HEALTHCARE REGULATORY ROUND-UP - Episode #55

Emergency Medical Treatment & Labor Act (EMTALA) Update

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Introductions

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Agenda

1. EMTALA Overview
2. Three Tenets of EMTALA
3. Regulatory Checklist
4. EMTALA Enforcement
5. Resources

EMTALA Overview

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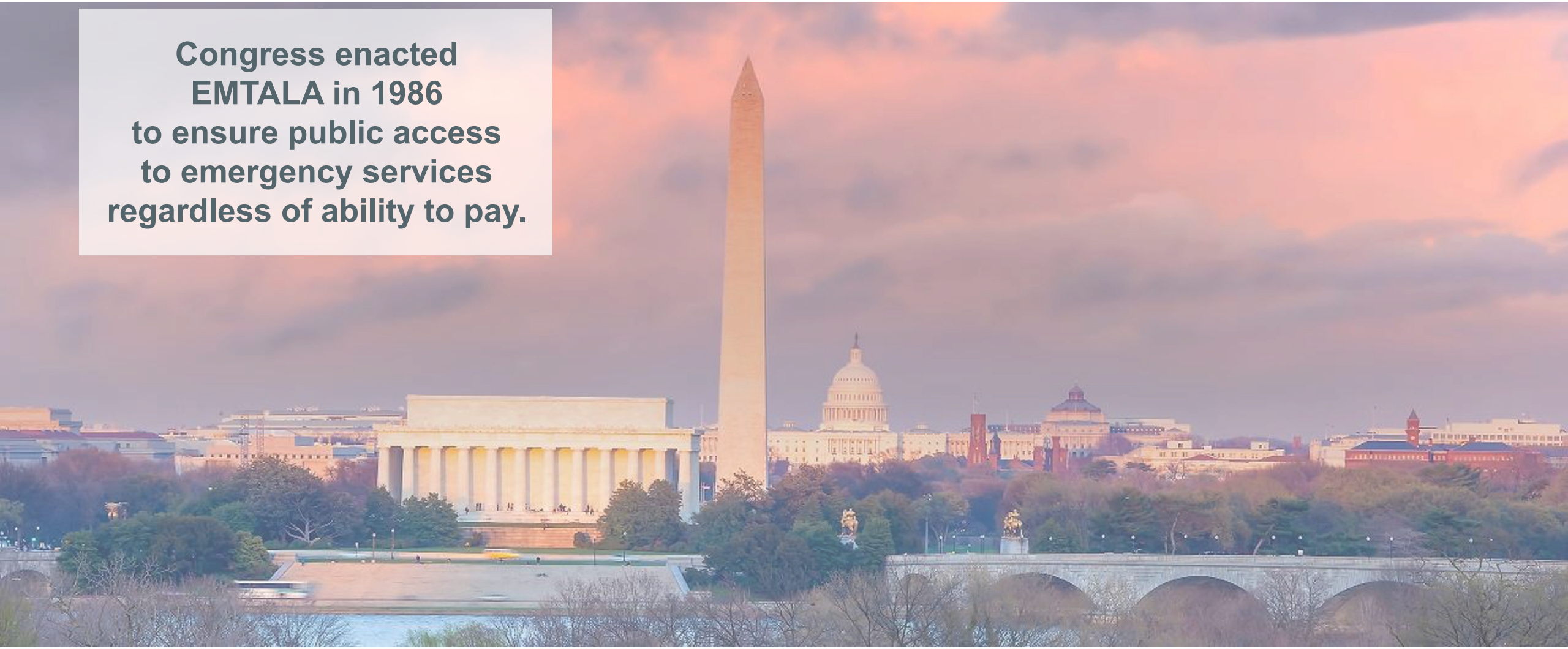

Congress enacted EMTALA in 1986 to ensure public access to emergency services regardless of ability to pay.

