Information and guidance related to COVID-19 is changing rapidly. Please refer to the Physicians Insurance website for the most up-to-date information.

Guidance on EMTALA Implications for COVID-19

Draft Date: April 16, 2020

Waiver of Certain EMTALA Obligations.

On March 13, 2020, the President formally proclaimed the coronavirus disease/COVID-19 a National Emergency under the National Emergencies Act and/or the Stafford Disaster Relief and Emergency Assistance Act[1]. Prior to that, on January 31, 2020, the HHS Secretary had declared a public health emergency under the Public Health Service Act. These actions allowed the Secretary of HHS to invoke the emergency provisions of Section 1135 of the Social Security Act and waive certain requirements of the Act[2]. These Section 1135 waivers take effect beginning March 1, 2020 (the effective date of the president's declaration of a national emergency) and apply to all providers in the United States. The March 1, 2020 effective date also applies to any authorized waiver approved by CMS.

On March 13, 2020, the HHS Secretary then issued several waivers under 1135(b) of the Social Security Act, 42 U.S.C. 1320b-5 (Authority to waive requirements during national emergencies).[3] Further, HHS authorized CMS to issue 1135 waivers under the Act. However, any waivers issued by CMS apply only to Federal requirements, and do not apply to state requirements for licensure and conditions of participation.[4] As of March 31, WSHA is advocating for the Governor's Office to issue additional state waivers on a number of related topics.

Under the Secretary's waiver, there are **two exemptions from sanctions for noncompliance with EMTALA** (among other stated waivers), absent any determination of fraud or abuse, for health care providers that furnish health care items and services in good faith, but are unable to comply

[1] https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/ (Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak).

[2] Specifically, 42 CFR 489.24(a)(2)(i) provides, "[w]hen a waiver has been issued in accordance with section 1135 of [the Social Security Act], that includes a waiver of section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to received medical screening at an alternate location do not apply to a hospital with a dedicated emergency department if the following conditions are met:
(A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period.
(B) The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan.

[3] https://www.phe.gov/emergency/news/healthactions/section1135/Pages/covid19-13March20.aspx

[4] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/1135-Waivers-At-A-Glance.pdf (*See* CMS 1135 "Waiver at a Glance" bottom of page 1.)

with one or more of the listed requirements as a result of the consequences of the 2019 Novel Coronavirus (COVID-19):

1. Direction or relocation of an individual to another location to receive medical screening pursuant to an appropriate state emergency preparedness plan; or

2. For the transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared Federal public health emergency of the COVID-19 pandemic.[5]

Additionally, in the case of individuals with suspected or confirmed COVID-19, hospitals and critical access hospitals (CAHs) are expected to consider current guidance of CDC and public health officials in determining whether they have the capacity to provide appropriate isolation required for stabilizing treatment and/or to accept appropriate transfers.[6] HHS and other reliable public health entities (*e.g.* the CDC and the World Health Organization) continue to publish new and evolving information on a frequent basis, which relate to screening and treatment for Coronavirus/COVID-19. As a good start, please read the recent global CMS EMTALA COVID-19 Guidance[7].

With respect to 1135 waivers, providers must apply one of the following claim-level identifiers for disaster or emergency-related claims[8]:

- The CR Modifier or
- DR Condition Code

These waivers DO NOT require a request to be sent to the 1135waiver@CMS.hhs.gov mailbox or that notification be made to any of CMS's regional offices.[9]

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[5] *See* waiver at 1.3 and 42 CFR 489.24(a)(2) (Sanctions under section 1867 of the Act (the Emergency Medical Treatment and Labor Act, or EMTALA) for the direction or relocation of an individual to another location to receive medical screening pursuant to an appropriate state emergency preparedness plan or for the transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared Federal public health emergency for the COVID-19 pandemic).

[6] https://www.cms.gov/files/document/qso-20-15-hospital-cah-emtala-revised.pdf (CMS Center for Clinical Standards and Quality/Quality, Safety and Oversight Group, Ref: QSO-20-150) Hospital/CAH/EMTALA, "CMS EMTALA COVID-19 Guidance, Revised" March 30, 2020 [from original March 9, 2020 Guidance], referred to herein as "CMS EMTALA COVID-19 Guidance").

