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Complying with the Emergency Medical Treatment and Labor Act (EMTALA): Challenges and Solutions

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Abstract

The Emergency Medical Treatment and Labor Act (EMTALA), which requires Medicare-participating hospitals to provide emergency care to patients regardless of their ability to pay, plays an important role in protecting the uninsured. Yet many hospitals do not comply. This study examines the reasons for noncompliance and proposes solutions. We conducted eleven semi-structured key informant interviews with hospitals, hospital associations, and patient safety organizations in the Centers for Medicare & Medicaid Services region with the highest number of EMTALA complaints filed. Respondents identified five main causes of noncompliance: financial incentives to avoid unprofitable patients, ignorance of EMTALA's requirements, high referral burden at hospitals receiving EMTALA transfer patients, reluctance to jeopardize relationships with transfer partners by reporting borderline EMTALA violations, and opposing priorities of hospitals and physicians. Respondents suggested five methods to improve compliance, including educating subspecialists about EMTALA, informally educating hospitals about borderline violations, and incorporating EMTALA-compliant processes into hospital operations such as by routing transfer requests through the emergency department. To improve compliance we suggest: 1) more closely aligning Medicaid/Medicare payment policies with EMTALA, 2) amending the Act to permit informal mediation between hospitals about borderline violations, 3) increasing the hospital's role in ensuring EMTALA compliance, and 4) expanding the role of hospital associations.

INTRODUCTION

During the 1980s, newspapers reported that hospitals were turning away uninsured patients, "dumping" unstable patients on safety net hospitals, and even allowing people to die on the

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street outside of an emergency room to avoid treating nonpaying patients. (1) In response, Congress passed the Emergency Medical Treatment and Labor Act (EMTALA) in 1986. Although EMTALA is meant to prevent patient dumping (2) and ensure access to emergency care for all patients, (3) the Act is particularly important for patients whom hospitals have financial incentives to avoid treating. Even if the country achieves near universal insurance, EMTALA will remain an important protection for patients who remain uninsured or whose insurance provides inadequate reimbursement. (4) For instance, providers may receive lower reimbursement from enrollees who are out-of-network, or who are in high deductible plans.

Despite physicians' (5) and patients' (6) self-reported familiarity with EMTALA, and public and professional concern about compliance, (7-11) hospitals continue to violate the Act. (12-14) In the first decade after it was passed, approximately a third of hospitals were investigated for EMTALA violations (15,16) and, as of 2011, almost 30 years after the Act was passed, 40% of investigations still found violations. (17)

Understanding why hospitals do not comply with EMTALA will help hospitals address noncompliance and, ultimately, help policymakers improve access to care. However, to our knowledge, previous research has only conjectured about the root reasons for noncompliance. Two common suggestions for noncompliance offered are that: (i) hospitals find the costs of compliance greater than benefits, particularly because detection is unlikely; and (ii) hospitals do not understand or have inadequate systems to comply with the complexity of EMTALA. (14,18)

The goals of this qualitative study were to explore systemic reasons for EMTALA noncompliance and suggest ways to reduce it. We based the analysis and suggestions on semi-structured interviews with hospitals, hospital associations, and patient safety organizations that review clinical data on EMTALA violations.

Overview of EMTALA

EMTALA is a condition of Medicare participation that requires hospitals with an emergency department (ED) (19) to provide all patients who come to the ED with an appropriate medical screening exam to detect an emergency medical condition (EMC). (20) An exam is not deemed appropriate if the hospital provides different tests for patients with the same symptoms because of a patient's insurance status. (21) If the screening exam finds an emergency medical condition, the Act also requires hospitals to provide patients with treatment sufficient to stabilize the emergency condition. (22) Stabilization under the Act means that either no material deterioration is likely to result from or occur during the transfer or, for women in active labor, that the infant and placenta have been delivered. (23) If a patient is cannot be stabilized, s/he must be appropriately transferred. (22) What constitutes an appropriate transfer is defined by statute, and includes providing pre-transfer patients with treatment within the hospital's capacity that minimizes the risks to the patient's health. (24,25) The Act further requires hospitals with specialized capabilities such as burn, neonatal intensive care, or trauma units ("hospitals with recipient responsibilities") to accept an EMTALA transfer if it has capacity (26) (defined as the ability to accommodate the patient in terms of occupancy, qualified staff, and equipment) (27). The Act does not include any such requirement for non-EMTALA transfer patients.

