PATIENT DUMPING AFTER COBRA

ASSESSING THE INCIDENCE AND THE PERSPECTIVES OF HEALTH CARE PROFESSIONALS

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this study was to gain additional information and insight into the issue of patient dumping 1 1/2 years after the enactment of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 which prohibited the practice. The inspection sought to determine if objective measurement of the problem of patient dumping could be made using existing records and if perspectives of health care professionals identified vulnerabilities in the current process of identifying and reporting alleged cases.

The overall objectives of this inspection were to determine:

- if records maintained by hospitals reflected information needed to assess the actual incidence of patient dumping;

- reporting practices and procedures in place at hospitals for referring possible cases and complaints to the proper authorities; and

- the extent to which public hospitals continue to perceive patient dumping as a problem, and their estimates of the frequency of patient dumping at their facility.

BACKGROUND

The COBRA included provisions that require all Medicare-participating hospitals with emergency departments to provide necessary medical examinations and treatments to stabilize individuals with emergency medical conditions and women in active labor. After the patient is stabilized, the hospital may provide for appropriate transfer to another facility. The COBRA also allowed for penalties if a hospital or provider violates these antidumping provisions. In addition to COBRA, the Hill-Burton Act of the Public Health Service Act and various State laws also outline the responsibilities of hospitals for the care of the indigent.

Recent articles published in professional journals, as well as newspaper accounts of patient dumping, suggest that the problem may continue to occur despite Federal and State efforts to prevent it. In July 1987, the Human Resources and Intergovernmental Relations Subcommittee of the U.S. House of Representatives held an oversight hearing focusing on patient dumping. Testimony focused on medical problems which have resulted from alleged cases of patient dumping, economic causes for patient dumping, and the Federal role in preventing and investigating such cases.

METHODOLOGY

Emergency room (ER) and other hospital records for the month of October 1987 for all patients transferred to the ER were subpoenaed from 25 hospitals in 25 standard metropolitan areas (SMAs) randomly selected with probability porportionate to size. The OIG staff also conducted telephone interviews with administrators and health care practitioners in 88 randomly selected public hospitals which had 100 or more beds and were located in or near an SMA to obtain their perspectives on the nature and incidence of cases of patient dumping.

MAJOR FINDINGS

- Current record keeping by hospitals makes objective measurement of the problem difficult. The hospitals in our record sample of 25 could not uniformly or consistently identify all patients transferred to their ER from other ERs. Even if transferred patients can be identified, information contained in the record is limited.

- Due to the difficulty in objectively measuring the incidence of dumping, confusion exists as to the actual extent of the problem. Perceptions vary widely among health care practitioners. For example, the hospitals in our administrator and practitioner sample of 88 could offer only anecdotal estimates of dumping prevalence and these differed considerably. Of those hospitals in our sample willing to estimate the rate of dumping, 25 (32 percent) reported no problem at all with dumping, while 35 (45 percent) believe they currently experience COBRA dumping at least once a month.

- A significant number of hospitals (39 percent) in our administrator and practitioner sample of 88 did not have procedures or reporting mechanisms to effectively deal with patient dumping when it occurs. Hospitals seem unaware of mechanisms for the proper reporting of dumping incidents. When they are aware of such mechanisms, they are reluctant to use them.

- Practices persist, such as the diversion of patients en route during ambulance transportation; the referral of patients to another facility without making a record of their request for treatment at the primary facility; or the transfer of patients citing inability to treat the patient properly, when the facility in fact appears equipped to care for the patient. These practices, at minimum, subvert the intent of COBRA even though they may not directly violate its provisions.

- In the absence of statistically reliable information on this problem, the Department of Health and Human Services (HHS) must rely heavily on hospitals to file complaints under Hill-Burton and COBRA. Given the lack of record keeping and reporting by hospitals, as documented in this report, the ability of HHS to monitor and oversee this problem is jeopardized.

RECOMMENDATIONS

- Reporting of suspected cases of patient dumping should be made a condition of participation in the Medicare program or part of a hospital's provider agreement in order to increase reporting. This recommendation was communicated to the Health Care Financing Administration (HCFA) in an early alert on this subject. The HCFA has accepted this recommendation and included it as a requirement in the HHS regulations on dumping issued in June 1988.

- In view of the reliance on referrals from patients and hospitals to enforce their authority, HCFA and the Office for Civil Rights (OCR) should use existing authority to require and ensure that hospitals post notices such as the ones currently posted in California hospitals and those provided by OCR to Hill-Burton facilities. All Medicare-participating hospitals and all Hill-Burton facilities should post notices in their ERs which (1) inform patients of their rights under COBRA and Hill-Burton and (2) indicate a local or toll-free number to call with complaints.

- The COBRA regulations should require that all ER records clearly identify all transferred patients to and from other ERs. All patients should be asked upon arrival at an ER if they have sought treatment elsewhere.

- Direct outreach to professional associations should be pursued by the program areas responsible for COBRA and Hill-Burton compliance with increased vigor in order to increase awareness and stimulate proper reporting by health care professionals.

- The HCFA should move to clarify the definition of what constitutes "stabilization" and "emergent condition," as the American College of Emergency Physicians (ACEP) has done, in the COBRA regulations or through proposed legislation in order to clarify physicians' reponsibilities under COBRA. To the extent possible, coordination should take place with OCR to assure that the Department uses a common definition of terms when enforcing its authority in this area.

AGENCY COMMENTS

Comments to the draft report were received from HCFA, OCR and the Public Health Service. Although there was general agreement with the report's findings and recommendations, HCFA expressed reservation concerning our recommendations for increased record keeping and further definition of critical terms. Our findings indicate that action is needed and we are again recommending that HCFA take these steps to strengthen the Department's ability to enforce the COBRA provisions. Agency comments are contained in appendix 3.

INTRODUCTION

BACKGROUND

The practice of patient dumping--that is, the transfer of unstable patients or refusal to render emergency treatment to patients based on grounds unrelated to need or the hospital's ability to provide services--has become a serious concern in recent years. Some experts assert that, due to increasing financial pressures to maintain profitability and reduce costs and the increasing number of uninsured or underinsured Americans requesting access to health care, hospitals are turning away or transferring large numbers of indigent and uninsured people from their emergency rooms without appropriate medical evaluation.[1] Estimates of the national frequency of patients transferred for economic reasons have been placed as high as 250,000 cases annually,[2] although such estimates are statistically unsure.

In some cases, the denial of care results in dire consequences for the individual. Concerned members of the medical community, family members and friends, and patient advocates from across the country have reported deaths and serious illness resulting from denial of emergency treatment. One Tennessee woman, for example, related the story of her diabetic neighbor, a young carpenter, who was "physically removed" from an emergency room (ER) due to an inability to pay for services and stranded in the hospital's parking lot after arriving at the ER in an ambulance on his doctor's orders. He died the following day at home.[3] Such practices have stirred considerable debate in the medical community concerning the proper treatment of and responsibility toward indigent or other undesirable patients. In addition, Federal and State governments have both made efforts to provide protection for persons who seek emergency room care regardless of their ability to pay.

Federal Efforts

The first Federal effort in this area was the community services provisions included in the Hill-Burton Act of the Public Health Service Act, 42 U.S.C. 216, 300m-4 and 300o-1(6) (titles VI and XVI) in 1979. The regulations implementing the community service assurances apply to all hospitals that received Federal assistance under the Hill-Burton Act which was enacted into law in 1946. The act authorized the appropriation of funds, channeled through the States, for the construction or modernization of hospitals and other health facilities. The community service assurances prohibit Hill-Burton hospitals from denying emergency services to anyone who resides in the hospital's service area (title VI of the Public Health Service Act). Hospitals that have received Federal assistance under title XVI are also required to provide emergency services to persons who work in the hospital's service area. Unlike the "free care obligations" (42 C.F.R. Part 124, Subpart F) hospitals incurred under Hill-Burton, the community service assurance is a perpetual obligation.

The Department of Health and Human Services (HHS), Office for Civil Rights (OCR) is responsible for enforcing the community service assurances of the Hill-Burton Act. However, some difficulties have been documented concerning OCR's efforts in this area. For example,

OCR has been criticized for not providing facilities with formal technical assistance regarding their obligations.[4] Further, OCR cannot sanction hospitals for past violations if they are currently in compliance, as can the Office of Inspector General (OIG), and it must turn substantiated cases over to the U.S. Department of Justice for litigation or obtain voluntary compliance.

The second Federal effort to assure emergency services for all those that seek such care was enacted in April 1986 (effective August 1986) in the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, which amends title XVIII of the Social Security Act. The COBRA requires all Medicare participating hospitals with emergency departments to: (1) provide for an appropriate medical screening for patients presenting themselves for treatment to determine if an emergency medical condition exists or the person is in active labor; and (2) if such an emergency condition or active labor exists, provide treatment within the hospital's capacity or transfer the patient to another facility for treatment under the following restrictions:

- The patient must be stabilized, unless a certification has been signed by the physician attesting that the benefits of a transfer outweigh its risks.
- The receiving hospital must have the necessary space and personnel to effectively treat the patient.
- The receiving hospital must be notified of the transfer, and must accept the transfer.
- Medical records must accompany the patient.
- The transfer must be effected with proper transportation equipment and qualified personnel.

The COBRA also provides for termination or suspension of Medicare provider agreements if violations of the provision are knowingly and willfully, or negligently violated, and the imposition of civil monetary penalties against the hospital and/or responsible physician(s) where the provision is knowingly violated. In addition, individuals and receiving hospitals may bring a civil action against a referring hospital which violates the provisions of COBRA, and obtain damages for personal harm or financial loss.

Although similar to requirements included under the Hill-Burton Act, COBRA broadens the range of applicable providers, as well as the services required to be rendered in the emergency room. As noted above, remedies available under Hill-Burton to engender compliance are limited to voluntary measures and possible referral of the hospital to the U.S. Department of Justice, which can sue for specific performance. The COBRA, conversely, provides for more specific enforcement and remedies for violators, including the imposition of civil money penalties (CMPs).

Three HHS components are involved in compliance and enforcement activities of the Hill-Burton and COBRA provisions: the OCR, OIG, and Health Care Financing Administration (HCFA). Overlap does exist between agency authority generated in part by the inherent overlap of the statutes. For example, if a hospital that dumps a patient has obligations under Hill-Burton and participates in the Medicare program, all three agencies would become involved with investigating the complaint.

Other Efforts

In addition to the above-referenced Federal efforts, at least 23 States have enacted statutes or administrative regulations to address provision of emergency care for the indigent or uninsured. As the table in appendix 1 indicates, State initiatives in this area vary broadly in terms of defining an emergency, coverage of pregnant women, and provision of remedy for violations. Many do not contain remedies at all for violations. However, some States have instituted requirements that are stricter than those imposed at the Federal level.

The strictest State antidumping statutes are found in California, New York, and Texas.[5] California's is particularly extensive and merits some detailed discussion here. Under California law, patients must sign "informed consent" forms which outline "the reasons for transfer or refusal to provide emergency services and care and of the person's right to emergency services and care prior to transfer or discharge without regard to ability to pay."[6] The State of California also requires that notices be posted in all emergency rooms informing patients of their rights to emergency care. (Currently, OCR provides such notices to its Hill-Burton facilities, but HCFA does not require postings in all Medicare-participating facilities.) Records of transfers must be filed with the State. Receiving hospital personnel must report violations. Finally, the law requires that "as a condition of licensure, each hospital shall adopt, in consultation with the medical staff, policies and transfer protocols consistent with this article and regulations adopted hereunder."[7] A copy of the bill adopted in September 1987 and enacted on January 1, 1988 by the State of California is contained in appendix 2.

