MEMORANDUM

DATE: January 18, 2022

TO: Arizona Hospital and Healthcare Association (for distribution)

FROM: Karen Owens, Coppersmith Brockelman PLC

RE: EMTALA Review Including Surge Issues

*****THIS MEMORANDUM DOES NOT CONTAIN LEGAL ADVICE. PLEASE CONTACT YOUR LEGAL COUNSEL IF YOU NEED LEGAL ASSISTANCE.*****

With the surge in COVID-19 Omicron variant infections, hospitals in Arizona are again dealing with an overwhelming population of sick patients, most of whom come to the emergency department (ED). In addition, scarce home tests are bringing increasing numbers of people to the hospital looking for COVID tests, adding to the ED crunch. With all these factors in mind, this is a good time to review EMTALA, the federal anti-discrimination law and regulations that prohibit “dumping” patients from EDs.1 During the first COVID-19 surge in early 2020, CMS implemented a blanket waiver affecting medical screening examinations under EMTALA – but most EMTALA obligations remain in place. This memorandum reviews those EMTALA obligations, waivers, and specific acute issues plaguing hospitals during this new surge – particularly in the areas of medical screening and transfer.

1. **A Review of EMTALA Basics**

EMTALA imposes three basic obligations on hospitals, including critical access hospitals:

1. to provide a **medical screening examination (MSE)** to a patient who comes to a dedicated ED (broadly defined) seeking medical treatment, in order to determine

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whether the patient has an emergency medical condition (EMC). The medical screening examination should be geared to the patient’s presenting concern; an extensive examination is not necessarily called for or required. Keep in mind that even when the hospital lacks capacity, an individual who arrives in the ED seeking services cannot be turned away.

(2) if the patient has an EMC, to provide stabilizing treatment within the capabilities of the hospital; and

(3) to transfer a patient with an EMC only when the patient’s EMC is stabilized, upon the patient’s request, or to a facility with a higher level of care if the sending hospital does not have the capability to stabilize the patient’s condition and the benefits of transfer outweigh the risks.2 (Note that this requirement has been modified somewhat. See Section 3 below.)

A hospital that receives a transfer request from a hospital seeking specialized capabilities/facilities (aka a higher level of care) for the patient must accept the transfer if it has capability and capacity to do so. These capabilities/facilities can include (but are not limited to) burn units, shock-trauma units, NICUs, or in rural areas, regional referral center facilities and services). A receiving hospital has the capacity to take a patient if the hospital has a history of obtaining the necessary resources (staff, equipment) to accept such patients.3 CMS confirmed in 2020 guidance that a receiving hospital may refuse to accept a transfer if it does not have the capacity to provide the necessary care and services.4

The requirement to accept a transfer applies across state lines. The EMTALA regulations state explicitly that a hospital “may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.”5

CMS says that hospitals need not accept “lateral transfers” between hospitals of comparable resources and capabilities unless the transferring hospital “has a serious capacity problem,” or mechanical or environmental difficulties like the loss of power.6 In other words, capacity by itself can be a “specialized capability” if the sending hospital has a serious capacity problem. Generally, a receiving hospital cannot know the extent of the “capacity problem” at

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3 42 C.F.R. § 489.24(f); Interpretive Guidelines, supra.
5 42 C.F.R. § 489.24(f).
6 CMS Interpretive Guidelines, § 489.24(f).
the sending hospital. Thus, refusal to take a patient based on a suspicion that the sending hospital is not really in dire straits runs the risk of subjecting the receiving hospital to EMTALA money penalties.

2. **CMS COVID-19 Waiver Allowing Off-Site Screening**

CMS has not significantly changed its guidance to hospitals since it first provided EMTALA pandemic advice in March, 2020. At that time, CMS permitted hospitals to direct patients to alternative sites, on or off campus, for medical screening examinations, so long as the remote screening is consistent with the state’s emergency plan.\(^7\) That waiver remains in place today.

3. **State Surge Plan**

CMS also allowed hospitals to transfer unstable patients when the public health emergency made it necessary.\(^8\) In accordance with this, the Arizona Department of Health Services (ADHS) implemented a Surge Line to facilitate transfers of COVID-19 patients throughout the state.\(^9\) Other EMTALA transfer requirements remain in place.

