No. 09-438

In the Supreme Court of the United States

PROVIDENCE HOSPITAL, ET AL., PETITIONERS

v.

JOHNELLA RICHMOND MOSES, PERSONAL REPRESENTATIVE OF THE ESTATE OF MARIE MOSES-IRONS, DECEASED

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTIONS PRESENTED

The Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. 1395dd, requires a hospital with an emergency department that participates in the Medicare program to provide "an appropriate medical screening examination" to any individual who "comes to the emergency department" of the hospital to determine whether that individual has an "emergency medical condition." 42 U.S.C. 1395dd(a). In addition, if any individual "comes to a hospital" with an "emergency medical condition," the hospital is required either to provide "for such further medical examination and such treatment as may be required to stabilize the medical condition," or to transfer that individual to another hospital in accordance with certain statutory conditions. 42 U.S.C. 1395dd(b) and (c). The questions presented are:

1. Whether EMTALA's coverage terminates upon the hospital's good faith admission as an inpatient of an individual with an emergency medical condition.

2. Whether a 2003 regulation promulgated by the Department of Health and Human Services that clarifies the scope of a participating hospital's obligations under EMTALA may be applied to conduct occurring prior to its issuance.

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This brief is submitted in response to the order of this Court inviting the Solicitor General to express the views of the United States. In the view of the United States, the petition for a writ of certiorari should be denied.

STATEMENT

1. The Emergency Medical Treatment and Labor Act (EMTALA or Act), 42 U.S.C. 1395dd, was originally enacted in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985. Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. No. 99-272, § 9121(b), 100 Stat. 164. Congress was responding to "a growing concern about the provision of adequate emergency room medical services to individu-

als who seek care, particularly as to the indigent and uninsured." H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 3, 5 (1985) (*1985 House Report*). The Act was primarily designed to address "patient dumping," the practice of turning away or transferring indigent patients without evaluation or treatment. See *Harry* v. *Marchant*, 291 F.3d 767, 772-773 (11th Cir. 2002); *Summers* v. *Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1136 (8th Cir. 1996) (en banc).

EMTALA imposes two principal obligations on hospitals with emergency departments that have entered into Medicare provider agreements with the Secretary of Health and Human Services (HHS). 42 U.S.C. 1395dd(e)(2). *First*, when "any individual" "comes to the emergency department" of a participating hospital and a request is made on the individual's behalf for examination or treatment for a medical condition, the Act requires the hospital to provide "an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition * * * exists." 42 U.S.C. 1395dd(a); see 42 C.F.R. 489.24(b) (The phrase "[c]omes to the emergency department" means, *inter alia*, that an individual presents at the "dedicated emergency department" and requests examination and treatment for a "medical condition," or presents "on hospital property" and requests examination and treatment for an "emergency medical condition.").

Second, if a participating hospital determines that an individual who "comes to a hospital" is suffering from an emergency medical condition, the hospital must either (A) "within the staff and facilities available at the hospi-

tal," provide "for such further medical examination and such treatment as may be required to stabilize the medical condition," or (B) transfer the individual to another hospital in accordance with the provisions of Subsection (c). 42 U.S.C. 1395dd(b)(1). Subsection (c) states that, "[i]f an individual at a hospital has an emergency medical condition which has not been stabilized[,] * * * the hospital may not transfer the individual unless" (i) the individual (or a legally responsible person acting on the individual's behalf) makes an informed, written request to be transferred; (ii) a physician has signed a certification that the medical benefits outweigh the risks of the transfer; or (iii) "if a physician is not physically present in the emergency department at the time an individual is transferred," a qualified medical person, in consultation with a physician, has made the required risk/benefit determination. 42 U.S.C. 1395dd(c)(1)(A).[1]

The phrase "emergency medical condition" is defined as a condition "manifesting itself by acute symptoms of sufficient severity * * * such that the absence of immediate medical attention could reasonably be expected to result in * * * serious jeopardy [to the health of the individual or her unborn child], * * * serious impairment to bodily functions, or * * * serious dysfunction of any bodily organ or part." 42 U.S.C. 1395dd(e)(1)(A). The term "to stabilize" means "to provide such medical treatment of the [emergency medical] condition as may be necessary to assure, within reasonable medical prob-

