DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date APR 6 1995

From June Gibbs Brown
Inspector General

Subject Implementation and Enforcement of the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act by the Health Care Financing Administration (A-06-93-00087)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Implementation and Enforcement of the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act" (section 1867 of the Social Security Act (the Act)). The objective of our review was to determine the effectiveness of the Health Care Financing Administration's (HCFA) investigation and resolution of complaints involving potential violations of the Act.

The procedures prescribed by HCFA for investigating and resolving patient dumping complaints called for prompt investigations and enforcement actions. However, HCFA's regional offices included in our review were not always consistent in:

- conducting timely investigations of patient dumping complaints,
- sending acknowledgements to complainants,
- ensuring that provisions of the Act were addressed in substantiating violations, or
- ensuring that violations were referred to the Office of Inspector General (OIG) in accordance with HCFA policy for consideration of civil monetary penalties.

Adequate and timely investigations followed by appropriate enforcement actions help ensure that hospitals and physicians comply with the provisions of the Act. This in turn should help minimize the risk that individuals will be denied access to medical treatment for emergency medical conditions which could increase their risk of death. The Department of Health and Human Services has been subject to external criticism for lax enforcement of the Act. Inconsistent enforcement may contribute to this perception.

The inconsistent regional office implementation occurred because some of HCFA's interim guidelines were not clear for certain requirements, some HCFA regional officials were either not aware of or did not follow established guidelines, and HCFA's central office did not question regional performance. We are recommending that HCFA amend its guidelines to the regional offices, conduct training on the requirements concerning patient dumping, ensure that all regional offices are following established procedures, and improve its process for referring cases to the OIG, Office of Civil Fraud and Administrative Adjudications.

In response to our draft report, HCFA concurred with our findings and recommendations and has taken corrective action. The HCFA's comments are included as the Appendix to this report. We appreciate the cooperation given us in this audit.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 966-7104. Copies of this report are being sent to other interested Department officials.

To facilitate identification, please refer to Common Identification Number A-06-93-00087 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

IMPLEMENTATION AND ENFORCEMENT OF THE EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN LABOR ACT BY THE HEALTH CARE FINANCING ADMINISTRATION

JUNE GIBBS BROWN
Inspector General

APRIL 1995
A-06-93-00087

Memorandum

Date

From June Gibbs Brown
Inspector General

Subject Implementation and Enforcement of the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act by the Health Care Financing Administration (A-06-93-00087)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This report provides you with the results of our audit of the Health Care Financing Administration's (HCFA) implementation and enforcement of the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act as contained in section 1867 of the Social Security Act (the Act).

The objective of our review was to determine the effectiveness of HCFA's investigation and resolution of complaints involving potential violations of the Act. As part of our objective, we determined if: (1) complaints were acted on in a timely manner; (2) acknowledgements were sent to complainants; (3) provisions of the Act were appropriately addressed in substantiating violations; and (4) violations were referred to the Office of Inspector General (OIG) for civil monetary penalty (CMP) consideration.[1]

The procedures prescribed by HCFA for investigating and resolving patient dumping complaints called for prompt investigations and enforcement actions. However, HCFA's regional offices included in our review were not always consistent in:

- conducting timely investigations of patient dumping complaints,
- sending acknowledgements to complainants,
- ensuring that provisions of the Act were appropriately addressed in substantiating violations, or

[1]At the time of our review, violations were referred to the OIG, Office of Investigations (OI). Currently cases are referred to the OIG, Office of Civil Fraud and Administrative Adjudications (OCFAA) which was formerly part of the OIG OI.

- ensuring that violations were referred to OIG in accordance with HCFA policy for consideration of CMP.

Adequate and timely investigations followed by appropriate enforcement actions help ensure that hospitals and physicians comply with the provisions of the Act. This in turn should help minimize the risk that individuals will be denied access to medical treatment for emergency medical conditions which could increase their risk of death. The Department of Health and Human Services (HHS) has, in the past, been subject to external criticism for lax enforcement. Inconsistent enforcement may contribute to this perception.