[7] *Id.*

[8] https://www.cms.gov/media/137186 (Medicare Claims Processing Manual); https://www.cms.gov/files/document/se20011.pdf (CMS MLN Matters Number SE 20011, March 20, 2020).

[9] https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf (CMS COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers)

A. EMTALA obligations in light of COVID-19 and 1135 blanket waiver.

If an individual comes to the ED, the hospital must provide the individual with an appropriate medical screening exam (MSE) within its capability to determine whether an emergency medical condition (EMC) exists.[10] If the state emergency preparedness plan permits, the ED may direct or relocate an individual to another location to receive medical screening.[11] If an emergency medical condition is determined to exist (whether based on COVID-19 symptoms or other), the hospital must provide any necessary stabilizing treatment (subject to the above exception), as defined under EMTALA[12] or an appropriate transfer.[13]

1. Medical Screening Examinations (MSEs).

a. Under the Secretary's waiver, CMS is allowing hospitals, psychiatric hospitals, and critical access hospitals (CAHs) to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19, so long as it is not inconsistent with a state's emergency preparedness or pandemic plan.[14] Even so, it is a violation of EMTALA for hospitals and CAHs with EDs to use signage that presents barriers to individuals who are suspected of having COVID-19 from coming to the hospital, or to otherwise refuse to provide an appropriate MSE to anyone who has come to the ED for examination or treatment of a medical condition. However, use of signage designed to help direct individuals to various locations on the hospital property for their MSE would be acceptable.[15]

b. Hospitals and CAHs must conduct the MSE within its capability and capacity,[16] subject to the exception above.

c. An emergency medical condition is present when there are acute symptoms of sufficient severity such that the absence of immediate

[10] 42 CFR 489.24(a)(1)(i).

[11] *See* EMTALA Waiver, *supra* (the state emergency preparedness plan has not permitted such transfer to date).

[12] 42 CFR 489.24(d).

[13] 42 CFR 489.24(e).

[14] https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf (CMS COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers).

[15] CMS EMTALA COVID-19 Guidance, *supra*

[16] 42 CFR 489.24(a)(1)(i).

medical attention could reasonably be expected to result in serious impairment or dysfunction per 42 CFR 489.24(b).[17]

d. Every hospital or CAH with a dedicated ED is required to conduct an appropriate MSE of all individuals who come to the ED, including those suspected of having COVID-19, regardless of whether they arrive by ambulance or are walk-ins.[18]

e. Every ED is expected to have the capability to apply appropriate COVID-19 screening criteria when applicable, and:

(i) to immediately identify and isolate individuals who meet the screening criteria to be a potential COVID-19 patient (isolating patients does not equate to a requirement to admit those patients, see more on this below. It just means they should be isolated from the remaining patients during the rest of their time in the ED); and

(ii) to contact their state or local public health officials to determine next steps when an individual meeting the screening criteria is found.

2. EMTALA Obligations when Screening Suggests Possible COVID-19.

a. Isolation.

(i) If during the MSE, the hospital concludes that an individual who has come to its ED may be a possible COVID-19 case, consistent with accepted standards of practice for COVID-19 screening, the hospital is expected to isolate the patient immediately, to the extent of its capacity and capability or implement appropriate respiratory hygiene (i.e., place a mask on the patient and appropriate PPE for healthcare personnel, etc.) to minimize potential for transmission and direct the patient to an alternate site for testing if available.

(ii) Although levels of services provided by EDs vary widely across the country, it is CMS's expectation that all hospitals are able to, within their capability, provide MSEs and initiate stabilizing treatment, while maintaining the isolation requirements for COVID-19 and

[17] CMS EMTALA COVID-19 Guidance, *supra*.
[18] *Id.*

coordinating with their State or local public health officials, who will in turn arrange coordination, as necessary, with CDC. The CDC guidance is being updated frequently, so be sure to check for the latest guidance at the links below.

