

Extract of
FINAL REPORT
of
The Emergency Medical Treatment
and Labor Act
Technical Advisory Group

To the Secretary
U.S. Department of Health and Human Services

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April 2, 2008

The Honorable Mike Leavitt
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Secretary:

Enclosed is the final report of the Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group (TAG). The report compiles all of the recommendations made during our charter, which expired on September 30, 2007. Through the diligent efforts of all the TAG members, we reached consensus on many issues.

In its efforts to improve EMTALA, the TAG hopes that the Department of Health and Human Services not only will adopt the recommendations, but also give serious consideration to the five papers attached, which address challenges and potential solutions to some of the larger issues that affect the health care system in the areas of reimbursement, liability, workforce capacity, hospital capacity, and disparate care.

On behalf of the TAG, it has been an honor to have the opportunity to provide our input on issues we believe are vital to the provision of health care in the United States.

Sincerely,

David Siegel, M.D., J.D.
Chair, EMTALA TAG

Enclosed: Final Report of the EMTALA TAG

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Executive Summary

The Department of Health and Human Services (HHS) convened the Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group (TAG) to gather input on how revised regulations and enforcement are working in practice. Over the course of its 30-month charter, the TAG discussed concerns about EMTALA raised by TAG members and the public and deliberated on the best approach to revise the EMTALA statute, regulations, and Interpretive Guidelines to address those concerns. The TAG considered a wide range of problems facing hospitals and clinicians related to EMTALA. Most of the TAG's discussion and recommendations focus on the following questions:

- What constitutes appropriate and adequate emergency on-call service by a hospital in a given community and what should be required of individual physicians?
- When does a hospital's EMTALA obligation end?
- Do specialty hospitals or hospitals with specialized capabilities have different EMTALA obligations than other hospitals?
- What are the duties of transferring and receiving hospitals?
- Is EMTALA enforcement fair and consistent across the country?
- Should behavioral health issues be treated differently from other health conditions under EMTALA?
- Does EMTALA hinder communication among health care providers?

Many of these challenges are not unique to EMTALA; the health care system as a whole faces the same problems on a larger scale. The papers produced by the Framework Subcommittee address a number of systemic issues. It is hoped that HHS will give serious consideration to the recommendations made by the TAG and to the ideas put forth in the Framework Subcommittee papers.

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Introduction and Overview of the TAG

Charge to the TAG

Section 945 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) required the Secretary to establish the TAG to advise the Secretary concerning issues related to the regulations and implementation of EMTALA (governed primarily by section 1867 of the Social Security Act (Appendix 1) and regulations found at 42 CFR §489.20 (l), (m), (q) and (r), and §489.24). Since HHS adopted amended regulations and published revised Interpretive Guidelines in 2003 and 2004, new issues surrounding the application and enforcement of EMTALA have arisen, including questions about on-call obligations and specialty hospitals.

The TAG's functions, as identified in the charter (Appendix 2) were to: 1) review EMTALA regulations, 2) advise the agency and provide recommendations to the Secretary concerning these regulations and their application to hospitals and physicians, 3) solicit public comments regarding the implementation of the regulations, and 4) disseminate information on application of the regulations to hospitals, physicians, and the public. At the initial meeting of the TAG, Dr. Mark McClellan, who was then Administrator of the Centers for Medicare and Medicaid Services (CMS), emphasized that the agency was seeking input on how revised regulations and enforcement are working in practice.

Composition of the TAG

The MMA specified that the EMTALA TAG be composed of 19 members, including the Administrator of CMS, the Inspector General of HHS, and the following:

- Four representatives of hospitals, including at least one public hospital, who have experience with the application of EMTALA and, at least, two hospitals that have not been cited for EMTALA violations;
- Seven practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;
- Two representatives of patients;
- Two staff persons involved in EMTALA investigations from different CMS regional offices; and
- One representative from a State survey agency involved in EMTALA investigations and one representative from a Quality Improvement Organization (QIO), both of whom shall be from areas other than the regions represented by the CMS regional offices.

Public Meetings

The TAG met seven times (minutes from each meeting appear in Appendix 3):

- March 30–31, 2005

- June 15–17, 2005
- October 26–28, 2005
- May 1–2, 2006
- November 2–3, 2006
- May 3–4, 2007
- September 17–18, 2007

TAG members and members of the public identified issues for possible consideration. At the meetings, the TAG heard presentations from HHS staff as well as verbal and written testimony from the public (Appendix 4).

