

# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Renée D. Coleman-Mitchell, MPH  
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### HEALTHCARE QUALITY AND SAFETY BRANCH

### BLAST FAX 2020-26

TO: All Hospitals

FROM: Commissioner Renée D. Coleman-Mitchell, MPH *RDAM*

CC: Deputy Commissioner Heather Aaron, MPH, LNHA  
Barbara Cass, RN., Branch Chief, Healthcare Quality and Safety Branch  
Donna Ortelle, Section Chief, Facility Licensing and Investigations Section

DATE: April 1, 2020

SUBJECT: CMS Guidance for Infection Control and Prevention of Coronavirus Disease;  
EMTALA

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All Centers for Medicare and Medicaid Services (CMS) correspondence are specific to COVID-19, attached are:

- QSO-20-13: Guidance for Infection Control and Prevention of Coronavirus Disease;
- QSO-20-15: Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications



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Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-13-Hospitals-CAHs  
(REVISED)

DATE: March 30, 2020

TO: State Survey Agency Directors

FROM: Director  
Quality, Safety & Oversight Group

SUBJECT: Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Hospitals, Psychiatric Hospitals, and Critical Access Hospitals (CAHs): FAQs, Considerations for Patient Triage, Placement, Limits to Visitation and Availability of 1135 waivers.

Memorandum Summary

- *The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities and clinical laboratories are prepared to respond to the threat of the COVID-19.*
- *Coordination with the Centers for Disease Control (CDC) and local public health departments - We encourage all hospitals, psychiatric hospitals, and CAHs to monitor the CDC website for information and resources and contact their local health department when needed (CDC Resources for Health Care Facilities: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>).*
- *Hospital/CAH Guidance and Actions - CMS regulations and guidance support hospitals and CAHs taking appropriate action to address potential and confirmed COVID-19 cases to mitigate transmission and prepare for community spread transmission, including screening, discharge and transfers from the hospital, mitigation of staffing crises, and visitation.*
- *Hospital/CAH Flexibilities - Under Section 1135 of the Social Security Act (Act), CMS has waived a number of hospital/CAH requirements following the President's declaration of a national state of emergency and the Secretary's declaration of a Public Health Emergency to facilitate increasing hospital capacity, establishing alternate care sites, and removing administrative burdens.*

Background

CMS is committed to the protection of patients and residents of healthcare facilities from the spread of infectious disease. This memorandum responds to questions we have received and provides important guidance for hospitals, *psychiatric hospitals*, and critical access hospitals (CAHs) in addressing the COVID-19 outbreak and minimizing transmission to other

individuals. Specifically, we address FAQs related to optimizing patient placement, with the goal of addressing the needs of the individual patient while protecting other patients and healthcare workers.

## **Guidance**

Hospitals, *psychiatric hospitals*, and *CAHs* should monitor the Centers for Disease Control and Prevention's (CDC) website (<https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html>) for up-to-date information and resources *for the mitigation of transmission of COVID-19 for both inpatient and outpatient facilities*. They should contact their local health department if they have questions or suspect a patient or healthcare provider has COVID-19. Hospitals, *psychiatric hospitals*, and *CAHs* should have plans for monitoring healthcare personnel with exposure to patients with known or suspected COVID-19. Also, in light of limited staffing options, there should be a plan for how exposed or infected healthcare personnel may return to work. Additional information about monitoring healthcare personnel *and returning to work* is available here: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>; <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html>

### **Hospital, Psychiatric Hospital, and CAH Capacity for Acute Inpatient Care and Excluded Psychiatric and Rehabilitation Units**

*CMS has waived a number of requirements under Section 1135 for all hospitals including CAHs and psychiatric hospitals. Current information on 1135 waivers available to all hospitals/CAHs and psychiatric hospitals can be found at:*

*<https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf> and <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>*

*Case-by-case waivers may be requested at [1135waiver@cms.hhs.gov](mailto:1135waiver@cms.hhs.gov).*

### **Guidance for Mitigating Transmission and Preparing for Community Spread of COVID-19 Addressing Patient Triage, Placement of Patients with known or suspected COVID-19, Mitigation of Staffing Shortages (due to COVID-19 patient surges and/or staff becoming infected) and Expanded Visitation Recommendations**

*If healthcare personnel have been exposed or infected with COVID-19, when can they return to work to prevent staffing shortages?*

*According to CDC, in hospitals where testing is available, it is suggested that test-based strategies are preferred.*

*1. Test-based strategy. Personnel should be excluded from work until:*

- Resolution of fever without the use of fever-reducing medications, and*
- Improvement in respiratory symptoms (e.g., cough, shortness of breath), and*
- Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected  $\geq 24$  hours apart (total of two negative specimens)[1]. See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#).*

2. *Non-test-based strategy. Personnel should be excluded from work until:*

- *At least 3 days (72 hours) have passed since recovery, defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and,*
- *At least 7 days have passed since symptoms first appeared.*

*If healthcare personnel were never tested for COVID-19 but have an alternate diagnosis such as having tested positive for influenza, criteria for return to work should be based on existing guidance for that diagnosis.*

*Are there special considerations for previously exposed or infected healthcare personnel when returning to the workplace?*

*Before returning to work, exposed healthcare personnel should:*

- *Consult with their occupational health program, be monitored for symptoms, and seek re-evaluation from occupational health if fever and/or respiratory symptoms recur or worsen.*

*For more information on self-monitoring please see: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>*

*Healthcare personnel with confirmed or suspected COVID-19 should consult with their occupational health program and follow the CDC Interim guidance on return to work. <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html>*

*What additional measures should a hospital, psychiatric hospital, or CAH consider for the mitigation of transmission in outpatient settings?*

- *Reschedule non-urgent outpatient visits as necessary.*
- *Consider reaching out to patients who may be at a higher risk of COVID-19-related complications such as the elderly, those with medical co-morbidities, and potentially other persons who are at higher risk for complications from respiratory diseases, such as pregnant women to ensure adherence to current medications and therapeutic regimens, confirm they have sufficient medication refills, and provide instructions to notify their provider by phone if they become ill.*
- *Consider accelerating the timing of high priority screening and intervention needs for the short-term, in anticipation of the possible need to manage an influx of COVID-19 patients in the weeks to come.*
- *Symptomatic patients who need to be seen in a clinical setting should be asked to call before they leave home, so staff are ready to receive them using appropriate infection control practices, including providing a mask for the potentially infectious patient before or immediately upon entry into the healthcare facility, and personal protective equipment for the healthcare personnel.*

*What additional measures should a hospital, psychiatric hospital or CAH consider for the mitigation of transmission in inpatient settings?*

- *Reschedule elective surgeries, procedures, and other visits as necessary.*

- *Shift elective urgent inpatient diagnostic and surgical procedures to outpatient settings, when feasible.*
- *Maintain social distancing of at least six feet during group therapy interactions.*
- *Limit visitors to COVID-19 positive patients and persons under investigation (PUI).*
- *Plan for a surge of critically ill patients and identify additional space to care for these patients. Include options for:*
  - *Using alternate and separate spaces in the ER, ICUs, and other patient care areas to manage known or suspected COVID-19 patients.*
  - *Separating known or suspected COVID-19 patients from other patients (“cohorting”).*
  - *Identifying dedicated staff to care for COVID-19 patients.*

