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INSIDE:

Emergency Medical Treatment and Active Labor Act Regulations

Adults Left Behind

Reaffirming Diversity
Newly Revised Emergency Medical Treatment and Active Labor Act Regulations: Leaving Patients Knocking on the Hospital Door?

By Lourdes A. Rivera, Randolph Boyle, Jane Perkins, and Sarah J. Somers

On September 9, 2003, the Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration) issued a final rule amending the implementing regulations of the Emergency Medical Treatment and Active Labor Act (EMTALA). These regulatory changes were made in response to hospital and physician complaints that existing rules were too burdensome, overreached, and interfered with efficient patient care. EMTALA regulations were targeted as part of an overall effort by Tommy Thompson, the secretary of the U.S. Department of Health and Human Services (HHS), to reduce “burdensome” regulatory obligations and paperwork that “serve little purpose, that discourage efficiency and deplete the time and energy of health care providers.” CMS also expressed concern that EMTALA not be viewed as establishing a federal malpractice cause of action. Thus these new changes were implemented with the overall goal of limiting EMTALA’s scope and application.


2See, e.g., Comments of Dr. Margaret Barron, Providence Hospital, Washington, D.C., HHS (U.S. Department of Health and Human Services), Secretary’s Advisory Committee on Regulatory Reform, Afternoon Session (Washington, D.C., Jan. 7, 2002), at 8–9 [hereinafter Advisory Committee on Regulatory Reform Afternoon Session] (transcript on file with National Health Law Program, Los Angeles) (describing how application of EMTALA to an off-site hospital facility is problematic because it prevents the off-site facility from transferring a patient to a closer emergency room of another hospital and how paperwork requirements documenting the treatment of the patient is overly burdensome); Statement of the American Medical Association to the Practicing Physicians Advisory Council Re: Physician Fee Schedule Update Emergency Medical Treatment and Active Labor Act (June 3, 2002) (urging that CMS permit specialists to schedule surgeries and be on-call simultaneously at more than one hospital), www.cms.hhs.gov/faca/ppac/amappac6-3.asp; Letter from John Whitelaw, President, California Medical Association, to Thomas Scully, CMS, Re: Regulations to Implement the Emergency Medical Treatment and Active Labor Act (EMTALA) (July 3, 2002) (supporting CMS’ proposed regulations allowing a limited screen to rule out an emergency for individuals presenting themselves to the emergency department with nonemergency conditions; supporting eliminating EMTALA obligation for those patients admitted as inpatients) (on file with National Health Law Program, Los Angeles).

3Comments of Secretary Tommy Thompson, HHS, Secretary’s Advisory Committee on Regulatory Reform, Morning Session (Jan. 7, 2002), at 7 [transcript on file with National Health Law Program, Los Angeles]. Several consumer advocates commented on the lack of adequate consumer and advocate representation on this commission of twenty-seven members. See Comments of Steve Htov (National Health Law Program), Diana Zuckerman (National Center for Policy Research for Women and Families), and Bob Griss (Consortium for Citizens with Disabilities Health Task Force), Advisory Committee on Regulatory Reform Afternoon Session, supra note 2, at 29–31, 34–35

Background

In 1986 Congress passed EMTALA to address the health care crisis of hospital emergency room patient dumping, particularly of those unable to pay. Under the law, Medicare participating hospitals with emergency rooms (i.e., almost all hospitals) are required to

- conduct a medical examination for any patient who comes to their doors to determine whether the patient has an emergency medical condition;  

- provide stabilizing treatment within the capacity of the hospital;  

- transfer or discharge a patient only if stabilized.

Medical screens and stabilizing treatment may not be delayed to inquire about the patient’s method of payment or insurance status. A hospital may transfer an unstable patient only if the patient gives informed consent or if the physician on duty (or qualified medical personnel with the agreement of the physician) certifies in writing that the medical benefits of the transfer outweigh the risks to the individual. Further transfer requirements include that the transferring hospital provide the medical treatment within its capacity to minimize the risks to the individual, that the receiving hospital has space and qualified personnel and has agreed to accept the transfer, and that the transfer is effected through qualified personnel and transportation equipment.

CMS and the Office of Inspector General (OIG) (both within HHS) are EMTALA’s enforcers. CMS authorizes investigations of patient-dumping complaints by

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642 U.S.C. § 1395dd(a) (2003). “Emergency medical condition” is defined as “(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) 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, or (ii) serious dysfunction of any bodily organ or part; or (B) with respect to a pregnant woman who is having contractions (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child. Id. § 1395dd(e)(1).

7Id. § 1395dd(b)(1)(A).

8Id. § 1395dd(c)(1).

9Id. § 1395dd(h).

10Id. § 1395dd(c)(1)(A).

11Id. § 1395dd(c)(2). The transferring hospital must send the relevant records in its possession with the patient. Id.

