

Main Points

- EMTALA [Emergency Medical Treatment and Labor Act] is a federal law that requires hospital emergency departments to medically screen every patient who seeks emergency care and to stabilize or transfer those with medical emergencies, regardless of health insurance status or ability to pay — this law has been an unfunded mandate since it was enacted in 1986.
- America's emergency departments are under severe stress, facing soaring demands; many have closed because of uncompensated care due in part to the unfunded EMTALA mandate.
- Emergency physicians are dedicated to providing the highest quality emergency care to all.
- Emergency departments are essential to every community and must have adequate resources.
- ACEP advocates for recognition of uncompensated care as a practice expense for emergency physicians and for federal guidance in how fulfill the requirements of the EMTALA mandate in light of its significant burden on the nation's emergency care system.

Q. What is EMTALA?

EMTALA was enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd) .ⁱ Its original intent and goals are consistent with the mission of ACEP and the public trust held by emergency physicians.

- Originally referred to as the "anti-dumping" law, it was designed to prevent hospitals from refusing to see or transferring financially "undesirable" patients to public hospitals without, at a minimum, providing a medical screening examination and treatment to ensure they were stable for transfer. As a result, local and state governments began to abdicate responsibility for indigent care, shifting this public responsibility to all Medicare participating hospitals.
- Hospitals and physicians violating EMTALA are subject to civil monetary penalties (\$50,000 per violation) and threat of Medicare decertification. Between March, 2008 and May, 2012, there were 35 EMTALA violations that netted a little more than \$3 million.ⁱⁱ
- EMTALA has become the de facto national health care policy for the uninsured. It requires Medicare-participating hospitals with emergency departments to screen and stabilize ~~trear~~ patients with emergency medical conditions in a non-discriminatory manner, regardless of ability to pay, insurance status, national origin, race, creed or color. Ninety-two percent of all hospitalizations for the uninsured are directly linked with an emergency department visit.ⁱⁱⁱ
- The Institute of Medicine in 2006 recommended that the U.S. Department of Health and Human Services adopt regulatory changes to EMTALA and the Health Insurance Portability and Accountability Act (HIPAA) so the original goals of the laws are preserved.
- It remains to be seen how the implementation of health care reform may affect emergency departments and emergency patients. Evidence from Massachusetts indicates emergency visits will rise with increase in financial pressure due to cost saving measures imposed by health plans. EMTALA may have new found impact as the healthcare system adjusts to these new parameters.

Q. How does EMTALA define an emergency?

An emergency medical condition is defined as “a 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 placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs.”

Q. What is EMTALA's scope?

EMTALA applies when an individual "comes to the emergency department." A dedicated emergency department is defined as "licensed by the State . . . as an . . . emergency department" or "is held out to the public . . . as a place that provides care for emergency medical conditions." This means that hospital-based outpatient clinics are not obligated under EMTALA unless they provide more than one-third of care as unscheduled AND those 1/3 visits are emergency medical conditions as defined by the statute. EMTALA applies to all aspects of emergency care, including specialists, all available tests and procedures, and anything else necessary to determine or stabilize an emergency medical condition.

Q. What are the provisions of EMTALA?

Hospitals have three main obligations under EMTALA:

1. Any individual who comes and requests examination or treatment of a medical condition must receive a medical screening examination to determine whether an emergency medical condition exists. This cannot be delayed to inquire about methods of payment or insurance coverage. Emergency departments also must post signs that notify patients and visitors of their rights to a medical screening examination and stabilizing treatment.
2. If an emergency medical condition exists, treatment must be provided until it is resolved or stabilized. If the hospital does not have the capability to stabilize the emergency medical condition, an "appropriate" transfer to another hospital must be done in accordance with the EMTALA provisions.
3. Hospitals with specialized capabilities are obligated to accept transfers from hospitals who lack the capability to treat unstable emergency medical conditions.

