

days off, and other similar factors must be considered in determining the availability of staff. We also are aware that some hospitals, particularly those in rural areas, have stated that they incur relatively high costs of compensating physician groups for providing on-call coverage to their emergency departments, and that doing so can strain their already limited financial resources. CMS allows hospitals flexibility to comply with EMTALA obligations by maintaining a level of on-call coverage that is within their capability.

We understand that some hospitals exempt senior medical staff physicians from being on call. This exemption is typically written into the hospital's medical staff bylaws or the hospital's rules and regulations, and recognizes a physician's active years of service (for example, 20 or more years) or age (for example, 60 years of age or older), or a combination of both. We wish to clarify that providing such exemptions to members of hospitals' medical staff does not necessarily violate EMTALA. On the contrary, we believe that a hospital is responsible for maintaining an on-call list in a manner that best meets the needs of its patients as long as the exemption does not affect patient care adversely. Thus, CMS allows hospitals flexibility in the utilization of their emergency personnel.

We also note that there is no predetermined "ratio" that CMS uses to identify how many days a hospital must provide medical staff on-call coverage based on the number of physicians on staff for that particular specialty. In particular, CMS has no rule stating that whenever there are at least three physicians in a specialty, the hospital must provide 24 hour/7 day coverage in that specialty. Generally, in determining EMTALA compliance, CMS will consider all relevant factors, including the number of physicians on staff, other demands on these physicians, the frequency with which the hospital's patients typically require services of on-call physicians, and the provisions the hospital has made for situations in which a physician in the specialty is not available or the on-call physician is unable to respond.

B. Provisions of the Proposed Rule

To clarify our policies on EMTALA requirements regarding the availability of on-call physicians, in the May 9, 2002 proposed rule, we proposed to add to § 489.24 a new paragraph (j) to specify that each hospital has the discretion to maintain the on-call list in a manner to best meet the needs of its patients. This proposed paragraph further specified

that physicians, including specialists and subspecialists (for example, neurologists), are not required to be on call at all times, and that the hospital must have policies and procedures to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control.

C. Summary of Public Comments and Departmental Responses

1. General Comments

Comment: Numerous commenters expressed strong support for the proposal to clarify in regulations that physicians are not required to be on call at all times and that a hospital is responsible for maintaining an on-call list in a manner that best meets the needs of its patients.

Response: We appreciate these commenters' support and have kept their views in mind in evaluating the other comments recommending specific changes in the proposed rule for this final rule.

2. Minimal Interpretation of On-Call Responsibility

Comment: One commenter recommended that the requirement for an explicit list of on-call physicians be eliminated because, in the opinion of the commenter, physicians may be less willing to agree to be on call if they are required to commit in advance to be available at specific times. Numerous commenters did not request elimination of the requirement but stated that the requirement should be interpreted narrowly, as meaning only that the list of physicians willing to be on call is to be maintained and available in the emergency department, and that on-call services of those physicians must be available to each patient regardless of ability to pay. The commenters asked that the regulations be revised to specify that the on-call requirement does not require hospitals to maintain any particular level of on-call coverage, since hospitals are not legally authorized or practically empowered to control physician availability for on-call coverage.

Response: We cannot eliminate the requirement for an on-call list from the regulations, as that requirement is mandated by section 1866(a)(1)(I)(iii) of the Act. While we understand the rationale for interpreting section 1866 of the Act as imposing only a minimal on-call requirement, we also note that on-call physician services, like other services for the examination and treatment of emergency medical conditions, must be made available

within the capability of the hospital, under sections 1867(a) and (b) of the Act. Therefore, we are not adopting these commenters' recommendations.

Comment: Some commenters expressed concern that the proposed changes allowing hospitals and physicians more flexibility to set on-call policies might actually increase overcrowding in hospital emergency departments. The commenters stated that patients who require specialty physician care often must wait in the emergency department for extended periods, since the physician's presence is needed to authorize either admission or an appropriate transfer.

One commenter suggested that adoption of the more flexible regulations on on-call responsibility would only exacerbate this problem. To prevent that, the commenter recommended that a hospital that is unable to maintain full-time specialty coverage in one or more areas be required to have a transfer agreement with a hospital that has that level of coverage and will accept all patients in that specialty or subspecialty area. The commenter also recommended that we prescribe a maximum time for which patients could be required to wait in the emergency department for specialty care and that provision be made for patients who must be held beyond that time to be admitted either to an inpatient bed or to an outpatient holding area outside the emergency department, to await the arrival of a specialist. The commenter noted that this placement would not end the hospital's EMTALA obligation, but would free emergency department resources to permit more emergency patients to be treated.

Response: We agree that it is appropriate for hospitals to have referral agreements with other hospitals to facilitate appropriate transfers of patients who require specialty physician care that is not available within a reasonable period of time at the hospital to which the patient is first presented. Hospitals that cannot maintain full-time on-call coverage in specific medical specialties should also keep local EMS staff advised of the times during which certain specialties will not be available, thereby minimizing the number of cases in which individuals must be transferred due to lack of complete on-call coverage. However, we are not mandating the maintenance of such agreements in this final rule. Even though such agreements may be desirable, we recognize that hospitals may be unable, despite their best efforts, to secure such advance agreements from specialty hospitals. (We note that, even in the absence of an advance agreement,