[1] The transfer must also be an "appropriate transfer," 42 U.S.C. 1395dd(c)(1)(B), which means that the receiving hospital must agree to accept the transfer and to provide appropriate medical treatment, and the sending hospital must forward all relevant medical records, provide qualified personnel for the transfer, and take actions to minimize the risk of transfer, 42 U.S.C. 1395dd(c)(2).

ability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility." 42 U.S.C. 1395dd(e)(3)(A); see 42 U.S.C. 1395dd(e)(3)(B) (similar definition of "stabilized"). And the Act defines "transfer" as "the movement (including the discharge) of an individual outside a hospital's facilities." 42 U.S.C. 1395dd(e)(4).

EMTALA confers a private right of action on "[a]ny individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of [EMTALA]." 42 U.S.C. 1395dd(d)(2)(A) (permitting recovery of amount of "damages available for personal injury under the law of the State in which the hospital is located"). The Secretary of HHS may also impose civil monetary penalties on participating hospitals and on physicians for negligent violations of the Act. 42 U.S.C. 1395dd(d)(1).

2. In May 2002, the Centers for Medicare & Medicaid Services (CMS), within HHS, published a proposed rule to clarify, among other things, an issue that had "occasionally" been raised regarding whether EMTALA applied to individuals admitted to a hospital as inpatients. See 67 Fed. Reg. 31,475; see also *Roberts* v. *Galen of Va., Inc.*, 525 U.S. 249 (1999) (No. 97-53), 12/1/98 Tr. of Oral Argument at 20-21 (advising the Court that HHS was planning to engage in rulemaking on that question). The proposal was that EMTALA "would apply to inpatients only under limited circumstances"—namely, it would cover an individual who initially "come[s] to the emergency room" requesting care for an emergency medical condition, is admitted as an inpatient before that condition is "stabilized," and is not thereafter "stabilized" in any non-transient manner prior to transfer. 67 Fed. Reg. at 31,475. The proposed rule

would have further clarified that, except for these "limited circumstances," "EMTALA does not apply to hospital inpatients." *Ibid.* The agency expressed concern that "permitting inpatient admission to end EMTALA obligations would provide an obvious means of circumventing" the Act's requirements, but also noted that, although "the legislative history of EMTALA is replete with references to the problem of individuals denied emergency medical care at hospital emergency rooms, * * * there is no explicit reference to similar problems faced by hospital inpatients." *Ibid.*[2]

Following the receipt of comments, in September 2003, CMS promulgated a final rule "interpreting hospital obligations under EMTALA as ending once the individuals are admitted to the hospital [for] inpatient care," unless the hospital admission was not in "good faith with the intention of providing treatment." 68 Fed. Reg. 53,244-53,245. The agency explained that several courts of appeals had interpreted EMTALA's obligations as ending upon admission, and that state law remedies and the conditions of participation for a hospital's participation in Medicare provided adequate means to protect inpatients. *Id.* at 53,245.

The adopted regulation thus provides that a hospital satisfies EMTALA's requirements with respect to an individual found to have an emergency medical condition if it "admits that individual as an inpatient in good faith

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[2] The proposed rule was consistent with a view expressed in the preamble to an earlier version of the regulations, in which the agency interpreted the stabilization requirement "to mean, for example, that if a hospital were to admit and then transfer a patient before his or her condition is stabilized * * * it would be a violation of [EMTALA]." 53 Fed. Reg. 22,517 (1988) (proposed rule); see 59 Fed. Reg. 32,092 (1994) (summarizing proposed rule).

in order to stabilize the emergency medical condition." 42 C.F.R. 489.24(d)(2)(i); see 42 C.F.R. 489.24(a)(ii) ("If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section."); cf. 42 C.F.R. 489.24(d)(2)(iii) ("A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation."). The regulation defines "inpatient" as "an individual who is admitted to a hospital for bed occupancy * * * with the expectation that he or she will remain at least overnight." 42 C.F.R. 489.24(b).[3]

