adjustment models in order to reflect patterns of diagnoses and expenditures in the MA program.

Specifically, we are proposing to revise § 422.310(a) to clarify that risk adjustment data are data used not only in the application of risk adjustment to MA payments, but also in the development of risk adjustment models. For example, once encounter data for MA enrollees are available, CMS would have beneficiary-specific information on the utilization of services by MA plan enrollees. These data could be used to calibrate the CMS–HCC risk adjustment models using MA patterns of diagnoses and expenditures.

We are proposing to revise §§ 422.310(b), (c), (d)(3), and (g) to clarify that the term ''services'' includes items and services.

We are proposing to revise § 422.310(d) to clarify that CMS has the authority to require MA organizations to submit encounter data for each item and service provided to an MA plan enrollee. The proposed revision also would clarify that CMS will determine the formats for submitting encounter data, which may be more abbreviated than those used for the fee-for-service claims data submission process.

We are proposing to revise § 422.310(f) to clarify that one of the ''other'' purposes for which CMS may use risk adjustment data collected under this section would be to update risk adjustment models with data from MA enrollees. In addition, when providing that CMS may use risk adjustment data for purposes other than adjusting payments as described at §§ 422.304(a) and (c), we are proposing to delete the phrase ''except for medical records data'' from paragraph (f). Any use of medical records data collected under paragraph (e) of § 422.310 is governed by the Privacy Act and the privacy provisions in the HIPAA. Furthermore, there may be occasions when we learn from analysis of medical record review data that some organizations have misunderstood our guidance on how to implement an operational instruction. We want to be able to provide improved guidance to MA organizations based on any insights that may emerge during analysis of the medical record review data.

In addition, we are proposing a technical correction to § 422.310(f) to clarify that risk adjustment data are used not only to adjust payments to plans described at §§ 422.301(a)(1), (a)(2), and (a)(3) (which refer to coordinated care plans and private fee-for-service plans), but also to adjust payments for ESRD enrollees and payments to MSA plans and Religious Fraternal Benefit society plans, as described at § 422.301(c).

Under § 422.310(g), we would continue to provide that data that CMS receives after the final deadline for a payment year will not be accepted for purposes of the reconciliation. However, we are proposing to revise paragraph (g)(2) of § 422.310 to change the deadline from ''December 31'' of the payment year to ''January 31'' of the year following the payment year. We are also proposing to add language to provide that CMS may adjust deadlines as appropriate.

I. Hospital Emergency Services under EMTALA (§ 489.24)

1. Background

Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act impose specific obligations on certain Medicare-participating hospitals and CAHs. (Throughout this section of this proposed rule, when we reference the obligation of a ''hospital'' under these sections of the Act and in our regulations, we mean to include CAHs as well.) These obligations concern individuals who come to a hospital emergency department and request examination or treatment for a medical condition, and apply to all of these individuals, regardless of whether they are beneficiaries of any program under the Act.

The statutory provisions cited above are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA), also known as the patient antidumping statute. EMTALA was passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99–272. Congress incorporated these antidumping provisions within the Social Security Act to ensure that individuals with emergency medical conditions are not denied essential lifesaving services. Under section 1866(a)(1)(I)(i) of the Act, a hospital that fails to fulfill its EMTALA obligations under these provisions may be subject to termination of its Medicare provider agreement, which would result in loss of all Medicare and Medicaid payments.

Section 1867 of the Act sets forth requirements for medical screening examinations for individuals who come to the hospital and request examination or treatment for a medical condition. The section further provides that if a hospital finds that such an individual has an emergency medical condition, it is obligated to provide that individual with either necessary stabilizing treatment or an appropriate transfer to another medical facility where stabilization can occur.

The EMTALA statute also outlines the obligation of hospitals to receive appropriate transfers from other hospitals. Section 1867(g) of the Act states that a participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or, with respect to rural areas, regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires these specialized capabilities or facilities if the hospital has the capacity to treat the individual. The regulations implementing section 1867 of the Act are found at 42 CFR 489.24. The regulations at 42 CFR 489.20(l), (m), (q), and (r) also refer to certain EMTALA requirements. The Interpretive Guidelines concerning EMTALA are found at Appendix V of the CMS State Operations Manual.

