EMTALA: A SHIFTING LANDSCAPE

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Malpractice Damage Cap Factors

• Cases split on applicability of state medical malpractice damage caps in EMTALA cases when the challenged conduct also constitutes conduct covered by a state’s medical malpractice statute

• Current cases tend to favor application of medical malpractice caps
EMTALA Obligations

• Hospitals with emergency departments have two basic EMTALA obligations
  – The hospital must provide for "an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition ... exists." (42 U.S.C. § 1395dd(a))
  – If the hospital "determines that the individual has an emergency medical condition," it must provide "within the staff and facilities available at the hospital" for "such treatment as may be required to stabilize the medical condition" and may not transfer such a patient until the condition is stabilized or other statutory criteria are fulfilled. (42 U.S.C. § 1395dd(b))
EMTALA Obligations and Remedies

• Hospital also may not delay provision of medical screening or further examination and treatment to inquire about payment or insurance. (42 U.S.C. § 1395dd(h))

• A person who suffers personal harm as a direct result of a hospital’s violation of EMTALA may, in an action against the hospital, obtain those damages available for personal injury under the law of the applicable State, and appropriate equitable relief (42 U.S.C. § 1395dd(d)(2)(A))
  – Goal was to keep health care accessible and was designed to avoid exacerbating the medical malpractice insurance crisis. See Barris.
Arguments On Cap Applicability

- EMTALA is a Distinct Federal cause of action based upon “strict liability” rather than negligence and thus caps should not apply
  - A tort is defined as "a civil wrong other than a breach of contract, for which... the law... provides a remedy, " and noted ‘[a]ll torts share the elements of duty, breach of that duty, and damages arising from that breach.’... the substantive quality of [an] EMTALA civil action clearly sounds in tort.“ See e.g., Tep v. Southcoast Hospitals Group, Inc., CV13-11887-LTS (D. Mass. September 22, 2014)
Arguments On Cap Applicability

• EMTALA does not incorporate the state’s medical malpractice procedural limitations
  – Nearly all courts are in Agreement on this, but split on whether this is meaningful in ascertaining whether caps apply to damages given the statutory language - 42 U.S.C. §1395dd(d)(2)(A)
Arguments On Cap Applicability

• EMTALA claim is not analogous to a malpractice claim
  – EMTALA is a variation of a malpractice / tort claim
  – Looks at an internal comparison rather than a comparison to the prevailing medical standard
  – EMTALA claims are based upon professional negligence, even though they include other elements
Arguments On Cap Applicability

• Conflicting purposes of EMTALA and medical malpractice limitation statutes make limitation inappropriate – compensatory and deterrence goal of EMTALA vs. promoting insurance availability
  – Goals are not mutually exclusive and Congress was aware of malpractice insurance crisis and wanted to find a middle ground
Arguments On Cap Applicability

• EMTALA’s reference to personal injury vs malpractice injury in §1395dd(d)(2)(A) suggests malpractice limitation is inapplicable
  – Other Courts disagree and believe that the broader term was used to incorporate civil damage limitations other than malpractice cap limitations
Arguments On Cap Applicability

• Language of §1395dd(d)(2)(A) only limits EMTALA damages to the elements of damages recoverable under state law for personal injuries
  – Limitations are not an element of damages – “if Congress ... intended to incorporate malpractice damages caps into EMTALA it would surely have chosen more precise language.” Power v. Arlington Hosp., 800 F.Supp. 1384, 1392 (E.D. Va.1992) O’vrl'd 42 F.3d 851 (4th Cir. 1994)
  – Limitations are an element of damages and Congress need not be that precise
State Malpractice Cap Application

Is the act or omission alleged within the scope of acts covered by malpractice limitations act?

No

No Cap

Act is outside of malpractice limitations statute definition of malpractice

EMTALA is a strict liability statute

Emtala claim not analogous to a malpractice claim

Yes

De-facto violation

Involves consideration of professional standards

Involves internal case comparison rather than community standard – e.g. differential screening

Cap Applies

Cap Applies

EMTALA is a strict liability statute
California Medical Injury Compensation Reform Act

- Cal. Civil Code §3333.2 limits damage awards in professional negligence actions against health care providers.

  "[i]n any action for injury against a health care provider based on professional negligence, the injured plaintiff shall be entitled to recover noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage.... Provided that "[i]n no such action shall the amount of damages for noneconomic losses exceed two hundred fifty thousand dollars ($250,000)."

