

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**THE EMERGENCY MEDICAL
TREATMENT AND LABOR ACT**

Survey of Hospital Emergency Departments



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EXECUTIVE SUMMARY

PURPOSE

To determine whether staff and directors of hospital emergency departments are aware of the various provisions of the Emergency Medical Treatment and Labor Act (EMTALA) and find out how they believe the Act affects them, their hospitals, and their patients.

BACKGROUND

EMTALA

Congress passed EMTALA, part of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985, in April of 1986 to address the problem of “patient dumping.” The term “patient dumping” refers to certain situations where hospitals fail to screen, treat, or appropriately transfer patients. According to Section 9121 of COBRA, Medicare-participating hospitals must provide a medical screening exam to any individual who comes to the emergency department and requests examination or treatment for a medical condition. If a hospital determines that an individual has a medical emergency, it must then stabilize the condition or provide for an appropriate transfer. The hospital is obligated to provide these services regardless of the individual’s ability to pay and without delay to inquire about the individual’s method of payment or insurance status.

Hospitals' EMTALA responsibilities are incorporated in their Medicare provider agreements. The Health Care Financing Administration (HCFA) requires that hospitals comply with the above EMTALA provisions and also: post signs informing patients of their rights to screening and treatment, keep a central log of emergency department visits, maintain patient transfer records, and report any inappropriate transfers. Failure to fulfill any of these obligations is considered a breach of the provider agreement and grounds for termination. Medicare provider agreements also require hospitals to maintain a back-up call panel for any service for which the hospital promotes itself to the community. Failure of a specialist to report to the emergency department to complete a screening or provide stabilizing treatment can result in penalties for both the hospital and specialist.

Methodology

We conducted a telephone survey of emergency department directors at more than 100 randomly-selected hospitals across the nation and a mail survey of emergency department and on-call personnel at the same hospitals. In addition to the surveys, we met with representatives from the California chapter of the American College of Emergency Physicians and reviewed numerous articles and reports on the subject of

emergency medicine. Throughout this study, we protected the identities of our respondents.

FINDINGS

Emergency department personnel are familiar with EMTALA requirements, but many are unaware of recent policy changes

Emergency department physicians, nurses, registration staff, and on-call specialists indicate that they are familiar with most of EMTALA's requirements. Almost all directors say they regularly receive information about EMTALA, however, only 65 percent were aware of the 1998 Interpretive Guidelines and only 27 percent knew of the proposed Advisory Bulletin which had been published in the Federal Register.

Training increases EMTALA familiarity for all staff, but on-call specialists and staff in high-volume emergency departments are less likely to receive training

Training increases EMTALA awareness, and nearly two-thirds of emergency physicians, nurses, and registration staff receive training. However, only one-quarter of on-call specialists are trained on EMTALA guidelines. Aside from emergency physicians, staff in high-volume emergency departments are less likely to be trained than their counterparts in less busy environments.

Respondents report that hospitals generally comply with EMTALA, but some concerns about compliance remain

Ninety-five percent of staff say their hospital complies with EMTALA. Registration staff say that patients are normally not asked for health insurance information until after medical screening. Some hospitals routinely request authorization for services from health plans, but this usually takes place after the exam or treatment is underway or has been completed. A small number of respondents are concerned that some hospital practices may violate the law.

Respondents believe some aspects of EMTALA are unclear or questionable

Staff need more precise definitions of the terms "emergency medical condition," "medical screening exam," and "stability" as well as clarification of certain aspects of patient transfers under EMTALA. Directors and staff sometimes receive conflicting information which contributes to their confusion. Some respondents believe that some current EMTALA interpretations and practices exceed legislative intent, especially with regard to the law's application to inpatients.

Respondents believe that while EMTALA may help protect patients, it also may contribute to a hospital's administrative and financial problems

Directors find that EMTALA has generally had a positive effect or no effect on the delivery of emergency services. In contrast to any patient care improvements, respondents say that EMTALA has had a negative effect on other aspects of emergency medicine. Staff say it creates administrative entanglements, while some directors argue that mandating treatment without providing funding aggravates financial difficulties.

Investigations, many of which do not confirm violations, often prompt changes in forms and procedures

According to HCFA logs, violations were confirmed in less than one-third of investigations of the hospitals in our sample. Despite this, half of the investigated hospitals changed some aspect of their emergency department operation in response.

Managed care creates special problems for hospitals in complying with EMTALA

According to many directors, private managed care plans' reimbursement policies create financial stresses, a situation exacerbated by EMTALA. Prior authorization requirements leave many hospitals with a tough choice: risk an EMTALA violation or forgo reimbursement.

Hospitals have difficulty staffing on-call panels for some specialties

Medicare provider agreements require hospitals to maintain a specialty call panel for any service for which the hospital promotes itself to the community, but many hospitals have problems filling on-call rosters. Shortages most often occur because the community does not provide enough patients to support specialists or because certain services are not offered at the hospital. Specialists are increasingly refusing to join back-up panels, a critical element of the Nation's health care safety net, because they believe they might not be paid.