2. EMTALA Technical Advisory Group (TAG) Recommendations

Section 945 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. 108–173, required the Secretary to establish a Technical Advisory Group (TAG) to advise the Secretary on issues related to the regulations and implementation of EMTALA. The MMA specified that the EMTALA TAG be composed of 19 members, including the Administrator of CMS, the Inspector General of HHS, hospital representatives and physicians representing specific specialties, patient representatives, and representatives of organizations involved in EMTALA enforcement.

The EMTALA TAG's functions, as identified in the charter for the EMTALA TAG, were as follows: (1) Review EMTALA regulations; (2) provide advice and recommendations to the Secretary concerning these regulations and their application to hospitals and physicians; (3) solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and (4) disseminate information concerning the application of these regulations to hospitals, physicians, and the public. The TAG met 7 times during its 30-month term, which ended on September 30, 2007. At its meetings, the TAG heard testimony from representatives of physician groups, hospital associations, and others regarding EMTALA issues and concerns. During each meeting, the three subcommittees established by the TAG (the On-Call Subcommittee, the Action Subcommittee, and the Framework Subcommittee) developed

recommendations, which were then discussed and voted on by members of the TAG. In total, the TAG submitted 55 recommendations to the Secretary. If implemented, some of the recommendations would require regulatory changes. Of the 55 recommendations developed by the TAG, 5 have already been implemented by CMS. A complete list of TAG recommendations will be available shortly in the Emergency Medical Treatment and Labor Act Technical Advisory Group final report available at the Web site: *http://www.cms.hhs.gov/FACA/07_emtalatag.asp.* The following recommendations have already been implemented by CMS:

- That CMS revise, in the EMTALA regulations [42 CFR 489.24(b)], the following sentence contained in the definition of ''labor'': ''A woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable time of observation, the woman is in false labor.''

This recommendation was adopted with modification in the FY 2007 IPPS final rule (71 FR 48143). We revised the definition of ''labor'' in the regulations at § 489.24(b) to permit a physician, certified nurse-midwife, or other qualified medical person, acting within his or her scope of practice in accordance with State law and hospital bylaws, to certify that a woman is experiencing false labor. We issued Survey and Certification Letter S&C–06–32 on September 29, 2006, to clarify the regulation change. (The Survey and Certification Letter can be found at the following Web site: *http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp*).

- That hospitals with specialized capabilities (as defined in the EMTALA regulations) that do not have a dedicated emergency department be bound by the same responsibilities under EMTALA as hospitals with specialized capabilities that do have a dedicated emergency department.

This recommendation was adopted in the FY 2007 IPPS final rule (71 FR 48143). We added language at § 489.24(f) that makes explicit the current policy that all Medicare-participating providers with specialized capabilities are required to accept an appropriate transfer if they have the capacity to treat the individual. We issued Survey and Certification Letter S&C–06–32 on September 29, 2006, to clarify the regulation change. (The Survey and Certification Letter can be found at the following Web site: *http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp*).

- That CMS clarify the intent of regulations regarding obligations under EMTALA to receive individuals who arrive by ambulance. Specifically, the TAG recommended that CMS revise a letter of guidance that had been issued by the agency to clarify its position on the practice of delaying the transfer of an individual from an emergency medical service provider's stretcher to a bed in a hospital's emergency department.

This recommendation was adopted with modification by CMS in Survey and Certification Letter S&C–07–20, which was released on April 27, 2007. (The Survey and Certification Letter can be found at the following Web site: *http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp).*

- That CMS clarify that a hospital may not refuse to accept an individual appropriately transferred under EMTALA on the grounds that it (the receiving hospital) does not approve the method of transfer arranged by the attending physician at the sending hospital (for example, a receiving hospital may not require the sending hospital to use an ambulance transport designated by the receiving hospital). In addition, CMS should improve its communication of such clarifications with its regional offices.

This recommendation was adopted and implemented by CMS in Survey and Certification Letter S&C–07–20, which was released on April 27, 2007. (The Survey and Certification Letter can be found at the following Web site: *http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp*).

- That CMS strike the language in the Interpretive Guidelines (CMS State Operations Manual, Appendix V) that addresses telehealth/telemedicine (relating to the regulations at § 489.24(j)(1)) and replace it with language that clarifies that the treating physician ultimately determines whether an on-call physician should come to the emergency department and that the treating physician may use a variety of methods to communicate with the on-call physician. A potential violation occurs only if the treating physician requests that the on-call physician come to the emergency department and the on-call physician refuses.

