

a hospital's obligations to report the receipt of patients whom it has reason to believe may have been transferred inappropriately; to post signs in the emergency department describing an individual's rights to emergency treatment under section 1867 of the Act; and to maintain patient records, physician on-call lists, and emergency room logs. We are including this brief description for informational purposes but, because we are not changing the regulations in § 489.20, they will not be discussed further in this document.

In promulgating these cited regulatory sections and in enforcing the provisions of EMTALA, we are aware of the necessary balance between the hospital's and a physician's legal duty to provide examination and treatment (both under the statute and under the common law) and the practical realities of the manner in which hospitals and medical staffs are organized and operated on a day-to-day basis, as well as proper mobilization of resources within hospitals in order to comply with these legal duties. Reports of overcrowding are common in many parts of the country. Within the requirements of EMTALA, individuals should be treated at the appropriate site of care.

Hospitals and physicians have now had over 15 years of experience in organizing themselves to comply with the provisions of EMTALA. Therefore, in a proposed rule published in the **Federal Register** on May 9, 2002 as part of the annual proposed rules for the acute care hospital inpatient prospective payment system (67 FR 31469), we solicited comments from hospitals, physicians, patients, and beneficiary groups on certain proposed changes to the EMTALA policies as discussed in sections III. through XIV. of this preamble.

II. Special Advisory Bulletin on EMTALA Obligations

On November 10, 1999, CMS (then HCFA) and the Office of the Inspector General (OIG) published jointly in the **Federal Register** a Special Advisory Bulletin addressing the requirements of the EMTALA statute and the obligations of hospitals to medically screen all individuals seeking emergency services and to provide stabilizing medical treatment as necessary to all individuals, including enrollees of managed care plans, whose conditions warrant it (64 FR 61353). The Special Advisory Bulletin addressed issues of dual staffing of hospital emergency rooms by managed care and nonmanaged care physicians, prior authorization requirements of some

managed care plans, use of advance beneficiary notices (ABNs) or other financial responsibility forms, handling of individuals' inquiries about financial liability for emergency services, and voluntary withdrawal of a treatment request. Although it did not amend the Code of Federal Regulations, the Special Advisory Bulletin informs individuals of HHS policy regarding application of the EMTALA statute and offers advice on the best practices to follow to avoid violation of the requirements imposed under that statute.

As discussed further in section V. of this preamble, in the May 9, 2002 proposed rule, we proposed to codify certain policies on prior authorization that are currently stated only in the Special Advisory Bulletin. We believe these changes in the regulations are needed to ensure uniform and consistent application of policy and to avoid any misunderstanding of EMTALA requirements by patients, physicians, or hospital employees.

III. Summary of the Provisions of the May 9, 2002 Proposed Rule Relating to EMTALA and Hospital Responsibility for Communication With Medicare+Choice Organizations Concerning Post-Stabilization Care Services

A. Summary of the Proposed Provisions Relating to EMTALA

Recently, a number of questions have been raised about the applicability of § 489.24 to specific situations. These questions arise in the context of managed care plans' requirements for prior authorization, case experiences involving elective procedures, and situations where individuals have been admitted as inpatients without being stabilized, or patients who had been stabilized later experience a deterioration in their medical condition. Some hospitals are uncertain about whether various conditions of participation (CoPs) found in 42 CFR part 482 apply to these situations or whether the EMTALA requirements included in the provider agreement regulations at § 489.24 apply, or both. Some representatives of the provider community have asked us to reexamine CMS policy on the applicability of EMTALA to physicians who are "on call" and to hospitals that own ambulances when those ambulances operate under communitywide emergency medical services (EMS) protocols.

To help promote consistent application of the regulations concerning the special responsibilities of Medicare-participating hospitals in

emergency cases, in the May 9, 2002 proposed rule (67 FR 31469), we proposed changes to § 489.24 to clarify its application in these situations and at the same time address concerns about EMTALA raised by the Secretary's Advisory Committee on Regulatory Reform. These changes are discussed more fully below and include the following:

- We proposed to change the requirements relating to individuals who present with what may be emergency medical conditions at off-campus outpatient clinics and facilities that do not routinely provide emergency medical services. We believe these changes will enhance the quality and promptness of emergency care by permitting individuals to be referred to appropriately equipped emergency facilities close to such clinics, rather than being transported to the main campus emergency department, which may be located at a greater distance from the clinic.

- We proposed to clarify the extent to which EMTALA applies to inpatients and outpatients. We believe these clarifications will enhance understanding for hospitals as to what their obligations are under EMTALA, so that they more clearly understand to whom they are obligated under this provision of the statute, and whose care will be governed by the Medicare hospital CoPs.

- We proposed to clarify the circumstances in which physicians, particularly specialty physicians, must serve on hospital medical staff "on-call" lists. We expect these clarifications will help improve access to physician services for all hospital patients by permitting hospitals local flexibility to determine how best to maximize their available physician resources. We are currently aware of reports of physicians, particularly specialty physicians, severing their relationships with hospitals, especially when those physicians belong to more than one hospital medical staff. Physician attrition from these medical staffs could result in hospitals having no specialty physician service coverage for their patients. We proposed clarification of the on-call list requirements to permit hospitals to continue to attract physicians to serve on their medical staffs and thereby continue to provide services to emergency room patients.

- We proposed to clarify the responsibilities of hospital-owned ambulances so that these ambulances can be more fully integrated with citywide and local community EMS procedures for responding to medical emergencies and thus use these