CONCLUSIONS

- ▶ **Federal Register publication should be supplemented with other methods of communicating important policy decisions, such as e-mail and the Internet.**
- ▶ **The Department should continue to support legislation that would compel private managed care plans to reimburse hospitals for EMTALA-related services provided to their members, including screening exams which do not reveal the presence of an emergency medical condition.**

- ▶ **Uncompensated care and on-call panels are problems for many hospitals. These are very complex problems which exceed the scope of our study; solutions may involve action at the Federal, State, and local levels as well as from private entities.**

AGENCY COMMENTS

We received written comments from HCFA on the draft report (see Appendix B). The HCFA agreed with our conclusions. The HCFA also offered several technical comments, which we have incorporated where appropriate.

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INTRODUCTION

PURPOSE

To determine whether staff and directors of hospital emergency departments are aware of the various provisions of the Emergency Medical Treatment and Labor Act (EMTALA) and find out how they believe the Act affects them, their hospitals, and their patients.

BACKGROUND

EMTALA Requirements

Congress passed EMTALA, part of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985, in April of 1986¹ to address the problem of “patient dumping.” The term “patient dumping” refers to certain situations where hospitals fail to screen, treat, or appropriately transfer patients. According to Section 9121 of COBRA, Medicare-participating hospitals must provide a medical screening exam to any individual who comes to the emergency department and requests examination or treatment for a medical condition. If a hospital determines that an individual has an emergency medical condition², it must then stabilize the condition or provide for an appropriate transfer. The hospital is obligated to provide these services regardless of the individual’s ability to pay and without delay to inquire about the individual’s method of payment or insurance status. Hospitals may transfer unstable patients only if a physician determines that the benefits of the transfer outweigh the risks or if requested by a patient who has been informed of both the hospital’s EMTALA obligations and the risks of transfer. Hospitals with specialized care facilities, such as burn units, must, within their capacity, accept requests for appropriate transfers of patients who require such specialized care.

Hospitals' EMTALA responsibilities are incorporated in their Medicare provider agreements. The Health Care Financing Administration (HCFA) requires that hospitals comply with the above EMTALA provisions and also: provide a medical screening examination, provide necessary stabilizing treatment and appropriate transfers, post signs informing patients of their rights to screening and treatment, keep a central log of emergency department visits, maintain patient transfer records, and report any

¹EMTALA became effective on August 1, 1986

²Emergency medical condition is defined by law as “a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. . .”

inappropriate transfers. Failure to fulfill any of these obligations is considered a breach of the provider agreement and grounds for termination.

The EMTALA responsibilities extend to on-call specialists as well as to hospitals and emergency department staff. Medicare provider agreements require hospitals to maintain a list of on-call physicians who can complete medical screening exams or provide stabilizing treatment for any service for which the hospital promotes itself to the community. Failure of an on-call specialist to report to the emergency department to provide stabilizing treatment, unless he or she is unable to do so (e.g., already engaged in treating another emergency), can result in penalties for both the hospital and the specialist.

Enforcement

Within the Department of Health and Human Services, the Health Care Financing Administration (HCFA) and the Office of Inspector General (OIG) are jointly responsible for enforcement of EMTALA. The HCFA authorizes State survey agencies to investigate dumping complaints, determines if a violation occurred, and, if appropriate, terminates a hospital's provider agreement. The OIG³ assesses civil monetary penalties against hospitals and physicians and may exclude physicians from the Medicare program for gross and flagrant or repeated violations of EMTALA. The OIG may fine a physician or hospital up to \$50,000 per violation (\$25,000 for hospitals with fewer than 100 beds), but may impose smaller penalties depending on the situation and the financial state of the hospital. For more information on EMTALA investigations and the EMTALA complaint and enforcement process, see the companion report entitled *The Emergency Medical Treatment and Labor Act: The Enforcement Process (OEI-09-98-00221)*.

Previous OIG Work

Shortly after Congress enacted EMTALA, the Office of Inspector General conducted two EMTALA inspections. The first inspection, whose purpose was to determine if hospital records provide enough information to assess the incidence of patient dumping, found that (1) medical record review did not provide the necessary information to assess the incidence of dumping and (2) hospital staff disagreed about the prevalence of patient dumping. The second inspection, meant to assess the patient dumping complaint and investigation process within the Department of Health and Human Services, found that (1) the process was still evolving, (2) coordination among different components needed improvement, (3) dumping complaints were increasing, and (4) resolution of dumping complaints was time consuming. A third report, issued by OIG in 1995, focused on HCFA's role in the enforcement process. Although the report concluded that the investigation process was generally effective, it highlighted inconsistencies among the regional offices with respect to their procedures and compliance with HCFA guidelines.

³The Office of Counsel to the Inspector General performs this function for OIG.

Emergency Department Statistics⁴

According to the Centers for Disease Control and Prevention, there were 100.4 million emergency department visits in 1998. The expected source of payment for almost 40 percent of these visits was private insurance, with Medicaid and self-payment following at 18 and 15 percent, respectively. Eighteen percent of visits were from patients in health maintenance organizations.⁵ Triage staff classified 19 percent of visits as emergent (to be seen within 15 minutes) and another 31 percent as urgent (to be seen in 15 - 60 minutes). Chest pain was the principal complaint for over 40 percent of emergent patients, and their average actual wait time was about 20 minutes.

