Patient Dumping of Mentally Ill Individuals Needing Emergency Care

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TABLE OF CONTENTS

CHAPTER 1 | INTRODUCTION

Throughout the 20th century, hospitals had no affirmative duty to treat patients who entered emergency departments. Without any given reason, they could choose which patients to treat and which to refuse. The practice of "patient dumping" comes from this lack of duty.[2] Patient dumping refers to the act of hospitals denying individuals emergency medical screening and stabilization services, or transferring them to other hospitals, once a hospital discovers that the patients are uninsured or have no means to pay for treatment.[3] Patient dumping also encompasses a hospital's denial of treatment for discriminatory reasons.[4] As a matter of public policy, Congress believed that patients, namely women in active labor or individuals requiring urgent care for injuries, deserved the right to receive emergency care regardless of the ability to pay. This concern led to the passing of the Emergency Medical Treatment and Labor Act (EMTALA).[5]

Although one motivation behind EMTALA was to protect indigent and uninsured individuals from being denied potentially life-saving medical treatment, the scope of the law protects *all* individuals seeking evaluation or treatment at hospital emergency departments participating in the Medicare program.[6] The Commission's report specifically focuses on patients disabled with a psychiatric medical condition. The Commission has authority to study the enforcement of EMTALA because patient dumping may involve discrimination based on disability.[7] This report

[2] *See Hines v. Adair County Pub. Hosp. Dist. Corp.,* 827 F. Supp. 426, 432 (W.D. Ky. 1993) ("Prior to the enactment of EMTALA, most hospitals may have been under no duty to treat individuals . . . seeking emergency treatment."); *see also Guerrero v. Copper Queen Hosp.*, 537 P.2d 1329, 1330 (Ariz. 1975) ("As a general rule, a private hospital is under no obligation to accept any individual who applies as a patient."); *see also Le Jeune Road Hosp., Inc. v. Watson*, 171 So. 2d 202, 203 (Fla. Dist. Ct. App. 1965) ("Harsh as this rule may sound, it is permissible for a private hospital to reject for whatever reason, or no reason at all, any applicant for medical and hospital services."); *see also* Mary Jean Fell, *The Emergency Medical Treatment and Active Labor Act of 1986: Providing Protection from Discrimination in Access to Emergency Medical Care*, 43 Cath. U. L. Rev. 607, 612 (1994) ("At common law, private hospitals were under no obligation to treat any particular individual and, consequently, were not required to articulate any reason for refusing to provide treatment.").

[3] *See* 42 U.S.C. § 1395dd.

[4] *See Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 272 (6th Cir. 1990) (Discriminatory non-treatment of patients can result from "prejudice against the race, sex, or ethnic group; distaste for the patient's condition (for example, AIDS patients); personal dislike or antagonism between medical personnel and the patient; disapproval of patient's occupation; or political or cultural opposition"); *see also Hines*, 827 F. Supp. 426 at 434 (referring to characteristics such as age, race, sex, national origin, financial or insurance status, medical condition, social status, or politics as possible factors for discriminatory non-treatment).

[5] Pub. L. No. 99-272, 100 Stat. 82.

[6] 42 U.S.C. § 1395dd(a).

[7] *See* 42 U.S.C. § 1975a(a)(2) (2013) (The Commission has a duty to "study and collect information" regarding "discrimination or denials of equal protection of the laws under the Constitution of the United States because of . . . disability . . . .").

also examines the enforcement of EMTALA and the policies designed to ensure that hospitals, localities, or states are not "dumping" indigent, mentally ill patients in need of emergency care on other hospitals, localities, or states in violation of the law.[8] Finally, this report considers policy suggestions to better protect the rights of the mentally ill.

This chapter provides the historical background behind the problem of patient dumping and EMTALA legislation. Chapter Two addresses the roles of the Centers for Medicare & Medicaid Services, the Office of the Inspector General, and the Office for Civil Rights within the U.S. Department of Health and Human Services (HHS) in processing civil rights complaints and the remedies available to patients for EMTALA violations. Chapter Three considers whether existing regulations and enforcement mechanisms sufficiently address patient dumping, and questions the need for additional policies and procedures. Chapter Four offers the Commission's findings and recommendations.

Patient Dumping: A Historical Perspective

The impetus behind EMTALA legislation was concern about treatment of indigent and uninsured people during the 1980s, and courts have long noted problems with access to adequate care for those groups.[9] During the drafts of World War I and World War II, Selective Service physical examinations revealed an astonishing problem in the nation's health care system. Large numbers of American men were medically unfit for military service.[10]

Before the enactment of EMTALA, most hospitals enjoyed the common-law "no duty" rule, which allowed them to refuse treatment to anyone.[11] Hospitals believed indigent patients should receive care through charitable organizations or through uncompensated care provided by hospitals.[12] The common-law no duty rule was partly to blame for the poor state of the American health care system, and by extension, the poor health of the aforementioned men in the draft.

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[8] 42 U.S.C. § 1395dd.

[9] *See Cleland v. Bronson Health Care Group*, 917 F.2d 266, 268 (6th Cir. Mich. 1990) (noting that, "It is undisputed that the impetus to this legislation came from highly publicized incidents where hospital emergency rooms allegedly, based only on patient's financial inadequacy, failed to provide medical screening that would have been provided a paying patient, or transferred or discharged a patient without taking steps that would have been taken for a paying patient.").

[10] President's Message to Congress on Health Legislation, 1945 U.S.C.C.A.N. 1143 (Nov. 19, 1945).

[11] The common-law "no duty" rule was the majority approach for many years, but some courts held hospitals liable for patient dumping if hospitals were negligent, if they turned patients away after establishing a custom of providing emergency care, or if denying care violated public policy. Karen I. Treiger, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. Rev. 1186, 1196-97 (1986) [hereinafter *Preventing Patient Dumping*].

[12] Ibid., pp. 1191-92.

After World War II, President Truman expressed concern with America's health care system, and worked with Congress to pass the Hill-Burton Act (Hill-Burton) of 1946.[13] Hill-Burton Act provided federal funds to states for construction and modernization of hospitals. Further, the federal funding stipulated that for 20 years, hospitals must make their services available to all people in the territorial area of the facility and provide a "reasonable volume of free or below-cost care to any person unable to pay."[14]

However, Hill-Burton did not succeed in ending patient dumping because it was not properly enforced.[15] For example, Hill-Burton failed to define "emergency." Its regulations did not require states to develop their own regulations, to set-up monitoring and oversight, or to enforce the law. Finally, from a federal stance, HHS repeatedly failed to enforce Hill-Burton.[16] Specifically, HHS did not create regulations to accompany Hill-Burton until 1979, after litigation forced the Department's hand.[17] Another criticism of Hill-Burton was that it represented a limited, piecemeal effort at reforming the health care system.[18] In proposing Hill-Burton, President Truman envisioned the beginning of a larger overhaul of the nation's health care system.[19] Funding of new hospitals and modernization of existing hospitals was only the beginning of the reforms he sought.[20]

Congress quickly passed Hill-Burton but failed to act on Truman's other proposals; most significant among them was a national health insurance plan. Recognizing that the real problem facing the health care industry was the inability of people to pay for services, President Truman

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[13] Popularly called the Hill-Burton Act, the Hospital Survey and Construction Act of 1946 represented an attempt by Congress to reform the healthcare system. 42 U.S.C. § 291-291o-1 (1982 & Supp. II 1984); *see* President's Message to Congress on Health Legislation, 1945 U.S.C.C.A.N. 1143.

[14] *Preventing Patient Dumping,* pp. 1196-98.

[15] Hill-Burton failed to define "emergency," its regulations did not require states to develop regulations or monitor or enforce the Act, and HHS repeatedly failed to enforce the Act. Ibid., p. 1199.

[16] Ibid., pp. 1197-98.

[17] HHS promulgated final regulations in May of 1979 in compliance with a consent decree signed in Lugo v. Simon, 453 F. Supp. 677 (N.D. Ohio 1978). James F. Blumstein, *Symposium: Court Action, Agency Reaction: The Hill-Burton Act as a Case Study*, 69 Iowa L. Rev. 1227, 1245 (July 1984) [hereinafter *Court Action, Agency Reaction*].

[18] *See generally* Deborah K. Berk, *Note and Comment: Presbyterian Hospital of Dallas v. Harris: A Dubious Consequence of Piecemeal Health Care Legislation*, 9 Am. J. L. and Med. 205 (1983) [hereinafter *Dubious Consequence*].

[19] President Truman saw Hill-Burton and healthcare reform as part of a larger effort to create an "economic bill of rights," previously proposed by President Franklin Roosevelt. A right to medical care was a component of this second bill of rights. Franklin Roosevelt, State of the Union Address to the Congress (Jan. 11, 1944) *as reprinted in* 1944 U.S.C.C.A.N. 1357, 1362 ("The right to adequate medical care and the opportunity to achieve and enjoy good health").

[20] *Dubious Consequence,* p. 207 (citing President's Message to Congress on Health Legislation, 1945 U.S.C.C.A.N. 1143-1145).

noted Hill-Burton's limitations and repeatedly pressed Congress to enact further reforms.[21] He was unsuccessful. Understood in the context of President Truman's broader goals, Hill-Burton was only a preliminary effort to improve health care delivery, and was not intended as a national program to provide health care to the indigent.[22]

The government did not enforce the Hill-Burton requirements until decades later when people began suing for required administrative oversight and regulations.[23] Almost two decades after Congress enacted Hill-Burton, it enacted the Medicare and Medicaid programs. These programs were an attempt to alleviate the financial burden of medical expenses on vulnerable American populations—namely the elderly and the poor. However, the combination of Hill-Burton, Medicare, and Medicaid still did not resolve the underlying problems of lack of access to health care because of inability to pay. Millions of uninsured Americans fell within the gaps of coverage that these federal programs left open, and they did not have adequate ability to pay for hospital services.

It was not until the early 1980s that the problem of patient dumping began to receive national attention. It was reported that hospitals refused medical care to an estimated 250,000 patients annually because they were uninsured or lacked the ability to pay.[24] Although 22 states had passed anti-dumping statutes, private hospitals still denied patients emergency care in a majority of states.[25] In fact, several studies of hospitals in major cities revealed a spike in the number of patients being denied emergency medical attention in the mid-1980s.[26] Courts across the United States recognized the lack of adequate state remedies for harms resulting from patient

[21] "Federal aid in the construction of hospitals will be futile unless there is current purchasing power so that people can use these hospitals." President's Message to Congress on Health Legislation, 1945 U.S.C.C.A.N. 1151 (Nov. 19, 1945).

[22] *Court Action, Agency Reaction*, at 1228-29.

[23] Ibid., p. 1231.

[24] Thomas L. Stricker Jr., *Emergency Medical Treatment & Active Labor Act: Denial of Emergency Medical Care Because of Improper Economic Motives*, 67 Notre Dame L. Rev. 1121, 1129 (1992) (citing "Public Citizen Calls HHS' Enforcement of Patient Dumping Act 'Tragic Failure,'" Daily Report for Executives, April 24, 1991, at A-14) [hereinafter *Denial of Emergency Medical Care*]; *see generally* Beverly Cohen *Disentangling EMTALA from Medical Malpractice: Revising EMTALA's Screening Standard to Differentiate Between Ordinary Negligence and Discriminatory Denials of Care*, 82 Tul. L. Rev. 645, 650-55 (2007).

[25] *Denial of Emergency Medical Care,* p. 1129 (citing 131 Cong. Rec. S13,904 (1985) (statement of Sen. Kennedy)).

[26] The report showed the numbers of patients dumped increasing from 70 per month in 1982 to more than 200 in 1983 in Dallas; from 169 per year in 1981 to 930 in 1985 in Washington, D.C.; and from 1,295 per year in 1980 to 5,652 in 1984 in Chicago. *See Equal Access to Health Care: Patient Dumping,* H.R. Rep. No. 100-531, at 3-4 (1988) (reporting documented increases in patient dumping); *see also* Robert L. Schiff et al., *Transfers to a Public Hospital: A Prospective Study of 467 Patients*, 314 New Eng. J. Med. 552, 555-56 (1986) (Harvard Medical School Study); Dennis Andrulis & Larry Gage, National Ass'n of Public Hospitals, "Patient Transfers to Public Hospitals: A National Assessment" (Apr. 1986) (National Association of Public Hospitals Study).

dumping.[27] The dramatic increase observed in patients being refused emergency medical attention, coupled with the lack of state protection in a majority of the country, contributed to the passage of federal legislation. Congress sought to address it through EMTALA.

The Passage of EMTALA

Congress passed EMTALA as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). President Reagan signed EMTALA into law on April 7, 1986. Since then, Congress has amended the statute multiple times.[28]

Courts have interpreted the legislation's text as applying to any individual regardless of insurance status.[29] Congress's overriding purpose in enacting EMTALA was to address "the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance."[30] EMTALA was enacted to ensure that patients received an "adequate first response to a medical crisis . . . regardless of wealth or status."[31] Specifically, Congress was concerned that "medically unstable patients [were] not being treated appropriately" and "patients in an unstable condition have been

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[27] *See, e.g.*, *Bryan v. Rectors & Visitors of Univ. of Va.*, 95 F.3d 349, 351 (4th Cir. 1996) (noting that EMTALA's purpose is to provide treatment for patients who would otherwise "be left without a remedy because traditional medical malpractice law affords no claim for failure to treat"); *see also Malavé Sastre v. Hosp. Doctor's Ctr., Inc*., 93 F. Supp. 2d 105, 109 (D.P.R. 2000) (stating that EMTALA "filled a void which state tort law did not address"); *see also Root v. Liberty Emergency Physicians, Inc.*, 68 F.Supp. 2d 1086, 1091 (W.D. Mo. 1999), aff'd, 209 F.3d 1068 (8th Cir. 2000) ("EMTALA has been described as a 'gap-filler' for state malpractice law, giving patients who would otherwise have no claim in state court a forum to redress their injuries.").

[28] Because EMTALA originated as part of the Consolidated Omnibus Budget Reconciliation Act, it is alternatively referred to in literature either as "COBRA" or "OBRA." Thomas A. Gionis et al., *The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcomings of the Federal Emergency Medical Treatment and Active Labor Act (EMTALA)*, 52:1 Am. U. L. Rev. 171, 177-78 n. 14 (2002), *available at* http://digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?article=1731&context=aulr. EMTALA has been amended many times in OBRAs, starting with the OBRA of 1987, Pub. L. No. 100-203, 101 Stat. 1330-57; OBRA of 1989, Pub. L. No. 101-239, 103 Stat. 2249; OBRA of 1990, Pub. L. No. 101-508, 4008(b), 4207(a), 104 Stat. 1388, 1388-44, 1388-117 to 1388 -124, renumbered and amended Pub. L. No. 103-432, title I, § 160(d)(4), (5)(A); OBRA of 1994, Pub. L. No. 103-432; OBRA of 1997, Pub. L. No. 105-33, 108 Stat. 4444; OBRA of 2003, Pub. L. No. 108-173, 117 Stat. 2423; and OBRA of 2011, Pub. L. No. 112-40, 125 Stat. 423 [hereinafter *Intentional Tort of Patient Dumping*].

[29] *Id*. ("this statute applies to any and all patients"); *Arrington v. Wong*, 237 F.3d 1066, 1069 (9th Cir. 2001) ("The provisions of EMTALA are not limited to the indigent and uninsured").

[30] *Reynolds v. Mainegeneral Health*, 218 F.3d 78, 83 (1st Cir. 2000) (quoting H.R. Rep. No. 241(1), 99th Cong., 1st Sess. 27 (1986), reprinted in 1986 U.S.C.C.A.N. 42, 605).

[31] *Id.* (citing Baber v. Hospital Corp. of America, 977 F.2d 872, 880 (4th Cir. 1992) (quoting 131 Cong. Rec. S13904 (Oct. 23, 1985) (statement of Sen. Durenberger)).

transferred improperly, sometimes without the consent of the receiving hospital."[32] In drafting EMTALA, Congress created two statutory rights of action:

1. The first right of action is that of a patient against a Medicare-participating hospital.[33]

2. The second is a right of action of a medical facility that received an improperly transferred emergency patient or woman in labor against the transferring hospital.[34]

Congress did not intend for EMTALA to be a "substitute for state law on medical malpractice."[35] Congress further deferred to state law in adopting EMTALA's damages provision, stating that the damages in any suit are subject to the personal injury law of the state in which the hospital is located.[36]

Medicare-participating hospitals that violate any EMTALA requirements are subject to a maximum fine of $50,000 for each violation.[37] They are also subject to having their participation in Medicare and Medicaid terminated if they fail to correct EMTALA violations for which CMS has cited them. The statute imposes penalties for EMTALA violations by any physician responsible for the examination, treatment, or transfer of an individual in a participating hospital.[38] Hospitals and physicians are also subject to civil suits from patients who suffer personal injuries resulting from an EMTALA violation.[39] Finally, facilities may also bring suit against sending hospitals for costs incurred while treating patients who were improperly transferred to them.[40]

Currently in the United States, there are 6,181 hospitals participating in Medicare and/or Medicaid. Of this total number, 549 represent psychiatric hospitals and 1,605 represent short-

[32] H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 1 at 27, *as reprinted in* 1986 U.S.C.C.A.N. 579, 605.

[33] *Baber v. Hospital Corp. of America*, 977 F.2d 872, 877-878 (4th Cir. 1992) (rejecting an interpretation of EMTALA that would allow a right of action against individual doctors and interpreting EMTALA and congressional intent to create two specific rights of action).

[34] *Id*.

[35] *Hardy v. N.Y. City Health & Hosps. Corp*., 164 F.3d 789, 792 (2d Cir. 1999) (citing Power v. Arlington Hosp. Ass'n, 42 F.3d 851, 856 (4th Cir. 1994)). *See* 42 U.S.C. § 1395dd(f) ("The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with the requirement of this section.").

[36] *Hardy*, 164 F.3d at 793 (citing 42 U.S.C. § 1395(dd)(2)(A)).

[37] 42 U.S.C. § 1395dd(d)(1)(A).

[38] 42 U.S.C. § 1395dd(d)(1)(B).

[39] 42 U.S.C. § 1395dd(d)(2)(A).

[40] 42 U.S.C. § 1395dd(d)(2)(B).

term acute care hospitals that have a psychiatric inpatient unit.[41] Very few hospitals can elect to not participate in either federal program.[42] EMTALA applies to all Medicare-participating hospitals that operate a "dedicated emergency department," and/or has specialized capabilities. The law imposes the four basic statutory obligations highlighted in Table 1 below.[43]

Table 1: Statutory Obligations

Medical Screening	Hospitals must provide an appropriate **medical screening** examination to any individual who arrives at the emergency department seeking medical treatment.
Stabilization	If it is determined that an emergency medical condition exists, hospitals must provide further examination and treatment to **stabilize** the medical condition.
Appropriate Transfer	If the hospital cannot stabilize the patient, the hospital must provide an **appropriate transfer** to another medical facility.
Recipient Hospital	Hospitals with specialized capabilities, regardless of whether they have a dedicated emergency department, are required to accept an appropriate transfer of an individual requiring such capabilities, if it has the capacity to treat the individual.

Note: Words bolded above are defined in the EMTALA Statute Table in *Appendix A*.

Further, EMTALA prohibits hospitals from delaying medical screening exams or providing stabilizing treatment in order to inquire about the patient's method of payment or insurance status.[44] Recipient hospitals must report any inappropriate transfers.[45] In addition to several other administrative requirements, EMTALA also contains strict enforcement provisions.[46]

It is important to note that EMTALA has no provision related to compensation.[47] There is a legal expectation for hospitals to provide an appropriate medical screening and, as applicable,

[41] Information provided by CMS through its official survey and certification database, CASPER (Certification and Survey Provider Enhanced Reports), reflecting the certification data entered by the State Survey Agencies and the CMS Regional Offices. The count was current as of May 15, 2014.

[42] American Hospital Association, "Underpayment by Medicare and Medicaid Fact Sheet," Nov. 2009, http://www.aha.org/content/00-10/09medicunderpayment.pdf.

[43] 42 U.S.C. § 1395dd(a)-(c).

[44] 42 U.S.C. § 1395dd(b)(1); 42 U.S.C. § 1395dd(h).

[45] The definition of transfer also includes discharge of a patient. 42 U.S.C. § 1395dd(e)(4).

[46] 42 U.S.C. § 1395dd(d).

[47] Marilyn Dahl, testimony, *Patient Dumping Briefing Before the U.S. Commission on Civil Rights*, Washington, D.C., Mar. 14, 2014, transcript, p. 39 (hereafter cited as Briefing Transcript), *available at* http://www.eusccr.com/2014%20Statutory%20Enforcement%20Report-Patient%20Dumping-Transcript%203-14-2014.pdf.

stabilization services.[48] However, a discussion of how and if hospitals are compensated for these services is outside the scope of EMTALA.[49] This has led some to refer to the law as an "unfunded mandate."[50] There is no obligation upon the hospital to provide any treatment beyond what is necessary to stabilize the patient, nor any prohibition against discharging or transferring the patient elsewhere.[51] If a hospital chooses to provide treatment, that is beyond the framework of EMTALA. As previously mentioned, in a majority of cases, hospitals rely on federal assistance to compensate them for medical services rendered.[52]

Patient Dumping: Recent Developments

Despite congressional intent to prohibit hospitals from denying emergency care to those in need, patient dumping continued to rise into the 1990s.[53] Studies and reviews conducted by HHS OIG and Public Citizen's Health Research Group revealed a 390 percent increase in EMTALA investigations and a 683 percent increase in findings of EMTALA violations from 1987 to 1998.[54] Most recently, OIG completed two EMTALA investigations that resulted in settlement negotiations. One included a $50,000 maximum penalty against Carolinas Medical Center in 2013 and the other a $180,000 penalty against Duke University Hospital in 2012.[55] Both of these settlement negotiations involved EMTALA violations against individuals with psychiatric conditions.

In addition to patient dumping cases highlighted by OIG, recent developments on the west coast of the United States have brought patient dumping back into the national spotlight. Specifically,

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[48] *See* 42 U.S.C. § 1395dd(a)-(b).

[49] Dahl Testimony, *Briefing Transcript*, p. 39.

[50] *See* Dustin W. Ballard et al., *EMTALA, Two Decades Later: A Descriptive Review of Fiscal Year 2000 Violations*, 24 Am. J. Em. Med. 197, 203 (2006); *see also* Gina Greenwood, testimony, *Patient Dumping Briefing Before the U.S. Commission on Civil Rights, Washington, D.C.*, Mar. 14, 2014, p. 68 (hereafter Briefing Transcript), *available at* http://www.eusccr.com/Greenwood_Written_Testimony_Revised%20FINAL.pdf.

[51] Dahl Testimony, *Briefing Transcript*, pp. 25-26.

