Revised and Amended Statement of Gina G. Greenwood, J.D.[1]
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This Statement is provided to the United States Commission on Civil Rights regarding the Emergency Medical Treatment and Labor Act ("EMTALA") and its applicability to mental health patients. It is my understanding that the Commission is considering petitioning the United States Congress to amend and expand the EMTALA Statute in order to help protect mental health patients' civil rights. I offer this Statement as explanation of the EMTALA law with the goal of providing insight to the Commission regarding the law, regulations, interpretations, and enforcement as it currently exists. I also offer at the end of this Statement suggestions for potential areas of focus for the Commission. Please let me know how I can be of further assistance.

Position Statement

As an EMTALA legal expert, I do not think amendment of the EMTALA Statute is required in order to address the civil rights of our nation's mental health patients. From my personal experience, I believe the Centers for Medicare & Medicare Services ("CMS") Region IV Office is interpreting the EMTALA Statute in a way that helps protect mental health patients' rights to emergent stabilizing treatment provided through the EMTALA Statute and its regulations.

However, I strongly agree that our mental health infrastructure is in dire crisis. I believe emergency room physicians are more than willing to order evaluations of mental health patients but these physicians are in need of solid treatment options for these patients.

Rather than focusing on amendment of the EMTALA law, I respectfully submit to the Commission that its focus should be shifted to long term and/or consistent treatment of the mentally ill. True change can best come through (1) research of medical root causes of and cures for mental illness, (2) education of the general public on the symptoms and potential causes of mental illness, and (3) funding (including Medicaid and other insurance coverage) of our country's mental health treatment infrastructure deficiencies (at the community level) in order to address the inpatient and outpatient treatment needs of the chronically mentally ill.

In short, emergency acute care stabilization is typically available to mental health patients through the EMTALA law. However, a mental patient cannot be cured in an emergency department setting - - any more than a mental health patient can be cured in our jails/prisons or

[1] Special thanks to Shannon L. Wiley, JD for her assistance in researching and writing this Statement.

[2] This Statement does not represent the opinions of Baker Donelson law firm, its shareholders, attorneys, employees or clients. This Statement is not to be interpreted as lobbying for any specific client or any group of clients; rather, this Statement is based on Gina Greenwood's own personal opinions and observations. Gina Greenwood is providing this Statement on a pro bono basis.

on our streets. Early detection, early intervention and day-to-day outpatient and (humane) inpatient treatment for mental illness are the keys to opening doors for this country's mentally ill.

- **My Background**

I have been practicing law as a fulltime health care regulatory attorney since 2001. I began my practice at a large law firm in Atlanta, Georgia and moved to Baker Donelson, Atlanta/Macon, Georgia approximately five (5) years ago. Both firms have a large contingency of hospital and physician clients who are highly regulated by the EMTALA law.

Through the years, I have represented dozens of hospital and physician clients in implementing EMTALA compliance programs (including drafting policies and procedures and forms and conducting employee and medical staff training sessions) and in defense of EMTALA violations, many of which involved psychiatric patients. I have also assisted in the defense of numerous private claims involving EMTALA.

Below is an explanation of the EMTALA law and its applicability to mental health patients for your reference.

- **THE LAW - EMTALA**

Medicare participating hospitals must meet the EMTALA statutory and regulatory requirements.

  - **The General Rule**

Specifically, the EMTALA Statute states,

> *"In the case of a hospital that has a hospital emergency department, if* ***any*** *individual (whether or not eligible for benefits under [Medicare and regardless of ability to pay]) 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. . . .*
>
> *If . . . the hospital determines that the individual has an emergency medical condition, the hospital must provide either—*
>
> *(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or*

(B) for transfer of the individual to another medical facility in accordance with [the EMTALA transfer requirement]."[3]

EMTALA's statutory language has been expanded dramatically through regulations. For example, the EMTALA regulations[4] define the following terms very expansively -

*"'**Comes to the emergency department'** means, . . . the individual--*

- Has presented at a hospital's dedicated emergency department, as defined in this section, and requests examination or treatment for a medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if 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;

- Has presented on hospital property, as defined in this section, other than the dedicated emergency department, and requests examination or treatment for what may be an emergency medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs emergency examination or treatment;

- Is in a ground or air ambulance owned and operated by the hospital for purposes of examination and treatment for a medical condition at a hospital's dedicated emergency department, even if the ambulance is not on hospital grounds. . .
...