At its initial meeting, members of the TAG elected David Siegel, M.D., J.D., to serve as chair. The TAG established three subcommittees: the On-Call Subcommittee (John A. Kusske, M.D., Chair) to identify the issues to be addressed related to emergency call; the Action Subcommittee (Julie Nelson, J.D., Chair) to identify other EMTALA issues, particularly issues that may be addressed through targeted changes to the Interpretive Guidelines; and the Framework Subcommittee (Charlotte S. Yeh, M.D., Chair) to develop documents describing the TAG’s philosophical approach to its recommendations by addressing general health care issues with which EMTALA intersects.

Issues were assigned to either the On-Call or Action subcommittee for in-depth review and discussion and preliminary drafting of recommendations. Subcommittees met via teleconference or in conjunction with TAG meetings.

Overview of EMTALA Issues

The TAG considered a wide range of issues facing hospitals and clinicians related to EMTALA, the most pressing of which related to hospitals’ lack of capacity: whether it be insufficient financial resources to treat uninsured patients, inadequate numbers of physicians—particularly specialists—willing and available to take emergency call, inadequate numbers of other health care providers (e.g., nurses, social workers with psychiatric training) to screen and treat patients, or inadequate facilities to accommodate the number of patients who come to the emergency department (ED). Faced with such barriers, and with demand for ED services growing, hospitals and individual health care providers are seeking ways to lessen their burdens. Most of the TAG’s discussion and recommendations focus on the following questions and concerns that were raised by individual TAG members:

What constitutes appropriate and adequate emergency on-call service by a hospital in a given community and what should be required of individual physicians?

Many questions surround a hospital’s obligation to provide on-call emergency services. Is a hospital required to ensure 24-hour call coverage for every specialty it offers? In the case of a shortage of physicians in a given specialty, what is the obligation of a specialist in that field to take emergency call? Where does a physician draw the line between “selective call” and professional courtesy? Do shared or community call protocols violate EMTALA guidelines? A great deal of concern among physicians relates to the perception that taking emergency call increases one’s

risk of being sued for malpractice and therefore increases the cost of professional liability insurance.

When does a hospital's EMTALA obligation end?

The statutory definition of “stable” is different from the common clinical use of this term, and hospitals and physicians want more specificity and clarity about when a patient is considered “stable” under EMTALA than the current Interpretive Guidelines afford. Clearly, once a patient’s condition is stabilized, a hospital has no EMTALA obligation to provide definitive treatment (although Medicare Conditions of Participation still apply). But much debate centered around the question of whether EMTALA applies to an inpatient who develops an emergency medical condition (EMC) that exceeds the capabilities of the admitting hospital, or whose EMC is never stabilized and who requires transfer.

Do specialty hospitals or hospitals with specialized capabilities have different EMTALA obligations from other hospitals?

Concerns have been raised that specialty hospitals are taking healthier, better-insured patients and better-paying procedures away from full-service hospitals, yet do not share the EMTALA burden, either because they do not have EDs or because they refuse to accept transfers of EMTALA patients. The TAG was asked to address whether specialty hospitals should be required to have EDs and whether they should be subject to EMTALA requirements for receiving hospitals, irrespective of whether they have EDs.

Others are concerned that hospitals with specialized capabilities bear more than their fair share of the EMTALA burden when patients are unnecessarily transferred to tertiary centers for conditions that could be treated by the referring hospital. Academic medical centers feel they are treating a disproportionate share of indigent patients, and allege that community hospitals have focused on profitable services and reduced the amount of charity care they provide.

What are the duties of transferring and receiving hospitals?

Clarification is desired about what constitutes an appropriate transfer, who makes that determination, when transfers can be refused, and what is required of hospitals on either end of the transfer. Providers at every level are concerned about loopholes used to transfer uninsured patients, which indirectly penalize hospitals that maintain a 24-hour call list of specialist physicians.

Is EMTALA enforcement fair and consistent across the country?

EMTALA enforcement relies on the judgment of individuals in different regional offices, leaving it vulnerable to variation. Some believe the current system lacks an adequate appeals process. Some individuals believe the process does not distinguish minor technical violations from more substantial ones in terms of investigating or assessing penalties. Some hospitals feel the current process for challenging the results of a regional office’s EMTALA enforcement actions does not provide hospitals sufficient opportunity to understand and address the issues raised.

Should behavioral health issues be treated differently from other health conditions under EMTALA?

