Statement of Marilyn Dahl
Briefing for the U.S. Commission on Civil Rights
On
CMS Enforcement of EMTALA
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Good morning. My name is Marilyn Dahl and I am the Director of the Division of Acute Care Services within the Survey & Certification Group at the Centers for Medicare & Medicaid Services (CMS). The Survey & Certification Group is charged with enforcing the compliance of Medicare-participating providers and institutional suppliers of health care services with Medicare Conditions of Participation, Conditions for Coverage, and, in the case of hospitals and critical access hospitals, the Emergency Medical Treatment and Labor Act, commonly referred to as EMTALA.

Section 1867 of the Social Security Act, entitled "Examination and Treatment for Emergency Medical Conditions and Women in Labor," establishes certain requirements for Medicare-participating hospitals and for Medicare-participating critical access hospitals , which are small, rural acute care facilities. (Throughout the remainder of this statement, when I refer to hospitals I am also referring to critical access hospitals.) It also establishes requirements for on-call physicians. There are also some provisions of Section 1866 of the Social Security Act governing the provider agreement between Medicare and a provider which are related to EMTALA and its enforcement.

Enforcement mechanisms established under Sections 1866 and 1867 of the Social Security Act pertain to enforcement actions that CMS may take with respect to a hospital's Medicare provider agreement, as well as actions the U.S. Department of Health and Human Services Office of Inspector General may take with respect to hospitals and physicians. Section 1867 of the Act also provides for a private right of action by individuals or medical facilities; CMS has no role in such civil litigation.

Hospital Obligations under EMTALA

Depending on their characteristics, hospitals may be subject to either or both of two different types of EMTALA obligations: (1) obligations of hospitals with an emergency department towards individuals who come to the emergency department; and (2) obligations of hospitals with specialized capabilities. One misconception about EMTALA is that there are no EMTALA obligations for hospitals that do not have emergency departments. However, this is not always the case.

Obligations of Hospitals with Emergency Departments

If an individual comes to the emergency department of a Medicare-participating hospital and a request is made for examination or treatment for a medical condition, the hospital is required to conduct an appropriate medical screening examination, within the capabilities of that hospital, to determine if the individual has an emergency medical condition. Although the EMTALA provisions in Section 1867 are found in the Medicare portion of the statute, EMTALA protections apply to any individual who comes to a hospital's emergency department, regardless of his or her insurance or payment status.

If the individual is found to have an emergency medical condition, the hospital must provide further examination and treatment, within its capabilities and capacity, to stabilize the emergency medical condition. Or, the hospital must transfer the individual to another facility if the hospital lacks the capability to stabilize and if the medical benefits reasonably expected from provision of appropriate treatment at another facility outweigh the increased risks from being transferred. Hospitals are not permitted to delay screening for an emergency medical condition or stabilizing treatment in order to inquire about an individual's method of payment or insurance status. Hospitals are required to provide screening and stabilizing treatment regardless of the individual's ability to pay. In addition, the EMTALA regulations provide that if a hospital admits an individual as an inpatient in good faith in order to stabilize his or her emergency medical condition, then that hospital has fulfilled its obligations under EMTALA.

The law and regulations also specify definitions for an "emergency medical condition," "to stabilize" and "stabilized," and "transfer." The regulations also define additional terms, including what it means to "come to the emergency department," and what a "dedicated emergency department" is.

The statutory definition of an "emergency medical condition" contains provisions focusing on pregnant women in labor as well as provisions for all other cases. For the latter, an "emergency medical condition" is one that is manifested by acute, severe symptoms (including severe pain) that lead to a reasonable expectation that absence of immediate medical care would result in serious jeopardy to the individual's health, serious impairment of one or more bodily functions, or serious dysfunction of a bodily organ or part.

The EMTALA definition of "stabilized" is not the same as what clinicians typically mean when they refer to a patient as being stabilized. In addition to provisions specific to women in labor, the EMTALA statutory definition of "stabilized" means that one can reasonably expect that the individual's emergency medical condition will not materially deteriorate during or as a result of the individual's "transfer." "Transfer" is also specifically defined to mean the movement, including discharge, of an individual out of a hospital at the direction of hospital staff. To "stabilize" an individual's emergency medical condition, hospitals are expected to provide treatment that mitigates the severity of the acute episode so that when the individual leaves the hospital, his or her condition no longer meets the definition of an emergency medical condition when he or she is discharged or transferred. If a hospital lacks the capability to stabilize the emergency medical condition, then it is not only allowed but expected to transfer an unstabilized individual to a hospital that has the required stabilization capabilities. There are additional EMTALA requirements to assure that the transfer of an unstabilized individual is carried out appropriately.

