

flexibility should be singled out for inclusion in the regulations.

*Comment:* One commenter stated that Federally Qualified Health Centers (FQHCs) are required under policies of the Public Health Service to maintain referral arrangements with hospitals for acceptance of health center patients, and that it is recommended that FQHCs maintain admitting privileges at those hospitals for their patients. However, the commenter was concerned that any monetary penalties for noncompliance with EMTALA on-call responsibilities will have to be paid by the health centers, and that physicians who learn that they will incur an on-call responsibility at a hospital as a cost of being privileged there may choose to stop practicing at the health centers, thereby depriving the health centers' patients of the physicians' services. Therefore, the commenter recommended that CMS provide some safe harbors, such as unspecified personal services or a high volume of patients needing care, that would protect physicians from EMTALA liability if they fail to be on call or are on call but fail to come to the hospital emergency department when called.

*Response:* As we noted above, this final rule makes explicit provision for two of the occurrences that physicians and other commenters have indicated to us are responsible for physicians' inability to respond to calls even though they have agreed to do so. In addition, we plan to direct State surveyors, in enforcing the EMTALA provisions, to be aware of situations in which circumstances beyond a physician's control may prevent him or her from responding promptly to calls. We believe these actions on our part will ensure sufficient flexibility and, therefore, we are not at this time further defining a set of specific "safe harbors." However, we will continue to monitor the commenter's concerns and will undertake further rulemaking if warranted in the future.

*Comment:* One commenter stated that some physicians, such as orthopedists, frequently use physician assistants in their practices. The commenter provided a number of examples of how a physician assistant could respond appropriately to a call from an emergency department, participate in the screening of an individual, and either provide the necessary stabilization or post-stabilization services, or arrange for the performance of those services by the physician. The commenter asked us to clarify that, in some instances, physician assistants may appropriately provide on-call coverage, by revising the EMTALA

regulations to state that physicians included on a hospital's on-call list may delegate their on-call responsibilities to the physician assistants they supervise, as long as all services provided by the physician assistants are furnished in accordance with State scope of practice laws and with hospital and medical bylaws.

*Response:* We agree that there may be circumstances in which a physician assistant may be the appropriate practitioner to respond to a call from an emergency department or other hospital department that is providing screening or stabilization mandated by EMTALA. However, any decision as to whether to respond in person or direct the physician assistant to respond should be made by the responsible on-call physician, based on the individual's medical needs and the capabilities of the hospital, and would, of course, be appropriate only if it is consistent with applicable State scope of practice laws and hospital bylaws, rules, and regulations.

#### *D. Provisions of the Final Rule*

In this final rule, we are adopting the proposed § 489.24(j) as final with the following modifications: We are specifying that the on-call list must be maintained in a manner that best meets the needs of the hospital's patients who are receiving services required under EMTALA, in accordance with the capability of the hospital, including the availability of on-call physicians. We also are revising paragraph (j) to state the conditions under which simultaneous call and elective surgery while on call are permitted. For editorial reasons, we are revising the language of § 489.24 to state under paragraph (j)(3)(ii) that hospitals must "provide" rather than "insure" that emergency services are available. No change in policy is being made by this editorial change.

### **XII. EMTALA Applicability to Hospital-Owned Ambulances (§ 489.24(b))**

#### *A. Background*

We stated in the June 22, 1994 final rule (59 FR 32098) that if an individual is in an ambulance owned and operated by a hospital, the individual is considered to have come to the hospital's emergency department, even if the ambulance is not on hospital property. This policy, currently set forth at § 489.24(b), was necessary because we were concerned that some hospitals that owned and operated ambulances at that time were transporting individuals who had called for an ambulance to other hospitals, thereby evading their

EMTALA responsibilities to the individuals.

Concerns have since been raised by the provider industry about applications of this policy to ambulances that are owned by hospitals but are operating under communitywide EMS protocols that may require the hospital-owned and other ambulances to transport individuals to locations other than the hospitals that own the ambulances. For instance, we understand that some community protocols require ambulances to transport individuals to the closest hospital to the individual geographically, whether or not that hospital owns the ambulance.

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

To avoid imposing requirements that are inconsistent with local EMS requirements, in the May 9, 2002 proposed rule, we proposed to clarify, at proposed revised § 489.24(b), in paragraph (3) of the definition of "Comes to the emergency department", an exception to our existing rule requiring EMTALA applicability to hospitals that own and operate ambulances. We proposed to account for hospital-owned ambulances operating under communitywide EMS protocols. Under our proposal, the rule on hospital-owned ambulances and EMTALA does not apply if the ambulance is operating under a communitywide EMS protocol that requires it to transport the individual to a hospital other than the hospital that owns the ambulance. In this case, the individual is considered to have come to the emergency department of the hospital to which the individual is transported, at the time the individual is brought onto hospital property.

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

*Comment:* A number of commenters expressed strong support for the proposal to clarify that EMTALA does not apply to a hospital-owned ambulance when the ambulance is operating under communitywide protocols that require it to transport an individual to a hospital other than the hospital that owns the ambulance. One commenter asked whether a hospital would have any EMTALA obligation with respect to a patient who refuses transport from the planned pickup site (for example, the site of an automobile accident), and whether EMTALA would apply if the physician in the emergency department provides "medical command."

Another commenter recommended that the regulations be further revised to state that individuals presenting to