AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
SCIENTIFIC ASSEMBLY
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Federal COBRA/EMTALA Law: 1999 Update and New HCFA Interpretive Guidelines

Ensuring compliance with COBRA/EMTALA requirements has become even more difficult in the era of managed care. Penalties for failure are severe. This course will provide a review of the latest regulations and how they are being interpreted by the government. Efforts by ACEP to modify the law will also be presented.

- Describe the latest update on COBRA/EMTALA.
- Recognize the COBRA/managed care conflict.
- Discuss compliance issues when treating HMO patients.
- Discuss current ACEP work with HCFA to make the law more workable in the practical world of daily emergency practice.

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FACULTY

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AMERICAN COLLEGE OF EMERGENCY PHYSICIANS **SCIENTIFIC ASSEMBLY**
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EMTALA Update 1999: The Good, The Bad, & The Ugly.

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I. Introduction

"Life is short, the art long, opportunityfleeting, experience treacherous, judgement difficult." Hippocrates

Congresspassed THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA; a.k.a COBRA) in response to the widespread perception that private hospitals were "dumping" indigent or uninsured patients; denying them emergency care or transferring them to public institutions for purely economic reasons, even though the private hospitals were fully capable of providing the appropriate medical care to the patient.

EMTALA represents the first time the Medicare program was used to directly regulate the delivery of healthcare services to non-Medicare patients. It is also the first time Medicare was used to define a standard of care for emergency services and to create new federal rights for individual patients and other hospitals if that standard was violated. It was intended to be an anti-discrimination statute; substantively, it created a federal right to emergency care.

II. Objectives

A. The primary objective of this presentation is to address the impact of EMTALA from the perspective of the practicing emergency physician,

1. Has EMTALA achieved Congress's stated goal?
2. What have been the unintended consequences concerning patient care, managed care, and hospital/physician relationships?
3. How has the governments enforcement proceedings effected the delivery of hospital based emergency medicine?

B. HCFA and OIG regulations and enforcement interpretations as well as HCFA's new interpretive guidelines on EMTALA w-ill be discussed.

C. Increasing hospital & physician civil liability under EMTALA will also be covered.

III. "The Good."

A. Improved Access to General Emergency Care

1. federal right to hospital based emergency medical services

2. preempts conflicting State laws, regulations, protocols

   a. California Proposition 187
   b. hospital licensure law and regulations
   c. state psychiatric treatment and hospitalization programs
   d. EMS protocols

3. "any individual" entitlement

   a. not just indigent
   b. not just Medicare/Medicaid patients
   c. includes illegal aliens
   d. includes managed care enrollees
   e. includes "private patients" of medical staff
   f. includes minors

4. nondiscrimination

   a. federally prescribed standard of care
   b. uniform standard: process vs. outcome

5. scope ofrequired examination and treatment

   a. medical screening exam (MSE)
   b. stabilizing treatment or transfer
   c. ancillary services
   d. access to physician specialists
   e. access to tertiary or referral hospital care

6. consensus in the medical community

   a. societal good; fundamental need vs. fundamental right
   b. actual practice reality vs. on-paper right

B. Controlling Abuses by Managed Care (MCO) Entities

1. managed care fundamentally irreconcilable with EMTALA

   a. exists to reinstate economic incentives/controls
   b. imposes practice patterns outside the normal, standard processes
   c. scientific studies prove harmful effects of MCO practices

2. two sections of EMTALA directly regulate the initial interaction of emergency departments with managed care patients; the "Appropriate Medical Screening Examination" (MSE) requirement, and the "No-Delay on Account of Insurance" provision:

   a. *If **"any individual" "comes to the emergency department,"** and **a request is made on the individual's** behalffor examination and treatment, the hospital must provide an appropriate medical screening exam 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. "* 42 USC 1395dd(a).

   b. *"A hospital **may not delay** provision of an appropriate medical screening examination or necessary stabilizing treatment... in order to inquire about the individuals method ofpayment or insurance status."* 42 USC 1395dd(h)

