

Frequently Asked Questions for Hospitals and Critical Access Hospitals regarding EMTALA

DATE: April 30, 2020

PATIENT PRESENTATION TO THE EMERGENCY DEPARTMENT

1. **Q: Has CMS provided guidance to patients on when it is appropriate to come to the Emergency Department for COVID-19 symptoms?**

A: The Centers for Disease Control and Prevention (CDC) has provided guidance for the general public on steps individuals should take in regard to treatment when they believe they have symptoms of COVID-19 (<https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/steps-when-sick.html>). The CDC guidance is available in several languages including Spanish, Chinese (simplified), Vietnamese and Korean.

CMS will continue to share CDC materials to address concerns about the appropriate methods for seeking COVID-19 testing and treatment. These guidance documents are updated as new guidance becomes available.

2. **Q: May hospitals place a sign outside an Emergency Department (ED) stating "COVID-19 testing is not being offered to asymptomatic patients?"**

A: Yes. In general, signage may be used to inform individuals about the availability of COVID-19 testing or to provide direction to alternative sites on the hospital's campus where medical screening examinations (MSE) are available; for example, directing the patient to a parking lot test site for COVID-19.

Hospitals also 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 a section 1135 waiver for the COVID-19 public health emergency (PHE) the ability to redirect patients to an offsite location for screening, in accordance with a state emergency preparedness or pandemic plan.

We emphasize that it is a violation of EMTALA for hospitals and critical access hospitals (CAHs) with EDs to use signage that presents barriers to individuals, including those who are suspected of having COVID-19, from coming to the ED, 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.

3. **Q: Are individuals (who present on a hospital campus or ED) that are referred to an alternative off-campus screening site limited strictly to those individuals with COVID-19 symptoms? For example, can an individual with an ankle injury be**

referred off-campus? Can ambulance patients be referred off-campus (i.e. without off-loading or any evaluation before being referred)?

A: Yes. Redirection to another location (offsite alternate screening location) to receive a medical screening exam is allowed via a section 1135 waiver under a state emergency preparedness or pandemic plan regardless of the presence of COVID-19 symptoms.

Public health officials, EMS systems, and hospitals may 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. For 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 presenting individual is considered to have come to the ED of the hospital to which the individual is transported. The receiving hospital is subject to EMTALA at the time the individual is brought onto hospital property. Even in the case of ambulances that are owned and operated by a hospital, it is permissible to transport an individual to a hospital other than that which owns the ambulance for screening and treatment, so long as they are operating in accordance with a community-wide EMS protocol.

WHERE DOES EMTALA APPLY?

1. **Q: Can EMTALA be relaxed to allow hospitals to refer patients to urgent care facilities? (Urgent care centers do not have the ability to test at this time, but are expecting to be able to test in the coming weeks).**

A: Hospitals and community officials may encourage the public to go to off-campus sites to be screened for COVID-19 instead of the hospital, as long as those sites are operating in accordance with the state or local pandemic plan, are identified specifically by the hospital as the location to receive a medical screening examination, and have the capability and capacity to provide the required medical screening examination. In addition, CMS has approved via a section 1135 waiver of the Social Security Act, for the duration of the PHE, the ability for hospitals to re-direct patients that had presented to the ED to an offsite location for the MSE in accordance with a state emergency preparedness or pandemic plan. Under the section 1135 waiver, hospital EDs may redirect incoming patients to alternative screening sites staffed by qualified medical workers, to ensure that symptomatic or COVID-19-positive patients are directed to appropriate settings of care.

Please see the QSO memo 20-15 for additional guidance on alternative care sites at: <https://www.cms.gov/files/document/qso-20-15-hospital-cah-emtala-revised.pdf>

2. **Q: Given different ways that hospitals are trying to triage and treat patients, please clarify the definition of “on campus”?**

A: The definition of campus at 42 CFR 413.65(a)(2) means the physical area immediately adjacent to the provider’s main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis.

