[Buffalo Law Review](https://digitalcommons.law.buffalo.edu/buffalolawreview)

Volume 53
Number 2 *Symposium on Health Care*

Article 3

4-1-2005

EMTALA and Hospital "Community Engagement": The Search for a Rational Policy

Sara Rosenbaum
The George Washington University School of Public Health and Health Services

Bruce Siegel
The George Washington University School of Public Health and Health Services

Marsha Regenstein
The George Washington University School of Public Health and Health Services

Follow this and additional works at: https://digitalcommons.law.buffalo.edu/buffalolawreview

Part of the Health Law and Policy Commons

Recommended Citation

Sara Rosenbaum, Bruce Siegel & Marsha Regenstein, *EMTALA and Hospital "Community Engagement": The Search for a Rational Policy*, 53 Buff. L. Rev. 499 (2005).
Available at: https://digitalcommons.law.buffalo.edu/buffalolawreview/vol53/iss2/3

This Symposium Article is brought to you for free and open access by the Law Journals at Digital Commons @ University at Buffalo School of Law. It has been accepted for inclusion in Buffalo Law Review by an authorized editor of Digital Commons @ University at Buffalo School of Law. For more information, please contact lawscholar@buffalo.edu.

EMTALA and Hospital "Community Engagement": The Search for a Rational Policy

SARA ROSENBAUM†

BRUCE SIEGEL††

MARSHA REGENSTEIN†††

INTRODUCTION

In U.S. health law, the Emergency Medical Treatment and Labor Act (EMTALA)[1] is unique in both structure and scope. Codified as part of the Medicare statute, EMTALA creates a universal, explicit, and individually enforceable right to certain emergency services from Medicare-participating hospitals;[2] as such, the law occupies a singular position in a legal environment otherwise devoid of health care rights and shaped primarily by market forces.[3]

---

† J.D.; Hirsh Professor and Chair, Department of Health Policy, The George Washington University School of Public Health and Health Services

†† M.D., M.P.H.; Research Professor, Department of Health Policy, The George Washington University School of Public Health and Health Services

†††Ph.D.; Associate Research Professor, Department of Health Policy, The George Washington University School of Public Health and Health Services

1. 42 U.S.C. § 1395dd (2005).

2. 42 U.S.C. § 1395dd(e)(2). For an excellent overview of EMTALA, see Tiana Mayere Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement*, 13 ANNALS HEALTH L. 145, 151-53 (2004).

3. For a discussion of health care rights and the dominance of markets in U.S. health law, see RAND E. ROSENBLATT, SYLVIA A. LAW & SARA ROSENBAUM, LAW AND THE AMERICAN HEALTH CARE SYSTEM, at ch. 2(A)(1) (1997 & Supp. 2001). For a highly market-driven view of the U.S. health care system, see FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004).

EMTALA specifies a relatively straightforward (we emphasize the word "relatively," since there are countless EMTALA cases in which hospitals challenge the nature and scope of their legal obligations)[4] set of duties regarding provision of emergency care to persons who seek help. The law specifies government sanctions for violators,[5] as well as private suits for damages by injured persons[6] and by other facilities that suffer financial losses as a direct result of a violation of the law.[7] In its scope and reach, EMTALA can perhaps best be understood as a reflection of a public belief that in the wealthiest nation in the world, people should not be turned away from, or thrown out of, hospitals to die on the streets.[8]

Not surprisingly perhaps, many hospitals and physicians are ambivalent about EMTALA. Public institutions that perform a disproportionate proportion of health care for the indigent[9] tend to support the law because of its access-promoting and redistributive effects. The powerful private health care institutions that comprise the bulk of U.S. hospitals and that are not bound by legal obligations[10] to treat potentially non-paying patients,

---

4. Lee, *supra* note 2, does a nice job of reviewing many of the most important cases. Standard health law textbooks similarly review EMTALA cases at length. *See, e.g.*, ROSENBLATT, LAW & ROSENBAUM, *supra* note 2, at ch. 1(D); BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS, at ch. 8(II) (5th ed. 2004).

5. 42 U.S.C. § 1395dd(d)(1)(A) authorizes the imposition of civil money penalties on hospitals for the negligent violation of the law. Physicians also can be subject to civil money penalties under § 1395dd(d)(1)(B).

6. § 1395dd(d)(2)(A) permits private suits against participating hospitals. Private suits against physicians are not authorized. 42 U.S.C. § 1395dd(d)(2)(A).

7. 42 U.S.C. § 1395dd(d)(2)(B).

8. The roots of EMTALA lie in the publicity of extreme cases. *See* Lee, *supra* note 2, at 146-51.

9. For an overview of the uncompensated care costs borne by public hospitals, see Ingrid Singer et al., *National Association of Public Hospitals, America's Safety Net Hospitals and Health Systems, 2002* (Sept. 2004), *at* http://www.naph.org//Content/ContentGroups/Publications1/MON_2004_9_Character 2002.pdf. In fiscal year 2002, eighty-one public hospitals furnished more than 24% of all uncompensated hospital care furnished nationally. *Id.* at 2.

10. Of course many institutions may believe that they have a moral or ethical obligation to furnish at least some care to persons who cannot pay, as well as to furnish lifesaving emergency care. Hospitals are not always so heroic

frequently object to the duties imposed under the law. The objection to the imposition of federal legal duties as a virtual condition of participation in Medicare is shared by the emergency care and specialty physicians who must carry out EMTALA's obligations. A frequently heard refrain is that the law makes it impossible for overburdened medical staff to divert individuals who allege a medical emergency but who, in their opinion, could be better managed in a community clinical setting.[11] EMTALA's clear and tough sanctions and liability exposure are intensified by the fact that the law contains no direct financing mechanism, but instead operates as a condition of Medicare participation and an unfunded mandate.[12]

The absence of a direct financing mechanism has taken on real significance as the nation's uninsured problem has reached the point at which no community is spared.[13] In

---

in performing basic access functions. In recent years, attention has been focused on hospital billing practices aimed at the uninsured, with hospitals charging the most exorbitant fees to their uninsured patients and pursuing aggressive billing practices including seizure of homes and meager bank accounts and attachment of modest earnings. *See Health Care Costs and Instability of Insurance: Impact on Patients' Experiences with Care and Medical Bills: Hearing on a Review of Hospital Billing and Collection Practices Before the Subcomm. on Oversight and Investigations, Comm. on Energy and Commerce, U.S. House of Reps.*, 108th Cong. (June 24, 2004) (statement of Sara Collins, Senior Program Officer, The Commonwealth Fund), *at* http://www.cmwf.org/usr_doc/collins_impact_test_760.pdf. The hospital industry has argued that federal Medicare payment rules compel this conduct, a charge that was publicly refuted in a 2004 letter from United States Department of Health and Human Services (HHS) Secretary Tommy Thompson to the President of the American Hospital Association. Letter from Tommy G. Thompson, Secretary of Health and Human Services, to Richard J. Davidson, President, American Hospital Association (Feb. 19, 2004), http://www.hhs.gov/news/press/2004pres/20040219.html. At the same time, Medicare's own bad debt payment policies require hospitals to use aggressive collection efforts prior to claiming financial recovery under the program. *See, e.g.*, In re Battle Creek Health System, [2004 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶81,261 (CMS Adm'r Nov. 12, 2004).

11. Collectively the authors of this article have had this very conversation with health professionals on countless occasions. See Lee, *supra* note 2, at 164-68, for a litany of issues typically raised in opposition to EMTALA.

12. *See id.* at 166.

13. *See* INSTITUTE OF MEDICINE, A SHARED DESTINY: COMMUNITY EFFECTS OF UNINSURANCE (2003). This study focuses on the community-wide effects of high numbers of uninsured persons, identifying both overcrowded emergency departments and system-wide strains on health care services and institutions. The report also found that the higher the proportion of uninsured low-income

2003, some forty-five million persons[14]—more than 18% of the non-elderly population—were uninsured. If analysis of the uninsured is expanded to include persons who experienced some time without insurance coverage over the 2002-2003 two-year time period, this forty-five million figure leaps to eighty-two million persons.[15] Moreover, the problem is not only a total lack of insurance; under-insurance is becoming a major concern as well, as employers raise deductibles and co-payments and introduce limits on benefits as a means of containing costs.[16] The economic effects of being underinsured fall on the sick with particular harshness.[17]

While hospitals might perceive EMTALA's financial burdens as considerable, it is also difficult to imagine the disappearance of so fundamental a public safety protection as the right of access to emergency hospital care. The duties and rights afforded by EMTALA did not appear overnight; indeed, the law rests on a series of federal and state law

---

persons as a total proportion of the community population, the more serious the access barriers. *Id.* at ch. 2.

14. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE, INCOME, POVERTY AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2003, tbl. C-1 (Aug. 2004), *available at* http://www.census.gov/prod/2004pubs/p60-226.pdf.

15. FAMILIES USA, ONE-IN-THREE: NON-ELDERLY AMERICANS WITHOUT HEALTH INSURANCE, 2002-2003 (June 2004), *available at* http://www.familiesusa.org/site/DocServer/82million_uninsuremergencydepartment_report.pdf?docID=3641.

