HOSPITALS’ LEGAL OBLIGATION TO PROVIDE EMERGENCY SERVICES

I. LAWS OBLIGATING HOSPITALS TO PROVIDE EMERGENCY SERVICES

A. Federal

1. The Emergency Medical Treatment and Active Labor Act (“EMTALA”)

   a) Passed by Congress in 1985 to stop patient dumping – i.e., the refusal by hospitals to treat uninsured patients with emergency medical conditions. See Section 1867 of the Social Security Act (“Examination and Treatment for Emergency Medical Conditions and Women in Labor”), codified at 42 U.S.C. § 1395dd.

   b) As a condition of Medicare participation, hospitals with dedicated emergency departments must provide emergency medical services without delay to any and all patients who present with an emergency medical condition, and inquire about or seek payment only after the patient has been stabilized.

   c) Courts have consistently re-affirmed that EMTALA is not a federal malpractice statute.

   d) The Centers for Medicare & Medicaid Services (“CMS”) has promulgated an extensive implementing regulation for the statute. See 42 C.F.R. 489.24 (“Special responsibilities of Medicare hospitals in emergency cases”).
e) Under the implementing rules, hospitals with specialized capabilities, even if they lack dedicated emergency departments, must provide services to individuals with unstabilized emergency medical conditions who are transferred from other hospitals that lack the capability to provide the services required. 42 C.F.R. § 489.24(f).

2. IRS Revenue Ruling 69-545 indicates that a nonprofit hospital with an emergency department must treat patients who require emergency medical services without regard to payment source as a condition of maintaining the hospital’s status as a nonprofit corporation under § 501(c)(3) of the Internal Revenue Code.

B. State (Pennsylvania as example)

1. Condition of Medicaid participation
   a) In Pennsylvania, hospitals must participate in Medicare as a precondition to participating in Medicaid
   b) Participation in Medicare requires compliance with EMTALA

2. Managed care laws – If an enrollee of a managed care plan “seeks emergency services and the emergency health care provider determines that emergency services are necessary, the emergency health care provider shall initiate necessary intervention to evaluate and, if necessary, stabilize the condition of the enrollee without seeking or receiving authorization from the managed care plan.” 40 P.S. § 21116.

3. Health and safety regulations – Hospitals that provide a broad range of services must “provide effective care for any type of patient requiring emergency services.” 28 Pa. Code § 117.13(1).

4. Essential life-saving services – Even hospitals that provide the most limited range of services, and that may therefore elect to refer emergency patients to other facilities, must “institute essential life-saving measures and provide emergency procedures that will minimize aggravation of the condition of the patient during transportation when referral is indicated.” 28 Pa. Code §§ 117.1(a) & 117.13(2)-(3).

II. EMTALA BASICS: SCREENING AND STABILIZATION

A. Screening Requirement: If any individual comes to the emergency department of a hospital and a request is made on the individual’s behalf for examination or treatment, the hospital must provide for an appropriate medical screening examination within the capability of the department, including any ancillary services routinely available to it, to determine whether or not an emergency medical condition exists. 42 U.S.C. § 1395dd(a).
1. CMS defines **comes to the emergency department** (at 42 C.F.R. 489.24(b)) to include when an individual:

   a) Presents to the hospital’s emergency department or (with some exceptions) elsewhere on the main hospital campus;

   b) Is in a hospital-owned ground or air ambulance for transport to the ED; or

   c) Is in a non-hospital-owned ground or air ambulance for transport to the ED that is on the hospital’s grounds.

2. CMS has further determined that an individual in a **nonhospital-owned ambulance** off of hospital property “is not considered to have come to the hospital’s emergency department, even if a member of the ambulance staff contacts the hospital . . . and informs the hospital that they want to transport the individual to the hospital for examination and treatment.” 42 C.F.R. § 489.24(b)(4). In that circumstance, the “hospital may direct the ambulance to another facility if it is in ‘diversionary status,’ that is, it does not have the staff or facilities to accept any additional emergency patients.” Id.

3. The statute defines an **emergency medical condition** as:

   (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in –

   (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

   (ii) serious impairment of bodily functions, or

   (iii) serious dysfunction of any bodily organ or part; or

   (B) with respect to a pregnant woman who is having contractions –

   (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

   (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

   42 U.S.C. 1395dd(e)(1).

4. CMS regulations provide that the statute no longer applies after an individual has been **admitted** to the hospital as an **inpatient**. See 42 C.F.R. § 489.24(d)(2) (If a hospital “admits an individual” it found to have an emergency medical condition “in good faith in order to stabilize the
emergency medical condition, the hospital has satisfied its special responsibilities under this section with regard to that individual”;

B. **Stabilization Requirement:** Only if the **hospital determines** that the individual **does have** an emergency medical condition, it must – given the staff and facilities it has available, including **on-call physicians** – provide such further examination and treatment as required **to stabilize** the emergency medical condition **or** arrange for a **transfer** to another facility in accordance with the statute. 42 U.S.C. § 1395dd(b)(1).

1. **To stabilize** the emergency medical condition does not necessarily mean to resolve the condition, but rather only to provide the necessary medical treatment to assure “within reasonable medical probability, that no material deterioration of the condition is likely to occur during the transfer” of the patient to another facility **or** the discharge of the patient. 42 U.S.C. § 1395dd(e)(3)(A) & (4) (emphasis added).

2. Under 42 U.S.C. § 1395dd(c)(1), a hospital **may not transfer** an individual with an unstabilized emergency medical condition **unless:**
   
a) The individual requests a transfer in writing; or

b) A physician certifies in writing that the medical benefits reasonably expected from the transfer outweigh the risks involved; or

   c) If a physician is not physically present, a qualified non-physician medical person makes the same written certification in (b) above in consultation with a physician.

3. CMS rules state that a hospital that participates in Medicare and has **specialized capabilities or facilities** may not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities, provided it has the capacity to treat the individual. 42 C.F.R. § 489.24(f).

C. **On-Call Requirements:** With respect to **on-call physicians**, CMS rules provide that:

1. A hospital with an emergency department must maintain a list of on-call physicians to provide treatment necessary to stabilize individuals with emergency medical conditions at the hospital, 42 C.F.R. § 489.20(r)(2), and that list must identify the on-call physicians by name. See State Operations Manual CMS Pub. 100-07), Appendix V, Interpretive Guidelines, § 489.20(r)(2).

