National Association of Public Hospitals and Health Systems

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Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1350-NC: Medicare Program; Emergency Medical Treatment and Labor Act (EMTALA): Applicability to Hospital Inpatients and Hospitals With Specialized Capabilities

Dear Ms. Tavenner,

The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to comment on the above-cited proposed rule. NAPH supports the Centers for Medicare & Medicaid Services' (CMS') decision not to propose changes with respect to the EMTALA obligations of hospitals with specialized capabilities and admitting hospitals. Although counterintuitive, expanding EMTALA beyond its intended purpose of ensuring access to emergency services could potentially harm patients who need highly specialized care.

NAPH represents more than 140 major safety net hospitals and health systems that share the common mission of providing high-quality health care to all patients regardless of their ability to pay. Our members represent only 2 percent of the nation's acute care hospitals, but delivered 20 percent of the uncompensated care provided by hospitals nationwide in 2009. NAPH members provide low-income and uninsured patients a full range of services, from primary care to essential specialized services such as trauma and burn care. Based on 2009 data, about three-quarters of NAPH members operate a level 1 or 2 trauma center and almost half of all members offer burn care services. In 2009 alone, NAPH members saw more than 7 million emergency department (ED) visits, one-third of which were for uninsured patients. Of all ED visits, 16 percent led to an inpatient stay. And more than 60 percent of all inpatients were admitted through the ED.

Congress adopted EMTALA to address hospitals' practice of turning patients away from the ED due to their inability to pay. And as is clear from the data above, NAPH members strongly support EMTALA and access to needed care for all patients. However, NAPH believes that expanding EMTALA will not protect patient access, and instead could potentially disrupt patient care and place unnecessary burdens on the safety net hospitals that strive to ensure access for all.

The following three points speak directly to the negative effects of an EMTALA expansion and offer a proposal for strengthening CMS' EMTALA guidance further.

1. **CMS Should Not Create an EMTALA Obligation for Hospitals With Specialized Capabilities**

NAPH supports CMS' decision not to require hospitals with specialized capabilities to accept the transfer of inpatients who were admitted to a hospital under EMTALA, yet require specialized capabilities that are not available at the admitting hospital. Such an 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, in practice, hospitals have developed formal and informal arrangements to provide for the transfer of inpatients who require specialized care. NAPH members in particular, which often provide burn, trauma, neonatal, and additional otherwise unavailable services, have repeatedly accepted transfers from neighboring hospitals that lack the specialized capabilities necessary to stabilize their patients.

Creating an EMTALA obligation for hospitals with specialized capabilities, such as NAPH member hospitals, would erode their ability to efficiently allocate already scarce resources, impairing their ability to maintain capacity for emergency care and placing them under even further financial strain. As major providers of uncompensated and uninsured care, NAPH members work hard to maintain their capacity to provide essential, specialized services to their communities. And as CMS has acknowledged in prior rulemaking, these medical institutions are already facing significant and growing challenges in providing emergency services.[1] In fact, NAPH members have raised concerns that they are receiving EMTALA transfers for mostly uninsured patients, who often have longer lengths of stay due to a lack of appropriate post-discharge settings in the community. If CMS were to create this EMTALA obligation, safety net hospitals with specialized capabilities would have an even tougher time declining inappropriate transfers. In short, not only is there no need to create an EMTALA obligation to ensure patients receive the necessary care, but doing so could jeopardize the very hospitals on which these patients rely.

2. **CMS Should Not Extend the EMTALA Obligation to Hospital Inpatients**

NAPH also supports CMS' decision not to propose changes with respect to the EMTALA obligations of admitting hospitals. Congress did not adopt EMTALA to impose indefinite inpatient treatment obligations on hospitals.[2] And although the Sixth Circuit held that the

[1] 73 Fed. Reg. 48659 (Aug. 19, 2008).

[2] *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.").

language of EMTALA imposes inpatient treatment obligations on hospitals, we agree with the reasoning of the Fourth, Ninth, and Eleventh Circuits, which have all concluded that EMTALA does not apply to inpatients.[3,4] NAPH believes Congress would need to amend EMTALA to allow an interpretation that extends the statute's reach to inpatients; CMS does not have the authority to make this change through regulatory action.

As CMS has recognized in prior EMTALA rules, the Medicare conditions of participation and state malpractice laws already provide adequate legal protection for hospital inpatients. Furthermore, expanding EMTALA obligations to inpatients could unintentionally burden the safety net while reducing already scarce specialty care access in communities. For example, some hospitals might 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 such a case, overall access to specialty services would be reduced in a community.

In addition to reducing patient access, expanding EMTALA to inpatients could also negatively impact patient care. Admitting hospitals may inappropriately rely on an expanded EMTALA obligation to transfer patients who could safely and appropriately be treated within their own institutions. 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 patient's best interest. Because of the potential for expanded EMTALA liability, the receiving hospital would 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.

For these reasons, NAPH supports CMS' decision not to propose changes with respect to EMTALA obligation of admitting hospitals.

3. CMS Should Further Improve Its Regulations and Guidance to Enhance Hospitals' Ability to Continue to Provide Emergency Care

NAPH appreciates CMS' efforts to continuously improve its regulations and guidance and encourages the agency to consider options that would give hospitals the tools to better allocate their already scarce emergency care resources. Specifically, NAPH urges CMS to increase transparency around on-call rosters and allow receiving hospitals to confirm the capability or capacity of the referring hospital to treat a patient prior to accepting a transfer. As part of confirmation, receiving hospitals should be able to check specialist availability through the referring hospital's on-call roster. CMS, either directly or through the states, should also monitor all hospitals' referral patterns to detect hospitals that are only transferring uninsured patients. CMS should clarify through guidance that a discriminatory or disparate pattern of selective referral for specialty care on the basis of patients' ability to pay—e.g., only transferring

[3] Moses v. Providence Hospital and Medical Centers Inc. 561 F.3d 573, (6th Cir. 2009).

[4] 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).

uninsured patients to receiving hospitals located hundreds of miles away when many hospitals are located in between the transferring and receiving hospitals, including those that are affiliated with the transferring hospital, have the capability and capacity to treat the uninsured patient—is potentially a violation of EMTALA. These efforts would further ensure that transfers are appropriate under EMTALA and not simply due to the patient's lack of insurance coverage.

NAPH also urges CMS to further improve its enforcement activities with respect to potential EMTALA violations. At a minimum, CMS should develop uniform guidance for its regional offices so that investigation and resolution of EMTALA violations are conducted in a consistent manner across the country.

Lastly, NAPH urges CMS to continue to develop policies that would enable safety net hospitals that face severe financial and operational pressures to fully meet the needs of their communities. To that end, NAPH encourages CMS to seek legislative changes that would further enhance hospitals' ability to maintain capacity and deliver emergency care. For example, CMS could seek liability protection for hospitals, physicians, and other licensed independent practitioners who provide service to patients covered by EMTALA and a sustainable funding mechanism for hospitals and physicians that deliver emergency care. Such changes are also endorsed by the EMTALA Technical Advisory Group in its 2008 final report.[5]

NAPH appreciates the opportunity to submit these comments and looks forward to working with CMS as it continues to monitor and review this issue. If you have any questions, please contact Xiaoyi Huang, assistant vice president for policy, at 202-585-0127.

Sincerely,

Bruce Siegel, M.D., M.P.H.
President and Chief Executive Officer

[5] See recommendations 52 and 53 in the Final Report of the Emergency Medical Treatment and Labor Act Technical Advisory Group, Apr. 2008.