EMTALA: Current Issues and Cases

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July 17, 2009

Emergency Medical Treatment and Labor Act (EMTALA)

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EMTALA Applicability to Hospital Inpatients: CMS Regulations

- CMS 2003 Final Rule, 68 Fed. Reg. 53222, 53243 - 48 (Sept. 9, 2003).
  - Once a hospital has screened an individual, determined that they have a medical emergency, and have admitted the patient in good faith as an inpatient, "the hospital has satisfied its responsibilities under this section with respect to that individual."
    - 42 C.F.R. § 489.24(d)(2)
  - Thus, EMTALA does not apply to unstable inpatients
  - Left unanswered in the 2003 Final Rule was whether the "specialized capabilities" requirements from Section 1867(g) apply to hospital inpatients.

- Section 1867(g) obligation:
  - "A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or, with respect to rural areas, regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires these specialized capabilities or facilities if the hospital has the capacity to treat the individual."

EMTALA Applicability to Inpatients: CMS Regulations

- In the FY2009 Hospital IPPS Proposed Rule, CMS proposed to specify that the specialized capabilities requirements also apply to individuals admitted to another hospital and who have not been stabilized. 73 Fed. Reg. 23528, 23669 - 71 (April 30, 2008).

  – CMS stated that "Permitting inpatient admission at the *admitting* hospital to end EMTALA obligations for *another* hospital to which an unstabilized individual is being appropriately transferred to receive specialized care would seemingly contradict the intent of section 1867(g) of the Act to ensure that hospitals with specialized capabilities provide medical treatment to individuals with emergency medical conditions to stabilize their conditions. 73 Fed. Reg. 23670. (Emphasis added).

  – A contrary interpretation would also seem to contradict the plain language of the regulation, which only speaks in terms of "**the** hospital" satisfying "**its** responsibilities" to the admitted inpatient – clearly referring to the admitting hospital, not the hospital with specialized capabilities.

EMTALA Applicability to Inpatients: CMS Regulations

- CMS reversed its April 30 proposal in the Final Rule issued August 19, 2008, and adopted a policy that the subsection (g) responsibility of hospitals with specialized capabilities toward unstable patients does *not* apply to inpatients admitted at another hospital. CMS stated that:

  – "Due to the concerns that commenters raised, we are not finalizing the proposed policy. Rather, we are finalizing a policy that a hospital with specialized capabilities is not required under EMTALA to accept the transfer of a hospital inpatient." 73 Fed. Reg. 48434, 48656 - 61.

  – "Numerous commenters opposed the proposal in the FY 2009 proposed rule regarding the applicability of EMTALA to hospital inpatients. Many commenters asserted that, rather than being a clarification of current regulations, CMS' proposal represents a significant change in policy which runs counter to CMS' policy expressed in the September 9, 2003 ["Final Rule." 73 Fed. Reg. 48657.

  – "Although we believe that the language of section 1867(g) of the Act can be interpreted as either applying or not applying to inpatients, after reviewing the comments raised by many commenters, we have serious concerns about the impact the proposed policy would have had on patient care and the possibility that it may overburden many hospitals that are currently having difficulties providing sufficient emergency care." 73 Fed. Reg. 48667.

EMTALA and on-call physicians

- 2003 CMS Final Rule
  - "… we believe that a hospital is responsible for maintaining an on-call list in a manner that best meets the needs of its patients as long as the exemption does not affect patient care adversely. Thus, CMS allows hospitals flexibility in the utilization of their emergency personnel." 68 Fed. Reg. 53251 (Sept. 9, 2003).
  - CMS did not adopt prescriptive rules such as how many hours physicians must be on-call in the Emergency Department, as these are issues that should be dealt with at the individual hospital level. 68 Fed. Reg. 53253.

EMTALA and on-call physicians (cont.)

- 2008 CMS Proposed Rule:
  - CMS proposed that hospitals may comply with the on-call list requirement by participating in a formal "community call" plan so long as the plan includes the required elements. 73 Fed. Reg. 23671 (Apr. 30, 2008). The formal plan:
    - Permits a specific hospital in a region to be designated as the on-call facility for a period of time, or for a specific service, or both.
    - Includes a clear delineation of on-call coverage responsibilities;
    - Defines the specific geographic area to which the plan applies;
    - Is signed by a representative of each hospital participating in the plan;
    - Ensures that any EMS system protocol formally includes information on community on-call arrangements;
    - Participating hospitals engage in an analysis of the specialty on-call needs of the community for which the plan is effective;
    - Plan would include a statement specifying that even if an individual arrives at the hospital that is not designated as the on-call hospital, that hospital still has an EMTALA obligation to provide a medical screening examination and stabilizing treatment within its capability, and hospitals must abide by the EMTALA regulations on appropriate transfers; and
    - Participating hospitals conduct an annual reassessment of the plan.

- 2008 CMS Final Rule:
  - CMS finalized the community call provision as proposed, with one modification – deleting the proposed requirement [for the community plan-- that it includes:] "Evidence of engagement of the hospitals participating in the community call plan in an analysis of the specialty on-call needs of the community for which the plan is effective." 73 Fed. Reg. 48667 (Aug. 19, 2008).