This recommendation was adopted and implemented by CMS in Survey and Certification Letter S&C–07–23, which was released on June 22, 2007. (The Survey and Certification Letter can be found at the following Web site: *http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp).*

We are considering the remaining recommendations of the EMTALA TAG and may address them through future changes to or clarifications of the existing regulations or the Interpretive Guidelines, or both.

At the end of its term, the EMTALA TAG compiled a final report to the Secretary. This report includes, among other materials, minutes from each TAG meeting as well as a comprehensive list of all of the TAG's recommendations. The final report will be available shortly at the following Web site: *http://www.cms.hhs.gov/FACA/07_emtalatag.asp.*

3. Proposed Changes Relating to Applicability of EMTALA Requirements to Hospital Inpatients

While many issues pertaining to EMTALA involve individuals presenting to a hospital's dedicated emergency department, questions have been raised regarding the applicability of the EMTALA requirements to inpatients. We have previously discussed the applicability of the EMTALA requirements to hospital inpatients in both the May 9, 2002 IPPS proposed rule (67 FR 31475) and the September 9, 2003 stand alone final rule on EMTALA (68 FR 53243). As we stated in both of the aforementioned rules, in 1999, the United States Supreme Court considered a case (*Roberts* v. *Galen of Virginia*, 525 U.S. 249 (1999)) that involved, in part, the question of whether EMTALA applies to inpatients in a hospital. In the context of that case, the United States Solicitor General advised the Court that HHS would develop a regulation clarifying its position on that issue. In the 2003 final rule, CMS took the position that a hospital's obligation under EMTALA ends when that hospital, in good faith, admits an individual with an unstable emergency medical condition as an inpatient to that hospital. In that rule, CMS noted that other patient safeguards protected inpatients, including the CoPs as well as State malpractice law. However, in the 2003 final rule, CMS did not directly address the question of whether EMTALA's ''specialized care'' requirements (section 1867(g) of the Act) applied to inpatients.

As noted in section IV.I.2. of this preamble, the EMTALA TAG has developed a set of recommendations to the Secretary. One of those recommendations calls for CMS to revise its regulations to address the situation of an individual who: (1)

Presents to a hospital that has a dedicated emergency department and is determined to have an unstabilized emergency medical condition; (2) is admitted to the hospital as an inpatient; and (3) the hospital subsequently determines that stabilizing the individual's emergency medical condition requires specialized care only available at another hospital.

We believe that the obligation of EMTALA does not end for all hospitals once an individual has been admitted as an inpatient to the hospital where the individual first presented with a medical condition that was determined to be an emergency medical condition. Rather, once the individual is admitted, admission only impacts on the EMTALA obligation of the hospital where the individual first presented. (Throughout this section of the preamble of this proposed rule, we will refer to the hospital where the individual first presented as the ''admitting hospital.'') Section 1867(g) of the Act states: ''Nondiscrimination—A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.'' Section 1867(g) of the Act therefore requires a receiving hospital with specialized capabilities to accept a request to transfer an individual with an unstable emergency medical condition as long as the hospital has the capacity to treat that individual, regardless of whether the individual had been an inpatient at the admitting hospital. Furthermore, in the September 9, 2003 final rule (68 FR 53263), we amended the regulations at § 489.24(d)(2)(i) to state: ''If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual'' (emphasis added). We did not intend for the regulation to end the EMTALA obligation for any other hospital to which the individual may appropriately be transferred to stabilize his or her emergency medical condition. Permitting inpatient admission at the admitting hospital to end EMTALA obligations for another hospital to which an unstabilized individual is being appropriately transferred to receive specialized care would seemingly contradict the intent of section 1867(g) of the Act to ensure that hospitals with specialized capabilities provide medical treatment to individuals with emergency medical conditions to stabilize their conditions.

