The cost of treating medical patients has grown rapidly during the last fifty years,\(^1\) with the United States currently having, per capita, the most expensive healthcare system in the world.\(^2\) During the middle to late twentieth century, many hospitals focused on a patient’s ability to pay for treatment rather than the patient’s actual medical condition; in many cases, meeting a proof-of-payment burden was the initial hurdle to be seen by a physician.\(^3\) Hospitals routinely turned away patients who complained of acute medical issues if those patients did not demonstrate their ability to

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\(^{2}\) See Thomas Bodenheimer, *High and Rising Healthcare Costs Part I: Seeking an Explanation*, 142 ANNALS OF INTERNAL MED. 847, 850 (2005) (comparing per capita income averages with per capita healthcare expenditures and showing that the United States far surpasses all other nations as having the most expensive healthcare costs).

\(^{3}\) See 131 CONG. REC. 35,813 (daily ed. Dec. 10, 1985) (statement of Rep. Fortney Stark) (explaining that the practice of determining whether a patient could pay for medical treatment has been dubbed by some as a “wallet biopsy”).
pay. Even in recent cases, hospital emergency rooms hired taxicabs to drive untreated patients to other hospitals (usually public ones), or had the driver simply desert the ill patient in impoverished areas. This act of turning away patients complaining of emergency medical ailments due to their inability to pay has become known as “patient dumping.” The term “patient dumping” can refer to a wide range of acts: a hospital’s outright refusal to provide necessary emergency medical care; a hospital’s unwillingness to provide sufficient and stabilizing medical care before arranging to transport the individual to another facility; or, perhaps the most shocking, a hospital’s solicitation of drivers to abandon patients on the side of the road.

As the public became aware of the widespread patient-dumping practices of hospitals across the nation, many pushed for some type of Congressional action. Congress had already addressed the question of whether the government could compel a public hospital to treat patients that show up at its doors in the Hospital Survey and Construction Act of 1946, commonly known as the Hill-Burton Act. Congress also addressed the minimum

4. See Karen I. Treiger, Preventing Patient Dumping: Sharpening the COBRA’s Fangs, 61 N.Y.U. L. Rev. 1186, 1186 (1986) (providing four specific examples of patients being denied emergency medical services during the early 1980s due to their lack of health insurance).

5. See Richard Winton and Cara DiMassa, L.A. Files Patient ‘Dumping’ Charges, L.A. TIMES (Nov. 16, 2006), http://articles.latimes.com/2006/nov/16/local/me-dumping16 (describing how video surveillance showed taxi cabs leaving psychiatric patients on “Skid Row” in Los Angeles while the patients were still dressed in hospital gowns).

6. See EDWARD C. LIU, EMTALA: ACCESS TO EMERGENCY MEDICAL CARE, CRS-1, n.2 (Cong. Research Serv. 2008) (explaining that “‘patient dumping’ occurs when a hospital turns away indigent or uninsured persons seeking treatment so that the hospital will not have to absorb the cost of treating them”).

7. See 131 CONG. REC. 35,813 (daily ed. Dec. 10, 1985) (statement of Rep. Fortney Stark); see also Winton and DiMassa, supra note 5. Additionally, as discussed in Part V of this Note, there appears to be a problem in appropriately defining the scope of “patient dumping” in the federal statutes and regulations addressing the issue. See infra Part V.


medical treatment that must be provided to patients covered under the Medicare system in the Social Security Act of 1965. But reliance on these Acts to ensure treatment for all patients with emergency medical conditions was no longer practical as of the 1980s because the Hill-Burton Act only applies to those state-funded hospitals participating in the Hill-Burton program, while the Social Security Act of 1965 primarily covers elderly patients seeking emergency medical care. In an effort to address the problem of patient dumping on a broad scale, Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986. While EMTALA provides patients who are improperly turned away from emergency departments with a federal claim against the hospital, controversy has arisen over whether a hospital has satisfied the requirements of EMTALA once it admits an emergency room patient into inpatient care.

This Note seeks to provide insight into EMTALA, and the scope of federal regulations of this Act. Part II of this Note analyzes the major provisions of EMTALA and seeks to ascertain the general legislative intent of the 99th Congress. Part III addresses the initial split among the federal circuits regarding the application of the Act to inpatients admitted through a hospital’s emergency department. Part IV analyzes the proposed and final attempts by the Centers for Medicare & Medicaid Services (CMS) to cure the split in interpretations through the issuance of regulations interpreting the Act. Part V presents and critiques the recent holding in Moses v.

financing to state-funded hospitals in order to make “available in the facility or portion thereof to be constructed or modernized a reasonable volume of services to persons unable to pay therefor . . . .” 42 U.S.C. § 291c(e) (2003). Failure to comply with the provisions of the Act would result in a withholding of federal funding to the noncompliant state hospital programs. § 291g(e).


12. § 1395o(2).

Providence Hospital and Medical Centers, Inc.,\textsuperscript{14} whereby the Sixth Circuit refused to give deference to CMS' implementing regulations. Finally, Part VI provides one possible and workable amendment to the federal statute, which would appropriately mend the differences between CMS and the Sixth Circuit.

II. THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT

During the mid-1980s, Congress sought to alleviate the growing problem of patient dumping by relying on the principal government healthcare system, the Medicare and Medicaid programs.\textsuperscript{15} As part of its larger Comprehensive Omnibus Budget Reconciliation Act (COBRA) of 1986,\textsuperscript{16} Congress passed EMTALA to address the practice of patient dumping in Medicare-participating hospitals.\textsuperscript{17} Because EMTALA created a new federal cause of action and allowed for significant civil monetary penalties against Medicare-participating hospitals,\textsuperscript{18} EMTALA effectively reached a significant portion of the private hospitals that the Hill-Burton Act could not. At its most basic level, EMTALA requires that all hospitals participating with CMS reimbursement programs "provide for an appropriate medical screening examination" to all persons who "come to the emergency department."\textsuperscript{19} It goes on to state that if an emergency condition is determined to exist, "the hospital must provide . . . for such further medical examination and such treatment as may be required to stabilize the medical condition,"\textsuperscript{20} before transferring the patient to another facility.\textsuperscript{21} Under

\begin{enumerate}
\item \textsuperscript{14} 561 F.3d 573 (6th Cir. 2009).
\item \textsuperscript{15} In 1986, Medicare and Medicaid were managed by the Health Care Financing Administration (HCFA) of the Department of Health and Human Services. This division has since been renamed the Centers for Medicare and Medicaid Services (CMS). HOFFMAN, supra note 1, at 3.
\item \textsuperscript{16} § 9121(b), 100 Stat. 82 (1986).
\item \textsuperscript{18} 42 U.S.C. § 1395dd(d).
\item \textsuperscript{19} § 1395dd(a).
\item \textsuperscript{20} § 1395dd(b)(1)(A).
\item \textsuperscript{21} § 1395dd(c)(1). An exception to this rule applies only when the patient makes an informed request for a transfer, if a physician certifies that the benefits associated with
EMTALA, the patient is stabilized when “no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer.”\(^\text{22}\) Whether the stabilization requirement continues indefinitely or is extinguished upon admitting the patient to the hospital for inpatient care is unclear in the statutory language, and, as discussed below, has caused a major division among the federal circuits.

**A. Congressional Intent**

While it is largely preferred that statutory interpretation be done using the language of the statute itself,\(^\text{23}\) when the plain language causes divergent understandings and interpretations, it is necessary to look to the legislative history of a statute to find its true meaning.\(^\text{24}\) Ascertaining the legislative intent behind EMTALA is difficult because the Act was only a small part of COBRA.\(^\text{25}\) There was little floor discussion of COBRA’s EMTALA provisions in either the House or Senate during the First Session of the 99th Congress, and only two committee reports were produced on the matter.\(^\text{26}\) Because of the lack of significant legislative history, discerning the general policy that the 99th Congress sought to further arguably provides better insight into the overall intent of EMTALA. In order to find the overarching policy behind the Act, it is important to parse through the few floor comments and committee reports related to the EMTALA amendment of COBRA to determine whether it advanced any specifically announced policies.

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22. \(\S\) 1395dd(e)(3)(B).