[52] American Hospital Association, "Underpayment by Medicare and Medicaid Fact Sheet," Nov. 2009, http://www.aha.org/content/00-10/09medicunderpayment.pdf.

[53] *Intentional Tort of Patient Dumping*, at 199-207.

[54] Ibid. Additionally, the OIG data showed the number of EMTALA investigations between 1994 and 1998 averaged approximately 400 a year, and as of January 2001, OIG had processed 677 dumping cases.

[55] Statement of Sandra Jean Sands, Chief of Counsel, Office of Inspector General, Dep't of Health and Human Serv. submitted to the U.S. Comm'n on Civil Rights, at 2-3 (Mar. 14, 2014) (statement available at http://www.eusccr.com/Sandra%20Sands%20Written%20Statement.pdf) [hereinafter *Sands Statement*]. Duke University Hospital's penalty reflects the penalty for refusing to accept multiple patient transfers. *See* Figure 3 for more OIG enforcement actions.

during the last five years, *The Sacramento Bee* uncovered that Rawson-Neal Psychiatric Hospital ("Rawson-Neal") in Las Vegas, Nevada had been busing mentally ill patients across states lines.[56] Following these reports, CMS initiated an investigation into Rawson-Neal and found that the hospital sent most of these patients, some suffering from severe mental illnesses, to unfamiliar states and cities with no plan in place to ensure that they would receive adequate medical care.[57] The investigation ultimately resulted in Rawson-Neal's decision to close its mental health clinic, which had been functioning as a dedicated emergency department and was subject to EMTALA obligations.[58] A separate CMS investigation of the hospital's compliance with the Medicare Hospital Conditions of Participation resulted in Rawson-Neal correcting its deficient discharge planning practices related to inpatients.

A panelist at the Commission's March 14, 2014 briefing discussed the facts of one of the Rawson-Neal cases. Staci Pratt, of the ACLU of Nevada, described the case of James, a 48-year old schizophrenic man who was involuntarily committed to Rawson-Neal in February 2013 while enduring a psychotic episode. After receiving care for a few days, the hospital discharged James to a Greyhound Bus station via taxi service.[59] A Rawson-Neal nurse signed discharge papers with his address listed as "Greyhound Bus Station to California."[60] For his trip, Rawson-Neal gave James a three-day supply of medication and several bottles of Ensure for sustenance. The hospital provided no money and no identification documents. Further, the hospital instructed James to call 911 when he arrived in Sacramento.[61]

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[56] The newspaper reported that since 2008, nearly 1,500 patients were given one-way bus tickets to other states. Cynthia Hubert and Phillip Reese, *Nevada Psychiatric Hospital's Busing of Mental Patients was Disturbing to Workers*, *The Sacramento Bee* (May 5, 2013; modified Feb. 4, 2014), *available at* http://www.sacbee.com/2013/05/05/5395588/nevada-psychiatric-hospitals-busing.html.

[57] Ibid. Additionally, some or all of the patients released from Rawson-Neal were unaccompanied by hospital personnel.

[58] *See* Andrew Doughman, "Drop-in Mental Health Clinic at Rawson-Neal to Close Friday," *Las Vegas Sun* (Jan. 23, 2014), http://www.lasvegassun.com/news/2014/jan/23/drop--mental-health-clinic-rawson-neal-close-frida/.

[59] Stacy Pratt, testimony, *Patient Dumping Briefing Before the U.S. Commission on Civil Rights, Washington, D.C.*, March 14, 2014, transcript, p. 60 (hereafter cited as Briefing Transcript), *available at* http://www.eusccr.com/2014%20Statutory%20Enforcement%20Report-Patient%20Dumping-Transcript%203-14-2014.pdf.

[60] Ibid., pp. 60-61.

[61] Ibid., p. 61. The ACLU of Nevada, alongside the lead private attorney, Mark Merin, filed a class action lawsuit against Rawson-Neal on behalf of James Flavy Coy Brown in June 2013 in federal district court in the District of Nevada. The case was dismissed in February 2014 on the grounds that Mr. Brown did not suffer any "personal harm" by Rawson-Neal, as he was given enough medication for his trip to Sacramento and was treated at the University of California at Davis Medical Center shortly after he arrived in California. *See Brown v. S. Nev. Adult Mental Health Servs.*, No. 2:13-CV-1039-JCM-PAL, 2014 WL 580780, at *7 (D. Nev. Feb. 13, 2014). Mr. Merin and the ACLU of Nevada filed a Motion to Reconsider and vowed to continue fighting for the psychiatric patients bused from Nevada to California. Ken Ritter, "Federal Judge Dismisses Lawsuit in Nevada 'Patient Dumping'

Rawson-Neal dumped most of the patients in California. Three hundred twenty-five, of approximately 1,500 patients bused from Rawson-Neal, were sent to California.[62] In September of 2013, the city attorney of San Francisco, Dennis Herrera, filed a class action lawsuit against the state of Nevada, Nevada's Department of Health and Human Services, and Rawson-Neal, among others.[63] According to Herrera's complaint, patients did not have adequate food, water, or medication; nor did patients have instructions or arrangements for continued care once they reached their destination. Twenty of the patients required medical care shortly after their arrival in San Francisco–some within hours of getting off of the bus.[64] Their medical care, shelter, and basic necessities cost San Francisco taxpayers approximately $500,000.[65] According to the complaint filed by the city, one 36-year-old male bused to San Francisco—and diagnosed with psychosis, schizophrenia, and suicidal/homicidal ideation—had a history of 13 prior visits to Rawson-Neal.[66] Another patient, who had three prior suicide attempts, was bused to San Francisco despite evidence that he lived and worked in Las Vegas.[67] The hospital gave this patient a one-way Greyhound bus ticket to San Francisco and a day's worth of food.[68] Although litigation is pending as of the date of this report, its results may be instructive for other psychiatric hospitals receiving Medicare funding.

Case," *Las Vegas Sun*, Feb. 13, 2014, *available at* http://m.lvsun.com/news/2014/feb/13/federal-judge-dismisses-lawsuit-nevada-patient-dum/.

[62] Pratt Testimony, *Briefing Transcript*, pp. 61-62.

[63] *See* Complaint for Damages, Equitable, and Class-wide Declaratory and Injunctive Relief, City of San Francisco v. Nevada, 2013 WL 5290245 (Cal. Super. 2013) (No. 13-534108), *available at* http://www.sfcityattorney.org/modules/showdocument.aspx?documentid=1343 [hereinafter *Complaint for Damages*]; *see also* Laila Kearney, *San Francisco Sues Nevada over Patient Dumping*, NBC News (Sept. 10, 2013), *available at* http://www.nbcnews.com/health/mental-health/san-francisco-sues-nevada-over-patient-dumping-f8C11126850.

[64] *Complaint for Damages*, at *6.

[65] *Id.,* at *1.

[66] *Id.,* at *8.

[67] *Id.,* at *7.

[68] *Id., at *8.*

CHAPTER 2 | THE ADMINISTRATIVE PROCESS TO ENFORCE EMTALA

The Centers for Medicare and Medicaid Services (CMS), the Office of the Inspector General (OIG), and the Office for Civil Rights (OCR), each within the U.S. Department of Health and Human Services, play different roles in addressing patient dumping. Any of these three offices may receive complaints, but each derives its legal authority to investigate such complaints from different sources. CMS and OIG have jurisdiction under EMTALA and the Social Security Act, while OCR has jurisdiction under specific federal civil rights laws: the Rehabilitation Act of 1973, the Americans with Disabilities Act, and the Hill-Burton Act. When processing a patient dumping complaint, these three HHS components may work together or independently toward resolution, depending on the facts of the case.

Centers for Medicare & Medicaid Services

EMTALA is codified in sections 1866 and 1867 of the Social Security Act, which establish specific EMTALA requirements for Medicare-participating hospitals and on-call physicians. Section 1867 of the Social Security Act specifies enforcement actions available to CMS and to OIG.[69] In addition, section 1867 provides a private right of action by individuals, but CMS has no role in litigation arising out of that provision.[70] Section 1866 of the Social Security Act also includes some EMTALA-related requirements for hospitals and governs Medicare provider agreements.[71]

Complaints under EMTALA may arise either from individuals, hospitals, or through media reports.[72] After learning of a potential patient dumping case, CMS may self-generate complaints if it feels an investigation is necessary.[73] CMS relies heavily on health agencies in each state to monitor hospitals. These state survey agencies, or "state surveyors," work with CMS pursuant to Section 1864 agreements, which CMS has with every state, the District of Columbia, and Puerto Rico. State surveyors periodically review compliance with all Medicare requirements and

[69] Now codified as 42 U.S.C. § 1395cc & 42 U.S.C. § 1395dd.

[70] 42 U.S.C. § 1395dd; Statement of Marilyn Dahl, Dir. of the Div. of Acute Care Serv, Ctr. for Medicare and Medicaid Serv., Dep't of Health and Human Serv. submitted to the U.S. Comm'n on Civil Rights (March 14, 2014), at 1, *available at* http://www.eusccr.com/Written%20Statement%20of%20Marilyn%20Dahl.pdf [hereinafter *Dahl Statement*].

[71] *See* 42 U.S.C. § 1395dd; 42 C.F.R. 489.24(f)(1) (stating explicitly that recipient hospital responsibilities under EMTALA apply to any Medicare-participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department).

[72] *Dahl Statement*, at 4.

[73] Dahl Testimony, *Briefing Transcript*, p. 4.

investigate complaints from patients or residents about any Medicare-participating facility, regardless of whether it is accredited.[74] The goal of onsite inspections is to assess compliance with Medicare requirements, and in the case of long-term care and other facilities, Medicaid requirements as well.[75]

State surveyors receive a majority of complaints. For complaints concerning hospitals, it is the surveyors' responsibility to sift through complaints to determine if an EMTALA violation may be at issue, even when EMTALA is not explicitly invoked by the complaint.[76] State surveyors are required to then forward complaints suggesting potential EMTALA violations to one of the ten CMS regional offices and seek authorization for an investigation.[77] In an overwhelming majority of cases, the regional office will authorize an investigation.[78] In this way, CMS and its regional offices operate in a decentralized manner, relying heavily on these surveyors who are on the ground. State surveyors—who make unannounced visits to the hospitals—conduct a majority of investigations in the field.[79] However, sometimes CMS employees or contractors may conduct part or all of the survey or participate in a state's federal survey team.[80]

After their investigation, the state surveyors forward their survey report—including documentation and evidence of EMTALA noncompliance—to their appropriate CMS regional office. Finally, the CMS regional office determines whether the hospital is compliant with EMTALA. The focus is on the hospital's compliance at the time of the survey. If surveyors find evidence of noncompliance in the past, but also find that the hospital identified the issue and took effective corrective action prior to the survey, CMS will not pursue EMTALA enforcement actions against the hospital.[81]

When further action is necessary, CMS—in consultation with OIG—determines whether to pursue its own enforcement action under its Section 1867 authority. Alternatively, CMS may choose to refer a case to OCR if a hospital delayed or denied a medical screening to a patient with an emergency medical condition or if the hospital discharged the patient before stabilization

[74] 42 U.S.C. § 1395aa; Dahl Testimony, *Briefing Testimony*, p. 31. This includes the District of Columbia.

[75] Dahl Testimony, *Briefing Testimony*, p. 32.

[76] Ibid.

[77] Ibid.

[78] Ibid.

[79] *Dahl Statement*, p. 4.

[80] Ibid., p. 5.

[81] Ibid., pp. 5-6.

due to the patient's race, color, national origin, age, religion, sex, or disability status.[82] If the CMS regional office finds evidence of current EMTALA noncompliance for clinical or medical reasons, then CMS must send the case to a Quality-Improvement Organization (QIO).[83] The QIO, in turn, assigns a physician to review the case and answer questions for CMS. Then, after considering both the state survey report and the QIO physician review, the CMS regional office determines whether there is noncompliance and, if there is, issues a Statement of Deficiencies to the hospital.[84] The hospital is required to correct the deficiencies in a timely manner and the state must conduct another survey to confirm compliance.[85] If the state finds that the hospital is still in noncompliance, CMS may terminate the hospital's Medicare provider agreement, though this is rare.[86] Figure 1 below highlights the complaint process in conjunction with OIG. [87]

[82] Statement of Eileen Hanrahan, Supervisory Civil Rights Analyst, Office of Civil Rights, Dep't of Health and Human Serv, submitted to the U.S. Comm'n on Civil Rights, at 1-2 (Mar. 14, 2014), *available at* http://www.eusccr.com/Eileen%20Hanrahan%20Written%20Statement.pdf [hereinafter *Hanrahan Statement*].

[83] *See* William Rollow, et al., *Assessment of the Medicare Quality Improvement Organization Program*, 145:5 Annals of Internal Medicine 342 (2006) (describing the generally positive effects of QIOs on healthcare in the United States), *available at* http://annals.org/article.aspx?articleid=727999.

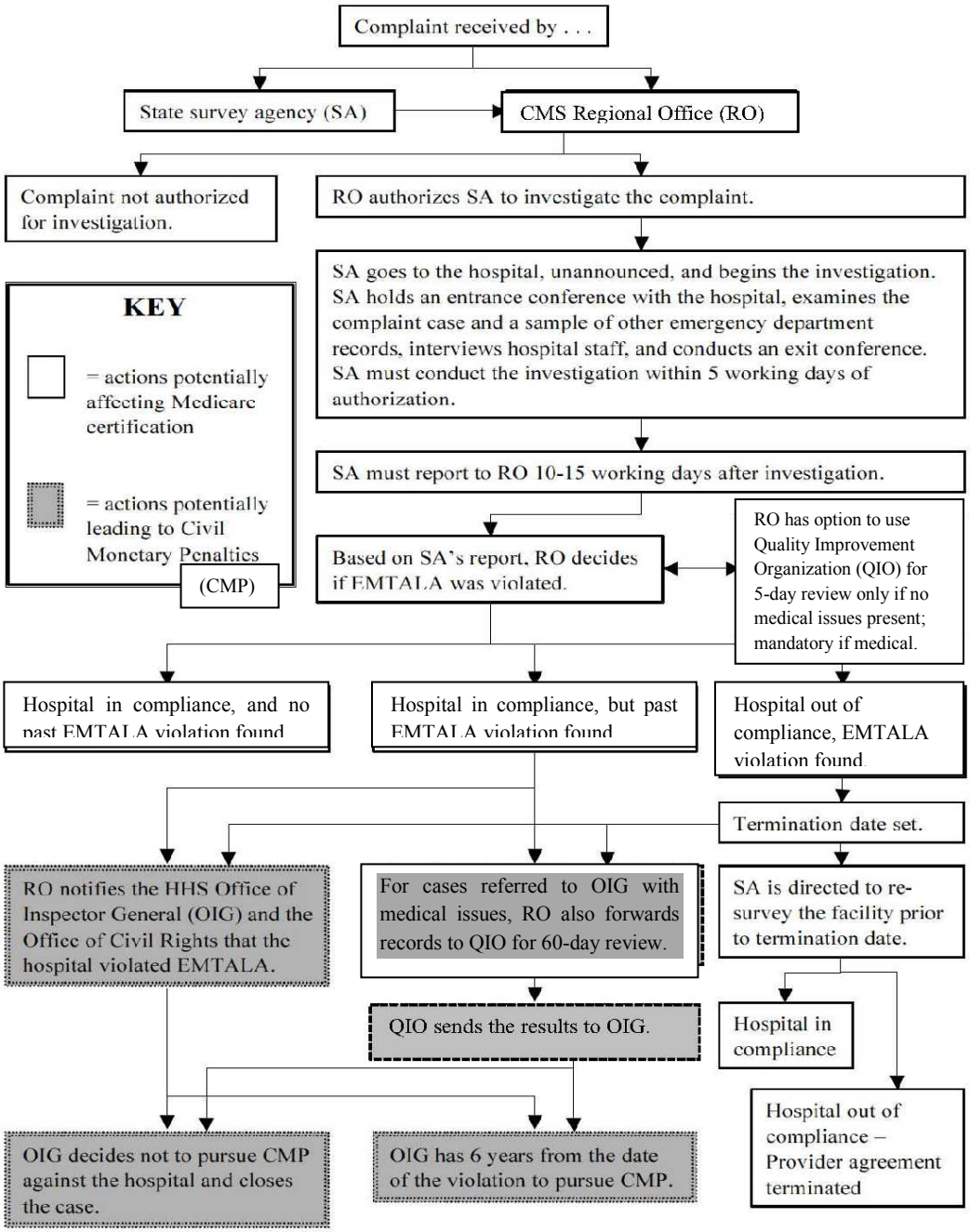
[84] *Dahl Statement*, p. 6.

[85] Ibid., p. 5.

[86] Ibid., p. 6.

[87] Figure 1 was adapted from an HHS OIG complaint flow chart and amended to reflect current changes in the law. *See* Department of Health and Human Services, Office of the Inspector General, "The Emergency Treatment and Labor Act: The Enforcement Process," January 2001, p. 7, *available at* http://oig.hhs.gov/oei/reports/oei-09-98-00221.pdf.

Figure 1: EMTALA Complaint Process



Office of the Inspector General

OIG also has authority to pursue certain administrative remedies to enforce EMTALA.[88]

After CMS has determined that a hospital violated EMTALA, it may refer the case to OIG (see Figure 1). OIG makes a preliminary review of the case in order to recommend whether OIG should pursue administrative remedies or close the case. A majority of cases that move forward are resolved in negotiation settlements. If negotiations between OIG and the hospital do not resolve the case, it will go to trial before the Departmental Appeals Board (DAB) and then to the appellate division of the DAB. Further appeal may be filed directly with the appropriate U.S. Court of Appeals.[89]

Cases arrive from CMS via two different paths:

1. If the hospital was in compliance at the time of the unannounced inspection by state surveyors, but inspectors found a past violation arising for a clinical or medical reason, then the CMS regional office may refer the case to OIG and forward the medical records to a Quality Improvement Organization (QIO) for a 60 day review (see Figure 1).[90] The QIO then sends the results to OIG, and OIG has six years to determine whether to pursue further action.[91]

2. If the hospital was not in compliance, the CMS regional office notifies OIG that the hospital violated EMTALA.[92] If the violation arises from a clinical or medical issue, the CMS regional office will forward the medical records to a QIO for a 60 day review. The QIO then sends its results to OIG. OIG has up to six years to decide whether to pursue its own administrative remedies (see Figure 1).[93]

Office for Civil Rights

OCR enforces federal civil rights laws, including Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act, and the Hill-Burton Act. In addition, OCR

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[88] *Sands Statement,* p. 1.

[89] Ibid.

[90] OIG periodically identifies the criteria it prefers CMS to use in determining which cases to refer to OIG. *See* CMS State Operations Manual, Publication 100-07, § 5180.2.

[91] Department of Health and Human Services, Office of the Inspector General, "The Emergency Treatment and Labor Act: The Enforcement Process," January 2001, at 7, *available at* http://oig.hhs.gov/oei/reports/oei-09-98-00221.pdf.

[92] Ibid.

[93] Ibid.

enforces the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.[94] OCR enforces these laws in a number of ways, including investigating complaints, conducting compliance reviews, providing technical assistance for voluntary compliance, and conducting outreach to educate individuals about their rights and to educate medical institutions and providers about their legal responsibilities.[95]

Section 504 of the Rehabilitation Act of 1973 prohibits discrimination on the basis of disability by recipients of federal financial assistance, and Title II of the Americans with Disabilities Act prohibits discrimination by state and local governments on the basis of disability.[96] These laws forbid entities from discriminating against people with disabilities in covered programs, including the denial of care to individuals with a psychiatric disability or their relocation, transfer, or improper discharge.[97] The Hill-Burton Act assures that public and other nonprofit medical facilities provide services in exchange for federal assistance. Under the Community Service Assurance provisions of Titles VI and XVI of the Public Health Service Act, recipients of Hill-Burton funds are required to make services available without discrimination on the basis of race, color, national origin, or creed. In addition, a Hill-Burton facility must make emergency services available without discrimination on the basis of any other ground unrelated to the individual's need for the service or the availability of the needed service in the facility.[98]

When OCR initially identifies compliance concerns related to one of the laws it enforces, the first step is to attempt to bring the entity into voluntary compliance.[99] If voluntary compliance is not forthcoming, OCR has authority to take other actions, such as terminating federal financial assistance and/or referring the case to the Department of Justice (DOJ).[100]

Remedies

The law provides for remedies for patients who experience EMTALA violations, as well as for medical facilities incurring financial harm from such violations. Specifically, the statute and regulations provide for civil monetary penalties against hospitals or physicians who are found to be liable after an HHS investigation.[101] In addition, patients who experience personal harm or

[94] *Hanrahan Statement*, pp. 1-2.

[95] Ibid., p. 1.

[96] 29 U.S.C. § 794; 45 C.F.R. §§ 84-85; 42 U.S.C. §§ 12101 & 12132.

[97] *Hanrahan Statement*, p. 2.

[98] *See* 42 U.S.C. §§ 291 & 300; 42 C.F.R. § 124.603.

[99] *Hanrahan Statement*, pp. 1-2.

[100] Ibid., p. 2.

[101] 42 U.S.C. § 1395dd(d).

medical facilities incurring financial loss each have a private cause of action, which allows the filing of lawsuits in federal court within two years of the violation.[102] In the case of civil penalties which the government seeks to impose, the investigations conducted by HHS originate with CMS. Both CMS and OIG are responsible for enforcing EMTALA, but CMS has primary responsibility.[103]

Enforcement Responsibilities of CMS and OIG

The specific requirements of EMTALA are incorporated in each hospital's Medicare provider agreement. CMS requires that—in addition to providing a medical screening examination, necessary stabilizing treatment, appropriate transfers, and acceptance of transfers under the statute—hospitals must also post signs, maintain a central log, an on-call roster and patient transfer records. In addition, hospitals that believe they have received an inappropriate transfer of an individual with an un-stabilized emergency medical condition must report such suspected EMTALA violations to CMS or the state survey agency.[104] Failure to meet any of these requirements constitutes a breach of the Medicare provider agreement and a possible basis for termination. Although the termination of a Medicare provider agreement or the exclusion of a physician from Federal health care programs seldom occurs, civil monetary penalties are more common.[105]

Under federal law, a "participating hospital that negligently violates a requirement of [EMTALA] is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation."[106] In addition, "any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of [EMTALA] … is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in [Medicare] and state health care programs."[107]

Both OIG and CMS may pursue these administrative remedies in conjunction with one another, although complaints can originate in either office. CMS is the primary investigator of such complaints.[108]

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[102] 42 U.S.C. § 1395dd(d)(2)(A)-(C).

[103] *Sands Statement*, pp. 1-2.

[104] *Dahl Statement*, p. 5; 42 C.F.R. 489.24; 42 C.F.R. 489.20.

[105] *Dahl Statement*, p. 6.

[106] 42 U.S.C. § 1395dd(d)(1)(A).