16. For a comprehensive analysis of changes in the employer-sponsored health plan market, see *Trends and Indicators in the Changing Health Care Marketplace*, KAISER FAMILY FOUNDATION, (The Henry J. Kaiser Family Found., New York, N.Y.), 2004, at § 4, *at* http://www.kff.org/insurance/7031/ti2004-4-set.cfm (information updated Feb. 2, 2005).

17. The magnitude of the underinsured problem (i.e., inadequate coverage in relation to need for care and ability to pay for care) can be seen in a recent study examining the proportion of all U.S. bankruptcies related to medical care costs. *See* David U. Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF., Feb. 2, 2005, *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1. This study found that about half of all personal bankruptcies during the 2001 study period reported medical costs as the underlying problem and that half of all debtors had some form of health insurance at the onset of their illness. *Id.*

precedents,[18] and its key elements are reflected in the hospital industry's own operating standards.[19]

As U.S. hospital policy enters the twenty-first century, we believe that it is useful to take a step back and consider EMTALA in the broader arena of U.S. health policy as it relates to accessible community health services. In this context, two important but related challenges emerge. The first is how to pay for emergency care screening and stabilization services, which are essential to any health care system, but particularly so in a society without a universal financing mechanism for even basic health care. The second broader challenge—and one that emerges from an exploration of how hospitals function within communities—is how to promote what we term in this article a policy of "active engagement" among hospitals in building accessible health care systems within their service areas.

In our view, the concept of "active engagement" in community health care should be understood as part of the fundamental mission of hospitals in the twenty-first century. We believe that this shift in view regarding the proper role of hospitals is consistent with the growing emphasis on the provision of care outside of the four walls of hospitals,[20] as well as a growing understanding of the need to promote access to early and timely health care as a basic element of health care quality.[21] Toward that end, we believe that U.S. health care financing policies should be revised to incentivize such conduct. Thus, we advocate

---

18. ROSENBLATT, LAW & ROSENBAUM, *supra* note 3, at 60-64.

19. *See, e.g.*, Jackson v. Power, 743 P.2d 1376 (Alaska 1987) (finding the duty to maintain properly functioning emergency departments is so basic as to be nondelegable).

20. In 1975, there were more than 7100 licensed U.S. hospitals with nearly 1.5 million beds. By 2002, that number had declined to fewer than 5800 hospitals with about 976,000 beds. NATIONAL CENTER FOR HEALTH STATISTICS, CENTERS FOR DISEASE CONTROL & PREVENTION, U.S. DEP'T OF HEALTH & HUMAN SERVICES, Pub. No. 2004-1232, HEALTH UNITED STATES, tbl. 109 (2004).

21. *See generally* INSTITUTE OF MEDICINE, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (2001). The basic tenet of this landmark report is that health care should be safe, effective, patient-centered, timely, efficient, and equitable. *Id.* at 39-60. The essential meaning of this basic tenet is that people ought to be able to secure good health care in the setting most appropriate to their health care needs and ought not to have to turn to emergency departments for timely treatment unless they have medical emergencies.

reforms that create a financing mechanism for emergency screening and stabilization services, with eligibility tied to measurable standards of "engaged community action" on the part of hospitals. Our recommendations are consistent with the recent and growing emphasis on the concept of "pay for performance," which has attracted considerable attention in recent years[22] and which seeks to link health care payments to specific types of quality-promoting activities.[23]

Our conclusion regarding the need for an active engagement policy stems principally from a multi-year project undertaken for the Robert Wood Johnson Foundation. The project had a dual purpose: to improve the performance of hospital emergency departments and to examine the problem of hospital emergency department over-crowding within the broader context of health care access in the communities served by the study hospitals. Following an overview of EMTALA in Part II, we present the results of this project in Part III and discuss the concept of "active engagement" in Part IV.

II. AN OVERVIEW OF THE EMTALA STATUTE AND IMPLEMENTING REGULATIONS

A. *The Statute*

EMTALA was enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985.[24] From a legal perspective, EMTALA can be understood in part as an outgrowth of the broad community service obligation[25] contained in the Hospital Survey and Construction Act of

---

22. *See id.* at 81-206.

23. When the official Medicare Payment Advisory Commission released its 2005 report on Medicare payments to Congress for example, the concept of "pay for performance" dominated the analysis. *See* News Release, Medicare Payment Advisory Commission, Medicare Payment Advisory Commission Releases Report on Medicare Payment Policy (Mar. 1, 2005), http://www.medpac.gov/publications/other_reports/Mar05_NewsRelease .pdf

24. Pub. L. No. 99-272, 100 Stat. 82 (codified as amended in scattered sections of 42 U.S.C.). As a result of political disagreements, although the legislation is titled "1985," it was not enacted into law until the following year.

25. 42 U.S.C. § 291c(e) (2005).

1946 (Hill-Burton Act),[26] which was subsequently translated into an explicit emergency care obligation in the 1979 regulations.[27] EMTALA also has roots in state law: as of its enactment, twenty-two states had their own laws mandating at least a limited amount of emergency hospital care.[28] Furthermore, in a number of jurisdictions, courts already had begun to articulate a legal duty on the part of hospitals to render care in emergencies, using long-standing common law theories such as public function, undertaking, and detrimental reliance.[29] In short, by the time of EMTALA's passage, the societal belief (as reflected in the law) that hospitals should make emergency care available to all persons in need of care was hardly radical, although the scope of EMTALA surpassed any previous set of obligations.

The popular context for EMTALA's enactment was a spate of stories regarding denial of emergency care and hearings on the practice of "patient dumping."[30] But the precipitating legal event lay in Medicare payment reform and in growing Congressional concern over the foreseeable results of its 1983 enactment of the Medicare hospital inpatient Prospective Payment System (PPS).[31] PPS constrained hospital payments by replacing Medicare's retrospective system for determining costs with a prospective, fixed-fee arrangement that tied payments to diagnostic and treatment pairs.[32] In its statutory structure, EMTALA reflects two basic concerns on Congress' part

26. 42 U.S.C. § 291 (2005).

27. HHS Medical Facility Community Service Provisions, 42 C.F.R. 124.603(b)(1) (2005). The rule does not define the term "emergency" but provides that "[a] facility may not deny emergency services to any person who resides . . . in the facility's service area on the ground that the person is unable to pay for those services." *Id.*

28. *See* H.R. REP. NO. 99-241, pt. 3, at 5 (1985).

29. ROSENBLATT, LAW & ROSENBAUM, *supra* note 3, at 47-52.

30. Lee, *supra* note 2, at 147-50.

31. H. R. REP. NO. 99-241, pt. 1, at 27.

32. 42 U.S.C. §§ 1395ww-1395yy. For a full explanation of the Prospective Payment System, see MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC), REPORT TO CONGRESS: MEDICARE PAYMENT POLICY 40-44 (March 2005), *available at* http://www.medpac.gov/publications/generic_report_display.cfm?report_type_id=1&sid=2&subid=0.

regarding potential PPS fallout: first, hospitals' refusal to undertake *any* care and turning away patients with life- and health-threatening emergencies and second, the premature discharge of patients with unstabilized, but costly, emergency medical conditions.

In response to these concerns, EMTALA imposes fundamental obligations on all Medicare-participating hospitals, regardless of the insured status of persons seeking care. Since Medicare finances more than 30% of all hospital care expenditures in the United States,[33] its potential to influence hospital conduct was obvious.

The legislative history accompanying the House bill[34] underscored members' caution that "pressures for greater hospital efficiency" as a result of PPS not be "construed as license to ignore traditional community responsibilities and loosen historic standards."[35] This caution was expressed through Medicare amendments that transformed society's expectations of hospitals into a broad, enforceable federal legal obligation to undertake care in medical emergencies, regardless of who sought the care, and regardless of ability to pay.[36] Because the EMTALA amendments contained no financing mechanism, the Congressional Budget Office scored the obligations as being without cost to the federal government.[37] In essence, the establishment of screening and stabilization obligations in medical emergencies became a *quid pro quo* for Medicare hospital financing.

EMTALA encompasses two basic obligations–paralleling Congress' twin concerns—on all Medicare-participating hospitals with emergency departments.[38] The first is the duty to furnish an "appropriate medical screening examination" to "any individual" who "comes to" the emergency department, where a "request is made on the individual's behalf for examination or treatment for a

33. *See* NATIONAL CENTER FOR HEALTH STATISTICS, *supra* note 20, at 330, tbl. 119.

34. *See* H.R. REP. NO. 99-241, pt. 1, at 27, pt. 3, at 5.

35. H.R. REP. NO. 99-241, pt.1, at 27.

36. *See* H.R. REP. NO. 99-241, pt.3, at 5.

