

The New EMTALA Squeeze

BY PETER LEIBOLD, JD

On December 2, 1998, the Department of Health and Human Services' Office of Inspector General (OIG) and the Health Care Financing Administration (HCFA) issued a draft special advisory bulletin concerning patients seen in the emergency rooms of Medicare-participating hospitals. The bulletin is intended to clarify hospitals' obligations under the Emergency Medical Treatment and Active Labor Act (EMTALA) in their treatment of patients who are insured by managed care organizations (MCOs). This guidance sheds light on how patients may be hurt and hospitals may lose deserved reimbursement when caught between "prior authorization" requirements of MCOs and the EMTALA requirements of the Medicare statute.

EMTALA'S LEGAL REQUIREMENTS

In 1986, Congress enacted EMTALA, the federal anti-dumping statute. The legislation was intended to remedy two related problems:

- Some hospitals' refusal to treat patients who were unable to pay
- Some hospitals' practice of transferring indigent patients before life-threatening conditions had been stabilized.¹

EMTALA requires all Medicare- and Medicaid-participating hospitals that have emergency departments to provide an "appropriate medical screening examination" to any individual who comes to the emergency room and requests treatment.² The purpose of this screening is to determine whether an emergency medical condition exists. If such a condition exists, the hospital must either stabilize or transfer the individual. The hospital may only transfer an individual if he or she, or a surrogate, requests a transfer after being informed of the individual's EMTALA rights or if a physician certifies that the benefits of transfer outweigh the risks associated with it.³

HHS may mete out severe penalties for violations of EMTALA. A hospital or a physician negligently violating the statute's requirements is



*Mr. Leibold is
general counsel,
Catholic Health
Association,
St. Louis.*

subject to a civil monetary penalty of up to \$50,000.⁴ If a violation is gross and flagrant, or is repeated, the offending institution or healthcare professional may be excluded from the Medicare and Medicaid program. More important, individuals who suffer personal harm as a direct result of a hospital's violation of EMTALA may initiate a civil action and obtain those damages available for "personal injury" under the law of the state in which the hospital is located.⁵

THE OIG/HCFA SPECIAL ADVISORY BULLETIN

In the December 2 bulletin, the OIG and HCFA assert that EMTALA prevents a hospital from delaying the provision of appropriate medical screening examination in order to inquire about the individual's method of payment or insurance status. The agencies express concern that prior authorization requirements by MCOs are causing hospitals to violate EMTALA: "It has come to our attention that some hospitals routinely seek prior authorization from a patient's primary care physician or from the plan when a managed care patient requests emergency services, since the failure to obtain authorization may result in the plan refusing to pay for the emergency services."⁶

The OIG and HCFA acknowledge that hospitals are "caught between the legal obligations imposed under the anti-dumping statute and the terms of agreements that they have with managed care plans."⁷ Although recognizing the dilemma, the agencies nevertheless conclude that efforts to ascertain insurance status and obtain pre-authorization before providing the appropriate emergency medical screening required in the statute could result in a violation.

The OIG and HCFA also seem to take a broad view of EMTALA's statutory language to preclude certain conversations between hospital personnel and patients. If, for instance, an individual needs hospital services that are not covered by his or her insurance, the hospital might inform the individual that he or she would be financially liable for the services. The OIG and HCFA

expressed concern that this might discourage the individual from requesting an appropriate medical screening examination. The agencies concluded that "discussions between a hospital staff member and a patient regarding potential prior authorization requirements and their financial consequences that have the effect of delaying a medical screening are violations of the anti-dumping statute."⁸

Using this legal analysis, HCFA and the OIG made five recommendations to hospitals and MCOs:

- Neither hospitals nor MCOs should require preauthorization before a patient has received a medical screening examination or before the patient's emergency medical condition is stabilized.

- Prior to performing an appropriate medical screening examination, the hospital should not ask a patient to complete a financial responsibility form or to provide a copayment.

- Hospitals should ensure that either a physician or other qualified medical personnel provide an appropriate medical screening examination to all individuals seeking emergency services.

- A patient's questions about financial liability should only be answered by an individual who is well trained in answering these questions *and* is knowledgeable of the hospital's obligation under EMTALA.

- Hospitals must ensure that individuals voluntarily requesting the withdrawal of emergency services are informed of the risks and benefits of such a decision and that all reasonable steps are taken to obtain written consent.

HOSPITALS SHOULD OBTAIN STATUTORY RELIEF

The OIG and HCFA recognize the dilemma of hospitals that, on one hand, must not delay an appropriate emergency medical screening under EMTALA but, on the other, must obtain prior authorization for that screening if they are to be reimbursed by an MCO. However, the agencies did not provide any substantive protection for

Hospitals
should lobby
for a
provision
requiring a
health plan
to cover
emergency
services a
"prudent
layperson"
believes vital
to health.

hospitals. This situation is untenable. The agencies' admonition that contracts between hospitals and MCOs should not contain such provisions will not be helpful if the contract is already in existence.

Therefore, hospitals must simultaneously take two courses of action:

Negotiate with MCOs Hospitals should negotiate aggressively with MCOs that try to include or renew such provisions in contracts. They should use this special advisory to argue that such provisions are of questionable legality and should not be included in their contracts.

Lobby Congress Hospitals should lobby Congress to enact a statutory provision that was included in one form or another in last year's patient protection bills.⁹ The provision requires that a health plan cover emergency services if a "prudent layperson" believes that without emergency care his or her health condition would be in serious jeopardy. Under these circumstances, the plan must cover the emergency service "without the need for any prior authorization determination" and regardless of whether the healthcare provider furnishing the services is a participating healthcare provider. If applied correctly, this statutory change will help to ensure that hospitals complying with EMTALA will not run afoul of contradictory contractual provisions.