Other States, while not matching California in scope of coverage, have also enacted laws with provisions of interest. For example, the State of Michigan's antidumping statute includes a prohibition against ambulance diversion: "An ambulance operation, or a limited advanced or an advanced mobile emergency care service shall provide emergency care consistent with its license to all patients without prior inquiry into ability to pay or source of payment."[8] Missouri and Utah include psychological or mental emergencies in their coverage of emergency services to which the indigent will have access. Utah defines emergency medical services to mean "services used to respond to perceived individual needs for immediate medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury."[9]

Wisconsin's law, like that of Massachusetts, specifically prohibits delays in treatment: "No hospital providing emergency services may delay emergency treatment to a sick or injured person until credit checks, financial information forms or promissory notes have been initiated, completed or signed if, in the opinion of one of the following, who is an employee, agent or staff member of the hospital, the delay is likely to cause increased medical complications, per-

manent disability or death: (a) a physician, registered nurse or emergency medical technician advanced (paramedic); (b) a trained practical nurse under the specific direction of a physician or registered nurse; or (c) a physician's assistant or any other person under the specific direction of a physician."[10] The Wisconsin law also requires that hospitals establish written procedures to carry out this directive. Further, each hospital must create a plan for referrals when the hospital cannot provide care and the State will identify the ER capabilities of each hospital and update the list annually.

The Texas antidumping law has been used as a model for several States and for the Federal COBRA legislation. It prohibits the refusal to provide diagnosis or care if the diagnosis so warrants to any person based on age, sex, physical condition or economic status. The Texas law defines emergency services to mean "services that are usually and customarily available at the respective hospital and that must be provided immediately to sustain a person's life, to prevent serious permanent disfigurement or loss or impairment of the function of a bodily member or organ, or to provide for the care of a woman in active labor if the hospital is so equipped, and, if the hospital is not so equipped, to provide necessary treatment to allow the woman to travel to a more appropriate facility without undue risk of a serious harm."[11]

In addition, at least five States--Florida, Massachusetts, New Jersey, New York and South Carolina--have established "indigent pools" which finance health care for the poor and help to relieve the financial burden imposed on hospitals caring for such patients.

Medical experts agree that the need to provide an appropriate medical evaluation of the patient prior to transfer is crucial if the patient's well-being is to be ensured. If the patient's medical condition necessitates treatment prior to effecting the transfer, appropriate services must be provided. Several professional medical organizations have adopted policies which underscore the need of the medical professional to provide such care.[12] The American Medical Association (AMA) has adopted a position indicating that all physicians and health care facilities have a moral obligation to provide needed medical care to all those who seek it regardless of their ability to pay. Furthermore, the AMA supports the position that an interfacility transfer should take place *only if it is done for the patient's best interest.* Also, the transfer should take place only if both the transferring and receiving physician consent to the transfer; and, the AMA recommended that interhospital transfer agreements be worked out at the local level.

The American College of Emergency Physicians' (ACEP) policy statement is similar to the AMA's, but, unlike the AMA, specifies that the patient should be stabilized prior to transfer. The ACEP also provides more detailed information regarding appropriate transfer, and stabilizing steps which should be taken prior to transfer.[13] These steps include: establishing an adequate airway and ventilation, controlling bleeding, splinting factures, taking vital signs, and starting intravenous medication or initiating blood replacement.

The ACEP has also provided a detailed description of what constitutes a medical emergency: "(1) any condition resulting in admission of the patient to a hospital or nursing home within 24 hours; (2) evaluation or repair of acute (less than 72 hours) trauma; (3) relief of acute or severe pain; (4) investigation or relief of acute infection; (5) protection of public health; (6)

obstretical crisis and/or labor; (7) hemorrhage or threat of hemorrhage; (8) shock or impending shock; (9) investigation and management or suspected abuse or neglect of a person which, if not interrupted, could result in temporary or permanent physical or psychological harm; (10) congenital defects or abnormalities in a newborn infant, best managed by prompt intervention; (11) decomposition or threat of decomposition of vital functions, such as sensorium, respiration, circulation, excretion, mobility, or sensory organs; (12) management of a patient suspected to be suffering from a mental illness and posing an apparent danger to the safety of himself, herself, or others; and (13) any sudden and/or serious symptom which might indicate a condition which constitutes a threat to the patient's physical or psychological well-being requiring immediate medical attention to prevent possible deterioration, disability or death."[14]

Both the American Hospital Association (AHA) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO) support the position that patients should not be transferred arbitrarily. Both AHA and JCAHO indicate the decision to transfer should be medically permissible (the patient is stable), and the transfer should be made only after the receiving hospital consents to the transfer.

Previous studies of patient dumping have been conducted by medical and health experts. Himmelstein and Woolhandler[15] conducted a study in a large urban area, examining transfers from private to public hospital emergency rooms. The study found that transfer seems to "triage patients into the public sector based on financial and social factors." The authors also noted that of the 458 consecutive patient transfers studied, 33 of the patients received substandard care either because of potential complications that could arise during transit, or because treatment was delayed. They additionally found an absence of medical reasons for the transfer to the public hospital emergency room suggesting the reason for transfer was economic.

Schiff and Ansell[16] conducted a similar study of patient transfers to a public general hospital in a large urban area. The researchers examined reasons for patient transfers, whether the patient was admitted to the intensive care unit, length of stay, and outcome, among other factors. The researchers found that the reason for transfer in 87 percent of the cases was lack of insurance. Seventy-three percent of the patients were admitted to the surgical service, and 27 percent admitted to the medical service. In addition, of the charts the researchers were able to review, 24 percent were classified as being in an unstable condition upon arrival, and the transfer process resulted in an average delay of treatment of 5.1 hours.

The authors estimate that during 1983, nonreimbursable costs shifted to the public hospital from private hospitals for the care of transferred patients totalled $24.1 million dollars, or 12 percent of the hospital's operating budget. This cost estimate, the authors note, represents costs attributable only to those patients transferred and admitted to the surgical service or medical service and not other areas such as obstetrics. The estimate also does not include patients transferred that were not admitted. The authors state: "If our patients are representative of medical and surgical emergency-department transfers in other areas of the country, extrapolation to a national level suggests an annual cost shift of hundreds of millions of dollars from the private to the public sector."[17]

In July of 1987, the Human Resources and Intergovernmental Relations Subcommittee of the U.S. House of Representatives held an oversight hearing focusing on patient dumping. Testimony was heard from victims of patient dumping, patient advocacy groups, and representatives from HHS. Testimony focused on medical problems which have resulted from patient dumping, economic causes of patient dumping, and the Federal role in preventing such cases.

The subcommittee was particularly interested in HHS' efforts to implement the COBRA provisions and enforcement efforts of existing laws prohibiting patient dumping. The Administrator of HCFA testified that HCFA had sent interim operating instructions to their regional offices (ROs) detailing what actions the regions should take upon receipt of a patient dumping complaint. Also, it was noted that the regulations formally implementing the COBRA provisions (the COBRA provisions were self-implementing) would be published soon. A Notice of Proposed Rulemaking (NPRM) was eventually published in June 1988 containing draft regulations.

In March 1988, a report describing the patient dumping problem as pervasive and critical of HHS' actions to date in this area was published by the House Committee on Government Operations.

OBJECTIVES

The purpose of this study was to gain additional information and insight into the issue of patient dumping 1 1/2 years after the enactment of the Comprehensive Omnibus Budget Reconciliation Act of 1985, which prohibited the practice. The inspection sought to determine if objective measurement of the problem of patient dumping could be made using existing records and if perspectives of health care professionals identified vulnerabilities in the current process of identifying and reporting alleged cases.

The overall objectives of this inspection were to determine:

- if records maintained by hospitals reflected information needed to assess the actual incidence of patient dumping;

- reporting practices and procedures in place at hospitals for referring possible cases and complaints to the proper authorities; and

- the extent to which public hospitals continue to perceive patient dumping as a problem, and their estimates of the frequency of patient dumping at their facility.

METHODOLOGY

Records Review

In order to obtain objective information and attempt to statistically determine the prevalence of patient dumping under COBRA, OIG subpoenaed emergency room records for a randomly selected month (October 1987) from 25 large (300 beds or more) public and nonprofit hospitals in 25 SMAs randomly selected with probability proportionate to size. The subpoenas requested (1) any and all emergency room logs or other ER records for the month of October 1987, which indicate those patients who were transferred from other hospitals to the ER for treatment; and (2) any record indicating the payment status (Medicare, Medicaid, commercial, none or other) for each of the patients identified as having been transferred from another hospital to the ER for treatment during the month of October 1987.

The purpose of this effort was to obtain information regarding the hospital's ability to identify patients at risk *(i.e.*, patients transferred from other hospitals with a payment status of Medicaid or none) and to then request medical records for those patients from the transferring and receiving hospitals. Those records would then be reviewed by a physician panel to determine the stability or instability of the patient upon transfer.

Perspectives of Health Care Professionals

In order to obtain hospital perspectives on this subject, OIG surveyed administrators and practitioners in 88 hospitals concerning practices and experiences in connection with patient dumping. The hospitals were selected randomly from the universe of 581 Medicare-participating public hospitals containing at least 100 beds located near standard metropolitan areas (SMAs). One hundred hospitals were selected. Of those 100, 4 declined to respond to our survey; 5 did not offer emergency services and were therefore dropped from the sample; 2 could not be reached; and 1 was a for-profit hospital erroneously included in the sample. Consequently, 88 hospitals comprised our study sample. Fifteen of these hospitals are located in the Northeast (HCFA regions 1, 2, and 3); 26 are in the South (HCFA region 4); 28 are in the Midwest (HCFA regions 5 and 6); and 19 are in the West and Southwest (HCFA regions 7, 8, 9, and 10).

Interviews were conducted by telephone by OIG staff in Dallas, Texas; Baltimore, Maryland; and Washington, D.C. Initial contact calls were made to the hospital administrator, who was informed of the reason for our call and asked to designate someone to whom we could direct questions. In 11 percent of the cases, the administrator indicated that he/she would like to respond. Thirty-three percent designated another member of the hospital administration (Assistant Administrator, Administrator for Financial Services, etc.) to respond; 47 percent designated an emergency room Medical Director; and 9 percent designated an emergency room head nurse. In most cases, follow-up calls were made to the designated respondent after the administrator had the opportunity to inform the designated contact to expect our call.

The interview took approximately 20-25 minutes and concentrated on the following areas:

- existence of procedures in ER to deal with cases of patient dumping;
- existence of transfer agreements between responding and neighboring hospitals outlining procedures for the appropriate transfer of patients;
- the occurrence of instances of COBRA violations (i.e., emergent or active labor patients transferred to the respondent's hospital who were not provided medical screening at the sending hospital; who were transferred without a medical certification that benefits outweigh risks or the patient requesting the transfer; who were transferred without advance notice by the sending hospital; who arrived without medical records; or who arrived without proper transportation or medical equipment);
- rate of COBRA dumping experienced; and
- experience with ambulance diversions.

FINDINGS

Current record keeping practices by hospitals make objective measurement of the problem of patient dumping difficult. For example, the hospitals in our record sample of 25 could not uniformly or consistently identify all patients transferred to the emergency room.

Several hospitals could not identify transferred patients at all without a case by case review of the records. Some hospitals can only identify those that were transferred *and* admitted. Some hospitals define transfers to include referrals from private physicians, nursing homes, or other health care facilities--not just other hospitals. Insurance information was not always obtained, or if obtained, confirmed, particularly for nonadmitted patients.

For example, one Chicago hospital responded to our subpoena that "the information which is currently collected on our [ER admission] logs does not include patients transferred from other institutions. The only way to obtain that information would be a retrieval of 2801 [individual] medical records for the month of October 1987." One Connecticut hospital worker stated that "patients transferred and then discharged are lost from our system." The ER logs we received did not typically contain a column for referral or transfers, or even for payment source. Payment source information on the ER records themselves was often blank or did not refer to a policy number, thereby bringing into question the actual existence of the policy cited by the patient.

None of the hospitals in our sample maintain a transfer log of any kind, such as the one maintained at Cook County Hospital and used by Schiff and Ansell in their study of transfers received at that facility.

As a result of this inability by hospitals to identify transferred patients, the ability of OIG, HCFA, or OCR to conduct efficient compliance reviews may be jeopardized. Based on this finding, we reported the results of our record review to the regional directors of OCR and HCFA and informing them of the specific findings of the reviews conducted in hospitals in their regions. We noted, among other things, that improved record keeping is necessary in order to ensure the ability of the Department to conduct efficient compliance reviews and that those reviews might have to consist of a system-wide approach in order to fully understand the pattern of referrals and transfers among hospitals in a given geographic area.

A prospective data collection method (such as that used by Schiff and Ansell) may be the only way to accurately count and identify transferred patients at selected facilities.

