Dobbs Ruling Creates Compliance Dilemmas For Hospitals

By **Mary Ellen Palowitch, Holley Thames Lutz and Susan Banks** (June 27, 2022)

Mary Ellen Palowitch

Holley Thames Lutz

Susan Banks

On June 24, the U.S. Supreme Court issued its much anticipated and inherently controversial opinion in Dobbs v. Jackson Women's Health Organization.[1]

The majority opinion, adopted by five justices, overturned the landmark 1973 Supreme Court case of Roe v. Wade,[2] which had held that, subject to limited restrictions, a woman had a fundamental right under the federal Constitution to seek an abortion.

In so doing, the Dobbs majority cleared the way for the immediate implementation and imminent promulgation of multiple state criminal laws prohibiting most abortions or otherwise severely curtailing the ability to seek, assist with obtaining or perform an abortion. The ensuing national debate will be fraught with emotion and vitriol.

Largely overlooked in the discourse, at least thus far, is a novel and largely untested aspect of hospital law: the interplay between the various anti-abortion state laws and the federal mandates of the Emergency Medical Treatment and Labor Act.[3] This article begins to explore the potential nature and scope of this dynamic — one that warrants close attention and further discussion in post-Roe America.

EMTALA Obligations

Enacted in 1986, EMTALA is a federal law that requires hospitals, including small and rural critical access hospitals, which have an emergency department — effectively, most hospitals in America — to stabilize and treat any person who presents at the hospital with a potential medical emergency, regardless of their insurance status or ability to pay.

Specifically, EMTALA requires any hospital that offers emergency services to perform a medical screening examination of such patients to determine if they are experiencing an emergency medical condition. If the answer is yes, then the hospital must furnish stabilizing treatment to the patients, which could include the provision of medications, surgery and other procedures, diagnostics, consultation with specialists, extended observation and/or inpatient admission.

If the hospital is not equipped or is unable to stabilize the patient's emergency condition, the hospital must arrange for the patient to be transferred to a facility that has the capabilities and capacity to treat and stabilize the patient. Transfer also must occur upon the patient's request. Every hospital that participates in and receives funding from the Medicare program commits in its Medicare provider agreement that it will comply with these EMTALA requirements.[4]

EMTALA's protections are unequivocal. They apply to all patients who present to a hospital's dedicated emergency department with an emergency medical condition,[5] and they continue until the patient's condition is stabilized, even if the patient is transferred to another facility for treatment.

Emergency medical conditions are those with sufficiently severe symptoms, such that an absence of immediate medical attention could be reasonably expected to result in (1) serious jeopardy to health, (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or body part.[6]

Hospital emergency departments commonly evaluate pregnant women who present with symptoms that appear to indicate an emergency related to pregnancy. Some of these obstetric emergencies include, without limitation, ectopic pregnancies, fetal demise, preeclampsia and other hypertensive conditions, hemorrhage, and infections.

Each of these conditions could qualify as an emergency medical condition, as that term is defined under EMTALA. The options for care in these emergency situations include surgical procedures and the administration of medications, including, on occasion, medications with toxic side effects that could impair the pregnancy.

Failure to provide stabilizing treatment in these emergent situations, whether through medical or surgical intervention, may result in the pregnant woman's death or cause her bodily harm. But, what if stabilizing medical treatment requires or results in the termination of the pregnancy or contributes to a termination that is already underway?

State Abortion Laws

Many of the existing and anticipated state anti-abortion laws broadly criminalize the performance of abortions, even in situations that would constitute an emergency medical condition under EMTALA.

To facilitate our consideration of state abortion laws, it is useful to differentiate between elective and therapeutic abortions.

As a general proposition, an elective abortion involves the affirmative decision of a pregnant woman to terminate her pregnancy for reasons other than the desire to avoid serious medical consequences, including life endangerment or risk of serious physical harm. Even before Dobbs, the Supreme Court recognized a legitimate state interest in the regulation and even outright prohibition of elective abortions after the point of fetal viability, with certain exceptions.[7]

Accordingly, many states have long limited access to elective abortions through a variety of restrictions based on, for example, length of gestation, location of procedure, age of the pregnant person, mandatory waiting periods, sonogram requirements and the like.