The inconsistent regional office implementation occurred because some of the central office interim guidelines were not clear for certain requirements, some HCFA regional officials were either not aware of or did not follow established guidelines, and HCFA's central office did not question regional performance. We are recommending that HCFA amend its guidelines to the regional offices, conduct training, ensure that all regional offices are following established procedures, and improve its process for referring cases to the OIG OCFAA.

In response to our draft report, HCFA concurred with our findings and recommendations and has taken corrective action. The detailed response is included as an Appendix to this report.

BACKGROUND

In a report dated March 25, 1988, the Committee on Government Operations, U.S. House of Representatives, identified patient dumping as follows:

> "Patient dumping can take many forms. The most common is the transfer of a patient from one hospital emergency room to another for economic reasons, that is, lack of insurance and inability to pay. Dumping may occur from any part of a hospital, but the majority of these incidents take place from emergency rooms. It can mean turning patients away who may be actually ill, seriously injured, or in active labor, and it can be accomplished by transferring patients to other hospitals, refusing to treat them, or subjecting them to long delays before providing care. These transfers may involve discrimination on the basis of poverty, race, ethnicity, or appearance."

The Act, section 1867, "Examination and Treatment for Emergency Medical Conditions and Women in Labor," prohibits patient dumping. This statute requires Medicare-participating hospitals with emergency departments to:

- screen individuals who present themselves to hospital emergency rooms and request treatment or have treatment requested on their behalf;
- stabilize emergency medical conditions or effect an appropriate transfer as defined within the Act;
- restrict transfers of unstabilized individuals unless (1) the individual, or a person acting in the individual's behalf, makes a written request for the transfer; or (2) a physician certifies in writing that the benefits of the medical treatment to be received at another hospital outweigh the risks of a transfer;
- accept individuals who are being transferred if the hospital has the capacity to accept the individual and the hospital has specialized capabilities or facilities; and
- not delay the examination or treatment of an individual by inquiring about the individual's method of payment or insurance status.

Further, the Act provides for whistleblower protection to any qualified medical person or physician who refuses to authorize the transfer of an individual in violation of the Act or to any hospital employee who reports violations.

While regulations to implement the requirements of the Act were evolving, the HCFA regional offices relied on interim guidelines issued by their central office to investigate and resolve patient dumping complaints. The most recent guidelines were dated November 1991. On June 22, 1994, HHS issued interim final regulations with an effective date of July 22, 1994, to implement the requirements of this Act. A synopsis of responsibilities as contained in the guidelines concerning HCFA's regional offices, State agencies, and the applicable peer review organization (PRO) are listed below:

1. The State agency is responsible for reporting to HCFA's regional office all complaints relating to the anti-dumping provisions of the Act.

2. The regional office must decide whether the reported complaint warrants an investigation. If warranted, the regional office then authorizes the State agency to conduct the investigation.

3. The State agency must complete the investigation within 5 working days after the regional office authorization and it must provide the regional office with a report within 2 working days after completing the on-site investigation.

4. The regional office must send the complainant, if known, a letter acknowledging receipt of the allegation. This letter must inform the complainant of the right to pursue independent civil action.

5. The regional office oversees the investigation to ensure that it is thorough and that it addresses the statutory requirements.

6. After receiving the State agency report, the regional office must decide if a violation occurred. The regional office is solely responsible for this decision.

7. The regional office notifies the hospital and the complainant of its decision.

8. If the regional office substantiates a violation, it initiates corrective action to ensure that the hospital continues to meet the Medicare conditions of participation. It also obtains a PRO review before making a referral to OIG for possible CMP action.

9. The PRO conducts a review to determine whether the individual involved had an emergency medical condition which had not been stabilized and provides the regional office with the results of its findings. The PRO has at least 60 days to conduct its review during which time it must give notice to the hospital and physician involved and offer them an opportunity to provide additional information.

