No.

In The
Supreme Court of the United States

PROVIDENCE HOSPITAL AND
MEDICAL CENTERS, INC.,
Petitioner,

v.

JOHNELLA RICHMOND MOSES, Personal Representative
of the Estate of MARIE MOSES-IRONS, Deceased,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

PETITION FOR WRIT OF CERTIORARI

SUSAN HEALY ZITTERMAN
Counsel of Record
KITCH DRUTCHAS WAGNER
VALITUTTI & SHERBROOK
ONE WOODWARD AVENUE
SUITE 2400
DETROIT, MI 48226
(313) 965-7905

Counsel for Petitioner

October 13, 2009

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

Blank Page

QUESTION PRESENTED

The Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd ("EMTALA"), requires hospitals to "screen" any individual who "comes to the emergency department" and to "stabilize" an individual who is determined to have an "emergency medical condition." The Fourth and Ninth Circuits have held, and the Centers for Medicare and Medicaid Services ("CMS") by clarifying regulation in 2003 directed, that the obligation to stabilize does not apply to an individual who is admitted to the hospital in good faith for inpatient care. The Sixth Circuit in this matter has created a direct conflict with other circuits, and has ruled CMS's regulation invalid, by holding that EMTALA's stabilization requirement extends indefinitely to those admitted to a hospital for inpatient care.

The questions presented are:

1. Whether EMTALA's requirement that any individual who comes to a hospital's emergency department with an emergency medical condition be screened and stabilized should be expanded to continue indefinitely, after the individual has been admitted as an inpatient to the hospital for care or treatment?

2. Whether the CMS's regulation clarifying that EMTALA is inapplicable to hospital inpatients, 42 C.F.R. § 489.24(d)(2)(i), is valid, and applies retroactively?

LIST OF PARTIES AND CORPORATE DISCLOSURE STATEMENT

The parties to the proceeding in the Court of Appeals were Johnella Richmond Moses, Personal Representative of the Estate of Marie Moses-Irons, deceased, Providence Hospital and Medical Centers, Inc., and Paul Lessem, M.D. Dr. Lessem was a defendant as to whom summary judgment was affirmed by the Court of Appeals. Christopher Walter Howard was a third party defendant in the District Court (named by Providence acting as a third party plaintiff), but did not participate in proceedings before the Court of Appeals.

Providence Hospital and Medical Centers, Inc. is a private nonprofit corporation and does not have a parent corporation. There is no publicly held corporation owning more than 10% of its stock.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

COURT RULES, STATUTES AND OTHER AUTHORITIES

Blank Page

PETITION FOR A WRIT OF CERTIORARI

Providence Hospital and Medical Centers, Inc., respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.

OPINIONS BELOW

The decision of the Sixth Circuit Court of Appeals is reported at *Moses v. Providence Hosp. and Med. Ctrs., Inc.*, 561 F.3d 573 (6th Cir. 2009), and is reproduced at Appendix, pp. 1a-33a. The order denying Petitioner's motion for rehearing en banc, with dissent, is reported at *Moses v. Providence Hosp. and Med. Ctrs., Inc.*, 573 F.3d 397 (6th Cir. 2009), and is reproduced at Appendix, pp. 34a-36a. The Order of the District Court for the Eastern District of Michigan granting defendants' motion for summary judgment entered July 30, 2008, is unreported, and is reproduced at Appendix, pp. 31a-33a.

JURISDICTION

This Court has jurisdiction to review the judgment of the U.S. Court of Appeals for the Sixth Circuit pursuant to 28 U.S.C. § 1254(1).

The judgment of the U.S. Court of Appeals for the Sixth Circuit sought to be reviewed was filed April 6, 2008. Petitioner's timely filed motion for rehearing en banc was denied by order filed on July 17, 2009. This petition is timely under 28 U.S.C. § 2101 and Supreme Court Rule 13.3, as it is being filed within 90 days of entry of the order denying rehearing of the opinion and judgment sought to be reviewed.

