CMS Reverses Course for the EMTALA Obligations of Hospitals With Specialized Care and Eases the Burdens of On-Call Coverage

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Practice Area: Health Law

CMS has once again clarified the responsibilities of a Medicare-participating hospital under the Emergency Medical Treatment and Active Labor Act (EMTALA). The final rule, effective October 1, 2008 (the "2009 IPPS Final Rule"), follows additional revisions and guidance adopted by CMS in the past several years and is intended to ease the burden on emergency medical services.

In the 2009 IPPS Final Rule, CMS has reversed course from its proposed rule in April 2008, and has clarified that a hospital with specialized capabilities (*e.g.,* burn units, shock trauma units and neonatal intensive care) does not have an EMTALA obligation to accept the transfer of an individual who has been admitted at another hospital as an inpatient with an unstable emergency condition. Additionally, the 2009 IPPS Final Rule permits hospitals to fulfill their call duties by participating in a formal community call plan.

EMTALA Obligations for Hospitals with Specialized Capabilities
The 2009 IPPS Final Rule clarifies the boundaries of EMTALA, as applied to inpatients. In particular, CMS has addressed the situation in which an individual presents at a hospital with an unstable emergency medical condition and the hospital admits the patient, but later refers the patient to a hospital with specialized capabilities because the patient requires such care for stabilization.

CMS previously addressed the EMTALA obligations of the admitting hospital in its 2003 IPPS Final Rule. CMS added a rule clarifying that a hospital's EMTALA obligations end once the hospital admits an individual as an inpatient in good faith. In adopting this position, CMS believed that EMTALA was not necessary to protect patients after their admission because the Conditions of Participation (CoPs) for Medicare and other state laws provided protection for inpatients. Consequently, under the 2003 Final Rule, once a hospital admits a patient as an inpatient, the hospital's EMTALA obligations end, even if the patient's unstable emergency medical condition persists.

Although the 2003 Final Rule clarified the boundaries of EMTALA for the admitting hospital, it remained unclear whether the 2003 IPPS Final Rule similarly limited the EMTALA obligations of Medicare-participating hospitals with specialized capabilities. The regulations provide that such hospitals have an EMTALA obligation to accept appropriately transferred patients in need of specialized medical care for stabilization, provided they have the capacity to treat the patient. The regulations and the 2003 IPPS Final Rule left unanswered whether EMTALA obligations continued for hospitals with specialized capabilities, even though EMTALA was no longer applicable to inpatients at the referring hospital.

The 2009 IPPS Final Rule now clarifies that specialized hospitals do not have EMTALA obligations to accept the transfer of patients who have already been admitted to another hospital, even if the unstable condition present at admission still remains and the patient needs specialized care. The final rule, marks a clear departure from CMS's stance when it first proposed the rule.

In the proposed rule, CMS took the position that a patient's inpatient status only affected the EMTALA obligations of the admitting hospital and not the obligations of a specialized hospital to accept appropriate transfers. CMS believed that the EMTALA obligations were necessary, given the inapplicability of CoPs and other laws to the specialized hospital that has not yet admitted a patient. Consequently, the proposed rule expressly maintained the EMTALA obligations of the specialized hospital after the patient's formal admission at the referring hospital.

The proposed rule met strong opposition. Commenters claimed that the changes were contrary to the 2003 regulation by "reopening" the admitting hospital to EMTALA regulations covering appropriate transfers. Still others were concerned that the proposed rule would encourage patient dumping, further increase unnecessary patient transfers to hospitals with specialized capabilities, and reduce the efforts of hospitals to carefully assess patients prior to admission. Commenters asserted that the proposed rule would over-burden tertiary care hospitals, urban safety net hospitals and teaching hospitals that provide a substantial amount of care to uninsured patients. Finally, commenters contended that hospitals would be burdened with the decision of determining whether a particular inpatient had been admitted with an unstable condition and was therefore eligible for transfer under EMTALA.

After considering these comments, CMS not only declined to adopt its proposed regulation, but took exactly the opposite position in its 2009 IPPS Final Rule. Under the rule, once a patient is admitted as an inpatient in good faith to a hospital after presenting with an unstable emergency medical condition, another hospital with specialized capabilities does not have an EMTALA obligation to accept a transfer patient, even if the patient requires specialized capabilities for stabilization.

Community Call Plans

The 2009 IPPS Final Rule also permits hospitals to develop formal community call plans with other hospitals. With the community call plan option, CMS aims to provide flexibility for hospitals in meeting their emergency services obligations. Specifically, CMS noted in the proposed rule that hospitals were experiencing difficulty in acquiring on-call coverage for specialty care and cited reports of physicians with simultaneous, multi-hospital call coverage breaking ties with hospitals to reduce their on-call duties.

CMS states that the new community call provisions will ease the burden of hospitals seeking to acquire specialty care coverage and increase access to such care. Commenters to the proposed rule generally agreed with CMS, citing the potential forcommunity call coverage to "eliminate the need for duplicative coverage of nearby hospitals, increase physician retention of specialists, and regionalize scarce resources."

Current EMTALA regulations require hospitals to maintain policies and procedures for responding to the unavailability of a particular specialty, the unavailability of the oncall physician because of circumstances beyond the physician's control, and the unavailability of the on-call physician if the hospital permits its physicians to schedule elective surgery while on call or to simultaneously take call at multiple hospitals. These plans and procedures do not require on-call coverage for each specialty 24 hours a day, 7 days a week, however.

