October 5, 2018

Kate Goodrich, M.D.
Director, Center for Clinical Standards and Quality, & Chief Medical Officer
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Need for Direction to Regional Offices and Surveyors Regarding EMTALA and the Care of Patients with Psychiatric and Substance Use Disorders

Dear Dr. Goodrich:

On behalf of our member hospitals, health systems and the communities they serve, the American Hospital Association and the Federation of American Hospitals write to urge the Centers for Medicare & Medicaid Services (CMS) to provide additional instruction to state surveyors and regional offices regarding the correct application of the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA). We have recently been made aware of instances in which hospitals have been required by surveyors to take steps that are not in the best interest of the patient, nor in accord with current CMS rules and guidance.

These instances all concern the treatment of patients with behavioral health conditions or substance use disorder (SUD) who present to hospital emergency departments (EDs). As you know, the 2016 National Survey on Drug Use and Health estimated 44.7 million adults in the U.S. have a mental disorder. A recent study by the Agency for Healthcare Research and Quality found that number is growing especially given increasing drug abuse. This influx of patients has put pressure on hospitals, and especially EDs, to be able to address the needs of these patients.

EMTALA requirements apply to all patients who arrive at our hospital in distress from any disease, disorder or trauma. We believe that, while well-intentioned, some surveyors have misstated the requirements. We want to share three specific ways in which we believe surveyors are incorrectly interpreting the standards, substituting their own judgement for that of the professionals charged with the care of the patient and, in so doing, putting patients and health care personnel in jeopardy.
The attached white paper provides greater detail and case examples of how surveyors have overstepped their authority by requiring hospitals to do things that are not in the best interests of the patient and, in some cases, violate other laws or regulations. Specifically, we believe state surveyors allege that:

- The intervention of a psychiatrist is required to achieve an appropriate medical screening examination (MSE) of a patient with psychiatric signs or symptoms;

- The intervention of a psychiatrist and/or inpatient admission is required to achieve appropriate stabilizing treatment of a patient with psychiatric signs or symptoms; and

- A hospital with an inpatient behavioral health unit must admit a patient as an inpatient regardless of whether that hospital has the capacity and capability to safely admit that patient.

We ask CMS to address our concerns. The information contained in this letter and its attachment provide a fuller understanding the issues.

We would welcome the opportunity to speak with you and your staff to provide additional details and examples if that would be helpful. Thank you for your attention to this issue. Please contact Nancy Foster, AHA vice president for quality and patient safety policy, at 202-626-2337 or Katie Teneover, FAH senior vice president and general counsel, at 202-624-1500 if you have additional questions.

Sincerely,

/s/       /s/
Ashley Thompson     Katie Teneover
Senior Vice President  Senior Vice President and General Counsel
Public Policy Analysis and Development  FAH
AHA

Enclosure

cc:  David Wright
EMTALA Citations Related to Behavioral Health Services:

Issue Presented:

This Discussion Paper highlights emerging concerns from the hospital field regarding perceived trends in Centers for Medicare & Medicaid Services (CMS) enforcement of the Emergency Medical Treatment and Labor Act (EMTALA). Specifically, recent citations on numerous surveys raise questions about what constitutes an appropriate medical screening examination and appropriate stabilizing treatment for a patient presenting with psychiatric signs and symptoms, as well as questions about what (and who) defines a hospital’s capabilities and capacity for EMTALA purposes.

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Discussion:

Behavioral health and substance use disorders are growing rapidly in the U.S., and leading many patients to seek care in hospital emergency departments (EDs). The 2016 National Survey on Drug Use and Health estimated 44.7 million adults in the U.S. have a mental disorder, representing 18.3 percent of all U.S. adults.1 Approximately one in eight ED visits involves a behavioral health or substance use disorder (SUD).2 A recent Agency for Healthcare Research and Quality (AHRQ) study indicated that, between 2007 and 2011, the rate of ED visits related to mental illness and substance misuse increased by more than 15 percent.3 This same study indicated that, between 2006 and 2013, the rate of ED visits per 100,000 related to mental and SUDs increased 55.5 percent for depression, anxiety or stress reactions; 52.0 percent for psychoses or bipolar disorders; and 37.0 percent for SUDs.4 This increasing need places incredible strain on hospitals, their EDs, ED staff, practitioners, and patients alike. Much of this falls on hospitals with inpatient behavioral units.