The most significant commentary on EMTALA came from California Representative Fortney Stark, a sponsor of the Amendment. In his floor statement, Rep. Stark recounted two specific incidents of patient dumping, and opined that, "if these patients had been middle class with health insurance they never would have faced the horrors that they encountered." He proceeded to outline the provisions of EMTALA that were eventually adopted in the Act. He also proposed significant civil and criminal fines against physicians who violated the Act's standard of care provisions. Representative Stark's only stated purpose for enacting these provisions was "to prevent this kind of dumping of indigent patients."

The two House committee reports related to the EMTALA provisions, which should be the main source used to discern the primary intent of the 99th Congress when drafting the Act, actually add little to the overall motive asserted by Representative Stark. The Committee on Ways and Means produced a report that generally adopted the proposed language of the EMTALA Amendment to COBRA. The Committee asserted that the goal of the statute was to ensure that hospitals did not "ignore traditional community responsibilities and loosen historic standards." It based this belief on the notion that hospitals were engaging in patient dumping as a response to "pressures for greater hospital efficiency" through the prospective payment system.

27. See generally 131 Cong. Rec., 35,813, supra note 3.

28. Id.

29. Id.

30. Id.; see also H.R. REP. NO. 99-241, pt. III, at 7 (discussing the criminal sanctions in the proposed language of EMTALA).


34. Id. at 27.

35. Id. The Prospective Payment System sets fixed values that CMS will reimburse a hospital or physician for certain medical procedures. See OVERVIEW OF PROSPECTIVE PAYMENT SYSTEMS-GENERAL INFORMATION, http://www.cms.gov/prospmedicare feesvcptmtgen (last visited Aug. 12, 2010).
Although the Judiciary Committee took a much harder stance against the criminal sanctions in the proposed Act,\(^{36}\) it maintained the same general policy intent expressed in the report from the Committee on Ways and Means.\(^{37}\) The Judiciary Committee's report and final amendments to the statute focused on the proposed penalties that it deemed to be "too severe," and asserted that "some hospitals, particularly those located in rural or poor areas, may decide to close their emergency rooms entirely rather than risk the civil fines, damage awards, and, as to physicians, criminal penalties that might ensue."\(^{38}\) The Judiciary Committee's proposed amendments were designed to ensure the "major goal of the section" remained "an increase in [available medical] care," and, as drafted, would provide civil fines against physicians to deter violations of EMTALA, including causes of actions for patients and hospitals impacted by another hospital's patient dumping, and remove the criminal penalties for violations of the Act.\(^{39}\) The policy the Committee sought to further in EMTALA was to "respond to the medical needs of individuals with emergency medical conditions and women in active labor."\(^{40}\) When juxtaposed with the policy of EMTALA noted by the Committee on Ways and Means, the policy of the Judiciary Committee is, for all intents and purposes, the same: to provide emergency medical assessment and necessary treatment to all those who request it.\(^{41}\)

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36. See H.R. REP. NO. 99-241, pt. III, at 7 ("The Committee deleted the criminal sanction because . . . it is unnecessary, and unwise, and raises serious Constitutional questions under the due process clause.").

37. See id. at 6.

38. Id.

39. Id. at 6, 7.

40. Id. at 6.

41. Compare id. at 6 (demonstrating that the intent of EMTALA is to "respond to the medical needs of individuals with emergency medical conditions and women in active labor") with H.R. REP. NO. 99-241, pt. I, at 27 (asserting that EMTALA will ensure hospitals do not "ignore traditional responsibilities" by requiring these hospitals "to provide an appropriate medical screening examination and treatment for any individual who requests it [and] . . . to determine whether an emergency medical condition exists or if the patient is in active labor").
B. The Continued Need for EMTALA under the Patient Protection and Affordable Care Act of 2010

In light of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), it is important to note a few characteristic features of EMTALA that demonstrate why there is continued need for its protections and why the recent reforms do not replace the patient safeguards provided by EMTALA. First, EMTALA acts as the bare minimum of what acceptable actions hospital emergency departments may take. It provides the absolute minimum procedural standards for hospitals responding to a person seeking emergency care. Second, EMTALA prevents a patient’s health insurance coverage from being considered as part of the medical triage performed by a hospital’s emergency department. Third, by acting as the minimum threshold of what is acceptable, EMTALA presumes that hospitals will normally function well above the procedural standards it mandates. What these characteristics demonstrate is that EMTALA functions irrespective of whether a patient has health care insurance or not.

42. See 42 C.F.R. § 489.24(a)(i) (2009) (stating simply that a hospital must “[p]rovide an appropriate medical examination within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department,” but not providing any further details about the examination requirements). EMTALA generally does not provide the process or method of medical care that an emergency department must follow before it is liable. This can be seen in its broad definitions of the medical terms included in the statute. EMTALA simply directs hospitals to follow certain procedural steps while leaving exactly what medical care is needed to the discretion of the physician. In so doing, it cannot act as a medical malpractice statute. See H.R. Rep. No. 99-241, pt. III, at 8 (suggesting that criminal penalties in EMTALA would be improper because the statute requires only an “appropriate medical screening examination” without providing specific requirements of this screening).

43. See 42 U.S.C. § 1395dd(a) (asserting that it applies to any person who seeks emergency medical care, regardless of his or her status as a Medicare recipient).


45. A key element of the federal health care reform bill is that nearly all persons in the United States will obtain some form of health insurance by 2014. See generally House Committees on Ways and Means, Energy and Commerce, and Education and Labor, Affordable Healthcare for America Summary (March 23, 2010), http://waysandmeans.house.gov/Media/pdf/111/HCare/2010_SUMMARY.pdf. However, while there are some provisions of the Act that require coverage of the costs of emergency medical services, there is no unified determination of what exact services must be covered. See
The act of patient dumping may be driven by a hospital’s concern over a patient’s ability to pay, but the language of EMTALA restricts the transfer of any unstable patient seeking emergency care, regardless of the hospital’s motive for such an improper patient transfer.\(^{46}\) Furthermore, Medicare and Medicaid are paying out less to participating hospitals while patient visits to emergency departments are increasing.\(^{47}\) Thus, with the Affordable Care Act expanding Medicaid coverage while seeking to reduce overall CMS spending,\(^{48}\) patient dumping and the need for patient protection in emergency departments is an ongoing concern.

EMTALA may also provide a balance between two potential viewpoints regarding the impact of the Affordable Care Act of 2010. Optimists might argue that government-regulated health insurance will end patient dumping, making EMTALA obsolete. On the other hand, pessimists might counter that patient dumping based on private health insurance being favored over government subsidized plans will become the status quo. Even though

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\(^{46}\) See 42 U.S.C. § 1395dd(a) (“[I]f any individual . . . comes to the emergency department and a request is made on the individual’s behalf for examination . . . the hospital must provide for an appropriate medical screening examination . . . .”) (emphasis added).


nearly all Americans will now be required to carry some form of health care insurance, EMTALA would continue to play a significant role in protecting patient rights by providing the patient with some type of legal relief should a CMS-participating hospital engage in patient dumping. Finally, because the role of CMS remains prominent in the Affordable Care Act, CMS will remain an effective tool to encourage and enforce EMTALA compliance.

III. THE INITIAL DIVIDE OVER APPLYING EMTALA TO INPATIENTS

Whether EMTALA applies to individuals who present to the hospital with an emergency medical condition, but are then admitted to the hospital for ongoing care, has caused a wide split among the federal circuits. To illustrate this divide, consider the following hypothetical: A middle-aged female feels a sudden onset of chest pain while she is at home. Upon the patient’s arrival at her local hospital’s emergency department, the hospital’s staff recognizes the patient is suffering from an acute myocardial infarction (a “heart attack”) and administers the appropriate intravenous medications. The emergency department physician then admits the patient into the hospital’s cardiac unit. Her vital signs remain inconsistent for the next two days, whereupon additional tests reveal her infarction has worsened and is nearly complete. The on-call cardiologist reviews the patient’s chart, discovering she will need the implantation of a stint. The patient’s medical insurance does not cover the use of the type of stint the hospital uses, as it is coated in an experimental antibiotic, but does cover stints used at a nearby hospital.

