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***EMTALA Compliance
In
Disaster Circumstances***

**Prepared by:
Steve Gravely, J.D., M.H.A.
Erin Whaley, J.D., M.A.**

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Table of Contents

I. Overview of EMTALA..... 1

II. EMTALA and Disasters 3

 a. Regulatory Exception for Otherwise Inappropriate Transfers During a National
 Emergency 4

 b. Section 1135 Waiver..... 7

 c. Hospital Responsibilities When Exceptions and Waivers Are Not Applicable 10

 i. Capability 11

 ii. Medical Screening Exams..... 14

 iii. Stabilization and Transfer 17

III. Recommended Courses of Action to Ensure Compliance with EMTALA during Disasters
and Emergencies 20

I. Overview of EMTALA

In 1986, Congress enacted the Emergency Medical Treatment and Active Labor Act (“EMTALA”) to combat the perceived problem among hospital emergency departments of “patient dumping” – the transferring of under or uninsured patients prior to treatment.¹ Since then, CMS has issued both regulations in the Code of Federal Regulations² and Interpretive Guidelines in the CMS State Operations Manual³ to help implement and outline hospitals’ responsibilities under the statute.

**Sources of
EMTALA
authority:**

- **Statute**
- **Regulation**
- **Interpretive Guidelines**

EMTALA mandates that a Medicare-participating hospital with a dedicated emergency department (“ED”) medically screen anyone who comes to the emergency department seeking treatment for a medical condition so as to determine whether an “emergency medical condition” (“EMC”) exists.⁴ The term “emergency medical condition” is defined to mean a medical condition that without immediate medical attention could result in “(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.”⁵

¹ 42 U.S.C. § 1395dd.

² See generally 42 C.F.R. § 489.

³ See SOM, Appendix V-Interpretive Guidelines-Responsibilities Medicare Participating Hospitals in Emergency Cases, Part I, Interpretive Guidelines (Rev. 1, 05-21-04) (“Interpretative Guidelines”).

⁴ 42 U.S.C. § 1395dd. EMTALA does not apply to hospital inpatients or to individuals arriving at off-campus facilities that are not considered “dedicated emergency departments” under the law. See 42 C.F.R. § 489.24(d)(2)(ii); 68 Fed. Reg. 53,240 (Sept. 9, 2003).

⁵ 42 U.S.C. § 1395dd(e)(1).

If, after conducting a Medical Screening Exam (“MSE”), it is determined that no emergency medical condition exists, the hospital’s EMTALA obligation ends and the individual

EMTALA requires hospitals to provide MSEs and stabilization care to all comers.

may be discharged, admitted to the hospital or transferred to another facility.⁶ If, however, the MSE shows that the patient has an emergency medical condition, the hospital is obligated under EMTALA to stabilize and/or transfer the individual to another hospital, depending on the specific circumstances. Under EMTALA, an individual will be deemed “stabilized” if the

physician attending to the patient has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved, even though the underlying medical condition may persist.⁷ In general, the transfer of a non-stabilized patient may only be effected by a hospital (i) if the medical benefits of the transfer outweigh the risks or (ii) if the patient requests the transfer.⁸

Enforcement of EMTALA is a complaint driven process.⁹ Alleged violations of EMTALA are reported to the Centers for Medicare and Medicaid Services (“CMS”), usually by either a patient who was subjected to the alleged violation or hospitals that believe another hospital has violated its obligations.¹⁰ CMS will initiate an investigation of the alleged violation, which will be conducted by the state Medicare survey agency. Among other things, the investigation should include an in-depth analysis of the hospital’s policies and processes governing triage, a record

⁶ Interpretative Guidelines Tag A406. *See also Slabik v. Sorrentino*, 891 F.Supp. 235 (E.D. Pa. 1995).

⁷ Interpretive Guidelines Tag A407.

⁸ *But see infra* Section I (discussion of patient transfer pursuant to community-wide disaster response plan).

⁹ See Interpretative Guidelines.

¹⁰ See GAO-01-747, EMTALA Implementation and Enforcement Issues, U.S. General Accounting Office, June 2001.

review for the specific complaint and interviews with facility staff involved in the alleged violation.¹¹ If CMS determines that an EMTALA violation has occurred, it may impose civil monetary penalties of up to \$50,000 for each violation.¹²

In addition to CMS's investigative action, a person who suffers personal harm as a direct result of a hospital's EMTALA violation may bring a civil action for damages and/or equitable relief against the hospital.¹³ If the plaintiff prevails in his suit, he is entitled to "obtain those damages available for personal injury under the law of the State in which the hospital is located."¹⁴ In Virginia, the Fourth Circuit Court of Appeals has ruled that this provision makes Virginia's malpractice cap applicable to recovery in EMLATA actions.¹⁵ This means that plaintiff's in EMTALA actions are able to recover up to the amount authorized by Virginia's malpractice cap.¹⁶

***Currently, the
medical malpractice
cap in Virginia is
\$1,850,000.***

II. EMTALA and Disasters

¹¹ *Id.*

¹² 42 U.S.C. § 1395dd(d)(1)(A). Physicians responsible for an EMTALA violation are likewise subject to civil monetary penalties up to \$50,000 and/or exclusion from the Medicare program (*see generally* 42 U.S.C. § 1395dd(d)(1)(B)). www.oig.hhs.gov/fraud/enforcement/administrative/cmp/cmphitemspd.html for a list of EMTALA related fines since 2002.