37. See CBO cost estimates contained in H.R. REP. NO. 99-241, at 83, tbl.2.

38. *See* 42 U.S.C. § 1395dd(a) (2005).

medical condition."[39] The second duty arises once the initial exam uncovers the presence of an "emergency medical condition;"[40] at this point, a hospital "must provide either" for such "further medical examination and such treatment" of the individual "within the staff and facilities available at the hospital" as may "be required to stabilize the medical condition,"[41] or alternatively, for "transfer of the individual to another medical facility"[42] in accordance with federal standards.[43] The statutory transfer standard in essence seeks to halt "patient dumping" by prohibiting the transfer of unstable patients unless the transferring facility certifies the medical appropriateness of the transfer and acts appropriately to minimize its risks; in addition, the transferring facility's physician who authorizes the transfer must certify that the benefits of transfer reasonably can be expected to outweigh the risks.[44] Transfers must be conducted in an appropriate fashion in terms of the procedures and resources used to move the patient and the patient's accompaniment by detailed medical records.[45] In addition, the facility receiving the transfer must have consented to the transfer,[46] although facilities with regional specialized systems (such as shock trauma centers) are prohibited from discriminating in whom they accept for transfer.

Within the overall obligation to screen and stabilize, EMTALA requires considerable depth of care. Thus, the statute obligates facilities to place their medical staff specialists "on-call" to their emergency physicians in the event that a specialist is required, either as a result of the initial examination or where further diagnosis or treatment becomes necessary to achieve stabilization.[47] As such, the failure or refusal of an on-call physician to appear within a

39. *Id.*

40. 42 U.S.C. § 1395dd(b).

41. 42 U.S.C. § 1395dd(b)(1)(A).

42. 42 U.S.C. § 1395dd(b)(1)(B).

43. 42 U.S.C. §1395dd(c)(2).

44. 42 U.S.C. § 1395dd(c)(1)(A)(ii).

45. 42 U.S.C. § 1395dd(c)(2)(A)-(C).

46. 42 U.S.C. § 1395dd(c)(2)(B).

47. 42 U.S.C. § 1395cc(a)(1)(I)(iii).

reasonable time is a specifically sanctionable event, although a physician who orders a medically appropriate transfer as the result of the absence of necessary specialty care, is not subject to sanction.[48]

It is also worth noting that the statutory obligation to stabilize patients does not appear to be location-limited. That is, the law requires that "within the staff and facilities available at the hospital," the facility provide "such further medical examination and such treatment as may be required to stabilize the condition."[49] Thus, under the statute, there would appear to be no stopping point to the stabilization obligation; indeed, stabilization can last months.[50]

EMTALA's definitions further clarify the scope of the statute. The law defines an emergency medical condition as

> a medical 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--(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.[51]

Under EMTALA, furthermore,

> [t]he term "to stabilize" means, with respect to an emergency medical condition . . . , 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

---

48. 42 U.S.C. § 1395dd(d)(1)(C).

49. 42 U.S.C. § 1395dd(b)(1)(A).

50. *See, e.g.,* Power v. Arlington Hosp. Ass'n, 42 F.3d 851 (4th Cir. 1994) (EMTALA case in which the patient, once admitted, remained over four months). *But see* Harry v. Marchant, 291 F.3d 767, 771 (11th Cir. 2002) (finding no duty to stabilize under EMTALA in the absence of a transfer).

51. 42 U.S.C. § 1395dd(e)(1).

> individual from a facility or . . . [in the case of a pregnant woman in labor], to deliver (including the placenta).[52]

Governmental enforcement of EMTALA is carried out by the United States Department of Health and Human Services through its Centers for Medicare and Medicaid Services (the federal agency that administers Medicare and oversees Medicare provider agreements) and the Office of the Inspector General, which has authority over EMTALA's financial penalty provisions.[53] The individual right of enforcement is express; at the same time, the law limits financial recovery to damages that are "available for personal injury under the law of the State in which the hospital is located."[54]

The authors' practical and research-related experiences with EMTALA enforcement have helped illuminate for us the difference between how hospitals view the legal and financial burdens of EMTALA compared to other legal duties (such as health care quality standards), adherence to which also can be complex and costly.[55] First, EMTALA violations tend to lead to more pronounced and systemically visible legal consequences than "simple" malpractice actions.[56] It is only in the rarest of malpractice cases that

---

52. 42 U.S.C. § 1395dd(e)(3)(A). The fact that drafters felt compelled to specify "including the placenta" should provide readers some insight as to the types of inappropriate transfers that went on. In 1984, for example, Professor Rosenbaum became involved in a situation in South Texas in which physicians of a community health center were ordered to remove their uninsured patient from the local hospital delivery room (following a long fight to get her admitted to begin with, which culminated with rushing her past the admissions desk when the staff changed at the end of the day) prior to completion of a delivery, including the placenta and necessary suturing to stop hemorrhagic bleeding.

53. Lee, *supra* note 2, at 157-60.

54. 42 U.S.C. § 1396dd(d)(2)(A).

55. For example, hospitals generally do not claim that they cannot afford to comply with national professional and legal standards of health care quality, even though compliance clearly carries weighty financial implications.

56. Where screening services are concerned, courts are quite careful to distinguish between an EMTALA claim (the discriminatory failure to furnish screening services of comparable scope to services furnished other patients) and malpractice claims (the failure to furnish services of adequate quality). *See, e.g.*, Summers v. Baptist Med. Ctr. of Arkadelphia, 91 F.3d 1132 (8th Cir. 1986) (en banc). At times, this effort to distinguish between an EMTALA claim and a professional negligence claim can appear to verge on the extreme, since a

state health regulators might descend on a hospital.[57] In the case of EMTALA, on the other hand, on-site federal investigators and a good deal of publicity are not out of the ordinary.

Second, in EMTALA, the potential legal exposure goes beyond civil money penalties, since noncompliance effectively can implicate the hospital's Medicare participation itself.[58] Certainly a medical error, if sufficiently serious, could also lead to loss of a facility's operating license (which in turn would trigger the loss of Medicare participation rights). But health care licensure agencies simply do not appear to occupy the same "psychological space" in the heads of hospital administrators and their counsel.

Third, the EMTALA statute focuses on a part of the hospital that is frankly unpopular. A hospital's emergency department is the very part of a facility that many administrators and medical staff would like to forget. Even in a "high end" hospital that caters to the "carriage trade," by and large, the emergency department treats the poor, the very ill, the unsponsored—and often, the strange and difficult patient. The hardest work in an emergency department typically comes in the middle of the night, when everyone would prefer to sleep, and specialists hardly want to be rousted to treat a person who is not even their personal patient. Days off for a relaxing outing can go up in smoke in an instant with a single emergency.[59] In short, as vital as they might be to their communities, emergency

---

quality claim might lie in the failure to do anything at all and conversely, discriminatory care is substandard care. Nonetheless, the courts appear to have interpreted the law's preemption provisions, 42 U.S.C. § 1395dd(f), also to include non-preemption of state law remedies.

57. ROSENBLATT, LAW & ROSENBAUM, *supra* note 3, at 968-74.

58. Technically the law is not a "condition of participation." *See* 42 U.S.C. § 1395cc. But the statute functions as such in that investigations of EMTALA violations by the Office of the Inspector General are also referred to the Center for Medicare and Medicaid Services, the federal agency that oversees Medicare and provider participation in the program.

59. In the first and highly celebrated formal prosecution of a case by the Inspector General, Burditt v. U.S. Dep't. of Health and Human Servs., 934 F.2d 1362 (5th Cir. 1991), a specialist who was contacted to come to the emergency department to help treat an emergency case refused to leave his duck hunting excursion and ordered the nurses to send the patient (a woman in emergency labor) away.

departments simply are not a source of joy and personal reward to hospitals, although the revenues flowing from the admission of emergency cases actually can be quite lucrative.[60]

Hospital unhappiness with EMTALA grew as the use of emergency departments climbed and enforcement efforts rose. Following a slow start, HHS enforcement efforts gained steam throughout the 1990s, as did the number of private actions.[61] These legal developments coincided with a notable rise in the rate of use of hospital emergency departments.[62] A 2003 General Accounting Office (GAO) study found that two-thirds of hospitals reported having to go on "[d]iversion," meaning that "[h]ospitals request that ambulances bypass their emergency departments and transport patients that would have been otherwise taken to those emergency departments to other medical facilities."[63]

---

60. Glenn A. Melnick et. al., *Emergency Department Capacity and Access in California, 1990-2001: An Economic Analysis*, HEALTH AFF., Mar. 24, 2004, *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.136v1.

61. See cases in Lee, *supra* note 2, and standard health law textbooks. Many of the most important cases construing the extent of the obligation were decided in the mid-to-latter 1990s.

62. One leading study of hospital emergency room use reported a significant 16% rise in the use of hospital emergency services between 1996 and 2001, a period of time when the uninsured rate actually declined slightly. Peter Cunningham & Jessica May, *Insured Americans Drive Surge in Emergency Department Visits*, ISSUE BRIEF: FINDINGS FROM HSC (Center for Studying Health System Change), Oct. 2003, at 1, http://hschange.org/CONTENT/613. This study reported more than 100 million visits to hospital emergency departments during 2001; it attributed much of this growth in the use of hospital emergency care to changes in care-seeking patterns among insured persons, not simply to more use by the uninsured. *Id.* In the case of insured persons, the study reported that the rising trend in emergency department usage coincided with a rising trend in the use of ambulatory health care generally, while in the case of the uninsured, the rise in emergency room use coincided with a 37% decline in the use of physician care services. *Id.* at 2. Between 1996-1997 and 2001-2002, hospital emergency department visits rose from 17% to more than 25% of all outpatient medical care visits made by the uninsured. *Id.* at 2-3. In addition, the study concluded that fewer than half of all emergency department visits which occurred over the 1997-2001 time period were for conditions that health care experts would classify as emergent (care needed within fifteen minutes) or urgent (care needed within an hour). *Id.* at 3. Poor, publicly insured, and uninsured patients showed more serious conditions and waited longer to be seen. *Id.* at 4.