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Some of the new regulatory changes may improve emergency room operations, but many others pose barriers for patients attempting to access services: The following explains the most significant changes:

1. **Before providing screens and stabilizing care, what information may hospitals ask from patients?**
   - **May hospitals get prior authorization from insurers or HMOs?**

The revised final rules maintain the general rule that hospitals may not delay providing the required screens and stabilizing treatment in order to inquire about the individual’s method of payment or insurance status. CMS and the OIG did not adopt EMTALA’s final regulations until June 1994, eight years after EMTALA’s passage. In 1995 CMS and the OIG issued interpretive guidelines (revised in 1998) for surveyors to use in assessing hospital compliance. In 1999 CMS and the OIG issued additional guidelines to hospitals to address how obligations under EMTALA should apply to individuals in managed care plans. The regulations were amended in April 2000 to address how EMTALA applied to off-campus hospital departments.

**The New EMTALA Regulations**

Any individuals who suffer personal harm from a hospital’s emergency medical treatment violation also may ask for enforcement of the law. EMTALA authorizes civil actions against the hospital for damages as well as appropriate equitable relief. Damages are limited to those available for personal injury under state law. A receiving hospital that suffers a financial loss as a direct result of a transferring hospital’s EMTALA violation may also bring a civil action for damages and equitable relief. Any agency enforcement or private action must be brought within two years after the date of the violation.

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13 Id. at 1.
14 Id.
15 Id. at 8.
16 Id. at 8-9.
18 Id.
19 Id. § 1395dd(d)(2)(B).
20 Id. § 1395dd(d)(2)(C).
21 Medicare Program: Participation in CHAMPUS (Civilian Health and Medical Program for the Uniformed Services) and CHAMPVA (Civilian Health and Medical Program of the Department of Veteran Affairs), Hospital Admissions for Veterans, Discharge Rights Notice, and Hospital Responsibility for Emergency Care, 59 Fed. Reg. 32086 (June 22, 1994).
may not seek prior authorization from an individual’s insurance provider until they have provided an appropriate medical screen and initiated stabilizing treatment.\textsuperscript{26}

However, CMS added two qualifiers that raise serious concerns. First, CMS allows hospitals to follow “reasonable registration processes,” which may include asking whether an individual is insured and, if so, what the insurance is. The registration process may not delay screenings or “unduly discourage” individuals from remaining for further evaluation.\textsuperscript{27} In the preamble, CMS also explains that hospital staff may discuss potential financial liability upon inquiry from a patient; however, CMS encourages patients to defer such discussions until after the screen is performed.\textsuperscript{28}

Second, CMS allows hospitals to seek information other than about payment from the insurer about the patient and to seek authorization for all services concurrently with providing stabilizing treatment, as long as screening and stabilizing services are not delayed.\textsuperscript{29} In adding this provision, CMS states that EMTALA says only that a hospital “may not delay EMTALA screening or stabilization in order to inquire about the individual’s method of payment or insurance status” but EMTALA does not address the issue of when contact may be made with insurers.\textsuperscript{30}

While CMS clearly states in the preamble that hospitals must provide services even if prior authorization is denied, and should explain to patients that services would be provided regardless of ability to pay, the rules open the door for hospitals to pressure patients to leave the hospital before providing stabilizing services.\textsuperscript{31} To be questioned about one’s health insurance status or “to be informed” about potential financial liability even before a screen is provided or to be informed that perhaps one’s insurance provider does not approve the service can be extremely intimidating from a patient’s point of view.

Some commentators also raised concern that hospital staff charged with making contact with insurers would not necessarily know when a screening service ended and when stabilizing treatment began or that administrative staff may not know the condition of the patient before they took action. CMS’ response to these concerns is that hospitals and staff are capable of developing appropriate procedures.\textsuperscript{32} Ironically CMS explains that the rules strike a balance between ensuring that services are not delayed and the “equally important need to protect the individual from avoidable liability for the costs of emergency health care services.”\textsuperscript{33}

Advocates must be vigilant to ensure that inquiry from patients regarding their insurance and the “registration process” do not pressure patients to leave the emergency room before necessary screening and treatment.

The final rules also clarify that emergency medical personnel may contact the patient’s doctor at any time to seek advice and information regarding the patient’s medical history and needs that may be relevant to the medical screening.

\begin{footnotes}
\item[26] Id. § 489.24(d)(4)(ii)(2003).
\item[27] Id. § 489.24(d)(4)(iii); 68 Fed. Reg. at 53227.
\item[28] 68 Fed. Reg. at 53227.
\item[30] 68 Fed. Reg. at 53226; 42 U.S.C. § 1395dd(h) states: “A participating hospital may not delay provision of an appropriate medical screening examination … or further medical examination and treatment … in order to inquire about the individual’s method of payment or insurance status.”
\item[31] Id.
\item[32] Id. at 53226–27
\item[33] Id.
\end{footnotes}
and treatment as long as the consultation does not inappropriately delay required screening or stabilizing treatment.\textsuperscript{34}

2. To which part or parts of the hospital does EMTALA apply? Where must a patient go in order to be protected by EMTALA?

An individual is protected under EMTALA if the individual “comes to the emergency department.”\textsuperscript{35} An individual will be considered to have come to the emergency department in one of four places: at the hospital’s “dedicated emergency department,” on “hospital property,” in a ground or air ambulance owned and operated by the hospital, or in a ground or air ambulance that is not owned and operated by the hospital but is on hospital property.\textsuperscript{36} Limiting EMTALA to these four locations is more restrictive than the previous rules, which more generally defined “hospital with an emergency department.”\textsuperscript{37} Each of the four locations has its own particular rules and exemptions as set forth below.