Hospitals with recipient responsibilities are required to file a complaint with the Centers for Medicare and Medicaid Services (CMS) or the state survey agency if the EMTALA transfer patient it receives was transferred in an unstable medical condition. (28) The Act does not require any other organization to file other types of complaints, although it permits any individual or organization to do so. If the CMS regional office authorizes an investigation of a complaint, (17) the state survey agency conducts an unannounced, on-site investigation and reports the results back to the CMS regional office, which, along with the Office of Inspector General, decides whether there was an EMTALA violation and what the administrative penalties should be. (29)

Violations for EMTALA may be either administrative penalties or civil suits. EMTALA violations can result in hospital fines of up to $50,000 per violation ($25,000 for hospitals with fewer than 100 beds) or termination from participating in Medicare, and physician fines of up to $50,000 per violation and exclusion from Medicare. (30) Termination is rare; not only did one study suggest that only 2% of hospitals violating EMTALA excluded from Medicare, and about half are later reinstated, (15) but another suggested that no hospital has been excluded from Medicare since 2007. (18)

In addition to administrative penalties, patients may file civil suits against hospitals for EMTALA violations. (30) Physicians are not subject to civil liability under EMTALA. (37) (38,39) An EMTALA claim may be in addition to malpractice claims, even if the two arise from the same facts. For example, a patient could sue a hospital both under malpractice for negligently failing to detect an emergency medical condition and under EMTALA if s/he was not screened according to the hospital's policies. Filing both claims may be attractive to patients because, although the Act expressly limits financial recovery for EMTALA claims to the damages recoverable for state malpractice claims, (30) other state tort reform laws may not apply to EMTALA claims. For instance, courts have suggested that some reforms such as prior review by malpractice review panels, shorter statute of limitations, or protection of peer review proceedings do not apply to EMTALA claims. (31-36)

Another reason plaintiffs may wish to assert an EMTALA claim against hospitals is because hospitals may have greater liability under EMTALA than malpractice. This greater liability arises because hospitals are responsible for any EMTALA violation that occurs within the hospital. Thus, even if a hospital can disclaim liability for the malpractice claim, such as if the hospital is indemnified by the physician for the malpractice claim (i.e. the physician is responsible for the malpractice claim), the hospital is still responsible for the EMTALA violation. (38,39)

Despite these legal risks, hospitals continue to violate the law. Some violations may reflect uncertainty about the application of EMTALA, such as its continued application when a patient is on observation status. (40) Other situations may appear suspicious but are not clear EMTALA violations. For example, some cases may reflect an EMTALA violation, an inaccurate diagnosis, or just a change in patient condition, such as a patient discharged from one hospital's ED for cholelithiasis (gallstones) and being admitted the next day by another hospital's ED for the more serious cholecystitis (gallbladder inflammation). (12) Although each individual case may not indicate a violation, when many such cases occur at a hospital,

a pattern may arise suggesting that at least some cases included violations. Thus, a safety net hospital may be suspicious that a transferring hospital is violating EMTALA if that hospital appears to be transferring primarily indigent patients under EMTALA, citing the lack of an on-call gastroenterologist, while admitting insured patients who require those services. (13)

Egregious violations have also been widely reported. For instance, an uninsured patient died from lack of treatment because a doctor allegedly refused to leave the sleep room (11) and an ED director hung up on a paramedic seeking help when the paramedic could not assure him that the patient was insured. (41) Over five years, a psychiatric hospital discharged over 1500 patients with commercial bus tickets to other cities where the patients had no connections; (42) CMS determined that 40% of the discharges constituted EMTALA violations. (43) This example highlights the difficulty of detecting EMTALA violations, and emphasizes the importance of determining systematic reasons for violations and possible ways to prevent these violations.

