



EMTALA: Access to Emergency Medical Care

Edward C. Liu
Legislative Attorney

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Summary

The Emergency Medical Treatment and Active Labor Act (EMTALA) ensures universal access to emergency medical care at all Medicare participating hospitals with emergency departments. Under EMTALA, any person who seeks emergency medical care at a covered facility, regardless of ability to pay, immigration status, or any other characteristic, is guaranteed an appropriate screening exam and stabilization treatment before transfer or discharge. Failure to abide by these requirements can subject hospitals or physicians to civil monetary sanctions or exclusion from Medicare. Hospitals may also be subject to civil liability under the statute for personal injuries resulting from the violation.

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In 1986, Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA)¹ to address the problem of “patient dumping” in hospital emergency departments. Patient dumping refers to instances in which a hospital turns away indigent or uninsured persons seeking treatment so that the hospital will not have to absorb the cost of treating them. Although attempts to facilitate indigent access to emergency health care already existed in state and federal law, legal frameworks prior to EMTALA were plagued with poor enforcement mechanisms and vague standards of conduct.² Amid graphic media reports of hospitals sending away critically ill patients without proper stabilization treatment and delivery rooms unwilling to accept indigent or uninsured women in labor, Congress passed EMTALA as part of the Consolidated Omnibus Budget Reconciliation Act of 1985.³

EMTALA’s statutory scheme has traditionally been deconstructed into two principal categories: (1) provisions that ensure an appropriate medical screening, and (2) provisions that require stabilization before transfer or discharge.⁴ EMTALA only requires stabilization of whatever emergency conditions a hospital detects, and does not provide a right to indefinite care for anyone who comes to an emergency room. EMTALA’s requirements may be suspended by the Secretary of Health and Human Services during national emergencies, such as the recent landfall of Hurricane Ike in Texas.⁵ Hospitals and physicians that fail to comply with these requirements may be fined \$50,000 and/or excluded from participation in Medicare, and hospitals may also be held civilly liable to persons who suffer personal injury.⁶

The Screening Requirement

Only hospitals that (1) participate in Medicare and (2) maintain an emergency department are required to screen patients under EMTALA.⁷ Hospitals that do not have a “dedicated emergency department” are not subject to the screening requirement of EMTALA.⁸ Similarly, emergency

¹ P.L. 99-272, 100 Stat. 164 (1986) codified at 42 U.S.C. § 1395dd et seq. (2007).

² Tiana Mayere Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement*, 13 ANNALS OF HEALTH L. 145, 146-147 (2004) (discussing the Hill-Burton Act and state statutory and common law). See also H.Rept. 99-241, pt. 3, at 5 (1985) (discussing state remedies).

³ Lee, *supra* note 2 at 147-148, 151.

⁴ 42 U.S.C. § 1395dd(a), (b).

⁵ 42 U.S.C. § 1320b-5(b)(3). See Waiver or Modification of Requirements Under Section 1135 of the Social Security Act, Michael O. Leavitt, Secretary of the Department of Health and Human Services, (Sept. 11, 2008), available at <http://www.hhs.gov/disasters/emergency/naturaldisasters/hurricanes/ike/1135waiver.html>. Sanctions are only lifted for inappropriate transfers or redirections. 42 C.F.R. § 489.24(a)(2).

⁶ 42 U.S.C. § 1395dd(d). Civil fines are limited to \$25,000 for hospitals with fewer than 100 beds. *Id.* at (d)(1)(A). Private suits may not be brought against physicians individually. See e.g. Heimlicher v. Steele, 442 F. Supp. 2d 685 (N.D. Iowa 2006) (citing King v. Ahrens, 16 F.3d 265 (8th Cir. 1994), Delaney v. Cade, 986 F.2d 387 (10th Cir. 1993), and Baber v. Hosp. Corp. of Am., 977 F.2d 872 (4th Cir. 1992)). Medicare termination appears to be infrequently invoked as a sanction. Laura D. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding*, 14 J. L. & Policy 695, 701 n. 29 (2006) (stating that between 1986 and 2001 only four hospitals had their Medicare agreements terminated).

