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COMPLIANCE WITH THE EMTALA [EMERGENCY MEDICAL TREATMENT & LABOR ACT] STATUTE IS THE KEY TO FINANCIAL SUCCESS FOR LOW-VOLUME AND UNDERFUNDED SAFETY-NET HOSPITALS

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I. DEFINITION OF SAFETY-NET HOSPITALS

Healthcare in the USA has undergone massive changes over the past 10 years in order to provide medical services for the uninsured, uncompensated, and low-income vulnerable populations. In most states, care for these individuals begins in the emergency room and extends well beyond the hospital to the outpatient setting possibly requiring chronic hemodialysis to sustain life thus redefining the concept of emergency medical conditions for acute and long-term care with financial resource allocations to manage this extended encounter.[1] This continuum of care creates an encounter that begins with an initial medical screening in the ER and an opportunity for the hospital to introduce itself to the patient and community and perform its statutory duty to care for all patients per EMTALA[2] regardless of ability to pay.

The medical encounter requires a multidisciplinary team of individuals such as physicians, registration personnel, social workers, phlebotomist, radiology, administrators, and a governing body to maintain operational efficiency and accountability to deliver safe, effective care daily.[3] For some individuals, the ER may be their only experience with the health care environment due to low-income, uninsured, uncompensated, or non-citizen (illegal alien) status and because of these conditions, these patients receive medical care at an urban (inner-city) Safety-Net Hospital (SNH).

The rising costs of treating uninsured, low-income, uncompensated-care individuals lead to landmark healthcare changes. The most recent change was the PPACA 2010 (ACA; PL. 111-148, as amended)[4] which led to the expansion of federal funding with Medicaid, providing access to medical services and quality-based treatment reimbursements to prevent hospital readmissions for diseases such as CHF, Pneumonia, and CAD. Id. at 3. Compliance with the PPACA allowed participating states to provide coverage for this vulnerable population of low-income US citizens less than 65 years of age that meet the federal poverty guidelines[5] ($12,880 per single adult and $26,500 for a family of 4 in 2021).

As a result of the PPACA providing health care for the uninsured and low-income individuals, DHHS has a provision to reduce DSH allotment payments from FY 2014 to 2020 with DSH Medicaid reductions to be in effect from May 23, 2020, to FY 2025, per current law. Thus, states that manage low volumes of low-income patients and uncompensated care may receive the greatest DSH payment reductions due to the reduced number of uninsured and uncompensated patients. The definition of Safety-Net Hospitals has changed in the USA due to DSH percent payment allotments including care for uncompensated individuals. Thus, global organizations such as the Institute of Medicine state SNHs are:

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[1] Scottsdale Healthcare, Inc. v. Ariz. Health Care Cost Containment Sys., 206 Ariz. 1
[2] § 1395dd(d)(2)(e)(1)(A). EMTALA
[3] 24 Ann. Health L. Advance Directive 40, Saving the Safety Nets: The Patient Protection and Affordable Care Act and Hospital Readmissions Reduction Programs
[4] https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf
[5] https://obamacarefacts.com/federal-poverty-levels-for-aca-coverage/

"Those providers that organize and deliver a significant level of health care and other needed services to uninsured, Medicaid and other vulnerable patients."[6]

The new definition of an SNH per CMS includes patients who qualify for Medicare, Medicaid, and uncompensated care, broadening the definition of vulnerable populations. The management of low-income, uninsured, uncompensated, and Medicaid patients has led to financial crises and operational disasters for SNHs due to unpredictable funding with higher volumes of uninsured and uncompensated patients.[7] As a result, on April 30, 2017, CMS issued a "Final DSH Rule"[8] encompassing third-party payers, eligible Medicaid, Medicare, and uncompensated care[9] costs pursuant to 42 CFR § 447.299 (c)(10)). These changes broadened the definition of the financial criteria for SNHs to obtain DSH funding and per Section 3133 of the ACA thus establishing §1886(r) including uncompensated care with the following new definition of DSH payment allocations summarized as:

I. 25% of the statutory amount they formerly received from MC
II. 75% of the payments for uncompensated care becoming available after the adjustment for changes in the percentage of individuals that are uninsured and comparison of the percentage of a hospitals uncompensated care to all DSH

This new CMS-DSH payment allocation allows organizations receiving federal financial support to manage low-income, uninsured, and uncompensated patients thus, creating an opportunity to verify compliance with the Act and provide measurable data demonstrating the need for increased federal financial support. Compliance with the Act allows SNHs to increase admissions, federal funding, and possible long-term growth of the hospital enterprise with the development of service lines. In a 2019 study published in JAMA Network Open,[10] which evaluated 2600 American hospitals that were designated as SNHs, they found that in comparing SNHs v. Non-SNHs, the SNH defined by "DSH Index, the volume of Medicaid, Uninsured patients, and Uncompensated care" were likely to have the following higher categories:

1. Southern and Midwestern state locations
2. Racial/ethnic minorities
3. Medicaid/uninsured patient volume
4. Uncompensated care
5. Patients from low-income communities
6. Maternal/neonatal hospital stays
7. Higher patients with injuries
8. Higher DSH Index received higher Medicare payments ($854,263 v. $176,511) ($p< .001$)

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[6] Institute of Medicine. America's health care safety net: intact but endangered. http://www.nationalacademies.org/hmd/Reports/2000/Americas-Health-Care-Safety-Net-Intact-but-Endangered.aspx. Published January 1, 2000. Accessed October 24, 2018

[7] COMMENT: THE KILLER MANDATE: EMTALA AND ITS FINANCIAL EFFECTS ON HOSPITALS AND IMMIGRANTS, 80 UMKC L. Rev. 881

[8] FY 2022 IPPS Final Rule Home Page | CMS

[9] https://www.federalregister.gov/documents/2017/04/03/2017-06538/medicaid-program-disproportionate-share-hospital-payments-treatment-of-third-party-payers-in

