United States General Accounting Office

GAO

Report to Congressional Committees

June 2001

EMERGENCY CARE

EMTALA Implementation and Enforcement Issues

GAO-01-747

Contents

Abbreviations

CMS	Centers for Medicare and Medicaid Services
EMTALA	Emergency Medical Treatment and Active Labor Act
HHS	Department of Health and Human Services
OIG	Office of Inspector General
PRO	peer review organization

GAO
Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

June 22, 2001

Congressional Committees

In 1986, the Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985[1] primarily in response to concern that some emergency departments across the country had refused to treat indigent and uninsured patients or inappropriately transferred them to other hospitals, a practice known as "patient dumping." EMTALA requires hospitals that participate in Medicare to provide a medical screening examination to any person who comes to the emergency department, regardless of the individual's ability to pay. If a hospital determines that the person has an emergency medical condition, it must provide treatment to stabilize the condition or provide for an appropriate transfer to another facility. The regional offices of the Department of Health and Human Services' (HHS) Centers for Medicare and Medicaid Services (CMS)[2] are responsible for investigating complaints of alleged EMTALA violations and forwarding confirmed violations to HHS' Office of Inspector General (OIG) for possible imposition of civil monetary fines. The medical community has raised concerns that the implementation and enforcement of EMTALA have created burdens, such as overcrowded emergency departments, for hospitals and physicians. The Consolidated Appropriations Act, 2001 mandated that we examine the effect of EMTALA on hospitals and physicians serving emergency departments.[3] We addressed the following key questions in our review: 1) how has EMTALA affected hospital emergency departments and delivery of emergency care and 2) how have CMS and the OIG enforced EMTALA?

To answer these questions, we interviewed and obtained documents, such as EMTALA investigation logs, from officials at CMS' central office and the OIG. We also visited CMS' Atlanta and San Francisco regional offices, where we interviewed officials on the enforcement process and reviewed

[1]P.L. 99-272. The Omnibus Budget Reconciliation Act of 1989 deleted the word "active" from the title of EMTALA. Sec. 6211(h)(2)(C) of P.L. 101-239.

[2]On June 14, 2001, the Secretary of HHS changed the name of the Health Care Financing Administration to the Centers for Medicare and Medicaid Services. In this report, we refer to the agency as CMS.

[3]P.L. 106-554. A future study will examine providers' uncompensated care burden.

a random sample of 1999 EMTALA investigation files to ascertain the types of complaints investigated and the nature of confirmed violations. We selected the San Francisco regional office for a site visit because from fiscal year 1994 through 1998, it had the highest proportion of confirmed violations to investigations and the second highest number of confirmed violations among CMS' regional offices. We selected the Atlanta regional office because during this same time period it had the highest number of EMTALA investigations and confirmed violations; it also receives a high number of complaints. In addition, we obtained information from state agencies and physician peer review organizations (PRO) in Arizona, California, and Georgia on their roles in the EMTALA investigative process. Finally, we interviewed hospital officials, physicians, and attorneys representing several national and state hospital and physician organizations. (For additional information on our methodology, see app. I.) We conducted our work from January through May 2001 in accordance with generally accepted government auditing standards.

Results in Brief

Hospital and physician representatives told us that EMTALA has been beneficial in ensuring access to emergency services and reducing the incidence of patient dumping. The overall impact of EMTALA is difficult to measure, however, because there are no data on the incidence of patient dumping before its enactment, and the only measure of current incidence—the number of confirmed violations—is imprecise. Many hospital officials and physicians with whom we spoke said that the implementation of EMTALA adversely affects the efficiency and type of services provided in hospital emergency departments and results in additional costs to hospitals and physicians. For example, they told us that EMTALA has resulted in more people coming to the emergency department for nonurgent services, leading to overcrowding and delays. However, other factors, such as the growth of the uninsured population and the difficulty some managed care patients may have in obtaining timely appointments with their personal physicians, can also explain the increase in emergency department visits, and it is difficult to assess the relative importance of individual factors. Similarly, while some hospital officials and physicians told us that fewer physicians are joining hospital staffs and participating in emergency department on-call panels because EMTALA leads to on-call physicians providing uncompensated care, other factors, such as the ability to perform procedures in nonhospital settings, have also reduced incentives for certain specialists to serve on hospital staffs.

Some hospitals and physicians expressed uncertainty about the extent of their responsibilities under EMTALA. For example, they have questions about how a medical screening exam differs from initial triage or a general exam, how EMTALA applies to certain on-campus and off-campus hospital departments, and the extent to which they are obligated under EMTALA to provide follow-up care to emergency department patients. Violations of EMTALA continue to occur, underscoring the need for effective education and enforcement. CMS officials told us that they are aware of the difficulty providers have encountered in implementing some aspects of EMTALA and that it plans to provide more guidance and reestablish an advisory group of EMTALA stakeholders. Efforts by CMS to communicate clear, practical, and timely regulations and guidance to the medical community could make it easier for providers to ensure that they are in compliance with EMTALA, and reestablishing a stakeholder advisory group could help CMS work with hospitals and physicians to achieve the goals of EMTALA and avoid creating unnecessary burdens for providers.

CMS is responsible for investigating complaints of alleged EMTALA violations and has authority to terminate the Medicare provider agreement of a hospital that has violated EMTALA. CMS forwards confirmed violations to the OIG for possible imposition of civil monetary fines. The numbers of EMTALA violations and fines have been relatively small, and hospitals' Medicare provider agreements have rarely been terminated. On average, since 1995, CMS regional offices have directed state survey agencies to investigate about 400 hospitals per year and have cited about half of them for EMTALA violations. The numbers of investigations and proportion of confirmed violations vary among regions. CMS is taking steps to increase consistency among regions, which could assist providers in their efforts to comply with EMTALA. In reviewing confirmed violations in two regions, we found that in our sample all hospitals with confirmed violations were cited for violations involving patient care, such as failing to provide an appropriate medical screening exam, failing to provide stabilizing treatment, or inappropriately transferring a patient. Most of these hospitals also were cited for administrative deficiencies, such as failure to maintain a log on each person coming to the hospital seeking emergency services. If CMS determines that a violation has occurred, it immediately initiates the process to terminate the hospital's Medicare provider agreement within either 23 days or 90 days, the only actions its statutory authority permits. However, most cited hospitals develop corrective action plans to resolve deficiencies; since EMTALA was enacted only four hospitals have had their provider agreements terminated for EMTALA violations and two of those were recertified. Hospital officials said they would like CMS to have authority to impose intermediate

sanctions in some cases, and CMS officials also said they would like greater enforcement flexibility.

In determining whether enforcement action beyond CMS' is appropriate, the OIG has more discretion and flexibility. It considers a number of factors, including the nature and circumstances of the violation and the effect of a fine on a hospital's ability to provide care, when deciding whether to pursue civil monetary penalties and setting the amounts of fines. From 1995 through 2000, the OIG imposed fines totaling over $5.6 million on 194 hospitals and 19 physicians. The majority of hospital fines were $25,000 or less. The total number of physicians ever fined by the OIG for EMTALA violations is 28. HHS commented on a draft of this report and generally agreed with its findings.

Background

The Congress enacted EMTALA as part of the Consolidated Omnibus Budget Reconciliation Act of 1985. EMTALA contains three primary requirements for Medicare-participating hospitals. First, a hospital is required to provide a medical screening exam to any person who comes to the emergency department and requests examination or treatment for a medical condition. Second, if a hospital determines that the individual has an emergency medical condition, the hospital must provide further medical examination and treatment to stabilize the medical condition.[4] Third, if the hospital is unable to stabilize the patient, the hospital must provide for an appropriate transfer to another medical facility.[5] The statute prohibits hospitals from delaying a medical screening exam and stabilizing treatment in order to inquire about the person's method of payment or insurance status.[6] EMTALA also requires a hospital to accept a patient

[4]An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. (42 U.S.C. Sec. 1395dd(e)(1)).