*Can an acute care inpatient be admitted to an excluded psychiatric unit to temporarily expand bed capacity?*

*Yes, CMS will allow acute care hospitals/CAHs with excluded distinct part psychiatric units that need to relocate acute care inpatients to excluded distinct part psychiatric units to provide care for overflow due to COVID-19 patients.*

*Can an acute care inpatient be admitted to an excluded rehabilitation unit to temporarily expand bed capacity?*

*Yes, CMS will allow acute care hospitals/CAHs with excluded distinct part inpatient rehabilitation units that need to relocate acute care inpatients to excluded distinct part rehabilitation units in order to provide care for overflow due to COVID-19 patients. The distinct part unit’s bed must be appropriate for the acute care inpatient.*

*Can an inpatient of an excluded rehabilitation unit be admitted to an acute care inpatient unit to temporarily expand bed capacity?*

*Yes, CMS will allow acute care hospitals/CAHs with excluded distinct part inpatient rehabilitation units that relocate their inpatients to an acute care bed and unit units to provide care for overflow due to COVID-19 patients. This waiver may be utilized where the hospital/CAH’s acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.*

*Can an excluded unit psychiatric inpatient be admitted to an acute care inpatient unit to expand bed capacity?*

*Yes, CMS will allow acute care hospitals/CAHs with excluded distinct part inpatient psychiatric units to relocate their inpatients to an acute care bed and unit to provide care for overflow due to COVID-19 patients. This waiver may be used when the hospital/CAH’s acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others receive safe and appropriate care.*

**Which patients are at risk for severe disease for COVID-19?**

Based upon CDC data <https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html>, older adults and those with underlying chronic medical conditions or immunocompromised state may be most at risk for severe outcomes. This should be considered in the decision to monitor the patient as an outpatient or inpatient.

### **How should facilities screen visitors and patients for COVID-19?**

Hospitals, *psychiatric hospitals*, and *CAHs* should identify visitors and patients at risk for having COVID-19 infection before or immediately upon arrival to the healthcare facility. They should ask patients about the following:

1. *Signs or symptoms of a respiratory infection, such as a fever, cough, or difficulty breathing.*
2. *Contact with a person who is positive for COVID-19 or with someone who is considered a PUI or someone who is ill with respiratory illness.*
3. *Travel within the last 14 days to areas with widespread or ongoing COVID-19 community spread. For updated information on countries and restricted areas within the U.S., visit: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html>.*
4. *Residence or working in a community where community-based spread of COVID-19 is occurring. For more information on mitigation plans for communities identified to be at risk, visit: <https://www.cdc.gov/coronavirus/2019-ncov/community/index.html>.*

For patients, implement respiratory hygiene and cough etiquette (i.e., placing a facemask over the patient's nose and mouth if that has not already been done) and isolate the patient in an examination room with the door closed. If the patient cannot be immediately moved to an examination room, ensure they are not allowed to wait among other patients seeking care. Identify a separate, well-ventilated space that allows waiting patients to be separated by 6 or more feet, with easy access to respiratory hygiene supplies. In some settings, medically-stable patients might opt to wait in a personal vehicle or outside the healthcare facility where they can be contacted by mobile phone when it is their turn to be evaluated.

Inform infection prevention and control services, local and state public health authorities, and other healthcare facility staff as appropriate about the presence of a person under investigation for COVID-19. Additional guidance for evaluating patients in U.S. for COVID-19 infection can be found on the CDC [COVID-19 website](#). *For more specific guidance see resource links.*

Provide supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, facemasks, and tissues at healthcare facility entrances, waiting rooms, patient check-ins, etc.

### **How should facilities monitor or restrict healthcare facility staff?**

The same screening performed for visitors should be performed for hospital, *psychiatric hospital*, and *CAH* staff.

- Healthcare providers (HCP) who have signs and symptoms of a respiratory infection should not report to work.
- Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should:

- Immediately stop work, put on a facemask, and self-isolate at home.
- Inform the hospital, *psychiatric hospital*, or CAH's infection control professional/preventionist and include information on individuals, equipment, and locations the person came in contact with.
- Contact and follow the local health department recommendations for next steps such as testing and locations for treatment.
- Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>).
- *Report cases of illness to their supervisor, employee health service, and/or occupational health clinic. Employees should also consult their healthcare provider if they are experiencing signs/symptoms consistent with COVID-19*

Hospitals, *psychiatric hospitals*, and CAHs should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals (<https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html>).

### ***Can hospitals continue to procure organs for organ donation?***

*Yes. Ensuring that individuals have continued access to life-saving organs is critical. We understand that hospitals are preparing for a surge in COVID-19 patients; however, we would ask that donor hospitals continue with normal operations in regards to allowing organ procurement coordinators into hospitals to discuss organ donation with families wherever possible. Hospital and Organ Procurement Organization (OPO) leadership should communicate on risk assessments in their communities and any potential impacts for organ recovery operations.*

### **What are recommended infection prevention and control practices, including considerations for patient placement, when evaluating and care for patients with known or suspected COVID-19?**

Recommendations for patient placement and other detailed infection prevention and control recommendations regarding hand hygiene, Transmission-Based Precautions, environmental cleaning and disinfection, managing visitors, and monitoring and managing healthcare personnel are available in the [CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 \(COVID-19\) or Persons under Investigation for COVID-19 in Healthcare Settings](#).

### **Do all patients with known or suspected COVID-19 infection require hospitalization?**

No. Patients may not require hospitalization and can be managed at home if they are able to comply with monitoring requests. More information is available here: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html>

### **Are there specific considerations for patients requiring diagnostic or therapeutic interventions?**

Patients with known or suspected COVID-19 should continue to receive the intervention appropriate for the severity of their illness and overall clinical condition. Because some

procedures such as intubation create high risks for transmission additional precautions include: 1) HCP should wear all recommended *personal protective equipment (PPE)*, 2) the number of HCP present should be limited to essential personnel, and 3) the room should be cleaned and disinfected in accordance with environmental infection control guidelines.

Additional information about performing aerosol-generating procedures is available here: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>

*Please note that CDC has issued updated strategies for optimizing the use of facemasks. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/facemasks.html>.*

### **When is it safe to discontinue Transmission-Based Precautions for hospitalized patients with COVID-19?**

The decision to discontinue Transmission-Based Precautions for hospitalized patients with COVID-19 should be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials. This decision should consider disease severity, illness signs and symptoms, and results of laboratory testing for COVID-19 in respiratory specimens. More detailed information about criteria to discontinue Transmission-Based Precautions are available here: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>.

### **What are the considerations for discharge to a subsequent care location for patients with COVID-19?**

The decision to discharge a patient from the hospital, *psychiatric hospital*, or *CAH* should be made based on the clinical condition of the patient. If Transmission-Based Precautions must be continued in the subsequent setting, the receiving facility must be able to implement all recommended infection prevention and control recommendations.