METHODS

We conducted eleven semi-structured, key informant interviews with nonprofit hospitals, hospital associations and patient safety organizations. Because preliminary informational interviews suggested that respondents preferred talking informally and indirectly about EMTALA compliance, in part to avoid the risk of liability, we did not ask about specific examples of EMTALA noncompliance at the respondent's hospital. Instead, we asked general questions about experiences, knowledge, and perceptions of EMTALA by physicians and hospitals in the respondent's state. We also asked respondents questions designed to determine the depth of their EMTALA knowledge by asking about their exposure to a specific legal issue, whether EMTALA obligations cease upon inpatient admission. (See appendix for summary of topics discussed)

The study sample consisted of organizations within five states (Georgia, Kentucky, North Carolina, South Carolina, and Tennessee). These states are within CMS region 4, which has the highest number of EMTALA complaints filed among all CMS regions, accounting for 41% of all complaints nationally in 2007. (17) Because the study hospitals are within this region, they are likely more familiar with EMTALA violations. We generated the study sample from web searches and respondents identified through snowball sampling, where we asked participating subjects to identify colleagues who might also be interested in participating in our study. After identifying state hospital associations and patient safety organizations that conduct clinical reviews of EMTALA violations, we identified physicians who served on the board of directors of the hospital association, and added these physicians' hospitals to the sample.

We continued to add potential respondents until we reached saturation, meaning the point where additional interviews did not generate new themes. (44) To ensure that we did not prematurely conclude we had reached saturation, we continued interviews until the sample included at least one each of religious, network, community, rural, urban, academic, and non-academic hospitals.

The lead author made up to three attempts to contact 23 potential respondents through phone calls or e-mail. Seven (of the 23) potential respondents were at for-profit hospitals, none of which responded to our three separate requests for participation. (Appendix Table) Eleven potential participants agreed to participate, including seven participants at nonprofit hospitals. These hospitals included a mix of transferring (2) and receiving hospitals (3), and hospital networks consisting of both transferring and receiving hospitals (2). Respondent roles at these hospitals included general counsel (1), ED director (2), ED physician (1), associate chief of staff (1), Chief Medical Officer (1), and Chief Nursing Officer (1). The lead author conducted half-hour semi-structured interviews by phone from March to August 2014 and took notes during interviews, including short direct quotes, but did not record the interviews to keep them informal.

The lead author analyzed the interview notes for themes related to potential causes of or solutions to EMTALA violations. We borrowed from the grounded theory technique to do this, but did not engage in formal grounded theory analysis because the lack of a recording or transcript precluded close coding, a key component of that technique. Similarly, we analyzed our notes but did not use formal qualitative software because of the lack of a transcript.

This study was approved by the University of California, Los Angeles Institutional Review Board (IRB #13-000521).

RESULTS

We conducted eleven key informant interviews with representatives of nonprofit hospitals, hospital associations, and patient safety organizations within the CMS region with the highest EMTALA investigation rate. The respondents were highly knowledgeable about the Act, and thought the law was still relevant today. They described systemic causes and solutions to EMTALA compliance, which we classified into five general themes: financial pressure; complexity/knowledge; referral burden at recipient hospitals; inter-hospital relationships; and physician/hospital priorities.

1. Knowledge and Perception of EMTALA

The respondents' views regarding the significance of EMTALA for the quality of medical care varied. Some respondents reported that EMTALA obligations have been internalized by providers as the standard of care, and thus the Act has little ongoing importance. Others said that EMTALA continues to safeguard patient access and safety, creating a "baseline" level of care and providing ED physicians and hospitals with a "useful lever" to improve patient safety, such as by requiring specialists to follow on call obligations.

Respondents who thought EMTALA remains significant tended to be hospital administrators at recipient hospitals (i.e. those most likely to receive EMTALA transfer patients). They recounted transfers that were borderline inappropriate or that they suspected might be inappropriate. They also related seeing "general" patterns that they thought were consistent with EMTALA noncompliance, such as a higher percentage of EMTALA transfer patients who are uninsured, EMTALA transfer patients being sicker than reported, and a colleague

(pediatric surgeon) who had never had an *insured* EMTALA transfer patient (prior to Medicaid managed care). Respondents were unsure whether these general patterns were actually inappropriate, as most indicated that they would not be aware of an EMTALA investigation at another hospital or its results (unless it was widely publicized).

The respondents believed that ED physicians had high general knowledge of EMTALA, and they themselves showed a high level of specific knowledge about the law. To evaluate this knowledge, we asked about the 2009 case *Moses v. Providence Hospital and Medical Centers*, a decision by the Federal Court of Appeals for the Sixth Circuit ruling that EMTALA obligations may continue after inpatient admission. (45)(46) This decision overruled 2003 CMS rules, which end EMTALA obligations upon a good faith inpatient admission. (47) The effect of the *Moses* case and the CMS regulations (which the agency decided not to reconsider even after *Moses*) (48) is that there are essentially two different rules in place. In the Sixth Circuit (within our sample, Kentucky and Tennessee), EMTALA obligations extend beyond admissions, while outside of the Sixth Circuit (within our sample, Georgia, North Carolina, and South Carolina), it does not.

