



REGION 1

Regional Disaster Health Response System

Legal Resource Guide

As of September 1, 2021

James G. Hodge, Jr., JD, LLM

Peter Kiewit Foundation Professor of Law
Director, Center for Public Health Law and Policy
ASU Sandra Day O'Connor College of Law
111 E Taylor St. | Mail Code 9520
Phoenix, AZ 85004-4467
james.hodge.1@asu.edu

Table of Contents

PREFACE	4
<i>Acknowledgements</i>	4
<i>Disclaimer</i>	4
<i>Scope & Primary Purposes</i>	4
<i>Organization</i>	6
ABBREVIATIONS	7
INTRODUCTION	8
Checklist of Legal Issues Underlying Regional Coordination	9
I. EMERGENCY DECLARATIONS	11
<i>Federal Declarations</i>	11
<i>State & Local Declarations</i>	12
Figure 1. Region States Defining Emergency, Disaster, or PHE	13
<i>Timing</i>	13
<i>Dual Declarations</i>	14
<i>Interjurisdictional Coordination</i>	14
<i>VHP Programs</i>	14
<i>Practicing Legal Triage</i>	15
Figure 2. Region States Waiver Authorities.....	15
II. EMERGENCY MANAGEMENT ASSISTANCE COMPACT	16
Figure 3. EMAC Organization	16
Figure 4. Role of EMAC & Allocations.....	17
<i>Applications During COVID-19</i>	17
<i>International EMAC</i>	18
III. LICENSING, CREDENTIALING & PRIVILEGING	19
<i>Reciprocity</i>	19
Figure 5. Pathways to Licensure Reciprocity.....	19
<i>Emergency Laws</i>	20
Figure 6. Region States Licensure Reciprocity.....	20
<i>Emergency Waivers</i>	21
<i>Credentialing & Privileging</i>	22
<i>Expanding Scope of Practice</i>	23
IV. TELEHEALTH & TELEMEDICINE APPLICATIONS	24
<i>Legal Authorities</i>	24
<i>CMS Reimbursements</i>	25
<i>Fraud and Abuse Protections</i>	26

V.	CIVIL LIABILITY, IMMUNITY & INDEMNIFICATION.....	27
	Figure 7. Web of Liability Risks	27
	<i>Potential Liability for HCWs & VHPs</i>	<i>27</i>
	<i>Criminal Sanctions.....</i>	<i>28</i>
	<i>Administrative Sanctions</i>	<i>28</i>
	<i>Constitutional Claims.....</i>	<i>28</i>
	<i>Potential Entity Liability.....</i>	<i>29</i>
	<i>Liability Protections.....</i>	<i>30</i>
	Figure 8. Liability Protections for Personnel & Entities	31
	<i>Sovereign Immunity.....</i>	<i>31</i>
	<i>Statutory Protections & Limitations</i>	<i>31</i>
	Figure 9. Region States Explicit Liability Protections	32
	<i>Good Samaritan Acts</i>	<i>33</i>
	<i>PREP Act</i>	<i>33</i>
	<i>Workers' Compensation</i>	<i>33</i>
VI.	OTHER LEGAL ISSUES.....	35
	<i>Crisis Standards of Care</i>	<i>35</i>
	Figure 10. CSC Systems Framework	35
	<i>Emergency Use Authorizations</i>	<i>36</i>
	<i>Rights to Reemployment</i>	<i>37</i>
	<i>Health Information Sharing & Privacy.....</i>	<i>38</i>
	APPENDICES.....	40
	Table 1 - Emergency Declaration Authorities.....	40
	Table 2 - Licensure Reciprocity for HCWs	43
	Table 3 - Emergency Waiver Authorities.....	47
	Table 4 - Emergency Liability Protections	50
	Table 5 – Snapshot of Emergency Laws	56
	REFERENCES	57

PREFACE

Acknowledgements. This guide was developed by **James G. Hodge, Jr.**, J.D., LL.M., Peter Kiewit Foundation Professor of Law; Director, Center for Public Health Law & Policy, at the Sandra Day O'Connor College of Law, Arizona State University (ASU), with contributions by **Sarah Wetter**, J.D., M.P.H., Law Fellow, O'Neill Institute for National and Global Health Law, Georgetown University Law Center, and legal research students at ASU's Sandra Day O'Connor College of Law including **Emily Carey**, **Joshua Kalanick**, **Claudia Reeves**, **Hanna Reinke**, **Nora Wells**, and **Erica N. White**.

Disclaimer. Please note that information provided in this guide does not constitute legal advice in any jurisdiction. Please consult with legal counsel in your respective jurisdiction for specific legal guidance.

Scope & Primary Purposes. With core funding from the Assistant Secretary for Preparedness and Response (ASPR), the Region 1 Disaster Health Response (RDHRS) project commenced in 2018 with an aggressive mission: *create a regional disaster health community across 6 New England states (CT, NH, ME, MA, RI, VT) designed to coordinate resources and responses in emergencies.*

Through initial pilot activities, RDHRS project leaders determined a series of potential roles of a regional disaster medical program including:

- Recruit, train, and organize disaster subject matter experts (SMEs) to participate in state and RDHRS planning efforts;
- Leverage existing SME networks to improve disaster medical trainings and exercises;
- Maintain a system that can mobilize healthcare disaster SMEs to participate in regional disaster response;
- Develop, test, and improve a system of disaster healthcare response functions that works in partnership with federal, state, and other authorities;
- Establish hospital-hosted disaster medical teams to support rapid deployment across the region;
- Partner with other regional disaster medical centers to create a national network; and
- Standardize interactions with specialty organizations and evaluate disaster readiness and assurance of capabilities.

Recognizing these collective goals and objectives implicate extensive law and policy issues, the RDHRS sought assistance from legal SME related to several components of the continued development and expansion of the project, including to:

- Identify and reconcile differences among the N.E. states related to emergency declarations, waivers, liability protections, and crisis standards of care (CSC);
- Develop guidelines, model policies, and best practices to assist RDHRS activities align with state and local laws, regulations, and policies during emergencies;
- Generate specific model policy, regulatory, or other actions, including potential legislative proposals, that may be implemented to support planned RDHRS activities and healthcare system needs during emergencies;
- Provide legal information to RDHRS team members regarding its required development of a process for joint clinical policy development, including CSC;

- Identify mechanisms to engage in multi-state regional planning, sharing protocols and best practices for coordinated patient care in emergencies as well as potential conflicts and possible resolutions related to coordination of healthcare assets (e.g. patient movement, patient tracking, expertise and resource sharing, and policy support);
- Provide guidance on how to legally implement mechanisms to use appropriately licensed health professionals from states within and outside of the region in emergencies;
- Support RDHRS development of guidelines and best practices for the development of statewide and regional clinical virtual support (telemedicine and other systems); and
- Determine legal processes for establishing agreements among healthcare and EMS entities across region states to facilitate secondary distribution of patients and resources to balance healthcare demand.

Following a series of discussions and planning with region and specific state leaders, the development of a **blueprint** outline for a detailed project report addressing these and other issues was developed and refined prior to February 1, 2020. The rise of the COVID-19 pandemic over the ensuing months led to significant observations and changes to the prospective report and its timeline. Substantial learning stemming from the pandemic is incorporated into this report.

However, the core objectives, summarized below in the **Introduction** and detailed in the guide, remain largely the same: *produce a strategic assessment guide of legal or policy issues affecting the development of a regional health disaster program.* While many of the findings in this guide extend from core observations among Region 1 states (see below the illustration of aggregate legal findings based on **Appendix: Table 5**), key lessons and strategies may equally apply to other regions nationally.

Aggregate Table – RDHRS States’ Emergency Laws



Topic	CT	ME	MA	NH	RI	VT
I. Emergency/Disaster Declarations	✓	✓	✓	✓	✓	✓
II. Public Health Emergency Declarations	✓	✓	✓		✓	
III. Routine Licensure Reciprocity	✓	✓	✓	✓	✓	✓
IV. Emergency Licensure Reciprocity	✓	✓		✓	✓	✓
V. General Waiver Authority	✓	✓	✓	✓	✓	✓
VI. Specific Waiver Authority	✓	✓	✓	✓		✓
VII. General Liability Protections	✓	✓	✓	✓	✓	✓
VIII. Explicit Liability Protections		✓	✓	✓		✓

Organization. The guide is divided into 5 major parts as follows:

I. EMERGENCY DECLARATIONS, examines the changing legal landscape extending from federal, state, and local declarations of emergencies, disasters, and public health emergencies, notably including analyses extending from legal research across the region states.

II. EMERGENCY MANAGEMENT ASSISTANCE COMPACT, illustrates the scope, purposes, and utility of interjurisdictional agreements, specifically versions of EMAC executed among all 6 region states and internationally with Canadian provinces, to facilitate resource allocation and legal protections in regional emergencies.

III. LICENSING, CREDENTIALING & PRIVILEGING, explores how varied licensure, credentialing and privileging requirements, and reciprocity provisions implicate HCW responses across borders, including via telehealth initiatives.

IV. TELEHEALTH & TELEMEDICINE APPLICATIONS, distinguishes telehealth and telemedicine and how these practices have been legally implemented during COVID-19 (and beyond), as well as technical aspects of reimbursement and fraud and abuse protections for these services.

V. CIVIL LIABILITY, IMMUNITY & INDEMNIFICATION, assesses the liability risks for HCWs, entities, and VHPs during emergencies, including workers' compensation benefits, and corresponding liability protections for acts of ordinary negligence through multiple legal sources.

VI. OTHER LEGAL ISSUES, examines several key legal issues related to (1) allocating scarce resources during CSC; (2) use of EUAs to authorize otherwise non-approved tests, medications, and treatments; (3) rights to reemployment; and (4) health information privacy concerns underlying extensive data sharing practices in emergencies.

ABBREVIATIONS

Please see below specific acronyms used in one or more places throughout the guide:

Acronym	Term	Acronym	Term
ADA	Americans with Disabilities Act	MSEHPA	Model State Emergency Health Powers Act
ASPR	Assistant Secretary for Preparedness & Response	NAM	National Academy of Medicine
CDC	Centers for Disease Control & Prevention	NEMA	National Emergency Management Association
CMS	Centers for Medicare & Medicaid Services	NLC	Nurse Licensure Compact
CSC	Crisis Standards of Care	OCR	Office of Civil Rights
DEA	Drug Enforcement Agency	PAHPA	Pandemic & All-Hazards Preparedness Act
DMAT	Disaster Medical Assistance Team	PAHPRA	Pandemic & All-Hazards Preparedness Reauthorization Act
ED	Emergency Department	PHA	Public Health Authority
EMAC	Emergency Management Assistance Compact	PHE	Public Health Emergency
EMS	Emergency Medical Services	PHI	Protected Health Information
EMT	Emergency Medical Technician	PPE	Personal Protective Equipment
EMTALA	Emergency Medical Treatment & Active Labor Act	PREP Act	Public Readiness & Emergency Preparedness Act
ESAR-VHP	Emergency System for the Advance Registration of VHPs	REQ-A	Request for Assistance Form (EMAC)
EUA	Emergency Use Authorization	RDHRS	Regional Disaster Health Response
FDA	Food & Drug Administration	S-CHIP	State Children's Health Insurance Program
FEMA	Federal Emergency Management Agency	SME	Subject Matter Expert
GSA	Good Samaritan Act	SNS	Strategic National Stockpile
HCW	Health Care Worker	UEVHPA	Uniform Emergency Volunteer Health Practitioners Act
HHS	Department of Health & Human Services	USERRA	Uniformed Services Employment & Reemployment Rights Act
HIPAA	Health Insurance Portability & Accountability Act	VHP	Volunteer Health Professional
HIV	Human immunodeficiency virus	VSA	Volunteer Service Agreement
IEMAC	International Emergency Management Assistance Compact	SNS	Strategic National Stockpile
MAA	Mutual Aid Agreement	UEVHPA	Uniform Emergency Volunteer Health Practitioners Act
MOU	Memoranda of Understanding	USERRA	Uniformed Services Employment & Reemployment Rights Act
MRC	Medical Reserve Corps	VHP	Volunteer Health Professional
		VSA	Volunteer Service Agreement

INTRODUCTION

With core funding from ASPR, the Region 1 RDHRS project charted an aggressive objective in mid-2018: ***create a regional disaster health community designed to coordinate emergency resources and responses***. Following initial pilot activities, project leaders conceived that an effective regional program should be able to leverage existing and new SME networks and personnel to improve disaster medical preparedness, but also respond in real-time with governmental authorities and other regional systems.

Months later, these lofty goals were tested exponentially by the most significant public health threat in modern times, notably the COVID-19 pandemic. Facing tens of thousands of confirmed cases and thousands of deaths in the region, especially in its largest city, Boston, RDHRS leaders experienced potential and actual law and policy barriers to their laudable mission, as well as multiple states' solutions to many of these barriers.

As each of the Region 1 states systematically declared formal states of emergency (along with every other U.S. state), legal and policy roles emerged. To achieve the project objectives, law and policy must be assessed and wielded in real-time to generate solutions to barriers within a legal environment in constant flux as epidemiologic information about the pandemic materializes.

This report addresses these challenges in the backdrop of the COVID-19 pandemic to produce a “playbook” of viable lessons and options guiding system development now and for the future. At the core of these lessons are significant changes in the legal landscape underlying response efforts extending from multi-level emergency declarations. Although unpredictable in their scope, timing, and duration, emergency declarations facilitate an array of real-time legal solutions otherwise unavailable in routine events. Invocation of agreements like EMAC and IEMAC in response to COVID-19 and prior emergencies opens new pathways to interjurisdictional exchanges and protections.

Among the more profound needs of an operational regional disaster health system is the capacity to exchange HCWs quickly and easily across borders physically or virtually. Immediate legal impediments related to licensing, credentialing, and privileging requirements are resolved through routine and emergency exceptions facilitating cross-sharing, especially via telehealth initiatives.

Real-time health care responses invariably evoke fears of liability for HCWs, volunteers, entities, and others involved in delivering services when standards of care are shifting as resources become scarce. Risks of liability are real, but so are an extensive array of liability protections from acts of ordinary negligence for HCWs, VHPs, and entities in emergencies. Enhanced workers' compensation benefits and job protections may be extended for persons responding through organized channels of their own volition (and often at great risk). Additional concerns underlying emergency responses, such as temporary waivers of existing standards, rights to reemployment, and health information privacy concerns over data sharing also arise.

As per the **Checklist of Legal Issues Supporting Regional Coordination**, the issues are extensive but solvable through real-time interpretations among multiple legal options. While many of these findings extend from core observations within Region 1, lessons and strategies may equally apply to other regions nationally, lending to a cohesive strategy for maximizing regional alliances in the 21st century.

CHECKLIST OF LEGAL ISSUES UNDERLYING REGIONAL COORDINATION

The table below presents a numbered series of key questions derived from issues and analyses discussed in the accompanying guide for each jurisdiction to assess and resolve (as needed) in facilitating regional efforts to coordinate public health and health care services in emergencies:

Subject	#	Question
Emergency Declarations	1	Have state/local governments adopted a statutory or regulatory definition of an “emergency,” “disaster,” or other similar terms?
	2	Do state/local governments’ general emergency or disaster provisions also cover emergencies affecting the public’s health?
	3	Have state/local governments adopted a statutory or regulatory definition of a PHE or other similar terms (e.g., public health crisis or catastrophe)?
	4	Do state/local laws set procedures to follow in declaring a general emergency, disaster, or PHE?
	5	Do the procedures to declare require specificity as to the type, nature, location, or duration of the emergency?
	6	If a PHE is declared, are specific emergency powers assigned to state/local PHAs & other relevant entities to facilitate emergency response efforts?
	7	Do state/local laws require or provide for planning & coordination of emergency response efforts among various state/local agencies?
	8	Is there statutory or regulatory express authority on terminating emergency declarations or automatic termination under certain conditions?
	9	Do state emergency laws authorize general or explicit waiver of statutory or regulatory provisions to facilitate response efforts?
EMAC	10	Has the state invoked EMAC for purposes of seeking essential services or supplies during a declared emergency?
	11	Has the state authorized the exchange of state/local agents with other jurisdictions for the purpose of emergency response efforts?
	12	Is state government able to deputize private HCWs or VHPs to garner state based EMAC protections prior to their transfer out-of-state?
	13	Does the state anticipate reimbursement for specific allocation of essential supplies or personnel pursuant to EMAC?
Licensing & Privileging	14	What types of HCWs are required to have state licensure or certification to practice medicine, nursing, or other professions in the state?
	15	Does state law provide for civil or criminal penalties for HCWs or VHPs practicing without a license?
	16	Has the state adopted provisions for reciprocity of state licensure or certification requirements for HCWs who are licensed in another state?
	17	Has the state entered reciprocity agreements/compacts that recognize out-of-state licenses or certifications for HCWs (e.g., NLC)?
	18	Does state law require hospitals to establish medical staff bylaws including provisions for credentialing/privileging in declared emergencies?
	19	Have hospitals or other accredited health entities adopted disaster privileging policies in compliance with Joint Commission requirements?
	20	Does state law require hospitals to have an emergency management plan governing hospital responses to a declared emergency?
	21	Do state emergency laws or medical boards authorize shifts in scope of practice during declared emergencies?
Telehealth & Telemedicine	22	Are expedited telehealth practices explicitly authorized via declared emergencies in the state?

