NGA Center for BEST PRACTICES

Issue Brief

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Beyond EMAC: Legal Issues in Mutual Aid Agreements for Public Health Practice

Executive Summary

Emergency declarations by governors allow them to implement the Emergency Management Assistance Compact (EMAC), a multi-state agreement that facilitates the rapid sharing of equipment, personnel and other resources among states. Although states often face situations that threaten the health of their citizens and challenge the response capabilities of their public health infrastructure, those incidents rarely rise to the level of declared emergencies, preventing state officials from availing themselves of resources that may be located just across a state line. As a result, states are seeking alternative methods to assist each other during public health situations that are not declared emergencies.

The use of out-of-state assets in non-emergency situations, however, is complicated by legal considerations that increase in complexity according to the level of assistance contemplated. Information sharing efforts, for example, face few legal obstacles while efforts to share equipment, use out-of-state laboratories, or utilize out-of-state doctors and nurses raise significant legal questions relating to:

- cost reimbursement
- license and credential portability for medical or other personnel
- liability and
- workers compensation.

Any cross-border mutual aid agreement that envisions the fast and efficient transfer of equipment and/or personnel will require participating states to resolve conflicts or contradictions among applicable laws and regulations. To achieve this compatibility, governors should consider the following strategies:

- Assess whether the laws in their states allow for license portability from other states and consider joining existing multi-state agreements such as the Nurse Licensure Compact;

- Review their state's policies for the use of volunteer disaster workers, particularly as those policies relate to workers' compensation claims;

- Assess whether sovereign immunity, Good Samaritan laws or other statutes provide liability protections to volunteer health professionals;

- Assess whether the laws in their state effectively deal with the issue of private health organizations' ability to credential and privilege out-of-state medical professionals and work with the private sector to develop policies and protocols to allow for the use of out-of-state professionals;

- Determine whether existing interstate agreements or arrangements address issues of cost recovery, liability, and workers compensation and whether those arrangements might be applicable to situations affecting the public health;

- Work with governors, legislators and public health officials in neighboring states to determine an appropriate strategy for aligning laws and regulations to facilitate the cross-border movement of public health professionals in non-emergencies.

Introduction

In August and early September 2005, equipment, supplies and personnel flowed from across the nation into **Alabama**, **Louisiana**, **Mississippi** and **Texas** in the wake of hurricanes Katrina and Rita. This influx of assistance was largely the result of the Emergency Management Assistance Compact (EMAC), a congressionally approved interstate mutual-aid agreement. EMAC affords states providing and receiving post-disaster assistance the ability to move equipment and people across state lines rapidly by establishing systems and protocols for (1) the acceptance of out-of-state medical licenses; (2) the recovery of costs incurred by states providing assistance; (3) legal liability claims that arise from the activities of out-of-state workers; and (4) workers' compensation payments should those out-of-state workers be injured or killed while responding to the disaster. In short, EMAC provides for "mutual assistance between states … in managing any emergency or disaster that is duly declared by the governor of the affected state(s), whether arising from natural disaster, technological hazard, man-made disaster, civil emergency aspects of resource shortages, community disorders, insurgency, or enemy attack."[i]

To take effect, EMAC requires the governor of the affected state to declare a state of emergency. In incidents that do not result in emergency declarations, EMAC's authorities and protections do not exist and its application is limited. Nowhere is this limitation more evident than in incidents that stress a state's public health infrastructure. Such incidents, while common, often do not rise to the level of governor-declared emergencies. As a result, states are seeking alternative methods to draw on resources and expertise that may be located just across a state line but often are legally out of reach.

The use of out-of-state assets in non-emergency situations, however, is complicated by legal considerations that increase in complexity according to the level of assistance contemplated. While states probably can engage in pre-event planning and information sharing using authorities

found in EMAC and other national planning documents, it is more difficult for them to share equipment, use out-of-state laboratories, or utilize out-of-state doctors and nurses because of significant legal questions relating to cost reimbursement, license portability, liability, and workers compensation. This paper examines these issues from a policy perspective and offers some potential solutions.