STATUTORY PROVISIONS INVOLVED

The Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd ("EMTALA") and 42 C.F.R. §§ 489.24(a)-(d)(2) are reproduced in the Appendix, pp. 37a-57a.

STATEMENT

This case raises a nationally important issue concerning the scope of the obligation of Medicare-participating hospitals under The Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd ("EMTALA"), to provide care to individuals who come to the emergency department, irrespective of coverage by Medicare, ability to pay, length of stay, or medical standards of practice. Jurisdiction of the District Court was invoked under 42 U.S.C. §1395dd(d)(2)(A), which creates a civil action for damages by any individual who suffers a direct injury as a result of a violation of EMTALA, and under 28 U.S.C. § 1331 (general federal question).

A. EMTALA's Obligations And Penalties With Regard To A Hospital's Duty To Screen And Stabilize.

Congress enacted EMTALA, also known as the "Patient Anti-Dumping Act," in 1986 in response to concerns that hospital emergency rooms were refusing to treat patients with emergency conditions if the patient did not have medical insurance. See *Bryan v. Rectors and Visitors of the Univ. of Virginia*, 95 F.3d 349, 352 (4th Cir. 1996), quoting H.R. Rep. No. 241, 99th Cong., 1st Sess., Part I, at 27 (1985).

Under EMTALA, Medicare-participating hospitals must provide an "appropriate medical screening examination" to any individual who comes to the emergency department, to determine whether an "emergency medical condition" exists. 42 U.S.C. § 1395dd(a) (Appendix, pp. 37a.) An "emergency medical condition" is one of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in placing of the health of the individual in serious jeopardy, impairment or dysfunction. 42 U.S.C. § 1395dd(e)(1)(A). (Appendix, pp. 45a-46a.)

If an emergency medical condition is determined to exist, the hospital must either provide care to stabilize that condition, or transfer the individual to another medical facility if medically indicated. 42 U.S.C. § 1395dd(b)-(c). (Appendix, pp. 37a-41a.) "To stabilize" means "to assure, within reasonable medical probability, that no material deterioration of the [emergency medical] condition is likely to result from or occur during the transfer of the individual from a facility[.]" 42 U.S.C. § 1395dd(e)(3). "Transfer" is defined to include moving the individual to an outside facility, or discharging him. 42 U.S.C. § 1395dd(e)(4). (Appendix, pp. 46a-47a.)

EMTALA establishes penalties against hospitals and physicians who violate the requirements of the act of up to $50,000 per violation, and potential exclusion from the Medicare/Medicaid program. 42 U.S.C. § 1395dd(d)(1). The Act also creates a civil enforcement action for damages and appropriate equitable relief by any individual suffering personal harm, and by any medical facility suffering financial

loss. 42 U.S.C. § 1395dd(d)(2). (Appendix, pp. 41a-44a.)

B. Interpretation By The Fourth And Ninth Circuits, And By CMS Regulation, That EMTLA Does Not Apply To Individuals Admitted For Inpatient Care.

In *Bryant v. Adventist Health Sys.*, 289 F.3d 1162 (9th Cir. 2002), and *Bryan v. Rectors and Visitors of the Univ. of Virginia*, 95 F.3d 349, 352 (4th Cir. 1996), the Fourth and Ninth Circuits held that, consistent with EMTALA's limited purpose, its stabilization requirement does not apply once an individual who has come to the emergency department has been formally admitted to the hospital as an inpatient, rather than transferred or discharged. The Ninth Circuit in *Bryant*, *supra*, 1168, rejected as "dictum" the suggestion by the Sixth Circuit in *Thornton v. Southwest Detroit Hosp*, 895 F.2d 1131, 1135 (6th Cir. 1990), that EMTALA's stabilization requirement would extend indefinitely.

