

be adopted regarding the times at which physicians are expected to be on call.

Another commenter cited a study by the University of California at Los Angeles titled "A Day in the Life of a California Emergency Department: Waiting Times and Resources, Trends in Use and Capacity, and Perceptions of Emergency Professionals." The commenter stated that the study finding indicated that, during the study period (December 2000 through May 2001), a significant number of on-call physicians either did not respond to call at all or responded only after a delay of at least 20 minutes, and that many took longer than 35 minutes to arrive. The commenter stated that the study documents the refusal of many on-call physicians to fulfill their on-call responsibilities and argued that hospitals should not be held responsible in such cases.

Another commenter also believed the proposed rules unfairly burden hospitals with the responsibility for maintaining on-call coverage but do not provide any guidance on a medical staff member's obligation to participate in on-call panels. The commenter expressed concern that the proposed language would, if adopted, allow physicians to either refuse to be on call, shift their practices to facilities not requiring on-call service, or demand exorbitant payment for on-call service. To avoid these effects, the commenter recommended that CMS either furnish additional detailed guidance on how hospitals can obtain on-call coverage when physicians refuse to provide it, or mandate that participation on on-call panels at hospitals subject to EMTALA is required as a condition of being a Medicare-participating physician.

*Response:* We understand the commenters' concern, but do not believe it would be practical or equitable to attempt to adopt more prescriptive rules on such matters as the number of hours per week physicians must be on call or the numbers of physicians needed to fulfill on-call responsibilities at particular hospitals. We believe these are local decisions that can be made reasonably only at the individual hospital level through coordination between the hospitals and their staffs of physicians.

Regarding situations in which physicians may irresponsibly refuse to fulfill the on-call responsibilities they have agreed to accept, we note that current law (section 1867(d)(1)(B) of the Act) provides penalties for physicians who negligently violate a requirement of section 1867 of the Act, including on-call physicians who refuse to appear when called. We further note that

physicians who practice in hospitals do so under privileges extended to them by those hospitals, and that hospitals facing a refusal by physicians to assume on-call responsibilities or to carry out the responsibilities they have assumed could suspend, curtail, or revoke the offending physician's practice privileges. Moreover, when an EMTALA violation involving on-call coverage is found to have occurred, surveyors and CMS regional office staff will review all facts of the situation carefully to ensure that hospitals that have acted in good faith to ensure on-call coverage are not unfairly penalized for failure by individual physicians to fulfill their obligations.

Therefore, we are not making any change in the final rule based on these comments.

#### 5. Hospital Responsibility for On-Call Coverage

*Comment:* One commenter stated that when the initial EMTALA legislation was enacted in 1986, emergency physicians were finding it virtually impossible to find specialists willing to come to the emergency department to treat emergency patients, and that the 1988 amendments to the EMTALA statute making it explicit that physicians are covered by on-call requirements have significantly improved the availability of on-call services in hospital emergency departments. Because of this improvement, the commenter stated that CMS should not give credence to allegations that EMTALA is making on-call coverage more difficult to obtain. The commenter further stated that even though the proposed regulatory language is virtually identical to the position CMS has taken in the past regarding on-call responsibilities, in the current climate the language is very likely to be viewed as offering assurances that physicians have no obligation to provide on-call coverage. To avoid this result, which the commenter believed would compromise the quality of patient care and lead to patient deaths, the commenter recommended that CMS clearly state that the proposed regulatory language does not represent a change in policy and that hospitals and physicians that fail to meet their on-call obligations as determined by EMTALA will be cited for noncompliance. The commenter also recommended that a safe harbor be created for EMTALA compliance, but does not describe the specific terms under which the safe harbor should be made available.

Other commenters also expressed concern about diminished access to on-

call services as a result of perceptions of the proposals. These commenters stated that, because public hospitals typically are the only hospitals in a community committed to maintaining full-time on-call coverage in many specialties, other hospitals may view flexible requirements in this area as an opportunity to reduce their on-call coverage, thus further unfairly shifting the on-call burden to public hospitals and the physicians who practice in them. The commenters believed CMS should issue guidance stating more specifically how hospitals that maintain less than full-time on-call coverage will be evaluated under EMTALA.

*Response:* We understand the concerns expressed by the commenters about possible reductions in access to on-call services and wish to emphasize that the proposals are not intended to signal any change in CMS' position regarding hospitals' responsibility to comply with EMTALA. We also understand the desire by some for more specific guidance regarding the level of on-call coverage to be provided and the types of services for which on-call coverage must be available. However, under section 1867(a) of the Act, the EMTALA screening must be provided "within the capability of the hospital's emergency department" and that under section 1867(b) of the Act, further medical screening and stabilizing treatment must be made available only "within the staff and facilities available at the hospital." Given the wide variation in the size, staffing, and capabilities of the institutions that participate in Medicare as hospitals, we do not believe it is feasible for us to mandate any particular minimum level of on-call coverage that must be maintained by all hospitals subject to EMTALA, or to specify that on-call coverage is required for all services offered at the hospital. Therefore, we are not making any changes to our proposal in this final rule based on this comment.

*Comment:* Several commenters expressed support for the clarification that EMTALA does not require 24/7 on-call coverage at all hospitals, but some of the commenters suggested that the regulations be further strengthened to prohibit hospitals from maintaining such coverage when their capacity does not support it. Another commenter stated that we should not only clarify that EMTALA does not require "24/7" on-call coverage at all hospitals, but should prohibit hospitals from requiring physicians to be on call 24 hours a day, 7 days a week. Another commenter stated that CMS should prohibit hospitals from requiring physicians to be on call at times when they are