63. GENERAL ACCOUNTING OFFICE, GAO-03-460, HOSPITAL EMERGENCY DEPARTMENTS: CROWDED CONDITIONS VARY AMONG HOSPITALS AND COMMUNITIES

In another survey, 62% of all U.S. hospitals reported being "at" or "over" operating capacity, with the proportion rising to 79% for urban hospitals,[64] and 87% for Level I trauma centers.[65] Both studies cited the lack of inpatient capacity as a prime cause of long emergency department delays, as patients needing an inpatient bed were forced to wait and effectively became emergency department "boarders," receiving care in sub-optimal settings while simultaneously straining already overextended emergency department staff, treatment space, and equipment.

These facility experiences were hardly surprising, considering the rise in annual emergency department visits over the decade and the loss of emergency capacity as a result of hospital closures during the same period.[66] Findings from our community study sites indicate that the interaction of volume increases and facility closures led to a nearly 45% increase in the average volume of visits per emergency department.[67]

Other factors in overcrowding beyond increased demand and a reduced supply of services are also worth noting. For example, while the common wisdom says that emergency departments are overrun by uninsured persons, the reality may be much different. As noted, one highly publicized study found that increased emergency department utilization was chiefly the result of more visits by insured individuals.[68] More recent work has reinforced

---

6 (Mar. 2003), http://www.gao.gov/new.items/d03460.pdf.

64. THE LEWIN GROUP, EMERGENCY DEPARTMENT OVERLOAD: A GROWING CRISIS; THE RESULTS OF THE AHA SURVEY OF EMERGENCY DEPARTMENT AND HOSPITAL CAPACITY 4 (Apr. 2002), http://www.hospitalconnect.com/aha/press_room-info/content/ EdoCrisisSlides .pdf.

65. *Id.* at 7. Level I trauma centers are designed to have the ability to provide the full continuum of the most comprehensive care for injured patients and are so designated by the American College of Surgeons. These are the most advanced trauma centers.

66. *See* Linda F. McCaig & Catherine W. Burt, *National Hospital Ambulatory Medical Care Survey: 2002 Emergency Department Summary* (Mar. 18, 2004), http://www.cdc.gov/nchs/data/ad/ad340.pdf.

67. It is worth reinforcing that our study sites were selected for their representative nature and thus represented both affluent and depressed communities. Our study methodology is discussed at greater length *infra* Part III.

68. Cunningham & May, *supra* note 62.

and expanded upon these findings, demonstrating that uninsured individuals are no more likely to use emergency departments than persons who are insured, and indeed, that having a usual source of care appears to be associated with greater emergency department use.[69]

While these statistics may seem counterintuitive, to some observers the data are not surprising. The uninsured may not be flooding emergency departments because they know that ultimately they will be expected to pay out-of-pocket for the care. In contrast, for the insured with a regular source of health care, an emergency department may in fact be the shortest route to a specialist, as overwhelmed physicians, unable to schedule patients for days or weeks, may be more likely to tell their patients to go to the emergency department. Some health policy experts and emergency medicine physicians theorize that physicians may be more apt to refer their patients to emergency departments out of concern over potential medical liability exposure if they cannot see a patient immediately.[70] Thus, the drivers of this crisis may be broader and deeper than care-seeking by uninsured persons and may include factors such as the clash of expectations of immediate care among persons with the means to pay with a constrained supply of specialty care and underlying physician practice patterns and liability concerns. The enactment of state "prudent layperson" statutes in recent years,[71] which obligate insurers and managed care organizations to cover emergency visits based on the symptoms as understood by a "prudent layperson" rather than the actual diagnosis of health professionals, may have further propelled visits by insured persons unable to secure timely specialty access[72] or unwilling to wait. Finally, data

---

69. Ellen J. Weber et al., *Does Lack of a Usual Source of Care or Health Insurance Increase the Likelihood of an Emergency Department Visit?* 45 ANNALS EMERGENCY MED. 4, 6-7 (2005).

70. *See* Robert A. Berenson et al., *Medical Malpractice Liability Crisis Meets Markets: Stress in Unexpected Places* (Sept. 2003), http://www.hschange.org/CONTENT/605.

71. *See* Nurit Guttman et al., *The Many Faces of Access: Reasons for Medically Non-Urgent Emergency Visits*, 28 J. HEALTH POL. POL'Y & L. 1089, 1114-15 (2003).

72. *See, e.g.*, *State Appeals Court Holds HMO Breached Contract by Delaying Referral*, 14 HEALTH L. REP. (BNA) 265, 265-66 (Feb. 24, 2005). In

suggest that patients using emergency departments may simply be sicker than they once were.[73]

Other factors have amplified these trends. Shortages of nurses and the steady shrinkage of inpatient hospital capacity have made it harder for institutions to move patients through the emergency department and admit them in a timely fashion when necessary. Fewer "on-call" specialists could worsen crowding, as patients are forced to wait for consultative services.[74] Traditional relationships and organizational structures within hospitals also could exacerbate crowding, as the management "silos" of hospital emergency departments fail to properly interact with other portions of the facility. Operational factors are ones over which hospitals can be expected to have considerable influence. In recent years, experts have begun to question whether a focus on improving the hospital management processes that affect the flow of patients through and out of the emergency department, could fix overcrowding and bottlenecks. If the social and external dimensions of the problem were outside the hospital's control, nonetheless, perhaps other processes within the control of hospitals in a total institutional (not merely emergency care) context, could be improved.

Although hospital management experts had begun to focus on hospital operations themselves, it is also understandable that to a certain degree, hospital leaders might have reacted by giving up trying to cope with the crisis and instead begin to look for broader reforms to help address the problem. It certainly should come as no surprise therefore, that as growing legal enforcement coincided with growing demand and shrinking resources, the pressure for reduction or elimination of EMTALA legal obligations grew. Indeed, so agitated had hospitals become

---

Kotler v. PacifiCare of California, 24 Cal. Rptr. 3d 447 (Ct. App. 2005), a California Court of Appeals upheld a claim against an HMO for breach of contract following its failure to find an infectious disease specialist for a member, thereby forcing the member to go out of network for care.

73. Susan Lambe et al., *Trends in the Use and Capacity of California's Emergency Departments, 1990-1999*, 39 ANNALS EMERGENCY MED. 389, 393-94 (2002).

74. Loren A. Johnson et al., *The Emergency Department On-Call Backup Crisis: Finding Remedies for a Serious Public Health Problem*, 37 ANNALS EMERGENCY MED. 495, 497 (2001).

about their EMTALA duties that the initial response of HHS to hospital obligations in the face of a bioterror attack was to post information on its website suggesting (preposterously it would seem, given the requirements of EMTALA) that hospitals could deny screening and stabilization services to persons who sought emergency care following a bioterror attack.[75]

Regulations promulgated in 2003[76] by HHS appear to relax prior statutory interpretations in three significant respects. First, the rules limit the reach of hospitals' threshold obligation to undertake screening services at all. The rules narrow the threshold obligation by providing that the statutory screening obligation (which turns on the fact that an individual "comes to the emergency department")[77] is not triggered unless a person seeking care "[h]as presented at a hospital's dedicated emergency department,"[78] or "[h]as presented on hospital property" requesting care or appearing or behaving in a manner that would suggest an emergency to a "prudent layperson,"[79] or is coming to the hospital by "ground or air ambulance" in certain specified situations.[80]

In addition, the regulations also narrow the reach of the EMTALA statute in two ways. The rules reinterpret the stabilization requirements as ending upon inpatient admission.[81] This limitation is conditioned on the existence

75. Letter from Steven A. Pelovitz, Director of Survey and Certification Group, CMS, to Regional Administrators of State Survey Agencies (Nov. 8, 2001), *at* http://www.cms.hhs.gov/medicaid/survey-cert/110801.asp. Sanctions for EMTALA violations can be suspended at Secretarial discretion as a result of the Public Health Security and Bioterrorism Preparedness and Response Net of 2002. *See* P.L. 107-188, 116 Stat. 594, 627-28 (codified as amended at 42 U.S.C. § 1320b-5(b) (2005)); Sara Rosenbaum & Brian Kamoie, *Finding a Way Through the Hospital Door: The Role of EMTALA in Public Health Emergencies*, 31 J. L. MED. & ETHICS 590 (2003).

76. Medicare Program, 68 Fed. Reg. 53,222-53,261 (Sept. 9, 2003) (codified at 42 C.F.R. pts. 413, 482, 489).

77. 42 U.S.C. § 1395dd(a) (2005).

78. 42 C.F.R. § 489.24(b)(1) (2005).