[10] JAMA Network Open. 2019;2(8): e198577. doi:10.1001/jamanetworkopen.2019.8577

9. Higher Medicaid and uninsured patient volumes received higher payments ($241,196 vs $236,024) (P = .002).

The ability of an SNH to sustain and generate revenue will require federal and community support with consumer confidence that they are receiving safe, effective, and up-to-date care in their community. This endeavor of financial sustainability begins upon the initial evaluation in the emergency room. The ability to achieve financial stability and improve low patient census requires the Safety-Net Hospital to re-evaluate its mission and vision statement in addition to strategic planning. SNH compliance with the federal EMTALA Statute, 42 USC 1395dd,[11] may improve low volumes (low census) and create long-term financial success with the development of hospital systems/networks and operational improvements.[12] This document shall provide a detailed evaluation of the EMTALA and demonstrate how compliance with the Act may produce financial success and increase patient census in SNHs by demonstrating the following:

a. Defining the EMTALA Statute and how it directly affects financial success and patient census
b. Financial effects of non-compliance with the Act
c. Effects of financial success when obtaining compliance with the Act
d. Summary with detailed analysis of expected long-term success upon compliance with the Act

II. EMTALA STATUTE

The EMTALA Statute (anti-dumping statute), 42 USC 1395dd. Id. at 11., was enacted in 1986 to provide access to emergency medical services to all individuals in the USA in the absence of insurance or ability to pay pursuant to 42 CFR 489.1.[13] Unlike the Hill-Burton Act of 1946,[14] which provided financial compensation to hospitals for operational support with the requirement to provide a reasonable volume of charity care[15] consistent with 3% of the overall operating costs or 10% of the federal funding it received, without any meaningful enforceable regulatory provision. EMTALA in contrast to the Hill-Burton Act has specific requirements for all hospitals that provide emergency medical care and receive federal funding with Medicare/Medicaid funding[16] with enforcement for non-compliance pursuant to §1395dd of the Act. This statutory obligation also regulates the unsafe transfer of patients with penalties.[17] Thus, hospitals that are non-compliant may be terminated from CMS and lose their CoP (conditions of participation) and Medicare/Medicaid funding. Non-Compliant hospitals and negligent physicians may also receive

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[11] https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA
[12] Bazzoli GJ, Manheim LM, Waters TM. US hospital industry restructuring and the hospital safety net. Inquiry. 2003,40(1):6-24. doi:10.5034/inquiryjrnl_40.1.6
[13] 42 CFR 489.1
[14] 20. 79 P.L. 725, 60 Stat. 1040, 79 Congress. Ch. 958, Hospital Survey and Construction Act., 60 Stat. 1040 (Hill-Burton Act)
[15] Gordon v. Forsyth County Hospital Authority, Inc., 409 F. Supp. 708
[16] https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA
[17] Lynn Wagner, *Group Says Government is Lax in Enforcing Patient-Dumping Law*, MOD. HEALTHCARE, April 29, 1991, at 18

civil monetary penalties per §1867 (d) of the Act.[18] Elements of the EMTALA Statute include the following:

1. medical screening exam
2. stabilizing treatment
3. Discharge or Transfer of patient if unable to stabilize or upon patient request

Issues have occurred regarding whether EMTALA Statute extends to inpatients. In the case of *Thornton v. Southwest Detroit Hospital,*[19] the court determined that if a patient has a medical emergency, the individual must be stabilized prior to transfer to another facility; whereas in *Bryers v. Rectors,*[20] the court's holding was the EMTALA Statutory requirement ends upon inpatient admission to the hospital. The important issue here is, by remaining compliant with the EMTALA Statute patients will receive a medical screening examination and stabilization for admission or transfer to another facility which requires utilization of hospital-based services such as labs, radiology, hospitality, consulting physicians and hospitalists in addition to follow-up care at a hospital-owned outpatient clinic or skilled nursing facility within the community after discharge. The use of these services may lead to the following: an increase in admissions, identification of patients for enrollment in the ACA, treatment of Medicaid, Medicare, commercially insured, managed care patients with documentation of uncompensated patients to increase DSH payments. This statutory process has the possibility of developing the hospitals' provider network for both inpatient and outpatient services thus leading to the development of a diversified health network affiliation or unified health system to meet both the needs of the hospital and the community based on the facilities mission and vision, Id. at 8.

III. FINANCIAL EFFECTS OF NON-COMPLIANCE WITH THE EMTALA STATUTE

Market Share is defined as the "percentage of the market for a product or service that a company supplies."[21] In a competitive healthcare sector, market share can determine the financial success of the organization. The healthcare market is constantly evolving to provide more effective and efficient services that require the development of relationships with patients and focusing on the following concepts: customizable care, free flow of information, patient-centered care, evidence-based treatments, and elimination of wasteful resources for both the patients, community and the healthcare organization.[22] Non-compliance with EMTALA and failure to maximize market share may lead to the failure of the organization to prioritize its mission and focus on improving healthcare outcomes and the volume of Medicare, Medicaid, and Commercial payors.

