National Association of Public Hospitals and Health Systems

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Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, D.C. 20201

**Ref: CMS–1350–ANPRM: Medicare Program; Emergency Medical Treatment and Labor Act: Applicability to Hospital and Critical Access Hospital Inpatients and Hospitals With Specialized Capabilities**

Dear Dr. Berwick:

The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to submit comments on the above-captioned advance notice of proposed rulemaking. NAPH represents more than 140 metropolitan area safety net hospitals and health systems, who predominantly serve the uninsured and patients covered by public programs. Changes to the Emergency Medical Treatment and Labor Act (EMTALA) would have significant implications for our members, who receive a significant number of EMTALA transfers from other hospitals due to the specialized health care services they provide.

Because NAPH members, as safety net hospitals, provide services to many uninsured and underinsured patients, NAPH has historically been a strong supporter of ensuring that all patients receive needed care regardless of insurance status, and in particular has supported EMTALA. We do not, however, believe that CMS needs to revisit its current policies on the application of EMTALA to inpatients, nor do we support the expansion of EMTALA beyond its intended purpose of ensuring access to emergency services. The legislative history of EMTALA makes clear that Congress adopted EMTALA to address hospitals' practice of turning patients away from the emergency room due to their inability to pay—not to impose indefinite inpatient treatment obligations on hospitals.[1] We disagree with the Sixth Circuit's contrary holding in

[1] *See, e.g.*, H.R. Rep. No. 241(I), 99th Cong., 1st Sess. 27 (1986), *reprinted in* 1986 U.S.C.C.A.N. 42, 605 ("Under current law, hospitals that participate in [M]edicare have to meet defined conditions of participation . . . . There are no specific requirements relating to the appropriate treatment of emergency patients, including non-[M]edicare patients. . . . The Committee is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance."); H.R. Rep. No. 241(III), 99th Cong., 1st Sess. 5 (1986), *reprinted in* 1986 U.S.C.C.A.N. 42, 726 ("[T]here has been growing concern about the provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured.").

*Moses v. Providence Hospital and Medical Centers Inc.* that the language of EMTALA imposes inpatient treatment obligations on hospitals.[2] Rather, we agree with the reasoning of the Fourth, Ninth, and Eleventh Circuits that EMTALA does not apply to inpatients, and believe Congress would need to amend EMTALA to allow an interpretation that extends the statute's reach to inpatients.[3]

As CMS has recognized in prior EMTALA rules, the Medicare conditions of participation and state malpractice laws already provide adequate legal protections for hospital inpatients. These protections have not changed. Moreover, the expansion of EMTALA is not needed to ensure that unstable inpatients needing specialized care are transferred to a more appropriate care setting. Even though receiving hospitals are not legally bound to accept transfers of inpatients under current law, hospitals have in practice developed formal and informal arrangements to provide for the transfer of inpatients who require specialized care. NAPH members in particular, who often provide burn, trauma, neonatal, and other specialized services that are otherwise unavailable in their communities, have repeatedly demonstrated a willingness to accept transfers from neighboring hospitals that lack the specialized capabilities necessary to stabilize their patients. Furthermore, expanding EMTALA obligations to inpatients could unintentionally burden the safety net while reducing already scarce specialty care access in the community. For example, some hospitals might take this opportunity to use such an extension to reduce their on-call specialty coverage—which can be very expensive to maintain—believing they can transfer unprofitable cases requiring such specialty care to the local safety net hospital. In short, we believe that current laws and hospital practices provide adequate protection to hospital inpatients.

We also are concerned that expanding EMTALA to inpatients may in fact have a negative impact on patient care. If EMTALA is expanded to inpatients, admitting hospitals may inappropriately rely on an expanded EMTALA obligation to insist upon the transfer of patients whom the hospitals otherwise would and could safely and appropriately treat. In particular, NAPH is concerned that hospitals may identify additional high cost conditions after admission and use EMTALA to justify transferring a patient, even when the transfer is not in the best interest of the patient. Because of the potential for expanded EMTALA liability, the receiving hospital would effectively lose its ability to determine the appropriateness of the transfer and would have to accept questionable, and even inappropriate, transfers to avoid the risk of penalties.

NAPH encourages CMS not to revisit its well-established EMTALA policies. Hospital inpatients already have adequate legal protections, and we are concerned that extending EMTALA to inpatients may harm patient care, rather than advance it.

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[2] 561 F.3d 573, (6th Cir. 2009).
[3] Bryan v. Rectors and Visitors of the Univ. of Va., 95 F.3d 349 (4th Cir. 1996); Bryant v. Adventist Health Sys. West, 289 F.3d 1162 (9th Cir. 2002); Harry v. Marchant, 291 F.3d 767 (11th Cir. 2002).

NAPH appreciates the opportunity to submit these comments. If you have any questions about these comments, please contact Lynne Fagnani or Xiaoyi Huang at (202) 585-0100.

Sincerely,

Larry S. Gage
President