3. On December 13, 2002, Marie Moses-Irons brought her husband, Christopher Howard, to the emergency department of petitioner Providence Hospital. Pet. App. 3a. Howard's symptoms included severe headaches, muscle soreness, high blood pressure, vomiting, slurred speech, disorientation, hallucinations, and delusions. *Ibid.* Emergency room physicians admitted Howard as an inpatient to conduct more tests. *Ibid.* He was ultimately diagnosed with a migraine headache and atypical psychosis with delusional disorder and, although there allegedly were plans to transfer Howard to the psychiatric unit, he was released from the hospital

[3] In 2008, HHS examined whether EMTALA's "specialized care" provisions would require hospitals with specialized capabilities to accept the transfer of an individual who was an inpatient at the admitting hospital. See 73 Fed. Reg. 48,656-48,661. The agency ultimately clarified that "once an individual is admitted in good faith by the admitting hospital, the admitting hospital has satisfied its EMTALA obligation with respect to that individual even if the individual remains unstabilized[,] and a hospital with specialized capabilities does not have an EMTALA obligation to accept an appropriate transfer of that individual." *Id.* at 48,661.

on December 19, 2002. *Id.* at 4a-5a. Ten days later, Howard murdered his wife. *Id.* at 5a.

In 2004, the representative of Moses-Iron's estate commenced this suit against petitioner alleging a violation of EMTALA and state law negligence claims. Pet. App. 5a.[4] Petitioner filed a motion to dismiss, arguing, *inter alia*, that respondent lacked standing to bring an EMTALA claim because she was not the individual who had sought treatment from the hospital. *Ibid.* The district court denied that motion, concluding that "the plain language of the statute does not preclude a lawsuit by the injured third party." *Ibid.* (quoting C.A. App. 181).

Petitioner then moved for summary judgment, again challenging respondent's standing and asserting two other grounds: (1) EMTALA does not impose any obligations on a hospital once an individual is admitted as an inpatient, and (2) there was no EMTALA violation because Howard was properly screened and was not diagnosed as having an emergency medical condition. Pet. App. 6a, 10a. The district court granted summary judgment to petitioner because, "regardless of the standing issue," "[t]he hospital admitted Howard and did not turn him away" and, after a proper screening, the hospital did not recognize an "emergency medical condition." *Id.* at 7a (quoting C.A. App. 216). The court declined to exercise supplemental jurisdiction over respondent's state-law claims. *Id.* at 7a.

4. The court of appeals reversed and remanded for further proceedings. Pet. App. 1a-28a. As an initial matter, the court agreed that respondent had standing to sue under EMTALA because, the court explained, the

[4] The complaint also named an individual physician as a defendant, but the physician was dismissed, Pet. App. 26a-28a, and is not a petitioner before this Court.

plain language of the statute broadly confers a private right of action on "*any* individual who suffers personal harm as a direct result" of the hospital's violation. *Id.* at 10a-15a (emphasis added).

The court then held that "EMTALA imposes an obligation on a hospital beyond simply admitting a patient with an emergency medical condition to an inpatient care unit." Pet. App. 16a. Reasoning that EMTALA "requires 'such treatment as may be required to stabilize the medical condition,' § 1395dd(b), and forbids the patient's release unless his condition has 'been stabilized,' § 1395dd(c)(1)," the court concluded that "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." *Ibid.*; see *id.* at 17a ("Thus, the statute requires more than the admission and further testing of a patient; it requires that actual care, or treatment, be provided as well.").

The court refused to defer to HHS's regulation providing that a hospital's EMTALA obligations are satisfied upon the good faith admission of the individual as an inpatient, finding the regulation "contrary to EMTALA's plain language." Pet. App. 18a. The court thought it "unreasonable" to treat admission, in and of itself, as the equivalent of the "treatment as may be required to stabilize" that the Act requires. *Ibid.* In the alternative, the court concluded that it would be inappropriate to apply HHS's interpretation here because the regulation was promulgated after the conduct at issue in this case. *Id.* at 19a.

Finally, the court of appeals held that whether the hospital conducted an appropriate screening and found no emergency medical condition, and whether the hospi-

tal believed Howard was stabilized upon discharge, raised disputed issues of fact for the jury to decide. See Pet. App. 20a-26a.