49. See 42 U.S.C. § 1395dd(d)(2) (providing a federal cause of action for any person harmed by a physician’s or hospital’s failure to comply with EMTALA provisions). Consider also the situation of “frequent fliers,” who may inundate a hospital’s emergency department for every minor medical situation that arises. See Dave Jamieson, The Treatment of Kenny Farnsworth, WASH. POST MAGAZINE, Nov. 29, 2009, at 17 (describing the use of emergency departments as primary care facilities for some patients). Patient’s discouraged by long waits at primary care facilities may, and often do, turn to emergency departments for medical care regardless of their insurance status. Frustrated by these patients, some hospitals have begun diversion programs to discourage patients from repeatedly showing up to emergency departments. Id. Some people, however, view these programs as glorified patient dumping schemes. Id. Additionally, it is important to note that EMTALA does not contemplate the number of visits a patient is allowed before its statutory protection becomes ineffective, but its protections would presumably be renewed upon each time “any individual . . . comes to” a hospital’s emergency department. 42 U.S.C. § 1395dd(a).

50. See generally Title II-Role of Public Programs, Patient Protection and Affordable Care Act, H.R. 3590 § 2001 (2010) (expanding the role of Medicaid and Medicare under the new healthcare policies).
medical facility. Fearing that neither the patient nor her insurance will pay for the procedure, the hospital decides to transport the patient to the other medical facility that uses the insured cardiac stints. During the transport to the hospital covered by the patient’s insurance, the patient suffers cardiac arrest and dies. Does her family have standing to bring a lawsuit in federal court against the transferring hospital, under the EMTALA stabilization provision, even though the patient had been admitted to that hospital for inpatient care?51

A. The First and Sixth Circuits’ Approach: Inpatients Have Standing to Bring a Claim under EMTALA

The Sixth Circuit was one of the first federal appellate courts to address the question of whether EMTALA mandates appropriate medical care procedures once a patient is admitted to the hospital for inpatient care. In Thornton v. Southwest Detroit Hospital, the plaintiff alleged a violation of the stabilization requirement of EMTALA when the defendant hospital and physician failed to stabilize the patient before discharging her.52 The patient had been admitted to the hospital’s intensive care unit for ten days and an additional eleven days in general inpatient care for treatment of a stroke.53 The intended rehabilitation facility refused to accept the patient “because her health insurance would not cover the cost.”54 The physician discharged the patient to home care, where her condition worsened.55 In reaching its conclusion that the EMTALA stabilization requirement does extend to inpatients, the court focused on two seemingly distinguishable phrases in the language of EMTALA:

51. This hypothetical also includes another issue that has been subject to much litigation regarding EMTALA: whether the statute only allows the patient to bring a lawsuit or whether family members and those impacted by harm to the patient may bring the claim as well. The Sixth Circuit determined, in the case for which this Note generally focuses, that family members and those impacted by the patient’s harm have standing to bring a claim under EMTALA based on a plain language reading of the statute. See Moses v. Providence Hosp. & Med. Ctrs., Inc., 561 F.3d 573, 581-582 (6th Cir. 2009), cert. denied sub nom., Providence Hosp. v. Moses, 130 S. Ct. 3499 (2010).

52. 895 F.2d 1131, 1132 (6th Cir. 1990).

53. Id.

54. Id.

55. Id.
The Act states that the screening must be done for patients who come to a "hospital emergency room," and that the "hospital" must give the stabilizing treatment. The rules of statutory construction suggest that this change in wording indicates a change in meaning. The reasonable inference from this change in wording is that once a patient is found to suffer from an emergency medical condition in the emergency room, she cannot be discharged until the condition is stabilized, regardless of whether the patient stays in the emergency room.\footnote{56}{Id. at 1134 (emphasis added) (internal citation omitted).}

Therefore, the panel's focus in Thornton was on Congress's dropping of "emergency room" from the language in the stabilization requirement of EMTALA. According to the Sixth Circuit's interpretation of the statute, the "hospital," and all resources and departments within it, are required to stabilize the patient's emergency medical condition, regardless of which department treats the patient, or for how long the hospital undertakes to provide care for the patient.\footnote{57}{Id. ("[E]mergency care does not always stop when a patient is wheeled from the emergency room into the main hospital."); \textit{but see} Thornton, 895 F.2d at 1135 (Jones, J., concurring) ("[The Act] was not a measure to force hospitals to provide long-term care for uninsured patients.").}

The First Circuit indirectly addressed the application of EMTALA to inpatients nearly a decade later in Lopez-Soto v. Hawayek.\footnote{58}{175 F.3d 170 (1st Cir. 1999).} Here, the panel addressed a neonatal patient dumping case that arose out of the District of Puerto Rico.\footnote{59}{Id. at 172.} The plaintiffs brought an action under EMTALA after the defendant physician, without implementing any stabilization procedures, transferred their newborn son out of the birthing hospital to a hospital with a more advanced neonatal care unit, where the baby ultimately died.\footnote{60}{Id.} The panel's central focus was on the "comes to" language of EMTALA, and whether the plaintiff's neonatal son had actually "come to" the hospital by being born within it.\footnote{61}{Id. at 173-74.} The First Circuit concluded that a newborn does in fact "come to" a hospital even when he is born inside that hospital, and held
that EMTALA was applicable. The panel went on to apply the stabilization requirements of EMTALA to the hospital’s labor and delivery department (which is outside of the emergency department) asserting that, “[w]hile screening is arguably the key to ensuring the health of itinerants who arrive at an emergency room, stabilization is arguably the key to ensuring the health of those already admitted to the hospital who develop emergency medical conditions.”

The scope of the Thornton and Lopez-Soto decisions taken together appears to be very broad. The First Circuit determined that EMTALA’s stabilization requirement reaches nearly all patients in a hospital deemed to have an emergency condition, including inpatients. Additionally, because the First Circuit determined that the EMTALA stabilization requirement applies to the entire hospital, the Lopez-Soto decision could arguably apply to every birth that occurs within a hospital. Furthermore, the First and Sixth Circuits came to the same conclusion: specifically, that the stabilization requirement of EMTALA applies to the hospital as a whole, while the screening requirement is the only provision of EMTALA limited to the emergency department. Both circuits, therefore, seemed to use a disjunctive reading of EMTALA, by making a clear distinction between the scope of the stabilization requirement and the scope of the screening requirement.

**B. The Fourth and Ninth Circuits’ Approach: Inpatients Do Not Have Standing to Bring a Claim under EMTALA**

Nearly a decade after the enactment of EMTALA, and six years after the Sixth Circuit’s decision in Thornton, the Fourth Circuit had the opportunity to determine whether the stabilization requirement applies to patients admitted to a hospital for ongoing inpatient care. In Bryan v. Rectors and Visitors of the University of Virginia, a Fourth Circuit panel affirmed the lower court’s dismissal of an alleged violation of EMTALA, reasoning that “Congress’s sole purpose in enacting EMTALA was to deal with the problem of patients being turned away from emergency rooms for non-medical reasons.” In Bryan, one hospital transferred a patient to the defendant hospital for an emergency respiratory condition. The defendant hospital admitted the patient and treated her condition for approximately twelve days before refusing any further medical treatment, allegedly against

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62. Id. at 174.

63. Id. at 175 (emphasis added).

64. 95 F.3d 349, 351 (4th Cir. 1996).

65. Id. at 350.
the wishes of the patient's family. Refusing to extend standing to bring an EMTALA claim to inpatients, the panel found that "[t]he stabilization requirement is . . . defined entirely in connection with a possible transfer and without any reference to the patient's long-term care within the system." Contrary to the Sixth Circuit's broad interpretation in Thornton, the Bryan court's reading of EMTALA is narrow, applying it to the limited "purpose of ensuring that a hospital undertakes stabilizing treatment for a patient who arrives with an emergency condition.

For the Fourth Circuit, adopting a broad reading of EMTALA that requires the hospital "to do much more than merely provide immediate, emergency stabilizing treatment with appropriate follow-up" was unworkable. Rather, the panel in Bryan read EMTALA to be a "limited 'anti-dumping' statute, not a federal malpractice statute," with its overall goal being "to get patients into the system who might otherwise go untreated and be left without a remedy because traditional medical malpractice law affords no claim for failure to treat." Therefore, according to the Fourth Circuit, EMTALA was only meant to establish the physician-patient relationship, and "refusal of treatment after the establishment of a physician-patient relationship would be regulated by the tort law of the several states," not by EMTALA.

