Inside Accreditation & Quality

Use CMS memo on emergency abortions to educate staff on EMTALA obligations

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Use the July 11 CMS memo reminding hospitals of their obligations under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) as a good opportunity to review policies and to educate doctors, nurses, and other personnel on requirements for caring for emergent patients who are pregnant or experiencing pregnancy loss.

"I would advise hospitals to do some additional training with their staff members for both the emergency department and the labor and delivery area," says **Gayle Nash, RN, MPH,** CEO of Nash Healthcare Consulting.

"In the education components of the hospital, they rarely include EMTALA," Nash says, "so this is a good time for them to review what their policies and procedures are."

The requirements that EMTALA places on providers are not new, and the memo attempts to clarify the interpretations of those requirements for women who present to the emergency department (ED) and may need an abortion or related care, notes healthcare regulatory attorney **Delphine O'Rourke, JD,** a partner with the global law firm Goodwin with a specialty in women's healthcare law.

The federal law was passed in 1986 to address apractice known as patient dumping, where hospitals often turned away patients—and particularly women in labor—who did not have health insurance. The patients often were sent to other providers.

According to CMS' *State Operations Manual*, Appendix V, "EMTALA requires hospitals with emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination, and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition (EMC)."

Hospitals "have to follow EMTALA," says O'Rourke. "They don't have a choice. EMTALA is federal law."

She warns that if hospitals don't follow EMTALA, they risk losing their ability to participate in Medicare overall, which is often a large portion of a facility's income.

What does the memo say?

Memo QSO-22-22-Hospitals from the Quality, Safety & Oversight group to CMS state survey directors is part of thedirect response from the Biden administration and the Department of Health and Human Services (HHS) to the Supreme Court's ruling in late June overturning the long-standing *Roe v. Wade* decision that largely legalized abortions nationwide.

The memo reminds hospitals of their obligations under EMTALA to help pregnant patients who are experiencing a medical emergency, including pregnancy loss, but with an added emphasis that care must be offered "irrespective of any state laws or mandates that apply to specific procedures."

Texas, which has one of the more restrictive new abortion laws,sued the Biden administration three days after the memo was published. The state claimed the memo was an attempt to get around the Supreme Court ruling, which held that each state should be able to decide when or if abortions are allowed.

The lawsuit could be the first of many legal actions as state and federal officials work out next steps following the Supreme Court's ruling.

The CMS memo updates and expands on guidance issuedlast September outlining hospital obligations under EMTALA. The updated memo adds a new statement, with CMS' own bold emphasis:

"**If a physician believes that a pregnant patient**presenting at an emergency department is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition,

the physician **must** provide that treatment. When a state law prohibits abortion and does not include an exception for the life of the pregnant person — or draws the exception more narrowly than EMTALA's emergency medical condition definition — **that state law is preempted**."

The revised memo moves a section of the memo's original text into the summary to emphasize examples of what emergency medical conditions may include:

"The determination of an emergency medical condition is the responsibility of the examining physician or other qualified medical personnel. An emergency medical condition may include a condition that is likely or certain to become emergent without stabilizing treatment. Emergency medical conditions involving pregnant patients may include, but are not limited to, ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features."

The summary also adds a line, again with bold emphasis, stating, "The EMTALA statute requires that all patients receive an appropriate medical screening examination, stabilizing treatment, and transfer, if necessary, irrespective of any state laws or mandates that apply to specific procedures."

The earlier memo in September was issued as various states began passing more restrictive laws on abortions. However, that version of the memo never specifically mentioned abortion.

The new memo states: "The purpose of this memorandum is to restate existing guidance for hospital staff and physicians regarding their obligations under the Emergency Medical Treatment and Labor Act (EMTALA), in light of new state laws prohibiting or restricting access to abortion."

The updated memo still notes that a hospital "cannot cite state law or practice as the basis for transfer," then goes on to add the specific statement that "when a direct conflict occurs between EMTALA and a state law, EMTALA must be followed."

Memo also outlines penalties

Besides the loss of a hospital's ability to participate in Medicare, there are other penalties outlined in the revised memo.

It expands a section on what is defined as stabilizing treatment, as well as the section on how CMS enforces EMTALA regulations.

And, as in the original memo, the revised version outlines four hospital Conditions of Participation discussing care for inpatients, including that the governing body must ensure the medical staff as a group is providing quality care, and that the discharge planning process applies to all patients.