At present, situations arise in which EMTALA requirements conflict with State laws or local policies governing access to inpatient psychiatric care (often for uninsured and indigent patients). Many of these policies, or community protocols, relate to involuntary detainment of patients with psychiatric conditions. Transferring psychiatric patients under community protocols can be an EMTALA violation in some cases. Confusion surrounds the use of physical or chemical restraints used to ensure that a patient is stable for transport.

Does EMTALA hinder communication among health care providers?

EMTALA seeks to ensure that patients have equal access to emergency care, regardless of ability to pay, and so prohibits communication in which the goal is to discourage uninsured patients from seeking treatment. But some have interpreted EMTALA provisions as preventing legitimate and useful communication, for example, between the treating physician in the ED and the patient's personal physician, or between physicians at transferring and receiving hospitals. Hospitals are concerned that using telemedicine technology or shared call arrangements could violate EMTALA regulations.

Many of these challenges are not unique to EMTALA: The health care system as a whole faces the same problems on a larger scale. While the TAG sought to make recommendations that HHS could implement to improve the application of EMTALA, it also determined that the problems facing the health care system affect EMTALA and should be acknowledged by the TAG. The papers produced by the Framework Subcommittee address these systemic issues by providing background and data on five major issues—reimbursement, liability, workforce capacity, hospital capacity, and disparate care (Appendix 5). They offer potential solutions that represent a wide range of ideas without regard for which would be most effective or how they would be implemented.

The Recommendations Process and Other Considerations

TAG Approach

Subcommittee chairs presented to the TAG the consensus recommendations of their groups along with rationale (either verbal or written) to support the recommendation. The TAG members voted on whether to accept recommendations (as is or with revisions) and forward them to the Secretary of HHS. A simple majority was needed to pass a recommendation at the TAG level. In some cases, the TAG worded its recommendations precisely. However, for some recommendations, the TAG expressed the concept it wished to convey and asked that HHS supply the appropriate wording.

Implementing Recommendations

In some cases, accepting the TAG's recommendations would require revising the EMTALA statute, which involves action by Congress. The note "statutory change" in brackets follows these recommendations in the following cumulative list of recommendations. Some recommendations would require regulatory changes that can be handled by CMS through a public process that requires meeting APA requirements and provides for public input. In contrast, recommendations that only require revisions to the Interpretive Guidelines can be handled through an internal CMS process that requires less time than regulatory changes. Interpretive Guidelines are published by CMS in the State Operations Manual and, on an interim basis, through Survey and Certification memoranda. They are intended to provide guidance to CMS Regional Offices and to each State Survey Agency on the proper interpretation and application of CMS regulations.

Status and Prioritization of TAG Recommendations

Some recommendations have already been accepted and implemented by CMS, and they are noted below. Unless otherwise noted below, the recommendations are under consideration.

The TAG understands that addressing all of its recommendations will require significant effort on the part of HHS staff. It also recognizes that some issues are pressing, while others, particularly those involving administrative and educational changes, are less urgent. At its final meeting, the TAG reviewed its recommendations and prioritized them as high, medium, low, or already completed according to the need for action. Priority level was determined by the majority of TAG members.

Recommendations of the TAG (in Chronological Order)

June 15–17, 2005

1. The TAG recommends that CMS continue to not require physicians to take emergency call as a Condition of Participation in Medicare.
2. The TAG recommends that CMS delete the following sentence from the regulation in the definition of labor, “A woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable time of observation, the woman is in false labor.”

Status: Adopted with modification in the 2006 Inpatient Prospective Payment System final rule [71 FR 48143]. Regulations were revised to permit, in accordance with State law and hospital bylaws, a qualified non-physician clinician to certify that a woman is experiencing false labor (Appendix 6).

October 26–28, 2005

3. The TAG recommends that hospitals with specialized capabilities continue to not be required to maintain EDs.
4. The TAG recommends that hospitals with specialized capabilities (as defined in Section G of the EMTALA regulation) that do not have a dedicated ED be bound by the same responsibilities under EMTALA as hospitals with specialized capabilities that do have a dedicated ED.

Status: Adopted in the 2006 Inpatient Prospective Payment System final rule by adding regulatory language that makes explicit the current policy that all Medicare-participating providers with specialized capabilities are required to accept an appropriate transfer if they have the ability to treat the individual [71 FR 48143]. Survey and Certification letter issued to implement regulations (Appendix 6).

5. The TAG recommends that CMS move 489.24(j)(1), the provision dealing with maintaining a list of on-call physicians, to 489.20(r)(2), which relates to the Medicare provider agreement.