¹³ 42 U.S.C. § 1395dd(d)(2)(A). The statute of limitations for bringing a personal injury claim under EMTALA is two years (42 U.S.C. § 1395dd(d)(2)(C)).

¹⁴ *Id.*

¹⁵ *See* Va. Code § 8.01-581.15. *See also* Power v. Arlington Hospital Assc., 42 F.3d 851(4th Cir. VA 1994)(holding that recovery for an EMTALA claim that fits within the broad rubric of malpractice actions is limited by Virginia's malpractice cap).

¹⁶ Virginia imposes a cap on damages in medical malpractice cases. For claims arising out of acts or omissions on or after August 1, 1999, and before July 1, 2000, the cap is \$1.5 million. The cap limit of \$1.5 million increased on July 1, 2000, and increased each July 1 thereafter by \$50,000 per year. The two final increases on July 1, 2007 and July 1, 2008 will each increase the cap by \$75,000. Each annual increase applies to the act or acts of malpractice occurring on or after the effective date of the increase. Va. Code Ann. § 8.01-581.15.

When EMTALA was enacted in 1986, emergency preparedness and response in relation to large scale disasters and potential pandemics was not on the forefront of the government's agenda. As a result, the original EMTALA legislation, which was meant to ensure that everyone who presented to an ED for treatment of an emergency medical condition received such treatment, did not have any exceptions for large scale disasters in which EDs would not be able to meet their obligations. In the wake of September 11th and the subsequent Anthrax attacks, CMS and Congress recognized the inadequacies of the law with respect to such events and sought to rectify this. Beginning with a letter from CMS to Regional Administrators and State Survey Agencies in November 2001, CMS and Congress have taken various actions to clarify the application of EMTALA in a large scale disaster or pandemic. These actions have resulted in a regulatory exception to EMTALA and a statute that gives the Secretary of HHS the ability to waive EMTALA requirements during specified disasters and emergencies.

a. Regulatory Exception for Otherwise Inappropriate Transfers During a National Emergency

The EMTALA regulations prohibit a hospital from transferring a patient who has an emergency medical condition prior to stabilization, unless the transfer is "appropriate."¹⁷ As described in the Overview, a transfer is generally appropriate where it has been requested by the patient or where a physician certifies that the medical risks are outweighed by the benefits of the transfer.¹⁸ During an emergency or disaster, it is foreseeable that hospitals will need to transfer patients to other facilities for a variety of reasons, but, because of the nature of the emergency or disaster, they will not be able to comply with the "appropriate" transfer regulations.

¹⁷ 42 CFR § 489.24.

¹⁸ 42 CFR § 489.24(e).

In 2003, CMS amended the EMTALA regulations to provide an exception for patient transfers during a national emergency. Under this exception, hospitals in “emergency areas” will not be subject to sanctions under EMTALA for inappropriate transfers during a national emergency.¹⁹ While “national emergency” is not defined, “emergency area” is a defined term. It

The EMTALA TAG recently recommended expanding the exception to state, local and hospital-specific disasters.

means the geographical area in which there is a presidentially declared disaster or emergency under the Stafford Act²⁰ and a public health emergency as declared by the Secretary under the Public Health Service Act.²¹ Taken together, the use of both “emergency area” and national

emergency means that the regulatory exception for transfers will only be available to those hospitals in areas of declared a disaster by the President or an area with a public health emergency

¹⁹ 42 CFR § 489.24(a)(2)

²⁰ The Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (the “Stafford Act”), was created to “provide an orderly and continuing means of assistance by the Federal Government to State and local government in carrying out their responsibilities to alleviate the suffering and damage which result from disasters.”(42 U.S.C. § 5121(b)) To accomplish this lofty goal, the Stafford Act establishes a process for requesting and obtaining a Presidential disaster declaration, defines the type and scope of assistance available from the Federal government, and describes the conditions for obtaining that assistance. The Stafford Act requires that “all requests for a declaration by the President that a major disaster exists shall be made by the Governor of the affected State.”(42 U.S.C. § 5170) The Governor must make his request through the regional Federal Emergency Management Agency (“FEMA”) office and take appropriate action to execute the state’s emergency plan. (See *A Guide to the Disaster Declaration Process and Federal Disaster Assistance*, Federal Emergency Management Agency, available at http://www.fema.gov/pdf/rebuild/recover/dec_proc.pdf (last visited December 5, 2006). The Governor’s request must include information on the nature and amount of state and local resources that have been or will be committed to alleviating the disaster, an estimate on the amount and severity of damage caused by the disaster, and an estimate of the amount of federal assistance that will be needed. Based on the Governor’s request, the President may declare that a major disaster or emergency exists or deny the request.(Id.)