10. For substantiated violations, the regional office is responsible for referring the cases to OIG for potential CMP.

SCOPE

Our audit was made in accordance with generally accepted government auditing standards. Our objective was to review the effectiveness of HCFA's process for resolving complaints of potential violations of the Act. To accomplish this objective, we met with HCFA's central office representatives and conducted on-site visits at five HCFA regional offices. We reviewed documentation provided by the central office and the regional offices, including correspondence outlining the complaint resolution process, listings of authorized investigations, confirmed violations, and case file documentation. We did not conduct on-site visits of State agencies, PROs, or hospitals other than to review reports or other documentation from those entities that were in the case file.

As of June 1993, the 10 HCFA regional offices had investigated over 1,400 patient dumping complaints through its State agencies, and substantiated about 330 as violations. We reviewed a total of 63 cases at 5 regional offices as follows: New York, 10; Boston, 12; Atlanta, 11; San Francisco, 11; and Dallas, 19. Our sample included 29 cases for which the complaint was substantiated by HCFA as a violation and 34 cases that HCFA authorized the State agency to investigate but which were not subsequently substantiated by HCFA as violations. Our review of these cases, which we selected on a judgmental basis, primarily served to (1) identify the process used by each HCFA regional office for working complaints and (2) assess the regional offices' compliance with established procedures. We conducted our field work at the above regional offices from December 1993 to February 1994.

RESULTS OF REVIEW

Except for the inconsistencies discussed below, the investigation and resolution process employed by HCFA for complaints involving potential violations of the Act was generally effective. The HCFA assigned a high priority to patient dumping complaints and considered violations as potentially serious and immediate threats to the health and safety of individuals. The procedures prescribed by HCFA required timely and appropriate resolution of identified deficiencies and violations. For substantiated violations, HCFA acted on its authority to ensure that a hospital complied with the Medicare participation requirements.

We found that HCFA's regional offices included in our review were not consistent with the actual implementation of procedures prescribed in the guidelines. Specifically:

- one regional office allowed the State agencies 45 days to complete investigations instead of following the requirement that investigations be completed within 5 working days after being authorized by the regional office;

- three regional offices did not send direct acknowledgements to complainants as called for in the central office guidelines;

- one regional office's determinations that cases were not violations were based on State investigations that did not sufficiently address the provisions of the Act; and

- three regional offices did not adequately refer confirmed violations to OIG for possible consideration of CMP.

Adequate and timely investigations followed by appropriate enforcement actions help ensure that hospitals and physicians comply with the provisions of the Act. Without compliance, individuals with emergency medical conditions could be subjected to a greater risk that they will be denied access to necessary stabilizing medical treatment. Further, inconsistent investigations and enforcement actions could add to the perception that HHS is not doing all it can to ensure an effective program.

We found that central office interim guidelines were not clear for certain requirements, regional officials were either not aware of or did not follow established guidelines, and the central office did not question regional office performance.

TIMELINESS OF INVESTIGATIONS

One of five regional offices did not comply with the central office requirement that State agencies complete their investigations within 5 working days after receiving the regional office authorization. This regional office's practice was to allow State agencies 45 days to complete their investigations. The other four regional offices held the State agencies to the 5-working-day requirement.

The central office guidelines required expeditious investigations for patient dumping complaints because such complaints usually represent a serious and immediate threat to the health and safety of individuals. The guidelines

stipulated that a regional office would allow a State agency 5 working days to complete its investigation after receiving the regional office authorization. The guidelines further required that the State agency submit its report to the regional office within 2 working days after completing the on-site investigation.

