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EMTALA & Psychiatric Patients

Alexander M. Martell*

I. Introduction

Before the mid-twentieth century, hospitals primarily served the poor and helpless.¹ However, as technology progressed and business models in the United States changed, hospitals faced increasing costs to providing care.² Reacting to this change, many hospitals altered their models so that only those who could afford care would receive care, until the passage of the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA).³ Congress specifically enacted EMTALA to prevent federally participating hospitals from this practice of “patient dumping.”⁴ EMTALA was created to protect the most vulnerable populations from being turned away from medical treatment.⁵

EMTALA is overseen by the Centers for Medicare & Medicaid Services (CMS) and requires reporting from the federally participating hospitals.⁶ Any false reports to CMS result in a fraud to the system; a failure to properly treat, screen, or transfer a patient is an abuse of the system. In an effort to prevent these problems in hospital emergency departments (EDs), Congress imposed a penalty of up to a \$50,000 for each EMTALA violation as well as the potential for a permanent ban from Medicare and Medicaid.⁷ However, statutory ambiguity has led to conflicting jurisprudence, reducing the government’s ability to consistently enforce EMTALA. Some courts

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¹Alexa E. Welzien, *Balancing EMTALA's Duty to Stabilize Hospital Inpatients and CMS's Regulations in the Midst of A Struggling Hospital Industry*, 23 HEALTH LAW 21 (2011).

²*Id.*

³*Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1039 (D.C. Cir. 1991) (stating that EMTALA passed amid growing reports of denying emergency health care services to poor and uninsured individuals).

⁴42 U.S.C. §1395dd (2012).

⁵*Id.*

⁶*Id.*

⁷*Id.* Permanent bans from Medicare and Medicaid mean that the hospital will no longer be eligible for reimbursement for services provided to a Medicare or Medicaid recipient. It would create a situation where only private insurance would be accepted at the hospital. A permanent ban from federal health programs can have devastating financial consequences for a hospital.

have set improper precedent by allowing the problems EMTALA was designed to prevent to occur without finding a violation. This article will address how EMTALA has been misapplied by the courts and the resulting departure in enforcement from the initial congressional intent.

This article urges an interpretation of EMTALA that is consistent with the original congressional intent: to protect the most vulnerable patients. In furtherance of this claim, this article will examine the applicability of EMTALA to psychiatric patients, the difficulty in assessing those cases, and the few violations that have ended in settlements. Additionally, this article will argue that it is necessary to adopt a new standard regarding EMTALA psychiatric cases. The National Institute on Mental Health found, “there were an estimated 9.8 million adults aged 18 or older in the United States with SMI [severe mental illness] within the past year,” as of 2015.⁸ Since EMTALA passed in 1986, there have been eight reported settlements for violations involving psychiatric cases.⁹ Between 2002 and 2015, 192 cases were reported – only three settled.¹⁰ Since 2015, there have already been four reported EMTALA psychiatric settlements, one of which cost the hospital over one million dollars.¹¹

The growing number of psychiatric patients in the ED has been caused by several factors. One factor that is discussed by the Treatment Advocacy Center (Center), “a nonprofit organization dedicated to eliminating legal and other barriers to the timely and effective

⁸ *Serious Mental Illness (SMI) Among U.S. Adults*, NATIONAL INSTITUTE OF MENTAL HEALTH, <https://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml> (last visited Dec. 1, 2017).

⁹ Nadia Zuabi, Larry D. Weiss & Mark I. Langdorf, *Emergency Medical Treatment and Labor Act (EMTALA) 2002-15: Review of Office of Inspector General Patient Dumping Settlements* *Western Journal of Emergency Medicine* (2016), NAT'L INST. OF HEALTH, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4899053/> (last visited Dec. 1, 2017); Office of Inspector General, Department of Health and Human Services, *Civil Monetary Penalties and Affirmative Exclusions Civil Monetary Penalties and Affirmative Exclusions*, HHS, <https://oig.hhs.gov/fraud/enforcement/cmp/cmp-ae.asp> (last visited Dec. 1, 2017).

¹⁰ *Id.*

¹¹ Office of Inspector General, Department of Health and Human Services, *Civil Monetary Penalties and Affirmative Exclusions Civil Monetary Penalties and Affirmative Exclusions*, HHS, <https://oig.hhs.gov/fraud/enforcement/cmp/cmp-ae.asp> (last visited Dec. 1, 2017).

treatment of severe mental illness,” deals with the inefficiencies in EDs across the country.¹² According to the Center, “at least 70% of ER administrators held mentally ill patients for 24 hours or longer waiting for a bed.”¹³ These numbers are troubling and are exemplified by the large settlements that have occurred in recent years.¹⁴ The other major factor that the Center discusses is the current lack of psychiatric beds in hospitals.¹⁵ One shocking statistic published by the Center cites the massive decline in psychiatric beds, stating “the number of state hospital beds in the United States had plummeted almost 97% by 2016. Even when private hospitals are included, the number of psychiatric beds per 100,000 people in the United States ranks the nation 29th in the number of psychiatric beds per 100,000 people since 1955.”¹⁶ Psychiatric patients have been limited to EDs to seek treatment in recent years due to the shortages in adequate facilities.¹⁷ The use of EDs as primary care facilities for a growing number of psychiatric patients lends legitimacy and strength to the argument that hospitals should comply with the language of EMTALA as intended by the legislature.

