

resources more efficiently for the benefit of these communities.

In the May 9, 2002 proposed rule, we specifically solicited comments on all of these proposed changes. In response to the proposed rule, we received approximately 600 pieces of correspondence, most of which contained multiple comments. A large number of these comments were received on the last day of the comment period for the proposed rule (July 8, 2002). Because of the number and nature of the public comments we received on our proposed clarifications and our limited timeframe for developing the final acute care hospital inpatient prospective payment system regulations for publication by the statutory deadline of August 1, we decided, with one exception (application of the EMTALA provisions to provider-based entities), to address the public comments and finalize the proposed clarifications relating to implementation of EMTALA in a separate document. This final rule is that separate document.

In the next several sections of the preamble of this final rule, we summarize the public comments received on the proposed EMTALA clarifications and present our responses to those comments, including any further revisions that we are making in this final rule to the proposed regulation changes as a result of these comments.

#### *B. Summary of the Proposed Provisions Relating to Communication with Medicare+Choice Organizations Concerning Post-Stabilization Care Services*

In the May 9, 2002 proposed rule (67 FR 31471), we proposed to specify that a hospital must promptly contact the Medicare+Choice organization after a Medicare+Choice enrollee who is treated for an emergency medical condition is stabilized (proposed § 489.24(d)(6)). We received a number of public comments on this proposed provision. However, we are not addressing public comments received on this provision in this final rule but plan to address them in future policy guidance.

#### **IV. General Comments on the Proposed Rule**

*Comment:* Some commenters expressed overall support for our proposed clarifying changes to establish more flexible standards on EMTALA, but did not offer specific recommendations for modifying them. However, one commenter, the administrator of a small rural hospital in the Midwest, expressed concern that our

proposals appear to represent a shift from national requirements to community-based standards, under which the level of emergency care available in a community would be determined by the medical staffs of individual hospitals. This commenter stated that, in many cases, it is possible to continue to maintain emergency department services in the local community only because of the pressure exerted on physicians by EMTALA to continue to see patients in the emergency department. Therefore, the commenter recommended that any changes in EMTALA regulatory requirements be directed to making those requirements more stringent and specific and stated that relaxing EMTALA requirements as proposed will only undermine the efforts of small rural hospitals to maintain viable emergency services for their patients.

*Response:* We appreciate the commenters' support, and have kept their views in mind in considering the comments of those respondents who recommended revisions. In regard to the commenter's recommendations that we make the EMTALA requirements more stringent (rather than relaxing them) for the benefit of small rural hospitals, we note that we received many comments expressing concern that the current requirements may be too burdensome, and therefore, the commenters recommended more flexible EMTALA rules. We considered all of the comments received when finalizing our policy.

#### **V. Prior Authorization (§ 489.24(d)(4))**

##### *A. Provisions of the Proposed Rule*

Some managed care plans may seek to pay hospitals for services only if the hospitals obtain approval from the plan for the services before providing the services. Requirements for this approval are frequently referred to as "prior authorization" requirements. However, EMTALA (specifically, section 1867(h) of the Act and our existing regulations at § 489.24(c)(3)) explicitly prohibit hospitals from delaying screening or stabilization services in order to inquire about the individual's method of payment or insurance status. Thus, prior authorization requirements are a matter of concern because a hospital's actions in seeking prior authorization from an insurer could result in a delay in the provision of services required by EMTALA. Our existing policy prohibits a participating hospital from seeking authorization from the individual's insurance company for screening services or services required to stabilize an emergency medical condition until

after the hospital has provided the appropriate medical screening examination required by EMTALA to the individual and has initiated any further medical examination and treatment that may be required to stabilize the patient's emergency medical condition.

In the May 9, 2002 proposed rule, we solicited public comments as to whether the regulations should be revised to state that the hospital may seek other information (apart from information about payment) from the insurer about the individual, and may seek authorization for all services concurrently with providing any stabilizing treatment, as long as doing so does not delay required screening and stabilization services (67 FR 31471).

In addition, we proposed to clarify that an emergency physician is not precluded from contacting the patient's physician at any time to seek advice or information regarding the patient's medical history and needs that may be relevant to the medical screening and treatment of the patient, as long as this consultation does not inappropriately delay required screening services or stabilizing treatment.

As explained earlier, this policy was stated in a Special Advisory Bulletin published jointly by CMS (then HCFA) and the OIG. We proposed to clarify the existing language at § 489.24(c)(3) (which was proposed to be redesignated as paragraph (d)(4)) in the proposed rule to include this policy in the regulations.

#### *B. Summary of Public Comments and Departmental Responses*

##### **1. General Comments**

*Comment:* Several commenters expressed general approval of our proposals without recommending more specific changes.

*Response:* We appreciate the commenters' support of the proposals and have taken their views into account in considering the comments of those respondents who recommended revisions.

##### **2. Concurrent Authorization and Furnishing of Stabilizing Services**

*Comment:* Two commenters recommended that we delete any reference to seeking authorization for post-stabilization services concurrently with the provision of stabilizing treatment. The commenters believed clinical staff cannot easily distinguish between screening services and stabilizing treatment, and thus may be uncertain as to when stabilizing treatment has begun in order to seek authorization for the services. Another