EMTALA Overview

- Section 1867 of the Social Security Act imposes requires Medicare-participating hospitals that offer emergency services to provide **medical screening examination** (**MSE**) furnished by **qualified medical personnel** (**QMP**) when request is made for examination or treatment for **emergency medical condition** (**EMC**) (including active labor) regardless of individual's ability to pay.
  - **When a patient:**
    - Presents at **dedicated emergency department** (**DED**) requesting examination or treatment of any medical condition
    - Presents on hospital property requesting examination or treatment of what may be an EMC
    - Is in hospital-owned/operated ambulance
    - Is in a non-hospital owned ambulance on hospital property (e.g., 250 yards of main building) for presentation at the DED

EMTALA Overview

- Hospitals required to provide **stabilizing treatment** for patients with EMCs.
- If a hospital is unable to stabilize a patient within its capability, or if the patient requests, **appropriate transfer** should be implemented.

https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA

Three Tenets of EMTALA

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1. Medical Screening Examination

2. Stabilizing Treatment

3. Appropriate Transfer

1. Medical Screening Examination

MSE

- Performed by QMP to address and assess presenting symptoms, including but not limited to history, physician exam involving area or system, and ancillary tests or services to identify an EMC.

QMP

- Defined in medical staff bylaws. May include physicians, Advanced Practice Providers (APPs), and registered nurses (RNs).

EMC

- Acute and severe symptoms that, absent of immediate medical attention, could reasonably be expected to result in placing the individual in serious jeopardy (including health of an unborn child), serious impairment of bodily functions, or serious dysfunction of any organ or part.

Medical Screening Examination
No Delay/No Discrimination

- Hospital **cannot delay MSE/emergency care** to inquire about method of payment or insurance status.
  - Under No Surprises Act, payers cannot impose prior authorization requirements for emergency care
- Hospital must **provide emergency care** without regard to:
  - Age
  - Sex
  - Race
  - Color
  - National origin
  - Disability
  - Diagnosis
  - Financial status

Medical Screening Examination
What Constitutes an Adequate MSE?

- **Triage ≠ MSE**
- **Not based on failure to diagnose EMC**
- Persons with **similar conditions and symptoms must receive same care**
- Performed by a **QMP**
  - Designated in bylaws
  - Scope of practice/consistent with protocols
- **Mental health/medical conditions**

Medical Screening Examination
Evidence of an MSE

- Do physicians or QMPs document when MSE has been completed?
- Are ancillary services used as needed to evaluate the presenting complaint and determine if an EMC exists?
- Are persons presenting with the same symptoms treated in the same manner?

2. Stabilizing Treatment
Evidence of Treatment

- Is it performed **within the capability of facility and staff**?
- Confirm that **all physicians are presenting to the facility when called** and in compliance with timeframe set forth in facility policy.
- Is there **a communication process between the clinical staff and registration staff** so that any required prior authorization can be sought once stabilizing treatment has been initiated?
- **Continued care** could be reasonably performed as an outpatient or later as an inpatient?
- Are patients **discharged with appropriate instructions** for follow-up care?
- Has **follow-up care availability** been identified?

Stabilizing Treatment
HHS States Federal Law (EMTALA) Preempts State Law

- **Federal law**
  - **U.S. Supreme Court**
    - Dobbs v. Jackson Women's Health Organization (June 24, 2022)
      - Abortion is not a constitutional right; states have the authority to legislate abortion procedures
  - **U.S. President**
    - Executive Order (July 8, 2022)
  - **HHS**
    - Secretary's letter to Healthcare Providers (July 11, 2022) EMTALA to be followed (penalties: fines (CMP), Medicare/Medicaid exclusion)
  - **CMS**
    - Guidance QSO-22-22 to Surveyors (July 11, 2022), and QSO-21022 Patients who are pregnant/experiencing pregnancy loss (September 19, 2021, rev October 3, 2022)
    - **EMTALA "preempts any directly conflicting state law or mandate that might otherwise prohibit or prevent such treatment."** If a patient with an EMC requires an abortion as medical treatment to stabilize the patient, an abortion must be provided.