Accordingly, hospitals are in a unique position to increase economic value and cash flow by means of providing the necessary care for patients by simply complying with the EMTALA Statute. The ability of the SNH hospital to increase its market share will depend on its competition amongst the following: Geographic location, providers with similar or more effective resources (hospitals),

[18] https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA
[19] 895 F.2d 1131, 1990 U.S. App. LEXIS 1643
[20] Bryan v. Rectors and Visitors of the University of Virginia, 95 F.3d 349 (4th Cir. 1996)
[21] Market share Definition & Meaning - Merriam-Webster
[22] Crossing the Quality Chasm - Building a Better Delivery System - NCBI Bookshelf (nih.gov)

and other industry competitors such as outpatient clinics or hospital-owned home health agencies.[23] Market share development requires an analysis of the valuation and structure of the hospital. This process delineates who controls the hospital and the ability to make financial decisions that directly affect the bottom line of the organization. An SNH may have one of several structures: foundation structure (the foundation is created and controls the organization), foundation holding company (board and foundation elect their boards, administrators, and executives and Provider structure (separates entities into different categories for providing HC, leasing, hospitality, etc.). The ability of an SNH to take on a corporate structure allows clear delineation of patient care and non-patient care services and improves hospital efficiency in all departments. The inability to recognize the need for increased market share and corporate structure may produce the following:

- Poor debt management
- Reduction of finances for purchasing (e.g., medical equipment, physical facility upgrades/repairs, clinical growth, physician employment)
- Inability to attract investors
- Increased liability with insufficient diversification of assets thus higher financial exposure for the network (lack of separate balance sheets for subsidiaries)
- Loss of tax-exempt status and $50,000 fine due to inability to fulfill the 501(c)3 requirement of the IRS pursuant to ACA §501(r) 2014 requirement for organizations to conduct community health needs assessment (CHNA) once every 3 years and adopt an implementation strategy to address the community health needs.

As a result of a hospital's ability to perform its duty to provide services for underserved low-income poor patients, an Illinois Hospital became the first not-for-profit hospital to be denied property tax exemption due to aggressive attempts to collect money from the poor and uninsured patients leading to a cost of 1 million dollars per year. *Provena Covenant Med. Ctr. v. Dept. of Revenue, 925 N.E.2d 1131, 236 Ill. 2d 368, 339 Ill. Dec. 10 (Ill. Mar. 18, 2010).*[24]

These statutory requirements delineate how insufficient care and the inability to address the community needs can lead to failure to increase appropriate market share and maintain the hospital's mission and vision. The effects may lead to adverse clinical, community, and generational financial effects within the community and inadequate delivery of health care at SNHs in urban and low-income poor communities. A statistical study performed by the Healthcare Cost Utilization Project/Agency for Healthcare Research and Quality (AHRQ) in 2014, which evaluated data on greater than 30 million US citizens in 40 states at SNHs (10 million) and non-SNHs (20 million), determined that the percent and ages of treatment were as follows: 2 1%/0 – 17, 28%/18-44, 24%/45-64 and 21%/ 65-84 respectively, with the treatment of greater than 50% of females in a large metropolitan area (39%/3.9 million), with 41% of the SNH population residing in the lowest income per zip code, versus 13% within the highest income quartile, inpatient hospital stays with a payor mix of 26% Medicare, 50% Medicaid, 25% Private and 45% uninsured. This data also demonstrated that the most common reasons for inpatient hospital admissions were mental health, maternal and neonatal care, skin, and DM management with sepsis the most common diagnosis

[23] Valuation of Hospitals and Medical Centers, January 1, 1989 by James J. Unland
[24] Provena Covenant Med. Ctr. v. Dep't of Revenue, 236 Ill. 2d 368

for admission at SNHs (3.9%) and surgical procedures such as knee arthroplasty accounting for 1.2% of admissions versus 2.5% in the non-SNH evaluation of the 40 states.[25]

The evaluation and management of patients at SNHs require an understanding of the mission, vision, and corporate structure of the organization in accordance with the community needs which can guide decisions to increase market share and develop service lines such as wound care, burn unit/trauma, cardiac, maternal/neonatal care, DM center of excellence, orthopedics, ICU management of patients with sepsis, outpatient clinical and social support services within the community. These patients will present to the ER and require advanced management and treatment thus, qualified medical personnel, staff, equipment, and support services can be developed as market share increases which will directly impact compliance with EMTALA and improve the financial status of the hospital. It has been shown that SNHs provided inpatient care for 33% (greater than 10 million individuals) of Medicaid patients despite comprising only 25% of all hospitals evaluated in the 40 states per AHRQ. Id. at 25. This large volume of inpatient care creates significant growth and increased reimbursements with the current DSH index payment increases for healthcare management of uncompensated, low-income, Medicaid, and uncompensated patients.

The final issue regarding market share may occur with mergers of healthcare organizations and the ability to survive and provide safe and effective care for the community without violation of Section 7 of the Clayton Act. The Clayton Act (Antitrust Act 1914)[26] maintains economic equality and prevents monopolies from developing and eliminating business competition. In December 2020, The Third court of appeals evaluated the merger of two large hospitals designated as a non-for-profit and an SNH with a combined inpatient census of greater than 3000 beds and determined "there was no violation of the Clayton Act because a hospitals market share is dependent on its ability to be included in an insurers network and ability to attract insurers from health care plans thus the insurer, not the patient would be financially responsible for the increased price of care which is considered a commercial reality in the Government's markets"[27] thus, as market share increases there would not be any lessening of competition or price increases to the consumer resulting in an increase in patient census, access to advanced care, financial viability with community investments and compliance with EMTALA.

A. SNH OPERATIONS EFFECTS OF NON-COMPLIANCE WITH EMTALA

SNHs also require appropriate operations to remain compliant with the EMATALA Statute. Hospital operations require an in-depth evaluation of the governing body, senior executives, clinical and non-clinical directors, nursing staff, labor relations, medical staff, medical services offered, and how these entities relate to the mission and vision of the hospital and maintain compliance with EMTALA. This process ultimately determines the quality of care delivered at the hospital beginning with its reputation in the community, evaluation in the ER, inpatient treatment, discharge planning, and outpatient follow-up. It requires all employees including the governing body and executive team to make the operations effective, safe, and reproducible. When selecting hospital board members there should be no evidence of conflicts of interest and a balance