[107] 42 U.S.C. § 1395dd(d)(1)(A)-(B); § 1867(d) of the Social Security Act.

[108] *Sands Statement*, p. 1.

Between 2006 and 2012, CMS received approximately an average of 500 EMTALA complaints annually and investigated a majority of them. Of the complaints investigated, approximately 40 percent resulted in hospitals being cited for EMTALA violations, with most cases resulting in hospitals returning to compliance through corrective action.[109] Within the OIG, the Office of Counsel to the Inspector General assesses civil monetary penalties against hospitals and physicians (see Table 2). Further, they may exclude physicians from Federal health care programs.[110] By law, CMS must seek input of an appropriate, CMS-contracted QIO before it forwards a case to OIG if the EMTALA violation arises from a medical or clinical reason. OIG requires the opinion of a medical professional employed by a QIO to determine a hospital or physician's liability.[111]

OIG is required by federal regulation to take into account several factors when determining the amount of a penalty for an EMTALA violation. These factors include: 1) the degree of culpability of the accused hospital or physician; 2) the seriousness of the condition of the individual seeking emergency medical treatment; 3) previous instances where the hospital or physician failed to meet EMTALA obligations; 4) the financial condition of the hospital or physician; 5) the nature and circumstances of the violation; and 6) other matters as justice might require. [112]

Table 2 below highlights some recent cases in which OIG pursued civil monetary penalties.

Table 2: EMTALA Civil Monetary Penalties[113]

Date	Alleged Violation	Resolution
12-04-2013	OIG alleged that Carolinas Medical Center ("Carolinas") failed to provide an appropriate medical screening examination or stabilizing treatment to a patient that needed psychiatric treatment.	Carolinas agreed to pay $50,000.
09-05-2012	OIG alleged that Duke University Hospital ("Duke") failed to accept five appropriate transfers of individuals with unstable psychiatric emergency medical conditions.	Duke agreed to pay $180,000.

[109] *Sands Statement*, p. 4.

[110] 42 U.S.C.A. § 1395dd(d)(1)(B).

[111] The OIG can impose a civil monetary penalty without QIO review "[i]f a delay would jeopardize the health or safety of individuals or when there was no screening examination. . ." 42 C.F.R. § 489.24 (g)(3); 42 U.S.C. § 1395dd(d)(3).

[112] *Sands Statement*, p. 2; 42 C.F.R. §§1003.106(a)(4) & (d).

[113] Adapted for OIG's Patient Dumping Archive 2008-2013, *available at* http://oig.hhs.gov/fraud/enforcement/cmp/patient_dumping.asp.

Date	Alleged Violation	Resolution
02-10-2012	OIG alleged that Fort Lauderdale Hospital, Inc. (“FLH”) failed to provide an appropriate medical screening examination and stabilizing treatment to an autistic patient that presented to FLH's emergency department after physically attacking his mother. The patient was seen at another facility and admitted for six days due to a diagnosis of depression.	FLH agreed to pay $45,000.
11-15-2011	OIG alleged that Schoolcraft Memorial Hospital (“SMH”) failed to provide stabilizing treatment to a 15-year-old male who came to SMH's emergency department (“ED”) for examination and treatment of psychiatric and medical emergencies. The patient presented to SMH's ED after a suicide attempt. SMH transferred the patient to a psychiatric facility 169 miles away without stabilizing the patient's vital signs. Forty minutes into the transfer, the patient began experiencing hypotensive episodes.	SMH agreed to pay $20,000.
08-04-2008	OIG alleged that an emergency medical technician (“EMT”) informed Baptist Hospital, Inc. (Baptist) that the man had not taken his psychiatric medication, was suicidal, and claimed to hear voices. Baptist failed to perform a medical screening examination of the patient and he was left unsupervised in the triage area.	Baptist agreed to pay $22,500.
06-30-2008	OIG alleged that Cape Fear Valley Medical Center (“Cape Fear”) failed to provide an appropriate medical screening examination and stabilizing treatment to a 13 year-old mentally ill girl who threatened to kill herself. The patient was allegedly seen by a physician for approximately five minutes before she was released. Less than 50 minutes after the physician saw the patient, the patient jumped out of a car traveling approximately 40 miles per hour and fractured her skull.	Cape Fear agreed to pay $42,500.
06-25-2008	OIG alleged that Rogers Memorial Hospital failed to provide an appropriate medical screening examination and stabilizing treatment to a 57 year-old woman that presented to the hospital's emergency department with her family. The woman had a history of depression. The patient was transported by her family to another hospital where she was admitted for depression and suicidal ideations.	Rogers Memorial Hospital agreed to pay $30,000.
03-06-2008	OIG alleged that Tomball Regional Hospital (TRH) failed to provide an appropriate medical screening examination and stabilizing treatment to a patient who presented to its emergency department in a combative state and on narcotics. The patient had a psychiatric history of attention deficit disorder. Approximately an hour later, the patient arrived at another hospital accompanied by the police. The patient was admitted and diagnosed with bipolar disorder.	TRH agreed to pay $32,500.

OIG also considers, generally, whether an enforcement action would help educate a hospital or physician about obligations and responsibilities under EMTALA.[114] CMS focuses on ensuring that hospitals correct deficient practices, while maintaining access to care, without terminating the hospital's Medicare provider agreement when possible.[115]

Neither OIG nor CMS has a designated role in the litigation of cases where individuals or hospitals seek private civil enforcement against a participating hospital for personal or financial harm from an EMTALA violation. Often, OIG and CMS are not aware of these cases until resolution. Individuals or hospitals may obtain damages available for personal injury under state law and where equitable relief is appropriate.[116]

Enforcement Responsibilities of OCR

Although the Office for Civil Rights (OCR) does not have EMTALA enforcement responsibilities, it receives approximately 15,000 to 18,000 complaints a year, with 3,000 of these being civil rights complaints, and the remainder being health information privacy complaints.[117] Alternatively, OCR has the authority to conduct compliance reviews where there is reason to believe an entity receiving federal financial assistance may be discriminating based on disability.[118] OCR does a "fair amount of outreach," such as listening sessions with stakeholder organizations to determine whether to open compliance reviews.[119] OCR can take steps to terminate federal financial assistance or refer the case to DOJ's Civil Rights Division for enforcement.[120]

OCR has the power to enforce three different federal provisions related to mental health disabilities:

1) Section 504 of the Rehabilitation Act of 1973, which prohibits disability discrimination by recipients of federal assistance;

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[114] Sandra Jean Sands, testimony, *Patient Dumping Briefing Before the U.S. Commission on Civil Rights*, *Washington, D.C.*, Mar. 14, 2014, transcript, p. 16 (hereafter cited as Briefing Transcript), *available at* http://www.eusccr.com/2014%20Statutory%20Enforcement%20Report-Patient%20Dumping-Transcript%203-14-2014.pdf.

[115] *Dahl Statement*, p. 6.

[116] 42 U.S.C. § 1395dd(d)(2)(A)-(B).

[117] Eileen M. Hanrahan, testimony, *Patient Dumping Briefing Before the U.S. Commission on Civil Rights*, *Washington, D.C.*, Mar. 14, 2014, transcript, p. 19 (hereafter cited as Briefing Transcript), *available at* http://www.eusccr.com/2014%20Statutory%20Enforcement%20Report-Patient%20Dumping-Transcript%203-14-2014.pdf.

[118] Ibid., p. 20.

[119] Ibid., pp. 34-35.

[120] Ibid., pp. 19-20.

2) Title II of the Americans with Disabilities Act, which covers state and local government agencies' health and social services programs, and prohibits the denial of care to an individual with a psychiatric disability, or the transfer, relocation, or discharge of such a patient by a facility that otherwise has the ability to provide appropriate services; and
3) The Hill-Burton Act passed in 1946, which requires certain community service assurances by facilities in order to receive federal financial assistance and prohibits discrimination.[121]

Patients from Hill-Burton facilities, which are mostly hospitals and number over 6,800 nationwide, may claim discrimination based on a psychiatric medical condition directly to OCR. For EMTALA complaints where discrimination based on a violation of one of these three laws may overlap, CMS has the authority to refer the case to OCR.[122] From 2011 to present, OCR has received 60 such complaints. Almost all were referred from CMS and many were related to failure to stabilize a patient or to conduct an appropriate medical screening before discharge.[123] In many cases, the hospital had already taken the necessary corrective action. In other instances, OCR required additional corrective measures such as posting notices of the community service obligations required by federal anti-discrimination laws for Hill-Burton facilities.[124]

[121] Ibid., pp. 20-21.

[122] Ibid., pp. 21-22.

[123] Ibid., p. 22.

[124] Ibid.

CHAPTER 3 | CURRENT REGULATIONS AND EMTALA ENFORCEMENT MECHANISMS

Panelists at the Commission's March 14, 2014 briefing discussed the existing regulations and enforcement mechanisms designed to address patient dumping. Practitioners, advocates, and scholars spoke about their work-related experiences with EMTALA and its requirements. Some of the panelists offered anecdotes about navigating the intersection of EMTALA and care for the mentally ill. Some advocates discussed the need for additional policies and procedures to end patient dumping, while other practitioners described the overregulation of hospitals and the need to devise non-punitive enforcement measures. Scholars spoke about the need to create written protocols, share best practices, and explore diversion options for patients with a mental disability. Throughout the discussion, five major themes emerged:

Theme 1: The Lack of Adequate Data Collection

Part of the problem in dealing with patient dumping of the mentally ill is that there is very little data to illustrate the scope of the problem. CMS does not collect data on the nature of the emergency medical condition at issue in each EMTALA case.[125] CMS's data collection schemes do not divide data based on the type of medical emergency. Therefore, it is difficult to determine how many EMTALA cases derive from psychiatric disabilities.[126] Another explanation for imperfect data is psychiatric patients' potential incapacity to file complaints or reluctance to do so.[127] Other people—such as a physician, hospital staff member, friend, or family member—may file a civil rights complaint with OCR on behalf of a victim.[128] Complaints filed by other individuals also lack the necessary data that would identify how many civil rights complaints are based on mental disability. The case data system currently employed by OCR does not allow for a search by type of disability.[129]

OCR has the ability to search its complaints database by the source of legal authority necessary to investigate that civil rights complaint: 1) Section 504 of the Rehabilitation Act of 1973; 2) Title II of the Americans with Disabilities Act; or 3) Hill-Burton Act of 1946. However, in the normal course of business OCR does not disaggregate this data to identify which section of each

[125] Dahl Testimony, *Briefing Transcript*, p. 32.

[126] Ibid.

[127] Hanrahan Testimony, *Briefing Transcript*, pp. 34-35.

[128] Ibid., p. 35.

[129] Ibid., pp. 42-43.

law is implicated in the complaint.[130] For example, a complaint filed with the Hill-Burton Act as the source of legal authority would not identify which part of Hill-Burton was violated. OCR could obtain such data, but this would be burdensome. Eileen Hanrahan, of OCR, testified that, "conceivably," her office could "go through case by case" to complete data "analysis and identify categories of cases that raise specific civil rights issues" such as patient dumping or discrimination based on mental disability.[131] However, she noted this would be time-intensive.[132] In the alternative, Ms. Hanrahan suggested a new and different way to configure data systems to obtain different types of data and prepare the data for analysis.[133]

Professor Katharine Van Tassel, of the University of Akron School of Law, stated that the "biggest problem that we have right now is that there is no data collection, so there isn't an ability to say if there is a particular group that's being disproportionately impacted by patient dumping."[134] She suggested tracking uninsured patients more closely to determine the most vulnerable populations. Gina Greenwood, of litigation firm Baker Donelson, also testified that the scope of the patient dumping issue is completely unknown, and she suggested creating a national taskforce to research the prevalence of the problem.[135] Without understanding the scope of the issue and determining whether reports of patient dumping in the media represent the exception or the rule, the federal government should be cautious of requiring any further regulation of the hospital industry.[136]

Theme 2: The Amount of Regulatory Oversight

Ms. Greenwood listed the number of regulatory barriers placed upon hospitals to receive federal funding in the United States.[137] There are state licenses for hospitals, annual to tri-annual state inspections where hospitals may be fined or lose their licensure, Medicare and Medicaid

[130] Ibid., p. 43.

[131] Ibid.

[132] Ibid., pp. 43-44.

[133] Ibid., p. 44.

[134] Katharine Van Tessel, testimony, *Patient Dumping Briefing Before the U.S. Commission on Civil Rights*, *Washington, D.C.*, Mar. 14, 2014, transcript, p. 154 (hereafter cited as Briefing Transcript), *available at* http://www.eusccr.com/2014%20Statutory%20Enforcement%20Report-Patient%20Dumping-Transcript%203-14-2014.pdf.

[135] Gina Greenwood, testimony, *Patient Dumping Briefing Before the U.S. Commission on Civil Rights*, *Washington, D.C.*, Mar. 14, 2014, transcript, p. 68 (hereafter cited as Briefing Transcript), *available at* http://www.eusccr.com/2014%20Statutory%20Enforcement%20Report-Patient%20Dumping-Transcript%203-14-2014.pdf.

[136] Ibid., pp. 67-68.

[137] Ibid., pp. 99-100.

certifications outside of EMTALA, a Condition of Participation in Medicare related to emergency services and discharge planning, hospital accreditation which surveys on an annual or tri-annual basis, medical malpractice liability and negligence, and finally EMTALA.[138] She believes the overregulation of hospitals at the federal and state level will only create a greater disdain for treating mentally-disabled patients in hospitals.[139]

Susan Preston, of litigation firm Goodell, DeVries, Leech & Dann, LLP, agreed with Ms. Greenwood. Ms. Preston cited that only 4 percent of confirmed EMTALA violations were economically-motivated refusals to treat patients.[140] That equated to six cases of identifiable failures to treat for economic reasons. Ms. Preston stated that although the six cases are reason enough for EMTALA to exist, the evidence is certainly not enough to conclude there is a systemic failure to treat the mentally ill.[141] She did acknowledge that underestimation of EMTALA violations is inevitable given that it is a complaint-driven system. However, it is difficult to ask the federal government to increase surveillance of hospitals without knowledge that patient dumping is systemic—especially because EMTALA "was not written with chronic psychiatric conditions in mind."[142]

Ms. Preston reiterated that Congress passed EMTALA to "assure access to emergency medical care in emergency departments," not to establish a federal standard of care.[143] Specifically, EMTALA does not apply to inpatient services, and Ms. Preston warned against expanding EMTALA's purpose beyond acute medical episodes. She referred to a Sixth Circuit federal court decision in *Thornton v. Southwest Detroit Hosp.*, which applied EMTALA to the inpatient context, after a patient was treated for nearly seven days and still found to be insufficiently stabilized before discharge.[144] In Ms. Preston's opinion, such decisions would create an

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[138] Ibid., p. 100.

[139] Ibid., p. 85.

[140] Susan T. Preston, Partner, testimony, *Patient Dumping Briefing Before the U.S. Commission on Civil Rights, Washington, D.C.*, Mar. 14, 2014, transcript, p. 58 (hereafter cited as Briefing Transcript), *available at* http://www.eusccr.com/2014%20Statutory%20Enforcement%20Report-Patient%20Dumping-Transcript%203-14-2014.pdf; Dustin W. Ballard et al., *EMTALA, Two Decades Later: A Descriptive Review of Fiscal Year 2000 Violations*, 24 Am. J. Em. Med. 197, 201-3 (2006).

[141] Ibid., pp. 58-59.

[142] Ibid., p. 59.

[143] Ibid., p. 56.

[144] Ibid., p. 81; *Thornton v. Southwest Detroit Hosp.*,895 F.2d 1131, 1134 (6th Cir. 1990) ("[O]nce a patient is found to suffer from an [emergency medical condition] in the emergency room, she cannot be discharged until the condition is stabilized."); *see also Moses v. Providence Hospital and Medical Center*, Inc., 561 F.3d 573, 586 (6th Cir. 2009) (deeming a patient "stable" and discharged although psychiatric symptoms and diagnosis present from initial visit, creating dispute of fact whether an emergency medical condition was present, and defeating entry of summary judgment for hospital). Contra Bryan v. Rectors and Visitors of the Univ. of Va., 95 F.3d 349, 352 (4th Cir. 1996); *Bryant v. Adventist Health Systems/West*, 289 F.3d 1162, 1168 (9th Cir. 2002) and *Harry v. Marchant*,

expansion of EMTALA and place a financial burden on inpatient psychiatric hospitals, which have been dwindling in number over the past four decades.[145]

Ms. Preston testified that state medical malpractice penalties are sufficient to address negligence of physicians in emergency departments, and more regulations would contribute to increasing health care costs. As examples of regulations that lead to higher costs, she cited state law licensing applications and damage requirements that already exist in most states to prevent patient dumping.[146]

Other panelists disagreed that more regulation would have negative consequences. Ms. Staci Pratt, of the ACLU of Nevada, proposed a regulatory scheme that increases affirmative, proactive enforcement by CMS regional offices. Specifically, Ms. Pratt posited that CMS should provide independent proactive federal investigations of psychiatric emergency providers through federal contractors, not state survey agencies on a randomized basis.[147]

For facilities with known EMTALA violations, Ms. Pratt recommended that CMS institute independent monitors to ensure compliance with corrective action plans and EMTALA mandates. Additionally, she suggested using fines more aggressively to finance anti-dumping funds would support the cost necessary for these independent investigations and proactive CMS enforcement.[148] While OIG may seek civil monetary penalties against hospitals or physicians who violate EMTALA, these fines are rarely assessed. A report by the nonprofit Public Citizen found that, between EMTALA's enactment in 1986 and 2001, agencies referred a total of 975 cases to OIG and only 27 percent of those referred actually received penalties.[149] Even though EMTALA allows for a potential suspension or bar from Medicare participation for violations, OIG rarely employs this consequence because so many hospitals are "too big to fail."[150]

Ms. Pratt also recommended an additional "administrative check on discharges where all prospective discharge and transfer orders would be subject to a second layer of review."[151]

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291 F.3d 767, 775 (11th Cir. 2002) (en banc) (finding EMTALA obligations end once an unstable patient has been admitted to the hospital, even if not subsequently stabilized before discharge).

[145] Preston Testimony, *Briefing Transcript*, p. 82.

[146] Ibid.

[147] Stacy Pratt, testimony, *Patient Dumping Briefing Before the U.S. Commission on Civil Rights*, *Washington, D.C.*, Mar. 14, 2014, transcript, p. 64 (hereafter cited as Briefing Transcript), *available at* http://www.eusccr.com/2014%20Statutory%20Enforcement%20Report-Patient%20Dumping-Transcript%203-14-2014.pdf.

[148] Ibid.

[149] Ibid., pp. 64-65.

[150] Ibid., p. 65.

[151] Ibid.

Hospitals would report very detailed information on a quarterly basis to CMS to identify any failures to obtain secondary approval on discharge decisions in the absence of data in after-care planning fields.[152] This reporting could be a part of the regular data transfers CMS regional offices already receive from area institutions.[153]

Ms. Pratt testified that she believes the federal government has an important role in ensuring civil rights and protecting the mentally-disabled population.[154] Many states, like Nevada, have serious limitations on medical malpractice suits; thus, the existing state and federal private litigation options are too difficult to pursue—especially for disempowered populations.[155] Pratt explained that individuals who lack access to the system—often mentally ill and homeless—cannot rely on private litigation. This vulnerable population is the reason EMTALA exists, in her opinion. Ms. Pratt explained that one of the federal government's core obligations is to guarantee that EMTALA remains meaningful to disabled patients, and this translates to the need for increased regulatory oversight.[156]

Mr. Vera, of Public Counsel, agreed and stated that he believed greater regulatory oversight and administrative reporting was a necessary deterrent against patient dumping practices.[157] Mr. Vera noted that plaintiff's attorneys do not take on patient dumping cases because of the lack of clear damages and the years it takes to litigate in civil court. Non-profit attorneys usually handle patient dumping cases on behalf of patients.[158]

On the other hand, Ms. Greenwood testified that the mentally ill in many hospitals are viewed negatively as "frequent flyers" in emergency departments and problem cases to avoid.[159] She suggested that expanding the regulatory framework would only foment more negativity and resentment against the mentally ill in hospitals.[160] Ms. Preston agreed, stating that the mentally disabled are filling up emergency departments and are undesired, unpredictable patients.[161] She

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[152] Ibid.

[153] *See* Theme 3, *infra*.

[154] Pratt Testimony, *Briefing Transcript*, p. 86.

[155] Ibid., p. 87.

[156] Ibid., p. 86.

[157] Hernan D. Vera, testimony, *Patient Dumping Briefing Before the U.S. Commission on Civil Rights*, *Washington, D.C.*, Mar. 14, 2014, transcript, pp. 82-83 (hereafter cited as Briefing Transcript), *available at* http://www.eusccr.com/2014%20Statutory%20Enforcement%20Report-Patient%20Dumping-Transcript%203-14-2014.pdf.

[158] Ibid.

[159] Greenwood Testimony, *Briefing Transcript*, pp. 68-69.

[160] Ibid., p. 85.

[161] Preston Testimony, *Briefing Transcript*, p. 55.

cited the 2003 estimation by Dr. Steven Sharfstein, of the Sheppard and Enoch Pratt Hospital, that 2.5 million emergency department visits occurred annually for mental health disorders.[162] Ms. Preston also said that the Bazelon Center for Mental Health Law estimated, in 2007, that annually one in every eight visits, or nearly 12 million, were due to mental illness and/or substance abuse since the prior seven years and subsequent recession.[163]

Theme 3: Non-punitive Methods for Hospital Reporting

Ms. Pratt mentioned the availability of already-existing technology to enhance enforcement. Specifically, she explained that CMS regional offices already accept data transfers from hospitals under their purview on a routine basis to ensure Medicare agreement compliance and reporting.[164] Ms. Pratt suggested requiring the use of "after-care planning" fields to trigger a red flag in the data sent to CMS if left blank.[165] Hospitals would complete after-care planning fields, including information about a patient's shelter visits or eligibility for Supplemental Security Income. While this is not within the scope of EMTALA and the stabilization of a patient presenting an emergency medical condition, a blank field or only cursory information can signal the need for CMS to conduct proactive oversight—especially in cases involving mentally ill patients.[166] This avoids the need to conduct investigations of hospitals only where complaints are filed. But it requires capturing the correct data about patients presenting at emergency departments and the need for CMS attention and staff resources.

Theme 4: Following the Money

The federal government offers financial assistance to hospitals to treat patients through Medicare provider agreements and federal funding programs. Hospitals are often worried they will not be reimbursed for psychiatric emergencies, so there is a need for (1) more emergency department diversion programs such as crisis intervention or social work assistance; and (2) an increase in beds for psychiatric institutions or the expansion of psychiatric wings in acute care hospitals.