**Dedicated Emergency Department.**

The “dedicated emergency department” is the center of the obligations under EMTALA. To meet the definition, the dedicated emergency department must meet at least one of three requirements.\textsuperscript{38} The first requirement is that it be licensed as an emergency room or emergency department under state law.\textsuperscript{39} A facility that the state licenses as an emergency department is recognized as such for EMTALA purposes, but such a facility is not the only one that should be considered to meet the definition.\textsuperscript{40}

The second requirement is that the facility holds itself out to the public as a place that provides care for emergency medical conditions without requiring a previously scheduled appointment.\textsuperscript{41} Although the facility’s actual functions are pivotal in this determination, the name of the facility or department, signage, advertising, or other means help in determining whether the facility meets this definition.\textsuperscript{42} CMS did not see a significant difference between a facility treating “urgent need” and one that provided care for an “emergency medical condition” if both provided care for emergency medical conditions without an appointment.\textsuperscript{43} In its proposed rule CMS rejected language that determined whether a facility met this definition by virtue of special equipment or staffing at the facility.\textsuperscript{44}

If a facility does not meet one of the first two requirements, it may meet the third. The third requirement encompasses a facility or department which, based on a representative sample of patient visits during the previous calendar year, provides “at 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.”\textsuperscript{45} Note that the representative sample is of outpatient visits and requires treatment, not simply an evaluation of an emergency medical

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\textsuperscript{34}42 C.F.R. § 489.24(d)(iii) (2003); 68 Fed. Reg. at 53226–27.
\textsuperscript{35}42 C.F.R. § 489.24(b) (2003).
\textsuperscript{36}Id.
\textsuperscript{37}Compare 42 C.F.R. § 489.24(b) (2002) (definition of hospital with an emergency department.)
\textsuperscript{38}Id. § 489.24(b)(2003).
\textsuperscript{39}Id.
\textsuperscript{40}68 Fed. Reg. at 53230.
\textsuperscript{41}42 C.F.R. § 489.24(b) (2003).
\textsuperscript{42}Id.
\textsuperscript{43}68 Fed. Reg. at 53231.
\textsuperscript{44}Id. at 53232. Compare proposed version of Section 489.24(b) at 67 Fed. Reg. 31506 (2002).
\textsuperscript{45}42 C.F.R. § 489.24(b) (2003).
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condition. CMS stated that it adopted this objective definition in order to enable hospitals to know in advance whether they are subject to EMTALA. CMS expects to issue future guidelines for determining a representative sample and other clarification. CMS considered and rejected several other proposed definitions of a dedicated emergency room, including defining it by how a prudent layperson would view it.

Notably the dedicated emergency department encompasses more than the immediate “emergency room.” The dedicated emergency department also includes departments such as labor and delivery and psychiatric units where individuals may present themselves for emergency treatment. However, the department where individuals present themselves need not be the place that performs the medical screening and stabilization. A hospital does not need to maintain emergency screening or treatment capabilities in every part of the hospital. If the hospital operates a facility that meets the definition of a dedicated emergency department, but that facility is located off the main hospital campus, EMTALA still applies to individuals who present themselves to that facility. CMS expects to determine what physical locations constitute a dedicated emergency department on a case-by-case basis.

Hospital Property. A second area in which EMTALA protection applies is on “hospital property.” An individual need not actually enter the hospital’s emergency department for EMTALA to apply because “hospital property” is defined as the entire main hospital campus as defined at § 413.65(b)… 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.

The new regulations exempt a provider-based entity, a health facility that can be a separate Medicare provider although it is owned and operated by the hospital, regardless of where the provider-based entity is located and regardless of what emergency care capabilities the entity may have. Thus a fully staffed, hospital-owned clinic or skilled nursing facility or a physician office immediately adjacent to an emergency department usually would not be under EMTALA obligations. A hospital gift shop located next to the emergency room would not be

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47 Id. at 53229.
48 Id.
49 Id. at 53230–33.
50 Id. at 53229.
51 Id.
52 Id. at 53230.
53 Id. at 53238.
54 Id. at 53228, 53248.
55 Id. at 53236.
57 Id., 68 Fed. Reg. at 53243.
considered part of the “hospital property” either. Section 413.65(b) of Title 42, which is included in the definition, actually describes how a determination of a provider-based entity is made, while Section 413.65(a)(2) has definitions of “campus” and “provider-based entity.” Under the latter section, “campus” includes the physical area immediately adjacent to the provider’s main buildings, other areas and structures that are not strictly contiguous to the main buildings but within 250 yards of the main building, and other areas as CMS determines on a case-by-case basis.59