This article will consider the trend of settlements alongside the trend of statutory interpretation. Violations of EMTALA constitute both fraud and abuse to the healthcare system. The recent increase of settlements suggests violations will continue. To better address these issues, the courts should require a clear standard for interpreting EMTALA cases involving psychiatric patients. This article argues that the best way to combat fraud and abuse affecting

¹² *Public Service Costs*, TREATMENT ADVOCACY CENTER, <http://www.treatmentadvocacycenter.org/key-issues/public-service-costs> (last visited Mar. 1, 2018).

¹³ *Id.*

¹⁴ *See generally* Office of Inspector General, Department of Health and Human Services, *Civil Monetary Penalties and Affirmative Exclusions Civil Monetary Penalties and Affirmative Exclusions*, HHS, <https://oig.hhs.gov/fraud/enforcement/cmp/cmp-ae.asp> (last visited Dec. 1, 2017).

¹⁵ *Psychiatric Bed Shortages*, TREATMENT ADVOCACY CENTER, <http://www.treatmentadvocacycenter.org/key-issues/bed-shortages> (last visited Mar. 1, 2018).

¹⁶ *Id.*

¹⁷ *Id.*

psychiatric patients is to adopt the reasoning applied by the Sixth Circuit. The reasoning and rule developed by the Sixth Circuit will help to quickly resolve cases and provide the healthcare system with a clear standard for treatment. Section II of this article conducts a plain language interpretation of the statute, as is required for courts to use when applying EMTALA. Section III of the article looks at the statutory interpretation and legislative intent of EMTALA, the second stage of analysis for courts if the plain language of the statute is unclear. Section IV considers the judicial interpretations of EMTALA and the recent settlements. Section V covers the conclusion of the article, a demand that courts apply the Sixth Circuit's interpretation of EMTALA to protect all patients, most importantly psychiatric patients.

II. Plain Language Interpretation Demands Stabilization to Satisfy the Act's Requirements

Subsection (b)(1) of EMTALA declares that when an individual arrives in the Emergency Department (ED) with an emergency medical condition, “the hospital must provide either-- within the staff and facilities available at the hospital, . . . treatment as may be required to stabilize the medical condition, *or* transfer of the individual to another medical facility in accordance with subsection (c) of this section.”¹⁸¹⁹ EMTALA generally limits the ability to transfer a patient unless that patient is deemed to be stabilized.²⁰ Subsection (c) provides guidance for the limited circumstances in which an unstable patient may be transferred, as well as explains the situations in which appropriate transfer of the patient exists.²¹ EMTALA defines “stabilized” to mean “that no material deterioration of the condition is likely, within reasonable

¹⁸ 42 U.S.C.A. § 1395dd(b)(1) (emphasis added).

¹⁹ Determining what qualifies as being an emergency medical condition will be discussed further in the following section of statutory interpretation, but for the purpose of this section, psychiatric conditions are considered emergency medical conditions.

²⁰ *See generally* 42 U.S.C.A. § 1395dd.

²¹ 42 U.S.C.A. § 1395dd(c).

medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).”²² Because of the difficulties of determining whether a “material deterioration” would occur with respect to psychiatric conditions, the Centers for Medicare & Medicaid Services (CMS) clarified, “[p]sychiatric patients are considered stable when they are protected and prevented from injuring or harming him/herself or others.”²³ With the definitions of stabilization established, we now turn to the appropriateness of transfers as explained by subsection (c).

Subsection (c)(1) outlines the limited situation in which an unstable patient may be transferred.²⁴ It should be noted that at no time does EMTALA allow for an unstable patient to be *discharged*.²⁵ The subsection provides for three situations when an unstable patient may be transferred to another hospital: (1) when the patient or their representative requests in writing to transfer to another hospital “after being informed of the hospital's obligations;” (2) when a physician signs a certification that “treatment at another medical facility outweighs the increased risks to the individual. . . from effecting the transfer;” or (3) when a qualified medical person (not a physician) signs a certification that “treatment at another medical facility outweighs the increased risk to the individual . . . from effecting the transfer” based on a consultation with a physician.²⁶ If any of the three conditions have been met, the appropriateness of the transfer must also be satisfied as enumerated in subsection (c)(2).

