RULES AND REGULATIONS

Title 28—HEALTH AND SAFETY

DEPARTMENT OF HEALTH

[28 PA. CODE CHS. 101 AND 117]

Sexual Assault Victim Emergency Services

The Department of Health (Department), following consultation with the Health Policy Board, amends Chapters 101 and 117 (relating to general information; and emergency services). The amended regulations are set forth in Annex A.

A. *Scope and Purpose of the Rulemaking*

This final-form rulemaking amends Chapter 117 to add minimum requirements for the physical and psychological treatment of sexual assault victims by hospitals of this Commonwealth. Although most hospitals currently provide medical services to sexual assault victims, there are no standard requirements for what services must be provided. This final-form rulemaking provides minimum requirements to be observed by all hospitals for "sexual assault emergency services," which include services related to assessment and prophylactic treatment of sexually transmitted diseases, counseling regarding the assault either onsite or at a rape crisis center, and information and services related to emergency contraception. Further, this final-form rulemaking takes into consideration the needs of law enforcement in protecting the community by making evidence gathering easier and more consistent, and helping in the prosecution of sex crimes.

This final-form rulemaking includes an exemption from requirements relating to the provision of emergency contraception services for hospitals that believe provision of that particular service would be contrary to the stated religious and moral beliefs of the hospital. This final-form rulemaking also provides that hospitals currently offering the most limited range of services and electing to refer all emergency patients after institution of essential lifesaving measures may also elect not to provide any sexual assault emergency services. These hospitals will be required to comply with certain notice and transport provisions.

The Department published notice of the proposed rulemaking at 36 Pa.B. 6403 (October 21, 2006) and provided a 30-day public comment period.

The Department received comments from a variety of commentators including insurers, advocacy groups, professionals and religious organizations. The Department also received comments from the Independent Regulatory Review Commission (IRRC). The comments and the Department's responses to them appear in the summary of this final-form rulemaking.

B. *Summary*

General Comments and Revisions

In addition to comments on specific sections of the regulations discussed, the Department received some general comments as follows.

IRRC suggested the Department provide additional information regarding the need for these regulations, including quantifying the number of victims who did not receive the appropriate and necessary care and services. Unfortunately, for a variety of reasons, many sexual assaults go unreported and victims are less likely to seek treatment for injuries related to a sexual assault than for injuries related to other crimes. A 2001 report from The Center for Sex Offender Management (a collaborative effort of the Office of Justice Programs, the National Institute of Corrections, and the State Justice Institute administered by the Center for Effective Public Policy and the American Probation and Parole Association), included statistics from the National Crime Victimization Surveys (Bureau of Justice Statistics) conducted in 1994, 1995 and 1998. These studies indicated that only 32% of sexual assaults against persons 12 or older are reported to law enforcement. A separate 3-year longitudinal study of 4,008 adult women found that 84% of respondents who identified themselves as sexual assault victims did not report the crime to authorities. Because of this underreporting, it is not possible for the Department to accurately quantify some of the information requested by IRRC.

However, research conducted by the ACLU and the Clara Bell Duvall Reproductive Freedom Project indicate that approximately 48% of hospitals in this Commonwealth provide emergency contraception to female sexual assault victims on a regular basis. Almost 35% of the hospitals surveyed had some emergency contraception policy, but it varied and was unclear. This final-form rulemaking seeks to ensure increased access to appropriate medical and psychological treatment for sexual assault victims by standardizing the policies and procedures which hospitals develop for treatment of sexual assault victims. Proper implementation of this final-form rulemaking will significantly increase the number of hospitals that provide emergency contraception on a regular basis, and eliminate any uncertainty as to established procedures which may currently exist.

One commentator noted the regulations do not address issues regarding parental consent for minors. Currently, the laws of the Commonwealth recognize that minors may individually consent to certain medical treatment or services that pertain to reproductive health and rights. See, *Parents united for Better Schools, Inc. v. School District of Philadelphia Board of Education*, 978 F.Supp. 197 (E.D. Pa. 1997); *Carey v. Population Services International*, 431 U.S. 678 (1977); *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976); 42 U.S.C. § 300 et seq.; 42 U.S.C. § 1396(a)(10)(A); and section 3 of the act of February 13, 1970 (P. L. 19, No. 10) (35 P. S. § 10103). This includes the right to obtain emergency contraception without parental consent, and over the objections of a parent or guardian. A minor may also refuse to take emergency contraception notwithstanding a parent or guardian's insistence that the medication be provided. A reference card which includes information regarding a minor's right to obtain emergency contraception and many of the other services required by these regulations has been developed by several groups, including the Children's Hospital of Philadelphia, Children's Hospital of Pittsburgh, Penn State Children's Hospital, St. Christopher's Hospital for Children, the ACLU of Pennsylvania and *Physicians for Reproductive Choice and Health*. This card can be located online at www.aclupa.org/downloads/PAminorscard2005.pdf, or www.prch.org/med_ed/minors_rights/Penn.pdf. As information regarding the rights of minors to obtain the necessary treatment for a sexual

assault is readily available, the Department has decided not to include additional information in the final-form rulemaking.

Another commentator noted that Plan B, an emergency contraception drug, is now available over-the-counter for individuals 18 or older. The commentator questioned the need for this rulemaking in light of these developments. The Department is aware that even prior to the Food and Drug Administration's (FDA) approval of Plan B as an over-the-counter drug, sexual assault victims could obtain emergency contraception by prescription at many local pharmacies, clinics, physicians offices and at some hospitals which had developed procedures for treating sexual assault victims. However, the goal of these regulations is to ensure a victim receives full and adequate care at one location. Therefore the Department has made no revisions to the regulations.

One commentator suggested the Department seek to have funds made available for increased Sexual Assault Nurse Examiner, Sexual Assault Forensic Examiner and Sexual Assault Response Team training. Although the Department hopes these regulations will encourage practitioners to seek this training and for hospitals and local government and law enforcement authorities to encourage this training, the Department is not able at this time to provide funding. However, the information available to the Department about this training shows it is not cost prohibitive for hospitals or practitioners to seek the training as a means to increase their awareness of the appropriate treatment of sexual assault victims and provide the highest level of services possible for their communities.

The Department has also made other minor and nonsubstantive revisions to the regulations. These revisions correct grammatical or spelling errors or make more appropriate reference to provisions which were not properly identified in the proposed regulations.

Section 101.4. Definitions.

One commentator suggested the Department amend the definition of "emergency contraception" to mirror that in Senate Bill 990 of the 2005-2006 Pennsylvania Legislative Session (PN 2109), the Compassionate Assistance for Rape Emergencies Act (SB 990). The commentator argued that the definition proposed by the Department might prohibit some hospitals from providing emergency contraception, because interfering with the implantation of a fertilized ovum within the uterus may be contrary to the religious or moral beliefs of these hospitals. The definition in SB 990 had been revised to exclude the phrase "implantation of a fertilized ovum within the uterus." Although the Department did not adopt the suggested definition, it has revised the definition in a manner it believes addresses the concerns of the commentators.

Although none of the comments received indicated that the commentators were confused about the difference between emergency contraception and mifepristone, it is important to distinguish the two here for clarification. The most recognized brand name for emergency contraception, Plan B, contains levonorgestrel, a synthetic version of the hormone progestin. By taking two pills within the time period specific by the manufacturer, levonorgestrel can prevent pregnancy. Levonorgestrel primarily acts by stopping ovulation, that is, the release of an egg from the ovary. It may also inhibit or prevent fertilization if an egg has already been released, or inhibit or prevent the implantation of a fertilized egg within the uterus. If a fertilized egg is implanted before taking levonorgestrel, the drug will not be effective.

Mifepristone, often referred to as RU-486, is a synthetic steroid compound which is used as an abortifacient in the first 2 months of pregnancy. Unlike emergency contraception which is only effective before pregnancy, mifepristone has the effect of a medical abortion. To be clear, the Department is not sanctioning the use of mifepristone by this final-form rulemaking and, due to the fact that it would have the effect of causing the termination of an existing pregnancy, the use of mifepristone is governed by separate provisions of law. Furthermore, although some studies have indicated that a 10 mg dose of mifepristone may have contraceptive effects of preventing ovulation, the smallest dose approved by the FDA at this time is 200 mg. As a result, under current approvals, mifepristone could not be used as emergency contraception under this final-form rulemaking.

Some commentators suggested revisions to the definitions of "rape crisis center" and "sexual assault counselor." IRRC also suggested a revision to the definition of "sexual assault counselor," and inquired as to the training requirement in the definition. The Department has not changed the proposed rulemaking in response to these comments. For both of these terms, the Department utilized the definitions currently existing in 42 Pa.C.S. § 5945.1 (relating to confidential communications to sexual assault counselors). This section of the *Pennsylvania Consolidated Statutes* creates the confidentiality of communications between victims and sexual assault counselors. The Department will keep the definitions as proposed to ensure hospitals refer victims to the appropriate individuals and locations, and that the statutory confidentiality is preserved.

One commentator also suggested the term "sexual assault" and its definition, as presented in the proposed regulations, may be considered limited to just those crimes included under the term "sexual assault" as defined in 18 Pa.C.S. § 3124.1 (relating to sexual assault). Because the term "sexual assault" is generally understood to include various sex crimes, as is evidenced by the term "sexual assault counselor" in 42 Pa.C.S. § 5945.1, the Department decided to retain this term. The term "sexual assault" was also used in SB 990, and is found in legislation recently enacted in the Commonwealth, the Sexual Assault Testing and Evidence Collection Act (35 P. S. §§ 10172.1—10172.4). Although the Department has retained the term "sexual assault" in this final-form rulemaking, the definition has been revised to more clearly indicate that all crimes defined in 18 Pa.C.S. Chapter 31, Subchapter B (relating to definition of offenses) except indecent exposure as defined in 18 Pa.C.S. § 3127 (relating to indecent exposure) and sexual intercourse with an animal as defined in 18 Pa.C.S. § 3129 (relating to sexual intercourse with animal), are included in the regulation's definition of "sexual assault."