Per 42 CFR 489.24(b), “Hospital property” means the entire main hospital campus, including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital’s main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities. Also, per the American Disabilities Act (ADA), hospital campuses must be accessible to individuals with disabilities.

In addition, we know that, during the COVID-19 PHE, non-hospital properties, such as hotels, dormitories, and field hospitals at parks, are becoming extensions of hospitals, otherwise known as temporary expansion sites. This is permissible under the section 1135 waiver of the provider-based regulations at 42 CFR § 413.65 and certain requirements under the Medicare conditions of participation at 42 CFR § 482.41 and § 485.623. Please see our description of Temporary Expansion Locations at <https://www.cms.gov/files/document/covid-hospitals.pdf>.

For the duration of the COVID-19 PHE, these waivers allow a hospital to establish and operate as part of the hospital any location meeting the Conditions of Participation (CoPs) for hospitals that continue to apply during the PHE. These waivers also allow a hospital to change the status of its current provider-based department locations to the extent necessary to address the needs of hospital patients as part of the state or local pandemic plan. As such, it is acceptable to triage and treat patients in Temporary Expansion Locations.

3. Q: Can multiple hospitals with different Medicare provider numbers join together to establish the off-site location in accordance with the state emergency plan? If so, what EMTALA implications would result for each hospital involved?

A: Yes. Temporary Expansion Location sites may serve multiple hospitals if it is consistent with their state emergency plan. Unless the off-campus site is already a dedicated ED (DED) of a hospital, as defined under EMTALA regulations at 42 CFR § 489.24(b), EMTALA requirements do not apply. If an individual being treated at a Temporary Expansion Location needs additional medical attention on an emergent basis, the site is required, under the Medicare CoPs, to arrange referral/transfer. When multiple hospitals join to establish an off-site location, the hospitals should operate in distinct clinical spaces within the location or designate one facility that will assume responsibility for ensuring compliance with the CoPs including EMTALA requirements (if applicable). If the space is shared across multiple hospitals, we note that noncompliance problems at a Temporary Expansion Location may implicate associated certified hospitals depending upon the type of noncompliance.

4. **Q: How does EMTALA apply if a community has exhausted its supply of beds and/or ventilators and a patient presents with an emergent condition that needs these resources for stabilization?**

A: Hospitals are required to provide stabilizing treatment to individuals determined to have an emergency medical condition within the hospital's capability prior to arranging an appropriate transfer. In situations where facilities may not have the necessary services or equipment, they should provide stabilizing interventions within their capability until the individual can be transferred. For example, in cases where the hospital does not have available ventilators, establishing an advanced airway and providing manual ventilation can assist in stabilizing the individual until an appropriate transfer can be arranged.

5. **Q: Is a full set of vital signs required for EMTALA to be met?**

A: 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 emergency medical condition (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.

6. **Q: Hospitals may consider providing telehealth appointments for patients at home as emergency medicine providers; what obligation does this create?**

A: The use of telehealth to provide evaluation of individuals who have not physically presented to the hospital for treatment does not create an EMTALA obligation.

QUALIFIED MEDICAL PROFESSIONALS (QMPs)

1. **Q: Has CMS removed the requirement to have a QMP, approved by the governing body, perform the MSE?**

A: No. QMPs responsible for performing MSEs must still be approved by the hospital's governing body. Hospitals may request a case-by-case section 1135 waiver to allow MSEs to be performed by qualified medical staff authorized by the hospital, who are acting within their scope of practice and licensure, but are not designated in the hospital bylaws to perform the MSEs. These waivers can be submitted at 1135waiver@cms.hhs.gov. CMS will update our website if additional blanket waivers become available at: <https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers>

MEDICAL SCREENING EXAM (MSE)

1. **Q: Can emergency physicians and other health care practitioners conduct medical screening exams (MSEs) under EMTALA via telehealth?**

A: Yes. QMPs, including emergency physicians, can perform MSEs using telehealth equipment. The QMP may be on-campus and using technology to self-contain or offsite due to staffing shortages. The MSE may be performed solely via telehealth if clinically appropriate. If the patient is seen by a QMP located on campus via electronic two-way technology, the service would not be considered a telehealth visit. Regardless of location, the QMP must be performing within the scope of his/her state practice act and approved by the hospital's governing body to perform MSEs.