The example in Nevada, where individuals were bused and transferred to California, illustrates the financial motivation for dumping patients with psychiatric disorders. The impetus behind Rawson-Neal's plan to taxi psychiatric patients to bus stations was to save money and relieve

[162] Ibid., p. 56

[163] Ibid.

[164] Pratt Testimony, *Briefing Transcript*, p. 114.

[165] Ibid., pp.114-15.

[166] Ibid.

financial burdens.[167] Ms. Pratt explained it costs nearly $500 a day to offer inpatient treatment for a mentally-ill individual, compared to just $60 for a bus ticket.[168] The state of Nevada cut mental health funding by approximately $80 million over the course of several years in the lead up to the patient dumping incident. Ms. Pratt explained that following the money would show that there is a financial incentive to discharge mentally-disabled, often homeless, patients onto the streets.[169]

Ms. Greenwood explained that EMTALA requires appropriate transfer if an emergency department does not have the capacity to receive a patient with a psychiatric disability. However, due to decreased state funding for mental health institutions across the country, there are fewer appropriate psychiatric facilities available to accept such patients.[170] She suggested that states with appropriate mental health facilities could serve as examples of best practices for the entire nation. To address needs specific to the mentally-ill population, Ms. Greenwood also suggested creating specific reimbursement codes under Medicare for treatment of mental illness or assigning social workers to patients upon discharge. Instead of changing EMTALA, HHS could make these improvements by creating additional billing and reimbursement codes.[171]

Additionally, Ms. Greenwood suggested linking available data with an alternative, state-funded and sponsored diversion program. For example, a program could create a data bank for first responders to track homeless mentally-ill individuals.[172] Rather than transporting these patients to emergency departments, the data would allow first responders to take these patients to a state-run crisis intervention program or to meet with a patient advocate or social worker.[173] Wake County Department EMS's Mobile Integrated Health Care Practice does exactly what Ms. Greenwood suggests. Dr. Brent Myers, Adjunct Assistant Professor at the University of North Carolina School of Medicine and Director of Wake County Department of Medical Services, heads the program, which provides options to mental health patients at the level of first response to a 911 emergency situation.[174] He explained that five to ten percent of the entire U.S. population accesses healthcare through the emergency medical services (EMS) system every

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[167] Ibid., pp. 61-64.

[168] Ibid. p. 79.

[169] Ibid., p. 80.

[170] Greenwood Testimony, *Briefing Transcript*, p. 69.

[171] Ibid., p. 71.

[172] Ibid., p. 112.

[173] Ibid.

[174] Dr. Brent Myers, testimony, *Patient Dumping Briefing Before the U.S. Commission on Civil Rights*, *Washington, D.C.*, Mar. 14, 2014, transcript, pp. 129-30 (hereafter cited as Briefing Transcript), *available at* http://www.eusccr.com/2014%20Statutory%20Enforcement%20Report-Patient%20Dumping-Transcript%203-14-2014.pdf.

year.[175] This transforms EMS from simply a trauma response issue to an access to health care issue—especially for those disenfranchised and often uninsured populations.[176]

Dr. Myers' advanced paramedic program screens patients outside of the hospital setting and then diverts some away from emergency departments, toward appropriate mental health care treatment programs.[177] The program relies on protocol-driven evaluation methods of patients with three layers of review. Initial screening can occur two ways: either by the 911 center or by EMS first responders once they arrive on the scene and determine that mental health is at issue.[178] Patients may choose between alternative treatment options or the standard emergency department visit. Allowing individuals with mental health conditions to choose their treatment is a concern because of potentially diminished mental capacity. However, Dr. Myers explained that EMS personnel regularly deal with other individuals who have little or no capacity to consent.[179] For example, although unconscious trauma patients lack the capacity to consent, first responders route them to the nearest trauma center, rather than the nearest hospital. Dr. Myers explained that this same logic applies to mentally-ill patients. His EMS system takes great care to retain patients' right of choice to visit mental health or substance abuse facilities to immediately monitor and care for them in a specialized setting, instead of hospital emergency departments.[180] Providing these options lowers hospital costs significantly, even if the diversion is not reimbursable by Medicare.[181] Making diversion a reimbursable expense under Medicare would increase the potential for widespread application of this practice.

Data from the Mobile Integrated Health Care Practice shows that 34 percent of patients in the Wake County, North Carolina community met diversion criteria between July 1, 2012 and July 1, 2013.[182] Among those who met diversion criteria, 61 percent—315 patients—chose the option to go to a mental health or substance abuse facility. Only 2 percent—four out of 315—required transport to a local emergency department from the alternative option facility within 90 minutes of arrival.[183] Alternative facilities treated and discharged approximately 200 which accounted for

[175] Ibid., p. 130.

[176] Ibid.

[177] Ibid., p. 131.

[178] Ibid., p. 133. Dr. Myers believes that law enforcement officers are not equipped to make these medical screening decisions. Ibid., p. 141.

[179] Ibid., pp. 132-33.

[180] Ibid.

[181] Ibid., p. 132.

[182] Ibid., p. 134.

[183] Ibid.

63 percent of the 315 patients. The discharge specified immediate follow-up with a community-based mental health care center, rather than requiring an admission to the psychiatric facility.[184]

Dr. Richard Elliott, of the Mercer University School of Medicine, discussed linking financial incentives of community-based programs with local area hospitals so that patients benefit from an "overall system of care."[185] In this model, the same source of revenue would connect the financial interests of all involved agencies so all agencies benefit when patients do well. Importantly, he noted this change would not require increased funding.[186] Dr. Elliot mentioned a number of pilot projects funded by The Robert Wood Johnson Foundation as examples of models linking patient services through common funding pools.[187] Specifically, a program in Georgia links a small portion of the hospital budget to community services so that community mental health centers can increase their funding when providing for the most vulnerable mentally ill patients.[188]

In Dr. Elliot's opinion, this linking allows community centers to recover some of their treatment costs while decreasing hospital emergency department admits.[189] He added that some jails have similar arrangements with community mental health centers and hospitals.[190] This is especially important because, in Dr. Elliott's opinion, many mentally ill patients languish in jails for minor offenses before ever going to trial, at a great expense to the public, and without receiving proper treatment.[191] The criminalization of the mentally ill is a result of improper medical treatment and the desire of some police to clean the streets of homeless individuals, some of whom are mentally disturbed. Dr. Elliott believes that community partnerships are key to properly treating these individuals.[192]

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[184] Ibid., pp. 134,130.

[185] Dr. Richard Elliot, testimony, *Patient Dumping Briefing Before the U.S. Commission on Civil Rights*, *Washington, D.C.*, Mar. 14, 2014, transcript, pp. 127 (hereafter cited as Briefing Transcript), *available at* http://www.eusccr.com/2014%20Statutory%20Enforcement%20Report-Patient%20Dumping-Transcript%203-14-2014.pdf.

[186] Ibid., pp. 126-27.

[187] Ibid., p. 137.

[188] Ibid., pp. 137-38.

[189] Ibid., p. 138.

[190] Ibid.

[191] Ibid., pp. 150-51. Dr. Elliot blames the failure of the Community Mental Health Centers Act to adequately provide for treatment of the sickest mentally ill patients by resulting in the release of thousands of mentally ill patients onto the streets. He stated that in 1954, there were 550,000 inpatients in the United States, but now we only have over 60,000 inpatients. Ibid., p. 148.

[192] Elliot Testimony, *Briefing Transcript*, pp. 147-48.

Theme 5: Increased Training and Education

Marilyn Dahl, of CMS, explained two distinct EMTALA obligations: 1) obligations of hospitals with an emergency department toward individuals who come to that emergency department; and 2) obligations of hospitals with specialized capabilities to accept transfers.[193] Patients who arrive at emergency departments with severe psychiatric disturbances would only fall under the statutory umbrella of EMTALA when presenting a psychiatric emergency medical condition—expressing homicidal or suicidal thoughts or gestures, and determination to be a threat to self or others.[194] Under EMTALA, these patients, like all individuals who visit a hospital's emergency department, must be screened and stabilized before being discharged or transferred. EMTALA deals only with acute episodes, and the legal obligation ends when the individual is considered stabilized.[195]

Ms. Dahl described CMS's efforts to ensure hospitals and emergency departments understand and manage their obligations under EMTALA and other federal laws. Hospitals with specialized capabilities, such as psychiatric units, are required to accept appropriate transfers from other hospitals, regardless of whether the accepting institution has an emergency department itself.[196] Anecdotally, she acknowledged that CMS hears about the difficulty of finding appropriate placements for transfer patients, and that CMS has attempted to make regulations more clear and explicit regarding the obligation to accept appropriate transfers.[197]

Ms. Greenwood explained the lack of proper education exists not only on EMTALA requirements, but also on identification of psychiatric disabilities. She stated that many first responders, ambulance drivers, emergency department physicians, and hospital staff are not properly trained to identify the medical root causes of mental illness in patients who enter an emergency facility.[198] The fact that mental illness can be the result or symptom of another medical, physiological problem complicates the factors considered by hospital personnel in treating a patient. She believes CMS and OCR should provide greater education to medical personnel. While CMS has regional offices that liaise with area hospitals to receive complaints and conduct surveys, CMS and OCR should request increased training dollars to outreach on EMTALA requirements.[199]

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[193] Dahl Testimony*, Briefing Testimony*, p. 10.

[194] Ibid., p. 12.

[195] Ibid., p. 25.

[196] Ibid., p. 14.

[197] Ibid., p. 27.

[198] Greenwood Testimony*, Briefing Testimony*, p. 69.

[199] Ibid., p. 86.

Mr. Vera explained the need to share best practices amongst hospitals by creating materials like discharge protocols. In his experience suing hospitals for EMTALA violations and settling out of court, some of the hospitals agreed to adopt best practices in discharge planning.[200] Mr. Vera believed this was one of the most important results of litigation. Public Counsel has brought suit against seven hospitals and has two lawsuits currently under investigation.[201] Additionally, Public Counsel held a regional hospital symposium sponsored by the California Endowment to bring together over 50 representatives from hospitals, advocates, and housing providers to create a state task force and share best practices.[202] Mr. Vera also described federally-funded Medical/Legal Partnership contracts where attorneys and social workers from nonprofit organizations, such as Public Counsel, operate in facilities to assist mentally-ill patients and educate them of their rights before discharge.[203] Although discharge planning falls under the scope of Medicare Hospital Conditions of Participation and not EMTALA, there are other best practices hospitals may share regarding the stabilization and/or appropriate transfer of patients with emergency medical conditions.

Professor Van Tassel agreed that adopting best practices is critical in addressing patient dumping. Specifically, she believes that hospitals nationwide should adopt uniform written protocols, based on clinical practice guidelines, to avoid disparate treatment of patients with a psychiatric disability.[204] She cited recent efforts of several major physician and nursing organizations with the American Academy of Emergency Medicine to recommend the adoption of the Emergency Care Psychiatric Clinical Framework.[205] This framework supports the adoption of evidence-based treatment protocols for the emergency treatment of those with mental health disabilities and moves away from a simple customary care model based on the individual clinical judgment of each physician.[206]

Professor Van Tassel is concerned about the dismissal of EMTALA civil cases based on procedural grounds, often at the stage of granting summary judgment to hospitals or physicians, without ever reaching the merits.[207] Professor Van Tassel says this is because EMTALA's allowance of a customary care model of medical practice creates a broad range of possible treatment choices for physicians. She believes the adoption of written protocols would limit the use of the procedural strategy to dismiss EMTALA lawsuits at the outset of litigation because

[200] Vera Testimony*, Briefing Transcript*, pp. 73-74.

[201] Ibid., p. 74.

[202] Ibid., pp. 75-76.

[203] Ibid., p. 114.

[204] Van Tassel Testimony*, Briefing Transcript*, pp. 118-19.

[205] Ibid., p. 119.

[206] Ibid., p. 118.

[207] Ibid., p. 120.

there would be a much narrower set of clinical decisions and guidelines for a physician to follow.[208] Thus, expectations of physicians and hospitals would be clearer, and reduce potential personal biases and stereotyping of patients with mental illness.[209] New electronic data sharing under the Affordable Care Act could help track the outcomes of written protocols in order to continuously improve them and decrease disparities in treatment.[210] By modifying EMTALA and CMS regulations to include written protocols through evidence-based best practices, there could be greater equality of care across institutions.[211]

Dr. Elliott agrees that sharing best practices is important, but he does not believe a move away from clinical judgment of physicians is a simple or scientifically-feasible method to accomplish this goal.[212] While written protocols are a worthy goal, they can also be unfair when drug companies develop them to feed economic interests.[213] Dr. Elliot cautioned that restricting physicians to written protocols would ignore the fact that clinical decision-making is not an exact science.[214] He also believes that collecting more data should not be the goal to address patient dumping. Dr. Elliot believes the real goal should be promoting the best models of patient care in the field, such as the Assertive Community Treatment program, to reduce emergency room crowding, provide better care for patients, and create either revenue-neutral or decreased overall cost to the system.[215]

On the other hand, Dr. Myers is a strong proponent of written protocols, which form the basis of his Mobile Integrated Health Care Practice. He believes that evidence-based treatment can replace clinical judgment in a majority of situations.[216] Dr. Myers explained that there should be little room for debate in medically treating an acute mental health condition, just as there is little room for debate in treating a heart attack victim.[217] However, he explained that written protocols must be flexible enough to accept modifications by the community, so long as there is an evidence-based reason to do so.[218] He cited North Carolina's statewide EMS protocols that all

[208] Ibid.

[209] Ibid., pp. 120-21.

[210] Ibid., p. 122.

[211] Ibid., pp. 121-22.

[212] Elliot Testimony*, Briefing Transcript*, p. 156.

[213] Ibid., pp. 155-56.

[214] Ibid., p. 156.

[215] Ibid., pp. 127-28.

[216] Myers Testimony*, Briefing Transcript*, pp. 136-37.

[217] Ibid., p. 137.

[218] Ibid., p. 136.

paramedics are expected to follow as an example, which may be changed or modified by each community as necessary through evidence-based medicine.[219]

Dr. Myers stated that the Mobile Integrated Health Care Practice is now spreading from North Carolina to the Sacramento community in California, and he expects more communities across the nation to implement such practices to both reduce costs and provide more specialized treatment.[220] However, it is important to note that EMTALA does not apply to EMS if the ambulance is not owned and operated by a hospital receiving Medicare dollars, and it is often the case that ambulances are county-based or privately contracted.[221]

Dr. Myers also discussed the new electronic data sharing introduced by the Affordable Care Act for EMS, which he believes will improve the quality of patient care through real-time data exchanges among previously competing health care environments.[222] These uninsured patients represent the disenfranchised elements of our society. He explained that when there is a community response to patients with psychological disabilities, frequent users of emergency health services can receive proper treatment.[223]

[219] Ibid.

[220] Ibid., p. 140.

[221] Ibid., pp. 143, 153.

[222] Ibid., pp. 149-50. *See* PATIENT PROTECTION AND AFFORDABLE CARE ACT, PL 111-148, March 23, 2010, 124 Stat 119.

[223] Dr. Myers provided an example from his Wake County community in North Carolina. He saw the same patients sometimes four times in 30 days. The number of these patients went from 80 to just 39 after implementing his program. These patients are now receiving care through community-based programs, rather than emergency departments. Ibid., pp. 156-57.

CHAPTER 4 | FINDINGS AND RECOMMENDATIONS

Theme 1, The Lack of Adequate Data Collection

Findings

- One of the biggest problems with EMTALA enforcement and tracking patient dumping incidents is the lack of data collection.
- HHS CMS, OIG, or OCR does not organize the data received from EMTALA complaints by type of discrimination alleged.
- No HHS component currently organizes patient data to know if any particular group is being disproportionately impacted by patient dumping.
- HHS OCR has the authority to survey Hill-Burton facilities to request data, although it has not done so in the recent past.

Recommendations

- HHS CMS, OIG, and OCR should categorize data received from EMTALA complaints by type of discrimination alleged with a specific category for disability, and a subcategory for type of disability to include "psychiatric disability." This will assist in identifying if any particular group is being disproportionately impacted by patient dumping.
- HHS should establish a national taskforce to analyze available data, further research the prevalence of patient dumping, and determine which populations are most vulnerable and disparately impacted.[1]

Theme 2, The Amount of Regulatory Oversight

Findings

- The identification of EMTALA violations is primarily a complaint-driven system.
- People disabled with a psychiatric medical condition may experience difficulty in reporting EMTALA violations due to diminished capacity or access to resources.

[1] Greenwood testimony, *Briefing report*, p. 22.

- HHS CMS contracts with State surveyors to collect patient complaints, identify whether these complaints could be EMTALA violations, and eventually conduct investigations of these complaints.

Recommendation

HHS CMS should not rely entirely on State surveyors to collect complaints, determine which complaints may violate EMTALA, and then conduct investigations of these complaints. An independent federal contractor should be employed as an additional layer of review in the process and to conduct random unannounced audits of state agency investigations. This independent contractor can relieve State surveyors of at least one portion of the complaint process.

Theme 3, Non-punitive Methods for Hospital Reporting

Findings

- Most hospitals in the United States participate in Medicare and must regularly transfer data to HHS CMS.

- The current use of surveys and technology to transfer Medicare data to HHS CMS also allows electronic flagging of specific data fields for the detection of potential EMTALA violations.

- CMS has the discretion to refer an EMTALA case to OCR if there is a claim of discrimination on the basis of race, color, national origin, sex, age, or disability, and religion. OCR may pursue its own enforcement action under civil rights laws that protect against discrimination.

Recommendations

- HHS CMS should institute electronic filtering of the data it already gathers from State surveyors and hospitals for Medicare purposes in order to proactively determine whether to initiate an EMTALA noncompliance investigation. Such a filter could create a flag in the system for discharge planning fields with little to no information entered, which would be particularly helpful to protect patients with a psychiatric disability.

- By default, HHS CMS should forward all EMTALA cases it receives to OCR for a determination whether a civil rights violation also exists.

Theme 4, Following the Money

Findings

- Linking the budgets of community-based mental health programs with local area hospitals allows for community centers to recover some costs for providing treatment, reduces the number of patients in hospital emergency departments, and allows financial reimbursement for services.
- Reimbursement for certain medical services, through Medicare or other programs, creates assurances for payment of services.
- Creating reimbursement codes establishes a cost-sharing system and ensures payment for services for patients with a psychiatric disability who get medical treatment at community-based mental health centers and social service providers.

Recommendation

- HHS should consider creating Medicare-reimbursement codes for any state mental health facilities or social service providers that work in conjunction with hospitals to care for patients with a psychiatric disability. This will distribute the financial burden for treating patients with a psychiatric disability, which has been solely on hospitals' emergency departments.

Theme 5, Increased Training and Education

Findings

- Patients with a psychiatric disability only fall under EMTALA if they present a psychiatric emergency medical condition by expressing homicidal or suicidal thoughts and gestures and being a threat to self or others.
- Hospitals with specialized capabilities, such as psychiatric units, are required to accept appropriate transfers from other hospitals, regardless of whether the accepting institution has an emergency department itself.
- HHS CMS reported anecdotal evidence that patients still experience difficulty being accepted by specialized hospitals that do not have an emergency department.
- HHS CMS and OCR already train some hospitals and physicians on EMTALA obligations and the protection of patients' civil rights.

- Some hospitals have adopted best practices guidelines and written protocols to treat patients who present at emergency departments more uniformly.

Recommendations

- Congress should provide HHS additional funding for proactive and strategic training efforts to educate hospitals and physicians on EMTALA obligations.

- CMS Regional Offices should encourage sharing of adopted best practices guidelines among hospitals in their respective regions. This would help hospitals share models of evidence-based, written protocols for treating psychiatric patients presenting at emergency departments. As appropriate, health care providers should consider adopting approaches and procedures that have proven successful and provided better care at less cost.

- HHS CMS should create a monitoring program for Medicare-accepting specialized hospitals. The program should collect data and determine whether these institutions are fulfilling their obligations of accepting and treating EMTALA patients appropriately.

***Disclaimer**: We understand that EMTALA's jurisdiction ends once a medical unit stabilizes a patient. However, we believe that the following findings and recommendations below would help prevent the problem of patient dumping of the mentally ill.*

Theme 6, Stabilization and EMTALA

Findings

- The legislative definition of stabilization, as outlined in EMTALA, differs from the medical definition of stabilization. A hospital's EMTALA obligation ends once the hospital changes a patient's status from emergency to in-patient.

- The current definition of stabilization does not lend itself to effective delivery of emergency care.

- The fact that mental illness can be the result or symptom of another medical, physiological problem complicates the factors hospital personnel consider to treat a patient.[2]

[2] Greenwood testimony, *Briefing report*, p. 29-30.

Recommendations

- Congress should make EMTALA's definition of stabilization consistent across contexts to ensure that hospital do not release people before they are able to properly care for themselves or have arrangements for assisted and/or recuperative care.

- Congress should update EMTALA's definition of an emergency medical condition to acknowledge that mental health emergencies differ from purely physical emergencies.

- When a hospital eliminates the threat a person poses to him/herself or to others—because the person is physically stabilized, medically manageable and/or controllable— the hospital should transfer the individual to a specialty hospital or facility that is better suited to deal with mental stabilization, management and/or control of the person's mental health issues.

Theme 7, Learning from Best Practices

Findings

- Mental health emergencies present unique challenges that may not be suitable for traditional emergency departments.

- Communities throughout the nation are testing model programs that work to reduce emergency room crowding and provide better care for patients. In some instances, these programs are revenue neutral or decrease the overall cost of emergency care within health systems. For example, Wake County, North Carolina's EMS uses an advanced paramedic program that screens patients in an out-of-hospital setting and includes an option to divert them away from emergency departments, toward appropriate mental health care treatment programs. In some instances, these programs are revenue neutral or decrease the overall cost of emergency care within health systems even when the diversion is not reimbursable by Medicare.[3]

- Prior to EMATLA, states paid for mental health care and institutionalization when necessary. When states closed their mental institutions, they reallocated their mental health budgets. Now, states do not provide adequate community mental health services and many states seek federal reimbursement under Medicare/Medicaid to supplant the states' original obligation to pay for this care -- even though it was a state responsibility prior to EMTALA.

[3] Dr. J. Brent Myers, Director, Wake County Department of Medical Services and Adjunct Assistant Professor, University of North Carolina School of Medicine, Testimony, *Briefing report*, pp. 27-28

Recommendations

- If an individual is suffering a mental health emergency—and the emergency is not accompanied by a physical health emergency—HHS/CMS should encourage EMS professionals to divert patients to Medicare-participating facilities that specialize in mental health issues, instead of requiring the individual be cared for at a traditional emergency department.

- The federal government has instituted a program called the CMS Medicaid Emergency Psychiatric Demonstration,[4] which utilizes a form of Medicaid reimbursement to cover the cost of emergency services for mentally ill patients in several states. It covers a portion, or all, of the state's original obligation to pay for the care of mentally ill patients. The demonstration project should continue and HHS/CMS should make recommendations to Congress based on its outcomes.