May 1–2, 2006

6. The TAG recommends the regulations regarding communication with the patient’s physician (489.24(d)(4)(iii)) be revised as follows:

At any time, a treating physician or qualified medical person (QMP) is not precluded from contacting the patient’s physician to seek advice regarding the patient’s medical history and needs that may be relevant to the medical treatment and screening of the patient.

7. The following statement represents the consensus of the TAG, which recommends that CMS incorporate the concepts into the Interpretive Guidelines for 489.24(d)(4)(iii) on communication with the patient's physician:

At any time, the treating physician or QMP may seek advice or clinical information from a clinician or other appropriate source regarding the patient's medical history or needs that may be relevant to the patient's medical screening examination (MSE) or stabilizing treatment. While the contacted clinician may provide information or render advice, the treating physician or QMP is ultimately responsible for the patient's care. There is no requirement that the treating physician or QMP engage in this contact. The treating physician or QMP determines whether this contact is necessary. While awaiting the clinician's response, the treating physician or QMP shall proceed with the patient's MSE or stabilizing treatment as indicated. In the event that a difference of opinion exists between the treating physician or QMP and the contacted clinician, the medical judgment of the treating physician or QMP shall prevail.

8. The following statements represent the consensus of the TAG, which recommends that CMS incorporate the concepts into Interpretive Guidelines for 489.24(f), recipient hospital responsibilities:
 - The presence of a specialty physician on the call roster is not, by itself, sufficient to be considered a specialized capability. At the time of the transfer, the receiving hospital should also have available the necessary equipment, space, staff, etc. to accommodate the patient transfer.
 - The presence of a physician who has privileges at the receiving hospital but is not on the call roster or who is not on call at the time of the transfer should *not* be considered a specialized capability.

*Status: This recommendation was not discussed at the September 2007 meeting.
Priority not assigned.*

9. The TAG recommends that 489.20(r)(2) be interpreted by CMS as meaning that all hospitals, including specialty hospitals, should maintain a call list in accordance with the statute and provider agreement. If necessary, the Interpretive Guidelines at Tag 404A should be revised to clarify this point.
10. The TAG recommends that CMS add to its website a list of frequently asked questions specific to EMTALA, categorized into sub-topics.
11. The TAG recommends that CMS replace the word "certifies" with the phrase "determines and documents" in the definition of labor and as needed in the Interpretive Guidelines.

12. The following statements represent the consensus of the TAG, which recommends that CMS incorporate these concepts into the Interpretive Guidelines for 489.24(j), availability of on-call physicians:

- Response times should be defined in a range of minutes, not a single number of minutes.
- Response time should refer to the initial response by the physician on call.
- Through their medical staff bylaws, hospitals may define who may respond on behalf of the on-call physician (i.e., physician's designated representative).
- The initial response may occur by phone (or other means).
- Hospitals should develop policies and procedures to address the response time and appropriate exemptions.
- A physician's failure to respond when called or failure to arrive at the hospital when requested may be a violation of EMTALA.

13. The TAG recommends that CMS delete the following paragraph in the Interpretive Guidelines for 489.24(j), availability of on-call physicians:

Physicians that refuse to be included on a hospital's on-call list but take calls selectively for patients with whom they or a colleague at the hospital have established a doctor-patient relationship while at the same time refusing to see other patients (including those individuals whose ability to pay is questionable) may violate EMTALA. If a hospital permits physicians to selectively take call while the hospital's coverage for that particular service is not adequate, the hospital would be in violation of its EMTALA obligation by encouraging disparate treatment.

14. The following statements represent the consensus of the TAG, which recommends that CMS incorporate these concepts into the Interpretive Guidelines for 489.24(j), availability of on-call physicians:

- When a physician takes call for patients with whom he/she has a preexisting medical relationship, that is *not* considered "selective call."
- When a physician is not on the call roster, he/she is not obligated to provide call coverage (e.g., when he/she is in the hospital seeing patients).
- If the EMTALA-related call list is adequate and meets the requirements of the statute, physicians may see patients in the hospital as they see fit.
- A physician on call must see patients without regard for any patient's ability to pay.
- If a physician volunteers to see patients in the ED while not participating in the call list, the physician must agree to see patients regardless of any patient's ability to pay.
- If a surveyor identifies a discriminatory or disparate pattern of selective referral for specialty care on the basis of patients' ability to pay, that is potentially a violation of EMTALA.