Regional officials, in the region discussed above, acknowledged that their practice allowed State agencies 45 days to complete investigations. They informed us that they also granted extensions of time as requested. This practice was used because regional officials believed that the 5-day requirement was unreasonable. They explained that State agencies had limited staff to conduct investigations, and complaints did not require an urgency to investigate because they had occurred sometime in the past. As a result, State agency investigations authorized by this regional office took an average of 18 calendar days longer than those completed by other regional offices in our review. The other regional offices completed their investigations within 6 to 10 calendar days. This delay lessened the urgency to remove any potentially serious and immediate threat to the health and safety of individuals caused by a hospital's noncompliance. We believe that regional offices should treat patient dumping complaints with the urgency established by the central office.

ACKNOWLEDGEMENTS TO COMPLAINANTS

Three regional offices did not comply or comply fully with the requirement to send direct acknowledgements to complainants. Two of those offices relied on State agencies to acknowledge complaints that originated through the State agency; the other office communicated the results of HCFA's regional office determination to the complainant but had not, as a matter of procedure, acknowledged complaints when received. At those three regional offices, officials were unaware of the requirement or the purpose of corresponding directly with the complainants. The central office guidelines alluded to the requirement but did not emphasize the timing or importance of direct communications.

According to HCFA's central office guidelines, regional offices were responsible for sending the complainant a letter to acknowledge the receipt of the allegation and to inform the complainant of the right to pursue independent civil action. The guidelines did not specify when to send the acknowledgements or when to report the results of the investigation to the complainant. However, model letters included in the guidelines as Attachment 3, Exhibit XX, suggested that: (1) the acknowledgements should be sent when the regional office authorized a State agency to conduct an

investigation and (2) the results of the investigation should be reported to the complainant immediately after the regional office notified the hospital of its findings.

Under section 1867(d)(2) of the Act, individuals who suffer personal harm or medical facilities which suffer a financial loss as a direct result of a participating hospital's violation of a requirement of the Act can pursue an independent civil action. The Act stipulates that such actions cannot be initiated after 2 years. If regional offices do not send acknowledgements directly to complainants, complainants may not be aware that the Federal Government is taking any action on their concerns. Further, there is no assurance that complainants are made aware of their right to seek independent civil actions. Conversely, by responding directly to individuals and provider organizations, HCFA can assure itself of better accountability, consistency, and responsiveness to individuals and provider organizations. We believe that regional offices should assume this responsibility directly as specified in the central office guidelines.

APPROPRIATENESS OF DECISIONS ON WHETHER COMPLAINTS COULD BE SUBSTANTIATED AS VIOLATIONS

Of the five regional offices in our review, four regional offices appropriately considered the provisions of the Act in determining whether patient dumping complaints were substantiated as violations. The other regional office based its decisions on conclusions reached by the State agencies without regard to the appropriateness of those conclusions. Concerning that office, we questioned whether the provisions of the Act were adequately addressed in five of six cases in our sample that the regional office had determined were not violations. Two cases involved conflicting evidence that was not resolved; two cases were closed based on inadequate or missing documentation; and one case was closed based on the hospital's policy rather than on the provisions of the Act. For each case, the regional office accepted without question the conclusion reached by the State agency that a violation did not occur. The prescribed guidelines stipulate that regional offices are solely responsible for determining whether violations occurred and for ensuring that State agencies conduct thorough investigations.

Conflicting Evidence

One case involved a woman in labor who was on Medicaid and had a history of herpes and marijuana use. She was discharged from the hospital that she originally went to and was told to go to her personal physician at a hospital 80 miles away. Her personal physician charged that the individual was placed at extreme risk by sending her on the 80 mile trip. The

physicians at the initial hospital contended that there was no emergency condition. The question of whether the woman had an emergency medical condition as defined by the Act was in dispute and was not resolved. The investigation could have been enhanced if the regional office had obtained an independent PRO review.

Another case involved an individual who was evicted from the emergency room without being seen by a physician. The individual died about 4 hours later. The following represents the State agency investigator's account.