²² 42 U.S.C.A. § 1395dd(e).

²³ Centers for Medicare & Medicaid Services, Medicare State Operations Manual, Appendix V Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases, Revision 60, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_v_emerg.pdf, July 16, 2010.

²⁴ 42 U.S.C.A. § 1395dd(c).

²⁵ See generally 42 U.S.C.A. § 1395dd.

²⁶ 42 U.S.C.A. § 1395dd(c)(1).

“An appropriate transfer to a medical facility is a transfer in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child.”²⁷ In addition to the basic requirements that the receiving hospital have greater capabilities to treat the affected patient, EMTALA requires that the receiving hospital “has available space and qualified personnel for the treatment of the individual, and has agreed to accept transfer of the individual and to provide appropriate medical treatment.”²⁸ The text of the statute is clear: when a patient is unstable, they cannot be transferred unless certain criteria have been met, and it is never appropriate to discharge an unstable patient.²⁹ However, the courts and CMS have started to ignore the plain language of the statute as well as the clearly illustrated statutory intent outlined in Section III.³⁰

In 2012, CMS released its proposed rules regarding EMTALA.³¹ First, CMS claimed, “EMTALA requirements do not extend to stabilized inpatients even if they subsequently become unstable because those inpatients are protected by a number of Medicare conditions of participation (CoPs) as well as the hospital’s other legal, licensing, and professional obligations with respect to . . . treatment of its patients.”³² Alleging that an individual has other potential remedies to harms committed against him or her does not exempt a hospital from the statutory

²⁷ 42 U.S.C.A. § 1395dd(c)(2).

²⁸ *Id.*

²⁹ *See generally* 42 U.S.C. § 1395dd (2012).

³⁰ *See Bryan v. Rectors and Visitors of the Univ. of Virginia*, 95 F.3d 349, 350-2 (4th Cir. 1996); *see also Bryant v. Adventist Health Sys./West*, 289 F.3d 1162, 1168-70 (9th Cir. 2002) (concluding that a hospital’s obligations under EMTALA end at the time that a hospital admits an individual to the facility as an inpatient); *see also Medicare Program; Emergency Medical Treatment and Labor Act (EMTALA): Applicability to Hospital Inpatients and Hospitals With Specialized Capabilities*, 77 Fed. Reg. 5213, 5214 (proposed Feb. 2, 2012).

³¹ *Medicare Program; Emergency Medical Treatment and Labor Act (EMTALA): Applicability to Hospital Inpatients and Hospitals With Specialized Capabilities*, 77 Fed. Reg. 5213 (proposed Feb. 2, 2012).

³² *Id.* at 5214.

requirements imposed on them by EMTALA. The policy implications of these “justifications” would have a potentially catastrophic effect on future litigation as well as reducing the penalties statutorily imposed by the Act. EMTALA carries a penalty up to \$50,000 per violation.³³ CMS’s interpretation reduces the monies received by EMTALA-violating hospitals, for they essentially create avenues that allow a hospital to avoid EMTALA requirements simply due to the existence of options that could potentially help a victim collect funds for harms the patient endures. Instead, these penalties are payments to the government for the wrongs committed on society by the hospital and the provider. This loophole, created by CMS, justifies those wrongs. Moreover, in justifying the statutory non-compliance of EMTALA, this action hurts the victims’ ability to recover any damages through the other avenues that CMS proposed. This will be further explained in Section IV, which discusses the judicial responses to EMTALA violations. The action proposed by CMS is akin to the Consumer Financial Protection Bureau allowing banks to violate federal fraud laws because each individual harmed would have other avenues of recourse.

Further exacerbating the situation, CMS explained in its 2003 Rule, “[If] the hospital provides an appropriate medical screening examination and determines that an EMC [emergency medical condition] exists, and then admits the individual in good faith in order to stabilize the EMC, that hospital has satisfied its EMTALA obligation towards that patient.”³⁴ However, prior to instituting the 2003 Rule, CMS expressed the exact concerns that are being addressed now, namely that allowing admissions to end the EMTALA inquiry, “would provide an obvious means of circumventing [EMTALA] requirements that would seemingly contradict the point of

³³ 42 U.S.C. § 1395dd(d)(1)(A) (2012).