The new regulations remove much of the EMTALA obligations that previously applied to an off-campus facility. Under the former regulations, if individuals presented themselves with an emergency condition at an off-campus facility, the hospital was required to provide screening and stabilization, whether or not that off-campus facility qualified as an emergency department.60 The new regulations exempt an off-campus facility unless it is a dedicated emergency department in its own right.61 Off-campus facilities not meeting that definition may refer an individual to an appropriately equipped emergency facility, but the referring facility is not expected to transport the individual to the main campus emergency department.62 CMS expects hospitals to have appropriate protocols for people who present themselves at nonemergency, off-campus facilities for emergency care.63 However, these protocols are expected to be implemented only within the off-campus facility’s hours of operation and only within the normal staffing capability of the facility.64

Ambulances. The final locations to which EMTALA potentially applies are in hospital-owned and non-hospital-owned ambulances. The new regulations broaden EMTALA’s reach to include air ambulances.65 However, they reduce the number of situations in which a person in an ambulance is covered. For either hospital-owned or non-hospital-owned ambulances, EMTALA coverage depends on the individual being in the ambulance for purposes of “examination and treatment of a medical condition at a hospital’s dedicated emergency department.”66 This provision could be significant. According to CMS, EMTALA would not apply, for example, to an apparently stable person who is being transferred from one nursing home to another and who experiences an emergency condition en route.67

Hospital-Owned Ambulances. Generally EMTALA protects an individual who is in an ambulance, including air ambulances, owned and operated by the hospital even though the ambulance may not be on the hospital grounds.68 However, the rule has several important exceptions. The largest exception is for hospital-owned and -operated ambulances under communitywide or state-law-required emergency medical service (EMS) protocols requiring the ambulance to take a patient to the nearest appropriate facility.69 In those cases, the individual is considered to have

5942 C.F.R. § 413.65(a)(2).
61Id. § 489.24(b) (2003); 68 Fed. Reg. at 53248.
63Id. at 53229.
64Id. at 53259.
65Id. at 53257.
“come to the emergency department” of the hospital to which the individual is transported only when the individual is brought onto the hospital property.70 Another exception is when the ambulance is operating “under medical command,” that is, when the ambulance’s destination is determined by a physician who is in radio contact with ambulance personnel. In this type of situation the patient is not considered “coming to the hospital” if the physician is not employed or otherwise affiliated with the hospital that owns the ambulance.71 CMS also notes that there may be situations in which redirection of the ambulance to the closest appropriate facility capable of treating the individual’s condition is necessary to protect the life or safety of the individual.72 The facility to which the ambulance takes the individual need not be a hospital.73

Non-Hospital-Owned Ambulances. If an individual is in a non-hospital-owned ground or air ambulance on hospital property, EMTALA applies.74 Before the individual arrives on the hospital property, EMTALA does not apply even if the ambulance has contacted the hospital to inform the hospital that it is bringing in a patient.75 The hospital may direct the ambulance to another facility if the hospital is on “diversionary status.”76 If the ambulance staff ignores the diversionary instructions and transports the individual to that hospital, EMTALA applies once the patient is transported onto hospital property.77

3. What must a patient request from the hospital in order for EMTALA to apply? What is a request for services that would trigger EMTALA’s obligations?

In order for EMTALA to apply, a patient (or someone on the patient’s behalf) must make “a request for services.” Under the new rules, what the individual must request varies with where at the hospital the individual presents herself. An individual who arrives at the dedicated emergency department (see discussion above) must request examination or treatment for a medical condition. The request need not be regarding an emergency medical condition.78

As CMS points out, EMTALA clearly requires a medical examination for individuals who present themselves at the hospital emergency department with a medical condition.79 However, what the individuals request upon presenting themselves at the emergency department is key. For example, in response to a suggestion that EMTALA not apply to requests for nonemergency care, such as previously scheduled care or follow-up care, CMS agrees that screening services are necessary only to the extent that they rule out an emergency. (See discussion below.)80 A screen is not necessary at all, according to CMS, for individuals presenting themselves at the emergency department with requests for preventive care services or for individuals who make no request.81

70 68 Fed. Reg. at 53256.
72 68 Fed. Reg. at 53257.
73 ld. at 53258.
74 42 C.F.R. § 489.24(b)(4).
75 Id.
76 ld.
77 Id. This section is not significantly different from what previously existed under 42 C.F.R. § 489.24(b) (2002).
80 ld.
81 Id. at 53235. An example of “no request” perhaps can be found in Rios v. Baptist Memorial Hospital System, 935 S.W. 2d 799 (Tex. 1996) (finding that patient’s act of walking—while raising a swollen arm—through the emergency room is not the same as presenting oneself to the emergency room and requesting care).
The distinctions among the types of care that a patient requests may not always be clear. Some guidance is in the preamble to the proposed rules in which CMS contemplates that an individual would be entitled to an EMTALA screen if she arrives at the emergency department and says that she has sutures that needed to be removed that day. CMS also says that an individual’s statement that she is not seeking emergency care—together with brief questioning by qualified medical personnel (in other words, a screen)—would be sufficient to establish that there is no emergency medical condition and the hospital’s EMTALA obligation would end. At that point the individual needing sutures removed could but would not be required to be referred to outpatient care. The hospital would have no obligation to remove the sutures under a nonemergency situation.