Our respondents within the Sixth Circuit's jurisdiction were generally aware of *Moses* or of the controversy regarding whether EMTALA extends to inpatients. Most understood the case to mean EMTALA obligations might extend to inpatients. However, they disagreed about the extent to which other hospitals were aware of the case. Some respondents doubted that employees at other hospitals knew about the case, while others thought there was "a lot of buzz" about *Moses* when the case was decided, and that even if physicians did not know the case by name "they do talk about the holding"; since *Moses,* "we know that we can't avoid EMTALA obligations simply by admitting [the patients]." One hospital association within the Sixth Circuit discussed the case "at length" with their member hospitals.

In contrast, the respondents outside the Sixth Circuit knew of the CMS regulations, but only a few knew about the controversy regarding EMTALA's application to inpatients. One respondent said that key individuals within her hospital network were aware of the case, but they did not disseminate information about the case to the network's ED physicians because the administration did not think the case applied since they are outside the Sixth Circuit's jurisdiction. One state hospital association disseminated educational information about the case when it was first decided.

2. Why Hospitals Do Not Comply with EMTALA

Our respondents suggested several potential causes for EMTALA violations more specific than the commonly ascribed reasons – economic cost and lack of fear of enforcement. We classified these into five themes: financial pressure, complexity/knowledge of the law, perception of referral burden, inter-hospital relationships, and different hospital and physician priorities about EMTALA. The table summarizes these themes, and the potential causes of and solutions to EMTALA noncompliance that our respondents suggested for each theme.

Financial Pressure.—The respondents stated that hospitals may be financially interested in avoiding Medicaid and uninsured patients because reimbursement rates are typically too

low to cover the hospital's costs. One respondent predicted that hospitals, if left on their own, would "literally put in a credit card swipe on the front door." This finding is consistent with research suggesting low margins in the ED for Medicaid and uninsured patients (−54.4% and −35.9%) compared to Medicare and commercially-insured patients (−15.6 and 39.6%). (49) Because EMTALA requires hospitals to treat patients they might otherwise avoid for financial reasons, respondents described EMTALA as an "unfunded mandate." As such, they may view EMTALA obligations as "painful" or "potentially burdensome," particularly in states that have not expanded Medicaid.

States' Medicaid reimbursement policies and rates may aggravate the financial pressure experienced by hospitals treating Medicaid patients. Specifically, state Medicaid agencies did not always agree that all the screening procedures were necessary, resulting in the agency providing minimal reimbursements for care required by EMTALA. For instance, one respondent gave an example of a MRI being conducted on a baby who had fallen on the sidewalk. According to the hospital, giving an MRI was standard care. Because EMTALA requires that hospitals use the same screening procedures for all patients presenting with comparable symptoms regardless of insurance status, (50-52) the hospital argued that forgoing the MRI because of the patient's Medicaid status would violate EMTALA. However, the respondent's state Medicaid agency reimbursed the hospital only the $25 EMTALA screening fee, claiming that the MRI was unnecessary. That state's Medicaid agency had a reputation for having difficult reimbursement policies and rates, so much so that respondents in a bordering state were reluctant to accept EMTALA transfers from the first respondent's state, with one hospital even asking requesting hospitals from the first respondent's state if there was an in-state alternative available unless the patient was from very near the border.

Complexity/knowledge.—The respondents generally agreed that ED physicians are knowledgeable about EMTALA, but that some aspects are still "mysterious" and difficult to understand, such as EMTALA obligations for psychiatric patients. Respondents complained that non-ED physicians and staff, particularly subspecialists, lack knowledge about EMTALA; one respondent said that a subspecialist from a transferring hospital "acted as though he had never even heard about EMTALA before." (That respondent subsequently filed an EMTALA complaint against the transferring hospital). The respondents suggested that EDs of rural hospitals may be particularly vulnerable to gaps in knowledge about EMTALA, as these EDs may be staffed with family physicians who are not as familiar with the Act.

Because of the law's complexity, physicians sometimes disagreed with their own hospitals about EMTALA's requirements. For example, a respondent at one regional referral center (level 4) said that EMTALA sometimes delayed transfers because physicians believed the Act requires full diagnostic workups before transferring a patient to the local level 1 hospital.