[25] https://hcup-us.ahrq.gov/reports/statbriefs/sb213-Safety-Net-Hospitals-2014.jsp
[26] 63 P.L. 212, 38 Stat. 730, 63 Cong. Ch. 323
[27] FTC v. Thomas Jefferson Univ., 505 F. Supp. 3d 522

of diverse professionals. The board should act with obedience, due care, and loyalty, and make appropriate decisions regarding regulatory and financial affairs.[28] The Sarbanes-Oxley Act (Corporate Oversight and Criminal Act 2002)[29] requires public hospitals to have most of the board be independent members, create ethics policies, conduct training on financial responsibilities, and improve fraud detection to create a more effective board with accountability delineated by law to maintain licensure.[30] As a result, Medicare has several responsibilities for the board: Appoint a CEO, provide appropriate healthcare, approve medical staff credentialing and by-laws, develop and approve the organizational budget and operational plan, oversight of vendor and healthcare contracts and provide effective emergency service.[31] Organizations such as The Joint Commission (TJC) have quasi-government authority allowing them to waive the Medicare Conditions of Participation status and provide a "deemed status" to hospitals providing the board maintains and oversees safety and quality, maintains governance responsibility, ensures resources and medical staff involvement and collaboration at the hospital.[32] The selection of board members and the executive team requires a clear delineation of responsibilities and board development, and succession plans with ongoing evaluations by third-party organizations such as the National Quality Forum (NQF) which evaluates the quality, patient safety, and performance of the board and CEO. One of the most significant responsibilities of the board is maintaining the hospital licensure which requires the governing body to provide a public purpose and effectively manage ill and injured patients. Hospital boards are now faced with a "NEW GOVERNANCE LICENSURE MODEL"[33] which is based on a hybrid of concepts such as management and responsive-based regulations that focus on planning with regulated entities and application of a hierarchy self-regulatory framework due to the failure of regulating entity and negotiated obligations encompassing market share, institutional size, and financial status of the hospital which clarifies the board expectations and responsibilities. The requirement of a hybrid model for regulatory compliance with a self-regulatory assessment to maintain quality and safety benchmarks with appropriate evaluation of board members and CEO assures a check and balance producing public safety and effective healthcare that is driven by charitable purposes thus, ensuring adequate selection and termination of hospital officers, board members and executives that are not compliant with the mission and vision of the organization or the EMTALA which would lead to loss of licensure and financial ruin for the hospital and community.

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[28] Dan Culica & Elizabeth Prezio, Hospital Board Infrastructure, and Functions: The Role of Governance in Financial Performance, 6 INT'L J. ENVTL. RES. & PUB. HEALTH 862 (2009). A dispute over board malfeasance occurred recently at Tri-City Hospital in San Diego, where a hospital board dismissed a CEO and eight executives, calling into question the feasibility of the institution's governance structure. See Rebecca Vesely, A Storm in Southern California, MODERN HEALTHCARE, June 8, 2009, at 18.

[29] Sarbanes-Oxley Act of 2002, Pub. L. No. 107-204, §§301-08, 116 Stat. 745, 775-85 (2002)
90 N.C.L. Rev. 1845

[30] Journal Legal Medicine, 31: 35-57

[31] 42 USCS § 1865

[32] Conditions of Participation for Hospitals, 42 C.F.R. § 482 (2009); THE JOINT COMMISSION, ACCREDITATION PROGRAM: HOSPITAL, CHAPTER: LEADERSHIP § LD.01.05.01 (2009)

[33] David M. Trubek & Louise G. Trubek, Narrowing the Gap? Law and New Approaches to Governance in the European Union: New Governance and Legal Regulation: Complementarity Rivalry and Transformation, 13 COLUM. J. EUR. L. 539 (2007

B. Regulatory Compliance issues associated with non-compliance with the EMTALA ACT

Regulatory compliance is defined as a set of rules that an organization must adhere to meet business goals, legal requirements, applicable laws (state/federal, international), guidelines, and government regulations thus allowing the organization to market to customers with transparency and safety or face possible civil monetary penalties by the OIG for non-compliance.[34] Violations of the EMTALA ACT may lead to fines of up to $50,000 per violation and possible termination of the hospital and physician per §1867 of the ACT (defined at 42 CFR 489.24 (b) revised with the Final Rule including individuals requesting medical screening at a hospitals' dedicated emergency room specifically equipped and staffed for the treatment and evaluation of at least one-third of all its' outpatients including labor and delivery and psychiatric services for emergent conditions located on the main hospital campus or within 250 yards of hospital property.[35]

Compliance with the ACT requires three elements: Medical Screening, Treatment/Stabilization, and Transfer/Discharge. Upon arrival in the hospital's emergency room, the patient receives medical treatment and evaluation with the development of a differential diagnosis to determine and manage the most likely ailment leading to a final diagnosis.[36] This process should lead to effective evidence-based treatment and stabilization of the patient. The issue concerning stabilization and compliance with the ACT extends to the inpatient unit for unstable patients pursuant to FY 2003 IPPS proposed rule[37] with the 2003 EMTALA final rule[38] defined as the hospital's requirement to provide stabilizing treatments to admitted patients in good faith and not to any patient who is admitted per EMTALA and remained unstable. The Act also provides a private right of action for individuals who received direct harm pursuant to §1867(d)(2) of the Act., *Bryan v. Rectors.*[39] EMTALA requires hospitals to post signs in the emergency dept., describe individual's rights, maintain patient records, on-call physician call schedule, document inappropriate transfers, and ER logs pursuant to §§489.20 (l)(m), (q), (r)(1), (r)(2) and (r)(3) in addition to the restriction of transfers until stabilization, requirements for accepting hospitals, consultation with Quality Improvement Organizations and possible termination of provider agreement for failure to comply, §489.24. The request for prior authorization requirements from managed care plans to delay screening or stabilization is prohibited pursuant to §1867(h) and §489.24(c)(3).