Background

Governors do not enjoy absolute authority to declare states of emergency in the wake of natural disasters, terrorist attacks, or disease outbreaks. That authority is granted by state law and is subject to the existence of specific conditions. State laws also vary in granting governors the authority to declare emergencies specific to situations threatening the public's health. As a result, the requirements of state law may prevent a governor from declaring emergencies even in situations that test the limits of a states' public health infrastructure. Examples of these scenarios abound:

- During a four-month period in 1999, 100 cases of rubella were diagnosed in Nebraska (only 167 additional cases were reported in the entire United States that year). The source of the outbreak appeared to be a Spanish-speaking immigrant who worked in a meat-packing plant. Seventy percent of the cases involved Hispanic immigrants with little or no English-language skills. Nebraska had few Spanish-speaking epidemiologists or nurses and, particularly during the early stages of the outbreak, the state had a clear need to obtain epidemiologists and nurses from other states.

- In October and November 2003, an outbreak of hepatitis-A began at a restaurant in Monaca, Pennsylvania. Eventually, 610 people were infected. However, 9,000 people who ate at the restaurant or had exposure to those who ate at the restaurant were administered immune globulin shots. The outbreak was controlled, but the state public health infrastructure would have been overwhelmed had another communicable disease outbreak occurred at the same time. In that case, the ability to fall back on resources in neighboring states would have been essential.

- On January 18, 2002, a freight train derailed near Minot, North Dakota, rupturing eight tanker cars and releasing about 300,000 pounds of anhydrous ammonia into the air. First responders went door-to-door to evacuate people or assess their level of exposure. The time needed to conduct those visits could have been decreased significantly had North Dakota been able to bring in experts from neighboring states.[ii]

Political considerations also may inform a governor's decision to declare an emergency, because that step can result not only in significant expenditures but also in public perceptions of official overreaction. Whether for legal or political reasons, none of the incidents noted above resulted in emergency declarations, but in each case state officials report they could have benefited from assistance from outside their borders. As a result of those and similar experiences, several states are exploring interstate agreements to facilitate sharing supplies, services, and personnel during non-emergencies.

In 2004, 10 states (**Colorado**, **Iowa**, **Kansas**, **Missouri**, **Montana**, **Nebraska**, **North Dakota**, **South Dakota**, **Utah** and **Wyoming**) launched the Mid-America Alliance, an effort to develop an interstate public health mutual-assistance agreement that could be used in non-emergencies. States in the Pacific Northwest (**Alaska**, **Idaho**, **Oregon** and **Washington**), the Northeast (**Maine**, **New Hampshire**, **New York** and **Vermont**), the Southwest (**Arizona**, **California**, **New Mexico** and **Texas**) and the Great Lakes (**Michigan**, **Minnesota**, **New York**, and **Wisconsin**) are exploring similar efforts among themselves and with states and provinces in Mexico and Canada. (Those international cross-border initiatives also involve legal questions relating to the constitutional prohibition on states entering into international accords.)

Such interstate regional approaches to planning and response are encouraged through the Department of Homeland Security's National Incident Management System (NIMS) and in the Centers for Disease Control and Prevention's (CDC) guidelines for the new state cooperative agreement on Public Health Emergency Preparedness.[†] EMAC also recognizes that planning for interstate assistance should take place in advance of any incident for which an emergency could be declared. EMAC, in fact, lists several planning activities as *responsibilities* of party states.[iii] The inclusion of those activities in the language of the compact appears to provide the legal authorization for states to engage with one another in pre-event planning activities for any incident, whether or not that incident results in an emergency declaration. Outside EMAC, state laws also may allow the sharing of epidemiologic information, and perhaps epidemiologists—who in most cases are not licensed by the state—to better detect and control infectious disease outbreaks before they reach disastrous proportions.