Referral Burden at Recipient Hospitals.—Several respondents indicated that EMTALA compliance at hospitals with recipient responsibilities has become increasingly difficult because the referral burden at these hospitals has increased the past few years. The

respondents described two causes of the increased referral burden: smaller hospitals handling general medical problems only; and smaller hospitals no longer contracting for on-call services because specialty physician groups require high fees to be on-call. One respondent suggested that certain sub-specialty groups like orthopaedics may charge a hospital "millions of dollars just to be on call."

A high referral burden at recipient hospitals may indirectly affect EMTALA noncompliance at other hospitals. Specifically, a high referral burden in the ED may make recipient hospitals "very reticent" to accept inpatient transfers. Because this makes it difficult to transfer inpatients, other hospitals may be less likely to admit sicker indigent ED patients that they want to transfer, resulting in uninsured patients "get[ting] stuck" while waiting for an EMTALA transfer. Thus, some EMTALA transfer patients may be sicker than receiving hospitals were told; one respondent at a hospital with recipient responsibilities stated that these patients were so often sicker than what the hospital was told (once a month, an EMTALA transfer patient would need to be moved to an ICU) that that hospital shifted from directly admitting EMTALA transfer patients to making ED-to-ED transfers.

Inter-hospital Relationships.—The respondents indicated that physicians at recipient hospitals report inappropriate transfers that are egregious EMTALA violations. However, they often refrain from reporting transfers that may be borderline inappropriate or those that they only suspect may be EMTALA violations but are not certain about. They refrain from doing so to avoid being characterized by other hospitals as being even "a little bit difficult" since they do not want to lose the other hospital as a transfer partner. Thus, in order to maintain existing inter-hospital relationships, hospitals may be reluctant to file EMTALA complaints.

Physician/Hospital Priorities.—Our interviews suggest that physicians may emphasize EMTALA less than hospitals do, creating a potential principal-agent problem. Hospitals are "acutely aware" of the importance of EMTALA; they want to "stay out of EMTALA jail" and are very concerned about losing Medicare certification even though termination is rare. In contrast, physicians think of EMTALA as primarily a hospital liability issue; many respondents indicated that ED physicians may be more concerned with malpractice ("their hair turns on end") or professional obligations than EMTALA, and may be unaware that physicians may also be fined under EMTALA.

This difference in priorities might lead to EMTALA violations. Even if hospitals want to accept a transfer patient to avoid EMTALA liability, our respondents suggest that physicians may refuse because they are too busy or because the eligible medical expenses payment may not be enough.

3. Ways to Improve EMTALA Compliance

The respondents suggested several strategies to prevent EMTALA violations related to the themes described above (Table).

Financial Pressure.—The hospital association of the state with particularly restrictive Medicaid reimbursement policies and low rates said that the state legislature appeared to

misunderstand EMTALA requirements, thinking that hospitals were “gouging the system” by providing medical screenings, and appearing to be of the opinion that, “if we manage the money, hospitals will figure out how to divert patients [away from the ED].” One legislator wanted to repeal EMTALA because he could “walk through the ER and figure out who isn’t an emergency case.” Thus, one way to improve Medicaid reimbursement policies and rates may be to increase state policymakers’ understanding about EMTALA, which in turn may result in states requiring Medicaid agencies and managed care organizations (MCOs) to cover EMTALA screening exams.

Complexity/knowledge.—The respondents suggest that a key strategy to address EMTALA complexity is to implement internal hospital processes to encourage EMTALA compliance. Among our respondents, hospitals often developed processes that “hardwire” compliance systems after being investigated for an EMTALA violation, even if the investigation did not find a violation. For instance, hospitals revised intake forms or integrated EMTALA compliance into electronic health records, potentially averting EMTALA complaints that are focused on specific formalities being met. Some recipient hospitals went further, creating systematic processes to manage ED transfer requests, such as routing all such requests through the ED. If EMTALA is implicated, either the chief of staff makes the transfer decision or transfer denials are recorded, reviewed post-hoc, and feedback provided to the ED physician if there is an issue.

In addition, the respondents gave examples of relying on hospital associations to help clarify EMTALA requirements with CMS.