We were unable, based on the information provided to us by the hospitals, to identify accurately the universe of patients transferred to those hospitals from other hospitals' emergency rooms. Consequently, we did not undertake the second part of our records review, which was to involve the review of medical records by a physician panel. Therefore we cannot at this time make any judgment concerning the extent of a dumping problem at these facilities, or the universe of hospitals at large. Based on our experience, it appears that considerable time and

resources would be required to obtain this information on a national level. To our knowledge, no one has yet undertaken such an effort.

Even if transferred patients can be identified, information contained in the record is limited.

Many of the ER records sent to us do not indicate if prior approval to transfer the patient was obtained, or if medical records were sent with the patient, and it is not clear if records from the transferring facility will indicate these facts or not. Additionally, this approach will not identify those patients who were turned away at a private hospital without medical screening and told to drive themselves to the public hospital's ER, or patients diverted en route (both vulnerabilities identified by practitioners in our telephone interviews and discussed later in this report).

Due to the difficulty in objectively measuring the incidence of dumping, confusion exists as to the actual extent of the problem. Perceptions vary widely among practitioners as to the extent of dumping at their facilities.

Seventy-eight of the 88 respondents in our telephone sample of administrators and practitioners were willing to estimate the amount of dumping at their facility. Responses varied widely. For example, 25 (32 percent) of these hospitals reported no problem at all with dumping. However, 35 (45 percent) reported they currently experience receiving transfers in violation of COBRA standards at least once a month. Ten hospitals (13 percent) reported experiencing five or more cases in violation of COBRA a month. Some of those hospitals reporting problems cited specific cases. A Texas hospital practitioner described two: "A woman about to have a baby was sent across land, then by ferry, to us from a nonprofit hospital. She left there six centimeters dilated and had the baby practically at our doorstep. (In another case), an older male went to his local hospital for a heart problem, medication was not provided and was told to drive to (us). He arrived with acute myocardial infarction."

Twenty-one of the 88 hospitals in our sample (24 percent) reported receiving emergent or active labor transfers from area hospitals who had not been medically screened before transfer. Twenty-five (28 percent) reported transfers arriving without medical certification or at the patient's request. Twenty-six (29 percent) reported transfers arriving without medical records; 23 (26 percent) reported patients arriving without proper transportation or medical equipment. By far the most reported problem, identified by 50 hospitals (57 percent), was the lack of advance notice by the sending hospital.

For our sample the mean number of dumps per month reported was 3.9. However, as indicated above, there was wide variation in the responses, ranging from zero (reported by 25 of the hospitals) to as much as 105 (reported by one hospital). We did not verify these estimates.

Many hospitals do not have procedures or reporting mechanisms to effectively deal with incidents of patient dumping when they occur.

Many hospitals (39 percent) do not have procedures that address proper handling of inappropriate transfers received in the emergency room. Of those saying that they do have procedures, 33 percent state that they are not written.

Overall, 25 (28 percent) of the hospitals indicated that they do not or would not report instances of patient dumping. Of those indicating they would report such instances, 35 (57 percent) indicated their own hospital administration as the highest level to which they would report. Only 11 percent indicated they would report to the State survey agency, the contact point encouraged by HCFA.

Twenty-three of the 35 hospitals which indicated that the highest level of reporting was their own hospital administration also reported problems with dumping. Follow-up calls were made to these 23 hospital administrators to determine if they reported cases outside of the hospital once alerted by their ER staff of a possible violation. Only three routinely file complaints with State or Federal authorities.

Hospitals seem unaware of mechanisms for proper reporting of dumping incidents. When they are aware of such mechanisms, they are reluctant to use them.

> "We usually just call and fuss at them (the sending hospital) when inappropriate transfers are made. Other than that, no reporting is done. I'm just not sure who to go to." (Alabama hospital)
>
> "We would handle it between hospitals. We avoid putting negatives in writing." (Florida hospital)
>
> "COBRA puts the major responsibility of reporting on the receiving hospital. Often times, there is not the time nor the staff to monitor this." (Oklahoma hospital)

A subsample of hospitals (29 of the 88 hospitals in the total sample) were asked to explain or volunteered why they did not report incidents of patient dumping to State or other authorities. Eighteen--all hospital administrators--indicated that they were not aware to whom such reporting should be made. Two indicated that they prefer to work out such matters between hospitals rather than involving a third party. Nine indicated that they "didn't know" why reporting was not made to State or Federal authorities.

One hospital also noted that the responsibility for reporting violations rested in receiving hospitals. Such reporting would require proper monitoring and record keeping, as well as follow up work, which expend resources in short supply.

Currently HCFA does not require hospitals to post notices in their emergency rooms informing patients of their rights under COBRA and indicating a number to call in the event a viola-

tion has occurred. The OCR provides notices to Hill-Burton facilities to post in ERs and business offices stating, "Notice--This Facility is Legally Obligated to Serve the Community." The notice explains that the facility cannot deny emergency services, if it provides them, to any person who needs them but cannot pay. However, the notice does not provide a number to call in the event a person has a complaint.

Practices persist which may subvert the intent of COBRA although not directly violating its provisions.

> "Patient dumping is well hidden. Outlying hospitals usually come up with an 'appropriate' medical reason to transfer." (New York hospital)
>
> "Hospitals are getting around COBRA by not making an ER chart when a patient arrives or when the patient is discharged from the ER and told to go someplace else." (Mississippi hospital)
>
> "'Pure' dumps have decreased. But now there's a lot of gray areas. The transferring hospital says they can't take care of the patient, but they get here and in our judgment the sending hospital could have in fact taken care of them. We don't report these because it is an area of physician judgment, a gray area. It seems that dumping continues but transferring hospitals are careful to disguise the real reasons for the transfer." (Florida hospital)
>
> "What is likely to happen is that the paramedics who must take an emergency case to a hospital perform an informal triage of which 'socioeconomic status' is a part, before selecting a receiving hospital." (California hospital)

A number of respondents offered the opinion that hospitals are "getting around" COBRA by diverting patients during ambulance transportation, transferring patients they maintain are stabilized who may not be, transferring patients they "can't handle" when the receiving hospital's judgment is otherwise; and turning away indigent patients before they get in the door.

Although 41 of the hospitals (49 percent) reported never experiencing the diversion of patients from nearby private hospitals to theirs during ambulance transportation, 20 (24 percent) called it a "occasional" occurrence, 13 (16 percent) called it a "sometime" problem and 9 (11 percent) labeled it a "frequent" occurrence. In a few cases, hospitals labeled this their "major" problem.

In the absence of statistically reliable information on this problem, HHS must rely heavily on precise record keeping and reporting by hospitals to fulfill its responsibilities under Hill-Burton and COBRA. Given the lack of such record keeping and reporting by hospitals, as documented above, the ability of HHS to monitor and oversee this problem is jeopardized.

It is critically important for the HCFA and OCR to take strong steps to strengthen the record keeping and reporting requirements of hospitals which must form the first layer of vigilance in this area. Several recommendations follow which could be used to begin addressing this issue.

RECOMMENDATIONS

This inspection identified a number of possible vulnerabilities in the identification of patient dumping and the enforcement of the COBRA and Hill-Burton provisions which prohibit it. Although we were unable to determine the incidence of patient dumping on a national level, we recommend that certain actions be taken in order to address those vulnerabilities.

In an early alert to the Administrator of HCFA on this subject, we recommended that, among other things, HCFA make reporting suspected violations of COBRA a condition of participation or part of the provider agreement for all Medicare-participating hospitals. The HCFA agreed with this recommendation and this requirement is included in the NPRM released in June and will be made part of the provider agreement.

Based on our record review of 25 hospitals which indicated that the Department's ability to conduct efficient compliance reviews might be jeopardized by lack of necessary records maintained by hospitals, we have sent letter reports to the regional directors of OCR and HCFA to inform them of our general findings and specific results of the records reviews conducted in their regions. We note that efficient compliance reviews might require increased record keeping by hospitals and a system-wide approach so that the pattern of referrals and transfers among hospitals in a given geographic area can be understood fully.

We further recommend that the following additional measures be taken:

1. The HCFA and OCR should use existing authority to require and ensure that hospitals post notices, such as those posted in California, informing patients of their rights under COBRA and Hill-Burton in emergency rooms of Medicare-participating and Hill-Burton facilities, in order to increase patient awareness of rights to access and to encourage the reporting of violations. If dumping is now camouflaged and hospitals are reluctant to report cases, affected parties may be made more likely to report violations if they are aware of their rights and know to whom reporting should be made. Currently, OCR provides such notices to Hill-Burton facilities.

   Consideration should be given to the use of joint notice in HCFA/OCR shared facilities. All notices, in any event, should contain a local or toll-free number to call with complaints.

2. The COBRA regulations should require that emergency room records clearly delineate if a patient was transferred, to what facility or from what source; or, a transfer log should be maintained containing relevant information (including method of transportation, facility transferred to/from, reason for transfer, etc.). Optimally, such records would be maintained by both transferring and receiving hospitals. This will effectively aid the OIG, HCFA and OCR in conducting compliance reviews to ensure that all patients transferred to other emergency rooms were transferred in stable condition.

   In addition, as part of the intake process, all patients arriving at hospital emergency rooms

should be asked if they have previously requested treatment at another emergency room and were denied treatment or told to pursue treatment elsewhere. Proper record keeping concerning a patient's attempt to pursue treatment elsewhere will also significantly aid compliance reviews and enforcement efforts in this area, as well as raise awareness at the patient and provider level of the importance of this information. Lastly, hospitals should be encouraged to develop formal procedures for ER staff in the event of a suspected case of dumping.

3. In order to increase awareness and encourage reporting, direct outreach to professional associations composed of emergency room and/or obstetric personnel, such as the American College of Emergency Physicians (ACEP), should be undertaken to educate ER practitioners concerning rights and responsibilities under COBRA. In addition, OCR has suggested that outreach be extended to community and advocacy groups. Those program areas responsible for compliance, HCFA and OCR, should offer to send representatives to annual conventions and meetings to discuss COBRA and Hill-Burton and the issue of patient dumping.

   Positive efforts have begun in this area since the draft of this report was released for Departmental comment in May 1988. For example, in June 1988, a letter discussing COBRA requirements and the Department's commitment to enforcement in this area was signed by the HCFA Administrator, the Inspector General of HHS, and the Director of OCR and sent to administrators of all Medicare-participating hospitals. Copies of those letters were also sent to representatives of the American Medical Association, American Osteopathic Association, National Association of Public Hospitals, Federation of American Health Systems, and the American Hospital Association.

4. The HCFA should move to clarify the definition of what constitutes "stabilization" and "emergent condition," such as the ACEP has done, through the rulemaking process or as a legislative initiative. Various medical associations (AMA, ACEP, JCAHO) should be consulted in the development of those definitions. Because no such definition exists under COBRA, "gray" areas emerge and COBRA is made vulnerable to abuse. Further, because physicians may genuinely disagree on their responsibilities under COBRA, a lack of uniform expectations exists in the medical community as to the nature of those responsibilities. As indicated above, this may decrease the likelihood that physicians will report suspected cases.

   The HCFA should work with OCR and OIG in this area to ensure that there is a common Departmental understanding as to the meaning of these terms so that investigations in this area are consistent.

APPENDIX 1

STATE INITIATIVES IN PATIENT DUMPING AREA[18]

State	Mechanism	Defines Emergency	Includes OB Cases	Remedies
California*	Law	Yes	Yes	See Note 1.
Colorado	Law	Yes	Yes	None
Florida*	Law	No	No	None
Georgia	Law	Yes	Yes	See Note 2.
Hawaii	Law	No	No	None
Illinois	Law	Yes	No	None
Kentucky	Law	No	No	See Note 3.
Louisiana*	Law	Yes	Yes	See Note 4.
Maryland*	Law	No	No	See Note 5.
Massachusetts*	Law	Yes	No	See Note 6.
Michigan	Law	Yes	No	None
Montana	Law	No	No	None
New Jersey	Regulation	No	No	None
New York*	Law	No	No	See Note 7.
Oregon	Regulation	Yes	No	None
Pennsylvania*	Law	No	No	None
Rhode Island	Law	Yes	No	None
South Carolina	Regulation	No	No	None
Tennessee*	Law	Yes	No	See Note 8.
Texas	Law	Yes	Yes	See Note 9.
Utah	Law	Yes	No	None
Wisconsin	Law	No	No	See Note 10.
Wyoming	Law	Yes	No	None

**Passed in state after passage of COBRA in 1985.*

Notes to Table

1. Civil money penalties of no more than $10,000 per violation for inhibiting the reporting of violations through threat or intimidation; maximum fine of $25,000 for violation of anti-dumping for hospitals, $5,000 maximum for individual physicians, with maximum limit of $30,000 assessed against hospitals for the same circumstances under State and Federal law. Provisions for criminal proceedings by the local district attorney and civil proceedings brought by persons harmed, as well.