2. Q: Can CMS waive certain elements of EMTALA to allow for more flexibility in meeting the current medical screening exam (MSE)?

A: CMS has temporarily waived some EMTALA requirements to allow screening for patients at a location *offsite* from the hospital's campus to prevent the spread of COVID-19, so long as it is not inconsistent with a state's emergency preparedness or pandemic plan.

Under the waiver, hospital EDs may redirect incoming patients to alternative screening sites staffed by qualified medical workers, to ensure symptomatic or COVID-19-positive patients are directed to appropriate settings of care. The updated guidance can be found at <https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/emergency-medical-treatment-and-labor-act-emptala-requirements-and-implications-related-covid19>

3. Q: Can Emergency physicians perform medical screening exams outside of the ED, such as in tents in the parking lot, under EMTALA?

A: Yes. 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 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.

Please refer to additional guidance at <https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/emergency-medical-treatment-and-labor-act-emptala-requirements-and-implications-related-covid19>.

4. Q: Can the MSE be conducted by a Registered Nurse (RN)?

A: Yes. MSEs must be conducted by qualified personnel, which may include physicians, nurse practitioners, physician's assistants, or RNs trained to perform MSEs, acting within the scope of their state licensure law, and as approved by the hospital's governing body. Hospitals may request a waiver to allow MSEs to be performed by other personnel,

including trained RNs not previously approved by the governing body to perform MSEs. CMS will update our website if additional blanket waivers become available at: <https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers>

5. **Q: If there is an on-site COVID-19 testing location (e.g., tent outside main ED), would EMTALA apply if individuals are only requesting COVID-19 testing? Would a MSE be required?**

A: EMTALA would apply if a patient who was solely seeking COVID-19 testing made a request for medical treatment while on the hospital campus or demonstrated a medical condition that a prudent layperson would believe, based on the individual's appearance or behavior, indicated that the individual needed examination or treatment of a medical condition. However, patients who present solely for the purpose of COVID-19 testing and are not making a request for treatment of a medical condition, do not necessarily require a MSE. If the person complains of or exhibits any symptoms of a medical condition, then that person should receive an appropriate MSE to determine whether an EMC exists. The EMTALA obligation is satisfied if the MSE determines no emergency medical condition exists.

6. **Q: Can a hospital conduct an MSE if the patient remains in an automobile and meet its EMTALA obligations?**

A: It depends. The MSE does not have to take place in the ED to satisfy EMTALA. The content of the MSE varies according to the individual's presenting signs and symptoms, and it can be as simple or as complex, as needed, to determine if an emergency medical condition 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. If a clinically-appropriate MSE can be performed in an automobile to determine whether or not an emergency medical condition exists, that MSE would be permissible under EMTALA.

7. **Q: For off-campus, hospital-controlled sites, can a person first presenting to the ED be redirected from the ED to the off-campus site where the MSE will be completed?**

A: Yes. Hospitals may redirect patients presenting to the ED to an off-campus site where an MSE will be completed. 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 issued a blanket section 1135 waiver for the duration of the COVID-19 PHE, the ability to re-direct patients to an offsite location for screening, in accordance with a state emergency preparedness or pandemic plan. Hospitals are generally able to manage the separation and flow of potentially infectious patients through alternate screening locations on the hospital campus during the COVID-19 PHE.