Subject	#	Question
	23	Are there any parity laws or federal waivers in place that may affect financial reimbursement and coverage?
	24	Has the state suspended HIPAA Privacy Rule requirements for HCPs conducting rapid, good-faith administration of telehealth treatments?
	25	Has the state adopted or proposed new provisions impacting telehealth practice, including mental health treatment or interstate compacts?
Liability & Immunity	26	Are civil liability protections framed within state/local emergency, disaster, or PHE authorities or other relevant laws?
	27	Does the state tort claims act provide civil liability protection for “discretionary acts” by state/local actors in declared emergencies?
	28	Does state law or compacts explicitly provide HCWs or VHPs with immunity from civil liability (e.g., VPAs, GSAs) when responding to an emergency?
	29	Are there exceptions to civil liability protections for acts that involve gross negligence, recklessness, or willful or wanton misconduct?
	30	Do health care entities face potential civil liability for their acts, or those of their employees, agents, or volunteers, in response to emergencies?
	31	Does state law immunize health care entities for their own negligent acts or those of its employees, agents, or volunteers?
	32	Are VHPs required to register with the state/local governments to qualify for workers’ compensation for injuries sustained in performance of their duties?
	33	Are existing employers of VHPs required to provide workers’ compensation coverage for injuries sustained in performance of their duties as volunteers?
	34	Do workers’ compensation laws cover occupational diseases contracted during the performance of employed or volunteer activities?
Other Legal Issues	35	Have state/local governments crafted pre-existing CSC plans to facilitate emergency response efforts?
	36	Are state/local governments prepared to implement CSC decisions in real-time through advanced training or preparedness activities?
	37	Do state/local CSC plans, where available, defer to front-line responders’ specific decisions & appeals regarding allocation of scarce resources?
	38	Do CSC plans or implementation protocols require reporting of real-time information re: patient outcomes or available supplies like PPE?
	39	Are state/local governments prepared to use or implement new or emerging products or services authorized by FDA via EUAs?
	40	Does FDA’s issuance of specific EUAs preempt state/local statutes, regulations, or policies that conflict with implementation (e.g., licensing or scope of practice limitations)?
	41	Do state/local laws support rights to reemployment of HCWs or VHPs temporarily assigned to emergency response efforts outside their normal employment settings?
	42	Do state/local laws include paid sick & safe time protections for HCWs & VHPs temporarily disabled by infection or other injuries in emergencies?
	43	Are state/local health information privacy laws sufficiently flexible to allow exchanges of PHI to protect public health & maximize patient care?
	44	Do state/local emergency laws explicitly allow waivers of health information privacy laws that may limit the flow of essential public health data?
	45	Are state/local legal protections of PHI in a declared emergency sufficient to assure patient privacy notwithstanding compelling state needs?
	46	Do state/local privacy laws or corporate proprietary protections limit PHAs access to critical syndromic or other data to efficiently allocate scarce resources?

I. EMERGENCY DECLARATIONS

During pandemics like COVID-19 or other major events impacting the public's health, the legal environment is transformed in real-time through declared states of emergency, disaster, or PHE.¹ These declarations at federal, state, or local levels trigger an array of powers to facilitate public and private sector response efforts by: (1) offering flexible options to expedite responses; (2) waiving legislative or regulatory provisions impeding effective responses; (3) transitioning shifts from conventional standards of care to CSC;² (4) allowing out-of-state HCW's to practice in-state via licensure reciprocity; (5) expanding professional scopes of practice for HCWs;³ and (6) instituting special liability protections from ordinary negligence for providers and entities.⁴

Each of these authorities depends in part on the level and type of emergency declared.⁵ As summarized below, the federal government, every state, many territories, and local governments may declare either general states of "emergency" or "disaster" in response to public health crises. HHS, many states, and some local governments may also declare states of PHE. Each of these declarations can change the legal landscape instantly and significantly to facilitate regional response efforts, including through supplemental emergency executive orders used extensively by governors in response to COVID-19. Massachusetts Governor Charlie Baker, for example, explicitly authorized expedited uses of federal and interstate resources via executive order during the pandemic.⁶ This allowance was terminated with the rescission of Massachusetts' state of emergency on June 15, 2021.⁷

Federal Declarations. An array of emergency declarations is available to federal authorities to respond to public health events/crises. The President can declare a state of emergency or disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act ("Stafford Act")⁸ upon request of any state governor when federal assistance is needed "to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe."⁹ The President can also declare a state of emergency pursuant to the National Emergencies Act¹⁰ for incidents requiring a national response.¹¹ On March 13, 2020, President Trump simultaneously declared emergencies under these acts in response to COVID-19.¹² Together these declarations authorized emergency management agencies to coordinate emergency responses, mobilize funding, and activate specific programs. Both declarations were extended under the Biden administration.¹³

Pursuant to the Public Health Service Act,¹⁴ HHS may also declare a state of "public health emergency"¹⁵ to enable the distribution of key resources (see text box below), waive specified federal requirements related to Medicare or Medicaid reimbursement, temporarily set aside certain provisions of federal laws (e.g., HIPAA Privacy Rule), and conduct other emergency

Strategic National Stockpile

HHS' SNS is a national reserve of vaccines, drugs, and medical supplies allocated to supplement and resupply state and local resources when emergency response efforts exhaust resources. SNS medicines are distributed free to the public. As needs for certain supplies arise, HHS may increase SNS stocks. During the 2014 Ebola outbreak CDC ordered \$2.7 million of PPE for SNS supplies, with each kit capable of meeting the care needs of an Ebola patient for 5 days. During the COVID-19 pandemic, SNS PPE supplies were quickly drained and repeatedly re-stocked. State requests issued to HHS trigger SNS asset deployment. Once the state receives the deployment, the authority to distribute and dispense SNS assets transfers to state officials to assure efficient SNS management.

response activities. On January 31, 2020, HHS Secretary Alex Azar rapidly declared a PHE at the inception of the COVID-19 outbreak in the U.S., which took effect retroactively on January 27. This was most recently renewed on April 15, 2021.

Some of HHS' PHE powers are only authorized when coupled with a declaration of a national emergency. In response to the 2009/2010 H1N1 pandemic, for example, HHS immediately declared a state of PHE on April 26, 2009, just days after initial domestic cases were confirmed. Months later, on October 23, 2009, President Obama declared a national state of emergency. Coupled with HHS' PHE declaration, the President's subsequent declaration allowed for broader waivers of federal regulatory requirements (e.g., specific provisions of S-CHIP and EMTALA (see text box below)).¹⁶ In 2013, Congress passed the Pandemic and All-Hazards Preparedness Reauthorization Act¹⁷ (PAHPRA) to expand HHS' PHE powers, in part, without the need for an additional national emergency declaration. These more extensive powers assisted HHS Secretary Azar in responding through broader powers during COVID-19 for the 1.5 months prior to President Trump's national emergency declarations on March 13, 2020.

Emergency Medical Treatment and Active Labor Act (EMTALA)

EMTALA normally requires Medicare-participating hospitals with emergency departments (EDs) to receive, screen, and stabilize (or transfer, where warranted) any patient who comes to the hospital in an emergency condition and requests treatment. In some circumstances, transfer to specially equipped, designated facilities may be necessary, such as in response to Ebola in 2014. EMTALA may also apply to urgent care clinics, labor and delivery departments, and some psychiatric departments. In federally declared emergencies, such as in response to COVID-19, HHS and CMS may waive some EMTALA provisions, allowing for non-traditional reception, screening, and treatment of emergency patients.

State & Local Declarations. All states and territories (and some localities) are legally authorized to declare states of emergency or disaster in response to multifarious events, including crises that impact the public's health (e.g., pandemics, bioterrorism events). As of 2011, 33 states and D.C. also authorize declarations of PHE, or like terms.¹⁸ Many of these states' approaches are based on the Model State Emergency Health Powers Act (MSEHPA) originally developed by the *Center for Law and the Public's Health* in response to the anthrax exposures in late 2001.¹⁹

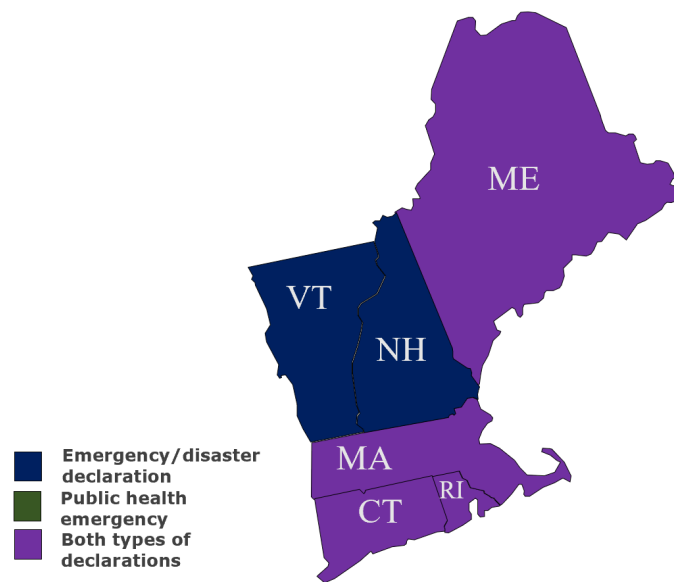
PHE declarations typically empower state public health officials (in collaboration with emergency management agencies) to focus on the public health aspects of emergencies. Though designed originally for application in bioterrorism events or widespread emerging infectious diseases like West Nile virus, H1N1, or COVID-19, states and localities have increasingly declared PHEs for other purposes, including:

- Contamination of public water supplies;
- Localized measles outbreaks;
- Release and threatened release of amphibole asbestos;
- Shortage of affordable, safe medical cannabis;
- Abuse of prescription medication and illegal drugs; and
- Food insecurity.

Some larger cities and counties may also be empowered to declare states of emergency depending on their degree of "home rule." Home rule refers to the discretionary power allotted by

states to local governments to address largely local matters. A 2010 study²⁰ reviewing emergency legal authorities of 20 select local jurisdictions of various population sizes across the U.S. found that 19 (95%) of the localities authorized local officials to declare either an emergency or disaster. This included cities in region states like Burlington, VT, and Augusta, ME, both of which were authorized to declare local states of emergency. In Boston, Massachusetts, the Boston Public Health Commission can declare a PHE, which it did on March 15, 2020, in response to COVID-19.²¹ **Figure 1**, below, provides a brief illustration of emergency/disaster and PHE statutory authorizations among region states, which are described further in Table 1 in the Appendices.

Figure 1. Region States Defining Emergency, Disaster, or PHE



Timing. While all states are authorized to declare states of emergency in some form, predicting their declaration, scope, timing, and duration can be precarious. While all states initiated their pandemic flu response plans in response to the spread of H1N1 in 2009/2010, for example, only 12 states formally declared states of emergency, disaster, or PHE over the first 6 months of the pandemic. In response to the Ebola threat in the Fall 2014, only Connecticut declared a PHE.²² In the unprecedented response to COVID-19, all 50 states and most territories declared varied states of emergency but not all on the same date. Some states' declarations came before the determination of any known cases; other states only declared after the rise of COVID-19 cases in their jurisdictions became manifest. Among the region states, Rhode Island declared COVID-19 an emergency on March 9, 2020; Connecticut and Massachusetts on March 10; Maine on March 12; and New Hampshire and Vermont on March 13.²³

Gradual declarations of state or local emergencies over time complicate advance planning concerning regional roles and responsibilities. Potential legal changes invoked by the declarations are specious or unpredictable. During the COVID-19 pandemic multiple state legislatures (e.g., CO, IL, KY, MI, OH) challenged gubernatorial emergency powers through legislative or judicial intervention. On May 13, 2020, the Wisconsin Supreme Court nullified an emergency "stay home" order issued by the Wisconsin Secretary of Health in a case brought by the state legislature.²⁴ Multiple state legislatures curbed their governors' emergency declaration powers as public health

impacts of COVID-19 lessened. By July 1, 2021, only about a half of states remained in a formally declared emergency or disaster.

As a result, legal response efforts to similar infectious disease or other threats may have to be crafted differently in jurisdictions that (1) do not formally declare states of emergency compared to those that do; or (2) face legislative or judicial challenges to such declarations. This can complicate uniform response efforts across states within a specific region, but may also be addressed in part via effective, advance agreements, MOUs, contracts, or existing public health laws.

Dual Declarations. Other issues arise when state or local governments declare states of emergency coupled with a PHE. Issuance of two or more declarations in a single jurisdiction is possible because each type of declaration shares similar statutory definitions and constructs.²⁵ In Delaware, for example, an influenza pandemic could simultaneously trigger statutory declarations of emergency, disaster, and PHE.²⁶ In response to COVID-19, governors in Florida and Maryland, among other jurisdictions, both issued emergency and public health emergency declarations. Overlapping declarations within and across jurisdictions can obfuscate response efforts when divergent actors are mobilized or authorized to act under different declarations pursuant to distinct powers and chains of command as experienced during Hurricane Katrina in 2005.

Interjurisdictional Coordination. Lessons learned from the 2014 Ebola outbreak and 2009/2010 H1N1 and 2020 COVID-19 pandemics include the need for strong, interjurisdictional coordination among varied actors to craft and effectuate organized responses to emergencies. Multiple logistical and other obstacles challenge the seamless sharing of personnel, supplies, information, and other resources across boundaries and between public and private sectors. Wise utilization of numerous legal tools can support effective sharing, collaboration, and coordination among and between responders before, during, and after declared emergencies. Some agreements may embrace a legal contractual approach, obligating parties to adhere to specific terms. Others, such as MOUs or compacts (see **Part II**), may avoid binding parties by enabling flexibility for participants needing to adapt to unforeseen circumstances.

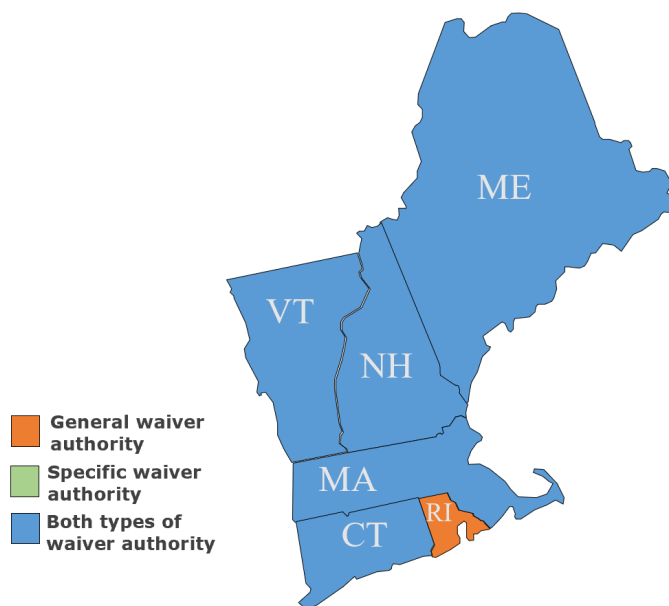
VHP Programs. Congress passed the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (PL 107-188) to facilitate the effective use of VHPs during PHEs. The Act led to HHS' establishment of the ESAR-VHP program in April 2004, which was subsequently reassigned to ASPR with the passage of the Pandemic and All-Hazards Preparedness Act (PAHPA) in December 2006.²⁷ State-based ESAR-VHP programs follow federal guidelines, standards, and definitions and receive supplemental funding and technical assistance, to support their development. ESAR-VHP systems may be linked with MRC or other comparable systems to organize and allocate VHPs in emergencies.

In August 2007, the Uniform Law Commission finalized the UEVHPA²⁸ to facilitate the deployment and use of VHPs in declared emergencies. "VHPs" include compensated and uncompensated individuals acting of their own volition during declared emergencies. As discussed in various sections below, the Act provides reasonable safeguards to assure that VHPs are appropriately licensed and regulated. It also authorizes state governments to regulate, direct, and restrict the scope and extent of services provided by VHPs to promote disaster recovery operations. Public and private sector VHPs are also entitled to workers' compensation benefits and affirmative civil liability protections. Numerous jurisdictions have introduced or enacted UEVHPA, or portions thereof.²⁹

Practicing Legal Triage. Predicting the timing, duration, and variance of emergency declarations is difficult. Yet, emergency laws might also fail to ensure best practices due in part to their lack of specificity and potential limitations stemming from constitutional requirements or contractual limitations. Framed in broad language, shaped by political realities, and subject to frontline fluctuations, emergency laws offer more so a menu of legal powers and options rather than definitive guidance.