In a comment related to the issue of the use of the term "sexual assault," some commentators, including IRRC, recommended the Department consider changing to the term "sexual assault victim" and definition of that term. This comment was based on the possibility that the Department would revise the term "sexual assault" under the previous comments. Because of the revisions to the definition of "sexual assault" and the other reasons previously listed, no revisions to this term or its definition are necessary.

§ 117.15. Community-based plan.

§ 117.41. Emergency patient care.

Although these sections of the existing Department regulations relating to emergency services in hospitals

were not included in the proposed rulemaking, IRRC suggested that the Department revise the proposed rulemaking or existing provisions in Chapter 117 to resolve inconsistencies between the use of the terms "rape" currently existing in § 117.15(b)(4)(iii) and (9) and the term "sexual assault" as included in the proposed rulemaking. In response to these suggestions, the Department has revised § 117.15(b)(4)(iii) and (9) to replace the term "rape" with "sexual assault." This change does not alter the intent or reading of these existing provisions and in fact assists in providing a clearer understanding as to their applicability.

Sexual Assault Victim Emergency Services

Section 117.51. Scope.

As a result of the following changes, the Department has renamed this section from "Principle" to "Scope" to more accurately describe its purpose in this final-form rulemaking.

IRRC questioned the need for this section of the regulations, stating that the section appeared to serve as a "table of contents" for the other provisions in the proposed rulemaking, and did not add any substantive material to it. In response to this comment, and as a result of changes made to other sections of the regulations as discussed in more detail as follows, § 117.51 has been revised to more clearly establish its purpose of identifying which hospitals are subject to this final-form rulemaking.

Some commentators requested the Department remove any language that allowed facilities to elect not to provide any sexual assault emergency services pursuant to the exemption provisions of § 117.58 (relating to exemption for hospitals providing limited emergency services). Alternatively some commentators suggested the Department clarify the language in this section to require all hospitals proficient in providing these services to be required to do so. As these comments are more specifically related to the exemption provisions of § 117.58, the Department has included its response to the comments to § 117.58.

One commentator suggested the Department include language indicating the specific governmental interest in the promulgation of this final-form rulemaking. The statement is not appropriate for the regulations as it does not direct facility conduct or set a regulatory standard under which the Department's surveyors can review a facility for compliance. However, the governmental interest for promulgating this final-form rulemaking was discussed in the preamble published with the proposed regulations, and is also discussed throughout this preamble.

Section 117.52. Minimum requirements for sexual assault emergency services.

Most of the commentators commended the Department on the establishment of comprehensive minimum guidelines for the treatment of sexual assault victims in proposed § 117.52. However, some commentators did make comments and suggestions.

One commentator suggested this final-form rulemaking be more explicit as to the type of evidence that must be collected under the provisions of proposed § 117.52(a)(1). The commentator also suggested the Department mention the use of rape kits in this section. IRRC agreed with these comments. Following the publishing of proposed rulemaking by the Department, the Sexual Assault Testing and Evidence Collection Act (35 P. S. §§ 10172.1—10172.4) was enacted, requiring the Department to administer a Statewide sexual assault evidence collection program. As part of this program, the Department is to consult with the Pennsylvania Coalition Against Rape and the Pennsylvania State Police to develop minimum standard requirements for all rape kits used in hospitals and to test and approve commercially available rape kits for use in this Commonwealth. As a result of this legislation and in response to these comments, the Department has revised § 117.52(a)(1) to include a requirement that all hospitals providing sexual assault emergency services utilize the minimum standards and rape kits as approved by the Department under that act. A list of minimum standards for rape kits and rape kits approved by the Department under the Sexual Assault Testing and Evidence Collection Act will be published in the *Pennsylvania Bulletin*.

One commentator recommended the Department revise proposed subsection (a)(1) to add "as indicated by the history of the incident" at the end of the paragraph. Due to the nature of a sexual assault, this information may not be available to a practitioner before the practitioner begins to provide services. Further, the Department does not wish to include language which may be read to limit the practitioner's ability to decide what information is important for determining the appropriate examinations and tests which should be conducted. Accordingly, the Department has decided not to include the suggested language.

Another commentator suggested specific revisions to the requirements in proposed subsection (a) to create a more general requirement of diagnostic testing and treatment as deemed appropriate by the physician, and eliminating some of the more specific requirements in proposed subsection (a)(4)—(6). Due to the overwhelming comments commending the Department for its comprehensive approach to treatment of sexual assault victims, including the specific provisions in this section, the Department has retained the language included in the proposed regulations. Based on these and other comments, however, the Department has revised the language of proposed subsection (a)(5) to make it clear that a determination of the necessary testing is left to the professional judgment of the examining practitioner based on the practitioner's assessment of the victim's condition.

Another commentator recommended the Department specify that a hospital is only required to provide a victim with the initial dosage of STD or HIV prophylaxis and to give the victim information on how to obtain the rest of the recommended regimen, if any. Similar comments were received in response to proposed § 117.54 (relating to prevention of sexually transmitted diseases). This comment is addressed as follows along with the comments received in response to proposed § 117.54, and revisions have been made accordingly.

Three commentators also recommended that the Department revise the regulations to require hospitals to contact a rape crisis center or sexual assault counselor immediately upon a sexual assault victim presenting at the facility. Those commentators indicated the rape crisis center or sexual assault counselor could then advise the sexual assault victim about the services they offer and provide other counseling and information regarding treatment of the sexual assault. Although the Department believes contact with a rape crisis center or sexual assault counselor would be of great assistance to sexual assault victims, the sexual assault victim should have the ability to decide whether a center or counselor will be contacted both to protect the privacy of the victim and to

allow the victim to make an informed decision about the extent of the treatment the victim wishes to receive. Based on their experience, hospitals and their practitioners could inform the sexual assault victim of the benefits of speaking with a rape crisis center or sexual assault counselor. The Department has, however, revised subsection (a)(7) to require prompt notification of a rape crisis center or sexual assault counselor if the victim makes that request.

Two commentators suggested that the Department include a requirement for the provision of emergency contraception in this section to clearly indicate its importance in the appropriate treatment of female sexual assault victims. Similar comments were received in response to proposed § 117.53 (relating to emergency contraception). Although the Department believes the regulations do sufficiently identify the importance of emergency contraception, language has been added to this section in subsection (a)(9) to address the commentators' concerns.

Some commentators suggested the Department establish certain minimum training standards that physicians and nurses who treat sexual assault victims must meet. Another commentator recommended that the Department require that hospitals staff their facilities with Sexual Assault Nurse Examiners or Sexual Assault Forensic Examiners, or that the hospitals work with Sexual Assault Response Teams to perform evaluations and treatment and to conduct evidence collection. IRRC also made a similar suggestion. While the Department would encourage hospitals to utilize the most appropriately trained staff to provide the services required by this final-form rulemaking, the Department believes hospitals and their staff are best suited to determine the appropriate training for practitioners treating sexual assault victims under this final-form rulemaking.

IRRC inquired as to how the requirements in subsection (a) are to be balanced with other potential acute care needs of a sexual assault victim. IRRC also submitted similar comments in response to proposed §§ 117.57 and 117.58 (relating to religious and moral exemptions; and exemption for hospitals providing limited emergency services). The Department is cognizant of the fact that a sexual assault victim may present at a hospital with other physical injuries from the sexual assault, some of which may take medical priority for treatment over the requirements of these regulations. To eliminate any concerns that the regulations may be read as taking priority over other medical care which may require more immediate attention, the Department has revised subsection (a) to require a hospital to provide the required services promptly, or as immediately thereafter as medically appropriate depending on the condition of the victim. A hospital shall also provide other services for treatment of the sexual assault as medically indicated by the condition of the victim, including treatment for any injuries or trauma resulting from a violent physical attack.

IRRC also inquired as to the accessibility of medical records under these provisions. First, IRRC noted one commentator's concern that gathering information about the sexual assault and the victim and including it in the medical record may lead to its use against the victim in a court of law. Some commentators also noted the regulations do not speak directly to confidentiality or privacy. IRRC also questioned the accessibility of this information by others. Second, IRRC inquired as to the length of time a hospital is required to maintain medical records under this final-form rulemaking.

As to the concerns for confidentiality and privacy, the Department notes confidentiality and privacy of medical information is currently addressed and protected by various provisions of law which must be adhered to by the facility and practitioners, including common law and statutory privileges like the doctor-patient privilege, Federal law like the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. § 1320d et. seq.; 45 CFR 160.101 (relating to statutory basis and purpose)) and State law like the Department's hospital regulations (Chapter 115 (relating to medical records services)). For example, § 115.27 (relating to confidentiality of medical records) provides for the confidentiality of medical records and procedures for their release. Hospitals and practitioners would be required to maintain any confidentiality or privileges provided in State and Federal law. Similarly, nothing in these regulations conflicts or supersedes the provisions of the "Rape Shield Law," 18 Pa.C.S. § 3104(a) (relating to evidence of victim's sexual conduct), which provides for the inadmissibility of evidence of a sexual assault victim's past sexual conduct in criminal proceedings.

With regards to the length of time medical records must be maintained, the Department notes its regulations, as they appear in Chapter 115, already address issues relating to medical records in hospitals. Specifically, § 115.23 (relating to preservation of medical records) provides the time periods for the retention of records. To ensure hospitals are aware of the requirement to maintain these records in a manner consistent with the provisions in Chapter 115, the Department has revised subsection (b) of this section to include reference to this chapter.