3. law requires equal access to medical screening exams and stabilizing treatment

   "Managed healthcare plans cannot deny a hospital permission to examine or treat their enrollees. They may only state what they will and will notpayfor, and regardless of whether a hospital is to be reimbursedfor the treatment, it is obligated to provide the services specified in EMTALA."
   HCFA's Rules and Regulations - 59 Fed. Reg. @ 32,116 (1994)

   HMO authorization is for payment only and **NOT** authorization for treatment
   Thus, HMO's have no liability under EMTALA, only the hospital does.

   a. prohibits "special" procedures for managed care enrollees
      i. nurse "triage away" is illegal
      ii. state Medicaid programs illegal; "waiver" irrelevant
   b. prohibits delay in examination and treatment due to "prior authorization"
   c. prohibits "economic coercion"
   d. screening personnel must be the same; prohibits "dual staffing"?
   e. scope of the screening exam and treatment must be the same

4. Definition of an “Appropriate MSE”

   a. HCFA's new definition of an “appropriate” MSE:

      “A MSE is the process required to reach with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist.”

      “If a hospital applies in a non-discriminatory manner, a screening process that is reasonably calculated to determine whether an emergency medical condition exists, it has met its obligations under EMTALA.”

   b. the hospital must provide a ‘standard screening exam uniformly to all those who present with substantially similar complaints

   c. the “standard screening exam” must be exactly the same for managed-care patients, Medicaid patients, private patients, illegal aliens, and every other category of patients. EMTALA is an anti-discrimination statute.

   d. the adequacy of the MSE to identify an EMC is not the relevant issue under EMTALA (it is ordinary state malpractice), the issue is whether the hospital deviated from its customary (‘standard’) procedures to evaluate a patient with a similar condition, **as perceived to exist** by the examining physician

   e. triage is NOT a medical screening examination

   f. ability to screen in areas other than the ED; L&D, UC, etc.

5. MCO admissions and transfers

   a. “no-delay” provision protects patient from gatekeepers, hospitalists, designated specialists, prior authorization quagmires
   b. prohibits “premature discharge or transfer " due to utilization denials
   c. mandates transfers to “appropriate” facilities, not MCO designated facilities
   d. mandates acceptance by tertiary facilities, regardless of MCO contract issues

C. Controlling Hospital Administrators and The Medical Staff

1. economic triage: the “wallet biopsy” bites the dust

2. complicity with MCO in violating law to secure contracts

   a. hospital’s power over emergency physicians vs.
   b. “just do what’s right” -Phoenix, AZ Samaritan hospitals 8129197

3. strengthens emergency physicians position with administration without jeopardizing contract or job security

4. sets standard for care of “private patients” in the ED

   a. delay of care waiting for private MD to come to the ED and see patient
   b. prohibits ordering administration of medications in ED without MSE conducted in the ED
   c. determines proper procedure for ordering of outpatients labs and xrays

5. utilization of ancillary resources and on-call physician services

6. arranging admissions, accepting transfers of “less desirable” patients

D. Improved Access to Physician Specialists and Referral Hospitals

1. hospital must provide on-call physicians to ED

2. on-call physicians must respond within a “reasonable” period of time

3. non discrimination clause prohibits “reverse dumping”

   "Hospitals with specialized capabilities orfacilities shall not refuse to accept appropriate transfers of individuals who require such specialized capabilities or facilities if the hospital has the capacity to treat the individual.”