2. $500 for each violation. A hospital with three or more violations in one 12-month period is subject to suspension or revocation of license.

3. Minimum fine of $100 and maximum fine of $500.

4. Civil money penalties of up to $5,000 for an officer or employee, or suspension from the state medical assistance program for hospitals in violation.

5. Civil money penalties of up to $1,000 for hospitals that violate provisions.

6. In the event of a violation, the patient has the right to sue.

7. Up to 1 year imprisonment and a $1,000 fine for practitioners in violation.

8. Offending hospitals subject to suspension or revocation of license.

9. Offense is a Class A misdemeanor, or 3rd degree felony if patient dies.

10. Fines of $1,000 for each offense.

APPENDIX 2

CALIFORNIA ANTI-DUMPING LEGISLATION

CALIFORNIA
Regular Session

Chapter 1240, Laws 1987

Senate Bill No. 12

An act to amend Sections 1317, 1798, 1798.170, 1798.172, and 1798.208 of, to add Sections 1317.1, 1317.2, 1317.2a, 1317.3, 1317.4, 1317.5, 1317.6, 1317.7, 1317.8, 1317.9, 1317.9a, and 1798.205 to, and to add Chapter 2.5 (commencing with Section 1797.98a) to Part 1 of Division 2.5 of, the Health and Safety Code, and to add Section 1465 to the Penal Code, relating to emergency medical services.

The people of the State of California do enact as follows:

SECTION 1. (a) The Legislature finds and declares that the provision of emergency medical care is a vital public service of great benefit to Californians. It is necessary for the protection of the health and safety of Californians that a comprehensive and high quality system of emergency medical services be provided.

(b) The Legislature also finds that the costs of emergency medical services are greater than the costs of delivering other forms of medical services in the state, as emergency services must be readily available on a 24-hour-a-day basis and must be provided to all, regardless of ability to pay, which is required by existing law.

(c) The Legislature recognizes the breadth of the uncompensated and undercompensated care problems facing California providers which serve large numbers of unsponsored persons. The addition of Chapter 2.5 (commencing with Section 1797.98a) to Part 1 of Division 2.5 of the Health and Safety Code is an effort at addressing only one segment of the uncompensated care problem: the area of emergency services. The Legislature further believes that ~~hospitals and~~ physicians who provide emergency care to anyone in need, regardless of ability to pay, incur losses resulting from care of patients who have no third-party source of payment or for whom available payment is grossly inadequate to cover the costs of providing such care. The Emergency Medical Services Fund created by Section 15 of this act would provide limited funding to partially offset the losses providers incur for treating unsponsored patients who arrive in need of emergency care. This act provides only partial compensation for a small but important aspect of the larger problem regarding provision of services to the unsponsored.

(d) As a result, the Legislature finds that providers of emergency medical services must bear the higher

expenses of providing these services and must suffer from partial or no reimbursement from many of their patients. If allowed to continue, these higher costs and lower reimbursements could force many physicians ~~and hospitals~~ to reduce the quality and availability of emergency medical services, to the detriment of Californians.

(e) Therefore, by enacting this legislation, the Legislature is providing a means of partial funding for these vital services. Further, it is the intent of the Legislature that the source of funding of emergency medical services be related to the incident of emergencies requiring immediate medical care. Thus, this act will levy an additional penalty assessment on traffic and other fines. In this way, the costs of emergency medical services shall be borne to a degree by those who have a relationship to creating the emergencies.

SEC. 2. Section 1317 of the Health and Safety Code is amended to read:

1317. (a) Emergency services and care shall be provided to any person requesting the services or care, or for whom services or care is requested, for any condition in which the person is in danger of loss of life, or serious injury or illness, at any health facility licensed under this chapter that maintains and operates an emergency department to provide emergency services to the public when the health facility has appropriate facilities and qualified personnel available to provide the services or care.

(b) In no event shall the provision of emergency services and care be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(c) Neither the health facility, its employees, nor any

physician, dentist, or podiatrist shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition, or that the health facility does not have the appropriate facilities or qualified personnel available to render those services.

(d) Emergency services and care shall be rendered without first questioning the patient or any other person as to his or her ability to pay therefor. However, the patient or his or her legally responsible relative or guardian shall execute an agreement to pay therefor or otherwise supply insurance or credit information promptly after the services are rendered.

(e) If a health facility subject to the provisions of this chapter does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency exists and shall direct the persons seeking emergency care to a nearby facility which can render the needed services, and shall assist the persons seeking emergency care in obtaining the services, including transportation services, in every way reasonable under the circumstances.

(f) No act or omission of any rescue team established by any health facility licensed under this chapter, or operated by the federal or state government, a county, or by the Regents of the University of California, done or omitted while attempting to resuscitate any person who is in immediate danger of loss of life shall impose any liability upon the health facility, the officers, members of the staff, nurses, or employees of the health facility, including, but not limited to the members of the rescue team, or upon the federal or state government or a county, if good faith is exercised.

(g) "Rescue team," as used in this section, means a special group of physicians and surgeons, nurses, and employees of a health facility who have been trained in cardiopulmonary resuscitation and have been designated by the health facility to attempt, in cases of emergency,

to resuscitate persons who are in immediate danger of loss of life.

(h) This section shall not relieve a health facility of any duty otherwise imposed by law upon the health facility for the designation and training of members of a rescue team or for the provision or maintenance of equipment to be used by a rescue team.

SEC. 3. Section 1317.1 is added to the Health and Safety Code, to read:

1317.1. Unless the context otherwise requires, the following definitions shall control the construction of this article:

(a) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

(b) "Emergency medical condition" means 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 any of the following:

(1) Placing the patient's health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(c) "Active labor" means a labor at a time at which either of the following would occur:

(1) There is inadequate time to effect safe transfer to another hospital prior to delivery.

(2) A transfer may pose a threat to the health and safety of the patient or the unborn child.

(d) "Hospital" means all hospitals with an emergency department licensed by the state department.

(e) "State department" means the State Department of Health Services.

(f) "Medical hazard" means a material deterioration

in, or jeopardy to, a patient's medical condition or expected chances for recovery.

(g) "Board" means the Board of Medical Quality Assurance.

(h) "Within the capability of the facility" means those capabilities which the hospital is required to have as a condition of its emergency medical services permit and services specified on Services Inventory Form 7041 filed by the hospital with the Office of Statewide Health Planning and Development.

(i) "Consultation" means the rendering of an opinion, advice, or prescribing treatment by telephone and, when determined to be medically necessary jointly by the emergency and the specialty physicians, includes review of the patient's medical record, examination and treatment of the patient in person by a specialty physician who is qualified to give an opinion or render the necessary treatment in order to stabilize the patient.

SEC. 4. Section 1317.2 is added to the Health and Safety Code, to read:

1317.2. No person needing emergency services and care may be transferred from a hospital to another hospital for any nonmedical reason (such as the person's inability to pay for any emergency service or care) unless each of the following conditions are met:

(a) The person is examined and evaluated by a physician, *including, if necessary, consultation,* prior to transfer.

(b) The person has been provided with emergency services and care so that it can be determined, within reasonable medical probability, that the transfer or delay caused by the transfer will not create a medical hazard to the person.

(c) A physician at the transferring hospital has notified and has obtained the consent to the transfer by a physician at the receiving hospital and confirmation by the receiving hospital that the person meets the hospital's admissions criteria relating to appropriate bed, personnel, and equipment necessary to treat the person.

(d) The transferring hospital provides for appropriate

personnel and equipment which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use to effect the transfer.

(e) All the person's pertinent medical records and copies of all the appropriate diagnostic test results which are reasonably available are transferred with the person.

(f) The records transferred with the person include a "Transfer Summary" signed by the transferring physician which contains relevant transfer information. The form of the "Transfer Summary" shall, at a minimum, contain the person's name, address, sex, race, age, insurance status, and medical condition; the name and address of the transferring doctor or emergency department personnel authorizing the transfer; the time and date the person was first presented at the transferring hospital; the name of the physician at the receiving hospital consenting to the transfer and the time and date of the consent; the time and date of the transfer; the reason for the transfer; and the declaration of the signor that the signor is assured, within reasonable medical probability, that the transfer creates no medical hazard to the patient. Neither the transferring physician nor transferring hospital shall be required to duplicate, in the "Transfer Summary," information contained in medical records transferred with the person.

(g) The transfer conforms with regulations established by the department.

(h) Nothing in this section shall apply to a transfer of a patient for medical reasons.

(i) Nothing in this section shall prohibit the transfer or discharge of a patient when the patient or the patient's representative requests a transfer or discharge and gives informed consent to the transfer or discharge against medical advice.

SEC. 5. Section 1317.2a is added to the Health and Safety Code, to read:

1317.2a. (a) A hospital which has a legal obligation, whether imposed by statute or by contract, to the extent of that contractual obligation, to any third-party payor, including, but not limited to, a health maintenance

organization, health care service plan, nonprofit hospital service plan, insurer, or preferred provider organization, a county, or an employer to provide care for a patient under the circumstances specified in Section 1317.2 shall receive that patient to the extent required by the applicable statute or by the terms of the contract, or, when the hospital is unable to accept a patient for whom it has a legal obligation to provide care whose transfer will not create a medical hazard as specified in Section 1317.2, it shall make appropriate arrangements for the patient's care.

(b) A county hospital shall accept a patient whose transfer will not create a medical hazard as specified in Section 1317.2 and who is determined by the county to be eligible to receive health care services required under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code, unless the hospital does not have appropriate bed capacity, medical personnel, or equipment required to provide care to the patient in accordance with accepted medical practice. When a county hospital is unable to accept a patient whose transfer will not create a medical hazard as specified in Section 1317.2, it shall make appropriate arrangements for the patient's care. The obligation to make appropriate arrangements as set forth in this subdivision does not mandate a level of service or payment, modify the county's obligations under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code, create a cause of action, or limit a county's flexibility to manage county health systems within available resources. However, the county's flexibility shall not diminish a county's responsibilities under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code or the requirements contained in Chapter 2.5 (commencing with Section 1440)

(c) The receiving hospital shall provide personnel and equipment reasonably required in the exercise of good medical practice for the care of the transferred patient.

(d) Any third-party payor, including, but not limited

to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, or preferred provider organization, or employer which has a statutory or contractual obligation to provide or indemnify emergency medical services on behalf of a patient shall be liable, to the extent of the contractual obligation to the patient, for the reasonable charges of the transferring hospital and the treating physicians for the emergency services provided pursuant to this article, except that the patient shall be responsible for uncovered services, or any deductible or copayment obligation. Notwithstanding this section, the liability of a third-party payor which has contracted with health care providers for the provision of these emergency services shall be set by the terms of that contract. Notwithstanding this section, the liability of a third-party payor that is licensed by the Insurance Commissioner or the Commissioner of Corporations and has a contractual obligation to provide or indemnify emergency medical services under a contract which covers a subscriber or an enrollee shall be determined in accordance with the terms of that contract and shall remain under the sole jurisdiction of that licensing agency.

(e) A hospital which has a legal obligation to provide care for a patient as specified by subdivision (a) of Section 1317.2a to the extent of its legal obligation, imposed by statute or by contract to the extent of that contractual obligation, which does not accept transfers of, or make other appropriate arrangements for, medically stable patients in violation of this article or regulations adopted pursuant thereto shall be liable for the reasonable charges of the transferring hospital and treating physicians for providing services and care which should have been provided by the receiving hospital.

(f) Subdivisions (d) and (e) do not apply to county obligations under Section 17000 of the Welfare and Institutions Code.

(g) Nothing in this section shall be interpreted to require a hospital to make arrangements for the care of a patient for whom the hospital does not have a legal

obligation to provide care.