2. A hospital may permit physicians who are on-call (i.e., available to provide stabilizing services to individuals as necessary under EMTALA) also to schedule elective surgery during the on-call time and to have

3. The failure or refusal of an on-call physician to appear in a reasonable period of time to provide stabilizing treatment requested by an examining physician subjects both the on-call physician and the hospital to EMTALA liability under 42 U.S.C. § 1395dd(d)(1)(C).

D. Elements of Proof in EMTALA Actions: To establish a violation of EMTALA, plaintiff must show that: (i) hospital is a participating hospital, covered by EMTALA, that operates an emergency department; (ii) an individual came to the emergency department and a request was made on the individual’s behalf for examination or treatment for a medical condition; (iii) there was a failure to screen and/or to stabilize the individual within the meaning of the statute.

1. To prove a “failure to screen” claim, plaintiff must show that the hospital failed to afford him or her a screening reasonably calculated to identify critical medical conditions that may be afflicting symptomatic patients, which the hospital uniformly provides to all those who present with substantially similar complaints. Correa v. Hospital of San Francisco, 69 F.3d 1184, 1189-92 (1st Cir. 1995), cert. denied, 517 U.S. 1136 (1996); del Carmen Guadalupe v. Negron Agosto, 299 F.3d 15, 19 (1st Cir. 2002).

a) Substantive element: screening must be reasonably calculated to uncover existence of EMC. Does not impose a standard of care, although extreme conduct (if screening is “so delayed or so paltry as to amount to no screening at all”) can violate EMTALA. See, e.g., Byrne v. Cleveland Clinic, 684 F.Supp.2d 641, 653-54 (E.D. Pa. 2010) (denying motion to dismiss screening violation claim pursuant to which plaintiff alleged that hospital took “excessive time” to assess his complaint of chest pains).

b) Procedural element: Same level of screening must be uniformly provided to all individuals with substantially similar complaints. Disparate treatment can be demonstrated by showing that hospital did not follow its own screening procedures. See, e.g., Phillips v. Hillcrest Med. Ctr., 244 F.3d 790, 797 (10th Cir. 2001) (hospitals held to screening standards they create).

2. To prove a “failure to stabilize,” the plaintiff must show that he or she “(1) had ‘an emergency medical condition; (2) the hospital actually knew of that condition; [and] the patient was not stabilized before being transferred.’” Toretti v. Main Line Hospitals, Inc., 580 F.3d 168, 178 (3rd Cir. 2009) (quoting Baber v. Hosp. Corp. of Am., 977 F.2d 872, 883 (4th Cir. 1992)).

3. Civil enforcement of EMTALA by individuals
a) Action must be brought within two years of violation. 42 U.S.C. § 1395dd(d)(2)(C).

b) No cause of action by an individual against ED physicians, only against participating hospital. 42 U.S.C. § 1395dd(d)(2)(A).

c) Damages available for personal harm in the amount available for “personal injury under the law of the State in which the hospital is located.” 42 U.S.C. § 1395dd(d)(2)(A).

ISSUES AND RECENT CASES IN EMTALA LAW

III. APPLICATION OF EMTALA TO INPATIENTS

A. Prior to 2003: Federal courts reached different conclusions as to whether EMTALA applied to unstable inpatients. For example:

1. Thorton v. Southwest Detroit Hospital, 895 F.2d 1131, 1134 (6th Cir. 1990) (applying EMTALA to inpatients).

2. Bryan v. Rectors and Visitors of the Univ. of Va., 95 F.3d 349 (4th Cir. 1996) (finding that EMTALA did not apply to inpatients); Harry v. Marchant, 291 F.3d 767 (11th Cir. 2002) (same).

3. Courts recognize narrow “bad faith” exception to rule that stabilization requirement is met once hospital admits patient as inpatient. See, e.g., Bryant v. Adventist Health System/West, 289 F.3d 1162 (9th Cir. 2002) (Hospital cannot escape liability under EMTALA by admitting unstable patient with no real intention of providing treatment, and then discharging or transferring the patient without having met the stabilization requirement. Burden is on patient to prove that admission was not in good faith).

B. September 2003: CMS issues final rule to the effect that treating hospital’s obligation under EMTALA to a patient with an EMC ends either when the individual’s EMC is stabilized or when the hospital, in good faith, admits the individual as an inpatient. 42 C.F.R. 489.24(d)(2).


D. August 2008: CMS takes position that all EMTALA obligations end upon patient’s admission as inpatient

1. In August 2008, CMS amended 42 C.F.R. § 489.24(f) to state that a specialized care hospital also has no obligation under EMTALA to accept an appropriate transfer of an inpatient at another hospital whose emergency medical condition is still unstable and who requires the
services of the specialized care hospital to stabilize the condition. 73 Fed. Reg. 48434, 48661 (August 19, 2008).

2. Thus, CMS took the position that EMTALA obligations now definitively end at admission for both the admitting hospital and any specialized care hospital to which the admitting hospital might seek to transfer the patient, even if the inpatient’s condition has not been stabilized.

3. The specialized capabilities hospital rule guidance exemplified the benefits of “notice and comment rulemaking.”

   a) Based on the recommendations of the EMTALA Technical Advisory Group, CMS initially had proposed that the specialized care hospital would have had a continuing obligation under the statute to accept transfer of an inpatient who required the specialty care to stabilize his or her continuing unstabilized emergency medical condition.

   b) Public comments in response to the proposed rule raised numerous concerns. These included, most prominently, that tertiary care, urban safety net, and teaching hospitals that already provide care to indigent and uninsured patients would become even further overburdened. Id. at 48658.

E. April 2009: Sixth Circuit refuses to follow CMS regulation on EMTALA and inpatients


   a) Facts: Plaintiff took husband to emergency room because he had physical and psychological symptoms, and had threatened her. Husband admitted to hospital and physicians planned to transfer him to psychiatric unit, but did not do so. Discharged after six days with diagnosis of “atypical psychosis with delusional disorder,” husband killed plaintiff 10 days later.

   b) Procedure: Plaintiff’s estate brought EMTALA and negligence claims. Trial court granted Hospital summary judgment on EMTALA claim on the ground that plaintiff lacked standing to bring it once hospital admitted husband.

   c) Holding: Reversed. Plaintiff had standing and hospital’s obligation to stabilize husband’s emergency medical condition did not end upon his admission to the hospital as an inpatient.

   d) Analysis: Court found that hospital had obligation under statute to provide treatment (on inpatient or outpatient basis) such that no
material deterioration of condition was likely to result from or occur during patient’s release from hospital. Court declined to follow, as “contrary to EMTALA’s plain language,” the CMS rule that says that obligation ends upon admission. Noted also that CMS issued September 2003 rule after plaintiff’s husband was discharged from the hospital, and the court would not in any event apply the rule retroactively in this case. Court found issues of fact as to whether husband had emergency medical condition when he presented to the hospital and whether condition remained unstable upon his discharge.