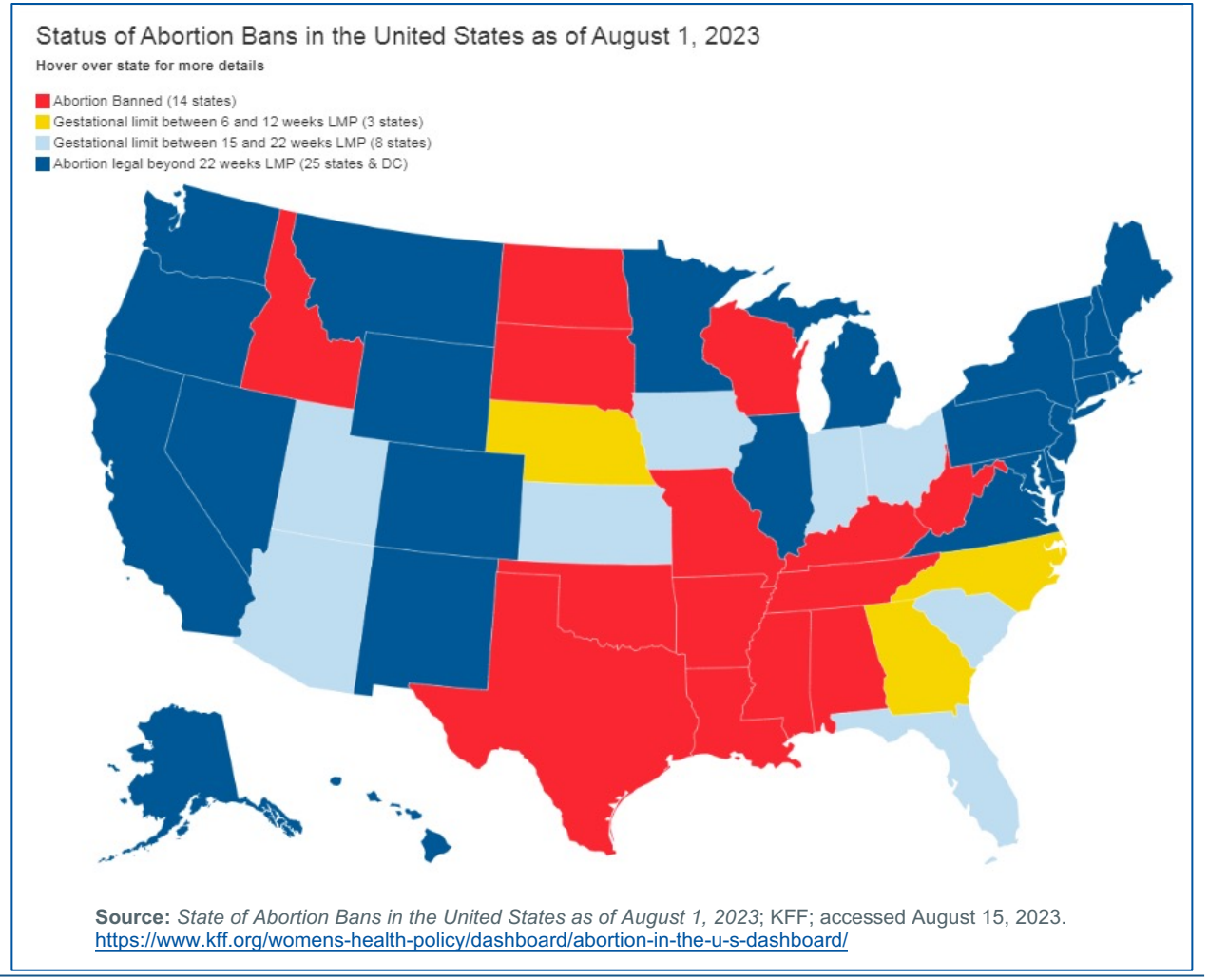
Stabilizing Treatment

- Providing treatment within hospital's capabilities to stabilize for discharge or transfer
  - If physician believes pregnant patient presenting at ED is experiencing EMC, and that abortion is stabilizing treatment necessary to resolve that condition, physician must provide that treatment.
  - When state law prohibits abortion and does not include exception for the life of pregnant person — or draws exception more narrowly than EMTALA's EMC definition — state law is preempted.
  - When direct conflict exists between EMTALA and state law, EMTALA must be followed.
  - EMTALA's whistleblower provision prevents retaliation by hospital against any employee or physician who refuses to transfer patient with EMC whose has not been stabilized by initial hospital, e.g., patient with emergent ectopic pregnancy, patient with incomplete medical abortion.

https://www.cms.gov/files/document/qso-22-22-hospitals.pdf

Stabilizing Treatment
What if Providers Do Not Follow State Law?

- **State law**
  - Every state law varies:
    - **15 complete bans**
    - **11 restrictions (gestational limit)**
    - **5 states bans were blocked**
    - **20 states legal with enhanced protections**
    - **4 states (plus D.C.) legal**



Source: *State of Abortion Bans in the United States as of August 1, 2023*; KFF; accessed August 15, 2023. https://www.kff.org/womens-health-policy/dashboard/abortion-in-the-u-s-dashboard/

Stabilizing Treatment
Federal vs. State Law

- States have initiated litigation claiming that EMTALA does not preempt state laws (Texas and Idaho), leading to CMS guidance placed on hold in Texas.
  - Texas v. Becerra
    - Stabilizing treatment to conform with Texas's medical exception for abortion…"when patient's condition is life-threating or poses serious risk of substantial impairment of a major bodily function."
    - Court issued Injunction that stops physicians from providing emergency abortion care when deemed medically necessary to stabilize a patient).