- Hospitals should be reminded of their obligation to fulfill call coverage duties, e.g., they should not permit discrimination to occur.
15. The TAG recommends that CMS clarify its position regarding shared or community call: that such community call arrangements are acceptable if the hospitals involved have formal agreements recognized in their policies and procedures, as well as backup plans. It should also be clarified that a community call arrangement does not remove a hospital's obligation to perform an MSE.
16. The following statement represents the consensus of the TAG, which recommends that CMS incorporate the concept into the Interpretive Guidelines for 489.24(f), recipient hospital responsibilities:
- Physician to physician communication, i.e., between the sending physician (or designated representative) at the transferring hospital and the receiving physician (or designated representative) at the receiving hospital, should be permitted and encouraged.

November 2–3, 2006

17. To clarify the intent of CMS regulations regarding obligations under EMTALA to receive patients who arrive by ambulance, the TAG recommends that CMS/HHS promulgate the letter written by TAG member and representative of CMS Region VI Dottie Guioa with the following changes:
- In the first paragraph, revise the sentence as follows: “The specific concern was that hospital ED staff deliberately delay the transfer of individuals from the EMS [emergency medical service] provider’s stretcher to an ED bed with the impression that the ED staff is relieved of their EMTALA obligation by doing so. This practice constitutes a potential violation of EMTALA.”
 - Delete the sentence, “When individuals arriving via EMS providers are required to wait several hours with only EMS provider staff attending to them, then this practice may be viewed as a violation of the EMTALA requirements.”
 - Revise the last paragraph as follows: “It was not the intent of the guidance in the Letters that there should be enforcement action against any hospital when the delay in the immediate provision of an appropriate [MSE] and/or stabilizing treatment is due to circumstances beyond the hospital’s control (e.g., the hospital does not have the capacity or capability at the time of presentation).”

Status: Adopted and implemented by CMS in Survey and Certification Letter 07-20, released 4/27/2007(Appendix 7).

18. The TAG recommends that HHS pursue statutory and regulatory changes, as well as changes to the Interpretive Guidelines, addressing waiving EMTALA obligations in an emergency as declared by a Federal, State, county, or city government or by an individual hospital (consistent with the Action Subcommittee’s document, “Application of EMTALA in a State of Emergency”). [statutory change]

Note: In the 2007 Inpatient Prospective Payment final rule [72 FR 47384] CMS revised the regulations at 42 CFR §489.24(a)(2) to reflect statutory changes as follows: “Sanctions under this section for an inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act. A waiver of these sanctions is limited to a 72 hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1)(B) of the Act.”

19. The TAG recommends that HHS amend the Interpretive Guidelines with respect to follow-up care to clarify that once a patient has been stabilized, the hospital and physician have no further follow-up care obligation under EMTALA. The hospital must, however, comply with applicable Medicare Conditions of Participation. The TAG believes this interpretation is more consistent with the EMTALA statute and regulations, which no longer apply once the patient is stabilized, and current CMS interpretation.

20. The TAG recommends that HHS incorporate into the Interpretive Guidelines the educational issues identified by the Action Subcommittee’s document, “Follow-Up Care,” with the following changes:

- For bullet two, replace “For insured patients” with “For patients with a personal physician.”
- For bullet 5, delete the parentheses but retain the text in the parentheses.

Status: This recommendation was not discussed at the September 2007 meeting. Priority not assigned (Appendix 8).

21. The TAG recommends that HHS clarify that a hospital may not refuse to accept an individual protected under EMTALA on the grounds that it (the receiving hospital) does not approve the method of transfer arranged by the attending physician at the sending hospital (e.g., a receiving hospital may not require the sending hospital to use an ambulance transport designated by the receiving hospital). In addition, HHS should improve its communication of such clarifications with its regional offices.

Status: Adopted and implemented by CMS in S & C Letter 07-20, released 4/27/2007 (Appendix 7).

22. The TAG recommends that HHS strike the language in the Interpretive Guidelines on telehealth/telemedicine (489.24(j)(1)) and replace it with language that clarifies that the treating physician ultimately determines whether the on-call physician should

come to the ED and that the treating physician may use a variety of methods to communicate with the on-call physician. A potential violation occurs only if the treating physician requests that the on-call physician come to the ED and the on-call physician refuses.

Status: Adopted and implemented by CMS in S & C Letter 07-23, released 6/22/2007 (Appendix 9).

23. The TAG recommends that HHS insert the following sentence into the Interpretive Guidelines (489.24(a)) in the paragraph defining qualified medical personnel to perform a MSE (before the last sentence of the paragraph beginning “The MSE must be conducted by an individual(s) who is determined qualified...”): “For the purpose of screening psychiatric patients, hospitals may utilize contracted agencies or services to assist with the psychiatric MSE if they are properly credentialed in accordance with the above.”