2. Sixth Circuit also diverges from other circuits by requiring that to establish a violation of EMTALA’s screening requirement, patient must show that hospital acted with “improper motive” in not applying screening procedures uniformly (e.g., hospital screened patient differently because he or she was not insured). See Burd v. Lebanon HMA, Inc., No. 3:09-cv-0262, 2010 U.S. Dist. LEXIS 124696, at *11-*23 (M.D. Tenn. Nov. 23, 2010) (criticizing but necessarily following the Sixth Circuit’s unique improper motive requirement, and granting defendant’s motion for summary judgment based on plaintiff’s failure to provide evidence of such motive).

F. December 2010: CMS issues advanced notice of proposed rulemaking (“ANPRM”) soliciting comments on need to revisit the September 2003 and August 2008 final rules – i.e., the applicability of EMTALA to inpatients and the responsibilities of hospitals with specialized capabilities. 75 Fed. Reg. 80762 (December 23, 2010).

1. Notice acknowledges “range of opinions even at the Circuit Court level on the topic of EMTALA’s application to inpatients.”

2. Notice specifically requests information regarding any situations in which patient with unstabilized EMC was admitted as inpatient, transfer was attempted to hospital with specialized capabilities needed to stabilize the EMC, and hospital with specialized capabilities refused to accept the transfer because it was not obligated to do so under current CMS rules.

G. February 2012: CMS issues request for comments on the applicability of EMTALA to hospital inpatients and hospitals with specialized capabilities. 77 Fed. Reg. 5213 (February. 2, 2012). Sets forth the CMS position in light of the comments received in response to the ANPRM.

1. CMS is not proposing to change the EMTALA obligations for hospitals admitting an individual through their dedicated emergency departments. That is, if an individual “comes to the [hospital’s] emergency department,” as defined in regulation, and the hospital provides an appropriate medical screening examination and determines that an EMC 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.

2. CMS is not proposing to change current regulations for hospitals with specialized capabilities. That is, if an individual comes to the hospital’s dedicated emergency department, is determined to have an EMC, is admitted as an inpatient, and continues to have an unstabilized EMC which requires the specialized capabilities of another hospital, the EMTALA obligation for the admitting hospital has ended and a hospital with specialized capabilities also does not have an EMTALA obligation towards that individual.

IV. ON-CALL ARRANGEMENTS

A. In 2008, CMS amended 42 C.F.R. § 489.24(j)(2)(iii) to permit hospitals to participate in formal community call plans to meet their obligation to have on-call physicians available to provide stabilizing services required by EMTALA. 73 Fed. Reg. 48434, 48667 (August 19, 2008).

1. The rule makes clear that the hospital itself would still be required to perform medical screening examinations and to conduct appropriate transfers. 42 C.F.R. § 489.24(j)(2)(iii).

2. With regard to specialty care necessary to stabilize emergency medical conditions, however, a hospital may participate in a joint plan with other facilities “that permits a specific hospital in a region to be designated as the on-call facility for a specific time period, or for a specific service, or both.” 73 Fed. Reg. at 48663.

3. Necessary elements of such a formal plan include:
   a) a clear delineation of on-call coverage responsibilities;
   b) a description of the specific geographic area to which the plan applies;
   c) a signature by an appropriate representative of each hospital participating in the plan;
   d) assurances that any local and regional EMS system protocol formally includes information on community call arrangements;
   e) a statement specifying that all the hospitals retain the obligation to provide medical screening examinations, stabilizing treatment within their respective capabilities, and appropriate transfers, in accordance with the EMTALA regulation; and
   f) an annual assessment of the community call plan by the participating hospitals.
4. CMS noted that it promulgated the community call provision to further address concerns, identified previously in 2002, over physicians severing their relationships with hospitals because of on-call obligations and resulting shortages in the hospitals’ specialty physician coverage for their patients.

B. Payment for on-call ER services:

1. **OIG Advisory Opinion No. 09-05 (May 21, 2009).** OIG concluded that it would not impose administrative sanctions for violations of the federal antikickback statute (“AKS”) against a Requesting Hospital for a proposed arrangement under which the hospital would pay members of its medical staff for *on-call ER services the physicians provided to indigent patients.*

2. **Legal Background.** On-call arrangements implicate the AKS, federal and state physician self-referral statutes (i.e., the Stark laws), and various Medicare payment issues.

   a) Because on-call physicians may order items and services paid for by federal health care programs from the hospital, hospital payment to these physicians implicates the AKS.

      (1) On-call arrangements may satisfy certain statutory and regulatory safe harbors to the federal law, including those for employment and for personal services and management contracts. 42 U.S.C. § 1320a-7b(b)(3)(B); 42 C.F.R. § 1001.952(d) & (i). Even if arrangement does not meet safe harbor, it may still be permissible under the law.

      (2) State AKSs frequently result in the imposition of criminal and civil penalties, and may not include safe harbor protection.

   b) On-call arrangement will violate **Stark** if it results in a contracted on-call physician referring a Medicare patient to the hospital for a designated health service (such as for an x-ray) and the physician (or a member of his or her immediate family) has a financial relationship with the hospital, unless that relationship meets the requirements of a statutory or regulatory Stark exception.

      (1) Stark exceptions for which on-call arrangements may qualify include:

         (a) physician services and in-office ancillary services exemptions, 42 U.S.C. § 1395nn(b)(2) & 42 C.F.R. § 411.355(a); and

         (b) compensation arrangement exceptions for: (i) personal service arrangements, 42 U.S.C. §
1395nn(e)(3) & 42 C.F.R. § 411.357(d); (ii) bona
fide employment relationships, 42 U.S.C. §
1395nn(e)(2) & 42 C.F.R. § 411.357(c); (iii) fair
market value compensation arrangements, 42
C.F.R. § 411.357(l); and (iv) indirect compensation
arrangements, 42 C.F.R. § 411.357(p).

