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EMERGENCY CARE EMTALA ALTERATIONS DURING THE COVID-19 PANDEMIC IN THE UNITED STATES

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Contribution to Emergency Nursing Practice

- The current literature on the Emergency Medicine Treatment and Active Labor Act, or EMTALA, indicates that although the statute has existed in US law since 1986, many health care practitioners are unfamiliar with the requirements of the Act and how they apply to them.
- During the 2020 coronavirus pandemic, changes to EMTALA and its enforcement have been enacted by the Department of Health and Human Services/Centers for Medicare and Medicaid Services, but many clinicians are unaware of how this affects their daily practice in emergency care.
- To practice to the best of our ability, knowledge of how emergency clinical practice, law, and regulation interact is critical, and this article gives a concise update for those in this clinical practice area.

Abstract

The coronavirus 2019 pandemic has affected almost every aspect of health care delivery in the United States, and the emergency medicine system has been hit particularly hard while dealing with this public health crisis. In an unprecedented time in our history, medical systems and clinicians have been asked to be creative, flexible, and innovative, all while continuing to uphold the important standards in the US health care system. To continue providing quality services to patients during this extraordinary time, care providers, organizations, administrators, and insurers have needed to alter longstanding models and procedures to respond to the dynamics of a pandemic. The Emergency Medicine Treatment and Active Labor Act of 1986, or EMTALA, is 1 example of where these alterations have allowed health care facilities and clinicians to continue their work of caring for patients while protecting both the patients and the clinicians themselves from infectious exposures at the same time.

Key words: Emergency Medicine Treatment and Active Labor Act; Coronavirus disease 2019; Emergency medicine; Telemedicine

The coronavirus disease 2019 (COVID-19) pandemic has affected almost every aspect of health care delivery in the US, and the emergency health care system has been hit particularly hard while dealing with this public health crisis. In an unprecedented time in our history, health care systems and clinicians have been asked to be creative, flexible, and innovative, all while continuing to uphold the important standards we trust in our US health care system. To continue providing quality services to patients during this extraordinary time, care providers, organizations, administrators, and insurers have needed to alter longstanding models and procedures to fit the contextual dynamics of the pandemic. Although there have understandably been some errors and confusion, there has also been some pivotal assistance from leaders during this upheaval. Provisions disseminated by the government issuing guidance regarding the Emergency Medicine Treatment and Active Labor Act of 1986 (EMTALA) are 1 example where quickly enacted changes assisted the

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US health care system in carrying on the business of caring for patients while ensuring safety in the middle of a worldwide health catastrophe.[1]

The History of EMTALA and Emergency Medical Care in the US

In 1986, as part of the Omnibus Spending Act passed by Congress into law, EMTALA began to ensure patients were afforded protections when seeking care at emergency departments.[2] Under EMTALA, all persons seeking emergency care must be evaluated and stabilized by the health care team.[3] Before this landmark legislation was enacted, persons presenting to the hospital for emergent reasons were routinely turned away and denied proper care, often based on financial motivations.[4] In this much needed statute, lawmakers attempted to provide a threshold at which all patients would be entitled to emergent care when needed.[2] This administrative law was the first federal statute in the US to provide for an affirmative right to health care, irrespective of a patient's ability to pay for that care. In addition, the use of the term "duty to treat" became irrevocably tied to ED care in the US, whereas earlier there existed wide latitude afforded to providers in choosing who to see and who not to. In EMTALA, a clear exception to the "no-duty principle" was established for cases of emergency medical care, mandating that a duty to treat a patient does exist for emergency health care providers and facilities for all patients who present for care, regardless of prior relationship or ability to pay for services.[4]

The so-called "dumping" of patients based on their demographics or insurance has become a practice of the past, and health care entities and providers face stiff penalties if care is refused to anyone who meets the criteria under EMTALA.[5] Specifically, provisions were put into the application of the law to clearly identify what constituted an emergency medical condition and what qualified as seeking care. Persons were deemed to be able to decide for themselves if they needed to go the emergency department for care, with the prudent layperson standard stating that a "reasonable person with no medical training to devise that the situation is emergent, and care is needed" was sufficient.[4] In addition, the comes-to test was applied liberally in this new legislation, indicating that patients desiring medical evaluation who travel near, not just to the emergency department, should be considered under this rule.[2]

Historical EMTALA Requirements

Since 1986, EMTALA has required that a medical facility's responsibility to a person presenting to the emergency department for care is twofold: a qualified medical screening examination must be provided and treatment given must be sufficient to achieve stabilization of the patient's presenting condition.[4]

MEDICAL SCREENING EXAMINATION

Any patient presenting to the emergency department for what they have deemed to be an emergency, under the prudent layperson standard, must receive an appropriate medical screening examination by a clinician.[2] Generally, the examination must be performed by a licensed, independent health care provider denoted as a "qualified medical professional" or QMP (usually a physician, nurse practitioner, or physician assistant), and registered nurses, paramedics and other personnel are restricted from performing this duty based on their scope of practice.[1] There are no clear rules in the statute about what this examination must consist of, and so they may be cursory and lack any additional diagnostic evaluation, but the edict is clear that provider screening of any person who comes to the emergency department for care is mandatory.[4] There are many avenues to minimize impact of this requirement, but this burden must be met, as for facilities and clinicians this is a common foundation of EMTALA investigations from the Department of Justice.