METHODOLOGY

We conducted two surveys to achieve the objectives of this study. The first was a telephone survey of emergency department directors at hospitals across the nation. The second was an anonymous mail survey of emergency room and on-call personnel at the same hospitals. In addition to the surveys, we met with national representatives from the American College of Emergency Physicians (ACEP) as well as ACEP's California chapter. We also reviewed numerous articles and reports on the subject of emergency medicine.

To create the sample of hospitals used for both surveys, we first used Medicare provider certification data to create a universe of Medicare-participating hospitals with emergency departments. We then removed military and psychiatric hospitals from the universe.⁶ We stratified the remaining hospitals into three categories (small, medium, and large) and selected a random sample of hospitals from each stratum (see Figure 1).

Figure 1: Hospital Strata⁷

Size	Number of beds	Number in universe	Number selected	Number valid
Small	1 to 99	3007	62	47
Medium	100 to 399	2433	47	33
Large	400 or more	665	48	43

⁴All statistics are from the CDC's National Hospital Ambulatory Medical Care Survey: 1998 Emergency Department Summary, available on CDC's website at <http://www.cdc.gov/nchs/data/ad317.pdf>.

⁵For 37 percent of visits, the patient's HMO status was unknown

⁶We removed military hospitals from the universe because they have extremely limited contact with private managed care plans. We removed psychiatric hospitals from the universe because of their unique nature and because our sample contained too few of them to constitute a statistically valid sub-population.

⁷Frequency totals are current as of May 1998.

In our initial call to the hospital, we verified that the hospital operated an emergency department and obtained the name of its director. We completed telephone interviews with directors in 121 of the 123 valid hospitals, meeting our goal of 30 in each stratum. Each interview lasted from 15 to 30 minutes.

We requested lists of emergency physicians, emergency nurses, on-call specialists, and registration staff from each valid hospital⁸; we received the lists from 109. For each hospital, we selected a random sample of six individuals from each category to whom we sent the mail survey.⁹ In total, we received 855 responses to the 2316 surveys (37 percent) we mailed, including responses from 36 percent of emergency physicians, 46 percent of nurses, 32 percent of on-call specialists, and 33 percent of registration staff. As shown in the appendix, we received enough valid responses to make national projections with acceptable precision. Our analysis of the mail survey revealed that respondents were from slightly smaller hospitals located in slightly less urban areas than non-respondents.

To increase our response rate and to promote candor, we were committed to protecting the identities of our respondents throughout the study. Each hospital was assigned a code number which linked the surveys to hospital identification information. After we finished gathering demographic data for each hospital, we deleted the database which contained the identification information, leaving no way to link a hospital's code with its name, address, or Medicare provider number. Our coding of the mail surveys prevented the connection, at any time, of a respondent to a particular survey.

⁸For the remainder of this report, we will refer to these four groups collectively as “emergency department staff,” although emergency and on-call physicians are not always emergency department employees.

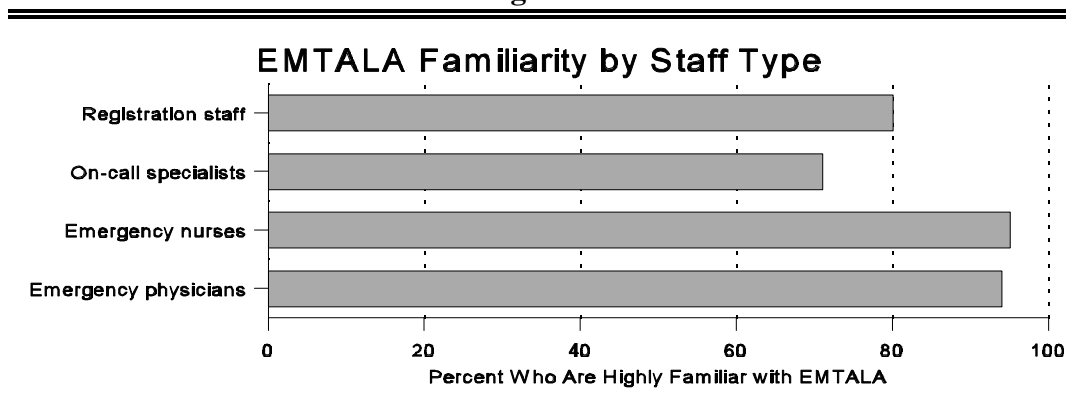
⁹In instances where fewer than six individuals were employed in a staff category, we sent surveys to all staff members of that category.

FINDINGS

Emergency department personnel are familiar with EMTALA requirements, but many are unaware of recent policy changes

The majority of emergency physicians, nurses, registration staff, and on-call specialists indicate that they are familiar with most of EMTALA's requirements. Overall, more than 80 percent of emergency department staff are familiar with at least 12 of the 15 EMTALA provisions listed on our survey. We conclude that staff meeting this threshold are “highly familiar” with EMTALA. Conversely, only 6 percent of staff are familiar with three or fewer requirements. Emergency physicians and nurses are more likely to be familiar with EMTALA than either registration staff or on-call specialists (see Figure 2).