5. The court of appeals denied rehearing en banc with one judge dissenting. Pet. App. 34a-36a.

DISCUSSION

The court of appeals erred in holding that EMTALA's coverage unambiguously continues after an individual has been admitted in good faith to the hospital as an inpatient. Congress did not speak directly to this issue, and HHS is entitled to deference as the expert agency. Nonetheless, review is not warranted at this time. The conflict among the circuits is shallow, HHS has committed to initiating rulemaking to reconsider this issue in the coming year, and the case is in an interlocutory posture and is atypical in several respects that further weigh against review. The Court therefore should deny the petition for a writ of certiorari.

A. EMTALA's Coverage Does Not Unambiguously Continue Once An Individual Has Been Admitted In Good Faith As A Hospital Inpatient

The familiar two-step framework established by *Chevron U.S.A., Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843 (1984), governs this case. At the first step, a court asks "whether Congress has directly spoken to the precise question at issue"; if Congress has unambiguously expressed its intent, the court must give effect to that intent. *Ibid.* If the statute is silent or ambiguous, however, the court must determine "whether the agency's answer is based on a permissible construction of the statute." *Id.* at 843. Congress did not directly answer the question presented in this case—but in a 2003 regulation promulgated after

notice and comment HHS did. The court of appeals should have deferred to the agency's "permissible construction of the statute." *Ibid.*

1. The statutory text does not unambiguously provide that EMTALA's coverage continues after an individual is admitted to the hospital as an inpatient. To be sure, nothing in Subsection (b) expressly states that EMTALA's requirements are satisfied upon admission to the hospital as an inpatient. But there is also no express statement that coverage will continue indefinitely, beyond appropriate screening and treatment in the emergency room.

a. On the one hand, Subsection (b) is written in expansive terms. It refers to any individual who "comes to a hospital" and is determined to have an "emergency medical condition." 42 U.S.C. 1395dd(b)(1). It then states that the hospital must either (A) provide, "within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition," or (B) transfer the individual in accordance with Subsection (c). *Ibid.* And the Act measures stabilization under Subsection (b) by whether the condition will deteriorate if the individual is moved "from a facility" or "outside a hospital's facilities," 42 U.S.C. 1395dd(e)(3) and (4). In contrast, the medical screening requirement in Subsection (a) refers to any individual who "comes to the emergency department" and requires the hospital to provide an examination "within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department." 42 U.S.C. 1395dd(a). As respondent argues (Br. in Opp. 10), the references to the "emergency department" in Subsection (a) compared to the absence of any such

mention in Subsection (b), or in the definitions of "to stabilize" or "transfer," could suggest that the stabilization requirement applies to the treatment of "emergency medical conditions," whether or not they exist in the "emergency department." See *Thorton* v. *Southwest Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir. 1990) ("[T]his change in wording" leads to a "reasonable inference" that the stabilization requirement applies "regardless of whether the patient stays in the emergency room.").

On the other hand, Subsection (b) permits a hospital to transfer an individual before he is stabilized only in accordance with Subsection (c)—*i.e.*, only if, *inter alia*, a physician signs a certification attesting to the risks and benefits of the transfer. 42 U.S.C. 1395dd(c)(1)(A)(ii). And it further provides an alternative way of effectuating an appropriate transfer if a "physician is not physically present in the emergency department" at that time. 42 U.S.C. 1395dd(c)(1)(A)(iii). Congress's decision to condition transfers on whether a physician is physically present in the emergency department could indicate that "it meant to be speaking in subsection (c) about decisions to be made in the emergency room." See *James* v. *Sunrise Hosp.*, 86 F.3d 885, 889 (9th Cir. 1996). But see *Lopez-Soto* v. *Hawayek*, 175 F.3d 170, 176 (1st Cir. 1999) (rejecting that reading and arguing that "the provision addresses only a discrete subset of transfer circumstances," whereas the more generally applicable provision does not impose "any limitation on where certification decisions must be made").