  - United States v. Idaho
    - "…abortion was necessary to prevent the death of the pregnant woman."
    - Court issued temporary injunction (July 31, 2023) –Idaho's Attorney General is prohibited from enforcing Idaho's criminal abortion statute per Crane letter

https://www.americanhealthlaw.org/content-library/connections-magazine/article/b7a49aa7-ec78-48dd-b254-be04e2db46f7/between-emtala-and-state-abortion-restrictions-the

EMTALA Enforcement

Provider Liability – State Law Violations

- Will abortion procedure provided to stabilize EMC cause provider to violate state law?
- **Provider penalties for violation of state law:**
  - Fines
  - Suspension of medical license
  - Imprisonment
- **What is a provider to do?**
  - American College of Emergency Physicians requested CMS to advise – CMS pointed to the 2021 Pregnant Patient/Pregnancy Loss CMS Guidance.
  - Document the EMC (ectopic pregnancy, complications of pregnancy loss, emergent hypertensive disorders/preeclampsia). EMC *"may include a condition that is likely or certain to become emergent without stabilizing treatment."*
  - Document continuing stabilizing treatment (D&C, anti-hypertensive therapy)
  - Transfer permitted only if benefits to woman/unborn child outweigh risks

What Is an ER Provider to Do?

- Continue to comply with EMTALA.
- Know your state laws to aid in documenting necessary information regarding decisions made.

3. Transfer

1. Provide treatment minimizing risk of individual's health or health of unborn child during transfer

2. Contact receiving facility confirming space and personnel and receiving hospital agrees to receive the transfer.

3. Send copies of medical record.

4. Arrange for transfer by qualified personnel and appropriate equipment.

Accepting Transfers

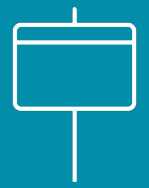
- Hospital may not refuse requested transfer if patient requires specialty capabilities provided at hospital, unless:
  - Hospital lacks capacity to treat; ***or***
  - Hospital on diversionary status.