⁷ 42 U.S.C. § 1395dd(a), (d)(1)(A), and (e)(2). Although the screening and stabilization requirements are phrased such that they apply to “hospitals” generally, enforcement of EMTALA is only authorized against hospitals that have entered into a Medicare provider agreement. *Id.*

⁸ 42 U.S.C. § 1395dd(a). A dedicated emergency department is defined as any facility that is licensed or held out to the public as such, or that provides urgent care to one third of its outpatients during the preceding calendar year. 42 C.F.R. § 489.24(b).

care providers that are unaffiliated with a hospital need not comply with EMTALA, even where those providers are the only medical care facilities reasonably accessible.⁹ For example, in *Rodriguez v. American Int'l Ins. Co. of Puerto Rico*, the First Circuit declined to extend EMTALA protections to a 24-hour emergency room clinic in rural Puerto Rico because the clinic was not associated with a hospital. The Federal District Court for the District of Puerto Rico had initially held that, because the clinic was the primary provider of 24-hour emergency health care in its area, applying EMTALA to the clinic best furthered the statutory goal of universal access to emergency medical care.¹⁰ However, the First Circuit reversed, holding that any considerations of the goals of Congress were inappropriate where the text of the statute was clear.¹¹

When Is the Screening Requirement Triggered?

The screening requirement is triggered when an individual “comes to the emergency department” of a hospital and requests to be treated.¹² Under HHS regulations, an individual may be deemed to have come to the emergency department in certain circumstances, even though the individual is not physically present in the emergency department or elsewhere on the hospital campus.¹³ For example, a patient en-route to a hospital in an ambulance or air transport owned by that hospital has “come to the emergency department” of that hospital and may not be refused a screening exam under EMTALA. These regulations also state that incoming patients in ambulances that are not owned by the receiving hospital have not “come to the emergency department.” The regulations further allow the hospital to redirect the non-owned ambulance if the hospital is in “diversionary status.”¹⁴ However, at least one Federal Court of Appeal has rejected this interpretation of the statute and has held that EMTALA could be triggered by an incoming ambulance that was not owned by the receiving hospital.¹⁵

In *Morales v. Sociedad Espanola*, the hospital had argued that HHS regulations clearly state that patients in non-owned ambulances have not yet “come to the emergency department,” and therefore EMTALA did not apply. However, according to the First Circuit’s reading of the pertinent regulations, a hospital is only permitted to take the *affirmative action* of refusing a non-owned ambulances if it is actually in “diversionary status.” The court argued that this reading

⁹ *Rodriguez v. American Int'l Ins. Co. of Puerto Rico*, 402 F.3d 45 (1st Cir. 2005).

¹⁰ *Rodriguez v. American Int'l Ins. Co. of Puerto Rico*, 263 F. Supp. 2d 297 (D. Puerto Rico 2003) (arguing that the nature of the services provided should be determinative, not whether a facility is defined as a hospital).

¹¹ *Rodriguez v. American Int'l*, 402 F.3d at 49 (noting that Congress was free in drafting the statute to extend EMTALA to rural clinics unaffiliated with hospitals, but had not done so). EMTALA does apply to facilities designated as “critical access hospitals,” which provide 24-hour emergency services and acute inpatient care to rural areas. 42 U.S.C. § 1395dd(e)(5).

¹² 42 U.S.C. § 1395dd(a). Requests for treatment may be made on the individual’s behalf and a request may be implied if a prudent layperson observer would believe that the individual needs emergency medical care. 42 C.F.R. § 489.24(b) (2006).

¹³ 42 C.F.R. § 489.24(b). The campus includes areas within 250 yards of a hospital’s main buildings. 42 C.F.R. § 413.65(b).

¹⁴ 42 C.F.R. § 489.24(b). A hospital is in diversionary status if it lacks the staff or facilities to treat additional emergency patients. *See also* *Arrington v. Wong*, 237 F.3d 1066, 1072 (9th Cir. 2001) (reasoning through negative implication that a hospital may not divert an ambulance if it is *not* in diversionary status).

