SJIF Impact Factor: 5.464

WORLD JOURNAL OF ADVANCE HEALTHCARE RESEARCH

ISSN: 2457-0400
Volume: 4.
Issue: 2.
Page N. 07-09
Year: 2020

Review Article www.wjahr.com

EMERGENCY MEDICAL TREATMENT AND LABOR ACT

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Received date: 24 December 2019 **Revised date:** 14 January 2020 **Accepted date:** 04 February 2020

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INTRODUCTION

The United States Congress, in 1986, passed the Emergency Medicine Treatment and Labor Act (EMTALA) as part of Consolidated Omnibus Budget Reconciliation Act (COBRA) of the Social Security Act to ensure that emergency care was available to the public regardless of the ability to pay (CMS.gov, 2015). This act required that all hospitals, which accepted Medicare reimbursements from the government with emergency services, to provide emergency medical screenings when requested and offer emergency medical treatment as needed including stabilization of active labor to all needful patients regardless of the financial resources of the patient; although, it does not prohibit the hospital from asking about the patients insurance status or payment method, if any. In cases of active labor, this act insists that hospitals stabilize patients until delivery is complete including discharge of the placenta. The origins of this law was based on practices noticed in Cook County Hospital (a public institution) in Chicago were the physicians noticed that an inordinate number of patients were transferred there from private hospitals in Chicago with the vast majority being minorities and unemployed and 87% of them lacking health insurance (Zibulesky, 2001). Furthermore, only 6% had signed informed consent paperwork and 24% were medically unstable at the time of transfer (Zibulewsky, 2001). The United States Congress took it upon themselves to pass this law (a rare show of bipartisanship) to prevent such outrageous behavior by hospitals for monetary gain. Hospitals were not only obligated to stabilize patients medically but also transfer them to other appropriate venues as medically indicated upon the patients request. In essence, due to the vast majority of hospitals accepting reimbursement from the Centers of Medicare and Medicaid, this act basically applies to virtually every hospital in the United States. There are specific sub-statues in EMTALA: a) a hospital is bound by affirmative duty to treat any existing emergency medical condition b) a hospital is obliged to conduct a medical screening exam to rule out any emergent medical condition c) a hospital is restricted from transferring any patient who presents with active labor or any emergent medical condition (Emtala.com, 2015). Another important mandate, which the EMTALA requires is that no hospital deny transfer of patients to its facility regardless of payment if they have specialized (burn unit, neonatal intensive care unit), services to treat patients needing such services and if there is available capacity at the hospital.

EMTALA Provisions

EMTALA also require healthcare institutions to adhere to other provisions in the law, which include that the hospital post a visible sign that makes it clear to patients and staff that no patient with an emergent condition will have care withheld (Emergency care, 2020). If a patient does not have an emergency medical condition as determined by the hospital staff, the hospital can refuse treatment and/or transfer the patient to a lower level of acuity service (Emergency care, 2020). The patient must be evaluated by a "qualified medical provider" which is a clinician deemed by the hospital as qualified based on the hospital bylaws. Additionally, this hospital should be an institution, which does have an emergency medical department or a site where emergency medical treatment is provided for the EMTALA to be triggered if requested by a patient. This act attempts to define a medical emergency as a situation where if care is withheld from a patient could lead to increased morbidity to the patient including patients presenting with severe pain. Furthermore, if a patient presents with labor contractions, the law states that a determination must be based on medical evidence if this is real labor and if it is deemed that the patient cannot be transferred due to increased likelihood of delivery, then it is an emergent medical condition. A pregnant patient can be transferred if it is medically determined that this is false labor contractions or if the patient is medically stabilized for treatment in another medical facility. This law further defines medical stabilization has a process where no undue harm will

occur to the patient if this process takes place at the current time. The process of transfer involves the attending physician at the current hospital certifying in writing that the patient is able to be transferred in a medically safe manner, there are adequate medical personal to ensure this transfer takes place via ambulance or other appropriate means, the accepting hospital has all the medical information to take care of the patient in a regulated manner and all medical paperwork is transferred with the patient to provide seamless care. In cases where emergent medical treatment is refused, EMTALA guidelines require the institution to document in writing that the patient was informed of all the risks and benefits of the treatment, the patient was deemed to have mental capacity to make this decision and, if possible, the patient's refusal must be taken in writing.