For example, emergency declarations may allow for waivers of state-based laws or policies that otherwise hinder emergency response.³⁰ **Figure 2**, below, denotes RDHRS states with specific waiver authorities pursuant to emergency declarations. Effective utilization of waiver allowances entails legal triage decisions. Advance planning and artful, well-communicated interpretations in real-time can alleviate specific legal impediments that may hinder regional responses and coordination. Vermont's governor has the authority to temporarily suspend or modify state laws or rules if it is essential to provide temporary housing for disaster victims.³¹ In Massachusetts, a law was enacted to waive the one-week waiting period for unemployment benefits for persons out of work because of COVID-19.³²

Figure 2. Region States Waiver Authorities

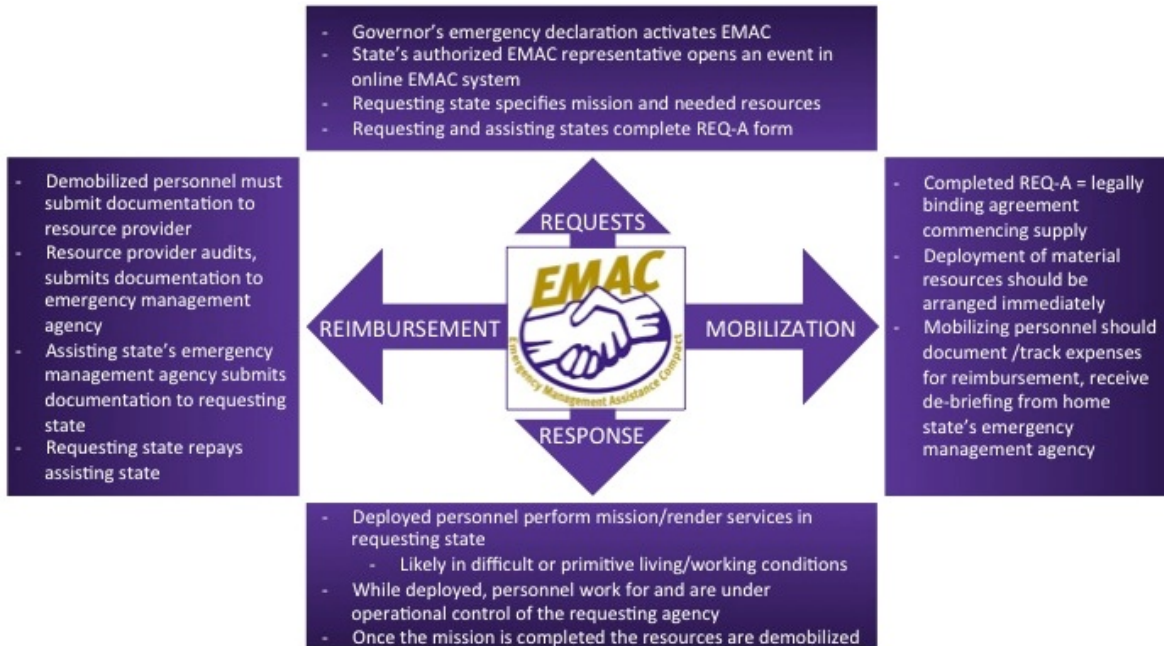


Without affirmative direction, regional responders may act unknowingly outside of legal boundaries. Alternatively, they may fail to act at all because of erroneous legal advice, liability fears, or other actual or perceived legal consequences. Neither of these outcomes is acceptable. As a result, emergency planners, public health practitioners, HCWs, and their legal counsel must be prepared to triage legal issues and solutions in emergencies to effectuate legitimate public health responses. They must make critical legal decisions that balance communal and individual interests in emergencies where facts may be unclear, resources are scarce, and communal well-being is imperiled.³³

II. EMERGENCY MANAGEMENT ASSISTANCE COMPACT

The Emergency Management Assistance Compact (EMAC) is an interstate mutual aid agreement (MAA) between all states (as well as D.C. and several territories) administered by NEMA. When activated (see **Figure 3**, below) EMAC allows for mutual assistance between states in response to any declared emergency or disaster. As resources become scarce, personnel or resources can be deployed quickly across state lines to facilitate efficient and effective responses.

Figure 3. EMAC Organization³⁴



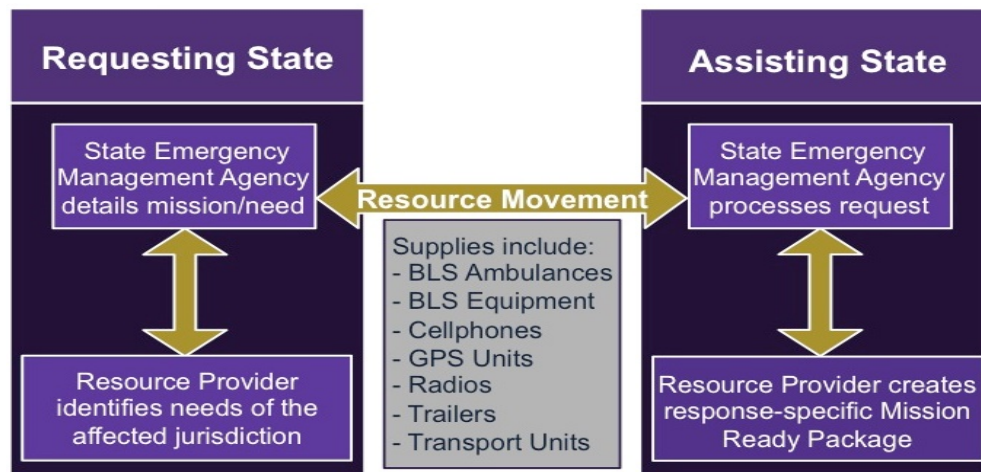
In multiple emergency scenarios, EMAC entails participation of individuals from numerous health and non-health related professions. Jurisdictions assist each other by providing requested goods (e.g., generators, temporary shelters, equipment) or services (e.g., security, medical personnel). Within 36 hours of Hurricane Katrina's landfall in September 2005, for example, over 6,000 health care personnel were deployed to the affected regions through EMAC.³⁵

Out-of-state HCWs cannot normally legally practice in a state in which they are not licensed (see **Part. III**). To facilitate interstate sharing of HCWs, EMAC authorizes a requesting state to recognize out-of-state medical or other licenses for purposes of rendering aid in declared emergencies or disasters, subject to limitations imposed by the requesting state's governing body. Persons holding an out-of-state license, certificate, or permit are "deemed licensed, certified, or permitted by the state requesting assistance" when deployed through EMAC.³⁶ These personnel must adhere to the requesting state's scope of practice requirements and other requirements. Furthermore, individuals providing aid through EMAC are considered agents of the requesting state and are not liable for any acts or omissions conducted in good faith.³⁷ States participating in EMAC exchanges of personnel to other states must also provide workers' compensation benefits for persons they deploy.³⁸ If these persons are injured or killed while active in response efforts, the sending state will compensate personnel or their families through such protections.

In most jurisdictions, only public sector professionals can be deployed through EMAC. In response to Hurricane Katrina, however, some states deputized private sector individuals as state agents or issued executive orders to allow private sector volunteers to be deployed through EMAC. Some persons may enter into volunteer services agreements (VSAs) or MOUs with their state emergency management agency prior to deployment. In Ohio, for example, state officials executed MOUs with county governments that authorize the use of local personnel for EMAC response efforts. In Connecticut, designating volunteers as “agents of the state” enabled the deployment of volunteers to New York to assist in the EMAC response for Hurricane Sandy in 2012.³⁹

EMAC also provides a key pathway for states’ mutual assistance during declared emergencies by facilitating the exchange of supplies (e.g., PPE, GPS units), equipment (e.g., ambulances, trailers), or even entire facilities (e.g., mobile field hospitals or units) provided to requesting states (see **Figure 4**, below).⁴⁰ EMAC contracts also list the resources the requesting state must supply, including fuel, area maps, medical supplies, and lodging and meals for assisting personnel.

Figure 4: Role of EMAC & Allocations



Any state aiding another must be reimbursed by the receiving state for any cost incurred in connection with providing the assistance or for expenses due to loss or damage incurred in the operation of equipment.⁴¹ The REQ-A⁴² details expenses that are eligible for reimbursement.⁴³ States may also donate resources and services to the requesting state. Referred to often as “zero-dollar missions” states may provide resources at no charge to the emergency-impacted state. REQ-As between states must reflect a \$0 cost estimate to show the state is donating the resource or service.⁴⁴

Applications During COVID-19. COVID-19 presented unique EMAC applications. Unlike emergencies like Hurricane Katrina that were localized to a single state or region, all states experienced significant impacts from COVID-19. Health care systems nationally have strained to meet surging numbers of patients, including large hospitals (e.g., Mass General in Boston), and smaller rural hospitals (e.g., Berkshire Medical Center in Pittsfield, MA). Still, the spread of COVID-19 did not hit all parts of the U.S. equally, allowing resources to be directed or re-directed to regions with high COVID-19 cases and hospitalizations. As different parts of the country

reached epidemic peaks, EMAC facilitated the relocation of HCWs, PPE, ventilators, and medical supplies, among other essentials.

On March 27, 2020, FEMA Administrator Pete Gaynor commented to state and local emergency managers how some areas, like New York, Massachusetts, and Louisiana were in the center of the COVID-19 battle, while other jurisdictions still had relatively few cases. As of May 4, 2020, for example, among the 6 RDHRS states, only Massachusetts (69,087), Connecticut (29,973), and to a lesser degree Rhode Island (9,652), were experiencing relatively higher rates of known infections. Other region states, specifically Maine (1,205), New Hampshire (2,518), and Vermont (902) had relatively lower rates of known infections. Actual numbers of non-confirmed infections were much higher based on prevalent epidemiologic estimates. Suggesting a “collective responsibility” to blunt the spread of COVID-19 anywhere in the U.S., Gaynor requested jurisdictions with excess capacity consider using EMAC to offer resources to struggling areas.⁴⁵ On April 9, California Governor Newsom loaned 500 ventilators to 6 states (e.g., DE, IL, MD, NV, NJ, and NY), as well as D.C., via their EMAC requests.⁴⁶ Considerable, additional EMAC requests are anticipated across states as the pandemic continues to impact populations in its initial and subsequent waves.

International EMAC. IEMAC is a compact signed in 2000 between several region states (CT, MA, ME, NH, RI, VT) and multiple Canadian provinces and territories (New Brunswick, Newfoundland and Labrador, Nova Scotia, Prince Edward Island, and Quebec).⁴⁷ In 2007, Congress passed Joint Resolution 13, granting Congressional consent to IEMAC.⁴⁸ This compact enables its members to participate in cross-border emergency management assistance through mutual aid pursuant to advance plans and procedures. IEMAC can be used to share resources and personnel during emergencies and facilitate joint preparedness through planning and exercises. In April 2018, for example, New Brunswick issued an IEMAC request to help meet resource requirements during the historic flooding of the St. Johns River system.⁴⁹

As with EMAC, when a jurisdiction issues an IEMAC request for personnel, responding HCWs’ licenses are recognized as valid by the requesting jurisdiction for the duration of the workers’ response efforts within the jurisdiction.⁵⁰ The responding jurisdiction, and persons rendering aid under the IEMAC request, become agents of the requesting state for purposes of tort liability and immunity. As with EMAC, IEMAC includes liability protections for any act done in good faith in rendering aid under the compact. Through these mechanisms and protections, IEMAC dispenses with legal hindrances that might impair the sharing of personnel across the U.S. and Canadian border during emergencies.

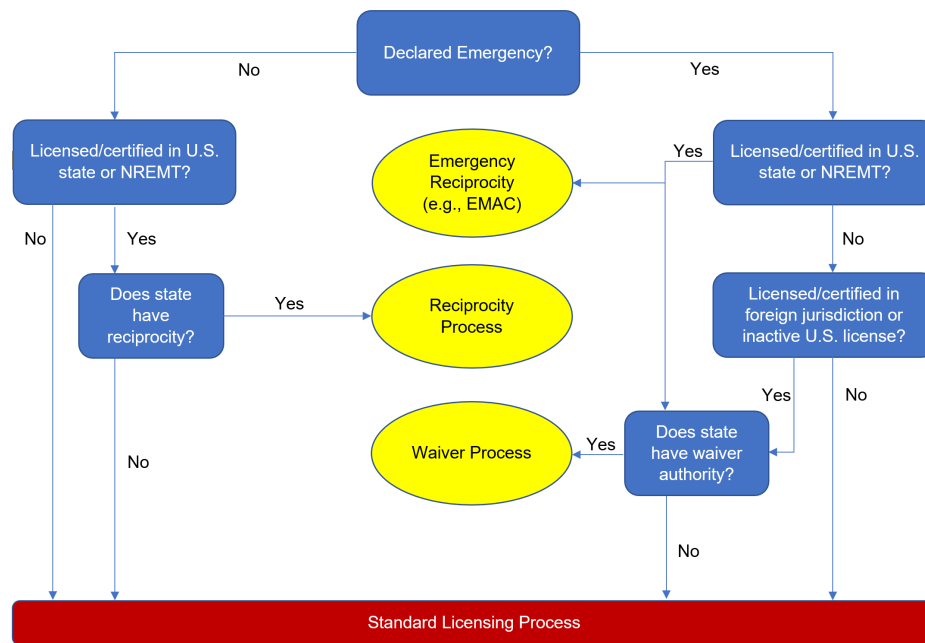
III. LICENSING, CREDENTIALING & PRIVILEGING

Professional licensure (or certification) of HCWs (e.g., physicians, nurses, EMTs, pharmacists, behavioral health professionals) is undergirded by specific state laws that vary across jurisdictions.⁵¹ State licensure requirements dictate the circumstances under which a health professional may practice her profession within the state, as well as the scope of practice for each profession. HCW licensing typically occurs through a state’s department of professional regulation or occasionally its department of health. Each profession typically has its own licensing board responsible for evaluating personnel, granting licenses, and conducting disciplinary hearings when necessary. Health professionals or others practicing without a license can be subject to criminal or civil penalties, depending on the jurisdiction.⁵²

Variations in state licensure or certification laws present practical and legal challenges within regional health systems. Inconsistencies can engender confusion about the appropriate scope of practice for licensed HCWs working actually or virtually across state lines. Potential legal constraints may arise when a HCW desires to practice or volunteer in a state where she is not licensed. Additional legal concerns may emerge if a worker’s license is restricted in one state and that practitioner engages in practice outside the scope of the restrictions in another state during emergencies.

Reciprocity. Despite potential legal barriers, several pathways to licensure in non-emergency and declared emergency environments may facilitate rapid deployment and use of HCWs from other jurisdictions. **Figure 5**, below, illustrates multiple routes authorizing HCWs to practice out-of-state. When an emergency has been declared, HCWs licensed or certified in a U.S. state may be able to obtain licensure reciprocity through existing processes (e.g., EMAC – see **Part II**) or via waivers of licensing requirements from the state requesting assistance. Absent an emergency declaration, licensed HCWs may be able to obtain licensure reciprocity through expedited or routine reciprocity processes.

Figure 5: Pathways to Licensure Reciprocity

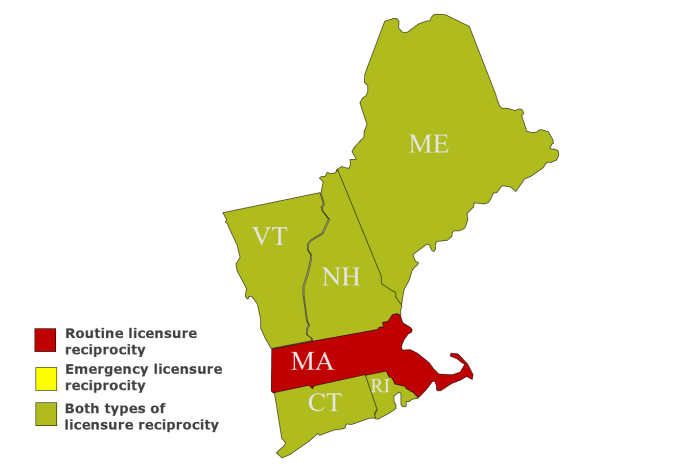


In non-emergencies, licensure reciprocity among HCWs is available in some states for those who are licensed in good standing in other states.⁵³ Examinations and other requirements are generally waived for reciprocity applicants, although application forms and fees may be required. Additional fees may also be charged by the applicant’s home state for certification of status. Most jurisdictions similarly offer “fast-track” licensure for military veterans and others with sufficient certification.⁵⁴ While this type of reciprocity significantly reduces the time required to obtain licensure, it is not instantaneous, and thus of limited utility during a rapid, catastrophic emergency when HCWs are needed immediately.

Other licensure reciprocity structures facilitate cross-border exchanges of HCWs. Thirty-five states have adopted the Nurse Licensure Compact (NLC), including Maine and New Hampshire.⁵⁵ The NLC allows nurses to practice in any of the compact states pursuant to expedited application processes. Similar agreements may be adopted to extend similar reciprocity to other licensed personnel. Eighteen states have enacted and been fully adopted into the PSYPACT Commission, including New Hampshire. Maine enacted PSYPACT legislation which will officially go into effect in September 2021, while Rhode Island and Vermont introduced PSYPACT legislation in 2021.⁵⁶ Under PSYPACT, licensed psychologists in compact states may apply for telepsychology and temporary in-person practice privileges across state lines.⁵⁷ Despite these legal routes, crafting licensure reciprocity may be tenuous given variations across states as to classifications, scope of practice, and other elements.