(2) State statutes prohibiting physician self-referrals may pose
further obstacles, as these statutes may, for example, be
unlimited by payor type, extend more broadly to on-
physician clinicians, and/or require disclosure of financial
interests to referred patients.

c) Valuation and Insurance Issues

(1) Independent and accurate valuation of physician services is
the key to establishing their fair market value, both for
purposes of meeting Stark exceptions and AKS safe
harbors, and in arguing that OIG should not sanction an
arrangement even though it does not meet an AKS safe
harbor.

(2) Note that an AKS safe harbor (42 C.F.R. § 1001.952(o))
and Stark exception (42 C.F.R. § 411.357(r)) may protect
hospital subsidy payments to reduce physicians’
malpractice costs so as to encourage physician on-call
participation. Those provisions as currently drafted,
however, protect only insurance subsidies provided to
obstetricians.

3. Several factors led the OIG in Opinion No. 09-05 to conclude that even
though it did not qualify for any of the safe harbors to the AKS, the
proposed arrangement presented a low risk of fraud and abuse, including
that:

a) Requesting Hospital certified that it would pay physicians within
the range of fair market value for the services rendered, and
without regard to referrals or other business generated between the
parties;

b) Requesting Hospital historically had experienced difficulty
maintaining sufficient on-call specialist coverage, which suggested
a legitimate rationale for revising its on-call coverage policy;

c) Proposed arrangement included features that further minimized
any risk of fraud and abuse, including that the arrangement: (i)
would be offered uniformly to all medical staff and imposed
tangible responsibilities on the same; (ii) employed an equitable
scheduling methodology that did not reward highest referrers of
business to Requesting Hospital; and (iii) required that physicians document in detail the actual services that would be reimbursed under the arrangement; and

d) Proposed arrangement was an equitable mechanism for the Requesting Hospital to compensate physicians who actually provide care that the hospital must furnish to be eligible for state program funding.

4. While favoring the proposed arrangement, the OIG identified other potential methods of paying on-call physicians that would be more likely to lead to liability under the AKS, including:

   a) compensating on-call physicians for “lost opportunity” costs or making similarly designated payments that do not reflect bona fide lost income;

   b) payment structures that compensate physicians when no identifiable services are provided;

   c) aggregate on-call payments that are disproportionately high compared to the physicians’ regular medical practice income; and

   d) payment structures that compensate on-call physician for professional services for which he or she receives separate reimbursement from insurers or patients, resulting in the physician being paid twice for the same service.

V. THE MEANING OF “COMES TO THE EMERGENCY DEPARTMENT”

A. EMTALA regulations make clear that an individual in a non-hospital-owned ambulance is not considered “to have come to the hospital” if the ambulance is not on hospital property, even if a member of the ambulance staff contacts the hospital. Hospital could still direct ambulance to another facility, if hospital did not have the capacity to treat the patient (i.e., was in “diversionary status”). 42 C.F.R. § 489.24(b)(4).

B. Unsettled whether hospital could direct ambulance to another facility even if the hospital was not in diversionary status.


   1. Facts: Paramedics transporting patient to Hospital in non-Hospital owned ambulance contacted emergency department while en route. Director of Hospital’s hung up on paramedics without stating that Hospital was in diversionary status. Paramedics interpreted this as a refusal to treat patient and took her to another facility.
2. **Procedure:** Patient brought EMTALA claim and tort claims. Hospital moved for summary judgment on EMTALA claim, which the trial court granted.

3. **Holding:** Reversed. Under 42 C.F.R. § 489.24(b)(4), Hospital could only have turned away plaintiff if it had been in diversionary status. That was not the case here.

4. **Analysis:** *Morales* follows the interpretation of *Arrington v. Wong*, 237 F.3d 1066 (9th Cir. 2001) that “comes to” could mean both “on the way to” or “has arrived at,” and that the regulation is unclear as to whether being on “diversionary status” is the only permissible basis for turning away a patient en route. Concludes that a rule to that effect is consistent with the goal of EMTALA to prevent refusals to treat uninsured patients.

5. **Dissent:** Makes similar arguments as dissent in *Arrington* – (i) “comes to” must mean “arrives at,” otherwise statute/regulation would say “is coming to”; (ii) EMTALA limited to physical presence at hospital; and (iii) majority’s interpretation makes the first and second sentences of § 489.24(b)(4) superfluous.

VI. **OVERVIEW OF EMTALA CASE LAW IN 2008-2011**

A. Federal courts in 2008 to 2011 continued to emphasize the narrow practical scope of an EMTALA violation. These holdings reinforced, among other things, that:


3. A hospital automatically meets the screening and stabilization obligations when it admits an individual as an inpatient in a good faith intent to


5. EMTALA does not apply to hospital outpatients and stabilization requirement does not apply to patients who are not transferred. See, e.g., Toretti v. Main Line Hospitals, Inc., 580 F.3d 168 (3d Cir. 2009); Alvarez-Torres v. Ryder Memorial Hospital, 582 F.3d 47 (1st Cir. 2009).

B. Between 2008 and 2011, however, the federal courts did find potential EMTALA violations in certain extreme cases, including decisions:

1. Denying defendant hospital’s motion to dismiss an allegation that it discharged without adequate screening an uninsured patient who had recently and suddenly lost the ability to walk. See Stowe v. Russell, 564 F.Supp.2d 666 (E.D. Tex. 2008).

2. Denying defendant hospital’s motion for summary judgment regarding a plaintiff who was at high risk for coronary artery disease, based on the providers’ failure to perform enzyme tests, serial EKGs, a cardiology consultation, or a cardiac perfusion scan. Martinez v. Porta, 598 F.Supp.2d 807 (N.D. Tex. 2009). The court reached this decision despite the fact that plaintiff had been admitted as inpatient;

3. Denying defendant hospital’s motion for a new trial based on finding that a physician’s certification for transfer did not absolve the hospital of liability for an EMTALA violation, given that the patient was not stable at time of and did not request the transfer, and that the certification failed to identify why the benefits of transfer outweighed the risks. Heimlicher v. Steele, 615 F.Supp.2d 884 (N.D. Iowa 2009).