[†] The National Incident Management System states that "Each jurisdiction should be party to a mutual-aid agreement (such as the Emergency Management Assistance Compact) with appropriate jurisdictions from which they expect to receive or to which they expect to provide assistance during an incident. *National Incident Management System*, Chapter 3, Part B, Section 4(e), at www.nimsonline.com. The CDC's Cooperative Agreement prevention preparedness goal lists six required critical tasks, including: improving regional, jurisdictional, and State all-hazards plans; increasing and improving mutual aid agreements; and providing support for continuity of public health operations at all levels of government. *CDC Cooperative Agreement Guidance for Public Health Emergency Preparedness* at http://www.bt.cdc.gov/planning/guidance05/pdf/annoucement.pdf.

Legal Obstacles to Non-Emergency Mutual Aid

Although the EMAC language allows pre-event planning and information sharing among states, at least one legal expert has concluded that EMAC probably does not authorize states "to enter into agreements for interstate movement of equipment or resources containing EMAC-like binding provisions governing reimbursement, compensation and liability in the absence of an emergency declaration."[iv] EMAC notably does not explicitly prohibit those exchanges either, and the compact recognizes that some interstate mutual aid agreements pre-date the enactment of the EMAC legislation. The EMAC language stipulates that the compact does not "preclude any state from entering into supplementary agreements with another state or affect any other agreements already in force between states." According to the compact, supplementary agreements may include provisions for activities such as the "evacuation and reception of injured and other persons and the exchange of medical, fire, police, public utility, reconnaissance, welfare, transportation and communications personnel, and equipment and supplies."[v]

Statutes in some states specifically address cross-border mutual aid outside the bounds of EMAC. **Minnesota** state law, for example, authorizes the state emergency management director, with the approval of the governor, to enter into mutual aid agreements with emergency management agencies or organizations in other states and Canadian provinces "for reciprocal emergency management aid and assistance in case of disaster too great to be dealt with unassisted." The statute is silent on the need for an emergency declaration in either the receiving state or in Minnesota. Other sections of the statute address cost reimbursement, liability and license portability during declared disasters, but state officials say mutual aid agreements would have to be negotiated on a case-by-case basis to ensure those issues are fully addressed.[vi]

A more comprehensive mechanism would therefore be useful for states to share assets and personnel quickly and effectively during events that are not declared emergencies. Any such strategy, however, must take into account the legal issues that EMAC resolves in emergency situations.

Cost Reimbursement

States can incur a variety of costs as a result of providing assistance to other states, including (1) direct expenses related to shipping equipment and transporting people and fuel, (2) depreciation costs related to the use of machinery and equipment, and (3) potential overtime costs for workers needed to fill in for those deployed as part of the relief effort.

EMAC addresses cost reimbursements by requiring that the state receiving the assistance pay donor states for "any loss or damage to or expense incurred in the operation of any equipment and the provision of any service in answering a request for aid and for the cost incurred in connection with such requests." The compact also allow states to donate equipment and services without

charge and allows two or more EMAC party states to enter into supplementary agreements establishing different cost allocations.[vii]

Governors should obtain a legal opinion on whether the supplementary agreement provision provides the legal authority to establish cost-reimbursement protocols for non-emergency situations. Any mutual-aid agreement, however, must effectively address the reimbursement question to ensure participation by member states.

Licensing, Credentialing and Privileging
The licensing of doctors, nurses, psychiatrists, dentists and other medical and health professionals is a state responsibility, and each state has laws that set out the requirements for licensure. States guard their authority to issue professional licenses and are wary of accepting personnel with licenses issued outside their borders.

In addition, state law forms the basis for the credentials and privileges granted by the private health care industry to health professionals. Credentialing refers to the verification and assessment of an individual's qualifications to provide care and treatment. Privileging refers to the authorization granted by a health care provider (hospital, HMO, etc.) to an individual to offer specific care, treatment and services with well-defined limits at a specific facility. Privileging is based on license, education, training, experience, competence, and judgment.[viii] States and the private health industry generally are unwilling to accept out-of-state licenses or to recognize credentials and privileges issued by outside organizations in non-emergency situations, primarily because of liability concerns.