66. Id. The hospital's decision not to continue providing the patient with medical care was based on "internal procedures." Id.

67. Id. at 351 (emphasis added).

68. Id. The court concluded its analysis of the scope of EMTALA by asserting "the stabilization requirement was intended to regulate the hospital's care of the patient only in the aftermath of the act of admitting her for emergency treatment and while it considered whether it would undertake longer-term full treatment." Id. at 352.

69. Bryan, 95 F.3d at 351.

70. See id. ("Rather, without regard to professional standards of care or the standards embodied in the state law of medical malpractice, the hospital would have to provide treatment indefinitely . . . We do not find this reading of the statute plausible.").


72. Id. (citing 61 Am.Jur.2d Physicians, Surgeons, and Other Healers §§ 234, 238 (1981)).
In 2002, the Ninth Circuit addressed whether EMTALA applies to inpatients that never fully stabilize from their emergency medical conditions. *Bryant v. Adventist Health System/West* involved a chronically ill minor, who was presented to the defendant’s emergency room with a fever and coughing up blood. The treating physician failed to recognize the underlying condition causing his emergency medical symptoms, resulting in a misdiagnosis. Subsequently, the hospital discharged the patient. Upon reevaluation of the patient’s radiological tests, a different physician from the same hospital discovered that the patient had a large lung abscess. The new physician advised the patient’s family of his condition and admitted the patient to the hospital for ongoing treatment. After three days of inpatient treatment, the patient’s condition deteriorated rapidly, prompting the hospital to transfer the patient to a larger medical facility. He was eventually discharged from the second hospital, but died within a month of his release.

In *Bryant*, the panel noted that once a patient’s underlying medical condition is appropriately diagnosed, the hospital has an affirmative obligation under EMTALA to “stabilize” that particular condition. The panel, however, appeared to focus on the fact that the patient’s emergency medical condition subsequently worsened, and that he succumbed to his condition after being transferred to another hospital’s intensive care unit.

73. *Bryant v. Adventist Health Sys./W.*, 289 F.3d 1162, 1164 (9th Cir. 2002).

74. *Id.* The misdiagnosis of the underlying medical condition was not at issue in the case because, as the panel noted, EMTALA does not apply when a physician makes a legitimate mistake in rendering emergency medical care. *Id.* at 1166 (discussing *Jackson v. E. Bay Hosp.*, 246 F.3d 1248 (9th Cir. 2001)).

75. *Id.* at 1164.

76. *Id.*

77. *Id.*

78. *Bryant*, 289 F.3d at 1164.

79. *Id.* The patient’s family brought an EMTALA claim against the hospital that transferred the patient to the larger medical facility; however, the claim was that the patient had not been “stabilized,” not that the transfer to the larger facility was itself a violation of EMTALA. *Id.*

80. *Id.* at 1166.

81. *Id.* at 1167.
The patient's family alleged that the transferring hospital failed to stabilize their son's condition after he was admitted to the hospital and before the transfer, thereby violating EMTALA. The panel, however, succinctly noted that "the stabilization requirement normally ends when a patient is admitted for inpatient care," and upheld the lower court's dismissal of the charges.

A close reading of the Bryant opinion indicates that the Ninth Circuit's rationale for declining to extend EMTALA standing to inpatients is somewhat different when compared to the Fourth Circuit's reasoning in Bryan. Because the plaintiff in Bryant did not allege that the transfer of the decedent violated EMTALA, the Ninth Circuit had to determine only whether EMTALA applied during the delayed hospitalization.

Thus, the Bryant panel reached two conclusions that seem contradictory: first, that the hospital's duty to "stabilize" under EMTALA "appears to reach a patient's care after the patient is admitted to a hospital for treatment"; and second, that "the term 'stabilize' was not intended to apply to those individuals who are admitted to a hospital for inpatient care." The distinction for the panel came from the absence of an improper transfer from the emergency room, which would normally serve as the trigger for any EMTALA compliance analysis. According to Bryant, a patient who is treated in the emergency room, even if improperly so, is not protected under EMTALA once he or she becomes an inpatient because the statute is only designed to ensure that the emergency medical patient is not inappropriately turned away from the medical treatment system. Inpatients, as recipients of extended medical treatment, are part of the medical treatment system and would not be the

82. Id. at 1165-66.

83. Bryan, 289 F.3d at 1167, 1170.

84. Id. at 1165-66.

85. Id. at 1167.

86. Id.

87. See id. at 1167 ("[T]he term ['stabilize'] is defined only in connection with the transfer of an emergency room patient.") (emphasis added and footnote omitted).

88. Bryan, 289 F.3d at 1167-68 (discussing Bryan v. Rectors & Visitors of the Univ. of Va., 95 F.3d 349, 349 (4th Cir. 1996) and Thornton v. Sw. Detroit Hosp., 895 F.2d 1131, 1131 (6th Cir. 1990)).
intended recipients of any EMTALA protections. Accordingly, inpatients are unable to bring a claim for a potential violation of the statute.89

Thus, the Fourth and Ninth Circuits, in addressing the issue of whether EMTALA would continue to apply once an emergency room patient with an emergency medical condition was admitted for inpatient care, each came to the same general interpretation of EMTALA: to provide access to the emergency medical care system.90 Accordingly, in the opinion of these circuits, an inpatient receiving ongoing medical care does not need the protections established under EMTALA.91

IV. THE 2003 REGULATIONS BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES

In 1998, the Supreme Court of the United States granted certiorari on a case addressing the proper interpretation of a specific EMTALA provision.92 However, even though the application of EMTALA to inpatients was a central focus of oral arguments,93 the Supreme Court declined to rule on the

89. See id. at 1169 ("Once [the hospital] admitted [the patient] for inpatient care, EMTALA no longer applied."). The Eleventh Circuit followed similar reasoning in Harry v. Marchant, 291 F.3d 767 (11th Cir. 2002), which was decided in the same year as Bryant. The panel in Harry asserted that EMTALA was enacted "to guarantee patient entry into the medical system via mandatory appropriate medical screenings and stabilization prior to transfer." Id. at 773. The panel explained that without the existence of a "transfer," there cannot be any violation of EMTALA as the patient would have been allowed access to the medical system. Id. at 774-75.

90. Bryan, 95 F.3d at 351; Bryant, 289 F.3d at 1165.

91. Consider the scenario of the heart attack patient. See supra Part III. Under the approach of the Harry panel, the patient (or her executors) would likely not have standing. Harry, 291 F.3d at 775. Any other reading of Harry would give an ambiguous result. There is no doubt that EMTALA would apply to a patient refused care by the emergency department. Id. at 768. Based on the Harry decision, the EMTALA provisions end upon admission as an inpatient. The refusal of further care of an inpatient (i.e. the "transfer" or "dumping" of that inpatient), could not be said to "jumpstart" or in some way bring back the provisions of EMTALA as some may argue could be a possible reading of the Harry decision. To do so would create a complex statutory scheme well beyond the overall goal of the statute, which is to provide access to the emergency medical care system for all individuals.


93. See generally Transcript of Oral Argument at 6-45, Roberts v. Galen of Va., Inc., 525 U.S. 249 (1999) (No. 97-53) (showing a significant number of questions and
issue because it was improperly preserved on appeal. The inconsistent application of EMTALA to inpatients across the federal circuits and the Supreme Court's restraint from curing the circuit split prompted CMS to promulgate regulations on the issue of whether inpatients have standing to bring an EMTALA claim. While CMS initially proposed regulations that agreed with the First and Sixth Circuits' interpretations of the inpatient standing issue, the regulations that CMS ultimately enacted reflected the Fourth and Ninth Circuits' interpretations.

A. The 2002 Draft Proposals by CMS

In May 2002, CMS published its proposed changes to the inpatient payment systems, and included a proposed rule regarding the application of EMTALA to hospital inpatients. The proposed rule sought to advance the theory presented by the Sixth Circuit in Thornton; CMS believed that "the hospital continues to be obligated under [EMTALA] irrespective of the inpatient admission." Accordingly, CMS contended that failure to extend protections to inpatients "would provide an obvious means of circumventing [EMTALA] requirements that would seemingly contradict the point of the statute to protect emergency patient health and safety." Inherent in this assertion is the federal circuits' split over what CMS simply deduced as "the point of the statute." On one side, CMS and the First and Sixth Circuits argued that the overall purpose of EMTALA is to provide ongoing care for all who seek emergency medical care; on the other side, the Fourth and

arguments on the applicability of EMTALA to inpatients admitting through a hospital's emergency department).