In some cases, the required stabilizing treatment could also be definitive treatment, as, for example, when an individual who presents with symptoms of acute appendicitis undergoes surgery for removal of the appendix. In other cases, particularly with individuals who have underlying chronic diseases, such as asthma, diabetes, or congestive heart failure, hospitals are required under EMTALA to address the acute episode, but are not required to provide ongoing treatment of the underlying disease.

Individuals who come to a hospital's emergency department with symptoms of severe psychiatric disturbances present particular challenges for hospitals and their staffs, both in terms of determining whether these individuals have an "emergency medical condition" under EMTALA and, if so, when they are "stabilized" under EMTALA. Notably, the regulatory definition of an emergency medical condition includes psychiatric disturbances among the acute, severe symptoms suggesting there is a medical emergency. In CMS interpretive guidance on how to assess compliance with the EMTALA regulations with respect to individuals with psychiatric disturbances, CMS has elaborated on the definition of an emergency medical condition to clarify that an individual is considered to have a psychiatric emergency medical condition if he or she is expressing homicidal or suicidal thoughts or gestures and is determined to be a threat to self or others.

Between 2004 and 2007, a technical expert panel mandated by Congress met to consider many aspects of EMTALA regulations and enforcement. The published minutes of this panel note that it deliberated at length on whether there was another way to describe a psychiatric emergency medical condition, but the panel did not offer an alternative definition.

CMS has issued guidance in order to help hospital staff determine if a psychiatric emergency medical condition has been "stabilized" per the EMTALA definition, particularly if the individual's acute symptoms have been mitigated through the use of physical or chemical restraints. CMS guidance on determining whether a psychiatric emergency medical condition has been stabilized says, "Psychiatric patients are considered stable when they are protected and prevented from injuring or harming [themselves] 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 [emergency medical condition] but the underlying medical condition may persist and if not treated for longevity the patient may experience exacerbation of the [emergency medical condition]. Therefore, practitioners should use great care when determining if the medical condition is in fact stable after administering chemical or physical restraints." It is also important to note that any use of physical or chemical restraints must be utilized in accordance with the CMS conditions of participation (COPs) for hospitals (42 CFR 482).

Importantly, although psychiatric hospitals are not typically thought of as having an emergency department in the same way that general acute care hospitals frequently do, they may, in fact, meet the definition under the EMTALA regulations for having a "dedicated emergency department," and therefore would have to meet the EMTALA requirements for hospitals with emergency departments. The CMS regulatory definition of a "dedicated emergency department" considers how the unit of a hospital *functions*, paying particular attention to whether it is handling unscheduled, walk-in patients, with a significant number having emergency medical conditions for which the patients are then admitted. Labor and delivery units of hospitals are one example. Likewise, a psychiatric hospital that has a walk-in clinic from which a significant volume of patients are directly admitted as inpatients is considered to have a "dedicated emergency department." In these cases, the "dedicated emergency department" is not expected to have the same capability to provide a broad range of medical screening or treatment that a more typical emergency department furnishes, so that a transfer to a more appropriate hospital might be in order. For example, if an individual came to a psychiatric hospital's "dedicated emergency

department" with serious self-inflicted wounds as well as other symptoms of psychiatric disturbances, the psychiatric hospital would not be expected or required to have the capability to treat the wounds, but would instead be expected to arrange an appropriate transfer to another hospital that could.

Additionally, EMTALA's focus is on assuring that *every* individual who comes to the emergency department, as defined in regulations, of a Medicare-participating hospital is screened appropriately for an emergency medical condition, and stabilized if found to have an emergency medical condition. Accordingly, CMS's assessment of compliance with EMTALA requirements makes no distinctions with respect to whether or not an individual coming to an emergency department has a disability of any sort, including a psychiatric disability. CMS's focus is on whether the individual was appropriately screened, whether he or she had an emergency medical condition, and, if so, whether he or she received appropriate stabilizing treatment or an appropriate transfer.

Obligations of Hospitals with Specialized Capabilities

Regardless of whether or not a hospital has a dedicated emergency department, if it has the specialized capabilities that are needed to stabilize the emergency medical condition of an individual who presented to another hospital's emergency department that lacks the required capability to stabilize the individual, then it must accept transfer of the individual, assuming it also has the capacity to treat the individual at the time of transfer. For example, psychiatric hospitals that have a bed available are required under EMTALA to accept an appropriate transfer of an individual who presented to the sending hospital with a psychiatric emergency medical condition. The EMTALA obligations of hospitals with specialized capabilities are governed by Section 1867(g) of the EMTALA statute. Additionally, CMS adopted regulations at 42 CFR 489.24(f)(1), which explicitly state that recipient hospital responsibilities apply to any Medicare-participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.