As widely reported during the pendency of the Dobbs case, many states have recently proposed or passed legislation further restricting access to elective abortions, for example by shortening the permissible window of time following conception or the woman's last menstrual period, or LMP, during which a pregnant woman may obtain an elective abortion.

A therapeutic abortion, by contrast, is one performed to terminate a pregnancy because it endangers the pregnant person's health or life. Some states appear willing to ignore or diminish the existence of competing health interests at play in these complex situations,[8] banning abortions from the moment of conception, with limited exceptions to save the life of the pregnant person, but not to prevent substantial or permanent impairment of the woman's physical health.

Other states ban abortions after a certain number of weeks post-conception or LMP (e.g., six or 15 weeks), but suffer from the same limitation, i.e., the failure to provide for exceptions that would appear necessary to satisfy EMTALA.

Between a Rock and a Hard Place

Given this patchwork of state-specific abortion restrictions, the collision course between state and federal law in the event of a pregnancy-related medical emergency is neither difficult to imagine nor academic.

What is a hospital to do under these circumstances, especially given the reality that emergency department personnel typically need to make critical clinical decisions within mere moments? These clinical issues are challenging enough to navigate in their own right; now, however, they will be laden with an additional legal layer of federalism, meaning that hospitals and practitioners could find themselves in the dreaded position of trying to reconcile contradictory state and federal legal regimes.

In short, there is obvious tension between EMTALA's stabilize-and-treat mandate and state criminal laws that, on their face, prohibit the performance of certain critical treatments or procedures.

Federal Preemption

Notably, the EMTALA statute contains an awkwardly worded clause that appears to create a presumption against preemption. Specifically, the statute states that EMTALA's provisions "do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section."[9]

Thus, the statute purports to provide that the patient protections afforded by EMTALA shall supersede directly contradictory state laws that would reduce or modify a provider's EMTALA obligations.

But whether a given state law indeed directly conflicts with EMTALA can be a nuanced analysis, and one that likely could be open to more than one reasonable interpretation. And remember, hospitals and their clinicians will have to make these decisions under the pressures of a medical emergency and without the luxury of time or judicial guidance.

All in all, in states where abortion rights are or will be severely restricted, hospitals may be placed in the untenable position of choosing to comply with state law versus complying with federal requirements, including EMTALA.

For example, in April, a woman named Lizelle Herrera presented to a hospital in Texas after experiencing a miscarriage. According to the reporting, state authorities were called, and the woman was charged with violating state law after she informed the staff she had been trying to end her pregnancy.[10] The charges were subsequently dropped.

As another example, physicians and other medical professionals have been threatened with loss of licensure or criminal prosecution for performing abortion procedures under Alabama law, which became effective in November 2019.[11]

These anecdotes are likely to replicate themselves over and again, and have a chilling or at least distorting effect on essential clinician-patient communications and the already limited availability of abortion and other reproductive health services.

Penalties for EMTALA Violations

Failure to comply with EMTALA may subject a hospital to the imposition of civil monetary penalties from the U.S. Department of Health and Human Services' Office of Inspector General, and/or a private cause of action brought by the patient, their family or legal guardians.

Moreover, noncompliance can also result in termination of the hospital's Medicare provider agreement, which would bring all Medicare and Medicaid reimbursement and other payments to an abrupt halt. In truth, however, the latter penalty is rarely used for EMTALA noncompliance.

The Centers for Medicare & Medicaid Services released a memorandum on Sept. 17, 2021,[12] after the six-week abortion ban was enacted in Texas.

The memo reminds hospitals of their responsibility to provide exams and stabilizing treatment to patients who come to the emergency department. It also reinforced federal regulators' position that it is inappropriate to transfer patients to other facilities — whether in- or out-of-state — in order to avoid running afoul of state law, if the hospital has the clinical capabilities to provide the necessary treatment.