Patients who present to the outpatient clinic and have an emergent medical condition will be transferred to the ER but would not be protected under the Act thus receiving protection under the Medicare hospital CoPs (conditions of participation) and State law. Id. at 39. The continuum of care from the ER to the inpatient unit is a dynamic process requiring competent evaluation and management upon presentation of the patient to the ER but also appropriate stabilization upon

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[34] What Is Compliance?: Legal & Business Definitions & Noncompliance (legalbeagle.com)
[35]42 CFR 413.6
[36] Differential Diagnosis: Definition and Examples (clevelandclinic.org)
[37] Federal Register: Medicare Program; Emergency Medical Treatment and Labor Act (EMTALA): Applicability to Hospital Inpatients and Hospitals With Specialized Capabilities
[38] Federal Register: Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions
[39] 95 F.3d 349 * | 1996 U.S. App. LEXIS 24139

transfer to the medical floor with subsequent treatment and discharge or transfer. *Roberts* v. *Galen of Virginia*, 525 U.S. 249 (1999).[40] The evaluation of patients requires policies and procedures consistent with regulatory requirements and national benchmarks. This process begins with the initial evaluation of the patient but extends well beyond the admission process thus requiring guidance and voluntary development of a compliance program developed by the OIG DHHS principles to prevent fraud, waste, and abuse, and improve healthcare by promoting adherence to State and Federal Law with use of templates to meet the following OIG Federal Sentencing Guidelines.[41]

- Code of conduct with written policies
    - Delineate organizations missions and strategic goals
    - Standards of conduct and ethical behavior for all employees/vendors/senior management/governing body/physicians
    - Commitment to compliance by governing body/CEO[42]
    - Emphasis on compliance with State and Federal laws to prevent fraud and abuse
    - Distribute standards in an employee handbook that is comprehensive and written at appropriate reading levels and translated in multiple languages with updates annually and as needed for applicable Federal healthcare statutes
    - Identify risks for regulatory exposure/risk for each dept.

- Compliance officer with independent oversight[43]
    - Designation of compliance officer with direct reporting to CEO/Board
    - Develop multidisciplinary compliance committee to obtain opinions from HR, UR, SW, finance, operations, and legal counsel
    - Implement/monitor/oversee and audit compliance with appropriate funding and staff to complete task
    - Quarterly and as needed reporting to CEO/Governing body on quality, efficiency, and effectiveness of compliance program to prevent fraud, abuse, and waste
    - Educating staff, independent contractors, and vendors of Federal and State standards for compliance program

[40] 525 U.S. 249 * | 119 S. Ct. 685 ** | 142 L. Ed. 2d 648 *** | 1999 U.S. LEXIS 508 *

[41] Compliance Program Guidance for Hospitals (hhs.gov)

[42] Indeed, recent case law suggests that the failure of a corporate Director to attempt in good faith to institute a compliance program in certain situations may be a breach of a Director's fiduciary obligations. See, e.g., In re Caremark International Inc. Derivative Litigation, 698 A.2d 959 (Ct. Chanc. Del. 1996).

[43] The OIG believes that there is some risk to establishing an independent compliance function if that function is subordinate to the hospital's general counsel, comptroller or similar hospital financial officer. Free-standing compliance functions help to ensure independent and objective legal reviews and financial analyses of the institution's compliance efforts and activities. By separating the compliance function from the key management positions of general counsel or chief hospital financial officer (where the size and structure of the hospital make this a feasible option), a system of checks and balances is established to achieve the goals of the compliance program more effectively

- Coordinating with the HR team to monitor National Data Bank and Cumulative Sanction Report[44] to verify all physicians, staff, and vendors are employable
  - Ability to review all relevant documents related to compliance such as patient records, billing, marketing, and independent contractors, and seek legal advice where appropriate
  - Establish a compliance committee to assist the CCO with the development and assessment of policies, legal requirements, internal systems, and controls to adhere to the organization's policies, assist with the incorporation of compliance as part of the operating structure

- Education and Training
  - Mandatory continuous training of all staff/vendors annually with documentation by compliance committee/officer
  - Ethics training with an emphasis on the organization's commitment to compliance
  - Submitting claims for physicians and non-physicians
  - Alterations in the medical records
  - Duty to report misconduct or violation of the code of conduct
  - Minimal number of educational hours/training for employment responsibilities (e.g., billing/coding, medical records)
  - Failure to participate in training may lead to termination of employment

- Appropriate lines of communication with a hotline for anonymous reporting
  - Independent open lines of communication to CCO to prevent the diversion of information
  - Encourage communication with written confidentiality and non-retaliation policies
  - Policy for submission of questions/complaints for clarity of policies
  - Conspicuous posting of a Hotline for anonymous disclosure of possible misconduct with a readily available number for all employees/contractors in common workplaces documented, logged and presented to the governing body by CCO

- Monitoring and auditing
  - Ongoing monitoring of compliance reports with regular reporting to the governing body and senior executives
  - Internal and external auditors with subject matter expertise regarding Federal and State healthcare statutes, programs, and requirements focusing on EMTALA, AKS (anti-kickback statute), FCA (false claims act), Stark

[44] The Cumulative Sanction Report is an OIG-produced report available on the Internet at http://www.dhhs.gov/progorg/oig. It is updated on a regular basis to reflect the status of healthcare providers who have been excluded from participation in Medicare and Medicaid programs. In addition, the General Services Administration maintains a monthly listing of debarred contractors on the Internet at http://www.arnet.gov/epls. Also, once the database established by the Health Care Fraud and Abuse Data Collection Act of 1996 is fully operational, the hospital should regularly request information from this databank as part of its employee screening process

Law (physician self-referral), CPT coding, marketing, cost reporting, and OIG Special Fraud Alerts
    - Use of sampling protocols to focus on previously identified specific areas of concern for the institution
    - Annual compliance reports confirming training, education, compliance with standards, and disciplinary action taken with corrective action plans