Section 117.53. Emergency contraception.

The Department received a comment requesting that it remove any specific requirement that the hospital provide a female sexual assault victim with emergency contraception. The commentator argued the language was unnecessary and that individual practitioners should determine which medication would be appropriate for the victim. As recent events in this Commonwealth have demonstrated that at least one hospital did not include emergency contraception in the policies and procedures for treating sexual assault victims, the Department believes specific language requiring hospitals to provide emergency contraception is appropriate, and has not revised the regulations.

The Department received several comments on the requirements for the oral and written emergency contraception information that must be provided by hospitals to sexual assault victims contained in proposed subsection (a)(1) and (2). The Department has addressed those comments in its discussion of § 117.55 (relating to emergency contraception informational materials).

The Department also received comments requesting the regulations specify that the oral information about emergency contraception hospitals give to sexual assault victims also be objective and medically and factually accurate. The requirement of paragraph (2), formerly proposed subsection (a)(2), that hospitals provide oral information goes beyond that of the written information materials, which only requires the hospital provide the materials to the victim without further explanation or information regarding the availability of emergency contraception. This provision requires hospitals to inform the victim of the fact that emergency contraception is available at the hospital and to explain its use, risks and efficacy. This requirement, and other requirements in §§ 117.52(a),

117.54 and 117.56 (relating to minimum services for sexual assault emergency services; prevention of sexually transmitted diseases; and information regarding payment for sexual assault emergency services) will assist in opening a dialogue between the hospital and the victim to ensure that the victim is fully informed of the available treatment for the sexual assault. Information provided by a hospital to a patient is required by other provisions of law to be medically and factually accurate, and as such, including that requirement here is unnecessary. The Department has added language to require that, at a minimum, the oral information about emergency contraception required by the regulations be objective.

Several commentators recommended revisions to the language in proposed subsection (b) regarding pregnancy testing prior to the provision of emergency contraception to female sexual assault victims. One commentator also suggested the Department broaden the language to include ovulation testing in order to allow certain hospitals to exercise moral conscience. Other commentators requested that the Department limit the ability of a facility to conduct a pregnancy test or to condition providing emergency contraception on a pregnancy test. Some commentators suggested language regarding pregnancy tests be eliminated altogether. IRRC also questioned the need for this provision, considering emergency contraception will have no effect in eliminating an existing pregnancy. IRRC commented, however, that if pregnancy is a contraindication of emergency contraception this should be specifically mentioned in the regulations.

Having considered all these comments, the Department has removed proposed subsection (b) to eliminate any of the potential problems raised by the commentators, and has renumbered the section accordingly. A hospital or practitioner may choose to exercise conscience without a regulation from the Department. Although pregnancy is a contraindication for the administration of emergency contraception, hospitals and health care practitioners should exercise professional judgment in informing sexual assault victims about the contraindications of medications and treatment available to the victim. Accordingly, the Department has clarified paragraph (3) to indicate that emergency contraception must be provided unless medically contraindicated or unless the hospital is operating under the religious or moral exemption of § 117.57.

Section 117.54. Prevention of sexually transmitted diseases.

One commentator suggested the Department eliminate this section entirely, and instead create and provide written informational materials which could be used by the victim to determine the treatment they wish to receive. While the Department is charged with promoting the health, safety and adequate care of residents in healthcare facilities in this Commonwealth, it is not appropriate for the Department to supplant the role of healthcare providers and practitioners in providing appropriate medical information and treatment to individuals. Substituting the compassionate care which is offered by health care providers and health care practitioners in this Commonwealth with written informational materials may be viewed as inappropriate, especially for an individual who presents at a hospital as the victim of a traumatic event such as a sexual assault. The Department has, therefore, retained this section with certain revisions as described as follows.

Two commentators requested the Department delete the phrase "significantly prevalent" as it appeared in subsections (a) and (c). The commentators also suggested the Department add "including Hepatitis and HIV" to these subsections. As the hospital providing treatment to a victim is best able to determine which tests and treatments are appropriate, the Department has revised the regulations to incorporate these suggestions and allow hospitals more latitude in making these decisions.

These commentators also suggested the Department delete "and tests that may be conducted" from proposed subsection (b)(1). The commentators included no explanation for this recommendation. The risk assessment required by subsection (a) would include consideration of results from tests which may be conducted by the hospital to ensure that a victim receives the appropriate treatment. The Department has not revised the proposed subsection in response to these comments.

Some commentators suggested the Department clarify the requirement that hospitals provide STD prophylaxis to indicate that only an initial 72-hour dosage be provided, with the hospitals providing the victim information and the means, such as prescriptions, for obtaining the remainder of the medication if it is deemed necessary. Although, based on risk assessment conducted by the hospital pursuant to the regulations, some victims may not need STD prophylaxis medication, in other instances certain findings of the risk assessment or the unavailability of some information needed to complete the risk assessment may necessitate a victim receiving at least the initial 72-hour dosage. During this 72-hour period, additional information may be obtained by the hospital which would allow it to inform the victim as to whether continuing with the full dosage is necessary. A victim should not be burdened with the expense and difficulty of continuing with a 30-day regimen of STD prophylaxis if it is determined the full regimen is unnecessary. The Department has revised the regulations to incorporate the commentators' suggestions.

Some commentators asked who would be responsible for payment of the cost of STD prophylaxis and noted the potential high cost of this medication. The Department has included provisions in § 117.56 to require that hospitals inform victims of known resources for payment, including programs for the uninsured or underinsured. In fact, another commentator recommended the inclusion of text from 42 Pa.C.S. § 1726.1 (relating to forensic examination costs for sexual offences), which specifically provides that the "cost of a forensic rape examination or other physical examination conducted for the purpose of gathering evidence in any criminal investigation and prosecution under 18 Pa.C.S. Chapter 31 (relating to sexual offenses) and the cost to provide medications prescribed to the victim therein shall not be charged to the victim. If appropriate insurance is unavailable, reimbursement may be sought pursuant to the provisions of section 477.9 of the act of April 9, 1929 (P. L. 177, No. 175), known as The Administrative Code of 1929." (42 Pa.C.S. § 1726.1.) The referenced section of The Administrative Code of 1929 provides for reimbursement by the Victims Compensation Assistance Program. Because of existing law, therefore, the Department believes no revisions are necessary to address this concern.

IRRC recommended the Department include a more specific citation to the United States Department of Health and Human Services Centers for Disease Control and Prevention (CDC) risk assessment standards referenced in subsections (b) and (c). At the current time, the CDC includes its recommendations in a guidance document entitled "Sexually Transmitted Diseases Treatment Guidelines, 2006." This document, and its recommenda-

tions, can currently be found at www.cdc.gov/std/treatment/default.htm. This document was also included in the August 4, 2006, edition of the CDC's *Morbidity and Mortality Weekly Report*. Centers for Disease Control and Prevention, *Sexually Transmitted Diseases Treatment Guidelines*, 2006. MMWR 2006;55 (No. RR-11). However, as the Department is unable to predict when this document will be updated (previously the recommendations were included in "Sexually Transmitted Diseases Treatment Guidelines, 2002") or whether the recommendations will be incorporated into another CDC publication, the regulations do not include a specific document citation which may require constant revisions in the future. Hospitals and their staff should be capable of locating these guidelines for inclusion in their treatment policies and procedures and are likely already aware of these guidelines. Accordingly, no revisions have been made under IRRC's recommendations.

Section 117.55. Emergency contraception informational materials.

One commentator suggested the Department eliminate this section, because the substance of this section is addressed in § 117.52 (relating to minimum requirements for sexual assault emergency services). This section, however, contains additional information not included in § 117.52, and it is necessary for implementation of the regulations. Therefore, the Department has not revised this section.

Some commentators suggested the Department include more specific standards for the written informational materials, or review and approve the materials created by the hospitals. At least one commentator suggested the Department create the materials and make them available to hospitals. After considering these comments, the Department has revised § 117.55(b) to provide that the Department will develop the written emergency contraception informational materials and make them available to hospitals in electronic format. Hospitals, and the general public, will be able to obtain these materials from the Department's website or by requesting an electronic copy from the Department. Hospitals will be required to obtain the information materials, print them, and make them available to their staff and to sexual assault victims. This will ensure consistency in the information provided and reduce the cost to hospitals for compliance with these provisions.

Another commentator suggested the Department produce a list of locations where emergency contraception can be obtained. Some commentators suggested the written emergency contraception informational materials include a list of locations where emergency contraception is available. Due to the Department's limitations, it is not possible to create individual documents for each hospital to use, identifying the locations nearest to each hospital where emergency contraception is available. Although the materials will not include a specific list of locations where emergency contraception is available, the materials will inform victims of its availability, including the requirements that certain hospitals provide emergency contraception to sexual assault victims. Further, the materials will include contact information for rape crisis centers, where victims can obtain additional assistance, including counseling and referral for emergency contraception.

In contrast to the previous comments, one commentator suggested that requiring hospitals that exercise the religious or moral exemption provided under § 117.57 to refer victims to locations where emergency contraception can be obtained could constitute material cooperation by the hospital in an activity it finds contradicts with its stated religious or moral beliefs. The Department will be producing the written emergency contraception materials to be used by hospitals, so that this concern should no longer be an issue. Furthermore, the commentator noted that providing a victim with contact information for a rape crisis center would not violate the stated religious or moral beliefs with which this commentator was concerned. The materials prepared by the Department will not include a list of locations to obtain emergency contraception, but will provide a toll free number that a sexual assault victim can call to contact a local rape crisis center.

Section 117.56. Payment for sexual assault emergency services.