The updated memo also expands the enforcement section to state: "HHS, through its Office of the Inspector General (OIG), may impose a civil monetary penalty on a hospital ($119,942 for hospitals with over 100 beds, $59,973 for hospitals under 100 beds/per violation) or physician ($119,942/violation) pursuant to 42 CFR §1003.500 for refusing to provide either any necessary stabilizing care for an individual presenting with an emergency medical condition that requires such stabilizing treatment, or an appropriate transfer of that individual if the hospital does not have the capacity to stabilize the emergency condition. Under this same authority, HHS OIG may also exclude physicians from participation in Medicare and State health care programs. CMS may also penalize a hospital by terminating its provider agreement."

Who will enforce the guidance outlined in the latest memo remains unclear. While the first version of the memo in September included a sentence that the "enforcement of EMTALA is a complaint driven process," the second version does not mention that, although it does outline how to lodge complaints.

CMS has also been known to cite hospitals that received patients in violation of EMTALA for not reporting the first facility that illegally transferred the patient.

Accrediting organizations such as The Joint Commission (TJC) in general are required to follow CMS guidance.

However, "I don't usually see TJC initiate EMTALA investigations," says **Kurt Patton, MS, RPh,** pharmacist, founder of Patton Healthcare Consulting, and TJC's former director of accreditation services.

What to do now

There are still many challenges ahead, notes O'Rourke. For instance, what happens if a doctor or hospital refers a patient from a state that has restrictive abortion laws to a facility or provider in a state that does not? What about licensing and privileging of those doctors from state to state, especially if an activity in one state becomes reportable in another state?

What happens with the licensing and privileging of traveling ED doctors and nurses who might cross state lines? How will the now-common practice of embryo reduction be impacted in cases of in-vitro fertilization in which several eggs become viable? How might varying abortion laws impact doctors who consult across state lines via telehealth? What happens with genetic counseling done across state lines? And what about health systems who have broad policies and procedures for hospitals across multiple states?

There are few, if any, such cases yet, notes O'Rourke. "We're going to have to see how it plays out." But don't panic, she says: "It's a manageable issue."

One first step is to identify the providers in your hospital who have licenses in multiple states, including states with new or revived laws against abortion, she recommends. Then determine which providers may be performing procedures impacted by the abortion laws. In practice, you may find that not many providers fall into these categories.

Then you need to determine your risk. And, perhaps most importantly, you need to talk with those providers to determine what level of risk they are comfortable with, says O'Rourke.

It's especially crucial to discuss with your legal team, providers, and C-suite how or whether you will support providers who follow the requirements of EMTALA but face a legal challenge, she says. Will your organization pay for the defense?

Have that conversation "now, not after the fact," O'Rourke advises. "Be proactive, and find out what's your risk."

Educate staff now

It will also be important to educate staff on obligations under EMTALA and what the hospital's expectations are, says O'Rourke.

The revised memo clearly states that under EMTALA requirements, if a patient comes to the ED and requests examination and treatment, "hospitals must provide an appropriate medical screening examination to determine whether an emergency medical condition exists or whether the person is in labor."

"If the hospital refers any pregnant patient to labor and delivery after the initial contact in the ED, the labor and delivery department usually performs a very thorough exam," notes Nash.

With that in mind, "if the labor and delivery department nurses are the ones performing the initial triage, they should have updated education on this [CMS] notification and a review of the EMTALA rules and hospital policies and procedures," advises Nash. "If the nurses in labor and delivery are doing the medical screening exam, they should have education performed annually, and the medical screening exam components should be approved by their section medical staff leadership."

Meanwhile, "for the emergency department, if they are performing the medical screening exam for pregnant women, they must ensure that they have documented competencies, and it would be wise to review this notification from CMS as well," she continues.

And for the hospital as a whole, notes Nash, "they must ensure that they have updated policies and procedures [that are] approved by their normal approval route such as the medical executive committee and the governing body."

It's best to work through your legal team regarding any decisions on policies and procedures, recommends Patton.

And there may be doctors, nurses, or other staff members who balk at providing care under certain conditions now, especially as state abortion laws take effect, says O'Rourke. But this reticence isn't new, she notes; there have been other instances of staff taking a moral or religious stance, such as when faced with treating a suspect in a terrorist attack or mass shooting.

Talk to your human resources department and legal team. Decide what your position is going to be in advance, advises O'Rourke.

"Right now the biggest challenge is that physicians are afraid," she says. So start talking to them now. "Be proactive about it."

To read the full six-page memo, go online to *https://www.cms.gov/files/document/qso-22-22-hospitals.pdf*.

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