Theme 8, Protocols and Discharge Planning

Findings

- There is a disconnect and lack of consistency between the HHS/CMS requirements and their practical implementation in the medical profession.

- Patients experiencing a psychiatric emergency may lack the necessary capacity to be fully aware of EMTALA violations or the necessary procedure for discharge from the hospital.

- EMTALA merely requires the posting of a patient's EMTALA rights in a conspicuous place within the emergency room. This posting may not be adequate as emergency room patients are in distress upon admission and may not be totally lucid and focused upon discharge.

Recommendations

- CMS should use the pre-existing "after-care planning" fields to trigger a red flag in the data sent to CMS if left blank. The questions included in such aftercare planning fields should detail a patient's shelter visits or eligibility for Supplemental Security Income.[8]

- Congress should expand EMTALA to include a requirement for patient discharge protocols. When a hospital receives an appropriate transfer patient, it should be

[4] http://innovation.cms.gov/initiatives/Medicaid-Emergency-Psychiatric-Demo/

responsible for discharge planning. A qualified and adequately trained individual should draft a discharge plan to include the social aspect of the patients' release. A similarly trained patient advocate should consult with the patient prior to discharge. *Medical and Social discharge plans should contain, but may not be limited to:* information on the type of follow-up care and treatment necessary for recovery, where follow-up care can be obtained, information on obtaining relevant government benefits that may include: Supplemental Security Income Social Security Disability, Section 8, Supplemental Nutritional Assistance, and housing that may be obtained.

- Working with medical professionals, HHS/CMS should develop protocols for: patient intake, psychiatric evaluation, psychiatric stabilization, transfer plans, medical discharge planning, and social discharge planning. This type of discharge planning would decrease repeated use of emergency departments for care by mentally disabled persons.

- HHS/CMS should require that each EMTALA patient get a full-page notice of their rights under EMATLA and a second page describing how to log commendations or complaints under EMTALA. This page shall also contain contact information HHS/CMS (telephone, address and email) in a large, bold typeface.

COMMISSIONER STATEMENTS AND REBUTTALS

Statement of Chairman Martin R. Castro joined by Commissioner Michael Yaki

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

-- Dr. Martin Luther King, Jr.

July 15, 2014

As I said at the outset of our briefing on patient dumping, I believe that access to healthcare is a civil right. It is among the most fundamental of rights for, without our health, we cannot enjoy any of our other rights, we cannot seek the American Dream, and indeed we cannot reach our full potential. Thus, in my estimation, healthcare is the right which allows us to exercise all other rights.

While there are so many healthcare issues that we could and should address, such as health inequalities based on race and ethnicity, language access issues, food deserts, etc., it is important that we look at the little known, but profoundly devastating issue of patient dumping. Patient dumping occurs when a hospital prematurely discharges a patient due to an inability to pay for care. From the research conducted for us by our staff, and from the materials and presentations of our expert panels, it appears to me that the victims of patient dumping fall into three distinct categories:

- The mentally disabled
- The homeless
- The undocumented immigrant

The common denominator among these groups is a lack of health insurance. Hopefully, with the dawn of the Affordable Care Act, we will see less of this as more and more people will now have access to health insurance. However, we cannot depend solely on that expectation. Therefore, I am pleased that we chose this as a topic to address, particularly since so many Americans are not aware that this is going on.

Our report is clear on the nature of the problem of patient dumping of the mentally disabled and makes key findings and strong recommendations which, if followed, will help address this gross violation of a person's civil rights and human dignity.

During the briefing, I raised the issue of international patient dumping or medical repatriation. This is the practice of U.S. hospitals forcibly and without consent of a patient returning that patient—usually an undocumented immigrant (although legal permanent residents and U.S. citizens have been victimized by this conduct also), via private transportation and without the intervention of immigration officials or courts, to the patient's country of origin or ancestral homeland, due to lack of ability to pay for continuing care. Based on an important recent study by Seton Hall Law School entitled "Discharge, Deportation and Dangerous Journeys: A Study on the Practice of Medical Repatriation," between 846 and 978 patients have been involuntarily repatriated by hospitals in15 different states.[1] However, these are only the ones that have been documented. It is believed that many more of these medical repatriations occur than are recorded or reported.

The Emergency Medical Treatment and Active Labor Act ("EMTALA)[2] protects persons from patient dumping regardless of their citizenship or immigration.[3] However, despite this fact, medical repatriation occurs, and the end result can often be the death of the repatriated patient who is sent to a country that does not have the level of care to provide for the patients' needs.[4]

Ultimately, medical repatriation is private deportation that is undertaken by a hospital, generally without the intervention of a court. Therefore, this form of patient dumping, in addition to potentially violating EMTALA, is also unconstitutional. The Fifth and Fourteenth Amendments to the U.S. Constitution afford immigrants the right to due process. That right is denied when a hospital conducts forcible private repatriations—regardless of the reason.

The Seton Hall Law study sets forth a number of solid recommendations to address the issue of medical repatriation of the undocumented, and I would strongly urge policy makers to undertake these steps to address this conduct of medical repatriation, which for many, is a *de facto* death sentence:

To the U.S. Congress:

- Convene hearings to investigate the practice of unlawful medical repatriations by private hospitals under international and domestic law.

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[1] "Discharge, Deportation and Dangerous Journeys: A Study on the Practice of Medical Repatriation," (hereafter "Seton Hall Law study"), a project by the Center for Social Justice at Seton Hall Law School and the Health Justice Program at New York Lawyers for the Public Interest, p. 5, http://law.shu.edu/ProgramsCenters/PublicIntGovServ/CSJ/upload/final-med-repat-report-2012.pdf.

[2] Pub. L. No. 99-272, 100 Stat. 82

[3] Healthcare and undocumented immigrants: What about EMTALA?, Immigration Service and Aid Center Blog, August 17, 2009, http://isaac-project.blogspot.com/2009/08/healthcare-and-undocumented-immigrants.html.

[4] Seton Hall Law study, p. 6.

- Repeal all laws that impose bars to Medicaid benefits based upon immigration status.

To the Department of Health and Human Services:

- Immediately promulgate regulations that prohibit and impose sanctions on any hospital that performs an involuntary repatriation.

- Develop a process by which hospitals must document and report international patient transfers.

- Develop an auditing process through which the department can monitor compliance with such rules and regulations.

To the Department of State:

- Engage in a dialogue with foreign consulates within the U.S. and implement a formal procedure for international medical transfers, so that transfers can be verified with receiving hospitals prior to the issuing of travel documents.

To Hospitals:

- In the absence of state or federal regulations, establish protocols to ensure that consent to unlawful, international transfers is informed, which would include disclosure of potential immigration consequences.

- Confirm (in cooperation with foreign consulates) that destination hospitals can provide the necessary long-term care before a transfer is deemed viable.

- Train hospital social workers and advocates on the special issues of working with immigrants, both documented and undocumented.

To States:

- Repeal any bars to funding for means-tested and long-term medical care based on immigration status.

- Establish a fund for long-term care for catastrophically injured immigrants.

To State Courts:

- Acknowledge federal preemption limitation on jurisdiction when discharge proceedings involve de facto deportations.

- Stay any orders of international discharge until determinations of immigration status, removability, and potential relief have been rendered by an Immigration Court.

- Direct any appointed guardians to consider immigration consequences when acting on behalf of the patient and seek independent assessment of the patient's situation.

To Community Groups and Advocates:

- Document cases of actual or threatened medical deportation.

- Raise awareness concerning discharge and language access rights and Emergency Medicaid.

- Create a rapid response working group to assist undocumented immigrants at risk of medical deportation." [5]

Only through a collective collaboration will our most vulnerable charges - the mentally ill, homeless and undocumented immigrants - be protected.

[5] Seton Hall Law study, pp. 9-10.

Patient Dumping

Statement of Commissioner Roberta Achtenberg with the concurrences of Chairman Martin R. Castro and Commissioner Michael Yaki

I. The complaint-driven system for enforcement of the Emergency Medical Treatment and Labor Act is inadequate to protect patients' rights. The U.S. Department of Health and Human Services should utilize in a more proactive and systematic manner the powers that it has to investigate and resolve possible violations.

One process for detection and resolution of patient care problems under the Emergency Medical Treatment and Labor Act (EMTALA) requires that a patient file, or arrange for the filing of, a complaint with the U.S. Department of Health and Human Services (HHS).[1] Many of the patients who receive emergency medical care under EMTALA are compromised in any of a number of ways – be they severely mentally ill, destitute, transient,[2] or otherwise ill-situated to file an administrative complaint with a federal agency and then to pursue that complaint.

HHS can also initiate its own investigations into hospitals' compliance with EMTALA. HHS has responsibility for enforcing EMTALA through the Centers for Medicare and Medicaid Services (CMS). While the HHS Office for Civil Rights (OCR) agrees that its enforcement power is very limited, it also acknowledges that patients may be reluctant to file complaints. HHS counters that anyone can file a complaint on behalf of someone else. HHS also acknowledges that although it has authority to seek data from or open a compliance review on any institution, it has not done so recently.[3] Therefore, it is clear that the investigation and remediation process for EMTALA violations is often, in reality, complaint-driven.

EMTALA is only as strong as the enforcement powers that HHS both has and utilizes. HHS should make better use of the investigative tools which it already possesses. Panelist Staci Pratt of the Nevada ACLU suggested that "affirmative proactive enforcement [of EMTALA] by CMS regional offices" is needed. She also "posited that CMS should provide independent proactive federal investigations of psychiatric emergency providers through federal contractors rather than state survey agencies on a randomized basis."[4]

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[1] Pub. L. No. 99-272, 100 Stat. 82.

[2] *2014 Statutory Report: Patient Dumping,* U.S. Commission on Civil Rights, September 2014, ("Report"), footnote 126, p. 23.

[3] *See, e.g., Briefing Transcript, Testimony of Eileen Hanrahan, U.S. Department of Health & Human Services Office for Civil Rights,* U.S. Commission on Civil Rights, March 14, 2014, p. 33, l. 20 – p. 34, l. 3; p. 35, l. 21 – p. 36, l. 10; and p. 36, l. 13 – p. 37, l. 2, *available at* http://www.eusccr.com/2014%20Statutory%20Enforcement%20Report-Patient%20Dumping-Transcript%203-14-2014.pdf.

[4] *Report,* p. 26.

Ms. Pratt and her fellow panelist Hernan Vera of Public Counsel agreed that much of the problem could be solved if HHS simply made better use of its existing enforcement powers, its technology,[5] and the data which hospitals are already required to provide. If HHS were to thoroughly review the hospitals' work by analyzing the data it receives, it could trigger investigations upon learning that critical data points were empty.[6] HHS should utilize all of its authority and tools, especially the data that hospitals already submit and the algorithms which the data could be used to generate, to initiate and conduct more compliance reviews of hospitals on a proactive basis.

II. The Department of Health and Human Services should provide restorative justice[7] for patients discharged in violation of EMTALA.

Unanswered questions remain about the fates and needs of those people discharged in violation of EMTALA. We simply do not know how many people have been treated to "Greyhound therapy," if they are still alive, where they might be, in what state of health they might be, or what services to meet their physical and mental health needs might be necessary.

We have an obligation to people who may have been discharged in violation of EMTALA. To execute this duty, HHS must make meaningful efforts to ensure that they are found, assessed, and given the help that was due to them in the first instance. HHS should ensure that patients who may have been discharged illegally are afforded a real opportunity to ask for assistance to right the wrongs done to them. This will be a large but important task. Among other work, HHS will need to gather data on questionable discharges from hospitals, try to determine where the patients at issue are currently to be found, and provide them with notice of the right to ask for assistance if, in fact their discharges were illegal. Access to a restorative justice process could go far toward ensuring that these people, if possible, are safe and engaged with medically appropriate services.

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[5] *Briefing Transcript,* p. 94 and p. 112.

[6] *Briefing Transcript,* p. 93 l. 4 – l. 7 and p. 112, l. 23 – p. 113, l. 16.

[7] The core concept of restorative justice is simple: it defines an offense or injustice as a harm against the victim and against the community (however narrowly or broadly defined in the relevant context) which is need of repair. The focus can be on reparations for victims, rehabilitation and amnesty for wrong-doers, and overall community healing. *See, e.g.,* Restorative Justice Online *at* http://www.restorativejustice.org/.

Statement of Commissioner David Kladney

In April of 2013, the *Sacramento Bee* began a series of investigative journalism about James Flavy Coy Brown, a former patient at the Rawson-Neal Psychiatric Hospital in Las Vegas.[240] The allegations made in the series of articles spoke to the early termination of care for mentally disabled patients in Nevada under the Emergency Medical Treatment and Labor Act (EMTALA) and lack of patient discharge plans.

After a brief Internet search, it became evident that the mentally impaired faced problems receiving adequate emergency care throughout the country. It was also clear that the current system fails to provide safeguards for the general public, who may encounter emergency departments that are shut down because too many beds are filled with sedated, mentally impaired people. This leaves, as one doctor told me, "Too many people sitting in the chairs, not getting treated."

All people deserve proper emergency medical care pursuant to EMTALA. Among other things, the United States Commission on Civil Rights is responsible to investigate deprivations because of disability.[241] Patient dumping of the mentally disabled is a problem faced by far too many mentally impaired Americans.

The Purpose of EMTALA

The Emergency Medical Treatment and Labor Act (EMTALA) exists to protect the most vulnerable Americans and ensure access to emergency medical treatment, regardless of ability to pay.[242] Although EMTALA was passed to protect our nation's most vulnerable populations, it has failed to protect many of the mentally disabled from the practice of patient dumping.[243] This problem disproportionately affects people without medical insurance. People with mental impairments are overrepresented in the population of uninsured. Of the 27 million uninsured people in this country, 6.7 million—nearly 25 percent—have a mental disability.[244]

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[240] http://www.sacbee.com/2013/04/07/6045057/cast-out-by-nevada-he-finds-kindness.html.

[241] The Statutory duties of the U.S. Commission on Civil Rights are available online here: http://www.law.cornell.edu/uscode/text/42/1975a. Last accessed July 17, 2014.

[242] https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/emtala/.

[243] For another set of investigative news articles that address the issue of patient dumping, see the Los Angeles Times. Articles on the issues are available at: http://www.latimes.com/local/la-me-hospital-patient-dumping-20140104-story.html and http://articles.latimes.com/2014/jan/03/local/la-me-ln-patient-dumping-skid-row-20140103. These articles were last accessed on July 17, 2014.

[244] Dashed Hopes; Broken Promises; More Despair: How the Lack of State Participation in the Medicaid Expansion Will Punish Americans with Mental Illness. Feb 2014. Page 1. Available at http://www.amhca.org/news/detail.aspx?ArticleId=792. Last accessed July 18.

Stabilization and Discharge

Congress designed EMTALA to provide access to quality emergency healthcare for all people. However, the statutory obligation ends as soon as a patient becomes "stable."[245] As a result, some hospitals discharge mentally disabled patients before they are ready to go.[246] This results in repeat emergency room admissions. It is problematic because EMTALA's definition of stability is not aligned with the medical definition of stability.[247] The medical definition of stability does not consider whether the average person could care for himself or herself outside the hospital environment, and the EMTALA definition requires even less. Determinations of stabilization are especially difficult for people with mental disabilities because stabilization often includes sedation or another intervention that does not address the root problem in any **real** way.

Long Wait Times and Emergency Department Closings

The problem of injustice in treatment of mentally disabled patients negatively affects other types of service delivery in emergency departments. Emergency rooms are losing the ability to deal with imminent physical emergencies because they are crowded with people suffering mental emergencies. Because mentally disabled patients require a different[248] type of treatment, their presence in the emergency department frequently leads to longer wait times for individuals who present at the emergency room in need of acute medical care.

The practical effect of emergency department over-capacity, due to an influx of mentally disabled patients, happened one night in February of 2014 when four Las Vegas, Nevada hospitals closed their doors to incoming ambulances because they had reached capacity.[249] Dr. Dale Carrison, chief of staff and head of emergency services at University Medical Center commented that the influx in mentally disabled patients means, "true emergencies are being delayed in care."

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[245] Witness Dahl testified, "The concept of stabilization is challenging, particularly because the EMTALA statutory definitions are not the way the terms are typically used by clinical individuals." Briefing transcript. Testimony of Marilyn Dahl. Page 25, lines 19-20.

[246] Richard Winton. January 3, 2014. L.A. City Atty. Mike Feuer vows to crack down on 'patient dumping.' The Los Angeles Times. http://www.latimes.com/local/la-me-hospital-patient-dumping-20140104-story.html. Last Accessed July 17, 2014.

[247] Testimony of Marilyn Dahl. Page 25, lines 15-18.

[248] Whereas the average stay for most medical emergencies is four hours, the stay for mentally disabled patients can last for more than 24 hours. For more on this, see: Inundated by the mentally ill, valley emergency rooms close to ambulances. Yesina Amaro. 26 Feb 2014. Las Vegas Review Journal. Available at: http://www.reviewjournal.com/news/inundated-mentally-ill-valley-emergency-rooms-close-ambulances (last Accessed July 7, 2014).

[249] Ibid.

Mentally disabled people would be better served by having regular access to community mental health clinics instead of repeat admissions to emergency rooms for the most expensive care possible. Adequate primary care would be far cheaper, and would dramatically reduce the wait time in emergency rooms for people who are suffering physical emergencies.

Solutions: The Way Forward

While I acknowledge the difficulty and expense in creating systems that work effectively to manage health care for people with mental disabilities, I believe there are steps Congress and the President can take to mandate through CMS/HHS to improve conditions for mentally disabled persons. The Commission's findings and recommendations - included in this report on page 37 - are ripe with suggestions. I will highlight a few of them here:

1) Expanding the definition of emergency
2) Revising the definition of stability
3) Considering Alternative-Destination Programs
4) Establishing care and discharge protocols
5) Managing the IMD exclusion and payments from the federal government to states
6) Making the most of advances in data collection
7) Launching proactive and independent investigation of hospitals

Expanding the definition of emergency

EMTALA's definition of emergency does not acknowledge the nuance of emergencies caused by, or resulting from, mental disability. Instead, it treats these emergencies the same as physical emergencies. I posit that people may face two types of medical emergencies: physical and/or mental. Physical emergencies are potentially life threatening, and occur within the body. They may be caused by loss or impairment of bodily function. Mental health issues cause mental emergencies. These may have life threatening consequences if left untreated because the person with the mental disability could cause harm to themselves or others.

Where both physical and mental emergencies exist, medical professionals should handle physical emergencies first. Where a mental emergency is present, but physical emergencies do not exist, medical professionals should be prepared to implement a set of protocols or use alternative-destination programs (both discussed below) to address the issue. EMS professionals should direct mentally disabled people to facilities, that accepts Medicare, which are best equipped to deal with the type of emergency the patient is experiencing.

The definition of stability

With different definitions of emergency, we can establish different, more effective definitions of stability. Stability should account for a person's ability to care for her or himself and/or their access to care after the hospital stay. Levels of stability would be beneficial as a model for determining when mentally disabled patients should be released from the care of emergency departments or other medical facilities. The first level of stability should acknowledge that a person is no longer in critical condition. The second level of stability should account for a person's ability to function outside a hospital setting. A person should not be declared completely stable until they are strong enough to function without medical supervision or until the hospital accounts for the type of care necessary to keep that person stable outside the hospital. Absent this the emergency room is merely a revolving door for the mentally disabled.

The different levels of stability would also help toward the goal of increasing the practical effectiveness of EMTALA. The practice of patient dumping might be reduced because hospitals would no longer be able to discharge people with mental disabilities before they were prepared to care for themselves or had recommendations/accommodations for their care.

Alternative-Destination Programs

Congress and CMS/HHS should empower specially trained EMS professionals and emergency department staff to choose the most effective intervention for patients who present emergencies related to mental disability. Giving EMS and other first responders the ability to choose alternatives to the emergency room works to solve the problem of patient dumping in three ways. First, and most importantly, it gets mentally disabled people exactly the kind of help they need. Second, it reduces the problem of overcrowding by diverting them from traditional emergency departments, which decreases wait times for individuals who are experiencing emergencies that can only be handled in emergency rooms. Third, medical facilities could use the funds saved from providing less expensive, appropriate care to assist in aftercare or respite care for people with mental illness.[250]

Some localities have already implemented programs that tailor emergency response for people based on what an individual needs. For example, Wake County EMS[251] has an Alternative-Destination Screening system that standardizes the initial interaction with trained EMS staff.[252] In short, EMS professionals determine whether an individual has the ability to decide for him or

[250] Briefing Transcript. Testimony of Richard Elliott. Pages 127 at line 20 through page 128, line 4. See also: page 137 at line 22 through page 138, line 22.

[251] Briefing Transcript. Testimony of Brent Myers. Pages 131 starting at line 16 through page 132.

[252] Greg Guillaume, et. al. Taking Substance Abuse and Mental Health Out of the Emergency Department. January 2014. Available at: http://www.emsworld.com/article/11289649/advanced-practice-paramedics-and-alternative-destinations. Last accessed July 17, 2014.

herself where they want to go for treatment. If the person is not experiencing an imminent physical emergency, they may choose to go to a facility that specializes in the treatment of mental impairments, which accepts Medicare, or they may choose to go to a traditional emergency department. "The goal of the alternative-destination program is getting the right services to the right patient at the right time rather than just providing transport to the emergency department. If the patient refuses the recommended alternative destination, we offer transport to the emergency department if they choose."[253]

Alternative-destination systems have proven remarkably effective in preventing emergency room overcrowding. Many of the patients who interact with the EMS choose to forgo traditional emergency departments, opting instead for care at mental health facilities. In a six-month period from July-December of 2010, EMS professionals "successfully diverted 126 patients to facilities other than EDs."[254] The number of participants in the program has grown steadily since its inception. During the program's first full year, it "assisted 212 patients, then 252 in 2012. Due to expanding partnerships in the community, the number of transports to alternative destinations has increased dramatically; as of December 18, 2013, it stood at 350." Wake County has earned accolades for its work, and has served as a model for other cities.

Establishment of care and discharge protocols

Subjective assessments of individuals with mental disability present a different type of problem with EMTALA enforcement. Mental disabilities are frequently misunderstood, and are best handled by professionals who are specifically trained to deal with those issues. However, for a number of reasons, demand for specialized mental care out weights the supply. One way to prevent the potential for desperate treatment of mentally disabled people is to create and implement protocols[255] for ways that medical professionals should interact with patients based on their problems.

Planning protocols could prevent many of the problems of patient dumping by revealing potential problems that a person would face when they leave the hospital. Therefore, hospitals should be required to follow a set of protocols. Further, as a part of declaring a person discharged, hospitals could require meeting with trained professionals to give patients information on their eligibility for medical and social benefits and other measures to facilitate a smooth transitions from medical supervision.