One commentator suggested this section was unnecessary because hospitals already provide patients with information on financial resources available to pay for services received. The commentator asked that this section be deleted. Several other commentators commended the Department on requiring this information be provided by hospitals. Although § 103.22(b)(18) and (19) (relating to implementation) do contain language similar to that in § 117.56, this section goes further in identifying some of the specific resources for payment, including, for example, the Victim Compensation Assistance Program administered by the Pennsylvania Commission on Crime and Delinquency. By including this section, the Department will be able to identify additional financial resources in the regulations as they become available. It is imperative that a sexual assault victim is properly informed of financial resources for payment of the care, to ensure that a victim does not refuse treatment based on a concern of the inability to pay for the services. IRRC also commented on this section, and stated that "the regulations should require that victims receive comprehensive information on their financial responsibility and all resources available to them for covering the costs of their treatment." The Department agrees, and has accordingly retained this section of the regulations.

Another commentator requested the Department include clarification about Medicaid and Medicare payment methods for these services. It is impractical for the Department to provide more specifics about these programs in its regulations, since they are currently operated by other agencies, and are subject to change before the Department has an opportunity to amend its regulations. To ensure the regulations will not require regular revisions, no revisions have been made in response to these comments. More information regarding the treatment or services covered by Medicaid or Medicare can be obtained from the agencies responsible for administering these programs.

One commentator suggested the Department explore ways to reduce the cost of services to victims, such as working with drug manufacturers to lower medication costs. Although reducing costs of services and medications for sexual assault victims is certainly important, it would be inappropriate for the Department to engage in the negotiations and transactions required to accomplish these goals. However, there are several sexual assault victim advocacy groups in this Commonwealth that can negotiate with hospitals and drug manufacturers to achieve the same goals, and this is preferable to government intervention in cost of services or medication.

One commentator suggested the Department more clearly state whether victims will be responsible for any costs associated with the provision of these services. Because the costs for services and payment methods for

each sexual assault victim are unique, the Department cannot develop specific language to address each separate circumstance. The Department has not revised the regulations in response to the commentator's concerns.

One commentator noted that sexual assault victims should be provided information to inform them that any applicable medical insurance company need not be notified of the fact the individual was the victim of a sexual assault. However, the commentator did not provide sufficient information for the Department to determine the specific circumstances under which this statement would apply. Further, the method by which a hospital or individual requests reimbursement from a health insurer, and the information that must be provided to the insurer in order for reimbursement to occur, are not within the Department's control. The Department has not revised the regulations in response to this comment.

Section 117.57. Religious and moral exemptions.

Some commentators suggested the Department include a religious and moral exemption for individual practitioners similar to that included in this section for hospitals. The Department has not revised the regulations in response to these comments. The Health Care Facilities Act (HCFA) (35 P. S. §§ 448.101—448.904a) provides the Department with the authority to license and regulate health care providers and facilities, not health care practitioners. The authority to license and regulate the health care practitioners who would provide the services in hospitals under the regulations is vested in the Department of State. A hospital should develop procedures that would assure the provision of sexual assault victim emergency services in accordance with the Department's regulations and yet still accommodate an individual practitioner's needs. Furthermore, the Department, through its regulations relating to civil rights (28 Pa. Code §§ 51.11—51.13 and 101.161—101.165 (relating to civil rights)), requires compliance with all civil rights laws with regards to the treatment of patients and facility personnel, and discrimination against a practitioner on the basis of religion is prohibited.

Some commentators suggested that hospitals should not be provided a religious or moral exemption to the requirement that hospitals provide emergency contraception to sexual assault victims. The religious or moral exemption regarding the provisions of emergency contraception by hospitals is not created by the Department through its regulations. Instead, the regulations recognize the language of the HCFA, which creates the exemption, and provides for certain notification and transport provisions for hospitals eligible for and availing themselves of the exemption. Further, even if the HCFA did not provide the exemption, some stakeholders have argued that Pennsylvania's Religious Freedom Protection Act (RFPA) (71 P. S. §§ 2401—2407) would prohibit the Department from requiring certain hospitals to provide emergency contraception. As any exemption which may exist is a matter of statutory language enacted by the General Assembly, the Department cannot revise the regulations to address the commentators' concerns.

One commentator suggested a facility's denial of emergency contraception could be considered discriminatory towards the victim and a violation of the sexual assault victim's constitutional and statutory rights. IRRC also submitted comments to the Department on this issue and asked that it be resolved in light of one commentator's concerns that requiring hospitals to provide emergency contraception may violate the RFPA. The Department has not been presented with any law or court ruling which would support the position that an individual has a religious or civil right to be provided a particular medication in a hospital. The Department is not in a position to make ultimate determinations on whether a hospital's refusal to provide emergency contraception would violate any rights conferred to the victim. A review is up to the applicable courts. However, the Department does enforce applicable law, and would reexamine the regulations if presented with sufficient legal authority to support the commentator's position.

Some commentators suggested that, even if a hospital were able to avail itself of a religious or moral exemption to the requirement that the hospital provide emergency contraception to a sexual assault victim, the exemption should not be extended to the requirements in § 117.52(a)(2). That section states that a hospital must orally inform the victim of the availability of emergency contraception. Comments submitted by one commentator suggest that providing oral information regarding emergency contraception would not violate a facility's religious or moral beliefs. Having reviewed material regarding religious objection to providing emergency contraception, the Department agrees with these comments and it has revised the regulations to require all hospitals to provide oral information about emergency contraception.

One commentator provided alternative language which, although similar to that in the proposed regulations, did not give reference to the HCFA, and did not ensure that arrangements would be made to arrange for transportation for a victim to a location that could provide emergency contraception. Although the Department appreciates comments which provide alternative language, the Department has not incorporated the language into this final-form rulemaking.

Some commentators suggested the "safeguards" of the RFPA be incorporated into the regulations to ensure a hospital does not improperly claim a religious or moral exemption. Another commentator suggested a hospital should be required to apply to the Department for an exception to exercise a religious or moral belief. One commentator requested additional clarification on what constituted a "religious" hospital. IRRC similarly inquired as to what the Department would deem "religious or moral beliefs."

Because the HCFA applies to all hospitals, where the RFPA only applies to those hospitals which fall within the RFPA's definition of "person," the Department opted to make reference to the HCFA which is equally applicable to hospitals within the Department's regulatory authority. However, neither the HCFA nor RFPA grant the Department the authority to make determinations of the applicability of these laws to a hospital's stated religious or moral beliefs. Those determinations can be made by a court of law. Accordingly, the Department is only requiring that a hospital inform the Department of its intent to exercise the exemption in § 117.57, and provide it with documentation, reviewed and approved by the hospital's governing body, to confirm the hospital's stated religious or moral beliefs. The Department will review this notification to ensure a facility does in fact have a stated religious or moral belief against the provision of emergency contraception. It should be noted that the *Pennsylvania Code* currently provides for a similar arrangement with regards to a facility's stated ethical policy as it pertains to abortion or sterilization. (*See* 16 Pa. Code §§ 51.31—51.33 (relating to rights and obligations of hospitals and other health care facilities).)

Another commentator argued the referral and transport provisions could violate a hospital's rights and the RFPA. The Department's regulations do not require referral of the victim to a facility where emergency contraception is provided, nor do they require transport by the hospital. As noted previously, the written emergency contraception informational materials will list a telephone number for a rape crisis center. This Center can make the appropriate referral of the victim to a location where emergency contraception can be obtained without the hospitals involvement. Further, a hospital is not required to actually transport the victim, but instead is required to arrange for transportation for the victim. This can be accomplished, and the regulations complied with, by having the hospital make arrangements with a local rape crisis center or other similar sexual assault victim assistance organization to provide transportation to the victim. The RFPA states that an agency shall not "substantially burden the free exercise of religion without compelling justification." 71 P. S. § 2402(1). The Department does not believe that the regulations present a substantial burden to the free exercise of religion under the RFPA. Even if it could be argued that the regulations present a substantial burden to the free exercise of religion, they do so in furtherance of compelling interests of the Department and are the least restrictive means of furthering the interest.

The Department has a compelling interest in the protection of the health, safety and welfare of the residents of this Commonwealth. Furthermore, the Department has a compelling interest in the reduction of the harmful effects, health concerns and complications which may be caused by unwanted and unplanned pregnancies which may result from sexual assaults. As drafted, the regulations are the least restrictive means of achieving these compelling interests as they reduce and even eliminate an objecting hospitals involvement in the provision of emergency contraception to sexual assault victims and allow hospitals to comply with these requirements by seeking the assistance of third-parties who can provide transportation for a victim to a location where emergency contraception could be obtained.

One commentator requested the Department require hospitals operating under this exemption inform sexual assault victims verbally and in writing that it can arrange for a transfer of the victim, at no cost, to a facility that will provide emergency contraception. Other commentators suggested the hospitals should be required to inform the victims of their objections to emergency contraception immediately upon the victims presenting at the hospitals. The regulations have been revised to clearly indicate that a hospital is required to provide oral and written information to a victim of the availability of the arrangement for transportation. (*See* § 117.57(5).) A similar revision has been made to § 117.58. (*See* § 117.58(5).) The written emergency contraception materials created by the Department will also provide this information. Furthermore, it is important to allow the practitioners at a facility to make the appropriate assessment of each sexual assault victim and determine the timing of the services and treatment that will be provided. As detailed as follows, the Department has also revised the regulations to require prominent posting of the facility's exercise of the exemption. (See §§ 117.57(5) and 117.58(5)).