³⁴ Medicare Program; Emergency Medical Treatment and Labor Act (EMTALA): Applicability to Hospital Inpatients and Hospitals With Specialized Capabilities, 77 Fed. Reg. 5213, 5217 (proposed Feb. 2, 2012).

the statute to protect emergency patient health and safety.”³⁵ CMS went on to reject the Sixth Circuit’s conclusion that admission of a patient did not satisfy the stabilization requirement enumerated by the statute even though the admission and subsequent discharge led to the death of the patient’s wife.³⁶ This explanation has led to a majority of the problems with psychiatric patients. The stabilization prong is satisfied when psychiatric patients are admitted, but when patients are discharged before they are truly stabilized, both patients and third-parties may be harmed. As will be discussed further in the next section, the framers of EMTALA did not wish to create a law that would allow for hospitals to find loopholes for treating patients.

III. Statutory Interpretation

Congress passed EMTALA as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 in an effort to curb the increased reports of patient dumping throughout the nation.³⁷ In certain cases of patient dumping, patients are typically transferred to another hospital, usually public hospitals because they are legally required to treat all patients, without first being properly stabilized.³⁸ The House Committee on Ways and Means (HCWM) clearly stated the purpose and intent behind EMTALA: “The Committee is most concerned that medically unstable patients are not being treated appropriately. There have been reports of situations where treatment was simply not provided. In numerous other instances, patients in an unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital.”³⁹

³⁵ Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates, 67 Fed. Reg. 31404, 31475 (proposed May 9, 2002).

³⁶ *Id.*; see also *Moses v. Providence Hosp. and Med. Ctrs., Inc.*, 561 F.3d 573, 582-4 (6th Cir. 2009).

³⁷ See 42 U.S.C. § 291c(e); 42 C.F.R. § 53.111 (2018). (I think this may be miscited).

³⁸ *Id.* (Same issue as citation 37)

³⁹ H.R. REP. NO. 99-241, pt. 1, at 27 (1985).

With the creation and passage of EMTALA, Congress wanted “to provide a strong assurance that pressures for greater hospital efficiency [were] not to be construed as license to ignore traditional community responsibilities and loosen historic standards.”⁴⁰ The traditional responsibilities referenced were the hospital’s historic role of caring for underserved communities.⁴¹ The problems that faced EDs thirty years ago, at the time EMTALA was enacted, are the same problems the nation faces today, with ever-growing healthcare costs. As the HCWM said, “[i]n recent years there has been a growing concern about the provision of adequate emergency room services to individuals who seek care, particularly as to the indigent and uninsured.”⁴² Representative Stark, one of the sponsors of the Act, presented the issues facing EDs and declared the need for the passage of EMTALA “to prevent this kind of dumping of indigent patients.”⁴³ Violations to EMTALA amount to fraud and abuse of the healthcare system.

The language of the statute states that EMTALA applies to EDs within Medicare-participating hospitals.⁴⁴ EMTALA duties begin when anyone “comes to the [ED] and a request is made on the individual's behalf for examination or treatment for a medical condition.”⁴⁵ There is no requirement that the individual appearing in the ED be a participant of either Medicare or Medicaid, though the statute is specific to Medicare-participating hospitals.⁴⁶

After an individual requests treatment, “the hospital must provide for an appropriate medical screening examination” in an effort to determine the presence of an “emergency medical

⁴⁰ *Id.*

⁴¹ See Welzien, *supra* note 1, at 21-2.

⁴² H.R. REP. NO. 99-241, pt. 1, at 5 (1985).

⁴³ 131 CONG. REC. E55, 221 (daily ed. Dec. 10, 1985) (statement of Rep. Stark).

⁴⁴ 42 U.S.C. § 1395dd(a).

⁴⁵ *Id.*

⁴⁶ *Id.*

condition [EMC].”⁴⁷ This section of EMTALA is the root of most EMTALA interpretation issues because while EMTALA defines an “emergency medical condition,” it fails to outline what an “appropriate medical screening” would consist of, instead relying on the opinions of medical personnel to determine what is “appropriate” for each specific case.⁴⁸ CMS made clarifications in 2010 for psychiatric emergency medical conditions stating, “in the case of psychiatric emergencies, if an individual expressing suicidal or homicidal thoughts or gestures, is determined dangerous to self or others, [the patient] would be considered to have an EMC,” but failed to provide any clarification as to an “appropriate” screening aside from it being conducted “to the best abilities of the hospital.”⁴⁹ If an EMC is discovered through the medical screening, the hospital is required to “stabilize the medical condition” or provide an appropriate transfer to a better-situated medical facility after the individual has been stabilized.⁵⁰ In 2010, CMS clarified that “[p]sychiatric patients are considered stable when they are protected and prevented from injuring or harming him/herself or others.”⁵¹

The legislative history makes clear that Congress intended to prevent patient dumping, and specifically feared that certain individuals were not having their conditions treated appropriately in emergency settings.⁵² However, the language of EMTALA itself has served to limit the government’s ability to enforce any violations and has served to create poor precedent in EMTALA-related litigation. Specifically, §1395dd(h) of EMTALA prohibits any delays in either the screening or stabilization of an individual “in order to inquire about the individual’s

⁴⁷ *Id.*

⁴⁸ *Id.*; see also § 1395dd(e)(1); see generally § 1395dd(e).

