

of its EMTALA obligation (67 FR 31475). We proposed that such an individual would continue to be covered by EMTALA until the individual's overall medical stability with respect to all conditions is achieved.

Based on an analysis of the statute (sections 1867(b)(1)(A), (c)(2), and (e)(1) of the Act) and the legislative history (131 Cong. Rec. 28,587 and 28,588 (1985) and H.R. Rept. No. 241 (I)(1985), reprinted in 1986 U.S.C.C.A.N. 579, 605.), we explained why we believed that EMTALA continued to apply to admitted emergency patients until they have been stabilized or appropriately transferred.

For a detailed discussion of the proposed policy on the applicability of EMTALA to admitted patients with unstabilized emergency medical conditions, see the preamble to the May 9, 2002 proposed rule at 67 FR 31475.

In addition, except for the limited circumstances described above, we proposed to clarify that EMTALA does not apply to nonemergency hospital inpatients. Most hospital admissions do not consist of emergency cases. In most cases, an individual who comes to the hospital and requests admission does so to obtain elective (nonemergency) diagnosis or treatment for a medical condition. We noted that once a hospital admits an individual as a patient, that hospital has a variety of other legal, licensing, and professional obligations with respect to the continued proper care and treatment of such patients.

We proposed to redesignate paragraph (c) of § 489.24 as paragraph (d), and include stabilization requirements under a new proposed § 489.2(d)(2). (Proposed redesignated paragraph (d) was proposed to be revised further as explained in section V.K.9.b. of the preamble of the May 9, 2002 proposed rule (67 FR 31456).) In addition, we proposed to include the requirements for nonapplicability of EMTALA to nonemergency hospital inpatients under proposed redesignated § 489.24(d)(2).

B. Summary of Public Comments and Departmental Responses

1. Applicability of EMTALA to Inpatients

Comment: Many commenters expressed concern about our clarification in the proposed rule on the applicability of EMTALA to hospital inpatients. Some commenters agreed with the entirety of the CMS proposed policy that a hospital's EMTALA stabilization and transfer obligations should continue to apply to an admitted emergency patient. One commenter

stated that "this clarification will allow hospitals to find an endpoint to their EMTALA obligations, specifically when the patient's emergency [medical] condition is stabilized."

However, many commenters expressed the view that EMTALA should not apply to any inpatient, even one who was admitted through the dedicated emergency department and for whom the hospital had incurred an EMTALA obligation to stabilize. Several commenters noted that hospitals have extensive CoPs responsibilities with respect to inpatients or State tort law obligations, and argued that the hospital's assumption of responsibility for the individual's care on an inpatient basis should be deemed to meet the hospital's obligation under EMTALA. Many commenters recommended that the regulations be revised to state that a hospital's EMTALA obligation may be met by admitting an individual as an inpatient.

Two commenters stated that CMS has "no evidence there is a current problem" for the dumping of inpatients with emergency medical conditions. Therefore, the commenters believed EMTALA applicability should end upon inpatient admission.

One commenter (a group of neurosurgeons and neurologists) believed that EMTALA was not intended to apply to an inpatient admitted through the dedicated emergency department. Several commenters cited the recent ruling by the Court of Appeals for the Ninth Circuit in *Bryant v. Adventist Health System* (289 F.3d 1162 (9th Cir. 2002)) that EMTALA generally ceases to apply once an individual is admitted for inpatient care; these commenters believed we should adopt the opinion for the national policy.

Response: In attempting to resolve the issue about EMTALA applicability to admitted emergency patients, we were assisted by referring to cases in which the courts have had to address the same issue. In several instances, the courts concluded that a hospital's obligations under EMTALA end at the time that a hospital admits an individual to the facility as an inpatient. See *Bryan v. Rectors and Visitors of the University of Virginia*, 95 F.3d 349 (4th Cir. 1996); *Bryant v. Adventist Health Systems/West*, 289 F.3d 1162 (9th Cir. 2002); and *Harry v. Marchant*, 291 F.3d 767 (11th Cir. 2002). In reaching this result, the courts focused on the definition of "to stabilize" set out in the statute at section 1867(e)(3)(A) of the Act. In this definition, the Congress defined this concept by specifically linking the hospital's obligation to provide

stabilizing treatment to individuals presenting with emergency medical conditions to the context in which the services are provided.

In particular, the courts found that the statute requires that stabilizing care must be provided in a way that avoids material deterioration of an individual's medical condition if the individual is being transferred from the facility. The courts gave great weight to the fact that hospitals have a discrete obligation to stabilize the condition of an individual when moving that individual out of the hospital to either another facility or to his or her home as part of the discharge process. Thus, should a hospital determine that it would be better to admit the individual as an inpatient, such a decision would not result in either a transfer or a discharge, and, consequently, the hospital would not have an obligation to stabilize under EMTALA. The courts have generally acknowledged that this limitation on the scope of the stabilization requirement does not protect hospitals from challenges to the decisions they make about patient care; only that redress may lie outside EMTALA. For example, a hospital may face liability for negligent behavior that results in harm to persons it treat after they are admitted as inpatients, but such potential liability would flow from medical malpractice principles, not from the hospital's obligations under EMTALA.

As many courts have ruled, EMTALA does not purport to establish a medical malpractice cause of action nor establish a national standard of care. In our view, apart from the possible malpractice implications redressable outside the statute, hospitals that fail to meet their obligations to provide quality care to inpatients may also face consequences affecting their Medicare certification under the applicable CoPs at 42 CFR Part 482. We discuss these CoPs and the process by which we enforce compliance with these CoPs in greater detail in section XIII. of this preamble. In a January 24, 2003 final rule (68 FR 3435), we explained that if our surveyors discover noncompliance with the hospital CoPs, "the hospital will be scheduled for termination from the Medicare and Medicaid programs." Thus, for hospital CoPs violations, as well as for EMTALA violations (compliance with which is a Medicare participation requirement), hospitals face the extreme sanction of termination from the Medicare program.

As a result of these court cases, and because we believe that existing hospital CoPs provide adequate, and in some cases, superior protection to patients, we are interpreting hospital