Statement of Sandra Jean Sands

Briefing for the U.S. Commission on Civil Rights

On

OIG Enforcement of EMTALA

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Good morning. My name is Sandra Jean Sands and I work in the Office of Counsel to the Inspector General (OCIG), Office of Inspector General (OIG), United States Department of Health and Human Services. I started work for the OIG in early 1989, shortly after Congress passed the Emergency Medical Treatment and Labor Act (EMTALA). From the beginning of my tenure at OIG I have worked on patient dumping enforcement and since 1997 I have shared oversight responsibility for OIG's enforcement of EMTALA.

OIG Enforcement Authority

Enforcement of EMTALA is bifurcated between CMS and OIG, with CMS having primary responsibility. Section 1867(d) of the Social Security Act (Act) provides that a "participating hospital that negligently violates a requirement of [EMTALA] is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation." In addition, "any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of EMTALA] … is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in [Medicare] and State health care programs." OIG has authority to pursue these administrative remedies. EMTALA also provides for private civil enforcement against a participating hospital in cases in which an individual suffers personal harm as a direct result of a participating hospital's violation of EMTALA. In these cases the individual may obtain damages available for personal injury under the law of the state in which the hospital is located and such equitable relief as is appropriate. OIG does not have a designated role in a private civil case and is rarely aware of such cases before they are resolved in the federal courts.

OIG Case Processing

OIG receives its EMTALA cases from CMS after CMS has found a hospital to be in noncompliance with its EMTALA obligations and CMS has completed its enforcement action against a hospital. The case is first reviewed by OIG for the purpose of making a recommendation on whether OIG should pursue its administrative remedies against a hospital and/or a responsible physician or exercise its prosecutorial discretion and close the case. Federal regulations require that OIG take into account various factors in determining the amount of a penalty for EMTALA violations. One factor in determining whether OIG will pursue a case is whether an administrative law judge would agree that a higher, versus lower, penalty is justified in a case. In general terms, these factors include: (1) the degree of culpability of the respondent; (2) the seriousness of the condition of the individual seeking emergency medical treatment; (3) other instances where respondent failed to meet its obligations under EMTALA; (4) respondent's financial condition; (5) the nature and circumstances of the violation; and (6) other matters as justice might require. *See* 42 C.F.R. Sections 1003.106(a)(4) and (d). OIG also considers issues related to whether an enforcement action would help educate and/or emphasize a hospital's or physician's responsibilities under EMTALA. OIG then closes the case or decides to pursue it. The vast majority of pursued cases are resolved through negotiations. On occasion, the case goes to trial before the Departmental Appeals Board (DAB). An unfavorable opinion by the Administrative Law Judge may be appealed by either party to the appellate division of the DAB. If respondent choses to appeal after that, the appeal would be filed directly with the appropriate United States Court of Appeals.

Enforcement Actions Related to Psychiatric Emergencies

OIG has reviewed and pursued cases involving psychiatric emergencies throughout our enforcement history. Two such recent cases include enforcement actions against Carolinas Medical Center in North Carolina and Duke University Hospital, also in North Carolina. Both cases were resolved by settlement agreements.

Effective December 3, 2013, OIG entered into a settlement with Carolinas Medical Center for a maximum penalty of $50,000 to resolve allegations that it did not provide an appropriate medical screening examination or stabilizing treatment to patient, K.C. OIG alleged the following facts: On May 16, 2010, K.C. presented to Carolina's Emergency Department with complaints of homicidal ideation and acute depression. He stated that he feared hurting himself and his wife and that he had visual hallucinations. A little over two weeks earlier, he presented to Carolinas with similar complaints. At that time,

Carolinas learned that K.C. had access to firearms. After what OIG alleged was a cursory examination, K.C. was discharged from the Emergency Department with a prescription for a mild anti-depressant. Shortly after discharge, K.C. killed his wife and two of his children. When police came to his home, he killed himself.

Effective September 5, 2012, OIG entered into a settlement with Duke University Health System d/b/a Duke University Hospital for $180,000. The settlement resolved allegations that Duke violated EMTALA by failing to accept five appropriate transfers of individuals with unstable emergency medical conditions who required the stabilizing specialized capabilities available at Duke's Williams Unit, a 19-bed adult psychiatric unit located within Duke's main hospital. OIG alleged the following: Three of the patients were refused transfer by Duke because Duke impermissibly restricted transfers to the Williams Unit to certain business hours. The restrictive schedule was not reflective of Duke's specialized capabilities available at the times the transfers were requested. One of the other two patients was refused transfer because he was too aggressive (a charge the government's investigation did not support). The fifth patient was refused transfer because the Williams Unit did not treat patients primarily suffering from substance abuse and Duke had yet to receive the patient's lab results that would indicate whether or not substance abuse was an issue. OIG did not find that the facts of this case justified such a refusal.

Thank you for the opportunity to discuss OIG's role in enforcing EMTALA. I am happy to answer questions you may have.