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VIA ELECTRONIC SUBMISSION

February 22, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS-1350-ANPRM
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Comments on Medicare Program; Emergency Medical Treatment and Labor Act (EMTALA):
Applicability to Hospital and Critical Access Hospital Inpatients and Hospitals With
Specialized Capabilities

CMS-1350-ANPRM

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. NHeLP works to improve health care for America's working and unemployed poor, minorities, the elderly and people with disabilities. NHeLP serves legal services programs, community-based organizations, the private bar, providers and individuals who work to preserve a health care safety net for the millions of uninsured or underinsured low-income people. NHeLP also works to support laws, regulations, and policies which low-income individuals depend upon to receive timely and high-quality medical treatment.

Accordingly, NHeLP is pleased to offer our comments on the Advance Notice of Proposed Rulemaking (CMS-1350-ANPRM) on the applicability of EMTALA to the inpatient setting:

I. Background

Intro

Millions upon millions of hard-working Americans live without health insurance, because they work in jobs that don't offer insurance, they can't afford insurance, and/or no one will sell them insurance due to their illness. For these Americans, EMTALA is their only protection when they need emergent medical treatment. EMTALA literally amounts to the difference between life and death. The integrity of EMTALA is among the most critical protections in our health care system. This is particularly true for highly vulnerable and sometimes unpopular populations who might otherwise be unable to obtain charitable treatment due to discrimination – the homeless, individuals with mental health disability, racial and ethnic minorities, etc.

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While the Affordable Care Act (ACA) will provide affordable insurance coverage to 31 million Americans by 2019, millions will remain uninsured or still unable to afford coverage. The majority of the residual uninsured patients will be immigrants, who remain excluded from any affordable health insurance under the ACA. In addition, the remaining uninsured will also include individuals who for reasons other than their immigration status are unable to establish or maintain eligibility for coverage. This may include individuals who are over-income for Medicaid but unable to afford subsidized coverage, the homeless population, and individuals with limited English proficiency. The needs of this diverse uninsured population, and the needs of the nation's safety net hospitals, for EMTALA's protection will be greater than ever. The phase-down of Disproportionate Share Hospital (DSH) payments, which will occur as the ACA is implemented, will limit the capacity of safety net hospitals to care for uninsured patients who are dumped by other hospitals in violation of EMTALA.

As an organization that serves the most vulnerable communities who will continue to rely on EMTALA, we support CMS's proposal to address existing problems with EMTALA compliance, for we know how important the law is, and will remain.¹

Growing threats to the integrity of EMTALA

Nonetheless, any expansion of EMTALA must take into account the difficulties in enforcing the current law. All too often, individuals present at Emergency Rooms and their conditions are not stabilized as the law requires. In many cases, the hospital finds an illegitimate excuse to not treat the individual, and to recommend their transfer. Certain patients are consistently targeted for this mistreatment, such as those who appear "foreign-born" or are not proficient in English or are otherwise time-consuming, and cannot always rely on the health system for prompt treatment of their emergency medical condition.² Sometimes patients are simply targeted for transfer because they have medical conditions that will be more expensive to treat. All of this also leads to certain safety-net hospitals receiving undue numbers of transfers, thus complicating their already challenging mission. In worse cases, some patients bounce around until they give up without receiving treatment, or, in the worst cases, die. Any rule should consider these on-going issues.

Hospitals use a number of improper tactics to avoid their obligations. Some hospitals understate their on-call coverage capacity for EMTALA purposes, or have weak oversight and by-laws relating to physician availability which allows them to claim they lack sufficient on-call capacity when a patient presents at the Emergency Room. Other hospitals may have a practice of transferring select populations (for example, mental health emergencies or children) to specialized hospitals even though

¹ As the proposed rule would limited to the in-patient setting and in-patient transfer obligations under EMTALA, we limit our comments to these issues. However, as many uninsured individuals will continue to rely on EMTALA protections after health reform is implemented, we encourage CMS to further strengthen EMTALA protections and ensure it meets the needs of those most vulnerable.