Although many hospitals have chosen to provide access to much-needed inpatient behavioral health care, these hospitals have capacity limitations in the face of an ever-growing need and shrinking availability of inpatient beds. This situation is even more challenging because many states have shuttered their state-run inpatient facilities. In terms of state hospital bed capacity (for which the most recent data is available), capacity dropped 96 percent between 1955 and 2016: there are now just 11.7 beds per 100,000 people in the U.S. Of those 11.7 beds, nearly half are occupied by criminal offenders, leaving approximately six state/county beds per 100,000 people in the U.S. available for non-criminal behavioral

4 Id.
health patients. This places immense pressure on private hospitals, which, as a result, are frequently at capacity and need to transfer patients to other appropriate settings.

This Discussion Paper aims to establish a common framework within which to discuss the recent increase in CMS EMTALA enforcement actions against hospitals providing behavioral health services and making good faith efforts to meet their statutory and regulatory EMTALA obligations. These hospitals have recently noted that state surveyors (acting as agents of CMS) are citing them for certain EMTALA deficiencies related to treatment for psychiatric patients, despite an apparent lack of legal support for the citations.

This targeted enforcement is particularly problematic because hospitals have no meaningful due process mechanisms to contest the cited deficiencies with which they disagree. A formal appeal is only an option after a hospital’s provider agreement has been terminated—a devastating result that hospitals avoid at all costs. Hospitals recognize that Section 3016E of the CMS State Operations Manual (SOM) offers them the opportunity to document any disagreements with survey citations in their plans of correction. However, hospitals are often hesitant to avail themselves of this opportunity with the provider agreement (and imminent public notice) hanging in the balance. Moreover, recent experience has been that, when a hospital includes an argument within its plan of correction, most CMS Regional Offices ignore the information or, more troubling, insist that the hospital remove the argument before they will accept the plan of correction. Driven by fear of termination, hospitals rush to provide plans of correction that address the cited deficiencies, even if the hospitals do not agree that a citations is warranted by the facts or supported by EMTALA and its implementing regulations.

Against the backdrop of this challenging legal environment, this Discussion Paper addresses three recent types of findings by state surveyors, which were cited by certain CMS Regional Offices as the basis for a finding of immediate jeopardy, and which we respectfully assert are not supported by EMTALA, its implementing regulations or the CMS SOM, which is CMS’s own guide to state surveyors. Specifically, we believe the following conclusions are legally correct and supportable by CMS regulation and guidance, despite state surveyor findings to the contrary:


6 CMS SOM, Chapter 3 - Additional Program Activities. Sec. 3016E (Rev. 1, 05-21-04), page 45 of 149. As a separate but related issue, hospitals have recently experienced certain CMS Regional Offices refusing to release the 5-day report of the QIO, which does not comport with a plain reading of 42 U.S.C. §1395dd(d)(3). Hospitals also continue to encounter access issues with regard to the 60-day report. This issue is beyond the scope of this Discussion Paper, but it is an issue that we would like to discuss with CMS at a future date.
1. A medical screening examination (MSE) of a patient with psychiatric signs or symptoms does not always require consultation with or in-person examination by a psychiatrist. Rather, a qualified medical professional (QMP), such as an ED physician, nurse practitioner or other clinical personnel acting within his or her recognized scope of licensure and/or practice, is clinically competent to provide an appropriate MSE to determine whether the patient has an emergency medical condition (EMC). If the QMP, in his or her clinical judgment, requires a consult with (or the presence of) a psychiatrist, the QMP will seek the assistance of the on-call psychiatrist.

EMTALA requires hospitals to “provide an appropriate medical screening examination within the capability of the hospital’s emergency department . . . to determine whether or not an EMC exists.”7 Increasingly, state survey agencies and certain CMS Regional Offices are citing a failure to provide an appropriate MSE if a hospital fails “to ensure on-call psychiatrists who were available and on-call for duty performed an adequate examination . . . for all patients who presented to the [ED] with psychiatric signs/symptoms seeking treatment.” That is, even if the hospital ensures that a designated QMP provides the MSE, and even if that QMP engages with an on-call psychiatrist via telephone to receive specialized consult services and concludes that the on-call psychiatrist need not present to the ED, state survey agencies and certain CMS Regional Offices are citing hospitals for non-compliance with EMTALA.