[5]A transfer is appropriate if, among other things, the transferring physician has signed a certification that the medical benefits of the transfer outweigh the risks, the transferring hospital forwards the patient's medical records to the receiving hospital, and the receiving hospital has available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the patient and to provide appropriate medical treatment.

[6]In addition, the statute allows individuals suffering personal harm and medical facilities suffering financial loss as a direct result of a hospital's EMTALA violation to bring a civil action against the offending hospital and obtain personal injury damages; all civil actions must commence within 2 years of the date of the violation. (42 U.S.C. Sec. 1395dd(d)(2)).

from a transferring hospital if it can provide the specialized care the patient needs and to report any inappropriate transfers.

Other EMTALA-related statutory requirements for hospitals that participate in Medicare include posting a sign in the emergency department specifying individuals' rights under EMTALA, maintaining medical and other records of patients transferred to or from the hospital, and maintaining a list of physicians who are on call and available to provide treatment needed to stabilize individuals with emergency medical conditions.[7] These obligations are included in the agreements that hospitals sign in order to participate in Medicare. Failure to fulfill these obligations is considered a breach of the provider agreement and grounds for termination from the Medicare program. In 1994, CMS issued regulations for EMTALA and the other related statutory requirements.[8]

In May 1998, CMS issued Interpretive Guidelines that provide instructions and policy interpretations on several issues, including what is a medical screening exam, what it means to stabilize a patient, and the requirement to maintain a list of on-call physicians. In November 1999, CMS and the OIG jointly issued a Special Advisory Bulletin that focused on the application of EMTALA provisions for individuals insured by managed care plans and provided some "best practices" to help hospitals comply with EMTALA in a managed care environment. The bulletin states that it is not appropriate for a hospital to seek, or direct a patient to seek, authorization to provide screening or stabilizing services from the individual's health plan or insurance company until after the hospital has provided a medical screening exam and initiated stabilizing treatment for an emergency medical condition. It also advises against informing patients that they would be responsible for paying for their care if their insurer does not provide payment, or otherwise attempting to obtain patients' agreement to pay for services, before they are stabilized. The bulletin said a hospital may follow a reasonable registration process, including asking for insurance information, as long as it does not delay screening and treatment and does not discourage patients from obtaining care. According to the 1999 Special Advisory Bulletin, a hospital could violate EMTALA if it routinely keeps patients waiting so long that they leave without being seen, particularly if the hospital does not attempt to

[7]42 U.S.C. Sec. 1395cc.

[8]42 CFR Sec. 489.20 and Sec. 489.24.

determine and document why individual patients are leaving and tell them that the hospital is prepared to provide a medical screening if they stay.

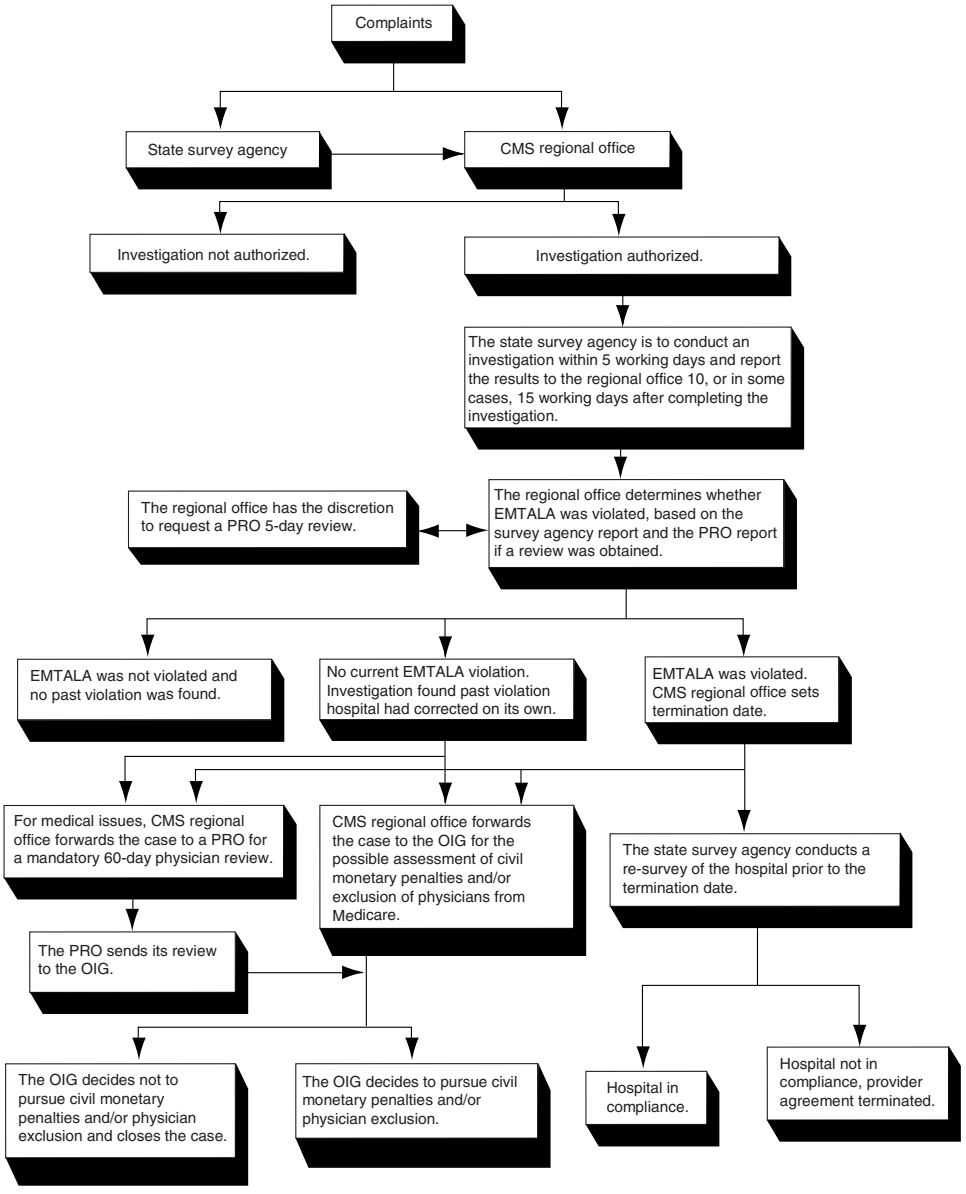
In April 2000, CMS issued additional regulations that apply EMTALA screening, treatment, and stabilization requirements to off-campus hospital-based departments.[9] These include entities that classify themselves as hospital outpatient departments and are paid Medicare's hospital outpatient rates. They may be a facility, organization, or physician office that is either established or acquired by a hospital. Hospital off-campus departments are required to establish protocols for handling potential emergency conditions. The regulations also define a hospital campus to include an area within 250 yards of the main buildings. In August 2000, CMS issued an interim final rule to clarify the requirements for off-campus departments in emergency situations.

The EMTALA enforcement process involves multiple agencies and organizations. (See fig. 1.) CMS and the OIG are jointly responsible for enforcing EMTALA. CMS initiates EMTALA investigations in response to complaints of alleged violations.[10] Complaints are received by CMS regional offices and state survey agencies and can be generated by several sources, including a patient, another hospital, or a report from the hospital itself. In addition, a state surveyor may identify a potential EMTALA violation while performing a hospital licensing or recertification survey. The CMS regional offices screen complaints and potential EMTALA violations identified by state surveyors to determine whether to authorize an investigation.

[9]Medicare Program Prospective Payment System for Hospital Outpatient Services Final Rule, 42 CFR Sec. 489.24.