Emergency Laws. As discussed in **Part I**, declarations of emergency, disaster, or PHE may activate various compacts and agreements that can facilitate out-of-state licensure recognition for HCWs. Pursuant to EMAC (see **Part II**), persons licensed or certified in any other compact jurisdiction are automatically “deemed licensed” by the requesting state (subject to any limitations or conditions imposed by the state’s governor).⁵⁸ HCWs may thus provide services in response to the emergency to the same extent as if they were licensed in the affected jurisdiction so long as they are registered and deployed by their home jurisdiction as part of coordinated response efforts. Many states’ laws provide significant flexibility in recognizing out-of-state licensure during an emergency. The aforementioned MSEHPA (see **Part I**) provides for recognition of out-of-state licenses among HCWs during a declared PHE.⁵⁹ **Figure 6**, below, illustrates region states authorizing non-emergency and emergency licensure reciprocity.

Figure 6. Region States Licensure Reciprocity



All 6 region states authorize licensure reciprocity for HCWs during routine operations outside of formal emergency declarations (see **Appendix - Table 2**). For example, Connecticut law allows physicians and surgeons residing and employed in another state to practice in state without a Connecticut license for up to 30 consecutive days.⁶⁰ In Massachusetts, the state's examining board may grant licenses to out-of-state nurses without further examination.⁶¹

Other than Massachusetts, the 5 other region states also have specific statutory or regulatory authority for licensure reciprocity during declared emergencies. Emergency declarations can trigger expedited processes for licensure reciprocity than otherwise allowed under routine provisions. In Maine, the state is *required* to issue a temporary license to a physician who otherwise meets the necessary practice qualifications to serve during declared emergencies.⁶² In Rhode Island, a PHE declaration enables the health director to grant temporary licenses to out-of-state health care workers for up to 90 days.⁶³ On August 20, 2021, Massachusetts acting Department of Public Health Commissioner ordered the extension of some emergency healthcare licenses until December 31, 2021.⁶⁴

Several state health departments have ordered the granting of temporary licenses amid the COVID-19 declared emergency. For example, MA's Department of Public Health issued an Order granting the state's medical board to issue 90-day licenses. Connecticut's Department of Public Health's Order suspends licensure renewal requirements for six months after the Governor's state of emergency expires.⁶⁵ On March 23, 2020, Connecticut's Department of Health issued an order suspending requirements for licensure, certification, or registration for specific health practitioners for 60 days.⁶⁶ Rhode Island's Department of Health grants 90-day, out-of-state emergency licenses for physicians, EMTs, Dieticians, Nutritionists, PNSs, RNs APRNs, and nursing assistants/students.⁶⁷

Among the states adopting the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) (see **Part I**) (including Maine) VHPs can be granted temporary out-of-state license recognition for the duration of an emergency.⁶⁸ However, they must be listed within volunteer registrations systems, such as ESAR-VHP or MRC, and serve through coordinated efforts. "Spontaneous volunteers"⁶⁹ may not legally be entitled to licensure reciprocity. Public and private entities may be reluctant to fully utilize spontaneous volunteers who cannot be fully vetted in advance due to liability concerns, as discussed below. However, they may still carry out other roles, like coordination and communication activities, that do not require licensure.

Emergency Waivers. As noted in **Part I**, federal, state, and some local governments may suspend or waive legal provisions, including licensure laws, during a declared emergency. All 6 region states authorized some form of licensure reciprocity during the COVID-19 pandemic – either by allowing persons to apply for emergency licenses, or just by waiving in out-of-state licenses temporarily.⁷⁰ Waiver of licensure provisions is generally accomplished via a governor's executive order pursuant to formal declaration of emergency or disaster. Waivers may enable qualified HCWs from other states (or countries in some cases) and those with expired or inactive licenses, to assist response efforts depending on state law and the content of the waiver.

Pursuant to § 1135 of the Social Security Act, HHS' Secretary may waive or modify certain requirements for Medicare, Medicaid, S-CHIP, EMTALA, and the HIPAA Privacy Rule.⁷¹ Multiple § 1135 waivers were authorized in 2009/2010 for the H1N1 influenza pandemic, in 2012 for Hurricane Sandy⁷² and extensively in 2020 in response to COVID-19. Two conditions precipitate the Secretary's invocation of HHS' waiver authority:⁷³

- (1) the President must declare a major disaster via the Stafford Act or an emergency under the National Emergencies Act; and
- (2) HHS' Secretary must declare a PHE.⁷⁴

Once these conditions are met, the Secretary may modify: (a) certain conditions of participation or other certification requirements for health care providers; (b) requirements that health care providers hold a license in the state in which they provide health care services for purposes of reimbursement; and (c) limitations on payments for health care items and services provided to Medicare Advantage enrollees to allow use of out-of-network providers.⁷⁵ Health care facilities may receive specific waivers or modifications. Even if such facilities do not comply with Medicare, Medicaid, or other requirements while the waiver is in effect, facilities can continue to be reimbursed for covered services.⁷⁶ Implementation of these waivers or modifications is usually delegated to CMS.

Credentialing & Privileging. Credentialing and privileging play a vital role in the ability of health care organizations and public health agencies to assess the qualifications and shape the practice of licensed HCWs. Health professionals credentialed in their fields have additional opportunities to practice in health care organizations that require credentialed status. Likewise, many health care facilities require professionals to undergo clinical privileging prior to practicing in their facility. The level of privileges granted to a health professional within a specific facility affects that practitioner's scope of practice. State laws generally require hospitals and other health care organizations to formulate procedures governing credentialing and privileging for health professionals, frequently via a hospital's medical bylaws.⁷⁷

Credentialing processes involve "obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient care, treatment, and services in or for a health care organization."⁷⁸ Credentialing determinations utilize criteria such as a HCW's licensure, education, training, experience, and other qualifications.⁷⁹ Hospitals and other health organizations may engage in credentialing internally or accept credentialing determinations made by external organizations, such as credential verification organizations.

Privileging processes entail the integral role in the relationship between physicians (or other health professionals) and a health care organization. Privileging allows an organization to evaluate a professional's credentials and qualifications, and to grant permission to engage in a defined scope of practice at a specific organization (with or without supervision) based upon these qualifications.⁸⁰ Thus, a practitioner seeks clinical privileges to obtain necessary authorization to provide specific care, treatment, and services in an organization.

Privileging decisions are usually within the discretion of the organization and are made on a case-by-case basis with patient safety and quality of care as primary concerns.⁸¹ Determinations are based on the practitioner's applicable experience, education, licensure, training, experience, and judgment.⁸² Unlike licensure and credentialing, however, privileges only apply within well-defined parameters of scope of practice, and only within the specific institution granting them. Thus, a health care professional who has satisfied credentialing and privileging requirements for one health care organization may not necessarily be offered privileges elsewhere.

Several legal and policy provisions may alter credentialing and privileging requirements in declared emergencies to facilitate the rapid assessment and deployment of HCWs and VHPs across facilities and jurisdictions. The Joint Commission requires medical staff bylaws to feature emergency management plans that include a means by which hospitals identify health

professionals to provide care during emergencies. A hospital may grant disaster privileges to a health professional upon a showing by the individual of: (1) a hospital ID card; (2) a current license to practice and a valid picture ID issued by a governmental authority; (3) identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT); (4) identification indicating that the individual has been granted authority to care for and treat patients under disaster circumstances; or (5) a hospital staff member attests to the individual's identity.⁸³

The Joint Commission also requires hospitals to have policies regarding the granting of temporary clinical privileges when a new applicant is awaiting formal approval by the medical staff executive committee or "to fulfill an important patient care, treatment, and service need." Prior to granting temporary privileges, the hospital must verify the professional's licensure and competence.⁸⁴ State or regional volunteer health registries like ESAR-VHP or MRC can play a role in this process by advance reviews of credentials of VHPs to determine if they are qualified to provide the type of care requested of them. Health facilities may also utilize the information provided by ESAR-VHP to grant temporary or disaster privileges to VHPs.

Expanding Scope of Practice. HCW's legally defined "scope of practice" details the services they may provide with a specific license or certification. Variations in the scope of practice between states can impinge HCWs working or volunteering across state lines in times of medical surge. Specific guidance may also derive from waiver authority used to recognize out-of-state HCW licensure during a declared emergency, restricting workers' scope of practice as a condition of temporary license recognition. Some emergency laws explicitly address conflicting scope of practice provisions and determinations as to which set of standards controls. EMAC similarly provides for conditions and restrictions on scope of practice as determined by the state requesting assistance.⁸⁵

Scope of practice restrictions limit who may provide what services and where services may be delivered. For example, EMS personnel are generally authorized to assess and treat patients at the scene of an emergency, during patient transportation, or, in some jurisdictions, within a health care facility.⁸⁶ Non-traditional and expanded EMS functions in declared emergencies may not come under traditional conceptions of "emergency" care. While day-to-day patient assessment activities are fully authorized, some activities during declared emergencies may not readily fall into these categories, such as assisting in mass public vaccination campaigns and other prevention efforts.

Temporary waivers or suspensions of state or local laws can set aside scope of practice restrictions, enabling HCWs to act consistent with their education and training even beyond what they are legally authorized to engage in normally. During the 2009/2010 H1N1 pandemic, Maryland authorized paramedics and Cardiac Rescue Technicians to vaccinate public safety personnel, health care providers, and the public.⁸⁷ Other states have used similar authority to address significant public health crises, such as emergency waiver authorization to allow increased Narcan access for Massachusetts' first responders addressing rising rates of opioid overdose.⁸⁸ During the COVID-19 outbreak, waivers of routine requirements in Massachusetts facilitated (1) advanced practice nurses to perform broader services without physician supervision to help fill medical personnel shortages; (2) medical student emergency responses through the issuance of temporary, 90 day medical licenses.⁸⁹

IV. TELEHEALTH & TELEMEDICINE APPLICATIONS

Telehealth and telemedicine are highly efficacious tools to assist patients in routine settings and during PHEs. Though often used interchangeably, these terms have distinct meanings and scope. Telehealth broadly refers to the use of electronic and telecommunications technologies to provide health care and services at-a-distance. Telehealth encompasses clinical and non-clinical services.

Telemedicine (often considered a subset of telehealth) refers to the provision of clinical care by a physician, nurse, or other providers via remote services (video/audio) to a distant patient in real time.⁹⁰ In states effectuating routine or emergency licensure reciprocity, the provider and the patient need not be in the same jurisdiction. During PHEs like COVID-19, telemedicine increases the accessibility of HCPs to meet surge capacities, facilitating patient communication with HCWs and VHPs located in other jurisdictions.

Beyond telemedicine, additional models for telehealth include provider trainings, provider-to-provider communications, administrative meetings, continuing medical education, and public health and health administration. These models are conducted through a broad range of technologies. During infectious disease outbreaks like COVID-19, telehealth not only facilitates patient care, but also helps insulate providers and patients from potential disease exposure in hospitals, clinics, and other settings.

Legal Authorities. Federal and state laws may restrict who (e.g., type of provider), where (e.g., interjurisdictional) and how (e.g., video or audio only) telehealth and telemedicine can be practiced. During the COVID-19 outbreak, several laws and regulations have been temporarily altered to remove barriers to telehealth. At the federal level, the Coronavirus Preparedness and Response Supplemental Appropriations Act allowed HHS to temporarily waive certain Medicare telehealth restrictions or requirements during the emergency.⁹¹ DEA also issued guidance that DEA-registered practitioners may prescribe schedule II-V controlled substances without the normally required in-person evaluation under certain conditions.⁹² HHS' OCR issued guidance that non-compliance with HIPAA Privacy Rule regulatory requirements during "good-faith" telehealth applications would not result in penalties during the COVID-19 PHE.⁹³ Multiple federal legislative proposals aim to remove additional telehealth barriers by:

- removing geographic restrictions;⁹⁴
- improving telehealth for underserved communities;⁹⁵
- establishing certain permanent key waivers due to COVID-19;⁹⁶
- conducting studies and report actions taken to expand telehealth access;⁹⁷ and
- permitting HHS to waive additional Medicare requirements.⁹⁸

State laws have improved access to telehealth services. Twenty-nine states, have enacted "parity" laws, requiring private insurers to reimburse for telehealth services as they would for in-person care.⁹⁹ These laws generally do not restrict a patient's location, unlike Medicaid telehealth laws that have more restrictive "origination site" requirements. In Maine, what constitutes telehealth services expanded via legislation passed on June 21, 2021, broadening the definitions of eligible services.¹⁰⁰ Within Medicaid programs, 26 states¹⁰¹ explicitly allow personal homes as valid origination sites for telehealth, but reimbursement may be reserved only for those patients suffering from a chronic condition (e.g., congestive heart failure, diabetes, hypertension).¹⁰² Licensing requirements likewise restrict physicians from administering telehealth services to out-of-state patients. The Interstate Medical Licensing Compact allows physicians to practice across

state lines.¹⁰³ Furthermore, PSYPACT (noted above) specifically allows for cross-state telepsychology and temporary in-person psychological services between inducted states.

Other telehealth restrictions are temporary, addressed via state-based emergency declarations and gubernatorial executive orders expanding reimbursement and easing usual consent, licensure, and prescription requirements. Governors from each of the region states issued emergency orders or other guidance to facilitate telehealth during COVID-19. All the region states expanded their Medicaid programs to cover telehealth services¹⁰⁴ and required private insurance plans to allow in-network providers to provide covered services via telehealth. Each of the region states provided parity of reimbursement for telehealth services as per in-person services.¹⁰⁵ Three region states (MA, NH, RI) required medically necessary COVID-19 telehealth services to be covered with no cost sharing.¹⁰⁶

Governors in Connecticut, Massachusetts, Maine, New Hampshire, and Rhode Island issued orders to suspend telehealth provider licensure, certification, or registration requirements. In Massachusetts, Governor Baker's order also prohibited specific requirements on telehealth technologies and prohibited prior authorization requirements for treatment delivered via telehealth.¹⁰⁷ In Vermont, legislation passed in response to COVID-19 temporarily allows healthcare professionals licensed and in good standing in other states to be deemed licensed in Vermont to provide patients with telehealth services or direct care in licensed facilities.¹⁰⁸

CMS Reimbursements. Federal or state reimbursements for telehealth or telemedicine services present substantial concerns among providers. Prior to COVID-19, CMS could only reimburse clinicians providing telehealth services for Medicare beneficiaries under limited circumstances.¹⁰⁹ For example, a Medicare beneficiary receiving such services had to (1) reside in a designated rural area; and (2) travel to a local medical facility to receive services from a physician in a different location.

On March 16, 2020, however, CMS reimbursement for telehealth services for Medicare beneficiaries was drastically expanded via President Trump's Stafford Act emergency declaration and Social Security Act § 1135 waiver. Under the waiver, Medicare can pay for office, hospital, and other health visits (including in one's residence) conducted via telemedicine across the country. In addition to physicians, other HCWs, including nurse practitioners, clinical psychologists, and licensed clinical social workers, were authorized to offer covered telehealth services to their patients. CMS also allowed telehealth providers to waive patient deductibles and co-payments for the extent of the emergency.

On May 1, 2020, CMS further expanded the: (1) type of telehealth provider eligible for Medicare reimbursement (including physical and occupational therapists and speech pathologists); (2) list of allowable audio-only services (including behavioral health); and (3) type of facility that can bill for telehealth services (including federally qualified health clinics and rural health clinics).¹¹⁰ Absent further developments, expansion of Medicare coverage for telehealth services lasts only as long as the § 1135 waivers remain in place. On June 9, 2020, CMS Administrator Seema Verma expressed support for making permanent changes in response to COVID-19,¹¹¹ which would require significant reforms to the CMS fee schedules via rule-making processes.

Contrasted with Medicare reimbursements, state-based Medicaid programs already feature sufficient flexibility to use telehealth services. Federal approval is not required for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services.¹¹² States that expanded Medicaid coverage

in light of COVID-19 within the realm of their routine authority may continue to do so permanently subject to state discretion.