8. **Q: Is there a specific time frame in which the MSE has to take place if a patient is referred to an off-campus site? Would it have to happen that same day?**

A: There is no specified time frame in which the MSE has to occur after the referral from the hospital to an off-campus site. However, triage entails the clinical assessment of the individual's presenting signs and symptoms at the time of arrival at the hospital, in order to prioritize when the individual will be seen by a physician or other QMP. Individuals presenting must be provided an MSE appropriate to the individuals' presenting signs and symptoms, as well as the capability and capacity of the hospital. The MSE must be the same MSE that the hospital would perform on any individual coming to the hospital's dedicated emergency department with those signs and symptoms, regardless of the individual's ability to pay for medical care. If a hospital applies a nondiscriminatory screening process that is reasonably calculated to determine whether an EMC exists, it has met its obligations under EMTALA. The required MSE and stabilizing treatment should not be delayed. If the MSE is appropriate and does not reveal an EMC, the hospital has no further obligation.

9. **Q: If a hospital set up a COVID-19 testing location offsite, and patients only present to the hospital for testing without requesting additional services, do those patients need an MSE before we refer them offsite?**

A: Those patients would not be subject to an MSE in this case unless they are requesting examination or treatment for a medical condition or demonstrate a medical condition for which a MSE is necessary. EMTALA requires that all persons who present to the hospital or ED for a medical condition be provided an MSE to determine whether they have an EMC.

TRANSFER AND STABILIZATION OF A PATIENT

1. **Q: Has CMS waived elements of EMTALA to allow for more flexibility in the transfer and stabilization requirements?**

A: No. CMS has not waived EMTALA transfer or stabilization requirements. Hospitals are expected to provide stabilizing treatment within their capabilities and capacity prior to the initiation of a transfer to another hospital. However, when a section 1135 waiver has been issued, sanctions for an inappropriate transfer of a patient or for the direction or relocation of a patient to receive a MSE at an alternate location do not apply if certain conditions are met, as enumerated at 42 C.F.R. §489.24(a)(2)(i)(A)-(E).

2. **Q: Is transfer to a designated facility permissible under EMTALA? Can hospitals transfer non-COVID-19 patients to better isolate or cohort patients?**

A: Yes. Patients may be transferred in accordance with the state emergency preparedness and pandemic plan following an appropriate MSE and determination that the individual is stable for an appropriate transfer.

3. **Q: Is transfer to a designated facility permissible regardless of COVID-19 status, as long as positives go to designated positive facilities and negatives go to designated negative facilities?**

A: Yes. A patient transfer under the state emergency and pandemic plan would apply to all patients regardless of COVID-19 status following an appropriate MSE and determination that patient is stable for an appropriate transfer.

4. **Q: Is the transfer of unstable patients (as determined during the MSE) permissible? Is there a standard for “instability” under EMTALA?**

A: When an emergency medical condition is determined to exist, the hospital must provide any necessary stabilizing treatment within the hospital’s capability for an appropriate transfer. With respect to an “emergency medical condition” as defined at 42 CFR § 489.24(b) “to stabilize” means to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or that, if, in the case of a woman in labor, the woman has delivered the child and the placenta. If an individual at a hospital has an emergency medical condition that has not been stabilized, the hospital may not transfer the individual unless:

- The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under EMTALA and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer;
- A physician has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or
- If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its by-laws or rules and regulations) has signed a certification in consultation with the qualified medical person and agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.

5. **Q: Can hospitals transfer patients from hospitals to urgent care centers?**

A: Urgent care facilities are medical clinics equipped to diagnose and treat a variety of non-life and limb threatening illnesses and injuries. Unlike EDs associated with a hospital, urgent care facilities do not have state or federal mandates to see, treat, or stabilize patients without regard for the patient's ability to pay.