[10]Hospitals can be found in violation of EMTALA and/or their Medicare Provider Agreement if they fail to (1) comply with hospital policies and procedures that address the EMTALA provisions, (2) report suspected inappropriate transfers (this applies to receiving hospitals), (3) post required signs, (4) maintain transfer records for 5 years, (5) maintain a list of on-call physicians, (6) maintain a central log on each individual that comes to the hospital seeking emergency services, (7) provide appropriate medical screening, (8) provide stabilizing treatment, (9) provide examination or treatment without a delay in order to inquire about payment status, (10) provide appropriate transfer, (11) provide whistleblower protections, and (12) meet receiving hospital responsibilities (nondiscrimination).

Figure 1: EMTALA Enforcement Process



Source: CMS' *State Operations Manual* (July 14, 1998) and *The Emergency Medical Treatment and Labor Act: The Enforcement Process*, Department of Health and Human Services, Office of Inspector General, January 2001.

If the regional office determines that an investigation is warranted, it authorizes a state survey agency to perform an unannounced, on-site investigation of the hospital to assess potential violations.[11] The on-site investigation includes an entrance conference with the hospital; a review of the emergency department log and a sample of patient records, including the complaint case; interviews with hospital staff and physicians involved in the incident; and an exit conference. The survey agency is required to complete the investigation in 5 working days and report the results to the regional office within 10, or if there appears to be no violation, 15 working days after completion of the investigation. The survey agency also reports to the CMS regional office its view on whether a violation occurred. If a medical judgment or physician action is in question and in the view of the survey agency, a physician review is necessary to determine whether an EMTALA violation occurred, the survey agency can recommend that the regional office obtain such a review. CMS has the discretion to obtain physician review of the case. Appropriate physician review, which must occur within 5 days, may be performed under contract with a state PRO by physician reviewers who are board certified and have experience in peer review.[12]

The regional office uses the state surveyor's and, if applicable, the PRO's findings to determine if a violation occurred. If a violation is confirmed, the CMS regional office can terminate the hospital's Medicare provider agreement. It initiates either a 23-day termination process, for violations that represent an immediate and serious threat to patient health and safety, or a 90-day termination process for other violations. If the facility submits a plan of correction and CMS accepts it within these time frames, the termination process ends.

When CMS determines that an EMTALA violation has occurred, it also forwards the case to the Office of Counsel to the Inspector General for the

[11]CMS' *State Operations Manual* (July 14, 1998) contains instructions for conducting EMTALA investigations.

[12]The PRO examines the medical records in the case and completes a physician review form for each medical record reviewed. The form addresses such issues as whether the patient had an emergency medical condition, the patient received an appropriate medical screening exam, the patient's emergency medical condition was stabilized at the time of transfer, and the hospital provided an appropriate transfer. The PRO is not asked to determine whether an EMTALA violation occurred. Physician review may also be provided by other qualified physicians, such as physicians who are employees of the state survey agency or CMS regional office and physicians who have contracts with state or local medical societies.

possible assessment of civil monetary penalties.[13] At the same time, if an alleged violation requires the opinion of a medical expert, CMS must send the case to a PRO to obtain a medical opinion of the case within 60 days; the PRO's report is also sent to the OIG. The OIG focuses on compliance with the specific EMTALA statutory requirements and assesses civil monetary penalties only for these statutory violations.[14] The OIG can fine a hospital a maximum of $50,000 per violation, $25,000 for a hospital with fewer than 100 beds. In addition, any physician responsible for examination, treatment, or transfer of an individual in a participating hospital, including an on-call physician, who negligently violates a requirement of the statute, may be fined a maximum of $50,000 and excluded from the Medicare program by the OIG.

Changes in the Health Care Environment

Many emergency departments have experienced an overall increase in patient volume. From 1994 to 1998, the U.S. population increased by about 4 percent. During the same period, emergency department visits nationwide increased from about 90.5 million to 94.8 million, an increase of about 5 percent. The amount of the increase in emergency department visits varied by state; for example, the increase was 2 percent in Arizona and 12 percent in California, while Georgia experienced a 10-percent decline. Changes in local communities and individual hospitals could also vary widely. Studies have found that many emergency department visits are for primary care services and treatment of nonurgent conditions.[15,16]

[13]CMS also forwards to the OIG cases where the investigation found no current violation but did find a past violation that the hospital had already corrected on its own.

[14]All enforcement actions are taken on behalf of the Secretary of HHS. The OIG has been delegated the authority to assess civil monetary penalties for violations that involve failure to provide an appropriate medical screening or stabilizing treatment, and inappropriate transfers. CMS has been delegated the authority to terminate a hospital's provider agreement for those violations as well as violations of other EMTALA-related statutory requirements such as maintaining a central log and posting signs.

[15]Nonurgent conditions are neither life- or limb-threatening nor time sensitive.

[16]John Billings and others, "Emergency Department Use in New York City: A Substitute for Primary Care?" The Commonwealth Fund, Issue Brief (November 2000). David Baker and others, "Regular Source of Ambulatory Care and Medical Care Utilization by Patients Presenting to a Public Hospital Emergency Department," *JAMA,* Vol. 271, No. 24 (1994). Kevin Grumbach and others, "Primary Care and Public Emergency Department Overcrowding," *American Journal of Public Health*, Vol. 83, No. 3 (1993). *Emergency Departments: Unevenly Affected by Growth and Change in Patient Use* (GAO/HRD-93-4, Jan. 4, 1993).

Between 1994 and 1998, the number of uninsured Americans grew steadily from 39.4 million (17.1 percent of the U.S. nonelderly population) to 43.9 million (18.4 percent). Uninsured people are less likely to have a usual source of health care and are more likely to have difficulty in gaining access to care. Compared with the insured, uninsured adults are four times and uninsured children five times more likely to use the emergency department.

Hospitals and Physicians Have Concerns About Effects and Extent of EMTALA Responsibilities

Hospital officials and physicians we interviewed said that EMTALA's purpose is laudable and that EMTALA has helped reduce the incidence of patient dumping. However, no reliable measurement is available to ascertain how the extent of the problem has changed. Hospital and physician representatives also told us that EMTALA has contributed to the increased use of emergency departments for the treatment of nonurgent conditions and a decline in physicians' willingness to provide on-call services to emergency departments. However, other factors, such as the increase in the number of uninsured, also contribute to these changes and it is difficult to determine how much is due to EMTALA. Hospitals and physicians are uncertain about the extent of their responsibilities under EMTALA and how to apply certain EMTALA requirements. CMS is aware of the difficulty hospitals and physicians have encountered in implementing some aspects of EMTALA and is drafting additional guidance on EMTALA. The agency also is planning to reestablish an advisory group to help clarify some of these issues.

Providers of Emergency Care Generally Support EMTALA's Goals

Hospital officials and physicians we interviewed generally agreed that EMTALA has an important purpose—to ensure that no one is denied emergency medical care because of lack of insurance or an inability to pay. Hospitals and physicians told us that EMTALA has helped to ensure access to emergency services by reducing the incidence of patient dumping. In addition, they said EMTALA has made it easier for hospitals to ensure that physicians who participate in on-call panels come to the hospital when asked and enabled managed care beneficiaries to receive care without waiting for hospitals to seek prior authorization.

There continue to be concerns, however, that patients' ability to pay can affect the care they receive. Representatives of tertiary care hospitals and public hospitals, which are more likely to receive patient transfers from other hospitals, agree that EMTALA has reduced the number of inappropriate transfers they receive but told us that transfers based on financial factors continue to occur. For example, they said that some

transferring hospitals claim that a patient needs specialized care when in their view the transferring hospital could adequately care for the patient within its capabilities. Furthermore, representatives of public hospitals said that some hospitals operating within larger hospital networks were transferring uninsured patients to public hospitals instead of to hospitals in their networks capable of providing for the patient's care.

The overall impact of EMTALA is difficult to measure. There are no data on the incidence of patient dumping before the enactment of EMTALA, and there is no measure of current incidence other than the number of confirmed violations. Confirmed violations are an imprecise measure of patient dumping because suspected violations may not always be reported. For example, hospital officials said they may not always report possible cases of patient dumping because they are reluctant to jeopardize their relationships with other hospitals in their community. They said they need to maintain a positive working relationship with other hospitals and sometimes they rely on other facilities for patient referrals.