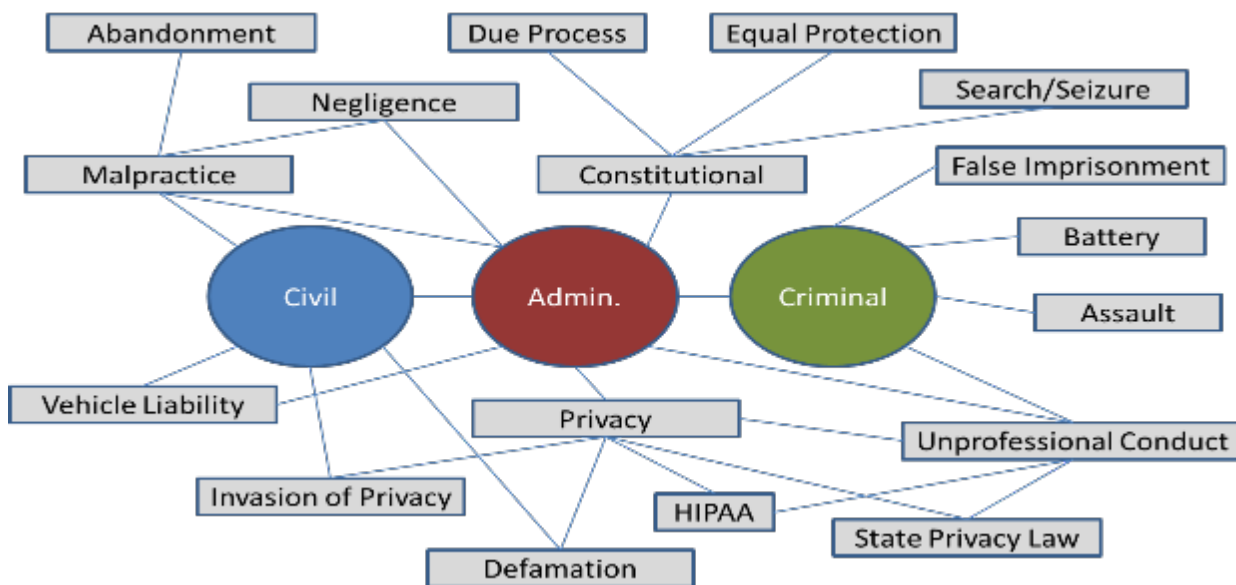
States can also broaden access to telehealth using Medicaid emergency authorities, which requires federal approval. As of June 15, 2020, all 50 states and D.C. have used §1135 waivers to allow out-of-state providers licensed in another state to provide care to Medicaid beneficiaries.¹¹³ Forty-eight states and DC have used other waiver strategies to amend home and community-based services to expand telehealth access.¹¹⁴ While these expansions terminate at the conclusion of declared emergencies, members of Congress, CMS, and other federal actors are considering an array of options, including new legislation, to make permanent specific legal reforms allowing greater use of telehealth practices after the COVID-19 pandemic subsides.¹¹⁵

Fraud & Abuse Protections. While expansion of telehealth services during COVID-19 has clear health benefits, concerns have arisen over increased risks of fraud and abuse for providers and patients.¹¹⁶ For example, with increased telehealth reimbursement, providers may be more inclined to encourage health services for patients, yielding an overuse of unnecessary services. Given telemedicine's relaxed setting, marketers may be more likely to obtain Medicare or Medicaid beneficiaries' billing IDs, and fraudulently bill the government for expenses. If telehealth expansions from COVID-19 are made permanent, updates of federal protections against healthcare fraud, waste, and abuse are needed and anticipated.

V. CIVIL LIABILITY, IMMUNITY & INDEMNIFICATION

Health care providers (individuals and entities) face varied liability risks in emergencies due to inadequate supplies or facilities, atypical protocols, shifting standards of care, and multiple other factors. As illustrated in **Figure 7** below, civil, criminal, and administrative liability issues comprise a complex web of interconnected risks for HCWs and entities.

Figure 7: Web of Liability Risks



Despite heightened risks of liability, a series of legal protections extend to HCWs and entities from non-emergency laws and emergency declarations. Changes in the legal standards of care during crises also may help insulate providers from claims for injuries or deaths related to the provision of care. The dichotomy between potential for increased liability risks and availability of additional liability protections is examined below.

Potential Liability for HCWs & VHPs

Potential civil liability for HCWs and VHPs is typically grounded in legal claims of negligence, notably malpractice. Negligence claims against physicians typically require proof of a breach of an affirmative duty to meet the standard of care, or other requirement to perform, that caused patient harms leading to damages. Non-physicians following established protocols or standing orders may be protected from liability in some jurisdictions if they follow instructions from supervising physicians in good faith.¹¹⁷ However, HCWs are generally not protected if their actions: (1) are intentionally harmful, (2) are completely lacking in care (which may be referred to legally as “recklessness,” “gross negligence,” or “willful and wanton” negligence), or (3) constitute an inexcusable violation of statute or regulation, such as practicing without a license (e.g., often referred to in legal terms as “negligence per se”).¹¹⁸

Properly developed treatment protocols and standard operating procedures can significantly reduce the risk of civil liability for HCWs to the extent they help establish and reinforce the appropriate standard of care. Deviations from protocols and standard procedures, in contrast, increase liability risks unless adequately justified.¹¹⁹ Yet prevailing circumstances, and not protocols, generally determine the standard of care. Strict adherence to standing orders and

similar tools may incentivize HCWs to ignore potential patient harms to protect against liability claims.¹²⁰ Courts recognize that circumstances like medical surge may require deviation from standard procedures, but development and use of comprehensive adaptable protocols coupled with advance and real-time training can mitigate liability risks.

Additional liability claims may surface during emergencies. Patient abandonment occurs if a HCW with a duty to care ends a patient relationship without ensuring the patient has necessary care, adequate notice, or access to a competent replacement.¹²¹ In emergencies, abandonment claims may stem more so from a lack of personnel and resources. Like other claims, abandonment may be assessed based on medical and legal standards of care dependent on prevailing circumstances.

From 2020-2021, some states have considered and rejected explicit liability protections for workers. For example, two MA bills establishing liability protections for HCWs and facilities during the COVID-19 pandemic failed.¹²² Other states have directly introduced legislation eliminating immunity for COVID-19 civil claims. For example, 3 bills were introduced in the Connecticut legislature establishing a cause of action against nursing homes for negligence related injuries during the COVID-19 pandemic, though all have failed as of June 2021.¹²³

Criminal Sanctions. Beyond civil claims, HCWs may also be subject to criminal sanctions in limited circumstances. For example, if they completely ignore the risks or consequences of their actions, they may be charged criminally. Criminal charges may also include assault (provoking fear of bodily harm), battery (physical touching without consent), false imprisonment, child endangerment,¹²⁴ or abject failures to assist. In 2010, a New York EMT was charged with official misconduct for allegedly failing to assist a woman in distress in a restaurant where she and another EMT were taking a break. The EMTs never saw the woman despite being informed of her situation. Only after 3 years of legal proceedings were criminal charges eventually dropped.¹²⁵

Administrative Sanctions. HCW misconduct may also lead to administrative sanctions through formal complaints with employers or regulatory and oversight agencies.¹²⁶ Complaints may stem from failures to maintain patient confidentiality or comply with “Do Not Resuscitate” orders, incompetence, unprofessional conduct, or other misconduct.¹²⁷ Employers may conduct their own investigations under the guidance of regulatory bodies and pursuant to established disciplinary plans.¹²⁸ Resulting sanctions may include employer discipline (e.g., suspension), censure, fines, or license probation or revocation orders.¹²⁹ State regulatory agencies may report these adverse actions to the National Practitioners Data Bank.¹³⁰

In response to the 2014 Ebola outbreak, for example, Rhode Island’s EMS Chief collaborated on a joint statement regarding professional responsibility and HCW’s refusals to treat. The statement clarified that individual HCWs are “obliged to treat and/or care for Ebola patients” and failure to do so would result in an investigation and potential sanctions.¹³¹ In routine events and declared emergencies, disciplinary actions stemming from criminal convictions, negligence, fraud, substance abuse, or actions outside professional standards may impact individual licensure and livelihoods.¹³² During the COVID-19 outbreak, the Massachusetts Nurses Association sent a letter to Governor Baker asking that every frontline worker be provided with an N95 mask.¹³³ In California, nurses’ licenses were suspended for refusing to treat COVID-19 patients without a N95 mask.¹³⁴

Constitutional Claims. Government officials and employees generally are not liable for their official actions unless they deprive a person of constitutional rights while acting “under color” of state law or policy,¹³⁵ meaning their actions are or appear to be officially authorized. Resulting

cases are often referred to as “§ 1983” claims based on the applicable federal statute under which they are brought. Governmental HCWs may be subject to § 1983 liability if they violate due process, equal protection, or other constitutional rights. These claims are difficult to prove because they require demonstration of intent to harm the patient or violate his or her rights. In *Davidson v. City of Jacksonville*, a Florida federal court held that EMS professionals did not violate a disoriented and resistant patient’s due process right to be free from unreasonable seizure when they tied and carried him to an ambulance (based on mistaken belief that a stretcher would not fit into his bedroom) because they did not intend to harm him.¹³⁶

Additionally, § 1983 claims generally do not apply to employees of private entities, even when they act on behalf of governmental agencies. In *Williams v. Richmond County*, a Georgia federal court stated that there likely was no “state action” (required for § 1983 claims) when medical workers employed by a private hospital took custody of a woman detained and handcuffed by police and transported her to a hospital at the officers’ request. The court held that even if this constituted state action, the workers did not display a deliberate indifference to serious medical needs in the form of unreasonable refusal, denial, or delay of treatment.¹³⁷

Potential Entity Liability

Entities employing and supervising HCWs face their own liability risks during emergencies under multiple themes. Health care entities may be liable for their own negligence or that of their employed HCWs and volunteers. Most liability claims against entities for the actions of others tend to require “proof of agency,” or some level of control over the “agent.” Proof of agency is relatively easy to establish in cases where a health care entity employs HCWs and fails to properly supervise their efforts, leading to patient harms.

Under legal theories known as “corporate negligence,” health care entities must use reasonable care in maintaining facilities and equipment, ensuring competence among employees, providing required oversight and supervision, and developing and adopting policies to ensure adequate patient care.¹³⁸ For example, a Florida regional medical center was held liable for the death of a 5-year-old child in 1990 because it failed to properly supervise, educate, train, and instruct paramedics who acted negligently in providing care.¹³⁹ In 2019, the Vermont Supreme Court found that a patient could sue both the hospital and the employee for negligent disclosure of personal information to an outside party.¹⁴⁰ Entity liability may extend directly from noncompliance with provisions of EMTALA, HIPAA Privacy Rule, or multiple other federal or state legal requirements.

Establishing proof of agency is considerably harder where the connections between the entity and its affiliates are less direct or tangential. For example, medical professionals who are members of a nonprofit entity are not typically viewed as agents of the entity,¹⁴¹ thus negating entity liability for their acts. In *MCG Health, Inc. v. Nelson*, a patient in Georgia brought a negligence claim against multiple health entities including a nonprofit association involved in the billing and collecting of medical service fees. The patient argued that the nonprofit was liable for the physicians’ negligence because it had an employer-employee relationship with the physicians. The court disagreed. To the degree the nonprofit had no control over the medical personnel’s activities it was not responsible for their actions.¹⁴²

Nonprofit entities providing registrants or contributing to the operation of emergency registrations systems may be concerned about liability risks if their submitted registrants cause harm to patients due to their lack of essential skills or improper vetting. Claims may arise against the nonprofit entity on the theory it is partially responsible for the negligent or intentional actions

of the medical registrants. In addition to liability protections (see section below), however, these risks can be minimized through:

- careful crafting of legal documents clarifying the limits of the nonprofit's participation in the registration system;
- proper vetting and training medical volunteers by the host entity receiving the registrants;
- advising patients of the limited nature of the registrants' involvement and lack of agency with the nonprofit entity; and
- advance confirmation with insurers of medical registrants or nonprofits that they cover specific claims prior to emergencies.

Governmental health entities may also face potential § 1983 liability (noted above) for employees' actions depriving individuals of constitutional rights. Note, however, that municipalities are generally not liable for employees' acts (for § 1983 purposes¹⁴³) unless rights deprivations extend from formal municipal policies, widespread custom or practice, a conscious disregard of unconstitutional application of policy, or failure to train or supervise employees in a manner that amounts to deliberate indifference to constitutional rights of the public.¹⁴⁴

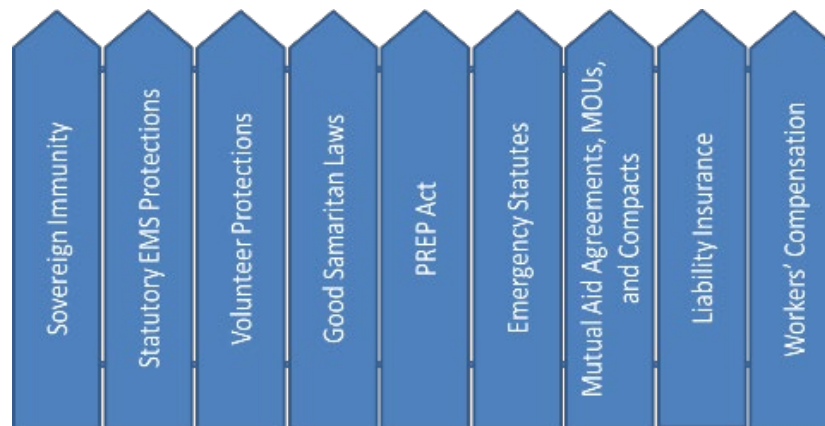
Similarly, the ADA,¹⁴⁵ federal Rehabilitation Act,¹⁴⁶ and corresponding state laws prohibit public entities from discriminating against individuals with physical or mental disabilities through services or programs. ADA violations can occur through laws, policies, or programs leading to direct or indirect discrimination. Individuals with disabilities may require special accommodations. Failing to adequately account for the needs of vulnerable populations may result in liability for public entities and municipalities. Municipalities like New York City and Los Angeles County have been sued for failing to properly accommodate persons with disabilities in their emergency preparedness plans.

Discrimination concerns may also arise if HCWs or entities refuse to treat specific patients with specific conditions. In 1998 the U.S. Supreme Court determined that human immunodeficiency virus (HIV) infection was a disability under the ADA even in early, asymptomatic stages. Refusing to treat an HIV-positive patient may violate the ADA unless the condition poses a significant risk of infection to others under the circumstances, as determined by available medical and other objective evidence.¹⁴⁷ Similar observations arise from ongoing efforts to successfully treat COVID-19 patients despite lack of efficacy of existing interventions pending further assessments.

Liability Protections

Despite multifarious liability risks for HCWs, VHPs, and health care entities, there are also significant protections from liability during emergencies (illustrated in **Figure 8** and summarized below). These federal and state legal protections include sovereign immunity for government actors, statutory protections for HCWs, emergency laws (e.g., based on MSEHPA and UEVHPA), interstate compacts (e.g., EMAC), and Good Samaritan Acts (GSAs). Together, these laws may immunize or indemnify persons or entities for acts of ordinary negligence (but not for gross negligence or willful, wanton, or criminal acts). In declared emergencies, additional protections are activated, further insulating HCWs and entities from liability. Yet there is no universal protection to defend against all possible sources of liability, and no laws can fully prevent the filing of meritless claims.

Figure 8: Liability Protections for Personnel & Entities

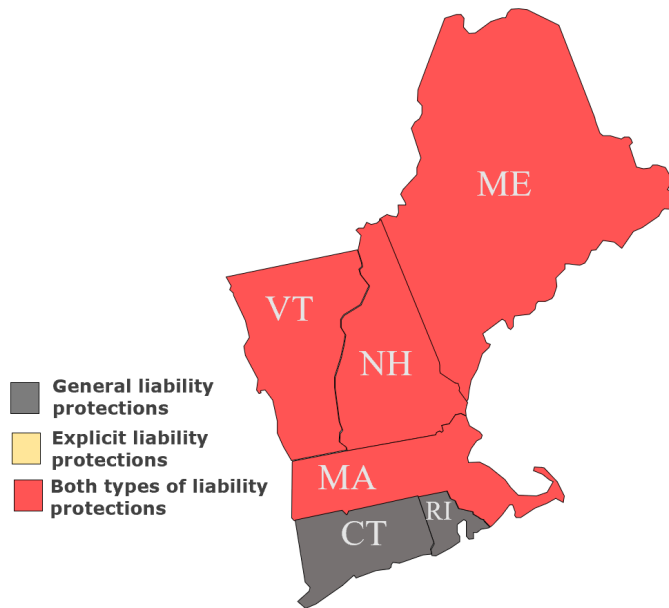


Sovereign Immunity. Legal principles of sovereign immunity protect many government entities and their personnel from civil liability related to official functions. In general, sovereign immunity protects a state (the “sovereign”) and its agencies from civil suits unless the state consents (usually via statutory law) to being sued. State “Tort Claims Acts” specify when state and local governments and their employees may be sued (e.g., Maine).¹⁴⁸ These protections also extend to municipalities and their employees in some states. Employees who are held liable for acts in their official capacity may be indemnified by the state, meaning that the state assumes responsibility for expenses related to claims.¹⁴⁹ Maine’s Tort Claims Act broadly provides that all government entities are immune from suit on “any and all tort claims seeking recovery of damages.”¹⁵⁰ Personal liability of a government employee for negligent acts or omissions within the course and scope of employment is limited to \$10,000 per claim. No employee is liable for any amount over that limit.

Even in states where sovereign immunity doctrine applies, governmental entities are not always relieved of liability. In *Velazquez v. New York City Health & Hospital Corporation*, a court held that sovereign immunity did not bar a suit by a home attendant allegedly injured while attempting to prevent her client from falling down a stairwell due to the negligence of 2 municipal EMS workers. The court held that the plaintiff could recover from the municipality if she proved that the workers’ negligence endangered her client and that her injury resulted from an attempt to rescue the client from that danger. When the practitioners undertook transportation of the client, concluded the court, they assumed a duty of reasonable care not only to her, but also to the home attendant.¹⁵¹

Statutory Protections & Limitations. HCWs are often statutorily protected from civil liability in carrying out their duties at the scene of an emergency or during initial patient transport. Volunteer protection acts may also insulate personnel, but often apply only to volunteers associated with non-profit or governmental entities.¹⁵² Similar protections of the federal Volunteer Protection Act¹⁵³ were further reflected in the federal Coronavirus Aid, Relief & Economic Security (CARES) Act concerning VHPs responding to COVID-19.¹⁵⁴ Other state-based legal protections may explicitly immunize HCWs from liability during declared emergencies, as per **Figure 9**, below.