Recommendation: CMS should instruct surveyors and CMS Regional Offices to adhere to EMTALA regulations and survey instructions regarding a hospital’s right to designate its QMPs and to consistently utilize those QMPs in a non-discriminatory manner to care for behavioral health patients for purposes of satisfying EMTALA MSE requirements. Any other instruction to surveyors, or silently continuing to allow surveyors to require the involvement of an on-call specialist in an MSE, would be a substantive change to CMS policy. Such a policy change may only be effectuated after a notice-and-comment period, and would also require an explanation as to why behavioral health is now being singled out and treated differently than other medical specialties.

The sole purpose of the MSE is to determine, within the capability of the hospital’s ED (including ancillary services), whether an EMC exists. CMS considers behavioral health patients to have an EMC when they are suicidal or homicidal and are determined to pose a danger to themselves or to others.8 Reaching that determination does not require the discrete diagnosis of a specialist, and there is absolutely no requirement in EMTALA, its implementing regulations or the SOM that requires a specialist to provide the MSE.

CMS’s own guidance to its surveyors provides that “[i]f a hospital applies in a nondiscriminatory manner (i.e., a different level of care must not exist based on payment status, race, national origin, etc.) a screening process that is reasonably calculated to determine whether an EMC exists, it has met its obligations under EMTALA” (emphasis added).9 Based on the standards of nondiscrimination and reasonableness, and the hospital’s authority to identify QMPs, utilization of ED physicians (or other

7 42 C.F.R. §489.24(a)(1).
qualified practitioners) for behavioral MSE purposes is clinically appropriate and consistent with CMS regulations and survey instructions. ED practitioners are reasonably trained to identify EMCs, including behavioral health emergencies. If an ED physician or other QMP determines that a behavioral health patient has an EMC, such as active suicidal ideation or psychosis of sufficient severity that the patient is determined to be dangerous to self or others, the MSE is complete.10 Nothing in EMTALA requires consultation with a specialist.

To allow deficiency citations when hospitals meet their MSE obligations with designated QMPs (and without a consultation with a psychiatrist) is to ignore clear EMTALA statutory and regulatory direction that (i) hospitals designate QMPs consistent with hospital bylaws (or rules and regulations) (which includes consistency with scope of licensure and/or practice) and (ii) the hospital is not obligated to perform any MSE beyond its capability.

With regard to designated QMPs, EMTALA regulations give hospitals discretion to (and, in fact, require them to) identify who may act as a QMP for MSE purposes.11 Indeed, the governing regulation provides that: “The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction.”12 Section 482.55 requires that a qualified member of the medical staff provide direction and supervise emergency services, and that there are “adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility.”13

Despite this clarity, recent CMS Regional Office Statements of Deficiency second-guess hospitals’ QMP designations, and even go so far as to conclude that even an ED physician is not qualified to be a QMP with regard to behavioral health MSEs. Beyond lacking support in guidance or regulation, this determination inappropriately singles out behavioral health issues as somehow different from other medical specialties by deeming psychiatrists as the only type of individual qualified to serve as QMPs for behavioral health MSE purposes. Imposing the burden of having psychiatrists perform all assessments is unnecessary and, more importantly, is not consistent with EMTALA statutes, regulations or CMS guidance to surveyors. CMS’s statement in the 2003 Final Rule preamble expressly states:

[G]enerally, psychiatric patients with emergency medical conditions are treated no differently for purposes of EMTALA than any other individual who presents to the hospital with an emergency medical condition.14

With regard to a hospital’s capability, the EMTALA statute and regulations both acknowledge that the MSE expected of a hospital must be within the hospital’s routine capability.15 Requiring psychiatrist consults would expand many hospitals’ MSE obligations beyond their routine capability. This is the case

10 The CMS SOM recognizes that evidence of chronic suicidal ideations or psychosis may not, alone, be deemed signs of an EMC as there may be no evidence that the patient, or any other person, is in imminent danger. Rather, hospitals should focus on the acute, exacerbated presenting signs and symptoms in determining whether an EMC exists.
11 42 C.F.R. §489.24(a)(i).
12 Id.
13 42 C.F.R. §482.55.
15 42 U.S.C. §1395dd(a); 42 C.F.R. §489.24(a)(i). (emphasis added.)
particularly for rural hospitals, which are located in communities with well-documented access-to-care challenges.