Hospitals and Physicians Have Concerns About EMTALA's Effects on Emergency Care

While they support the basic purpose of EMTALA, many hospital officials and physicians with whom we spoke said that the implementation of EMTALA adversely affects the efficiency and type of services provided in hospital emergency departments and results in additional costs to hospitals and physicians.

Emergency Department Use

Hospital and physician representatives told us that more people are coming to emergency departments with nonurgent conditions as a result of EMTALA. Factors other than EMTALA, however, could explain such an increase. The provider representatives said that patients who face financial or other barriers to care use emergency departments as their primary health care provider because they know they will receive care there. The representatives also noted that it is EMTALA that requires emergency departments to provide a medical screening exam to every patient who requests examination or treatment for a medical condition. Although from 1994 to 1998, the rate of growth of emergency department visits nationwide barely exceeded the rate of population growth, the number of emergency departments declined by 8 percent from 1994 to 1999, so the end result could be increased volume in certain hospitals. Treating patients with nonurgent conditions in an emergency department can be more costly and less appropriate than treatment in a clinic or physician's office—settings that are more conducive to providing continuity of care. It can also lead to overcrowding that may delay care for

patients with true emergency needs and cause hospitals to divert ambulances to other facilities,[17] resulting in further delays in urgent care.

Any growth in emergency department visits, particularly for the treatment of nonurgent conditions, can be attributed to a number of factors, including increased numbers of indigent and uninsured patients. Some insured patients with nonurgent conditions seek care in an emergency department because alternatives are inaccessible when they want or need care. For example, some Medicaid patients seek care in emergency departments because they have difficulty gaining access to primary health care. In addition, some patients enrolled in managed care programs may have difficulty seeing their personal physician in a timely fashion. Factors that may contribute to crowded emergency departments include a shortage of health care professionals, especially nurses, and a shortage of beds for patients needing admission to the hospital.

Uncompensated care

Hospital and physician representatives contend that EMTALA has contributed to an increase in uncompensated care in hospital emergency departments. According to the American Hospital Association, overall hospital uncompensated care as a proportion of hospital total expenses declined from 6.4 percent in 1986 to 6.2 percent in 1999. Although the nationwide aggregate uncompensated care burden fell, the situations faced by individual hospitals can vary considerably and some may be providing a greater amount of uncompensated care. For example, some hospital officials told us that care to illegal immigrants contributes to their uncompensated care burden, so hospitals serving communities with an increased illegal immigrant population could be providing more uncompensated care.[18]

Hospital representatives also told us that EMTALA hinders their ability to ensure that they receive payment for care, partly because they cannot obtain patients' insurance information before examining them. However, EMTALA does not prohibit hospitals from seeking all financial information from emergency department patients. They may follow normal registration procedures, which may include collecting insurance information, as long

[17]In certain situations, a hospital may deny access to patients because it does not have the staff or facilities to accept any additional emergency patients at that time.

[18]Illegal immigrants are covered by Medicaid for emergency treatment, but they may be reluctant to seek Medicaid coverage out of fear that program participation could effect their ability to remain in the country.

as they do not delay care in order to inquire about the patient's method of payment or insurance status. CMS and the OIG have recommended that hospitals defer discussing a patient's financial responsibility or attempting to obtain a patient's agreement to pay for services until after stabilizing treatment has begun.

Hospital and physician representatives told us that some reimbursement issues have arisen as a result of managed care companies denying payment for treatment. The 1999 Special Advisory Bulletin says hospitals should not obtain prior authorization from an individual's insurance company before screening or stabilizing treatment begins. Some hospitals and physicians told us that when they comply with this guidance, certain health plans deny or reduce payment, claiming that the treatment was not medically necessary, the patient did not have an emergency condition, or the treatment was provided at a nonnetwork hospital. According to the American College of Emergency Physicians, 36 states and the District of Columbia have adopted laws to address issues related to managed care organizations' payment for emergency services, such as prudent layperson standards.[19] These standards compel managed care organizations to base their decision on whether to pay an emergency department claim on the patient's presenting symptoms rather than on the final diagnosis. The Balanced Budget Act of 1997 required managed care organizations to use a prudent layperson standard for Medicare and Medicaid beneficiaries.[20]

Hospital and physician representatives told us that uncompensated care associated with complying with EMTALA has contributed to a decline in the number of physicians willing to serve on emergency department on-call panels.[21] They said that some physicians limit their time on call or completely avoid participating in the on-call panel. Furthermore, they said that some specialists are reducing the number of procedures that they have credentials to perform and are not seeking privileges at hospitals in efforts to avoid being on call, resulting in a reduced range of services

[19]State prudent layperson laws call for coverage of emergency services by managed care organizations without preauthorization when symptoms are severe enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her health or the health of an unborn child is in immediate jeopardy.

[20]Sections 4001 and 4702 of P.L. 105-33, 42 U.S.C. Sec. 1395w-22 and Sec. 1396u-2.

[21]Hospital emergency departments often supplement their staff with services provided by on-call physicians. The on-call physician may provide consultation, surgical, or other services as necessary for patients who need care beyond the capabilities of the emergency physician and staff.

being available to patients in some hospitals. However, other factors besides EMTALA may also affect physicians' willingness to serve on call. In the past, physicians in certain specialties had inducements to join hospital staffs and provide on-call services because they were dependent on the hospital setting to be able to perform procedures and needed emergency patients to build their practices. Today, however, they can perform many procedures in outpatient settings and gain patients through managed care networks, resulting in fewer advantages to balance the inconveniences of serving on call.

Off-Site Facilities

Some hospital representatives also expressed concern about EMTALA's application to their off-site departments. All off-site departments are required to have protocols that provide for direct contact between their staff and emergency staff at the main hospital, and off-site department staff may not routinely respond to all emergencies by calling 911 and always relying on the emergency medical system to assume responsibility for the patient.[22] If an off-site department is routinely staffed by physicians, registered nurses, and licensed practical nurses, the staff must be trained in the handling of emergency cases, and at least one person must be designated as a qualified medical person to initiate screening and stabilization and arrange appropriate transfers when necessary. Hospital and physician representatives told us that implementing these requirements will increase costs and may not result in the most appropriate care for some patients. Hospital officials reported that there are substantial costs associated with training off-site facility staff in the handling of emergency cases. They also said that contacting the main hospital, arranging for transportation, and completing EMTALA paperwork to document a transfer could delay the patient's care.

CMS' position is that it is reasonable to expect off-site hospital departments to comply with EMTALA. In seeking designation as a hospital-based provider by CMS, these off-site departments have chosen to operate under the name, ownership, and financial and administrative control of the hospital and provide the same type of services as the hospital. In return, they receive higher reimbursement from CMS than if the facility operated as a free-standing entity that would not be responsible for complying with EMTALA. To clarify the requirements for off-campus departments, CMS said in its August 2000 interim final rule that off-site department staff should contact the main hospital either after or at the

[22]In some emergency situations, CMS would consider calling 911 the appropriate response.

same time they arrange for an appropriate transfer to another facility if the patient's life or health would otherwise be in jeopardy.

Providers Are Uncertain About the Extent of Their Obligations

An overarching concern among numerous hospital officials and physicians is uncertainty about the extent of some of their responsibilities under EMTALA. More than 40 percent of emergency physicians and more than 60 percent of emergency department directors responding to a recent OIG survey reported that some parts of the EMTALA law or regulations were unclear.[23] Providers have raised questions about the amount of care they are required to give patients to comply with certain EMTALA requirements and about when their obligations under EMTALA end. Table 1 summarizes several of the specific issues that have generated concerns.