In other respects, the stabilization requirement can be read as one that is limited in duration. For example, it is keyed to the identification of an "emergency medical condition," which is defined as a condition manifesting

itself by "acute symptoms" requiring "immediate medical attention." 42 U.S.C. 1395dd(e)(1). Those words connote a sense of imminence and urgency that is in some tension with an ongoing stabilization obligation of indefinite duration. The Act also includes protections for women in labor and defines "to stabilize" in that context as "to deliver (including the placenta)." 42 U.S.C. 1395dd(e)(3). This could suggest that EMTALA was intended to apply to inpatients, because Congress intended to cover pregnant women until "delivery," which could occur after admission to the maternity ward. Cf. *Lopez-Soto*, 175 F.3d at 176-177. But EMTALA's inclusion of pregnant women in labor imposes an obligation on the hospital that is inherently limited in duration; it does not suggest that Congress necessarily envisioned that the Act would govern the hospital's actions on an open-ended basis.

b. As a general matter, EMTALA's legislative history makes clear that Congress was primarily focused on the problem of hospitals dumping indigent and uninsured individuals from hospital emergency rooms. See, *e.g.*, *1985 House Report*, Pt. 1, at 27 ("The Committee is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance."); *1985 House Report*, Pt. 3, at 6 ("The Judiciary Committee shares the concern of the Ways and Means Committee that appropriate emergency room care be provided."); 131 Cong. Rec. 28,568 (1985) (Sen. Durenberger); *id.* at 28,569 (Sen. Kennedy); *ibid.* (Sen. Heinz).

In discussing the EMTALA obligations more specifically, including the stabilization requirement, the legislative history at times suggests a focus on treatment

provided within the emergency department. For example, the report of the House Ways and Means Committee described the stabilization obligation as requiring "hospital emergency departments" to "provide appropriate treatment to stabilize patients who have emergency medical conditions or to provide treatment for patients in active labor, and provide for appropriate transfers." *1985 House Report*, Pt. 1, at 4; see 131 Cong. Rec. 29,829 (1985) (Sen. Stark). During Senate floor debates, at least one Senator's comments suggested that the obligations imposed by EMTALA were intended to have a temporal limit. See *id.* at 28,569 (Sen. Dole) ("Under the provision[s] of this amendment, a hospital is charged *only* with the responsibility of providing an adequate *first response* to a medical crisis.") (emphases added); see also *ibid.* (Sen. Dole) (describing patient dumping as a practice "whereby a hospital, for purely financial reasons, refuses to *initially* treat or stabilize an individual with a true medical emergency") (emphasis added). But while Congress's primary focus was on patient dumping from hospital emergency rooms, the legislative history also suggests a more inclusive belief that "all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress." *Id.* at 28,568 (Sen. Durenberger).

c. In sum, a review of the statutory text, structure, and purpose of EMTALA reveals that Congress did not speak "directly * * * to the precise question at issue." *Chevron*, 467 U.S. at 842. The court of appeals therefore erred when it concluded that EMTALA's coverage unambiguously continues after an individual has been admitted as a hospital inpatient. See Pet. App. 16a-19a. Nor does the legislative history suggest that Congress

clearly intended that EMTALA's coverage would continue after admission as an inpatient.

2. Congress has expressly authorized the Secretary of HHS to promulgate rules and regulations interpreting and implementing EMTALA, see 42 U.S.C. 1302(a); 1395hh(a)(1), and to administer the civil monetary fine provisions of EMTALA, see 42 U.S.C. 1395dd(d)(1)(A) and (B) (incorporating 42 U.S.C. 1320a-7a). Accordingly, as the court of appeals recognized (Pet. App. 18a-19a), the Secretary's regulations, adopted after notice and comment, are entitled to *Chevron* deference.

In 2003, HHS promulgated a final rule clarifying that a hospital's obligations under EMTALA are satisfied once it "admits [an] individual as an inpatient in good faith in order to stabilize the emergency medical condition." 42 C.F.R. 489.24(d)(2); see 42 C.F.R. 489.24(a)(ii); see also 73 Fed. Reg. 48,659 (2008) (clarifying "that if an individual presents to the admitting hospital that has a dedicated emergency department, is provided an appropriate medical screening examination and is found to have an emergency medical condition, and is admitted as an inpatient in good faith for stabilizing treatment of an emergency medical condition, then the admitting hospital has met its EMTALA obligation to that individual, even if the individual remains unstable").