79. 42 C.F.R. § 489.24(b)(2).

80. 42 C.F.R. § 489.24(b)(3).

81. 42 C.F.R. § 489.24(d)(2).

of a "good faith" admission,[82] but it is doubtful that a patient discharged in an unstable state following an admission ever could prove that the admission was merely a subterfuge to terminate his or her EMTALA rights. One previous judicial decision appears to provide support for the proposition that stabilization obligations attach only to transferred patients; to offset the impact, the rules also clarify that the general Medicare Conditions of Participation would apply to all admitted patients, thereby trying the discharge of unstable patients to potential sanctions for quality violations.[83]

Finally, the rules narrow prior policy interpretations governing the obligation to make on-call specialists available, by specifying that even if a full complement of specialists is within the staff and capabilities of the hospital, a hospital is free to maintain an on-call list for emergency coverage purposes "in a manner that best meets the needs of the hospital's patients who are receiving services required under [EMTALA] in accordance with the resources available to the hospital."[84] The meaning of this provision, and its application to individual situations, is fuzzy, although the Preamble makes clear that the purpose of the change is to allow on-call questions to be "worked out between individual hospitals and their medical staff [sic]" rather than holding hospitals to national on-call reasonableness standards.[85] Ironically perhaps, the narrowing of the on-call obligation may increase the potential for a transfer if no specialist is available, thereby increasing a hospital's stabilization duties. (The potential for increased transfers, of course, assumes that the transfer is appropriate and that there is a receiving hospital willing to accept the transfer; neither may in fact be true.)

In sum, EMTALA is a powerful and unique statute, whose enactment echoed public expectations of hospital conduct in emergencies, and whose increasingly rigorous interpretation and enforcement coincided with a surge in

---

82. 42 C.F.R. § 489.24(d)(2).

83. 42 C.F.R. § 489.24(c)(2)(iii); *see* Harry v. Marchant, 291 F.3d 767 (11th Cir. 2002).

84. 42 C.F.R. § 489.24(j).

85. Medicare Program, 68 Fed. Reg. 53, 222, 53,254 (Sept. 9, 2003) (codified at 42 C.F.R. pts. 413, 482, 489).

the use of emergency care facilities. This surging use of emergency care was, in turn, apparently driven by a host of factors having little to do with the law itself. Nonetheless, the existence of the law compelled hospitals to respond to the surge, at least to some degree, with screening and stabilization services rather than with an outright refusal to furnish care. Growing agitation for a relaxation of standards led to promulgation of the 2003 regulations, which collectively make certain notable interpretive changes in hospitals' obligations but leave EMTALA's fundamental thrust in tact. The termination of EMTALA rights at the point of admission and the diminution in on-call specialty requirements may in fact provide some "release valve" for anti-EMTALA pressures, but the general unhappiness with the law–as well as a continuing sense of the statute as an enormous and unfunded mandate– undoubtedly will continue to play a prominent role in U.S. hospital policy.

Focusing solely on EMTALA obligations, however, can cause one to miss the bigger picture. Despite its demands on hospital resources, EMTALA is not triggered until a person actually comes to the facility looking for care; as a result, hospitals can discharge their EMTALA obligations while remaining passive players in community health systems. Unless and until a person with a suspected emergency medical condition actually makes it to a hospital's emergency department, the hospital is under no legal obligation to engage in broader efforts to upgrade the accessibility of community-based primary care services, despite the fact that these services might in turn serve as more appropriate sources of care. In other words, EMTALA gives hospitals a "bye" on their community engagement and asks only that they engage under certain narrowly defined circumstances.

The implications of this sanctioned passivity are particularly serious for persons with chronic conditions such as cardiovascular disease, diabetes, mental illness or addiction disorders, and asthma. These and other conditions are considered by experts to be amenable to ambulatory management. If left unmanaged, however, they ultimately can lead to medical emergencies requiring intensive resources and rapid intervention to achieve stabilization. Timely and effective outpatient care has been shown to reduce the probability of admission for

ambulatory care-sensitive conditions.[86] But viewed in the context of the relationship between hospitals and their overall community health systems, EMTALA does nothing by itself to either compel or incentivize hospital involvement in broader community solutions to unnecessary institutional care. Indeed, the financial losses to which hospitals are exposed under EMTALA ironically may be more than offset by the revenues they gain through the excessive and costly admission of persons with conditions that could have been better treated in communities.

To be sure, many hospitals have pursued strategies of ongoing and active engagement in order to upgrade community health resources. But many of the most active players are themselves either public facilities or facilities that serve a disproportionate percentage of poor residents; in other words, they are already "on the hook" and thus strongly incentivized toward more affirmative involvement. Nothing about EMTALA would necessarily incentivize a facility located in and serving an affluent part of a community to reach out to improve community resources in poorer areas. Indeed, in its structure, EMTALA reinforces long-held views of hospitals as passive spaces to be utilized by their medical staffs in accordance with their own customs and practice preferences, and otherwise without an independent community presence.[87]

U.S. tax policy does not require specific forms of community benefit activities on the part of hospitals claiming nonprofit tax exempt status (only a portion of all U.S. hospitals).[88] In recent years, Congress enacted a small grants program to modestly incentivize community

86. *See* John Billings et al., *Impact of Socioeconomic Status on Hospital Use in New York City*, HEALTH AFF., Spring 1993, at 162, 169.

87. The notion of hospitals as passive "doctors' workplaces" is longstanding and still highly embedded in culture. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 145-79 (1983).

88. In 1969, the Internal Revenue Service issued Rev. Rul. 69-545, which eliminated any obligation that in order to qualify for tax exempt status hospitals would be obligated to care for patients for free or reduced charges. *See* Rev. Rul. 69-545, 1969-2 C.B. 117. In 1983, the IRS issued Revenue Ruling 83-157, which abolished even the link between the exemption and the maintenance of emergency services available to the community. *See* Rev. Rul. 83-157, 1983-2 94.

engagement between hospitals and community providers such as community health centers and free clinics.[89] But no significant investment of funds has ever been made in order to fundamentally redirect the performance and orientation of hospitals toward their communities.

III. THE HOSPITAL EMERGENCY AND COMMUNITY CARE STUDY

In the fall of 2002, the Robert Wood Johnson Foundation, concerned about the state of America's safety net, launched the *Urgent Matters* program. Based at the George Washington University School of Public Health and Health Services, *Urgent Matters* had two goals: improving hospitals' ability to respond to the increasing volume of emergency department patients and simultaneously, raising public awareness of the serious limitations in the health care safety net for vulnerable populations, which in turn threaten to escalate dependence on hospital emergency departments. The program established a ten-hospital-site learning and technical support collaborative[90] effort that employed a series of highly regarded quality and management improvement techniques (including "rapid cycle change")[91] aimed at reducing emergency department overcrowding. Simultaneously, project researchers led a

89. In 2000, Congress appropriated $25,000,000 to fund a demonstration program to aid health care providers in banding together to serve uninsured persons. By fiscal year 2003, the program had grown to more than $100,000,000 and Congress authorized the Healthy Communities Access Program. As of 2004, there were 158 grantees, making the allocation of funds to any single community a miniscule event. See the description supplied by the Healthy Communities Access Coalition (2003), *at* http://www.hcac.info/history.html (last visited June 4, 2005).

90. The hospitals included Boston Medical Center, Boston, MA; BryanLGH Medical Center, Lincoln, NE; Elmhurst Hospital Center, Queens, NY; Inova Fairfax Hospital, Fairfax County, VA; Grady Health System, Atlanta, GA; Henry Ford Health System, Detroit, MI; St Joseph's Hospital and Medical Center, Phoenix, AZ; The Regional Medical Center at Memphis, Memphis, TN; University Health System, San Antonio, TX; and The University of California, San Diego, CA. *See* Urgent Matters, *Urgent Matters Communities* (2003), *at* http://www.urgentmatters.org/about/um_communities.htm (last visited May 19, 2005).

91. For a fuller discussion of rapid cycle change and related quality improvement techniques, see Mike Stoecklein, *Quality Improvement Systems, Theories and Tools, in* THE HEALTHCARE QUALITY BOOK: VISION, STRATEGY, AND TOOLS 63 (Scott B. Ransom et al. eds., 2005).

detailed assessment of the health care "safety net" in the communities served by each participating hospital.[92]

A. *Hospital Emergency Department Performance Improvement*

Participating hospitals were chosen through a competitive selection process; the criteria applied in the selection process (which was overseen by an expert advisory committee) included the presence within the hospital of a Level I or Level II[93] trauma center, as well as patient volume, evidence of overcrowding, and commitment to serving uninsured and other vulnerable populations. Selected facilities began the process of collaboration immediately and continued their collaboration with Foundation support for one year. During this twelve-month time period, hospitals also had access to a variety of resources including on-site technical assistance, defined metrics for measuring patient flow and system performance, a model for understanding patient flow, training in quality improvement techniques, and a toolkit of best practices.[94]

The *Urgent Matters* project researchers hypothesized that several fundamental drivers underlie emergency department overcrowding: "input" drivers related to a high volume of demand including demand by medically underserved persons with low incomes and inadequate or no health insurance who rely on emergency departments for treatment of conditions that could be treated (and better managed) in more appropriate and less costly primary care

92. The communities around each hospital included Boston, MA; Lincoln; NE; Queens, NY; Fairfax County, VA; Atlanta, GA; Detroit, MI; Phoenix, AZ; Memphis, TN; San Antonio, TX; and San Diego, CA. *See* Urgent Matters, *Urgent Matters Communities* (2003), *at* http://www.urgentmatters.org/about/um_communities.htm (last visited May 19, 2005).

