Emergency Medical Treatment and Active Labor Act

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The Emergency Medical Treatment and Active Labor Act (EMTALA) is a U.S. Act of Congress passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA). It requires hospitals to provide care to anyone needing emergency healthcare treatment regardless of citizenship, legal status or ability to pay. There are no reimbursement provisions. Participating hospitals may only transfer or discharge patients needing emergency treatment under their own informed consent, after stabilization, or when their condition requires transfer to a hospital better equipped to administer the treatment.

EMTALA applies to "participating hospitals." The statute defines "participating hospitals" as those that accept payment from the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) under the Medicare program. However, in practical terms, EMTALA applies to virtually all hospitals in the U.S., with the exception of the Shriners Hospitals for Children, Indian Health Service hospitals, and Veterans Affairs hospitals. The combined payments of Medicare and Medicaid, $602 billion in 2004, or roughly 44% of all medical expenditures in the U.S., make not participating in EMTALA impractical for nearly all hospitals. EMTALA's provisions apply to all patients, and not just to Medicare patients.

The cost of emergency care required by EMTALA is not directly covered by the federal government. Because of this, the law has been criticized by some as an unfunded mandate. Similarly, it has attracted controversy for its impacts on hospitals, and in particular, for its possible contributions to an emergency medical system that is "overburdened, underfunded and highly fragmented." More than half of all emergency room care in the U.S. now goes uncompensated. Hospitals write off such care as charity or bad debt for tax purposes. Increasing financial pressures on hospitals in the period since EMTALA's passage have caused consolidations and closures, so the number of emergency rooms is decreasing despite increasing demand for emergency care. There is also debate about the extent to which EMTALA has led to cost-shifting and higher rates for insured or paying hospital patients, thereby contributing to the high overall rate of medical inflation in the U.S.
Mandated care

Congress passed EMTALA to combat the practice of "patient dumping," i.e., refusal to treat people because of inability to pay or insufficient insurance, or transferring or discharging emergency patients on the basis of high anticipated diagnosis and treatment costs. The law applies when an individual with a medical emergency "and a request is made on the individual's behalf for examination or treatment for a medical condition." [10] It does not matter whether the condition is visible to others, or is simply stated by the patient with no external evidence.[citation needed]

The U.S. government defines an emergency department as "a specially equipped and staffed area of the hospital used a significant portion of the time for initial evaluation and treatment of outpatients for emergency medical conditions."[citation needed] This means, for example, that outpatient clinics not equipped to handle medical emergencies are not obligated under EMTALA and can simply refer patients to a nearby emergency department for care.[11]

An emergency medical condition is defined as "a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs." For example, a pregnant woman with an emergency condition must be treated until delivery is complete, unless a transfer under the statute is appropriate.[11]

Though patients treated under EMTALA may not be able to pay or have insurance or other programs pay for the associated costs, they are legally responsible for any costs incurred as a result of their care under civil law.[citation needed] Patients whose advance intention it is to receive
medical care and fail to pay cannot be held criminally liable unless they intentionally and knowingly provide false identifying information to dodge billing. [citation needed]

**[edit] Hospital obligations**

Hospitals have three obligations under EMTALA:

1. Individuals requesting emergency care, or those for whom a representative has made a request if the patient is unable, must receive a medical screening examination to determine whether an emergency medical condition (EMC) exists. The participating hospital cannot delay examination and treatment to inquire about methods of payment or insurance coverage, or a patient's citizenship or legal status. The hospital may only start the process of payment inquiry and billing once they have stabilized the patient to a degree that the process will not interfere with or otherwise compromise patient care.

2. The emergency room (or other better equipped units within the hospital) must treat an individual with an EMC until the condition is resolved or stabilized and the patient is able to provide self-care following discharge, or if unable, can receive needed continual care. Inpatient care provided must be at an equal level for all patients, regardless of ability to pay. Hospitals may not discharge a patient prior to stabilization if the patient's insurance is canceled or otherwise discontinues payment during course of stay.

3. If the hospital does not have the capability to treat the condition, the hospital must make an "appropriate" transfer of the patient to another hospital with such capability. This includes a long-term care or rehabilitation facilities for patients unable to provide self-care. Hospitals with specialized capabilities must accept such transfers and may not discharge a patient until the condition is resolved and the patient is able to provide self-care or is transferred to another facility.

**[edit] Amendments**

Since its original passage, Congress has passed amendments to this act. Additionally, state and local laws in some places have imposed additional requirements on hospitals. These amendments include:

