prior to discharge or transfer.

- If the patient's medical condition cannot be stabilized before a transfer requested by the patient (or determined to be in the patient's best interest by the responsible medical personnel), the hospital is required to follow very specific statutory requirements designed to facilitate a safe transfer to another facility.

- A hospital may not delay the provision of an appropriate medical screening examination or further medical examination and stabilizing medical treatment in order to inquire about the individual's method of payment or insurance status.

Regulations implementing these statutory obligations are found at 42 CFR part 489. The anti-dumping statute is enforced jointly by the Health Care Financing Administration (HCFA) and the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS).

Sanctions that may be imposed by HHS for violations of the anti-dumping statute include the termination of the hospital's provider agreement, and the imposition of civil money penalties against both the hospital and the physician responsible for examination, treatment, or transfer of an individual. In addition, the anti-dumping statute provides for the exclusion of such physician if the violation is gross and flagrant or repeated.

Why is there a Special Concern about the Provision of Emergency Services to Enrollees of Managed Care Plans?

Many managed care plans require their members to seek prior authorization for some medical services, including emergency services. As noted above, the anti-dumping statute prohibits a hospital's inquiry about a patient's method of payment or insurance status, or use of such information, from delaying a screening examination or stabilizing medical treatment. It has come to our attention that some hospitals routinely seek prior authorization from a patient's primary care physician or from the plan when a managed care patient requests emergency services, since the failure to obtain authorization may result in the plan refusing to pay for the emergency services. In such circumstances, the patient may be personally liable for the costs.

A reasonable argument can be made that patients (other than those arriving in dire condition) should be informed when they request emergency services of their potential financial liability for services. Some would go further and argue that the hospital itself should seek prior approval from the patient's health plan for emergency services to preserve the patient's right to seek coverage for such services. However, our concern is that, such an inquiry may improperly or unduly influence patients to leave the hospital without receiving an appropriate medical screening examination. This result would be inconsistent with the goals of the anti-dumping statute and could leave the hospital exposed to liability under the statute.

Investigations of allegations of the anti-dumping statute violations across the country have persuaded the OIG and HCFA that managed care patients may be at risk of being discharged or transferred without receiving a medical screening examination, largely because of the problems inherent in seeking "prior authorization." Hospitals sometimes are caught between the legal obligations imposed under the anti-dumping statute and the terms of agreements which they have with managed care plans. For example, some Medicaid managed care contractors, as a condition of contracting with hospitals to provide services to their enrollees, have attempted to require such hospitals to obtain prior authorization from the plan before screening or treating an enrollee in order to be eligible for reimbursement for services provided.

The OIG's and HCFA's view of the legal requirements of the anti-dumping statute in this situation is as follows.

Notwithstanding the terms of any managed care agreements between plans and hospitals, the anti-dumping statute continues to govern the obligations of hospitals to screen and provide stabilizing medical treatment to individuals who come to the hospital seeking emergency services regardless of the individual's ability to pay. While managed care plans have a financial interest in controlling the kinds of services for which they will pay, and while they may have a legitimate interest in deterring their enrollees from over-utilizing emergency services, no contract between a hospital and a managed care plan can excuse the hospital from its anti-dumping statute obligations. Once a managed care enrollee comes to a hospital that offers emergency services, the hospital must provide the services required under the anti-dumping statute without regard for the patient's insurance status or any prior authorization requirement of such insurance.(1)

What About Arrangements Between Hospitals and Managed Care Plans for "Dual Staffing" of Emergency Departments?

Some managed care organizations (MCOs) and hospitals have entered into, or are considering entering into, arrangements whereby the hospital permits the MCO to station its own physicians in the hospital's emergency department, separate from the hospital's own emergency physician staff, for the purpose of screening and treating MCO patients who request emergency services. This kind of arrangement is known as "dual staffing." In a dual staffing setting, two separate groups of physicians would be providing emergency care, perhaps using different policies and protocols, performing different procedures, using different referral practices and drug formularies, relying on different on-call physicians, and having different credentials.