²¹ Section 319(a) of the Public Health Service (PHS) Act, authorizes the Secretary of the Department of Health and Human Services (HHS) to declare a public health emergency and “take such action as may be appropriate to respond” to that emergency consistent with existing authorities. (42 U.S.C. § 247d.) The Secretary may declare a public health emergency when, after consultation with public health officials, he finds that “a disease or disorder presents a public health emergency or a public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists.”(42 U.S.C. § 247d(a))

by the Secretary. This exception will, therefore, not be available during hospital-specific, local or state declared emergencies and disasters for which there is no presidential declaration.²²

The Interpretive Guidelines unfortunately do not elaborate on the exception. These Guidelines only state that “CMS will issue guidelines as appropriate in the event of a national emergency and its impact upon the EMTALA regulations.”²³ The Guidelines do, however, elaborate on the applicability of the EMTALA requirements in general during a national emergency. Specifically, the Interpretive Guidelines state that while hospitals in the area of the national emergency will remain responsible for providing MSEs to all individuals who request examination or treatment, transfers or referrals of individuals in accordance with a “community response plan” will not result in sanctions under EMTALA.²⁴ There is no definition of “community response plans,” but the Guidelines suggest that a State or local EMS plan that designates specific entities with the responsibility of handling certain categories of patients during catastrophic events would qualify.²⁵ While the Interpretative Guidelines only specifically reference a State or local EMS plan, a fair interpretation of “community response plan” could include any emergency and disaster response plan at the state or local level.

Community disaster response plans should address hospital’s EMTALA obligations.

²² The EMTALA Technical Advisory Group (“TAG”) recently recommended this exception be expanded to provide protections during declared state, county and city emergencies as well as hospital-specific emergencies as determined by CMS/OIG on a case-by-case basis. This would be a significant expansion of the existing regulation. See *Report Number Five to the Secretary of U.S. Department of Health and Human Services From the Emergency Medical Treatment and Labor Act Technical Advisory Group*, November 2-3, 2006 (issued February 6, 2007) (available at https://www.cms/hhs.gov/FACA/07_emptalatag.asp).

²³ Interpretive Guidelines § 489.24(a)(2).

²⁴ TAG A406 Interpretative Guidelines § 489.24(a).

²⁵ *Id.*

Even with this broad interpretation, Virginia hospitals cannot take solace in this Guideline because Virginia's state and local emergency preparedness and response plans were not written with this issue in mind. The plans, therefore, do not adequately address the EMTALA compliant transfer of certain categories of individuals to designated facilities during catastrophic events. The Virginia Department of Health is currently reviewing its pandemic influenza response plans.

b. Section 1135 Waiver

Congress has recognized that, in certain situations, enforcement of EMTALA requirements will need to be waived. In 2002, Congress enacted the Public Health Security and Bioterrorism Response Act, which added a Section 1135 to the Social Security Act. Upon a Presidential

The All Hazards and Pandemic Preparedness Act of 2006 expanded Section 1135 to include EMTALA waivers related to pandemics.

declaration of emergency or disaster pursuant to the Stafford Act²⁶ and a Secretarial declaration of public health emergency pursuant to the Public Health Service Act²⁷, Section 1135 authorizes the Secretary of HHS to “temporarily waive or modify the application of” certain Medicare, Medicaid and SCHIP requirements to the

extent necessary to exempt healthcare providers from sanctions when emergency circumstances have left them unable to comply with such requirements.²⁸ Included in the list of requirements for which sanctions can be waived are the EMTALA requirements.

²⁶ See note 21.

²⁷ See note 22.

²⁸ 42 U.S.C. § 1320b-5(a)(2).

