

# TRAUMA CENTER ASSOCIATION OF AMERICA

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*Submitted electronically*

February 22, 2011

Donald M. Berwick, M.D., M.P.P.

Administrator

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

**Re: CMS-1350 –ANPRM; Emergency Medical Treatment and Labor Act: Applicability to Hospital and Critical Access Hospital Inpatients and Hospitals with Specialized Capabilities; (Vol. 75, No. 246); December 23, 2010.**

Dear Dr. Berwick:

On behalf of the Trauma Center Association of America (TCAA), we appreciate the opportunity to provide comments on the Advanced Notice of Proposed Rulemaking regarding a potential application of Emergency Medical Treatment and Labor Act (EMTALA) to hospital inpatients. TCAA is a non-profit Trade Association representing several hundred trauma centers and trauma systems dedicated to fostering the development of a national system of trauma care which ensures proximate access to the appropriate level of trauma care for the seriously injured.

Ensuring that complex injury victims have access to specialized trauma centers as part of a coordinated systemic response is necessary to lower the high medical cost of traumatic injury and improve patient outcomes. The availability and effective use of specialized trauma centers has a close correlation with improvements in mortality and other quality measures. Trauma centers are specialized hospitals distinguished by the *immediate* availability of *specialized* personnel, equipment and services to *treat* the most severe and critical injuries. Trauma centers have a highly trained interdisciplinary team of up to 16 subspecialist physicians, nurses and other health care professionals immediately available around the clock to that perform immediate stabilization, surgery and other necessary procedures for people with serious or life-threatening injuries to save their lives and prevent further disability or physical deterioration. Many traumatic injuries lead to lengthy and expensive recuperative and rehabilitative services. Trauma center services improve the efficiency of care by reducing the utilization of subsequent services.

More specifically, it is important to understand the evidence surrounding the cost and treatment of traumatic injury in examining the implications of extending EMATLA to the inpatient setting.

First, trauma is widespread, despite the best prevention efforts, and often deadly. There are 35 million people treated each year for traumatic injuries -- 1 person every 90 seconds and 1 person every 15 minutes requiring hospitalization. Trauma is the leading cause of death under age 44 -- more than stroke and AIDS combined.

Second, trauma is costly. Approximately \$80 billion annually is attributed to trauma medical expenses; \$326 billion is estimated for lifetime productivity losses for almost 50 million injuries that required medical treatment. The costs of maintaining a trauma center for a hospital results in millions lost each year for standby costs that are never recovered through reimbursement.



Third, ensuring that traumatic injury victims receive the appropriate level of trauma care in a short period of time saves lives. Severely injured trauma patients treated at Level I trauma centers have a 25% reduction in mortality. Conversely, nearly 1 in 4 patients is more likely to die when not initially taken to a Level I Trauma Center -- mortality increases 3.8 times if a severely injured patient is treated initially at a non-trauma hospital instead of direct transport to a Level I Trauma Center. Thus, it is essential to ensure that victims of serious traumatic injury are not admitted to non-trauma hospitals, but rather are stabilized and transferred to the appropriate level trauma center as quickly as possible.

Fourth, the trauma system nationally, and the trauma centers that serve as the hubs of trauma care, are extremely fragile. Less than 10% of hospitals have a Level I or II trauma center and only 8 states have fully developed trauma systems. One in five people are more likely to survive a traumatic injury in a state with an established trauma system than one without (there is a 20% reduction in the risk-adjusted odds of death in the state with a trauma system). Forty-five million people lack access to a trauma center within one hour following injury during which definitive treatment can make the difference between life and death. At least 23 trauma centers have closed over the past decade, including St. Vincent's in Manhattan which treated 848 patients on 9/11 and a number of other trauma centers downgraded one or two levels. The primary stressors for trauma centers and causes of closures are due to the high cost of uncompensated care, poor reimbursement and inadequate physician support due to the decreasing supply of specialist physicians who provide trauma care. Accordingly, it is imperative that additional stressors not be added to the already burdensome costs of maintaining a trauma center.

**TCAA strongly believes that CMS should continue with the current policies regarding EMTALA as established in the September 9, 2003 final rule and the August 19, 2008 IPPS final rule. Specifically, TCAA urges CMS to maintain the current interpretation that EMTALA does not apply to any inpatient.** If CMS applies EMTALA in the inpatient setting, TCAA is concerned with the implications it may have on the initial hospital receiving the patient, particularly non-trauma hospitals or Level III or IV trauma centers that have marginal resources or less than 24/7 specialist coverage. Such hospitals may be inappropriately incentivized for liability purposes to admit unstable and potentially morbid patients and undergo extensive diagnostics and delay transfer to a higher level trauma center. Further, patients may potentially develop complications that would otherwise be identified in the early phase of care by a Level I or II center who are trained in treating more seriously injured patients. It is essential that EMTALA not inadvertently jeopardize earlier and faster transfer to definitive trauma care treatment at the appropriate specialized trauma center.

In June 2006, the Institute of Medicine (IOM) released its landmark report series, *Future of Emergency Care in the United States Health System*. This report found that hospital emergency departments and trauma centers are severely overcrowded and emergency care is highly fractured. Due to higher medical liability exposure and the lack of reimbursement for uncompensated care, critical surgical specialists are often unavailable to provide emergency and trauma care. The IOM called for a complete overhaul of our nation's emergency and trauma care by creating a coordinated and regionalized system of care. As evidenced by the Mexican Hat Bus Crash mass casualty incident, regionalization of emergency care must be a high priority in all areas of the nation. Such a change in EMTALA policy in its application to inpatients would constitute a return to our historic past when preventable mortality was the rule rather than the exception and disincentives the regionalized system of emergency and trauma care called for by the IOM.

**In summary, TCAA believes that existing EMTALA rules are appropriate and sufficient to protect patients and that applying EMTALA to the inpatient setting is contrary to and will jeopardize the best interests of trauma victims in receiving appropriate transfer to definitive trauma centers on a timely basis.**

Sincerely,



Connie J. Potter, RN, MBA  
President