It is believed by some that dual staffing in emergency departments can facilitate the expeditious provision of services to MCO patients by physicians and other practitioners in their own health plans, particularly when patients present in emergency departments in stable condition. However, some hospitals and emergency physicians have raised questions about how the requirements of the patient anti-dumping statute may affect dual staffing arrangements, and we have been considering how to respond. As interpreted by this Department, the statute requires that a hospital and its physicians provide medically adequate screening and stabilization, supported by professionally recognized standards of

care, to individuals seeking emergency services. Theoretically, one could construct two equally good emergency service "tracks," each adequately staffed and each with equally good access to all of the medical capabilities of the hospital, such that both MCO and non-MCO patients received equal access to screening and stabilizing medical treatment. This arrangement would seem to satisfy the requirements of the anti-dumping statute.

Absent such equivalency, implementation of dual staffing raises some concerns under the patient anti-dumping statute. For example, what if either the MCO or non-MCO track is understaffed or simply overcrowded, and a patient in a particular track is subjected to a significant delay in screening and stabilizing treatment, even though a physician in the alternative track was available to see the individual? What if the protocols, referral patterns, use of specialists and patient guidelines are substantially different between the MCO and non-MCO tracks such that two different standards of care are provided in performing screenings or stabilizing treatment? How can a hospital be sure that all patients requesting emergency services receive, as required by statute, an appropriate screening examination within the full capabilities of the hospital, and necessary stabilizing treatment within the capability of the staff and facilities of the hospital, if the MCO track operates independently from the hospital's own emergency care system? These are difficult questions, and we have not yet determined how to treat issues related to dual staffing under the patient anti-dumping act. As a result, we are specifically soliciting comments and suggestions from the public on this issue, and we expect to offer some specific guidance in this area in the final version of this Special Advisory Bulletin.

What are the Rules Governing Medicare and Medicaid Managed Care Plans with Respect to Prior Authorization Requirements and Payment for Emergency Services?

There are special requirements for managed care plans that contract with Medicare and Medicaid to provide services to beneficiaries of those programs. Congress has specified that Medicare and Medicaid managed care plans may not require prior authorization for emergency services, and must pay for such services, without regard to whether the hospital providing such services has a contractual relationship with the plan. Under statutory amendments recently enacted in the Balanced Budget Act (BBA) of 1997 (Pub.L. 105-33)(2), Medicare and Medicaid managed care plans are prohibited from requiring prior authorization for emergency services, including those that "are needed to evaluate or stabilize an emergency medical condition." Moreover, Medicare and Medicaid managed care plans are required to pay for emergency services provided to their enrollees. The obligation to pay for emergency services is based on a "prudent layperson" standard, which means that the need for emergency services should be determined from a reasonable patient's perspective at the time of presentation of the symptoms.(3)

What Practices Will Promote Compliance with the Anti-Dumping Statute by Hospitals When Managed Care Enrollees Seek Emergency Services?

The OIG and HCFA are concerned that discussion by hospital personnel with a patient regarding the possible need for prior authorization, or his or her potential financial liability for medical services provided by a hospital that offers emergency services, could

influence patients to leave the emergency department without receiving an appropriate medical screening examination.

Without also informing the patient of his or her rights to a medical screening examination and to stabilizing medical treatment if the patient's condition warrants it, a discussion about insurance, ability to pay and seeking prior authorization may impede a hospital's compliance with its obligation under the anti-dumping statute. Discussions between a hospital staff member and a patient regarding potential prior authorization requirements and their financial consequences that have the effect of delaying a medical screening are violations of the anti-dumping statute. Moreover, the OIG and HCFA believe that in the absence of an initial screening, the decision of a managed care plan regarding the need for treatment is likely to be ill-informed. Patients are entitled to receive a medical screening examination and stabilizing medical treatment under the anti-dumping statute regardless of a hospital's contract with a health plan that requires prior authorization. Accordingly, the OIG and HCFA suggest the following practices to minimize the likelihood that a hospital will violate the statute:

No Prior Authorization Before Screening or Stabilization. It is not appropriate for a hospital to request or a health plan to require prior authorization before the patient has received a medical screening examination to determine the presence or absence of an emergency medical condition or before the patient's emergency medical condition is stabilized.(4)

No Financial Responsibility or Advanced Beneficiary Notification Forms. Prior to performing an appropriate medical screening examination, the hospital should not ask a patient to complete a financial responsibility form or an advanced beneficiary notification form, and should not ask the patient to provide a co-payment for any services rendered. Such a practice could deter the patient from remaining at the hospital to receive care to which he or she is entitled and which the hospital is obligated to provide regardless of ability to pay, and could cause unnecessary delay.