¹⁵ *Morales v. Sociedad Española de Auxilio Mutuo y Beneficencia*, 524 F.3d 54 (1st Cir. 2008) (cert. denied *Sociedad Espanola v. Morales*, 77 U.S.LW. 3396 (2009)).

gives effect to every word in the regulation and also best effectuates EMTALA's statutory goal of preventing patient dumping.¹⁶

Regardless of whether the ambulance is owned by a hospital or not, should an ambulance ignore a redirection request, EMTALA is triggered if the patient physically arrives on the hospital's property.¹⁷

What Constitutes an "Appropriate Screening Exam"?

Although hospitals with dedicated emergency departments are required to perform screening exams, it is not necessarily a violation of EMTALA if a screening exam falls short of either a local or national medical malpractice standard.¹⁸ The language of the statute requires only "an appropriate medical screening exam."¹⁹ The majority of the federal circuits have held that, because the chief evil sought to be prevented was the lack of access for uninsured patients, an "appropriate" exam is one comparable to what a paying patient would receive under similar circumstances.²⁰ However, the Sixth Circuit has construed the statute more narrowly, holding that there is no violation of EMTALA without the additional allegation of an "improper motive" that led to a substandard screening exam.²¹

The Stabilization Requirement

Like the screening requirement, the stabilization requirement applies to all Medicare participating hospitals with a dedicated emergency department. However, in some cases the stabilization requirement may also apply to a Medicare participating hospital even if it does not have an emergency department. For example, if treatment of an individual's medical condition requires a particular hospital's unique equipment or expertise, federal regulations compel that hospital to accept a transfer of that patient from any nearby U.S. hospital.²²

The stabilization requirement is triggered when a hospital discovers that an individual has an emergency medical condition. Actual knowledge of an emergency medical condition is

¹⁶ *Id.* at 59-62.

¹⁷ 42 C.F.R. § 489.24(b). Prior to the promulgation of these regulations, the Seventh Circuit had held that contacting a hospital via telemetry alone does not invoke EMTALA. *Johnson v. Univ. of Chicago Hosps.*, 982 F.2d 230 (7th Cir. 1993). These regulations are consonant with that holding.

¹⁸ *Phillips v. Hillcrest Med. Ctr.*, 244 F.3d 790 (10th Cir. 2001) (noting that EMTALA was not enacted to create a federal medical malpractice standard).

¹⁹ 42 U.S.C. § 1395dd(a). Screening exams may vary based upon a hospital's capabilities and the nature of an individual's request. 42 C.F.R. § 489.24(a)(i) and (c).

²⁰ *Correa v. Hosp. San Francisco*, 69 F.3d 1184 (1st Cir. 1995), *Baber v. Hosp. Corp. of America*, 977 F.2d 872 (4th Cir. 1992), *Marshall v. E. Carroll Parish Hosp. Serv.*, 134 F.3d 319 (5th Cir. 1998), *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996), *Jackson v. E. Bay Hosp.*, 246 F.3d 1248 (9th Cir. 2001), *Holcomb v. Monahan*, 30 F.3d 116 (11th Cir. 1994), *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037 (D. C. Cir. 1991).

²¹ *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 272 (6th Cir. 1990). Gender, race, nationality, financial insolvency, bias against a particular medical condition, and personal animosity were examples of improper motivation offered by the *Cleland* court.

²² 42 C.F.R. § 489.24(f). Examples of specialized equipment or expertise include burn units, shock-trauma units, neonatal intensive care units, or regional referral centers.

required.²³ Therefore, if a hospital fails to accurately detect an individual's emergency condition and discharges that individual without stabilizing the medical condition, the hospital may not have violated EMTALA's stabilization provisions. However, the hospital may still be civilly liable to the individual based upon state medical malpractice claims if the failure to detect an emergency condition was due to negligence during the screening exam.²⁴

Interpretations of the Stabilization Requirement

Except where medically necessary, hospitals must ensure that an individual is stabilized before discharge or transfer. Federal regulations define an individual as stabilized as either (1) when there is a reasonable assurance that no material deterioration would result from that individual's transfer or discharge from the hospital or, (2) in the case of women in labor, after delivery of the child and placenta.²⁵ Unlike the screening requirement, the language of the stabilization requirement does not qualify the care to be given as "appropriate."²⁶ Based on this textual distinction, the U.S. Supreme Court has held that no "improper motive" need be alleged to show a violation of EMTALA's stabilization provisions.²⁷

