



THE ABA HEALTH LAW SECTION

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EMERGENCY PREPAREDNESS AND RESPONSE: LEGAL ISSUES IN A CHANGING WORLD

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landscape with respect to the government and the health care delivery system, this article presents potential issues in numerous areas related to preparedness and response activities.

I. Introduction

Threats of biological terror attacks (“BT”) and a renewed fear of epidemic disease such as Severe Acute Respiratory Syndrome (“SARS”) have spurred critical reevaluation of comprehensive strategies for containing communicable diseases. This reevaluation, and in many cases revamping of laws, creates new demands on lawyers who advise health care organizations. The challenge for private practice attorneys will be understanding the vast expanse of state and federal laws, regulations and agencies involved in Homeland Security and Emergency Preparedness and Response in order that they may best counsel health care clients prior to and during emergencies.¹

This article provides an overview of this emerging area of law. As it is still in its infancy, there is not a rich history and body of literature on which to base such a discussion. Instead, one must look at the existing laws, listen to the concerns of individuals involved in preparedness activities, and try to anticipate issues that may arise. After outlining the preparedness

II. Preparedness and the Government

Federal, state and local governments are at the center of our nation’s preparedness and response infrastructure. While each of these governments has a unique role to play in preparedness, these roles may overlap, causing conflict and confusion. Currently under debate is the question of which level of government can best fulfill various preparedness responsibilities. Each has its own strengths and weaknesses that make it a good choice for some preparedness activities and a poor choice for others.

The federal government has the responsibility and the authority to coordinate preparedness on a national level. It has vast resources, access to numerous agencies that may participate in preparedness planning, and an ability to monitor activity on a national level. The federal government can also facilitate the coordination and cooperation of interstate state initiatives. Bureaucracy, political considerations, and constitutional limitations,

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however, may negate some of these strengths.

State governments have more limited resources, in terms of funds, availability of manpower and political power. At the same time, each state government may be able to focus its activities on the area that it knows best, the state. Although state governments are unquestionably bureaucratic, due to their smaller size (if nothing else), they are easier to navigate than the federal government. States may also have exclusive jurisdiction over certain parts of preparedness planning based on their police powers. Most notably, planning in the health care delivery system usually falls under the purview of the state, as opposed to the federal government.

Local governments have the most limited resources. They also have the most limited bureaucracies and the most homogenous constituency. While not everyone in a local political subdivision will desire the same goal or support the same preparedness plan, these individuals have at least one thing in common: they are from a relatively local area. This similarity and a desire to safeguard the locality may make it easier to develop certain preparedness plans on a local level. Importantly, it is at the local level that most “first responders” are based.

Conflicts arise among the three levels of government for many reasons. Jurisdictional issues present a frequent source of angst. In some respects, the jurisdictional boundaries of each government are clear. The federal government’s jurisdiction is national. The state’s jurisdiction is limited to the state. The boundaries become blurred, however, when one begins thinking about specific preparedness programs. Public health activities, for example, are within the state’s purview under its police powers. The federal government may, however, want states to report incidences of specific diseases and illnesses to the Centers for Disease Control (“CDC”).²

While in many instances the states will cooperate without question, there may be a situation in which the state does not want to report for fear of repercussions or other adverse side effects. For example, some states were afraid to report HIV for fear of that it would drive those infected underground.³ In such a case, is the state required to report? What authority does the federal government have for requiring such reporting?

With governments in the background, the foreground of the Emergency Preparedness and Response landscape is sprinkled with many other components, the most dominant being a legal framework to govern preparedness activities and responses to public health emergencies. Within this framework are statutes and regulations on both the national, state and local levels. These laws can either facilitate or inhibit an effective response to emergencies. Laws regarding isolation and quarantine, emergency services and disasters, and public health are of the utmost importance for a successful preparedness program. While many laws have been amended since 9-11, many other laws remain archaic and unwieldy.