SEC. 6. Section 1317.3 is added to the Health and Safety Code, to read:

1317.3. (a) As a condition of licensure, each hospital shall adopt, in consultation with the medical staff, policies and transfer protocols consistent with this article and regulations adopted hereunder.

(b) As a condition of licensure, each hospital shall adopt a policy prohibiting discrimination in the provision of emergency services and care based on race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(c) As a condition of licensure, each hospital shall require that physicians who serve on an "on-call" basis to the hospital's emergency room cannot refuse to respond to a call on the basis of the patient's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient. If a contract between a physician and hospital for the provision of emergency room coverage presently prevents the hospital from imposing those conditions, the conditions shall be included in the contract as soon as is legally permissible. Nothing in this section shall be construed as requiring that any physician serve on an "on call" basis.

(d) As a condition of licensure, all hospitals shall inform all persons presented to an emergency room or their representatives if any are present and the person is unable to understand verbal or written communication, both orally and in writing, of the reasons for the transfer

or refusal to provide emergency services and care and of the person's right to emergency services and care prior to transfer or discharge without regard to ability to pay. Nothing in this subdivision requires notification of the reasons for the transfer in advance of the transfer where a person is unaccompanied and the hospital has made a reasonable effort to locate a representative, and because of the person's physical or mental condition, notification is not possible. All hospitals shall prominently post a sign in their emergency rooms informing the public of their rights. Both the posted sign and written communication concerning the transfer or refusal to provide emergency services and care shall give the address of the department as the government agency to contact in the event the person wishes to complain about the hospital's conduct.

(e) If a hospital does not timely adopt the policies and protocols required in this article, the hospital, in addition to denial or revocation of any of its licenses, shall be subject to a fine not to exceed one thousand dollars ($1,000) each day after expiration of 60 days' written notice from the state department that the hospital's policies or protocols required by this article are inadequate unless the delay is excused by the state department upon a showing of good and sufficient cause by the hospital. The notice shall include a detailed statement of the state department's reasons for its determination and suggested changes to the hospital's protocols which would be acceptable to the state department.

(f) Each hospital's policies and protocols required in or under this article shall be submitted for approval to the state department within 90 days of the department's adoption of regulations under this article.

SEC. 7. Section 1317.4 is added to the Health and Safety Code, to read:

1317.4. (a) All hospitals shall maintain records of each transfer made or received, including the "Memorandum of Transfer" described in subdivision (f) of Section 1317.2, for a period of three years.

(b) All hospitals making or receiving transfers shall file

with the state department annual reports on forms prescribed by the department which shall describe the aggregate number of transfers made and received according to the person's insurance status and reasons for transfers.

(c) The receiving hospital, and all physicians, other licensed emergency room health personnel, and certified prehospital emergency personnel at the receiving hospital who know of apparent violations of this article or the regulations adopted hereunder shall, and the corresponding personnel at the transferring hospital and the transferring hospital may, report the apparent violations to the state department on a form prescribed by the state department within one week following its occurrence. The state department shall promptly send a copy of the form to the hospital administrator and appropriate medical staff committee of the transferring hospital and the local emergency medical services agency, *unless the state department concludes that the complaint does not allege facts requiring further investigation, or is otherwise unmeritorious, or the state department concludes, based upon the circumstances of the case, that its investigation of the allegations would be impeded by disclosure of the form.* When two or more persons required to report jointly have knowledge of an apparent violation, a single report may be made by a member of the team selected by mutual agreement in accordance with hospital protocols. Any individual, required to report by this section, who disagrees with the proposed joint report has a right and duty to separately report.

A failure to report under this subdivision shall not constitute a violation within the meaning of Section 1290 or 1317.6.

(d) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to a physician or other personnel for reporting in good faith an apparent violation of this article or the regulations adopted hereunder to the state department,

hospital, medical staff, or any other interested party or government agency.

(e) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to a physician who refused to transfer a patient when the physician determines, within reasonable medical probability, that the transfer or delay caused by the transfer will create a medical hazard to the person.

(f) Any person who violates subdivision (d) or (e) of Section 1317.4 is subject to a civil money penalty of no more than ten thousand dollars ($10,000) per violation. The remedy specified in this section shall be in addition to any other remedy provided by law.

(g) The state department shall on an annual basis publish and provide to the Legislature a statistical summary by county on the extent of economic transfers of emergency patients, the frequency of medically hazardous transfers, the insurance status of the patient populations being transferred and all violations finally determined by the state department describing the nature of the violations, hospitals involved, and the action taken by the state department in response. These summaries shall not reveal the identity of individual persons transferred.

(h) Proceedings by the state department to impose a fine under Section 1317.3 or 1317.6, and proceedings by the board to impose a fine under Section 1317.6, shall be ~~conducted in accordance with the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code~~ *conducted as follows:*

(1) If a hospital desires to contest a proposed fine, the hospital shall within 15 business days after service of the notice of proposed fine notify the director in writing of its intention to contest the proposed fine. If requested by the hospital, the director or the director's designee, shall hold, within 30 business days, an informal conference, at the conclusion of which he or she may affirm, modify, or dismiss the proposed fine. If the director or the director's

designee affirms, modifies, or dismisses the proposed fine, he or she shall state with particularity in writing his or her reasons for that action, and shall immediately transmit a copy thereof to the hospital. If the hospital desires to contest a determination made after the informal conference, the hospital shall inform the director in writing within 15 business days after it receives the decision by the director or director's designee. The hospital shall not be required to request an informal conference to contest a proposed fine, as specified in this section. If the hospital fails to notify the director in writing that it intends to protest the proposed fine within the times specified in this subdivision, the proposed fine shall be deemed a final order of the state department and shall not be subject to further administrative review.

(2) If a hospital notifies the director that it intends to contest a proposed fine, the director shall immediately notify the Attorney General. Upon notification, the Attorney General shall promptly take all appropriate action to enforce the proposed fine in a court of competent jurisdiction for the county in which the hospital is located.

(3) A judicial action to enforce a proposed fine shall be filed by the Attorney General after a hospital notifies the director of its intent to contest the proposed fine. If a judicial proceeding is prosecuted under the provisions of this section, the state department shall have the burden of establishing by a preponderance of the evidence that the alleged facts supporting the proposed fine occurred, that the alleged facts constituted a violation for which a fine may be assessed under Section 1317.3, 1317.4, or 1317.6, and the proposed fine is appropriate. The state department shall also have the burden of establishing by a preponderance of the evidence that the assessment of the proposed fine should be upheld. If a hospital timely notifies the state department of its decision to contest a proposed fine, the fine shall not be due and payable unless and until the judicial proceeding is terminated in favor of the state department.

(4) Action brought under the provisions of this section

shall be set for trial at the earliest possible date and shall take precedence on the court calendar over all other cases except matters to which equal or superior precedence is specifically granted by law. Times for responsive pleading and for hearing any such proceeding shall be set by the judge of the court with the object of securing a decision as to subject matters at the earliest possible time.

(5) If the proposed fine is dismissed or reduced, the state department shall take action immediately to ensure that the public records reflect in a prominent manner that the proposed fine was dismissed or reduced.

(6) In lieu of a judicial proceeding, the state department and the hospital may jointly elect to submit the matter to binding arbitration, in which case, the department shall initiate arbitration proceedings. The parties shall agree upon an arbitrator designated by the American Arbitration Association in accordance with the Association's established rules and procedures. The arbitration hearing shall be set within 45 days of the parties' joint election, but in no event less than 28 days from the date of selection of an arbitrator. The arbitration hearing may be continued up to 15 days if necessary at the arbitrator's discretion. The decision of arbitrator shall be based upon substantive law and shall be binding on all parties, subject to judicial review. This review shall be limited to whether there was substantial evidence to support the decision of the arbitrator.

(7) Proceedings by the board to impose a fine under Section 1317.6 shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 8. Section 1317.5 is added to the Health and Safety Code, to read:

1317.5. (a) All alleged violations of this article and the regulations adopted hereunder shall be investigated by the state department. The state department, with the agreement of the local EMS agency, may refer violations of this article to the local EMS agency for investigation. The investigation shall be conducted pursuant to

procedures established by the state department and shall be completed no later than 60 days after the report of apparent violation is received by the state department.

(b) At the conclusion of its investigation, the state department or the local EMS agency shall refer any alleged violation by a physician to the board of medical quality assurance unless it is determined that the complaint is without a reasonable basis.

SEC. 9. Section 1317.6 is added to the Health and Safety Code, to read:

1317.6. (a) Hospitals found by the state department to have committed or to be responsible for a violation of this article or the regulations adopted pursuant thereto shall be subject to a civil penalty by the state department in an amount not to exceed twenty-five thousand dollars ($25,000) for each hospital violation.

(b) Notwithstanding this section, the director shall refer any alleged violation by a hospital owned and operated by a health care service plan involving a plan member or enrollee to the Department of Corporations unless the director determines the complaint is without reasonable basis. The Department of Corporations shall have sole authority and responsibility to enforce this article with respect to violations involving hospitals owned and operated by health care service plans in their treatment of plan members or enrollees.

(c) Physicians found by the board to have committed, or to be responsible for, a violation of this article or the regulations adopted pursuant thereto shall be subject to any and all penalties which the board may lawfully impose and may be subject to a civil penalty by the board in an amount not to exceed five thousand dollars ($5,000) for each violation. A civil penalty imposed under this subdivision shall not duplicate federal fines, and the board shall credit any federal fine against a civil penalty imposed under this subdivision.

(d) The board may impose fines when it finds any of the following:

(1) The violation was knowing or willful.

(2) The violation was reasonably likely to result in a

medical hazard.

(3) There are repeated violations.

(e) It is the intent of the Legislature that the state department has primary responsibility for regulating the conduct of hospital emergency departments and that fines imposed under this section should not be duplicated by additional fines imposed by the federal government as a result of the conduct which constituted a violation of this section. To effectuate the Legislature's intent, the Governor shall inform the Secretary of the federal Department of Health and Human Services of the enactment of this section and request the federal department to credit any penalty assessed under this section against any subsequent civil monetary penalty assessed pursuant to Section 1867 of the federal Social Security Act for the same violation.

(f) There shall be a cumulative maximum limit of thirty thousand dollars ($30,000) in fines assessed against hospitals under this article and under Section 1867 of the federal Social Security Act for the same circumstances. To effectuate this cumulative maximum limit, the state department shall do both of the following:

(1) As to state fines assessed prior to the final conclusion, including judicial review, if available, of an action against a hospital by the federal Department of Health and Human Services under Section 1867 of the federal Social Security Act, (for the same circumstances finally deemed to have been a violation of this article or the regulations adopted hereunder, because of the state department action authorized by this article), remit and return to the hospital within 30 days after conclusion of the federal action, that portion of the state fine necessary to assure that the cumulative maximum limit is not exceeded.

(2) Immediately credit against state fines assessed after the final conclusion, including judicial review, if available, of an action against a hospital by the federal Department of Health and Human Services under Section 1867 of the federal Social Security Act, which results in a fine against a hospital (for the same

circumstances final, deemed to have been a violation of this article or the regulations adopted hereunder, because of the state department action authorized by this article), the amount of the federal fine, necessary to assure the cumulative maximum limit is not exceeded.

(g) Any hospital found by the state department pursuant to procedures established by the state department to have committed a violation of this article or the regulations adopted hereunder may have its emergency medical service permit revoked or suspended by the state department.

(h) Any administrative or medical personnel who knowingly and intentionally violates any provision of this article, may be charged by the local district attorney with a misdemeanor.

(i) Notification of each violation found by the state department of the provisions of this article or the regulations adopted hereunder shall be sent by the state department to the Joint Commission for the Accreditation of Hospitals, ~~and state~~ *the state emergency medical services authority,* and local emergency medical services agencies.

(j) Any person who suffers personal harm and any medical facility which suffers a financial loss as a result of a violation of this article or the regulations adopted hereunder may recover, in a civil action against the transferring or receiving hospital, damages, reasonable attorney's fees, and other appropriate relief. Transferring and receiving hospitals from which inappropriate transfers of persons are made or refused in violation of this article and the regulations adopted hereunder shall be liable for the reasonable charges of the receiving or transferring hospital for providing the services and care which should have been provided. Any person potentially harmed by a violation of this article or the regulations adopted hereunder, or the local district attorney or the Attorney General, may bring a civil action against the responsible hospital or administrative or medical personnel, to enjoin the violation, and if the injunction issues, the court shall award reasonable

attorney's fees. The provisions of this subdivision are in addition to other civil remedies and do not limit the availability of the other remedies.