Figure 9. Region States Explicit Liability Protections



All region states feature general legal authorities to shield HCWs from legal liability during declared emergencies (see Appendix - **Table 4**). For example in Massachusetts, any person or entity acting in good faith to comply with orders under an emergency declaration is immune from civil liability for any injury or death caused by those actions, with exceptions for cases of gross negligence.¹⁵⁵ In Connecticut, persons acting to respond to a declared emergency are considered agents of the state, and are provided immunity from liability as if they were governmental personnel (see section above on Sovereign Immunity).¹⁵⁶ The remaining 4 states have additional authority to protect HCWs from liability during declared emergencies. For example, Maine law protects persons from liability related to reporting or participating in a communicable disease investigation for actions performed in good faith.¹⁵⁷

Governors may also be empowered to issue specific emergency executive orders or other legal requirements to extend liability protections for HCWs and entities for the duration of the declaration. In response to COVID-19, for example, Connecticut's Governor issued Executive Order No. 7U¹⁵⁸ on April 5, 2020, to immunize HCWs and health care facilities for civil liability for:

“any injury or death alleged to have been sustained because of the individual's or health care facility's acts or omissions undertaken in good faith while providing health care services in support of the State's COVID-19 response[.]”

This includes acts or omissions undertaken “because of a lack of resources, attributable to the COVID-19 pandemic” rendering the HCW or entity unable to provide the sufficient care that would have otherwise been provided.

Attorneys general may also clarify statutory protections through Opinion Letters. For example, NH's Attorney General opined that R.S.A. § 21-P:41 applies to “health facilities, and their employees and volunteers, that engage in emergency management activities so long as the

health facility ... compl[ies] with or reasonably attempt[s] to comply with applicable state of emergency orders or rules[.]”¹⁵⁹

Good Samaritan Acts. Many states’ GSAs protect persons who provide care at the scene of an emergency. New Hampshire explicitly includes the rendering of emergency care by *any person* at the scene of an emergency, or while in transit in an ambulance or other emergency vehicle.¹⁶⁰ Some states’ GSAs may only apply to persons responding to ad hoc emergencies or without a pre-existing duty to provide aid.¹⁶¹ Courts may look to the legislative purpose in enacting such protections to determine how broadly to apply them.¹⁶²

Charitable Immunity Protection. Select states may also apply “charitable immunity” liability protections to certain nonprofit organizations (including nonprofit healthcare facilities) and its employees. Maine provides limited liability protections to nonprofit entities, unless they are actively covered by an insurance policy.¹⁶³ Maine’s charitable immunity laws also provide liability protections to directors, officers, and volunteers as long as the act occurs within the course and scope of the nonprofit’s activities.¹⁶⁴

PREP Act. In addition to a series of state law protections, HCWs and public and private entities may also be protected under the Federal Public Readiness and Emergency Preparedness (PREP) Act.¹⁶⁵ During a federally declared emergency, the PREP Act provides significant liability protections with respect to the use of covered countermeasures defined by HHS’ Secretary. Covered countermeasures include pandemic and epidemic products, security countermeasures, and drugs, products, and devices approved under an EUA. Countermeasures may come initially from federally-owned caches (e.g., SNS) or from other public or private sources.¹⁶⁶ Protection under the PREP Act applies to all qualified persons (including institutional and governmental entities) who prescribe, administer, or dispense countermeasures and to officials, agents, and employees of these persons or entities.¹⁶⁷ In December 2014, for example, a PREP Act declaration was issued to provide liability protection related to 3 prospective vaccines for Ebola.¹⁶⁸ PREP Act liability protections were also widely invoked in response to COVID-19.¹⁶⁹

The Biden administration amended PREP Act protections to permit certain qualified professionals such as nurses and retired doctors not licensed under state law to administer COVID-19 vaccines.¹⁷⁰ The Administration additionally encouraged states to allow rapid re-licensure for HCWs and provide temporary vaccination licenses for clinical students and foreign-educated HCWs, including physician assistants, pharmacists, and registered nurses.¹⁷¹

Workers’ Compensation. Workers’ compensation is a government administered system providing limited benefits to victims for work-related injuries or death, regardless of fault.¹⁷² Each state (and the federal government) has enacted workers’ compensation laws, which require work-related injuries to be reported and compensated in accordance with specific guidelines.¹⁷³ Every injury or death which occurs at work is subject to administration under workers’ compensation for covered employees, often including “occupational diseases” such as infectious diseases for HCWs. Generally, the employer is liable if the employee sustains an injury that arises out of or occurs in the course of employment. Injured employees typically file claims for limited reimbursement for direct costs of medical treatment, lost wages, and resulting disabilities. Most claims are paid via insurance coverage, although some large employers, including state governments, may be self-insured and administer their own claims.¹⁷⁴

Workers' compensation is often the exclusive remedy for injured employees.¹⁷⁵ Direct lawsuits against employers outside the workers' compensation system are forbidden in most instances.¹⁷⁶ Employers cannot generally settle workers' compensation claims without advance approval of state workers' compensation administrators. Other forms of health insurance including private insurance policies, Medicaid and Medicare, and automobile personal injury protection, may deny claims for medical charges where a workers' compensation carrier is principally liable for these costs. Lost wages due to injury are compensable only where a claim is filed, and thus compensation for disabilities may only occur through filing a workers' compensation claim.¹⁷⁷

Extending Workers' Compensation

Generally, workers' compensation laws only cover "employees" and thus exclude unpaid volunteers or gratuitous workers. States may legislatively extend explicit coverage to VHPs, but otherwise these persons may be excluded from coverage. Each state's law defines who is considered an employee, often tied to direct payments (e.g., payroll or other significant form of compensation for services). Some courts have held that an emergency situation may create a presumption of employment through an implied contract for hire, but not typically when a VHP registers his or her willingness to offer services before the emergency situation arises. States like Connecticut explicitly cover VHPs under workers' compensation provisions and assure compensation is rendered to members of civil preparedness forces (e.g., Medical Reserve Corps). In most states, VHPs may be excluded from coverage under a narrower statutory approach. Massachusetts explicitly excludes certified Red Cross volunteers who take time off to respond to disasters.

Interstate agreements like EMAC (see **Part II**) may provide workers' compensation protections for VHPs and emergency management workers. IEMAC similarly requires states to provide for the payment of workers' compensation and death benefits for responders that are injured or killed during response efforts.

Even if VHPs are covered through workers' compensation programs, benefits may still be elusive. Spontaneous or improperly registered VHPs may not be protected. In addition, the "employee" status of VHPs may not apply across state lines. Absence of workers' compensation benefits is risky for workers who may face hazardous working conditions during emergencies. During the COVID-19 pandemic, whether HCWs or VHPs may be covered depends on provisions related to occupational diseases, (i.e., diseases contracted during and resulting from employment). State coverage of occupational diseases varies. To receive compensation, states may also require: (1) the employment involve peculiar or unusual risks of the disease—beyond that of the general population; and (2) the disease is attributable to a contact that occurred on the job.¹⁷⁸ During a disease outbreak, it may be difficult to prove that a disease was contracted in the course of employment when the spread impacts the general population, especially when the burden of proof falls upon the worker.¹⁷⁹

VI. OTHER LEGAL ISSUES

Crisis Standards of Care. The concept of CSC refers to the substantial changes in typical healthcare operations and level of care that can occur during pervasive or catastrophic disasters. CSC was originally crafted by the National Academy of Medicine (NAM) in its 2009 original report in the throes of the H1N1 pandemic, updated in 2012, and revisited in a 2019 workshop (just prior to the COVID-19 outbreak). NAM also responded in March 2020 to ASPR’s rapid request for guidance on salient issues for consideration related to medical triage decisions involving COVID-19 patients.¹⁸⁰

In all its guidance, NAM describes how the level of patient care in emergencies falls along a continuum from “conventional” to “contingency” to “crisis.”¹⁸¹ Conventional medical standards of care resonate professional norms and expectations. Although they are flexible depending on circumstances, they do not generally address the type of care provided in a PHE when resources are scarce and critical decisions must often be made.¹⁸² As illustrated in **Figure 10**, there are multiple facets, represented as pillars, critical to emergency responses in crises, including health care in hospitals and other settings, public health, EMS, and emergency management.

Figure 10: CSC Systems Framework¹⁸³



Shifting to CSC in declared emergencies requires a change in focus from individual to population needs. Under CSC, persons with the greatest needs tend to receive available care first until everyone requiring services can be assessed and initially treated.¹⁸⁴ Tough decisions outside HCWs’ normal practices must be made. For example, during the COVID-19 pandemic, EMS workers were instructed in multiple states, including NY and NJ, to avoid CPR interventions for patients found at home whose heart rates flat lined as per EKGs performed on site.¹⁸⁵ CSC implementation also requires coordination of public and private entities, as well as significant advance planning and engagement.¹⁸⁶ Several of the New England states have developed general CSC policies, including MA, NH, and VT; MA and NH have recast their plans specifically to address COVID-19.

Collectively, these plans address many areas, such as emergency management policies, community and stakeholder outreach, and ethical guidance. Sophisticated plans also entail

modifications of public health laws, privacy laws, liability concerns, and other elements consistent with a systems approach framework. Assessing potential liability claims during crises is difficult (as noted in **Part V** above) when the standards of care change in real-time. CSC decisions may be assessed under changing legal standards resulting in uncertainty over potential liability, necessitating specific liability protections as discussed above.

CSC planning can help mitigate potential controversial issues inherent in implementation. During the COVID-19 outbreak, numerous states' CSC plans were criticized prior to or during implementation related to their potential impacts on persons with disabilities (as chronic conditions are a risk factor for survival) and unequal applications leading to treatment disparities for minorities, the elderly, or other vulnerable populations. HHS' Office of Civil Rights opined in March 2020 that several states' plans invoked unlawful, discriminatory criteria for making triage decisions. Several lawsuits also arose related to direct harms to prospective patients extending from anticipated CSC implementation.

Emergency Use Authorizations. PAHPRA significantly enhanced the authority of HHS and FDA to issue emergency use authorizations (EUAs) to allow use of otherwise non-approved tests, medications, or treatments. Prior to or during an HHS-declared PHE,¹⁸⁷ FDA can issue an EUA to allow emergency use of tests or drug products. EUAs were used during the 2009/2010 H1N1 pandemic, for example, to (1) allow unapproved uses of zanamivir (Relenza[®]) and oseltamivir (Tamiflu[®]) for treatment and prophylaxis of young children and hospitalized patients;¹⁸⁸ and (2) use certain lots of antivirals beyond their expiration dates through a series of EUAs.¹⁸⁹ During COVID-19, EUAs were heavily relied on to authorize use for an array of COVID infection and antibody tests, as well as experimental treatments. On May 1, 2020, FDA issued an EUA for the investigational antiviral drug remdesivir (Veklury[®]) for treating suspected or confirmed COVID-19 cases where symptoms are severe and require hospitalization.¹⁹⁰ FDA also issued several EUAs for medical devices during COVID-19, including for personal respiratory protective equipment.¹⁹¹

FDA issued 3 EUAs for COVID-19 vaccines after extensive data analysis and independent and public review from members of FDA's Vaccines and Related Biological Products Advisory Committee. On November 20, 2020, Pfizer-BioNTech submitted an EUA request to FDA for an investigational COVID-19 vaccine. The EUA request included efficacy and safety data from an ongoing randomized, placebo-controlled study in approximately 44,000 participants. Reported efficacy in preventing COVID-19 at least 7 days after the second vaccine dose was 95%. On December 11, 2020, FDA granted an EUA to Pfizer-BioNTech. On November 30, 2020, Moderna submitted an EUA request to FDA for an investigational COVID-19 vaccine, which was authorized on December 18. Moderna's application was based on data from a double blinded, placebo-controlled study in approximately 30,400 participants.

Three months later, on February 4, 2021, Johnson & Johnson submitted an EUA request to FDA for an investigational single-shot COVID-19 vaccine based off randomized, double-blind, placebo-controlled clinical trials in 43,783 adults ages 18 and older.¹⁹² The EUA was authorized on February 27,¹⁹³ but paused briefly on April 13 after reports of medical complications among some recipients.¹⁹⁴ On April 23, 2021, the EUA was reaffirmed and amended with a warning about the potential for rare blood clotting issues, primarily in women between 18-49 years old.¹⁹⁵

Pfizer-BioNTech later submitted its vaccine for full approval in early May 2021 for those 16 and older. A priority review was granted by FDA on July 16, 2021, and the vaccine was granted full approval on August 23.¹⁹⁶ Moderna applied for priority review of its vaccine on June 1, 2021. Johnson & Johnson has yet to apply for full approval.¹⁹⁷

EUAs permit the dispensing of products that are either (a) not yet approved for use or (b) approved but sought for an unapproved use.¹⁹⁸ An EUA can help make available for a temporary period a specific product that might otherwise be off limits in non-emergencies. Prior to issuing an EUA, FDA's Commissioner must conclude that:

1. a disease or other condition specified in the declaration poses a risk of serious or life-threatening disease or condition;
2. it is reasonable to believe that the drug or test may be effective in diagnosing, treating, or preventing the disease or condition;
3. known and potential benefits of use of the product outweigh the risks; and
4. no adequate, approved, and available alternative exists to address the disease or condition.¹⁹⁹

Once issued, EUAs take effect nationally²⁰⁰ and may remain in effect for the duration of the emergency (up to 1 year unless revoked or renewed).²⁰¹ FDA can also set conditions on activities carried out under an EUA to protect the public's health. These include ensuring that HCWs and patients are informed of risks, benefits, and alternatives, and that adverse events are monitored by manufacturers, HCWs, or public health authorities.²⁰²

Through its expanded authority pursuant to PAHPRA,²⁰³ FDA can issue advance approval (prior to any declaration of emergency) if HHS determines that there is significant potential for a PHE involving a biological, chemical, radiological, or nuclear agent that affects (or has significant potential to affect) national security or the health and security of U.S. citizens abroad. FDA requirements on the distribution and administration of EUA-approved products cannot be more restrictive than conditions on the approved use of the medical product.²⁰⁴

Rights to Reemployment. In emergencies, various persons including VHPs or members of the National Guard or DMAT teams, may be called away from their employment to respond to requests by a hospital or other entity in another jurisdiction. They may seek assurance that their positions are retained when they return. Some states have enacted laws providing reemployment protection to individuals engaged in emergency response services. In addition, the federal government has adopted similar reemployment protections. For example, individuals who are members of federal governmental emergency response teams, such as a DMAT composed of civilian medical personnel, are given job, seniority, and wage protection in accordance with federal law when they are deployed for disaster response.²⁰⁵

The Uniformed Services Employment and Reemployment Rights Act (USERRA)²⁰⁶ provides reemployment protection to non-career members of uniformed services who are called up for duty and provide written notice to their employers. Employees are generally entitled to reemployment upon the termination of the uniformed service, unless doing so would impose an undue hardship on the employer or the employer's circumstances have changed so much as to make reemployment impossible or unreasonable. USERRA also provides for protection from termination upon the return to work after uniformed service, as well as employees' seniority rights and benefits during their period of absence. Essentially, during an employee's period of uniformed service, employers must treat employees as though the employees are on furlough or leave of absence.²⁰⁷

Some states also offer limited employment protections for practitioners responding to PHEs via Disaster Service Volunteer Leave Acts.²⁰⁸ These acts provide state employees who are disaster service volunteers with employment protection, subject to exceptions. In Rhode Island,

state employees who are certified disaster volunteers of the American Red Cross may be granted up to 10 days of leave per year to provide services, without loss of any other allocated time off.²⁰⁹ Connecticut law similarly offers up to 15 days of leave for state employees volunteering as firefighters, with ambulance services, with the American Red Cross, or as part of search and rescue teams.²¹⁰ Connecticut, Massachusetts, Rhode Island, and Vermont legally feature paid sick and safe time for employees caring for themselves and family members when ill. These provisions could be extended to afford paid leave to VHPs assisting in emergency response efforts. During COVID-19, 3 states outside the region (Colorado, New York, and North Carolina) issued orders to temporarily expand their paid time off requirements.²¹¹

Health Information Sharing & Privacy. Planning, preventing, and responding to a potential or actual emergency event requires extensive coordination and information sharing among public health authorities, HCWs, and hospitals. HCWs and VHPs need identifiable data to provide clinical, therapeutic, or pharmaceutical care. Public health authorities (PHAs) (broadly defined via the HIPAA Privacy Rule to include governmental public health agencies and their contractual partners) gather identifiable data through epidemiologic or environmental investigations, surveillance, laboratory testing, and other activities.

Questions may arise initially regarding responsibility for establishing and maintaining medical records in an emergency event. During shared staffing/full hospital augmentation missions involving DMATs, for example, are DMATs responsible for assuring complete and accurate medical records, or the entity (e.g., public or private hospital) in which they operate? This may depend in part on the legal route through which DMATs are deployed. If deployed pursuant to EMAC, specific agreements structured as part of the EMAC negotiation could spell out specific responsibilities for medical record issuance and control. DMAT agreements/handbooks may also address responsibility of DMAT members to complete medical documentation, but this does not address who has primary responsibility for maintaining medical records.