STABILIZATION OF THE PATIENT

If an emergent condition is identified during the medical screening examination, there is an obligation to treat the patient to the point of stabilization before discharge or transfer.[2] Under the provisos of EMTALA, sufficient treatment must be given before advising a patient to seek care elsewhere or continue self-care at home. To clarify, the law does not state that any presenting condition must always be treated in the emergency department to a point of resolution; just stabilization is required.[5] Transfers to another location or facility are particularly tricky under EMTALA, and require stabilization of the patient and certifying the medical necessity of the transfer to the receiving facility, or the burden of the statute has not been met by the provider.[4]

EMTALA in the Age of COVID-19

During the COVID-19 public health crisis in the US, deviations to standard practice became necessary to provide care to patients. The current pandemic emergency challenges health care systems to balance the need for extraordinary measures to ensure patient and staff safety and the desire to preserve the delivery of exemplary patient care.[3] Individuals and systems have struggled to balance their 2 primary goals during this emergency: protecting patients and staff from the risk of infection and continuing to ensure each person receives safe, prompt care.[6]

1135 WAIVERS

Early on in the pandemic in the US, official guidance on how to relieve some of the mounting pressure on US emergency departments came from the Department of Health and Human Services (HHS)/Centers for Medicare and Medicaid Services (CMS).[1] As a result of emergency declarations made by the US President and Section 1135 of the Social Security Act, a waiver to lighten restrictions historically imposed by EMTALA on facilities and providers was possible.[3] In a directive distributed to the health care community in March of 2020, CMS announced "aggressive actions [in] exercising regulatory flexibility" surrounding the requirements for compliance with EMTALA during the COVID-19 emergency.[7] These 1135 waivers, as they are known, are broad and can apply to many other legal statutes, including Stark and Stafford laws, and have ramifications for almost every aspect of patient care in various types of facilities. This waiver is termed a "blanket" and thus applies to all US emergency departments, and facilities do not have to apply individually for these protections.[1] These exceptions to EMTALA do not nullify the responsibility of facilities and providers with regard to patients seeking emergent care, but they do alter what constitutes providing a qualifying examination and stabilizing treatment to satisfy EMTALA responsibilities.[3]

How EMTALA has been Altered

The 2 major traditional provisions in EMTALA that were altered during this time are: (1) the ability to redirect individuals to on- or off-site alternative locations for their mandated medical screening examination and (2) allowance to transfer patients who are not medically stabilized fully.[7] In addition, and of note, during this time under the emergency order, CMS waived the necessity for a Medicare or Medicaid patient to be under the direct care of a physician, encouraging the use of "other practitioners to the fullest extent possible," which is a monumental step forward for advanced practice providers in the US.[1,7] Physician assistants and nurse practitioners are suitable QMPs according to CMS, and with this loosening of the oversight requirement, their ability to function as an invaluable part of the emergency department is enhanced.[6]

CHANGES TO MEDICAL SCREENING EXAMINATION

To the first point, the allowance to defer the immediate medical screening examination of a person seeking care at an emergency department "for the direction or relocation of an individual…to an alternate location" was included in this publication by CMS.[7] Under this change, patients may be directed prior to entering the emergency department to present elsewhere to begin their evaluation and the alternative location can be on- or off-campus from the emergency department itself.[1] During a time of very scarce health care resources, such as during this pandemic, focusing on patients who necessitate emergency management, and triaging those who do not to alternative locations, maintains quality delivery of care while prioritizing safety of everyone involved.[3] Facilities can encourage the community to use settings other than a hospital for screening under this policy alteration to decrease ED use, but CMS does encourage facilities to plan how to handle more emergent cases that present to these locations inappropriately.[1] Posting signage and advertising that directs individuals to go to these alternate locations for screening and treatment is allowable, but should not create unreasonable barriers for patients seeking care. Specifically, under this statutory change, as long as the medical screening examination is performed by a QMP and care is given accordingly, persons presenting to the physical facility of the emergency department need not be seen at that time/place.