There is a chronic shortage of psychiatrists in this country.\textsuperscript{16} As a result, hospitals often have only a small complement of psychiatrists on staff to provide inpatient and outpatient behavioral health services for their patients. Requiring these psychiatrists to provide an MSE for all ED patients presenting with behavioral symptoms would be untenable. The regulations do not state, and the guidance never implies, that an ED practitioner must consult with a psychiatrist, nor even that an ED practitioner must affirmatively document a reason why a consultation is not necessary. If CMS pursues this position of requiring even ED practitioners to consult with on-call psychiatrists, and particularly the position that the on-call psychiatrist must personally examine all patients with behavioral health symptoms, it will detract from the capacity of psychiatrists to care for patients with severe behavioral health and substance use disorders.

2. Stabilization of patients with psychiatric signs or symptoms does not always require the intervention of a psychiatrist or inpatient admission. Rather, as with other specialties, the ED practitioner must make a reasonable medical judgment about whether on-call specialists or inpatient admission are needed. Specifically, stabilization of psychiatric conditions does not always mean extensively treating the underlying condition, but rather, addressing acute signs and symptoms that cause relatively immediate risk of harm to the patient or others.

Increasingly, state survey agencies and certain CMS Regional Offices are citing hospitals for failure to provide appropriate stabilizing treatment to behavioral health patients while in the ED, pending admission, transfer, or discharge if that treatment is not provided by a psychiatrist. In some cases, hospitals have been cited for failure to admit the patient when admission was not necessary to provide stabilizing treatment."

\textit{Recommendation: CMS should instruct surveyors and CMS Regional Offices not to require that psychiatrists provide the stabilizing treatment for a patient nor require inpatient admission to satisfy the obligation for providing "stabilizing treatment" for every patient presenting with psychiatric signs and symptoms. Moreover, CMS’s instructions also should re-emphasize that the “stabilizing treatment” requirement may be met even if the underlying psychiatric condition is not fully resolved, provided that the patient is no longer in a position to harm him- or herself or others. If CMS adopts any other interpretation, or if CMS fails to clarify for surveyors that they may not require the involvement of an on-call specialist or inpatient admission to achieve stabilization, then CMS would be implementing a substantive change to policy. And, such a policy change may only be effectuated after a notice-and-comment period, and would also require an explanation as to why behavioral health is now being singled out and treated differently than other medical specialties.}

There is no requirement that an ED practitioner call in a specialist to provide stabilizing treatment of a patient with an EMC. In fact, CMS is very clear that “[i]f a physician is listed as on-call and requested to make an in-person appearance to evaluate and treat an individual, that physician must respond in person

in a reasonable amount of time”¹⁷ (emphasis added). Where no such request is made because an ED physician or other QMP, in his or her clinical judgment, has stabilized the EMC, the on-call psychiatrist is not obligated to present. Indeed, the hospital has no obligation to require that the ED physician or other QMP request the appearance of a psychiatrist.

The preamble discussion to the Final Rule further underscores the primacy of the medical judgment of the practitioner with eyes on the patient, rather than on a formulaic categorization of patients, in determining whether an on-call specialist is needed:

While the emergency physician and the on-call specialist may need to discuss the best way to meet the individual's medical needs, we also believe any disagreement between the two regarding the need for an on-call physician to come to the hospital and examine the individual must be resolved by deferring to the medical judgment of the emergency physician or other practitioner who has personally examined the individual and is currently treating the individual.¹⁸

CMS has clearly defined “stabilization” as the point at which, in the judgment of a physician or other QMP, no EMC exists, even though an underlying condition may still exist. As an example, the SOM describes stabilizing treatment for an asthma attack as providing medication and oxygen “to alleviate the acute respiratory symptoms.”¹⁹ The SOM also specifically addresses stabilization of psychiatric patients:

In the case of psychiatric emergencies, if an individual [is] expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, [the individual] would be considered to have an EMC. Psychiatric patients are considered stable when they are protected and prevented from injuring or harming him/herself or others.²⁰

Therefore, a hospital's EMTALA obligation to patients with psychiatric signs or symptoms is to alleviate acute symptoms causing risk of injury to the patient or others.