Advocates should monitor what pronouncements hospitals are requiring individuals to make before providing emergency medical screens.

In the absence of an individual’s verbal request for examination or treatment, such a request is inferred 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. CMS explains that this prudent-layperson standard does not apply to individuals who are fully capable of making a verbal request but elect not to do so. Thus not only must a prudent layperson believe that the individual needs examination or treatment for a medical condition, but also there has been no verbal request only because of the individual’s medical condition or some other factor beyond the individual’s control, such as a language barrier.

For individuals who do not find the right door for the dedicated emergency room, what constitutes a proper request to trigger EMTALA gets more complicated. Individuals presenting themselves on hospital property (see discussion above), other than the dedicated emergency room, must request examination or treatment for emergency medical conditions (or have such a request made on their behalf). Requesting services for a medical condition alone is not sufficient. However, an actual emergency need not exist. Individuals need only to believe that they have an emergency medical condition. The prudent layperson observer standard also applies in this situation, except that the prudent layperson must also believe that an emergency medical condition exists (e.g., profuse bleeding observed).

4. Who is entitled to EMTALA protection?

EMTALA protection of inpatients was not specifically addressed in the previous version of the rules but is the area in which CMS expresses the most concern regarding the use of EMTALA as a federal malpractice statute.

Inpatients. The final rule specifies that EMTALA is not applicable to inpatients who are admitted for elective (nonemergency) diagnosis or treatment. The final rule is explicit that obligations

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83 68 id. at 53236.
85 68 Fed. Reg. at 53241–42.
86 id. at 53242.
87 42 C.F.R. § 489.24(b)(2) (2003); see also 67 Fed. Reg. at 31474.
88 See supra note 4 and accompanying text.
under EMTALA end once individuals are admitted to hospital inpatient care. Therefore individuals who have been admitted in good faith to inpatient sections of the hospital, whether or not the individuals experience emergency medical conditions after admission, are not subject to EMTALA protection. Instead, according to CMS commentary, Medicare conditions of participation (discussed below), state tort law, standards of practice and ethical considerations adequately protect patients. If a hospital violates the conditions of participation, it may, among other penalties, lose Medicare certification and face possible termination, just as it would if it violated EMTALA. In support of its position, CMS cited recent Fourth, Ninth, and Eleventh Circuit decisions agreeing with its conclusions. CMS did leave open, however, the possibility that liability under EMTALA could attach if a hospital admitted a patient with the intent of evading its requirements.

The requirements applicable to inpatients are closely linked to the statutory definition of “stabilize,” discussed below. By definition in these regulations, stabilization occurs only after individuals come to the hospital with emergency medical conditions. Accordingly CMS finds that EMTALA obligations do not attach to inpatients even if they later develop emergency conditions.

Outpatients. EMTALA does not apply to an individual who experiences what may be an emergency medical condition if the individual is an outpatient. An outpatient is defined as a person who has not been admitted as an inpatient but who is registered on the hospital records as an outpatient and who receives services directly from the hospital. The final rule clarifies that EMTALA does not apply to any individual “who, before the individual presents to the hospital for examination or treatment for an emergency medical condition, has begun to receive outpatient services as part of an encounter.” CMS opined that outpatients, like inpatients, would be adequately protected by requirements of the Medicare conditions of participation.

Conditions of Participation. The preamble to the final rule describes the six Medicare conditions of participation protecting inpatients and outpatients: (1) emergency services; (2) governing body; (3) discharge planning; (4) quality assessment and performance improvement; (5) medical staff; and (6) outpatient services. First, if a hospital inpatient develops an emergency condition in a hospital, the hospital must ensure that it conforms with accepted standards of medical practice in responding to the emergency. Second, the governing body of the hospital is required to ensure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral. Third, all hospitals must have discharge planning to identify patient needs and ensure appropriate transfers and referrals. Fourth, the governing body must have an

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90 42 C.F.R. § 489.24(d)(2)(iii) (2003); 68 Fed. Reg. at 53243–45, 53263. Interestingly, CMS had the opposite view in the proposed regulations. Based on its analysis of the statute and legislative history, CMS had determined that EMTALA continued to apply to admitted emergency patients until they were stabilized. See 67 Fed. Reg. at 31475; 68 id. at 53244.


92 id. at 53244.

93 id., citing Bryan v. Rectors & Visitors of Univ. of Va., 95 F.3d 349 (4th Cir. 2002); Bryant v. Adventist Health Sys./West, 289 F.3d 1162 (9th Cir. 2002); Harry v. Marchant, 291 F.3d 767 (11th Cir. 2002).


95 id. at 53244.

96 42 C.F.R. § 410.2.

97 68 Fed. Reg. at 53239.

98 id. at 53258.