Sanctions can be waived for both transfers and redirection. Specifically, the Secretary is empowered to waive sanctions for the “transfer of an individual who has not been stabilized in violation of [EMTALA] if the transfer arises out of the circumstances of the emergency.”²⁹ The Secretary may also waive sanctions for the direction or relocation of an individual to receive a MSE if the relocation is done pursuant to either an “appropriate State emergency preparedness plan” or, in the case of a declared public health emergency involving a pandemic infectious disease, a State pandemic preparedness plan.³⁰

Waivers are generally limited to the 72-hour period beginning upon implementation of a hospital disaster protocol unless the Waiver arises out of a public health emergency involving a pandemic.³¹ If related to a pandemic, the Waiver terminates upon the first to occur of either the termination of the underlying declaration of a public health emergency or 60 days after being first published.³² If the waiver terminates because of the latter, the Secretary may extend it for subsequent 60 day periods.³³

As alluded to above, the Secretary can only issue this Section 1135 Waiver for health care services rendered during an “emergency period” in an “emergency area.” The statute defines “emergency area” and “emergency period” as the geographical area and period (respectively) in which there is a presidentially declared disaster

***Section 1135 Waivers
are not available for
local and state
emergencies.***

²⁹ 42 U.S.C. § 1320b-5(b)(3)(A).

³⁰ 42 U.S.C. § 1320b-5(b)(3)(B).

³¹ 42 U.S.C. § 1320b-5(b). The EMTALA TAG is recommending that the 72-hour limitation be extended to allow the waiver to remain in effect until the hospital is no longer in an emergency situation or the government-declared emergency has been terminated. See note 23.

³² 42 U.S.C. § 1320b-5(e).

³³ *Id.*

or emergency under the Stafford Act³⁴ or a public health emergency as declared by the Secretary under the Public Health Service Act.³⁵ This means that Section 1135 waivers will not be available for local and state declared emergencies and disasters for which there is no presidential declaration.³⁶

In the wake of the Presidential declaration of emergency in Louisiana and surrounding states for Hurricane Katrina in August 2005,³⁷ the Secretary of HHS issued a Section 1135 Waiver related to various statutes and regulations, including EMTALA. Among other things, this waiver exempted hospitals in the affected areas from sanctions under EMTALA for the “redirection of an

The EMTALA Waiver issued post-Katrina was only effective for 72 hours.

individual to another location to receive a medical screening examination pursuant to a state emergency preparedness plan or transfer of an individual who has

not been stabilized if the redirection or transfer arises out of hurricane related emergency circumstances.” While it appears broad on its face, this waiver was only effective for 72 hours after hospitals implemented their hospital disaster protocols, as required by the Section 1135 statute.³⁸ After this 72 hour mark, hospitals had to comply with all EMTALA obligations or risk penalties for noncompliance.

During the time the waiver was in effect, hospitals were permitted to make otherwise prohibited transfers after conducting a medical screening exam so long as the transfer was

³⁴ Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206.

³⁵ Id. and the Public Health Service Act P.L. 109-374, 42 U.S.C. § 201 et seq.

³⁶ The EMTALA TAG recently recommended that Section 1135 Waivers be expanded to provide protections to include declared state, county and city emergencies as well as hospital-specific emergencies as determined by CMS/OIG on a case-by-case basis. See note 23.

³⁷ See Statement on Federal Emergency Assistance for Louisiana issued The White House, August 27, 2005, available at <http://www.whitehouse.gov/news/releases/2005/08/20050827-1.html> (last visited December 5, 2006).

³⁸ 42 U.S.C. 1320b-5(b)(3).

necessitated by the disaster circumstances. Furthermore, hospitals were permitted to transfer patients *prior* to conducting a medical screening exam so long as such transfer was performed pursuant to a “state emergency preparedness plan.” If the state did not have an emergency preparedness plan which provided guidelines for such redirection, hospitals remained responsible for providing medical screening exams to all who came to its EDs.

When taken as a whole, the Section 1135 Waiver statute suggests that both the State emergency preparedness plan and the State pandemic preparedness plan should have language regarding the direction or relocation of an individual to receive a MSE in an alternative location. While Virginia does have robust emergency preparedness plans, these plans do not contemplate or provide guidelines for redirection of patients at a hospital prior to a medical screening exam. The Virginia Department of Health is currently reviewing its pandemic influenza response plans.

c. Hospital Responsibilities When Exceptions and Waivers Are Not Applicable

The exception and waiver discussed above will have limited applicability outside of Presidentially declared disasters. Even during such events, the protections from sanctions for EMTALA violations are sparse. Hospitals may remain obligated to provide a medical screening exam and stabilizing treatment for all who come to the ED during a disaster. While these are considerable responsibilities, hospitals may take solace in the fact that EMTALA only requires a hospital to provide these services “within the capabilities” of the facility. The remainder of this section will address this all important caveat as well as a hospital’s responsibility for performing a MSE, stabilization and transfer in a disaster.

A hospital is required to provide MSEs and stabilization care within its “capabilities”.

i. Capability

A disaster or emergency, whether local, state or national, will likely call into question a hospital's "capability" to provide medical screening exams, stabilization and transfers. "Capability" is a term of art in the EMTALA regulations. It is defined as "the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. [Capability] encompasses such things as numbers and availability of qualified staff, beds and equipment and the hospital's past practices of accommodating additional patients in excess of its occupancy limits."³⁹ The Interpretive Guidelines further elaborate on this issue stating that

Capabilities of a medical facility mean that there is physical space, equipment, supplies, and specialized services that the hospital provides (e.g., surgery, psychiatry, obstetrics, intensive care, pediatrics, trauma care).

