Friday, March 13, 2020

In response to the spread of COVID-19 infections and questions from the provider community, the Centers for Medicare and Medicaid Services (CMS) Quality, Safety and Oversight Group (QSO) issued a series of three memoranda providing updated guidance to healthcare facilities on March 9, 2020.

This alert focuses on QSO-20-15 Hospital/CAH/EMTALA, entitled Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implication Related to Coronavirus Disease 2019 (COVID-19). Click here for an analysis of the other QSO memos that address issues specific to nursing homes, hospice and home health agencies, and dialysis providers.

In Depth

Background and Current Crisis

EMTALA was first established in the 1980s as an “anti-dumping” law to dissuade hospitals from refusing to care for uninsured patients seeking emergency care. It requires Medicare-participating hospitals and critical access hospitals (collectively...
referred to herein as “hospitals”) with emergency departments (EDs) to minimally provide the following:

- A medical screening examination (MSE) to every individual who presents to the ED for examination or treatment of a medical condition to determine whether the individual has an emergency medical condition (EMC) (for EMTALA purposes, an EMC exists when the individual has “acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in serious impairment or dysfunction”)
- Necessary stabilizing treatment for individuals with EMCs within the hospital’s capability and capacity
- Transfers of individuals with EMCs to other hospitals, when appropriate and transferred in a manner that meets EMTALA requirements.

These requirements describe the basic foundation of EMTALA. The statute, regulations and their interpretation by CMS and courts over the years has resulted in additional complexity that must also be considered. For example, EMTALA requires that hospitals with specialized capabilities accept patients with EMCs in transfers as long as the recipient hospital has the capabilities and capacity to treat those patients, even if that hospital does not have an ED. EMTALA also limits hospitals as to how and where MSEs are conducted.

Hospitals have expressed concern regarding their ability to comply with EMTALA in the face of increasing ED visits from individuals with potential coronavirus exposure or full-blown disease. QSO-20-15 provides specific compliance guidance and identifies steps hospitals can take in the key areas of transfers, screening, patient access/constructive dumping and EMTALA waivers. Read on for a summary of the guidance provided in QSO-20-15 and key takeaways for hospitals to consider as they work through their EMTALA obligations during the COVID-19 crisis.

**Patient Transfers**

QSO-20-15 confirms that, regardless of a patient’s COVID-19 status, hospitals with the capacity and specialized capabilities necessary to provide stabilizing treatment are required to accept appropriate transfers from hospitals that do not have the necessary capabilities.

This requirement is dependent upon (1) coordination with state or local public health officials on placement of patients, and (2) at the time standards of practice to treat patients with COVID-19 (which in certain circumstances could potentially support standards such as clustering patients in specific facilities or locations).

In assessing a violation of EMTALA regarding acceptance of transfers under these circumstances, CMS notes that it would “take into account the CDC’s [Center for Disease Control and Prevention’s] recommendations at the time of the event in question in assessing whether a hospital has the requisite capabilities and capacity.” Specific to “capacity,” QSO-20-15 states that the presence or absence of negative pressure patient treatment rooms (also known as airborne isolation rooms) is not dispositive in determining capacity or capability when in some cases COVID-19 patients can be safely treated in a private patient room.
**Key Takeaways:** Barring a state or local public health pronouncement on patient placement, or specific standards adopted for COVID-19 treatment, all hospitals with the capability and capacity to care for patients with presumptive or confirmed COVID-19 based on current CDC treatment guidance must be prepared to accept appropriate transfers, regardless of the size of the facility or the presence of available negative pressure patient treatment rooms. CMS expects that all hospitals are capable of maintaining isolation requirements for COVID-19.

**Screening and MSEs**

CMS recognizes a range of potential screening sites for COVID-19 infection and other “influenza-like-illnesses” (ILIs), including alternative sites on a hospital’s campus, off-campus hospital controlled sites and community-based screening clinics not under hospital control.

**On-Campus Screening Sites**

On-campus screening sites may be located outside of the ED as long as (1) patients are consistently logged by the hospital as presenting for care and (2) any direction of patients to the screening site is made by qualified personnel (such as a registered nurse) to ensure that patients that require immediate care in the ED are directed appropriately.

Screening sites may be outside of the ED and may conduct MSEs tailored to the patient’s presenting signs and symptoms, as long as the site is able to determine whether an EMC is present. All sites must be part of the certified hospital, or added as a new practice location under the hospital’s provider enrollment, and approved from a state licensure perspective, which could be complicated should temporary structures or tents be used.

In these locations, MSEs must be conducted by “qualified medical personnel” as defined by EMTALA, and stabilizing treatment or an appropriate transfer must be provided to individuals found to have an EMC (including transfer to other on-campus locations for care). CMS expects hospitals to have policies and procedures in place on alternative care sites.