We also note that, as we discussed in the preamble of the September 9, 2003 stand alone final rule, once a hospital has admitted an individual as an inpatient, the individual is protected under the Medicare CoPs and may also have additional protections under State law. Accordingly, we believe it is consistent with the intent of EMTALA to limit its protections to individuals who need them most; for example, individuals who present to a hospital but may not have been formally admitted as patients and thus are not covered by other protections applicable to inpatients of the hospital. As noted above, once the individual is admitted, the CoPs apply to the admitting hospital's care of that individual. A hospital that fails to provide treatment to such individuals could face termination of its Medicare provider agreement for a violation of the CoPs. However, these CoPs do not, of course, apply to a hospital with specialized capabilities to which the individual might be transferred unless and until the individual is formally admitted as a patient at that hospital. Therefore, in order to ensure an individual the protections intended by the EMTALA statute, especially section 1867(g) of the Act (obligating a hospital with specialized capabilities to accept an appropriately transferred individual if it has the capacity to treat that individual), we believe it is appropriate to propose to clarify that section 1867(g) of the Act continues to apply so as to protect even an individual who has been admitted as an inpatient to the admitting hospital who has not been stable since becoming an inpatient. We believe that this proposed clarification is necessary to ensure that EMTALA protections are continued for individuals who are not otherwise protected by the hospital CoPs. (We note that this proposed clarification is consistent with the EMATLA TAG's recommendation that EMTALA does not apply when an individual is admitted to the hospital for an elective procedure and subsequently develops an emergency medical condition.)

We recognize that this proposed clarification that EMTALA applies to a hospital with specialized capabilities when an inpatient (who presented to the admitting hospital under EMTALA) is in need of specialized care to stabilize his or her emergency medical condition may raise concerns among the provider community that such a clarification in policy could hypothetically result in an increase in the number of transfers. However, the intention of this proposed clarification is *not* to encourage patient dumping to hospitals with specialized capabilities. Rather, even if the hospital with specialized capabilities has an EMTALA obligation to accept an individual who was an inpatient at the admitting hospital, the admitting hospital transferring the individual should take all steps necessary to ensure that it is providing needed treatment within its capabilities prior to transferring the individual. This means that an individual with an unstabilized emergency medical condition should be transferred only when the capabilities of the admitting hospital have been exceeded.

Accordingly, we are proposing to revise § 489.24(f) by adding to the existing text a provision that specifies that paragraph (f) also applies to an individual who has been admitted under paragraph (d)(2)(i) of the section and who has not been stabilized.

While we are not including the following in our proposed clarification, we are seeking public comments on whether the EMTALA obligation imposed on hospitals with specialized capabilities to accept appropriate transfers should apply to a hospital with specialized capabilities in the case of an individual who had a period of stability during his or her stay at the admitting hospital and is in need of specialized care available at the hospital with specialized capabilities. CMS takes seriously its duty to protect patients with emergency medical conditions as required by EMTALA. Thus, we are seeking public comments as to whether, with respect to the EMTALA obligation on the hospital with specialized capabilities, it should or should not matter if an individual who currently has an unstabilized emergency medical condition (which is beyond the capability of the admitting hospital) (1) remained unstable after coming to the hospital emergency department or (2) subsequently had a period of stability after coming to the hospital emergency department.

In summary, to implement the recommendation by the EMTALA TAG and clarify our policy regarding the applicability of EMTALA to hospital inpatients, we are proposing to amend § 489.24(f) to add a provision to state that when an individual covered by EMTALA was admitted as an inpatient and remains unstabilized with an

emergency medical condition, a receiving hospital with specialized capabilities has an EMTALA obligation to accept that individual, assuming that the transfer of the individual is an appropriate transfer and the participating hospital with specialized capabilities has the capacity to treat the individual.

4. Proposed Changes to the EMTALA Physician On-Call Requirements

a. Relocation of Regulatory Provisions

During its term, the EMTALA TAG dedicated a significant portion of its discussion to a hospital's physician on-call obligations under EMTALA and made several recommendations to the Secretary regarding physician on-call requirements that are included in its final report (will be available shortly at the Web site: *http://www.cms.hhs/gov/FACA/07_emtalatag.asp).* The TAG recommended that CMS move the regulation discussing the obligation to maintain an on-call list from the EMTALA regulations at § 489.24(j)(1) to the regulations implementing provider agreements at § 489.20(r)(2). We agree with the TAG's recommendation. The requirement to maintain an on-call list is found at section 1866(a)(1)(I)(iii) of the Act, the section of the Act that refers to provider agreements. Section 1867 of the Act, which outlines the EMTALA requirements, makes no mention of the requirement to maintain an on-call list.

To implement the EMTALA TAG's recommendation, we are proposing to delete the provision relating to maintaining a list of on-call physicians from § 489.24(j)(1). We note that a provision for an on-call physician list is already included in the regulations as a hospital provider agreement requirement at § 489.20(r)(2). We are proposing to incorporate the language of § 489.24(j)(1) as replacement language for the existing § 489.20(r)(2) and amend the regulatory language to make it more consistent with the statutory language found at section 1866(a)(1)(I)(iii) of the Act. Proposed revised § 489.20(r)(2) would read: ''An on-call list of physicians on its medical staff available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services required under § 489.24 in accordance with the resources available to the hospital; and''. These proposed changes would make the regulations consistent with the statutory basis for maintaining an on-call list.