Figure 2



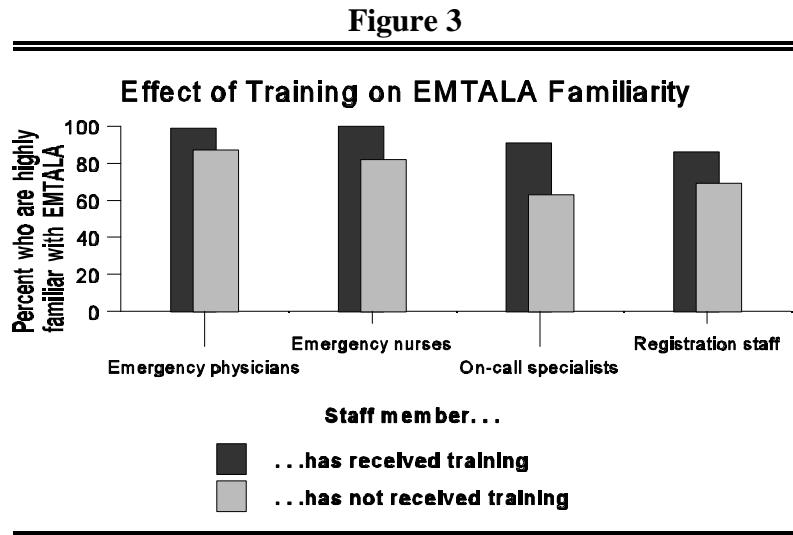
While more than 90 percent of staff are familiar with the guidelines governing the treatment of emergency department patients, fewer are familiar with other aspects of the law and regulations. About 80 percent are aware of requirements to post patients' rights signs in the emergency room and to maintain a central log of emergency visits. Fewer than 70 percent know that transfer records must be kept for 5 years and that hospitals are enjoined from taking retaliatory action against employees who refuse to authorize inappropriate transfers or who report violations.

Although almost all emergency department directors are informed about EMTALA, they often are not aware of recent policy changes. While almost 90 percent of directors regularly receive information about EMTALA, it generally comes from other hospital staff, professional associations, newsletters, or the Internet. Only 11 percent receive information directly from HCFA. Perhaps as a consequence, only 65 percent of directors are aware of HCFA's Interpretive Guidelines, published in June 1998, and only

27 percent knew of the proposed EMTALA Advisory Bulletin issued by HCFA and the OIG in November 1998.¹⁰

Training increases EMTALA familiarity for all staff, but on-call specialists and staff in high-volume emergency departments are less likely to receive training

Not surprisingly, training has a considerable positive effect on EMTALA awareness. On-call specialists who are trained show the most significant increase in familiarity; other staff experience smaller, but still substantial, gains (see Figure 3). One sign of increased familiarity is that registration staff who have received EMTALA training are significantly less likely than those who have not to request insurance information before a screening exam is provided.

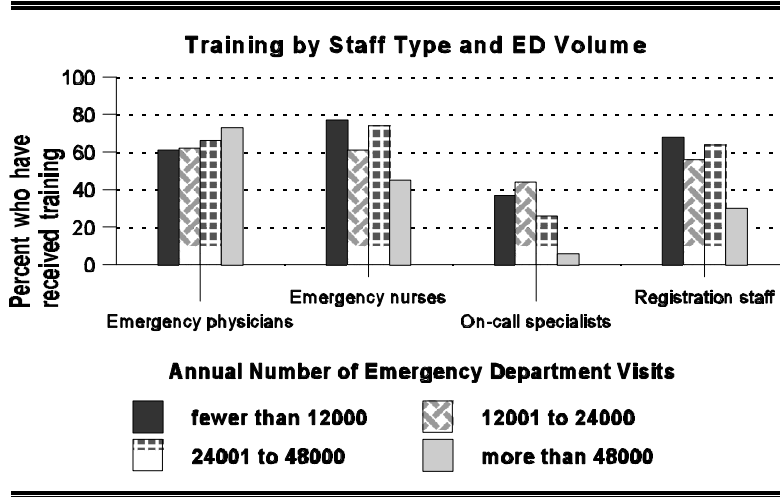


Almost two-thirds of emergency physicians, nurses, and registration staff have received some training on EMTALA, compared to only about one-quarter of on-call specialists. Training usually covers most aspects of EMTALA, though emergency physicians and nurses are more likely to receive extensive training. Training received by respondents usually occurred within 12 months prior to the survey and was conducted by hospital staff. Professional associations, such as ACEP, and private consultants also provide training.

Aside from emergency physicians, staff in high-volume emergency departments are less likely to receive training than their counterparts in less busy environments (see Figure 4 on the following page). In high-volume departments, emergency physicians were more likely than any other staff type to access multiple information sources, which may be why training for emergency physicians does not follow the same trend as for other staff.

¹⁰The Advisory Bulletin became final on November 10, 1999 — after our survey was completed.