"Dedicated emergency department" *means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:*

- It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

- It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

- During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at

[3] 42 U.S.C. §1395dd (emphasis added).
[4] 42 C.F.R. § 489.24(b) (emphasis added).

> *least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.*
> ...
> ***"Hospital property"*** *means the entire main hospital campus . . ., including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities."*

Because of these expansive regulatory definitions, EMTALA now requires the majority of general hospitals in this country (including critical access hospitals) to provide a medical screening examination to **ANY** individual who comes to a hospital emergency department or within 250 yards of hospital property and requests (or is in apparent need of) an examination for an emergency medical condition, regardless of the individual's ability to pay.

EMTALA is an unfunded federal mandate required of for-profit and not-for-profit hospitals simply as part of the contractual conditions of the hospitals' participation in the Medicare program. The requirements apply to all individuals (including psychiatric patients) - not just Medicare beneficiaries. If the hospital violates this law, it is subject to termination from the Medicare program, fines and private lawsuit. Individual physicians may be subject to penalties as well.

CMS issues Interpretive Guidelines to its surveyors to help them interpret the EMTALA Statute and regulations consistently. The intent of EMTALA is for hospitals to be prohibited from refusing to care for emergent patients in need of stabilizing treatment who are indigent or self-pay (i.e., who do not have insurance). EMTALA is meant to be a statute that creates a legal duty to all patients (and in particularly indigent patients) to provide a medical screening examination ("MSE") to determine whether there is an acute emergency medical condition ("EMC").

- **Medical Screening Examination to Determine Whether There is an Emergency Medical Condition**

Once EMTALA is triggered, **ALL** individuals in apparent need of emergency help must be receive an appropriate medical screening examination by a qualified medical person to determine whether an Emergency Medical Condition is present.

When used in the context of EMTALA, “appropriate” medical screening examination means that the screening examination is suitable for the symptoms presented and conducted in a non-

disparate fashion.[5] The hospital "must provide a medical screening examination to any individual regardless of diagnosis (e.g., labor, AIDS), financial status (e.g., uninsured, Medicaid), race, and color, national origin (e.g. Hispanic or Native American surnames), and/or disability, etc."[6] The Interpretive Guidelines further state, "For individuals with psychiatric symptoms, the medical records should indicate an assessment of suicide or homicide attempt or risk, orientation, or assaultive behavior that indicates danger to self or others."[7]

The EMTALA Regulations specifically define that "emergency medical condition" to include mental health emergencies stating an Emergency Medical Condition is --

> *"A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain**, psychiatric disturbances and/or symptoms of substance abuse**) such that the absence of immediate medical attention could reasonably be expected to result in--*
>
> *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;*
>
> *Serious impairment to bodily functions; or*
>
> *Serious dysfunction of any bodily organ or part; . . ."*[8]

The EMTALA Interpretive Guidelines provide, "In the case of psychiatric emergencies, if an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an EMC [i.e., emergency medical condition]." In other words, an emergency medical condition for a mental patient is presumed in the case of suicidal or homicidal ideations.

In my experience, hospitals will be cited by surveyors for a violation of EMTALA if qualified medical personnel do not separately access **both** the physical and mental conditions of the presenting patient - and stabilize both the mental health condition and the underlying physical conditions. CMS regional offices have been very clear on their enforcement of this portion of the EMTALA law.

- **Stabilizing Treatment**

If an emergency medical condition is present, then the hospital must provide stabilizing treatment within its capability and/or appropriately transfer the patient for stabilizing treatment.

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[5] EMTALA Interpretive Guidelines.
[6] EMTALA Interpretive Guidelines.
[7] EMTALA Interpretive Guidelines.
[8] 42 C.F.R. § 489.24(b) (emphasis added).

42 C.F.R. § 489.24(b) defines stabilized to mean: "… that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to an "emergency medical condition" . . . , that a woman has delivered the child and the placenta." The EMTALA Interpretive Guidelines provide -