² Contrary to popular opinion, citizens and those with health insurance most often use the emergency room. See Peter Cunningham, "What Accounts for Differences in the Use of Hospital Emergency Departments across U.S. Communities?", Health Affairs, July 18, 2006; and "Are Immigrants Responsible for Most of the Growth of the Uninsured?" (Kaiser Commission on Medicaid and the Uninsured, 2005).

the first hospital has the capacity to treat, or clearly at least stabilize, the patient. Similarly, hospitals sometimes fail to stabilize a patient who they could stabilize and then transfer to another hospital with a specialized service, like a burn unit or specialized NICU. Yet other hospitals apply the definition of stabilization so loosely so as to not fully treat individuals prior to release or transfer. Again, every time a hospital shirks its EMTALA duty, some other hospital that has good policies and plays by the rules ends up doing double duty.

The threats to the integrity of EMTALA are only growing, especially for vulnerable populations. To highlight two critical current issues:

- Immigrants are being unfairly targeted by dangerous EMTALA policies. This includes proposals for mandated immigration reporting which would eviscerate the EMTALA protections of millions of immigrants (including legal immigrants, U.S. citizen children and naturalized citizens) and medical deportation exceptions which often violate EMTALA as well as hospital discharge procedures.
- There are problems with the weakening of EMTALA protections for women. Some hospitals, frequently those adhering to strict religious-based non-medical guidelines, may confuse *capacity* to treat with *willingness* to treat. EMTALA has never has an exception for ‘conscience’, and for good reason – these are urgent life or death situations. With religiously affiliated hospitals dominating about 20% of the market and growing, rules will need to be clear that hospitals cannot claim conscience exceptions³ as a way to disclaim capacity to treat.

Any new rules around EMTALA should pay special attention to the ways EMTALA’s protections are systematically weakened for vulnerable populations.

None of these problems negate the incredibly positive efforts and heroic work of many hospitals and emergency rooms across the country. But these issues do serve to highlight the importance of EMTALA as context for implementing new rules around EMTALA admissions and post-admission transfer. Rules must be drawn to prevent malfeasance by hospitals in skirting their EMTALA requirement, passing the costs and responsibility on to compliant hospitals, and most importantly, endangering patients’ lives in the process. While we support the effort to apply EMTALA to the admission setting, any amendments to the EMTALA regulations must be made only after concerted investigation and assessment to ensure that the regulations do not have the unintended effect of creating new loopholes for patient dumping.

³ Some hospitals refuse to provide any service that could be construed as abortion (strictly defined in some religious-based guidance as “when there is a heartbeat”) including some treatments of ectopic pregnancies, terminating a pregnancy even when woman is in distress, providing EC to victims of sexual assault; emergent pregnancy issues include ectopic pregnancy, pre-eclampsia, premature rupture of membranes, or a woman’s underlying health condition, in particular diabetes and cardiovascular disease. (In one recent case in Arizona religious officials told a hospital that sometimes both patients will die because they cannot choose the fetus life over the woman). Emergency medicine, and EMTALA decisions about capacity and stabilization, should be based on objective clinical standards, not the moral standard of the doctor who happens to be on duty, or the emergency room that happened to be closest when the emergency began.

II. Proposed Rules

EMTALA Post-Admission

Proposed rules around post-admission applicability of EMTALA have the possibility to eliminate a major loophole created in the EMTALA regulations⁴ that some hospitals have at times taken advantage of to the detriment of patient care. Hospital admission alone has been used to avoid the EMTALA obligation to stabilize patients, leading to delays in their stabilization and in the most extreme cases to an eventual discharge without stabilization. Furthermore, the non-applicability of EMTALA after admission can also be used by hospitals as a tool to immunize themselves from bad emergency room conduct. For example, a hospital that allows a patient to languish for hours in a waiting room with an emergency condition, and then has a few doctors see the patient without ever attempting to stabilize the condition, is shielded from any EMTALA malfeasance by the simple act of admitting the patient. Some other examples (based on real cases):