Stabilization and Inpatient Status

When an emergency medical condition is detected, a hospital may decide to admit the individual as an inpatient for further treatment. Whether the stabilization requirement continues to apply to patients after they have been admitted is a disputed issue. Because the statute only defines "stabilization" in the context of transfers, the Fourth, Ninth and Eleventh Circuits have held that a hospital has no stabilization duties that are enforceable under EMTALA once an individual has been admitted.²⁸ However, the Sixth Circuit had held otherwise in *Thornton v. Southwest Detroit Hospital*.²⁹ In that case, a stroke victim alleged she was discharged from the ICU without being stabilized, in violation of EMTALA, after 21 days of inpatient care. The Sixth Circuit held that EMTALA still required stabilization before discharge, despite her inpatient status.³⁰

Despite this split in circuit authority, the Supreme Court declined to rule on this issue in *Roberts v. Galen*, although it had an opportunity to do so.³¹ During oral arguments for that case, the office of the Solicitor General, arguing as amicus curiae, informed the Court that the Department of Health and Human Services intended to begin rule-making procedures to provide guidance on

²³ 42 U.S.C. § 1395dd(b)(1) and 42 C.F.R. § 489.24(a)(1)(ii).

²⁴ *Bryant v. Adventist*, *infra* note 28 at 1166.

²⁵ 42 C.F.R. § 489.24(b).

²⁶ 42 U.S.C. § 1395dd(b)(1)(A).

²⁷ *Roberts v. Galen*, 525 U.S. 249, 252-3 (1999). The Court expressly declined to decide whether the "improper motive" requirement was required with respect to EMTALA's screening provisions. *Id.* at 253 n.1. *See also supra* notes 20-21 and accompanying text.

²⁸ *Bryan v. Rectors & Visitors of the Univ. of Virginia*, 95 F.3d 349, 352 (4th Cir. 1996), *Bryant v. Adventist Health Sys.*, 289 F.3d 1162, 1168-1169 (9th Cir. 2002), *Harry v. Marchant*, 291 F.3d 767 (11th Cir. 2002).

²⁹ *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1135 (6th Cir. 1990).

³⁰ The Sixth Circuit argued in dictum that if EMTALA did not apply to inpatients, hospitals could avoid EMTALA liability by admitting, and immediately discharging, a patient. *Id.* at 1135.

³¹ *Roberts v. Galen*, 525 U.S. at 253-4 n.2.

this question.³² In 2002, the Centers for Medicare and Medicaid Services (CMS) issued a notice of a proposed rule extending EMTALA protections to inpatients.³³ Many comments noted the *Bryant v. Adventist*³⁴ decision holding otherwise,³⁵ and in 2003, CMS reversed its position, stating that if, after performing a screening exam, a hospital admits an individual for treatment of an emergency medical condition, then the hospital has satisfied its duties under EMTALA.³⁶

In August of 2008, HHS further clarified its position by stating that EMTALA does not apply to an individual who has been screened and admitted at one hospital but requires a transfer to a second hospital that has specialized facilities.³⁷ As described above, where a patient has not yet been admitted, nearby specialized hospitals are generally required to accept transfers of the patient from the original hospital.³⁸ However, the new regulations clearly state that once the individual has been admitted as an inpatient in one hospital, other specialized hospitals do not continue to have a duty to accept a transfer under EMTALA.³⁹

Despite the promulgation of these rules, the Sixth Circuit has continued to hold that the mere admission of an individual, without further treatment, does not satisfy EMTALA.⁴⁰ In *Moses v. Providence Hospital*, the court found CMS's regulations to be contrary to the plain language of the statute. Therefore, the regulations were not entitled to deference.⁴¹ In particular, the court relied upon language in EMTALA which prohibits hospitals from releasing patients with emergency medical conditions without providing treatment to stabilize the condition. According to the court, the CMS regulations would permit hospitals to avoid EMTALA liability by simply admitting and immediately discharging patients, without providing any treatment. The court found such a construction to be unreasonable and contrary to the language of the statute.⁴² However, one could argue that by admitting an individual, a hospital is subject to potential medical malpractice liability under state law. Therefore, while the CMS regulations may provide a means of avoiding EMTALA liability by admitting and discharging individuals, compliance with CMS's interpretation would not necessarily immunize hospitals from applicable state law claims. Insofar as the intent of EMTALA was to prevent situations in which hospitals could "dump" patients without incurring any liability, providing an incentive for hospitals to admit emergency room patients may be consistent with that goal. Once a patient is admitted, it could be argued that EMTALA liability is unnecessary as state medical malpractice law could provide an incentive for the hospital to ensure the provision of necessary stabilizing treatment.