99 id.
effective, hospitalwide quality assessment and improvement of patient care. Fifth, the hospital is required to have an organized medical staff responsible for the quality of medical care.\textsuperscript{100} If a hospital fails to meet these requirements, CMS may issue a finding of noncompliance and then terminate the hospital’s Medicare provider agreement.\textsuperscript{101}

CMS asserts that these safeguards adequately protect patients.\textsuperscript{102} However, CMS does acknowledge that hospitals accredited by the Joint Commission on Accreditation of Health Care Organizations or the American Osteopathic Association are deemed to meet the conditions of participation and therefore are not routinely surveyed.\textsuperscript{103} Advocates need to monitor how hospitals are treating inpatients and outpatients who experience emergent medical conditions to ensure that hospitals are not attempting to evade EMTALA and to determine whether the Medicare conditions of participation and other safeguards are actually protecting patients.

Other Individuals. The final rule clarifies that EMTALA would apply to individuals who come to the hospital for reasons other than to seek medical services (e.g., visitors, employees). The rationale is that the conditions of participation would not protect these individuals if they happened to experience an emergent medical condition while on the hospital property because they are not patients. Accordingly these people would be considered to have “come to the emergency department” and thus protected by EMTALA.\textsuperscript{104}

The rule is not applicable to individuals who, after receiving information about risks and benefits, do not consent to examination or treatment.

5. What is considered a “screen”? Who may perform the screen?

CMS did not change the basic rule on screening, which is to provide “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.”\textsuperscript{105} Qualified personnel (as determined under the hospital’s bylaws, rules, or regulations) who are properly supervised may conduct the screen.\textsuperscript{106} However, as discussed above, if the nature of the individual’s request for services is such that the medical condition is not of an emergency nature, the hospital is required only to perform a screen to determine that the individual does not have an emergency medical condition.\textsuperscript{107}

Thus, while hospitals have an obligation to conduct a screen for any individual who comes to the emergency room and requests services for a medical condition, the hospital need not respond with an equally extensive screen to all individuals. According to CMS, “brief questioning” by qualified medical personnel (e.g., a registered emergency room nurse) would be sufficient to rule out an emergency for an individual whose request for services is “clearly unlikely”

\begin{itemize}
  \item \textsuperscript{100} Id.; 42 C.F.R. pt. 482.
  \item \textsuperscript{101} 68 Fed. Reg. at 53258.
  \item \textsuperscript{102} In a settlement agreement between Mercy San Juan Medical Center in Carmichael, California, and the Office of the Inspector General the hospital paid a fine of $25,000 for an allegation of admitting a patient without providing a medical screen or stabilizing treatment and then transferring the patient after insurance information was obtained. A CMS spokesperson stated that the new regulation was intended to settle this unclear area. EMTALA, according to CMS, does not apply unless a hospital admits the patient in an attempt to skirt the rule. Mark Taylor, \textit{Settlement in California: Hospital Accused of Admitting Patient to Evade Law}, \textit{Modern Healthcare}, Dec. 15, 2003, at 12.
  \item \textsuperscript{103} 68 Fed. Reg. at 53259.
  \item \textsuperscript{104} Id. at 53240.
  \item \textsuperscript{106} Id.; see also id. § 482.55.
  \item \textsuperscript{107} Id. § 489.24(c).
\end{itemize}
to involve an emergency medical condition.\textsuperscript{108} Thus, for the individual requesting sutures removal, questioning and examination of the wound by a qualified nurse would be sufficient to determine that an emergency does not exist.\textsuperscript{109} At this point the hospital’s EMTALA obligation would end, and there is no further obligation to the individual, including referrals to outpatient care.\textsuperscript{110} While CMS states that hospitals must determine “with reasonable clinical confidence” that there is no emergency medical condition and that the type of medical screening required should be commensurate with the condition presented, this new provision potentially allows hospitals to conduct only a cursory examination for individuals who may not be able to articulate the emergency nature of their medical conditions.\textsuperscript{111} CMS appears to contemplate little federal oversight: Whether the extent and quality of a nonemergency screen was sufficient would be subject to review by state surveyors in investigating specific complaints.\textsuperscript{112}

CMS distinguishes between a “medical screen” and a “triage.” CMS clearly states that a triage, that is, determining the order in which patients are seen and not the presence or absence of an emergency condition, is not equivalent to a screen.\textsuperscript{113}

6. What services does EMTALA cover?

In response to a suggestion that EMTALA not apply to requests for preventive services, pharmaceutical services, or medical clearances for law enforcement purposes (such as police-required blood alcohol tests), CMS made distinctions among these services. First, EMTALA is not applicable to preventive care services because the request is not for examination or treatment of a “medical condition.”\textsuperscript{114}

Second, requests for pharmaceutical services are subject to EMTALA because they may be for treatment of medical conditions. CMS uses the specific example of an individual who is using psychotropic medication and comes to the emergency room complaining of suicidal or homicidal urges because he has exhausted his supply of medication. If examination of the individual confirms the existence of the emergency medical condition, and the medication is needed to stabilize the condition, then the hospital is obligated under EMTALA to provide the medication.\textsuperscript{115} CMS clarifies, however, that the hospital need not give medication to individuals with no emergency medical condition simply because the individual cannot afford or does not wish to purchase the medication at a pharmacy.\textsuperscript{116} CMS notes that it will be addressing the latter situations in a future interpretive guidance.