> *"After the medical screening has been implemented and the hospital has determined that an emergency medical condition exists, the hospital must provide stabilizing treatment within its capability and capacity. Capabilities of a medical facility mean that there is physical space, equipment, supplies, and specialized services that the hospital provides (e.g., surgery, psychiatry, obstetrics, intensive care, pediatrics, trauma care). Capabilities of the staff of a facility means the level of care that the personnel of the hospital can provide within the training and scope of their professional licenses. This includes coverage available through the hospitals on-call roster. The capacity to render care is not reflected simply by the number of persons occupying a specialized unit, the number of staff on duty, or the amount of equipment on the hospital's premises. Capacity includes whatever a hospital customarily does to accommodate patients in excess of its occupancy limits §489.24 (b). . . .*
>
> *To comply with the MSE and stabilization requirements of [EMTALA] all individuals with similar medical conditions are to be treated consistently.*
>
> ***Psychiatric patients** are considered stable when they are protected and prevented from injuring or harming him/herself or others. The administration of chemical or physical restraints for purposes of transferring an individual from one facility to another may stabilize a psychiatric patient for a period of time and remove the immediate EMC but the underlying medical condition may persist and if not treated for longevity the patient may experience exacerbation of the EMC. Therefore, practitioners should use great care when determining if the medical condition is in fact stable after administering chemical or physical restraints."*[9]

If there is no emergency medical condition and/or once the patient is stabilized for EMTALA purposes, the hospital's EMTALA obligations are over, but by this point, the other Medicare/Medicaid Conditions of Participation and professional standards of care apply and the physician - patient relationship has been established to help to ensure the patient is not discharged inappropriately.

[9] EMTALA Interpretive Guidelines (emphasis added).

- **Transfers of Unstable ED Patients**

If a hospital is unable to stabilize the patient, then it cannot simply discharge the patient. It must transfer the patient to a facility with a higher level of care.

The EMTALA Statute provides specific protection of unstable patients who are being transferred for stabilizing treatment. Specifically the EMTALA Statute states -

> *"(1) Rule. If an individual at a hospital has an emergency medical condition which has not been stabilized ..., the hospital may not transfer the individual unless —*
>
> > *(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under [EMTALA] and of the risk of transfer, in writing requests transfer to another medical facility,*
> >
> > *(ii) a physician . . . has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or*
> >
> > *(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person . . . has signed a certification described in clause (ii) after a physician . . . , in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and*
> >
> > *(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.*
> >
> > *A certification described [above] shall include a summary of the risks and benefits upon which the certification is based.*
>
> *(2) Appropriate transfer.—An appropriate transfer to a medical facility is a transfer—*

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided [as required by EMTALA], and the name and address of any on-call physician . . . who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary [of HHS] may find necessary in the interest of the health and safety of individuals transferred."[10]

- **Recipient Hospitals Are Required to Accept an Appropriate Transfer**

Further, certain hospitals are prohibited from refusing to accept an appropriate transfer of EMTALA patient, if -

"The receiving facility--(A) Has available space and qualified personnel for the treatment of the individual; and (B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment."[11]

[10] 42 U.S.C. §1395dd(c) (emphasis added).

"For example, if an individual is found to have an emergency medical condition that requires specialized psychiatric capabilities, a psychiatric hospital that participates in Medicare and has capacity is obligated to accept an appropriate transfer of that individual. **It does not matter if the psychiatric hospital does not have a dedicated emergency department**."[12]

As such, EMTALA reaches past the four (4) corners of the hospital ED / property to require many hospitals to accept unstable ED patients if the hospital has specialized capability and the capacity. Hospitals and on-call physicians refusing to accept appropriate transfer requests for EMTALA transfers are subject to violation of the EMTALA law. In my experience, CMS Regional IV understands these requirements well and will call an EMTALA violation on both the recipient hospital and the on-call physician who refused to accept a psychiatric patient when implicated.

- **Expansion of EMTALA is not Necessary but Clear Interpretation of the Statute and Regulations and Expansion of the Mental Health Treatment Options are Necessary**

EMTALA contemplates and protects mental health patients at every stage of the emergent treatment process. Therefore, I am unclear how an expansion of the EMTALA statutory language (an emergency department - based law) will significantly help mental health patients.

Hospital EDs are typically already under EMTALA obligations to screen and stabilize and/or appropriately transfer mental health patients, and recipient hospitals are already under the obligation to accept appropriate transfers of EMTALA mental health patients in need of stabilizing treatment. The EMTALA Statute itself appears to address the civil rights of the mentally ill.

  - **Unintended Consequences of Harsh Enforcement**

I fear that an unnecessary expansion of the EMTALA Statute could lead to the unintended consequences of hospitals closing their inpatient psychiatric departments out of fear that they will be held to a higher standard of care (based on the ancillary services they offer) and will be forced to treat more than their fair share of the indigent mental health population.