> "Based upon review of the medical record and staff interviews, patient #00195620 was brought into the emergency room (ER) by paramedics who noted the patient to be lethargic and refusing to answer questions. The ER nurse assessed the patient as alert and refusing to answer questions. Since the patient was uncooperative, the ER nurse called for security. The patient reportedly refused to sign a form that he wanted to leave against medical advice. Before a physician had evaluated the patient, hospital security guards removed the patient from the ER and took him by wheelchair to a nearby corner of the property where he was released at a bus stop. Security guards interviewed stated the patient looked too sick to walk back to the ER. Less than four (4) hours later, the patient was found in near arrest at the same location where he was left by security. He was brought back to the ER by paramedics where he expired. Documentation in the ER record lacked the following:
>
> "1. A complete assessment of the patient's level of consciousness when he was not answering questions. (The patient's hemoglobin and hematocrit of 2.2 and 7.3 on the last ER visit indicated the patient was probably unable to answer questions from the earlier visit.)
>
> "2. Specific information about discontinuing an IV that had been started in the field by paramedics."

Still, the State agency investigator concluded that a violation was not substantiated. The conflicting assessments of the individual made by the staff nurse and the paramedics were not resolved.

Insufficient Evidence

Two other cases involved individuals who were alleged to have been transferred with unstabilized emergency medical conditions and later died after being transferred. In both cases, the State agency investigator concluded that the transferring hospital did not have adequate documentation to determine whether a violation occurred.

The first case involved an individual with respiratory distress and throat cancer. The investigator noted that there was no documentation of a physician evaluation. Further, the investigator documented that the transfer form was incomplete and that it could not be determined from the records if the individual requested the transfer in writing. The Act requires an appropriate screening to determine if an emergency medical condition exists. For a transfer, there must be written documentation that either the individual or someone acting in the individual's behalf requested the transfer or that the physician certified in writing that the benefits of the transfer outweighed the risks. The investigator did note that emergency room technicians and triage assistants were performing duties beyond the scope of their practice by being required to recognize emergent conditions. The investigator, nonetheless, concluded that there was no documentation to substantiate a violation.

In another case, a 67-year-old individual with pneumonia, emphysema, and shortness of breath was transferred to a hospital 32 miles away where he died approximately 1 hour after arrival. The State agency investigator noted that he could not determine from the transferring hospital's records that the individual had an emergency medical condition and he concluded that a violation was not substantiated. In contrast, the receiving hospital noted that the transferring hospital's "flowsheets and laboratory studies" showed that it was readily apparent that the individual was very unstable and should not have been transferred. The authorization and consent form at the transferring hospital showed that the physician at the transferring hospital recommended that the individual be transferred, but there was no physician certification that the benefits of the transfer outweighed the risks of the transfer. Also, there was no documentation that the individual requested the transfer.

For both cases, the investigators concluded that there was inadequate documentation to support a violation of the Act. On the contrary, the lack of records did not support compliance with the Act. We believe that HCFA should have raised these issues rather than accept the State agency's conclusions without question.

Conclusion Not Supported by Facts

In the last case, an on-call physician who was called at 1 a.m. refused to respond to treat a 6-year-old child who had been diagnosed with pneumonia on the basis that he did not treat children. The nospital did not have a pediatric unit and only admitted children on specific occasions. The emergency room physician attempted to have other hospital physicians admit the child, but all refused. The emergency room physician then arranged to transfer the child to another hospital where a physician agreed to admit and treat the child. The child was hospitalized for 2 days and released. Records at the receiving hospital listed the pay source for the patient as "self pay." Regional officials informed us that they made an error in not substantiating a violation in this case.

Section 1867(d)(1)(B) of the Act provides that physicians who are responsible for the examination, treatment, or transfer of an individual, including on-call physicians, are subject to a CMP or exclusion from participation in the Medicare program for negligent violations of the Act. The State agency investigator did not address the on-call physician's refusal to treat the child. Instead, the investigator faulted the emergency room physician for not following hospital policy in examining, stabilizing, and immediately transferring the patient to another hospital.