(iii) Isolation, per the CDC guidance, includes immediately implementing recommended infection prevention and control practices.[19] This Guidance is being updated very frequently, so be sure to check for the latest guidance at the link below. Key concepts are outlined below. Also, we strongly recommend consulting the document linked below for further detail.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html

(A) Reduce Facility Risk: Limit how germs can enter the facility: cancel elective procedures, use telemedicine when possible, limit points of entry and manage visitors, screen patients for respiratory symptoms, encourage patient respiratory hygiene using alternatives to face masks (*e.g.,* tissues to cover cough).

(B) Isolate symptomatic patients as soon as possible: set up separate, well-ventilated triage areas, place patients with suspected or confirmed COVID-19 in private rooms with door closed and private bathroom (as possible), prioritize AIIRs for patients undergoing aerosol-generating procedures.

(C) Protect healthcare personnel: Emphasize hand hygiene, install barriers to limit contact with patients at triage, cohort COVID-19 patients, limit the numbers of staff providing their care, prioritize respirators and AIIRs for aerosol-generating procedures, implement PPE optimization strategies[20] to extend supplies.

[19] https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html (CDC Coronavirus Disease 2019 (COVID-19) Infection Control Guidance).

[20] https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

b. Stabilization.

(i) If an emergency medical condition is determined to exist, the ED must provide any necessary stabilizing treatment.[21] However, if a transfer of an individual who has not been stabilized is necessary due to the circumstances of the declared emergency – COVID-19 – it is permissible under the Federal waiver. As with any actions taken under the waivers, it should be documented.

(ii) Stabilizing treatment means, with respect to an "emergency medical condition," to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the patient's condition is likely to occur. Once an individual is admitted to the hospital or the emergency medical condition is stabilized, the hospital's obligations under EMTALA end.[22]

(iii) In the case of individuals with suspected or confirmed COVID-19, hospitals and CAHs are expected to consider current guidance of CDC and public health officials in determining whether they have the capability to provide appropriate isolation required for stabilizing treatment and/or to accept appropriate transfers.[23] In the event of any EMTALA complaints alleging inappropriate transfers or refusal to accept appropriate transfers, CMS will take into consideration the public health guidance in effect at the time.

(A) CDC FAQs for Healthcare Professionals:[24] While the CDC FAQs do not directly address when a patient is stabilized or may be safely transferred, it does provide information useful in making that determination. The CDC guidance, under Treatment and Management, provides:

[21] 42 CFR 489.24(a)(1)(ii).

[22] CMS EMTALA COVID-19 Guidance, *supra*.

[23] https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and/emergency-medical-treatment-and-labor-act-emtala-requirements-and-implications-related-coronavirus (CMS EMTALA Requirements and Implications Related to Coronavirus Disease 2019 (COVID-19)).

[24] https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html (CDC Coronavirus Disease 2019 (COVID-19) FAQ for Healthcare Professionals)

1) Q: Do patients with confirmed or suspected COVID-19 need to be admitted to the hospital?

   A: Not all patients with COVID-19 require hospital admission. Patients whose clinical presentation warrants in-patient clinical management for supportive medical care should be admitted to the hospital under appropriate isolation precautions.

   Some patients with initial mild clinical presentation may worsen in the second week of illness. The decision to monitor these patients in the inpatient or outpatient setting should be made on a case-by-case basis. This decision will depend not only on technical presentation, but also on the patient's ability to engage in self-monitoring, the feasibility of safe isolation at home, and the risk of transmission in the patient's home environment.[25]

2) Q: How are COVID-19 patients treated?

   A: Not all patients with COVID-19 will require medical supportive care. Clinical management for hospitalized patients with COVID-19 is focused on supportive care for complications, including supplemental oxygen and advanced organ support for respiratory failure, septic shock, and multi-organ failure. Empiric testing and treatment for other viral or bacterial etiologies may be warranted.

   Corticosteroids are not routines recommended for treatment of viral pneumonia or ARDS, due to potential for prolonging viral replications, as has been observed with MERS coronavirus and influenza. Corticosteroids should be avoided unless they are indicated for another reason (e.g., COPD exacerbation or refractory septic shock following the Surviving Sepsis Campaign Guidelines).