Regulatory Checklist

Regulatory Checklist

On-call

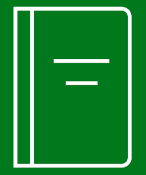
Patient refusal forms



Signage

Central log

Record retention



Policies

On-Call

- On-call physicians
  - Maintain list of on-call physicians
    - Identify individual, not physician group
    - On-call physician responsible for keeping ED apprised of schedule changes
  - Respond in pre-established time limit
  - Present in person upon request of emergency room physician or QMP

How Often Must a Physician Be On Call?

- Hospital must maintain on-call list in manner that best meets needs of the hospital's patients in accordance with capability of hospital, including availability of on-call physicians.

Patient Refusal

- Patient has the right to refuse examination, treatment, or transfer.
- Hospital **must**:
  - Offer examination, treatment, or transfer
  - Document refusal
  - Explain risks and benefits
  - Obtain written informed refusal (if possible)

Required Signage

- **EMTALA rights to be posted conspicuously:**

1. Emergency Department

2. Labor & Delivery Department

3. Areas where patient may wait for exam or treatment

Entrances and Signages

- **Identify all entrances into facility which could be utilized by persons presenting for examination and treatment (including ambulance bay).**
  - Are required EMTALA signs **posted at each such entrance**?
  - Identify all DEDs (including Labor and Delivery).
  - Are required EMTALA signs **posted in the registration/waiting area** of each DEDs?
  - Are all **signs clearly visible** from 20 feet or the expected vantage point of the patron?
  - Are **signs in the languages of the population(s) most frequently served** by the facility?
  - Is there a **process for checking on signs**?

Central Log

- Maintain log for **every patient seeking treatment.**
  - Left without being seen (John Doe)
  - Refused treatment
  - Transferred
  - Admitted and treated
  - Stabilized and transferred
  - Discharged

Record Retention

- Call list
- Central log
- Medical records

"Maintain medical and other records related to individuals transferred to and from the hospital for a period of five years from the date of the transfer…"

CMS Operating Manual for Surveys

Policies

- Adopt and enforce policies and procedures to comply with the requirements of 42 CFR §489.24

Hospital property	Triage	EMC	MSE	QMP
Transfer	Discharge	Physicians on call	Signage	Process for violations

Training

Who?

- All staff that may encounter patients seeking emergency care (registration clerk, nurse, MD, QMP)
- Departments: psych outpatient, labor and delivery, ER

How Often?

- When changes to policies, protocols, laws
- An issue was identified, requiring retraining
- Routinely

What do we train on?