Although COVID-19 patients with mild symptoms may be managed at home, the decision to discharge to home should consider the patient's ability to adhere to isolation recommendations, as well as the potential risk of secondary transmission to household members with immunocompromising conditions. *Special consideration should be given to patients with psychiatric or cognitive disabilities to ensure they are able to adhere to the COVID-19 discharge recommendations and fully comprehend the significance of the precautions, or they have a family member or significant other involved to assist with these restrictions.* More information is available here: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html>

### **What are the implications of the Medicare Hospital, *psychiatric hospital*, *Psychiatric Hospital*, and *CAH* Discharge Planning Regulations for Patients with COVID-19?**

Medicare's Discharge Planning Regulations (which were updated in November 2019) require that *the hospital, psychiatric hospital, or CAH* assess the patient's needs for post-hospital, *psychiatric hospital or CAH* services, and the availability of such services. When a patient is discharged, all necessary medical information (including communicable diseases) must be provided to any post-



acute service provider. For COVID-19 patients, this must be communicated to the receiving service provider prior to the discharge/transfer and to the healthcare transport personnel.

### **Can hospitals, *psychiatric hospital*, and *CAHs* restrict visitation of patients?**

Medicare regulations require a hospital, *psychiatric hospital*, or *CAH* to have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital, *psychiatric hospital*, or *CAH* may need to place on such rights and the reasons for the clinical restriction or limitation. CMS sub-regulatory guidance identifies infection control concern as an example of when clinical restrictions may be warranted. Patients must be informed of his/her visitation rights and the clinical restrictions or limitations on visitation.

The development of such policies and procedures require hospitals to focus efforts on preventing and controlling infections, not just between patients and personnel, but also between individuals across the entire hospital, *psychiatric hospital*, and *CAH* setting (for example, among patients, staff, and visitors) as well as between the hospital, *psychiatric hospital*, and *CAH* and other healthcare institutions and settings and between patients and the healthcare environment. Hospitals, *psychiatric hospitals*, and *CAHs* should work with their local, state, and federal public health agencies to develop appropriate preparedness and response strategies for communicable disease threats.

### ***Limiting visitors and individuals: Expanded recommendations:***

*CMS is providing the following expanded guidance for hospitals, psychiatric hospitals, and CAHs located in States with COVID-19 cases are present to prevent the spread of COVID-19:*

- a) *Visitors should receive the same screening as patients, including whether they have had:*
  - *Fever or symptoms of a respiratory infection, such as a cough and difficulty breathing.*
  - *International travel within the last 14 days to CDC Level 3 risk countries. For updated information on restricted countries visit: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html> and for considerations after recent international travel visit: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html>*
  - *Recent trips (within the last 30 days) on cruise ships. For updated information on recent cruise ship travel, visit the CDC website: <https://wwwnc.cdc.gov/travel/page/covid-19-cruise-ship>*
  - *Contact with someone with known or suspected COVID-19 or ill with respiratory illness.*
  - *Travel in the last 14 days within the United States to restricted areas. Information and guidance on restricted areas within the US, visit: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-in-the-us.html>*
- b) *Healthcare facilities should set limitations on visitation. For example, limitations may include restricting the number of visitors per patient, or limiting visitors to only those that provide assistance to the patient, or limiting visitors under a certain age.*
- c) *Facilities must ensure patients have adequate and lawful access to chaplains or clergy in conformance with the Religious Freedom Restoration Act and Religious Land Use and Institutionalized Persons Act.*
- d) *Healthcare facilities should provide signage at entrances for screening individuals, provide temperature checks/ ask about fever, and encourage frequent hand washing and use of hand sanitizer before entering the facility and before and after entering patient rooms*

- e) *If visiting and not seeking medical treatment themselves, individuals with fevers, cough, difficulty breathing, body aches or runny nose or those who are not following infection control guidance should be restricted from entry.*
- f) *Facilities should instruct visitors to limit their movement within the facility by reducing such things as walking the halls or trips to the cafeteria.*
- g) *Facilities should establish limited entry points for all visitors and/or establish alternative sites for screening prior to entry.*
- h) *Facilities can implement measures to:*
  - *Increase communication with families (phone, social media, etc.)*
  - *Potentially offer a hotline with a recording that is updated at set times so families can stay current on the facility's general status.*
  - *If appropriate, consider offering telephonic screening of recent travel and wellness prior to coming in for scheduled appointments. This may help limit the amount of visitor movement throughout the organization and congestion at entry points.*
- i) *Consider closing common visiting areas and encouraging patients to visit with loved ones in their patient rooms.*

### **CDC Resources:**

- *Coronavirus Disease 2019 (COVID-19) Hospital Preparedness Assessment Tool*  
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/hcp-hospital-checklist.html>
- *CDC Resources for Health Care Facilities:* <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>
- *CDC Updates:* <https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html>
- *CDC FAQ for COVID-19:* <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html>
- *CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID19) or Persons Under Investigation for COVID-19 in Healthcare Settings.:* [https://www.cdc.gov/coronavirus/2019-ncov/infection-control/controrecommendations.html?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html](https://www.cdc.gov/coronavirus/2019-ncov/infection-control/controrecommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html)
- *Health Department Directories:* <https://www.naccho.org/membership/lhd-directory>

### **CDC Updates:**

<https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html>

### ***Mental Health Resources:***

*SAMHSA has developed guidelines for Psychiatric Hospitals which can be found here:*  
<https://www.samhsa.gov/sites/default/files/covid19-interim-considerations-for-state-psychiatric-hospitals.pdf>

### **CMS Resources:**

CMS has additional guidance which may be beneficial to hospitals, *psychiatric hospitals, and*

*CAHs related to screening patients for COVID in alternate locations, Emergency Medical Treatment and Labor Act (EMTALA) requirements and other topics surrounding the health and safety standards during emergencies: <https://www.cms.gov/files/document/qso-20-15-hospitalcahemtala.pdf>.*

The document Provider Survey and Certification Frequently Asked Questions (FAQs), Declared Public Health Emergency All-Hazards are located at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/All-Hazards-FAQs.pdf>. These FAQs are not limited to situations involving 1135 Waivers, but are all encompassing FAQs related to public health emergencies and survey activities and functions.

**Contact:**

Questions about this memorandum should be addressed to [QSOG\\_EmergencyPrep@cms.hhs.gov](mailto:QSOG_EmergencyPrep@cms.hhs.gov). Questions about COVID-19 guidance/screening criteria should be addressed to the State Epidemiologist or other responsible state or local public health officials in your state.

**Effective Date:**

Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/  
David R. Wright

cc: Survey and Operations Group Management

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**Center for Clinical Standards and Quality/Quality, Safety and Oversight Group**

Ref: QSO-20-15 Hospital/CAH/EMTALA REVISED

**DATE:** March 30, 2020

**TO:** State Survey Agency Directors

**FROM:** Director  
Quality Safety and Oversight Group

**SUBJECT:** Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications Related to Coronavirus Disease 2019 (COVID-19) (Revised)

**Memorandum Summary**

**COVID-19 and EMTALA Requirements:** This Memorandum conveys information in response to inquiries from hospitals and critical access hospitals (CAHs) concerning implications of COVID-19 for their compliance with EMTALA. *The memo was revised to include additional guidance related to the establishment of drive-through testing sites; clarification of expectations in relation to the triage process and the medical screening examination; and use of telehealth.*

- **EMTALA Screening Obligations:** Every hospital or CAH with a dedicated emergency department (ED) is required to conduct an appropriate medical screening examination (MSE) of all individuals who come to the ED, including individuals who are suspected of having COVID-19, regardless of whether they arrive by ambulance or are walk-ins. Every ED is expected to have the capability to apply appropriate COVID-19 screening criteria when applicable, to immediately identify and isolate individuals who meet the screening criteria to be a potential COVID-19 patient, and to contact their state or local public health officials to determine next steps *when an individual meeting the screening criteria is found.*
- **EMTALA Stabilization, Transfer & Recipient Hospital Obligations:** In the case of individuals with suspected or confirmed COVID-19, hospitals and CAHs are expected to consider *the* 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. 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.