One commentator suggested that if a victim cannot be transferred to a facility that will provide emergency contraception, the treating hospital should be required to provide emergency contraception notwithstanding any religious or moral belief to the contrary. The regulations require a hospital to ensure that all treatment is provided. If a hospital determines the extended treatment of a victim could result in a victim not receiving emergency contraception due to the hospital's religious or moral belief, the hospital should inform the victim and make arrangements to transfer the victim to a facility that will continue with any treatment required for the victim, including emergency contraception. If a hospital delays informing the victim of the availability of emergency contraception, or delays in arranging for transportation, until such time as emergency contraception would no longer be effective, the hospital may not be in compliance with the regulations.

Another commentator suggested the Department address any conflict between § 117.57 and SB 990. At the end of the 2005-2006 Regular Session, SB 990 had failed to pass. On February 7, 2007, the Pennsylvania House referred House Bill 288 (HB 288), the Sexual Assault Victim Emergency Treatment Act, to the Health and Human Services Committee. Although similar to SB 990, HB 288 does not contain the religious exemption language that was included in SB 990. To date, no bill has been passed by the General Assembly regarding requirements for the provision of emergency contraception in hospitals in this Commonwealth. The Department will review these regulations periodically to determine their consistency with any subsequent legislation at either the State or Federal level which may provide for requirements similar to or related to those in these regulations.

Some commentators, including IRRC, asked the Department to require a victim to be transferred to the "closest" hospital, not just a hospital in "close proximity." Similar comments were made with regards to the transfer provision in § 117.58. The Department is cognizant of the possibility that in some areas, a hospital may exist which is not located in this Commonwealth but does provide the required services and is the closest hospital to where the victim is located. Further, in situations when other treatment has been provided and arrangements need only be made to ensure the victim receives emergency contraception, locations other than hospitals may be available. The Department has revised the regulations in light of these possibilities, including permitting transportation to out-of-State hospitals and to locations other than hospitals where emergency contraception is available.

One commentator suggested hospitals operating under the exemptions in either this section or § 117.58 prominently post this information in the hospital's emergency services area so a sexual assault victim receives additional notice of the limitation of services provided by the hospital. IRRC agreed with this recommendation. The Department has revised the regulations to include prominent posting of notice in the hospital's emergency service areas. (*See* § 117.57(1).)

Some commentators inquired as to applicability of the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 U.S.C.A. § 1395dd) and related regulations at 42 CFR 489.24 (relating to special responsibilities of Medicare hospitals in emergency cases) to these regulations, and specifically to the exemptions and transfer provisions in this section and § 117.58. The Department notes that nothing in the regulations contradicts EMTALA or requires or allows a facility to violate the provisions of EMTALA. All hospitals which provide emergency services and are subject to EMTALA must provide the appropriate medical screening examinations and are required to treat or transfer sexual assault victims in

accordance with the requirements of EMTALA. However, there is no indication that the Centers for Medicare and Medicaid Services (CMS) considers the provision of emergency contraception to be an emergency medical service which in itself would invoke the requirements of EMTALA. It should be noted that guidance issued by CMS provides that preventative care services (which, although not specific, could include medications to prevent pregnancy) and a request for gathering of evidence for criminal law cases (rape kits) are not considered, by CMS, to be medical care services under EMTALA, and do not invoke the provision of a medical screening examination under EMTALA. The implications of EMTALA on hospitals operating under the § 117.58 exemption present distinct issues which are addressed in the responses to comments to that section.

Some commentators, including IRRC, inquired as to whether the Department required a transfer under § 117.57 be completed by an ambulance. The commentators also asked what authority the Department had to require a transfer by ambulance and who would be responsible for the cost. IRRC was also concerned about the cost of transporting victims for what may be considered nonemergency treatment. One commentator argued that requiring hospitals operating under the § 117.57 exemption to pay for the transfer would be a tax on the hospital for the exercise of their religious or moral beliefs.

If a transfer by ambulance would be required under EMTALA or other applicable law, the Department would expect the applicable parties to comply with those laws. However, if current laws do not require transfer by ambulance for the purposes of obtaining emergency contraception, then these regulations should not be construed as a new requirement to do so. The Department is requiring a hospital operating under the exemption in § 117.57 to arrange for reasonable transportation for the victim. (See, § 117.57(2).) This can be accomplished in any one of various methods, including transfer by law enforcement, by a sexual assault counselor, or by a hospital transportation service. To avoid confusion, the Department has revised the regulations to eliminate the use of the word "transfer" in § 117.57 and replace it with "transportation."

In response to the inquiry regarding payment for the transportation, the Department is only requiring that the victim not bear the cost of this transportation. Depending on the transportation arrangements made by the hospital, these costs could be covered by one of the programs available to cover the costs for sexual assault victims, or transportation could be provided by a rape crisis center who might not seek reimbursement for its services. It is not possible, therefore, to quantify these costs or determine a payer in the regulations.

Section 117.58. Exemption for hospitals providing limited emergency services.

Some commentators suggested the Department revise the proposed rulemaking to prevent hospitals from electing not to provide emergency services to sexual assault victims under § 117.58. One commentator suggested the Department more specifically define who is permitted to exempt themselves from the regulations under this exemption. Conversely, one commentator noted it was appropriate to allow hospitals to individually determine whether nor not they would provide emergency services to sexual assault victims, to ensure victims receive treatment in hospitals with more experience and whose practitioners are proficient in the treatment of sexual assaults. That commentator, however, did have concerns about some of the more proficient hospitals electing not to provide sexual assault emergency services.

Generally, the Department's regulations relating to health care facilities do not require hospitals to provide any specific services or treatment or any particular level of services. However, the existing hospital regulations do provide hospitals with guidelines for determining which level of emergency services to provide based on the scope of services otherwise generally provided by the hospital. Specifically, § 117.13 (relating to scope of services) provides for three levels of care which are acceptable in a hospital, ranging from full "effective care for any type of patient requiring emergency services" by hospitals that otherwise "offer a broad range of services," (§ 117.13(1)) to allowing hospitals to "refer all emergency patients after institution of essential life-saving measures" for hospitals that otherwise offer only "the most limited range of services." (§ 117.13(3).) Based on the concerns raised by some commentators on the exemption provisions in § 117.58, the Department has revised this section to allow only hospitals with the "most limited range of services" to continue to refer all emergency patients and exempt themselves from treating sexual assault victims in accordance with the regulations. These hospitals currently have procedures for ensuring patients in need of emergency services are not transported to their facilities and for referral and transfer of those who nevertheless present at the hospital. However, nothing should be construed to prevent a hospital operating an emergency service area under § 117.13(3) from providing emergency services to sexual assault victims if that hospital believes it can appropriately provide the services and the community which they serve would benefit from them providing the services. Hospitals electing not to provide services must still comply with certain notification provisions and should transfer victims in accordance with their current transfer policies.

Some commentators were concerned as to how a hospital electing not to provide sexual assault emergency services should respond to a victim who presents with a need for services relating to the sexual assault but not directly covered by these regulations, such as injuries from a physical assault. Again, the revisions made by the Department address these concerns. Hospitals governed by this section should have current policies and procedures that include provisions to deal with stabilizing the victim prior to transfer to another facility. These policies and procedures would apply for transfer and transport of sexual assault victims.

Another commentator asked whether hospitals that elect not to provide emergency contraception under the religious and moral exemption in § 117.57 in only limited circumstances must still comply with the notification provisions. Although the refusal by these hospitals to provide emergency contraception may be limited, the fact that a hospital could legally exercise its religious rights to deny emergency contraception demands that the public be notified to limit the occasions in which a victim will be required to receive services in piecemeal fashion. Accordingly, all hospitals which at any time may deny emergency contraception under a stated religious or moral belief must comply with the notification provisions of this section. To clarify this requirement, the regulations have been revised to include separate notification provisions in § 117.57 and this section.

Some commentators asked which law enforcement agencies and ambulance and emergency medical care and transport services must be notified under the provisions

of proposed subsection (a). Under existing regulations, hospitals are required to develop a community based plan for the provisions of emergency services. (See §§ 117.11—117.15.) This plan is to be developed "with community participation and be coordinated with the local emergency health services council." (§ 117.15(b)(1).) Based on these existing provisions, hospitals are aware of the law enforcement agencies and ambulance and emergency medical care and transport services which may transport sexual assault victims to their facilities. Accordingly, the Department has made no revisions to the regulations.

One commentator suggested the Department require that hospitals notify their local emergency health services council of their exercise of either of the exemptions in proposed § 117.57 or this section. As stated previously, a hospital's community based plan is to be developed "with community participation and be coordinated with the local emergency health services council." (§ 117.15(b)(1).) Therefore, notification can be achieved pursuant to existing regulatory requirements. Furthermore, as the Department will publish notice in the *Pennsylvania Bulletin* of hospitals operating under the exemptions in § 117.57 and this section, there are adequate provisions to ensure these groups will be notified. (See §§ 117.57(1)(ii) and 117.58(1)(ii).) The Department has made no revisions to this section.

One commentator suggested hospitals be required to provide posted notice at the facility if they do not provide sexual assault victim emergency services under the exemption proposed in this section. The Department has revised the regulations to incorporate the commentator's suggestion. (See § 117.58(5).)

Another commentator suggested the Department require hospitals notify the applicable law enforcement agency if they receive and transfer a sexual assault victim under the provisions of proposed § 117.58. To respect the privacy of the victim, and in light of the possibility that the victim may not desire to report the crime to law enforcement, revisions have not been made to address these comments. Hospitals are nevertheless required to comply with any laws requiring notification to law enforcement of the treatment of victims of crimes, and nothing in these regulations should be construed as superseding those requirements.

Some commentators were concerned the exemption provisions of § 117.58 might limit the number of hospitals providing emergency services to sexual assault victims and increase the time it takes to transport a victim to a hospital. The commentators argued this could lead to higher costs, reduction on the number of ambulances available to respond to the emergency calls at a particular time, limit patient choice and delay treatment. One commentator asked the Department to remove "at no cost" from proposed subsection (b)(2) in response to concerns of how these costs would be reimbursed.

