Federation of American Hospitals®

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President and CEO

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VIA COURIER AND ELECTRONIC MAIL

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1350-ANPRM
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Medicare Program: Emergency Medical Treatment and Active Labor Act (EMTALA): Applicability to Hospital and Critical Access Hospital Inpatients and Hospitals with Specialized Capabilities; Advanced Notice of Proposed Rulemaking; CMS-1350-ANPRM 75 *Fed. Reg.* 80,762 (Dec. 23, 2010)

Dear Dr. Berwick:

The Federation of American Hospitals ("FAH") is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay and long-term care hospitals in urban and rural America, and provide a wide range of ambulatory, acute and post-acute services. We appreciate the opportunity to comment on the Advanced Notice of Proposed Rulemaking on the applicability of the Emergency Treatment and Active Labor Act ("EMTALA") to hospital inpatients (the "ANPRM").

The FAH strongly urges CMS to maintain its current policy on the application of EMTALA to hospital inpatients. Current CMS policy is that EMTALA obligations apply when a patient comes to a hospital's emergency department, but cease if and when that patient is admitted in good faith to inpatient status at that hospital. This policy is consistent with the legislative history that gave rise to EMTALA and the goal of Congress in enacting it: to ensure individuals with emergency medical conditions are not denied emergency, lifesaving services. There is no indication that Congress sought to create a more intrusive regulatory scheme, and in particular one that would become a new federal malpractice law, reaching into ongoing hospital care for inpatients as they move through the facility and on to their discharge.

Current CMS policy also provides that if a hospital inpatient needs to be transferred to another hospital to receive special services not available at the first hospital, EMTALA does not impose any obligations on the receiving hospital related to that patient transfer. We believe this policy also is appropriate and supported by the statutory language and legislative history. Finally, the FAH also supports the current policy because it provides a bright line test that affords certainty in its application for hospitals, for both government enforcement purposes and claims that may be made in private right of legal action cases.

I. Regulatory Analysis

Since 2002, CMS has thoughtfully considered the topic of how EMTALA should apply to hospital inpatients. Because the statute did not specifically address the issue, CMS undertook a comprehensive review of the topic. Through two rulemakings and the EMTALA Technical Advisory Group discussions, CMS vetted this issue with great analytical scrutiny to arrive at the current policy, which the FAH finds both permissible under the governing legal authority and an appropriate policy choice that has taken into account the considerations of all stakeholders. Importantly, this policy has achieved EMTALA's main goal, as it is very effective in making sure patients with emergency medical conditions have access to emergency, lifesaving services.

Notably, the EMTALA law was primarily designed to address concerns about hospitals dumping indigent and uninsured individuals from their emergency departments because of their inability to pay. In our view, enforcement activities, including private right of action cases, have sought over time to expand EMTALA's reach beyond that important focus, but with mixed results. In response to such initiatives, FAH members have been of the consistent view that the EMTALA law should not be viewed as a federal malpractice law.

This is why the reasoned decision-making that CMS undertook between 2002 and 2009 to reach its current policy is still so persuasive. In 2002, CMS first proposed that EMTALA should apply to some, but not all, inpatients. However, in considering the voluminous comments received from a diverse group of stakeholders, the agency concluded that such a policy would lead to a series of complexities in its application that would not provide the clarity that enforcement of this important law (with its serious sanctions) deserves. It is one reason why the FAH supports the current policy – the need for a truly bright line test based upon a good faith standard that allows for consistent application for both government enforcement and in private right of action jurisprudence.

It is also important to note that hospitals are subject to a myriad of legal and regulatory principles beyond EMTALA that help to ensure that patients receive appropriate inpatient medical care. The Hospital Conditions of Participation impose a series of regulatory requirements that protect patients and promote high quality of care, and subject hospitals that fail to meet those standards to the serious remedy of termination from the Medicare program. Further, hospitals are subject to state tort laws that provide a legal remedy if concerns arise about whether a patient received negligent medical care. Thus, as CMS correctly concluded, an expansion of EMTALA beyond its original intent is not necessary to protect patients or punish providers.

In fact, applying EMTALA to inpatients would likely have many unintended consequences. Unquestionably, the new policy would significantly burden strained hospital

resources by adding even more documentation and staffing requirements in a challenging operating environment. In addition, as CMS notes in the ANPRM, many have commented that they believe extending EMTALA to inpatients would provide an incentive for hospitals to transfer patients instead of treating them – a result that runs directly counter to the goal of the statute.

The ANPRM also asks for feedback as to the continuing accuracy of its prior statement that a hospital with specialized capabilities is likely to accept transfers of patients needing those services without regard to whether EMTALA obligations apply. Based on discussions with our members, the FAH believes this statement remains an accurate assessment of the reality in the field and continues to provide a sound basis to support CMS policy. While we found that occasionally our members have experienced situations where a hospital with specialized capabilities has sought to put parameters around its acceptance of a transfer, based upon our inquiries, those situations are clearly the exception and not the rule. Our members' experience is that in most cases these situations can be resolved between the facilities.

II. EMTALA Jurisprudence

It appears the recent decision by the U.S. Court of Appeals for the Sixth Circuit in the *Moses v. Providence Hospital* case has given rise to CMS revisiting its policy. In our opinion, the *Moses* decision, which held that EMTALA should continue to apply after a patient becomes an inpatient, is an anomaly that relies on unsound reasoning. While the hospital filed a petition for *certiorari* with the Supreme Court to overturn the appellate decision, we agree with the U.S. Solicitor General's recommendation that the Supreme Court not accept the case for review, and believed it was appropriate for the Court to deny review. Instead, we believe CMS's current policy provides a clear and appropriate policy statement, and one that should eliminate the possibility of both enforcement agencies and private litigants seeking an expanded EMTALA remedy in cases involving inpatients in situations far beyond the purposes for which the law was enacted.

III. Availability of Specialty Physicians

Although perhaps not strictly in the nature of a comment on the EMTALA proposal, it is in the overall context of the objective that patients receive the appropriate level and type of medical care promptly, a goal shared by all, that we take this opportunity to comment on a more challenging issue. The availability of specialty physicians is a significant factor when determining whether appropriate care can be received promptly and in the proper hospital setting, wherever the patient resides. The FAH firmly believes that patients would be better served if steps were taken to improve access to the availability of on-call physicians.

To this end, as it studied EMTALA and revisited the challenges in caring for patients, the FAH adopted a policy in 2008 that included four principles: (1) CMS should modify the Hospital Conditions of Participation regulations to promote on-call coverage; (2) Congress should enact federal legislation which mandates, or creates a strong incentive for, states to impose a requirement that physicians provide on-call services as a condition of their state licensure; (3) Congress should enact federal legislation requiring physicians to provide uncompensated on-call

coverage as a condition of receiving Medicare payment; and, (4) the HHS Office of Inspector General should provide guidance that provides greater clarity as to the appropriate compliance risk assessment regarding on-call compensation arrangements.

A more detailed statement of the FAH's policy on this topic is enclosed. The FAH continues to believe that this is a very important and complementary topic for discussion. We welcome the opportunity to work with CMS to advance the ideas to help ensure a full complement of medical professionals as a cornerstone to achieving a more integrated system, with greater access to the provision of a variety of medical services.

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The FAH appreciates the opportunity to comment on the ANPRM. If you have any questions about our comments or need further information, please contact me or Jeff Micklos of my staff at (202) 624-1500.

Sincerely,

Enclosure