As noted in the memo, and codified in both the EMTALA statute and regulations, federal EMTALA requirements preempt state laws restricting access to stabilizing treatment and life-preserving care.

Hospitals that receive individuals who may have been transferred inappropriately, e.g., a patient transferred for stabilizing treatment that was available at the transferring hospital, are legally obligated to report such incidents to CMS.

Failure to report inappropriate transfers can also trigger enforcement actions against the receiving hospitals, including the imposition of fines or loss of provider agreement. Once reported, CMS would likely authorize an onsite complaint investigation of the sending hospital, which would lead to a cascade of events including enforcement actions by both CMS and OIG, as discussed above.

Concluding Remarks

The Dobbs decision will affect individual patients and providers differently, of course, depending on state law.

Many states have so-called trigger laws that have now gone into effect, banning or severely limiting abortions in the aftermath of the Dobbs decision, or other abortion restrictions already on the books that have remained unenforced, but are now revived by the Supreme Court's decision.

Other states are actively proposing and enacting legislation in the wake of Dobbs to exercise their newly expanded authority to restrict abortions.

All hospitals, regardless of where they are located, should review EMTALA requirements and carefully consider their approach to handling of pregnancy-related medical emergencies to ensure they remain in compliance with federal law.

EMTALA compliance is essential to ensure continued Medicare and Medicaid funding. Now is the time to retrain emergency department and hospital staff on the federal requirements, before providers and their clinicians finds themselves needing to make difficult clinical decisions with potentially significant legal ramifications.

As always, such EMTALA training should focus on providing the highest quality of care to all individuals who present with emergencies and, when necessary, arranging transfers to locations with specialized capabilities when needed.

By focusing on care provided to the patient, hospitals can ensure all patients receive the emergency services they are guaranteed under federal law, while minimizing the risk of generating complaints that may result in onsite surveys, enforcement actions, loss of funding and imposition of additional fines.

Mary Ellen Palowitch is a senior managing director at Dentons and was the EMTALA technical lead at the Centers for Medicare & Medicaid from 2012 to 2020.

Holley Thames Lutz is a partner at the firm.

Susan J. Banks is a partner at the firm.

[1] Dobbs v. Jackson Women's Health Organization, __ U.S. __ (No. 19-1392) (June 24, 2022).

[2] Roe v. Wade, 410 U.S. 113 (1973).

[3] 42 U.S.C. § 1395dd.

[4] See 42 C.F.R. §§ 489.20 and 489.24.

[5] Dedicated emergency departments, as defined in the EMTALA regulations at 42 C.F.R. § 489.24(b), include labor and delivery departments, as well as specialized emergency departments (e.g., cardiac, eye, pediatric), and provider-based emergency department locations.

[6] 42 C.F.R. § 489.24(b).

[7] See generally Roe; Planned Parenthood Southeastern Pa. v. Casey, 505 U.S. 833 (1992).

[8] Among many similar resources and compilations available online through various organizations, the Guttmacher Institute maintains this helpful state-by-state summary chart: https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions.

[9] 42 U.S.C. § 1395dd(f) (emphasis added).

[10] See Yeganeh Torbati, Texas woman charged with murder after abortion, Wash. Post, Apr. 9, 2022, available at https://www.washingtonpost.com/politics/2022/04/09/abortion-texas-murder-charge/.

[11] See, e.g., Leah Torres, Doctors in Alabama Already Turn Away Miscarrying Patients. This Will Be America's New Normal., Slate Magazine, May 17, 2022, available at https://slate.com/news-and-politics/2022/05/roe-dobbs-abortion-ban-reproductive-medicine-alabama.html.

[12] See CMS Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG), Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss (Ref: QSO-21-22-Hospitals) (Sept. 17, 2021), available at https://www.cms.gov/files/document/qso-21-22-hospital.pdf.