- “Professional negligence” means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital."
Malpractice Damage Cap
California Cases

• Barris v. Cty. of Los Angeles, 20 Cal.4th 101 (1999) - California Supreme Court concluded that damages awarded under EMTALA for failure to stabilize were subject to the state's MICRA cap where baby was not provided diagnostic tests or treatment based upon patient’s HMO’s instructions to the ER physician.
  - Courts look at the conduct challenged and its legal basis to determine whether, if brought under state law, it would constitute a cause of action subject to the state’s medical malpractice cap
  - “An EMTALA claim for failure to stabilize is ‘based on professional negligence,’” although it also includes other elements
  - EMTALA damages provision reference to “personal injury” incorporates general provisions of state personal injury damage law, but also includes specific provisions of state law such as damage limitations
  - Concurring Opinion – “any action ... for a violation of EMTALA’s duty of care provisions qualifies as an action based upon professional negligence subject to [the malpractice caps] without regard to whether the particular claim entails consideration of prevailing medical standards of care.”
Malpractice Damage Cap
California Cases


  – EMTALA claim for failure to certify that a patient is stable before transfer and failure to stabilize “appears to fall within the [California Medical Injury Compensation Reform Act] cap” relying on *Barris*
Malpractice Damage Cap
California Cases

  
  – A failure to stabilize EMTALA claim would fall within MICRA cap, but **disparate medical screening claims** would not be limited by MICRA, because those are not "medical negligence" claims
  
  • Under a **disparate** screening theory, the hospital’s conduct is **not judged against the prevailing professional standard of care**, rather the hospital’s **conduct is compared to its own screening standards** or protocols in order to determine if the patient received the same screening as other similarly symptomed patients
  
  – e.g. a high quality hospital could have a screening violation whereas a low quality hospital would not for the very same conduct, without regard to community professional standards
  
  – A claim brought on other than a negligence theory is not within the ambit of MICRA
  
  – Professional standard of care is not inextricably intertwined
Older California Case Split

• Older California cases held that the MICRA damages cap did not apply to a claim brought under EMTALA because of a narrow interpretation of MICRA’s covered conduct
  – “EMTALA did not preclude the application of MICRA restrictions per se, [however] the MICRA restrictions did not apply because MICRA applies only to claims "based on Professional negligence," while EMTALA is a strict liability statute. It is well-established that EMTALA does not create a federal remedy for medical negligence, nor does it duplicate state-law medical malpractice claims; rather, EMTALA creates a separate cause of action which makes hospitals strictly liable for refusing essential emergency care because of a patient's inability to pay.”

The Louisiana District Court Split

  - Patient’s request to be seen in the ER was allegedly refused – hence a failure to screen case
  - Court held Louisiana Medical Malpractice Act (“LMMA”) did not limit EMTALA liability because
    - EMTALA is not a malpractice statute – EMTALA provides a distinct cause of action
    - EMTALA is an independent federal cause of action based on a strict liability standard
    - EMTALA does not incorporate state malpractice procedural limitations
  - Treated as a screening claim – arguably should have been considered as a delay in screening case – 42 U.S.C. §1395dd(h).
  - No analysis of LMMA limitations applicability to a failure to screen or delay claim
The Louisiana District Court Split

  - ER physician’s request for an MRI delayed until insurance approval was received
  - Court held EMTALA liability limited by LMMA caps because:
    - Considered EMTALA’s prohibition on delay as well as differential screening claim
      - 1395dd(h) – can’t delay screening or the administration of further medical examination and treatment to inquire about payment or insurance
    - Found most courts applied malpractice caps where the conduct falls within the definition of malpractice and then analyzed in detail whether the conduct was within the scope of the malpractice statute using LMMA’s “Coleman” factors.
      - Found that failure to render services timely constitutes malpractice under the express language of the LMMA and that the delay in this case was treatment related.
      - California MICRA has no language addressing delay – hence result may be different between California and Louisiana cases
    - Found no conflict between damage limitations and EMTALA’s remedies provision
The Louisiana District Court Split

• *Scott* decision is consistent with the majority of cases
• *Jeff* decision logic has been rebutted in a number of cases:
  – *See e.g.*, *Barris*
    • Premise that EMTALA doesn’t require evidence of negligence or failed to provide adequate treatment is incorrect - EMTALA requires that hospital provide a minimum level of professional care based upon resources
    • EMTALA is not a strict liability statute – statute looks at whether minimum level of care was provided – strict liability would hold hospital liable for an injury without regard to services provided.
      – Some courts have referred to EMTALA as a strict liability statute as no specific mental state or intent is required with respect to a violation especially with respect to medical screening claims. *See e.g.* *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996). *But see Abercrombie v. Osteopathic Hosp. Founders Ass’n*, 950 F.2d 676 (10th Cir.1991) and *Stevison v. Enid Health Sys., Inc.*, 920 F.2d 710 (10th Cir.1990).
      – When a statute creates a duty of care, a violation of the statutory duty is often categorized as “negligence per se” or “statutory liability.”
Cases Supporting Applicability of Malpractice Limitations