- Enforcement and remediation policies and procedures
    - Immediate investigation of non-compliance by CCO
    - Case-by-case analysis of non-compliance with a possible referral for criminal or civil law enforcement[45] or development of a corrective action plan with legal counsel[46]
    - Review of documents and interviews of individuals alleged to commit fraud/misconduct or violation of the code of conduct
    - Use of consistent disciplinary protocols and practices imposed per hospital written standards/policies for disciplinary actions
    - Maintain and prevent the destruction of all records relevant to the investigation
    - Confirmed misconduct should be reported to government authorities in 60 days[47] including Federal and State officials[48]

- Publicized Disciplinary Guidelines
    - Written policies detailing degrees of procedures of disciplinary action for all employees, governing body, and corporate executives and who will be responsible for taking action
    - Fair and equitable disciplinary action with consistent enforcement
    - Prominently Post the HHS OIG Hotline telephone number 1-800-HHS-TIPS (447-8477) with the organization's hotline number
    - Obtain background checks with references for employees who have discretionary authority. Id. at 44, 42 U.S.C. 1320a–7b(f))

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[45] 53 Instances of non-compliance must be determined on a case-by-case basis. The existence, or amount, of a monetary loss to a health care program is not solely determinative of whether or not the conduct should be investigated and reported to governmental authorities. In fact, there may be instances where there is no monetary loss at all, but corrective action and reporting are still necessary to protect the integrity of the applicable program and its beneficiaries.

[46] 54 Advice from the hospital's in-house counsel or an outside law firm may be sought to determine the extent of the hospital's liability and to plan the appropriate course of action.

[47] To qualify for the "not less than double damages" provision of the False Claims Act, the report must be provided to the Government within thirty (30) days after the date when the hospital first obtained the information. 31 U.S.C. 3729(a)

[48] Appropriate Federal and State authorities include the Criminal and Civil Divisions of the Department of Justice, the U.S. Attorney in the hospital's district, and the investigative arms for the agencies administering the affected Federal or State health care programs, such as the State Medicaid Fraud Control Unit, the Defense Criminal Investigative Service, and the Offices of Inspector General of the Department of Health and Human Services, the Department of Veterans Affairs and the Office of Personnel Management (which administers the Federal Employee Health Benefits Program).

Implementation of the OIG Federal Sentencing Guidelines for the development, management, and monitoring of a compliance program may lead to the governing body, senior management, employee, and vendor compliance with the EMTALA Act. The guidelines delineate appropriate steps with written codes of conduct, ethical behavior, policies, procedures, and disciplinary action needed to maintain efficient evaluation of patients from the ER, within 250 yards of the main hospital, and expectations upon admission and discharge from the hospital which are components of the Act. Id. at 40.

Hospitals face significant financial fines with possible exclusion from the Medicare/Medicaid Federal Healthcare Program if found in violation of the EMTALA Act. Id. at 18. A recent article published in 2021, in the *Journal of Health Risk Management* evaluated the most common reasons for non-compliance with the Act in non-for-profit hospitals within CMS region 4 (Georgia, Kentucky, North Carolina, South Carolina, and Tennessee) which has the highest number of EMTALA violations complaints approximately 41% nationally. Thus, finding that financial reimbursement, knowledge, the complexity of the Act, referral obligation at accepting hospitals, internal hospital relationships, hospital, and physician priorities/expectations[49] were the most identified issues leading to violation of the Act. The study determined that insufficient knowledge of the Act regarding indications for transfer and work-up and obligations to provide psychiatric care by staff, concerns regarding low reimbursement of Medicaid and uninsured patients compared to Medicare and commercially insured patients (-54%/-35% v. -15.6%/39.6%, respectively),[50] costly financial referral burden of recipient hospital to pay subspecialists to be available/on-call to accept and manage transfers thus leading to uninsured/indigent patients waiting long periods for transfer, inappropriate transfers, and uncertainty regarding enforcement of the Act upon hospital admission all leading to doubts regarding patient care. The 2009 case regarding *Moses v. Providence Hospital and Medical Center* decision made by the Sixth Circuit found that EMTALA requirements extend to inpatient admission.[51] This decision delineates the importance of understanding the elements of the Act and maintaining compliance with the use of the OIG Federal Sentencing Guidelines for Compliance as a template to maintain education, training, and accountability of all staff and performing internal and external audits of patients who transferred out of the facility to demonstrate compliance with the Act thus validating the need for Federal financial support to manage Medicaid and uninsured patients pursuant to the new definition CMS DSH funding and per Section 3133 of the ACA thus establishing §1886(r) including uncompensated care. Id. at 9. Compliance with the Act may also occur with the following. Id. at 49:

- aligning MA/MC payments with EMTALA due to the Act being a CoP for MC/MA payments thus possibly eliminating financial losses due to underpayment of services
- allow informal discussions regarding inappropriate transfers/denials with hospitals to provide education regarding EMTALA and prevent filing complaints of violation of the Act

[49] J Healthc Risk Manag. Author manuscript; available in PMC 2021 Aug 5. *Published in final edited form as:* J Healthc Risk Manag. 2018 Jan; 37(3): 31–41. Published online 2017 Nov 8. doi: 10.1002/jhrm.21288

[50] Wilson M, Cutler D. Emergency Department Profits Are Likely to Continue Asco the Affordable Care Act Expands Coverage. *Health affairs (Project Hope)*. 2014;33(5):792–799

[51] 45. *Moses v. Providence Hospital and Medical Centers, Inc., 561 F.3d 573 (6th Cir. 2009)*

- implement hospital EMTALA Training and disseminate to all staff/vendors and emphasize that physicians are subject to fines and exclusion for violations of the Act
- encourage hospital associations to survey and educate key hospital decision-makers regarding best practices for improving and maintaining compliance of all healthcare facilities in the network

EMTALA violations led to fines of over $6 million dollars between 2002 and 2015 despite confirmation of violations occurring in only 3% of cases.[52] Non-compliance and lack of education with the EMTALA Act can lead to financial ruin for a healthcare facility. In 1998, a hospital in Illinois refused to admit a 15-year-old patient who suffered a gunshot wound less than a block away from the hospital. Thus, staff refused to retrieve the patient and he was eventually brought into the hospital by correctional officers but expired.[53] As a result, the EMTALA Act was expanded to include the 250-yard rule. Id. at 35. The hospital settled the EMTALA violation for $12.5 million dollars[54] greater than 20 years after the violation. The use of the OIG Federal Sentencing Guidelines with a designation of a CCO to develop a code of conduct/ethics, educate, evaluate, monitor, and enforce regulatory changes in the law may mitigate long-term federal and civil monetary penalties and lead to the treatment of a vulnerable and uninsured population and compliance with the Act.