4. civil enforcement - how to get paid by those that dumped upon you

IV. The “Bad.”

A. Disruption of the Practice of High Quality Emergency Care

1. triage of patients to urgent care centers, pediatric clinics, L & D

2. disruption of traditional follow-up in physician offices; eye, ortho

3. disruption of patient-physician relationship: e.g., inability to send patient to ED for medication injections after examination in office; private patient issues

4. community services: mental health/psychiatric services, police blood alcohols. sexual assault evidence collections, EMS protocols

5. added costs to hospital for providing on-call physicians, specialized services

6. definition of "capacity" - difficulty in controlling allocation of resources; Oklahoma City University Hospital **'Dateline NBC'** experience

7. Baby K case: provide treatment regardless if clinically or ethically indicated

B. HCFA's definition of "comes to the emergency department"

1. HCFA deems anyone on hospital property to have 'come' to the ED **(42** CFR 489.24(b))

2. HCFA defines hospital property to include:

   a. **anywhere** on the hospital's campus - land contiguity; including the parking lot, cafeteria, waiting room (Ravenswood Hospital experience)
   b. hospital owned urgent cares, clinics, freestanding surgicenters, and doctor's offices - if under the hospital's same MC provider number
   c. hospital owned and operated ambulances or helicopters, whether or not on the premises of the hospital

3. Federal courts don't agree with HCFA -patient must actually present to the ED to trigger EMTALA's screening requirement (compare to trigger of stabilization requirement – "comes to the hospital") E.g., Baber v. Hospital Corp of America, 977 F.2d 872, 883 (4th Cir. 1992)

4. EMS telemetry does not constitute "coming to the ED" - Johnson v. University of Chicago Hospitals, 982 F.2d 230 (7th Cir. 1992)

5. Telephone contact with the hospital by a patient or a physician does not constitute "coming to the ED" - Miller v. Medical Ctr. of SW La., 22 F.3d 626 (5th Cir. 1994), and Arrington v. Wong, 19 F.Supp.2d 1151 (D. Haw. 1998)

6. Importance of hospital policy and procedure addressing care of persons, including employees, who become ill or injured while on the hospital's premises – main hospital campus and off-campus facilities.

C. Civil Actions/Preemption of State Tort Reform Laws

"There is no helter way of exercising the imagination than the study of law
No poet ever interpreted nature as freely as a lawyer interprets truth."
JeanGirandoux(1X82-1944)

Civil Liability continued

1. new cause of action against hospitals

   a. not a malpractice action vs. federal malpractice statute?
   b. any person harmed, not just patient as intended
   c. patients can sue hospitals only, not doctors; but hospitals can and do sue doctors for indemnification
      i. common law indemnity
      ii. statutory indemnity
      iii. contractual indemnity (often unilateral for emergency physicians)
   d. hospital directly liable, not vicariously liable, for physician violations
   e. on-call physician's EMTALA duty may subject him to new state MP liability
   f. not a negligence claim - strict liability? 1395dd(a) vs. (b) claim
   g. retrospective analysis - nebulous concept of "stability"
   h. HCFA/OIG investigations benefit plaintiffs

2. federal jurisdiction option – concurrent jurisdiction

3. medical definitions vs. legal definitions

   "The statutory definition renders irrelevant any medical definition."
   Judge in Burditt v. US Dept. of HHS, 934 F.2d 1362 (5th Cir. 1991).

4. "failure to provide an appropriate MSE claim"

   a. plaintiff lawyers learning curve
   b. failure to screen
   c. disparate screening
   d. process vs. adequacy standard; "condition as perceived by the EP"
   e. failure to follow your own rules
   f. improper motive required? 6th Cir. v other circuits; S.Ct. did NOT decide

5. "failure to stabilize claim"

   a. actual knowledge EMC exists
   b. no stabilization
   c. disparate stabilization
   d. ordinary malpractice standard
   e. improper motive not required – U.S. Supreme *Court* case, *Roberts v. Galen*
   f. applies to inpatients
      i. admitted via ED
      ii. direct admits
   g. opens the floodgates – federal malpractice statute
   h. potential liability to EP and hospital based on HCFA's interpretive guideline bifurcation of the definition of "stable" into 'stable for transfer' and 'stable for discharge'; probably superceded by the statutory language.

