American Hospital Association

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Submitted electronically

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Donald M. Berwick, M.D., M.P.P.
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: CMC - 1350 –ANPRM; Emergency Medical Treatment and Labor Act: Applicability to Hospital and Critical Access Hospital Inpatients and Hospitals with Specialized Capabilities; (Vol. 75, No. 246); December 23, 2010.

Dear Dr. Berwick:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) request for comments on the need to revisit the agency's current policy concerning the applicability of the *Emergency Medical Treatment and Labor Act* (EMTALA) to hospital inpatients and the responsibilities of hospitals with specialized capabilities.

Community hospitals are the medical safety net for this country. AHA members support the intent of EMTALA – to assure that people who need emergency services receive them. Our answer to the question posed by CMS in the advance notice of proposed rulemaking (ANPRM) – whether it should revisit its current policies on the application of EMTALA to inpatients – is "no." The current policies are the appropriate interpretation of the law and are achieving what Congress intended. They do not need to be revisited. If anything, a move by CMS to expand the scope of EMTALA is out-of-step with President Obama's call for improving regulations by minimizing burden and unnecessary regulation.

The background discussion in the ANPRM and the Solicitor General's defense of the current regulations and underlying policy in its brief (as referenced in the ANPRM) to the Supreme Court last year, persuasively makes the legal and public policy case for maintaining CMS'

current regulations. In enacting EMTALA, Congress concluded that in a number of states there was no statutory, regulatory or common law requirement for hospitals or physicians to treat patients coming to a hospital emergency department. The requirements of EMTALA were intended to close that gap in state law. Congress recognized that once a hospital-patient or physician-patient relationship was established, as occurs when a patient is admitted as an inpatient, all of the related legal rights of a patient and duties of a provider or practitioner would apply.

Hospitals take seriously their EMTALA responsibilities and all other responsibilities to their patients. It is unclear why CMS, after 10 years of recurring examination of this issue, and the apparent lack of "real world" examples that hospitals are not meeting their responsibilities for patient care, is again asking this question. A brief review of the existing Medicare conditions of participation (CoPs) for hospitals and critical access hospitals (CAHs) makes clear that CMS has adequate means to oversee the care hospitals provide inpatients.

All inpatient care is subject to the general Medicare CoPs, which should provide an appropriate foundation for safe care of all inpatients, including inpatients admitted with an unstabilized emergency medical condition. These CoPs include:

- *A Responsible Physician for Each Patient* (42 CFR 482.12(c)(4)).
- *Physician On Duty or On Call* (42 CFR 482.12(c)(3)) at all times.
- *RN Supervision & Availability 24/7* (42 CFR 482.23(b)) to evaluate the care of each patient be immediately available, when needed, to provide bedside care to any patient.
- *Right to Care in a Safe Setting* (42 CFR 482.13(c)(2)).
- *Governing Body Ensures Accountability* (42 CFR 482.12(a)(5)) of the medical staff to the governing body for the quality of care provided to patients.
- *Medical Staff – Organized and Accountable* (42 CFR 482.22(b)) to the governing body for the quality of care provided to patients.
- *Quality Assessment and Performance Improvement (QAPI)* (42 CFR 482.21(e)) governing body, medical staff, and administrative officials are responsible and accountable for ensuring that clear expectations for safety are established and that adequate resources are allocated for reducing risk to patients.
- *Discharge Planning* (42 CFR 482.43(a),(d)) process applicable to all patients; identification at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning; transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.
- *Agreements* (42 CFR 485.616) with another hospital are required of CAHs in rural health networks for patient referral and transfer, communications systems and the provision of emergency and nonemergency transportation between the CAH and the hospital.

The CoPs, coupled with state medical liability and other laws governing the duties of a hospital or physician to their patients, accreditation and other oversight entities, provide appropriate and uniform protections for an individual admitted as an inpatient.

CMS has suggested in the past that EMTALA could and, therefore, should, be used to address the larger issues affecting the emergency department related to overcrowding, patient boarding, ambulance diversion and the precarious operational and financial situations in which many trauma centers and psychiatric hospitals find themselves. As demonstrated through the extensive deliberations of the EMTALA Technical Advisory Group (TAG), and as continues to be the case, there is no evidence that EMTALA would be helpful. It cannot create resources that do not exist; it cannot help manage the use of limited resources.

As a practical matter, hospitals routinely engage with each other on the transfer of an inpatient who needs care that is beyond the capability of the admitting hospital. In many cases, there are pre-existing agreements based on the limits of a hospital's capability, such as the case for CAHs. In others, consultations and arrangements are made on an as-needed basis. Interjecting EMTALA would have adverse and unintended consequences. The working relationships among hospitals that are essential to getting patients the care they need would be interrupted. Concerns about the increased and unnecessary burden and liability exposure would have a chilling effect on appropriate transfers. In addition, the TAG members expressed concern that unnecessary transfers would be made when the services could have been provided at the sending hospital.

All of this makes CMS' apparent view that EMTALA is a potential tool to address the systemic resource challenges facing hospitals, all that more puzzling and troubling. EMTALA was designed with a significant, and limited, objective – to assure that all individuals in need of emergency services have access to care. It achieves that goal. Attempting to use EMTALA for more than it was designed is legally unsound, and most importantly, would adversely affect patient care.

If you have questions regarding our comments, feel free to contact me, Maureen Mudron, deputy general counsel, at mmudron@aha.org or 202-626-2301, or Roslyne Schulman, director of policy development, at rschulman@aha.org or 202-626-2273.

Sincerely,

/s/

Rick Pollack
Executive Vice President