[25] For more information, see Interim Infection Prevention and Control Recommendations for patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in a Healthcare Setting at https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html and Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for Coronavirus Disease 2019 (COVID-19) at https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html

3) Q: When can patients with confirmed COVID-19 be discharged from the hospital?

A: Patients can be discharged from the healthcare facilitiy whenever clinically indicated. Isolation should be maintained at home if the patient returns home before the time period recommended for discontinuationg of hospital Transmission-Based Precautions.[26]

(iv) Patients with COVID-19 can be discharged from a healthcare facility whenever clinically indicated. Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge.[27]

B. Diversion.

1. Facilities may only divert an inbound ambulance if it is on diversionary status because it lacks the staff or facilities to accept any additional emergency patients at that time.[28] Such instances should be well documented.

2. **Washington State:** regardless of the EMTALA diversion option[29], some regions in Washington State (including King County) have adopted regional "no diversion" policies, in association with the EMS regional system planning.

   a. Under the King County policy,[30] "hospitals may close their emergency departments only in an internal emergency such as facility damage or lockdown." In addition, "The decision on where to transport a patient will remain at the discretion of the pre-hospital provider unless directed to a specific facility by medical control."

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[26] *See* https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html (CDC Coronavirus Disease 2019 (COVID-19) Disposition of Hospitalized Patients with COVID-19)

[27] https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html (CDC Coronavirus Disease 2019 (COVID-19) Disposition of Hospitalized Patients with COVID-19, Guidance as of March 23, 2020).

[28] 42 CFR 489.24; *Arrington v. Wong*, 237 F.3d 1066, 1072 (9th Cir. 2001).

[29] See CMS State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases (Rev. 191, 08-19-19) at Tag A2406, emphasis added).

[30] King County has a "no diversion" policy. https://www.doh.wa.gov/portals/1/Documents/2900/crplan.pdf (Central Region EMS and Trauma Care System Plan July 1, 2019 – June 30, 2021)

b. Other regions in the state have adopted similar policies.[31] Hence, each hospital county must be aware of whether there is a "no diversion" policy affecting it.[32]

3. **Oregon**: regardless of the EMTALA diversion option[33], Oregon counties (or two or more contiguous counties) are required to have ambulance (EMS) service plans.[34] These plans may separately provide for patient diversion guidance.

a. By way of specific example, the greater Portland Metropolitan area (Multnomah, Clackamas, and Washington counties, and in coordination with Clark County Washington) has previously established patient diversion guidelines for emergency departments and ambulance providers. These detailed guidelines, revision date 11/2018, are linked here at Section 50.030 - https://multco.us/sites/default/files/health/documents/2013-50_operations_ems.pdf.

4. Patients

A hospital may divert patients where warranted under the hospital's diversion policy for the hospital to divert patients to another hospital. Patients presenting to the hospital must still be screened and stabilized as required by law except where exempted by the HHS waiver.[35]

5. Ambulances

A hospital may direct *non-hospital owned ambulance* to go to a different facility if the hospital is in "diversionary status," that is, when the hospital "does not have the staff or facilities to accept any additional emergency patients.[36] However, if

[31] https://www.doh.wa.gov/portals/1/Documents/2900/nrplan.pdf (North region including Snohomish agreement not to divert trauma patients)

[32] https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/EmergencyMedicalServicesEMSSystems/EMSandTrauma/Publications (heading for "Regional Plans")

[33] See CMS State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases (Rev. 191, 08-19-19) at Tag A2406, emphasis added).

[34] This requirement is codified as ORS 682.062. Per the Oregon Administrative Rules, "ambulance service plan" is defined as "a written document, which outlines a process for establishing a county emergency medical services system. A plan addresses the need for and coordination of ambulance services by establishing ambulance service areas for the entire county and by meeting the other requirements of these rules." OAR 333-260-010(4).

[35] *But see* waiver, per analysis above; *see also* DOH FAQs, link cited above.

[36] 42 CFR 489.24(b)(4); MS State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases (Rev. 191, 07-19-19) at Tag A2406.

the ambulance ignores its request to divert and brings the patient to the ED, the hospital must provide an MSE under EMTALA.