⁴⁹ Centers for Medicare & Medicaid Services, Medicare State Operations Manual, Appendix V Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases, Revision 60, July 16, 2010.

⁵⁰ 42 U.S.C. § 1395dd(b)(1).

⁵¹ Centers for Medicare & Medicaid Services, Medicare State Operations Manual, Appendix V Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases, Revision 60, July 16, 2010.

⁵² See H.R. REP. NO. 99-241, *supra* note 39.

method of payment or insurance status.”⁵³ This language has led to some jurisdictions requiring specific evidence of an individual’s denial of service for economic reasons in order to make a valid EMTALA claim, thus rendering any other reasons for denial or delay acceptable.⁵⁴ The division of the courts’ decisions has created unpredictable outcomes in EMTALA cases, disadvantaging some of the most vulnerable that EMTALA was envisioned to protect: psychiatric patients.

IV. EMTALA Judicial Interpretation and Settlements

A. General Judicial Interpretation

The initial years of EMTALA litigation created improper precedents that severely limited the finding of hospital violations. In one of the earliest cases, the parents of a deceased infant attempted to make an EMTALA claim.⁵⁵ The parents brought the infant into the ED exhibiting flu-like symptoms, and the physician tested the child believing there was no serious condition present. Both parents were told to go to another hospital to meet with a pediatrician, but no ambulance was provided for their transport.⁵⁶ The infant’s condition worsened and approximately one hour after arriving at the second hospital, the child died.⁵⁷ The court found the parents’ claim invalid because they failed to “allege that their financial condition or lack of health insurance contributed to Dr. Estabrook’s decision not to treat their son.”⁵⁸ In announcing its reasoning, the court required a showing of economic concerns to have standing under EMTALA, ignoring the actual language of the Act, which requires the patient to be screened and

⁵³ 42 U.S.C. § 1395dd(h).

⁵⁴ See *Nichols v. Estabrook*, 741 F. Supp. 325, 330 (D.N.H. 1989).

⁵⁵ *Id.* at 329.

⁵⁶ *Id.* at 326.

⁵⁷ *Id.*

⁵⁸ *Id.* at 330.

stabilized prior to transfer or discharge.⁵⁹ However, the court in *Nichols* completely overlooked the civil enforcement section of EMTALA which reads:

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.⁶⁰

Since *Nichols* was one of the first EMTALA decisions, courts began adopting its improper analysis, creating a precedent of legitimizing EMTALA violations.⁶¹

The Sixth Circuit did not fail, as other circuits have, to interpret the language correctly, and it should be used as a guide for all EMTALA cases in the future. The Sixth Circuit follows the language and statutory intent of EMTALA better than any other circuit, as will be demonstrated in the remainder of this article. Aside from the fact that the Sixth Circuit was one of the first federal courts to discuss whether EMTALA mandates appropriate medical care procedures once a patient is admitted to the hospital for inpatient care, the Sixth Circuit is the only Circuit to have rejected CMS's proposed regulation on the grounds that it was contrary to the legislative intent of EMTALA. In *Thornton v. Southwest Detroit Hospital*, the plaintiff claimed that both the hospital and the physician failed to stabilize her before discharge, in violation of the stabilization requirement of EMTALA.⁶² After the patient arrived at the ED, the patient was admitted to the hospital's intensive care unit for ten days after she suffered a stroke.⁶³ Following the initial ten days in intensive care, the patient spent an additional eleven days in general inpatient care for the continued treatment of her condition.⁶⁴ The physician discharged the patient to home care,

⁵⁹ *Id.*; 42 U.S.C. §1395dd(a).

⁶⁰ 42 U.S.C. § 1395dd(d)(2)(A).

⁶¹ See *Evitt v. University Heights Hospital*, 727 F. Supp. 495 (S.D. Ind. 1989).

⁶² 895 F.2d 1131, 1132 (6th Cir. 1990).