4. **Current Issues**

With all the above in mind, we turn to questions that hospitals are grappling with today.

A. **Medical Screening Examination: Individuals Coming to the ED for COVID-19 Testing**

Today, hospitals are facing emergency departments crowded with people with either mild or no symptoms seeking COVID-19 testing. Indeed, a January 14 blog post from the Arizona Department of Health Services stated “With emergency rooms on the front lines of the COVID-19 response, we need everyone to help make sure ERs are reserved for immediate medical needs. . . . If you don’t have an emergency, an urgent care, your doctor and tele-health are alternatives to the emergency room. Please don’t seek COVID-10 testing at an ER.”\(^10\)

But what can hospitals do with individuals who haven’t seen the ADHS blog post? The CMS waiver discussed above does provide some flexibility here. Patients seeking testing for no or mild symptoms can be intercepted *outside* the ED either by signage or non-medical personnel (or both) and directed elsewhere for testing.\(^11\) Signage must not dissuade patients truly seeking

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\(^7\) Note 4, *supra*.
treatment from coming into the ED; but it may provide welcome assistance to individuals who simply did not know where else to go for a test. Signage plus an individual properly trained to provide the correct messaging is ideal. For example, signage might state:

IF YOU ARE SEEKING CARE FOR A MEDICAL CONDITION, PLEASE COME IN. TESTING/VACCINATION ARE NOT AVAILABLE IN THIS EMERGENCY DEPARTMENT EXCEPT FOR PATIENTS SEEKING MEDICAL CARE. THERE ARE MANY ALTERNATIVE LOCATIONS WHERE YOU CAN HAVE A COVID-19 TEST OR BE VACCINATED: [insert 2 or more testing locations with contact information and the ADHS webpage with that info]

This information should be placed outside the ED entrance, at other hospital entrances, and on the hospital’s website. With demand for COVID-19 testing expanding and contracting over time, it may be useful to confer with local public health authorities on the availability and location of alternative testing sites near the hospital’s campus. Signage should be updated if testing sites change.

Be aware that if the patient does enter the ED, despite the signage:

- They must be logged in and offered an MSE suited to their reported symptoms. If they disclaim having symptoms, they can be offered an abbreviated MSE to confirm that there is no EMC. If they refuse an MSE, they can be offered the opportunity to leave and obtain testing elsewhere. (Ideally, a fact sheet will be available to hand to the patient with alternative testing locations.) The patient’s refusal of an MSE should be documented in accordance with the hospital’s refusal of care protocols.

- If the patient requests an examination, they are entitled to one. Only the qualified medical personnel (QMP) who performs the examination can decide whether the patient has an emergency condition; triage personnel cannot do this. The QMP’s exam need not be a full-fledged exam beyond that necessary to evaluate a patient who may have COVID-19 for a potential emergency condition. Hospitals may want to create a protocol for a truncated (but adequate) MSE for these patients.

- If the hospital has a separate on- or off-site location dedicated to COVID-19 screening, the patient can be redirected to that location. While CMS guidance says the patient can be logged in at the alternative location, I suggest logging the patient in when they come to the ED, and documenting that they have been sent to the alternative location.

- Some hospitals may wish to provide a separate “track” within the ED space for patients with mild or no COVID-19 symptoms, using a qualified mid-level provider to provide the MSE.
B. Other Medical Screening Exam Issues

(1) **Who can perform an MSE:** Midlevel providers like RNs, NPs and PAs are permitted to do MSEs. The hospital must document authorization of that provider category, and the individual’s credentials must be established in their personnel file.

(2) **Visitors in the ED:** Hospitals may refuse admittance to anyone other than the patient seeking medical care. Security should be available to deal with unhappy visitors. If any visitors are allowed in the ED, they can be required to wear a mask and refused entry or removed if they decline to do so. EMTALA has nothing to say about visitors.