## Background

Due to increasing public concerns with COVID-19, CMS is receiving inquiries from the hospital industry concerning implications for their compliance with EMTALA. Concerns center around the ability of hospitals and CAHs to fulfill their EMTALA screening obligations while minimizing the risk of exposure from COVID-19 infected individuals to others in the ED, including healthcare workers, *along with* the isolation requirements for COVID-19. In addition, we have also received questions about the applicability of EMTALA stabilization, transfer, and recipient hospital obligations in the case of individuals who are found to have met the screening criteria for possible COVID-19 infection or who have been determined to have COVID-19.

Please note this memorandum applies to both hospitals and critical access hospitals (CAHs) wherever the term “hospital” is referenced.

EMTALA requires Medicare-participating hospitals and CAHs that have a dedicated emergency department to, at a minimum:

- Provide a medical screening exam (MSE) to every individual who comes to the ED for examination or treatment for a medical condition to determine if the individual has an emergency medical condition (EMC). An emergency medical condition is present when there are acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in serious impairment or dysfunction *per 42 CFR 489.24(b)*.
- Provide necessary stabilizing treatment for individuals with an EMC within the hospital’s capability and capacity.
- Provide for transfers of individuals with EMCs, when appropriate.

Please see *Attachment 1* for a discussion of alternate screening locations and increased surges in numbers of patients presenting to the ED.

***Are hospitals required to accept transfers of patients with suspected or confirmed COVID-19 from small or rural hospitals that don’t have appropriate or sufficient isolation facilities or equipment to meet current state or local public health or CDC recommendations?***

Hospitals with capacity and the specialized capabilities needed for stabilizing treatment are required to accept appropriate transfers from hospitals without the necessary capabilities. *However, the receiving hospital may refuse the transfer if they do not have the capacity to provide the necessary care and services.* Hospitals should coordinate with their State/local public health officials regarding appropriate placement of individuals who meet specified COVID-19 assessment criteria, and the most current standards of practice for treating individuals with confirmed COVID-19 infection status.

As in any case concerning a hospital’s EMTALA obligations with respect to transfers of individuals, CMS would evaluate the capabilities and capacity of both the referring and recipient hospitals in order to determine whether a violation has occurred. Among other things, we would take into account the CDC’s recommendations at the time of the event in question in assessing whether a hospital had the requisite capabilities and capacity. We note that CDC’s recommendations focus on factors such as the individual’s recent travel or exposure history and presenting signs and symptoms in differentiating the types of capabilities hospitals should have to screen and treat that individual. The presence or absence of negative pressure rooms (Airborne Infection Isolation Rooms (AIIRs)) *is not the sole determining factor* related to transferring patients from one setting to another when in *most* cases all that *is required for appropriate care is* a private room. See the CDC website for the most current infection prevention and

control recommendations for hospital patients with suspected or known COVID-19:  
<https://www.cdc.gov/coronavirus/2019-ncov/infection-control/index.html>

In addition, per 42 CFR 489.24 (f), all Medicare-participating hospitals with specialized capabilities are required to accept appropriate transfers of individuals with EMCs if the hospital has the specialized capabilities an individual requires for stabilization as well as the capacity to treat these individuals. This recipient hospital obligation applies regardless of whether the hospital has a dedicated emergency department.

*What are the screening sites that may be set up?*

#### **Hospitals may set up alternative screening sites on campus**

- The MSE does not have to take place in the ED. A hospital may set up alternative sites on its campus to perform MSEs.
  - Individuals may be redirected to these sites. *Whether the individual is seen at the alternate on-campus site or in the ED, they should be logged in where they are seen. Individuals do not need to present to the ED, first, and if they do present to the ED, they may still be redirected to the on-campus alternative screening location for logging and subsequent screening.*
  - *This is a triage function and the person providing the redirection from the ED should be qualified (e.g., a Registered Nurse (RN)) to recognize individuals who are obviously in need of immediate treatment in the ED. Hospital non-clinical staff stationed at other entrances to the hospital may provide redirection to the on-campus alternative screening location for individuals seeking COVID-19 testing.*
- The content of the MSE varies according to the individual's presenting signs and symptoms. It can be as simple or as complex as needed to determine if an EMC exists.
- MSEs must be conducted by qualified personnel, which may include physicians, nurse practitioners, physician assistants, or RNs trained to perform MSEs and acting within the scope of their State Practice Act.
- The hospital must provide stabilizing treatment (or appropriate transfer) to individuals found to have an EMC, including moving them as needed from the alternative site to another on-campus department.

#### ***B. Hospitals may set up screening at off-campus, hospital-controlled sites.***

- Hospitals and community officials may encourage the public to go to off-campus sites to be screened for COVID-19 instead of the hospital. *Normally, a hospital may not tell individuals who have already entered an ED to go to the off-site location for the MSE—such a redirection usually only occurs to an on-campus alternative site. However, CMS has approved via 1135 waiver for the COVID-19 pandemic the ability to re-direct patients to an offsite location for screening, in accordance with a state emergency preparedness or pandemic plan,*
- Unless the off-campus site is already a dedicated ED (DED) of the hospital, as defined under EMTALA regulations at 42 CFR 489.24(b), EMTALA requirements do not apply.
- The hospital should not hold the site out to the public as a place that provides care for EMCs in general on an urgent, unscheduled basis. They can hold it out as a *respiratory or potential/presumed COVID-19 patient screening center.*
- The off-campus site should be staffed with medical personnel trained to evaluate individuals with *respiratory or potential/presumed COVID-19 symptoms.*
- If an individual needs additional medical attention on an emergent basis, the hospital is required, under the Medicare Conditions of Participation, to arrange for

referral/transfer. Prior coordination with local emergency medical services (EMS) is advised to develop transport arrangements.

**C. Communities or hospitals may set up *testing stations* at sites not under the control of a hospital (such as a mall or retail parking lot)**

- There is no EMTALA obligation at these sites, *even if hospital personnel assist with the testing.*
- Hospitals and community officials may encourage the public to go to these sites instead of the hospital for *COVID-19 testing*. *However, a hospital may not tell individuals who have already come to its ED to go to the off-site location for the COVID-19 testing until they have been provided a MSE and determined not to have an emergency medical condition.*
- Communities and hospitals are encouraged to staff the sites with medical personnel trained to evaluate individuals with *respiratory or potential/presumed COVID-19 symptoms*.
- *There should be protocols or a process in place to deal with patients who arrive in medical distress and need transport to a hospital which may be as simple as calling 911.*

**EMTALA Obligations when Screening Suggests Possible COVID-19**

If an individual comes to an ED of a hospital, as the term “comes to the emergency department” is defined at 42 CFR 489.24(b), either by ambulance or as a walk-in, the hospital must provide the individual with an appropriate MSE. We emphasize that 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. *In addition, it is acceptable for a hospital to post signage informing individuals, who are seeking COVID-19 testing about alternative community locations (non-hospital controlled sites) for COVID-19 testing but do not want a medical screening exam or think they have an emergency medical condition.* If the hospital is intending to use another location to conduct the MSE, please see *Attachment 1* for additional information.

