



February 22, 2011

Submitted electronically

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 5,300 members, the American Society for Healthcare Risk Management (ASHRM) appreciates the opportunity to respond to 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. ASHRM has been an advocate for safe and trusted healthcare for more than 30 years.

ASHRM members support the intent of EMTALA – to ensure that people who need emergency services receive them. **We believe that the current policies reflect the appropriate interpretation of the law and are achieving what Congress intended; we do not believe that they need to be revisited.** In fact, the changes proposed by CMS would impose a severe burden on the nation's already beleaguered health care facilities.

Under the proposed changes, hospitals could face a significant and burdensome increase in litigation exposure. The changes would, in essence, turn EMTALA into a federal malpractice statute, and would create the potential for professional liability for all inpatient care provided to patients who come through the emergency department. This could conceivably result in EMTALA being applied months after a patient originally presents to a hospital emergency room, which unnecessarily broadens the scope of EMTALA and, frankly, dilutes its purpose. It is clear that this is not what Congress

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intended when enacting this statute. The legal adequacy of the care of a patient after admission to a hospital should continue to be governed by state law. When a provider-patient relationship has been established, issues of refusal or negligence in care already are adequately governed by state malpractice laws. There is no basis for EMTALA to pre-empt this system.

It is also important to note that EMTALA provides for a two-year statute of limitations. If the proposed changes are made, EMTALA could then be routinely used by plaintiffs to circumvent shorter limitation periods for medical malpractice cases, which exist in a number of states. Case law on EMTALA issues demonstrates that in some jurisdictions, bringing a claim under EMTALA already has resulted in the evisceration of state caps on damages in malpractice cases. Notably, this increase in exposure would only affect the hospitals involved, and not individual physicians. See *Jackson v. East Bay Hospital, et. al.*, 980 F. Supp. 1341 (US District Court Northern District of California, October 6, 1997); *Abney v. University Medical Center of Southern Nevada, et. al.*, 2010 US Dist. Lexis 35303 (US District Court for District of Nevada, April 8, 2010).

In summary, the proposed changes could increase the unnecessary burden and expense for hospitals to defend and seek dismissal of claims filed under EMTALA that should be raised under state medical liability laws. It also is important to note that these changes would cause federal courts to become clogged with what should be state malpractice lawsuits, which would drastically increase the costs and burdens on not only the hospitals, but the already overwhelmed federal court system.

The costs to hospitals of the proposed changes cannot be over emphasized. According to the 2010 AON/ASHRM Hospital Professional Liability and Physician Liability Benchmark Analysis, for the upcoming 2011 accident year, hospitals will experience an annual loss rate of \$3,280 per occupied bed equivalent. Loss rates are increasing at a 5 percent annual rate, and have increased at a rate higher than general inflation every year since 2006. The analysis projects that U.S. hospitals will incur more than 44,000 non-zero claims related to 2010 occurrences and that the cost of these claims will total more than \$8.6 billion dollars. Emergency departments contribute nearly \$1.0 billion to the overall cost. Every dollar that a hospital spends on liability claims is a dollar that is unavailable to provide for patient care. Facilities could be forced to close their doors should the potential increase in exposure and cost represented by these proposed changes come to pass.

ASHRM champions education that empowers members, promotes development of the profession, and supports protecting the financial stability of healthcare institutions. Today, more than ever before, risk management is essential to an institution's overall health as the profession has grown from identifying risk to also preventing harm. So, on behalf of our members, who play an essential role in risk management and patient safety within their own organizations, thank you for the opportunity to comment on this matter.

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If you have questions regarding our comments, feel free to contact me or Vivian Miller, BA, CPHQ, LHRM, CPHRM, FASHRM, interim senior risk management specialist, ASHRM, at (312) 505-1869.

Sincerely,

A handwritten signature in black ink that reads "Kara L. Clark". The signature is written in a cursive, flowing style.

Kara L. Clark
Executive Director
ASHRM