³² Transcript of Oral Argument at 17-20, *Roberts v. Galen*, *supra* note 27. The Solicitor General also argued that the question of inpatient status had not been properly raised in the courts below.

³³ Notice of Proposed Rule, 67 Fed. Reg. 31,403, 31,475-6 (May 9, 2002).

³⁴ *Bryant v. Adventist Health Sys.*, 289 F.3d at 1168-1169.

³⁵ Notice of Final Rule, 68 Fed. Reg. 53,221, 53,243-5 (Sept. 9, 2003). Comments also expressed concerns that EMTALA would usurp existing protections for inpatients.

³⁶ 42 C.F.R. § 489.24(d)(2). Inpatients are still protected by other Medicare conditions of participation. Persons admitted for elective treatment or diagnosis are still covered under EMTALA. *Id.*

³⁷ 73 Fed. Reg. 48,656-61.

³⁸ *See supra* note 22 and accompanying text.

³⁹ 42 C.F.R. 489.24(f)(2).

⁴⁰ *Moses v. Providence Hosp. & Med. Ctrs., Inc.*, 561 F.3d 573, 582 (6th Cir. 2009), *cert. denied*, *Providence Hosp. v. Moses*, 2010 U.S. LEXIS 5301 (June 28, 2010).

⁴¹ *Id.* at 583.

⁴² *Id.*

The defendant hospital in *Moses* petitioned the Supreme Court for review, but the Court declined to hear the case.⁴³ This would appear to indicate that a split of circuit authority remains with respect to EMTALA's application to admitted persons. However, it should be noted that the Sixth Circuit's decision in *Moses* also relied on the fact that the underlying hospital visit occurred in 2002 before CMS had promulgated its regulations on inpatient status. Additionally, the Court noted that CMS's regulations did not expressly indicate an intent to apply retroactively. Furthermore, presuming retroactive application would have adversely affected the patient's expectations at the time care was sought, based on the Sixth Circuit's earlier decision in *Thornton*. Because of these considerations, the Sixth Circuit held, in the alternative, that even if CMS's interpretation of the statute was entitled to deference in prospective cases, it should not be given retroactive effect to the specific facts before it.⁴⁴ However, despite these alternative grounds, at least one federal district court in the Sixth Circuit has cited *Moses* for the proposition that "EMTALA imposes an obligation on a hospital beyond simply admitting a patient with an emergency medical condition to an inpatient care unit."⁴⁵

Stabilization of Known Emergency Conditions

The stabilization requirement may preempt certain state laws authorizing physicians to decline administering treatment where deemed inappropriate based upon their medical judgment. In *In re Baby K*, a hospital sought a declaratory judgment that they were permitted to refuse to treat an anencephalic infant in respiratory distress.⁴⁶ The hospital argued that the prevailing standard of care for anencephalic infants was to provide warmth and nutrition without mechanical respiration, and that Virginia state law authorized physicians to refuse to provide care they believed would be inappropriate.⁴⁷ The Fourth Circuit disagreed and held that the requirement of stabilization prior to transfer or discharge was compulsory once an emergency medical condition had been identified by hospital personnel, even where the treating physician believed stabilization treatment would have been futile. Furthermore, the court held that EMTALA preempted the Virginia statute authorizing the physician to refuse to provide treatment he reasonably believed to be inappropriate.⁴⁸

Requirements for Transfers After Stabilization

All transfers must be conducted with qualified personnel and equipment. An individual may not be transferred unless the receiving hospital consents to receive the individual. The receiving hospital must have the capacity and expertise to treat the transferred individual, and all medical records must be sent to the receiving hospital. It is the transferring hospital's obligation to ensure that the transfer has been performed as described above and the transferring hospital remains

⁴³ *Providence Hosp. v. Moses*, 2010 U.S. LEXIS 5301 (June 28, 2010) (denying *certiorari*).