Additionally, a hospital must report any time it has reason to believe it may have received an individual who has been transferred in an unstable condition in violation of EMTALA.

Q. What are the requirements for transferring patients under EMTALA?

- EMTALA governs how unstable patients are transferred from one hospital to another. Under the law, a patient is considered stable for transfer if the treating physician determines that no material deterioration is reasonably likely to occur during or as a result of the transfer between facilities. EMTALA does not apply to the transfer of stable patients; however, if the patient is unstable, then the hospital may not transfer the patient unless: A physician certifies the medical benefits expected from the transfer outweigh the risks OR a patient makes a transfer request in writing after being informed of the hospital's obligations under EMTALA and the risks of transfer.

In addition, the transfer of unstable patients must be "appropriate" under the law, such that (1) the transferring hospital must provide ongoing care within its capability until transfer to minimize transfer risks, (2) provide copies of medical records, (3) must confirm that the receiving facility has space and qualified personnel to treat the condition and has agreed to accept the transfer, and (4) the transfer must be made with qualified personnel and appropriate medical equipment.

Q. What are the penalties for violating EMTALA?

- Both CMS (hospitals) and the OIG (hospitals and physicians) have enforcement powers with regard to EMTALA violations. There is a 2-year statute of limitations for civil enforcement of any violation. Penalties may include:
 - Termination of the hospital or physician's Medicare provider agreement.
 - Hospital fines up to \$50,000 per violation (\$25,000 for a hospital with fewer than 100 beds).
 - Physician fines \$50,000 per violation, including on-call physicians.
 - The hospital may be sued for personal injury in civil court under a "private cause of action"
- A receiving facility, having suffered financial loss as a result of another hospital's violation of EMTALA, can bring suit to recover damages.
- An adverse outcome does not necessarily indicate there is an EMTALA violation; however, a violation can be cited even without an adverse outcome. There is no violation if a patient refuses examination &/or treatment unless there is evidence of coercion.

Q. Who pays for EMTALA-related medical care?

- Ultimately we all do, although the greatest responsibility is on hospitals and emergency physicians who provide this health care safety net shouldering the financial burden of providing EMTALA related medical care.
- Some health insurance plans retrospectively deny claims for emergency departments visits, based on a patient's final diagnosis, rather than the presenting symptoms (e.g., when chest pain turns out not to be a heart attack). These practices endanger the health of patients and threaten to undermine the emergency care system by failing to financially support America's health care safety net.
- ACEP advocates for a national prudent layperson emergency care standard that provides coverage based on a patient's presenting symptoms, rather than the final diagnosis. In addition, health insurers should cover EMTALA-related services up to the point an emergency medical condition can be ruled out or resolved.

Q. Is EMTALA-related care the driver of rising health care costs?

- Emergency care in America is just 2 percent (\$47.3 billion) of all U.S. medical costs,^{iv} and the emergency care costs of EMTALA [excludes hospital inpatient and other] have been estimated to be about \$4.2 billion. EMTALA's effect on the nation's emergency care system itself is huge with direct costs for uncompensated care to physicians about \$4.2 billion.^v

For more information, visit www.acep.org.

ⁱ "Emergency Medical Treatment and Labor Act (EMTALA), Centers for Medicare and Medicaid Services, <http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html>

ⁱⁱ Office of Inspector General, U.S. Department of Health and Human Services website, http://www.oig.hhs.gov/fraud/enforcement/cmp/patient_dumping.asp

ⁱⁱⁱ "Emergency Care in California: Robust Capacity or Busted Access?" Health Affairs, March 2004, <http://content.healthaffairs.org/content/suppl/2004/03/24/hlthaff.w4.143v1.DC1>

^{iv} "Medical Expenditure Panel Survey," Department of Health and Human Services, Agency for Healthcare Research and Quality, 2008, <http://tinyurl.com/489fa06>.

^v "Physician Marketplace Report: The Impact of EMTALA on Physician Practices" 2003. AMA Center for Health Policy Research.