- *Powers v. Arlington Hospital Association*, 42 F.3d 851 (4th Cir. 1994) (EMTALA limited by Virginia cap on medical malpractice damages) (*compare Brooks v. Maryland Gen. Hosp., Inc.*, 996 F.2d 708, 710 (4th Cir. 1993) (opposite result by the same Court based upon limitations of Maryland’s malpractice statute being limited to “traditional malpractice claims” resulting from a failure to comply with the standard of care.))

Delay / Available Resources

AnMed Health Settlement

- AnMed Health settled with the HHS OIG over allegations that in 36 instances it:
  - Held unstable psychiatric patients with emergency mental health conditions in its ER for 6 – 38 days – “Reverse dumping”
  - Failed to provide on-call psychiatric visits to involuntarily committed patients
    - Treated by ED physicians in the ED – Was this inappropriate psychiatric treatment
    - No allegation that patients were re-evaluated before transfer
- Settlement Amount - $1,295,000 ($36,111 per instance)
  - Largest EMTALA settlement to date
  - 7 months after the new OIG regulations increasing the civil monetary penalty amounts for EMTALA violations to up to $104,826 per violation (because AnMed’s events occurred in 2012 and 2013, AnMed was not subject to increased CMP)
AnMed – Tip of the Federal Standard of Care Iceberg

- Increased CMS scrutiny across regions on EMTALA mental health care in emergency departments.
- CMS allegations:
  - Inadequate medical screening examination (MSE) for mental health
  - Failure of the MSE to be ongoing, especially when the patient remained in the emergency department for extended time periods
  - Holding mental health patients in emergency departments for extended time periods
  - Elopement
  - Inadequate safety measures for suicidal and homicidal patients
  - Improper use of psychoactive medications as chemical restraints
  - Inadequate documentation of MSE, psychiatric interventions, and justification for psychiatric interventions
Delay / Available Resources
AnMed Health Settlement

• Issues
  – What level of treatment must be provided
    • Must hospital arrange for specialists to see a patient rather than relying on ED doctors
  – Must all facilities be available to all EMTALA patients
    • Can a hospital limit admissions to voluntary mental health admissions and exclude EMTALA involuntary admissions from a behavioral health unit
    • AnMed had a policy of only admitting voluntarily committed patients to its behavioral health unit
• HHS alleged that the hospital “had on-call psychiatrists and beds available in its psychiatric unit to further evaluate and/or stabilize the patient’s emergency medical condition…. In each case the individual was not examined and/or treated by an AnMed psychiatrist.”
Delay / Available Resources
AnMed Health Settlement

• HHS claims may go beyond statutory and regulatory requirements
  – No EMTALA requirement for a specialist to conduct an EMTALA screening examination, unless the ER physician needs the specialist (psychiatrist) to confirm whether an emergency condition exists
  – No allegation is set forth in the settlement that the ED physicians or hospital failed to provide "such treatment as may be required to stabilize the medical condition" and may not transfer such a patient until the condition is stabilized or that the hospital delayed the provision of examination and treatment to inquire about payment or insurance
    • However, the allegation regarding the length of time the patients were in the ED may point to a claim that the hospital parked these patients in the ED without stabilizing treatment in violation of 42 U.S.C. 1395dd(b) or (h).
Is Observation Status an Admission For EMTALA

• Court in *Dicioccio v. Chung*, CV14-1772 (E.D. PA. Jan. 19, 2017) held Admission for observation was not an admission for EMTALA purposes
  – Relied on
    • CMS regulation, 42 C.F.R. §489.24(d)(2)(i)
    • CMS Healthcare Benefit Policy Manual – Observation status is defined as an outpatient status
Is Observation Status an Admission For EMTALA

• *Dicioccio v. Chung*
  
  – "Individuals who are placed in observation status are not inpatients, even if they occupy a bed overnight. Therefore, placement in an observation status of an individual . . . does not terminate the EMTALA obligations of that hospital or a recipient."
Improper Motive – 6th Circuit

• On March 9, 2018 the Sixth Circuit found that the Circuit’s precedent requires patients to show that an "improper motive" led to a hospital’s failure to provide an appropriate medical screening in order to recover under EMTALA (Elmhirst v. McLaren Northern Michigan, March 9, 2018, Gilman, R.)