Qualified Medical Personnel Must Perform Medical Screening Examination. A hospital should ensure that either a physician or other qualified medical personnel (i.e., hospital staff approved by the hospital's governing body to perform certain medical functions) provides an appropriate medical screening examination to all individuals seeking emergency services. Depending upon the individual's presenting symptoms, this screening examination may range from a relatively simple examination to a complex one, which requires substantial use of ancillary services available at the hospital and on-call physicians.

When a Patient Inquires About Financial Liability for Emergency Services. If a patient inquires about his or her obligation to pay for emergency services, such an inquiry should be answered by a staff member who has been well trained to provide information regarding potential financial liability. This staff member also should be knowledgeable about the hospital's anti-dumping statute obligations and must clearly inform the patient that, notwithstanding the patient's ability to pay, the hospital stands ready and willing to provide a medical screening examination and stabilizing treatment, if necessary. Hospital staff should encourage any patient who believes that he or she may have an emergency

medical condition to remain for the medical screening examination and to defer further discussion of financial responsibility issues until after the medical screening has been performed. If the patient chooses to withdraw his or her request for examination or treatment, a staff member with appropriate medical training must discuss the medical issues related to a "voluntary withdrawal."

Voluntary Withdrawal. If an individual chooses to withdraw his or her request for examination or treatment at the presenting hospital, a hospital must perform the following: (1) offer the individual further medical examination and treatment within the staff and facilities available at the hospital as may be required to identify and stabilize an emergency medical condition; (2) inform the individual of the risks and benefits of such examination and treatment, and of the risks and benefits of withdrawal prior to receiving such examination and treatment; and (3) take all reasonable steps to secure the individual's written informed consent to refuse such examination and treatment. The medical record should contain a description of the examination, treatment, or both, if applicable, that was refused.

In the event that an individual, e.g., nurse, doctor, other emergency room staff member or patient, believes that a hospital may have violated the anti-dumping statute, that individual should report the alleged violation to the HCFA office in the region in which the hospital is located.

DATED: November 24, 1998

_____/s/_____

June Gibbs Brown
Inspector General

DATED: November 24, 1998

_____/s/_____

Nancy-Ann Min DeParle
Administrator, Health Care Financing Administration

FOOTNOTES:

1. Separate and apart from the anti-dumping statute, in accordance with sections 1857(g), 1876(i)(6), 1903(m)(5) and 1932(e) of the Social Security Act, the OIG (acting on behalf of the Secretary) has the authority to impose intermediate sanctions against Medicare and Medicaid contracting managed care plans that fail to provide medically necessary services, including emergency services, to enrollees where the failure adversely affects (or has a substantial likelihood of adversely affecting) the enrollee. Medicare and Medicaid managed care plans that fail to comply with the above provision are subject to civil money penalties of up to $25,000 for each denial of medically necessary services.

2. See section 4001 of the BBA, which created section 1852(d) of the Act. Section 1852(d) covers emergency services and prior authorization for Medicare enrollees. Also, section 4704 (a) of the BBA created section 1932(b) of the Act, which contains Medicaid provisions covering emergency services and prior authorization.

3. With respect to Medicare, prior authorization requirements were already explicitly prohibited by regulations before the passage of the BBA for emergency services provided outside an HMO or competitive medical plan (42 CFR 417.414(c)(1)), and by implication for services provided within such a plan. Similarly, while the BBA clarified and codified the "prudent layperson" standard, a variation of this standard has always been part of the Medicare policy for managed care plans. However, all of these requirements are new to Medicaid.

4. Of course, this would not preclude an emergency physician from contacting the patient's physician at any time to seek advice regarding the patient's medical history and needs that may be relevant to the medical screening and treatment of the patient. Further, a patient who has not already contacted his or her health plan is free to do so at any time during his or her wait for emergency services.