III. Preparedness and Health Care Delivery Systems

Health care providers are an essential component of responding to any emergency, as there are almost always casualties and the need for medical care. Increasingly, one hears hospitals describe themselves as “first responders”, a term traditionally reserved for police, fire and emergency medical services (“EMS”) agencies.⁴ Few would dispute that our health care delivery system is fragmented, and access to services varies significantly by geography and other factors. Physicians, allied health care professionals (such as nurses and physician’s assistants), and EMS responders are the main human components of the system. Hospitals and other institutions

provide the physical resources and the equipment and technology needed to deliver care. The diversity of these institutions is significant, including not only hospitals, but also ambulatory care centers, diagnostic centers, home health agencies, urgent care centers, and long term care facilities, to name a few.

Importantly, the government’s main roles in health care are as a payor and regulator. The actual delivery of care is largely a private sector function — which distinguishes the United States from the rest of the world. This creates an interesting juxtaposition: the government’s responsibility for preparedness activities, the need for the health care delivery systems to play a large part in preparedness planning, and the government’s lack of involvement in health care delivery. From this situation arises the need for public-private cooperation among the government, public health agencies, and the private sector health care delivery system.

While this sounds simple, it is not. The health care system, operating under normal conditions, is already stressed: Hospitals are overcrowded.⁵ Waits in the emergency room are excessive.⁶ There is a shortage throughout the country of more than 168,000 health care professionals.⁷ Physicians are working harder than ever, being paid less than ever, paying malpractice insurance premiums that are higher than ever and becoming more disillusioned with the practice of medicine than ever before. EMS agencies are taxed. There is very limited ability in the system to “surge”, i.e. to create additional space for an influx of patients created by a public health emergency.⁸

It was once thought that, in the event of BT or any other public health emergency, health care delivery systems would only need to plan to operate on their own for a few hours, after which time federal reinforcements and resources would arrive. Many now

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recognize this as a myth. It is now commonly believed that local and state systems will have to operate for unspecified amounts of time before federal resources will be allocated in relief.⁹ The timing will vary based on the extent of the incident. If a BT event affects numerous states or regions of the country, local systems will have to operate on their own for a longer period of time than if the event is localized in one state or region. Due to the existing strain on health care delivery systems, the prospect of handling a public health event without federal resources seriously complicates preparedness planning.

IV. Preparedness, Health Care Delivery Systems and Counsel

Health care providers and institutions need to fully understand what will be expected of them in a public health emergency. They need to understand the roles of other players and the effect it will have on them as providers, institutions or payors. For instance, understanding a public health officer's role, responsibilities, and authority may make cooperation with such an official easier and more amiable. Finally, they need to understand the laws that will govern their actions during a public health emergency.

One study has shown that hospitals are often surprised when told what might occur during a public health emergency. The National Defense University study regarding hospital readiness found that, despite the investment of significant resources in hospital preparedness, rural hospitals are especially ill-prepared for mass casualty and infectious disease incidents.¹⁰ Urban community hospitals did not fare much better.¹¹ Literature on surge capacity has indicated the same findings.¹²

Due to the apparent lack of preparedness and understanding of

health care providers and institutions, counsel will be called upon for advice and guidance. These calls may often come in the midst of an emergency with little time for research and reflection. Non-health care clients will also need to consult counsel during a public health emergency to inquire about certain health-related legal issues. Counsel will have to be conversant in the statutes and regulations governing the following scenarios in order to advise clients in a timely and effective manner. During public health emergencies, time is of the essence. Health care attorneys must think about these issues now so that they can educate clients before a public health emergency arises and re-educate and advise clients during an emergency.

The range of topics on which counsel may be consulted is expansive. They cannot all be addressed here. The most likely categories of questions and examples of each are presented below.

A. Government Authority Parameters

During a public health emergency, public officials will most likely have the power to do a variety of things that will affect health care providers, institutions, private citizens, and businesses. Since these officials rarely, if ever, have exercised such powers, doing so may be met by skepticism and resistance. One can imagine a hospital CEO frantically calling his lawyer because a public health officer just presented him with an order that authorizes the officer to take control of the hospital for the duration of the emergency. Alternatively, a small business owner may choose to consult his lawyer to determine whether he can fire an employee who refuses to come to work because she is afraid to leave her house. The local sheriff may consult counsel to find out whether his deputies should arrest a man in a pharmacy who they believe is under home quarantine. The man under home quarantine may contact an attorney to inquire as to how

he is supposed to obtain food and basic necessities without leaving his house.