The HCFA central office's instructions stipulated that the regional offices:

- had the sole responsibility to determine whether a violation of section 1867 occurred, and
- were responsible for overseeing the State agency investigations to ensure that they were thorough and that they addressed the statutory requirements.

Regional officials, however, informed us that they relied on and accepted the conclusions reached by State agency investigators. To effectively deter violations of the Act, regional offices need to ensure that State agencies gather the proper evidence to establish whether a hospital acted appropriately under the circumstances and did not violate any of the provisions of the Act. Without good evidence to make proper determinations, there is an increased risk that violations will not be detected and sanctioned.

CASE REFERRALS TO THE OIG FOR CMP CONSIDERATION

Three of the five regional offices did not request the mandatory PRO reviews for confirmed violations prior to referring the violations to OIG. This occurred because, at these regional offices, HCFA officials believed that it was OIG's responsibility to request a PRO review if OIG determined that the violation warranted a penalty. These perceptions were contrary to the requirements prescribed in guidelines established by HCFA's central office. Further, the PRO review is required by the Act before a CMP can be assessed, and it is intended to give hospitals and physicians an opportunity to provide additional information. Without a determination by the PRO as to whether the hospital complied with certain requirements of the Act, it would be difficult for OIG to make an assessment on whether a penalty should be imposed since there is no independent investigation conducted by HCFA or OIG.

As of August 1993, OIG's central office had received only 78 violations from over 330 violations identified by HCFA's regional offices since 1987. We did not identify all the reasons why violations were not forwarded to OIG's central office; however, one HCFA regional office's practice was to send to OIG's field office only an informational copy of the predetermination letter that it routinely sent to hospitals for confirmed violations. This regional office, which accounted for about one-third of all violations nationwide (128 of 330 through June 1993), did not obtain the mandatory PRO reviews for these violations. The OIG's field office did not consider the informational copies of the letters as referrals and did not take any action to pursue CMPs. Consequently, about one-third of all confirmed violations did not have mandatory PRO reviews and were not considered for CMP actions.

Hospitals and physicians are subject to sanctions under section 1867(d) as follows: A hospital is subject to a CMP of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each negligent violation of a requirement of the Act. A physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital who negligently violates a requirement of the Act is subject to a CMP of not more than $50,000 for each such violation. Further, a physician can be excluded from Medicare participation for flagrant or repeated violations.

Before assessing a penalty or excluding a physician from Medicare participation, section 1867(d)(3) requires that an appropriate PRO assess whether the individual had an emergency medical condition which had not been stabilized. This section of the Act specified that a PRO was to be allowed at least 60 days to conduct its review and provide a report on its

findings. Section 1154(a)(16) requires that the PRO provide (1) reasonable notice of the review to the physician and hospital involved and (2) a reasonable opportunity for the physician and hospital to submit additional information.

According to HCFA's central office guidelines, the regional offices were responsible for obtaining the required PRO reviews before recommending the imposition of CMP or the exclusion of physicians from the Medicare program. The guidelines further recognized that the issue of obtaining a PRO review to determine whether the individual had an emergency medical condition would not apply when the violation concerned an individual who was denied a screening. However, the guidelines stipulated that a PRO review was required by the Act and that regional offices should request a PRO review for all violations to obtain a "yes," "no," or "not applicable" answer to the issue of whether an emergency medical condition existed, as well as the rationale for the response.

A greater number of violations can be considered for CMP actions through improved coordination and cooperation between HCFA's regional offices and OIG OCFAA. Making referrals of patient dumping violations to OIG OCFAA that include PRO reviews will help assure better evidence, quicker enforcement action, and compliance with statutory requirements. This in turn will help ensure an effective program to deter violations.