Another unintended consequence is that mental health patients (who unfortunately are already viewed with concept by society at large) will be blamed within the health care industry for an increase in harsh enforcement of the EMTALA law. I would much prefer mental health patients be seen as the heroic group who fought the brave fight and found more dollars for much -needed treatment for our citizens.

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[11] 42 C.F.R. §489.24(e)(2)(ii) (emphasis added).
[12] EMTALA Interpretive Guidelines (emphasis added).

- **Clarification of EMTALA Interpretive Guidelines**

Although I do not believe expansion of the Statute or regulations is necessary, depending on the type of mental health resources available in a given State, certain States' citizens might benefit from an interpretation of the current EMTALA Statute and regulations that allows for the transfer of suicidal / homicidal patients to an appropriate mental health treatment "facility" -- even where the facility is not a licensed "hospital." This likely would not require a change in the Statute or regulations. The EMTALA Statute and regulatory language appear to allow transfer to a receiving treatment "facility." However, the CMS Interpretive Guidelines indicate that in order for an unstable ED transfer to be compliant with EMTALA, the transfer must be made to a "hospital."[13]

Both the EMTALA Statute at 42 U.S.C. §1395dd(c) and the EMTALA regulations at 42 C.F.R. §489.24(e)(2)(ii) (as part of the appropriate transfer requirements) allow a transfer of an unstable patient to a receiving **"facility"** -- if certain requirements are met.

Specifically, 42 C.F.R. §489.24 states -

> *"(A) A transfer to another medical* ***facility*** *will be appropriate only in those cases in which [among other requirements] -*
>
> > *(i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;*
> >
> > *(ii) The receiving* ***facility****--*
> >
> > > *(A) Has available space and qualified personnel for the treatment of the individual; and*
> > > *(B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment; . . ."*[14]

The use of the word "facility" (as opposed to "hospital") in the Statute and regulatory text indicates that a patient could be transferred to a mental health treatment facility or center that is not necessarily licensed as a "hospital" - which presumably would allow for treatment of patients at specialty psychiatric units and would allow for more flexibility and more availability of treatment options.

However, the CMS Interpretive Guidelines appear to interpret this provision more narrowly, requiring transfer to a licensed recipient hospital. For example (among numerous other

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[13] I personally have not had to deal with this particular issue because my clients are typically hospitals that are clearly subject to EMTALA appropriate transfer and recipient hospital requirements, but I am sure CMS could offer further explanation of its interpretation. I would be happy to research upon your request.
[14] (emphasis added).

references in the Interpretive Guidelines), the Interpretive Guidelines for 42 C.F.R. §489.24(e)(2)(ii) state --

> *"The transferring hospital must obtain permission from the receiving (recipient)* ***hospital*** *to transfer an individual. The transferring* ***hospital*** *should document its communication with the receiving (recipient) hospital, including the date and time of the transfer request and the name and title of the person accepting the transfer."*

This might be an area that the Commission could focus on to address the ability of hospitals to utilize facilities such as community-based crisis intervention centers that might be better able to assist mental health patients (where the centers do not also happen to be "hospitals").

- **Follow the Money and You Will Find the Problems**

Respectfully, true help for mental health patients will come when appropriate focus and allocation of funding and insurance coverage is directed at long-term inpatient and outpatient mental health treatment. States are closing mental health facilities and funding has been cut dramatically over the years. It is my understanding that mental health patients do not have consistent early intervention or quality long term treatment to ensure they obtain the necessary treatment and medications to avoid the proverbial "deep end" of incarceration or homelessness.

Mental health patients are in need of (1) safe housing, (2) consistent treatment options (and insurance coverage) and (3) opportunities to ensure that they have a meaningful day (e.g., work, volunteer, adult school, adult day care, support groups, etc.). They need a chance - a small chance to survive.

I would encourage the Commission to reach out to mental health professionals and investigate the deficiency of funding for this country's mentally ill. All State mental health agencies and hospital associations would likely be more than willing to offer this information because most, if not all, seem to be desperate for mental health funding. I would also like to encourage the Commission to investigate model mental health programs that are working.

I guarantee if you will "follow the money" (or lack thereof), you will find the problems. True change will come when focus is appropriately placed on funding, reimbursement, research, education and treatment before the mental health condition rises to the level of being emergent.

Thank you for this opportunity to testify before the Commission on this worthy and urgent topic. It is truly an honor. Please let me know how I can be of further assistance.