CMS officials acknowledged that hospitals and physicians have had difficulty implementing some EMTALA regulations and guidelines and that additional guidance is needed. CMS has identified several areas in which it believes its position needs to be further explained and clarified, including the definition of a hospital's campus, the application of EMTALA in areas that have state or local emergency medical system policies, and the responsibilities of hospitals to provide on-call coverage in emergency departments. CMS officials also told us that they are planning to establish a group of EMTALA stakeholders to help clarify issues; in the past the agency had such an advisory group. The OIG recently recommended that CMS, in light of EMTALA's complexity and impact on hospitals and physicians, reestablish an EMTALA technical advisory group to help the agency resolve emerging issues related to the law. [24]

[23] *The Emergency Medical Treatment and Labor Act: Survey of Hospital Emergency Departments*, Department of Health and Human Services, Office of Inspector General, January 2001.

[24] *The Emergency Medical Treatment and Labor Act: The Enforcement Process*, Department of Health and Human Services, Office of Inspector General, January 2001.

Table 1: Provider Uncertainties About EMTALA Requirements

Issue	Requirement	Provider uncertainty	CMS comment[a]
Medical screening exam	Individuals must be given a medical screening exam that determines presence or absence of an emergency medical condition.	How the exam differs from triage or a general exam.	Interpretive Guidelines say triage determines order in which patients will be seen, not presence or absence of an emergency medical condition. CMS is not currently developing additional guidance.
Stabilizing treatment	Patient must be stabilized. CMS uses terms "stable for transfer" (physician believes patient's condition will not materially worsen during transfer to another facility) and "stable for discharge" (patient can reasonably be cared for as outpatient or later as inpatient).	Whether the determination that a patient is stable for transfer or discharge ends the hospital's EMTALA obligation or whether the hospital must also ensure follow-up care is provided.	The requirement is fulfilled when a physician determines the patient is stable for transfer or stable for discharge. The regulations on transfer requirements refer to patients who are unstable; therefore they do not apply when a patient is stable for transfer or stable for discharge.[b]
Follow-up care	Stabilized patients must be given a plan for appropriate follow-up care.	Whether a hospital must ensure that follow-up care is obtained.	Hospitals are not required to ensure that follow-up care is obtained. CMS is not currently developing additional guidance.
250-yard rule	Screening and stabilization are required for all patients seeking emergency services within 250 yards of the hospital's main buildings.	Who designates "main" buildings and how. Also, whether the rule applies to entities not related to the hospital, such as a restaurant or apartment complex.	CMS officials are developing further guidance on how to apply the 250-yard measure and what properties are covered by EMTALA.
Hospital campus	Screening and stabilization are required at both on-campus and off-campus hospital departments.[c]	Whether this applies to all individuals seeking care in departments that normally require an appointment.	It applies if the person says there is an emergency or a reasonable person would say there may be one. Further guidance is being developed.
On-call coverage	Hospital must keep a list of specialty physicians on call to stabilize emergency patients.	The extent to which physicians must be on call for each specialty a hospital has on staff. Some hospitals and physicians believe CMS requires full-time coverage of a specialty if the hospital staff includes three or more physicians in that specialty.	There is no rule linking extent of coverage with the number of specialists on staff. Physicians are not required to be on call at all times. Further guidance is being developed.

Issue	Requirement	Provider uncertainty	CMS comment[a]
Ambulance	A hospital must screen and stabilize patients transported in ambulances the hospital owns or operates.[d]	What to do when local emergency medical system policies mandate taking patients to the nearest hospital.	Compliance with local emergency medical system policies is acceptable, according to Interpretive Guidelines. Further guidance is being developed.

[a]This column presents information CMS staff provided to us about each issue.

[b]Transfer requirements include documenting the risks and benefits of transfers and forwarding the patient's medical records to the receiving facility.

[c]Off-campus departments can include clinics, primary care centers, diagnostic facilities, and urgent care facilities for which the hospital has obtained designation as a hospital outpatient department.

[d]The Ninth U.S. Circuit Court of Appeals also applied EMTALA to nonhospital-owned ambulances. The Court said that hospitals could not turn away ambulances after radio contact is made unless they do not have the staff, facilities, or equipment to treat the patient. Arrington v. Wong 237 F. 3d 1066 (9th Cir. January 22, 2001).

Numbers of EMTALA Violations and Fines Relatively Small, and Hospitals Are Rarely Terminated

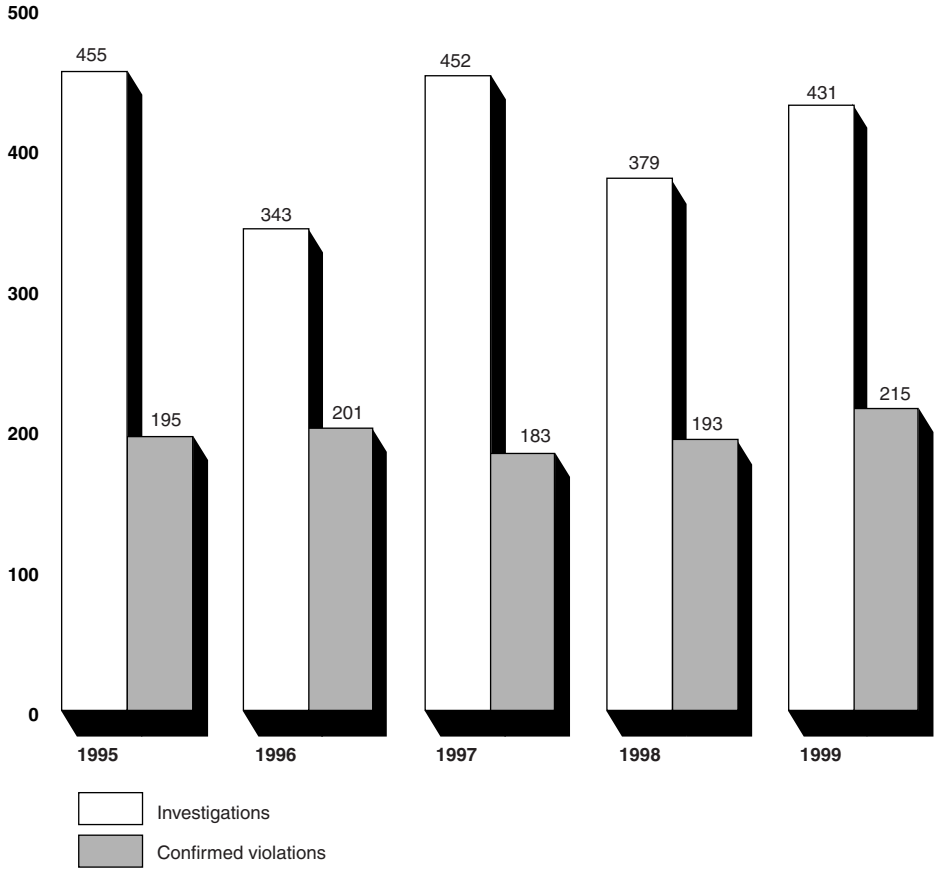
CMS conducts about 400 EMTALA investigations a year; on average, about half result in confirmed violations. Hospitals' EMTALA violations usually involve failure to provide a medical screening exam, stabilizing treatment, or an appropriate transfer for patients seeking care in the emergency department. Few hospitals have been terminated from the Medicare program for committing EMTALA violations; most adopt corrective actions that resolve the EMTALA deficiencies. Hospitals are concerned about several aspects of the enforcement process, including CMS' minimal enforcement flexibility. CMS officials would also like to have more EMTALA enforcement flexibility, such as the range of sanctions it can use in enforcing nursing home standards. In deciding whether to pursue civil monetary penalties, the OIG is most concerned with encouraging a hospital's or physician's future compliance with the statute and has assessed fines in less than half of the violation cases forwarded by CMS. Very few physicians have been fined.