(k) The civil remedies established by this section do not apply to violations of any requirements established by any county or county agency.

SEC. 10. Section 1317.7 is added to the Health and Safety Code, to read:

1317.7. This article does not preempt any governmental agencies acting within their authority from regulating emergency care or patient transfers, including the imposition of more specific duties, consistent with the requirements of this article and its implementing regulations. Any inconsistent requirements imposed by the Medi-Cal program shall preempt this article with respect to Medi-Cal beneficiaries. To the extent hospitals and physicians enter into contractual relationships with counties which impose more stringent transfer requirements, those contractual agreements shall control.

SEC. 11. Section 1317.8 is added to the Health and Safety Code, to read:

1317.8. If any provision of this article is declared unlawful or unconstitutional in any judicial action, the remaining provisions of this chapter shall remain in effect.

SEC. 12. Section 1317.9 is added to the Health and Safety Code, to read:

1317.9. The state department shall adopt on an emergency basis regulations to implement the provisions of this article by July 1, 1989.

SEC. 13. Section 1317.9a is added to the Health and Safety Code, to read:

1317.9a. (a) This article shall not be construed as altering or repealing Section 2400 of the Business and Professions Code.

(b) Nothing in Sections 1317 et seq. and 1798.170 et seq. shall prevent a physician from exercising his or her professional judgment in conflict with any state or local regulation adopted pursuant to Section 1317 et seq. or

1798.170 et seq., so long as the judgment conforms with Sections 1317, 1317.1, and, except for subdivision (g), Section 1317.2, and ~~was made in~~ *acting in compliance with the state or local regulation would be contrary to* the best interests of the patient.

SEC. 14. Chapter 2.5 (commencing with Section 1797.98a) is added to Part 1 of Division 2.5 of the Health and Safety Code, to read:

CHAPTER 2.5. THE EMERGENCY MEDICAL SERVICES FUND

~~1797.98a. The Emergency Medical Services Fund is hereby created in the State Treasury. The money in the fund shall be available, when appropriated by the Legislature, for the reimbursements required by this chapter.~~

1797.98a. Each county may establish an Emergency Medical Services Fund, upon adoption of a resolution by the board of supervisors. The money in the fund shall be available for the reimbursements required by this chapter. The fund shall be administered by each county, except that a county electing to have the state administer its medically indigent services program may also elect to have its Emergency Medical Services Fund administered by the state. Costs of administering the fund shall be reimbursed by the fund, up to 10 percent of the amount of the fund. The fund shall be utilized to reimburse physicians ~~and hospitals~~ for patients who do not make payment for ~~services and for losses incurred in the provision of~~ emergency medical services ~~on and after July 1, 1988. After provision for the payment to the State Department of Health Services of its cost of administering this fund and the patient transfer provisions contained in Sections 1317 to 1317.9a, inclusive, two-thirds~~ *and for other emergency medical services purposes as determined by each county. Two-thirds* of the money in the fund shall be distributed to physicians for emergency services provided by all physicians, except those physicians employed by county hospitals or district

hospitals, in general acute care hospitals that provide basic or comprehensive emergency services up to the time the patient is stabilized, and one-third of the fund shall be distributed ~~to disproportionate share hospitals~~ *for other emergency medical services purposes as determined by each county*. The source of the money in the fund shall be the penalty assessment made for this purpose, as provided in Section 1465 of the Penal Code.

~~1797.98b. (a) The administration of the Emergency Medical Services Fund shall be performed by the State Department of Health Services. The department may contract with private entities on a statewide basis for all or portions of the services necessary to administer this chapter.~~

~~(b) The State Department of Health Services, on~~ *1797.98b. Each county establishing a fund, on* January 1, 1989, and on each January 1 thereafter, shall report to the Legislature on the implementation and status of the Emergency Medical Services Fund. The report shall include, but not be limited to, all of the following:

(1) The fund balance and the amount of moneys disbursed under the program to physicians and ~~hospitals~~ *for other emergency medical services purposes*.

(2) The pattern and distribution of claims and the percentage of claims paid to those submitted.

(3) The amount of moneys available to be disbursed to physicians ~~and hospitals~~, the dollar amount of the total allowable claims submitted, and the percentage at which such claims were reimbursed.

(4) A statement of the policies, procedures, and regulatory action taken to implement and run the program under this chapter.

1797.98c. (a) Physicians wishing to be reimbursed shall submit ~~to the department~~ their losses incurred due to patients who do not make any payment for services and for whom no responsible third party makes any payment. No physicians shall be reimbursed greater than 40 percent of those losses.

(b) If, after payment from the fund, a physician can reasonably expect payment from the patient or a

responsible party, then the physician shall continue to make efforts to receive payment, notwithstanding previous payment from the fund. If, after payment from the fund, a physician is reimbursed by a patient or a responsible payor, the physician shall notify the ~~State Department of Health Services~~ *fund* and the physician's future submission of claims to the fund shall be reduced accordingly. In the event there is not a subsequent submission of a claim for reimbursement of services by the fund pursuant to this chapter by the physician within one year, the physician shall reimburse the fund in an amount equal to the amount collected from the patient or other payor, but not more than the amount of reimbursement received from the fund for care of that patient.

(c) For the purposes of this chapter, reimbursement for losses incurred due to patients for whom no payment is received shall be restricted to the following:

(1) Patients for whom the physician has inquired if there is a responsible private or public third-party source of payment.

(2) Patients for whom the physician expects to receive reimbursement for the services provided.

(3) Patients for whom the physician has billed for payment, or has billed a responsible private or public third party.

(4) Patients for whom the physician has made reasonable efforts to collect payment.

(5) Claims which have been rejected for payment by the patient and any responsible third party.

For purposes of this chapter, rejection means either of the following:

(A) Actual notification from the person, responsible third party, or governmental agency that no payment will be made for the services rendered by the provider.

(B) The passage of six months' time from the date the physician has billed the patient and made reasonable efforts to obtain reimbursement from the responsible third parties or governmental agencies, and during which time the physician has not been wholly, or in part,

reimbursed for providing the services rendered.

(d) A listing of patient names shall accompany a physician's submission, and those names shall be given full confidentiality protections by the administering agency.

1797.98d. One-third of the Emergency Medical Services Fund shall be disbursed ~~by the department to disproportionate share hospitals, as defined by California Medical Assistance Commission in accordance with subdivision (k) of Section 14083 of the Welfare and Institutions Code, in proportion to their disproportionate share of emergency services rendered on behalf of indigent patients.~~ *for other emergency medical services purposes as determined by each county.*

1797.98e. (a) It is the intent of the Legislature that a simplified, cost-efficient system of administration of this chapter be developed ~~by the department~~ so that the maximum amount of funds may be utilized to reimburse physicians and hospitals *for other emergency medical services purposes.* The ~~department~~ *administering agency* shall establish procedures and time schedules for the submission and processing of proposed reimbursement requests submitted by physicians ~~and hospitals~~. The schedule shall provide for disbursement of all available money in the fund at least annually on a pro rata basis to all applicants who have submitted accurate and complete data for payment by a date to be established by the ~~department~~ *administering agency*. It is anticipated that the moneys in the Emergency Medical Services Fund will be sufficient to meet only a fraction of the requests for reimbursement from physicians ~~and hospitals~~. In this circumstance, the ~~department~~ *administering agency* shall equitably prorate payments so that the amount of payment from the fund is based upon the magnitude of the physician's ~~or hospital's~~ losses. The ~~department~~ *administering agency* may, as necessary, request records and documentation to support the amounts of reimbursement requested by physicians ~~and hospitals~~, and the ~~department~~ *administering agency* may review and audit such records for accuracy. Reimbursements

requested and reimbursements made that are not supported by records may be denied to and recouped from physicians ~~and hospitals~~. Physicians ~~and hospitals~~ found to submit requests for reimbursement that are inaccurate or unsupported by records may be excluded from submitting future requests for reimbursement.

(b) Each provider of health services which receives payment under this chapter shall keep and maintain records of the services rendered, the person to whom rendered, the date, and any additional information the ~~department~~ *administering agency* may, by regulation, require, for a period of three years from the date the service was provided.

(c) During normal working hours, the ~~department~~ *administering agency* may make any inspection and examination of a hospital's or physician's books and records needed to carry out the provisions of this chapter. A provider who has knowingly submitted a false request for reimbursement shall be guilty of civil fraud.

SEC. 15. Section 1798 of the Health and Safety Code is amended to read:

1798. (a) The medical direction and management of an emergency medical services system shall be under the medical control of the medical director of the local EMS agency. This medical control shall be maintained in the following manner:

(1) Prospectively by written medical policies and procedures to provide standards for patient care.

(2) Immediately by direct voice communication between a certified EMT-P or EMT-II and a base hospital emergency physician or, an authorized registered nurse and, in the event of temporary unavailability of voice communications, by utilization by an EMT-P or EMT-II of authorized, written orders and policies established pursuant to Section 1798.4.

(3) Retrospectively by means of medical audit of field care and continuing education.

(b) Medical control shall be within an EMS system which complies with the minimum standards adopted by the authority, and which is established and implemented

by the local EMS agency.

(c) In the event a medical director of a base station questions the medical effect of a policy of a local EMS agency, the medical director of the base station shall submit a written statement to the medical director of the local EMS agency requesting a review by a panel of medical directors of other base stations. Upon receipt of the request, the medical director of a local EMS agency shall ~~within 30 days~~ *promptly* convene a panel of medical directors of base stations to evaluate the written statement. The panel shall be composed of all the medical directors of the base stations in the region, except that the local EMS medical director may limit the panel to five members.

This subdivision shall remain in effect only until the authority adopts more comprehensive regulations that supersede this subdivision.

SEC. 16. Section 1798.170 of the Health and Safety Code is amended to read:

1798.170. A local EMS agency may develop triage and transfer protocols to facilitate prompt delivery of patients to appropriate designated facilities within and without its area of jurisdiction. Considerations in designating a facility shall include, but shall not be limited to, the following:

(a) A general acute care hospital's consistent ability to provide on-call physicians and services for all emergency patients regardless of ability to pay.

(b) The sufficiency of hospital procedures to ensure that all patients who come to the emergency department are examined and evaluated to determine whether or not an emergency condition exists.

(c) The hospital's compliance with local EMS protocols, guidelines, and transfer agreement requirements.

SEC. 17. Section 1798.172 of the Health and Safety Code is amended to read:

1798.172. (a) The local EMS agency shall ~~, by January 1, 1990,~~ establish guidelines and standards for completion and operation of formal transfer agreements between

hospitals with varying levels of care in the area of jurisdiction of the local EMS agency consistent with the provisions of Sections 1317 to 1317.9a, inclusive, and Chapter 5 (commencing with Section 1798). Each local EMS agency shall solicit and consider public comment in drafting guidelines and standards. These guidelines shall include provision for suggested written agreements for the type of patient, *initial patient care treatments*, requirements of interhospital care, and associated logistics for transfer, evaluation, and monitoring of the patient. ~~The local EMS agency shall also establish guidelines for necessary initial care treatments in accordance with this section or by reference to regulations adopted by the department pursuant to Section 1317.9 governing necessary initial care and treatment.~~

(b) Notwithstanding the provisions of subdivision (a), and in addition to the provisions of Section 1317, a general acute care hospital licensed under Chapter 2 (commencing with Section 1250) of Division 2 shall not transfer a person for nonmedical reasons to another health facility unless that other facility receiving the person agrees in advance of the transfer to accept the ~~transfer. Draft guidelines and standards shall be the subject of a public hearing.~~ *transfer.*

SEC. 18. Section 1798.205 is added to the Health and Safety Code, to read:

1798.205. Any alleged violations of local EMS agency transfer protocols, guidelines, or agreements ~~shall be investigated by the local EMS agency. The investigation shall be completed within 60 days after the apparent violation is reported. If the local EMS agency~~ *shall be evaluated by the local EMS agency. If the local EMS agency* has concluded that a violation has occurred, it shall take whatever corrective action it deems appropriate within its jurisdiction, including referrals to the district attorney under Sections 1798.206 and 1798.208 and shall notify the State Department of Health Services if it concludes that any violation of Sections 1317 to 1317.9a, inclusive, has occurred.