⁶³ *Id.*

⁶⁴ *Id.*

where her condition worsened after the rehabilitation facility refused to accept her.⁶⁵ As the court explained in its conclusion that the stabilization of a patient extends beyond merely admitting them as an inpatient, it stated:

The Hospital argues that the repeated use of the phrase, “emergency room,” in these statements indicates that Congress intended that the requirement to care for a patient not extend to where the patient was admitted to the hospital. A fairer reading is that Congress sought to insure that patients with medical emergencies would receive emergency care. Although emergency care often occurs, and almost invariably begins, in an emergency room, emergency care does not always stop when a patient is wheeled from the emergency room into the main hospital. Hospitals may not circumvent the requirements of EMTALA merely by admitting an emergency room patient to the hospital, then immediately discharging that patient. Emergency care must be given until the patient’s emergency medical condition is stabilized.⁶⁶

The court’s reasoning shows that it considered both the statutory language and the congressional intent in making its decision. The Sixth Circuit properly identified that the stabilization requirement of EMTALA cannot logically end when a patient is admitted into another area of the hospital. It also correctly identified that hospitals may use the admissions as an avenue to “circumvent the requirements of the Act.” While this case did not specifically address an EMTALA violation with a psychiatric patient, the framework and reasoning set forth by the *Thornton* court would be applied in the later, seminal, Sixth Circuit psychiatric case of *Moses v. Providence Hosp. and Medical Centers, Inc.*

B. Psychiatric Cases

Patient stabilization is essential to EMTALA cases involving psychiatric patients. Whether patient admittance allows a hospital to avoid abiding by the stabilization requirement is particularly at issue in EMTALA psychiatric cases.⁶⁷ The plain language of the statute, along

⁶⁵ *Id.*

⁶⁶ *Id.* at 1135.

⁶⁷ See *Hollinger v. Reading Health Sys.*, No. CV 15-5249, 2016 WL 3762987 (E.D. Pa. July 14, 2016).

with the legislative history, requires that once a hospital identifies that an EMC exists, it must stabilize the patient prior to discharge or transfer.⁶⁸

In the wrongly decided *Hollinger* case, a patient brought to the ED by ambulance exhibited signs of delirium and suffered from seizures.⁶⁹ Medical personnel admitted the patient for further treatment and testing, but the patient continued to exhibit signs of delirium in addition to being violent toward staff members, striking at least one.⁷⁰ A doctor that had not treated the patient reviewed the notes of the treating physician and determined that the patient's delirium had been resolved and was discharged, but the patient was, "at high risk of violent behavior and 1:1 observation [was] recommended for safety."⁷¹ Immediately following discharge, the patient was arrested by the local police and taken to jail for striking the medical personnel.⁷² In dismissing the plaintiff's claim of an EMTALA violation for failure to stabilize the patient prior to discharge, the court reasoned that admission to the hospital ended the EMTALA inquiry.⁷³ However, the court failed to look at the plain language of the statute and failed to consider the stabilization definition provided by CMS. Nothing in the statute states that admitting a patient negates the requirement of stabilization, nor does the evidence in the case show that the patient was stable before discharge.⁷⁴ The doctor stated that the patient was still "at high risk of violent behavior,"⁷⁵ and therefore was not "protected and prevented from injuring or harming him/herself or others."⁷⁶ This case stands as an example of how the statutory construction and

⁶⁸ 42 U.S.C. §1395dd(a).

⁶⁹ *Hollinger*, 2016 WL 3762987, at *1.

⁷⁰ *Id.* at *2.

⁷¹ *Id.* at *3.

⁷² *Id.*

⁷³ *Id.* at *9.

⁷⁴ 42 U.S.C. §1395dd(a).

⁷⁵ *Hollinger*, 2016 WL 3762987, at *3.

⁷⁶ Centers for Medicare & Medicaid Services, Medicare State Operations Manual, Appendix V Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases, Revision 60, July 16, 2010.

legislative history have been completely overlooked when deciding EMTALA cases involving psychiatric patients.

In contrast to *Hollinger* and in furtherance of the correct application of the EMTALA statutory language, the Sixth Circuit's decision in *Moses v. Providence Hosp. and Medical Centers, Inc.* involved a psychiatric EMTALA case decided in accordance with the statutory language as well as the legislative intent, making it better precedent for all psychiatric EMTALA cases going forward.⁷⁷ In *Moses*, the patient was brought to the emergency room of Providence Hospital after he exhibited signs of physical and mental illness, specifically hallucinations and delusions.⁷⁸ Doctors determined that the patient should be admitted for further testing to determine the best treatment for his "atypical psychosis."⁷⁹ The patient was tested for one day and then discharged, despite a report stating that he still had "atypical psychosis" as well as his wife's fear that he was still a danger to her or himself.⁸⁰ Ten days after the patient was released, he murdered his wife. This suit resulted when he sued the hospital for discharging him prior to stabilization, in violation of EMTALA. The lower court dismissed the case, claiming that admitting the patient exempted the hospital from further EMTALA compliance.⁸¹

The Sixth Circuit reversed the lower court's dismissal after looking at the statutory language, reasoning that "a hospital may not release a patient with an emergency medical condition without first determining that the patient has actually stabilized, even if the hospital properly admitted the patient."⁸² After conducting a plain language interpretation, the court added that hospitals under

⁷⁷ 561 F.3d 573 (6th Cir. 2009).