(3) **Patients refusing to wear masks:** Hospitals may impose mask requirements to prevent the transmission of COVID-19 to hospital staff and other patients. Persons who come to the ED seeking care but refuse to wear masks may be deemed to be refusing care. The hospital then would follow its EMTALA refusal of care protocols. The patient’s refusal of care ends the hospital’s obligations under EMTALA, and the refusal to provide care because an individual refuses to wear a mask should not be a violation of EMTALA. If the hospital chooses not to remove the patient from the ED, the patient would need to be isolated to the best of the hospital’s ability.

(4) **Patients coming to the ED for vaccination:** These patients should be handled in the same way that patients seeking testing are handled.

(5) **Patients coming to the ED for early treatment (e.g., monoclonal antibodies, anti-virals):** Presumably these patients are symptomatic and should receive an MSE. If the ED does not have these early treatments, the patient can be told this but should be encouraged to stay and have an MSE and such treatment as the ED does have available.

(6) **Violent patients in the ED:** Violence against health care personnel is always a risk in the pandemic environment. Understandably, hospital staff will not want to deal with patients who are aggressive or violent. However, if the patient has come to the ED seeking evaluation/treatment, the hospital’s EMTALA obligation turns on whether the hospital has the capacity to treat the patient. EMTALA requires a hospital to stabilize a

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12 Bloomberg Law, “Revisiting EMTALA Obligations for Violent Patients,” 1/24/18
patient with a behavioral emergency medical condition if the hospital has the capacity and capability to do so. Hospitals should have plans in place to deescalate patients.

C. Capacity: Beds Versus Staffed Beds

Capacity is a complex concept under EMTALA. It is not solely dependent on the number of beds. If a hospital cannot obtain staff to care for patients in some of its beds, its capacity is diminished. However, keep in mind that after the fact, CMS is likely to review the hospital’s customary efforts to obtain staff in such situations.

D. Wait Lists

Some hospitals have allowed sending hospitals to place patients on wait lists for transfer. A wait list is not an EMTALA concept, however, and nothing in EMTALA requires its use. Wait lists may be of limited utility in the current climate of constant overcrowding in any event. Hospitals choosing to discontinue wait lists should do so consistently to avoid confusion.

E. Interstate/Long Distance Transfers

Arizona hospitals are reporting transfer requests from states as far away as Texas and Kansas. Transfers from so far away can take time and result in beds sitting empty for hours at a time. EMTALA requires out-of-state requests to be treated like other transfer requests. However, the EMTALA Interpretive Guidelines state: “[h]ospitals that request transfers must recognize that the appropriate transfer of individuals with unstabilized emergency medical conditions that require specialized services should not routinely be made over great distances, bypassing closer hospitals with the needed capability and capacity.”\(^{13}\) Unfortunately this statement, while relevant, does not relieve receiving hospitals of their duties to take patients if they have capability and capacity.

F. Transfers of Inpatients

EMTALA does not apply to patients once they have been admitted.\(^{14}\) Note, however, that observation status is not considered inpatient admission. It is permissible for a receiving hospital to inquire whether the patient at a sending hospital is an inpatient.

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\(^{14}\) 42 C.F.R § 489.24(f)(2).
5. **Conclusion**

It is no accident that news stories about hospital overcrowding focus on Arizona. A National Public Radio article just posted quotes an Arizona physician as stating that ED wait times “are double what they were in 2021 and doctors are seeing a third more patients.”¹⁵ No one modification will totally mitigate the deluge of patients. But at least some relief may be available through simple signage and use of trained volunteers to give the message not to come to the ED just for testing. The use of midlevel providers, including RNs, to perform MSEs also may assist in throughput. With respect to transfers, there are no easy answers. Continued use of the Arizona Surge Line may be the best available mechanism to move COVID-19 patients when needed (although of limited utility when staffed beds throughout the state are full). Ultimately, EMTALA is not the real villain here; it’s COVID-19.

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¹⁵ National Public Radio, “ERs are overwhelmed as omicron continues to flood them with patients,” 1/13/2022 [https://www.npr.org/sections/health-shots/2022/01/13/1072902744/ers-are-overwhelmed-as-omicron-continues-to-flood-them-with-patients](https://www.npr.org/sections/health-shots/2022/01/13/1072902744/ers-are-overwhelmed-as-omicron-continues-to-flood-them-with-patients).