4. Denying defendant hospital’s motion for summary judgment as to plaintiff’s EMTALA screening violation claim because of unresolved questions regarding the hospital’s interpretation of plaintiff’s chest pain, the extent to which the hospital followed its own chest pain protocol, and the length of time it took to administer an EKG to the patient. Johnson v. Portz, No. 08-593, 2010 U.S. Dist. LEXIS 40538 (D. Del. Apr. 22, 2010).
See also Byrne v. Cleveland Clinic, 684 F. Supp.2d 641 (E.D. Pa. 2010) (likewise denying defendant’s motion for summary judgment as to plaintiff’s EMTALA screening violation claim based on allegations of “excessive time” it took to perform a screening).


VII. OVERVIEW OF EMTALA CASE LAW IN 2011-2013

A. Federal courts in the past three years have continued to emphasize the narrow practical scope of an EMTALA violation. These holdings reinforce, among other things, that:

1. Whistleblower protections do not apply to a plaintiff who was not directly or personally harmed or retaliated against for reporting an existing EMTALA violation, i.e., a failure to screen a patient, stabilize a patient, or transfer a patient in an unstable condition. Genova v. Banner Health, 896 F. Supp. 2d 993 (D. Colo., 2012), aff’d, Genova v. Banner Health, 734 F.3d 1095 (10th Cir. 2013), cert. denied, 13-904, 2014 WL 318444 (U.S. Feb. 24, 2014).


5. A physician’s medical judgment may not substitute for a hospital’s internal protocols for the purposes of meeting the EMTALA’s appropriate screening requirements. Cruz-Vazquez v. Mennonite Gen. Hosp., 717 F.3d 63 (1st Cir. 2013).

6. The Seventh Circuit affirmed the dismissal of a patient’s EMTALA claims, agreeing with the lower court that because a later clarification to the definition of “come to the emergency room” applied, plaintiff failed to state a claim under EMTALA. Beller v. Health and Hospital Corp., 703 F.3d 388 (7th Cir. 2012).

7. A federal court in Minnesota denied a defendant hospital’s motion to dismiss an EMTALA claim alleging it failed to provide a mental health screening or stabilizing treatment to a patient who sought care there. Lee v. Hennepin County, CIV. 13-1328 PJS/AJB, 2013 WL 6500159 (D. Minn. Dec. 11, 2013).


11. There is no private cause of action against physicians for violations of EMTALA, and a hospital may not recover indemnification from those same physicians so as to permit the hospital to accomplish indirectly what their patients are not permitted to accomplish directly. Cisneros v. Metro Nashville Gen. Hosp., No. 3:11-0804, 2013 WL 817243 (M.D. Tenn. Mar. 5, 2013).

B. Since 2011, the federal courts have also limited the extent to which hospitals have been able to collect payment for out-of-network emergency services:


3. For a recent, academic discussion of calculating the reasonable value of out-of-network services, see George A. Nation III, Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients, 65:2 BAYLOR L. REV. 426 (2013).

VIII. OVERVIEW OF OIG PATIENT DUMPING CIVIL MONETARY PENALTIES SETTLEMENTS IN 2011-2013

Under various federal laws, the Office of Inspector General of the U.S. Department of Health and Human Services (“OIG”) may impose administrative sanctions against hospitals for activities that pose a risk to federal health care programs and their beneficiaries. These sanctions include the imposition of civil monetary penalties (“CMPs”) for violating EMTALA.

The OIG resolves many of the cases it pursues under EMTALA through settlement agreements. In each CMP case resolved through a settlement agreement referenced in the table below, the settling party contested the OIG’s allegations and denied liability. No CMP judgment or finding of liability was made against the settling party.
The following table summarizes the settlement agreements entered into by entities subject to EMTALA and the OIG in 2011, 2012, and 2013.

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PAYMENT AND REIMBURSEMENT FOR EMERGENCY SERVICES

IX. COST REPORTING REQUIREMENTS

A. Under Medicare rules, hospitals that contract for ER department on-call services may include as allowable costs on cost reports the “reasonable costs” incurred in furnishing healthcare services. 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. §§ 415.50-.70.

B. To do so, a hospital must submit a written allocation agreement between the physician and the hospital that identifies the time the physician has committed to hospital services, patient services, and services not payable under Medicare Parts A or B.

X. MEDICARE ADVANTAGE PLANS (FEDERAL LAW)

A. Medicare Advantage members are entitled to receive emergency coverage, whether or not the provider is under contract with the plan; plans are “financially responsible” to pay providers. 42 C.F.R. § 422.113(b)(2), (c).

B. For patients enrolled in non-contracted Medicare Advantage Plans (“MAPs”) or risk sharing plans, § 1866 of the Social Security Act (“SSA”), 42 U.S.C. § 1395cc(a)(1)(O), requires, as a condition of Medicare participation, that any non-participating provider of services shall “accept as payment in full” for covered services “the amounts that would be made as payment in full” for a fee-for-service Medicare enrollee, “less any pass-through payments” made for the managed care enrollees “under sections 1886(d)(11) and 1886(h)(3)(D)” of the SSA (i.e., IME and GME). 42 U.S.C. § 1395cc(a)(1)(O); 42 C.F.R. §§ 422.214, 422.100(b), 412.106(g), § 413.76. This rate applies to both emergency and non-emergency care, if covered.

C. As HHS explained at 65 F.R. 40170, 40242-43 (June 29, 2000):

1. Under Section 1852(a)(2) of the SSA, 42 U.S.C. §1395w-22(a)(2), a Medicare MCO (other than a MSA plan) must pay Medicare FFS amount (and no less) for services rendered by a nonpar provider to: coordinated care plan enrollees; private fee-for-service plan enrollees.

2. MAPs may pay the lesser of the Medicare FFS amount or the nonpar provider’s billed charges for the following services rendered by a nonpar provider:
a) emergency services (Section 1852(d)(1)(E));

b) urgently needed services (Section 1852(d)(1)(C)(i));

c) renal dialysis services provided out of the MCO’s service area (Section 1852(d)(1)(C)(ii)); and

d) maintenance care or post-stabilization services furnished to a coordinated care enrollee (Section 1852(d)(1)(C)(ii)).

3. CMS counsel have indicated informally that federal law relating to out-of-network (“OON”) payments for emergency services does not preclude a Medicare MCO from paying the provider a higher amount than the Medicare FFS payment (less pass-throughs), or prohibit a provider from accepting as payment from the Medicare MCO a greater amount.

D. Providers may not balance bill Medicare enrollees for amounts not paid by MCOs for covered services except for authorized co-payments. Section 1866(a)(1)(A) & (O) of the SSA (42 U.S.C. § 1395cc(a)(1)(A) & (O)).