⁷⁸ *Id.* at 576.

⁷⁹ *Id.*

⁸⁰ *Id.* at 577.

⁸¹ *Id.* at 583.

⁸² *Id.*

EMTALA were required “not just to admit the patient into the inpatient care unit, but to treat him in order to stabilize him” before a discharge or transfer.⁸³

The court in *Moses* went beyond simply rejecting the CMS regulations. It instead dissected the CMS rule and attacked the rule’s validity based on a plain language interpretation of the EMTALA statute.⁸⁴ While the Sixth Circuit did not provide a definition of what a “bad faith” admission is, it provided a clear basis for rejecting the interpretation of the rule proposed by CMS.⁸⁵ The *Moses* court reasoned that “[t]he CMS rule appears contrary to EMTALA’s plain language, which requires a hospital to ‘provide . . . for such further medical examination and such treatment as may be required to stabilize the medical condition.’”⁸⁶ The reasoning proposed by the Sixth Circuit focused on the term “treatment” in the statute.⁸⁷ As discussed in Section II of this article, the Sixth Circuit properly focused its analysis on the plain language interpretation of the statute, which was further reinforced in its analysis of the legislative intent.⁸⁸ The court focused on the fact that the statute demands that a patient be stabilized prior to discharge or transfer.⁸⁹

The Sixth Circuit’s rejection of an administrative rule was unfounded. According to the rule established in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, a court may reject a rule created by an administrative agency if the rule runs contrary to the legislative intent or statutory construction.⁹⁰ The *Moses* court refused to accept the CMS regulation because it

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ *Id.* (quoting 42 U.S.C. § 1395dd(b)(1)(A) (emphasis in original)).

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Id.* (reasoning “a hospital may not release a patient with an emergency medical condition without first determining that the patient has actually stabilized, even if the hospital properly admitted the patient.”)

⁹⁰ 467 U.S. 837, 842-43 (1984).

viewed CMS’s interpretation to be “contrary to the plain language of the statute.”⁹¹ The Sixth Circuit has been the sole circuit to reject the CMS admission regulation. This rejection is proper under the *Chevron* standard established by the Supreme Court in 1984. While the Supreme Court has not yet had the opportunity to hear an EMTALA case involving a psychiatric patient, the reasoning applied by the Sixth Circuit is most closely aligned with the plain language interpretation as well as the legislative history of EMTALA. Additionally, the most recent settlements of psychiatric cases involve almost identical facts, further bolstering the applicability of the Sixth Circuit’s model for analyzing these cases.⁹²

C. Recent Settlements

In the past two years, the government has settled four cases in which there was an EMTALA violation involving a psychiatric patient. The largest settlement occurred in June 2017, involving AnMed Health in South Carolina. In that particular settlement, the government found thirty-six incidents of EMTALA violations involving psychiatric patients.⁹³ One particular case involved a patient being kept in the ED for thirty-eight days without treatment or stabilization.⁹⁴ The result of these thirty-six violations led to a \$1,295,000 settlement agreement.⁹⁵ The Research Medical Center in Kansas City settled for \$360,000 for seventeen violations involving the failure to provide an adequate medical screening examination and improper transfer of a patient in November 2016.⁹⁶ The reported incident that led to the settlement involved a psychiatric patient being transferred to another facility without stabilization, causing the individual to leave the

⁹¹ *Moses v. Providence Hosp. & Med. Centers, Inc.*, 561 F.3d 573, 583 (6th Cir. 2009).

⁹² Office of Inspector General, Department of Health and Human Services, *Civil Monetary Penalties and Affirmative Exclusions Civil Monetary Penalties and Affirmative Exclusions*, HHS, <https://oig.hhs.gov/fraud/enforcement/cmp/cmp-ae.asp> (last visited Dec. 1, 2017).

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.*

vehicle and be struck by another car on the road.⁹⁷ In May 2016, Grady Memorial Hospital in Atlanta settled for \$40,000 after failing to provide an adequate medical screening examination and failing to provide stabilizing treatment to a psychiatric patient.⁹⁸ Grady counselors determined that the patient required further testing and stabilization; however, the on-call physician discharged the patient without consulting the counselors and without stabilization.⁹⁹ The facts of the last settlement are strikingly similar to those of *Hollinger*, reinforcing the need to depart from the line of reasoning that decision has perpetuated. In January 2016, Floyd Medical Center in Georgia entered into a \$50,000 settlement agreement for failure to evaluate and treat a mentally ill patient who was transferred from another hospital.¹⁰⁰ The patient was aggressive, but instead of providing treatment to stabilize the individual, hospital security detained him and transferred the patient to police custody without any form of treatment, aside from the emergency physician stating the individual was medically cleared.¹⁰¹

The fact that there has been a growing number of settlements in recent years reinforces the need for judicial intervention on this topic. Settlements for EMTALA cases do not arise until the government has been alerted by a private party about an EMTALA violation.¹⁰² Additionally, when the courts determine that an EMTALA violation did not occur, that determination makes it harder for CMS to make a settlement with the offending hospital or physician.¹⁰³ The effect this has on EMTALA recovery is disastrous for both the government and the harmed party. When a court finds no EMTALA violation, the victim is harmed without a remedy and the government is

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² See generally *Moses v. Providence Hosp. & Med. Centers, Inc.*, 561 F.3d 573, 583 (6th Cir. 2009).