6. creative use by plaintiff attorneys

   a. threaten to report/report to HCFA, OIG, OCR, DOJ, JCAHO, SA, etc.. ...
   b. obtain/use HCFA/OIG investigation data, determinations, and the hospital and medical staff peer review materials
      i. Freedom of Information Act
      ii. federal rules of evidence preempt state peer review protections
   c. separate theory of liability, easier burden of proof
   d. option of federal jurisdiction
   e. failure to follow own rules sinks hospitals – very important issue!
   f. failure to align privileges of on-call MDs with actual practice patterns
   g. establish duty of on-call MD so can sue physician in state court for damages resulting from breach of that duty

7. preempts state procedural tort reforms: notice provisions, review panels, discovery restrictions, statutes of limitations, non-state sovereign immunity, charitable immunity, good Samaritan immunity, expert witness requirements

8. *State* sovereign immunity preserved by 11th Amendment to Constitution, but not municipal immunity

9. may not preempt state substantive reforms such as caps on damages; techmcal language in state statutes controlling

   a. Virginia - caps not preempted; Virginia's cap law used language "personal injury", which included acts of professional negligence and injuries from other tortious acts, such as EMTALA violations. *(Power v. Arlington Hospital, 42* F.3d 854 (4th Cir. 1994))

   b. California - Medical Injury Compensation Reform Act (MICRA) caps may not be preempted by EMTALA. Federal court held MICRA applies only to actions based on professional negligence, and EMTALA claims are not based on negligence; contrarily, the California supreme court held that MICRA did apply to EMTALA claims based on failure to stabilize (holding that 'failure to stabilize' was a professional negligence claim). The court may hold that caps on failure to screen claims are preempted by EMTALA, since screening claims are not based on professional negligence. Stay tuned.

D. Mandatory Reporting (tattletale provisions)

1. hospitals which receive an inappropriate transfer of an unstable patient

2. on-call physicians who fail or refuse to respond to ED requests

3. led to marked increase in HCFA investigations/citations and OIG tines

4. failure to report is itself a violation of the law

V. The "Ugly."

A. Health Care Financing Administration (HCFA) Enforcement

*"What we have here is a **failure** to communicate."*
(Warden to prisoner Paul Newman in "Cool Hand Luke")

1. no due process
   a. won't reveal identity of complainant
   b. includes the index case in "sampling", rather that putting all the facts in dispute out in the open.
   c. focuses on bringing "guilty" hospital into compliance, rather than determining if allegation is really accurate

2. no peer review required

7. violations represent "immediate threat to health and safety"; 23 day termination tract vs. 90 day tract (changed with new interpretive guidelines)

8. patient outcome instead of process focussed; HCFA/State Agency substitutes its medical judgement, retrospectively, for that of examining physicians.
   a. inconsistent with federal appellate court rulings - "The courts decide how they want to interpret the law, we [HCFA] decide how we want to interpret the law." HCFA Reg. IX.
   b. new Interpretive Guidelines agree with courts, but actual experience is inopposite.

5. investigations inordinately expensive, time consuming for providers
   a. fishing expeditions by HCFA beyond examining facts of allegation, regulatory minutia
   b. New Jersey experience; closing down hospital EDs, weeks of investigation
   c. hospital has no recourse action vs. bogus complaints
   d. average cost of investigation to hospital >$200,000, before fines

6. often strains relationships of hospitals and medical staff; scapegoating
   a. emergency physician often fired or privileges curtailed; no due process through medical staff bylaws; reportable to national data bank
   b. hospitals will do ANYTHING to come into compliance, avoid certain death penalty of termination from Medicare participation; often to detriment to relations with medical staff - emergency physicians or on-call physicians

7. investigators do not tell physicians/hospital staff that “mere discussions” of the facts, data gathering, and conversations on actions taken to come into compliance can be used against them in enforcement actions by OIG and are potentially discoverable in civil proceedings.