94. Roberts, 525 U.S. at 253-54.


96. Id.

97. Id.

98. Id.

99. Id. ("[O]nce a hospital has incurred an EMTALA obligation with respect to an individual, that obligation continues while the individual remains at the hospital . . . ."); Thornton v. Sw. Detroit Hosp., 895 F.2d 1131, 1135 (6th Cir. 1990) ("[E]mergency care does not always stop when a patient is wheeled from the emergency room into the main hospital . . . . Emergency care must be given until the patient’s emergency medical
Ninth Circuits contended that the overall purpose is to ensure that all persons are treated equally at the initial stage of medical care, when seeking emergency medical care.  

The proposed CMS regulation directed that inpatient coverage under EMTALA would only apply when an inpatient is admitted through the emergency department of the hospital. Accordingly, the regulations would not apply to inpatients that enter through other avenues, such as previously scheduled surgical procedures. Interestingly, CMS noted that, while the legislative history of EMTALA included many references to patients’ being denied emergency medical treatment, there were no references to inpatients being denied similar medical care. As shown below, this point has become a basis for arguing that EMTALA should not be applicable once a patient attains inpatient status.

B. The 2003 Final Rule Adopted by CMS

After it received comments on its proposed regulations of EMTALA, CMS promulgated its final rule in 2003 in the Code of Federal Regulations. In language contrary to its original proposal a year earlier, CMS codified the following as its official EMTALA regulation:

(2) Exception: Application to inpatients. (i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual in good faith in order to

100. Bryan v. Rectors & Visitors of the Univ. of Va., 95 F.3d 349, 351 (4th Cir. 1996) ("[EMTALA’s] core purpose is to get patients into the system who might otherwise go untreated and be left without a remedy because traditional malpractice law affords no claim for failure to treat."); Bryant v. Adventist Health Sys./W., 289 F.3d 1162, 1168 (9th Cir. 2002) ("We hold that EMTALA’s stabilization requirement ends when an individual is admitted for inpatient care.").

101. Changes, supra note 95.

102. Id.

103. Id. at 31,475.

stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual.\textsuperscript{105}

CMS's earlier concern – that any failure to extend protection to inpatients entering through the emergency room would create another route for patient dumping – was largely disregarded in the language of the enacted regulation.\textsuperscript{106} According to the final version of the regulation, an inpatient, regardless of how he or she reaches that status, is not owed any special treatment or care under EMTALA, and thus does not have standing to bring a claim thereunder.\textsuperscript{107} Thus, the language of the final rule rejected the broad interpretation and holdings in \textit{Thornton} and \textit{Lopez-Soto};\textsuperscript{108} instead, the regulation favored the much stricter statutory interpretation of EMTALA adopted in \textit{Bryan} and \textit{Bryant}.\textsuperscript{109}

\textbf{C. Reasoning for Reversal of the Draft CMS Interpretation}

CMS's major shift in statutory interpretation required significant explanation, which CMS attempted to provide in an EMTALA-clarifying publication in the Federal Register.\textsuperscript{110} CMS discussed many comments it had received that criticized its intent to extend EMTALA obligations of a hospital to any inpatient.\textsuperscript{111} Several comments focused on the "extensive [Medicare conditions of participation] responsibilities with respect to

\begin{itemize}
\item \textsuperscript{105} \textit{Id.} at § 489.24(d)(2)(i) (second emphasis added).
\item \textsuperscript{106} \textit{Compare} Changes, \textit{supra} note 95 (asserting its concern that “permitting inpatient admission to end EMTALA would provide an obvious means of circumventing [EMTALA] requirements”), \textit{with} 42 C.F.R. § 489.24(d)(2) (asserting that once a hospital admits a patient “in good faith,” it satisfies its requirements under EMTALA).
\item \textsuperscript{107} 42 C.F.R. § 489.24(d)(2).
\item \textsuperscript{108} \textit{Thornton} v. Sw. Detroit Hosp., 895 F.2d 1131, 1135 (6th Cir. 1990); Lopez-Soto v. Hawayek, 175 F.3d 173 (1st Cir. 1999).
\item \textsuperscript{109} \textit{Bryan} v. Rectors & Visitors of the Univ. of Va., 95 F.3d 349, 351 (4th Cir. 1996); Bryant v. Adventist Health Sys./W., 289 F.3d 1162, 1168 (9th Cir. 2002).
\item \textsuperscript{110} \textit{See} Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions; Final Rule, 68 Fed. Reg. 53,222 (proposed Sept. 9, 2003) [hereinafter Medicare Program] (to be codified at 42 C.F.R. pt. 413, 482, 489).
\item \textsuperscript{111} \textit{Id.} at 53,244.
\end{itemize}
inpatients.112 These conditions of participation (CoPs) ensure that a patient admitted to a hospital, regardless of whether it was through the emergency department, receives sufficient medical care to meet his underlying medical needs.113 CMS explained that, if applied to inpatients, EMTALA would no longer serve as a procedural medical safeguard to persons with emergency medical conditions, but would instead act as a malpractice statute, which it was never intended to do.114

The clarifying publication of 2003 also addressed certain comments that questioned the factual knowledge of CMS regarding “patient dumping” generally.115 These criticisms asserted “that CMS has ‘no evidence there is a current problem’ for the dumping of inpatients with emergency medical conditions.”116 Additionally, as noted in the original proposal by CMS, no Congressional records demonstrate a problem with dumping inpatients with emergency medical conditions, only those who arrived at emergency departments.117

The Ninth Circuit decision in Bryant v. Adventist Health, which came out shortly after the original CMS proposal was published,118 appeared to be a heavily weighted factor for CMS in reversing its proposed regulation.119 Based upon comments that argued for the adoption of Bryant as a nation-

112. Id.

113. Id. at 53,244-45.

114. Id. at 53,244.

115. Id.

116. See Medicare Program, supra note 110 (quoting an unidentified commentator to the proposal published in 67 Fed. Reg. 31,404 (May 9, 2002)).

117. See Changes, supra note 95 (“[T]he legislative history of EMTALA is replete with references to the problem of individuals denied emergency medical care at hospital emergency rooms, whereas there is no explicit reference to similar problems faced by hospital inpatients.”) (citing 131 Cong. Rec. 28,587, 28,588 (1985)).

118. CMS published its original proposal for EMTALA regulations on May 9, 2002, while the Ninth Circuit reported its decision in Bryant v. Adventist Health System/West on May 20, 2002.

119. See Changes, supra note 95 (“Several commenters cited the recent ruling by the Court of Appeals for the Ninth Circuit in Bryant v. Adventist Health System . . . 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.”).
wide policy, CMS constructed an agreeable policy: "[S]hould 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 discharge, and consequently, the hospital would not have an obligation to stabilize under EMTALA."\(^{120}\) After weighing the comments, federal court interpretations, and the availability of CoPs to ensure that appropriate medical care would be provided to inpatients with emergency medical conditions, CMS determined it would "[interpret] hospital obligations under EMTALA as ending once the individuals are admitted to the hospital inpatient care."\(^{121}\)

V. THE SIXTH CIRCUIT REJECTION OF THE 2003 ANTI-DUMPING REGULATIONS

In late 2008, the Sixth Circuit heard arguments in Moses v. Providence Hospital & Medical Centers, Inc., a case considering the application of EMTALA when the patient had been admitted to a hospital for testing as well as continuing psychiatric care.\(^{122}\) The case was on appeal from the District Court for the Eastern District of Michigan, which had granted summary judgment for the defendant hospital.\(^{123}\) In addressing the divide between its own prior interpretations of EMTALA\(^{124}\) and the more recently promulgated CMS regulations,\(^{125}\) the Sixth Circuit had two options: the panel could adopt the CMS final regulations as the official interpretation of EMTALA and reject further use of Thornton on the issue of inpatient standing; or the panel could follow its own precedent in Thornton, and in so doing, downplay the application of the CMS regulations.