• The panel, however, acknowledged the Circuit’s precedent was out of step with the majority of other Circuits addressing the issue and suggested en banc review
Peer Review Standard

• Federal Peer Review Privilege

• Examples of state issues
  – New Mexico
  – California
Federal Peer Review Privilege-- Grenier

• Federal EMTALA Claim and State Medical Malpractice Claim

• What privilege law applies?
  – Federal if federal law supplies the rules of the decision
  – State if state law supplies the rules of the decision
Federal Peer Review Privilege (cont’d)

- Federal law supplies rule of decision for EMTALA
- State law supplies rules of decision for medical malpractice claim
- Court found federal privilege law applied where the facts necessary to prove both claims overlapped
Federal Peer Review Privilege (cont’d)

- Neither U.S. Supreme Court nor 2nd Circuit recognized peer review privilege for federal EMTALA claims or medical malpractice claims
- Rule 501 FRE gives district courts “flexibility to develop rules of privilege on a case-by-case basis”
Federal Peer Review Privilege (cont’d)

• Factors courts should consider
  – Whether the privilege serves private and public interests
  – The evidentiary benefit that would result from the denial of the privilege
  – Recognition of the privilege among the States
Federal Peer Review Privilege (cont’d)

• Difference between civil rights and antitrust actions and medical/dental malpractice
  – Federal laws touching on medical malpractice incorporate state law
  – Courts have recognized “EMTALA’s intended purpose of supplementing, rather than supplanting, state medical malpractice law”
Federal Peer Review Privilege (cont’d)

- Multiple courts have recognized state peer review privileges in EMTALA and Federal Tort Claims Act cases presented with state law claims.
- Several other courts have applied state law peer review privileges without recognizing a federal privilege.
Federal Peer Review Privilege (cont’d)

• Court held that federal peer review privilege exists on the facts of the case
• Discussion focused on the need for confidentiality to provide a safe place for medical professionals to review care with their peers to improve care
State and Other Peer Review Laws

• According to the Grenier opinion, all 50 states and the District of Columbia recognize some sort of peer review privilege.

• Congress passed the Patient Safety and Quality Assurance Act in 2005, protecting some medical quality control documents.
Examples of State Peer Review Issues

• New Mexico
  • Peer Review statute does not create a privilege
  • Includes criminal penalties for violation
  • Most recent decision (2005) allowed private right of action for provider claiming harm as a result of disclosure of information about what occurred in peer review proceeding
  • Even hospital administration is not entitled to know what occurs during peer review proceedings
Examples of State Peer Review Issues (cont’d)

• California
  – Pending case involving medical staff claims against hospital
  – Hospital moved to compel production of medical peer review materials and won
  – Hospital now seeks to preclude admission at trial based on peer review statute
  – Medical staff says privilege applies to discovery not admissibility
Sovereign Immunity

• Bansal v. MD Anderson – 502 S.W. 2d 347 (Tex. App-Houston [14th Dist.] 2016)
  – Immune under state sovereign immunity law
    • Participation in Medicare does not express a waiver of state immunity laws
  – Immune under 11th Amendment
    • Congress did not unequivocally express an intent to waive state’s immunity
    • EMTALA doesn’t fall within a Constitutional provision allowing Congress to waive immunity
Sovereign Immunity

• Glaskox v. George County Hospital, CV1:16cv9-HSO-JCG (S.D. Miss. Aug. 1, 2016
  – EMTALA plaintiff against political subdivision was required to comply with TCA notice requirements
    • TCA incorporated by EMTALA with damages language
    • Notice is an element of damages
State Sovereign Immunity

• Sovereign immunity statute which completely bars recovery under EMTALA directly conflicts with EMTALA and is therefore pre-empted.
State Sovereign Immunity

• Contra case law
    • “Emtala ... contains no clear expression of [Congress’] intent to abrogate the state’s immunity”
EMTALA Violation as an Unfair Competition Claim Predicate

  – Air Ambulance service alleged that insurer’s requirement for hospitals to obtain prior authorization before arranging emergency transport violated EMTALA and constituted unfair competition
EMTALA – QUASI Contractual Right with Third Party Payer

• *HCA Health Services of Tennessee Inc. v. Bluecross Blueshield of Tennessee, Inc.*, M2014-01869-COA-R9-CV, Court of Appeals of Tennessee, Nashville (June 9, 2016)

  – Whether as a result of EMTALA a hospital has a direct quasi-contractual cause of action against a third party payer for unjust enrichment if the payer unilaterally pays a discounted rate for EMTALA covered services

  • Held – EMTALA and insurance statute requiring BCBS to pay emergency services claims will not support a direct quasi-contractual cause of action because HCA has not conferred a benefit on BCBS. Benefit was conferred on the patients
Questions & Answers