Other issues surrounding the limits of government power include questions about the role of the courts in public health emergencies. Once a public health officer quarantines an emergency room, can the hospital appeal that decision, and if so, how? While the appeal is being processed, how will the emergency room be classified? Will it be considered quarantined or will it be allowed to operate as usual? Will the hospital be entitled to an injunction that will allow it to operate the emergency room as normal?

Clients may also have questions regarding the consequences for disobeying a public health order. While attorneys may not advise their clients to disobey the law, they may explain the consequences of such behavior. For example, a private citizen under home quarantine may ask about the validity of the order and the ramifications of disobeying the order if he goes to the grocery store for a gallon of milk and a loaf of bread.

That same citizen may call regarding questions of redress. The client may explain that he has been ordered to stay at home because he was exposed to SARS in Toronto. He explains to you that he has never been to Toronto, nor associated with anyone who has been to Toronto, and cannot possibly have SARS. He is obeying the home quarantine, but considers it to be false imprisonment. He wants to sue. Who should he sue? What type of recovery can he seek? Against what, if any, government institution could a judgment be enforced?

There is a large range of questions that clients may ask regarding the government's authority during a public health emergency. A lawyer must be versed in the public health emergency statutes and regulations, the emergency and disaster laws, and the isolation and

quarantine laws of his state. He must not only know about the limits of the government's power, but he must also understand the limits of the scope of appeal and redress.

B. Impact Of "Quarantined" Facility Designation

During a public health emergency, it may be necessary for public health authorities to limit access to health care facilities which may have been contaminated by pathogens or because persons with suspected highly contagious diseases are present in the facility. Memorial Hermann The Woodlands Hospital in Texas was forced to close and quarantine its emergency department ("ED") after a patient entered the ED with an envelope full of a white powder, which spilled, contaminating the entire department.¹³ The white powder ultimately tested negative for anthrax; however, the ED remained closed for five hours.¹⁴ When faced with this type of situation, health care institutions may ask counsel about the power of the public health authority to even take such action. Counsel might be asked if a hospital can suspend discharges until public health authorities can determine that current patients do not pose a threat. Indeed, the mere mention of SARS in the same sentence with the name of a specific health care facility can create panic among patients and families, and cause significant damage to the facility's reputation as well as its ability to continue to treat patients.

C. EMTALA Compliance

Hospitals in particular may have questions about compliance with the Emergency Medical Treatment and Active Labor Act ("EMTALA")¹⁵ during public health emergencies. EMTALA requires a hospital ED to evaluate all patients who present to it and, if they are experiencing an emergency, to stabilize them before transfer. During a disaster, a hospital may experience an impaired ability to comply with EMTALA requirements. It is foreseeable that a hospital would close its doors to keep the ED from being overwhelmed.

Instead of accepting patients in the ED and triaging them there, they may be redirected to an off-site location that is better equipped to handle large numbers of people. There, triage could be conducted in the most efficient manner.

This situation presents numerous issues for hospitals. It is far from clear that battlefield triage is EMTALA compliant. It may also be a violation of EMTALA to turn away an individual who presents to the ED even if the ED is closed. In fact, a Guidance from the Department of Health and Human Services ("HHS") suggests that hospitals would not be relieved of their EMTALA duties when experiencing capacity issues due to a public health emergency.¹⁶

It is also foreseeable that a hospital would transfer a potentially infectious patient before evaluating or stabilizing the patient. Normally, this would be in violation of EMTALA. An HHS Guidance on this issue suggests, however, that if the transfer is done pursuant to a community plan, it may not violate the statute.¹⁷ Overall, it is simply not clear how the federal government will enforce EMTALA during public health emergencies.