Referral Burden at Recipient Hospitals.—As described above, an increased referral burden at recipient hospitals may lead to transferring hospitals being less likely to admit sicker indigent EMTALA patients because these patients are more likely to be accepted as transfer patients if they remain in the ED. To ease the referral burden at recipient hospitals, one respondent at a receiving hospital suggested amending EMTALA to require a transferring hospital to pay a receiving hospital for transfers. (53)

Inter-hospital Relationships.—The respondents stated that receiving hospitals used three different strategies to address borderline EMTALA violations: “very gently” providing informal education about EMTALA to requesting hospitals’ physicians; phone calls from the associate chief of staff to the requesting hospital; or holding formal “come to Jesus” meetings with other hospitals confronting them about the borderline violations, and questioning the appropriateness of a suspicious transfer. Unfortunately, these strategies sometimes triggered miscommunication between hospitals, which itself may lead to a suspected EMTALA violation. For instance, one hospital filed an EMTALA complaint against another when a physician at the receiving hospital asked the requesting physician whether there was a certain on-call specialist at the requesting hospital; the requesting hospital thought this was a denial of transfer (an EMTALA violation) but the other hospital thought this was clarification (consistent with EMTALA).

Physician/Hospital priorities.—Our respondents suggested that better educating physicians about EMTALA may help address differences in hospital and physician priorities.

Although many network hospitals offered EMTALA trainings directly or arranged for the hospital association to offer them, other (non-network) hospitals assumed without verifying that hospital associations would train their physicians. In fact, one hospital association thought that hospital legal and risk managers provide this training, while another declined to participate in our study because it did not offer any EMTALA training at all. In addition, respondents suggested that medical schools should offer more EMTALA training to non-ED physicians in order to address the fact that new graduates and residents do not have a good understanding about EMTALA.

DISCUSSION

Although EMTALA provides an important way to improve patient safety and access, hospitals continue to violate the Act. Despite not being specifically asked about EMTALA violations, our respondents, particularly those at receiving hospitals, volunteered examples of suspected EMTALA violations. However, concern over pre-existing hospital relationships may deter hospitals from reporting these suspected or borderline violations. This suggests that EMTALA complaints filed likely underestimate the number of actual EMTALA violations, even in the CMS region with the highest number of EMTALA complaints. In addition, this suggests that attempting to increase emphasis on reporting suspected inappropriate transfers in order to improve EMTALA compliance would likely not be successful.

This study has several limitations. First, because we wanted to identify the causes of noncompliance and potential responses, we focused on the CMS region with the highest number of EMTALA complaints filed. In other words, organizations within this region may have more exposure to EMTALA noncompliance than those outside the region, making it more likely that the respondents would have knowledge on the research question of why hospitals do not comply with EMTALA. This strategy of purposeful sampling is one of the most common sampling techniques in qualitative research. (54) Nonetheless, although our analysis identified general causes of and solutions for noncompliance that may be helpful to hospitals across the country, we may be missing some causes and solutions that are present in other regions. However, hospitals in other geographic regions have the same, or even lower, levels of compliance but have less stringent enforcement, making the results more broadly applicable. We attempted to address generalizability concerns by excluding Florida, the state with the highest number of complaints within CMS region 4, (17) which we thought might be least similar to other states if there were a generalizability issue. Nonetheless, our approach may have limited the generalizability of our findings.

Second, as is common with qualitative interviews, our sample was composed of willing respondents. Furthermore, with the exception of one hospital, we only interviewed one respondent at each organization. Thus, our results may reflect opinions of individuals and organizations that are particularly interested in EMTALA or most likely to comply with the terms of the Act, and may not reflect the opinions of those that may be less concerned with EMTALA. For instance, although receiving hospitals may also violate EMTALA (e.g. because of an on-call violation or because they refuse to accept an EMTALA transfer when they have capacity), these types of violations may not have been as salient to our

respondents if they were more likely to comply with the Act. Thus, one respondent recommended that transferring hospitals pay receiving hospitals for transfers, a comment that reflects experience at a receiving hospital. We attempted to address concern by speaking with a mix of receiving and transferring hospitals, and the themes from the respondents were consistent in both receiving and transferring hospitals. Third, the study sample only includes nonprofit hospitals; we were unable to speak with for-profit hospitals directly. However, the majority of ED visits in the states making up our study sample are to nonprofit hospitals (62%). (55-57) Finally, although we spoke with participants from all five states, we did not speak with representatives of every type of hospital for each state. However, the themes from our participants applied across the five states.