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.* Although levels of services provided by EDs vary greatly 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 coordinating with their State or local public health officials, who will in turn arrange coordination, as necessary, with CDC.

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.

At the time of this memo’s publication, CDC’s screening guidance (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>) called for hospitals to contact their State or local public health officials when they have a case of suspected COVID-19. Officials will advise of next steps, in accordance with CDC recommendations on testing.

## Other Enforcement Considerations

*The guidance in this memorandum regarding EMTALA is consistent with the implementation and enforcement of conditions of participation to ensure hospital actions in accordance with this guidance do not raise COP concerns.*

Should CMS receive complaints alleging either inappropriate transfers by a sending hospital or refusal of a recipient hospital to accept an appropriate transfer, it will take into consideration CDC guidance and state or local public health direction at the time of the alleged noncompliance. It will also take into consideration any clinical considerations specific to the individual case(s).

Consistent with their obligations under the hospital and CAH Conditions of Participation (CoPs) found at 42 CFR 482.42 and 485.640, hospitals and CAHs are expected to adhere to accepted *or nationally-recognized* standards of infection control practice to prevent the spread of infectious disease and illness, including COVID-19. Standard, contact, and airborne precautions with eye protection should be used when caring for the patient as noted in CDC's Interim Health Care Infection Prevention and Control Recommendations for Patients Under Investigation for Coronavirus Disease 2019 (COVID-19). CDC has issued extensive guidance on applicable isolation precautions and CMS strongly urges hospitals to follow this guidance. CMS recognizes the difficulties securing the recommended personal protective equipment (PPE) required for training and patient care that may be present in some circumstances at the time of this memorandum. *Alternatively, hospitals that have adopted policies requiring adherence to World Health Organization guidance may continue to do so.* Hospitals and CAHs are expected under their respective CoPs at 42 CFR 482.11(a) and 485.608(a) to comply with Occupational Safety and Health Administration (OSHA) requirements, but CMS and state surveyors acting on its behalf do not assess compliance with requirements of other Federal agencies.

## Latest CDC Guidance

The most up-to-date guidance regarding screening, testing, treatment, isolation, and other COVID-19 topics can be found on the CDC website at <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html>. Hospitals and CAHs are strongly urged to monitor this site as well as their state public health website and follow recommended guidelines and acceptable standards of practice. State Survey Agencies are also encouraged to monitor the CDC and their state public health websites for up-to-date information.

## CMS Resources

CMS has released a memo regarding triage, assessment and discharge for hospitals which will provide additional information about responding to COVID-19 cases.  
<https://www.cms.gov/files/document/qso-20-13-hospitalspdf.pdf-2>

CMS has additional guidance related to EMTALA which may be beneficial, and other topics surrounding health standards and quality. The document Provider Survey and Certification Frequently Asked Questions (FAQs), Declared Public Health Emergency—All-Hazards is located at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/All-Hazards-FAQs.pdf>. These FAQs are not limited to situations involving 1135 Waivers, but are all encompassing FAQs related to public health emergencies and survey activities and functions.

Questions about this memo should be addressed to [QSOG\\_EmergencyPrep@cms.hhs.gov](mailto:QSOG_EmergencyPrep@cms.hhs.gov).

## FDA Resources:



- Emergency Use Authorizations: <https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations>

**ASPR Resources:**

- *Hospital Surge Capacity and Immediate Bed Availability:*  
<https://asprtracie.hhs.gov/technical-resources/58/hospital-surge-capacity-and-immediate-bed-availability/0>
- *ASPR TRACIE: Considerations for the Use of Temporary Surge Sites for Managing Seasonal Patient Surge*

**Effective Date:** Immediately. This policy should be communicated with all survey and certification staff, their managers, and the State/Regional Office training coordinators immediately.

/s/

David Wright

cc: Survey & Certifications Group Management

Attachment (2)



**Emergency Medical Treatment and Labor Act (EMTALA)  
& Surges in Demand for Emergency Department (ED)  
Services**

**I. What is EMTALA?**

- EMTALA is a Federal law that requires all Medicare-participating hospitals (**including critical access hospitals (CAHs)**) with dedicated EDs to perform the following for **all** individuals who come to their EDs, regardless of their ability to pay:
  - An *appropriate* medical screening exam (MSE) to determine if the individual has an Emergency Medical Condition (EMC). If there is no EMC, the hospital's EMTALA obligations end. *Triage is the process of sorting individuals based on their need for immediate medical treatment and is not considered to be a medical screening examination in and of itself. It is appropriate for hospital staff to triage individuals for purposes of directing them to the appropriate location of the hospital where the medical screening exam will occur, based on the hospital's triage and alternate screening protocols.*
  - If there is an EMC, the hospital must:
    - + Treat and stabilize the EMC within its capability (including inpatient admission when necessary); **OR**
    - + Transfer the individual to a hospital that has the capability and capacity to stabilize the EMC.
- *Medical testing can detect a condition and confirm a diagnosis for which a treatment plan is developed. Drive through testing sites that have been established for COVID 19 testing alone, including on a hospital campus, do not have EMTALA implications. However, EMTALA would still apply if a patient who was seeking only COVID-19 testing made a request for emergency medical treatment while on the hospital campus.*
- Hospitals with specialized capabilities (with or without an ED) may not refuse an appropriate transfer under EMTALA if they have the capacity to treat the transferred individual.
- EMTALA ensures access to hospital emergency services; it need not be a barrier to providing care in a disaster.

**II. Options for Managing Extraordinary ED Surges Under Existing EMTALA Requirements (No Waiver Required)**

**A. Hospitals may set up alternative screening sites on campus**

- The MSE does not have to take place in the ED. A hospital may set up alternative sites on its campus to perform MSEs.
  - *Individuals may be redirected to these sites. Whether the individual*

*is seen at the alternate on-campus site or in the ED, they should be logged in where they are seen. Individuals do not need to first present to the ED, and if they present to the ED, may still be redirected to the on-campus alternative screening location for logging and subsequent screening,*