The EMTALA TAG made additional recommendations regarding how a hospital would satisfy its on-call list obligations, including calling for an annual plan by the hospital and medical staff for on-call coverage that would include an assessment of factors such as the hospital's capabilities and services, community need for emergency department services as indicated by emergency department visits, emergent transfers, physician resources, and past performance of previous on-call plans. The TAG also recommended that a hospital have a backup plan for viable patient care options when an on-call physician is not available, including such factors as telemedicine, other staff physicians, transfer agreements, and regional or community call arrangements. While community call arrangements are discussed below, we intend to address the remainder of the TAG recommendations at a later date.

b. Shared/Community Call

As noted in the previous section, section 1866(a)(1)(I)(iii) of the Act states, as a requirement for participation in the Medicare program, that a hospital must keep a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. If a physician on the list is called by a hospital to provide stabilizing treatment and either fails or refuses to appear within a reasonable period of time, the hospital and that physician may be in violation of EMTALA as provided for under section 1867(d)(1)(C) of the Act. Thus, hospitals are required to maintain a list of on-call physicians, and physicians or hospitals, or both, may be held responsible under the EMTALA statute if a physician who is on call fails or refuses to appear within a reasonable period of time.

In the May 9, 2002 proposed rule (67 FR 31471), we stated that we were aware of hospitals' increasing concerns regarding their physician on-call requirements. Specifically, we noted that we were aware of reports of physicians, particularly specialty physicians, severing their relationships with hospitals because of on-call obligations, especially when those physicians belong to more than one hospital medical staff. We further noted that physician attrition from these medical staffs could result in hospitals having no specialty physician service coverage for their patients. In the September 9, 2003 final rule (68 FR 53264), we clarified the regulations at § 489.24(j) to permit on-call physicians to schedule elective surgery during the time that they are on call and to permit on-call physicians to have simultaneous on-call duties. We also specified that physicians, including specialists and subspecialists, 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. We expected these clarifications would help to improve access to physician services for all hospital patients by permitting hospitals flexibility to determine how best to maximize their available physician resources. Furthermore, we expected that these clarifications would permit hospitals to continue to attract physicians to serve on their medical staffs, thereby continuing to provide services to all patients, including those individuals who are covered by EMTALA.

As part of its recommendations concerning physician on-call requirements, the EMTALA TAG recommended that hospitals be permitted to participate in ''community call.'' Specifically, the language of the recommendation states: ''The TAG recommends that CMS clarify its position regarding shared or community call: that such community call arrangements are acceptable if the hospitals involved have formal agreements recognized in their policies and procedures, as well as backup plans. It should also be clarified that a community call arrangement does not remove a hospital's obligation to perform an MSE [medical screening examination].'' The TAG also recommended in a subsequent recommendation that ''A hospital may satisfy its on-call coverage obligation by participation in an approved community/regional call coverage program. (CMS to determine appropriate approval process).''

We believe that community call (as described below) would afford additional flexibility to hospitals providing on-call services and improve access to specialty physician services for individuals in an emergency department. Therefore, we are proposing to amend our regulations at § 489.24(j) to provide that hospitals may comply with the on-call list requirement specified at § 489.20(r)(2) (under our proposed revision), by participating in a formal community call plan so long as the plan meets the elements outlined below. We are further proposing to revise the regulations to state that, notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to

provide for an appropriate transfer when appropriate.

We propose ''community call,'' to be a formal on-call plan that permits a specific hospital in a region to be designated as the on-call facility for a specific time period, or for a specific service, or both. For example, if there are two hospitals that choose to participate in community call, Hospital A could be designated as the on-call facility for the first 15 days of each month and Hospital B could be designated as the on-call facility for the rest of each month. Alternatively, Hospital A could be designated as on-call for cases requiring specialized interventional cardiac care, while Hospital B could be designated as on-call for neurosurgical cases. We anticipate that hospitals and their communities would have the flexibility to develop a plan that reflects their local resources and needs. Such a community on-call plan will allow various physicians in a certain specialty in the aggregate to be on continuous call (24 hours a day, 7 days a week), without putting a continuous call obligation on any one physician. We note that generally if an individual arrives at a hospital other than the designated on-call facility, is determined to have an unstabilized emergency medical condition, and requires the services of an on-call specialist, the individual would be transferred to the designated on-call facility in accordance with the community call plan.