In its web guidance, HHS clarifies that DMATs organized through NDMS "are responsible for establishing an initial (electronic) medical record for each patient, including assigning patient unique identifiers in order to facilitate tracking throughout the NDMS."²¹² Responsibility for these records after DMATs complete their mission likely depends on the setting in which they were deployed. If deployed to a pre-existing hospital or other health care enterprise, that entity would likely take over the record. The Joint Commission Emergency Management Standards state that hospitals should (1) be prepared to maintain a medical record for each patient served; (2) have sufficient storage space to ensure security and maintain integrity of medical records; and (3) ensure medical records are readily accessible and promptly retrievable when needed.²¹³

In PHEs like COVID-19, options for exchanging non-identifiable data may be compromised in some cases. PHAs may not have sufficient time or resources to selectively identify some patient health information prior to its exchange. The use of non-identifiable health data may also lead to inaccuracies or duplications that may thwart prevention or response efforts. For example, PHAs may need to instantly and accurately verify the numbers of persons who may have contracted a contagious condition. Sharing identifiable health information facilitates these efforts and offers opportunities for PHAs to efficiently help those in need or at risk. Federal, state, and local health information privacy requirements should be carefully considered in planning for emergencies to assess how they may address the practical need for uses and disclosures of identifiable information in emergency situations.

Among other laws, the protection of health information privacy in many settings is federally regulated primarily by the HIPAA Privacy Rule.²¹⁴ It provides a national floor of privacy protections that treats all identifiable health data as private, and thus entitled to considerable protections and security assurance. Individuals cannot bring direct claims under the Privacy Rule, but violations are prosecuted by HHS' Office of Civil Rights (OCR).

Although the Rule seeks to protect patient privacy, it also allows considerable exchanges of protected health information (PHI) without written authorization of patients or their guardians for legitimate public health purposes, especially during emergencies. Some provisions of the Rule may also be effectively waived temporarily during national emergencies, such as COVID-19.²¹⁵ Similar waivers or exceptions may apply to other federal privacy laws. For example, laws related to patient data sharing from federally funded substance use programs allow temporary exchanges of health information without patient consent during declared emergencies that disrupt normal operations at these facilities. Considerable, additional information about the application of the Rule and other federal privacy laws to public health and research uses and disclosures of identifiable health data in routine events and during emergencies is available from CDC and HHS' OCR.²¹⁶

Additional health information privacy protections are found in state and local privacy laws and public health departmental (or other state agency) policies. These varied privacy and security provisions address the responsible acquisition, use, disclosure, and storage of identifiable health data by PHAs, health care providers, insurers, and others. Individual and communal interests in these health data are often weighed to protect the public's health while respecting individual privacy.

These laws, in concert with the HIPAA Privacy Rule and other federal privacy laws, may impact the conduct of syndromic surveillance activities as well even though specific patient data are not collected. For example, during the COVID-19 pandemic, multiple states used emerging technologies to create real-time surveillance dashboards regarding available PPE and other essential resources. Relying on data from specific hospitals and other providers, these information sources provided instant assessments of the availability of key resources as well as potential patient placements, facilitating the implementation of CSC. However, some corporate and other entities in the information chain raised privacy and other concerns about requested data. Proprietary interests, for example, may stymie the reporting of PPE supplies against the backdrop of potential re-allocation CSC strategies. Absent resolution, these issues can limit the flow of accurate syndromic or other non-identifiable data, inhibiting effective CSC responses.



Table 1: Emergency Declaration Authorities

This table provides state statutory authorities for emergency declarations in all the Region 1 states. It includes emergency/disaster declarations, PHE declarations, and other types of declarations related to the public’s health as categorized in columns I – III:

- I. **Emergency/Disaster** cites legal authorities for state declarations of “emergency,” “disaster,” and similar terms, as well as specific information on personnel responsible for issuing declarations.
- II. **Public Health Emergency** cites legal authorities for specific declarations of a PHE based in part on the MSEHPA, or other statutory bases for emergency/disaster declarations premised on public health concerns, as well as specific information on personnel responsible for issuing declarations.
- III. **Other Declarations** notes select, illustrative types of declarations that may relate to public health (note - additional types of emergency declarations unrelated to public health are not included).

State	I. Emergency/Disaster	II. Public Health Emergency	III. Other Declarations
CT	In the event of serious disaster ... the Governor may proclaim that a state of civil preparedness emergency exists, in which event the Governor may personally take direct operational control of any or all parts of the civil preparedness forces and functions in the state. (CONN. GEN. STAT. § 28-9(a), <i>amended by</i> H.B. 6672, 2021 Gen. Assemb., Reg. Sess. (Conn. 2021) (granting the governor power to renew the COVID-19 emergencies) (<i>amended by</i> H.B. 6686, 2021 Gen. Assemb., Reg. Sess. (Conn. 2021) (altering date ranges listed in H.B. 6672)); H.B. 5653, 2021 Gen. Assemb., Reg. Sess. (Conn. 2021) (granting the governor further renewal powers through March 1, 2022, subject to legislative checks, and creating a commission to study sections to “provide greater legislative oversight of declarations of public health and civil preparedness emergencies and the exercise of executive authority pursuant to said sections.”))	In the event of a state-wide or regional public health emergency, the Governor shall ... (1) Order the commissioner to implement all or a portion of the public health emergency response plan ... (CONN. GEN. STAT. § 19a-131a, <i>amended by</i> H.B. 6672, 2021 Gen. Assemb., Reg. Sess. (Conn. 2021) (<i>amended by</i> H.B. 6686, 2021 Gen. Assemb., Reg. Sess. (Conn. 2021)); H.B. 5653, 2021 Gen. Assemb., Reg. Sess. (Conn. 2021) (see bill purposes in previous column)).	Air Pollution Emergency (CONN. GEN. STAT. § 22a-181) Public Drinking Water Supply Emergency (CONN. GEN. STAT. § 25-32b) Water Supply Emergency (CONN. GEN. STAT. § 22a-378)

State	I. Emergency/Disaster	II. Public Health Emergency	III. Other Declarations
	<p>Notwithstanding any other provision of the general statutes, the Commissioner of Transportation may declare a state of emergency and may employ, in any manner, such assistance as he may require to restore any railroad owned by the state or any of its subdivisions or the facilities, equipment or service of such railroad, or any transit system or its facilities, equipment or service, or any airport ... (CONN. GEN STAT. § 13b-4d)</p>		
ME	<p>Whenever a disaster or civil emergency exists or appears imminent, the Governor shall, by oral proclamation, declare a state of emergency in the State or any section of the State. (ME. REV. STAT. tit. 37-B § 742(1))</p>	<p>In the event of an actual or threatened epidemic or public health threat, the department may declare that a health emergency exists and may adopt emergency rules for the protection of the public health ... (ME. REV. STAT. tit. 22, §§ 802(2))</p> <p>The Governor may declare an extreme public health emergency ... (ME. REV. STAT. tit. 22, 802(2-A))</p>	<p>Energy Emergency (ME. REV. STAT. tit. 37-B, § 742(2))</p> <p>Marine Resources Emergency (ME. REV. STAT. tit. 12, § 6171-A)</p> <p>Oil Spill Emergency (ME. REV. STAT. tit. 37-B, § 742(3))</p> <p>Uncontrolled Hazardous Substance Emergency (ME. REV. STAT. tit. 38, § 1368)</p>
MA	<p>Because of the existing possibility of the occurrence of disasters of unprecedented size and destructiveness resulting from enemy attack, sabotage or other hostile action, in order to insure that the preparations of the commonwealth will be adequate to deal with such disasters, and generally to provide for the common defense and to protect the public peace, health, security and safety, and to preserve the lives and property of the people of the commonwealth ... (1950 Mass. Acts ch. 639 § 5)</p>	<p>Upon declaration by the governor that an emergency exists which is detrimental to the public health, the commissioner may, with the approval of the governor and the public health council, during such period of emergency, take such action and incur such liabilities as he may deem necessary to assure the maintenance of public health and the prevention of disease. (MASS. GEN. LAWS ch. 17, § 2A)</p>	<p>Air Pollution Emergency (MASS. GEN. LAWS ch. 111, § 2B)</p> <p>Energy Emergency (MASS. GEN. LAWS ch. 25A, § 8)</p> <p>Water Emergency (MASS. GEN. LAWS ch. 21G, § 15)</p> <p>Emergency Vaccine Distribution (MASS. GEN. LAWS ch. 111, § 5A)</p> <p>Procedures for Public Health Emergency (correctional facilities) (105 MASS. CODE REGS. 451.410)</p>

State	I. Emergency/Disaster	II. Public Health Emergency	III. Other Declarations
NH	<p>The governor shall have the power to declare a state of emergency ... by executive order if the governor finds that a natural, technological, or man-made disaster of major proportions is imminent or has occurred within this state[.] ... As soon as is practicable, the governor shall notify the speaker of the house of representatives and the senate president of the impending issuance of emergency orders under this section and provide a description of such orders. The general court shall have the same power to declare a state of emergency by concurrent resolution of the house and senate. (N.H. REV. STAT. ANN. § 4:45, <i>amended by H.B. 2, 2021 Leg., Reg. Sess. (N.H. 2021)</i>)</p>		<p>Oil Discharge Emergency (N.H. REV. STAT. ANN. § 146-A:12)</p> <p>Public Water Supply Emergency (N.H. REV. STAT. ANN. § 485:23)</p> <p>Civil Emergency (N.H. REV. STAT. ANN. § 9:13-D)</p>
RI	<p>A state of emergency shall be declared by executive order or proclamation of the governor if he or she finds a disaster has occurred or that this occurrence, or the threat thereof, is imminent. (R.I. GEN. LAWS § 30-15-9)</p>	<p>Whenever the administrator finds that an emergency exists requiring immediate action to protect the public health or welfare, he or she may issue an order reciting the existence of the emergency and requiring that action be taken that he or she deems necessary to meet the emergency. (R.I. GEN. LAWS § 23-1.3-9)</p>	<p>Local Disaster Emergency (R.I. GEN. LAWS § 30-15-13)</p>
VT	<p>[I]n the event of an all-hazards event in or directed upon the United States or Canada that causes or may cause substantial damage or injury to persons or property within the State in any manner, the Governor may proclaim a state of emergency within the entire State or any portion or portions of the State. (VT. STAT. ANN. tit. 20, § 9, <i>amended by H. 366, 2021-2022 Leg., Reg. Sess. (Vt. 2021)</i>)</p>		<p>Air Pollution Emergency (VT. STAT. ANN. Tit. 10, § 560)</p> <p>Request to Governor by Municipal Authorities (local emergency declaration) (VT. STAT. ANN. tit. 20, §10)</p>



Table 2: Licensure Reciprocity For HCWs

This table provides state statutory authorities allowing for licensure reciprocity of HCWs for emergency purposes (see Table 1 for more information re: declarations) as categorized in columns I – III:

- I. **Routine Licensure Reciprocity** cites legal authorities of potential licensure reciprocity for HCWs in routine times.
- II. **Emergency Licensure Reciprocity** cites legal authorities of potential licensure reciprocity for HCWs in declared emergencies.
- III. **Additional Measures** notes select, illustrative paths (e.g., general empowerments) to licensure reciprocity in declared emergencies.

State	I. Routine Licensure Reciprocity	II. Emergency Licensure Reciprocity	III. Additional Measures
CT	<p>Any physician or surgeon residing out of this state who holds a current license in good standing in another state and who is employed to come into this state to treat, operate or prescribe for any injury, deformity, ailment ... may practice in this state without a Connecticut license for a period not to exceed thirty consecutive days; (CONN. GEN. STAT. § 20-9(b)(5))</p> <p>Any physician licensed . . . authorized to practice medicine by the armed forces of the United States may practice as a physician without a license in a free clinic in this state provided (1) the physician does not receive payment for such practice, and (2) the physician carries, either directly or through the clinic, professional liability insurance or indemnity against liability for professional</p>	<p>In the event of a state-wide or regional public health emergency, the Governor shall ... (5) order the commissioner to suspend certain license renewal and inspection functions during the period of the emergency and during the six-month period following the date the emergency is declared to be over. (CONN. GEN. STAT. § 19a-131a)</p> <p>The commissioner may issue an order to temporarily suspend, for a period not to exceed sixty consecutive days, the requirements for licensure, certification or registration . . . to allow persons who are appropriately licensed, certified or registered in another state or territory of the United States or the District of Columbia, to render temporary assistance within the scope of the profession for which a person is licensed , certified or registered, in managing a public health emergency in this state, declared by the Governor pursuant to section 19a-131a. (CONN. GEN. STAT. ANN. § 19a-131j(a), <i>amended by</i> H.B. 6666, 2021 Legis. Serv., Reg. Sess. (Ct. 2021))</p> <p>Whenever a person holds a license, certificate, or other permit issued by any party jurisdiction evidencing the meeting of qualifications for professional, mechanical, or other skills, and when such assistance is requested by a party jurisdiction, such person is deemed to be licensed, certified, or permitted by the</p>	<p>Intrastate Mutual Aid Compact (CONN. GEN. STAT. § 28-22a)</p>

State	I. Routine Licensure Reciprocity	II. Emergency Licensure Reciprocity	III. Additional Measures
	<p>malpractice equal to or greater than that required of state-licensed physicians under section 20-11b.(CONN. GEN. STAT. ANN. § 20-12(f))</p> <p>No status on adopting Interstate Medical Licensure Compact.</p>	<p>jurisdiction requesting assistance to render aid involving such skill to meet an emergency or disaster ... (International Emergency Management Assistance Compact, CONN. GEN. STAT. § 28-22d)</p>	
ME	<p>The [medical] board may, at its discretion, grant licensure without written examination ... who has been ... B. Examined and licensed by a board of another state (32 ME. REV. STAT. § 3275(1))</p> <p>Adopted Interstate Medical Licensure Compact (32 ME. REV. STAT. § 18502)</p> <p>Nurse Licensure Compact (32 ME. REV. STAT. § 2172(10))</p>	<p>A physician who presents a current active unconditioned license from another United States licensing jurisdiction and who can provide reasonable proof of meeting qualifications for licensure in this State must be issued a license to serve temporarily for declared emergencies in the State or for other appropriate reasons as determined by the board. The license is effective for not more than 100 days. (32 ME. REV. STAT. § 3278)</p> <p>During a declared state of emergency in Maine as a result of COVID-19, the Governor may modify or suspend occupational licenses if licensing requirements hinder effective emergency response. (37-B ME. REV. STAT. § 742)</p>	<p>Mutual Aid Arrangements (37-B ME REV. STAT. § 784) Waivers for Out-of-State Businesses and Employees (ME. REV. STAT. tit. 10 § 9903)</p>
MA	<p>Massachusetts does not expressly provide for reciprocity for medical doctors. The board may grant license reciprocity to a registered, certified or licensed naturopathic doctor... (MASS. GEN. LAWS 112 § 271)</p> <p>The board may register or license in like manner, without examination, any person who has been registered as a nurse or licensed as a practical nurse, as the case may be, in another state (MASS. GEN. LAWS ch. 112 § 76)</p>		

State	I. Routine Licensure Reciprocity	II. Emergency Licensure Reciprocity	III. Additional Measures
	<p>Temporary registration as a qualified physician may be granted . . . to a physician holding a license to practice in another state or territory or [D.C.] to permit him to act as a substitute physician for a registered physician in the commonwealth, to be granted only upon written request of said registered physician and to be limited to three months or less . . . (MASS. GEN. LAWS ANN. ch. 112, § 9B)</p> <p>Introduced Interstate Medical Licensure Compact. (H. 3773, 192nd Gen. Ct. (Ma. 2021))</p>		
NH	<p>The Office of Professional Licensure and Certification may issue a temporary license, valid for 120 days, to a person who: holds a current equivalent license from another jurisdiction in the U.S. and has a statement of good standing from the licensing authority, presents a certification that the person has committed no acts which are grounds for disciplinary action in another jurisdiction, and pays a fee not to exceed \$100. (N.H. REV. STAT. ANN. § 332-G:14)</p> <p>Adopted Interstate Medical Licensure Compact (N.H. REV. STAT. ANN. § 329-C)</p>	<p>Whenever any person holds a license, certificate, or other permit issued by any party jurisdiction to the compact . . . such person shall be deemed licensed, certified, or permitted by a receiving jurisdiction to render aid involving such skill in any party jurisdiction to meet an emergency or disaster situation . . . (Emergency Management Assistance Compact, N.H. REV. STAT. ANN. § 108:3)</p>	<p>Mutual Aid Agreements (N.H. REV. STAT. ANN. § 21-P:40)</p> <p>Emergency Medical Services Personnel Licensure Interstate Compact (N.H. REV. STAT. ANN. § 153-A:36)</p>
RI	<p>Rhode Island does not have reciprocity for medical doctors.</p> <p>No status on adopting Interstate Medical Licensure Compact.</p>	<p>In the event of a public health emergency, the director is authorized to grant a temporary Rhode Island health care provider license for a period not to exceed ninety (90) days and limited to those health care providers who hold an active valid license in another state. (R.I. GEN. LAWS § 23-1-17(b))</p>	<p>International Emergency Management Assistance Compact (R.I. GEN. LAWS § 30-15-44)</p>

