



Michael D. Maves, MD, MBA, Executive Vice President, CEO

February 21, 2011

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

Re: Advance Notice of Proposed Rule Making concerning *Medicare Program; Emergency Medical Treatment and Labor Act: Applicability to Hospital and Critical Access Hospital Inpatients and Hospitals with Specialized Capabilities [CMS-1350-ANPRM]*

Dear Dr. Berwick:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide our comments regarding the Centers for Medicare and Medicaid Services' (CMS) advanced notice of proposed rulemaking (ANPRM) regarding *Medicare Program; Emergency Medical Treatment and Labor Act: Applicability to Hospital and Critical Access Hospital Inpatients and Hospitals with Specialized Capabilities [CMS-1350-ANPRM]*.

The AMA has long opposed the expansion of the Emergency Medical Treatment and Labor Act (EMTALA). Physicians are already bound by a host of legal and ethical obligations to provide necessary patient care, and take those obligations seriously. Further, EMTALA obligations often result in over-utilization of physician resources, uncompensated care, and administrative hurdles. We are generally supportive of CMS' efforts to examine issues of patient care delivery and access. However, in this instance, we do not believe an expansion of EMTALA is warranted. We offer below our detailed comments on the ANPRM.

EMTALA's Impact on Physicians

The AMA has for some time expressed concern about the ever-increasing expansion of the scope of EMTALA from what was initially envisioned by the Congress. Past expansions of EMTALA requirements to settings other than the emergency department have increased the financial and legal liability of those caring for these patients and decreased the willingness of some physicians to provide on-call services.

The AMA requests that CMS address the issue of uncompensated care mandated by EMTALA. Hospitals and physicians cannot continue to shoulder the financial burden of providing EMTALA-mandated screening and stabilization services to all persons who present themselves to an emergency department without adequate health insurance coverage. CMS should require that Medicare, Medicaid, and Medicare Advantage organizations pay for EMTALA-mandated services.

Application of EMTALA to Inpatients

The AMA does not believe that CMS should revisit the current policy regarding EMTALA application to inpatients, as expressed in CMS' September 9, 2003 final rule on EMTALA. In that final rule, CMS stated that a hospital's obligation under EMTALA ends when the individual's emergency medical condition (EMC) is stabilized or when that hospital, in good faith, admits an individual with an unstable EMC as an inpatient. We agree with CMS' conclusion in that final rule that EMTALA does not apply to any inpatient, even one who was admitted through the dedicated emergency department, for whom the hospital had initially incurred an EMTALA obligation to stabilize, and who remained unstabilized after admission as an inpatient.

EMTALA was enacted to prevent hospitals from refusing to treat patients arriving at the emergency room with an emergency condition. It is clear that hospitals are not attempting to evade patient treatment by admitting patients with unstable conditions as inpatients, as those patients are, in fact, being treated as inpatients. We agree with CMS' prior determination that it is consistent with the intent of EMTALA to limit its protections to individuals who need them most. As CMS has previously pointed out, in the case of inpatients, there is no need or requirement to supplement the hospital's obligation to its patients in order to further the objectives of EMTALA.

Physicians and hospitals are already required under the Medicare conditions of participation (CoPs) and State tort law to treat patients who have been admitted to the hospital as inpatients and later develop emergency conditions. As CMS noted in its 2003 final rule on EMTALA, hospital CoPs provide adequate, and in some cases, superior, protection to patients. A hospital that fails to provide necessary treatment to such patients could face termination of its Medicare provider agreement for a violation of the CoPs. The AMA believes that once patients are admitted as inpatients, as a bright line standard, the Medicare CoPs should govern physician and hospital care of patients, rather than EMTALA.

Although EMTALA is intended to ensure that individuals in need of emergency care are provided timely and appropriate treatment, extending EMTALA to inpatients may have the unintended consequence of limiting patient access to care. There have been reports of emergency department and trauma center closures due, in part, to the high cost of complying with EMTALA requirements. Such closures impact all individuals in need of emergency care and are devastating in small communities where there might be only one trauma center or

emergency department. We are concerned that, if EMTALA is extended to inpatients, physicians and hospitals may begin to see the same phenomenon in the inpatient setting.