In 2002, Centers for Medicare and Medicaid Services (CMS), of the Department of Health and Human Services, the administrative agency charged with interpreting and implementing EMTALA, initially proposed rules extending EMTALA's stabilization requirement to inpatients. However, after extensive comments were received and considered, CMS withdrew that interpretation. In comments to its final rules promulgated in 2003 to clarify hospital responsibilities under the Act, CMS expressly endorsed the approach of the Courts in *Bryant* and *Bryan*, Federal Register, Vol. 68, No. 174, pp. 53244-5, and adopted 42 C.F.R. §489.24(a)(1)(ii)

and (d)(2), directing that a hospital's obligations under EMTALA end upon inpatient admission to the hospital. (Appendix, pp. 49a, 57a.)

C. Underlying Facts And Allegations In This Matter.

Respondent Johnella Richmond Moses, Personal Representative of the Estate of Marie Moses-Irons, deceased, in this matter seeks damages for an asserted violation of EMTALA in 2002, based upon the alleged premature discharge of Christopher Walter Howard, following 6 days of treatment as an inpatient at Petitioner Providence Hospital and Medical Center.

Marie Moses-Irons brought Mr. Howard to the emergency department of Providence Hospital in Southfield, Michigan, on December 13, 2002, because he was exhibiting signs of illness, including disorientation, hallucinations, and nausea. Mr. Howard was examined in the emergency department by an emergency medicine physician and a neurologist to determine why Mr. Howard was acting inappropriately. (Appendix, p. 3a.)

Based on that examination and testing, it was determined by hospital staff that longer term, inpatient care was necessary. Mr. Howard was admitted as an inpatient at Providence Hospital, and received inpatient medical and psychiatric care for the next 6 days. He was seen on a daily basis by Dr. Lessem, a psychiatrist, and was also seen by the neurologist, and an internal medicine specialist. (Appendix, pp. 3a-4a.)

Mr. Howard was discharged from the hospital on December 19, 2002, with a diagnosis of atypical psychosis, with delusional disorder. (Appendix, p. 5a.) At discharge, Mr. Howard was prescribed three types of medication. He was also given instructions to schedule office appointments for follow-up care with his primary care provider, and with the neurologist and psychiatrist who had treated him as a hospital inpatient. (Court of Appeals Joint Appendix, p. 179, Discharge Summary.)

Respondent's claim of a violation of EMTALA is directed to Mr. Howard's discharge on December 19. Respondent has alleged that at that time of Mr. Howard's discharge as an inpatient, hospital staff was aware that he still suffered from an unstabilized emergency medical condition, but discharged him when notified that his psychiatric care would not be covered by insurance. (Court of Appeals Joint Appendix, pp. 5, 8, first amended complaint.) Respondent alleges that as a result of the failure to stabilize Mr. Howard's psychiatric problem before he was discharged on December 19, 2002, Mr. Howard murdered his wife, Marie Moses-Irons, on December 29, 2002. (Appendix, p. 5a.)

In the District Court, defendants filed a motion for summary judgment on the ground that, *inter alia*, EMTALA does not apply after a patient has been admitted to a hospital and is discharged after 6 days of inpatient care. The District Court granted the motion, and respondent appealed. (Appendix, pp. 6a-7a.)

D. Court Of Appeals Decision.

The Sixth Circuit Court of Appeals in an opinion filed April 6, 2009, reversed summary judgment as to Providence Hospital and Medical Centers. The Court held, *inter alia*, that EMTALA forbids an individual's release (transfer or discharge) until the individual has been stabilized regardless of whether, or for how long, the individual was admitted from the emergency department to the hospital and treated as an inpatient. (Appendix, pp. 15a-20a.)[1] The Court held that the language of EMTALA requires treatment of the patient indefinitely until the emergency medical condition is stabilized, citing to a statement in *dicta* in its earlier decision in *Thornton v. Southwest Detroit Hospital*, 895 F.2d 1131, 1134 (6th Cir. 1990). (Appendix, pp. 16a-17a.)