For all the reasons explained above, that interpretation is a reasonable one. Although it is not the only permissible reading, the HHS regulation is consistent with the text, structure, purpose, and history of EMTALA, and the court of appeals should have given it "controlling weight." *Chevron*, 467 U.S. at 844.

B. Further Review Is Not Warranted At This Time

1. Before the HHS regulation was promulgated, three courts of appeals, including the Sixth Circuit in dicta, had addressed the question presented. No other court of appeals has examined this question in light of the current regulation.[5] The circuit split is relatively shallow and further percolation is warranted.

In *Thorton*, 895 F.2d at 1135, the Sixth Circuit reviewed EMTALA's text and legislative history and stated that "[e]mergency care must be given until the patient's emergency medical condition is stabilized." The court found it significant that Subsection (a) refers to the "emergency department" on several occasions, whereas Subsection (b) refers to the "hospital." *Id.* at 1134. Looking to the legislative history, the court explained that Congress sought to ensure that emergency care is provided and, "[a]lthough emergency care often occurs, and almost invariably begins, in an emergency room, emergency care does not always stop when a patient is wheeled from the emergency room into the main hospital." *Id.* at 1135. Because the plaintiff's condition had been stabilized at the time of her discharge, however, the court affirmed the dismissal of the case. The Sixth Circuit's discussion of EMTALA's coverage in *Thorton* therefore appears to have been dictum.

Several years later, in *Bryan* v. *Rectors and Visitors of the University of Virginia*, 95 F.3d 349 (1996), the Fourth Circuit held, contrary to the Sixth Circuit's view in *Thorton*, that the EMTALA stabilization requirement applies only "in the immediate aftermath of the act of

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[5] In *Torretti* v. *Main Line Hospital, Inc.*, 580 F.3d 168, 175-176 (2009), the Third Circuit examined and deferred to the HHS regulation with respect to outpatients.

admitting" and while the hospital "consider[s] whether it [will] undertake longer-term full treatment or instead transfer the patient to a hospital" that will do so. *Id.* at 352. The court viewed EMTALA as a "limited 'anti-dumping' statute, not a federal malpractice statute," that has the "sole purpose" of "deal[ing] with the problem of patients being turned away from emergency rooms for non-medical reasons." *Id.* at 351. Once the hospital accepts the patient, the court reasoned, the patient's care becomes the legal responsibility of the hospital and is governed by state tort law. *Id.* at 351-352. The court also found support for its interpretation in the statutory phrase "to stabilize" which, the court explained, is defined "entirely in connection with a possible transfer and without any reference to the patient's long-term care within the system." *Id.* at 352.

In 2002, shortly before the HHS regulation was promulgated, the Ninth Circuit held that "the stabilization requirement normally ends when a patient is admitted for inpatient care." *Bryant* v. *Adventist Health Sys./W.*, 289 F.3d 1162, 1167. The court acknowledged that the term "'stabilize' appears to reach a patient's care after the patient is admitted to the hospital for treatment," but it explained that "the term is defined only in connection with the transfer of an emergency room patient." *Ibid.* While recognizing the concerns raised by the Sixth Circuit in *Thorton*, the court ultimately agreed with the Fourth Circuit, holding that "EMTALA's stabilization requirement ends when an individual is admitted for inpatient care," unless "a patient demonstrates in a particular case that inpatient admission was a ruse to avoid EMTALA's requirements." *Id.* at 1168-1169; see also *Morgan* v. *North Miss. Med. Ctr., Inc.*, 225 Fed. Appx. 828 (11th Cir. 2007) (affirming, without opinion, district

court decision adopting *Bryant* rule), cert. denied, 552 U.S. 1098 (2008).[6]

The Sixth Circuit in this case adopted the dictum from its prior decision in *Thorton* as a holding, despite HHS's promulgation of its regulation in the interim. And it did so without citing the conflicting decisions in the Fourth and Ninth Circuits.[7]