Further, systemic problems under EMTALA only compound physicians' ongoing concerns about such matters as medical liability and steep Medicare cuts, and create an environment where physicians literally cannot afford to be available for medical emergencies, which can seriously affect patient access to emergency care.

The AMA strongly opposes a revision of the current inapplicability of EMTALA to inpatients. We strongly support CMS' existing policy: following inpatient admission of a patient evaluated in an emergency department, where a patient is not yet stable, EMTALA should not apply.

Application of EMTALA to Hospitals with Specialized Capabilities

The AMA does not believe that CMS should expand EMTALA obligations through a revision of CMS' August 19, 2008 IPSS final rule. In that final rule, CMS stated that if an individual with an unstable emergency medical condition is admitted as an inpatient, the EMTALA obligation has ended, even if the individual's EMC remains unstabilized and the individual requires treatment only available at a hospital with specialized capabilities. In other words, CMS determined that a hospital with specialized capabilities does not have an EMTALA obligation to accept an appropriate transfer of an individual who had been admitted in good faith as an inpatient at the first hospital.

In 2008, CMS concluded that extending an EMTALA obligation to a hospital with specialized capabilities after a patient has already been admitted to a first hospital could result in hospitals with specialized capabilities experiencing an increase in inappropriate transfers, or "patient dumping," at such hospitals. Further, CMS acknowledged that medical institutions such as academic medical centers, tertiary care centers, and public safety net hospitals are already facing significant and growing challenges in providing emergency services, and could effectively be put out of business by increased patient dumping. Prevention of patient dumping, which results in overutilization of physicians' services and uncompensated care, is a key policy reason for EMTALA. It is nonsensical for CMS to implement new EMTALA policy that is likely to contravene the legislative intent of EMTALA.

We believe that hospitals with specialized emergency care capabilities should have a means to ensure medical staff responsibility for patient transfer acceptance and care. However, we think that physicians and hospitals should work together, on a case-by-case basis, and in the development of general policy, to ensure such responsibility, rather than extending EMTALA, which could cause patient dumping.

We point out that professionalism and ethics drive physicians' actions when issues of treatment and transfer arise. For example, the AMA's Code of Medical Ethics sets forth an obligation to provide emergency care and an obligation not to abandon. Physicians take the precept of responsibility for their patients' care very seriously, and determinations regarding what is in the

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best interest of the patient in the context of transfer are best left to the professional judgment of the physicians concerned.

We urge CMS to consider incorporating appropriate standards that prohibit the discharge or inappropriate transfer of unstable hospitalized patients into the Medicare CoPs for hospitals, in lieu of utilizing EMTALA for this purpose. Extending the reach of EMTALA exacerbates the fundamental flaws of that law's application: overutilization and inadequate compensation of physicians, as well as an increasing shortage of on-call specialists.

Conclusion

Extending EMTALA to inpatients, or to individuals who have been admitted as inpatients at one hospital in good faith and then need to be transferred to another hospital with specialized capabilities for stabilizing treatment, would further exacerbate EMTALA's drain on physician time and resources and the availability of on-call specialists. Further, it is duplicative of already-existing legal and ethical physician obligations. Therefore, we urge CMS not to revise the policies on inpatients and transfers to hospitals with specialized capabilities that were established in the September 9, 2003 final rule on EMTALA and the August 19, 2008 IPPS final rule, respectively.

We appreciate the opportunity to comment on these issues and look forward to a productive working relationship whereby the views of the physician community may positively inform CMS' work. Should you have any questions on these comments, please contact Mari Savickis, Assistant Director, Federal Affairs, at mari.savickis@ama-assn.org.

Sincerely,

A handwritten signature in black ink that reads "Mike Maves". The signature is written in a cursive, flowing style.

Michael D. Maves, MD, MBA