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120. See Medicare Program, supra note 110.

121. Id. at 53,244-45.


123. Id. at 577.

124. See generally Thornton v. Sw. Detroit Hosp., 895 F.2d 1131, 1131 (6th Cir. 1990) (interpreting EMTALA to apply to inpatients for as long as the patient’s emergency medical condition has not been stabilized).

125. See generally 42 C.F.R. § 489.24(d)(2) (2009) (interpreting EMTALA to apply only while a person with an emergency medical condition is in the emergency department, but not when that patient is admitted for inpatient care).
A. Background to Moses v. Providence Hospital

After Christopher Howard began exhibiting serious physical and psychological symptoms of illness, his wife, Marie Moses-Irons, brought him to Providence Hospital for treatment. The hospital staff admitted Howard to conduct more tests in order to determine the source of his symptoms. An examining physician ruled out “an acute psychotic episode” as being among the initial possibilities. Four days later, a psychiatrist determined that Howard was not stable psychically, and sought to have Howard admitted to the hospital’s psychiatric unit with a diagnosis of “atypical psychosis” and “depression.” The hospital staff, however, did not admit Howard to the psychiatric unit and prepared him for discharge just one day later. While the discharging physician noted that Marie Moses-Irons feared her husband, he nevertheless determined that Howard was stable and could be properly discharged without further psychiatric care. Ten days after his discharge from Providence Hospital, Howard murdered his wife, presumably due to his ongoing mental health condition. Johnella Richmond Moses, acting as representative for the estate of Marie Moses-Irons, subsequently brought a claim against the

126. Moses, 561 F.3d at 576. Among the symptoms he was exhibiting, Irons had “severe headaches, muscle soreness, high blood pressure[,] vomiting . . . slurred speech, disorientation, hallucinations, and delusions.” Id.

127. Id.

128. Id. (internal citations to the record omitted). In granting summary judgment for the defendant, the District Court for the Eastern District of Michigan asserted that the physicians never actually diagnosed Irons with an emergency medical condition as required by EMTALA; however, the Sixth Circuit rejected this argument, determining that “[a] legitimate possibility that the patient might commit suicide would appear to ‘place the health of the individual . . . in serious jeopardy,’ and could thus fall under the category of ‘emergency medical condition.”’ Id. at 585-86 (citing 42 U.S.C. § 1395dd(e)(1)(A)(i)).

129. Id. at 576.

130. Moses, 561 F.3d at 576.

131. Id. at 576-77.

132. Id. at 577.
hospital and two physicians for violating the stabilization procedural requirement of EMTALA.\textsuperscript{133} The District Court granted the defendant's motion for summary judgment, asserting that "[t]he patient was undisputedly completely screened, as the statute requires, even if on the basis of a wrong diagnosis; and he was thereafter admitted to the Defendant hospital, and no emergency medical condition was recognized on the screening."\textsuperscript{134} On appeal, a panel of Sixth Circuit judges determined, \textit{inter alia}, that Howard did, in fact, have an emergency medical condition at the time he was admitted,\textsuperscript{135} and that the plaintiffs, as third-party representatives, did have standing under EMTALA.\textsuperscript{136} The panel's more controversial holding, and the central focus of this Note, was its disregard of the CMS regulations and its determination that the defendant hospital had been required to ensure that Howard, even as an inpatient, was stabilized under EMTALA before discharge.\textsuperscript{137} Over a strongly worded dissent, the Sixth Circuit later denied a petition for an \textit{en banc} rehearing on the issue of inpatient standing.\textsuperscript{138} The Supreme Court denied certiorari on June 28, 2010.\textsuperscript{139}

B. The Sixth Circuit's Analysis of EMTALA Stabilization Requirements and Rejection of the CMS Regulations Regarding Inpatients

In reaching its conclusions, the \textit{Moses} panel relied heavily on the Sixth Circuit's earlier decision in \textit{Thornton}.\textsuperscript{140} Before discussing \textit{Thornton}, however, the \textit{Moses} panel independently determined that EMTALA:

\begin{itemize}
  \item \textsuperscript{133} \textit{Id.}
  \item \textsuperscript{134} \textit{Id. at 578.}
  \item \textsuperscript{135} \textit{Id. at 585-86.}
  \item \textsuperscript{136} \textit{Moses, 561 F.3d at 582.}
  \item \textsuperscript{137} \textit{See id. at 584.}
  \item \textsuperscript{138} \textit{See Moses v. Providence Hosp. \& Med. Ctrs., Inc., 573 F.3d 397, 398 (6th Cir. 2009) (Griffin, J., dissenting) ("The majority has perpetuated a serious conflict between our circuit and the Ninth Circuit . . . the Fourth Circuit . . . the federal regulations . . . and the vast majority of lower court decisions.") (internal citations omitted).}
  \item \textsuperscript{139} Providence Hosp. v. Moses, 130 S. Ct. 3499 (2010).
  \item \textsuperscript{140} Moses v. Providence Hosp. \& Med. Ctrs., Inc., 561 F.3d 573, 582 (6th Cir. 2009); \textit{see also} Thornton v. Sw. Detroit Hosp., 895 F.2d 1131, 1134 (6th Cir. 1990)
\end{itemize}
requires "such treatment as may be required to stabilize the medical condition," and forbids the patient's release unless his condition has 'been stabilized.' A patient with an emergency medical condition is "stabilized" when "no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during" the patient's release from the hospital. Thus, EMTALA requires a hospital to treat a patient with an emergency condition in such a way that, upon the patient's release, no further deterioration of the condition is likely.141

Based on the final sentence of this passage, it appears that the Moses panel adopted the disjunctive method of reading the statute used in Thornton.142 The panel interpreted EMTALA's protections to be initiated upon a patient's arrival at the hospital and to end only when the patient is fully stabilized, irrespective of whether the patient has been admitted to inpatient care for ongoing medical treatment.143

The Sixth Circuit had to justify its use of Thornton and its broad interpretation of EMTALA in light of the narrow interpretation proffered in the recent CMS regulations.144 The defendant, Providence Hospital, relied heavily upon the CMS regulations and argued that once Moses was admitted to the hospital, the special stabilization requirements under EMTALA were no longer in force.145 However, as the panel noted, the CMS regulations

(determining that EMTALA requirements do not end once the patient is admitted to the hospital for ongoing inpatient care).

141. Moses, 561 F.3d at 582 (citations omitted).

142. Compare id. (providing several different subsections of EMTALA to demonstrate the statutory procedural process) with Thornton, 95 F.2d at 1134 (distinguishing a separate meaning among the terms "hospital emergency room" and "hospital").

143. Moses, 561 F.3d at 582.

144. See 42 C.F.R. § 489.24 (d)(2) (refusing to extend EMTALA to individuals with emergency medical conditions who become inpatients during their care).

145. Moses, 561 F.3d at 582. Interestingly, just prior to reaching the Defendant hospital's argument based on the final CMS regulations, the panel stated that "the statute requires more than the admission and further testing of a patient; it requires actual care, or treatment, be provided as well. Accordingly, Defendants could not satisfy their EMTALA obligations merely by screening Howard and admitting him to conduct further testing." Id. The panel could have simply determined that no proper "treatment" occurred upon the admission of Moses and the panel did not need to discuss the CMS
regarding inpatient standing were not yet in effect at the time of the incidents leading to the Moses case. Relying upon case law precedent, the Moses panel concluded that applying the CMS regulations would be improper because “courts should not construe congressional enactments and administrative rules . . . to have retroactive effect unless their language requires this result.”

Instead of simply rejecting the CMS regulations for their procedural inapplicability in the Moses case, the panel seized its opportunity to attack the regulations that were contrary to its prior holding in Thornton. Even when provided an opportunity to find a “bad faith” basis for admission by the hospital, the panel moved forward with attacking the reliability of the regulations. The Sixth Circuit panel stated that “[t]he CMS rule appears contrary to EMTALA’s plain language, which requires a hospital to ‘provide . . . for such further medical examination and such treatment as may be required to stabilize the medical condition.” By focusing on the term “treatment,” and asserting that the obligation to treat continues until the emergency condition is stabilized, the panel concluded that “a hospital may not release a patient with an emergency medical condition without first determining that the patient has actually stabilized, even if the hospital

146. Id. at 583.

147. Id. (quoting BellSouth Telecomms., Inc. v. S.E. Tel., Inc., 462 F.3d 650, 657 (6th Cir. 2006) (internal quotations omitted)).