Most EMTALA Violations Involve Failure to Screen, Stabilize, or Transfer Appropriately

The number of confirmed EMTALA violations is relatively small compared to the total number of emergency department visits, which totaled about 97 million in 1999. Enforcement of EMTALA is a complaint-driven process; CMS investigates a hospital only when it receives information about an alleged EMTALA violation. Since CMS issued EMTALA regulations in 1994, the agency has conducted an average of 400 investigations per year; on

average, about half have resulted in confirmed violations (see fig. 2).[25] The average annual number of hospitals with confirmed violations represents less than 5 percent of hospitals with emergency departments. In fiscal year 1999, CMS conducted 431 investigations and found 215 confirmed violations; most of the termination processes it initiated were in the 90-day category.

Figure 2: Total EMTALA Investigations and Confirmed Violations, Fiscal Years 1995 - 1999



Source: CMS central office EMTALA investigation logs.

[25]In some cases the original complaint was not substantiated, but other EMTALA violations were identified during the investigation.

We reviewed a randomly selected sample of fiscal year 1999 EMTALA case files in two CMS regions, Region IV (Atlanta) and Region IX (San Francisco), to ascertain the types of complaints investigated and the nature of confirmed violations. In our sample of 36 case files, 21 of which involved confirmed violations, the violations usually involved multiple deficiencies, with the deficiencies per case ranging from 1 to 6.[26] All the cases with confirmed violations that we reviewed included deficiencies related to medical screening, stabilizing treatment, appropriate transfers, or receiving hospital responsibilities. None of these hospitals was cited for an EMTALA violation that involved only administrative or documentation deficiencies, such as deficiencies involving hospitals having and following appropriate policies and procedures, sign posting, or maintaining an emergency department log or transfer records. These types were always joined with at least one deficiency related to patient treatment. For example, in Region IV a hospital in violation of EMTALA was cited for not maintaining a central log on each individual coming to the hospital seeking emergency services, not providing a medical screening exam and treatment, and for inappropriately transferring a patient who had arrived at the emergency department in an ambulance. (See app. II for examples of confirmed violations from the cases we reviewed.)

The OIG recently reported that CMS' regional offices differed in the number of EMTALA investigations conducted and the proportion of their investigations that result in confirmed violations;[27] we found that the regions also differed with respect to the proportion of their termination actions that fell into the 23-day and 90-day categories. Our analysis showed that for complaints received during fiscal year 1999, 25 percent of Region IV's 103 investigations resulted in confirmed violations and 77 percent of Region IX's 52 investigations resulted in confirmed violations. One possible reason for this difference is variation in the two regions' approach to screening complaints. In both regions, EMTALA complaints are generally made to the state survey agency. CMS Region IV authorizes an investigation for almost all complaints that allege EMTALA violations because, according to regional officials, initial complaint intake at the state agency usually does not obtain enough facts to determine that a

[26]Three case files in our sample had one deficiency each. In one case a hospital was cited for not providing stabilizing treatment and in two cases the hospitals were cited for refusing to accept a transfer.

[27]*The Emergency Medical Treatment and Labor Act: The Enforcement Process*, Department of Health and Human Services, Office of Inspector General, January 2001.

violation did not occur. State agencies in region IX also often receive incomplete complaint information. However, when the Arizona and California state survey agencies receive a complaint without enough initial information to determine whether to forward the complaint to the regional office for investigation authorization, they conduct a preliminary review at the hospital. They refer the complaint to the regional office only if they believe it warrants an EMTALA investigation.

Regions IV and IX also vary in their use of the discretionary 5-day PRO review. In Region IV, cases that involve screening, treatment, and stabilization are always sent to the PRO for a 5-day review, while Region IX generally does not use 5-day PRO reviews for EMTALA investigations. Region IX officials told us they have not been necessary because the cases they have investigated have involved basic, straightforward violations of EMTALA—e.g., a person presented at a hospital emergency department and was not given a medical screening exam—rather than issues regarding the extent of physician care provided. However, hospital officials and physicians in Region IX said that judgments on physician care have been involved in some deficiency findings done without a 5-day PRO review. In its recent report, the OIG found that CMS did not always obtain a 5-day peer review before it considered terminating a hospital for deficiencies involving medical reasons and recommended that CMS ensure that peer review occurs before initiating termination actions in such cases.

CMS Usually Accepts Corrective Action Plans and Rarely Terminates Hospitals

Most hospitals in violation of EMTALA avoid termination by developing and implementing corrective action plans that outline how they will correct their deficiencies and prevent future problems. Only four hospitals have been terminated from the Medicare program because of EMTALA violations, all more than 11 years ago (one in 1987, two in 1988, and one in 1989). Two of the four hospitals were later recertified. A hospital must submit a corrective action plan prior to the date on which the CMS regional office would notify the public of the proposed termination action and with enough time for the state agency to conduct a resurvey and verify

the corrections.[28] If the regional office determines that the hospital is in compliance, termination is rescinded.[29]

Corrective action plans need to address each of the deficiencies for which a hospital has been cited, detail the steps the hospital has taken or will take to resolve the deficiencies, state when the correction took place, and identify someone responsible for monitoring the correction. For example, one hospital's corrective actions included mandatory in-service education for hospital staff on EMTALA requirements, a revised emergency department triage policy, and a revised medical screening exam policy that prohibited performing medical screening exams in the lobby area of the emergency department and prohibited nurses from performing them. Another hospital's corrective actions included establishing a central emergency room log for the registration of every patient who presents to the emergency department and revising its medical screening policy to provide medical screening exams to all patients arriving in the emergency room, including those arriving by ambulance.

Hospitals Have Concerns About CMS Enforcement

Hospital representatives have raised concerns about CMS' enforcement process. They are troubled that there is no procedure for hospitals to challenge or appeal a violation decision before the termination process begins.[30] In addition to submitting a plan of correction, hospitals may submit evidence that the deficiencies did not exist. However, hospital officials told us that they do not have time to focus on the accuracy of CMS' information or the appropriateness of the decision because as soon as they receive a termination letter, the 23- or 90-day termination period begins. They said that to avoid risking termination from the Medicare program, hospitals focus on developing a corrective action plan to satisfy CMS rather than attempting to appeal the violation determination.

[28]In a 23-day termination action, public notice is published on the 21st day; in a 90-day termination action, public notice is published on the 75th day.

[29]In a 23-day termination action, if the corrective action plan provides credible evidence that the immediate and serious threat to patient health and safety has been removed after initiation of termination action, the survey agency will conduct a resurvey. If that evidence is verified, the regional office will switch from 23-day to 90-day termination procedures. This allows the hospital time to prove that the corrective action is adequate to ensure that no further violations will occur. The state agency will conduct a second resurvey within 60 days of the first resurvey to assess continued compliance.

[30]The statute does not provide for any interim action short of termination. See 42 U.S.C. Sec. 1395cc.

Hospital representatives have also expressed other concerns. Although state surveyors are generally nurses and sometimes physicians, hospital representatives told us that CMS regional offices should use PRO 5-day reviews more frequently; they say that if a state surveyor is assessing whether sufficient medical intervention occurred, clinical judgment is in question and physicians from a PRO should be involved. Hospital and physician representatives have also expressed concern that when CMS assesses whether an appropriate medical screening exam or needed stabilizing treatment occurred, the agency sometimes moves beyond these issues to evaluate the quality of care. Although CMS officials told us that an EMTALA investigation is a review of a hospital's process and not a quality of care review, the distinction is not always clear. For example, the peer reviewer must determine whether the examination was sufficiently thorough to identify the presence of an emergency medical condition.