6. **Q: When could a hospital refer a patient who comes to the ED for medical treatment to an urgent care center?**

A: Hospitals must provide a MSE to all patients who come to the ED requesting treatment for a medical condition or where the individual is demonstrating presence of a medical condition to determine if an EMC exists. The content of the MSE varies according to the individual's presenting signs and symptoms, but should be provided within the capabilities of the hospital's ED, including ancillary services routinely available to the hospital. Once the MSE is complete and if the patient is determined not to have an EMC, the hospital's EMTALA obligation ends and the patient may be referred to an urgent care center for continued care of non-emergency illnesses or injuries. However, a section 1135 waiver gives the ability for hospitals to re-direct patients that had presented to the ED to an offsite location for the MSE in accordance with a state emergency preparedness or pandemic plan. Under the section 1135 waiver, hospital EDs may redirect incoming patients to alternative screening sites staffed by qualified medical workers, to ensure that symptomatic or COVID-19-positive patients are directed to appropriate settings of care.

7. **Q: Under a section 1135 waiver, can a hospital redirect a patient to a location operated by a state public health entity instead of one operated by the hospital?**

A: Under the section 1135 waiver, hospitals may redirect patients to locations operated by a state public health entity for the MSE in accordance with the state emergency preparedness or pandemic plan.

8. **Q: If an acute care hospital has a psychiatric distinct part unit located off-campus from its main campus (i.e., more than 250 yards), would the movement of a patient with an emergency medical condition from the acute care hospital to the psychiatric distinct part unit be considered a "transfer" for EMTALA purposes?**

A: No. The movement of a patient between departments of a hospital is not considered a "transfer." The patient would be "transported" not "transferred" to the hospital's own distinct part unit.

TELEHEALTH

1. **Q: Can out-of-state emergency physicians provide telehealth to beneficiaries in a different state?**

A: For Medicare and Medicaid, CMS has waived the licensure requirement, provided that the physician has a valid license in another state. However, in order for this federal waiver to be effective, the state also would have to waive its licensure requirements, either individually or categorically, for the type of practice for which the physician is licensed in their home state.

2. **Q: Under the new guidance, what codes can emergency physicians use if they want to perform telehealth services from the ED?**

A: ED physicians can perform telehealth services from any location. CMS has temporarily added the ED E/M codes (CPT codes 99281 to 99285), the critical care codes (CPT codes 99291 and 99292), and the observation codes (CPT codes 99217-99220, 99224-99226, and 99234-99226) to the list of Medicare telehealth services for the duration of the COVID-19 national emergency. When delivering emergency telehealth services, ED physicians should use the code that most accurately reflects the service they furnish and use the place of service code that they would have used if that service was delivered in-person. They should also attach modifier 95 to the claim. For example, regardless of their location, ED physicians who are delivering emergency services can use the ED E/M codes with place of service 23 (ED) and attach modifier 95.

When the patient and the practitioner are in the same location, such as in different areas of the same hospital buildings, they are not considered to be furnishing Medicare telehealth services, and the services are not subject to telehealth rules and restrictions. Instead, they should be reported as in-person services.

3. **Q: Is the rule to allow for direct supervision using interactive audio and video technology limited to the duration of the public health emergency?**

A: Yes. Waivers under section 1135 typically end no later than the termination of the PHE period, or 60 days from the date the waiver or modification is first published unless the Secretary of the Department of Health and Human Services (HHS) extends the waiver by notice for additional periods of up to 60 days, up to the end of the public health emergency period.

4. **Q: For teaching physician and resident cases, the April 6, 2020 Interim Final Rule with comment period per 85 FR 19820 states “the teaching physician must provide supervision either with a physical presence or be present through interactive telecommunications technology during the key portion of the service.” Does the teaching physician have to interact with the patient via telecommunications or can their discussion of the case with the resident via telecommunications to determine appropriate diagnostic or treatment interventions be considered the key portion of the service?**

A: Teaching physicians can provide services with medical residents virtually through audio/video real-time communications technology. During the PHE, the teaching physician can be present during the key portion of the service using interactive telecommunications technology. This does not apply in the case of surgical, high risk, interventional, or other complex procedures, services performed through an endoscope, and anesthesia services.