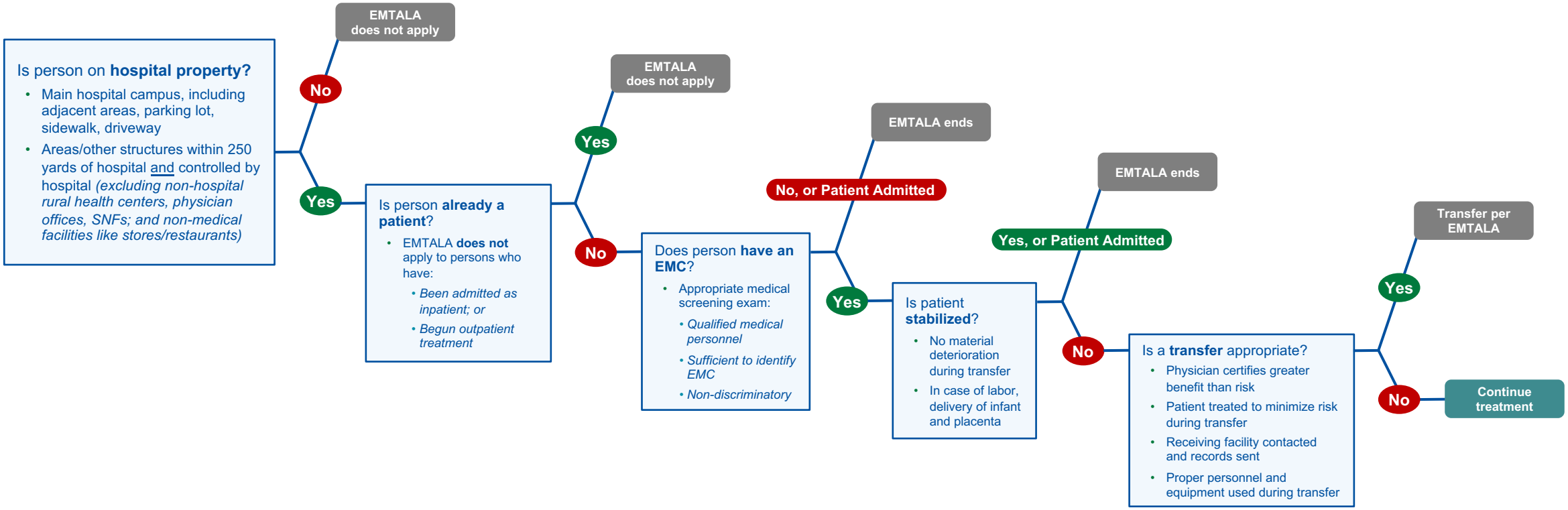
EMTALA requirements and Policies

Findings of internal audits

EMTALA Decision Tree

EMC:

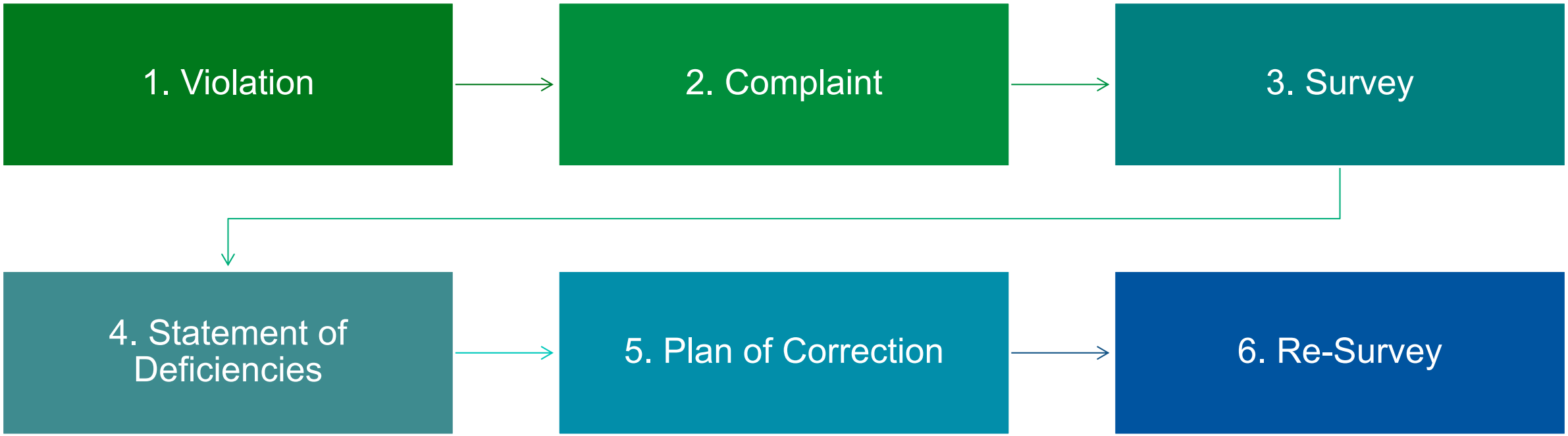
1. Absence of immediate medical attention would seriously jeopardize/impair patient's health, body/organ/part function; and/or
2. Insufficient time to transfer a pregnant person to another facility before delivery, or transfer may pose serious health/safety threat; and/or
3. Acute psychiatric/substance abuse symptoms are manifested; expression of suicidal/homicidal thoughts/gestures and patient determined to be threat to self or others