CONCLUSION AND RECOMMENDATIONS

The HCFA's implementation of the Act was generally effective, but regional offices were not consistent with conducting timely investigations, sending acknowledgements to complainants, ensuring that investigations were thorough, or ensuring that violations were referred to the OIG in accordance with HCFA policy for possible CMP action. We found that the central office interim guidelines were not clear for certain requirements, and regional officials were either not aware of certain responsibilities or requirements set forth in the guidelines or chose not to follow them. Also, HCFA's central office did not question regional performance. These weaknesses point to a need for revised guidelines, regional office training to ensure that all regional offices are following established procedures, and better coordination with OIG OCFAA to ensure that hospitals and physicians comply with the provisions of the Act.

Without proper compliance, there is an increased risk that individuals with emergency medical conditions will not receive the treatment needed to stabilize their condition, which may place them in greater risk of death. Further, these weaknesses create a perception, whether valid or not, that HHS is not as effective as it should be in responding to complaints, resolving issues in a timely manner, or taking any serious action against confirmed violators. By streamlining its process and increasing its oversight, HCFA can eliminate or minimize these weaknesses and create a more effective program that emphasizes deterrence.

We recommend that HCFA:

1. Amend its guidelines to clarify regional offices' responsibilities, incorporate requirements in the final regulations, and emphasize compliance.

2. Conduct training on the requirements concerning patient dumping and ensure that all regional offices stay informed of and are following the basic requirements of the investigation, resolution, and referral process.

3. Coordinate with the OIG OCFAA in pursuing CMPs by making referrals of substantiated violations in accordance with HCFA policy and pursuing the outcome of the CMPs to ensure that the cases are brought to closure.

HCFA'S RESPONSE

In response to our draft report, HCFA concurred with our findings and recommendations and has taken corrective action. The detailed response is included as an Appendix to this report.

OTHER MATTERS

In correspondence dated April 22, 1993, to the Department of Veterans Affairs, OIG (VA OIG), HCFA's Seattle regional office addressed the scope of the Act as applying only to cases which originated in a hospital emergency room and not to cases involving emergency medical conditions which were developed by hospital inpatients. The VA OIG took exception to this interpretation and raised a concern that the interpretation was inconsistent with decisions rendered in court cases. At the time of our field

work, the applicability of the Act to inpatients was being considered as a policy matter by HCFA and OIG components of HHS. A clarification of this issue is needed to ensure that HHS is following a correct and defendable policy.

APPENDIX

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

DATE FEB 17 1995

FROM Bruce C. Vladeck
Administrator

SUBJECT Office of Inspector General (OIG) Draft Report: "Implementation and Enforcement of the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act (the Act) the Health Care Financing Administration (HCFA)" A-06-93-00087

TO June Gibbs Brown
Inspector General

We reviewed the above-referenced report in which OIG concluded that HCFA is generally doing a good job, but needs improvements in four areas: Conducting timely investigations of patient dumping complaints, sending acknowledgements to complainants, ensuring that provisions of the Act are addressed in substantiating violations, and ensuring that violations are properly referred to OIG for possible civil monetary penalties.

We concur with the recommendations in your report, and we have started conducting training with our regional offices to ensure timely followup action.

Our detailed comments on the report findings and recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this draft report. Please contact us if you would like to discuss our comments and response.

Attachment

Health Care Financing Administration's (HCFA) Comments
on Office of Inspector General (OIG) Draft Report:
Implementation and Enforcement of the Examination
and Treatment for Emergency Medical Conditions
and Women in Labor Act by the Health Care
Financing Administration
(A-06-93-00087)

OIG Recommendation 1

HCFA should amend its guidelines to clarify regional offices' (RO) responsibilities, incorporate requirements in the final regulations, and emphasize compliance.