Capabilities of the staff of a facility means the level of care that the personnel of the hospital can provide within the training and scope of their professional licenses. This includes coverage available through the hospitals [*sic*] on-call roster.⁴⁰

The capacity to render care is not reflected simply by the number of persons occupying a specialized unit, the number of staff on duty, or the amount of equipment on the hospital's premises. *Capacity includes whatever a hospital customarily does to accommodate patients in excess of its occupancy limits...* If a hospital has customarily accommodated patients in excess of its occupancy limits by whatever mean [*sic*] (e.g., moving patients to other units, calling in additional

³⁹ 42 CFR § 489.24(b). Note: the definition is quoted above is the definition of "capacity." "Capacity" is not used in the statute, but the term "capability" is. We assume that these two words are interchangeable and reflect confusion in the legislative drafting process.

⁴⁰ Interpretive Guidelines Tag A407. *See also* Interpretive Guidelines Tag A406: "Hospital resources and staff available to inpatients at the hospital for emergency services must likewise be available to individuals coming to the hospital for examination and treatment of an EMC because these resources are within the capability of the hospital."

staff, borrowing equipment from other facilities) it has, in fact, demonstrated the ability to provide services to patients in excess of its occupancy limits.⁴¹

These Interpretive Guidelines have numerous implications for hospitals. Taken as a whole, the Guidelines suggest that a hospital has exceeded its capabilities only when it has exhausted its

A hospital's "capability" includes its customary strategies for stretching resources.

customary strategies to stretch its resources yet still cannot meet the needs of its ED patients. It is only at this point that hospitals do not have the capabilities to fulfill their EMTALA obligations and can "close" their EDs by going

on "diversionary status."⁴² "Diversionary status" signals to EMS providers that the hospital is unable to care for additional patients; therefore, any patients should be taken to other hospitals for medical care.

Most hospitals are familiar with, and have existing protocols that govern, implementation of diversionary status during "normal" times.⁴³ As in these normal diversions, during a disaster diversion, hospitals will continue to have EMTALA obligations with respect to patients who are

⁴¹ Interpretive Guidelines Tag A407.

⁴² See <http://questions.cms.hhs.gov>, Question #6010 (last visited May 12, 2006). Question #6010 asks, "[i]f a Hospital remains open during a disaster like Hurricane Rita and is operating at or in excess of its normal operating capacity and cannot get sufficient staff, may the hospital shut down its emergency department (ED) without violating EMTALA?" The answer is as follows:

Under these circumstances, EMTALA would not prohibit the hospital from closing its ED to new patients (in effect, going on diversion)... The hospital would continue to have an EMTALA obligation to individuals undergoing examination or treatment in its ED at the time it stops accepting new emergency patients. In addition, if any individual comes to such a hospital and requests examination or treatment for an [EMC], the hospital would be obligated by EMTALA to act *within its capabilities* to provide screening and, if necessary, stabilization.

⁴³ These policies, procedures and protocols should provide, *inter alia*, that a hospital should comply "to the extent circumstances permit" with any state or local notification requirements and follow its own established procedure for notification of diversionary status. CMS has indicated that during an emergency, a hospital will not be in violation of EMTALA if it transfers a patient without obtaining prior acceptance from the receiving hospital because telephone circuits are busy. In such a situation, a determination will be made as to whether the hospital acted reasonably and in the patient's best interest in transferring the patient without a proceeding agreement to accept. See <http://questions.cms.hhs.gov>, Question #6009 (last visited May 12, 2006).

in the ED when the hospital goes on diversion and those who come to the ED seeking treatment in spite of its closure. One CMS response to a “Frequently Asked Question” indicates that a hospital’s EMTALA obligation does not cease until it has evacuated all patients and staff from the ED thus leaving it with no capacity to render treatment.⁴⁴ This CMS interpretation will make it very difficult to argue that the hospital ED is “closed” even though care is still being provided in the ED for patients already in the hospital. With respect to these patients who remain in the ED or come to the ED, a hospital will be obligated to act within its capabilities to provide screening and, if necessary, stabilization. In a pandemic flu situation, this obligation may be particularly significant, given that many individuals, in particular the “worried well,” may come to the hospital of their own accord despite a declared closure of the ED.⁴⁵

In a disaster or emergency, hospitals should follow their current policies regarding diversion. In preparation for such an event, hospitals should consider modifying such policies to (i) ensure that they will have sufficient documentation of the circumstances that led them to exceed their capabilities; (ii) specify the point at which the hospital is operating at capacity; (iii) provide the decision-

Hospitals should consider developing specific diversion policies related to a pandemic.