Article V of EMAC states that if a person holds a license, certificate, or other permit issued by any state party to the compact, that 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."[ix]

EMAC does not compel private health care organizations to grant privileges to out-of-state medical professionals, although the Joint Commission on Accreditation of Health Care Organizations' standard for hospital emergency management plans allows hospital officials, at their discretion, to grant temporary privileges to doctors and licensed practitioners.[x] Interstate mutual-aid agreements for non-emergencies must address not only the need for interstate license portability (on at least a temporary basis), but also the role played by the private sector in credentialing and privileging licensed health care professionals.

Civil Liability
Legal liability questions are a significant obstacle to the creation of interstate mutual-aid agreements. Should patients be injured, harmed or killed during the response to an incident, the

courts will be asked to determine the liable party: the out-of-state health professional, the organizations that provided or accepted the professionals, or the officials administering the program under which the out-of-state professionals were provided.

In addition to common allegations of negligence, breach of privacy, and misrepresentation, liability claims during large-scale public health incidents could result from allegations of substandard care due to post-event patient surges. Liability claims also could arise from the use of out-of-state laboratories should an outside facility make a mistake that results in harm or injury. The information transferred from one lab to another also is likely to include protected personal information. Liability claims could arise if the receiving laboratory mishandles or misuses the protected information.

Under EMAC, employees of a state providing assistance to another state during an emergency "shall be considered agents of the requesting state for tort liability and immunity purposes; and no party state or its officers or employees rendering aid in another state pursuant to this compact shall be liable on account of any act or omission in good faith on the part of such forces while so engaged …"

EMAC specifies that "good faith" does not include willful misconduct, gross negligence, or recklessness. Similar standards may apply for assistance provided in situations that are not emergencies, although states may be less willing to accept liability for out-of-state workers in these situations. Mutual-aid agreements for non-emergencies must address those concerns.

Workers Compensation

Another challenge in moving personnel across state borders absent a declaration of emergency involves determining who is employing those personnel for purposes of workers compensation claims. Questions exist as to whether the employer would be the donor state, the recipient state or—in the case of private sector health professionals—the donor or recipient private sector organizations. According to one legal analysis, "In many jurisdictions, the existing employer is not likely to be liable for injuries its employees sustain volunteering services elsewhere if the employee's actions are outside the course of employment with the existing employer."[xi]

Some state statutes resolve the question by defining volunteers as state employees for the duration of an emergency, but in events that are not declared emergencies, those statutes may not apply. In those cases, the hospital or other facility that grants temporary privileges to the out-of-state health professional could be considered the employer for compensation purposes. In other states, no such statutes exist. EMAC requires member states to provide compensation and death benefits to its employees or their survivors if they are injured or killed while providing assistance to another state, "on the same terms as if the injury or death were sustained within their own state."[xii] Interstate agreements for non-emergencies must effectively address the workers compensation question.

Strategies for Delivering Effective Mutual Aid

Any cross-border mutual-aid agreement that envisions the fast and efficient transfer of equipment and/or personnel will require participating states to resolve conflicts or contradictions among applicable laws and regulations. Several strategies can be used to achieve that compatibility.

Identify and remedy areas of legal conflict on a case-by-case basis.
Governors, working with each other and state legislatures, can amend or enact relevant laws or regulations to ensure consistency in areas such as licensure, credentialing and privileging. That approach also could be used to address issues of workers compensation for employees mobilized to provide aid outside the state or to provide liability protection for volunteer workers.