In many cases, an ED physician or other QMP can fully stabilize a patient in the ED, without an inpatient admission. EMTALA does not require that a patient who presents to the ED with psychiatric symptoms (and is determined through an MSE to have an EMC) be admitted as an inpatient. Rather, EMTALA requires that the patient be stabilized, and once the patient is stabilized, the EMTALA obligation ends. The SOM expressly states that "[a] n individual will be deemed stabilized if the treating physician or QMP attending to the individual in the emergency department/hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved."²¹ The SOM goes on to say

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²⁰ Id. page 51 of 68.

²¹ Id. page 50 of 68.
that for an individual whose EMC has been resolved, the treating physician or other QMP can either discharge the patient or admit the patient. 22

The American Psychiatric Association Practice Guidelines23 and other medical literature24 provide support for the premise that stabilization of behavioral health patients is possible without inpatient admission. For example, hospitals can frequently stabilize patients through the use of "safe" rooms and close monitoring, regular mental condition assessments and medication.25 As with treatment for other types of conditions, non-inpatient treatment for psychiatric conditions can be more timely and focused, and patients may prefer it. And, like the determination of whether to consult a specialist, an ED physician or other QMP has the ability and the authority to determine, in his or her clinical judgment, whether inpatient admission is necessary to achieve stabilization. Accordingly, it is unfair to cite hospitals for failing to provide "stabilizing treatment" when patients receive appropriate and sufficient care, as described above, in the ED.

In sum, to the extent that stabilization requires the services of an on-call specialist and/or inpatient admission, hospitals understand this EMTALA obligation. It is not the case, however, that every patient presenting with a behavioral health emergency will require an inpatient admission or the services of an on-call specialist.

22 Id.

23 According to the APA Practice Guidelines for Suicidal Behaviors, release from an emergency setting may be possible without inpatient admission after a suicide attempt or suicidal ideation when: the suicidality is a reaction to precipitating events (e.g., exam failure, relationship problems) especially if the patient’s view of the situation has now changed; the plan and intent have low lethality; the patient has a stable and supportive living situation; and the patient is able to cooperate with follow-up recommendations. The guidelines also suggest that some patients with chronic suicidal ideation may benefit more from outpatient treatment, if a safe and supportive living situation is available. Suicidal behaviors, in: American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2004. Washington, DC: American Psychiatric Association, 2004:31, cited in S. Zeller. “Treatment of Psychiatric Patients in Emergency Settings.” Primary Psychiatry. (June 2010). Available at: http://primarypsychiatry.com/treatment-of-psychiatric-patients-in-emergency-settings/#PES.


25 One care model is the “Psychiatric Emergency Service,” a program that typically has extended observation capability, staffed with mental health professionals. See discussion of “the PES model” in the following article: S. Zeller. “Treatment of Psychiatric Patients in Emergency Settings.” Primary Psychiatry. (June 2010). Available at: http://primarypsychiatry.com/treatment-of-psychiatric-patients-in-emergency-settings/#PES.
3. **EMTALA does not require a hospital with an inpatient behavioral health unit to admit any and all patients requiring inpatient admission without regard to the hospital’s specific psychiatric capabilities and capacity.** Specifically, the hospital’s customary methods of patient placement, such as designating beds by gender, age, or type of condition, and the hospital’s exclusionary criteria with regard to the conditions the psychiatric unit cannot handle, are material to quality and safety, and partially define the hospital’s “capacity” and “capability” under EMTALA. Therefore, the hospital has no EMTALA obligation to deviate from its customary methods of patient placement in order to admit a patient for stabilization, as long as those customs are not discriminatory. When patients require care that is beyond the hospital’s capability and capacity, the hospital must appropriately transfer the patient for care. Additionally, in some cases where state law requires a particular procedure for admitting patients involuntarily, particularly where the state has not established infrastructure for fulfilling such requirements, a hospital lacks capability to admit such patients involuntarily.

Some surveyors are incorrectly indicating that hospitals with behavioral health units must accept all patients who need inpatient admission in order to be stabilized: (1) without regard to conditions the inpatient unit cannot manage, (2) into accommodations designed for patients of a different gender, age, or clinical status, and/or (3) regardless of whether a hospital has the staff to serve the bed in question. These requirements are beyond the legal authority of surveyors and contrary to CMS’s own guidance set forth in the SOM.