⁴⁴ See <http://questions.cms.hhs.gov>, Question #6008 (last visited May 12, 2006). Question #6008 asks whether a hospital that is evacuating in response to a mandatory or voluntary evacuation order may close its ED when it begins its evacuation. Again, CMS states that the hospital may close its ED to new patients (i.e., go on diversionary status), but must continue to attend (as appropriate) to its current ED patients. CMS further explains that, “[i]n most cases, this would mean that individuals would receive only triage followed by the minimum level of care needed to protect their health and safety while they and other patients are being evacuated to a site where screening and stabilization can be provided. Once the ED patients and staff have been evacuated and the ED has no capacity to render treatment, the hospital would no longer be obligated under EMTALA.”

⁴⁵ It is important to note that a hospital’s obligations under EMTALA apply not only to individuals who “come to the emergency department,” but may also apply to individuals who are elsewhere on hospital property. (See generally 42 CFR § 489.24(a) and Interpretive Guidelines Tag A406 for discussion of “hospital property,” which is applicable for public emergency and non-public emergency situations alike.) For the worried well in a pandemic flu outbreak, it is plausible, and perhaps more likely, that such individuals would present on hospital property other than the ED, seeking treatment for an emergency medical condition. Hospitals should re-familiarize themselves with protocols for treating non-ED EMTALA patients.

making authority for such a determination, (iv) outline notification mechanisms required by state or local law; and (v) establish transfer protocols consistent with EMTALA.

ii. Medical Screening Exams

Under current EMTALA law, hospitals will not be relieved of the obligation to perform a MSE even during disasters, unless a Section 1135 waiver is issued by the Secretary. The medical screening exam requirement is intimately tied to, and often confused with, triage. Triage refers to the ED’s mechanism for prioritizing patient care. Because triage is usually based on the severity of the injury or illness (i.e. the most ill patients are seen first), many think that it is a basic medical screening exam. While in some respects it may be a screening, it is not a MSE for purposes of EMTALA. In fact, the Interpretive Guidelines for EMTALA go so far as to state, “[t]riage is not

Triage is not equivalent to an MSE.

equivalent to a medical screening examination. Triage merely determines the ‘order’ in which patients will be seen, not the presence or absence of an emergency medical condition.”⁴⁶

The Interpretive Guidelines further indicate that individuals coming to a hospital emergency department must be provided a MSE “beyond initial triaging.” Hospitals are understandably concerned about their ability to provide these exams in a timely fashion during disasters, if at all, for those with minor injuries or ailments. While a hospital cannot deny an individual a medical screening exam, it may be able to postpone it, provided that these individuals are *eventually* given a MSE.

EMTALA does not dictate a timeframe in which a MSE must be conducted. Instead, the regulations only prohibit a hospital from delaying a MSE to inquire about the individual’s method

⁴⁶ See Interpretive Guidelines TAG A406.

of payment, insurance status, insurance pre-authorization or to complete a registration process that “unduly discourage[s] individuals from remaining for further evaluation.”⁴⁷ The Interpretive Guidelines suggest that inquiries into screening delays are fact-specific and will be part of an investigation into the alleged violation:

If a delay in screening was due to an unusual internal crisis whereby it was simply not within the *capability* of the hospital to provide an appropriate screening examination at the time the individual came to the hospital (e.g., mass casualty occupying all the hospital’s resources for a time period), surveyors are to interview hospital staff members to elicit the facts surrounding the circumstances to help determine if there was a violation of EMTALA.⁴⁸

Consistent with these Interpretive Guidelines is a statement in the minutes of the November 2006 EMTALA Technical Advisory Group (“TAG”) meeting, which says that “CMS staff indicated they do look at emergency situations when investigating potential EMTALA violations, and the Office of the Inspector General takes such conditions under consideration when determining civil penalties.”⁴⁹ Implicit in the Guideline and comments from CMS staff is the recognition that the hospital will still be required to defend investigations. If the delays were the result of the “unusual internal crisis” and all patients were treated in a similar fashion (i.e. uninsured patients were not treated in a discriminatory fashion), surveyors will be hard-pressed to find an EMTALA violation. The burden is for the hospital to demonstrate the unusual circumstances, which underscores the importance of documentation of the unusual circumstances that compromised the hospital’s capabilities to provide timely MSEs for all patients.

While EMTALA requires a hospital to provide a MSE to all patients presenting to the ED requesting examination or treatment, it does not define the contours of such examination. The

⁴⁷ 42 CFR § 489.24(d)(4)

⁴⁸ Interpretive Guidelines Tag A408 (emphasis added).

