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February 3, 2012

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

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

Dear Ms. Tavenner,

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing approximately 4,000 neurosurgeons in the United States, we appreciate the opportunity to comment on the above referenced notice. **The AANS and CNS strongly support the current EMTALA policy regarding inpatients, and therefore fully agree with CMS' proposal to maintain the current EMTALA requirements for hospitals.**

For a number of reasons, which we have previously outlined in comments to CMS, the AANS and CNS have long been proponents of the proposition that EMTALA does not apply to hospital inpatients. As discussed in the notice, when CMS revised the EMTALA regulations in 2003, the agency established a new policy that a hospital's EMTALA obligation ends when that hospital, in good faith, admits an individual with an unstable emergency medical condition as an inpatient to that hospital. The AANS and CNS supported this change given the fact that other patient safeguards adequately protect inpatients, including the Medicare hospital conditions of participation (CoPs)[1], accreditation standards, state duty of

[1] As noted in the American Hospital Association's February 15, 2011 letter to CMS in response to last year's advance notice of proposed rulemaking on this topic, 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

care requirements and medical malpractice laws. CMS adopted this policy to clarify what had been confusion over whether or not EMTALA applied to inpatients and to establish a bright-line rule. To reverse course would be to once again add unnecessary confusion and burdens to the emergency medical care system.

The AANS and CNS also agree with CMS that there is not a demonstrated need for revising current EMTALA policy. This topic was discussed at length during the deliberations of the EMTALA Technical Advisory Group (TAG), and no sufficient and compelling evidence was demonstrated to merit such a sweeping change in EMTALA policy. Since the TAG disbanded, it has not been established that there are widespread problems whereby hospitals and physicians are failing to meet their obligations to care for their patients and therefore no change in existing EMTALA requirements is warranted. While the TAG recommended that CMS revise its regulations to address the situation of an individual who is admitted to the hospital as an inpatient for purposes of stabilizing the emergency medical condition and subsequently needs to be transferred to another hospital with specialized capabilities, this was one of the TAG's most controversial recommendations and it only passed by a razor thin margin. Indeed, eight members of the TAG felt so strongly about this recommendation that they took the extraordinary step of writing a formal letter of dissent to the TAG's chair.[2] This letter stated in part:

> We are very concerned that this recommendation, if implemented, will adversely affect patient care and potentially increase the number of unnecessary patient transfers. All of the practicing surgical specialty physician representatives as well as all of the hospital representatives of the TAG are in opposition to this recommendation.

Even the two physician members of the TAG who supported this recommendation were sufficiently concerned about the potential unintended consequences that they too felt compelled to register their concerns in their own letter,[3] stating in part:

> We two physician members of the TAG who voted for the recommendation feel that its implementation should be carefully considered as having potential for abuse (ie. patient dumping)…We fear that the potentially unintended consequence may be the transfer of EMTALA patients for reasons other than those related to emergency care of the problem for which the patient was originally admitted when these services could have been provided at the sending hospital.

Like the EMTALA TAG, the AANS and CNS are concerned that a modified EMTALA inpatient policy could be potentially abused and an unintended consequence may be an increase in the number of patients being "dumped" from one hospital to another. In recent years, many academic medical centers, trauma centers and large tertiary care hospitals have reported an increased number of patients being transferred to them from hospital emergency departments (EDs) under the "specialized capabilities" transfer rules. According to a survey of neurosurgeons conducted by the AANS and CNS in late 2004, 45 percent of neurosurgeons practicing at an academic health center or Level 1 or 2 trauma center had

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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.

[2] Members signing this letter, which is contained in Report Number Seven from the EMTALA TAG, September 17-18, 2007, Appendix 4, were: James Nepola, MD, Julie M. Nelson, Rory S. Jaffe, MD, David W. Tuggle, MD, Richard Perry, MD, James L. Biddle, MD, Rachel Seifert, MD and John A. Kusske, MD.

[3] Members signing this letter, which is contained in Report Number Seven from the EMTALA TAG, September 17-18, 2007, Appendix 3, were: Mark D. Perlmutter, MD and Michael J. Rosenberg, MD.

experienced an increased number of neurosurgical emergency cases in the preceding two years and one-third of these stated that the reason for these transfers was that:

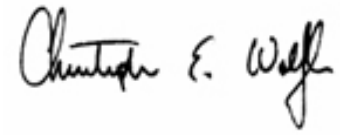
> The neurosurgeons in my area who are on call instruct their hospitals to transfer emergency neurosurgical cases to my hospital claiming the patients require specialized services and my hospital is considered a "higher level care" institution and under EMTALA requirements I must treat these patients.

These hospitals are already stretched thin and are experiencing ED overcrowding, ambulance diversion, and shortages of intensive care unit (ICU) and other inpatient beds. In addition, these patients are often uninsured or underinsured and as a result of the increased number of transfers, many of these hospitals are facing significant fiscal difficulties. Expanding this EMTALA transfer option for inpatients will only exacerbate these problems.

Given a lack of a documented need to expand EMTALA to inpatients, the plethora of other regulations governing appropriate inpatient care, including patient transfers, and the potential for increasing inappropriate transfers, the AANS and CNS fully support CMS' proposal to maintain the current EMTALA requirements for hospitals.

Thank you for considering our comments. If you have any questions or need additional information, please feel free to contact us.

Sincerely,



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