Figure 4



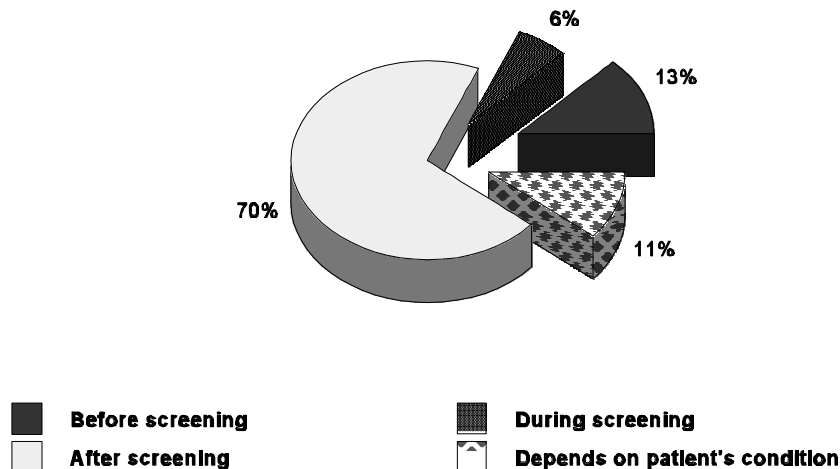
Respondents report that hospitals generally comply with EMTALA, but some concerns about compliance remain

Under EMTALA, a medical screening exam cannot be delayed in order to inquire about an individual's method of payment. According to more than 70 percent of registration staff, patients are not even asked for health insurance information until after a screening exam has been provided (see Figure 5). Nineteen percent collect insurance information before the screening exam or while it is taking place, but this does not necessarily mean

Figure 5

Q: When do emergency department staff ask patients about health insurance?*

* according to ER registration staff



care has been delayed. The remainder say that registration depends on the condition of the patient. Cases that appear to be serious are seen immediately, and less critical patients may be registered while they wait for qualified personnel to become available to perform a medical screening exam.

Almost 35 percent of registration staff report that they contact health plans for authorization of screening exams, and 25 percent seek authorization for stabilizing treatment. Staff¹¹ in hospitals with a high percentage of Medicaid patients are more likely to request authorization for stabilizing treatment than those in less Medicaid-dominated facilities. Staff usually request authorization while the screening or treatment is underway or after it has been performed.

While ninety-five percent of staff report that their hospital has implemented policies to comply with the above registration and other major EMTALA requirements, a small number believe that their hospitals are engaged in practices which may violate the law. Four percent believe an inappropriate transfer from their hospital has taken place in the past year. Eight percent, including almost 18 percent in hospitals with a large proportion of Medicaid beneficiaries,¹² believe that decisions regarding medical screening are at least sometimes influenced by a patient's ability to pay. Furthermore, 15 percent of staff in those hospitals that seek authorization for screening exams and 10 percent in those that seek authorization for stabilizing treatment believe that screening or treatment is not provided when authorization is denied.

Respondents believe that some aspects of EMTALA are unclear or questionable

Despite an overall high level of familiarity, more than 40 percent of emergency physicians and more than 60 percent of directors believe that some parts of the EMTALA law or regulations are unclear. Staff often mention that the terms “emergency medical condition” and “medical screening exam” need more precise definitions. “Stable for discharge” is another term that causes some anxiety among respondents. Since they cannot guarantee timely appointments with specialists, emergency physicians worry that EMTALA may obligate them to ensure that a patient has appropriate follow-up care outside the emergency department. In addition to concerns about these terms, many staff have questions about registration and other hospital procedures in light of EMTALA.

¹¹On-call specialists' responses were not considered for this issue.

¹²Medicaid percentage was determined by dividing the number of Medicaid adult and pediatric bed days by the total adult and pediatric bed days for each hospital. Data are from facility cost reports beginning in Fiscal Year 1997.

Many specific questions surrounding appropriate transfers surfaced in the two surveys. Several respondents were unclear whether EMTALA applied to a transfer of an emergency department patient to another building on the same medical campus. Conversely, a director at a hospital with buildings on two separate campuses wondered how EMTALA applied to transfers between those facilities. Others questioned EMTALA's applicability to patients who are otherwise stable but must be transferred to a specialist's office or another facility with special equipment in order to complete testing. One on-call specialist feared that "the exact nature of specialized care may encourage transfer, but fear of [an] EMTALA sanction may discourage [it]."

State law can further complicate the landscape for hospitals within a particular State. For instance, according to one director, Indiana's Medicaid regulations stipulate that the emergency physician should call the primary care physician before screening, but EMTALA mandates a screening without delay. In Delaware, according to another director, any adult candidate for involuntary psychiatric commitment must be transferred to the State hospital, but these patients are not defined as "stable for transfer" under EMTALA.

A number of respondents believe that some current interpretations and practices exceed legislative intent

While respondents generally agree that EMTALA is an important law, many believe that the effects of associated regulations exceed the intent of the legislation. Some directors believe that emergency medicine is becoming over-regulated, and that this increased regulation is not always in the best interest of the patient. Others say that assessing civil monetary penalties in EMTALA cases where there is a quality of care issue turns the law into a federal malpractice statute. "It seems to us that EMTALA has become a catch-all to enforce quality of care, instead of just the anti-dumping statute it was originally intended to be," summarized one director.

One particularly controversial question is "When does a hospital's EMTALA responsibility end?" Some believe that EMTALA covers patients who are admitted to the hospital through any department and later develop an emergency medical condition. Many of the respondents to our surveys disagree with this interpretation and believe that such an opinion represents a departure from the intent of the law. For example, one director expressed concern that such a view would expose hospitals to EMTALA whenever an appropriately discharged patient is readmitted for an exacerbation of the original condition. The Department plans to issue a Notice of Proposed Rulemaking on this issue in the near future.