IV. FINANCIAL EFFECTS OF SNH COMPLIANCE WITH THE EMTALA ACT

The ability of an SNH to maintain financial solvency is dependent on its ability to maintain a stable market share with visibility in the community, operational efficiency, quality of care, continuous capital for payroll, financial investments, long-term growth, and a continuously growing patient census to achieve the mission and vision for the organization. This endeavor must occur to maintain compliance with the EMTALA Act despite changes in the political landscape, federal funding, and competition.

SNHs are faced with limited means of generating revenue except by private insurers, the federal government (MA/MC), and self-pay patients. Statutory compliance with the EMTALA Act shall produce an increase in inpatient volumes and federal support in addition to the PPACA 2010[55] which increased financial support to states that participated in the expansion of Medicaid coverage. Hospitals that participated in the PPACA 2010 received significant financial increases in 2014: Grady Memorial Hospital in Atlanta, documented profits increased to nearly $30 million through November 2014, up from $17 million for the same period in 2013, Florida-based Broward Health, which recorded $69 million in profit in fiscal year 2014 and Orlando Florida Health, saw its profit grow to $161 million in the fiscal year ended in September 2014, up from $32 million the year prior.[56] The ability to capture market share and increase census via compliance with EMTALA allows citizens to obtain financial coverage via the PPACA and provide finances to struggling

[52] EMTALA: The ED law that could cost you and how to avoid it (advisory.com)
[53] 140 F. Supp. 2d 944 * | 2001 U.S. Dist. LEXIS 8584
[54] Hospital settles EMTALA violation for $12.5 million | 2003-07-01 |… (reliasmedia.com)
[55] https://www.dpc.senate.gov/healthreformbill/healthbill52.pdf
[56] https://www.beckershospitalreview.com/finance/safety-net-hospitals-experience-financial-success-due-to-economy.html

hospitals to fiscally manage the burden of compliance with the Act. The results of the PPACA allow greater access to healthcare, evaluation, admission, stabilization, and financial coverage of the patient to maintain compliance with the EMTALA Act. This process allows the capture of a higher volume (higher daily hospital and ER census) of uninsured and low-income patients with increased use of hospital service lines and higher statutory DSH payments with the creation of financially attractive, diverse streams of revenue for continued growth and investment.

The financial sustainability of SNHs may require the issuance of Municipal Bonds to create immediate cash flow, community investment with stakeholders, and government/local support thus leading to improvement in healthcare services and generational wealth for bond investors due to a 15–30-year average bond maturation and possible re-investment.

Bonds are a type of tax-exempt interest-collecting security sold by organizations such as corporations, hospitals, and governments to raise capital and are considered less risky than stocks.[57] A bond is a fixed-income unit that pays a fixed interest rate referred to as a coupon with dates of maturity delineating when the principal amount is paid in full. The minimal cost of the Bond may vary from $1000 – $5000.00, with interest payments paid in a semiannual time frame determined by the MSRB Rule G-33.[58] Bonds are obtained usually because organizations such as hospitals require more capital than banks are willing to lend thus, the ability of the hospital to sell the bond to investors is contingent upon its overall evaluation regarding its short and long-term goals/plans (strategic plans), service lines, revenue, debt management, investor opinions, market share, and reputation. The evaluation of the hospital/organization occurs via the Prospectus.[59] The Prospectus details the Bond Offering, the financial health of the hospital/organization, and how the funds shall be used for projects such as ER, Staff, Surgical Suite, Cardiac, Endoscopic Suite, Hyperbaric Clinic, Wound Care, Skilled Nursing Facility, and Substance Abuse Units. In 2020 nearly half a trillion dollars in municipal bonds were issued with proceeds used for ESG (environmental social governance) factors such as Education (29%), Healthcare 6.5%, Development (2.9%), General Purposes (28%), Housing (4.6%), Public Facilities (1.8%).[60] In a study published in 2019 by Fitch Ratings, it determined that the use of these principles may lead to the designation of the bond as a green or social designation with ESG factors and allow the issuer to obtain a lower rate for the offering of the bond[61] (cheaper for the hospital to sale the bond offer to the underwriter). The Fitch Rating demonstrated that the use of ESG had a 5% impact on credit ratings for public and infrastructure financing. Id. at 56. The use of these principles may lead to investors purchasing the bonds and capital investments in the SNH to maintain quality care, and environmentally safe and efficient hospitals while maintaining compliance with the Act. Municipal Bonds may also be issued by local and state governments to finance capital expenditures such as investments in hospitals and community projects.[62] The bonds (debt securities) are purchased by the federal government pursuant to the Municipal Liquidity Facility (MLF).[63] As a result of the COVID-19 Pandemic in April 2020, the federal reserve purchased $500 billion in