CMS EMTALA Enforcement Process

The potential for termination of their Medicare provider agreement highly motivates hospitals to comply with EMTALA obligations and proactively prevent violations from occurring. Despite this motivation, EMTALA complaints do arise. Complaints can come from a variety of sources, including affected individuals and their families, hospital staff, and other hospitals. Further, if CMS learns through media reports of potential EMTALA violations, it may treat them as a complaint and authorize an investigation.

Between 2006 and 2012, CMS received approximately 500 EMTALA complaints on average per year, and investigated the vast majority of these complaints. Of those complaints investigated, on average, approximately 40 percent resulted in hospitals being cited for EMTALA deficiencies. In most cases the hospitals corrected their deficiencies and came back into compliance, which is the goal of CMS's enforcement actions. Termination of a hospital's Medicare provider agreement due to violations of EMTALA is a rare occurrence.

EMTALA investigations are generally conducted on behalf of CMS by State surveyors who make an unannounced visit to the hospital. In accordance with Section 1864 of the Social

Security Act, CMS has entered into agreements with all of the States to have qualified staff conduct on-site inspections, or surveys, to assess the compliance of Medicare-participating hospitals with their respective Medicare Conditions of Participation and with the EMTALA requirements. In some cases, CMS employees or contractors may conduct part or all of a survey, or participate in a State's Federal survey team, but the overwhelming majority of EMTALA surveys are conducted by State surveyors.

CMS provides regular training to State surveyors and provides guidance on EMTALA via the State Operations Manual, which articulates the policy and processes surveyors are to follow when assessing compliance. Surveyors conducting an EMTALA complaint look not only at the complaint case, but also at a sample of other cases, and assess the hospital's compliance with all of the EMTALA regulations in 42 CFR 489.24 as well as the EMTALA-related provisions of 42 CFR 489.20, such as the hospital's obligation to maintain a list of physicians on-call to come to the hospital in an EMTALA case and the requirement for a log of all individuals who come to the emergency department, among others.

The State surveyors complete their investigation and forward to their CMS Regional Office not only their survey report, but also copies they have made of any medical records or other documents that the surveyors believe provide evidence of EMTALA noncompliance. There are ten CMS Regional Offices around the country, and based on the survey findings and the supporting documents, survey and certification staff in those offices make the determination as to whether the hospital is in compliance with all EMTALA requirements.

CMS focuses on the hospital's compliance with EMTALA at the time of the survey. For example, if the survey finds evidence that the deficient practices alleged in a complaint did occur, but that the hospital identified the noncompliance and took effective corrective action prior to the survey, CMS will not pursue an EMTALA enforcement action against that hospital. However, that case may be referred to the Office of Inspector General for consideration of whether it will pursue its own, separate enforcement action under its Section 1867 authority. In some instances, CMS may also refer a case to the Office for Civil Rights for consideration under its Hill-Burton Act authority.

If, after reviewing the case file from the State, the CMS Regional Office finds evidence of current EMTALA noncompliance *and* where there are clinical issues related to the types of noncompliance, the statute requires CMS to send the case file to the appropriate CMS-contracted Quality Improvement Organization (QIO). The QIO arranges to have a physician review the case and answer a standard series of questions for CMS. Applying accepted standards of practice, the QIO physician reviewer is expected to answer questions such as: given the individual's presenting signs and symptoms, did the hospital provide an appropriate medical screening examination; did the individual have an emergency medical condition; was the individual's emergency medical condition "stabilized" per the statutory definition, before he or she was transferred or discharged; and did the hospital have the capability to provide stabilizing treatment.

After considering both the State survey report and the QIO physician review, the CMS Regional Office issues the final survey report to the hospital, which is known as the Statement of Deficiencies. If the report identifies EMTALA deficiencies, the hospital must correct those

deficiencies in a timely manner and the State must conduct another survey to confirm that compliance has been achieved. Failure to correct deficiencies may result in CMS terminating the hospital's Medicare provider agreement, no longer enabling it to participate in the program and receive Federal funds. CMS' main focus is ensuring hospitals correct deficient practices while maintaining access to care, so termination of the provider agreement only rarely occurs.

Thank you for the opportunity to discuss hospitals' obligations under EMTALA and CMS's role in enforcing those obligations. I would now be happy to answer questions you might have.