Particularly in the behavioral health context, whether a hospital has an open bed in its inpatient behavioral health unit is not determinative of capacity and capability. For units with shared accommodations, a hospital behavioral health unit may have one bed for a female patient, but the patient in the ED requiring admission is a male. Routinely, hospitals with pediatric and adult inpatient behavioral units may have a bed open for a patient in one age group, only to find the patient in the ED, or the patient in need of a transfer is not age-appropriate for that open bed. Even when there are open beds, there may not be sufficient staff available to manage additional admissions. Finally, many behavioral health units are unable to safely manage patients with dementia who have no known psychiatric disorder and/or who have communicable diseases or severe and violent behaviors.

**Recommendation:** CMS should instruct surveyors and CMS Regional Offices to adhere to longstanding CMS policy that permits a hospital to define its own capability and capacity, taking into account the hospital’s resources, and not require hospitals to alter their patient care services in a manner that is inconsistent with the hospital’s customary practices and that the hospital determines would not be in the best interest of patients and staff.

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26 We note a separate but related issue regarding the stabilization requirement. Some hospitals are being cited for transferring patients with a condition within the capability of the hospital, when the patient has an additional clinical need beyond the current hospital’s capability. For example, freestanding psychiatric hospitals typically admit patients who need inpatient psychiatric treatment and transfer patients with possible physical emergencies beyond the capability of the hospital to manage. In one example, a psychiatric hospital received a citation for not keeping a heart transplant patient with chest pain at the psychiatric hospital and monitoring his vital signs, despite the hospital’s lack of capability to manage the cardiac problems. Another example may be a small, rural hospital with a patient presenting with both a psychiatric condition as well as a complication related to pregnancy and the rural hospital has no obstetrical capability. In that case, the patient’s obstetrical complication would place that patient beyond the small hospital’s capability even though that hospital offers psychiatric services.

27 Unlike treatment in an acute care medical/surgical unit, psychiatric treatment typically involves the patient’s interaction with other patients through participation in therapeutic groups and activities.
It has long been CMS policy that a hospital defines its own capability and capacity for providing services and that EMTALA does not require a hospital to expand its services. When a commenter asked whether EMTALA requires a hospital to treat emergency psychiatric disorders regardless of its capabilities, CMS stated long ago:

Neither the [EMTALA] statute nor the regulations mandate that hospitals expand their resources or offer more services. Rather, they focus on the hospital's existing capabilities. The thrust of the statute is that a hospital that offers emergency services to some members of a community who need their emergency services (for example, those that can pay) cannot deny such services to other members of the community with a similar need.\(^{28}\)

The regulation defines "capacity," in part, as encompassing "such things as numbers and availability of qualified staff, beds and equipment, and the hospital's past practices of accommodating additional patients in excess of its occupancy limits"\(^{29}\) (emphasis added). The SOM further enumerates the factors that define a hospital's "capacity," including: number of persons occupying a specialized unit, number of staff on duty, amount of equipment on hospital premises, and "whatever a hospital customarily does to accommodate patients in excess of its occupancy limits (§489.24(b))" (emphasis added). The SOM goes on to state:

If a hospital has customarily accommodated patients in excess of its occupancy limits by whatever mean[s] (e.g., moving patients to other units, calling in additional staff, borrowing equipment from other facilities) it has, in fact, demonstrated the ability to provide services to patients in excess of its occupancy limits.\(^{30}\)

The SOM also discusses what constitutes “capability”:

Capabilities of a medical facility mean that there is physical space, equipment, supplies, and specialized services that the hospital provides (e.g., surgery, psychiatry, obstetrics, intensive care, pediatrics, trauma care).

Capabilities of the staff of a facility means the level of care that the personnel can provide within the training and scope of their professional licenses. This includes coverage available through the hospital's on-call roster.\(^{31}\)

State law also may limit a hospital’s capability. A hospital does not have capability, and thus does not have the obligation, to admit a patient who presents to the ED under an involuntary commitment order/protocol where state law requires certain procedures to be followed and the hospital is not an option for admission under that state’s procedure. In some states, for example, state law or state agencies designate certain facilities to admit and treat involuntary psychiatric patients. Hospitals that are not so designated cannot admit involuntary psychiatric patients without violating state law. In other states, the state or local government may not have established the procedure to admit patients involuntarily to a

\(^{28}\) 59 Fed. Reg. 32086, 32100 (June 22, 1994).

\(^{29}\) 42 C.F.R. §489.24(b) (emphasis added).