Respondents believe that while EMTALA may help protect patients, it also may contribute to a hospital's administrative and financial problems

EMTALA may have a positive effect on care

Directors find that EMTALA generally has either a positive effect or no effect on the delivery of emergency services. At 44 percent of emergency departments, directors believe EMTALA has improved quality of care, mainly through the patient protections it provides. Forty-one percent, however, say that patient care is not affected. Many of these directors state that their hospital already had provided screening and stabilization services to all emergency patients before EMTALA was implemented.

Other aspects of the emergency department may suffer

In contrast to any patient care improvements, EMTALA has had a negative effect on other aspects of emergency medicine, according to more than 25 percent of directors and almost 40 percent of staff. Many staff believe that it creates layers of unnecessary bureaucracy and complicates routine procedures. Some also believe that it promotes overutilization of the emergency room, explaining that patients may obtain treatment for non-emergency conditions by exploiting hospitals' fear of violating EMTALA. According to some respondents, these are often managed care patients who do not or cannot obtain an office visit with their primary care physician.

Though not specifically asked, 12 percent of directors volunteered that EMTALA has contributed to the financial problems that many emergency departments are now facing. Mandating medical screening and stabilization of emergency conditions without providing a source of funding is one of their major concerns. Several respondents commented that having to provide screening exams for non-emergent patients who lack insurance or whose insurance will not pay is especially frustrating.

Investigations, many of which do not confirm violations, often prompt changes in forms and procedures

According to HCFA logs, since 1986 a total of 73 investigations were conducted at 47 of the 123 valid hospitals in our sample. Twenty of the hospitals were investigated multiple times in that period, one of which underwent five separate investigations. Larger hospitals and those with high-volume emergency rooms are more likely to be investigated, which is not surprising since they see more patients and have a greater chance of having a complaint lodged against them.

Violations were confirmed in only one-third of investigations, but almost half of the investigated hospitals changed some aspect of their emergency department's operation as a result. Typically, hospitals revised old forms, introduced new ones, or amended other practices. A smaller number provided training for staff or revised policies. For more information on investigations, see the companion report.

Managed care presents special problems for hospitals in complying with EMTALA

Almost 20 percent of directors say that dealing with managed care strains emergency department finances, a situation exacerbated by EMTALA. According to some respondents, as well as ACEP and other sources, private managed care organizations deny or reduce payment for mandated medical screening exams when the patient is found not to have an emergency condition. Though some directors indicate that “prudent layperson” standards, such as those that exist for Medicare and Medicaid managed care plans, have helped secure payment, others suggest that the standards are insufficient to guarantee adequate reimbursement. Indeed, a University of North Carolina analysis of two of that State’s payers found that 76 percent of the emergency visits denied as “not a medical emergency” met the State prudent layperson standard.

Although the Interpretive Guidelines and the Advisory Bulletin caution hospitals against seeking prior authorization, respondents report that many private plans will not pay for emergency services that have not been authorized before they are rendered. This leaves hospitals with the difficult choice of calling the health plan before the exam and possibly violating EMTALA or waiting until after the exam is provided and risking non-payment. In the Advisory Bulletin, HCFA and OIG state that they “were unable to resolve [the issue] because we do not have the authority under [EMTALA] . . . to regulate non-Medicare and non-Medicaid managed care plans.”

One approach that has been reported as a way for managed care organizations to address emergency services is known as “dual staffing.” “Dual staffing” refers to situations where a managed care organization stations its own physicians in a hospital emergency departments to screen and treat their enrollees who request emergency services. The Advisory Bulletin states that, while they are not a *per se* violation, hospitals which employ dual staffing arrangements face added burdens in complying with EMTALA. We found that dual staffing is not a widespread practice; only two of the hospitals in our sample have dual staffing arrangements. In fact, most directors we interviewed did not even know the meaning of the term.

Hospitals have difficulty staffing on-call panels for some specialties

Common factors contribute to many hospitals' specialist problems

A hospital's EMTALA responsibilities extend to on-call specialists. Medicare provider agreements require hospitals to maintain a list of on-call specialists who can complete medical screening exams or provide stabilizing treatment for any service for which the hospital promotes itself to the community. However, many hospitals are having difficulty filling on-call rosters. Although 63 percent of directors believe that specialist coverage in their emergency

department is more than adequate, 54 percent of doctors and nurses say staffing is a problem for some specialties. Figure 7 displays the most commonly mentioned areas of concern. Shortages most often occur because the community in which the hospital is located does not provide a sufficient base of patients to support specialists in a particular field or because certain services are not offered at the hospital.

Another aspect of the specialist problem is the refusal of specialists to serve on call panels, particularly in States with high managed care penetration or a large proportion of people without health insurance. Only 12 percent of emergency physicians and nurses give specialists' refusal as a reason for their on-call shortage, but, of these respondents, 63 percent work in California, Pennsylvania, Texas, or Nevada. These represent, respectively, the States with the highest and third highest rates of HMO penetration and uninsured persons among all of the States represented by hospitals in our sample.

