Several helpful publications are available through CHA including:

- California Health Information Privacy Manual
- California Hospital Compliance Manual
- California Hospital Survey Manual
- Consent Manual
- EMTALA — A Guide to Patient Anti-Dumping Laws
- Guide to Release of Patient Information
- Hospital Charity Care & Discount Policies
- Mental Health Law
- Minors & Health Care Law
- Model Medical Staff Bylaws & Rules
- Principles of Consent and Advance Directives
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Eighth edition 2012.

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Published by the California Hospital Association.
Printed in the United States of America.
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Introduction

EMTALA — *A Guide to Patient Anti-Dumping Laws*, 8th edition (2012), provides guidance to hospitals and physicians on compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA). Where applicable, the EMTALA manual also addresses California hospital licensing and managed care laws regarding the provision of emergency services and post-stabilization care. These laws, commonly referred to as the “patient anti-dumping laws,” were enacted in the late 1980s to ensure equal access to, and delivery of, emergency services without regard to a patient’s financial or insurance status.

Since the adoption of the final EMTALA regulations in 1994, the U.S. Department of Health and Human Services (HHS) has committed extensive resources to enforcing EMTALA. The Centers for Medicare & Medicaid Services (CMS) is charged with the administrative interpretation and enforcement of EMTALA. Upon a confirmed violation of EMTALA, CMS has the authority to notify a hospital of the termination of its Medicare provider agreement. To retain Medicare provider status, a hospital must submit an acceptable plan of correction and pass a follow-up survey. As discussed in a 2001 HHS Office of Inspector General (OIG) report, the number of EMTALA investigations and their disposition vary widely by CMS region; however, administrative enforcement by CMS Region IX (California, Arizona, Hawaii and Nevada) has been among the most active in the nation. In addition, the OIG has the authority to enforce EMTALA against hospitals and physicians by imposing civil money penalties or exclusion from the Medicare and Medicaid programs.

Despite more than two decades of experience with EMTALA, there is still considerable confusion by hospitals, physicians, state survey agencies and even CMS officials on the scope and application of the law. In 1994 and 2000, CMS expanded the scope of EMTALA; in 2003, CMS both limited and expanded the scope of EMTALA in an overhaul of the 1994 and 2000 regulations. This long overdue effort delineated when and where EMTALA begins and ends (*see chapter 2, “When and Where Does EMTALA Begin and End?”*).

Since 2004, CMS has amended the EMTALA regulations in piecemeal fashion almost every year. The revisions are contained in the annual rules for the IPPS program, as well as issuance of annual revisions to the EMTALA *Interpretive Guidelines* and Survey and Certification memoranda to CMS regional offices and state survey agencies.

Despite the efforts of CMS, the 2003 regulations and the issuance of the 2004 *Interpretive Guidelines* still do not fully resolve some of the long-standing areas of
confusion as to the application of EMTALA. For example, there is still uncertainty as to whether EMTALA applies to hospital urgent care centers, occupational medicine clinics and other services that serve both scheduled and drop-in patients, the scope of an appropriate medical screening examination, the meaning of “stabilization,” services to and transfers of patients with psychiatric emergencies (including patients on an involuntary hold), the obligations of receiving hospitals, and the standards for on-call coverage.

In addition to changing interpretations of EMTALA by CMS, the courts have established their own body of law in applying EMTALA, sometimes in ways that vary from the EMTALA regulations or the Interpretive Guidelines. As discussed in chapter 14, “Private Actions to Enforce EMTALA,” courts have issued decisions on the standard of proof for an EMTALA violation, the application of EMTALA to inpatients and individuals in nonhospital-owned ambulances en route to a hospital, the scope of an appropriate medical screening examination, and the obligations of a receiving hospital to accept emergency patient transfers.

The EMTALA manual is designed to summarize the EMTALA obligations for hospitals and physicians, and answer the most frequently asked questions. Readers familiar with EMTALA know that the interpretation of EMTALA is fast-changing (and at times, mind-numbing and frustrating). The 8th edition includes updates to the EMTALA regulations and Interpretive Guidelines and the issuance of CMS program memoranda through Aug. 31, 2012.