E. Non-contracted providers may be able directly to sue a plan for payment in the event of a dispute, based on the fact that federal law makes the Medicare MCO financially responsible for OON care, without regard to prior authorization. 42 C.F.R. § 422.113(b)(i) & (ii).

F. Exhaustion of administrative remedies is an issue. Plans have argued that providers’ payment claims “arise under” the Act, and that jurisdiction over common law claims is thus precluded and subject to exclusive “administrative remedies.”

1. Rencare, Ltd. v. Humana Health Plan of Texas, Inc., 395 F.3d 555, 557 (5th Cir. 2004), held that provider’s reimbursement dispute with a plan arises under contract law, not the Act; no administrative claim or exhaustion of federal administrative process is necessary (or even available).

XI. MEDICAID MANAGED CARE PLANS (FEDERAL LAW)

A. Medicaid MCOs must pay non-plan providers promptly for “emergency services” furnished to their enrollees without regard to a prior authorization from the MCO. See e.g., 42 U.S.C. §§ 1396b(2)(1)(vii), 1396b(m), 1396u-2(b), 1395mm(g)(6)(A); 42 C.F.R. § 438.114. See also 42 C.F.R. § 438.114(a) (defining “emergency services”).

1. Emergency services may include emergency transfers to a non-plan hospital.


3. Any case in which “a representative of the [MCO] . . . instructs the enrollee to seek emergency care” is deemed an emergency. 42 C.F.R. § 438.114(c)(2)(B). Should cover referrals by participating PCPs.

4. Medicaid MCOs may transfer patients to in-network provider if physician treating the enrollee deems patient stabile for transfer. 42 C.F.R. § 438.114(e) (Medicaid rules), incorporating 42 C.F.R. § 422.113(b) and (c) (M+C Rules). Physician, not MCO, determines if patient is stable. Id.

5. Medicaid MCO also must pay for “post-stabilization” care under defined circumstances. See 42 C.F.R. § 438.114(b), (e), incorporating § 422.113(c). Law and rules are silent on payment rates for post-stabilization services.

B. Payment Rates Under the Deficit Reduction Act of 2005

The SSA was amended by the Deficit Reduction Act of 2005, S. 1932 (the “DRA”), to adopt the following Medicaid default rate provision:

SEC. 6085. EMERGENCY SERVICES FURNISHED BY NON-CONTRACT PROVIDERS FOR MEDICAID MANAGED CARE ENROLLEES.

(a) In General - Section 1932(b)(2) of the Social Security Act (42 U.S.C. 1396u-2(b)(2)) is amended by adding at the end the following new subparagraph:

(D) EMERGENCY SERVICES FURNISHED BY NON-CONTRACT PROVIDERS - Any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity’s Medicaid managed care plan must accept as payment in full the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this title other
than through enrollment in such an entity. In a state where rates paid to hospitals under the state plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the state plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals. [Emphasis added.]

(b) Effective Date - The amendment made by subsection (a) shall take effect on January 1, 2007.

1. The DRA default rate is limited to emergency services; inapplicable to elective care and covered Medicaid services available only from an OON provider.

2. Policy implications: By limiting MCO obligation to FFS rates, it may tilt the negotiating table toward MCOs.


4. Providers may be able directly to sue Medicaid MCOs because federal law requires MCO to “hold harmless” the enrollee for services received from non-contracted providers. 42 C.F.R. §§ 438.106, 438.114(b)(i) & (c). Consider suits under 42 U.S.C. § 1983 (action by Medicaid MCO as under color of state law).

5. **Note:** It is not definitively clear that the SSA prohibits an OON provider from “balance billing” a Medicaid enrollee for whom emergency care is not paid in full by the Medicaid MCO. See generally § 1128B(d)(1) of the SSA, 42 U.S.C. § 1320a-7b(d)(1).

XII. OON COVERAGE BY MCOS UNDER STATE LAW

The payment rights and obligations of non-contracted providers may vary significantly depending on state laws, including such laws that pertain to coverage of OON services; holding members harmless (i.e., balance billing prohibitions); provider prompt payment requirements; and any willing provider laws.

Consider, for example, applicable law in Pennsylvania.

A. Medicaid:

1. Payment for OON emergency services is set based on the regular Medicaid fees under the DRA, supra, which, effective January 1, 2007, controls over any inconsistent state law as to Medicaid enrollees.
Assem., Reg. Sess. (Pa. 2002), included a provision that limited payment
for out-of-network emergency services rendered to Medicaid patients by
noncontracting providers to the Medicaid fee-for-service ("FFS") rates for
2002-2003 (i.e., fiscal year ending June 30, 2003). MCOs lobbied PA to
include similar provision in subsequent annual budget bills, but failed.
Providers challenged the constitutionality of the 2002-2003 default rate
provision. The Hospital & Healthsystem Ass’n of Pa v. Department of
dismissed the providers’ case on preliminary objections. On review, No.
219 MAP 2003 (Pa. Dec. 27, 2005), the Pennsylvania Supreme Court
struck the Medicaid FFS default rate as violative of the constitutional
prohibition against enacting substantive law through a GAA, concluding
that mandating the use of the Medicaid FFS rates was inconsistent with,
and would have required a substantive amendment of, the requirements
under Act 68, infra, to pay “all reasonably necessary costs of emergency
medical services.”

B. Pennsylvania’s Quality Health Care Accountability and Protection Act (“Act
68”): Applies to all MCOs (i.e., “gatekeeper” plans). Section 2116, 40 Pa. C.S. §
991.2116, relevantly states:

If an enrollee seeks emergency services and the emergency health care
provider determines that emergency services are necessary, the emergency
health care provider shall initiate necessary intervention to evaluate and, if
necessary, stabilize the condition of the enrollee without seeking or
receiving authorization from the managed care plan. The managed care
plan shall pay all reasonably necessary costs associated with the
emergency services provided during the period of emergency. If any
enrollee’s condition has stabilized and the enrollee can be transported
without suffering detrimental consequences or aggravating the enrollee’s
condition, the enrollee may be relocated to another facility.

Note: In a more general provision, Act 68 also states that the
responsibilities of a managed care plan include assuring 24/7 availability
of, and payment of a “reasonable payment or reimbursement for
emergency services.” 40 P.S. § 991.2111(4).

1. The Pennsylvania Supreme Court in HAP v. DPW, supra, held that
obligation to pay for reasonably necessary costs of emergency care did not
require providers to accept Medicaid fee-for-service rates as a default rate.