- *This is a triage function and the person providing the redirection from the ED should be qualified (e.g., an RN) to recognize individuals who are obviously in need of immediate treatment in the ED. Hospital non-clinical staff stationed at other entrances to the hospital may provide redirection to the on-campus alternative screening location for individuals seeking COVID-19 testing.*
- *The content of the MSE varies according to the individual's presenting signs and symptoms. It can be as simple or as complex, as needed, to determine if an EMC exists. MSEs must be conducted by qualified personnel, which may include physicians, nurse practitioners, physician's assistants, or RNs trained to perform MSEs and acting within the scope of their State Practice Act. Hospitals may request a waiver to allow MSEs to be performed by qualified medical staff authorized by the hospital, such as registered nurses, who are acting within their scope of practice and licensure, yet are not designated in the bylaws to perform MSEs.*
- *Hospitals may use telehealth equipment to perform the MSE by Qualified Medical Personnel (QMP). The QMP may be on-campus (and using telehealth to self-contain) or offsite (due to staffing shortages). Either way, the QMP must be performing within the scope of their state practice act, and approved by the Hospital's Governing Body to perform MSEs.*
- *The use of telehealth to provide evaluation of individuals who have not physically presented to the hospital for treatment does not create an EMTALA liability.*
- *The hospital must provide stabilizing treatment (or appropriate transfer) to individuals found to have an EMC, including moving them as needed from the alternative site to another on-campus department.*

***B. Hospitals may set up screening at off-campus, hospital-controlled sites.***

- *Hospitals and community officials may encourage the public to go to these sites instead of the hospital for screening of respiratory or potential/presumed COVID-19 illness. However, a hospital may not tell individuals who have already come to its ED to go to the off-site location for the MSE.*
- *Unless the off-campus site is already a dedicated ED (DED) of the hospital, as defined under EMTALA regulations at 42 CFR § 489.24(b), EMTALA requirements do not apply.*
- *The hospital should not hold the site out to the public as a place that provides care for EMCs in general on an urgent, unscheduled basis. They can advertise it as a COVID-19 testing center.*
- *The off-campus site should be staffed with medical personnel trained to evaluate individuals with respiratory or potential/presumed COVID-19 symptoms.*
- *If an individual needs additional medical attention on an emergent basis, the hospital is required, under the Medicare Conditions of Participation, to*

arrange referral/transfer. Prior coordination with local emergency medical services (EMS) is advised to develop transport arrangements.

**C. Communities or Hospitals may set up testing stations at sites not under the control of a hospital (such as a mall or retail parking lot)**

- *There is no EMTALA obligation at these sites, even if hospital personnel perform the testing.*
- *Hospitals and community officials may encourage the public to go to these sites instead of the hospital for COVID-19 evaluation. However, a hospital may not tell individuals who have already come to its ED to go to the off-site location for the COVID-19 testing until they have been provided a MSE and determined not to have an emergency medical condition.*
- *Communities and hospitals are encouraged to staff the sites with medical personnel trained to evaluate individuals with respiratory or potential/presumed COVID-19 symptoms.*
- *There should be protocols or a process in place to safely transport patients who arrive in medical distress and need to be admitted to the hospital which may be as simple as calling 911.*
- *Drive through testing sites that have been established for COVID-19 testing purposes-only do not have EMTALA implications*

**III. EMTALA Waivers**

- An EMTALA waiver allows hospitals to:
  - Direct or relocate individuals who come to the ED to an alternative off-campus site, in accordance with a state emergency or pandemic preparedness plan, for the MSE. *(This waiver has been approved for the COVID-19 pandemic.)*
  - Effect transfers *which may be prohibited* under EMTALA of individuals with unstable EMCs, so long as the transfer is necessitated by the circumstances of the declared emergency.
- CMS will provide notice of an EMTALA waiver to covered hospitals through its Regional Offices and/or State Survey Agencies *and on the CMS website <https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf>.*
- The EMTALA waiver for a pandemic infectious disease is effective until the termination of the declared public health emergency.

## Attachment 2: EMTALA Obligations & Coronavirus Disease 2019

### Question and Answer Document

*Note: For the purpose of this document, the term “hospital” includes all types of Medicare-participating hospitals, critical access hospitals (CAHs).*

#### **A. Patient Insurance/Payor Status**

***A.1. Is a Medicare-participating hospital required to provide EMTALA-mandated screening and stabilizing treatment for non-Medicare beneficiaries with likely or confirmed COVID-19?***

EMTALA applies to all individuals who come to the dedicated emergency department (ED) of a Medicare-participating hospital or CAH, regardless of type or presence of insurance coverage or ability to pay. Further, Medicare-participating hospitals with specialized capabilities are required within the limits of their capability and capacity to accept appropriate transfers of individuals protected under EMTALA from other hospitals, without regard to insurance or ability to pay.

#### **B. Specialized Capabilities**

***B.1. EMTALA requires that hospitals with specialized capabilities to treat COVID-19 accept appropriate transfers of individuals who require those services, if they have capacity to provide them. In the event of an EMTALA complaint related to an inappropriate transfer and/or a refusal of a recipient hospital to accept an appropriate transfer, how will CMS determine whether a hospital had the “specialized capabilities” with respect to COVID-19 required by the individual?***

At the time of this FAQ document, no formally designated COVID-19 treatment centers are established. Some of the early COVID-19 cases were sent to hospitals previously designated as Ebola treatment centers; however, no determination has been made that specialized centers would be developed for COVID-19 cases and therefore all hospitals are required at a minimum to screen, isolate, and begin stabilizing treatment as appropriate for any individual with suspected COVID-19 symptoms. If specially designated COVID-19 treatment facilities are implemented as part of a local, state, or national pandemic plan, then transfer of patients under these plans would be in compliance with EMTALA.

***B.2: Are hospitals required to accept transfers of patients with suspected or confirmed COVID-19 from small or rural hospitals that don’t have appropriate or sufficient isolation facilities or equipment to meet current state or local public health or CDC recommendations?***

Hospitals with capacity and the specialized capabilities needed for stabilizing treatment are required to accept appropriate transfers from hospitals without the necessary capabilities. Hospitals should coordinate with their state/local public health officials regarding appropriate placement of individuals who meet specified COVID-19 assessment criteria, and the most current standards of practice for treating individuals with confirmed COVID-19 infection status.

As in any case concerning a hospital’s EMTALA obligations with respect to transfers of individuals, CMS would evaluate the capabilities and capacity of both the referring and recipient hospitals in order to determine whether a violation has occurred. Among other things, we would take into account CDC’s recommendations at the time of the event in question in assessing

whether a hospital had the requisite capabilities and capacity. We note that CDC's recommendations focus on factors such as the individual's recent travel or exposure history and presenting signs and symptoms in differentiating the types of capabilities hospitals should have to screen and treat that individual. The presence or absence of negative pressure rooms (Airborne Infection Isolation Room (AIIR)) would not be the sole determining factor related to transferring patients from one setting to another when in some cases all that would be required would be a private room. See the CDC website for the most current infection prevention and control recommendations for hospital patients with suspected or known COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/index.html>

### **C. Screening Examinations and Stabilizing Treatment Requirements**

#### ***C.1: What are the EMTALA requirements for hospitals in regard to screening and treating individuals with possible COVID-19?***

The EMTALA requirements for hospitals and CAHs are the same for individuals with possible COVID-19 symptoms as all other possible emergency medical conditions (EMCs). Hospitals and CAHs must:

- Provide an appropriate Medical Screening Exam (MSE) to every individual who comes to the Emergency Department (ED) for examination or treatment of a medical condition, to determine if they have an emergency medical condition (EMC);
- Provide necessary stabilizing treatment for individuals with an EMC within the hospital's capability and capacity; and
- Provide for appropriate transfers of individuals with EMCs if the hospital lacks the capability to stabilize them.