HCFA Response

We concur with this recommendation. The final regulations for the anti-dumping law went into effect on July 22, 1994. This enabled HCFA to establish clearer guidelines on how these cases should be resolved. HCFA developed and released a draft of the revised enforcement guidelines (which we expect to be approved shortly), and conducted the training referred to below using those guidelines. We believe this will be the foundation for more effective and more consistent implementation of the patient dumping laws across ROs.

We have developed procedures and interpretive guidelines for inclusion in the RO Manual and in the State Operations Manual for implementing an effective enforcement program. These procedures delineate RO and State agency (SA) responsibilities and incorporate the requirements of the final regulation. We expect to publish these procedures as a final transmittal package for the manuals by the end of the year. Additionally, we held a training session on anti-dumping, September 27-29, for RO staff and SA surveyors. HCFA's trainers emphasized the importance of following procedures to assure standardized enforcement activities across the country.

OIG Recommendation 2

HCFA should conduct training on the requirements concerning patient dumping and ensure that all ROs stay informed of and are following the basic requirements of the investigation, resolution, and referral process.

HCFA Response

We concur with this recommendation. We conducted a satellite training conference with the ROs and SAs on August 4, 1994, to introduce the final regulation requirements and give an overview of enforcement procedures. In addition, these

procedures and guidelines were the focus of the training referred to above. The enforcement procedures require ROs to submit a monthly log of investigations, and to send copies of all correspondence concerning anti-dumping investigations to HCFA's Central Office (CO) for review. The CO will monitor these documents to assess the ROs' performance in following the enforcement procedures. In addition, HCFA's CO will continue to communicate with the ROs via telephone and in writing, as necessary, on policy issues regarding enforcement of the anti-dumping requirements.

OIG Recommendation 3

HCFA should coordinate with OIG in pursuing civil monetary penalties (CMP) by making proper referrals of substantiated violations and taking an active interest in the outcome of referred cases to ensure that the cases are brought to closure.

HCFA Response

We concur with this recommendation. HCFA and OIG staffs met over the past year to discuss forwarding confirmed dumping cases to OIG. The process of forwarding these cases is described in the draft RO Manual that implements the anti-dumping regulation, which we shared with OIG staff for comment. We believe we have developed procedures that will help OIG carry out its statutory obligation. The instructions describe required documentation and establish the ROs' responsibility at the time of referral for asking the peer review organizations (PROs) to give a medical opinion to OIG within 60 days. The instruction also requires the ROs to provide the PROs with all information in their possession or under their control that is relevant to the case, and instructs the ROs to follow up with the PROs if the RO does not receive a copy of the information requested within 60 days.

TECHNICAL COMMENTS

During a review of the working draft report, OIG agreed to drop the word "proper." A "proper referral" has never been defined by OIG; therefore, use of this term in this report is misleading. We acknowledge, and appreciate that you did drop this term from the body of the report, but it still appears in recommendation 3. We request that you drop the word from the recommendation.

Use of the words "active interest" in recommendation 3, could be interpreted to imply that HCFA does not currently take an active interest in or recognize the importance of CMP action and ensuring closure for referred cases. The RO follows each case to its resolution, until the time that the authority is transferred to OIG for CMP determination. While we acknowledge that certain communication problems

may exist between HCFA's ROs and the OIG with respect to the timing and process of obtaining PRO reviews and investigating the appropriateness of levying CMPs, we object to use of the words "active interest." As we reestablish our guidelines in concert with the final regulations, we will work with OIG to improve communication and the process of resolving these issues. We request that you drop the words from the recommendation.

The report implies, on page 12, that one source of differing regional interpretations is vagueness in the guidelines. However, the report failed to acknowledge that the guidelines were developed during a time when the implementing regulations were evolving.

The original notice of proposed rulemaking for patient dumping regulations was published on June 16, 1988. Interim guidelines for ROs based on the proposed rule were issued in November 1991.

Because the initial guidelines were based on a proposed rule and there were subsequent statutory changes to the patient dumping law, those guidelines inevitably were subject to varying interpretations of intent and procedure by ROs.