The Court of Appeals further held that the administrative rule promulgated by CMS, that declares that a hospital's EMTALA obligations end upon admitting an individual as an inpatient in good faith, 42 C.F.R. § 489.24(d)(2), was invalid as inconsistent with the language of EMTALA.

---

[1] The Court of Appeals also rejected alternative grounds advanced by defendants in support of the District Court's grant of summary judgment which are not at issue in this Petition. Those included arguments that there was no genuine issue of material fact that Mr. Howard did not have an unstabilized emergency condition at the time of his discharge, and that the estate of a nonpatient does not have standing to seek damages under EMTALA. (Appendix, pp. 10a-15a, 20a-26a.) The Court did affirm the dismissal of Dr. Lessem, holding that EMTALA does not create a cause of action for damages against an individual physician. (Appendix, pp. 26a-28a.)

(Appendix, pp. 18a-19a.) Alternatively, the Court concluded that the regulation would not in any event apply retroactively to Mr. Howard's care, which occurred before the regulation was implemented. (Appendix, pp. 19a-20a.)

Defendant Providence Hospital and Medical Centers timely filed a petition for rehearing en banc on April 20, 2009, which was denied by order of July 17, 2009. Judge Richard Griffin dissented, noting that the majority had "perpetuated a serious conflict" between circuits:

> By remaining loyal to the errant obiter dictum contained in *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990), the majority has perpetuated a serious conflict between our circuit and the Ninth Circuit, *Bryant v. Adventist Health Sys.*, 289 F.3d 1162 (9th Cir. 2002), the Fourth Circuit, Bryan v. Rectors and Visitors of the Univ. of Va., 95 F.3d 349 (4th Cir. 1996), the federal regulations, 42 C.F.R. § 489.24(d)(2)(i), and the vast majority of lower court decisions. See generally *Preston v. Meriter Hosp., Inc.*, 747 N.W.2d 173 (Wis. Ct. App. 2008), petition for review denied, 749 N.W.2d 662 (Wis. 2008), and cases cited therein. [Appendix, pp. 34a-36a.]

Judge Griffin concluded:

> Our panel decision misconstrues EMTALA, making it a general federal medical malpractice statute, rather than an act limited to emergency room screening and stabilization. *Bryan*, 95 F.3d at 351. [Appendix, p. 36a.]

REASONS FOR GRANTING THE PETITION

The decision in this matter has created a direct conflict among three circuits, and thus uncertainty within the remaining circuits, as to the scope of Medicare participating hospitals' federally mandated obligation to provide care in an acute, hospital setting. The decision has declared invalid the clarifying regulation by CMS expressly intended to ensure uniform and consistent application of policy and to avoid misunderstanding of EMTALA's requirements by individuals, physicians, or hospital employees nationwide. The decision has extended federally mandated hospital care far beyond the clear intent of Congress to address a specific and limited concern--turning away patients from the emergency departments of acute care hospitals, or, by transfer, "dumping" patients in need of emergency care on other facilities.

The conflict in the circuits will have far-reaching legal, practical and financial effects on the nation's healthcare system. Hospital systems with a nationwide or multi-circuit presence will now be faced with conflicting obligations under federal law as to facilities located in the Fourth, Ninth and Sixth Circuits. Individual patients, physicians, hospital employees and administrators in the remaining circuits will face uncertainty as to what their rights or obligations will be under EMTALA. This decision will have significant ramifications for hospitals, expanding and creating uncertainty in liability for civil damages under EMTALA, as well as with regard to their daily operations in attempting to comply with the Sixth Circuit's mandate.