Specific to COVID-19, hospitals are encouraged to follow the CDC guidance for appropriate isolation procedures to minimize the risk of cross-contamination to other patients, visitors, and healthcare workers. Hospitals should consult the latest CDC guidance and coordinate with state/local public health authorities for guidance related to ongoing care and treatment of patients with COVID-19.

#### ***C.2: Are all hospitals expected to screen and treat individuals with possible COVID-19 symptoms?***

Yes, all hospitals are expected, at a minimum to screen, isolate, and begin stabilizing treatment, as appropriate, for any individual with possible COVID-19 symptoms. Hospitals should coordinate with their state/local public health authorities regarding ongoing care and treatment.

#### ***C.3: Can hospitals ask patients to wait in their car or outside the hospital as CDC suggests in their COVID-19 guidance or is that violating EMTALA?***

The MSE requirement of EMTALA requires that it be timely depending on the presenting signs and symptoms of the individual. Hospitals must perform an appropriate examination by a Qualified Medical Practitioner to determine if the patient has an emergency medical condition. If the individual, after an appropriate medical screening exam, meets CDC criteria for potential COVID-19 and is determined to have no signs or symptoms that require immediate medical attention, then this would not present a direct EMTALA violation. In cases where a request is

made for medical care that is unlikely to involve an EMC, the individual's statement that s/he is not seeking emergency care, together with brief questioning by the QMP would be sufficient to establish that there is no EMC and the hospital's EMTALA obligation would be satisfied. However, the hospital should have a system in place to monitor those patients that opt to wait in their own vehicle to ensure that their condition has not deteriorated while awaiting further evaluation. Failure to do so could expose the hospital to a potential MSE violation because the MSE was not done timely. In that case, it could also be a violation of the Condition of Participation: Emergency Services. As noted during previous public health emergency situations such as EBOLA and H1N1, CMS will take into consideration any clinical considerations specific to the individual case(s).

***C.4: If a hospital does not have Intensive Care Unit (ICU) capabilities is it required to screen and, when appropriate, initiate stabilizing treatment for individuals with suspected or confirmed COVID-19?***

Yes. The lack of ICU capabilities does not exempt a hospital from performing an MSE and initiating stabilizing treatment for individuals with known or suspected COVID-19 who come to the hospital's ED seeking examination or treatment. Qualified medical personnel in hospitals that conduct the screening examination should be aware of the criteria for initial COVID-19 screening and should apply such screening when appropriate. Note that the CDC guidance for COVID-19, indicates that they should do the following:

- Promptly identify and triage patients with relevant exposure history AND signs or symptoms compatible with COVID-19 <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>.
- Immediately isolate any patient with relevant exposure history and signs or symptoms compatible with COVID-19 and take appropriate steps to adequately protect staff caring for the patient, including appropriate use of personal protective equipment (PPE).
- Immediately notify the hospital/facility infection control program, other appropriate facility staff, and the state and local public health agencies that a patient has been identified who has relevant exposure AND signs or symptoms compatible with COVID-19.

***C.5: May hospitals refuse to allow individuals with suspected cases of COVID-19 into their ED?***

No. For every individual who "comes to the emergency department," as that term is defined in §489.24(b) of the EMTALA regulations, for evaluation or treatment of a medical condition, whether by ambulance or by walking-in, hospitals are required to provide an appropriate medical screening examination. Qualified medical personnel in hospitals that conduct the screening examination should be aware of the criteria for initial COVID-19 screening and should apply such screening when appropriate. Hospitals that refuse to screen an individual who comes to their emergency department would likely be found to have violated EMTALA, regardless of presenting signs, symptoms, and possible diagnoses.

***C.6: If a hospital remains open during COVID-19 or any other infectious outbreak, 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?***

Under these circumstances, EMTALA would not prohibit the hospital from closing its ED to new patients if it no longer had the capacity to screen and treat individuals (in effect, going on diversion). The hospital should follow any applicable state and local notice requirements and its own previously established plan for public notification when it goes on diversionary status. 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, in spite of the “closure” if an individual comes to such a hospital and requests examination or treatment for an emergency medical condition, the hospital would be obligated by EMTALA to act within its capabilities to provide screening and, if necessary, stabilization.

***C.7: Are all hospitals expected to have Personal Protective Equipment (PPE) and other equipment/facilities to screen and take care of suspected or confirmed COVID-19 patients?***

There are no requirements established under EMTALA for hospitals to have specific PPE or equipment/facilities. Consistent with their obligations under the hospital and CAH Conditions of Participation (CoPs) at §482.42 and §485.640, hospitals and CAHs are expected to adhere to accepted standards of infection control practice to prevent the spread of COVID-19. However, the Emergency Preparedness Final Rule requires an all-hazards approach to the emergency preparedness planning and program. In February 2019, CMS updated subregulatory guidance in Appendix Z of the State Operations Manual (SOM), for facilities to plan for using an all-hazards approach, to include emerging infectious disease (EID) threats. Examples of EIDs include influenza, ebola, zika virus and others. Under this guidance, CMS specifically stated that these EIDs may require modifications to facility protocols to protect the health and safety of patients, such as isolation and personal protective equipment (PPE) measures.

The CDC has issued extensive guidance on applicable isolation precautions and CMS strongly urges hospitals to follow this guidance.

***C.8: May hospitals decline to perform an MSE on an individual who comes to their ED with potential or suspected COVID-19 due to a lack of PPE or specialized equipment/facilities?***

No. For every individual who “comes to the emergency department,” as that term is defined in §489.24(b) of the EMTALA regulations, for evaluation or treatment of a medical condition, whether by ambulance or by walking-in, hospitals are required to provide an appropriate medical screening examination. Qualified medical personnel in hospitals that conduct the screening examination must be aware of the criteria for initial COVID-19 screening and apply such screening when appropriate. Hospitals that refuse to screen an individual who comes to their emergency department would likely be found to have violated EMTALA, regardless of presenting signs, symptoms, and possible diagnoses.



***C.9: Will CMS issue EMTALA waivers for hospitals related to COVID-19?***

The statute governing EMTALA waivers sets a high threshold for issuing such waivers and also limits the nature and duration of an EMTALA waiver. *CMS has approved an 1135 waiver authority allows for the waiver of sanctions under the Emergency Medical Treatment and Active Labor Act (EMTALA) for redirection to another location to receive a medical screening exam under a state emergency preparedness or pandemic plan. A waiver of EMTALA sanctions is effective only if actions under the waiver do not discriminate as to source of payment or ability to pay. This 1135 waiver does not apply to transfer of an individual who has not been stabilized if the transfer arises out of an emergency.* For additional information, please visit <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers>.

***C.10: What about ambulances operating under emergency medical services (EMS) systems – are they subject to EMTALA?***

Public health officials, EMS systems and hospitals are free to develop protocols governing where EMS should transport individuals for emergency care. This includes developing protocols specific to individuals who meet criteria to be considered suspected cases of COVID-19. A hospital owned and operated ambulance operating under community-wide protocols that direct transport of individuals to a hospital other than the hospital that owns the ambulance, for example, to the closest appropriate hospital, the individual is considered to have come to the ED of the hospital to which the individual is transported, at the time the individual is brought onto hospital property and the hospital becomes subject to EMTALA.

