Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT

The Enforcement Process

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this inspection was to evaluate the enforcement process for the Emergency Medical Treatment and Labor Act (EMTALA).

BACKGROUND

Congress passed EMTALA, part of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985, in April 1986 to address the problem of "patient dumping." The term "patient dumping" refers to certain situations where hospitals fail to screen, treat, or appropriately transfer patients. According to Section 9121 of COBRA, Medicare-participating hospitals must provide a medical screening exam to any individual who comes to the emergency department and requests examination or treatment for a medical condition. If a hospital determines that an individual has a medical emergency, it must then stabilize the condition or provide for an appropriate transfer. The hospital is obligated to provide these services regardless of the individual's ability to pay and without delay to inquire about the individual's method of payment or insurance status.

Congress created a bifurcated enforcement mechanism for EMTALA within the Department of Health and Human Services. The Health Care Financing Administration (HCFA) authorizes investigations of dumping complaints by State survey agencies, determines if a violation occurred, and, if appropriate, terminates a hospital's provider agreement. The Office of Inspector General (OIG) assesses civil monetary penalties against hospitals and physicians and may exclude physicians from the Medicare program for repeated or gross and flagrant behavior. The HCFA *may* seek the input of the local peer review organization (PRO) after the State's investigation to help determine whether the hospital adequately screened, examined, and treated a patient but *must* seek PRO input in most circumstances before forwarding a case to the OIG if the alleged violation involves a question of medical judgment.

We interviewed staff at HCFA regional offices, State survey agencies, the PROs, and the OIG between June and December 1999. We also reviewed relevant HCFA manuals and guidelines as well as law journals. We obtained logs from HCFA that contain information about EMTALA complaints and the outcomes of investigations between Fiscal Years 1986 and 1998.

FINDINGS

The EMTALA enforcement process is compromised by long delays and inadequate feedback. Timely processing of EMTALA cases is a longstanding problem. Delays have worsened in recent years, despite a decline in dumping cases. In addition, HCFA regional offices often fail to communicate their decisions to State survey agencies and the PROs.

The number of EMTALA investigations and their ultimate disposition vary widely by HCFA region and year. Regional offices vary greatly in the number of EMTALA investigations that they conduct and the outcomes of those investigations. For example, one region found violations in 22 percent of its investigations while another region found violations in 68 percent of its investigations.

Poor tracking of EMTALA cases impedes oversight. The HCFA's investigation logs contain numerous errors and omit key information about dumping complaints and EMTALA investigations. Although HCFA's central office chose a particular software application for tracking EMTALA cases, some regional offices continue to use their own methods for data collection.

Peer review is not always obtained before HCFA considers terminating a hospital for medical reasons. The HCFA instructs States to obtain professional medical review during an EMTALA investigation, but this does not always occur. The HCFA has the option of requesting peer review, but this is discretionary even if the State did not obtain peer review. In most cases, the OIG must seek PRO input and may drop a case if the PRO finds that medical care was adequate.

RECOMMENDATIONS

We recommend that HCFA:

- **increase its oversight of regional offices,**
- **improve collection and access to EMTALA data,**
- **ensure that peer review occurs for cases involving medical judgment, and**
- **establish an EMTALA technical advisory group.**

AGENCY COMMENTS

We received written comments from HCFA on the draft report, which are included in the appendix. The HCFA concurred with our recommendations. The comments describe a dedicated HCFA effort to reduce backlogs, improve data collection, and increase coordination among the regions. The HCFA also offered several technical comments, which we have incorporated where appropriate.