D. Credentialing

Provider credentialing issues may also present a problem for health care providers and institutions. Credentialing typically involves examining the following aspects of the applicant's life: education; training; licensure status; experience; specialty board certification/eligibility; hospital affiliations, both current and past; membership in professional societies and organizations; malpractice claims history; professional liability insurance coverage; disciplinary action imposed by other hospitals or medical licensure boards; health status that would adversely affect care; specific procedures the applicant seeks to perform in the hospital, with evidence of clinical competence in those procedures; references; and Drug Enforcement Administration controlled substance registration, if applicable.¹⁸ Clearly, it is a lengthy process that usually cannot

be accomplished on a large scale, expedited basis.

During a public health emergency, hospitals will want all available medical providers to be able to render care. Presumably, most health care providers will want to participate and provide this aid. This includes regular medical staff physicians, hospital employees, and retired and out-of-state health care providers. If a provider is not licensed within the state, either because he is retired or licensed out-of-state, the hospital usually cannot credential him. The state's Emergency Medical Assistance Compact ("EMAC") may provide an avenue for credentialing out-of-state providers by causing the receiving state to honor the license of the host state.¹⁹ As for retired providers, the state Board of Medicine or Nursing may establish emergency regulations to reinstate these providers. Without such a regulation, however, there is not much that a hospital can do. Counsel must be familiar with the Board of Medicine and the Board of Nursing licensure regulations, as well as his state's EMAC in order to provide adequate assistance to hospitals with credentialing questions.

Hospitals may also encounter problems where providers credentialed at other institutions in the state are needed to provide care. In this situation, with the help of counsel, hospitals may be able to establish reciprocal credentialing agreements whereby each hospital will recognize the credentialing of each other hospital in the event of an emergency where additional providers are needed. These agreements will have to be put into place before an emergency occurs to ensure that the hospitals are comfortable with each other's credentialing process.

E. Volunteer Management, Integration And Liability

Volunteer management, integration and liability may also present issues that will be addressed to counsel for health care providers, health care institutions and medical and public health volunteer groups. There are a variety of volunteers

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who may offer assistance during an emergency. Possible volunteers include regular health care personnel who are not scheduled to work at the time of the emergency, health care personnel from other institutions, retired or out-of-state health care personnel, members of medical and public health volunteer organizations, and individuals with no health care background or experience who just want to help.

With each type of volunteer comes a separate set of issues. For instance, when a regular employee who is not scheduled to work presents herself to aid in an emergency, will she have to be paid overtime? Must she be assigned to her normal job duties or may she be asked to do something outside of the scope of her job description? Credentialing, which was discussed above, is one of the most pressing issues for volunteer health care personnel not already granted privileges at the hospital, which includes personnel from other hospitals, retired and out-of-state providers.

There are numerous medical and public health volunteer organizations that have been created to render aid to individuals and institutions during emergencies. One of the most visible organizations currently is the Medical Reserve Corps (“MRC”), composed of both health care providers and lay individuals. This program was started on a national level through HHS and is implemented through units established in localities across the country.²⁰ Lay individuals with no health care background and no affiliation with any volunteer group may also want to help in any way they can and present to the hospital for service.

With respect to the management of volunteers, questions will arise regarding which entity is responsible for delegating tasks to the volunteers. Even more basically, who will be in charge of deciding which tasks need to be delegated? If the ED attending physician delegates a

task to the head of the MRC and the MRC assigns the task to individual members, who will be responsible if the individual member is negligent? A hospital, together with counsel, may consider preparing for volunteer services in advance of an emergency by starting a dialogue with MRCs and other volunteer groups. They may also want to go a step further and create agreements that clearly delineate the management and liability structure of the relationship.

Integrating the services of regular hospital health care providers and volunteers during an emergency will certainly present a challenge. Adding to the difficulties of such a task may be a friction between the regular providers and the volunteers. While this may not be a legal problem that counsel will be called upon to address, it is a problem that counsel should flag for his institutional health care clients so that they may properly train their staff to avoid conflict in the event of an emergency.