Status: Replaced by recommendation no. 40, September 2007.

May 3–4, 2007

24. The TAG recommends that HHS reach out to providers to remind them that they can contact their regional offices for clarification of the Interpretive Guidelines or any other regulations regarding EMTALA, such as acceptable uses of telehealth for communication under the current Interpretive Guidelines.
25. The TAG reiterates its previous recommendation that HHS move 42 CFR 489.24(j)(1), the provision dealing with maintaining a list of on-call physicians, to 42 CFR 489.20(r)(2), which relates to the Medicare provider agreement.
26. The TAG recommends HHS change 42 CFR 489.20(r)(2) to read: “Each hospital must maintain an on-call list of physicians on its medical staff who are available to examine and stabilize the hospital’s patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians.”

Note: Recommendation assumes previous recommendation nos. 5 and 25 are adopted.

27. The TAG recommends HHS change the Interpretive Guidelines to state the following:
- If a hospital offers a service to the public, this service should be available for emergency care through on-call coverage. [statutory change]
 - To satisfy the requirement for on-call coverage, at least annually, hospital and medical staff must develop a plan for on-call coverage that includes, at a minimum, evaluation of the following factors:
 - hospital capabilities/services provided (advertised/licensed)

- community need for ED services as determined by ED visits
- transfers out of hospital for emergency services
- physician resources
- past call plan performance
- The hospital must have a backup plan for patient care when it lacks capacity to provide services or on-call physician coverage is not available. The backup plan should consist of viable patient care options, such as the following:
 - telemedicine
 - other staff physicians
 - transfer agreements designed to ensure that the patient will receive care in a timely manner
 - regional or community coverage arrangements
- A hospital may satisfy its on-call coverage obligation by participation in an approved community/regional call coverage program (*CMS to determine appropriate approval process*).

28. The TAG recommends that HHS take the following steps to improve understanding about EMTALA:

More Comprehensive, Prominent, User-Friendly CMS EMTALA Website, including the following:

- Statutes
- Regulations
- Interpretive guidance
- Current CMS/Office of the Inspector General (OIG) program memoranda/guidance letters
- EMTALA questions and answers
- Link to Medicare Conditions of Participation
- Enforcement statistics
- “Top 10” cited EMTALA deficiencies
- Special advisories of potential EMTALA violations
- Link to OIG website
- Topical cross-references
- EMTALA 101 “basics”
- Document downloads

Standardized Regional Office/State Surveyor Education

- Institute annual EMTALA surveyor education sessions (currently offered every 2 years).
- *Establish a system to improve consistency in regional office EMTALA interpretations and enforcement (e.g., assign CMS central office person to*

monitor deficiency statements for consistency with CMS policy and consistency among jurisdictions and remedy concerns).

- *Establish a system to monitor effectiveness of surveyor education.*
- *Establish a system to demonstrate surveyor competencies.*
- Confirm prompt distribution of CMS EMTALA guidance, including EMTALA opinion letters and program memoranda, to regional offices and State agencies.

Note: Items in italics removed and replaced by recommendation #33, September 2007.

Provider Education

- Designate/approve specific CMS/OIG personnel to participate in provider education through various educational forums (e.g., American Health Lawyers Association, hospital/physician association meetings). Consider joint presentations by both agencies and establish a process to confirm consistency of information provided.
- Ensure a timely response to provider queries regarding EMTALA compliance and interpretation questions.
- Establish a timely process to address new obstacles to EMTALA compliance and remedy through regulatory or interpretive guidance change.
- Establish listservs or other mechanism so that interested parties can receive regular updates and information regarding EMTALA from CMS/OIG.
- Consider EMTALA training by QIOs.

Patient Education

- Provide information about EMTALA rights and consequences (e.g., EMTALA requires hospitals to provide care irrespective of the patient's ability to pay; however, the hospital may still expect the patient to pay for services rendered). This information should be provided outside of the context of an ED visit.

Status: CMS is working with a contractor to develop a web-based basic EMTALA training module, including an assessment component, that would be available in fiscal year 2009 to regional offices and State agencies on demand. In-person training would become an advanced/update course. All other elements remain under consideration.

29. The TAG recommends that HHS establish an appeals process for hospitals/providers before making a termination decision.
 - Hospitals should be allowed to request QIO review for medical issues prior to termination.