Hospital Obligations

- **In summary…**
  - A hospital's EMTALA obligation ends when QMP determines -
    - No EMC exists (even though the underlying medical condition may persist); ***or***
    - An EMC exists, and individual is appropriately transferred to another facility; ***or***
    - An EMC exists, and individual is stabilized or admitted to hospital for further stabilizing treatment

EMTALA Enforcement by CMS



Suspected Violations

- Internally investigate all potential EMTALA violations
- Implement appropriate and necessary corrective action
  - Review and revise, if necessary, **policies and procedures**
  - **Re-educate personnel**
  - Impose **disciplinary action**, if warranted
  - Create and implement an **audit tool**

Complaints

- EMTALA is complaint driven.
- Sources of complaints:

Patients/families

Other healthcare providers
(physicians, receiving hospitals)

Employees
(disgruntled or otherwise)

Survey

- **Unannounced**
- Purpose of the survey:
  - Ascertain if EMTALA violation
  - Determine if violation constitutes immediate jeopardy to patient health and safety
  - Identify patterns of violations at the facility
  - Assess facility's existing policies and procedures
- Even if complaint that initiated survey is unsubstantiated, **CMS can (and will) cite other EMTALA violations it finds** as well as violations of the Medicare CoPs.
- **CMS is not limited in time or scope of its review of records**; however, traditionally surveys look back 6 to 12 months.

Statement of Deficiencies (SoD)

Hospital should receive the SoD within 30 days of the survey exit.

Cover letter indicates 23-day or 90-day termination track.

Termination from Medicare/Medicaid program is CMS' most severe penalty under EMTALA.

CMPs may be issued by CMS against violating providers.

Plan of Correction

- Generally submitted **within 10 days** of receipt of the SoD.
- Must adequately address the following:
  - Correction of the violation, if possible
  - Description of how facility will ensure continued compliance
  - Implementation of appropriate audit tools to track compliance
- Hospital must provide CMS with a credible allegation of compliance.
- CMS must approve before authorizing a re-survey.

Re-Survey

- Not limited to matters covered in the initial survey.
- Any Medicare CoP deficiency cited can continue a hospital towards termination.
- CMS may convert a hospital from a 23- to a 90-day termination track upon re-survey.

Termination

If fail to re-survey, receive notice of termination

No formal immediate appeal

Appeal to agency discretion

Fines

Hospital

- Civil Monetary Penalty (CMP) will typically follow an EMTALA violation.
- OIG will determine the amount of the penalty.
- For those violations involving clinical determinations, facility may seek QIO review.
- CMPs up to $119,942 per violation for hospitals > 100 beds ($59,973 < 100 beds)

Physician

- Physicians may also be assessed CMPs of up to $119,942 per gross or repeated violation
- OIG may also exclude a physician from participation in Medicare/Medicaid
- Violations may also be reported to the physician's licensing board

Resources

Resources

- CMS *Emergency Medical Treatment & Labor Act (EMTALA):* https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA
- CMS/QSOG/SOG *Reinforcement of EMTALA Obligations Specific to Patients Who are Pregnant or are Experiencing Pregnancy Loss* policy memo: https://www.cms.gov/files/document/qso-22-22-hospitals.pdf
- AHLA Health Law Connections: *Between EMTALA and State Abortion Restrictions*: https://www.americanhealthlaw.org/content-library/connections-magazine/article/b7a49aa7-ec78-48dd-b254-be04e2db46f7/between-emtala-and-state-abortion-restrictions-the
- Kaiser Family Foundation/KFF *Abortion in the United States Dashboard*: https://www.kff.org/womens-health-policy/dashboard/abortion-in-the-u-s-dashboard/

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