Reports in the national media and research conducted by private organizations suggest that financial concerns are at the heart of many specialists' reluctance to join call panels. Respondents to a survey developed by a task force comprised of members of ACEP, the California Medical Association, and the California Health Care Association ranked lack of adequate payment under managed care and resentment over not being paid as the second and third most important reasons for back-up panel problems. According to ACEP and several news articles, specialists do not wish to participate on call panels as they stand a good chance of not being reimbursed for services which they are required to provide.¹³

Figure 7

Areas for which specialist coverage is a problem, in rank order

1. Neurosurgery
 2. Cardiovascular surgery and cardiology
 3. Pediatrics and subspecialties
 4. Orthopedic surgery
 5. OB/GYN and neonatal services
 6. Neurology
 7. Plastic Surgery
 8. Psychiatry and subspecialties
-
-

¹³ For more information, see the article "Emergency Department Back-up Panels: A Critical Component of the Safety Net Problem" in *Defending America's Safety Net* (American College of Emergency Physicians, 1999).

CONCLUSIONS

Communication and Education

Many emergency department directors are not aware of important changes to Federal EMTALA policy. Since hospitals and physicians face serious penalties for any infractions, HCFA and OIG need to ensure that important decisions are communicated to hospitals, emergency department directors, and staff in a timely manner. We found that most directors and staff receive EMTALA information from professional associations and consultants. Therefore, HCFA and OIG should distribute information to these groups as well and may wish to consult with them to develop effective more outreach methods. Direct e-mail notification to hospitals and posting of decisions on websites are just two possibilities that could lead to better dissemination of information.

Managed Care

The Department should continue to support legislation that would require private managed care plans to reimburse hospitals for EMTALA-related services, including screening exams which do not reveal the presence of an emergency medical condition. This is important because EMTALA requires hospitals to provide screening exams and stabilizing treatment, but the Act imposes no requirements on private managed care plans to pay for these services. Although the Advisory Bulletin clearly states that seeking prior authorization is improper, HCFA and OIG have no authority to compel private health plans to pay for emergency services.

Uncompensated Care and On-Call Panels

Lack of compensation for screening and stabilization services to the uninsured is increasingly burdensome to hospitals. In addition, many hospitals are experiencing increased difficulty in retaining on-call specialists. These are very complex problems which exceed the scope of our study; solutions may involve action at the Federal, State, and local levels as well as from hospitals and other private entities.

AGENCY COMMENTS

We received written comments from HCFA on the draft report (see Appendix B). The HCFA agreed with our conclusions. The HCFA also offered several technical comments, which we have incorporated where appropriate.

Sample Confidence Intervals

The following table shows point estimates and 95 percent confidence intervals for selected statistics and their location in the report.

Statistic	Point Estimate	95% Confidence Interval
Familiarity by staff type (p.9, Figure 2) — Emergency physicians	94.1%	89.3% - 98.9%
Percent of directors who regularly receive EMTALA information (p.9)	87.2%	80.6% - 93.8%
Percent of directors who receive EMTALA information directly from HCFA (p.9)	11.4%	5.2% - 17.7%
Training by staff type — On-call physicians (p.10)	26.2%	16.4% - 36.1%
Percent of registration staff who say insurance status is collected before screening (p.11, Figure 5)	13.3%	6.7% - 19.8%
Percent of staff who believe an inappropriate transfer has taken place (p.12)	4.48%	2.4% - 6.6%
Percent of registration staff who say authorization is sought for stabilizing treatment (p.12)	24.7%	15.9% - 33.5%
Percent of directors who are unclear on or who question some aspect of EMTALA (p.12)	61.9%	52.4% - 71.4%
Percent of directors who say EMTALA does not affect patient care (p.14)	41.4%	31.6% - 51.2%
Percent of directors who say EMTALA has had a negative effect of finances (p.14)	12.0%	5.2% - 18.7%
Percent of investigated hospitals that changed something in response to investigation (pp.14-15)	49.8%	26.4% - 73.2%
Percent of emergency physicians and nurses who say that specialist coverage is a problem at their hospital (p.16)	54.4%	47.8% - 61.0%

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: JAN 16 2001

TO: June Gibbs Brown
Inspector General

FROM: Robert A. Berenson, M.D. *Robert A. Berenson M.D.*
Acting Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "The Emergency Treatment and Labor Act: Survey of Hospital Emergency Departments," (OEI-09-98-00220) and "The Emergency Treatment and Labor Act: The Enforcement Process," (OEI-09-98-00221)

Thank you for the opportunity to comment on the above draft reports. The Health Care Financing Administration (HCFA) is absolutely committed to vigorously implementing the Emergency Medical Treatment and Labor Act (EMTALA). Our efforts are two-pronged: by providing clear guidance to hospitals about EMTALA requirements through effective outreach and education we try to prevent violations, while taking fair and timely action when EMTALA violations occur.

Enacted in 1986 in response to concerns that patients were being denied emergency care for financial reasons, EMTALA has played a critical role in ensuring that individuals with emergency medical conditions receive a medical screening and stabilization, or an appropriate transfer to another facility. Between 1986 and 1994, the number of complaints of EMTALA violations rose steadily from 3 (of which 2 were confirmed) to 1,851 (465 confirmed). In 1994, we published an interim final rule, clarifying the obligations of hospitals under EMTALA. Since then, the number of complaints has hovered between 300 and 500, with confirmed violations, ranging between 180 and 210 per year.

While no violation is acceptable, we think the dramatic decline in number of complaints is a testimony to EMTALA's success in ensuring patient access to emergency care. At the same time, we are taking a number of steps to bolster our EMTALA efforts.