- Hospitals should be allowed to request an appeal from the CMS regional office on factual, policy, and legal issues before submission of a plan of correction or a decision to terminate. For example:
 - If the regional office believes a violation has occurred, a hospital is first given a draft statement of deficiencies, after which it has 10 days to provide CMS with any objections or additional information. CMS would have 10 days to consider the additional information and issue a final statement of deficiencies that responds to it. An expedited appeals process should be in place for hospitals to be placed on a 23-day termination track.
 - Region VI process (to be submitted by TAG member Dodjie Guioa).
30. The TAG recommends that HHS establish intermediate sanctions, such as an opportunity to correct with follow-up inspection or a system of warnings, for less serious EMTALA violations. Hospitals with technical violations (e.g., signage, log books) should receive lower sanctions. [statutory change]
31. The TAG recommends that HHS establish a method for consistent data collection of all EMTALA violations and central evaluation of the information, in a format determined by CMS to improve consistency of enforcement across the regions and that can serve as a resource for providers.
32. The TAG recommends the Secretary extend the charter of the TAG for 1 year to allow the TAG to continue its work. [statutory change]

Status: Replaced by recommendation no. 49, September 2007

September 17–18, 2007

33. The TAG recommends that CMS take the following steps to improve understanding about EMTALA among regional offices and State surveyors:
- Establish a system to improve consistency in regional office EMTALA interpretations and enforcement (e.g., assign CMS central office person to monitor deficiency statements for consistency with CMS policy and consistency among jurisdictions and remedy concerns).
 - Establish a system to monitor effectiveness of surveyor education.
 - Establish a system to demonstrate surveyor competencies.

Note: Replaces portions of recommendation no. 28, November 2006

34. The TAG recommends that HHS revise the Interpretive Guidelines, regulations, and statute as needed to clarify that EMTALA does not apply when a patient develops an EMC after being admitted to a hospital.
35. The TAG recommends that HHS revise the Interpretive Guidelines, regulations, and statute as needed to clarify the following: When a patient who is covered by EMTALA is admitted as an inpatient to the hospital and that patient's original EMC

remains unstabilized, the obligation of a receiving hospital that has specialized capabilities required to stabilize that patient's EMC under Subsection G of Title 42, U.S.C., 1395dd, is not altered.

36. The TAG recommends that HHS remove the current separate guidance on psychiatric EMCs so that the remaining rules apply equally to EMCs of either psychiatric or medical origin.
37. The TAG recommends that HHS generate specific examples or vignettes to shed more light on aspects of psychiatric EMCs that are causing confusion.
38. The TAG recommends that HHS describe that an MSE should attempt to determine whether an individual is gravely disabled, suicidal, or homicidal. "Gravely disabled" implies a danger to oneself due to extremely poor judgment or inability to care for oneself. If a patient is felt to be gravely disabled, suicidal, or homicidal, this does not necessarily mean that the patient has an EMC. The TAG supports the use of community protocols, community services, and other supportive resources (e.g., police custody, nursing home settings) to determine whether an EMC exists or to ensure appropriate disposition of the patient to a safe setting.
39. The TAG recommends that HHS explore educational tools, training options, and further education of ED physicians and other clinical staff in general acute care hospitals without psychiatric services about the proper psychiatric medical screening, discharge, and transfer of patients with behavioral health conditions.
40. The TAG recommends that HHS add to the Interpretive Guidelines the following statement: Hospitals shall be allowed to utilize contracted agencies or services to assist with psychiatric MSEs. Hospitals shall ensure that clinicians working for such agencies/services are properly credentialed in accordance with hospital and medical staff bylaws or policies and procedures.

Note: Replaces recommendation no. 23, November 2006.

41. The TAG recommends that receiving hospitals with specialized behavioral health capabilities, including freestanding facilities, should be required to accept the transfer of patients who are gravely disabled or a danger to self or others and who have an EMC if the receiving hospital has the resources and capacity to provide care to these patients and the transferring hospital does not have the capability to provide stabilizing care.
42. The TAG recommends that the following be incorporated into the Interpretive Guidelines: The administration of chemical or physical restraints does not in itself stabilize a psychiatric EMC. It may, however, provide a temporary safe environment by minimizing risk during patient transport. Unless the hospital or physician can demonstrate that a patient is stabilized irrespective of the chemical and physical restraints, EMTALA still applies to the patient's care, any subsequent transfer, and

the duty of a hospital with specialized capabilities to accept that patient. For example, a patient presents to the ED actively suicidal with a plan and is determined to have an EMC. The patient is either administered a sedating medication or placed in physical restraints to prevent him/her from harming himself/herself. In this situation, the patient is still considered to have an unstabilized EMC because the patient's underlying suicidal intent persists.