2. What comprises “all reasonably necessary costs” of emergency care as
used in Section 2116, was raised in a suit brought in August 2005,
Trustees of Univ. of Penn. d/b/a Univ. Penn. Health System v.
AmeriChoice Health Plan, Phil. Ct. Com. Pl. No. 004392 (“UPHS”). In
an interlocutory Order and Memorandum of January 23, 2007 in Trustees,
the Common Pleas Court concluded that the statutory phrase did not
contemplate HMOs having to indemnify beneficiaries or pay providers
based on the providers’ charges for the emergency services, but on the costs incurred by providers – with no margin – in furnishing the services. On February 6, 2007, plaintiff filed a motion to reconsider this order or certify it for interlocutory appeal. One other Pennsylvania court has relied on Trustees to likewise hold that § 2116 only requires plans to pay providers their costs for OON emergency services. Allegheny General Hospital v. UPMC Health Plan, Inc., Nos. GD02-022163, GD06-00771, & GD06-007769 (Allegheny Cty Ct. Comm. Pleas) (Memorandum and Order of Court of December 18, 2007).

3. It appears that to the extent not prohibited by federal law, patients may be balance billed by OON providers for amounts not covered by their MCOs under § 2116. The regulations relevantly require only that MCOs include provisions in their agreements with contracted providers to waive rights to balance bill 28 Pa. Code § 9.722(e)(1). See generally Prospect Medical Group, Inc. v. Northridge Emergency Medical Group, 39 Cal. Rptr. 3d 456 (2006) (construing similarly worded California statutes as precluding balance billing only by “contracted” providers under express written agreements). The rules recognize simultaneously that enrollees may have personal financial responsibility for OON emergency services. 31 Pa. Code § 154.15(g)(1). See also Baldwin Emergency Medical Serv. v. Highmark, Inc., 2005 WL 200666 (W.D. Pa. Jan. 10, 2005) (Pennsylvania Health Care Practitioners Medicare Fee Control Act does not proscribe balance billings for unpaid charges by ambulance services).

4. Contrary arguments can be made. The key language appears to refer to costs to patients for services reasonably necessary to treat not in context costs incurred by providers: that is, the provider’s charges (unless the MCO negotiates a lower rate for the case). Without insurance, such “costs” to patients generally would be noncontracted providers’ full billed charges. Also, the standard applies equally to emergency services provided by facilities and medical professionals; there are no “cost reports” or determinations of reasonable costs for the latter. Regulations implementing § 2116 likewise indicate that the measure of payment for emergency services is “reasonably necessary costs for enrollees meeting the prudent layperson definition of emergency services.” 31 Pa. Code § 154.14(b).

5. It is important to distinguish between pre-and post-stabilization services. If a plan declines to transfer a medically stable hospital patient upon notice from the OON hospital, consider claims for billed charges for such services – which are not controlled by § 2116 – under contact implied in fact. This theory finds support in the Restatement (2d) of Contracts.

6. Claims for OON payments based on Act 68 may be advanced under an unjust enrichment theory. There is a separate issue whether a provider also has an implied right of action to enforce statutory provisions requiring payments for OON emergency services. Solomon v. U.S. Healthcare Systems of Pennsylvania, Inc., 797 A.2d 346 (Pa. Super.), alloc. denied.

C. **Motor Vehicle Financial Responsibility Law:** Under the Pennsylvania MVFRL, providers’ charges are statutorily limited to no more than an amount based on 110% of the Medicare fee schedule. 75 Pa.C.S. § 1797(a).

D. **Workers Compensation Act:** Under the Pennsylvania Workers Compensation Act, all providers’ charges are statutorily limited to an amount based on 113% of the Medicare fees or 80% of the usual and customary charges. 77 P.S. § 531(3)(i). However, if acute care is provided to a trauma patient in a trauma center, or to a burn patient by a burn facility, or if basic advanced life support services as defined and licensed under the Emergency Medical Services Act are provided, the amount of payment is the usual and customary charge. 77 P.S. § 531(10).

E. **Pennsylvania Health Care Practitioners Medicare Fee Control Act (“MOMs Act”), 35 P.S. § 449.31 et seq.:** Under the MOMs Act, “health care practitioners” or entities that employ health care practitioners may not balance bill Medicare beneficiaries for a total amount that exceeds the regular Medicare FFS fees. Limit only applies to practitioners’ services. See Baldwin Emergency Medical Servs., supra.

**XIII. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010: EMERGENCY SERVICES PROVISIONS**

A. See, Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended by The Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (the “Affordable Care Act”).

B. “Section 1302(b) of the Affordable Care Act defines essential health benefits to ‘include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services;
hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.’’ Interim Final Rule, 75 Fed. Reg. 37194 (June 28, 2010)(emphasis added).

C. If a plan or health insurance coverage provides any benefits with respect to emergency services in an emergency department of a hospital, the plan or issuer must cover emergency services without the individual or the health care provider having to obtain prior authorization (even if the emergency services are provided out of network) and without regard to whether the health care provider furnishing the emergency services is an in-network provider. 75 Fed. Reg. 37194 (June 28, 2010).

D. For a plan or health insurance coverage with a network of providers that provides benefits for emergency services, the plan or issuer may not impose any administrative requirement or limitation on benefits for out-of-network emergency services that is more restrictive than the requirements or limitations that apply to in-network emergency services. Id.

E. Additionally, for a plan or health insurance coverage with a network, cost-sharing requirements expressed as a copayment amount or coinsurance rate imposed for out-of-network emergency services cannot exceed the cost-sharing requirements that would be imposed if the services were provided in-network. Out-of-network providers may, however, also balance bill patients for the difference between the providers’ charges and the amount collected from the plan or issuer and from the patient in the form of a copayment or coinsurance amount. Id.

1. To avoid the circumvention of the protections of Affordable Care Act, it is necessary that a reasonable amount be paid before a patient becomes responsible for a balance billing amount. In establishing the reasonable amount that must be paid, the interim final regulations consider three amounts: the in-network rate, the out-of-network rate, and the Medicare rate. Id.

2. Specifically, a plan or issuer satisfies the copayment and coinsurance limitations in the statute if it provides benefits for out-of-network emergency services in an amount equal to the greatest of three possible amounts:

   a) the amount negotiated with in-network providers for the emergency service furnished;

   b) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable charges) but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing provisions; or
c) the amount that would be paid under Medicare for the emergency service. Each of these three amounts is calculated excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee. Id.