Waivers Under Section 1135 of the Social Security Act

1. Q: Has EMTALA been broadly waived?

A: No. CMS has approved a section 1135 waiver for the COVID-19 PHE, which temporarily includes the ability to re-direct patients to an offsite location for screening in accordance with a state emergency preparedness or pandemic plan. Hospitals are still expected to provide an MSE to any individual who comes to the emergency department and requests examination or treatment, or has a request for examination or treatment made on their behalf. The purpose of the MSE is to determine if an emergency medical condition exists. If an EMC is determined to exist, the hospital must provide stabilizing treatment within the hospital capabilities or an appropriate transfer per 42 CFR § 489.24.

However, we do want to be clear that while certain aspects of EMTALA may be waived under the section 1135 waiver, Federal civil rights laws have not been waived. Hospitals who are federal financial assistance recipients are still obligated to comply with federal civil rights laws, including Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act and the Hill-Burton Act.

2. Q: Does the hospital have to initiate its disaster plan before the waiver becomes effective?

A: No. When a section 1135 waiver declaration is made, the hospital does not have to initiate the disaster plan before the section 1135 waiver is considered effective. Section 1135 waivers are effective upon the date of the section 1135 declaration and may be retroactive. The recent flexibilities and blanket waivers released by CMS are retroactive to March 1, 2020.

3. Q: Will CMS require notification that the hospital has initiated its disaster plan prior to implementing its MSE redirection plan?

A: No. Hospitals are not required to provide notification to CMS upon initiation of the disaster plan.

4. Q: When does the waiver end?

A: Waivers for the current PHE under section 1135 of the Social Security Act will end no later than the termination of the COVID-19 PHE period, or 60 days from the date the waiver or modification is first published unless the Secretary of the Department of Health and Human Services extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period.

5. **Q: Please describe what happens if states have already tried to individually pursue section 1135 waivers for EMTALA. Can states still apply for waivers? What happens to state waivers that have already been approved?**

A: State waivers regarding specific state requirements are separate from federal waivers of federal requirements. If section 1135 waivers have been approved, those waivers are still in effect. Any section 1135 waiver questions or requests may be submitted to the 1135waiver@cms.hhs.gov mailbox.

CMS continues to evaluate the need for additional determinations for individual and blanket waiver requests on an ongoing basis.

6. **Q: For states not on the section 1135 waiver list, can you clarify what restrictions hospitals have?**

A: Hospitals are still required to meet any requirements that have not been waived via a blanket or individual waiver. Please send any waiver requests or associated questions to 1135waiver@cms.hhs.gov.

OTHER

1. **Q: What is the communication strategy for disseminating information about changes to EMTALA?**

A: Any formal guidance, revisions to existing guidance, or additional clarifications will continue to be released via QSO memo or other CMS approved communication avenues. Please refer to the CMS website which has direct links to coronavirus information at <https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers>.

2. **Q: If a hospital sets up an alternative off-campus testing site, is that site regulated by the hospital conditions of participation (CoPs)?**

A: Yes. Alternative care sites and temporary extension sites that are established by the hospital are still required to follow the applicable hospital CoPs to the extent not waived under the blanket waivers issued by CMS. Community testing centers established by the

state would be under the state emergency and pandemic plan and are not required to meet the hospital CoPs.

3. **Q: What is the differentiation between triage, testing, and EMTALA screening requirements?**

A: 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.

Medical testing detects a condition and confirms 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 medical treatment while on the hospital campus. If the person complains of or exhibits any symptoms of a medical condition, then that person should receive an appropriate MSE to determine whether an EMC exists.

4. **Q: As a rural hospital, we have utilized our ER ambulance bay to use as a drive through COVID-19 testing location for patients that have been evaluated via telemedicine through our rural health clinic. Is it permissible for our ER RNs to do these swabs outside?**

A: 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 COVID-19 testing made a request for medical treatment while on the hospital campus or demonstrates a medical condition. If the person complains of, or exhibits any, symptoms of a medical condition, then that person should receive an appropriate MSE to determine whether an EMC exists. Clinically-appropriate hospital personnel working within their scope of practice and licensure may perform the testing for COVID-19.