With respect to other specific presentations, such as requests by law enforcement authorities for medical clearance of persons who are about to be incarcerated or for blood alcohol or other tests to be used as evidence in criminal proceedings, CMS will evaluate on a case-by-case basis whether they are subject to EMTALA.

\textsuperscript{108}68 Fed. Reg. at 53234–35.
\textsuperscript{109}67 id. at 31473.
\textsuperscript{110}68 id. at 53237–28.
\textsuperscript{111}Id. at 53234, 53236
\textsuperscript{112}Id. at 53237.
\textsuperscript{113}Id. at 53236.
\textsuperscript{114}Id. at 53235.
\textsuperscript{115}Id.
\textsuperscript{116}Id.
7. **What is considered “stabilization”***?

The new regulations do not change the basic EMTALA rule on stabilization. To stabilize means to provide medical treatment necessary to assure, with reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. For outpatients, CMS interprets that rule to mean that a hospital may stabilize an individual, thereby satisfying its EMTALA obligation, even though follow-up care may be needed. As discussed above, the EMTALA stabilization obligation also ends when a hospital admits an individual as an inpatient.

8. **How must hospitals ensure that physicians, including specialists, are available (on call) to provide needed care?**

EMTALA requires Medicare-participating hospitals to maintain a list of physicians who are on call to provide treatment necessary to stabilize individuals with emergency medical conditions. If a physician on the list is called by a hospital to provide emergency screening or treatment and either fails or refuses to appear within a reasonable time, the physician and hospital may be in violation of EMTALA.

The September 9, 2003, rules add a new regulatory provision, Section 483.24(j), that relaxes the agency’s rules on the EMTALA on-call requirement. Rather than iterate specific standards for on-call physicians, the new regulation allows each hospital “local flexibility to determine how best to maximize [its] available physician resources.” Each hospital is given the discretion to maintain the on-call list of physicians on its medical staff “in a manner that best meets the needs of the hospital’s patients” and “in accordance with the resources available to the hospital, including the availability of on-call physicians.” The regulation further provides that the hospital must have written policies and procedures in place to respond to situations where a particular specialty is not available or the on-call physician cannot respond and to provide that services are available to meet the needs of emergency patients if it elects to permit on-call physicians to schedule elective surgery when they are on call or have simultaneous on-call duties. Thus the regulations allow hospitals to list, as on-call, physicians who schedule elective surgery while they are on call, physicians who are simultaneously on multiple on-call lists, and physicians whose availability is otherwise restricted depending on the “resources available.”

CMS also states that, in determining EMTALA compliance, it uses no predetermined ratios in deciding the level of on-call staffing. Rather, CMS considers “all relevant factors, including the number of physicians on staff, other demands on these physicians, the frequency with which the hospital’s patients typically require services of on-call physicians, and the provision the hospital has made for situations in which a physician in the specialty is not available or the on-call physician is unable to respond.” CMS allows hospitals to exclude senior staff physicians from being on call.

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117 42 C.F.R. § 489.24(b).
120 Id. § 1395dd(d)(1)(C).
121 68 Fed. Reg. at 53224.
125 Id.
CMS refuses to mandate maximum limits on how long patients must wait in emergency departments, to require hospitals to keep local EMS staff informed of times during which specialists are not available, or to require hospitals to have referral agreements with other hospitals if specialty physician care is not going to be available. CMS also refuses to provide safe harbors that one commenter urged be developed to protect physicians from liability under EMTALA if they fail to respond properly while on call (e.g., due to high volume of patients needing care). CMS agrees that, in appropriate circumstances, physician assistants may respond to emergency room calls.

In an interesting twist, CMS refuses to require a hospital to provide on-call coverage in any specialty offered to the hospital’s patients, even though it agrees that this would be a “reasonable expectation.” CMS does say that a practice of allowing physicians to respond to calls for patients with whom they or a colleague have an established relationship, while declining calls from other patients, would “clearly be a violation of EMTALA.”

This regulation should be monitored closely. At a CMS-sponsored conference call on October 2, 2003, one participant’s hospital was said to be already having medical staff unwilling to accept on-call status. Thus hospitals’ development of written policies and procedures should be policed, as should the hospitals’ transfer agreements with other hospitals in the service area. As written, the regulation allows a worst-case scenario where public Hospital A, with three neurosurgeons on staff, provides twenty-four hour daily on-call coverage, while nearby Hospital B, with three neurosurgeons on staff, provides only ten days on-call coverage a month, thus leaving it to the public hospital to take most of the high-risk, high-cost emergencies.

9. When may a patient be appropriately transferred?

EMTALA and its implementing regulations describe the actions that each hospital must take to transfer a patient appropriately. The September 9, 2003, final rule does not amend the transfer requirements, but the regulation has been moved.