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[253] Ibid. page 2.

[254] Ibid. page 2.

[255] Witness Van Tassel comment, "I would actually have protocols that were fairly standardized, and that were also a part of the CMS review process." Page 135, line 11. Another set of protocols is included in Beverly Community Hospital's agreement with Los Angeles county, available online here: http://atty.lacity.org/stellent/groups/electedofficials/@atty_contributor/documents/contributor_web_content/lacityp_027545.pdf. Last accessed July 17, 2014.

Managing payments from the federal government to states and relaxing the IMD exclusion

When states maintained mental hospitals, they paid the cost of care for their mentally disabled residents. After states closed their facilities during deinstitutionalization, they reallocated most of these tax dollars to other uses instead of allocating the cost savings to community mental health clinics. This lack of funding degraded care for the mentally impaired in the community, which led to the repeated use of emergency rooms as a source of primary care by these citizens.[256] States had the responsibility to fund and care for the mentally impaired before EMTALA passed, and states *still* have that responsibility. However, today states have reallocated those funds to other uses, and are looking to the federal government to fund care for their mentally disabled residents.

Currently, EMATA allows for reimbursement of fees for Medicare expenses but does not reimburse costs for Medicaid recipients.[257] The Institutions for Mental Disease (IMD) exclusion, "bars federal contributions to the cost of medically necessary inpatient care incurred in treating Medicaid beneficiaries ages 21-64 who receive care in certain[258] institutions that fall within the definition of an "institution for mental disease."[259] The goal of this exclusion was to ensure that "states, rather than the federal government, continue to have principal responsibility for funding inpatient psychiatric services."[260] The logic of the IMD exclusion is problematic for at least two reasons. First, many of the people who use EMTALA are on Medicaid or uninsured. SAMHSA reports that upwards of 10 percent of the Medicaid population used mental health related services.[261] Second, lack of access to adequate medical care in psychiatric hospitals is driving mentally impaired individuals into emergency departments for their care.

As a part of the Affordable Care Act (ACA), the federal government is using a demonstration project to "reimburse private psychiatric hospitals for acute psychiatric inpatient services."[262]

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[256] Yanos, P.T., et al. Correlates of Health Insurance Among Persons with Schizophrenia in a Statewide Behavioral Health Care System. Psychiatric Services, 55(1). Cited in The Uninsured: A NAMI Facto Sheet. March 2007. Available online at: http://www.nami.org/Content/ContentGroups/Policy/Issues_Spotlights/Uninsured/fact_sheets_uninsured_fi nal.pdf. Last accessed July 17, 2014.

[257] See: Rosenbaum, S., Teitelbaum, J., and Mauery, D. (2002) An Analysis of the Medicaid IMD Exclusion.

[258] Institutions with 17 or more beds.

[259] Ibid. page 1. See also: 42 U.S.C. § 1396d.

[260] Ibid. page 9.

[261] Ibid. page 7.

[262] Medicaid Expansion & Mental Health Care. National Alliance on Mental Illness. May 2013.

The goal of the demonstration project is to "supply higher quality care at a lower cost."[263] Congress should closely monitor the progress of the demonstration project and re-write Medicaid legislation to eliminate the IMD exclusion, if the demonstration proves successful. The result would be that mentally disabled people gain access to quality care from a variety of sources, and rely less on emergency departments for their primary care needs.

Advances in data collection

It is difficult to fully understand the problem of patient dumping because interested parties lack the data they need to make claims about the scope and magnitude of the problem.[264] The data that exists is incomplete, and not organized in a manner that allows for sorting to identify civil rights abuses.[265]

The Affordable Care Act requires hospitals to "collect data and disaggregate it according to the minority status, disability status, according to gender, et cetera,"[266] Existing systems allow for more thorough data collection methods. However, medical professionals leave many of the fields blank.[267] Clearly, hospital staff should be mandated to collect and fully complete these data forms. Once the information is collected, it is important that Congress and CMS/HHS capitalize on the wealth of data. I look forward to the progress that we might make by understanding this problem completely.

Investigation of hospitals

Some of the problems of EMTALA violations could be solved through proactive investigations. I concur with witness testimony that CMS "should provide independent proactive federal investigation of psychiatric emergency providers... through federal contractors instead of state agencies."[268] Independent, federal investigations are key because they would encourage hospitals to be more proactive. They may also motivate hospitals to remain compliant because they know the investigative team could arrive at anytime.

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[263] Center for Medicare and Medicaid Innovation, "Medicaid Emergency Psychiatric Demonstration." Available online at: http://innovation.cms.gov/initiatives/medicaid-emergency-psychiatric-demo/. Last accessed September 19, 2014.

[264] Briefing Transcript. Testimony of witness Katherine Van Tassel. Page 154, lines 10-25 and page 155, lines 1-5.

[265] Briefing Transcript. Testimony of witness Hanrahan who states, "We have a case data system currently. It does not at the time allow us to search by type of disability, so we are not able to conduct research, for example, of individuals with psychiatric disabilities and complaints raising those issues."

[266] Testimony of witness Van Tassel at Page 144, line 11.

[267] Testimony of witness Staci Pratt. Page 94, line 8.

[268] Pratt, Page 64, line 10.

Conclusion

The system of emergency care management for mentally ill patients is broken, but not beyond repair. With some major adjustments to EMTALA, that would include, but not be limited to a funding care formula for Medicaid eligible persons, expanding the use of alternative-destination programs, and creating detailed uniform discharge protocols, we can make progress in stopping the problem of overcrowded emergency departments, which benefit all people and patient dumping.

Statement and Rebuttal of Commissioner Gail Heriot

I don't believe the Commission has jurisdiction over this topic. Nor does it have expertise here (except that hastily developed in order to turn out this report). It is not clear why we have wandered into it.

Our enabling statute allows us to "study and collect information relating to" and to "make appraisals of the law and policies of the Federal government with respect to" "discrimination or denials of equal protection of the laws[269] under the Constitution of the United States *because of color, race, religion, sex, age, disability, or national origin*, or in the administration of justice."[270]

The victims of EMTALA violations, however, are not being discriminated against on account of their *race, religion, sex, age, national origin or even their disability*. They are picked out on account of their inability to pay for their medical care.[271] They are uninsured and without independent means with which to pay those bills.[272] To be sure this is an important topic and

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[269] Denials of equal protection under the Fourteenth Amendment's equal protection clause (state) or under the Fifth Amendment's due process clause (federal) must involve intentional discrimination by the relevant governmental authority. See, e.g., *Arlington Heights v Metropolitan Housing Corp.*, 429 U.S. 252 (1977); *Washington v. Davis*, 426 U.S. 229 (1976). For that reason, giving the Commission the authority to study "denials of equal protection" does not expand the Commission's jurisdiction beyond discrimination.

[270] 42 U.S.C. § 1975a(a)(2)(emphasis added). Our statute also requires us to "submit to the President and the Congress one report annually that monitors Federal civil rights enforcement in the United States." See 42 U.S.C. § 1975a(c)(1). But in context "civil rights" refers the right to be free from "discrimination or denials of equal protection of the laws under the Constitution of the United States *because of color, race, religion, sex, age, disability, or national origin*, or in the administration of justice." This provision does not extend our jurisdiction. Rather it requires that at least one of our reports each year be connected to federal efforts to enforce law that seeks to prevent or punish "discrimination or denials of equal protection of the laws under the Constitution of the United States because of color, race, religion, sex, age, disability, or national origin." a

[271] In the case of Rawson-Neal Psychiatric Hospital in Las Vegas, Nevada, patients were apparently singled out on account of their inability to pay coupled with their out-of-state residence. Rather than continue to provide care, Rawson-Neal, a state hospital, made it a practice to purchase bus tickets for out-of-state psychiatric patients returning them to their home states. The situation at Rawson-Neal has been of special significance to this report, because it apparently triggered Commissioner Kladney's interest in the subject matter. Even before that proposal was made, he told the Sacramento Bee, "As a Nevadan, I am ashamed that my state is failing in its duty toward the neediest residents." Cynthia Hubert, Phillip Reese and Jim Sanders, *Nevada Buses Hundred of Mentally Ill Patients to Cities Around Country*, **SACRAMENTO BEE** (April 14, 2013). See also Ed Vogel, *Nevada Attorney Steers U.S. Civil Rights Commission to Patient Dumping*, **LAS VEGAS REVIEW-JOURNAL** (February 9, 2014).

A class action lawsuit was filed in federal court last year against the governmental unit that administers Rawson-Neal, but it has since been dismissed. An appeal is expected. *Brown v. Southern Nevada Adult Mental Health Services*, 2:13-CV-1039 JCM (PAL) (D. Nev. June 20, 2014)(Order). The plaintiff in the case was James Flavy Coy Brown, a 48-year-old schizophrenic who Rawson-Brown put on a bus for Sacramento. Rawson-Neal admitted mistakes in Brown's case in that Brown was apparently not from California and hence should not have

deserves a great deal of thought and examination[273]—but not from this Commission. We are not vested with the power to study a problem just because it deserves to be studied.[274] Our projects must fall within the jurisdiction granted to us by Congress.

The Commission cannot have jurisdiction over EMTALA violations simply on the ground that many of the individuals who are victimized by violations are disabled.[275] If it did, then by the

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been sent there. But it also told the Sacramento Bee that this was an aberration. Cynthia Hubert, *Mentally Ill Man "Dumped" by Nevada Has Happy Reunion with Daughter*, **SACRAMENTO BEE** (April 12, 2013).

[272] Judge Mahan drew a similar conclusion in rejecting plaintiff's cause of action under the Americans with Disabilities Act in the Rawson-Neal Psychiatric Hospital case, discussed *supra* at n.3. He stated: "To adequately plead such a claim, a plaintiff must plausibly state that the denial of a benefit occurred because of a disability…. In this case, plaintiff's claims revolve around the notion that defendants' actions were motivated by his indigency rather than his mental illness." *Brown v. Southern Nevada Adult Mental Health Services*, 2:13-CV-1039 JCM (PAL) at 7-8 (D. Nev. June 20, 2014)(Order).

[273] The problem of what to do with patients who are uninsured and unable to pay for their medical care is also an intensely controversial topic, which the Patient Protection and Affordable Care Act (the "ACA"), Pub. L. 111-148, 124 Stat. 119-1025 (March 23, 2010), attempts to resolve by requiring all uncovered Americans to buy health insurance. One issue that deserves to be studied is the extent to which the perverse incentives created by EMTALA (for hospitals, to close down emergency rooms, for individuals, to forgo health insurance) directly led to the adoption of the ACA.

[274] It is not even true that EMTALA is a statute specifically aimed at helping those with a "disability" within the meaning of our enabling statute. To begin with, "disability" in our statute takes on the meaning of "disability" in the Rehabilitation Act, Pub. L. No. 93-112, 87 Stat. 394 (Sept. 26, 1973), codified at 29 U.S.C. § 701. In that statute, disabled persons are "persons with a physical or mental impairment which substantially limits one or more major life activities" where "[m]ajor life activities include caring for one's self, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning." By contrast, EMTALA covers persons suffering an "emergency medical condition," which is defined to mean "a condition manifesting itself by acute symptoms of sufficient severity (including extreme pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organ." This would include persons with very transient medical issues, such as a laceration, a case of the measles or a drug overdose. A disability need not be long-term. See, e.g., *Summers v. Altarum Institute*, 740 F. 3d 325 (4th Cir. 2014)("[A] sufficiently severe temporary impairment may constitute a disability."). But it does need to be significant enough to substantially limit one or more major life activities in the employment context. The best one can say is that victims of violations of EMTALA are likely to be disproportionately persons who are disabled.

Even if we were to assume arguendo that the victims of EMTALA violations are "disabled" that does not mean that they have been discriminated against. The concern is that they have been treated the *same* way they would have been treated if they had been non-disabled (i.e. they have not received medical services that also would not have been given to a non-disabled person), not that they have been discriminated against. An EMTALA violation is not an event of discrimination because of the victim's disability. The complaint is not that they have been treated differently than non-disabled persons, but rather that they have not been treated adequately given that they remain in need of care after their time in the emergency room.

[275] The Commission also cannot gain jurisdiction over this situation on the ground that persons with psychiatric disabilities are victims of EMTALA violations more than persons with non-psychiatric disabilities.

same logic, the Commission would have broad jurisdiction over just about every federal policy under the sun. Ordinary decisions relating to Medicaid, Medicare and the Affordable Care Act ("ACA")[276] affect disabled persons more than they do non-disabled persons. But a decision that affects a disabled person is not the same thing as a decision that discriminates against a disabled person. If it is, why stop with disability? If the Commission has jurisdiction over policies that happen to affect disabled persons more than non-disabled persons, presumably that logic would also apply to race, sex, religion, national origin and age. That would give the Commission plenary jurisdiction over federal education policy (because it affects the young more than the old), Social Security (because it affects the old more than the young), child care (because more women than men are primary caretakers of children), and defense policy (because more men than women are in the military). That can't be right.[277]

If the Commission had adopted this topic without much thought, I would be less worried about our ability to work within our jurisdiction in the future. But oddly enough, this is the topic that was chosen after the Commission's original choice was abandoned on the ground that it did not fall within the Commission's statutory framework. The original choice had also been proposed (along with a handful of other topics) by Commissioner Kladney. The Commission had adopted it, not so much at Commissioner Kladney's behest, but as a compromise among the various members of the Commission at our June 14, 2013 meeting. Only a few weeks later, he urgently wished to change the topic to patient dumping under EMTALA, citing a belatedly-issued (and I believe erroneous) opinion from our General Counsel that the original topic would not satisfy our statutory responsibility to "submit to the President and the Congress one report annually that

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There is no evidence this is so, and the Director of the Division of Acute Care Services with the Survey and Certification Group at the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services repeatedly denied that there is any evidence showing it. Tr. at 37-39.

[276] See supra at n.5.

[277] Note that I am not making the argument that Congress never intended to give the Commission jurisdiction over disparate impact. In 1957, when Congress established the Commission, it is unlikely that Congress was thinking of disparate impact as a form of discrimination (although in some cases they may have thought evidence of disparate impact was information "relating to" discrimination, since it is arguably evidence of discrimination). In 1983, however, when Congress passed the Commission on Civil Rights Act, which re-configured the Commission, the Supreme Court had already decided *Griggs v. Duke Power Co.*, 401 U.S. 424 (1971), and *Albemarle Paper Co. v. Moody*, 422 U.S. 405 (1975), both of which applied disparate impact analysis to the employment discrimination context. Arguably, therefore Congress had disparate impact in mind in giving the Commission jurisdiction over discrimination based on color, race, religion, sex, age, disability, or national origin.

But disparate impact arguments are structured this way: Some policy affects a protected class of person (a particular race, sex, religion, national origin, age or disability group) in a way that makes that group worse off, and the group would prefer that this policy be eliminated so that they would instead be treated the same way as the non-members of the group who are disproportionately unaffected by the policy. But disabled persons in EMTALA cases are not seeking to be treated the way disproportionate numbers of non-disabled persons are being treated (i.e. not receiving medical care). That wouldn't solve their problem. If we were to call the issue in this case "discrimination" against the disabled, then the word "discrimination" loses all meaning.

monitors Federal civil rights enforcement in the United States."[278] By our November meeting, Commissioner Kladney had convinced a sufficient number of Commission members of the desirability of making the change, despite their well-founded misgivings over changing topics so late in the process.[279]

Curiously, however, the argument that the original topic was within the Commission's jurisdiction is considerably stronger than the argument that the present topic is, since the original topic concerned allegations of race discrimination in drug arrests. [280] Moreover, the argument

[278] See 42 U.S.C. § 1975a(c)(1). I would put more stock in the opinions issued by the General Counsel's office on jurisdiction issues if it had not issued an implausible opinion concerning the Commission's jurisdiction over the wage gap between men and women. When I proposed that the Commission study the gender wage gap—something that many people consider a core concern of the Commission—I was told that the Commission did not have jurisdiction because the Commissioner proposing the project did not believe that discrimination is the best explanation for the gap. See Office of the General Counsel, Concept Paper Review on Gender and the Wage Gap (Undated but sent via e-mail on May 12, 2014)("The concept paper as written is not within the Commission's jurisdiction. The concept paper's premise is that the wage gap is not due to discrimination based on sex but due to other variables. That is to say that the concept paper seeks to prove non-discrimination. As such, the concept paper is outside of the Commission's jurisdiction."). Of course, it was not my point that women did not suffer employment discrimination. The point was simply that the extreme gaps that are touted by political activists as proof of discrimination are misleading. For example, while the figure purports to represent all full-time employees, everything from 35 hours per week on up counts as full time, and men on average work more hours than women (who are more likely to have childcare responsibilities at home). Carmen DeNavas-Walt, Bernadette D. Proctor & Jessica C. Smith, Income, Poverty, and Health Insurance Coverage in the United States: 2012 at 20 (U.S. Department of Commerce Economics and Statistics Administration/U.S. Census Bureau 2013), available at http://www.census.gov/prod/2013pubs/p60-245.pdf. Moreover, men and women as broad groups are not performing the same jobs. Men are more likely to work in physically strenuous and/or hazardous jobs like coal mining, while women are more likely to have jobs that have relatively pleasant surroundings, like department store retailing. CONSAD Research Corporation, An Analysis for the Reasons for the Disparity in Wages Between Men and Women: Final Report Prepared for the Department of Labor (2009), available at http://www.consad.com/content/reports/Gender%20Wage%20Gap%20Final%20Report.pdf. If this is not information "*relating to*" "*discrimination ... because of ... sex*" within the meaning of our statute, then Congress's ability to rely upon the Commission's policy recommendations on sex discrimination issues would be paralyzed. The notion that the Commission has jurisdiction to study an issue with a connection to the contemporary debate over sex discrimination in employment only if the proposing Commissioner expects to find discrimination to be the predominant explanation and not if she believes other explanations to be more predominant is profoundly misguided.

[279] I voted in favor of the compromise package, but now regret that vote. At the time I was unfamiliar with the "patient dumping" situation and understood this to be an investigation into genuine disability discrimination. See U.S. Commission on Civil Rights, Transcript of November 15, 2013 Business Meeting at 43-44. I was less concerned over whether the topic would discharge our duty to "submit to the President and the Congress one report annually that monitors Federal civil rights enforcement in the United States," see 42 U.S.C. § 1975a(c)(1), because I believed we had already discharged that duty with another report. See infra at n.11.

[280] The previously selected topic was "Narcotics Policing: Discretionary or Discriminatory?" It sought, among other things, to determine whether the disparities in arrest rates for narcotics offenses were caused by actual race discrimination. There is no doubt that the Commission has jurisdiction over this subject matter. The real

that the original topic was an appropriate topic with which to discharge the Commission's statutory duty to "submit to the President and the Congress one report annually that monitors Federal civil rights enforcement in the United States"[281] was also stronger.[282]

I have never heard a good explanation for why the need to switch topics was so very urgent. The explanation that the original topic did not "monitor[] federal civil rights enforcement" I believe to be weak. But since the Commission has chosen to issue this report, I assume for the purposes of this report that indeed we do have jurisdiction and comment accordingly.[283] My substantive comments are relatively brief.

* * * * *

Hospitals to care for the sick and injured go back thousands of years. According to legend at least, Ashoka the Great opened many in the third century B.C. The problem of what to do with those who cannot pay for their hospitalization has been around equally long.[284] Here in the United States, both private and public solutions (as well as public-private collaborations) have been employed. In 1692, the Boston Board of Overseers of the Poor was established to see to the

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concern was whether a report on this topic would discharge the Commission's responsibility under its statute to "submit to the President and the Congress one report annually that monitors Federal civil rights enforcement in the United States." See 42 U.S.C. § 1975a(c)(1). It is my position that neither the originally-chosen topic nor this topic chosen in its place directly monitors a federal *statute* designed for the purpose of civil rights enforcement, but that a different report issued in the same fiscal year does and therefore clearly and unequivocally fulfills our duty to issue a report that monitors Federal civil rights enforcement. See U.S. Commission on Civil Rights, *Assessing the Impact of Criminal Background Checks and the Equal Employment Opportunity Commission's Conviction Records Policy* (December 2013). Of course, a report that monitors Federal civil rights enforcement need not specifically monitor the enforcement of a civil rights statute. It can instead monitor a *policy* that is designed to ensure equal protection, even if that policy is unattached to a statute. In this regard, a report that monitors the policies that the federal government has in place to prevent race discrimination in drug arrests at the state or federal level would make an adequate report that "monitors Federal civil rights enforcement in the United States." The original topic would thus likely qualify. On the other hand, since I do not believe the current topic concerns a kind of discrimination within our jurisdiction, it cannot be a report that "monitors Federal civil rights enforcement" within the meaning of our statute.

[281] See 42 U.S.C. § 1975a(c)(1). See *supra* at n.2.

[282] See supra at n.11.

[283] *Cf. Hamdan v. Rumsfeld*, 548 U.S. 557, 678 (2006)(Thomas, J., dissenting)(concluding that the court lacks jurisdiction, but stating that the "Court having concluded otherwise, it is appropriate to respond to the Court's resolution of the merits …); *Epperson v. Arkansas*, 393 U.S. 97 (1968)(Blackmun, J., concurring)(commenting on non-jurisdictional issues despite misgivings over jurisdiction issues, because majority had concluded that jurisdiction existed).

[284] See Charles Allen, **ASHOKA: THE SEARCH FOR INDIA'S LOST EMPEROR** (2012). Ashoka was a convert to Buddhism and is said to have founded not just hospitals to serve the needy, but also veterinary hospitals. In the book, Allen discusses the efforts to re-discover Ashoka, who at one point had become an obscure figure in the history of India as Buddhism became an increasingly minority religion on the subcontinent.

poor's necessities, including medical care.[285] Board members tended to be among the city's wealthiest residents, whose resources would be needed to finance that care. A few decades later, in 1736, Charity Hospital in New Orleans was established as a hospital dedicated to serving the indigent, financed by a bequest from the wealthy shipbuilder Jean Louis.

The Roman Catholic Church, which has always considered the care of the indigent to be one of its special responsibilities, has long been the largest non-governmental provider of health care in the country.[286] Other faith traditions—Baptist, Jewish, Lutheran, Methodist, Mormon, Presbyterian and others—as well as other non-profits have also made exemplary contributions. Many for-profit hospitals also have long pre-EMTALA histories of setting aside a portion of their resources for the care of those who cannot pay.[287]

Originally, local governments were far more likely to be involved in the provision of medical care for the indigent than the federal government—though the federal government has had a special role to play at times in the provision of medical care for veterans. In 1965, however, the federal government acquired a huge role with the creation of Medicare (for the elderly) and Medicaid (for the poor).[288] In 1972, Medicare was significantly expanded to cover younger persons with permanent disabilities who qualify for and receive Social Security Disability Insurance.[289]

Before EMTALA, private hospitals operated under a legal rule that did not require them to offer emergency medical services or any other kind of assistance to anyone if they did not wish to do so.[290] But, as I have suggested above, many did so wish. Indeed, for some, it was their raison

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[285] See Massachusetts Township Act of 1692, reprinted in **THE EIGHTEENTH CENTURY RECORDS OF THE BOSTON BOARD OF OVERSEERS OF THE POOR** (Eric Nellis & Ann Decker Cecere, eds., 2006). Curiously the Board of Overseers had a process similar to that employed by Rawson-Neal Psychiatric Hospital, see supra at n.3, under which newcomers without means of their own support were "warned out" and returned to their original town of residence. King Solomon may well have been right: Nothing is new under the sun. **ECCLESIASTES** 1:9.