After synthesizing results from the primary data collection and analyzing our interviews, we propose four major ways to improve EMTALA compliance, as we discuss in greater detail below: (i) more closely align federal and statement payment policies with EMTALA; (ii) amend EMTALA to explicitly permit informal mediation sessions between hospitals to address concerns about borderline EMTALA violations; (iii) increase the hospital role in EMTALA training and dissemination of information; and (iv) increase the role of hospital associations.

More closely align Medicaid and Medicare payments with EMTALA.

EMTALA is a condition of participation that conditions Medicare funding on hospitals providing emergency care to unprofitable patients they might otherwise avoid. However, our respondents view EMTALA as a separate obligation, and therefore see the Act as an “unfunded mandate.” As such, they identified financial pressure to avoid uninsured and Medicaid patients as one of the main reasons for EMTALA noncompliance.

While universal coverage and increasing Medicaid reimbursement for all services would likely improve EMTALA compliance, these strategies are unlikely to be successful given fiscal and political constraints. We instead propose that more closely aligning Medicaid and Medicare payment policies with EMTALA may improve EMTALA compliance.

For instance, our respondents suggested that financial pressure to avoid uninsured and Medicaid patients may be aggravated by Medicaid reimbursement policies and rates, particularly nonpayment (or nominal payment) for mandated EMTALA screening exams. Specifically, both Medicaid agencies and MCOs are required to pay for the services involved in an EMTALA screening exam only if a physician diagnoses a clinical emergency; otherwise, they have discretion to determine whether the services used in the screening exam were necessary. (58-60) Our respondents suggested that this was particularly contentious, as an EMTALA “screening exam” may include expensive diagnostic tests. We therefore suggest that the government (federal or state) could mandate Medicaid reimbursement for an EMTALA screening exam. Because these services may vary between hospitals, this change would also encourage hospitals to better document their screening procedures, a change that might itself reduce EMTALA violations.

Another opportunity to more closely align federal and state payment policies with EMTALA may arise in changes to the disproportionate share hospital (DSH) payments under Medicaid

and Medicare. In anticipation of increased insurance coverage, the Patient Protection and Affordable Care Act (ACA) reduces DSH funding. In addition, the ACA requires that the methodology to allocate the reduction takes into consideration the percentage of uninsured individuals in a state and how well states target DSH payments to hospitals that treat high volumes of Medicaid patients or that have higher levels of uncompensated care. (61) If the ACA is repealed, we recommend that the DSH funding reduction be reversed, but that lawmakers continue encouraging states to better target DSH payments to hospitals that are providing the most Medicaid and uncompensated care. Tying this change explicitly to EMTALA might be helpful in reducing EMTALA violations.

Permit Informal "Mediation" Sessions Between Hospitals.

As discussed, hospitals' pre-existing relationships may negatively affect EMTALA compliance by dissuading hospitals from reporting borderline violations. Unfortunately, existing strategies (such as informal education or phone calls/meetings between hospitals) may lead to miscommunication that may themselves be interpreted as EMTALA violations.

We propose amending EMTALA to permit informal mediation sessions between hospitals where hospitals may raise concerns about borderline EMTALA violations. These sessions may serve as a middle ground between the informal education hospitals currently undertake and filing a formal complaint, and may help disseminate information about EMTALA while still preserving trust and relationships between hospitals. One way of framing these sessions so that they are more acceptable to both parties is to emphasize the fact that permitting an inappropriate transfer (or transfer denial) exposes the other hospital to EMTALA liability.

Increase Hospital Role in EMTALA Training and Dissemination.

Although hospitals may be more motivated by EMTALA concerns than physicians, hospitals seem mostly passive about EMTALA compliance (at least until they are investigated for an EMTALA violation). This may leave hospitals vulnerable to administrative and civil liability for EMTALA violations. As discussed above, even if a hospital can disclaim malpractice liability for the same acts, such as if the hospital is indemnified by a physician for the malpractice claims (e.g. because the physician is an independent contractor), hospitals still may be subject to EMTALA liability in lawsuits (38,39)

In addition to implementing EMTALA-compliant processes or more formally relying on hospital associations to train their physicians, as our respondents propose, we suggest that hospitals may want to take a more active role in evaluating and disseminating knowledge about EMTALA. They can proactively identify which physicians need to be aware of new developments about EMTALA, and examine whether these physicians actually know of them. In addition, hospitals can focus on requiring contracted specialty physician groups to show that they are trained in EMTALA. Finally, in order to better align hospital and physician interests, hospitals may wish to emphasize that physicians are also subject to fines and exclusion for EMTALA violations.