148. Id. The Moses panel discussed the applicability of the CMS Regulations after it had refused to give any Chevron deference to it. Moses v. Providence Hosp. & Med. Ctrs., Inc., 561 F.3d 573, 582-84 (6th Cir. 2009). However, for the purposes of this Note, it is important to consider the possible procedural method by which the Sixth Circuit could have addressed and rejected applying the CMS Regulation rather than attacking its overall credibility. Accordingly, this Note considers the procedural aspect addressed by the Moses panel prior to the panel’s discussion of the overall correctness of the Regulation.

149. See 42 C.F.R. § 489.24 (d)(2)(i) (requiring that admission of a patient as an inpatient must be done in “good faith” in order to satisfy the special requirements under EMTALA).

150. Moses, 561 F.3d at 583.

151. Id. at 583 (quoting 42 U.S.C. § 1395dd(b)(1)(A) (emphasis in original)).
properly admitted the patient." In applying the rule established in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, which allows the rejection of administrative regulations contrary to legislative intent or based on impermissible statutory construction, the *Moses* panel refused to give deference to the CMS regulation it deemed to be "contrary to the plain language of the statute."

Rejecting the CMS regulation and accepting the holding in *Thornton*, the panel ultimately held that "defendants are not entitled to summary judgment simply on the ground that the hospital admitted Howard as an inpatient and subjected him to several days of testing," and remanded the case.

C. Implications of the Court’s Holding

Inherent in the panel’s reasoning in *Moses* are several important points that the Sixth Circuit accepts without providing any clear basis for doing so. Before analyzing what steps may be taken to remedy the ongoing split between the federal circuits regarding inpatients and EMTALA, it is critical to understand these points and the effect the *Moses* decision will have on them.

i. Presumption of Bad Faith by Participating Hospitals

One assumption that the *Thornton* panel struggled over, and one that the *Moses* panel inherently accepted, is that hospitals would unquestionably and deceitfully admit indigent patients from the emergency department only to dump them a short time later. CMS also considered this possibility, but created a workable standard in its final EMTALA regulations rather than

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152. *Id.*


155. *Id.* at 584.

156. See *Thornton v. Sw. Detroit Hosp.*, 895 F.2d 1131, 1135 (6th Cir. 1990) ("Hospitals may not circumvent the requirements of [EMTALA] merely by admitting an emergency room patient to the hospital, then immediately discharging that patient."); *see also Moses*, 561 F.3d at 582 ("In the case of most emergency conditions, it is unreasonable to believe that such treatment could be provided by admitting the patient and then discharging him.").
giving automatic standing to all inpatients.\textsuperscript{157} The Sixth Circuit feared that surreptitious patient admission would occur frequently if EMTALA did not require stabilization of inpatients admitted through the emergency department.\textsuperscript{158} As a result, \textit{Thornton, Moses}, and the initial CMS proposal all determined such mischievous admissions of inpatients to be against the congressional intent of EMTALA, and thus extended its obligations to cover inpatients as well as emergency room patients.\textsuperscript{159}

The problem with this assumption is, as noted in both the proposed regulations and the comments referenced in the 2003 CMS final regulation publication, there are neither examples nor any relevant data to suggest that such practices have occurred or would otherwise occur.\textsuperscript{160} Accordingly, this is an extreme concern and shows distrust of hospital emergency departments.\textsuperscript{161} To presume that a hospital will risk exposing itself to the extensive requirements of CoPs for inpatients,\textsuperscript{162} as well as state malpractice liabilities, implies complete inadequacy by emergency departments.

\textbf{157.} See Changes, \textit{supra} note 95 ("[W]e emphasize that an admission to inpatient status cannot be used to evade EMTALA responsibilities."); \textit{but see} Medicare Program, \textit{supra} note 110 at 53,245 ("If it is discovered upon investigation of a specific situation that a hospital did not admit an individual in good faith with the intention of providing treatment . . . then liability under EMTALA may attach.").

\textbf{158.} \textit{Thornton}, 895 F.2d at 1135 (holding EMTALA applies to inpatients immediately after asserting hospitals cannot circumvent EMTALA through temporary admission as inpatients).

\textbf{159.} See Changes, \textit{supra} note 95 ("[W]e emphasize that an admission to inpatient status cannot be used to evade EMTALA responsibilities.").

\textbf{160.} \textit{Id.; see also} Medicare Program, \textit{supra} note 110 ("Two commenters stated that CMS has 'no evidence there is a current problem' for the dumping of inpatients with emergency medical conditions.").

\textbf{161.} See Bryant v. Adventist Health Sys./W., 289 F.3d 1162, 1169 (9th Cir. 2002) (refusing to accept the assumption "that hospitals use the admission process as a subterfuge to circumvent the stabilization requirement.").

\textbf{162.} See Medicare Program, \textit{supra} note 110 at 53,245 (providing an example of a CoP that "includes specific procedural requirements that must be satisfied to show that there has been adequate consideration given to a patient's need for post-discharge care," which is not provided for in EMTALA).
EMTALA was enacted to stop the practice of *failure to initiate treatment*,\(^{163}\) as state law had been sporadic in creating a cause of action to handle such situations.\(^ {164}\) To presume that a hospital would try to alleviate one federal obligation in EMTALA by exposing itself to more federal regulations and CoPs, as well as to other state regulations through malpractice claims, not only does a disservice to the integrity of the medical community as a whole, but also ignores the overall intent of EMTALA: to fill the legal gap in providing equal access to emergency medical care.

**ii. Redefining “Patient Dumping”**

When Representative Stark introduced the provisions of EMTALA into COBRA, he understood “patient dumping” to be the act of turning away or refusing to initiate emergency medical care to indigent and uninsured persons.\(^ {165}\) However, the type of patient dumping that the Sixth Circuit seeks to protect in *Moses* is not the initial refusal of medical care by a hospital’s emergency department, but a type of dumping that may be best described as “downstream” patient dumping. This type of dumping, as demonstrated in the facts of *Moses,*\(^ {166}\) would occur when a hospital refuses to stabilize or treat the medical condition of an *inpatient* that enters through the emergency room.

By merging the concept of patient dumping with an act that may occur at any time in the medical care continuum, the Sixth Circuit readily applied EMTALA to an *inpatient* that was discharged without ever being fully stabilized.\(^ {167}\) However, this expansion of patient dumping is unsupported by

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163. *See H.R. Rep. No. 99-241, pt. I, at 27 (“The Committee is most concerned that medically unstable patients are not being treated appropriately. There have been reports of situations where treatment was simply not provided.”).*

164. *See H.R. Rep. No. 99-241, pt. III, at 5 (“Although at least 22 states have enacted statutes or issued regulations requiring the provision of limited medical services whenever an emergency situation exists . . . some are convinced that the problem needs to be addressed by federal sanctions.”); see also Bryant, 289 F.3d at 1168-69 (“Congress enacted EMTALA to create a new cause of action, generally unavailable under state tort law, for what amounts to failure to treat and not to duplicate preexisting legal protections.”) (internal quotations and citations omitted).*

165. *See 131 Cong. Rec. 35,813, supra note 3 (discussing specific cases of patients being turned away from emergency departments).*


167. *Id. at 584.*
the history of patient dumping, and causes the application of EMTALA to inpatients to be much more difficult. When enacting EMTALA, Congress did not contemplate applying it to "downstream" patient dumping; instead Congress intended it only to initiate care in the medical system. Additionally, the Sixth Circuit's redefinition of what it means to "dump" a patient creates an imbalance in the law: if a person comes through the emergency department but is later "dumped" as an inpatient for insufficient payment, EMTALA applies. But if a person enters the hospital for a scheduled medical procedure and is later "dumped" as an inpatient for insufficient payment, EMTALA does not apply. This approach implies too great a difference between inpatients that originally enter through the emergency department and inpatients that enter the hospital through other avenues.