For its part, Congress should take steps to ensure that MCOs do not technically comply with the special advisory while violating its spirit. For instance, Congress should not allow MCOs to delete technical requirements for "prior authorizations" while continually denying reimbursement for appropriate emergency medical screenings through retrospective review. In other words, the MCOs must be true to the meaning and spirit of a "prudent layperson" standard. These payment denials will have the same substantive impact as prior authorization requirements. They will apply pressure to hospitals and other healthcare providers that are caught between EMTALA

Continued on page 17

DSH payments are an integral part of the overall revenue structure of safety-net hospitals. Catholic hospitals alone received \$503 million in Medicare DSH payments last year.

Safety-net hospitals will have to rely more on Medicare DSH payments to cover the costs of low-income patients as commercial insurers increasingly compete on price by ratcheting down hospital reimbursement rates or lengths of stay. As a result, the ability to cost-shift the burden of paying for indigent care to privately insured patients will steadily decline. As the ability to cost-shift evaporates, however, some safety-net hospitals may have no choice but to reduce their commitment to serving the poor. Researchers have determined that this is already occurring. For example, the Prospective Payment Assessment Commission found that erosion of funds from private payers is strongly associated with reductions in hospital loads of uncompensated care.³

Further contributing to the scarcity of dollars to support hospital care for the low-income is the growth of Medicare managed care. Hospitals are losing a percentage of their overall DSH payments because managed care plans that enroll Medicare beneficiaries generally are not passing DSH adjustments on to hospitals. This problem will worsen with the expanding enrollment of beneficiaries in the Medicare+Choice program. A fairer alternative would be for Medicare to "carve out" DSH payments from the capitation amounts paid to Medicare+Choice health plans and instead pay them directly to hospitals that incur the costs of providing services to the poor.

PRESERVE DSH PAYMENTS

The shrinking pool of dollars to pay for hospital services for the nation's low-income populations poses a major policy dilemma. To remain competitive in a price-sensitive insurance market, private insurers are increasingly less likely to subsidize the healthcare of the poor. On the other hand, the long-term survival of Medicare argues against allowing its DSH obligations to grow unchecked.

To ensure continued access to hospital care for the low-income and elderly, a broader base of funding may eventually be needed to support DSH payments. One option is a shared responsibility model in which all payers contribute to a dedicated financing base for funding services provided for the public good, such as care for the low-income.

In the absence of such a shared responsibility structure, however, reductions in Medicare's commitment to DSH would be premature and potentially crippling. If Medicare DSH payments cease to be a source of dedicated funding, the healthcare safety net will surely no longer be able to support the weight of its obligations. Alternatively, assisting safety-net hospitals to discharge their larger social responsibilities by continuing Medicare DSH will guarantee that beneficiaries, who often rely on these facilities as their only source of care, have a dependable source of care.

Of course, the best approach to ensuring access to healthcare for the poor is to extend health coverage to all Americans. Yet until that goal is achieved, the federal government will need to play an extensive role in supporting hospitals and other providers of care to the uninsured—now 43.6 million people and growing. Medicare DSH payments are an essential element in funding for safety-net providers. If Mother Joseph were alive today, she would likely be in Washington doing what needed to be done to ensure continued Medicare DSH funding for Catholic and other hospitals serving low-income beneficiaries and their families. □

NOTES

1. *A Call to Care*, The Catholic Health Association, St. Louis, 1996, pp. 63-68.
2. Medicare Payment Advisory Commission, *Selected Medicare Payment Policies*, Washington, DC, October 1997.
3. Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress*, Washington, DC, June 1996, p. 48.

requirements and the reimbursement policies and procedures of MCOs. Hospitals should not be punished by MCOs because they have faithfully complied with federal law.

Logically and strategically, these statutory provisions should be included in the patients' rights legislation that the president has made a top priority for the 106th Congress. The provision was included in last year's legislation, and it is the most likely package to be passed into law in the next Congress.

CONUNDRUM IN THE ER

System and hospital legal counsel should study the new guidance provided by OIG and HCFA on a hospital's duty under EMTALA. They should also consider filing comments with OIG and HCFA to explain how this issue can arise in the real operations of a healthcare facility. Hospitals risk significant penalties if they abide by contractual provisions requiring prior authorization before providing individuals presenting at the hospital with an appropriate medical screening examination. Hospitals should not have to face a difficult emergency room conundrum: abiding by federal law and losing reimbursement, on one hand, or honoring contractual provisions and violating EMTALA, on the other. Congress can and should clarify this situation. □

NOTES

1. Leigh M. Chiles, "Summers v. Baptist Medical Center Arkadelphia: A 'Disparate' Application of EMTALA's Terms," *Arkansas Law Review and Bar Association Journal*, vol. 559, 1997.
2. 42 U.S.C. Section 1395dd (a).
3. 42 U.S.C. Section 1395dd(b), (c).
4. 42 U.S.C. Section 1395dd(d)(1)(A), (B).
5. 42 U.S.C. Section 1395dd(d)(2).
6. OIG and HCFA, *Solicitation of Comments on the OIG/HCFA Special Advisory Bulletin on the Patient Anti-Dumping Statute*, December 2, 1998, p. 3.
7. *Solicitation of Comments*.
8. *Solicitation of Comments*, p. 4.
9. See S. 1890, Patients' Bill of Rights Act of 1998, Section 101 (105th Cong. 2nd Session); S. 2330, Patients' Bill of Rights Act, Section 721 (105th Cong. 2nd Session).

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, January-February 1999
Copyright © 1999 by The Catholic Health Association of the United States