Increase Role of Hospital Associations.

Our results suggest that although hospitals rely heavily on hospital associations, both to provide EMTALA training and to clarify complex EMTALA issues, it is unclear whether this collaboration includes key hospital decision-makers. For instance, although hospital associations in our sample disseminated written updates about the *Moses* case, respondents outside the Sixth Circuit's jurisdiction were mostly unaware of the case, while those within knew about the case but doubted whether physicians at other hospitals were as knowledgeable. We recommend that hospital associations that provide EMTALA training survey physicians at member hospitals about specific EMTALA knowledge in order to gauge how much training is actually being disseminated to physicians.

In addition, hospital associations should collect best practices that help hospitals develop their own strategies for improving EMTALA compliance. Finally, the associations could work with CMS to disseminate examples of close cases that were ultimately deemed violations.

Despite its importance, EMTALA compliance continues to be a challenge, yet to our knowledge, no studies to date have investigated the reasons for noncompliance. In this study, we spoke with a representative sample of nonprofit hospitals, hospital associations, and patient safety organizations within the region with the highest EMTALA investigation rate. We explored systematic causes and solutions to EMTALA compliance and classified them into five themes, three of which (referral burden for recipient hospitals, inter-hospital relationships, and differences in priorities between hospitals and physicians) have not been previously discussed at length. Finally, we synthesized results from the study and suggested four major ways to improve EMTALA compliance: more closely aligning federal and statement payment policies with EMTALA; amending EMTALA to explicitly permit informal mediation sessions between hospitals to address concerns about borderline EMTALA violations; increasing the hospital role in EMTALA training and dissemination of information; and increasing the role of hospital associations.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table.

Themes, suggested reasons for EMTALA noncompliance, and proposed solutions as suggested by qualitative interview respondents.

Theme	Suggested Reason for Noncompliance	Suggested Solutions from Respondents
Financial pressure	Hospitals feel great financial pressure to avoid Medicaid and uninsured patients, a pressure which may be aggravated by difficult Medicaid reimbursement policies and rates	Increase state policymakers' knowledge of EMTALA to encourage states to require Medicaid reimbursement of EMTALA screening exams
Complexity/ knowledge	Although ED physicians are generally knowledgeable about EMTALA, there are still some areas about EMTALA that are "mysterious" and difficult to understand. Non-ED physicians and staff are less knowledgeable about EMTALA. This may leave rural hospitals particularly vulnerable, as those EDs may be staffed with family physicians unfamiliar with the Act.	Implement EMTALA-compliant processes within the hospital, such as revising forms or integrating EMTALA compliant processes into electronic health records. Some receiving hospitals use systematic processes to control ED transfer requests, routing all transfer requests through the ED and relying on the chief of staff to make the transfer decision or reviewing transfer decisions post-hoc and providing feedback to the ED physician.
Referral burden at recipient hospitals	Receiving hospitals may be overwhelmed by an increased referral burden, making it difficult to comply with EMTALA. The increased referral burden for these hospitals may also indirectly increase EMTALA noncompliance at other hospitals; because recipient hospitals are less willing to accept inpatient transfers, other hospitals may be reluctant to admit sicker indigent patients who they wish to transfer.	Amend EMTALA to require a transferring hospital to pay a receiving hospital when an EMTALA transfer is made (recommendation from respondent at a receiving hospital)
Inter-hospital relationships	Hospitals report egregious or obvious EMTALA violations, but will shy away from being even "a little bit difficult" about borderline inappropriate transfers because they do not want to lose other hospitals as transfer partners.	Provide informal education about EMTALA to requesting hospitals or formal meetings with other hospitals about potentially inappropriate transfers.
Physician/ hospital priorities	Although EMTALA is very important to hospitals, it may be less important to ED physicians, who may be more concerned with malpractice or professional obligations. This might create a principal-agent problem where, even if a hospital would want to accept a transfer patient to avoid EMTALA liability, physicians might refuse because they are too busy or because the payment may not be enough.	Better educate physicians about EMTALA and the importance of the law; more formally arranging for hospital associations to provide EMTALA training; encourage medical schools to offer EMTALA training to non-ED physicians