Pros of EMTALA

The original reason for EMTALA's passage was ensure that patients regardless of their ability to pay were able to access emergency medical services when needed and to prohibit the practice of patient "dumping" (a process in which private hospitals would transfer patients to public hospitals for financial reasons without concerning themselves with the patient's medical condition and medical stabilization for transfer) (Zibulesky, 2001). "Participating hospitals and physicians who negligently violate the statute are subject to a civil monetary penalty not to exceed $50,000 (or $25,000 for hospitals with <100 beds) for each violation. Because a single patient encounter may result in >1 violation, fines can exceed $50,000 per patient" (Zibulesky, 2001). The EMTALA law has gained widespread support in the community due to the fact that all patients regardless of financial resources, race, age, sex, and religion have equal right to be evaluated for their urgent medical issues. Hospitals are prohibited from discharging indigent patients for ones that are more lucrative, patients must be seen in the order of their medical necessity, and patients may not be discriminated against based on prior debt or non-payment to the hospital (Rudkin et al, 2009). Supporters of the law also are enthusiastic as they appreciate the universal access, which allows all citizens emergency medical care.

Cons of EMTALA

Opponents of EMTALA cite the fact that emergency room visits have increased sharply due to the uninsured using emergency rooms as a safety net and this law is merely a stop gap measure; furthermore, there is evidence that wait times have increased by 33% of patients who visit emergency room and folks leaving the emergency room as tripled (Monico, 2010). There has also been opposition by hospitals, which have complained about the provisions in EMTALA. The Institute of Medicine in its Fact Sheet (2006) reports that in the last 20 years since the EMTALA's passage financial pressure on hospitals, due to non-reimbursement by the federal government for emergency medical services has strained hospital financially leading to closure and consolidation of emergency room. It further states that between 1993 and 2003, the number of emergency room patients increased by 26% while the number of emergency rooms decreased by 425 (Institute of Medicine, 2003). Proponents of EMTALA voice the opinion that hospitals were consolidating emergency rooms even prior to the EMTALA passing to increase their in-house census and the trend of folks increasing visiting the ER was seen from the 1950's (Monico, 2010). The American Academy of Emergency Physicians have viewed EMTALA as a unfunded mandate from Congress and estimates that almost 55% of emergency medical care is not reimbursed which puts great strain on hospitals and staff in addition to difficulty having physicians staff ER's, fact that managed care companies retrospectively deny payments citing cases as not true emergencies and ER overcrowding (AAEP, 2010).

Analysis/Conclusion

The passage and implementation of the EMTALA has been a success albeit with serious consequences. While it is true that any patient with a true emergency will have access to emergent medical care without taking into consideration their ability to pay, it does not mean that this care is free. All this law states is that patients get care initially but soon the patient will get a bill from the hospital charging for various services. It is not clear if patients understand this aspect of the law as in my research for this article, I have chanced upon numerous examples where patients are surprised and shocked at the amount of the monies they owe the hospital. Additionally, due to the vast majority of uninsured patients not having a primary care provider and seeking medical care in the emergency room (for both urgent and non-urgent reasons), emergency rooms are bursting at their seams. This scenario is leading to overcrowding, lack of timely treatment for urgent medical issues, physician burnout, lack of compensation for clinicians and hospitals which may end up with hospitals closing their emergency room (the EMTALA does not mandate that hospital have ER's). The hospital might look at their bottom line and decide to invest in more elective surgical suites than see money drain away from an ineffective and costly emergency room service and thus burden will shift inordinately to public institutions. Congress need to take an initiative and make amendments to EMTALA which will rectify the unintended consequences of this act and yet help it meet its objectives. I propose a) Implementing a dual emergency room system where urgent care issues are triaged to urgent care type emergency scenarios and true emergencies be evaluated and treatment in emergency rooms b) Ensure adequate reimbursement to clinicians and institutions which treat emergency patients and involve the private sector in a partnership to help solve this issues c) Instill tax breaks for hospital which continue with their emergency room even if they are losing money and have student loan mitigation for physicians who continue to work in the money losing emergency rooms d) Prohibit the number of denials

which private insurance companies can initiate while reviewing medical cases which were deemed as an emergency before as often this is done with economic issues in mind e) Limit the number of litigations and have a cap on insurance payments to encourage clinicians and hospitals to proactive active and empathetic medicine rather than defensive medicine which increases costs for all f) Create an independent panel comprising of all interested parties in this debate (government advisors from the centers of Medicare and Medicaid, clinical providers, insurance company representatives, lawmakers, representatives from both public and private institutions and laymen) who can meet periodically on the challenges faced by the public and others involved and have an open dialogue of how to solve these issues and create new opportunities.

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