93. Emergency departments are defined by the American Hospital Association in its Annual Survey as "[h]ospital facilities for the provision of unscheduled outpatient services to patients whose conditions require immediate care. Must be staffed 24 hours a day." AM. HOSP. ASS'N, AHA GUIDE TO THE HEALTH CARE FIELD, at A7 (1999-2000 ed. 1999)

94. "Best practices" were identified through interviews and site visits with the leadership of approximately sixty hospitals, conducted by George Washington University researchers in 2002-2003.

settings and "throughput" and "output" drivers linked to hospital management and organizational practices, which deter the efficient movement of patients out of emergency care and either to inpatient care if needed or discharge if appropriate.

The "Input/Throughput/Output" (I/T/O) model of patient flow is depicted in Figure 1. This model provided a structure for examining the factors that affect emergency department operations and delays. Input factors are those that help explain why people present to an emergency department, such as aging and morbidity, availability of alternative sites of care, insurance status, perceptions of quality, physician referral practices, and other factors.[95] Throughput is centered on the actual operations of the emergency department, including issues such as the availability of on-call medical specialists, while output pertains to the ability of the hospital to move patients out of the emergency department in a timely fashion, often to an inpatient bed.[96] The model assumes that the ability of an emergency department to respond to demand is based on complex factors, including the emergency department interaction with the rest of the hospital.

Participating hospitals learned to implement changes through a process known as rapid cycle testing, which allowed the testing of hundreds of changes that combined better management of care for patients who need services with more rapid treatment and discharge for those who do not need extensive services and improvement in decision-making around the need to go onto diversion status.

---

95. Urgent Matters, *ED Crowding and the Safety Net* (2003), *at* http://www.urgentmatters.org/about/um_safety_net.htm (last visited May 19, 2005).

96. *Id.*

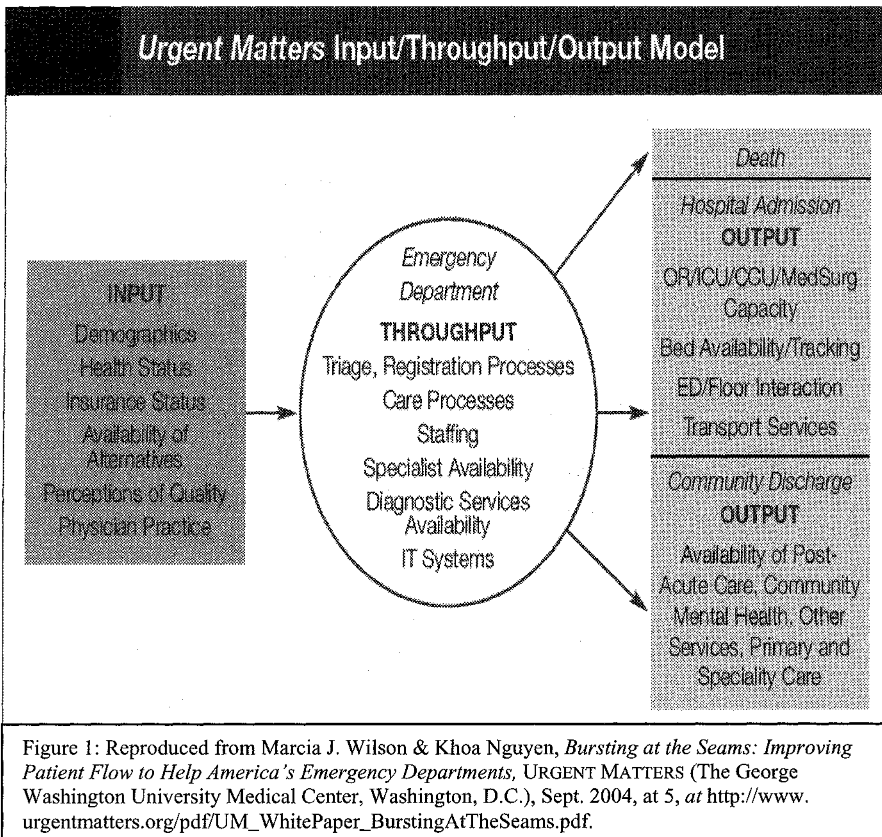

Figure 1: Reproduced from Marcia J. Wilson & Khoa Nguyen, *Bursting at the Seams: Improving Patient Flow to Help America's Emergency Departments,* URGENT MATTERS (The George Washington University Medical Center, Washington, D.C.), Sept. 2004, at 5, *at* http://www.urgentmatters.org/pdf/UM_WhitePaper_BurstingAtTheSeams.pdf.

Using this "input/throughput/output" model, researchers assessed participating hospitals' emergency departments. The project also studied the communities surrounding the ten participating *Urgent Matters* hospitals, in order to develop a deeper understanding of the role that emergency departments play as critical access points for uninsured and insured patients alike.

Use of this model in conjunction with careful quality improvement initiatives often led to dramatic improvements in emergency department (and overall hospital) performance. For instance, the average duration of a patient's visit to the emergency department at the Regional Medical Center in Memphis, Tennessee, decreased by 44%, to approximately five hours, over the course of the project. This result was related to the fact that the average bed assignment time for admitted emergency department patients decreased from 1057 to 55 minutes over the same

period. Other project hospitals experienced significant improvements in operations, with Boston Medical Center decreasing the amount of time on "diversion" by 40% and St. Joseph's Hospital and Medical Center in Phoenix, Arizona, decreasing the proportion of patients who leave the emergency department without being seen from 21% to 7%. Notably, nine of the ten hospitals reported a reduction or no change in hours on diversion. For example, Inova Fairfax Hospital, Virginia, reported that the monthly hours on diversion decreased from 136 to 21 over the course of the project. Hence, reductions in overcrowding and delays appear to have come from improvements in operations, not restrictions on access such as increased use of diversion. In most of these hospitals, the greatest gains came from improvements in their ability to move patients from the emergency department to an inpatient bed expeditiously.[97]

These results underscored for participants the fact that emergency department overcrowding is not simply a function of demand generated outside the hospital: it also is a function of internal hospital management and organizational structure. As patient flow management techniques improved (in particular, improving the expeditious assignment patients to inpatient beds when needed), crowding declined. The hospitals' experience revealed that management interventions designed to speed the "throughput" and "output" of emergency department patients could greatly reduce patient delays in receiving needed care. These changes tended to involve systems and incentives designed either to accelerate traditional emergency department processes such as triage, registration, and specialty consultation, or to influence hospital-wide systems, such as those that facilitate the admission of a patient from the emergency department to an inpatient unit. Figure 2 summarizes the most important management interventions identified in the project.

---

97. For greater detail on some of the experiences of the project hospitals, see Marcia J. Wilson & Khoa Nguyen, Bursting at the Seams: Improving Patient Flow to Help America's Emergency Departments, Urgent Matters (The George Washington University Medical Center, Washington, D.C.), Sept. 2004, at 1, at http://www.urgentmatters.org/pdf UM_WhitePaper_BurstingAtTheSeams.pdf.

Sample Strategies and Innovations	
Category	Strategies/Innovations
Patient Flow Coordination and Facilitation	Implement a "Bed Czar" or patient flow manager by designating a specific position responsible for ensuring the timely transfer of ED patients to assigned inpatient beds
	Dedicate a nurse with admission/discharge/transfer duties who is specifically responsible for facilitating pending discharges to accelerate available beds for admits
	Develop accelerated triage and registration processes to triage more efficiently based on the patient's acuity and to reduce patient waiting times by re-ordering or combining triage and registration processes
Early Discharge	Initiate preliminary discharge by designating patients for early discharge the next day
	Redesign rounding and discharge processes to focus on patients ready for discharge
	Create a discharge room/lounge for inpatients that have been discharged and are awaiting transportation, medications or education
	Establish a discharge coordinator position to coordinate procuring information that is required to discharge the patient
	Implement financial (bonuses) and non-financial (movie tickets or cafeteria vouchers) incentives for physicians and nurses to promote efficient and early discharge of patients who are ready to go home
Boarding and Inpatient Bed Assignment	Replace the traditional "push system" with a "pull system" in which the inpatient floors play an active role in pulling ED patients into available beds
Diversion Management and Reduction	Establish new protocols and monitoring systems to determine when the hospital is approaching maximum operating capacity and its threshold for diversion
	Develop a hospital-wide diversion response protocol to focus existing resources on facilitating all appropriate patient discharges in a more timely manner
	Create a community-wide diversion plan in collaboration with local hospitals and the community's emergency medical services unit to establish common protocol for hospitals going on and off diversion or bypass

Figure 2: Reproduced from Marcia J. Wilson & Khoa Nguyen, *Bursting at the Seams: Improving Patient Flow to Help America's Emergency Departments*, URGENT MATTERS (The George Washington University Medical Center, Washington, D.C.), Sept. 2004, at 11, *at* http://www.urgentmatters.org/pdf/UM_WhitePaper_BurstingAtTheSeams.pdf.