⁴⁹ See *infra* note 17.

regulations only require that the MSE be performed in a manner that allows the clinician to determine whether an emergency medical condition exists,⁵⁰ “nothing more, nothing less.”⁵¹ The scope of an appropriate MSE, therefore, will vary depending on the individual’s presenting symptoms and is typically left to the clinical judgment of the treating practitioner.⁵² For example, the EMTALA regulations clarify that individuals presenting in an ED for pharmaceutical services (i.e., prescription refills) need not be given a complete MSE, but rather, one that is appropriate for the request that they make.⁵³

This example was especially relevant following Hurricanes Katrina and Rita. Many evacuees from Louisiana, Mississippi, Alabama and Florida either lost or did not have copies of prescriptions when they evacuated affected areas. These evacuees presented to hospital EDs to obtain replacement prescriptions. CMS affirmed that such individuals need not be given a full EMTALA medical screening examination and suggested that hospitals develop specific protocols that include a streamlined screening examination for patients seeking prescription refills.⁵⁴ As this situation will likely occur after many types of disasters, hospitals should heed the advice of CMS and develop policies regarding MSEs for persons seeking prescription refills.

⁵⁰ 42 CFR § 489.24(a)(i)

⁵¹ *Collins v. DePaul Hosp.*, 963 F.2d 303, 306-07 (10th Cir. 1992); *see also Vickers v. Nash General Hosp., Inc.*, 78 F.3d 139 (4th Cir. 1996); *Power v. Arlington Hosp. Assoc.*, 42 F.3d 851, 856 (4th Cir. 1994).

⁵² An appropriate MSE includes ancillary services routinely available to the ED that may be necessary to treat the individual. 42 C.F.R. § 489.24(a)(1)(i). Such ancillary services may include, for example, imaging services available at a separate, on-campus hospital building. Depending on the circumstances, ancillary services “routinely available to the ED” may not be accessible in a disaster or emergency. While there is no specific guidance on the issue, it is unlikely that a hospital would be found to “violate” EMTALA in such a situation if it cannot offer ancillary services to its ED patients. Hospital emergency departments should, to the extent possible, attempt to stay updated on the capacity levels of other hospital service units during a disaster or emergency.

⁵³ 42 CFR § 489.24(c); *see* 68 Fed. Reg. 53,235 (Sept. 9, 2003). *See also* Interpretive Guidelines Tag A406, which notes that if an individual presents to an ED and requests services that are not for a medical condition, such as preventative care services (immunizations, allergy shots, flu shots) or the gathering of evidence for criminal law cases, the hospital is not obligated to provide an EMC.

⁵⁴ *See* <http://questions.cms.hhs.gov>, Question #5695 (last visited May 12, 2006).

Although the content of the MSE is left to the discretion and clinical judgment of the clinician, the EMTALA regulations do require that MSEs be conducted by a “qualified medical person,” or “QMP.” A QMP may be either a physician or non-physician health care provider. Regardless, the QMPs must be designated by the hospital in a Board-approved document, typically its bylaws and/or its rules and regulations.⁵⁵ Importantly, the Interpretive Guidelines state that “[i]t is not acceptable for the hospital to allow informal [QMP] personnel appointments that could frequently change.”⁵⁶ Because traditional QMPs may not be available during a disaster or may be tasked with patient treatment instead of performance of a MSE, hospitals are well-advised to give forethought to adopting special disaster QMP designations (for appropriately qualified personnel) in a Board approved document.⁵⁷

MSEs must be conducted by QMPs who are so designated in a Board approved document.

iii. Stabilization and Transfer

After conducting a MSE and determining that an individual has an emergency medical condition, a hospital has an EMTALA obligation to provide stabilizing treatment or make an appropriate transfer of the patient to another facility. Under EMTALA, an individual will be deemed “stabilized” if the physician attending to the patient has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved, even though the

⁵⁵ 42 CFR § 489.24(a).

⁵⁶ Interpretive Guidelines Tag A406.

⁵⁷ The EMTALA TAG recommends that the EMTALA regulations and Interpretative Guidelines be amended to permit the use of person not normally deemed “QMPs” to provide MSEs and stabilization services during an emergency or disaster. Alternatively, the EMTALA TAG recommends that hospitals add additional categories of QMPs in their disaster plans. See note 23.

underlying medical condition may persist.⁵⁸ The “national emergency” exception does not relieve a hospital of this responsibility. Instead, the exception permits otherwise inappropriate transfers when a hospital does not have capacity or capability to render stabilization treatments.