The Sixth Circuit's decision will have a direct adverse financial impact on the nation's already over-extended and under-reimbursed hospitals in mandating as a matter of federal law that hospitals provide acute, inpatient medical care indefinitely to those admitted with an emergency medical condition from the hospital emergency department. This obligation has been imposed regardless of the medical standard of practice or the futility of care, regardless of reimbursement, and regardless of the availability of care at other or less acute facilities that otherwise would be considered adequate by medical standards. The Court's decision will have a further adverse financial impact in creating near strict, federal tort liability and potential liability for civil fines when hospitals or physicians fail to provide care indefinitely, or transfer a patient to another, perhaps less acute, facility without the required certification.

The facts of this case well illustrate the implications of extending EMTALA to inpatient care, in questioning a physician's decision to discharge a patient after days of inpatient treatment, without regard to the reasonableness of the decision, or medical standards of care. As expressly concluded by CMS, the Medicare Conditions of Participation impose adequate safeguards for care, treatment and discharge of individuals admitted as inpatients. The Sixth Circuit's decision has turned EMTALA into a "super federal malpractice statute," superimposed upon and displacing state common law, directly contrary to what was intended by Congress.

The Sixth Circuit's decision in negating CMS regulations has decided an important federal question in a way that conflicts with the principles set forth by

this Court in *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43, 104 S. Ct. 2778, 81 L. Ed. 2d 694 (1984), requiring deference to regulations of an administrative agency such as CMS. This has further magnified the lack of certainty created by the conflict between circuits.

Finally, in further holding that CMS's interpretive rules would have an impermissible retroactive effect if applied to care before their promulgation, the Court has also decided an important federal question in a way that conflicts with the principles set forth by this Court in *Smiley v. Citibank*, 517 U.S. 735, 744 n. 4, 116 S. Ct. 1730, 135 L. Ed. 2d 25 (1996).

I THIS CASE DIRECTLY PRESENTS A CONFLICT AMONG CIRCUITS OVER WHETHER EMTALA'S OBLIGATIONS APPLY BEYOND A HOSPITAL EMERGENCY DEPARTMENT TO INPATIENTS.

In *Bryant v. Adventist Health Sys.*, 289 F.3d 1162 (9th Cir. 2002), and *Bryan v. Rectors and Visitors of the Univ. of Virginia*, 95 F.3d 349 (4th Cir. 1996), the Courts directly held that EMTALA's requirements do not apply once an individual who has come to the emergency department has been admitted to the hospital for inpatient care, rather than transferred or discharged. This conclusion is consistent with EMTALA's language and purpose, and Congress's intent that it not become a federal malpractice statute.

In *Bryan*, the Fourth Circuit held that EMTALA did not provide a remedy where, after 12 days of inpatient treatment, the medical staff determined that no further efforts should be made to prevent the

patient's death (a "do not resuscitate" decision), and the patient died. As recognized the Court in *Bryan*, and by nearly every decision applying the Act, Congressional intent is clear that "EMTALA is a limited 'anti-dumping' statute, not a federal malpractice statute." *Bryan*, 95 F.3d 349, 352. "EMTALA is quite clear that it is not intended to preempt state tort law except where absolutely necessary. See 42 U.S.C. § 1395dd(f) (mandating that EMTALA preempt no state law requirement "except to the extent that the requirement directly conflicts with a requirement of [EMTALA]")." *Bryan*, 95 F.3d 349, 352.

The Fourth Court rejected the assertion that the stabilization requirement continues to apply even after the patient is admitted for inpatient care, based upon this Congressional intent, and the context in which the stabilization requirement appears in the statute, reasoning:

> [EMTALA] defines "to stabilize" as "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual...." 42 U.S.C. § 1395dd(e)(3)(A). 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. It seems manifest to us that the stabilization requirement was intended to regulate the hospital's care of the patient only in the immediate aftermath of the act of admitting her for emergency treatment

> and while it considered whether it would undertake longer-term full treatment or instead transfer the patient to a hospital that could and would undertake that treatment. It cannot plausibly be interpreted to regulate medical and ethical decisions outside that narrow context. [*Bryan v. Rectors and Visitors of the Univ. of Va.*, 95 F.3d 349, 352 (4th Cir. 1996).]