8. Examples

   a. “severe pain” cases; Augusta Medical Center experience, W.VA
   b. capacity to accept transfers; Oklahoma City experience, OK
   c. triage categorization; Frye Memorial Hospital experience, NC
   d. psychiatric evaluation/transfers; Stuart Circle Hospital, VA
   e. “comes to the ED”; Ravenswood Hospital, Chicago

B. Office of Inspector General (OIG) Enforcement

1. “criminalization” of the everyday practice of hospital based medicine

2. civil monetary penalties (CMP) of up to $50,000 for &violation

   a. ordinary negligence standard
   b. no harm need come to patient - strict liability, speeding ticket analogy
   c. no intent to violate law required
   d. not covered by malpractice insurance policies
   e. peer review statutorily required before OIG can impose fines
   f. monetary penalty and settlement agreements
   g. reported to National Practitioner Data Base

3. OIG data

   a. Largest fines related to on-call physicians: Burditt case - OB on-call pays $20,000 fine; Charukuri case - surgeon on-call fined $100,000, reversed by federal court of appeals – 6th Circuit; on-call surgeon refused patient in transfer – Georgia hospital paid $45,000; California hospital paid $40,000 because emergency physician and on-call physician bumbled a request for transfer.

   b. OIG reports annually from Oct. 1, 1997 through Mar. 31, 1998 it collected $710,000 in CMPs from 21 providers; from April 1, 1998 to September 30, 1998 it collected $1.1M from 32 providers; from October 1, 1998 to March 31, 1999 it collected $985,000 from 34 providers

   c. Currently over 140 cases exist on the OIG’s docket, representing almost 500 EMTALA violations. It is currently litigating 4 cases against physicians (at least one is against an emergency physician) and 2 hospitals.

4. potential loss of Medicare participation agreement

   a. lose MC funds - appeal takes 2 years - financial death sentence
   b. take HCFA to court - file for emergency restraining order in district court
   c. "come into compliance" - only real option for hospitals; physicians at mercy of OIG

5. MC participation review standard "gross or flagrant, or repeated" violations

   a. "gross and flagrant" violation is one which:

      presents an imminent danger to the health, safety, or well-being of the individual who seeks emergency examination and treatment or places that individual in a high risk situation. 42 CFR 1003.105(a)(l)(C).

   b. this is not "gross negligence", and no improper intent is required

C. State and Federal Criminal Prosecutions

1. State prosecutor in California tried an emergency physician for murder for violating EMTALA in death of an infant transferred to another facility.

2. Some States have criminal penalties for violating the transfer provisions of the State's version of EMTALA; e.g., TX, CA, NY, TN.

D. Unfunded Mandate by U.S. Congress

1. Billions of uncompensated care provided annually by hospitals; EMTALA is the governments largest health care program, bigger that either MC or MA.

2. Border states such as Florida, Texas, California, Arizona - mandated to provide free care to illegal aliens; reportedly, courses are taught in Latin America on how to use the law to obtain free health care in Florida.

3. fundamental need vs. fundamental right; dangerous precedent

4. monopoly power of US government - largest payor of health care services; "strings" attached to Medicare/Medicaid

5. amount of uncompensated care threatens ability to sustain emergency services in some communities

VI. Conclusions

A. Improved access to care

B. Control MCO and hospitals

C. On-call physicians learning

D. HCFA/OIG quagmire

E. Federal malpractice act

VII. Effective EMTALA Compliance

A. Acknowledge EMTALA exists and is the law.

B. Hospital and medical staff cooperation is mandatory.

C. Education is key.

D. Draft policies very, very carefully!

E. New documentation paradigm.

VIII. EMTALA References/ Resources

1. Bitterman, RA: A Critical Analysis of the Federal COBRA Hosnital "Antidumping Law": Ramifications for Hospitals. Physicians, and Effects on Access to Healthcare, 70 University of Detroit Mercy Law Review 125-190 (1992).

An in depth legal and practical analysis, admittedly physician biased, based on case law determinations to date and the real-life experience of being the Director of a Hospital Emergency Department investigated by HCFA for an alleged EMTALA violation. This was written before implementation of HCFA's guidelines, but it details the clinical problems of dealing with hospitals and on-call physicians in providing emergency care.