43. The TAG recommends that HHS review its position on community protocols in consultation with State agencies and other stakeholders in the area of mental health.
44. The TAG approves the document "Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers" with revisions as discussed and recommends that HHS incorporate it as needed (*Appendix 10*).
45. The TAG recommends that HHS clarify that an EMC does not need to be resolved to be considered stabilized for the purpose of discharge home provided that, within reasonable clinical confidence, it is determined that the individual has reached the point where his/her continued care, including diagnostic workup and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, and provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions. The TAG further recommends that HHS add appropriate examples (such as early labor and abdominal pain).
46. The TAG recommends that HHS clarify that EMTALA only applies until a patient is stabilized, and a hospital has no EMTALA obligation to provide definitive treatment to the patient, although other rules (e.g., Medicare Conditions of Participation) may apply.
47. The TAG recommends that HHS provide the flexibility to permit hospitals to make and document determinations of qualified medical personnel in accordance with the hospital's and medical staff's usual credentialing procedures. If a hospital typically documents credentialing decisions in documents other than hospital bylaws or rules and regulations, then such documentation should be permitted.
48. The TAG recommends that HHS monitor and evaluate the consequences of "triaged out" and deferred care.
49. The TAG recommends that the Secretary of HHS recognize the ongoing need for continued review of EMTALA legislation and that the mission of the EMTALA TAG be continued. [statutory change]

Status: Replaces recommendation no. 32, May 2007.

50. The TAG recommends that HHS revise the Interpretive Guidelines to reflect the following: There are circumstances under which a patient in the ED may be discharged or transferred to a non-hospital-owned physician's office for continuation

of the MSE, determination of whether an EMC exists, or stabilization of an EMC.
[statutory change]

51. The TAG recommends that HHS better define the terms “capacity” and “capability” and review regulations and Interpretive Guidelines to ensure that the terms are used appropriately and consistently and that intent is clear throughout.
52. The TAG recognizes that professional liability is a concern for providers and that having protections would increase coverage in the ED. The TAG recommends that HHS act to support amending the EMTALA statute to include liability protection for hospitals, physicians, and other licensed independent practitioners who provide services to patients covered by EMTALA. [statutory change]
53. The TAG recognizes that reimbursement is a major factor that impacts hospitals’ and physicians’ ability to provide emergency care and recommends that HHS act to support amending the EMTALA statute to include a funding mechanism for hospitals and physicians. [statutory change]
54. The TAG recommends that HHS seek revisions that would limit the private right of action for personal harm to only those circumstances in which there is no alternative route to claim damages through professional liability laws. [statutory change]
55. The TAG recommends that HHS develop guidance on how and when a practitioner may discuss financial matters with a patient presenting with an EMC.

Recommendations of the TAG by Priority Level

Recommendation (no.)	High Priority	Medium Priority	Low Priority	Complete	Other
1	√				
2				√	
3			√		
4				√	
5	√				
6	√				
7		√			
8					Priority not assigned
9	√				
10		√			
11			√		
12		√			
13	√				
14	√				
15	√				
16		√			
17				√	
18	√				
19		√			
20					Priority not assigned
21				√	
22				√	
23					Replaced by no. 40
24			√		
25	√				
26	√				
27	√				
28		√			
29	√				
30	√				
31	√				
32					Replaced by no. 49
33	√				
34	√				

Recommendation (no.)	High Priority	Medium Priority	Low Priority	Complete	Other
35			√		
36		√			
37			√		
38	√				
39		√			
40		√			
41	√				
42	√				
43	√				
44	√				
45	√				
46		√			
47			√		
48	√				
49	√				
50	√				
51		√			
52	√				
53	√				
54		√			
55			√		

Conclusion

The TAG appreciates the efforts of HHS and its staff to better understand concerns about EMTALA by convening an advisory group with representation from various stakeholders. During its charter, the TAG reached consensus on a significant number of issues within the limits of its statutory mandate. Its recommendations, if adopted, would improve EMTALA and benefit both patients and health care providers. However, daunting challenges remain both for implementing EMTALA and for addressing the systemic concerns that affect access to health care in the United States. It is hoped that HHS not only will adopt the recommendations put forth by the TAG but also give serious consideration to the issues identified and proposals described in the five Framework papers.

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