As noted above, we are proposing that a community call plan must be a formal plan among the participating hospitals. While we do not believe it is necessary for the formal community call plan to be subject to preapproval by CMS, if an EMTALA complaint investigation is initiated, the plan will be subject to review and enforcement by CMS. We are proposing that, at a minimum, hospitals must include the following elements when devising a formal community call plan:

- The community call plan would include a clear delineation of on-call coverage responsibilities, that is, when each hospital participating in the plan is responsible for on-call coverage.
- The community call plan would define the specific geographic area to which the plan applies.
- The community call plan would be signed by an appropriate representative of each hospital participating in the plan.
- The community call plan would ensure that any local and regional EMS system protocol formally includes information on community on-call arrangements.
- Hospitals participating in the community call plan would engage in an analysis of the specialty on-call needs of the community for which the plan is effective.
- The community call plan would include a statement specifying that even if an individual arrives at the hospital that is not designated as the on-call hospital, that hospital still has an EMTALA obligation to provide a medical screening examination and stabilizing treatment within its capability, and hospitals participating in community call must abide by the EMTALA regulations governing appropriate transfers.
- There would be an annual reassessment of the community call plan by the participating hospitals.

Proposed revised § 489.24(j) would read *''Availability of on-call physicians.* In accordance with the on-call list requirements specified in § 489.20(r)(2), a hospital must have written policies and procedures in place—(1) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control; and (2) To provide that emergency services are available to meet the needs of individuals with emergency medical conditions if a hospital elects to—(i) Permit on-call physicians to schedule elective surgery during the time that they are on call; (ii) Permit on-call physicians to have simultaneous on-call duties; and (iii) Participate in a formal community call plan. Notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to conduct appropriate transfers. The formal community call plan must include the following elements: [proposed elements noted above in the bullets are included in regulations text].''

We welcome public comments on the proposed elements of the formal community call plan noted above. We are also soliciting public comments on whether individuals believe it is important that, in situations where there is a governing State or local agency that would have authority over the development of a formal community call plan, the plan be approved by that agency. In summary, we are proposing that, as part of the obligation to have an on-call list, hospitals may choose to participate in community call, provided that the formal community call plan includes, at a minimum, the elements noted in bullets above. Additionally, each hospital participating in the community call plan must have written policies and procedures in place to respond to situations in which the on-call physician is unable to respond due to situations beyond his or her control. We are further proposing that a hospital would still be responsible for performing medical screening examinations on individuals who present to the hospital seeking treatment and conducting appropriate transfers, regardless of which hospital has on-call responsibilities on a particular day.

5. Proposed Technical Change to Regulations

In the FY 2008 IPPS final rule with comment period (72 FR 47413), we revised § 489.24(a)(2) (which refers to the nonapplicability of the EMTALA provisions in an emergency area during an emergency period) to conform it to the changes made to section 1135 of the Act by the Pandemic and All-Hazards Preparedness Act. When we made the change to the regulations, we inadvertently left out language consistent with the following statutory language found in section 1135: ''pursuant to an appropriate State emergency preparedness plan; or in the case of a public health emergency described in subsection (g)(1)(B) that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan or a plan referred to in clause (i), whichever is applicable in the State.'' We also inadvertently left out the phrase in section 1135 ''during an emergency period'' when we state the nonapplicability of the sanctions in an emergency area. We are proposing to revise the language at § 489.24(a)(2) to include the aforementioned language to conform the regulation text to the statutory language. Proposed revised § 489.24(a)(2) would read as follows: *''Nonapplicability of provisions of this section.* Sanctions under this section for an inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan do not apply to a hospital with a dedicated emergency department located in an emergency area during an emergency period, as specified in section 1135(g)(1) of the Act. A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic

influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1)(B) of the Act.''