While not required of hospitals, CMS envisions physicians in some specialties now covering call at all times in the community. The new community call plan regulations contain six mandatory requirements for each plan. Plans do not require pre-approval by CMS but are subject to a later compliance review. The specific requirements included in the new regulations are:

1. A clear delineation of on-call coverage responsibilities; that is, when each hospital participating in the plan is responsible for on-call coverage;
2. A description of the specific geographic area to which the plan applies;
3. A signature by an appropriate representative of each hospital participating in the plan;
4. Assurances that any local and regional EMS system protocol formally includes information on community on-call arrangements;
5. A statement specifying that even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an obligation to provide a medical screening examination and stabilization treatment within its capability, and that hospitals participating in the community call plan must abide by EMTALA regulations governing appropriate transfers; and
6. An annual assessment of the community call plan by the participating hospitals.

In the preamble to the final rules, CMS states that the formal call plan requirements are designed to give hospitals flexibility in formulating their plans. For example, CMS stated that it specifically chose not to define a geographic boundary (*i.e.*, city, region, or state) for the community call plans, and the plans can accommodate variation in local resources and needs. As CMS notes in the preamble, a plan may take different forms. Hospitals may specify the days of the month in which they will provide on-call coverage or they may specify the on-call services each hospital will cover.

Although a community call plan may relieve some burden and increase coverage of specialty services, a community call plan does not alter a hospital's fundamental EMTALA obligations. Medicare participating hospitals must still provide medical screening examinations to patients who present at an emergency room and to transfer patients when appropriate. Additionally, hospitals participating in a community call plan must have policies and procedures to ensure the availability of emergency medical services for individuals in need of emergency care.

Developing a community call plan may pose difficulties for hospitals who operate as the sole hospital in the community, but CMS and commentators agreed that community call plans will be beneficial to rural areas facing physician shortages. Such hospitals may enter into a regional call plan for specialty services that are otherwise difficult to acquire.

Finally, some commenters questioned whether a multi-hospital community call plan could result in Sherman Anti-Trust Act liability or HIPAA liability. Consequently, hospitals desiring to create a community call plan should seek legal assistance in structuring the plan.

Other EMTALA Issues

CMS has also made a few technical changes concerning the obligations of hospitals to maintain an on-call list of physicians.

First, CMS has moved the regulations requiring hospitals to maintain on-call lists from the regulations governing EMTALA to the regulations governing provider agreements. That placement is more in line with the statutory structure since the source of the requirements on on-call lists is found in the statutes governing provider agreements, not EMTALA. Consequently, the failure to maintain an on-call list is no longer an EMTALA violation, but instead a violation of regulations governing provider agreements.

Second, CMS has altered the language of the on-call requirements. The new language reflects the addition of a formal community call plan option for hospitals, and does not contain a requirement for hospitals to maintain the list "in a manner that best meets the needs of the hospital's patients." CMS stated that it removed the "best meets the needs" language because it caused confusion, but further stated that the removal does not limit a hospital's "ability to set on-call expectations that physicians be on call." CMS also emphasized that hospitals provide on-call services in accordance with community needs and the hospital's resources. Consequently, CMS's comments suggest that the amendment to the language is merely technical and not substantive.

New Regulations In Perspective
The new regulations were suggested by the EMTALA Technical Advisory Group (TAG), a group with the task of recommending changes to EMTALA and follow a number of revisions and clarifications to EMTALA in recent years. With the new changes in the 2009 IPPS Final Rule, CMS has now adopted seven of TAG's 55 recommendations.

The changes to EMTALA, in the 2009 IPPS Final Rule likely will be welcomed by hospitals in search of definitive, "bright-line" rules for EMTALA's requirements. Much ambiguity has surrounded EMTALA since its inception. In some cases, court decisions attempting to resolve EMTALA's ambiguities have resulted in an apparent expansion of EMTALA's requirements for hospitals within those courts' jurisdictions. Additionally, those court decisions may result in inconsistent guidance in different jurisdictions.

For example, the United States Court of Appeals for the First Circuit has recently attempted to resolve an apparent ambiguity in EMTALA's regulations concerning whether patients in non-hospital owned ambulances en route to the hospital are said to have "come to the hospital's emergency department," thereby invoking EMTALA obligations.

In one sentence, EMTALA regulations suggests that individuals in non-hospital owned ambulances en route to the hospital have not yet "come to the hospital," and therefore, no EMTALA obligations yet exist. But the very next sentence of that regulation suggests that hospitals not on diversionary status breach EMTALA by diverting the non-hospital-owned ambulance.

In resolving the ambiguity, the First Circuit held that for purposes of EMTALA, hospitals cannot divert an ambulance once the ambulance staff have notified the hospital of the ambulance's imminent arrival, unless the hospital is on diversionary status. See *Carolina Morales v. Sociedad Espanola de Auxilio Mutuo y Beneficiencia*, 524 F3d 54 (1st Cir. 2008). The Ninth Circuit Court of Appeals has also issued a similar opinion (*see Arrington v. Wong*, 237 F3d 1066 (9th Cir. 2001)).

The decisions in *Morales* and *Arrington* clarify EMTALA's obligations for states and territories within their respective circuits. In resolving this ambiguity, however, these courts have seemingly expanded EMTALA's coverage for hospitals within their jurisdictions and created an obligation contradictory to the prevailing consensus on EMTALA's reach. In the preamble to the 2003 Final Rules, for example, CMS stated that EMTALA does not create obligations for patients in non-hospital-owned or operated ambulances when they are not on hospital-owned property. Notably, CMS made this statement after the decision in *Arrington*, suggesting a disagreement with *Arrington* and likely with *Morales*.

Consequently, given CMS's recent trend of amending and clarifying EMTALA, the additional recommendations by TAG, and the persistent ambiguity concerning many EMTALA obligations, hospitals may expect further changes and/or clarifications in the next few years.