¹⁰³ See *Hollinger v. Reading Health Sys.*, No. CV 15-5249, 2016 WL 3762987 (E.D. Pa. July 14, 2016) (finding that no EMTALA violation occurred because the hospital admitted the patient in “good-faith”).

harmful because it is precluded from entering a settlement. The adoption of the Sixth Circuit's reasoning for EMTALA cases will insure that other courts quickly and effectively resolve future cases involving psychiatric patients. This adoption would also strengthen the effect of EMTALA and force CMS to reconsider its flawed interpretation of the Act.

V. Conclusion

In addition to the recent settlements, reports have shown that psychiatric patients, in general, face extended stays in waiting rooms, highlighting the potential for EMTALA fraud and abuse.¹⁰⁴ Approximately 23% of those patients remain in an ED for more than six hours and just over 1% stay longer than twenty-four hours.¹⁰⁵ In contrast to psychiatric patients, only around 10% of medical patients remain for more than six hours and 0.5% remain in EDs for more than twenty-four hours.¹⁰⁶ This troubling report, along with the growing number of settlements, emphasizes the need for stronger enforcement of EMTALA with an interpretation consistent with the legislative intent to protect the most vulnerable populations. By adopting the rationale used by the Sixth Circuit in *Moses* for all EMTALA cases involving psychiatric patients, courts will be able to apply a clear framework with consistent results. Not every violation is as clear as situations like the settlement in South Carolina, but the violations still negatively affect those psychiatric patients. The courts must return to the congressional intent of the Act to best protect

¹⁰⁴ Shefali Luthra, *How Gaps In Mental Health Care Play Out In Emergency Rooms*, NPR (2016), <https://www.npr.org/sections/health-shots/2016/10/17/498270772/how-gaps-in-mental-health-care-play-out-in-emergency-rooms> (last visited Dec. 1, 2017).

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

these vulnerable individuals because the “[concern] that medically unstable patients are not being treated appropriately”¹⁰⁷ continues to be realized to the detriment of psychiatric patients.¹⁰⁸

The best solution for reviving the congressional intent of EMTALA is through the courts, specifically, the use of the Sixth Circuit’s reasoning and application for EMTALA cases. As discussed above, the precedent established, allows courts to reject administrative regulations contrary to legislative intent.¹⁰⁹ “Ordinarily, the construction and interpretation of a statute is a question of law for the courts where the administrative decision is not entitled to special deference, particularly where, as here, the statute has not previously been subjected to judicial scrutiny or time-tested agency interpretations.”¹¹⁰ CMS created a rule contrary to legislative intent, which allows hospitals to escape EMTALA liability so long as they “admit the patient in good faith.”¹¹¹ If more courts continue to reject CMS’s guidance, the Supreme Court will eventually be forced to address a growing circuit split, and provide stronger guidance about EMTALA. The Sixth Circuit remains the only circuit to reject CMS’s rule, and correctly interpreted EMTALA the way the enacting Congress intended. It is time for EMTALA to once again protect the most vulnerable patients from mistreatment.

¹⁰⁷ H.R. REP. NO. 99-241, pt. 1, at 27 (1985).

¹⁰⁸ Office of Inspector General, Department of Health and Human Services, *Civil Monetary Penalties and Affirmative Exclusions Civil Monetary Penalties and Affirmative Exclusions*, HHS, <https://oig.hhs.gov/fraud/enforcement/cmp/cmp-ae.asp> (last visited Dec. 1, 2017).

¹⁰⁹ See *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984).

¹¹⁰ *Connecticut State Medical Society v. Connecticut Board of Examiners in Podiatry*, 546 A.2d 830, 834 (Conn. 1988). see, e.g., *State ex rel. Celebrezze v. National Lime and Stone Company*, 627 N.E.2d 538 (Ohio 1994).

¹¹¹ Centers for Medicare & Medicaid Services, Medicare Program; Emergency Medical Treatment and Labor Act (EMTALA): Applicability to Hospital Inpatients and Hospitals With Specialized Capabilities, Proposed Rules, February 2, 2012.