In addition, telemedicine, which, in the past, has been less used in the emergency department, was also clearly emphasized as an option for evaluation and treatment of patients during COVID-19.[1] QMPs may be on- or off-location while providing telehealth services and, as long as they act within their scope of practice, they will be able to bill at full, appropriate E/M CPT codes. Telemedicine is described, in a situation such as this pandemic, as being an "electronic Personal Protective Equipment," providing an efficient and safe alternative means to evaluate patients.[6]

ALTERATIONS IN STABILIZATION/TRANSFER PLANS

Secondly, changes to the process of transferring patients, which includes discharge from the facility, was altered under the waiver for EMTALA in 2020.[4] Traditionally under

EMTALA, this transfer requirement mandates that persons seeking care in the emergency department must be given sufficient treatment to stabilize them from likely deterioration of their condition. However, under this new, revised statute under the COVID-19 alterations, this does not have to be the case.[5] What in the past may have been deemed an inappropriate transfer would now be acceptable under EMTALA provided the discharge or transfer is necessary based on the current declared emergency situation, as long as the facility is operating in compliance with local/state emergency plans.[1] Care still needs to be taken to ensure risks to the patient (or unborn child) are minimized as much as possible; however, transfer of an individual who has not yet been stabilized medically is potentially allowed.

Limitations on EMTALA Waiver

It is important to remember that the term blanket waiver refers to the edict affecting the entire country as a whole and covers all health care entities and providers.[1] This blanket waiver allows all facilities to make changes to their practice and procedures without applying to CMS directly for individual variances. It does not indicate, however, that there is a wholesale suspension of EMTALA or protection against prosecution for unlawful violation of this statute. In fact, most of the requirements of the law remain in force. For example, an unlawful violation would involve creating signs or public posts that create real or perceived barriers to seeking care.[7] Further, aligning alternative plans for patient care with current state and local emergency actions is critical to remain in compliance.[7] Entities must still be very careful to ensure they are providing the required medical screening examination by qualified professionals to protect themselves from possible investigation and/or litigation. The 1135 waivers are only intended to allow extra flexibility with providing the required screening examination and services to patients during this time of national emergency.[1]

The EMTALA Waiver in Practice

Since the publication of the HHS COVID-19 Guidelines in March of 2020, health care facilities have used the flexibility provided in this document to creatively sustain patient care during the pandemic. Many examples can be found in the current literature of how this newfound flexibility has allowed creative, potential solutions to the crisis in our emergency departments to be implemented.

EXAMPLE 1: ON-SITE ALTERNATIVE

One example of this flexibility is the Surge Clinic designed by Massachusetts General Hospital.[8] In this plan, an alternate area was designed, adjacent to but separate from the existing emergency department, to handle evaluation and treatment of noncritical patients. Often these persons arrived at the request of primary care providers, and if inclusion criteria were met upon discussion with a staff provider, limited testing and discharge could be accomplished in the ambulance bay without traditional ED management. This model, highlighting the use of an alternate on-site location for providing the medical screening examination to patients, has worked optimally to serve patients while limiting the possible infectious exposure of the main ED patients and staff.[1]

EXAMPLE 2: TELEHEALTH SERVICES

Another example of using the EMTALA waiver in the emergency department is from Baylor Scott and White Medical Facilities in Texas. Here, the facility employed telemedicine to screen presenting ED patients.[9] Whereas in the past, telemedicine was used to overcome a physical barrier between provider and patients, here it was harnessed to provide a physical barrier and protection against COVID-19 exposure. Because of the expansion CMS allowed specifically for ED clinicians to bill for telehealth services in the EMTALA waiver announcement, this method of protecting against infection by avoiding face-to-face interaction was possible. In this example, once isolated by staff, high risk patients can be evaluated by a clinician remotely via videoconference on an iPad, thus satisfying the requirement for both audio and video components of the visit to allow for full E&M billing.[1]

EXAMPLE 3: OFF-SITE ALTERNATIVE

Finally, diverting patients to a separate off-site setting for care has become an option during our current health care crisis.[3] In a novel idea for delivery of patient care under the EMTALA waiver, members of the American Dental Association have suggested partnerships with local dental facilities to see patients presenting to the emergency department with isolated dental issues. As a result of the exception carved out by HHS during COVID-19, the 79% of patients with dental emergencies who initially present to the emergency department could be, immediately and legally, diverted to a local oral health provider. Situations such as the 1 described here would need additional approval by CMS, unless the 2 entitles are owned or operated by the

same company, but it is another example of resourcefulness during this pandemic.[7] Redirecting patients who meet criteria to such off-campus options will decrease consumption of valuable ED time and resources and will minimize the risk of nosocomial exposures for the patient.[3]

Conclusion

In the midst of a global pandemic, and resulting toll on health care in the US, it is unclear how long the need for measures such as the COVID-19 emergency declaration and its related waivers will exist. The current legal and regulatory provisos will remain active at least until any emergency order currently in place in the US is allowed to expire.[7] Thus far, the emergency declarations and waivers have provided much needed relief to emergency departments, allowing flexibility and creativity with plans to continue providing high-quality care to patients while protecting those same patients and their own workforce.[1] EMTALA is a landmark piece of legislation, providing legal protections to citizens who were often neglected or purposefully overlooked, and has stood up to challenges since its passage in 1986.[4] However, during the COVID-19 pandemic public health crisis we are in currently, appropriate relaxations of some of the provisions of the statute have allowed facilities and clinicians to continue their work of caring for patients with protection from infectious exposures.

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