As also reasoned by the Court in *Bryan*, the interpretation of EMTALA urged by plaintiff there, and now imposed by the Sixth Circuit in this matter and all cases arising in this Circuit, requires a hospital to provide care ad infinitum:

> Under this interpretation, every presentation of an emergency patient to a hospital covered by EMTALA obligates the hospital to do much more than merely provide immediate, emergency stabilizing treatment with appropriate follow-up. 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 - perhaps for years - according to a novel, federal standard of care derived from the statutory stabilization requirement. We do not find this reading of the statute plausible. [*Bryan v. Rectors and Visitors of the Univ. of Va.*, 95 F.3d 349, 351 (4th Cir. 1996).]

The Court in *Bryan* noted that state tort law would apply to prevent and create a remedy for abandonment of inpatients prematurely discharged, a problem different than the national scandal being addressed by

Congress. The Court in *Bryan* concluded that the stabilization requirement only applied in the context of an imminent transfer or discharge of the patient from the emergency department:

> It seems manifest to us that the stabilization requirement was intended to regulate the hospital's care of the patient only in the immediate aftermath of the act of admitting her for emergency treatment and while it considered whether it would undertake longer-term full treatment or instead transfer the patient to a hospital that could and would undertake that treatment. It cannot plausibly be interpreted to regulate medical and ethical decisions outside that narrow context. [*Bryan, supra*, 352.]

Further, as noted by CMS in later endorsing this position, hospitals would also still be obliged by Medicare Conditions of Participation ("CoPs") to provide quality care to inpatients:

> As a result of these court cases, and because we believe that existing hospital CoPs provide adequate, and in some cases superior protections to patients, we are interpreting hospital obligations under EMTALA as ending once the individuals are admitted to the hospital inpatient care. As an example of a case in which the hospital CoPs provide protection superior to that mandated by EMTALA, the discharge planning CoP in 42 CFR 482.43 includes specific procedural requirements that must be satisfied to show that there has been adequate consideration given to a patient's

> needs for post discharge care. EMTALA does not include such specific requirements. [Federal Register, Vol. 68, No. 174, p. 53245.]

In *Bryant v. Adventist Health Sys.*, 289 F.3d 1162 (9th Cir. 2002), the Ninth Court affirmed summary judgment dismissing an EMTALA claim where plaintiff was admitted through the emergency department as an inpatient, received care for 2 days, and was then transferred to another hospital where he died. The Ninth Circuit agreed with the *Bryan* Court's interpretation of "stabilize" as being limited to the context of actual transfer or discharge of an emergency room patient:

> Although the term "stabilize" appears to reach a patient's care after the patient is admitted to a hospital for treatment, the term is defined only in connection with the transfer of an emergency room patient. *Id.* § 1395dd(e)(3)(A) ("The term 'to stabilize' means . . . to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility . . . ." (emphasis added)). Thus, the term "stabilize" was not intended to apply to those individuals who are admitted to a hospital for inpatient care. * * * [*Bryant, supra,* 1167.]

With virtual unanimity other federal district and state appellate courts have held that EMTALA does not apply after an individual is admitted from the emergency department as an inpatient. See *Preston v.*

Meriter Hosp., 747 N.W.2d 173, 307 Wis. 2d 704 (2009), *Causey v. St. Francis Med. Ctr.*, 719 So. 2d 1072 (La. App. 1998), *Benitez-Rodriguez v. Hosp. Pavia Hato Rey, Inc.*, 588 F. Supp. 2d 210 (D.P.R. 2008), *Lopes v. Kapiolani Med. Ctr. for Women & Children*, 410 F. Supp. 2d 939, 948 (D. Haw. 2005), *Quinn v. BJC Health Sys.*, 364 F. Supp. 2d 1046, 1054 (E.D. Mo. 2005), *Dollard v. Allen*, 260 F.Supp. 2d 1127 (D. Wyo. 2003), *Mazurkiewicz v. Doylestown Hosp.*, 305 F. Supp. 2d 437, 439 (E.D. Pa. 2004).