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[6] As respondent argues (Br. in Opp. 7-8), the underlying facts in both *Bryan* and *Bryant* are distinct in at least one respect: the patients did not allege an inappropriate "transfer," as that term is defined in EMTALA. In *Bryan*, there was no transfer at all; the individual died while a patient in the admitting hospital. See 95 F.3d at 350; 42 U.S.C. 1395dd(e)(4) (defining "transfer" as excluding the movement of a person declared dead). And in *Bryant* there was no allegation that the transfer itself violated EMTALA. See 289 F.3d at 1164. As noted above, both courts relied, in part, on the fact that the stabilization requirement is keyed to a "transfer," and some courts have held that EMTALA's stabilization requirement is not triggered unless there has been such a transfer. See p.17 n.7, *infra*. Neither court, however, rested on that rationale as the basis for its decision.

[7] The First and Eleventh Circuits have also addressed the scope of EMTALA's stabilization requirement, but have not squarely decided the question presented here. Both courts have relied on the definition of "to stabilize" to hold that "a hospital cannot violate the duty to stabilize unless it transfers [the] patient." *Alvarez-Torres* v. *Ryder Mem'l Hosp., Inc.*, 582 F.3d 47, 51-53 (1st Cir. 2009) (explaining that the definition of "to stabilize" shows that "the duty to stabilize attaches when a hospital transfers a patient" and does not "create a duty of care for medical services provided while a patient remains in the hospital"); *Harry* v. *Marchant*, 291 F.3d 767, 771 (11th Cir. 2002) (EMTALA "does not set forth guidelines for the care and treatment of patients who are not transferred."); cf. *id.* at 775 (Barkett, J., concurring) ("agree[ing]" with the majority that because the plaintiff "was admitted as a patient, redress" is not available under EMTALA). The First Circuit has also held that the stabilization requirement attaches regardless of where in the hospital a patient first presents with an emergency medical condition. See *Lopez-Soto*, 175 F.3d at 172-177; *id.* at 177 n.4 (declining to

2. The relatively shallow circuit split does not warrant the Court's review at this time. HHS has informed this Office that it is committed to initiating a rulemaking process that will reconsider the policy articulated in its 2003 regulation. Specifically, HHS is committed to promulgating a request for comment in 2010 and a notice of proposed rulemaking in 2011. In these circumstances, the Court should not grant review to address the same question.

Interpreting EMTALA to extend beyond the emergency department, as the court of appeals did, raises other questions not answered by Congress and best suited for expert agency consideration. For example, when HHS proposed in 2002 to extend EMTALA's coverage to some inpatients, it did not propose to extend it to *all* inpatients. See 67 Fed. Reg. at 31,475-31,476; see Br. in Opp. 10 (arguing that the statutory text does not "readily lend itself" to the conclusion that the Act has "no application whatsoever once a patient is admitted to the hospital"). Thus, if EMTALA's coverage were to extend in some circumstances beyond the point of admission as an inpatient, a further question would arise: would EMTALA's coverage be of open-ended duration, or would there be some temporal limitation apart from the point of admission? Cf. 42 U.S.C. 1395dd(e)(3) and (4) (defining "to stabilize" as requiring the hospital to

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address the temporal limitations of such a requirement and pointing to the Fourth Circuit's decision in *Bryan* as an example of a way in which courts have "cabin[ed] such undue expansion of EMTALA into the malpractice realm"); cf. *Smith* v. *Richmond Mem'l Hosp.*, 416 S.E.2d 689, 691-694 (Va. 1992) (holding that the transfer provisions of Subsection (c) apply regardless of whether the individual initially presented with an emergency medical condition, as long as he had an unstabilized emergency medical condition at the time of transfer).

provide treatment such that "no material deterioration of the condition is likely *to result from or occur during* the transfer," *i.e.*, "*the movement* * * * of an individual outside a hospital's facilities") (emphases added). These are questions that would benefit greatly from HHS's expertise and experience, and from public comment during a rulemaking process, as HHS reconsiders how best to effectuate Congress's intent. Accordingly, the prudent course would be to deny review at this time.