VI. THE NEXT STEPS

A. The Supreme Court's Denial of Certiorari

The Supreme Court recently denied certiorari in the Moses case, likely due to an amicus brief of the United States. In its brief, the United States requested that the Court refuse to hear the case because "[t]he conflict among the circuits is shallow" and because "[the Department of Health and Human Services] has committed to initiating rulemaking to reconsider the issue in the coming year." However, as of November 2010, there have

168. See H.R. REP. No. 99-241, pt. III, at 5 ("In recent years there has been a growing concern about the provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured.") (emphasis added); see also Bryan v. Rectors & Visitors of the Univ. of Va., 95 F.3d 349, 351 (4th Cir. 1996) ("[EMTALA's] core purpose is to get patients into the system who might otherwise go untreated and be left without a remedy because traditional medical malpractice law affords no claim for failure to treat.").

169. See Bryant v. Adventist Health Sys./W., 289 F.3d 1162, 1169 (9th Cir. 2002) (providing a similar analysis when comparing the Thornton decision to James v. Sunrise Hosp., 86 F.3d 885 (9th Cir. 1996)).


171. See Brief for the United States as Amicus Curiae at 9, Providence Hosp. v. Moses, 130 S.Ct. 3499 (2010) (No. 09-438) (requesting the Court deny certiorari to the Sixth Circuit).

172. Id.
been no proposed changes to the current regulation\textsuperscript{173} published in the Federal Register by CMS.

The government's suggestion that the Supreme Court refrain from granting certiorari and reviewing the EMTALA inpatient regulation in Title 42 of the Code of Federal Regulations at Part 489.24 may represent a genuine interest of the government to rework the regulation.\textsuperscript{174} More than likely, however, given that the United States argued "[t]he [Sixth Circuit] erred in holding that EMTALA's coverage unambiguously continues after an individual has been admitted in good faith to the hospital as an inpatient,"\textsuperscript{175} the request for denial of certiorari might be posturing by the United States to prevent the Supreme Court from siding with the Sixth Circuit and striking down the CMS regulation. A delayed review by the Supreme Court would not only allow the courts of appeals to support the CMS position of limiting EMTALA upon admission as an inpatient,\textsuperscript{176} but it will also allow CMS to reword the regulation while keeping the same general scope of EMTALA.

Additionally, while the United States categorized the divide among the circuits as "shallow,"\textsuperscript{177} it is difficult to accept that position. Two similarly-situated persons in different jurisdictions will have different abilities to bring a claim under EMTALA.\textsuperscript{178} A person who alleges an act of "downstream" patient dumping has standing to bring a claim under EMTALA in Detroit,

\textsuperscript{173} 42 C.F.R. § 489.24(d)(2) (2010).

\textsuperscript{174} See Brief for the United States as Amicus Curiae, supra note 171, at 9 (stating that the Department of Health and Human Services is planning to initiate rulemaking to address the issue of inpatient standing).

\textsuperscript{175} Id.

\textsuperscript{176} Many federal district courts have given favorable weight to the CMS regulation of EMTALA's application to inpatients since its implementation in 2003, though the Sixth Circuit is the only appellate court to discuss the regulations. See, e.g., Morgan v. N. Miss. Med. Ctr., Inc., 403 F.Supp.2d 1115, 1129 n.14 (S.D. Ala. 2005), aff'd, 225 Fed. Appx. 828 (11th Cir. 2007) (per curiam), cert. denied, 552 U.S. 1098 (2008).

\textsuperscript{177} Brief for the United States as Amicus Curiae, supra note 171 at 9.

\textsuperscript{178} Moses v. Providence Hosp. & Med. Ctrs., Inc., 561 F.3d 573, 584 (6th Cir. 2009) (overturning the lower court's grant of summary judgment to the hospital and allowing the EMTALA claim to move forward); Bryant v. Adventist Health Sys./W., 289 F.3d 1162, 1169 (9th Cir. 2002) (holding that a hospital is entitled to summary judgment in an EMTALA claim brought by the family of an individual who had been admitted into inpatient care).
but would lack standing in Los Angeles. Such a divide cannot be described as “shallow,” but instead represents a major discrepancy in the interpretation of the scope of EMTALA.

B. A Possible Proactive Resolution

In light of the Supreme Court’s denial of certiorari in Moses, the conflict among the circuits will only be fully resolved when one of two things happens: either the Supreme Court eventually grants certiorari on the EMTALA inpatient issue, or Congress amends the text of EMTALA to clarify its intent. It may be years before the Supreme Court grants certiorari on this issue, provided that CMS will likely reword its 2003 regulations of the EMTALA issue, and will probably retain the overall position that inpatients do not have standing to bring a claim under EMTALA. Given the Sixth Circuit’s express rejection of that position,179 it is foreseeable that new language with the same purpose will not convince the Sixth Circuit to deviate from Thornton and Moses and accept a CMS regulation excluding inpatients from EMTALA’s coverage. Therefore, the best and most proactive solution is for Congress to address the divide and clarify the appropriate scope for applying the protections of EMTALA. As discussed above, EMTALA is limited in its scope, and Congress would be correct to adopt the language, or at least the general intent, of the currently enacted CMS regulations as an amendment to 42 U.S.C. § 1395dd(b). Below is a proposed version of a portion of EMTALA, with the additional content in italics and underlined:

UNITED STATES CODE
Title 42. The Public Health and Welfare
   Chapter 7. Social Security Act
   Title XVIII. Health Insurance for the Aged and Disabled
      Part E. Miscellaneous Provisions
         § 1395dd. Examination and treatment for emergency medical conditions and women in labor.
         * * *

         (b) Necessary stabilizing treatment for emergency medical conditions and labor.

            (1) In general. If any individual (whether or not eligible for benefits under this title) comes to a hospital’s emergency department and the hospital’s emergency department determines that the individual has an emergency medical condition, the hospital’s emergency department must provide either
            (A) within the staff and facilities available at the hospital and subject to subsection (1)(C), for such further medical examination

179. Moses, 561 F.3d. at 584.
and treatment as may be required to stabilize the medical condition, or
(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(C) Inpatient exemption from stabilization requirement. If the hospital’s emergency department determines an emergency medical condition to exist and admits the patient into the hospital as an inpatient in order to provide additional medical treatment and any additional necessary medical testing, the hospital satisfies its special requirements under this section.\(^{180}\)

This Note’s proposed amendment to EMTALA rejects the decision in Moses and officially adopts the policy assertions of the current CMS policy,\(^{181}\) as well as those of the Fourth\(^{182}\) and Ninth\(^{183}\) Circuits. Under this proposed amendment, the protections of EMTALA would only apply to emergency rooms and serve as a means of providing all patients access to the emergency medical services system. By enacting EMTALA, Congress sought to correct the problem of emergency departments’ refusing to treat patients who do not have medical insurance. Congress corrected the problem by requiring all CMS-participating hospitals to provide emergency medical screenings to all those who seek emergency care, and to begin the steps of necessary treatment should any emergency medical conditions be found.\(^{184}\) Extending the treatment and stabilization requirement of EMTALA to inpatients strikes against the gap-filling nature of the statute and impedes upon already-existing medical treatment requirements through state law and federal regulations.\(^{183}\) Since Congress is in the best position to

\(^{180}\) 42 U.S.C. § 1395dd(b) (italicized and underlined text added as proposed amendment).

\(^{181}\) See 42 C.F.R. § 489.24(d)(2)(i).

\(^{182}\) See Bryan v. Rectors & Visitors of the Univ. of Va., 95 F.3d 349, 352 (4th Cir. 1996) (“The stabilization requirement is thus defined entirely in connection with a possible transfer and without any reference to the patient’s long-term care within the system.”).

\(^{183}\) See Bryant, 289 F.3d at 1167 (“[‘Stabilize’] is defined only in connection with the transfer of an emergency room patient.”) (emphasis added).

\(^{184}\) 42 U.S.C. § 1395dd(b)(1).

\(^{185}\) See 70 C.J.S. Physicians and Surgeons § 90 (2005) (citing case law showing that physicians are “not liable for arbitrarily refusing to respond to a call or render treatment,” but are liable once a relationship is established for “failure to possess the requisite skill,
provide meaningful clarity as to the original intent of EMTALA, it is now time for Congress to resolve the split among the federal circuits and appropriately amend the statute.