[57] https://www.msrb.org/sites/default/files/How-Are-Municipal-Bonds-Quoted-and-Priced.pdf
[58] http://www.msrb.org/Rules-and-Interpretations/MSRB-Rules/General/Rule-G-33.aspx
[59] https://financial-dictionary.thefreedictionary.com/prospectus
[60] Refinitiv 2021
[61] https://www.fitchratings.com/research/us-public-finance/introducing-esg-relevance-scores-for-public-finance-infrastructure-16-05-2019
[62] https://www.investopedia.com/terms/m/municipal-note.asp
[63]. https://www.investopedia.com/municipal-liquidity-facility

debt/bonds from states/local governments that had severe declines in revenue and spending,[64] [65] thus allowing hospitals to make investments in facilities, staffing, equipment, etc. The result of the federal government investment in the bond securities market in 2020 allowed the State of Illinois to borrow $2 billion from the Federal Reserve's MLF to provide short-term relief and allocation of funds to pay down Medicaid outstanding bills and leverage 1.1 billion in federal matching revenue.[66] The ability of local governments to obtain funding by the issuance of bonds allows the development of the state's infrastructure with improvement in hospitals, clinics, access to care, and Medicaid payment to SNHs which provide medical care to the uninsured and uncompensated patients who will be managed in the ER per EMTALA. Hospitals require revenue to reach strategic goals thus the use of interest-earning Municipal Bonds may provide appropriate financing as demonstrated by the University of Wisconsin Hospitals and Clinics Authority Prospectus[67] with the issuance of Bond series from 1997, 2002, and 2013 which led to the following:

- Net assets increased from $392,792,000 to $774,795,000
- Hospital bed size increase from 476 to 566 licensed beds
- Bond redemption restructuring with reduction of long-term debt
- Greater allocation of initial Bond Series 2013 bond revenue for the payment of previous bonds 1997, 2000, and 2013 Series Bonds
- Offering lower Bond Denominations of $5,000.00 for Series 2013 and higher yield for investors at maturity
- Increased income available for debt coverage in case of default comparison: 2002-$48,909,000, 2013- $174,343,000
- Increased Medicare/Medicare Managed Care, Medicaid/Medicaid Managed Care, and Commercial insurance from 2002 to 2013: 32% (2% increase), Medicaid 9.9% (2.8% increase), Commercial Managed Care 44% (NC)

The issuance of Bonds by SNHs to generate large sustainable sums of capital over many years may be the only way to provide long-term capital with stakeholders from the state and local government while offering affordable Bond denominations for individuals who reside in the community.[68] This process of creating stakeholder involvement at the community level may produce greater fiscal accountability with the development of specific healthcare service lines that are needed in the community thus fulfilling the intent of the EMTALA Act while increasing revenue and patient volumes.

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[64] Section 13(3) of the Federal Reserve Act (12 U.S.C. 343). (The Fed's ability to purchase municipal debt under its normal authority is far more limited.) Under this authority, actions must be temporary and approved by the Treasury Secretary. The interest rate must be higher than normal market rates. Actions also must provide security (e.g., collateral) that is sufficient to protect the taxpayer and be based on sound risk management practices to absorb potential losses.

[65] https://crsreports.congress.gov/product/pdf/IF/IF11621

[66]https://www.fitchratings.com/research/us-public-finance/illinois-mlf-borrowing-reflects-deep-challenges-options-remain-22-12-2020

[67] Michael Best & Freidrich LLP, Madison Wisconsin, Bond Counsel.

[68] Municipal Bonds and Nonprofit Hospitals on October 26, 2017; In Action, Healthcare, Home, Hospitals, Minnesota Nurses Association

V. SUMMARY

The EMTALA Statute (anti-dumping statute), 42 USC 1395dd was enacted in 1986 with the intent to prevent uninsured and uncompensated poor patients from being dumped from the hospital due to no insurance coverage or inability to pay for medical care. This has led to financial difficulties for healthcare organizations with the subsequent closure of the hospital.[69] The Act is an unfunded mandate to perform medical services for 45 – 50 million Americans who may have no insurance without guaranteed reimbursement and require up-to-date efficient services despite the costs.[70] This financial quagmire may result in hospitals performing illegal acts such as double billing, up-coding, or overcharging vulnerable insured patients even though 84 million Americans who are insured by employers do not have adequate insurance and are at risk of bankruptcy.[71] The inability of hospitals and healthcare organizations to sustain capital despite statutorily mandated unfunded evaluations requires a highly intelligent, sophisticated, up-to-date, aggressive, and politically savvy team of executives to maintain financial solvency. The following factors are required to maintain compliance with EMTALA Act and maintain financial success and increase patient volume:

- Define the hospital's mission and vision with a clear definition of SNH according to CMS to obtain appropriate DSH funding for MA, MC, Uninsured and Uncompensated patients to assure adequate statutory reimbursements.
- Educate Staff and Define the EMTALA Act to assure that elements of the Act are adhered to and make conspicuous signs available to educate staff and patients regarding their rights under the Act and penalties for violations.
- Define the organization's Market Share and how appropriate analysis may lead to increased hospital census and growth upon compliance with the Act.
- Demonstrate how appropriate Operations with the use of concepts such as NEW GOVERNANCE LICENSURE MODEL[72] (a hybrid of concepts such as management and responsive-based regulations) to obtain an effective, competent governing body, executive team, and managers to maintain compliance with EMTALA.
- Appointment of CCO with independent oversight and development of policies and procedures per OIG Federal Sentencing Guidelines and direct reporting to the Governing Body and CEO to maintain compliance with EMTALA.
- Development of diverse financial models with the use of statutory funding per CMS-DSH, Tax-exempt interest earning Municipal Bonds, Service lines, and market share to encourage community, local government, and investors (private individuals/banks) to become stakeholders in the strategic planning of the organization and maintaining compliance with the Act while increasing patient volumes and revenue.

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[69] Is EMTALA That Bad? | Journal of Ethics | American Medical Association (ama-assn.org)
[70] Funding the Unfunded Mandate - American Thinker
[71] Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2012 Sara R. Collins, Ruth Robertson, Tracy Garber, and Michelle M. Doty APRIL 2013
[72] David M. Trubek & Louise G. Trubek, Narrowing the Gap? Law and New Approaches to Governance in the European Union: New Governance and Legal Regulation: Complementarity Rivalry and Transformation, 13 COLUM. J. EUR. L. 539 (2007