The Department believes the revisions made to the regulations to allow only those hospitals providing emergency services under § 117.13(3) to exempt themselves from these regulations resolve these concerns. It is unlikely that victims are currently being taken to these facilities as the ambulance and law enforcement communities should be aware of which hospitals provide the broader range of services necessary for the appropriate treatment of a sexual assault victim. If a victim presents at one of these hospitals, there are procedures in the hospital's current operations for properly transferring the victim to a hospital that can appropriately provide the required services.

These revisions also address the concerns of commentators regarding who will pay for the transfer of these victims when they present to a hospital that does not provide sexual assault emergency services. Current practices with regards to these transfer costs may also be applied for the treatment sought for a sexual assault. As the transfer procedures for these hospitals are currently in place, the Department has removed "at no cost" from proposed subsection (b)(2) (renumbered as paragraph (6)) to eliminate any interference with those standing procedures.

Some commentators raised similar issues with respect to EMTALA and ambulance transfers with respect to this section and § 117.57. Commentators questioned the Department's authority to promulgate a regulation, and whether the ambulance community must respond if the transfer is not considered medically necessary. Commentators also raised the same issues regarding the applicability of EMTALA to hospitals that do not provide any sexual assault emergency services. These concerns are addressed in response to the comments relating to § 117.57. Further, they are also resolved by the revisions to this section, as current policies and procedure for the hospitals operating emergency services areas under § 117.13(3), which should be in compliance with State and Federal law and EMTATA, would apply to transfers and transports of sexual assault victims.

Some commentators, including IRRC, requested that additional guidance be included in the regulations for the term "close proximity" as used in proposed § 117.57, or to change this term to require transport to the "closest" hospital. The Department has revised paragraph (6) to address these concerns by incorporating the latter recommendation. (See § 117.58(6).)

IRRC suggested the final-form rulemaking clarify that the notification provisions of proposed subsection (a) apply to two types of exemptions, the exemption from providing only emergency contraception under proposed § 117.57 and the exemption from providing any sexual assault victim emergency services under proposed § 117.58. The Department has revised the regulations in response to this comment by providing separate notification requirements in §§ 117.57 and 117.58.

IRRC also suggested the Department clarify when the list of hospitals not providing services will be published. The Department has revised the regulations to provide that the list will be published annually. (See § 117.58(1)(ii).) Also, the Department will post the most recent listing on its website to reduce the need to regularly update the list between annual publications.

IRRC also suggested the regulations require ambulance or emergency medical service transport personnel inform victims of their hospital choices and whether emergency contraception would be available at certain hospitals. Although this information is very useful for victims, these regulations provide for requirements for hospital, and do not pertain to ambulance or emergency medical services personnel. However, ambulance and emergency medical services personnel are encouraged to provide sexual assault victims with any information the victim may find useful in seeking treatment for the sexual assault.

C. *Affected Persons*

This final-form rulemaking will affect all hospitals in this Commonwealth licensed by the Department, which will be required to consider whether or not they will provide sexual assault emergency services. Those hospitals eligible for one of the exemptions under § 117.57 or

§ 117.58, and electing to exercise one of those exemptions, will be required to inform the Department, ambulance and emergency medical care and transport services, and law enforcement agencies of this decision within a specified time frame. Further, hospitals choosing not to provide these services under § 117.57 or § 117.58 will be required to develop policies and procedures for informing sexual assault victims of the hospital's position on these issues, and for arranging to transport or transfer victims who request to be taken to locations that do provide the applicable services.

Hospitals required to provide sexual assault emergency services will need to develop policies and procedures to comply with the regulations, including those relating to provision of informational materials relating to emergency contraception, sexually transmitted diseases, and pregnancy.

This final-form rulemaking will also affect sexual assault victims, who will be offered the same information and care at all hospitals in this Commonwealth required to provide sexual assault emergency services. Victims will also be offered the opportunity to be transported to hospitals that did offer these services, if they present at a hospital that does not do so.

Lastly, this final-form rulemaking will affect law enforcement agencies and ambulance and emergency medical care and transport services, since those groups should make efforts to be aware of the list of hospitals that provide sexual assault emergency services, so that a victim may be taken to a hospital where the victim will receive appropriate sexual assault emergency services.

D. *Cost and Paperwork Estimate*

1. *Cost*

a. *Commonwealth*

There will be additional costs to the Commonwealth resulting from this final-form rulemaking associated with the Department's need to enforce the regulations. The Department estimates an additional position for a Health Facility Quality Administrator will be required to survey and inspect hospitals to ensure compliance with the regulations and respond to complaints relating to the manner in which these regulations will be implemented by the hospitals. These costs will include salary, benefits, workstation, computer, telephone, travel, training, and other related costs. Reducing the effects a sexual assault will have on victims through implementation of the regulations and the services offered through them, however, would outweigh the estimated costs.

The Department will also incur costs for the development of the written emergency contraception informational materials. The Department estimates that it will cost approximately $4,500 to develop the written informational materials in seven languages and in an English audio format. Additionally, the Department could add an additional language translation of the informational brochures each year to increase the accessibility of this information to all persons in this Commonwealth.

b. *Local Government*

There will be no additional cost to local government. Although the regulations will require that hospitals exercising either of the exemptions under § 117.57 or § 117.58 to send notice to law enforcement agencies of their decision not to provide those services, this requires no additional work on the part of law enforcement agencies. The Department will publish, on an annual basis, a compiled list of those hospitals in the *Pennsylvania Bulletin*, and post the list on its website.

c. *Regulated Community*

There will be additional cost to hospitals in this Commonwealth. Although the Department will develop the information materials regarding emergency contraception, hospitals will be required to obtain the electronic format of these materials from the Department and print them so that they may be provided to sexual assault victims they treat. The Department estimates the full color printing costs to range from $ 0.20 to $ 0.50 per page depending on the quantity and quality of the printing. Based on the high cost in this range and a printing of 5,000 brochures per year, the Department estimates it would cost the regulated community $2,500 per year to comply with these provisions of the regulations.

In addition to these costs, hospitals could have additional costs of reviewing current procedures and making any changes necessary to comply with the regulations. These costs will depend upon what procedures individual hospitals in this Commonwealth currently have in place. However, hospitals may be able to reduce their costs by coordination of these efforts.

d. *General Public*

There is no additional cost for the general public. In fact, since victims of rapes and other sexual offenses and their families are members of the general public, and may be subject to serious medical and psychological effects as a result of the crime, including sexually transmitted disease and pregnancy, there will be a benefit to the general public from the implementation of these regulations. Because the regulations will also aid in gathering information necessary for investigation and successful prosecution of a violent crime, society as a whole will benefit from the implementation of the regulations.

2. *Paperwork Estimates*

a. *Commonwealth*

To effectively survey and inspect hospitals for the purpose of enforcing the regulations, the Department estimates additional survey and inspection time equivalent to an additional position for one Health Facility Quality Administrator will be necessary. There will be the need to review complaints in this additional area of regulation; the Department, however, already has a process in place for the review and investigation of complaints against hospitals.

Further, the Department will be required to obtain and compile a list of hospitals that are eligible and claim one of the exemptions under § 117.57 or § 117.58, and to publish that list, on an annual basis, in the *Pennsylvania Bulletin*, and post the list on its website.

The Department will also be required to produce written emergency contraception information materials which will be made available to hospitals for distribution to sexual assault victims in accordance with the requirements of the regulations. The Department proposes to produce these materials in a variety of languages and in audio format.

b. *The Regulated Community*

Hospitals will be required to either develop or obtain informational materials on sexually transmitted diseases, pregnancy, emergency contraception and the need for additional testing. However, documents and written guid-

ance currently exist relating to these topics, many of which are currently in use by hospitals in this Commonwealth.

Hospitals will also be required to review current policies and procedures and make any changes necessary to comply with the regulations. Whether additional or revised policies or procedures are necessary depend upon what policies and procedures each hospital currently has in place.

b. *Local Government*

There is no additional paperwork requirement for local government. Although the final-form rulemaking will require that hospitals eligible for and exercising either of the exemptions under § 117.57 or § 117.58 to send notice to law enforcement agencies of their decision not to provide emergency contraception or sexual assault emergency services, this requires no additional work on the part of law enforcement agencies. The Department will publish a compiled list in the *Pennsylvania Bulletin* on an annual basis.

c. *General Public*

There is no additional paperwork requirement for the general public.

E. *Statutory Authority*

Section 803(2) of the Health Care Facilities Act (act) (35 P. S. § 448.803(2)), authorizes the Department to promulgate, after consultation with the Health Policy Board, regulations necessary to carry out the purposes and provisions of the act. See also, 35 P. S. § 448.601 ("The Department, in the exercise of its duties under this act shall have the power to adopt such regulations as are necessary to carry out the purposes of this act.") Section 801.1 of the act (35 P. S. § 448.801a), provides that a purpose of the act is to promote the public health and welfare through the establishment of regulations setting minimum standards for the operation of health care facilities. The same section provides that the minimum standards are to assure safe, adequate and efficient facilities and services, and are also to promote the health, safety and adequate care of patients or residents of the facilities. The General Assembly has also stated that a purpose of the act is, among other things, to assure that all citizens receive humane, courteous and dignified treatment. See 35 P. S. § 448.102. Finally, the act provides the Department with explicit authority to enforce its rules and regulations promulgated under the act. *See* 35 P. S. § 448.201(12).

The Department also has the duty to protect the health of the people of this Commonwealth under section 2102(a) of The Administrative Code of 1929 (71 P. S. § 532(a)). The Department has general authority to promulgate regulations under the Code for this purpose. See 71 P. S. § 532(g).