The Sixth Circuit's decision in this matter directly conflicts with the decisions of the Ninth and Fourth Circuits. The Court in this matter held:

> Contrary to Defendants' interpretation, EMTALA imposes an obligation on a hospital beyond simply admitting a patient with an emergency medical condition to an inpatient care unit. . . . 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. 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. [Appendix, p. 16a.]

The Sixth Circuit's rationale for its departure from other circuits, other state courts, and CMS, is in error in light of EMTALA's purpose and its language. The Court failed to address the rationale of the other circuits in concluding that EMTALA does not extend beyond the emergency department--that a patient who

becomes an inpatient is neither discharged nor transferred.

This Court addressed EMTALA in *Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249, 250, 119 S. Ct. 685, 142 L.Ed. 2d 648 (1999), resolving the issue as to whether section 1395dd(b) requires proof that a hospital acted with an improper motive in failing to stabilize a patient. In *Roberts* the transfer at issue occurred after several weeks of inpatient hospital care, a fact not of significance to the issue decided by the Court there.

The Court in *Roberts* was not asked to consider the issue since addressed by the Fourth, Ninth, and now the Sixth, Circuits and CMS--whether EMTALA applies to inpatients. The Court should accept this matter to resolve this conflict.

II WHETHER CMS'S REGULATION DIRECTING THAT EMTALA DOES NOT APPLY TO HOSPITAL INPATIENTS IS INVALID AS MANIFESTLY CONTRARY TO THE STATUTE, IS AN IMPORTANT QUESTION OF FEDERAL LAW WHICH SHOULD BE SETTLED BY THIS COURT.

CMS has the congressional authority to promulgate rules and regulations interpreting and implementing Medicare-related statutes such as EMTALA. See generally 42 U.S.C. §§ 1302, 1395hh; 5 U.S.C. § 551, et seq. In 2003 CMS promulgated final rules, 42 C.F.R. Parts 413, 482, and 489, which it deemed necessary to clarify where and when EMTALA applies. CMS solicited public comments and took into account a range of objections to the proposed Regulations, providing a lengthy discussion responding to the

comments and its reasons for its interpretation in the Final Rule. Federal Register, Vol. 68, No. 174, pp. 53222-53264.

> These reiterating and clarifying changes are needed to ensure uniform and consistent application of policy and to avoid misunderstanding of EMTALA requirements by individuals, physicians, or hospital employees. [Federal Register, Vol. 68, No. 174, p. 53222.]

In 42 C.F.R. §489.24(a) and (d) (Appendix, pp. 49a, 57a), CMS has declared that the requirements of EMTALA do not apply after an individual seeking emergency medical care has been admitted in good faith to the hospital:

> (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 as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual. [42 C.F.R. 489.24(d)(2)(i).]

In promulgating this rule, CMS expressly referenced with approval and endorsed as correct the holding of the Fourth and Ninth Circuits in *Bryan* and *Bryant*. As CMS reasoned:

> In reaching this result [that EMTALA does not apply to inpatients] the courts [in *Bryan* and *Bryant*] 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. * * *
>
> The courts gave great weight to the fact that hospitals have a discrete obligation to stabilize the condition of an individual when moving an 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. [Federal Register, Vol. 68, No. 174, p. 53244.]

The Court of Appeals here erred in declaring these regulations invalid as inconsistent with the statutory language, an error which will severely undermine CMS's goal of ensuring uniformity and predictability across the nation. The validity of CMS's construction of the EMTALA stabilization requirement is determined in accordance with the two-step process set forth by this Court in *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43, 104 S. Ct. 2778, 81 L.Ed. 2d 694 (1984). Contrary to the Court of Appeals' analysis here, the statute is at a minimum ambiguous, as best evidenced by conflicting decisions between the circuits as to its applicability to inpatients (with the vast majority endorsing the interpretation of CMS). Indeed, the statute is silent as to applicability

of EMTALA to the precise issue here--individuals who are not discharged or transferred upon identification of an emergency medical condition, but instead admitted as inpatients for further treatment.