Between fiscal years 1996 and 2000, we received over 2,000 EMTALA complaints across the country. Of those, more than one-third were attributable to one HCFA region, which, as a result, developed a backlog of unresolved cases. We have been addressing this problem by increasing the number of staff devoted to processing backlogs and redistributing a portion of the complaints to other ROs for reviews. In the past 6 weeks, for example, we have processed 127 cases in this region, reducing the backlog by 29 percent. Based on this experience, we expect to eliminate the backlog of complaints within 4 to 6 months.

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Similarly, we have found a disproportionate number of complaints in one state. We are working in that state, through focused intervention such as outreach and training to hospitals, to avert future EMTALA violations.

For the longer term, we are stepping up communication and coordination of our prevention and enforcement activities. We are revising our State Operations Manual and our Interpretative Guidelines to provide clearer guidance to our Regional Offices and the State Agencies on investigating EMTALA complaints. We are also developing standardized forms and procedures for handling EMTALA complaints, and maintaining regular contact via conference call with our regions, so we can intervene more promptly when problems arise.

We also plan to issue a Notice of Proposed Rulemaking in the near future that will further clarify EMTALA requirements as they apply to a changing healthcare delivery system.

It is in this context that we view the OIG reports. We welcome the OIG's recommendations and look forward to working together to ensure that the statute is effectively and appropriately enforced.

We find the observations in the first report, *Survey of Hospital Emergency Departments*, to be largely consistent with our own assessments of EMTALA compliance issues based on our own interviews with hospital emergency departments. We agree with the conclusions of this report, and have submitted only the attached technical comments.

We also agree with the conclusions of the second report, *The Enforcement Process*, regarding needed changes in how HCFA responds to complaints of EMTALA violations. We are pleased to report that we have already made significant inroads in strengthening our processes for complaint investigation and resolution. We have reduced complaint backlogs, developed resource redeployment strategies to address the geographic variation in complaints received, and improved data reporting.

We appreciate the opportunity to comment on the issues raised. Detailed information on concrete steps we have taken or planned are contained in our responses to each recommendation below.

OIG Recommendation

The HCFA central office (CO) should increase its oversight of ROs.

HCFA Response

HCFA concurs that there should be greater communication and coordination between the CO and the regions, and has already taken steps to achieve this. For example, in May 1999, CO staff implemented an improved log reporting process to assist RO staff in reporting complaints to CO and changed the reporting cycle from quarterly to monthly. In addition, monthly conference

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calls have been initiated to discuss EMTALA issues and clarify policies to promote consistent EMTALA enforcement across the regions.

Currently the State Operations Manual (SOM), rules, regulations, and interpretative guidelines are located on the HCFA website. The Center for Medicaid and State Operations is in the process of redesigning the website to establish clear and precise links to these documents. In addition, HCFA will review and examine the SOM policies and procedures concerning EMTALA enforcement and make revisions as appropriate.

In April 2000, a HCFA work group convened in Baltimore to begin revising the Interpretative Guidelines-Responsibilities of Medicare Participating Hospitals in Emergency Cases (Appendix V). The goal of this revision is to clarify national policies and to include in the SOM timeframes for HCFA to review State agencies' investigative findings. HCFA will monitor the status of these investigations and review activities and work closely with its regions to ensure that complaints are promptly and appropriately resolved.

OIG Recommendation

The HCFA should continue to improve collection and access to EMTALA data.

HCFA Response

EMTALA is a complaint-driven process requiring precise documentation to evaluate enforcement activity and assess the complaint investigation process. In 1999, HCFA took numerous steps to improve the timeliness and accuracy of reports of EMTALA allegations and investigations. Specifically, HCFA is now compiling reports monthly, rather than quarterly. The agency has also developed log instructions and a standardized log format to promote consistency of reporting among the regions. Although some advances in reporting have been made, HCFA will continue to work to identify other mechanisms to improve the reporting of EMTALA complaints.

We also expect that enhancements in a new survey and certification data system (Quality Improvement and Evaluation System or QIES) will address EMTALA enforcement issues, including more timely access and public disclosure of EMTALA findings.

OIG Recommendation

The HCFA should ensure that peer review occurs before initiating termination actions in cases involving medical judgment.

HCFA Response

HCFA generally agrees that prior to initiating termination actions in cases involving medical judgment, peer review of a physician's action should be performed by a physician (State agency consultant or Peer Review Organization (PRO)). HCFA is currently reviewing its hospital complaint investigation procedures, including handling of EMTALA complaints and will revise these policies as needed.

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The group reviewing these procedures is also coordinating its efforts with HCFA's Office of Clinical Standards and Quality, which is reexamining the PROs role in responding to complaints.

OIG Recommendation

The HCFA should establish an EMTALA technical advisory group.

HCFA Response

In 1996-1997, HCFA met with a group of interested stakeholders from professional organizations and consumer advocate groups. The group discussed possible clarifications or changes to the statute, regulation, and interpretative guidelines for EMTALA, and HCFA has developed and implemented some of the recommendations raised by the various stakeholders.

HCFA agrees that continued consultation with stakeholders is necessary and that a more formal approach may be effective. We will work closely with the OIG and the Office of the General Counsel to determine the best strategy to ensure meaningful consultation.

Attachment