It is noted that some of the interpretations of EMTALA discussed in the EMTALA manual are based on written or oral statements of CMS personnel; some of these views are not reflected in official pronouncements by CMS. Although these statements are included in the EMTALA manual, they do not necessarily represent official CMS policy and are subject to change without notice to hospitals or physicians.

The EMTALA manual is written for hospital staff and physicians; therefore, the text does not include footnotes identifying the sources for the content. To assist readers, the appendices to the manual include the EMTALA statute and regulations, the Interpretive Guidelines, CMS Program Memoranda and California hospital and managed care laws on emergency and post-stabilization services. Additional appendices include a model hospital compliance policy and other materials. References to these materials are marked with a ✍ throughout the manual.

The EMTALA manual is generally limited to EMTALA and California laws governing the provision of emergency services. It does not address numerous other laws and legal obligations applying to hospitals, physicians and other health care personnel in providing emergency care. These include hospital licensing laws for emergency departments; professional practice acts; accreditation standards; consent laws; reimbursement issues; requirements of regional emergency medical service networks; base station, involuntary detention designation, psychiatric patient hold, and trauma standards; and other laws.

The EMTALA manual is limited to legal obligations with respect to EMTALA and other emergency service laws. Hospitals are encouraged to consider ethical, philosophical (e.g., mission and values) and industry standards in making decisions related to emergency services and care, whether or not implicated by EMTALA and other laws.
Overview of Patient Anti-Dumping Laws

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Consultation

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Emergency Medical Condition

Emergency Services and Care

Hospital Property (also referred to as the “Campus of a Hospital”)

Labor

Psychiatric Emergency Medical Condition

To Stabilize

Stabilized

Transfer

Within the Capability of the Facility
A. EMTALA OVERVIEW AND HISTORY

The EMTALA Statute
The Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted by Congress as a part of the Consolidated Omnibus Budget Reconciliation Act of 1986 to ensure access to emergency services. The statute was amended in 1988, 1989 and 2003. EMTALA applies to anyone who presents for emergency services to a hospital that participates in the Medicare program (including psychiatric hospitals). The EMTALA statute is included as Appendix A.

EMTALA was enacted in response to studies that found that indigent emergency patients had been turned away from hospitals for necessary services or transferred (i.e., “dumped”) to public and charity hospitals in an unstabilized condition. Although EMTALA was passed to mandate access to emergency services by the indigent, Congress applied the EMTALA requirements to all patients regardless of financial or insurance status. In general, both the federal regulatory agencies and the courts have defined the primary objectives of EMTALA as twofold: to enhance access by all persons to emergency services and to prohibit discrimination in the provision of emergency services to persons presenting with the same or similar types of conditions.

The EMTALA Regulations
The initial EMTALA regulations were published in draft form in 1988, and issued as interim final regulations on June 22, 1994. On April 7, 2000, the regulations were amended to apply the EMTALA obligations to off-campus hospital services. In September 2003, the Centers for Medicare & Medicaid Services (CMS) published further changes to the EMTALA regulations, repealing part of the 2000 regulations and clarifying the application of EMTALA to emergency patients, outpatients and inpatients. Since 2004, CMS has amended the EMTALA regulations in piecemeal fashion in 2006, 2007, 2008 and 2009. The current regulations are included as Appendix B.

The EMTALA Interpretive Guidelines
CMS has adopted Interpretive Guidelines as part of the Medicare State Operations Manual to provide guidance for federal and state surveyors in their enforcement of EMTALA. Although the Interpretive Guidelines are not regulations, they are considered the official interpretation of EMTALA by CMS and are used by California Department of Public Health (CDPH) surveys and CMS regional offices in en-
Enforcement of the EMTALA obligations. The most recent update to the Interpretive Guidelines was July 16, 2010; the Interpretive Guidelines are included as Appendix C.