⁴⁴ *Moses v. Providence Hosp. & Med. Ctrs., Inc.*, 561 F.3d at 583-584.

⁴⁵ *Lilly v. Harper Hosp. Assocs.*, 2009 U.S. Dist. LEXIS 121405 (E.D. Mich. Dec. 3, 2009) (finding that defendant hospital did not violate EMTALA where patient was admitted for treatment and subsequently died at the hospital).

⁴⁶ *In re Baby K*, 16 F.3d 590 (4th Cir. 1994).

⁴⁷ *Id.* at 596-7.

⁴⁸ *Id.* EMTALA explicitly preempts any state laws that directly conflict with EMTALA's provisions. 42 U.S.C. § 1395dd(f). The Fourth Circuit later clarified *Baby K's* holding in *Bryan v. Univ. of Virginia*, ruling that EMTALA only mandates treating a patient's emergency medical condition, not the patient's general medical condition. *Bryan v. Univ. of Virginia*, 95 F.3d at 352. Therefore, had the hospital admitted *Baby K* after stabilizing her emergency respiratory distress, it would not have been required to then treat her underlying anencephaly beyond warmth and nutrition. *Id.*

liable under EMTALA until an appropriate transfer is completed.⁴⁹ It is not a violation of EMTALA to transfer an individual who has not been stabilized when it is medically necessary to do so. In such situations, a qualified medical person, as defined by the hospital's own rules and regulations, must certify that the benefits of transfer to a different facility outweigh the risks involved.⁵⁰

Hospital Liability to Third Parties

EMTALA provides a civil remedy to “any individual who suffers personal harm as a direct result of a participating hospital’s violation.” In 2009, the Sixth Circuit held that this language provided a civil remedy to third parties that were injured as a direct result of a violation of either the screening or stabilization requirements.⁵¹ In the case before the court, the hospital was alleged to have improperly discharged an emergency room patient who was psychiatrically unstable. Ten days after his discharge the patient murdered his wife. The wife’s estate subsequently brought suit against the hospital alleging that the hospital’s failure to stabilize before discharge was a direct cause of her death. The defendants argued that the patient’s wife lacked standing under EMTALA because it only permitted civil claims by persons that were personally denied treatment in violation of the statute. In support of this argument, the defendants noted that, during consideration of EMTALA, the House Judiciary Committee had issued a report stating

[The civil suit provision of EMTALA] authorizes only two types of actions for damages. The first of these could be 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 second type of action could be brought by a medical facility which received an improperly transferred emergency patient.⁵²

Because third parties were not mentioned in the legislative history, the defendants argued that this suit should not be permitted. The Sixth Circuit disagreed, noting that

where a House committee’s explanation of the meaning of a statute seems to differ from the statute’s actual wording, this Court should not rely on that committee’s statement as the exclusive explanation for the meaning of the statute.... We recognize that our interpretation of the civil enforcement provision may have consequences for hospitals that Congress may or may not have considered or intended. However, our duty is only to read the statute as it is written.⁵³

In the court’s view, the statutory text afforded a civil remedy to “*any* individual who suffers personal harm as a direct result” of the hospital’s actions, and the most logical reading of this text permits suits to be brought by harmed third parties.⁵⁴

⁴⁹ 42 C.F.R. § 489.24(e)(2).

⁵⁰ 42 C.F.R. § 489.24(e)(1)(ii)(B).

⁵¹ *Moses v. Providence Hosp. & Med. Ctrs., Inc.*, 561 F.3d at 579-582.

⁵² H.Rept. 99-241, at 6.

⁵³ *Moses*, 2009 U.S. App. LEXIS 7049, at 17-19.

⁵⁴ 42 U.S.C. § 1395dd(d)(2)(A) (emphasis added).

Author Contact Information

Edward C. Liu
Legislative Attorney
eliu@crs.loc.gov, 7-9166