Another issue some hospitals have raised is CMS' lack of flexibility for enforcement. By law, when a hospital has been found to have violated a provision of its provider agreement, the only sanctions are termination of the agreement and possibly civil monetary penalties. Hospital officials told us that an intermediate sanction other than termination might be appropriate in some cases. CMS officials told us that they would like more EMTALA enforcement flexibility, such as the additional actions that the Congress authorized CMS to take when enforcing nursing home standards, which include a directed plan of corrections, directed in-service training, on-site monitoring of corrections, and denial of payment.[31]

There is also concern about delays between an EMTALA investigation and the hospital's receiving notification of CMS' resolution of the case. In our sample of fiscal year 1999 cases, Region IV took an average of 11 months and Region IX took an average of 2 months to notify hospitals of the outcome of an investigation.[32] The OIG pointed out in its enforcement report that although state survey agencies must adhere to strict time frames when they investigate complaints, CMS is not subject to time frames. The OIG observed that after waiting a long time to learn the outcome of an investigation, a hospital could be subject to a fast-track termination for an incident that occurred months or years before, and the OIG stated that long delays in reviewing and deciding such cases defeat the purpose of the 23-day process, which is to address immediate threats

[31]42 U.S.C. Sec. 1395i-2a(h).

[32]Cases included both confirmed violations and findings of no violation.

to patient health and safety. The OIG recommended that CMS' central office increase its oversight of regional offices in connection with time frames and other aspects of the enforcement process, in part to improve the consistency of the process. In 1999, CMS began to conduct monthly teleconferences with the regional offices to improve consistent enforcement among the regions and to share information. The agency has a working group that is charged with establishing time frames for regional office actions, such as for determining a violation and reviewing PRO reports.

Inspector General Focuses on Future Compliance in Assessing Fines

The OIG has discretion to decide whether to assess civil monetary penalties, and OIG officials told us their major concern is encouraging future compliance with EMTALA and deterring future violations. When the OIG receives a case from CMS, it first determines whether there is a violation of the EMTALA statute, and it declines cases that do not involve specific EMTALA statutory violations. To make this decision, the OIG relies on the state survey report, the PRO review, and information collected by CMS. When a case involves a violation of the EMTALA statute, the OIG can decide either to pursue civil monetary penalties or exercise prosecutorial discretion and not impose a fine. In making this decision and in determining the amount of a fine, the OIG considers several factors, including the seriousness of the patient's condition, the nature of the violation, the culpability of the hospital or physician, and the effect of the penalty on the hospital's ability to provide care.[33] For example, in one case the OIG did not pursue a civil monetary penalty against a hospital that violated EMTALA because it was an urban hospital that played an important role in providing health care in its community and the hospital had taken steps to ensure its future compliance. The OIG may not pursue civil monetary penalties if a hospital has taken corrective action on its own or self-reported the violation, because OIG officials wish to reinforce hospitals' self-reporting and taking the initiative to implement corrective actions.

[33]The OIG undertakes a factual investigation to assess the hospital's culpability. The OIG asks the hospital to provide additional information and focuses on factors such as the hospital's actions or lack of actions and whether the hospital demonstrated knowledge of its responsibility under the statute, such as having policies and procedures that comply with EMTALA, in contrast to having policies that could easily result in violations. For example, if a hospital emergency department was aware that it had a problem with on-call coverage and did not attempt to resolve the coverage shortage, OIG would consider the hospital culpable. If, however, an on-call physician refused to come in despite being told by the hospital of his obligation, OIG would consider the hospital's culpability far smaller.

From January 1, 1995, through March 30, 2001, the OIG processed a total of 605 EMTALA violation cases; 237 cases were settled and 368 cases were declined.[34] Overall, the OIG has declined about 61 percent of the violation cases forwarded by CMS. The OIG told us it would not be accurate to conclude from the fact that the OIG decided not to assess fines in some cases that CMS had erred in its conclusion that a violation had occurred. As a prosecutor's office, they said, the OIG always considers a range of issues in deciding whether an additional enforcement action is warranted. Moreover, the OIG takes into account its resources and what it is trying to accomplish in education and future compliance. Some of the major factors that may influence its decision include the seriousness of the violation, CMS' enforcement activity that has already occurred, additional information discovered during the 60-day PRO review or brought to the OIG's attention by the hospital, and whether the hospital has been privately sued for its actions.

Once the OIG decides to pursue a civil monetary penalty, it tries to negotiate a settlement amount with the hospital.[35] If a settlement cannot be reached, the OIG initiates the administrative process to collect the civil monetary penalty amount it considers appropriate. If the hospital appeals the OIG action, the case is resolved at an administrative hearing. However, this rarely occurs; there have been fewer than 10 administrative hearings. From 1995 through 2000, the OIG collected over $5.6 million in fines from 189 hospitals and 19 physicians.[36] The majority of hospital fines were $25,000 or less. Between 1997 and 1998 there was a dramatic increase in the number of cases settled and the amount of fines collected. From 1995 to 1997, the OIG settled an average of about 16 cases per year and collected about $997,000 in fines in total. From 1998 to 2000, it settled an average of 55 cases per year and collected about $4.7 million in fines. According to the OIG, these increases reflected additional OIG staffing that resulted in the elimination of a backlog of cases rather than a surge in confirmed EMTALA violations.

[34]The OIG had 98 cases that were pending as of March 30, 2001.

[35]As part of settlement agreements, the OIG has required hospitals to publish community service announcements about their EMTALA responsibilities in a local newspaper twice a year.

[36]The money collected from civil monetary penalties is deposited in the Medicare trust fund.

The OIG has the authority to assess civil monetary penalties against physicians, and it examines the activities of the individual physician involved in every case forwarded by CMS. The OIG pursues a case against a physician only if it considers the physician largely responsible for the violation. Overall, the OIG has sought civil monetary penalties from 28 physicians and collected $412,500; it generally does not pursue a physician unless clearly culpable behavior is involved, such as an on-call physician refusing to come to the hospital to treat a patient when asked by the hospital.

Concluding Observations

Hospital emergency departments' and emergency physicians' concerns with overcrowding, long delays for patients, and local issues of uncompensated care are important. Although EMTALA may contribute to these problems, other factors associated with the changing health care environment, such as the growth in the uninsured population and aspects of managed care, also contribute to the conditions of emergency medical care. It is difficult to assess the relative importance of any one factor.

Violations of EMTALA continue to occur, underscoring the need for effective enforcement and education. At the same time, hospital and physician representatives have expressed frustration about the implementation and enforcement of EMTALA. They have sometimes found CMS' regulations and guidance to be confusing and are uncertain about how to apply them in some of the specific situations they encounter in their practice of emergency medicine. Efforts underway by CMS to improve the consistency of enforcement among its regional offices and to communicate clear, practical, and timely regulations and guidance to the medical community could make it easier for providers to ensure that they are in compliance with EMTALA. Similarly, CMS' efforts to respond to the OIG recommendation to reestablish a technical advisory group could help CMS work with hospitals and physicians to achieve the goals of EMTALA and avoid creating unnecessary burdens for providers.

Agency Comments

We provided a draft of this report to HHS for comment. HHS generally agreed with the report's findings. In addition, HHS said that it has taken steps to improve and simplify enforcement of EMTALA, including implementing procedures and standards for the timely investigation and resolution of complaints. HHS provided technical comments, which we incorporated where appropriate. (HHS' comments are in app. III.)

We are sending copies of this report to the Secretary of HHS, the Administrator of CMS, the Acting Inspector General of HHS, officials of the state survey agencies and PROs we interviewed, appropriate congressional committees; and others who are interested. We will also make copies available to others on request.

If you or your staffs have any questions, please contact me at (202) 512-7119. An additional GAO contact and the names of other staff who made major contributions to this report are listed in appendix IV.

Janet Heinrich, Director,
Health Care—Public Health Issues

List of Committees

The Honorable Max Baucus, Chairman
The Honorable Charles E. Grassley, Ranking Minority Member
Committee on Finance
United States Senate

The Honorable W.J. "Billy" Tauzin, Chairman
The Honorable John D. Dingell, Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable William M. Thomas, Chairman
The Honorable Charles B. Rangel, Ranking Minority Member
Committee on Ways and Means
House of Representatives

Appendix I: Scope and Methodology

To do our work, we interviewed officials at the Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) and Office of Inspector General (OIG). We also reviewed the relevant statute, regulations, and guidance, OIG reports on the Emergency Medical Treatment and Labor Act (EMTALA), and CMS central office and OIG EMTALA case logs.