NOTE: The Interpretive Guidelines are organized by “tag numbers,” each of which corresponds to a CMS regulation that establishes the rules for EMTALA. The tag numbers beginning with the letter “A” are applicable to hospitals and the tag numbers beginning with the letter “C” are applicable to critical access hospitals. Each tag number has four digits, with the number “2” at the beginning of each tag number.

Special Advisory Bulletins and Other Guidance
In November 1999, CMS and the Office of Inspector General (OIG) released a final Special Advisory Bulletin on EMTALA and managed care. The Bulletin discusses the rules on seeking health plan authorization prior to the medical screening examination (which were added to the EMTALA regulations in 2003), dual staffing of emergency departments and recommended patient registration practices to minimize violations of EMTALA. The Bulletin is discussed in chapter 4, “Financial Considerations — EMTALA and Managed Care,” and is included as Appendix H.

Following the 2004 Interpretive Guidelines, CMS issued a series of Program Memoranda on various subjects relating to the EMTALA obligations. All of these memoranda were subsequently incorporated into the Interpretive Guidelines (see Appendix C). The current edition of this manual also includes the latest CMS guidance on disaster and surge situations in Appendix R that was issued on Aug. 14, 2009.

Enforcement and Penalties
The EMTALA obligations are a condition of the Medicare provider agreement (rather than a Condition of Participation), thereby permitting CMS to terminate a provider upon a confirmed violation of EMTALA. As described in chapter 13, “Regulatory Enforcement of EMTALA,” the federal agencies charged with ensuring EMTALA compliance are CMS and the OIG.

CMS has the authority to conduct complaint and enforcement surveys for EMTALA compliance, and to terminate a hospital’s Medicare provider agreement upon confirming one or more violations of EMTALA.

OIG has the authority to impose civil money penalties up to $50,000 against hospitals and physicians ($25,000 for hospitals with less than 100 beds), and/or to exclude a hospital or physician from the Medicare and Medicaid programs for violations of EMTALA that are “gross and flagrant or repeated.”

The regional quality improvement organization (QIO) is responsible for assisting CMS and OIG with a review of patient stabilization and other medical matters pertaining to the delivery of emergency care and services.

For hospitals that have community service obligations under the Hill-Burton Act, the Office for Civil Rights (OCR) will follow up on violations of EMTALA confirmed by CMS with a request for copies of EMTALA compliance, transfer, admission and other hospital policies.
EMTALA Committees and Reports
Since 2001, there have been a number of committees and governmental agencies that have issued reports on EMTALA, including reports regarding compliance by hospitals and physicians with EMTALA standards, the enforcement process and the overall effect of the law.

Office of Inspector General
In January 2001, the OIG released two reports on EMTALA: “Survey of Hospital Emergency Departments” and “The Enforcement Process.”

The OIG’s “Survey of Hospital Emergency Departments” made the following findings:

- Emergency department personnel are familiar with the EMTALA requirements, but many are unaware of recent policy changes.
- Training increases EMTALA familiarity for all staff; unfortunately, on-call specialists and staff in high-volume emergency departments are less likely to receive training.
- Hospital staff report that hospitals generally comply with EMTALA, but some express concerns about compliance.
- Hospital staff believe that some aspects of EMTALA are unclear or questionable.
- Hospital staff believe that while EMTALA may help protect patients, it also may contribute to a hospital’s administrative and financial problems.
- Investigations, many of which do not confirm violations, often prompt changes in forms and procedures.
- Managed care creates special problems for hospitals in complying with EMTALA.
- Hospitals have difficulty staffing on-call panels for some specialists.

The OIG report made three conclusions:

- CMS should use a variety of methods to communicate important policy changes, including e-mail and the Internet.
- CMS should support legislation that compels managed care plans to reimburse hospitals for EMTALA-related services, including screening exams that do not reveal the presence of an emergency medical condition.
- Uncompensated care and on-call panels are very complex problems that may require action at the federal, state and local levels as well as by private entities.

The OIG reported that CMS concurred with its recommendations.

In “The Enforcement Process” report, the OIG issued the following findings on the EMTALA enforcement process:

- The EMTALA enforcement process is compromised by long delays and inadequate feedback.
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