- A child presents at an emergency room in the middle of an acute mental health crisis. The hospital, despite the obligation to *stabilize* the emergency medical condition (which it does not mean they need have all of the capacity to fully *treat* the condition), never does so. After hours of waiting, and suffering, the child is admitted. Eventually the child is discharged without the condition ever being fully stabilized. The hospital has skirted any EMTALA obligation to stabilize the child in the admission setting, and has immunized itself from EMTALA violations pre-admission.
- A pregnant woman in medical distress presents at an Emergency Room in a religiously affiliated hospital. Upon examination it is determined that she has a preterm premature rupture of membranes (PPROM), and that the fetus is not viable. She is not stabilized, because, although the hospital could terminate the pregnancy, it chooses not to do so because of the hospital's religious affiliations – effectively applying an illegal EMTALA conscience clause. The hospital admits and monitors the pregnant woman over the course of many hours. As would be expected in PPRM cases, the mother eventually goes into serious infection, her life is at risk, at which point the hospital terminates the pregnancy to save the woman. The hospital argues that its emergency department EMTALA violations are shielded by the admission, and that its post-admission monitoring of the woman when she could have been stabilized at any point after admission is not an EMTALA violation.

Post-admission Transfer

⁴ The EMTALA regulations, at 42 C.F.R. § 489.24(d)(2), create an exception to EMTALA for admitted patients. This exception has no statutory basis. See 42 U.S.C. § 1395dd(b)(1)(A). The regulation takes a far narrower view of the statute than is required, and based on experience with the rule it is well within the statute's scope and Secretary's authority to refine the EMTALA regulations to apply the EMTALA requirements to the admission setting. Note, in fact, that the specific inclusion of "discharge" in the statutory definition of transfers, at 42 U.S.C. § 1395dd(e)(4), implies that the statute was written to consider applying EMTALA to the admission setting.

When a patient presents at an emergency room with an emergency medical condition, a hospital that lacks the capacity to stabilize the patient has a duty to help transfer the patient to another hospital under EMTALA. (Note: A hospital that lacks the ability to *treat* a patient – for example in a burn unit admission – may still have the ability to *stabilize* the patient). The receiving hospital, if it has the specialized capacity needed, has an EMTALA obligation to accept and stabilize the condition. A patient under these circumstances is protected by the obligation of these hospitals to get the patient to the quickest place where she can be stabilized. In practice, the clarity of rules around the transfer, and the requirement to do this efficiently, may be the difference between life or death for the patient.

In contrast, an unstabilized patient who is suffering from the exact same emergency medical condition, but is admitted, has no such protection. If, after admission, the hospital cannot stabilize her, there will be no EMTALA obligation to initiate her transfer to a hospital that can stabilize her, and no requirement for a potential receiving hospital to accept transfer. This creates a senseless exception to the EMTALA obligation that may lead to dramatically different treatment outcomes for two patients who present at the same hospital with the same emergency medical condition. It also creates a dangerous incentive for hospitals to use the admissions process to skirt responsibilities around transfer. Rules requiring that unstable post-admission patients (who enter through the emergency room) be subject to the same protections as they would have at the emergency room point of entry make sense – they will protect patients who are admitted and eliminate a loophole for hospitals.

As mentioned earlier, the topic of transfers is a complex one. The reality is that most hospitals do not abuse the EMTALA transfer rules. More importantly, for every hospital that does abuse the rules, there may be another hospital that receives unfair, undue transfers. The patient always loses when EMTALA transfer policies are abused, but so do hospitals that have good acceptance policies. After all, receiving hospitals have no way of understanding the validity of the transfer until they have the patient and are committed to treatment. Therefore, transfer policies around this rule must be designed to discourage the minority of abusive hospitals from gaming the system to the detriment of safety-net hospitals. The ultimate goal should be a policy with strong and clear rules, such that the burden of treating EMTALA cases is evenly distributed by capacity, and hospitals do not have a disincentive to have good policies. The importance of transfer protection post-admission is important enough to the well-being of patients that a rule should be proposed to address this issue, notwithstanding and working to correct for the difficulties around EMTALA transfer policy.

Conclusion

NHeLP looks forward to working with CMS on the development of an EMTALA NPRM. If there is any information or assistance we can provide, please do not hesitate to contact us. You can reach Leonardo D. Cuello, Staff Attorney, in our office at 202-289-7661, ext. 301.

Sincerely,

Emily Spitzer
Executive Director