B. *The Community Perspective*

Using a combination of methods, including site visits, in-depth interviews with over 300 stakeholders across the communities, twenty-six focus groups with low-income patients who were likely to be either uninsured or covered by Medicaid, literature reviews, and analyses of publicly-available data, we developed profiles of health care utilization within each community's safety net of health care services for low-income, underserved, and vulnerable populations. Not surprisingly, we found that emergency departments served as the "safety net of the safety net." We also found that there was remarkable consistency across the communities in terms of the ways that patients viewed the quality and availability of emergency services.

In every community, patients' awareness of the availability of emergency services was considerably higher than their knowledge about the availability of other safety net services. This held true even for patients who were new to the area or the country. For example, we held focus groups with immigrants who spoke Spanish, Cantonese, Arabic, Haitian, Creole, and Vietnamese. Many of these individuals had been in the United States less than two years, yet virtually all knew about at least one emergency department in their community, and many had used these facilities for themselves or a family member. Many, but not all, knew that they could receive care from the emergency department regardless of insurance status or ability to pay. The vast majority of patients in the other focus groups were also aware of these provisions. When questioned about the availability of primary care, specialty services, low-cost pharmaceuticals, mental health or dental services, many patients indicated that they had no idea where they could receive this care, although most were more knowledgeable about care options for young children.

In every community, patients viewed care in the emergency department as being superior to care provided in most other settings. This assessment was based in part on the feeling that emergency department physicians and nurses were extremely well-trained and capable, and in part on the recognition that the full range of diagnostic services and specialty care were accessible through the emergency department. Time and again, patients said that despite the long waits associated with emergency care, they

turned to emergency services because they could get the care they needed and could see the "best" doctors, regardless of what was wrong with them.

The community analysis underscored the realities of health care access for low-income, underserved patients who often seek care from busy hospital facilities: despite ostensibly long wait times, the emergency department is likely to be the shortest route to needed care, even when that care does not necessarily have to be provided in an emergency department.

Three trends were apparent in our studies of the ten communities. First, patients routinely use the emergency department for care that could safely be provided in other settings. Using an emergency care use profiling algorithm developed by Billings and colleagues at New York University,[98] we analyzed emergency department visits at the ten *Urgent Matters* consortium hospitals to determine the proportion that could safely have been treated in non-emergency settings. The algorithm applies only to visits that did not result in an inpatient admission. We found that across the ten sites, 21.4% of visits were non-emergent (in other words, they did not require care within twelve hours) and another 20.6% were emergent, but could have safely been treated in a setting other than the emergency department.[99]

Second, low-income patients have considerable difficulties accessing specialty, mental health, and dental services. This is particularly true of uninsured patients but can also hold true for patients covered by Medicaid (where providers willing to accept Medicaid payments may be scarce, especially within certain specialties and in certain markets) and patients with commercial insurance. We spoke to many patients and providers who described a growing number of underinsured individuals who

98. For a discussion of the algorithm and the potential implications of its findings, see John Billings et al., *Emergency Room Use: The New York Story*, ISSUE BRIEF (The Commonwealth Fund, New York, N.Y.), Nov. 2000, at 1, 2-4, *at* http://www.cmwt.org/usr.doc/billings_nystory.pdf.

99. Marsha Regenstein et al., *Walking a Tightrope: The State of the Safety Net in Ten U.S. Communities*, URGENT MATTERS (The George Washington University Medical Center, Washington, D.C.), May 2004, at 1, 37, *at* http://www.urgentmatters.org/pdf/SNA_files/UrgentMatters_Walking_A_Tightrope.zip.

essentially carry catastrophic coverage with high out-of-pocket deductibles and co-payments. Thus, low-income, privately insured individuals also turn to the safety net–including the emergency department to supplement their other sources of health care. For uninsured and insured patients alike, the emergency department is a shortcut to emergent and non-emergent services that they cannot access from other providers in a reasonable amount of time. With each community reporting waits for at least some specialty services in the three to ten month range, it is not difficult to see how valuable the emergency department has become as a source of primary and specialty care.

Third, patients across all of the communities indicated that they were extremely reluctant to use emergency services, and would go to the emergency department only when, in their estimation, it was absolutely necessary. This may seem inconsistent with other trends, but the sentiments were clear and consistent across the ten communities: regardless of their trust in the health professionals they found there, patients hated going to the emergency department. They dreaded the long waits, they complained of rude treatment at times by hospital staff, and, although most knew they could receive care without payment at the point of service, they tried to delay or forgo care because they also knew they would eventually receive a bill for the services. Although most individuals were quick to bring their children to the emergency department if they felt they needed to be seen by a doctor, the majority indicated that, where they were the patient, they tended to put off seeking emergency care for as long as possible. Again, there was consistency across the ten communities: the most common reason given for finally going to the emergency department for care was that their pain became so severe, or lasted for so long, that they were no longer able to endure their conditions. In other words, regardless of whether their conditions met clinical definitions of "emergency," they were severe enough in their view to justify the intervention.

The research also yielded critical findings regarding health care safety net itself in each of the study communities. Between one-quarter and one-third of residents in the ten *Urgent Matters* communities were

either uninsured or covered through public insurance programs for low-income persons such as Medicaid[100] and the State Children's Health Insurance Program (SCHIP)[101] and thus more likely to turn to safety net providers for basic health care given their more limited access to physicians in private practice.[102]

Communities also were found to differ substantially with respect to the size and scope of their safety nets, with state and local financing to support the safety net subject to considerable variation. Assessing community service capacity for vulnerable populations across all ten sites, researchers concluded that primary health care services (i.e., preventive care, diagnostic and treatment of relatively routine acute health problems, and routine management of chronic health conditions) was relatively high, with the highest presence in communities that had succeeded in securing dedicated financing through programs such as the federal health centers program,[103] to establish and develop services. However, specialty care was strained, behavioral care quite limited, and dental care nonexistent. The results are illustrated in Figure 3.

---

100. *See id.* at 12-13. Medicaid is codified at Title XIX of the Social Security Act. 42 U.S.C. §§ 1396a-1396r (2002). In 2003, Medicaid covered 52,000,000 persons at a total state/federal cost of approximately $250 billion. *See The Medicaid Program at a Glance*, KAISER COMM'N ON MEDICAID AND THE UNINSURED (The Henry J. Kaiser Family Found., New York, N.Y.), Jan. 2005, *available at* http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=50450.

101. *See* Regenstein, *supra* note 99, at 12-13. The State Children's Health Insurance Program, is a smaller companion to Medicaid, covering "targeted" low-income children who are ineligible for Medicaid and otherwise uninsured. *See* 42 U.S.C. §§ 1397aa-1397jj (2002); Sara Rosenbaum et al., *Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP*, 1 J. HEALTH & BIOMEDICAL L. 1 (2004).

102. *See* Regenstein, *supra* note 99, at 12.

103. See *id.* at 22-23. The Health Centers program is authorized as part of the Public Health Service Act. 42 U.S.C. § 254c. The program provides grants to medically underserved communities to establish primary health care clinics. In 2003, over 800 health centers furnished services in several thousand sites, but estimates of need in relation to capacity showed enormous gaps in service capacity. *See generally Health Centers as Safety Net Providers: An Overview and Assessment of Medicaid's Role*, KAISER COMM'N ON MEDICAID AND THE UNINSURED (The Henry J. Kaiser Family Found., New York, N.Y.), May 2003, *available at* http://www.kff.org/medicaid/upload/14342_1.pdf.

Availability of Services and System Integration in *Urgent Matters* Communities

	Primary Care	Specialty Care	Emergency Department	Behavioral Health	Dental Care	Safety Net Integration
Atlanta	●	◑	●	◑	○	○
Boston	●	◑	●	◑	○	◑
Detroit	○	○	●	○	○	◑
Fairfax County	○	○	●	○	○	●
Lincoln	◑	○	●	◑	○	◑
Memphis	●	◑	●	○	○	◑
Phoenix	◑	○	●	◑	○	○
Queens	◑	◑	●	◑	○	●
San Antonio	◑	○	●	○	○	○
San Diego	◑	○	●	○	○	○

High ● Medium ◑ Low ○

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, Urgent Matters Safety Net Assessments, March 2004.

Figure 3: Reproduced from Marsha Regenstein et al., *Walking a Tightrope: The State of the Safety Net in Ten U.S. Communities*, URGENT MATTERS (The George Washington University Medical Center, Washington, D.C.), May 2004, at 4, 37, *at* http://www.urgentmatters.org/pdf/SNA_files/UrgentMatters_Walking_A_Tightrope.zip.