Second, where as here, Congress has expressly delegated rule-making authority to the agency, 42 U.S.C. § 1302(a), the agency's interpretation is permissible and must be given controlling weight unless it is "arbitrary, capricious, or manifestly contrary to the statute." *Id.* at 843-44. CMS is a "highly expert agency" that "administers a large and complex regulatory scheme" in "cooperation with many other institutional actors." *Community Health Ctr. v. Wilson-Coker*, 311 F.3d 132, 138 (2d Cir. 2002).

CMS's interpretation is not arbitrary or "manifestly" contrary to the statute. It is in line with the interpretation of two Courts of Appeals, and a multitude of federal district and state appellate courts. CMS's interpretation is the product of lawful rulemaking after the agency's consideration and extensive analysis of court decisions and many comments from the public and hospitals regarding the proposed rules, set forth in the Federal Register, Vol. 68, No. 174, pp. 53222-53264.

III THE COURT OF APPEALS' DECISION IN THE ALTERNATIVE THAT CMS'S REGULATION DOES NOT APPLY RETROACTIVELY CONFLICTS WITH RELEVANT DECISIONS OF THIS COURT.

The Court of Appeals decision establishes a standard by which CMS regulations would not be applied to care before their enactment which is clearly

inconsistent with fundamental principles established by this Court as to retroactivity. The "courts should apply the law in effect at the time they decide a case *unless* the law would have an impermissible retroactive effect as that concept is defined by the Supreme Court." *BellSouth Telecomms., Inc. v. Southeast Tel., Inc*, 462 F.3d 650, 657 (6th Cir. 2006). CMS's clarifying regulations would not have an impermissible retroactive effect.

The regulations were intended to clarify hospital obligations based upon case law existing at the time of the care at issue here, specifically *Bryan* and *Bryant*. These clarifying regulations were not inconsistent with any prior law or agency regulation; the statement in *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990), was, as recognized in the dissent to the denial or rehearing in this matter, "errant obiter dictum." (Appendix, p. 35a.) In *Smiley v. Citibank*, 517 U.S. 735, 744 n. 4, 116 S. Ct. 1730, 135 L.Ed. 2d 25 (1996), the Court characterized as "absurd" an argument that deferring to a clarifying regulation in a case involving antecedent transactions would make an administrative regulation impermissibly retroactive in violation of prior precedent:

> There might be substance to this point if the regulation replaced a prior agency interpretation--which, as we have discussed, it did not. Where, however, a court is addressing transactions that occurred at a time when there was no clear agency guidance, it would be absurd to ignore the agency's current authoritative pronouncement of what the statute means. [*Smiley v. Citibank*, 517 U.S. 735, 744 n. 4 (1996).]

So too here, petitioner submits, it would be "absurd" to ignore CMS's deliberate and authoritative pronouncement of what EMTALA means. The Sixth Circuit's determination that the regulations cannot be applied to Mr. Howard because they would have affected the extent of care that Mr. Howard could have expected is not warranted. Where two Circuit Courts of Appeals had directly addressed the issue consistent with CMS's later regulations, Mr. Howard could not have had any legitimate expectation of, or right to, potentially indefinite, lifetime hospital care.

The Court should grant certiorari to consider whether CMS's regulations are valid, and whether EMTALA applies to inpatients.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

KITCH DRUTCHAS WAGNER
VALITUTTI & SHERBROOK

By: SUSAN HEALY ZITTERMAN
Counsel for Petitioner
PROVIDENCE HOSPITAL AND
MEDICAL CENTER, INC.
One Woodward Avenue, Suite 2400
Detroit, MI 48226
(313) 965-7905

Dated: October 13, 2009