\(^{31}\) Id.
hospital in accordance with state law requirements. For example, state law may require that a county general sessions judge respond to a request for an involuntary admission order within 24 hours of the request, and if the county general sessions court does not have the infrastructure in place to respond to such a request within that timeframe, then state law prevents hospitals in that county from admitting psychiatric patients involuntarily. In such cases, as described above, the hospitals comply with EMTALA by providing stabilizing treatment while the psychiatric patients are in the ED pending transfer to a facility that can admit involuntary patients to an inpatient bed.

State surveyors, however, are citing hospitals for EMTALA violations for observing state laws that prevent involuntary admission of patients. These citations put the hospitals in the untenable position of violating state law to comply with regulators’ misimpression of what EMTALA requires. Some surveyors and Regional Office staff incorrectly assert that EMTALA, as a federal law, trumps any state law restrictions on admitting involuntary patients. However, EMTALA expressly does not pre-empt state law, unless there is a direct conflict between state law and an EMTALA requirement. In this scenario, there is no direct conflict. As described below, EMTALA may be satisfied either because: (1) the hospital lacks capability or capacity to stabilize the patient, or (2) the patient makes a valid refusal of treatment, appropriately documented, thus ending the EMTALA obligation.

First, EMTALA does not require admission of patients, and instead only requires stabilization of patients, or appropriate transfer if the hospital does not have capability (or capacity) to stabilize, including not having the capability to manage an involuntary patient. Second, a hospital meets its EMTALA requirements if it offers inpatient psychiatric treatment and the patient refuses. If a hospital offers inpatient admission and an involuntary patient (i.e., one who was not initially seeking treatment voluntarily) agrees to accept treatment, then the patient becomes a voluntary patient, the state’s involuntary process is no longer at issue, and the patient may be admitted to the hospital (presuming capacity). But, if the patient still refuses treatment, the hospital meets its EMTALA obligations by reviewing the risks and benefits and documenting the patient’s refusal. The EMTALA obligation ends at that point, and the hospital may proceed in accordance with the state law involuntary processes. If the hospital is unable to admit and treat involuntary patients, then the hospital must transfer the patient to another facility capable of admitting involuntary patients. Accordingly, there is no direct conflict between state law and EMTALA with respect to involuntary commitments, and the hospital should comply with applicable state law restrictions related to admission.

Because EMTALA does not require a hospital to change its capacity or capability, a surveyor lacks the authority to order a hospital to change its customs as long as they are not discriminatory. If a hospital does not "customarily" take unusual steps to accommodate a patient, then it is not obligated to do so under EMTALA. EMTALA does not require a hospital to alter its practices by accepting a male patient into a female room, by admitting a patient into an unstaffed bed, or by ignoring established exclusionary criteria and risking other patients’ safety by admitting violent patients who need a level of care the hospital is not equipped to provide, as some surveyors have suggested. The SOM is clear that the hospital's customary allocation of resources and judgment about where to place patients, staff and equipment is part of the definition of "capacity." Finally, hospitals that are not capable of admitting involuntary patients to their inpatient psychiatric unit comply with EMTALA by offering admission on a voluntary basis, and stabilizing treatment in the ED and transfer for patients who refuse admission and continue as involuntary patients under state law. EMTALA was never intended to push a hospital to take patients beyond its

32 42 U.S.C. §1395dd(f) ("The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.").
33 42 C.F.R. §489.24(d)(3).
capacity or capability, and doing so not only undermines clinical efforts to serve all patients with quality care but can also seriously jeopardize the health and safety of patients and hospital personnel.

* * *

Conclusion:

Hospitals are a vital part of the network of care needed to address the needs of individuals with behavioral health conditions. Hospitals respect their obligations to serve patients and, in particular, to provide evaluation and stabilizing treatment to patients with an EMC to the extent of the hospital's capacity and capability, and to do so in a nondiscriminatory way. If surveyors use EMTALA enforcement for other purposes, such as to seek to expand the capacity of the hospital or to change medical practices that are otherwise reasonable and nondiscriminatory, those actions are not consistent with the law and can be harmful to caregivers and patients. Therefore, we ask that surveyors be thoughtful about the legal authority behind citations related to behavioral patients and be mindful of the unintended consequences that could result from stepping beyond that authority. We understand that CMS may issue clarifying guidance on hospitals' EMTALA obligations with regard to behavioral patients and, if so, we urge CMS to ensure that such guidance is in line with the current authorities and existing policies discussed above.