Counsel may also be called upon to address questions of medical and public health volunteer liability, both in terms of the volunteer’s own liability for his acts and the institution’s liability for the acts of the volunteer. As for personal liability, volunteers may be immune for their actions. Volunteer liability varies from state to state, so it is important for counsel to be familiar with his or her state law. The federal Volunteer Protection Act (“VPA”) does provide some immunity from civil liability for volunteers, but this law unfortunately has some rather large loopholes that leave volunteers exposed.²¹ Possible state sources of immunity include so-called “volunteer protection acts;” charitable immunity if the volunteer is part of a charitable organization and this is a viable doctrine in that state;²² Good Samaritan immunity; sovereign immunity if the volunteer is an agent of the state government and the state has not waived its immunity through a Tort Claims Act; emergency services and

disaster law immunity if an emergency has been declared; and EMAC provisions that may extend immunity to out-of-state volunteers.

Any institutional liability for the acts of volunteers will be intimately tied to both the credentialing and management discussions above. Institutional liability may be based on respondeat-superior liability or negligent credentialing where the volunteer is seen as an agent of the institution. Counsel may be helpful in designing volunteer policies for health care institutions whereby the institution can ensure that it will not be construed as the principal nor the volunteer as its agent. If a principal-agent relationship does exist, counsel may be able to comfort the institution by finding it immunity in one of the laws mentioned above, most likely the emergency services and disaster state statute.

F. Communicable Disease Containment Laws

Counsel will also have to be familiar with state laws governing communicable disease containment, i.e. quarantine and isolation. Most states have recently modified their laws and continue modification efforts as new threats emerge. Isolation and quarantine policies will be contained within these laws as well as delineations of the responsibilities of various public health agencies and other public actors. The state statutes should address standards for isolation and quarantine, authority to impose isolation and quarantine, and the enforcement of these orders once imposed. In some cases, these laws provide sweeping powers to public health authorities to detain persons suspected of having a communicable disease. In other cases, the laws are vague and confusing about these same powers.

Detainment of persons suspected of having a communicable disease can raise numerous civil liberty and liability concerns. Health care providers may have to grapple with these concerns

during an emergency to the extent that they are being asked to enforce detainment orders. For instance, in the early stages of an ED quarantine, health care providers may be asked to ensure that people do not leave the ED. The health care providers assigned to this task may worry about personal liability when enforcing such orders and wish to consult counsel. Counsel will have to be conversant with these laws, which may prove difficult. The statutory law is relatively underdeveloped in most states and there is a dearth of case law on this issue, since quarantine has not been used in the United States on a large scale in nearly 100 years.

V. Conclusion

Emergency Preparedness and Response activities present significant legal issues for both the public and private sector. Health care providers are a critical part of the response infrastructure and will likely be at the epicenter of any event. These providers, and their legal counsel, must be prepared to respond effectively to future emergencies which can occur at any time. Counsel to health care providers will be challenged to master this emerging area of law in order to effectively serve their clients.