- A patient is defined as "stable," therefore ending a hospital's EMTALA obligations, if:
  - The patient is conscious, alert, and oriented
- The cause of all symptoms reported by the patient or representative, and all potentially life-threatening, limb-threatening, or organ-threatening symptoms discovered by hospital staff, has been ascertained to the best of the hospital's ability.
- Any conditions that are immediately life-threatening, limb-threatening, or organ-threatening have been treated to the best of the hospital's ability to ensure the patient does not need further inpatient care.
- The patient is able to care for themselves, with or without special equipment, which if needed, must be provided. The required abilities are:
  - Breathing
  - Feeding
  - Mobility
  - Dressing
  - Personal hygiene
  - Toileting
  - Medicating
  - Communication
- Another competent person is available and able to meet the patient's needs following discharge.
- All patients have EMTALA rights equally, regardless of age, race, religion, nationality, ethnicity, residence, citizenship, or legal status. If patient's status is found to be illegal, hospitals may not discharge a patient prior to completion of care, though law enforcement and hospital security may take necessary action to prevent a patient from escaping or harming others. Treatment may only be delayed as needed to prevent patients from harming themselves or others.
- Overloaded hospitals may not discharge a patient unable to pay to make room for a patient who is able to pay or is otherwise viewed by society as a more valued citizen. If the emergency room is overloaded, patients must be treated in an order based on their determined medical needs, not their ability to pay.
- Hospitals may not deny or provide substandard services to a patient who already has outstanding debt to the hospital, and may not withhold the patient's belongings, records, or other required services until the patient pays.
- Hospitals and related services cannot receive a judgment against the patient in court filings made more than 36 months after the date the patient was discharged, or the last partial payment the patient made to the hospital, contractor, or agent. After that period, the patient may not be threatened with legal action if payment is not made, and may not be denied future outpatient services from the same company/agency that a patient is able to pay.
- If a patient has been awarded monetary damages against the hospital or any related or affiliated services by a court of law, or has settled out of court on damages, the hospital and related/affiliated services may not withhold monies due to lack of payment, or count the money toward the bill in lieu of making payment to the patient. Voluntary consent for such an arrangement is permitted only if initiated by the patient. Hospitals may not threaten or coerce a patient into such a settlement, or mislead the patient into believing such an arrangement is required or recommended.

- Patients cannot face criminal prosecution for failure to pay, even if the patient came to the hospital aware of inability to pay. Hospitals and third-party agents may not threaten patients with prosecution as a means of scaring the patient into making payment. Patient can be prosecuted under existing federal, state, or local laws for providing false name, address, or other information to avoid payment, receiving bills, or to hide fugitive status.

- A hospital cannot delay treatment while determining whether someone can pay or is insured but that does not mean they are completely forbidden from asking or running a credit check. If the patient doesn't pay the bill, the hospital can sue the patient and the unsatisfied judgment will likely appear on the patient's credit report. A 3rd-party collector for a hospital bill would be covered under the Fair Debt Collection Practices Act.

- Hospitals are prohibited from discriminating against or providing substandard care to those who appear impoverished or homeless, are not well-dressed or groomed, or exhibit signs of mental illness or intoxication. If the hospital fears a patient may be a threat to others, the hospital may delay care only as necessary to protect others.

- Hospitals are required to sufficiently feed patients unable to pay at a level equal to those able to pay, while meeting all physician-ordered dietary restrictions.

- Hospitals are not required to provide premium services to the patient not related to medical care (such as television) when failure to provide this service does not compromise patient care.

- Hospitals and affiliated clinics are not required to provide continued outpatient care, drugs, or other supplies following discharge. In the event such services are recommended, but a patient is unable to pay, the hospital is required to refer the patient to a clinic or tax-funded or private program that enables the patient to pay for these services, and to which the patient has reasonable access. Hospitals must reasonably assist patients as necessary to obtain these services by providing information the patient requests.

[edit] EMTALA's effect

[edit] Improved health services for uninsured
The most significant effect is that, regardless of insurance status, participating hospitals cannot deny urgent medical assistance. Currently EMTALA only requires that hospitals stabilize the emergency. According to some analyses of the U.S. health care safety net, EMTALA is an incomplete and strained program.\[12\][13]

[edit] Cost pressures on hospitals

According to the Centers for Medicare & Medicaid Services, 55% of U.S. emergency care now goes uncompensated.\[14\] When medical bills go unpaid, health care providers must either shift the costs onto those who can pay or go uncompensated. In the first decade of EMTALA, such cost-shifting amounted to a hidden tax levied by providers.\[15\] For example, it has been estimated that this cost shifting amounted to $455 per individual or $1,186 per family in California each year.\[15\]

However, because of the recent influence of managed care and other cost control initiatives by insurance companies, hospitals are less able to shift costs, and end up writing off more in uncompensated care. The amount of uncompensated care delivered by nonfederal community hospitals grew from $6.1 billion in 1983 to $40.7 billion in 2004, according to a 2004 report from the Kaiser Commission on Medicaid and the Uninsured,\[14\] but it is unclear what percentage of this was emergency care and therefore attributable to EMTALA.

Financial pressures on hospitals in the 20 years since EMTALA's passage have caused them to consolidate and close facilities, contributing to emergency room overcrowding. According to the Institute of Medicine, between 1993 and 2003, emergency room visits in the U.S. grew by 26 percent, while in the same period, the number of emergency departments declined by 425.\[9\] Ambulances are frequently diverted from overcrowded emergency departments to other hospitals that may be farther away. In 2003, ambulances were diverted over a half a million times.\[9\]

[edit] See also

- Health care in the United States

[edit] Notes and references

1. 42 U.S.C. § 1395dd
2. ^42 U.S.C. § 1395dd
3. ^42 U.S.C. § 1395dd (e)(2) The term “participating hospital” means a hospital that has entered into a provider agreement under section 42 U.S.C. § 1395cc of this title.
4. ^Key Medicare and Medicaid Statistics from kff.org
5. ^Text of act from law.cornell.edu
6. ^EMTALA FAQ Website / Information from Garan Lucow Miller, P.C
8. ^Emergency Medical Services At the Crossroads, Institute of Medicine, 2006-06-14, accessed 2007-10-05
10. ^42 U.S.C. § 1395dd
14. ^The Uninsured: Access to Medical Care, American College of Emergency Physicians, accessed 2007-10-05

[edit] External links

- CMS EMTALA overview from hhs.gov
- State Operations Manual from hhs.gov
- EMTALA: Its Application to Newborn Infants, by Thaddeus M. Pope, ABA Health eSource, Vol. 4, No. 7 (March 2008)
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