3. Forgoing review is appropriate for additional reasons as well. First, the court of appeals' decision is interlocutory. The court reversed the district court's grant of summary judgment and remanded for further proceedings. Pet. App. 28a. If respondent prevails on remand, petitioner will be able to raise its current contentions—together with any other issues concerning the application of EMTALA that may arise as a result of the additional proceedings on remand—in a single petition for a writ of certiorari. See *Major League Baseball Players Ass'n* v. *Garvey*, 532 U.S. 504, 508 n.1 (2001) (per curiam).

Second, this is an atypical case. The hospital's alleged EMTALA violation occurred before the regulation at issue was promulgated. The court of appeals declined to defer to the agency's regulation on that independent basis. See Pet. App. 19a-20a. And while that ruling was wrong, it does not independently warrant this Court's review. See pp. 21-22, *infra*. In addition, the plaintiff in this case is a non-patient, third party. See 42 U.S.C. 1395dd(d)(2)(A) (providing private right of action for "[a]ny individual who suffers personal harm as a direct result" of the hospital's EMTALA violation); *1985 House Report*, Pt. 3, at 6 (explaining, prior to the 1986 enactment of EMTALA, that the proposed private right of

action is being amended to make clear that it authorizes only actions "brought by the individual patient who suffers harm as a direct result of [a] hospital's failure to appropriately screen, stabilize, or properly transfer that patient"). The court of appeals nevertheless concluded that respondent had standing to sue under EMTALA. Petitioner does not ask the Court to review that determination. But that is a threshold issue about respondent's ability to invoke EMTALA at all, and it could color consideration of the principal question on which petitioner does seek review.

Finally, the practical consequences of denying review while the agency engages in further rulemaking are likely to be minimal. In the almost 25 years since EMTALA was enacted, only three courts of appeals have directly addressed whether EMTALA's coverage continues after a hospital admits an individual in good faith as an inpatient, and only one court of appeals—the Sixth Circuit in this case—has addressed HHS's regulation interpreting EMTALA's stabilization requirement as applied to inpatients. Whether there is EMTALA liability or not, hospitals have an incentive to furnish appropriate treatment to individuals who have been admitted as inpatients. State tort law could ordinarily be expected to provide a remedy to an inpatient for negligent care. See, *e.g.*, *Bryant*, 289 F.3d at 1169; *Bryan*, 95 F.3d at 351-352; 68 Fed. Reg. at 53,244-53,245; 73 Fed. Reg. at 48,656. And hospitals with emergency departments participating as providers under Medicare—the category of hospitals to which EMTALA applies—are independently required by federal law to have a process in place that identifies patients who are likely to suffer adverse health consequences upon discharge if there is no adequate planning, and to provide a dis-

charge plan where appropriate. See 42 C.F.R. 482.43, 489.24(d)(2)(iii); 68 Fed. Reg. at 53,244-53,245. For these reasons, and because *Thorton*'s rather strong dictum, on which the Sixth Circuit relied in this case, has been extant for the last two decades, petitioner's suggestion (Pet. 9-10) that the decision below will have "significant ramifications" for hospitals in the Sixth Circuit appears to be overstated.

C. The Retroactivity Issue Does Not Independently Warrant This Court's Review

The court of appeals also held, in the alternative, that it would not defer to HHS's 2003 regulation because it was promulgated after the conduct at issue in this case and is impermissibly retroactive. Pet. App. 19a-20a. As petitioner explains (Pet. 21-22), the court of appeals' ruling on the retroactivity issue is in error and is contrary to this Court's decision in *Smiley* v. *Citibank (S.D.), N.A.*, 517 U.S. 735, 744 n.3 (1996). In *Smiley*, the Court explained that, "[w]here * * * 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." *Ibid*. Respondent does not disagree, suggesting only that the 2002 *proposed* rule, which would have applied EMTALA to some inpatients, should be treated as a "prior agency interpretation." Br. in Opp. 12. An agency proposal soliciting comments does not constitute "clear" agency guidance.

In any event, the court of appeals' error should have little impact beyond this case. HHS's regulation was effective November 10, 2003, and there is a two-year statute of limitations on EMTALA claims. See 42 U.S.C. 1395dd(d)(2)(C). Presumably, any timely filed

EMTALA case currently pending in the Sixth Circuit involves conduct that postdated HHS's promulgation of its regulation. Further review of this issue thus is not independently warranted.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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