SEC. 19. Section 1798.208 of the Health and Safety Code is amended to read:

1798.208. Whenever any person who has engaged, or is about to engage, in any act or practice which constitutes, or will constitute, a violation of any provision of this division, the rules and regulations promulgated pursuant thereto, or local EMS agency mandated protocols, guidelines, or transfer agreements, the superior court in and for the county wherein the acts or practices take place or are about to take place may issue an injunction or other appropriate order restraining the conduct or application of the authority, the Attorney General, or the district attorney of the county. The proceedings under this section shall be governed by Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure, except that no undertaking shall be required.

SEC. 20. Section 1465 is added to the Penal Code, to read:

1465. In addition to the assessments levied by Section 1464, an additional assessment is ~~imposed~~ of one dollar ($1) ~~The~~ *may be imposed by each county upon the adoption of a resolution by the board of supervisors. An* assessment imposed by this section shall be ~~forwarded once each month to the State Treasury for deposit in the Emergency Medical Services Fund created by Section 1797.98a of the Health and Safety Code.~~ *collected and disbursed as provided in Chapter 2.5 (commencing with Section 1797.98a) of Division 2.5 of the Health and Safety Code.*

SEC. 21. (a) No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for those costs which may be incurred by a local agency or school district because this act creates a new crime or infraction, changes the definition of a crime or infraction, changes the penalty for a crime or infraction, or eliminates a crime or infraction.

(b) The Legislature intends Section 5 of this act to be declaratory of existing law which requires certain

governmental payors, including counties under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code, to provide medical care, including emergency medical services, to certain patients unable to pay for medical services. Therefore, it is not the intent of the Legislature in enacting Section 5 of this act to mandate either a new program or higher level of service and therefore no reimbursement is required by this act for these provisions pursuant to Section 6 of Article XIII B of the California Constitution.

(c) Notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed five hundred thousand dollars ($500,000), reimbursement shall be made from the State Mandates Claims Fund.

Approved, September 27, 1987

APPENDIX 3

AGENCY COMMENTS TO THE DRAFT REPORT

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Memorandum

Date JUL 15 1988

From Deputy Assistant Secretary for Health Operations and Director, Office of Management

Subject OIG Draft Report "Patient Dumping After COBRA: Assessing the Incidence and the Perspectives of Health Care Professionals," OAI-12-88-00830

To Assistant Inspector General for Analysis and Inspections, OS

We have reviewed the subject draft report and concur with its conclusions and recommendations.

Allen Wommer for

Wilford J. Forbush

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

MEMORANDUM

OFFICE OF THE INSPECTOR GENERAL

1988 JUL 13 AM 9 58

IG	✓
DIG	✓
AIG-A	
AIG-AI	✓
AIG-I	
ADM	✓
OGC/IG	
EX SEC	
DATE SENT	7/13

DATE : June 13, 1988

FROM : Audrey F. Morton
Director
Office for Civil Rights

SUBJECT: OIG Draft Report: "Patient Dumping After COBRA: Assessing the Incidence and the Perspectives of Health Care Professionals," OAI-12-00830

TO : Richard P. Kusserow
Inspector General
Office of the Inspector General

We have completed the review of the OIG Draft Report entitled "Patient Dumping After COBRA: Assessing the Incidence and the Perspectives of Health Care Professionals," and submit the following comments for consideration in the preparation of the final document.

COMMENTS:

Page 2: The first full paragraph refers to criticism of OCR for not providing facilities with formal technical assistance regarding their obligations under Hill-Burton. We believe that mention should be made of some of OCR's efforts in this regard. Although OCR has not been able to provide technical assistance to every facility, our voluntary compliance activities have provided awareness and technical assistance to many hospitals and other segments of the community concerning their rights and the obligations of hospitals under the Hill-Burton Act. For example, in one of our Regional Offices, the following contacts and interviews have been held with various groups in an effort to understand their perspective of the problems of patient dumping, as well as to explain the role of OCR and the obligations of hospitals:

- Representatives from a union local of the Hospital Worker's Union
- Representatives of a local Congressman's office
- The President of the Health Federation of Philadelphia
- An Assistant Dean, School of Medicine
- Director of Local Government Affairs at a major University
- Hospital Administrators

Also, in another Regional Office, community based organizations that represent constituencies that are most likely to be "dumped" have been participants in meetings with OCR staff. The groups included the Chicago Urban League, Mexican American Legal Defense and Education Fund, Traveler AID and Immigrant Society, Chicago NAACP, and the American Refugee Committee. In 1987, OCR convened a "Patient Dumping" seminar designed to inform local community and advocacy groups of the Hill-Burton obligations of hospitals. As a result of this seminar, OCR developed a "patient dumping" Task Force headed by the Chicago Urban League. The Task Force assumed the responsibility, through its memberships and varied constituencies, to inform OCR of "patient dumping" problems in the Chicago Metropolitan Community. OCR is an ex officio member of this task force.

Page 3: The second paragraph contains the phrase "...referral of the hospital to the U.S. Department of Justice for criminal prosecution...." This should be revised to eliminate reference to "criminal prosecution." Remedies under the Hill-Burton legislation are limited to specific performance rather than monetary or criminal penalties.

Page 9: Reference is made to OCR's participation in drafting the regulations formally implementing the COBRA provisions. To date, OCR has not been involved in this effort. Should we be requested to participate in any way in this drafting process, I will have OCR staff available to assist in the accomplishment of this task.

Page 18: Item 2 recommends that "...emergency room records clearly delineate if a patient was transferred and from what source; or, a transfer log should be maintained. This will effectively aid the OIG, HCFA and OCR in conducting compliance reviews to ensure that all patients transferred from other emergency rooms were transferred in stable condition."

It should be mentioned in this paragraph that the receiving hospital is expected to maintain the information identified in this item. We agree that records of patient transfers must be maintained, and that such records will aid in the conduct of complaints and compliance reviews. However, for this information to be of maximum benefit, the records should contain information regarding the reason for the transfer whenever possible. This information will be valuable in identifying the cases of questionable transfers and provide the official record with the statement of the sending hospital regarding the reason for the transfer. This information may result from telephone conversations that are to precede the transfer from one hospital to another, or from records that may accompany the transferred patient.

The reference to a "transfer log" should be expanded to identify the type of information that is expected to be collected.

Item 3 focuses on outreach to professional associations. We believe that outreach efforts should extend to communities and advocacy groups that reach the potentially affected individuals. As mentioned in item 1, page 17 of this document, "affected

parties may be made more likely to report violations if they are aware of their rights...." Rather than relying on this awareness to result from posted notices in hospitals, we could effect increased public awareness of rights under COBRA and Hill-Burton by providing the information directly to the public through various forms of contacts, including the mediums of radio, television, and public meetings. Some of OCR's efforts in this regard are outlined in our comments for page 2.

If further discussion regarding these comments is required, you may contact me or have your staff contact Patricia L. Mackey on 245-6118.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date JUL 25 1988

From William L. Roper, M.D.
Administrator

Subject OIG Draft Report: "Patient Dumping After COBRA: Assessing the Incidence and the Perspectives of Health Care Professionals," OAI-12-88-00830

To The Inspector General
Office of the Secretary

We have reviewed the draft audit and find the report to be quite informative and indicative of the difficulty of tracking and monitoring patient dumping. We agree with the thrust of the OIG's findings and recommendations.

We have taken a number of steps towards implementation of the report's recommendations. Our specific comments are attached for your consideration. Thank you for the opportunity to comment on this draft report.

Attachment

Comments of the Health Care Financing Administration OIG Draft Report: "Patient Dumping After COBRA: Assessing the Incidence and the Perspectives of Health Care Professionals," OAI-12-88-00830

OIG Recommendation

Reporting of suspected cases of patient dumping should be made a condition of participation (COP) in the Medicare program in order to increase reporting.

HCFA Comments

As the OIG has indicated, HCFA has accepted this recommendation. We will, however, make this new requirement part of the Provider Agreement Regulations (42 CFR Part 489) instead of the hospital COPs (42 CFR Part 482). Section 489.24(f) of the recently published Notice of Proposed Rulemaking (NPRM), BERC 393-P, Participation in CHAMPUS and CHAMPVA, Hospital Admissions for Veterans, Discharge Rights Notice, and Hospital Responsibility for Emergency Care, would require hospitals which receive patients transferred in suspected violation of the patient dumping requirements to report the incident to the Medicare State survey agency and to HCFA, or be subject to termination from the Medicare program.

OIG Recommendation

HCFA and the Office of Civil Rights (OCR) should use existing authority require hospitals to post notices in their emergency rooms informing patients of their rights under COBRA and the Hill-Burton Act and indicating a local number to call with complaints.

HCFA Comments

We are confirming with the Office of General Counsel whether HCFA has the legal authority to require hospitals to post such notices.

OIG Recommendation

The COBRA regulations should require that all emergency room (ER) records clearly identify all transferred patients to and from other ERs. All patients should be asked upon arrival at an ER if they have sought treatment elsewhere.

HCFA Comments

The above requirements are already part of the recordkeeping requirements of the hospital COPs and the NPRM. Section 482.24(c) of the hospital COPs requires patient medical records to contain information on the patient's health history. Section 489.24(d)(2)(B) of the NPRM would require a

transferring hospital to provide the receiving facility with appropriate medical records (or copies of them) of the examination and treatment furnished at the transferring hospital. Additionally, in view of the termination, suspension and civil monetary penalty and civil enforcement provisions of COBRA and the NPRM, we expect that hospitals will take appropriate measures to identify all transferred patients in order to protect themselves from litigation. For these reasons, we see no need to require hospitals to question ER patients upon arrival.

OIG Recommendation

HCFA and the OCR should pursue direct outreach to professional associations to increase awareness of the patient dumping requirements and to stimulate reporting by health care professionals.

HCFA Comments

We have already taken action to conduct direct outreach to professional associations to increase awareness and stimulate reports of non-compliance by professionals. Attached are copies of letters from Dr. Roper to the American Hospital Association, the Federation of American Health Systems, the National Association of Public Hospitals, the American Medical Association and the American Osteopathic Association. Please note that these associations have been requested to inform their members about the COBRA provisions. Also attached is a copy of a letter signed by Dr. Roper, Richard P. Kusserow, the Inspector General, and Audrey Morton, Director of the Office for Civil Rights, sent directly to the administrator of each Medicare participating hospital. In this letter each hospital administrator has been advised that it is essential that all pertinent medical staff, including responsible physicians, nurses, admitting clerks and ambulance attendants (where such services are run out of the hospital) are reminded about their responsibilities and the potential consequences of violating the anti-dumping law.

The above letters notified the health care provider community that we will not tolerate cases of negligence and deliberate malfeasance and requested their assistance in preventing violations and notifying HCFA of cases that occur.

OIG Recommendation

HCFA should clarify the definitions of "stabilization" and "emergent condition", as the American College of Emergency Physicians (ACEP) has done, in COBRA regulations or through proposed legislation in order to clarify physicians' responsibilities under COBRA. Also, to the extent possible, HCFA and OCR should coordinate to assure that the Department uses a common definition of terms when enforcing the patient dumping provisions.

HCFA Comments

We believe the definitions of "to stabilize," "stabilized," and "emergency medical condition" contained in COBRA (section 1867(e)) and the NPRM (section 489.24(b)) are sufficient to identify bonafide emergencies and establish whether a transfer is appropriate. The ACEP definitions are too specific and detailed for this purpose. However, if public comments on the NPRM indicate more elaboration is needed, we will modify the definitions in the final rule.

HCFA has coordinated with OCR in the development of the patient dumping NPRM. HCFA will, of course, follow the same procedure in developing the final regulation.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JUN 15 1988

Carol McCarthy, Ph.D
President
American Hospital Association
840 N. Lake Shore Drive
Chicago, Illinois 60611

Dear Dr. McCarthy:

I am writing to inform you of a letter I have sent to the administrators of all hospitals participating in Medicare and Medicaid, and to ask your help in sharing its message with your members.

