HCFA's Antidumping Regulations Contain New Requirements

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On June 22, 1994, after an eight-year wait by hospitals and other healthcare providers, the Health Care Financing Administration (HCFA) finally issued regulations implementing the federal law prohibiting patient dumping, the Emergency Medical Treatment and Active Labor Act (EMTALA), also known as COBRA.

Generally, the regulations contain few surprises. However, hospitals should be aware of several new requirements, most of which became effective July 22, 1994.

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Reporting Requirement

When hospitals enter into Medicare provider agreements with HCFA, they make certain commitments required by statute. The new regulations now add to this list a requirement to report to HCFA, or the state licensing authority, any time a hospital has "reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of [EMTALA]." The penalty for failure to report is the same as the penalty facing the transferring hospital—termination from the Medicare program. Unlike the other provisions discussed here, the reporting requirements require approval from the Office and Management and Budget.

Although the regulations themselves require only reporting and are silent on the timing of reports, the preamble to the regulations states that a requirement to make the report within 72 hours will appear in the provider manual instructions issued by HCFA. Since the regulations are also silent on when the 72-hour period begins to run, presumably that question will also be answered in the provider manual.

It is questionable whether HCFA has the authority to impose this reporting obligation, since EMTALA itself does not contain this requirement. As for the 72-hour time limit, since this appears only in the preamble, its legal effect is also doubtful. Moreover, the provider manual does not have the force of law. Even so, when the new regulations become effective, hospitals will face at least the threat of exclusion from the Medicare program if they fail to report patient dumping violations by other facilities.

One difficulty for hospitals will be how to determine when they have "reason to believe" a patient dumping violation has occurred. Because the consequences for failure to report are so draconian, one can expect that hospitals will err on the side of reporting. Thus reported violations (and the resulting intrusive investigations) may well increase, often in cases in which the law has not, in fact, been violated.

Capacity to Treat

Under EMTALA, receiving hospitals with specialized capabilities or facilities must accept appropriate transfers of individuals requiring those services if those hospitals have the "capacity" to treat the individual. The new regulations now define "capacity" as "the ability of the hospital to accommodate the individual. . . . Capacity is defined to encompass such things as numbers and availability of qualified staff, beds and equipment and the hospital's past practices of accommodating additional patients in excess of its occupancy limits." This expanded definition now provides receiving hospitals some guidance as to how their conduct will be judged in accepting transfers.

Ambulance Provisions

The new regulations restrict the ability of hospitals to divert ambulance services to other facilities. These provisions are both remarkable and confusing. EMTALA's requirements for a medical screening examination and stabilizing treatment are triggered "when an individual comes to the emergency department." Under the regulations, this occurs when "the individual is on the hospital property." "Property" includes "ambulances owned and operated by the hospital, *even* if the ambulance is not on hospital grounds."

Continued on page 16

Continued from page 12

two elements: "(1) the operating system—that is, the framework of agreements and protocols that governs how patients are cared for, as well as the information systems that monitor that flow, and (2) the framework of incentives that governs how physicians and hospitals are paid," explained Goldsmith.

These trends all pose tremendous challenges to hospitals as they seek to position themselves in the evolving system. In some ways, a comprehensive reform plan such as President Clinton's would have provided a roadmap for healthcare providers and payers as to what was expected, but not necessarily how best to get there. Now that Congress has left reform to the marketplace, any number of directions may emerge, such as integrated delivery systems, only to change as we learn by trial and failure what does and does not work. To survive with such uncertainty, hospitals must be flexible, be forward thinking, and address the critical question of how to provide value, not just fill beds and maintain their institutions. □

NOTES

1. Katharine R. Levit et al., "National Health Spending Trends, 1993," *Health Affairs*, Winter 1994.
2. Levit et al.
3. George J. Schieber, Jean-Pierre Poullier, and Leslie M. Greenwald, "Health System Performance in OECD Countries, 1980-1992," *Health Affairs*, Fall 1994, pp. 100-112.
4. Schieber et al.
5. Schieber et al.
6. Stephen M. Shortell et al., "The New World of Managed Care: Creating Organized Delivery Systems," *Health Affairs*, Winter 1994.
7. Shortell et al.
8. Shortell et al.
9. Shortell et al.
10. Jeff C. Goldsmith, "The Illusive Logic of Integration," *Healthcare Forum Journal*, September-October 1994, pp. 27-31.

Continued from page 13

Hospitals must now have an internal policy for reviewing suspect transfers.

When the hospital does not own the ambulance, the individual is not "on the hospital property" until the ambulance is on the property.

An individual in a non–hospital-owned ambulance that is off the hospital's property however is *not* considered to have come to the emergency department, even if the ambulance staff contacts the hospital. In those situations, a hospital may deny access if it is in a "diversionary status," that is, lacking the staff or facilities to accept any additional emergency patients. The regulations, however, authorize the ambulance staff to disregard the hospital's instructions and deliver the patient to the hospital notwithstanding the denial. In such cases hospitals will legally be required to provide the screening examination and stabilizing follow-up care regardless of their situation at the time.

Defining Labor

One of the more troubling aspects of EMTALA has been the requirement to provide stabilizing treatment and care to pregnant women having contractions. The 1989 amendments to EMTALA deleted the definition and concept of "active labor" from the statute. The new regulations add a seemingly unnecessary definition of "labor." The purpose of this addition is unclear and suggests that HCFA might be intending to revert to the previous provisions of the law, which left little to a physician's discretion in cases involving pregnant women. If so, this is a development that hospitals must monitor carefully.

Physician Exclusion

EMTALA provides for the exclusion of physicians from the Medicare program for "gross and flagrant" violations of EMTALA. The regulations clarify that a gross and flagrant violation "is one that presents an imminent danger to the health, safety or well-being of the individual who seeks emergency examination and treatment or places that individual unnecessarily in a high-risk situation." This provision provides a welcome detail to a statutory term ("gross or flagrant") that was vague and appeared to leave excessive discretion to government regulators.

Policy Reviews

As with previous EMTALA amendments, all U.S. hospitals, as well as emergency department physicians and other physicians who see patients in the emergency department, should carefully review their internal policies regarding patient transfers in light of the new regulations. For example, hospitals must now have an internal policy for reviewing suspect transfers and reporting them to the authorities when indicated, since failure to report an inappropriate transfer can now potentially result in a Medicare decertification action. □

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