Use existing interstate agreements as a basis for cross-border mutual aid.
Several existing interstate agreements could be useful for developing multi-state agreements, either as direct mechanisms or as models for use by other states. For example, 20 states[*] have signed a Nurse Licensure Compact that establishes license reciprocity among the states that are party to the compact. The agreement requires nurses to meet their home states' requirements for licensure and all other applicable state laws, and allows party states to limit or revoke the privilege of any nurse to practice in that state, subject to due process requirements. The compact also requires nurses to comply with the laws and regulations of the states in which they are practicing and subjects nurses to the jurisdiction of the nurse licensing board and the courts in the party states. Similar agreements for doctors and other health care professionals could facilitate the movement of those people across state lines during public health incidents. Those agreements, however, would require the approval of each participating state's legislature, and if a multi-state compact was formed, it is possible that Congress also would have to approve it.

Establish policies that allow out-of-state professionals to practice under limited circumstances.
Connecticut permits physicians licensed in other states to practice in the state if they are employed by the federal government, if they are providing temporary assistance to a physician licensed in the state, or if they are employed by an individual within the state specifically to treat a condition that he or she is suffering at the time of the employment.

West Virginia allows out-of-state physicians to practice medicine for up to 90 days, on a one-time-only basis, if that physician is acting as a consultant for a physician licensed in the state.[xiii]

[*]The 20 states are Arizona, Arkansas, Delaware, Idaho, Indiana, Iowa, Maine, Maryland, Mississippi, Nebraska, New Jersey, New Mexico, North Carolina, North Dakota, South Dakota, Tennessee, Texas, Utah, Virginia, and Wisconsin.

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Nebraska uses the principle of *locum tenens*—literally, "to hold the place of"—to allow out-of-state physicians to work in a temporary capacity at a hospital or other health care facility for 90 days in any 12-month period, but its state board of medicine must review and approve these physicians' credentials using a process similar to that for granting state licenses. Nebraska's use of the *locum tenens* program does not require a governor-declared emergency.

Implement the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)

The applicability of a *locum tenens* program as part of an interstate mutual-aid agreement depends on how quickly a license-based review could take place, unless a system were implemented in advance to expedite the arrival of out-of-state doctors. Such an advanced registration system, known as the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), is now being developed—in part as a result of the terrorist attacks of September 11, 2001.

During the immediate response to the terrorist attacks, thousands of doctors offered their services as volunteers to New York City hospitals. In many cases, out-of-state doctors were turned away because hospital administrators could not confirm their identities or their medical credentials. Congress and the federal Department of Health and Human Services launched ESAR–VHP to register volunteer health professionals in advance of an emergency. Under the program, states will develop readily available, verifiable volunteer registries that include information on the volunteers' identities, licenses, credentials, accreditation and privileging.

ESAR–VHP, if successful, could facilitate the acceptance of both out-of-state licenses by state regulators and outside credentials and privileges by private health care organizations. The program also could be useful as a registry of licensing and credentialing information to expedite the temporary use of licensed professionals in non-emergencies.

Use "sovereign immunity" and "Good Samaritan" protections.

Legal liability concerns can be addressed in some cases through the use of the sovereign immunity enjoyed to varying degrees by governments at the local, state, and federal level. The principle of sovereign immunity shields the state from liability, and states generally indemnify their employees for actions carried out within the scope of their official duties—unless the plaintiff can prove the employee acted with gross negligence. Other statutory protections also may apply to health professionals responding to out-of-state incidents. Those protections include so-called Good Samaritan laws and other statues aimed at protecting the actions of volunteers acting in good faith.

Form a new interstate compact.