To summarize these rules, if a hospital cannot stabilize the patient, a transfer to another facility is permitted. A hospital may also transfer an unstable patient who makes an informed written request to be transferred. The transfer is appropriate when a physician or other qualified medical person (as defined in EMTALA and the regulations) certifies that the medical benefits of transfer outweigh the risks to the individual being transferred or, in the case of a woman in labor, to the woman or the unborn child. The receiving hospital must be capable of providing the needed care; it must have available space and qualified personnel; and it must have agreed to accept the transfer. The transferring hospital must send to the receiving facility all medical records related to the emergency medical condition and available at the time of transfer. The transfer must be accomplished through qualified personnel and transportation equipment.

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126 Id. at 53251–52.
127 Id. at 53256.
128 Id.
129 68 Fed. Reg. at 53252. Cf. CMS, MEDICARE STATE OPERATIONS MANUAL, supra note 22, at V-15 (stating that if a hospital offers a service to the public, the service should be available through on-call coverage of the emergency department).
130 68 Fed. Reg. at 53255.
132 Id. § 489.24(e).
133 Id.
10. What happens to EMTALA obligations during national emergencies?

During a national emergency, penalties on hospitals for inappropriate transfers do not apply. In adding this rule, CMS cites Section 143 of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Pub. L. 107–188), which allows the secretary of HHS to waive or modify temporarily the application of certain Medicare, Medicaid, and State Children’s Health Insurance Program requirements, including EMTALA requirements. In the event of such a national emergency, CMS will issue guidance to hospitals.

11. How does EMTALA apply to individuals in Medicare+Choice Plans?

A number of commenters reacted to a May 9, 2002, proposed rule (proposed Section 489.24(d)(6)) specifying that a hospital must promptly contact the Medicare+Choice organization after a Medicare+Choice enrollee who is treated for an emergency medical condition is stabilized. That regulation was not finalized in the September 9, 2003, rules, but CMS plans to address the requirement and comments received in a future policy guidance.

12. When do the new rules become effective?

The regulations announce a final rule, effective November 10, 2003. However, compliance with the Paperwork Reduction Act will delay the effective date of some of the regulations. Because the regulations require the collection of information, the Paperwork Reduction Act requires public comment on and

Office of Management and Budget approval of, before becoming effective, the following regulations:

- Section 482.12(f)(3), requiring the hospital governing body to assure that medical staff has written rules and procedures with respect to the appraisal of emergencies and appropriate referrals from off-campus departments that do not provide emergency services.
- Section 489.24(d), requiring hospital medical records to document circumstances where individuals do not consent to examination or treatment or to transfer to another hospital.
- Section 489.24(j), requiring each hospital to have an on-call list of physicians and written policy and procedures in place to respond to situations where a particular specialty or on-call physician may not be immediately available.

The regulations provide no information about the time frame for this review pursuant to the Paperwork Reduction Act.

Conclusion

While Secretary Thompson cited concern about patient and consumer care, the changes accomplished in the final rules clearly were overwhelmingly a response to providers and were developed with limited consumer and advocate input. Even with its tepid enforcement EMTALA has been useful in deterring hospital patient dumping but has not completely eliminated it. Some of these changes may serve to give more efficient access to patients but may also allow hospital and provider practices that deter needed care.

134 Id. § 489.24(a)(2) (2003).
136 See id. at 53225.
137 See id. at 53259–60 (including mailing addresses for comments).
138 “[T]he Committee’s ultimate goal will be to identify, prioritize, and to modify or eliminate regulations that form barriers and discourage health care providers from doing what they are trained for and are committed to, delivering safe, high quality care, service, and products to our patients and consumers.” Thompson, supra note 3, at 8.
Advocates assisting low-income and uninsured individuals need to be vigilant about how hospitals and physicians are complying with existing rules and applying the new regulations. For example, advocates can visit local hospital emergency rooms to observe whether signs explaining EMTALA protection are conspicuously posted. Client communities have to be educated about how to locate the “dedicated emergency room,” how to make requests for services for medical conditions, and how not to be deterred by hospital “registration processes.” In working with clients with potential EMTALA complaints, advocates should obtain the hospital’s written procedures on dealing with individuals presenting themselves with similar symptoms or health complaints to determine whether those individuals were treated differently. Obtaining specific details about what the registration process entailed—what information was requested from the patient, what financial or liability information was requested by the patient, and what information was provided to the patient and when—and what type of screen was provided also is important. Advocates should obtain and scrutinize the hospital’s specialist on-call lists, policies, and procedures. Advocates have to make contact with the local EMS authorities to understand how and when hospital emergency rooms are designated as being on “diversion” status.

Advocates may be assisting patients who are admitted but later discharged without being stabilized. In such cases, advocates may be able to file complaints alleging EMTALA violations for patients who are admitted for the purpose of sidestepping EMTALA, or violations of the Medicare conditions of participation requiring discharge planning, or both.

EMTALA was passed in response to publicized patient stories in the media and later in Congressional hearings. Advocates across the country had a critical role in compiling and publicizing those accounts. In a national conference call with the public on October 2, 2003, CMS indicated that it was open to “fine tuning” the regulations. Depending on what advocates can uncover, EMTALA may need just that, or dramatic revision to protect low-income patients. The time may come when patient stories focus attention on the need to strengthen the law yet again.

139CMS, supra note 67.