F. *Effectiveness/Sunset Dates*

This final-form rulemaking will become effective upon its publication in the *Pennsylvania Bulletin*. No sunset date has been established. The Department will continually review and monitor the effectiveness of these regulations.

G. *Regulatory Review*

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), the Department submitted a copy of a notice of proposed rulemaking, published at 36 Pa.B. 6403 (October 21, 2006), to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Health and Human Services Committee and the Senate Public Health and Welfare Committee. In compliance with section 5(c) of the Regulatory Review Act, the Department also provided IRRC and the Committees with copies of all comments received during the formal comment period, as well as other documentation.

In compliance with section 5.1(a) of the Regulatory Review Act, the Department submitted a copy of the final-form regulations to IRRC and the Committees on Monday, September 17, 2007. In addition, the Department provided IRRC and the Committees with information pertaining to commentators and a copy of a detailed Regulatory Analysis Form prepared by the Department. A copy of this material is available to the public upon request.

In preparing this final-form rulemaking, the Department has considered all comments received from IRRC, the Committees and the public.

This final-form rulemaking was deemed approved by the House Health and Human Services Committee and by the Senate Public Health and Welfare Committee on October 17, 2007. IRRC met on October 18, 2007, and approved the regulations in accordance with section 5.1(e) of the Regulatory Review Act. The Attorney General approved the regulations on January 9, 2008.

H. *Contact Person*

Questions regarding these regulations may be submitted to Sandra Knoble, Acting Director, Bureau of Facility Licensure and Certification, Department of Health, Room 932, Health and Welfare Building, 7th and Forster Streets, Harrisburg, PA 17120, (717) 787-8015. Persons with a disability may submit questions in alternative format such as by audio tape, Braille or by using V/TT (717) 783-6514 or the Pennsylvania AT&T Relay Service at (800) 654-5984 (TT). Persons who require an alternative format of this document may contact Sandra Knoble at that address or telephone numbers so that necessary arrangements may be made.

I. *Findings*

The Department, after consultation with the Health Policy Board, finds that:

(1) Public notice of intention to adopt the regulations adopted by this order has been given under sections 201 and 202 of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. §§ 1201 and 1202), and the regulations thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(2) A public comment period was provided as required by law and all comments were considered.

(3) The adoption of regulations in the manner provided by this order is necessary and appropriate for the administration of the authorizing statute.

J. *Order*

The Department, after consultation with the Health Policy Board, acting under the authorizing statute, orders that:

(1) The regulations of the Department, 28 Pa. Code Chapters 101 and 117, are amended by adding §§ 117.51—117.58 and by amending §§ 101.4, 117.15 and 117.41 to read as set forth in Annex A, with ellipses referring to the existing text of the regulations.

(2) The Secretary of Health shall submit this order and Annex A to the Office of General Counsel and the Office of Attorney General for approval as required by law.

(3) The Secretary of Health shall submit this order, Annex A and a Regulatory Analysis Form to IRRC, the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare for their review and action as required by law.

(4) The Secretary of Health shall certify this order and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(5) This order shall take effect immediately upon publication in the *Pennsylvania Bulletin*.

CALVIN B. JOHNSON, M. D., M.P.H.,
Secretary

(*Editor's Note:* For the text of the order of the Independent Regulatory Review Commission relating to this document, see 37 Pa.B. 5951 (November 3, 2007).)

Fiscal Note: 10-182. (1) General Fund; (2) Implementing Year 2007-08 is $40,000; (3) 1st Succeeding Year 2008-09 is $80,997; 2nd Succeeding Year 2009-10 is $85,765; 3rd Succeeding Year 2010-11 is $90,837; 4th Succeeding Year 2011-12 is $97,433; 5th Succeeding Year 2012-13 is $101,973; (4) 2006-07 Program—$16,057,000; 2005-06 Program—$14,529,526; 2004-05 Program—$14,157,071; (7) Quality Assurance; (8) recommends adoption.

Annex A

TITLE 28. HEALTH AND SAFETY

PART IV. HEALTH FACILITIES

Subpart B. GENERAL AND SPECIAL HOSPITALS

CHAPTER 101. GENERAL INFORMATION

§ 101.4. Definitions.

The following words and terms, when used in this subpart, have the following meanings, unless the context clearly indicates otherwise:

* * * * *

Emergency contraception—

(i) A drug, drug regime or device approved by the Food and Drug Administration that is used after sexual intercourse to inhibit or prevent ovulation or fertilization.

(ii) The term also includes a drug, drug regime or device approved by the Food and Drug Administration that is used after sexual intercourse to inhibit or prevent the implantation of a fertilized ovum within the uterus.

* * * * *

Rape crisis center—An office, institution or center that offers assistance to a sexual assault victim or the victim's family through crisis intervention, medical and legal accompaniment and follow-up counseling.

* * * * *

Sexual assault—Any offense specified in 18 Pa.C.S. Chapter 31, Subchapter B (relating to definition of offenses), except that the term does not include indecent exposure as defined in 18 Pa.C.S. § 3127 (relating to indecent exposure) or sexual intercourse with an animal as defined in 18 Pa.C.S. § 3129 (relating to sexual intercourse with animal).

Sexual assault counselor—A person who is engaged or employed by a rape crisis center that arranges for the provision of services to a sexual assault victim, who has undergone at least 40 hours of sexual assault training and is under the control of a direct services supervisor of a rape crisis center, whose primary purpose is the rendering of advice, counseling or assistance to victims of sexual assault.

Sexual assault emergency services—A medical examination, forensic examination, or other procedure or service provided by a hospital to a sexual assault victim because of a sexual assault.

Sexual assault victim or victim—A person who has been sexually assaulted.

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CHAPTER 117. EMERGENCY SERVICES

§ 117.15. Community-based plan.

(a) Every hospital, its governing board, its chief administrative officer and its medical staff shall promote and assist other local agencies to develop a written community-based emergency plan.

(b) The plan must:

(1) Be developed with community participation and be coordinated with the local emergency health services council, where one exists.

(2) Indicate where cooperative arrangements, if any, have been made with other local hospitals to coordinate emergency services, especially when the hospital offers a very limited range of emergency services.

(3) Indicate what arrangements with other local hospitals, agencies or municipal services have been made for transportation in receiving and referring emergency cases and for communication among relevant institutions and services.

(4) State specifically what services are available and what administrative procedures shall be followed for prompt, medically appropriate treatment of patients whose emergency conditions:

(i) Are psychiatrically related.

(ii) Involve the use of drugs or alcohol.

(iii) Arise from an alleged criminal act, including specific procedures in the case of an alleged sexual assault.

(iv) Arise from a motor vehicle accident.

(v) Involve radioactive contamination.

POLICIES AND PROCEDURES

§ 117.41. Emergency patient care.

(a) Emergency patient care shall be guided by written policies and procedures which delineate the proper administrative and medical procedures and methods to be followed in providing emergency care. These policies and procedures shall be clear and explicit; approved by the medical staff and hospital governing body; reviewed annually; revised as necessary; and dated to indicate the date of the latest review or revision, or both.

(b) Policies and procedures for emergency patient care should, at a minimum, do the following:

(1) Provide for the admission of a patient if, in the judgment of the physician, admission is warranted.

(2) Provide for the referral and placement of patients whose needs cannot be met by the hospital.

(3) Establish procedures to minimize the possibility of cross-infection and contamination.

(4) Provide for the discharge of patients only upon written orders of a physician. Telephone discharge orders may be accepted in accordance with § 107.62 (relating to oral orders).

(5) Specify explicitly the location and mode of storage of medications, supplies and special equipment.

(6) Establish methods for 24-hour-a-day procurement of equipment and drugs.

(7) Establish procedures for notification of the personal physician of the patient and the transmission of relevant reports to the physician.

(8) Establish procedures on disclosure of patient information. Policies on confidentiality of emergency room records must be the same as those which apply to other hospital medical records. The identity and the general condition of the patient may be released to the public after the next of kin have been notified.

(9) Plan for communication with police, local or State health or welfare authorities as appropriate, regarding accident victims and patients whose condition or its cause is reportable, for example, persons having contagious diseases or victims of suspected criminal acts such as sexual assault or gunshot wounds, see 18 Pa.C.S. § 5106 (relating to failure to report injuries by firearm or criminal act), and child abuse, see 23 Pa.C.S. Chapter 63 (relating to Child Protective Services).

(10) Instruct personnel in special procedures for handling persons who are mentally ill, under the influence of drugs or alcohol, victims of suspected criminal acts or contaminated by radioactive material or who otherwise require special care or have other conditions requiring special instructions.

(11) Instruct personnel how to deal with patients who are dead on arrival.

(12) Provide for a review by the appropriate committee of the medical staff of each death occurring on the emergency service or, if there is no service, of each death occurring during the performance of essential life-saving measures prior to transfer to another facility.

(13) Explain the role of the emergency service in the hospital's disaster plan established in accordance with Chapter 151 (relating to fire, safety and disaster services).

(14) Delineate medical staff obligations for emergency patient care.

(15) Specify which procedures may not be performed in the emergency area.

(16) Provide for appropriate utilization of any beds used for observation.

(17) Establish procedures to be used when the patient is required to return to the hospital for treatment, for example, when treatment is impossible to arrange otherwise.

(18) Establish procedures for early transfer of severely ill or injured patients to special treatment areas within the hospital, such as the surgical suite, the intensive care unit or the cardiac care unit.

(19) Delineate instructions to be given to a patient or the patient's family, or both, or others as appropriate regarding follow-up care.

(20) Make available to the emergency service current toxicological reference material along with the telephone numbers of the regional poison control center.