2. Frew, SA: Patient Transfers: How to Comply with the Law. Published by the American College of Emergency Physicians, Second Edition 1995

This booklet contains good example forms to be used in transfers; signature pages, certification documents, consent forms, transfer certificates, etc.. It clearly explains the difference between the medical and legal understandings of the law's language, and, importantly to physicians, the legal significance of the medical terms used everyday. It also details representative samples of HCFA's investigations and citations of hospitals which violated EMTALA.

3. Luce, GM: Defending the Hospital Under EMTALA: New Requirements & New Liabilities, Published by the National Health Lawyers Association, 1995

NHLA monograph addresses primarily the hospital's response to a HCFA administrative review for potential EMTALA violations and defense of EMTALA claims in court.

4. Stieber, JD & Wolfe, SM, Update on "Patient Dumping" Violations, Published by Public Citizen's Health Research Group, October 1994, March 1996, & December 1997.

Compendium and categorization of EMTALA violations by State and HCFA Region. It names hospitals which have been cited for violating EMTALA and specifies the nature of the violation, such as "failed to provide an appropriate medical screening exam'. Public Citizen periodically updates this information.

5. Furrow B. An Overview and Analysis of the Impact of the Emergency Medical Treatment and Active Labor Act. J Legal Med 16:325-355, 1995

Health lawyer's view of EMTALA's effect on patient care & access to care

6. Roberts v. Galen of Virginia, Inc., 111 F.3d 405 (6th Cir 1997), 119 S.Ct. 685 (1999)

References Continued

7. Bitterman, RA. "EMTALA", Chapter in Emergency Medicine Risk Management: A Comprehensive Review, Second Edition, Henry GL and Sullivan DJ, Editors. Published by the American College of Emergency Physicians, October 1997, pages 353-380.

Up to date summary of EMTALA, written specifically to address the issues confronted in the practice of emergency medicine.

8. Morgan D. Emergency Room Follow-Up Care and Malpractice Liability. *J of Legal Med* 1995;16:373-406.

9. Annas GJ. Legal Issues in Medicine: Asking the Courts to Set the Standard of Emergency Care - The Case of Baby K. NEJM 330:1542-1545, 1994

Discusses case of a hospital forced by the courts, under EMTALA, to provide emergency mechanical ventilation to an anencephalic infant, regardless of the ethics or medical appropriateness of the treatment.

10 Joy, LM. EMTALA: Interpreting and complying with the federal transfer law. American Health Lawyers Association practice and resource guide published in 1999.

11 Kuettel AC. The changing role of receiving hospitals under the EMTALA *J of Legal Med* 1998;19:351-376

12 *Inspector General v. Cherukuri,* Department of HHS, DAB - CR475 (May 23, 1997), Cherukuri v. Shalala, No.97-4464 1999 FED App. 0160P (6th Cir.) (May 3, 1999)

On-call surgeon fined $100,000 for failure to comply with EMTALA, even though no harm came to patients involved; fine overturned by federal appellate court.

13 HCFA's Revised Interpretive Guidelines: State Operations Manual Provider Certification, Dept. of HHS, HCFA, Transmittal No. 2, May 1998. Effective July 14, 1998

14 An "EMTALA Packet" is available from ACEP. It contains the EMTALA statute, the Revised Guidelines, & a comparison of the changes between the new and old guidelines. ACEP also posts an EMTALA Resource Page on its web site at www.acep.org/policy/rsemtala.htm.

15 Department of Health and Human Services OIG/HCFA Solicitation of Comments on the OIG/HCFA Special Advisory Bulletin on the Patient Anti-Dumping Statute: Notice of the proposed bulletin can be found at www.hhs.gov/progorg/oig/frdalrt/patientdump.htm

16 Bitterman, RA. HCFA's New Guidelines for Enforcement of EMTALA. *Emergency Department Legal Letter* 1998;9(12):113-120, December 1998.

17 Bitterman RA. Screening, Stabilization, and Transfer of Psychiatric Patients. *Emergency Deportment Legal Letter* 1998;9(10):97-104, October 1998.