[286] Mother Frances Xavier Cabrini and Mother Marianne Cope have been canonized in significant part for their heroic work establishing and maintaining hospitals in the United States and in places that became the part of the United States.

[287] In this way, for-profit hospitals resemble for-profit law firms that set aside a portion of their resources for the legal representation of those who cannot pay.

[288] The Social Security Amendments of 1965, Pub. L. 89-97, 79 Stat. 286 (1965).

[289] The Social Security Amendments of 1972, Pub. L. 92-603, 86 Stat. 1329 (1972).

[290] This was the so-called "no affirmative duty rule," which did not require any person (including any hospital, doctor, nurse, etc.) to intervene to prevent harms. The rule sounds harsh at first hearing. Under it, if a passerby sees a baby drowning face down in a puddle, he is under no legal obligation to gently turn the baby over to save his life—although he certainly is under a moral obligation to intervene. Legally, he can just keep walking.

d'être. In general, states operating hospitals were in a similar situation. While they were subject to the Fourteenth Amendment's equal protection clause and other Constitutional limitations, there was nothing other than the desire of the state's citizens to serve their indigent population requiring the states to provide medical care to those who could not afford it (or indeed to anyone).[291] Yet, again, the citizens did so desire.

In fact, however, the vast majority of Americans routinely intervene to prevent harm to others. Each year, Americans give billions of dollars to charities that serve the less fortunate. The internet is chock full of stories of Americans who risked their lives to assist strangers in distress. And I am aware of no babies that have been left to drown in puddles. More to the point, there is no evidence that Americans operating under the "no affirmative duty rule" are less likely to come to the assistance of strangers in distress than citizens of other countries where the law imposes a duty to act. Indeed, there is some evidence to the contrary. See Charities Aid Foundation, *World Giving Index 2013: A Global View of Giving Trends* (ranking the United States as #1 globally in overall world giving, with a #1 ranking in "helping a stranger," a #3 ranking in "volunteering time" and a #13 ranking in "donating money"). Interestingly of the top seven countries in this global ranking of 135 countries, all seven—the United States, Canada, Myanmar, New Zealand, Ireland, United Kingdom, Australia—have legal systems based on the English common law system, presumably including its "no affirmative duty" rule.

Some have argued that American jurisdictions should adopt the rule common in civil code jurisdictions requiring individuals to intervene to prevent harms when they can do so at only insignificant cost to themselves. But to my knowledge, no one has ever seriously proposed that no distinction should be made between the level of care that ought be employed to avoid inflicting a harm and the level of care that should be employed to prevent a harm that one had no role in inflicting. For the former situation, the well-known Hand Formula is often used to describe loosely how much caution should be undertaken. If the Burden of the precaution is less than the Probability of loss multiplied by the anticipated Loss, then the precaution should be undertaken—$B < Pr \times L$. In essence, such a standard requires individuals to observe the Golden Rule when it comes to exposing others to risk: Treat other people and their property with the same level of care a reasonable person would treat his or her own person and property. Applying that to affirmative duties would require an individual to risk his own live to save a stranger in some cases. In essence, we would be required to act as heroes—not foolhardy idiots—but rationally calculating heroes. That is asking a lot.

One of the most important arguments in favor of the traditional "no affirmative duty rule" is thus the difficulty of deciding where to draw the line. If an individual can be required to turn the drowning baby over, then he can be required to use his cell phone to call an ambulance. And if he can be required to use his cell phone, he can be required to run down the block and make a call from a landline. If the call turns out to be costly, he can be required to incur the cost if the baby's parents promise to reimburse him. And so on until he is required to transport the baby to the hospital himself, put the baby's medical care on his credit card (subject to reimbursement by the parents if they can be found). At some point, some individuals who would have been happy to turn the baby over in the puddle may start to pretend that they didn't see the baby after all. When an amorphous legal duty is placed on someone, the reaction is sometimes to avoid situations in which the duty would come into play—not just by claiming "I didn't see the baby," but also by things like opting not to learn CPR for fear that one will be legally required to administer it in situations where one does not feel confident of one's abilities. Sometimes it is better to rely on non-legal methods of influencing behavior.

[291] For the most part, if a state hospital or other governmental entity declined to provide care, those denied care would have no legal remedy. *See, e.g., Riss v. City of New York*, 22 N.Y.2d 579, 240 N.E.2d 860, 293 N.Y.S.2d 897 (1968)(police protection case). By all this, I do not wish to suggest that there were no exceptions to the "no affirmative duty rule" as applied either to private or public actors. The exceptions are discussed in James A. Henderson, Jr., Richard N. Pearson, Douglas A. Kysar & John A. Siliciano, **THE TORTS PROCESS** (8th ed. 2012) or

None of this is to say that between private charity and government we had all the quality medical care that was needed. That would be very far from true, then, now or ever. But it is also far from true that efforts to provide medical care for those who could not afford it were rare.

It is against that backdrop that EMTALA must be understood and evaluated. It is possible for well-meaning legislation to do more harm than good or to do more collateral harm than is necessary to accomplish its intended good. To my knowledge, no one has ever looked as carefully at EMTALA as I would like. I urge future researchers to do so.[292]

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in any torts casebook. The traditional exceptions include persons in certain special relationships to the victim (e.g. a mother to child or a common carrier to passenger) and persons who created the hazard (even if he or she did so non-negligently) that ultimately caused the harm.

The major exception to the "no affirmative duty rule" applicable to hospitals would have been the gratuitous undertaking rule, which holds that while no one is obligated to provide assistance to another, once one undertakes to do so, a duty arises to use reasonable care to ensure that at least the person in need of assistance is not rendered worse off. A few examples should suffice:

- A Good Samaritan brings an injured person to a hospital. The hospital intake desk takes down the injured person's information, including the fact that he has no insurance, and then tells him to wait for the doctor. The Good Samaritan departs, believing the injured person to be in good hands. The hospital then asks the injured person to leave untreated. He is worse off, since his Good Samaritan is now gone. He has a good common law cause of action for any injuries he can prove resulted from the hospital's negligent action or inaction.

- A police officer brings in a homeless person who is having hallucinations. The hospital admits him, and puts his clothing, including his coat, away for safekeeping. When his hallucinations subside, a hospital staff member takes him, still dressed in his hospital gown, back to the park where he has been living, where he suffers from exposure. He has a good cause of action in tort for any injuries he had experienced on account of the hospital's negligent failure to return his clothing.

Although the state law tort claims of James Flavy Coy Brown (who alleges that Rawson-Neal Psychiatric Hospital in Las Vegas wrongfully put him on a bus to Sacramento, where he had no friends, family, or residence – see supra at n.3) were dismissed by a federal court for lack of jurisdiction, Brown might prevail if he brings these claims in Nevada state court. See *Brown v. Southern Nevada Adult Mental Health Services*, 2:13-CV-1039 JCM (PAL) (D. Nev. June 20, 2014)(Order); 28 U.S.C. 1367 ("The district courts may decline to exercise supplemental jurisdiction over a claim under subsection (a) if … (3) the district court has dismissed all claims over which it has original jurisdiction." Even if it had been true that Rawson-Neal had no duty to treat him, Rawson-Neal did treat him before it arguably made him worse off by shipping him off to an unfamiliar city. Rawson-Neal admits that sending him to Sacramento was an error. See Cynthia Hubert, *Vegas Mental Hospital Goofed on Patient's Discharge to Sacramento, Official Conceded*, **SACRAMENTO BEE** (March 15, 2013). In order to prevail, Brown would have to prove that he did not consent to the trip or that he did not have the legal capacity to consent. In addition, he would have to show that that he was made worse off by the trip to Sacramento. *But cf.* Cynthia Hubert, *Mentally Ill Man "Dumped" by Nevada Has Happy Reunion with Daughter*, **SACRAMENTO BEE** (April 12, 2013)(reporting that after being reunited with his daughter Shotzy, whom he had not seen for years, he stated, "I'd say I was lucky to be shipped to Sacramento after all").

[292] It is entirely possible that EMTALA was not the first legislative shock to the system of providing medical care to those who could not pay. Some commentators argue that the medical care system changed direction

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It is easy to sympathize with EMTALA's aim. Using its spending power, Congress enacted a mandate requiring all hospitals that both receive Medicare funds (which means all or nearly all hospitals) and have an emergency department to treat a patient with an emergency until the patient is "stabilized" regardless of the patient's ability to pay.[293]

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in 1983, when congressionally mandated changes in Medicare reimbursement made it more difficult for hospitals to finance indigent patients' care by a mix of private charity and charging higher prices to better-off patients. As Dr. Edward Monico put it in an essay for the American Medical Association's Journal of Ethics (internal citations omitted):

> Before the 1980s, private hospitals charged patients according to their ability to pay, and this "cost shifting" allowed them to deliver a small amount of charity care.…. In 1983 the federal government established through Medicare a system that placed caps on how much hospitals could charge for treating patients with given diagnoses. This system, with charges tied to diagnosis-related groups (DRGs), made cost-shifting impossible, and, after its implementation, hospitals lost financial support for charity care. As changes in the economic climate made it more difficult for hospital EDs to care for indigent patients, reports surfaced that uninsured and publicly insured patients were either unable to access emergency care or were redirected from private EDs to public EDs. In the face of these pressures for greater hospital efficiency, Congress felt compelled to act to assure the public that seriously ill patients would not be left outside hospital doorsteps with no access to care. EMTALA was the result.

Edward Monico, *Is EMTALA That Bad?*, 12 **VIRTUAL MENTOR** 471 (June 2010). See also John O'Shea, M.D., "The Crisis in Hospital Emergency Departments: Overcoming the Burden of Federal Regulation," Heritage Foundation, July 2007, available at http://www.heritage.org/research/reports/2007/07/the-crisis-in-hospital-emergency-departments-overcoming-the-burden-of-federal-regulati: "Initially, hospitals could rely on internal subsidization, using surpluses obtained from affluent patients (as well as philanthropic contributions and government subsidies) to offset the costs of services for which they were not paid. However, further changes in health care financing in the 1980s, such as the Medicare diagnosis-related group (DRG) prospective payment system and the rise of managed care, severely limited hospitals' ability to generate the surpluses needed for cross-subsidization. Predictably, this gave hospitals greater incentive to avoid non-paying patients and resulted in a sudden and dramatic increase in reports of inappropriate transfers. Growing public awareness of these cases led to increased pressure to address the problem, and Congress responded with EMTALA, an amendment to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985."

This account suggests that hospitals were exercising some level of monopoly power over their patients and the carriers issuing insurance, since presumably hospitals operating in a highly-competitive market would not be able to charge better-off patients higher prices without having those patients lured away by competitors.

The relevant changes to Medicare reimbursement were contained in the Social Security Amendments Act of 1983, Pub. L. 98-21, 97 Stat. 149-171 (1983).

[293] For the reader's convenience, the statute reads in part:

> **Section 1395dd—Examination and treatment for emergency medical conditions and women in labor**
>
> ***(a) Medical screening requirement***

Note that the population that EMTALA primarily benefits is neither the indigent, nor the disabled, nor the elderly. For the most part Medicaid or Medicare covers those categories, making it less likely (though not impossible) that they would be refused service at a pre-EMTALA emergency room. Instead, the primary beneficiaries of EMTALA tend to be those who are just a little too well off to qualify for Medicaid and too young and healthy for Medicare or those who somehow slipped through the holes in the Medicare/Medicaid net. Such persons are at greater risk of being refused service, since it is in the hospital's financial interest to do so if they are uninsured and unable to pay. Put only somewhat differently, such persons in theory (and sometimes in practice) run the risk of being left for dead. For many Americans, allowing such a tragedy would be intolerable.

Yet at the same time, it is important not to lose sight of the fact that EMTALA essentially conscripts hospital emergency rooms to provide service for free, and that forcing one group of persons to pay for benefits for another group tends to create perverse incentives. If you look for the provision that reimburses the hospital for its services, you won't find it. EMTALA is

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> In the case of a hospital that has a hospital emergency department, if any individual … comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition … exists.
>
> ***(b) Necessary stabilizing treatment for emergency medical conditions and labor.***
>
> (1) In general—
>
> If any individual … comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—
>
> (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
> (B) for transfer of the individual to another medical facility ….
>
> ***(h). No delay in examination or treatment.***
>
> A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical treatment required under subsection (b) of this section in order to inquire about the individual's method of payment or insurance status.

essentially an unfunded mandate.[294] If a hospital wants to participate in Medicare it must agree. One opponent of the EMTALA system described it this way:

> To concretize what EMTALA does to a healthcare facility, transpose the law to the restaurant setting. If a hungry person goes to a restaurant and orders a cheeseburger and is unable to pay, restaurant personnel are completely free to withhold the sandwich and, if this is a frequent occurrence, to refuse entry of the person into the building. These actions are a clear exercise of the individual rights of the restaurant owner to do commerce with whom she wishes on a voluntary basis with terms mutually agreeable to both parties. This … is forbidden from occurring in the healthcare realm, and those who violate EMTALA are subject to heavy fines.[295]

Add to that the fact that the resources consumed in complying with EMTALA are anything but trivial and hit some hospitals and physicians (particularly those in poorer areas or areas with high rates of immigration) much harder than others. This creates a sense that some medical providers are being unfairly made to bear a disproportionate share of EMTALA's costs. One study reports on the costs to physicians (not counting the even greater costs to hospitals):

> In 2001, more than 30.0% of physicians provided care covered by EMTALA in a typical week of practice. Among some specialists this percentage was much higher, 60.9% among general surgeons and 95.2% among emergency medicine physicians. Emergency medicine physicians averaged 22.9 hours of EMTALA mandated care per week, about half of their total patient care hours, and 16.4% of those who provided such care averaged more than 40 hours per week.
>
> Emergency medicine physicians attributed 61.0% of the bad debt they incurred in 2000 to EMTALA, or $138,300 per year. Across all specialties EMTALA related bad debt amounted to $12,300 per self-employed physician in 2000, or nearly $4.2 billion dollars [sic] in the aggregate.[296]

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[294] Of course, if it turns out the patient's emergency is covered by Medicare or Medicaid or if it turns out the patient is willing and able to pay, the hospital will presumably be paid. But in large numbers of cases, no one ever compensates the hospital and doctors for their services.

[295] Amesh Adalja, *Universal Health Insurance Mandates and the Emergency Care Myth*, **FORBES** (October 8, 2012).

[296] Carol K. Kane, Physician Marketplace Report: The Impact of EMTALA on Physician Practices, American Medical Association Center for Health Policy Research 3-4 (February 2003). On the one hand, the $4.2 billion seriously understates the cost of EMTALA, since it only includes amounts owed for services by physicians and not the (much larger) amounts owed for services rendered by hospitals. On the other hand, it almost certainly overstates the cost for physicians specifically, since presumably many doctors would have performed some of these services even in the absence of EMTALA's mandate.

These figures provide a sense of why EMTALA would have an effect on the behavior of physicians, hospitals and patients. A lot is at stake. Is it possible that amounts like this will cause a medical student to decide to go into dermatology instead of emergency medicine as a specialty? Is it possible it will cause a medical student to start a career in a prosperous suburban hospital outside Minneapolis rather than an urban hospital in Los Angeles where the rates of bad debt on account of EMTALA are higher? Somebody is always at the margin in these sorts of decisions; something has to tip the balance.

The incentives created by EMTALA virtually guarantee that (1) some hospitals and physicians will try to avoid having to provide uncompensated medical services and (2) some individuals will decide not to purchase insurance, knowing that at least if their medical problems rise to the level of "an emergency medical condition," they will be able to secure service at a hospital emergency room regardless of their ability to pay.

This is not to say that EMTALA has done more harm than good or that it will do more harm than good in the future as the ACA comes into play. But it does raise serious questions.[297]

I was actually surprised at the hearing that the Commission didn't uncover more clear evidence of hospital violations than it did. Part of it was the result of an unfocused discussion. Many discussions of EMTALA (not just those at our hearing) seem to start from the premise that discharging a patient who comes to an emergency room with an emergency medical condition before that patient is well is an EMTALA violation. That appears to be a misinterpretation of the law. EMTALA requires hospitals with emergency rooms to provide emergency medical services to all persons with an emergency medical condition regardless of the person's ability to pay and to continue to provide care (or to transfer such patients to appropriate facilities) "as may be required to *stabilize* the medical condition."[298] Stabilizing a patient and restoring a patient's original good health are two very different things.[299] A bit more emphasis at the hearing on the proper interpretation of the word "stabilize" would have been helpful.[300]

My guess is that EMTALA causes some of the charitable funds that might otherwise be available for emergency medicine to dry up. Philanthropists generally refrain (wisely) from spending money on activities, no matter how worthy, that will take place regardless of whether they fund them. EMTALA costs are thus less likely to be spread than they otherwise would be, with hospitals and physicians located in areas with high emergency room use by non-payers just out of luck.

[297] Even if this question had been addressed thoroughly in the past, now that the ACA has become law, the issue, for good or ill, would have to be re-addressed.

[298] 42 U.S.C. § 1395dd(b)(A) (italics added).

[299] Commissioner Kladney appears to acknowledge this in his statement. In it, he calls for revising the definition of "stability." "A person should not be declared completely stable," he writes, "until they are strong enough to function without medical supervision or until the hospital accounts for the type of care necessary to keep that person stable outside the hospital." Strangely, Commissioner Kladney does little to acknowledge the arbitrary burden this would place on the hospitals and doctors who happen to be closest by when the emergency arises.

More importantly, I was disappointed that the Commission was not able to delve into what is certainly one of the most important issues raised by EMTALA: To what extent, if any, is the dwindling number of hospital emergency rooms across the country attributable to EMTALA (including the more aggressive enforcement of EMTALA that began in the late 1990s and continued to this day)?[301]

Nor did it delve into the other, perhaps equally important, side of the coin: To what extent, if any, has EMTALA been a contributing factor to the sharp rise in uninsured individuals who do not qualify for Medicare or Medicaid—a hugely important trend that eventually led to the ACA's insurance mandate?

It would be surprising if EMTALA did *not* contribute to these trends at least to some degree. One of the easiest and most profitable ways for a hospital to discharge its responsibility under EMTALA is to close its emergency room, since only hospitals with emergency rooms are required to accept all comers. Similarly, EMTALA makes it less likely that some individuals will purchase health insurance, because it makes it less necessary. Alas, I have had law students and recent law school graduates confess to me that they did not buy health insurance, because it was too expensive given the likelihood that they will become ill, and if an emergency arises they can always get free service at a hospital emergency room. These students and recent graduates were cash strapped—as most Americans their age are. But they were far from impecunious, so it was not a foregone conclusion that they would not buy health insurance. EMTALA increased the likelihood that they would act as they did.

Requiring them to provide services for free until a patient is "stabilized" in Commissioner Kladney's sense is an unstable solution to this problem. I might add that formulating healthcare policy is not for dilettantes. That is why the Commission should stick to issues that are within its sphere of expertise.

[300] It did not seem to me that any of the discharges that were mentioned in the course of our hearing were certain EMTALA violations. They may or may not be from the standpoint of the evidence we heard. Even the case of James Flavy Coy Brown, the 48-year-old schizophrenic whom Rawson-Brown Psychiatric Hospital put on a bus for Sacramento, discussed supra at n.3, may or may not have been—though his case is the one that triggered the Sacramento Bee's exposé of Rawson-Neal and hence Commissioner Kladney's (and by extension the Commission's) interest. It is unclear whether Brown's condition was stable within the meaning of EMTALA at the time of his release. Even if he was stable, there might well be a common law cause of action for the act of bussing him to Sacramento (assuming all the relevant elements for such cause of action are met). See supra at n. __. EMTALA is certainly not the first cause of action that comes to mind in a situation like Brown's. Suppose, however, that Brown had not been having obvious hallucinations and that Rawson-Neal had simply released him with instructions to the local police to bring him back in the event his hallucinations re-appear. It is not clear that would have been an EMTALA violation.

[301] Similarly, to what extent, if any, is the rise of "urgent care centers," which are not ordinarily connected to hospitals and which are thus not ordinarily subject to EMTALA, attributable to EMTALA? EMTALA gives independent urgent care centers a competitive advantage over hospital emergency rooms, since they are likely to be cheaper to run as well as less crowded and hence more pleasant to those who can afford to pay. For good or ill, it would be surprising if EMTALA were not contributing to the increase in this method of doing business.

Legislation often has unintended consequences; that's nothing new. But while the extent of EMTALA's effects is hard to gauge, at least the direction it pushes is, upon reflection, fairly clear.

Here's what we already know: The number of emergency rooms that have been closed since EMTALA's passage is quite alarming.[302] From 1990 to 2009, the number of hospital emergency rooms outside rural areas declined from 2446 to 1779, with 1041 emergency rooms closing their doors (including some closing along with their hospitals) and 374 hospitals opening emergency rooms.[303] Hospitals that provided a much higher than average level of medical care to uninsured, Medicaid and other vulnerable patients were more likely to close their emergency rooms than those that did not. Similarly, hospitals with lower than average profit margin were more likely to close their emergency rooms. And for-profit status (as opposed to not-for-profit or government status) was also positively correlated with emergency room closure. All three of these factors are consistent with the conclusion that EMTALA has contributed substantially to the problem of emergency room closure, perhaps even being the predominant factor.[304]
Indeed, the very hospital that was at the center of the controversy that sparked Commissioner Kladney's interest in this subject—Rawson-Neal Psychiatric Hospital in Las Vegas—is an example. After being cited for violations of EMTALA by federal authorities, Rawson-Neal opted to close its "Drop-In Clinic" rather than operate under what it considered to be EMTALA's onerous requirements.[305] Indeed, Rawson-Neal is one of the few cases where the

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[302] I am not the first to use the word "alarming." *See, e.g.,* Jason Silverstein, *The Decline of Emergency Care*, **ATLANTIC** (April 26, 2013)("Trauma Centers and emergency departments across the U.S. have been closing at alarming rates").

[303] *See* Renee Y. Hsia, Arthur Kellerman, & Yu-Chu Shen, *Factors Associated with Closures of Emergency Departments in the United States*, 305 J.A.M.A. 1978 (May 18, 2011). See also Yu-Chen Shen, Renee Y. Hsia & Kristen Kuzma, *Understanding the Risk Factors of Trauma Center Closures: Do Financial Pressure and Community Characteristics Matter?*, 47 **MED. CARE** 968 (September 2009).