(21) Provide for the ready availability of reference materials and charts relating to the initial treatment of burns, cardiopulmonary resuscitation and tetanus immunization.

(22) Provide for effective coordination with outpatient services, where these services are provided.

(23) Establish procedures to clearly inform patients of emergency service billing policies, including prominent display of that information in the emergency service area. This information must indicate whether patients are to be billed separately for physicians' services and other emergency services. Those hospitals having an obligation under section 2 of the Hospital Survey and Construction (Hill-Burton) Act (42 U.S.C.A. §§ 291—291o), shall comply with the provisions of that act as it relates to free and low-cost care.

SEXUAL ASSAULT VICTIM EMERGENCY SERVICES

§ 117.51. Scope.

Except as otherwise provided by §§ 117.57 and 117.58 (relating to religious and moral exemptions; and exemption for hospitals providing limited emergency services), a hospital shall provide sexual assault emergency services to a sexual assault victim in accordance with this section and §§ 117.52—117.58 (relating to sexual assault victim emergency services).

(1) A hospital that does not provide emergency contraception under the exemption in § 117.57 shall comply with the notification and transport provisions of that section.

(2) A hospital that provides the most limited range of services and elects to refer all emergency patients after institution of essential life-saving measures in accordance with § 117.13(3) (relating to scope of services), and elects not to provide any sexual assault emergency services under § 117.58, shall comply with the notification and transfer provisions of that section.

§ 117.52. Minimum requirements for sexual assault emergency services.

(a) Promptly upon a sexual assault victim presenting to a hospital that provides sexual assault emergency services, or as immediately thereafter as medically appropriate depending on the condition of the victim, the hospital shall, at a minimum and in addition to any other services required by the condition of the victim, provide, with the consent of the victim, the following:

(1) Medical examinations and laboratory or diagnostic tests required to ensure the health, safety and welfare of the victim, or which may be used as evidence in a criminal proceeding against a person accused of the sexual assault, or both. A hospital shall utilize a rape kit that complies with the minimum standard requirements developed by the Department or that is otherwise approved by the Department under the Sexual Assault Testing and Evidence Collection Act (35 P. S. §§ 10172.1—10172.4). The Department will publish a notice of minimum standard requirements for rape kits or approved rape kits in the *Pennsylvania Bulletin*.

(2) Oral and written information concerning the possibility of a sexually transmitted disease and pregnancy resulting from the sexual assault.

(3) Oral and written information concerning accepted medical procedures, medication and possible contraindi-

cations of the medication available for the prevention or treatment of infection or disease resulting from the sexual assault.

(4) Medication as deemed appropriate by the attending physician, including HIV and sexually transmitted disease prophylaxis.

(5) Tests and examinations as medically indicated to determine the presence or absence of a sexually transmitted disease.

(6) Oral and written instructions advising of the need for additional blood tests at time periods after the sexual assault as medically indicated to determine the presence or absence of a sexually transmitted disease.

(7) Information on the availability of a rape crisis center or sexual assault counselor and the telephone number of a local rape crisis center or sexual assault counselor. The hospital shall promptly contact the local rape crisis center or sexual assault counselor at the request of the victim.

(8) The opportunity for the victim to consult with the rape crisis center or sexual assault counselor in person and in private while at the hospital.

(9) Emergency contraception under § 117.53 (relating to emergency contraception) for a female sexual assault victim.

(b) A hospital shall maintain records of the results of all examinations, tests and services provided to a sexual assault victim in accordance with Chapter 115 (relating to medical record services) and other applicable laws and regulations, and make those records available to law enforcement officials upon the request and with the consent of the sexual assault victim.

§ 117.53. Emergency contraception.

A hospital shall provide the following services to a female sexual assault victim in addition to the minimum requirements set forth in § 117.52 (relating to minimum requirements for sexual assault emergency services):

(1) Provide the victim with written informational materials regarding emergency contraception prepared under § 117.55 (relating to emergency contraception informational materials).

(2) Objectively and orally inform the victim of the availability of emergency contraception, its use, risks and efficacy.

(3) Offer emergency contraception to the victim and provide emergency contraception onsite upon the victim's request, unless medically contraindicated or unless the hospital claims an exemption in accordance with § 117.57 (relating to religious and moral exemptions).

§ 117.54. Prevention of sexually transmitted diseases.

(a) A hospital shall provide a sexual assault victim with an assessment of the victim's risk for contracting a sexually transmitted disease, hepatitis and HIV.

(b) The hospital shall base the risk assessment upon the following considerations:

(1) Available information regarding the assault as well as the subsequent findings from medical examinations and tests that may be conducted.

(2) Established standards of risk assessment, including consideration of recommendations made by the United States Department of Health and Human Services Centers for Disease Control and Prevention.

(c) In addition to the assessment required in subsection (a), a hospital shall advise a sexual assault victim of sexually transmissible diseases, hepatitis and HIV, for which postexposure prophylaxis exists, and for which deferral of treatment would either significantly reduce treatment efficacy or would pose a substantial risk to the individual's health.

(d) Upon the victim's consent, the hospital shall provide the victim with an initial dosage of up to 72 hours of postexposure prophylactic treatment for sexually transmissible diseases, hepatitis and HIV, and provide the victim with information and prescriptions necessary to obtain the remainder of the treatment regimen. A hospital will not be required to comply with this subsection when risk evaluation, adopted by the United States Department of Health and Human Services Centers for Disease Control and Prevention, clearly recommends against the application of postexposure prophylaxis.

§ 117.55. Emergency contraception informational materials.

(a) A hospital that provides sexual assault emergency services shall ensure that each member of the hospital personnel that provides the services is furnished with written informational materials about emergency contraception developed by the Department under this section.

(b) The Department will prepare the written emergency contraception informational materials and make them available to hospitals in electronic format.

§ 117.56. Information regarding payment for sexual assault emergency services.

A hospital shall inform a sexual assault victim receiving sexual assault emergency services at the hospital of the availability of known financial resources for services provided to the victim due to the sexual assault, including payments by the victim's medical insurer, if applicable, the Victim's Compensation Assistance Program administered by the Pennsylvania Commission on Crime and Delinquency, government programs, public assistance programs and programs administered by the hospital. The hospital shall provide the victim any information required to secure the services, including copies of itemized bills and medical records.

§ 117.57. Religious and moral exemptions.

In accordance with section 902(a) of the act (35 P. S. § 448.902(a)), a hospital is not required to comply with § 117.53(3) (relating to emergency contraception) if compliance would be contrary to the stated religious or moral beliefs of the hospital. If the hospital does not provide emergency contraception under this religious and moral exemption, the hospital shall do the following:

(1) Notify the Department within 30 days of the hospital's decision not to provide emergency contraception.

(i) The hospital shall address and send the written notice to the Division of Acute and Ambulatory Care.

(ii) The Department will annually publish a list of hospitals in the *Pennsylvania Bulletin* that have chosen not to provide emergency contraception under this section.

(2) Notify the law enforcement agencies that may transport or refer a sexual assault victim to the hospital that the hospital has elected not to provide emergency contraception. The written notice to law enforcement agencies shall be sent no later than 30 days after the hospital's decision not to provide those services.

(3) Notify the ambulance and emergency medical care and transport services that may transport or refer a sexual assault victim to the hospital that the hospital has elected not to provide emergency contraception. The written notice to ambulance and emergency medical transport and care services shall be sent no later than 30 days after the hospital's decision not to provide those services.

(4) Provide individual oral and written notice to the sexual assault victim that emergency contraception is not provided at the hospital due to the stated religious or moral beliefs of the hospital.

(5) Provide oral and written notice to the victim of the hospital's obligation to arrange for transportation for the victim in accordance with paragraph (6). Notice shall also be prominently displayed in the hospital's emergency service area.

(6) Upon request of the victim, arrange for immediate transportation for the victim, at no cost to the victim, to the closest hospital where a victim could obtain emergency contraception. If the victim's medical condition does not require further inpatient hospital services, the hospital may arrange to transport the victim to a rural health clinic, Federally-qualified health center, pharmacy or other similar location where a victim could obtain emergency contraception.

§ 117.58. Exemption for hospitals providing limited emergency services.

A hospital offering the most limited range of services and that elects to refer all emergency patients after institution of essential life-saving measures under § 117.13(3) (relating to scope of services) may elect not to provide any sexual assault emergency services. If a hospital otherwise governed by this subpart elects not to provide any sexual assault emergency services under this section, the hospital shall:

(1) Notify the Department within 30 days of the hospital's decision not to provide any sexual assault emergency services.

(i) The hospital shall address and send the written notice to the Division of Acute and Ambulatory Care.

(ii) The Department will annually publish a list of hospitals in the *Pennsylvania Bulletin* that have chosen not to provide any sexual assault emergency services.

(2) Notify the law enforcement agencies that may transport or refer a sexual assault victim to the hospital that the hospital has elected not to provide any sexual assault emergency services. The written notice to law enforcement agencies shall be sent no later than 30 days after the hospital's decision not to provide those services.

(3) Notify the ambulance and emergency medical care and transport services that may transport or refer a sexual assault victim to the hospital that the hospital has elected not to provide any sexual assault emergency services. The written notice to ambulance and emergency medical transport and care services shall be sent no later than 30 days after the hospital's decision not to provide those services.

(4) Provide individual oral and written notice to the sexual assault victim that sexual assault emergency services are not provided at the hospital.

(5) Provide oral and written notice to the victim of the hospital's obligation to arrange for a transfer of the victim in accordance with paragraph (6). Notice shall also be prominently displayed in the hospital's emergency service area.

(6) Upon request of the victim, arrange for the immediate transfer of the victim to the closest hospital that provides sexual assault emergency services under §§ 117.51—117.56.

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