This is congruent with the generally applicable rule that when a hospital has exhausted all of its capabilities in attempting to resolve an individual’s emergency medical condition, it must effect an appropriate transfer of the individual.⁵⁹ The Interpretive Guidelines support this by

Hospitals should transfer patients if they do not have the capability or capacity to stabilize the patient.

stating that “if the individual’s condition requires immediate medical stabilizing treatment and the *hospital is not able to attend to that individual because the emergency department is operating beyond its capacity*, then the hospital should transfer the individual to a hospital that has

the capability and capacity to treat the individual’s EMC.”⁶⁰ Additionally, “a sending hospital’s appropriate transfer of an individual in accordance with community wide protocols in instances where it cannot provide stabilizing treatment would be deemed to indicate compliance with [EMTALA].”⁶¹

While the exception and Interpretive Guidelines do relieve hospitals of their obligation to stabilize when they do not have the capabilities to do so, they solidify the hospital’s obligation to effect a transfer to a hospital with such capabilities and capacity. Hospitals should be cautioned that if capacity levels in the ED have been reached and an individual with an EMC leaves the ED

⁵⁸ Interpretive Guidelines Tag A407.

⁵⁹ 42 CFR § 489.24(e)

⁶⁰ Interpretive Guidelines Tag A407 § 489.25(d)(1)(ii) (emphasis added)

⁶¹ Interpretive Guidelines Tag A407 § 489.24(d)(1)(i)

because the hospital is unable to timely attend to the condition, such a situation may present EMTALA liability. Specifically,

If a screening examination reveals an EMC and the individual is told to wait for treatment, but the individual leaves the hospital, the hospital did not “dump” the individual *unless... the individual’s condition was an emergency, but the hospital was operating beyond its capacity and did not attempt to transfer the individual to another facility.*⁶²

This Guideline emphasizes the importance of instituting policies and procedures that will control the hospital’s transfer of patients when it is not able to provide stabilization care because it is not within the facility’s capabilities. Again, hospitals should already have these policies and procedures in place, but they may need to be modified to reflect potential disaster circumstances.

One important caveat to this discussion of transfer, however, is the recognition that in a disaster or emergency situation, most, if not all, regional hospitals will likely be operating in excess of their capabilities. When that is the case, it is not clear to which facilities patients should be transferred. The situation may be further complicated by numerous factors including the unavailability of appropriate transport vehicles, the inability to traverse major roadways, or the inability to communicate with other facilities to inquire about capacity as a result of busy circuits or downed telephone lines.⁶³ In these circumstances, EMTALA provides little, if any, guidance. Hospitals should be advised to treat all patients in similar situations in the same way and do the best that they can. If circumstances

Transfers during disasters will be complicated by the very nature of the disaster.

⁶² Interpretive Guidelines Tag A406 (emphasis added).

⁶³ See <http://questions.cms.hhs.gov>, Question #6009 (last visited May 12, 2006). CMS indicated that during an emergency where all the circuits were busy such that a transferring hospital was unable to get acceptance before transfer, surveyors should “determine whether, given the absence of communication in the area, the hospital acted reasonably and in the patient’s best interest in transferring the patient without an agreement to accept the patient.”

become this burdensome and extreme, it is unlikely that CMS will find any violations of EMTALA for failure to stabilize or transport so long as hospitals act reasonably.

III. Recommended Courses of Action to Ensure Compliance with EMTALA during Disasters and Emergencies

Because EMTALA was not drafted with an eye toward disaster and emergency circumstances, it in many respects fails to provide adequate relief for hospitals operating in the midst of such events. Despite limited administrative relief, hospitals will still be required to comply with their EMTALA obligations regarding MSEs, stabilizations and transfers during disasters. The ultimate solution to this problem lies with Congress through amendment to the law. Hospitals across the country may consider forming a coalition of healthcare providers to pursue amendment of EMTALA to incorporate greater exceptions for disaster circumstances.

Forming such a coalition is a formidable, yet worthwhile, project that could ultimately result in much needed relief for hospitals. Until the coalition completes its mission, however, hospitals should take steps to identify the ways in which it will meet its EMTALA obligations during disasters. Those steps include, but are not limited to, the following:

- The Virginia Department of Health is currently reviewing its pandemic influenza response plans;
- Consider modifying existing EMTALA diversion policies to (i) ensure that the hospital will have sufficient documentation of the circumstances that led it to exceed its capabilities; (ii) specify the point at which the hospital is operating at capacity; (iii) provide the decision-making authority for such a determination, (iv)

outline notification mechanism required by state or local law; and (v) establish transfer protocols consistent with EMTALA;

- Develop policies regarding the scope and protocol for providing MSEs to persons seeking prescription refills;
- Adopting special disaster QMP designations (for appropriately qualified personnel) in a Board approved document; and
- Institute policies and procedures that will control the hospital's transfer of patients when it is not able to provide stabilization care because it is not within the facility's capabilities.

To the extent that hospitals appropriately plan for EMTALA compliance during an emergency or disaster, they will be in a better position to defend EMTALA claims that arise from the disaster.