EMTALA Applicability to Inpatients: *Moses v. Providence Hospital* (6th Circuit)

- *Moses v. Providence Hosp. and Med. Ctrs., Inc.*, 2009 US App Lexis 7049.

- Facts:
  - Plaintiff was the estate of Marie Moses-Irons.
  - Dec. 13, 2002: Marie Moses-Irons took her husband Howard to the ED at Providence Hospital because he was suffering from severe headaches, muscle soreness, high blood pressure, vomiting, slurred speech, disorientation, hallucinations, and delusions.
  - Dec. 13-17, 2002: The hospital admitted Howard and he was examined by several doctors. Dr. Lessem, a psychiatrist, examined Howard several times while Howard was at the hospital.
  - Dec. 17, 2002: Dr. Lessem determined that Howard was not "medically stable from a psychiatric standpoint," and decided Howard should be transferred to the hospital's psychiatric unit.
  - Dec. 18, 2002: Howard was never transferred to the psychiatric unit, but was informed he would be discharged; clinical progress report, signed by Dr. Mitchell, said "[patient] declines 4[E]ast, wants to go home. His affect is brighter. No physicial sympotms now. … wife fears him. Denies any suicidality." Howard's "final diagnosis," written by a resident, said he had a "migraine headache" and an "atypical psychosis [with] delusional disorder."
  - Dec. 19, 2002: Howard was released from the hospital.
  - Dec. 29, 2002: Howard murdered Marie Moses-Irons.

- Court Holding:
  - Plaintiff, non-patient third-party, has standing under EMTALA's civil cause of action to sue hospital for alleged violations.
  - Plain language of EMTALA's civil enforcement provision: broad with respect to who may bring a claim -- "*Any* individual who suffers personal harm as a direct result" of a hospital's EMTALA violation, may sue under EMTALA. § 1395dd(d)(2)(A) (emphasis added).
  - "Hospital was required under EMTALA not just to admit Howard into the inpatient care unit, but to *treat* him in order to stabilize him."

Applicability of CMS EMTALA Regulations to the Federal Courts

- Why was the Court in *Moses v. Providence Hospital* not bound by CMS regulations on hospital inpatients?
  - The incidents in the case took place in 2002, which was before the effective date of the 2003 Final Rule.
  - Even if the incidents had taken place later than 2003, the Court would not be bound by CMS's 2003 Final Rule because the EMTALA regulations are only binding on CMS surveyors. They are not binding on a court hearing a private right of action claim under EMTALA.
    - "[T]he decisions of the courts in these EMTALA private right of action cases are not necessarily binding for our enforcement purposes…."
      - EMTALA Final Rule, 68 Fed. Reg. 53222, 53245 (Sept. 9, 2003)
- Therefore, hospitals face some risk that their reliance on CMS regulations will not be a defense in a private right of action claim.

What is a hospital? *Rosa Rodriguez v. Centro San Cristobal-Villalba*

- *Rosa-Rodriguez v. Centro San Cristobal-Villalba*, 2009 U.S. Dist. LEXIS 40078.

- Facts
  - Nilshalys Rosa-Algarin, 13 years old, arrived at Centro San Cristobal-Villalba ("Centro"), a Center of Diagnosis and Treatment Center of Diagnosis and Treatment (CDT), with complaints of a headache, sore throat, fever, and diarrhea.
  - Physician examined, but did not take any tests. He discharged her with a diagnosis of tonsillitis or cold. Next day, Nilshalys lost consciousness and was taken back to Centro where she died.
  - The father of Nilshalys Rosa-Algarin, Plaintiff Rosa-Rodriguez, sued Centro and several physicians alleging EMTALA violations- that Nilshalys did not receive appropriate medical treatment prior to her death.

- Court Holding:
  - Court dismissed with prejudice all EMTALA claims against the facility.
  - EMTALA defines a "hospital" as an institution primarily engaged in providing medical services to inpatients.
  - A CDT, under Puerto Rico law, is a facility providing services to ambulatory patients, and thus, is not a "participating hospital" under EMTALA.
  - Court noted that it has previously held that EMTALA does not provide a private cause of action against physicians. Court ordered plaintiff to show cause as to why it should not also dismiss plaintiff's EMTALA claims against named physicians.

What does it mean to "come to the hospital"? *Morales v. Sociedad Espanola*

- *Morales v. Sociedad Española de Auxilio Mutuo y Beneficencia*, 524 F.3d 54, (1st Cir. 2008)

- Facts
  - Patient, suffering severe abdominal pain and vomiting after being diagnosed with a non-viable pregnancy two days before, was en route in a non-hospital-owned ambulance.
  - Paramedics called ahead to the emergency department and notified its director of patient's condition, forthcoming arrival, and need for treatment.
  - The hospital was not on diversionary status
  - In first call, director allegedly told paramedics that he was very busy and to call back when they had more information about the patient's condition. In second call, director allegedly "abruptly terminated" the call with the paramedics when they could not provide assurance that Plaintiff had insurance coverage or was a member of the Hospital insurance program.
  - Paramedics interpreted the director's action as a refusal to treat the individual at the hospital's emergency department and took the patient to a different facility, where she received treatment.
  - Patient brought suit against hospital and other defendants for violating EMTALA.
    - District Court granted defendants summary judgment, finding patient's circumstances did not create an EMTALA liability.