[304] The rise of urgent care centers parallels the decline of emergency rooms. Tracy Yee, Amanda E. Lechner & Ellyn R. Boukus, *The Surge In Urgent Care Centers: Emergency Department Alternative or Costly Convenience?,* Health System Change Research Brief No. 26 (July 2013)(stating that numbers have reached 9000 with only about 25% owned by a hospital). In theory, these centers are for things that do not quite rise to the level of an emergency. But in reality, the overlap between the services that emergency rooms provide and those that urgent care facilities provide is substantial.

It is not clear how these centers would fare under a different legal regime—such as the one originally envisioned by the ACA in which all or nearly all persons would be covered by some sort of insurance. Would they still be more efficient to run on a per patient basis than emergency rooms? Would individuals still find them more convenient? Or would emergency rooms' counter-advantage of being connected to a hospital and open 24 hours a day begin to assert itself?

[305] *See* Andrew Doughman, *Drop-In Mental Health Clinic at Rawson-Neal to Close Friday*, **LAS VEGAS SUN** (January 23, 2014).

hospital has made clear that a major reason for its emergency room's closure was its EMTALA liability. [306]

As for the proportion of Americans who have been going without health coverage, it may be unlikely that EMTALA is the predominant cause of that trend. But that doesn't mean it hasn't contributed, perhaps even contributed substantially. Between 1987 (the first year for which the Census Bureau has data) and 2012, the proportion of Americans without health insurance has reportedly risen from 11.7% to 15.4%.[307]

Attempting to gauge roughly EMTALA's contribution to these trends would be useful, even though it is doubtful that a definitive method of measuring that contribution can be agreed upon. One way open to future researchers would be simply to ask hospital administrators about the reasons they closed their emergency rooms (or doctors about their career choices or individuals about their insurance choices). While answers to questions about motivation can't always be taken at face value, they can't always be entirely discounted either. They are a piece of the puzzle that Congress and other policymakers would do well to examine.

Two final points are worth making: First, the ACA was originally designed to move us beyond EMTALA by ensuring that everyone would be covered by Medicare, Medicaid or private insurance. But like EMTALA itself, it is turning out not to work as it was designed. The individual mandate has teeth, but they aren't sharp enough to cause everyone to buy insurance. For that reason (as well as a few others), the incentives created by EMTALA will remain a significant force in the healthcare industry. Second, the core of Commissioner Kladney's concern seems to be that not enough money is being spent on psychiatric care for the indigent. He may well be right on that; indeed I am very much inclined to think he is. But there are two plausible sources for the funding for that care—the state or the federal government. EMTALA's solution of extracting the services from hospitals with emergency rooms and the doctors who

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[306] Rawson-Neal continues to maintain that its drop-in mental health clinic is not and never has been an emergency room within the meaning of EMTALA. HHS obviously disagreed. I am not in the best position to resolve that dispute. I point out only that Rawson-Neal is not coy about asserting that the closure was due to EMTALA. Regardless of which side is correct on the issue of law, this case hardly represents a victory for HHS. Nevada now has fewer emergency facilities for psychiatric patients.

[307] U.S. Census Bureau, Health Insurance Historical Tables, available at http://www.census.gov/hhes/www/hlthins/data/historical/index.html and U.S. Census Bureau, Health Insurance Historical Tables: Original Series, available at http://www.census.gov/hhes/www/hlthins/data/historical/orghihistt1.html. The Census Bureau's methodology for computing these figures changed in March 2007, meaning that there are limitations on the comparisons that can be made between annual figures computed before and after that date. But the change in methodology was intended to stop the under-counting of insured persons in the study, meaning that if anything, the rise in uninsured Americans is probably bigger than these figures suggest.

staff those emergency rooms is arbitrary and undesirable. There are very few questions for which EMTALA (or an expansion of EMTALA) is the right answer.

APPENDIX A: EMTALA RELEVANT STATUTES

Statute	Statutory Language	Key Term
42 U.S.C. § 1395dd(c)(2)	**Appropriate Transfer**—An appropriate transfer to a medical facility is a transfer-- (A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child; (B) in which the receiving facility-- (i) has available space and qualified personnel for the treatment of the individual, and (ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment; (C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment; (D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and (E) in which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.	Appropriate Transfer
42 U.S.C. § 1395dd(e)(1)	**Emergency Medical Condition**—the term emergency medical condition means-- (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the	Emergency Medical Condition

	absence of immediate medical attention could reasonably be expected to result in-- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or (B) with respect to a pregnant woman who is having contractions-- (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.	
42 U.S.C. § 1395dd(e)	**Participating Hospital—**The term participating hospital means a hospital that has entered into a provider agreement under section 1395cc of this title.	Participating Hospital(s)
42 U.S.C. § 1395x(r)	**Physician—**The term physician, when used in connection with the performance of any function or action, means--(1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action . . . (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) a doctor of podiatric medicine . . . but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) a doctor of optometry . . . with respect to . . . items or services . . . which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary . . . with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to	Physician

	perform by the State or jurisdiction in which such treatment is provided	
42 U.S.C. § 1395dd(e)(3)(A)	**Stabilize—**The term to stabilize means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).	Stabilize
42 U.S.C. § 1395dd(e)(3)(B)	**Stabilized—**The term stabilized means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).	Stabilized
42 U.S.C. § 1395dd(e)(4)	**Transfer—**The term transfer means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.	Transfer
42 U.S.C. § 1395x(e)	**Hospital—**The term hospital . . . means an institution which-- (1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons; (2) maintains clinical records on all patients; (3) has bylaws in effect with respect to its staff of physicians; (4) has a requirement that every patient with respect to whom payment may be made under this subchapter must be under the care of a physician, except that a patient receiving	Hospital

	qualified psychologist services (as defined in subsection (ii) of this section) may be under the care of a clinical psychologist with respect to such services to the extent permitted under State law; (5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times; except that until January 1, 1979, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided, during at least the regular daytime shift), where immediately preceding such one-year period he finds that-- (A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein, (B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individuals, and (C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area; (6)(A) has in effect a hospital utilization review plan which meets the requirements of subsection (k) of this section and (B) has in place a discharge planning process that meets the requirements of subsection (ee) of this section; (7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing; (8) has in effect an overall plan and budget that meets the	

	requirements of subsection (z) of this section; and (9) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.	
42 U.S.C. § 1395dd(e)(2)	**Participating Hospital**—The term participating hospital means a hospital that has entered into a provider agreement under section 1866.	Hospital
42 U.S.C. § 1395dd(e)(5)	**Hospital—**The term hospital includes a critical access hospital.	Hospital
42 U.S.C. § 1395x(mm)(1)	**Critical access hospital**—The term critical access hospital means a facility certified by the Secretary as a critical access hospital under section 1395i-4(e) of this title.	Critical Access Hospital
42 U.S.C. § 1395i-4(e)	**Certification by Secretary—**The Secretary shall certify a facility as a critical access hospital if the facility-- (1) is located in a State that has established a Medicare rural hospital flexibility program in accordance with subsection (c) of this section; (2) is designated as a critical access hospital by the State in which it is located; and (3) meets such other criteria as the Secretary may require.	Certification
42 U.S.C. § 1395x(u)	**Provider of Services—**The term "provider of services" means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1814(g) and section 1835(e), a fund.	Provider, Providers, Provider of Services
42 U.S.C. § 1395cc(j)(1)	**Agreements with providers of services—Enrollment process for providers of services and suppliers--Enrollment process--** (A) In general The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this subchapter. Such process shall include screening of providers and suppliers in accordance with paragraph (2), a provisional period of enhanced oversight in accordance with paragraph	Enrollment Process

	(3), disclosure requirements in accordance with paragraph (4), the imposition of temporary enrollment moratoria in accordance with paragraph (5), and the establishment of compliance programs in accordance with paragraph (6). (B) Deadlines The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of Medicare administrative contractors in meeting the deadlines established under this subparagraph. (C) Consultation before changing provider enrollment forms The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this subchapter.	
42 U.S.C. § 1395cc(j)(2)	**Agreements with providers of services—Enrollment process for providers of services and suppliers—Provider screening--** (A) Procedures Not later than 180 days after March 23, 2010, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under the program under this subchapter, the Medicaid program under subchapter XIX, and the CHIP program under subchapter XXI. (B) Level of screening The Secretary shall determine the level of screening conducted under this paragraph according to the risk of fraud, waste, and abuse, as determined by the Secretary, with respect to the category of provider of medical or other items or services or supplier. Such screening-- (i) shall include a licensure check, which may include such	Provider Screening

	checks across States; and (ii) may, as the Secretary determines appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, include-- (I) a criminal background check; (II) fingerprinting; (III) unscheduled and unannounced site visits, including preenrollment site visits; (IV) database checks (including such checks across States); and (V) such other screening as the Secretary determines appropriate. (C) Application fees (i) Institutional providers Except as provided in clause (ii), the Secretary shall impose a fee on each institutional provider of medical or other items or services or supplier (such as a hospital or skilled nursing facility) with respect to which screening is conducted under this paragraph in an amount equal to-- (I) for 2010, $500; and (II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year. (ii) Hardship exception; waiver for certain Medicaid providers The Secretary may, on a case-by-case basis, exempt a provider of medical or other items or services or supplier from the imposition of an application fee under this subparagraph if the Secretary determines that the imposition of the application fee would result in a hardship. The Secretary may waive the application fee under this subparagraph for providers enrolled in a State Medicaid program for whom the State demonstrates that imposition of	

	the fee would impede beneficiary access to care. (iii) Use of funds Amounts collected as a result of the imposition of a fee under this subparagraph shall be used by the Secretary for program integrity efforts, including to cover the costs of conducting screening under this paragraph and to carry out this subsection and section 1320a-7k of this title. (D) Application and enforcement (i) New providers of services and suppliers The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is not enrolled in the program under this subchapter, subchapter XIX, or subchapter XXI as of March 23, 2010, on or after the date that is 1 year after such date. (ii) Current providers of services and suppliers The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is enrolled in the program under this subchapter, subchapter XIX, or subchapter XXI as of such date, on or after the date that is 2 years after such date. (iii) Revalidation of enrollment Effective beginning on the date that is 180 days after such date, the screening under this paragraph shall apply with respect to the revalidation of enrollment of a provider of medical or other items or services or supplier in the program under this subchapter, subchapter XIX, or subchapter XXI. (iv) Limitation on enrollment and revalidation of enrollment In no case may a provider of medical or other items or services or supplier who has not been screened under this paragraph be initially enrolled or reenrolled in the program under this subchapter, subchapter XIX, or subchapter XXI on or after the date that is 3 years after such date. (E) Use of information from the Department of Treasury concerning tax debts In reviewing the application of a provider of services or	

	supplier to enroll or reenroll under the program under this subchapter, the Secretary shall take into account the information supplied by the Secretary of the Treasury pursuant to section 6103(l)(22) of the Internal Revenue Code of 1986, in determining whether to deny such application or to apply enhanced oversight to such provider of services or supplier pursuant to paragraph (3) if the Secretary determines such provider of services or supplier owes such a debt. (F) Expedited rulemaking The Secretary may promulgate an interim final rule to carry out this paragraph.	
42 U.S.C. § 1395f(a)	**Conditions of and limitations on payment for services—Requirement of requests and certifications--** [P]ayment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1395cc of this title and only if-- (1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period ending 1 calendar year after the date of service; (2) a physician, or, in the case of services described in subparagraph (B), a physician, or a nurse practitioner, a clinical nurse specialist, or a physician assistant . . . who does not have a direct or indirect employment relationship with the facility but is working in collaboration with a physician, or, in the case of services described in subparagraph (C), a physician enrolled under section 1395cc(j) of this title, certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that-- (A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the	Request and Certification Requirements

	psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes; (B) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital . . .) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services; (C) in the case of home health services, such services are or were required because the individual is or was confined to his home . . . and needs or needed skilled nursing care (other than solely venipuncture for the purpose of obtaining a blood sample) on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; such services are or were furnished while the individual was under the care of a physician, and, in the case of a certification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician himself or herself, or a nurse practitioner or clinical nurse specialist . . . who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife . . . as authorized by State law, or a physician assistant . . . under the supervision of the physician, has had a face-to-face encounter (including through use of telehealth . . . and other than with respect to encounters that are incident to services involved) with the individual within a reasonable	

	timeframe as determined by the Secretary; or (D) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services; (3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no later than the 20th day of such period; (4) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services; (5) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services, there was not in effect, at the time of admission of such individual to the hospital, a decision under section 1395cc(d) of this title (based on a finding that utilization review of long-stay cases is not being made in such hospital); (6) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group . . . including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization review that further inpatient hospital services or further post-hospital extended care services, as the case may	

	be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding; (7) in the case of hospice care provided an individual-- (A)(i) in the first 90-day period and (I) the individual's attending physician . . . (which for purposes of this subparagraph does not include a nurse practitioner), and (II) the medical director (or physician member of the interdisciplinary group . . .) of the hospice program providing (or arranging for) the care, each certify in writing at the beginning of the period, that the individual is terminally ill . . . based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness, (ii) in a subsequent 90- or 60-day period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill based on such clinical judgment; (B) a written plan for providing hospice care with respect to such individual has been established (before such care is provided by, or under arrangements made by, that hospice program) and is periodically reviewed by the individual's attending physician and by the medical director . . . of the hospice program; (C) such care is being or was provided pursuant to such plan of care; and (D) on and after January 1, 2011-- (i) a hospice physician or nurse practitioner has a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification under subparagraph (A)(ii) and attests that such visit took place (in accordance with procedures established by the	

	Secretary); and (ii) in the case of hospice care provided an individual for more than 180 days by a hospice program for which the number of such cases for such program comprises more than a percent (specified by the Secretary) of the total number of such cases for all programs under this subchapter, the hospice care provided to such individual is medically reviewed (in accordance with procedures established by the Secretary); (8) in the case of inpatient critical access hospital services, a physician certifies that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the critical access hospital.	
42 U.S.C. § 1395g(a)	**Payments to providers of services—Determination of amount--** The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the Government Accountability Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.	Payments, Determination of Amount, Amount of Payment
42 U.S.C. § 1395g(b)	**Payments to providers of services—Conditions-** No payment shall be made to a provider of services which is a hospital for or with respect to services furnished by it for any period with respect to which it is deemed . . . to have in effect an arrangement with a quality improvement organization for the conduct of utilization review activities by such organization unless such hospital has paid to such organization the amount due . . . to such organization for the review activities conducted by it pursuant to such arrangements or such hospital has provided assurances satisfactory to the Secretary that such organization will promptly be paid the amount so due to it from the proceeds of	Payments, Conditions to Payments

	the payment claimed by the hospital. Payment under this subchapter for utilization review activities provided by a quality improvement organization pursuant to an arrangement or deemed arrangement with a hospital under section 1395x(w)(2) of this title shall be calculated without any requirement that the reasonable cost of such activities be apportioned among the patients of such hospital, if any, to whom such activities were not applicable.	
42 U.S.C. § 1320d-2(a)(1)	**Standards for Information Transactions and Data Elements—Standards to enable electronic exchange—In General--** The Secretary shall adopt standards for transactions, and data elements for such transactions, to enable health information to be exchanged electronically, that are appropriate for-- **(A)** the financial and administrative transactions described in paragraph (2); and **(B)** other financial and administrative transactions determined appropriate by the Secretary, consistent with the goals of improving the operation of the health care system and reducing administrative costs . . .	Electronic Exchange Standards
42 U.S.C. § 1320d-2(a)(2)	**Standards for Information Transactions and Data Elements—Transactions--** The transactions referred to in paragraph (1)(A) are transactions with respect to the following: (A) Health claims or equivalent encounter information. (B) Health claims attachments. (C) Enrollment and disenrollment in a health plan. (D) Eligibility for a health plan. (E) Health care payment and remittance advice. (F) Health plan premium payments. (G) First report of injury. (H) Health claim status.	Electronic Exchange Standards

	(I) Referral certification and authorization. (J) Electronic funds transfers.	
42 U.S.C. § 300jj-33(a)	**State Grants to Promote Health Information Technology—In general--** The Secretary, acting through the National Coordinator, shall establish a program in accordance with this section to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards.	State Grants, Health Information Technology, Technology Incentives
42 U.S.C. § 300jj-33(b)	**State Grants to Promote Health Information Technology—Planning Grants--** The Secretary may award a grant to a State or qualified State-designated entity . . . that submits an application to the Secretary at such time, in such manner, and containing such information as the Secretary may specify, for the purpose of planning activities described in subsection (d).	State Grants, Health Information Technology, Technology Incentives
42 U.S.C. § 300jj-33(c)	**State Grants to Promote Health Information Technology—Implementation grants--** The Secretary may award a grant to a State or qualified State designated entity that-- (1) has submitted, and the Secretary has approved, a plan described in subsection (e) (regardless of whether such plan was prepared using amounts awarded under subsection (b);2 and (2) submits an application at such time, in such manner, and containing such information as the Secretary may specify	State Grants, Health Information Technology, Technology Incentives
42 U.S.C. § 300jj-33(d)	**State Grants to Promote Health Information Technology—Use of funds--** Amounts received under a grant under subsection (c) shall be used to conduct activities to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards through activities that include-- (1) enhancing broad and varied participation in the authorized and secure nationwide electronic use and exchange of health	State Grants, Health Information Technology, Technology Incentives

	information; (2) identifying State or local resources available towards a nationwide effort to promote health information technology; (3) complementing other Federal grants, programs, and efforts towards the promotion of health information technology; (4) providing technical assistance for the development and dissemination of solutions to barriers to the exchange of electronic health information; (5) promoting effective strategies to adopt and utilize health information technology in medically underserved communities; (6) assisting patients in utilizing health information technology; (7) encouraging clinicians to work with Health Information Technology Regional Extension Centers as described in section 300jj-32 of this title, to the extent they are available and valuable; (8) supporting public health agencies' authorized use of and access to electronic health information; (9) promoting the use of electronic health records for quality improvement including through quality measures reporting; and (10) such other activities as the Secretary may specify.	
42 U.S.C. § 300jj-33(e)	**State Grants to Promote Health Information Technology—Plan--** (1) In general A plan described in this subsection is a plan that describes the activities to be carried out by a State or by the qualified State-designated entity within such State to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards and implementation specifications. (2) Required elements	State Grants, Health Information Technology, Technology Incentives

	A plan described in paragraph (1) shall-- (A) be pursued in the public interest; (B) be consistent with the strategic plan developed by the National Coordinator, (and, as available) under section 300jj-11 of this title; (C) include a description of the ways the State or qualified State-designated entity will carry out the activities described in subsection (b); and (D) contain such elements as the Secretary may require.	
42 U.S.C. § 300jj-33(f)	**State Grants to Promote Health Information Technology—Qualified State-designated entity-** For purposes of this section, to be a qualified State-designated entity, with respect to a State, an entity shall-- (1) be designated by the State as eligible to receive awards under this section; (2) be a not-for-profit entity with broad stakeholder representation on its governing board; (3) demonstrate that one of its principal goals is to use information technology to improve health care quality and efficiency through the authorized and secure electronic exchange and use of health information; (4) adopt nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory participation by stakeholders; and (5) conform to such other requirements as the Secretary may establish.	State Grants, Health Information Technology, Technology Incentives
42 U.S.C. § 300jj-33(h)	**State Grants to Promote Health Information Technology—Continuous improvement** The Secretary shall annually evaluate the activities conducted under this section and shall, in awarding grants under this section, implement the lessons learned from such evaluation in a manner so that awards made subsequent to each such evaluation are made in a manner that, in the determination of the Secretary, will lead towards the greatest improvement in quality of care, decrease in costs, and the most effective	State Grants, Health Information Technology, Technology Incentives

	authorized and secure electronic exchange of health information.	
42 U.S.C. § 1395dd(a)	**Medical Screening Requirement—**In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.	Medical Screening Requirement
42 U.S.C. § 1395dd(b)(1)	**Stabilizing Requirement—In general**--If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either-- **(A)** within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or **(B)** for transfer of the individual to another medical facility in accordance with subsection (c) of this section.	Stabilizing Requirement
42 U.S.C. § 1395dd(b)(2)	**Stabilizing Requirement—Refusal to consent to treatment**-- A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.	Stabilizing Requirement
42 U.S.C. § 1395dd(b)(3)	**Stabilizing Requirement—Refusal to consent to transfer--** A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in	Stabilizing Requirement

	accordance with subsection (c) of this section and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.	
42 U.S.C. § 1395dd(c)(1)	**Restricting Transfers until individual is stabilized—**If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless-- **(A)(i)** the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility, **(ii)** a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or **(iii)** if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and **(B)** the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility. A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.	Restrictions on Transfer
42 U.S.C. §	**Non-discrimination—**A participating hospital that has specialized capabilities or facilities (such as burn units,	Non-

1395dd(g)	shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.	discrimination
42 U.S.C. § 1395dd(h)	**No delay in examination or treatment**—A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual's method of payment or insurance status.	Immediacy Requirement, Immediate treatment, No-Delay,
42 U.S.C. § 1395dd(d)(1)(A)	**Civil Money Penalties-Hospitals--**A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a-7a(a) of this title.	Civil Money Penalties, Hospitals
42 U.S.C. § 1395dd(d)(1)(B)-(C)	**Civil Money Penalties-Physicians—** (B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who-- (i) signs a certification under subsection (c)(1)(A) of this section that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or (ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section, is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and	Civil Money Penalty, Physicians

	flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a-7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a-7a(a) of this title. (C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc(a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.	
42 U.S.C. § 1395dd(d)(2)(A)	**Civil enforcement—Personal harm--**Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.	Civil Enforcement, Personal Harm
42 U.S.C. § 1395dd(d)(2)(B)	**Civil Enforcement—Financial loss to other medical facility--**Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.	Civil Enforcement, Financial loss, Medical Facility
42 U.S.C. § 1395dd(d)(2)(C)	**Civil Enforcement—Limitations on actions--**No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.	Civil Enforcement, Limitations on actions
42 U.S.C. §	**Consultation with quality improvement organizations--**In	Consultation,

1395dd(d)(3)	considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1) or in terminating a hospital's participation under this subchapter, the Secretary shall request the appropriate quality improvement organization (with a contract under part B of subchapter XI of this chapter) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B of subchapter XI of this chapter.	Quality Improvement Organizations
42 U.S.C. § 1395dd(d)(4)	**Notice upon closing an investigation--**The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.	Notice, Closing an Investigation
42 U.S.C. § 1395dd(f)	**Preemption--**The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.	Preemption
42 U.S.C. § 1395dd(i)	**Whistleblower protections--**A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) of this section or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.	Whistleblower protections