IV. USING EMTALA TO INCENTIVIZE ACTIVE COMMUNITY ENGAGEMENT AMONG HOSPITALS

The EMTALA statute is unique in health law, creating an enforceable right to certain types of health care for suspected or documented emergency medical conditions. At the same time, EMTALA implicitly adheres to the essentially passive character of hospitals; despite their obligations, they are permitted to remain institutions whose duties are triggered when individuals either are electively admitted or else seek them out when in dire need of care. Federal regulations promulgated in 2003 tend to reinforce this limited view of hospitals' role in their communities by narrowing EMTALA's reach in initial screening, patient

stabilization, and the obligation to provide specialty resources of the hospital to emergency cases.

The *Urgent Matters* project was initiated at a time of major pressure for EMTALA reform. This is ironic, since the project's central findings, published approximately eight months after issuance of the revised 2003 rules, indicate that, at a minimum, some of the EMTALA "downscaling" evident in the rules may have been premature. The *Urgent Matters* findings suggest that, to at least a significant degree, emergency department overcrowding can be attributed *not* to widespread and clinically unjustifiable consumption of hospital emergency care resources (only 20% of emergency department utilization could be considered inappropriate in terms of the presence of an emergent condition), but instead, to a combination of organizational and management weaknesses coupled with a heavy reliance on emergency departments by the surrounding community, many but not all, of whose members face access barriers and are in considerable need of health care. Access in the study communities was weakest with respect to the very specialty services that EMTALA is supposed to provide, but whose availability now has potentially been further limited. Furthermore, our findings suggest that even where alternative community resources exist, at least for basic management of serious health conditions, community residents fail to understand their availability, and thus will endure long waits for care, in difficult health care environments, in order to be seen. The picture that emerges is not that of heavy overuse of care, but lengthy delays in securing essential services, as well as reliance on unnecessarily difficult and costly care sites out of concerns over quality, ignorance of alternative sources of care, or the inability to secure timely specialty management for serious conditions.

To be sure, data show inappropriate use of emergency departments by insured patients with serious health needs, who are in one way or another looking to compensate for what they perceive to be the failings of the health care system to which they have access. This pattern suggests the need for fundamental changes in the manner in which insurers and health plans organize and buy health care services for their members. There is really not much incentive for insurers to make such deep changes, however, since even in states with "prudent layperson" statutes,

payment rates for covered benefits remain unregulated. Thus, it is unclear whether insurers' financial losses stemming from payment for "prudent layperson" care may not be more than offset by financial gains from slowing the use of insured benefits.

At the same time, much emergency care use is attributable to lower-income, uninsured, and publicly insured patients with little or no access to alternative sources of care. Despite the existence of emergency department overcrowding, this group may play a less dominant role than anecdotes suggest. Nonetheless, these patients are among the sickest and most vulnerable members of the community, and they have the most to lose, health-wise, from inadequate access to care.

Recent efforts to improve access to care have focused on small grants to community organizational efforts, or the expansion of the health centers program to finance the establishment of more clinical care sites. These are essential efforts and should be continued. By themselves however, these investments do little to change the fundamental behavior of hospitals, to incentivize them to partner with primary care facilities to help keep patients relatively healthy and in community care environments, or to supply specialty care when needed. Indeed, health centers report serious difficulties in securing specialty and inpatient care when their patients need it.[104]

We believe that our research supports several recommendations aimed at both upgrading hospitals' emergency care capacities and improving hospital interaction with their communities. The appropriate management of a hospital's emergency department and related facilities is an underlying factor critical to the achievement of EMTALA's fundamental goal of ensuring appropriate emergency care access. The findings from this study suggest that there is considerable room for improvement. The input/throughput/output performance measures and rapid-cycle improvement procedures used in this project serve as a basis, in our view, for fashioning performance standards related to Medicare hospital

104. *See* Michael K. Gusmano et al., *Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured,* HEALTH AFF., Nov.-Dec. 2002, at 188, 189-90.

conditions of participation, which would measure the quality of hospital emergency care and related services. So significant were the emergency department crowding reductions achieved through this project that, in our view, our findings call into serious question the wisdom of relaxing essential emergency care standards in the absence of compelling evidence regarding active efforts on hospitals' part to improve their performance where emergency management is concerned. Indeed, the results from this study indicate that more affirmative management of hospital emergency resources may go a long way toward improving emergency department performance without reducing hospitals' legal obligations to perform in emergencies. At the very least, the management lessons to be drawn from this study should be used as a basis for further refinement of Medicare conditions of participation in order to ensure that continuous improvement in hospital emergency care performance is a basic program expectation.

A second major lesson to be drawn from this project is that the demand on hospital emergency care services is a reflection of the serious barriers to accessible, timely, and decent quality health care that confront millions of Americans. The hundreds of focus group interviews conducted over the course of this study underscore the problems endured by low-income and vulnerable populations at risk for medical underservice. For many, health care is a critical service that must be used sparingly because of its financial costs and the struggle associated with its receipt. The burden of securing emergency care is so great that individuals apparently will endure substantial suffering and deterioration in health status rather than seek care early. For reasons that are not easy to understand, community residents do not appear to be aware of more appropriate primary health care services that might be available; at the same time, primary care awareness cannot compensate for the shortages of specialty care for physical and mental health conditions, as well as the total absence of dental care.

These findings suggest to us the need for a fresh look at how society expects hospitals to perform within broader community health systems, as well as how compensation arrangements coupled with certain legal incentives can be used to encourage what we term "active engagement."

EMTALA is fine as far as it goes; its terms guarantee basic emergency care when help is sought from a dedicated emergency department. This study suggests however, that more is needed from modern hospitals than simply waiting for emergency cases to show up. Communities need hospitals that are fully engaged and active participants in staffing, supporting, and widely publicizing affordable sources of primary and ambulatory specialty health care.

We believe that two types of changes might propel hospitals in the direction of active community engagement. The first is the establishment of a federal compensation arrangement that provides financial support to hospitals involved in "active community engagement" efforts, which would help offset the necessary costs that such "engaged" hospitals incur in both carrying out their EMTALA screening and stabilization requirements and undertaking management improvement efforts related to emergency care. One possible source of financing for such a program would be a federal surtax on the sale of all insurance products covering medical losses (i.e., not only health insurance but worker's compensation plans, auto insurance, and other forms of coverage that pay for medical care), as well as on services purchased by public and private employee health benefit plans. Given the community-wide reliance on hospital emergency departments, it seems only appropriate that all payers should contribute to the support of emergency care facilities.

Beyond financing, a program furnishing financial incentives for "active engagement" would require measures of "community engagement." Consistent with the modern movement toward "pay for performance" these measures should not be ambiguous directives, but instead, precise measures that participating facilities would have to satisfy, as well as a process of information collection to document satisfaction of the terms of payment. Measures of "engagement" might consist of written affiliation agreements with community clinics providing for a specific monthly volume of specialty referral services on a subsidized basis, the provision of measurable amounts of primary and specialty care in community settings, the co-location on hospital campuses of urgent care centers open on a round-the-clock basis, and other quantifiable and verifiable activities.

In addition to direct financial incentives, an "active engagement" program presumably would require the establishment of certain safe harbors against liability for fraud for hospitals that seek to collaborate with community service providers in "engagement" programs, as well as the possible creation of antitrust safety zones to insulate participants against charges of anticompetitive horizontal arrangements. Under current antitrust and fraud principles, collaboration among hospitals and community primary care services can constitute a basis for liability. Even where the collaboration involves the admission and treatment of low-income and medically vulnerable populations, the ostensible lack of economic attractiveness does not absolve facilities, since many patients might qualify for Medicaid coverage. Congress has previously granted safe harbors for arrangements that involve collaborations between health care practices and certain community health clinics, which might otherwise be deemed violative of federal fraud and abuse laws.[105] In our view, a program that incentivizes "active engagement" through EMTALA payments would simply be an extension of these earlier efforts to foster affiliations designed to strengthen community health care systems for low-income populations.

In a nation in which the non-elderly population has a one in three chance of going without health insurance coverage, the importance of the access guarantees created by EMTALA can hardly be overstated. In recent years, the emphasis has been on the scaling back of EMTALA's protections without any policies aimed at the creation of appropriate alternatives. The Bush Administration has promoted expansion of the health centers program to improve primary care access, but by themselves, health centers cannot overcome barriers to specialty care.

---

105. Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. 108-173, 117 Stat. 2066, 2287 (2003) (codified as amended at 42 U.S.C. § 1320a-7b(3)(H) (2005)). This provision exempts from the scope of the anti-kickback statute "any remuneration between a health center . . and any individual or entity providing . . . services . . . to such health center entity pursuant to a[n] . . . agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, or services provided to a medically underserved population served by the health center entity."

We believe that the evidence drawn from the *Urgent Matters* study points to the need to emphasize greater efficiencies in the administration of hospital emergency services, while simultaneously coupling management improvements with a fundamental shift in U.S. hospital payment policy where emergency care is concerned. EMTALA's real costs should be acknowledged–and they should be compensated through a federal mechanism that spreads the cost across all payers. In exchange, hospitals should be expected to be actively engaged in the improvement of health care in their communities, using defined and measurable standards of engagement that capture both primary and specialty access, as well as the appropriate management of chronic conditions.