3. For plans and health insurance coverage under which there is no per-service amount negotiated with in-network providers (such as under a capitation or other similar payment arrangement), the first amount above is disregarded, meaning that the greatest amount is going to be either the out-of-network amount or the Medicare amount. Additionally, with respect to determining the first amount, if a plan or issuer has more than one negotiated amount with in-network providers for a particular emergency service, the amount is the median of these amounts, treating the amount negotiated with each provider as a separate amount in determining the median. Id.

XIV. MISCELLANEOUS CASE LAW ON QUANTUM MERUIT

A. General

Absent a controlling statute or regulation, or a case-specific agreement, the payment rate for emergency medical services is likely to be determined based on common law principles of equity, specifically, “implied contract” or quantum meruit principles as applied through case law. The amount due is based on the fair market value of services to the consumer (payer), not the usual rates or charges set by a seller. See generally Iraolo & CIA, S.A. v. Kimberly Clark Co., 325 F. 3d 1274, 1282 (11th Cir. 2003). Application of quantum meruit principles to OON services varies among states. Under common law, there would be an “implied” contract for an MCO to reimburse a hospital if a plan would be “unjustly enriched” absent payment. This depends on the following factors:

1. Did the hospital perform the services in good faith?

2. Were the services willingly “accepted” by the person to whom they were rendered?


4. If the above three (3) standards are met, then there is an “implied contract” and the hospital is entitled to direct payment by the MCO. Where the parties cannot mutually agree as to price, the common law provides for payment based on the “equitable” standard (known as quantum meruit) of the “reasonable value of the services” at issue. Id.

B. Reasonable value under quantum meruit principles in various jurisdictions
1. Pennsylvania

a) Temple University Hosp. v. Healthcare Management Alternatives, Inc., 832 A.2D 501 (Pa. Super. 2003), appeal denied, 847 A.2D 1288 (Pa. 2004). After expiration of hospital services agreement, Temple sued HMA to recover full billed charges for post-termination emergency services rendered to HMA’s members on a OON basis. Involved claims arising prior to effective date of Pennsylvania’s Act 68. See infra at Section XII.B.

b) Trial court found on an initial remand that Temple was entitled to its full billed charges because they were “not unconscionable.” Id. at 508-09. On a second appeal, the Superior Court found that full billed charges, actually paid by only 1% to 3% of consumers, did not constitute “reasonable payment” for OON emergency services under principles of equity, but neither did the Medicaid FFS rate, which did not even cover actual costs. Ordered hearing on remand to determine the “average” amounts the hospital received from all third-party payors (governmental and non-governmental). Id. at 510. Case was settled without hearing.

c) Whether a hospital is entitled to be paid by a plan for a non-emergent or non-urgent service rendered to managed care patient will turn on the facts of each case.

(1) If MCO knew of, encouraged, or in some fashion authorized the care, there should be coverage because it will have been “accepted” by the plan, resulting in a “reasonable” expectation of coverage and payment from the MA MCO on assignment by the hospital.

(2) If a plan specifically refused to authorize elective or post-stabilization care, the hospital’s expectation of payment from the plan may be “unreasonable,” and the hospital’s recourse may be to a claim against the patient (or other non-health insurer, e.g., a liability carrier), subject to any applicable state laws on balance billing.

(3) In Temple, the fact that federal law required Temple to provide OON emergency services to HMA’s patients significantly influenced the Superior Court’s decision that HMA had been “unjustly enriched” and received a benefit that would be inequitable for it to retain without additional payment. 832 A.2d at 507.

(4) Under the standard contract between Medicaid MCOs and the PA Department of Public Welfare, as under federal rules, MCOs are “responsible for making timely payments
to OON Providers for medically necessary, covered services when . . . the services were prior authorized.”

2. Other jurisdictions

a) Some courts have applied the Medicaid (or Medicare) FFS rate by “default,” while others have endorsed the use of a hospital’s actual usual billed charge or some intermediate measure.

b) See, e.g., Rahway Hospital v. Horizon BCBS of New Jersey, 863 A.2d 1050, 1056 (N.J. Super. 2005) (dicta to the effect that after expiration of contract, hospital “presumably . . . could begin charging market or out-of-network rates” to Horizon BCBS of New Jersey); Burdette Tomlin Memorial Hosp. v. Estate of Mary Malone, 845 A.2d 615 (N.J. Super. 2003) (ordering “reasonable” fees for Medicare/Medicaid patient for services rendered after expiration of patient’s lifetime Medicare benefits based on what Medicare would have paid); HCA Health Servs. of Georgia v. Employers Health Ins. Co., 240 F.3d 982, 997, rehearing en banc denied, 254 F.3d 77 (11th Cir. 2001) (full-billed charges is proper measure absent volume discount for network participation status); Rush Presbyterian-St. Lukes v. Hellenic Republic, 980 F.2d 449 (7th Cir. 1992) (same); River Park Hosp., Inc. v. BlueCross BlueShield of Tenn., Inc., 173 S.W. 3d 43 (Tenn. Ct. App. 2002), appeal denied, 2003 Tenn. LEXIS 141 (2003) (refusing to apply either Medicaid rate or billed charges for OON emergency services; remanding for a hearing as to what constitutes “reasonable” amount taking into account nature and volume of services consumed by insurer, and factors such as expense of contesting arbitrary denials); Huntington Hosp. v. Abrandt, 4 Misc. 3d 1 (N.Y. Sup. 2004) (regular charges are not unreasonable simply because lesser fees must be charged to Medicaid program); Centron Servs., Inc. v. Perucca, 100 P.3d 167 (Mont. 2004) (medical clinic was not required to charge Medicaid rates in lieu of its usual and customary fee to non-Medicaid patients); Non-Profit Emergency Services of Beaver County v. Highmark, Inc., No. 02-1167 (W.D. Pa. 2005) (ordering carrier to pay full-billed charges to ambulance providers, not lower Medicare fees); Vencor, Inc. v. Physicians Mutual Ins. Co., 211 F.3d 1323 (D.C. Cir. 2000) (long term care hospital free to seek payment of full-billed charges for period of hospitalization of insured that post-dated the expiration of a Medicare and Medigap policy).

This outline does not constitute and is not a substitute for legal advice, and the authorities cited herein are subject to change or amendment.