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Endnotes

- 1 For the remainder of this article, "public health emergency" will be used to encompass BT events, communicable disease outbreaks such as SARS, and any other public health emergency to which hospitals and health care providers may be asked to respond.
- 2 See *Summary of Notifiable Diseases – United States, 2001*, MMWR 50(53);1-108. This article outlines the history of notifiable diseases within the United States. In 1912, the first nationally notifiable infectious disease list was created. The list is updated periodically, but since 1961 the CDC has been responsible for collecting information on these nationally notifiable diseases.
- 3 See Edward P. Richards, *Plagues, Police and Posse Comitatus: Legal Issues in Forensic Epidemiology and Public Health Emergency Response*, available at <http://biotech.law.lsu.edu/cphl/slides/56> (last visited May 28, 2005).
- 4 See American Hospital Association, *STAT: Tackling Today's Issues Building Emergency Readiness*, available at http://www.hospitalconnect.com/aha/annual_meeting/content/04mtgpaper_emergencyread.pdf (last visited Jan. 14, 2005).
- 5 See Illinois College of Emergency Physicians, *On Our Watch: Preparing for Overcrowding and Bioterrorism in the Emergency Department*, available at <http://www.ferne.org/Lectures/EDovercrowdbioterror.pdf> (last visited Jan. 13, 2005).
- 6 See Colleen Danz, *The State of Emergency*, available at <http://www.ama-assn.org/ama/pub/category/8888.html> (Last visited Jan. 13, 2005).
- 7 The Henry J. Kaiser Family Foundation, *American Hospital Association asks Congress not to cut funding*, available at http://www.kaisernetwork.org/adwatch/adwatch_index.cfm?display=detail&aw=330 (last visited Jan. 13, 2005).
- 8 See Bioterrorism Detection and Response, Testimony by Dr. Harvey Meislin, Committee on Senate Judiciary. Federal Document Clearing House Congressional Testimony, May 11, 2004. See also Janet Heinrich, *Public Health, Public Health Preparedness: Response Capacity Improving, but Much Remains to be Accomplished*, GAO-04-458T.
- 9 See James Jay Carafano, Ph.D., *Improving Federal Response to Catastrophic Bioterrorist Attacks: The Next Steps* (Nov. 13, 2003), available at <http://www.heritage.org/Research/HomelandDefense/BG1705.cfm#pgfId-1083616> (last visited Jan. 13, 2005).

¹⁰ Elin Gursky, *Hometown Hospitals: The Weakest Link? Bioterrorism Preparedness in America's Rural Hospitals*, available at <http://www.ndu.edu/ctnsp/rural%20hospitals.htm> (last visited Jan. 13, 2005).

¹¹ *Id.*; see also General Accounting Office, *HOSPITAL PREPAREDNESS: Most Urban Hospitals Have Emergency Plans but Lack Certain Capacities for Bioterrorism Response*, available at <http://www.gao.gov/new.items/d03924.pdf> (last visited Jan. 14, 2005).

¹² See *supra* note 7.

¹³ Jeff Tieman, *On the Front Lines; Anthrax Scare, jittery public put focus on Health Care Industry*, *Modern Healthcare*, October 22, 2001.

¹⁴ *Id.*

¹⁵ 42 U.S.C. § 1395dd (2004).

¹⁶ See also Department of Health and Human Services, Guidance (Nov. 29, 2001), available at <http://www.cms.hhs.gov/medicaid/survey-cert/112901.asp> (last visited Jan. 13, 2005).

¹⁷ See Department of Health and Human Services, Guidance (Nov. 8, 2001), available at <http://www.cms.hhs.gov/medicaid/survey-cert/110801.asp> (last visited Jan. 13, 2005).

¹⁸ See generally Virginia Hospital and Healthcare Association, *Hospital Credentialing Process*, available at <http://www.vhha.com/index.cfm?fuseaction=Page.viewPage&pageID=288> (last visited Jan. 13, 2005).

¹⁹ EMAC Model Legislation, available at http://www.emacweb.org/EMAC/About_EMAC/Model_Legislation.cfm (last visited January 13, 2005), as adopted by 47 states, two territories and the District of Columbia. Article V provides "[w]henever any person holds a license, certificate, or other permit issued by any state party to the compact evidencing the meeting of qualifications for professional, mechanical, or other skills, and when such assistance is requested by the receiving party state, such person shall be deemed licensed, certified, or permitted by the state requesting assistance to render aid involving such skill to meet a declared emergency or disaster, subject to such limitations and conditions as the governor of the requesting state may prescribe by executive order or otherwise."

²⁰ See <http://www.medicalreservcorps.gov> (last visited Jan. 13, 2005).

²¹ 42 U.S.C. § 14501 et seq.

²² Charitable immunity has been eliminated in some states.

Editor's Note: The ABA and the CDC are conducting Public Health Legal Preparedness Workshops in conjunction with state and local bar associations. If you are interested in setting up a workshop in your area, please contact Public Health & Policy Interest Group Chair Hal Katz at hkatz@mailbmc.com.