The letter, also signed by Richard Kusserow, the Inspector General, and Audrey Morton, the Director of the Office for Civil Rights, explains the statutory "anti-dumping" requirements and the consequences of violating them. I have enclosed a copy of the letter for your information.

I know you share my concern that our citizens receive emergency treatment to which they are entitled under law. I hope you will join me in a cooperative effort so that your members will be familiar with, and comply with, the requirements of the statute. By working together, we should be able to prevent dumping and the need to employ the rather formidable enforcement mechanism described in the letter.

Thank you for your assistance.

Sincerely,

Bill

William L. Roper, M.D.
Administrator

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JUN 15 1988

Mr. Michael D. Bromberg
Executive Director
Federation of American Health Systems
Suite 402
1111 19th Street, N.W.
Washington, D.C. 20036

Dear Mr. Bromberg: Mike

I am writing to inform you of a letter I have sent to the administrators of all hospitals participating in Medicare and Medicaid, and to ask your help in sharing its message with your members.

The letter, also signed by Richard Kusserow, the Inspector General, and Audrey Morton, the Director of the Office for Civil Rights, explains the statutory "anti-dumping" requirements and the consequences of violating them. I have enclosed a copy of the letter for your information.

I know you share my concern that our citizens receive emergency treatment to which they are entitled under law. I hope you will join me in a cooperative effort so that your members will be familiar with, and comply with, the requirements of the statute. By working together, we should be able to prevent dumping and the need to employ the rather formidable enforcement mechanism described in the letter.

Thank you for your assistance.

Sincerely,

Bill

William L. Roper, M.D.
Administrator

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JUN 15 1988

Mr. Larry S. Gage
President
National Association of Public Hospitals
Suite 635
1001 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

Dear Mr. Gage:

I am writing to inform you of a letter I have sent to the administrators of all hospitals participating in Medicare and Medicaid, and to ask your help in sharing its message with your members.

The letter, also signed by Richard Kusserow, the Inspector General, and Audrey Morton, the Director of the Office for Civil Rights, explains the statutory "anti-dumping" requirements and the consequences of violating them. I have enclosed a copy of the letter for your information.

I know you share my concern that our citizens receive emergency treatment to which they are entitled under law. I hope you will join me in a cooperative effort so that your members will be familiar with, and comply with, the requirements of the statute. By working together, we should be able to prevent dumping and the need to employ the rather formidable enforcement mechanism described in the letter.

Thank you for your assistance.

Sincerely,

Bill

William L. Roper, M.D.
Administrator

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JUN 15 1988

James H. Sammons, M.D.
Executive Vice President
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

Dear Dr. Sammons:

I am writing to inform you of a letter I have sent to the administrators of all hospitals participating in Medicare and Medicaid, and to ask your help in sharing its message with your members.

The letter, also signed by Richard Kusserow, the Inspector General, and Audrey Morton, the Director of the Office for Civil Rights, explains the statutory "anti-dumping" requirements and the consequences of violating them. I have enclosed a copy of the letter for your information.

I know you share my concern that our citizens receive emergency treatment to which they are entitled under law. I hope you will join me in a cooperative effort so that your members will be familiar with, and comply with, the requirements of the statute. By working together, we should be able to prevent dumping and the need to employ the rather formidable enforcement mechanism described in the letter.

Thank you for your assistance.

Sincerely,

William L. Roper, M.D.
Administrator

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C 20201

JUN 15 1988

Joseph W. Stella, D.O.
President
American Osteopathic Association
1736 Hamilton Street
Allentown, Pennsylvania 18104

Dear Dr. Stella:

I am writing to inform you of a letter I have sent to the administrators of all hospitals participating in Medicare and Medicaid, and to ask your help in sharing its message with your members.

The letter, also signed by Richard Kusserow, the Inspector General, and Audrey Morton, the Director of the Office for Civil Rights, explains the statutory "anti-dumping" requirements and the consequences of violating them. I have enclosed a copy of the letter for your information.

I know you share my concern that our citizens receive emergency treatment to which they are entitled under law. I hope you will join me in a cooperative effort so that your members will be familiar with, and comply with, the requirements of the statute. By working together, we should be able to prevent dumping and the need to employ the rather formidable enforcement mechanism described in the letter.

Thank you for your assistance.

Sincerely,

Bill Roper

William L. Roper, M.D.
Administrator

Enclosure

June 15, 1988

Dear Hospital Administrator:

This letter concerns the legal requirement that Medicare participating hospitals with emergency departments provide emergency medical treatment to individuals as a condition of their Medicare provider agreement.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) added a new section to the Social Security Act, Section 1867--Responsibilities of Medicare Hospitals in Emergency Cases. This provision establishes a statutory requirement that hospitals with emergency departments provide appropriate medical screening examinations to all individuals with emergency medical conditions and all women in active labor. They may either stabilize the condition or provide a medically appropriate transfer to another facility when indicated, unless the patient or their legal representative refuses treatment or transfer. Although the statute applies to hospitals participating in Medicare, it covers both Medicare and non-Medicare patients. The Health Care Financing Administration (HCFA) will terminate hospitals, and the Office of Inspector General (OIG) may suspend hospitals and exclude responsible physicians from the Medicare program when this requirement to provide needed emergency care is violated. Further, the OIG may levy civil monetary penalties of up to $50,000 per incident against hospitals and responsible physicians who have violated the statute. Individuals suffering personal harm and medical facilities suffering financial loss can bring civil suit under State law against the offending hospitals.

The Office for Civil Rights (OCR) is responsible for enforcing similar obligations contained in the Hill-Burton Act's Community Service requirements, as well as other non-discrimination statutes. Hospitals receiving funds under the Hill-Burton Act of 1946 are required to provide emergency medical services based on need.

The professionalism of a hospital and its staff is the first and greatest protection from harm any patient can receive. However, cases of negligence and deliberate malfeasance do occur. We will not tolerate such cases. We have directed our regional and field offices to enforce section 1867 and Hill-Burton Act Community Service requirements rigorously and also to work with State survey agencies and Peer Review Organizations, as appropriate, to investigate complaints quickly and aggressively.

Clearly our objectives are to prevent patient dumping and to stop it when it does occur. In meeting these objectives, it is imperative that you undertake certain actions to assist the Department of Health and Human

Services. First, it is essential that you share this information with all pertinent medical staff, including responsible physicians, nurses, admitting clerks and ambulance attendants where such services are run out of the hospital, and remind them about their responsibilities and of the potential consequences of violating the anti-dumping law. Secondly, it is imperative that you inform us of any situation where there may be a suspected violation of the requirements for medical screening, stabilizing treatment, or appropriate transfer so that we can initiate an investigation. We have enclosed a list of the HCFA and OCR regional offices, which will act as the focal point on all initial complaints, and a copy of the statute for your reference. You are to inform the appropriate Regional Administrator of HCFA or OCR Regional Manager of any violations as soon as you become aware of them.

Together we must prevent violations of the law. We are grateful to you and your hospital staff for your immediate, continuing, and effective response to this problem.

Sincerely,

Richard P. Kusserow
Inspector General

Audrey F. Morton
Director
Office for Civil Rights

William L. Roper (M.D.)
William L. Roper
Administrator
Health Care Financing Administration

Enclosures

EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN ACTIVE LABOR[368]

SEC. 1867. [42 U.S.C. 1395dd] (a) MEDICAL SCREENING REQUIREMENT.—In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists or to determine if the individual is in active labor (within the meaning of subsection (e)(2)).

(b) NECESSARY STABILIZING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND ACTIVE LABOR.—

(1) IN GENERAL.—If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide either—

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) REFUSAL TO CONSENT TO TREATMENT.—A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph but the individual (or a[369] person acting on the individual's behalf) refuses to consent to the examination or treatment.

(3) REFUSAL TO CONSENT TO TRANSFER.—A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) but the individual (or a[369] person acting on the individual's behalf) refuses to consent to the transfer.

(c) RESTRICTING TRANSFERS UNTIL PATIENT STABILIZED.—

(1) RULE.—If a patient at a hospital has an emergency medical condition with has not been stabilized (within the meaning of subsection (e)(4)(B)) or is in active labor, the hospital may not transfer the patient unless—

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[368] P.L. 99-509, §9343(c)(3), added subsection (g), applicable to contracts entered into or renewed after January 1, 1987.

[368] P.L. 99-272, §9121(b), added §1867, effective August 1, 1986.

See P.L. 99-272, "Consolidated Omnibus Budget Reconciliation Act of 1985", §9121(d), with respect to the report to Congress on compliance with §1867 of the Act; Vol II, p. 749.

[369] P.L. 99-509, §9307(c)(4), struck out "legally responsible", effective October 21, 1986.

[369] See footnote 369.

(B) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.

(3) CIVIL ENFORCEMENT.—

(A) PERSONAL HARM.—Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) FINANCIAL LOSS TO OTHER MEDICAL FACILITY.—Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) LIMITATIONS ON ACTIONS.—No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(e) DEFINITIONS.—In this section:

(1) The term "emergency medical condition" means 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—

(A) placing the patient's health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(2) The term "active labor" means labor at a time at which—

(A) delivery is imminent,

(B) there is inadequate time to effect safe transfer to another hospital prior to delivery, or

(C) a transfer may pose a threat of the health and safety of the patient or the unborn child.

(3) The term "participating hospital" means[371] hospital that has entered into a provider agreement under section 1866[372].

(4)(A) The term "to stabilize" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

(B) The term "stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a facility.

(5) The term "transfer" means the movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated,

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[371] As in original; possibly should insert "a".

[372] P.L. 99-514, §1895(b)(4), struck out "and has, under the agreement, obligated itself to comply with the requirements of this section", effective as if stricken by P.L. 99-272.

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ENDNOTES

1. George J. Annas, "Your Money or Your Life: 'Dumping' Uninsured Patients from Hospital Emergency Wards," *American Journal of Public Health*, 76 (January 1986), 75.

2. David A. Ansell and Robert L. Schiff, "Patient Dumping: Status, Implications, and Policy Recommendations," *Journal of the American Medical Association*, 257 (March 1987), 1500.

3. J. Lawrence, "Medical Experts Say Government Could Reduce 'Patient Dumping'," *The Associated Press*, July 23, 1987.

4. Michael A. Dowell, "Indigent Access to Hospital Emergency Room Services," *Clearinghouse Review*, 18 (October 1984), 483-499.

5. Information on States' initiatives in the area of patient dumping is based on Dowell, op. cit., 483-499, and Judith G. Waxman and Stan Dorn, "States Take the Lead in Preventing Patient Dumping ," *Clearinghouse Review*, Vol. XXII, No. 2, June 1988.

6. California Health and Safety Code, Chapter 1225, s 1317 et seq.

7. Health and Safety Code, 1317.3.

8. Mich. Stat. Ann. 14.15(20715).

9. Utah Code Ann. 216-8-2(12).

10. Wis. Stat. Ann 146.301.

11. Tex. Health and Safety Code Ann. 4438.

12. United States General Accounting Office, "Health Care: Patient Transfers from Emergency Rooms to D.C. General Hospital," April 1987.

13. See American College of Emergency Physicians, "Guidelines for Transfer of Patients," Annals of Emergency Medicine, December 1985, 125-6.

14. See American College of Emergency Physicians, "Definition of Emergency Medicine," 10 Annals of Emergency Medicine 385, 385-88 (1981).

15. D.U. Himmelstein, S. Woolhandler, et al., "Patient Transfers: Medical Practice as Social Triage," *American Journal of Public Health*, 74 (1984), 494-497.

16. R.L. Schiff, D.A. Ansell, et al., "Transfers to a Public Hospital: A Prospective Study of 467 Patients," *New England Journal of Medicine*, 314 (1986), 552-557.

17. Ansell and Schiff provide a more precise estimate in a later article of $1.04 billion annually in total costs shifted to the public sector from the private sector due to patient transfers. See Ansell and Schiff, "Patient Dumping: Status, Implications, and Policy Recommendations," *Journal of American Medical Association*, 257 (March 1987), 1500-1502.

18. Data extracted from Dowell, "Indigent Access to Hospital Emergency Room Services," *Clearinghouse Review* (October 1984) and Judith G. Waxman and Stan Dorn, "States Take the Lead in Preventing Patient Dumping," Clearinghouse Review, Vol. XXII, No. 2, June 1988.