**Off-Campus Screening Sites Under Hospital Control**

Off-campus, “hospital controlled” screening sites may be used to screen patients with ILIs, and hospitals and community agencies or officials may promote the option to go to such sites for this purpose, as long as the hospital does not route patients that have presented to its ED for similar screening or care to those sites to receive an MSE. Medical personnel with appropriate training to evaluate individuals with ILIs may staff these locations.

Managing public perception with regard to these sites is important. CMS has specified that off-campus locations should not be held out as a place that provides care for EMCs in general on an unscheduled, urgent basis. Rather, these locations should be identified as ILI screening centers.
CMS has not specifically articulated what it means for a screening site to be “controlled” by a hospital in this context. It has noted that if the off-campus location is not a dedicated ED as defined by EMTALA, EMTALA obligations do not apply to the care rendered at the location, but if the site is under the “control” of the hospital, the CMS Conditions of Participation for Hospitals do apply. As a result, any individuals screened for ILI who require additional medical care on an emergent basis must be transferred to an acute care hospital for further care. This suggests that “control” may be synonymous with provider-based status or other indicia that a location is part of a hospital, but that is not clear.

**Community-Based Screening Sites Outside of Hospital Control**

Screening sites established by community organizations or agencies that are outside the control of hospitals are not subject to EMTALA requirements. Hospitals and community agencies or officials may promote the option to receive ILI screening at these locations, as long as the hospital does not route patients that have presented to its ED for similar screening or care to those sites to receive an MSE.

CMS encourages community-based sites to use medical personnel trained in screening for ILIs and to have transport arrangements in place with EMS to ensure safe transport of individuals that need additional medical attention to appropriate care locations.

**Key Takeaways:** While CMS has identified three categories of screening locations that may be used to screen for ILIs, including COVID-19, it has clarified that these alternate screening sites cannot be used as a landing pad for individuals who present to the hospital ED requesting care. Up-front consideration of the nature of an alternate site and the regulatory requirements that attach to its use should be part of planning and implementation of screening at such sites.

**Patient Access/Constructive Dumping**

QSO-20-15 reiterates that it is a violation of EMTALA for hospitals with EDs to use signage that “presents barriers to individuals who are suspected of having COVID-19 from coming to or receiving an MSE at the hospital ED.”

It is important to distinguish between signage that directs patients to locations on hospital property for an MSE (i.e., to an on-campus screening site, as described above, or to a specific part of the ED where all individuals presenting with ILIs will be screened) and signage that risks interpretation as “constructive dumping” because it causes a patient to reconsider receiving care and to leave before an MSE can be performed and/or stabilizing treatment rendered. Hospitals that have established off-campus ILI screening sites may make ED patients aware of those sites, but may not direct patients who present to the ED to those sites for screening or care. Permitting a patient’s use of her own car as a waiting location outside the ED does not relieve the hospital of the obligation to monitor that patient and her clinical condition while the patient awaits further evaluation.

**Key Takeaways:** Hospital counsel should be involved in decision-making around ED signage specific to COVID-19 to avoid inadvertent miscommunication to patients and
third parties regarding screening processes and willingness to provide care to patients regardless of COVID-19 status.

**EMTALA Waivers**

QSO-20-15 further references EMTALA “waivers” that would permit hospitals to direct or relocate patients who present to the hospital ED and request an MSE to alternative, off-campus sites consistent with state or local emergency or pandemic preparedness plans, or to transfer unstable patients as long the transfer is required by the circumstances presented by the emergency. As mentioned in our prior *On the Subject*, these waivers are not available until:

- The president declares an emergency or disaster under the Stafford Act or National Emergencies Act
- The secretary of HHS declares a public health emergency
- The secretary of HHS invokes the waiver authority with 48 hours advance notice to Congress
- The waiver ultimately granted provides relief from EMTALA requirements and the hospital at issue qualifies for the waiver (which is based on a facts and circumstances analysis).

**Key Takeaways:** While EMTALA waivers are not presently available (as of the date of this article, there has not been a presidential declaration of emergency or disaster), hospitals should remain aware of their potential application in the future, should the requirements for their implementation be met.

**Conclusion**

CMS has made it clear that hospitals cannot simply refuse to screen and treat patients with suspected or confirmed COVID-19. Such refusal risks violating EMTALA, regardless of a patient’s signs and symptoms on arrival or eventual diagnosis.

Survey activity in relation to alleged EMTALA violations is largely complaint-based. While CMS announced a pause in most non-emergent survey activity, hospitals should be prepared for follow-up on alleged EMTALA violations inasmuch as they affect patient safety, are determined to cause immediate jeopardy, or are revived once the COVID-19 crisis has passed (i.e., it is possible that survey activity could occur long after an alleged violation occurs as CMS works through a backlog of complaints that were not fully reviewed during the time when non-emergent surveys were on hold).

While the potential for a federal waiver from compliance with certain of EMTALA’s regulatory requirements exists, currently such waivers are not available. If waivers are made available, hospitals should evaluate their applicability to their operations and determine whether additional steps are necessary to secure the protection of the waiver.

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