An alternative approach is to form an interstate compact that, through its language, appendices and amendments, addresses en masse the legal issues challenging the ability of states to assist

each other in non-emergencies. Scores of interstate compacts exist for myriad reasons, including establishing authorities to manage ports, such as the Port Authority of **New York** and **New Jersey** and to build bridges, such as the Woodrow Wilson Bridge and Tunnel Compact involving **Virginia**, **Maryland,** and the **District of Columbia**. Several interstate compacts also exist to provide for mutual aid in a variety of non-emergency situations. **Idaho**, **Oregon**, and **Washington** ratified the Interstate Forest Fire Suppression Compact to share prison inmates as part of each state's wildfire-fighting force. Similarly, **Maryland**, **New Jersey**, **Ohio**, **Pennsylvania**, **Virginia** and **West Virginia** have ratified the Middle Atlantic Interstate Forest Fire Protection Compact. The National Guard Mutual Assistance Counter-Drug Activities Compact allows member states to cooperate in the use of National Guard forces in interdiction, counter-drug, and demand-reduction activities.

The main obstacle to the creation of a new compact, however, is the U. S. Constitution. Article I, Section X of the Constitution states, "No State shall, without the consent of Congress…enter into any agreement or compact with another State or with a foreign power, or engage in war, unless actually invaded or in such imminent danger as will not admit of delay."[xiv] However, that provision has been proven to be less than absolute. Interstate compacts, in fact, predate the Constitution, particularly in the areas of boundary disputes,[xv] and the Supreme Court has held that compacts that do not encroach on the supremacy of the federal government do not require congressional approval.[xvi] According to one analysis, "because the attributes of State sovereignty not surrendered through the ratification of the U.S. Constitution survive to this day… not every interstate agreement requires congressional consent, but those that are properly approved by Congress become federal law."[xvii]

EMAC, for example, required congressional approval at least in part because it involved multi-state responses to emergencies—an area that previously had been the responsibility of the Federal Emergency Management Agency. A similar pact for non-emergencies may not require congressional approval, unless it specifically infringes on an area of federal authority. Such an agreement could nonetheless benefit from that congressional imprimatur because the resulting congressional action would take the form of a federal law and result in a single system that resolves conflicts in licensing, reimbursement, liability, and workers compensation.

Conclusion

Significant legal challenges face any effort to develop interstate mutual-aid agreements for non-emergencies. However, each of those issues has several potential solutions. In general, governors interested in establishing or participating in multi-state mutual-aid agreements for situations that do not result in emergency declarations should consider the following:

- Assess whether the laws in their states allow for license portability from other states and consider joining existing multi-state agreements such as the Nurse Licensure Compact.

- Review their states' policies for the use of volunteer disaster workers, particularly as those policies related to workers compensation claims.

- Assess whether sovereign immunity, Good Samaritan laws or other statutes provide liability protections to volunteer health professionals.

- Assess whether the laws in their state effectively deal with the issue of private health organizations' ability to credential and privilege out-of-state medical professionals and work with the private sector to develop policies and protocols to allow for the use of out-of-state professionals.

- Determine whether existing interstate agreements or arrangements address issues of cost recovery, liability, and workers compensation and whether those arrangements might be applicable to situations affecting the public health.

- Work with governors in neighboring states to determine an appropriate strategy for aligning laws and regulations to facilitate the cross-border movement of public health professionals in non-emergencies.

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[iii] EMAC, Article III – Party State Responsibilities, Par. A
[iv] Daniel Stier, E-mail to the Mid-America Alliance Legal Committee, June 03, 2005.
[v] EMAC, Article VII- Supplementary Agreements
[vi] Minnesota Homeland Security and Emergency Management Division, E-mail to the author, Dec. 8, 2005.
[vii] EMAC, Article IX- Reimbursement
[viii] Health Resources and Services Administration (HRSA), "Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP) – Legal and Regulatory Issues"; February 2005
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[x] Joint Commission on Accreditation of Healthcare Organizations, Medical Staff Standard on Emergency Privileging of Licensed Independent Practitioners for Hospitals—MS.5.14.4.1
[xi] HRSA, ESAR-VHP – Legal and Regulatory Issues
[xii] EMAC, Article VIII -- Compensation
[xiii] HRSA, ESAR-VHP – Legal and Regulatory Issues
[xiv] Constitution of the United States, Article I, Section X, Paragraph 3
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