

operated ambulances be given an exemption from the requirements for situations in which the individual or family asks that the individual be transported to another facility other than the hospital that owns the ambulance.

*Response:* We agree that it would be more appropriate to refer to requirements that the individuals be taken to the “closest appropriate facility” rather than the “nearest hospital”, and are including this change in paragraph (3) of the definition of “come to the emergency department” under § 489.24(b) of this final rule.

Regarding the redirection of an ambulance at the request of the individual’s family, we believe existing regulations at § 489.24(c)(2) (now § 489.24(d)(3) of this final rule) regarding informed refusals of treatment would permit the ambulance to transport the individual to another facility. A medical record for the individual must be established and the refusal clearly documented in that record, in accordance with these regulatory requirements.

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

We are adopting, as final, the proposed revision to paragraph (3) under the definition of “come to the emergency department” under § 489.24(b) as it related to the applicability to EMTALA to hospital-owned ambulances, with the following modifications:

We are specifying the nonapplicability of EMTALA to hospital-owned “air” ambulances (in addition to ground ambulances), when the ambulance is operating under communitywide protocols.

We are specifying that an individual in an ambulance owned and operated by the hospital is not considered to have “come to the emergency department” if the ambulance is operated under communitywide EMS protocols or EMS protocols “mandated by State law” that direct it to transport the individual to a hospital other than the hospital that owns the ambulance. We also are specifying that an individual in an ambulance owned and operated by the hospital is not considered to have “come to the emergency department” if the ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance or if the physician’s direction of the destination of the ambulance is subject to communitywide protocols that require the individual to be transported to a hospital other than the hospital that owns the ambulance.

We are changing the term “closest hospital” to “closest appropriate facility”.

In addition, we are adding a new § 489.24(a)(2) to specify EMTALA responsibilities in the event of a bioterrorist attack.

#### **XIII. Conditions of Participation for Hospitals**

We are reminding hospitals and others that while these final regulations make it clear that, while stabilizing an individual with an emergency medical condition (or admitting the individual to the hospital as an inpatient) relieves the hospital of its EMTALA obligations, it does not relieve the hospital of all further responsibility for the patient who is admitted. Stabilization or inpatient admission also does not indicate that the hospital is thus free to improperly discharge or transfer the individual to another facility. Inpatients who experience acute medical conditions receive protections under the Medicare hospital CoPs, which are found at 42 CFR part 482. In addition, as noted earlier in this preamble and in the May 9, 2002 proposed rule preamble, we believe that outpatients who experience what may be an emergency medical condition after the start of an encounter with a health professional would have all protections afforded to patients of a hospital under the Medicare hospital CoPs. There are six hospital CoPs that provide these protections: emergency services, governing body, discharge planning, quality assessment and performance improvement, medical staff, and outpatient services. In the May 9, 2002 proposed rule, we proposed to make only one change in these CoPs: one relating to the governing body having written policies and procedures in effect for off-campus departments that do not offer emergency services for appraisal of emergencies and referral when appropriate (§ 482.12(f)(3)).

If a hospital inpatient develops an acute medical condition and the hospital is one that provides emergency services, the hospital is required to ensure that it meets the emergency needs of the patient in accordance with accepted standards of practice. Similarly, regardless of whether the hospital provides emergency services, if an inpatient develops an acute medical condition, the governing body CoP (§ 482.12(f)(2), which applies to all Medicare-participating hospitals) would apply. This CoP requires that the hospital governing body must ensure that the medical staff has written policies and procedures for appraisal of

emergencies, initial treatment, and referral when appropriate.

The discharge planning CoP (§ 482.43, which applies to all Medicare-participating hospitals) requires hospitals to have a discharge planning process that applies to all patients. This CoP ensures that patient needs are identified and that transfers and referrals reflecting adequate discharge planning are made by the hospital. If an inpatient develops an acute medical condition and the hospital either does not offer emergency services or does not have the capability to provide necessary treatment, a transfer to another hospital with the capabilities to treat the emergency medical condition could be warranted. Hospitals are required to meet the discharge planning CoP in carrying out such a transfer.

The hospital CoP governing medical staff (§ 482.22) requires that the hospital have an organized medical staff that operates under bylaws approved by the governing body and is responsible to the governing body for the quality of medical care provided to patients by the hospital. Should the medical staff not be held accountable to the governing body for problems regarding a lack of provision of care to an inpatient who develops an emergency medical condition, this lack of accountability may be reviewed under the medical staff CoP, as well, and may result in a citation of noncompliance at the medical staff condition level for the hospital.

Finally, the quality assessment and performance improvement CoP (§ 482.21, which applies to all Medicare-participating hospitals) requires the governing body to ensure that there is an effective, hospital-wide quality assessment and performance improvement program to evaluate the provision of patient care. In order to comply with this CoP, the hospital must evaluate the care it provides hospital-wide. Complaints regarding a lack of provision of care to an inpatient who develops an emergency medical condition must be addressed under the hospital’s quality assurance program and may be reviewed under the quality assessment and performance improvement CoP.

A hospital’s failure to meet the CoPs requirements cited above may result in a finding of noncompliance at the condition level for the hospital and lead to termination of the hospital’s Medicare provider agreement. As we explained in the preamble to the January 24, 2003 final rule (69 FR 3435), the CoPs are the requirements that hospitals must meet to participate in the Medicare and Medicaid programs. The