J. Application of Incentives To Reduce Avoidable Readmissions to Hospitals

1. Introduction

A significant portion of Medicare spending—$15 billion each year—is related to hospital readmissions. According to a 2005 MedPAC analysis ,[17] nearly 18 percent of beneficiaries who are discharged from the hospital are readmitted within 30 days, resulting in approximately 2 million readmissions. By MedPAC's method, over 13 percent of 30-day hospital readmissions and an associated $12 billion in spending (⅘ of all Medicare spending for readmissions) were found to be potentially avoidable. Beyond cost considerations, readmissions may reflect poor quality of care and affect beneficiaries'' quality of life. Though not all readmissions are avoidable, hospitals should share accountability for readmission rates that could be much lower through the application of evidence-based best practices. Interventions that have been shown to reduce readmissions include better quality of care during the hospitalization, more complete care plans, emphasis on coordination of care at the point of transitions to home or postacute care, better use of after-hospital care, and more active involvement of patients and caregivers in decision making.

The application of incentives to reduce hospital readmissions, including payment and public reporting approaches, could promote the adoption and development of best practice interventions for averting avoidable readmissions, resulting in higher quality of care for Medicare beneficiaries and reduction in unnecessary costs for the program. Under the current payment system, readmissions are financially rewarding for hospitals. Application of payment incentives to encourage reduction of avoidable readmissions could help address unintended incentives in the current payment system.

In this section, following discussion of readmission issues related to measurement, accountability, and interventions, we are presenting three approaches to applying incentives to reduce avoidable readmissions for public comment: (1) Direct adjustment to hospital DRG payments for avoidable readmissions, (2) adjustments to hospital DRG payments through a performance-based payment methodology, and (3) public reporting of readmission rates. We note that either type of adjustment to hospital payments for readmissions would likely require new statutory authority for the Medicare program. We are seeking public comments on all of the ideas presented in this section.

2. Measurement

Routine, valid, and reliable measurement of hospital-specific rates of readmissions would be a prerequisite to any method of applying incentives for reducing hospital readmissions. Measurement data should be meaningful and actionable for hospitals and should be fair to encourage trust and engagement in the effort. Risk adjustment of measurement data is necessary to account for patientπspecific factors that influence the likelihood of readmission, such as age, disease severity, and comorbidities.

Another important consideration in measurement of readmission rates is the time period from discharge to readmission (for example, 7, 15, 30, or 90 days). In section IV.B. of the preamble of this proposed rule, measures of risk-adjusted 30-day readmission rates are proposed for the RHQDAPU program. The 9th Scope of Work for Medicare Quality Improvement Organizations (QIO 9th SOW) also includes 30-day readmission measures for communities.

Measures should be aligned across settings of care. Hospitals are not the only providers that affect the occurrence of readmissions. For example, the care delivered by SNFs and HHAs also has an important impact on whether a beneficiary is readmitted. Data from aligned readmissions measures, applicable to various settings of care, would provide better information about care coordination problems within and between settings. Alignment of readmissions measures would also facilitate more powerful application of incentives across Medicare's payment systems.

Another consideration is whether to focus on all readmissions or to focus on those that are known to be higher cost, more easily preventable, or most frequently occurring. For example, numerous hospitals have successfully implemented programs to reduce readmissions of heart failure patients, so more is known about the prevention of heart failure readmissions. Further, heart failure readmissions may be more costly than readmissions for other conditions. Another focus of efforts to prevent readmissions could be patients with multiple chronic conditions, who may be at the highest risk to experience readmissions.

3. Accountability

In the assignment of accountability for readmissions, risk adjustment of measurement data is one consideration of fairness; however, other factors must also be considered, including avoidability and shared accountability. Most clinicians would agree that a goal of zero readmissions may not be appropriate, as an extremely low rate of readmissions could indicate restricted access to needed medical services, overuse of hospital resources during the initial hospitalization (for example, prolonged length of stay), or excessive intensity of post-acute care services. Adequate risk adjustment could help to elucidate the avoidability of readmissions by identifying an expected readmission rate for a given patient or patient population.

Shared accountability is another important consideration. Hospitals are clearly accountable for the care provided during hospitalization and can also affect the quality of care provided after the hospitalization, but hospitals are not the only accountable entity. Both during and after hospitalization, physicians and other health professionals share accountability for the quality of care. Other provider entities, including skilled nursing facilities, rehabilitation facilities, home health agencies, and end-stage renal disease facilities, also share accountability for avoidable readmissions. Medicare beneficiaries themselves and their caregivers and social support systems play important roles in avoiding readmissions, particularly when beneficiaries have been discharged to home.

Assignment of accountability also requires consideration of situations where the patient presents for readmission with a different diagnosis or presents to a different hospital. If the

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