"Come to the Hospital" (cont'd.)

- EMTALA Requirements
  - "In the case of a hospital with a hospital emergency department, if any individual … **comes to the hospital**" and requests a medical screening examination, the hospital must provide one.
    - Social Security Act § 1867(a)
- Issue in the case: did a patient in an ambulance "come to the hospital?"
- Court Held:
  - "An individual can come to the hospital without physically arriving on the hospital's grounds as long as the individual is en route to the hospital and the emergency department has been notified of her imminent arrival."
    - Court's holding avoids the "perverse incentive" that would otherwise be created for hospitals to evade EMTALA by financially screening patients by radio.
  - Court limited its holding to cases that "fairly can be characterized as involving patient 'dumping.'"
  - Court followed prior ruling, though unbinding, of the Ninth Circuit in *Arrington v. Wong*, 273 F.3d 1066 (9th Cir. 2001).
- CMS Regulations
  - With respect to hospital-owned ambulances, EMTALA generally applies once the individual is in the ambulance. 42 C.F.R. § 489.24(b)
  - Exception if hospital is on diversion pursuant to local EMS protocols. *Id*.

EMTALA Private Rights of Action in Massachusetts

- Pursuant to the EMTALA statute, the EMTALA private right of action can only be brought against hospitals, and not physicians. §1867(d)(2)(A).
  - In Massachusetts there is a cap on tort damages that can be imposed on a charitable organization.
    - It shall not constitute a defense to any cause of action based on tort brought against a corporation, trustees of a trust, or members of an association that said corporation, trust, or association is or at the time the cause of action arose was a charity; provided, that if the tort was committed in the course of any activity carried on to accomplish directly the charitable purposes of such corporation, trust, or association, liability in any such cause of action shall not exceed the sum of twenty thousand dollars exclusive of interest and costs.
      - Mass. Gen. L. Ch. 231 § 85K

- One state lower court has found that the Massachusetts Charitable Immunity Cap applies to EMTALA violations.
  - "The statute's $20,000 liability cap applies to any claims that may be brought … in common law negligence or tort where the complained of acts were committed in the course of an activity carried on to directly accomplish the charitable goals of the hospitals..." *Derry et al. v. Saint Vincent Hospital et al.*, 12 Mass L. Rep. 631, 633
  - The court then addressed the question of whether an EMTALA claim, under Massachusetts law, may be said to lay in tort, and concludes that "[i]t seems clear to this court that, after a fair reading of the language of 42 U.S.C.A. Sec. 1395dd, the substantive quality of the EMTALA civil action clearly sounds in tort." *Id.*

- The Fourth Circuit Court of Appeals has stated that "[t]he fact that the duty giving rise to tort liability in this case arises from the federal statutory requirements in EMTALA, rather than common law, does not mean that Power's suit does not sound in tort."
  - *Power v. Arlington Hospital Assoc.*, 42 F.3d 851, 865 (1994).

OIG Enforcement Actions - EMTALA

- Physicians and hospitals, both, can be subject to penalties imposed upon them by the HHS Office of Inspector General including
  - Civil fines of up to $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) per violation and exclusion of a physician from participation in the Federal health care programs.
    - Social Security Act § 1867(d)(1)
- The OIG is authorized to impose a civil monetary penalty (CMP) against a participating hospital if:
  - the hospital has an emergency department and fails to provide a medical screening examination to individuals who present to the emergency department for treatment, or,
  - the individual has an emergency medical condition, and the hospital fails to provide stabilizing treatment.

OIG Enforcement Actions

- In January 2009, the OIG imposed against St. Joseph's Medical Center in Stockton, CA, the maximum CMP of $50,000 for violating EMTALA
  - St. Joseph's failed to provide required emergency care for an 88-year-old man, who died in their Emergency Department.
- As of May 2008, OIG had settled four EMTALA matters, collecting $162,500 in civil monetary penalties.
- In 2007, the OIG settled 13 cases under EMTALA and collected roughly $300,000 in civil monetary penalties.
  - E.g., a hospital in Indiana paid $40,000 to resolve allegations that it failed to treat a man who arrived at the Emergency Department by ambulance in an unresponsive state; the man was transferred more than 180 miles without stabilizing treatment and arrived at the second hospital "brain dead."

Conclusion

- Important activities at CMS, in the courts, and with the IG in past year
- Issues to watch in coming year:
  - Will CMS re-visit the issue of applicability of EMTALA to inpatients in light of the 6th Circuit decision?
  - Will other courts adopt the reasoning of the 6th Circuit with respect to inpatients?
  - Will CMS re-visit the issue of subsection (g) obligations of hospitals with specialized capabilities in light of the new Administration?
  - Will CMS issue further guidance on physician on-call requirements?
- No major EMTALA provisions were included in FY 2010 IPPS rule