Even in the case of ambulances that are owned and operated by a hospital, it is permissible to transport an individual to a different hospital for screening and treatment, so long as they are operating in accordance with a community-wide EMS protocol, or they are operating under the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance.

***C. 11: May hospitals set up alternative screening sites within the hospital to screen possible COVID-19 patients, even if they don't have an EMTALA waiver?***

Yes, hospitals have flexibilities to set up alternative screening sites at other parts of the hospital, both on- and off-campus. See *Attachment 1* for additional guidance regarding surges in emergency department services.

Additionally, per the Medicare Conditions of Participation, hospitals must have policies and procedures based on the facility's emergency preparedness plan and its role under a waiver declared by the HHS Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by public health and emergency management officials.

***C.11(a): What constitutes an alternative hospital location? For instance, can this include a tarped-off area of another room, a room constructed in the ambulance bay, or the room previously used as the decontamination room?***

Hospitals have flexibilities under EMTALA to determine alternative locations outside the ED but within the hospital or on the hospital's property for screening examinations of individuals potentially exposed to or infected with COVID-19. Please see the Attachment 1: Fact Sheet for Addressing Hospital Surges

***C.11(b): Do the Life Safety Code (LSC) requirements under the hospital or critical access hospital Conditions of Participation apply to alternative care sites?***

Since alternative care sites are expected to be within the hospital or on the hospital's property (operating as part of the hospital/under the hospital's CMS Certification Number), they would be expected to meet LSC requirements. However, there may be situations where temporary examination areas are set up (please refer to above on alternate care sites).

Additionally, if compliance issues come up in such localized situations where no applicable section 1135 waiver [for declared public health emergencies] is available, CMS focuses on fundamentals, such as assuring medical and nursing staff have proper credentials and, in the case of medical staff, have privileges; assuring that care is safe, that patients' rights are protected and that medical records with sufficient information to promote safe care are maintained. Additionally, for facilities subject to the Life Safety Code (LSC), past experience has demonstrated that many facilities, even when functioning in a degraded status, or in the case of the establishment of alternative care sites, may continue to meet the LSC by implementing reasonable and prudent measures. For example, there were several hospitals damaged by Hurricane Katrina which continued to comply with the LSC by implementing reasonable and prudent measures, and therefore were able to continue operations in a degraded but safe environment for weeks or months until repairs could be completed.

Archived information on H1N1 which discussed alternate care sites can be located at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/SCLetter-10-06-Influenza.pdf>

We would also encourage facilities to review resources provided by the Assistant Secretary of Preparedness and Response (ASPR) Technical Resources Assistance Center and Information Exchange (TRACIE) located here: <https://asprtracie.hhs.gov/technical-resources/48/alternate-care-sites-including-shelter-medical-care/47>

***C.11(c): Can alternative sites include outbuildings on the campus or use of tents in the parking lot?***

Alternative screening sites may be located in other buildings on the campus of a hospital or in tents in the parking lot, as long as they are determined to be an appropriate setting for medical screening activities and meet the clinical requirements of the individuals referred to that setting. We also defer to screening guidance provided by CDC.

***C.11(d): What would be an acceptable alternative location on campus? Must the location currently exist as a part of the certified facility?***

The location must be part of the certified hospital. If it is not currently part of the certified hospital, then the hospital must take steps to add the location as a new practice location of the hospital.

***C.11(e): What type of approval process needs to be in place for a hospital to use an alternative location?***

CMS does not require any approval process to use an alternative screening location that is already part of the certified hospital. If the hospital is adding a practice location, it must file a Form 855A with its Medicare Administrative Contractor to advise it of this action. The hospital is not required to obtain prior approval from CMS in order to bill Medicare for services at the added location. There is also no requirement for all added locations to be surveyed for compliance with the Medicare Hospital Conditions of Participation, but CMS retains the discretion to require a survey in individual cases.

States may have licensure requirements for prior approval of any additional practice locations, so hospitals are encouraged to consult with their state licensure authority on any applicable state requirements.

***C.11(f): In the past when there have been disasters that resulted in ED surges alternative locations needed to be submitted and approved by state licensure authorities and also by CMS. Does this hold true for alternative locations for screening of potential COVID-19 patients?***

See answer to the prior question. As stated, CMS does not require prior approval for hospitals that are adding a practice location. Hospitals should consult with their state licensure authority on any applicable state requirements.

#### **D. Patient Rights**

***D.1: What action should the hospital take if an individual who meets the screening criteria for suspected COVID-19 wants to leave the hospital against medical advice?***

Hospitals do not have authority to prevent the individual from leaving against medical advice. However, state or local public health authorities may have such authority under state or local law, and hospitals should coordinate with their local authorities on the appropriate way to handle an individual suspected of having COVID-19 who wants to leave the hospital environment.

Note that there is an EMTALA requirement at §489.24(d)(3) for a hospital to take all reasonable steps to secure the individual's written informed refusal (or that of the individual's representative) of further medical examination or treatment that the hospital has offered.

#### **E. Enforcement**

***E.1: What will CMS do when a survey reveals that a hospital is not following nationally recognized guidelines regarding COVID-19 infection control processes?***

EMTALA does not establish requirements for infection control practices. However, consistent with their obligations under the hospital and CAH Medicare CoPs at §482.42 and §485.640, hospitals and CAHs are expected to adhere to accepted standards of infection control practice and Medicare conditions.

The CDC has issued extensive guidance on applicable isolation precautions and CMS strongly urges hospitals to follow this guidance. Hospitals may be cited for deficiencies under the CoPs related to failure to follow accepted infection prevention and control standards of practice. Hospitals should regularly check [CDC COVID-19 \(https://www.cdc.gov/coronavirus/2019-ncov/index.html\)](https://www.cdc.gov/coronavirus/2019-ncov/index.html) and consider signing up for [Signing up for the newsletter to receive weekly emails about coronavirus disease 2019 \(COVID- 19\) https://tools.cdc.gov/campaignproxyservice/subscriptions.aspx?topic\\_id=USCDC\\_2067.](https://tools.cdc.gov/campaignproxyservice/subscriptions.aspx?topic_id=USCDC_2067)

***E.2: How will CMS handle complaints about violations of EMTALA related to transfers/attempts to transfer individuals suspected or confirmed as having COVID-19?***

If CMS receives complaints alleging either inappropriate transfers by a referring hospital or refusal of a recipient hospital to accept an appropriate transfer, the agency will consider the following (along with other factors) when making a determination of whether violations of EMTALA have occurred:

- The individual's clinical condition at the time of presentation to the referring hospital and at the time of the transfer request;
- The capabilities of the referring hospital;
- The screening and treatment activities performed by the referring hospital for the individual;
- Whether the request for transfer was consistent with any nationally recognized guidelines in effect at the time of the transfer request for COVID-19 screening, assessment, including guidance about transfer for further assessment or treatment of suspected or confirmed COVID-19; and;
- The capabilities of the recipient hospital and the recipient hospital's capacity at the time of the transfer request.