We conducted site visits to California and Georgia, where we interviewed and obtained documents from CMS' San Francisco regional office (Region IX) and Atlanta regional office (Region IV), and California and Georgia survey agencies and peer review organizations. The San Francisco regional office enforces EMTALA for Arizona, California, Hawaii, Nevada, American Samoa, and Guam. We selected the San Francisco regional office for a site visit because from fiscal year 1994 through fiscal year 1998, it had the highest proportion of confirmed violations to investigations and had the second highest number of confirmed violations among CMS' regional offices. The Atlanta regional office enforces EMTALA for Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. We selected the Atlanta regional office because during this same time period it had the highest number of EMTALA investigations and confirmed violations; it also receives a high number of complaints. We also conducted a site visit to Arizona where we interviewed the Arizona survey agency, the Arizona Hospital and Healthcare Association, and the Arizona Medical Association.

In Regions IV and IX, we reviewed a random sample of fiscal year 1999 EMTALA investigation case files; the results of these reviews cannot be projected to other files in these regions or CMS' other regional offices. Of the 103 completed investigations in Region IV, we reviewed 22 files—10 files in which CMS confirmed that a violation occurred and 12 files with unconfirmed violations. Of the 52 completed investigations in Region IX, we reviewed 11 files with confirmed violations and 3 files with unconfirmed violations. Where applicable and available, we reviewed the complaint, state survey agency report, PRO findings, CMS deficiency report, and hospital corrective action plans. The initial complaint was not always available in Region IX's files. The violation examples included in appendix II were randomly selected from our sample of cases.

We also reviewed the relevant literature and interviewed and obtained information from national health care organizations such as the American Hospital Association, American Medical Association, American College of Emergency Physicians, American Academy of Emergency Medicine, Association of American Medical Colleges, Federation of American

Hospitals, and National Association of Public Hospitals and Health Systems. We also had numerous discussions with hospital and managed care company officials, physicians, attorneys, and representatives of state hospital and physician groups. The people we spoke with came from the following states: Arizona, Arkansas, California, Florida, Georgia, Illinois, Missouri, New York, North Carolina, Pennsylvania, Virginia, and the District of Columbia.

We conducted our work from January through May 2001 in accordance with generally accepted government auditing standards.

Appendix II: Confirmed EMTALA Violations

Table 2 provides information from a random sample of the cases with confirmed violations that we reviewed at Centers for Medicare and Medicaid Services (CMS) regional offices in Atlanta (Region IV) and San Francisco (Region IX). For each hospital cited, the table indicates the deficiencies cited and provides more detailed information about one or more of the violations.

Table 2: Examples of 1999 Confirmed EMTALA Violations

Region	Nature of violation	CMS action[a]	OIG action
IV	Failure to provide appropriate transfer and keep log. A bicycle accident victim was transferred without a screening exam or entry into the central log. The hospital told the rescue crew that the patient should go to another hospital because he met trauma criteria when he did not meet the criteria. The hospital also did not contact or send records to the receiving hospital.	No action; hospital corrected problem before investigation	Pending
IV	Failure to screen, stabilize, and keep log. A patient with end stage renal disease was discharged without being stabilized and died 6 hours later. An infant did not receive an appropriate screening exam. A motor vehicle accident victim was not stabilized and became paralyzed in the emergency room.	23-day termination process	Pending
IV	Failure to screen and provide appropriate transfer. An uninsured patient with suicidal symptoms was put into a taxi for transfer to another hospital without being examined. Another patient seeking treatment for acute psychiatric symptoms also was not appropriately screened.	23-day termination process	Pending
IV	Failure to screen, stabilize, keep log, follow procedures, treat without delay, and provide appropriate transfer. Violations were connected with multiple patients, including one bleeding at a dialysis shunt site who was not screened or stabilized before transfer to a receiving hospital that had not been notified.	23-day then 90-day termination process	Pending
IV	Failure to meet receiving responsibilities, follow procedures, and provide appropriate transfer. Refused to accept transfer of an unstable patient with multiple traumas from a motor vehicle accident. Did not document transfer risks and benefits for two critical care patients transferred elsewhere.	23-day termination process	Pending
IX	Failure to screen, stabilize, follow procedure, and provide appropriate transfer. Obstetrics patients were screened by nurses when hospital policy did not indicate that they were qualified to do screening. Documentation was missing on whether other patients were screened or had left the hospital against medical advice. Some patients were not told the risks and benefits of transfer.	90-day termination process	Declined to take action
IX	Failure to screen, follow procedure, keep log and transfer records, and post signs. An insured patient with a rash received screening while an uninsured patient with the same symptoms was sent to a clinic without screening. Appropriate screening was not provided in 22 of 37 patient records reviewed.	90-day termination process	Pending
IX	Failure to screen, follow procedure, keep log, and provide appropriate transfer. A possible sexual assault victim who arrived in an ambulance was sent to another hospital without screening, and there was no evidence in the record that the receiving hospital was notified or had agreed to accept the patient.	90-day termination process	$25,000 settlement

Region	Nature of violation	CMS action[a]	OIG action
IX	Failure to stabilize and follow procedure. A 14-month-old patient with a broken arm was examined and given a splint, but family was not given proper discharge instructions.	90-day termination process	Declined to take action
IX	Failure to Screen, Stabilize, Treat Without Delay, and Follow Procedures. Before examining a patient with chest pain, the hospital called his physician, who denied insurance coverage for the emergency visit. The hospital told the patient he would be responsible for the cost of his visit, and the patient decided to leave and see his physician later that day. Another patient from a skilled nursing facility was diagnosed with pneumonia and medicated but sent back to the skilled nursing facility without a physician determination that he was stable; he returned later in worse condition and died.	90-day termination process	Pending

[a]For violations that represent an immediate and serious threat to patient health and safety, hospitals are given 23 days to submit an acceptable corrective action plan or be terminated from the Medicare program. For other violations, hospitals are given 90 days.

Appendix III: Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

JUN 18 2001

Ms. Janet Heinrich
Director, Health Care-Public Health Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Heinrich:

The Department has carefully reviewed your draft report entitled, "Emergency Care: EMTALA Implementation and Enforcement Issues" and generally agrees with the General Accounting Office's (GAO) findings.

The Department has already taken steps to improve and simplify enforcement actions. The Department's Centers for Medicare and Medicaid Services has implemented procedures and standards for the timely investigation and resolution of complaints and is in the process of revising their "Interpretative Guidelines and Survey Procedures" for investigating possible noncompliance concerning the responsibilities of hospitals in emergency cases.

The Department believes that the GAO report is fair in its summarization of the EMTALA enforcement process.

These comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department also provided extensive technical comments directly to your staff.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

Michael Mangano

Michael F. Mangano
Acting Inspector General

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Helene F. Toiv, (202) 512-7162

Staff Acknowledgments

Other major contributors to this report were Renalyn Cuadro, Janina Johnson, and Stefanie Weldon.

Ordering Information

The first copy of each GAO report is free. Additional copies of reports are $2 each. A check or money order should be made out to the Superintendent of Documents. VISA and MasterCard credit cards are also accepted.

Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:
U.S. General Accounting Office
P.O. Box 37050
Washington, DC 20013

Orders by visiting:
Room 1100
700 4th St., NW (corner of 4th and G Sts. NW)
Washington, DC 20013

Orders by phone:
(202) 512-6000
fax: (202) 512-6061
TDD (202) 512-2537

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

Orders by Internet
For information on how to access GAO reports on the Internet, send an e-mail message with "info" in the body to:

Info@www.gao.gov

or visit GAO's World Wide Web home page at:

http://www.gao.gov

To Report Fraud, Waste, and Abuse in Federal Programs

Contact one:

- Web site: http://www.gao.gov/fraudnet/fraudnet.htm
- E-mail: fraudnet@gao.gov
- 1-800-424-5454 (automated answering system)

PRINTED ON RECYCLED PAPER