State	I. Routine Licensure Reciprocity	II. Emergency Licensure Reciprocity	III. Additional Measures
VT	<p>The Board shall have an endorsement process for physician licensure that requires not more than three years of practice in good standing in another jurisdiction within the United States provided the applicant either graduated from a U.S. or Canadian accredited medical school and successfully completed at least two years of postgraduate training in an accredited program, or graduated from a Board-approved medical school outside of the U.S. or Canada and has completed at least three years of postgraduate training in an accredited U.S. or Canadian program. (VT. STAT. ANN. tit. 26, § 1395)</p> <p>Adopted Interstate Medical Licensure Compact (VT. STAT. ANN. tit. 26, § 1420)</p>	<p>Whenever a person holds a license, certificate, or other permit issued by any jurisdiction 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 jurisdiction, such person is deemed to be licensed, certified, or permitted by the jurisdiction requesting assistance to render aid involving such skill to meet an emergency or disaster ... (VT STAT. ANN. tit. 20 § 206)</p> <p>[The office of Professional Regulation may] Issue temporary licenses during a declared state of emergency. (VT STAT. ANN. tit. 3 § 129(10))</p> <p>Notwithstanding any provision of Vermont’s professional licensure statutes or rules to the contrary, through March 31, 2022, a health care professional, including a mental health professional, who holds a valid license, certificate, or registration to provide health care services in any other U.S. jurisdiction shall be deemed to be licensed, certified, or registered to provide health care services, including mental health services, to a patient located in Vermont using telehealth, as a volunteer member of the Medical Reserve Corps, or as part of the staff of a licensed facility or federally qualified health center, provided the health care professional: (1) is licensed, certified, or registered in good standing in the other U.S. jurisdiction or jurisdictions in which the health care professional holds a license, certificate, or registration; (2) is not subject to any professional disciplinary proceedings in any other U.S. jurisdiction; and (3) is not affirmatively barred from practice in Vermont for reasons of fraud or abuse, patient care, or public safety. (S.B. 117, 2021 Legis. Sess. (Vt. 2021))</p> <p>During a declared state of emergency the (A) The Board [of Medical Practice] or the Executive Director of the Board may issue a temporary license to an individual who is currently licensed to practice as a physician, physician assistant, or podiatrist in another jurisdiction, whose license is in good standing, and who is not subject to disciplinary proceedings in any other jurisdiction. The temporary license shall authorize the holder to practice in Vermont until the termination of the declared state of emergency or 90 days, whichever occurs first, provided the licensee remains in good standing . . . (VT. STAT. ANN. tit. 26, § 1353(11)(A))</p>	<p>International Emergency Management Assistance Compact (VT STAT. ANN. tit. 20 § 101)</p>



Table 3: Emergency Waiver Authorities

This table provides state statutory authorities allowing for temporary waivers of existing statutory, regulatory, or judicial laws or policies during declared emergency as categorized in columns I – III (see Table 1 for more information re: declarations):

- I. **General Waiver Authority** cites legal authorities of general authorities to waive laws in declared emergencies.
- II. **Specific Waiver Authority** cites legal authorities of specific authorities to waive laws in declared emergencies.

State	I. General Waiver Authority	II. Specific Waiver Authority
CT	<p>Following the Governor's proclamation of a civil preparedness emergency ... or declaration of a public health emergency ... the Governor may modify or suspend in whole or in part, by order as hereinafter provided, any statute, regulation or requirement or part thereof whenever the Governor finds such statute, regulation or requirement, or part thereof, is in conflict with the efficient and expeditious execution of civil preparedness functions or the protection of the public health. (CONN. GEN. STAT. § 28-9(b)(1))</p>	<p>In the event of a state-wide or regional public health emergency, the Governor shall ... (5) order the commissioner to suspend certain license renewal and inspection functions during the period of the emergency and during the six-month period following the date the emergency is declared to be over. (CONN. GEN. STAT. § 19a-131a)</p> <p>Upon the declaration by the Governor of a . . . public health emergency pursuant to section 19a-131a, the commissioner [of Early Childhood] may waive the provisions of any regulation adopted pursuant to this section if the commissioner determines that such waiver would not endanger the life, safety or health of any child. (CONN. GEN. STAT. ANN. § 19a-79(f))</p> <p>The provisions of [the child immunization standard of care and programs] shall not apply in the event of a public health emergency, ... or an attack, major disaster, emergency or disaster emergency. (CONN. GEN. STAT. § 19a-7f(4)(A))</p>
ME	<p>After the filing of the emergency proclamation and in addition to any other powers conferred by law, the Governor may:</p> <p>(1) Suspend the enforcement of any statute prescribing the procedures for conduct of state business, or the orders or rules of</p>	<p>Requirements for unemployment benefits may be waived for individuals under “a temporary medical quarantine or isolation restriction to ensure that the individual has not been affected by the subject condition of the state of emergency</p>

State	I. General Waiver Authority	II. Specific Waiver Authority
	any state agency, if strict compliance with the provisions of the statute, order or rule would in any way prevent, hinder or delay necessary action in coping with the emergency ... (ME. REV. STAT. tit. 37-B § 742(1)(C)(1))	and is expected to return to work” and those “temporarily laid off due to a partial or full closure of the individual's place of employment as a result of the state of emergency and is expected to return to work once the emergency closure is lifted.” (ME. REV. STAT. tit. 26 § 1199)
MA	<p>During [a state of emergency] ... the governor shall have and may exercise... The suspension of the operation of any statute, rule or regulation which affects the employment of persons within the commonwealth ... which are necessary because of the existence of a state of emergency. (1950 Mass. Acts ch. 639 § 7(k))</p> <p>Any provision of any general or special law or of any rule, regulation, ordinance or by-law to the extent that such provision is inconsistent with any order or regulation issued or promulgated under this act shall be inoperative while such order or such last-mentioned regulation is in effect; (1950 Mass. Acts ch. 639 § 8A)</p>	The directorship of unemployment assistance “shall waive the 1-week waiting period for any person making a claim for unemployment benefits who has become separated from work as a result of any circumstance relating to or resulting from the outbreak of the 2019 novel coronavirus, also known as COVID-19, or the effects of the governor’s March 10, 2020 declaration of a state of emergency.” (2020 Mass. Acts. Ch. 40)
NH	The governor shall have emergency management authority ... and pursuant to such authority may exercise emergency management powers including: ... The power to make, amend, suspend and rescind necessary orders, rules and regulations to carry out the provisions of this subdivision in the event of a disaster beyond local control. (N.H. REV. STAT. ANN. § 4:47(III))	The annual limitations on part-time employment [of public officers] ... shall be modified for retired members to exclude any hours worked during [a declared] emergency. (N.H. REV. STAT. ANN. § 100-A:7-b)
RI	[The governor may] Suspend the provisions of any regulatory statute prescribing the procedures for conduct of state business, or the orders, rules, or regulations of any state agency, if strict compliance with the provisions of any statute, order, rule, or regulation would in any way prevent, hinder, or delay necessary action in coping with the emergency, provided that the suspension of any statute, order, rule or regulation will be limited in duration and scope to the emergency action requiring said suspension. (R.I. GEN. LAWS § 30-15-9(e)(1))	
VT	The towns and cities of the State and other agencies designated or appointed by the Governor are authorized and empowered to make, amend, and rescind such orders and rules as may be	During a declared state of emergency in Vermont as a result of COVID-19, the Agency of Human Services shall consider waiving or modifying existing rules, or adopting emergency rules, to protect access to health care services,

State	I. General Waiver Authority	II. Specific Waiver Authority
	<p>necessary for emergency management purposes[.] (VT STAT. ANN. tit. 20 § 16, <i>amended by</i> H. 366, 2021 Leg., Gen. Assemb. (Vt. 2021)))</p> <p>The Governor is authorized and empowered . . . to make, amend and rescind the necessary orders and rules to carry out the provisions of this chapter with due consideration of the plans of the federal government. (VT. STAT. ANN. tit. 20, § 8(b)(1), <i>amended by</i> H. 366, 2021 Gen. Assemb., Legis. Sess (Vt. 2021))</p>	<p>long-term services and supports, and other human services under the Agency's jurisdiction. During a declared state of emergency as a result of COVID-19, the Secretary of Human Services may waive or permit variances from the following State rules and standards governing providers of health care services and human services as necessary to prioritize and maximize direct patient care. During a declared state of emergency as a result of COVID-19, to the extent permitted under federal law, the Department of Health Access shall relax provider enrollment requirements for the Medicaid program. (VT S.B. 117, 2021 Legis. Sess. (Vt. 2021))</p> <p>Select voting requirements and requirements that public bodies must meet in-person are temporarily suspended. (VT H.B. 681, 2020 Legis. Sess. (Vt. 2020))</p> <p>Whenever the Governor has proclaimed a disaster emergency under the laws of this State, or the president has declared an emergency or a major disaster to exist in this State, the Governor is authorized . . . to temporarily suspend or modify for not more than 60 days any public health, safety, zoning, transportation (within or across the State), or other requirement of law or rules within Vermont when by proclamation the Governor deems the suspension or modification essential to provide temporary housing for disaster victims. (VT. STAT. ANN. tit. 20, § 34(b), <i>amended by</i> H. 366, 2021 Leg., Gen. Assemb. (Vt. 2021))</p>

Table 4: Emergency Liability Protections

This table provides state statutory authorities allowing for temporary liability protections of physicians, nurses, or other HCWs during declared emergencies (see Table 1 for more information re: declarations) as categorized in columns I – III:

- I. **General Liability Protections** cites general legal authorities to protect HCWs or entities from liability in declared emergencies.
- II. **Explicit Liability Protections** cites explicit legal authorities to protect HCWs or entities from liability in declared emergencies.
- III. **Exceptions** notes specific exceptions to liability protections in declared emergencies (e.g., willful misconduct, gross negligence).

State	I. General Liability Protections	II. Explicit Liability Protections	III. Exceptions
CT	The provisions of §§ 4-165 [Torts Claims Act] and 5-141d [indemnification of state officers and employees] shall apply to any person acting on behalf of the state, within the scope of such person's practice or profession, and pursuant to §§ 19a-131 to 19a-131h [public health emergency response], inclusive. (CONN. GEN. STAT. § 19a-131i)		The provisions of this section shall not apply if a vaccination has been administered without consent. (CONN. GEN. STAT. § 19a-131i) ...not wanton, reckless or malicious. (CONN. GEN. STAT. § 4-165) ...such act or omission is found not to have been wanton, reckless, or malicious. (CONN. GEN. STAT. § 5-141d(a))
ME	Any person called and employed for assistance either within the State or in another state under chapter 16 or in a Canadian province under chapter 16-A is deemed to be an employee of the State for purposes of immunity from liability pursuant to §§ 822, 926 and 940 and for purposes of workers' compensation insurance pursuant to §§ 823, 928 and 942, except for persons excluded from the definition of	Any private institution, its employees or agents are immune from civil liability to the extent provided in Title 14, chapter 741, as if that institution were a state agency and its employees and agents were state employees, for any acts taken ... in support of the State's response to a declared extreme public health emergency in accordance with the provisions of this chapter and Title 37-B, chapter 13, subchapter 2. (ME. REV. STAT. tit. 22 § 816(1))	Good faith does not include instances when a false report is made and the reporting person knows or should know the report is false. (ME. REV. STAT. tit. 22 § 816(2))

State	I. General Liability Protections	II. Explicit Liability Protections	III. Exceptions
	<p>employee pursuant to Title 39-A, § 102, subsection 11. (ME. REV. STAT. tit. 37-B § 784-A)</p> <p>Neither the State nor any of its agencies or political subdivisions nor a person called out pursuant to § 784-A, including a voluntary and uncompensated grantor of a permit for the use of the grantor's premises as an emergency management shelter, may, while engaged in any emergency management activities and while complying with or attempting to comply with this chapter or any rule adopted pursuant to this chapter, be liable for the death of or injury to any person, or damage to property, as a result of those activities. (ME. REV. STAT. tit. 37-B § 822)</p>	<p>A private institution is immune from civil penalties and liability for any actions arising from allegations of inadequate investigation prior to that institution's hiring or engagement of a licensed health care worker, including but not limited to allegations of negligent hiring, credentialing or privileging, for services provided within the scope of that health care worker's licensure in response to an extreme public health emergency as defined in section 801, subsection 4-A or a disaster as defined in Title 37-B, § 703, subsection 2 as long as the private institution hires or engages the services of the licensed health care worker in accordance with this subsection. (ME. REV. STAT. tit. 22 § 816(1-A))</p> <p>Any person participating in reporting under this chapter or participating in a related communicable disease investigation or proceeding, including, but not limited to, any person serving on or assisting a multidisciplinary intervention team or other investigating or treatment team, is immune from civil liability for the act of reporting or participating in the investigation or proceeding in good faith. (ME. REV. STAT. tit. 22 § 816(2))</p> <p>Immunity for public institutions and employees shall be governed by Title 14, chapter 741 [Torts Claims Act]. (ME. REV. STAT. tit. 22 § 816(3))</p>	
MA	<p>On and after a declaration of an emergency neither the Commonwealth nor any political subdivision thereof, nor other agencies, nor any person engaged in any civil defense activities while in good faith complying with or attempting to comply with this act or any other rule or regulation promulgated pursuant to the provisions of this act, shall be civilly liable for the death of or any injury to persons or damage to</p>	<p>Health care professionals, health care facilities, and volunteer organizations shall be immune from suit and civil liability for any damages alleged to have been sustained by an act or omission while providing health care services during the COVID-19 emergency. (S.B. 2640, 191st Leg., Reg. Sess. (Mass. 2020))</p>	<p>...except that the individual shall be liable for his negligence. (1950 Mass. Acts ch. 639 § 12)</p> <p>The immunity provided in subsection (a) shall not apply: (i) if the damage was caused by an act or omission constituting gross negligence, recklessness or conduct with an intent to harm or to discriminate based on</p>

State	I. General Liability Protections	II. Explicit Liability Protections	III. Exceptions
	<p>property as a result of such activity except that the individual shall be liable for his negligence. (1950 Mass. Acts ch. 639 § 12)</p>		<p>race, ethnicity, national origin, religion, disability, sexual orientation or gender identity by a health care facility or health care professional providing health care services; (ii) to consumer protection actions brought by the attorney general; or (iii) to false claims actions brought by or on behalf of the commonwealth. (S.B. 2640, 191st Leg., Reg. Sess. (Mass. 2020))</p> <p>... unless it is established that the damages were caused by the volunteer organization's gross negligence, recklessness or conduct with an intent to harm. (S.B. 2640, 191st Leg., Reg. Sess. (Mass. 2020))</p>
NH	<p>All functions under this subdivision and all other activities relating to emergency management are hereby declared to be governmental functions. Neither the state nor any of its political subdivisions nor any agency of the state or political subdivision, nor any private corporations, organizations, or agencies, nor any emergency management worker complying with or reasonably attempting to comply with this subdivision, or any order or rule adopted or regulation promulgated pursuant to the provisions of this subdivision, or pursuant to any ordinance relating to precautionary measures enacted by any political subdivision of the state, shall be liable for the death of or injury to persons, or for damage to property, as a result of any such activity. (N.H. REV. STAT. § 21-P:41(I))</p>	<p>Any emergency management worker, performing emergency management services at any place in this state pursuant to agreements, compacts or arrangements for mutual aid and assistance, to which the state or one of its political subdivisions is a party, shall possess the same powers, duties, immunities, and privileges the worker would ordinarily possess if performing his or her duties in the state or political subdivision in which normally employed or rendering services. (N.H. REV. STAT. § 21-P:41(V))</p>	

State	I. General Liability Protections	II. Explicit Liability Protections	III. Exceptions
	<p>Any person owning or controlling real estate or other premises or private property who grants a license or privilege or otherwise permits the designation or use of the whole or any part or parts of such real estate or premises or private property for the purpose of compliance or attempting to comply with this subdivision during an actual or impending emergency or practice exercise, together with his or her successors in interest, if any, shall not be civilly liable for negligently causing the death of, or injury to, any person on or about such real estate or premises or private property or loss of, or damage to, the property of such person. (N.H. REV. STAT. § 21-P:42)</p>		
RI	<p>All functions under this chapter, and all other activities relating to disaster response, are hereby declared to be governmental functions. Neither the state, nor any political subdivision thereof, nor other agencies of the state or political subdivision thereof, nor, except in cases of willful misconduct, gross negligence, or bad faith, any disaster response worker complying with, or reasonably attempting to comply with this chapter, or any order, rule, or regulation promulgated pursuant to the provisions of this chapter, or pursuant to any ordinance relating to precautionary measures enacted by any political subdivision of the state, shall be liable for the death of, or injury to, persons, or for damage to property, as a result of disaster response activity. (R.I. GEN. LAWS § 30-15-15(a))</p> <p>Any person controlling real estate or other premises who voluntarily, and without</p>		<p>... except in cases of willful misconduct, gross negligence, or bad faith[.] (R.I. GEN. LAWS § 30-15-15(a))</p>

State	I. General Liability Protections	II. Explicit Liability Protections	III. Exceptions
	<p>compensation, grants a license or privilege, or otherwise permits the designation or use of the whole or any part or parts of that real estate or premises for the purpose of sheltering persons during an actual, impending, mock, or practice disaster shall, together with his or her successors in interest, if any, not be civilly liable for negligently causing the death of, or injury to, any person on or about the real estate or premises or for the loss of, or damage to, the property of that person. (R.I. GEN. LAWS § 30-15-16)</p>		
VT	<p>[T]he state, any of its agencies, state employees as defined in 3 V.S.A. § 1101, political subdivisions, local emergency planning committees, or individual, partnership, association, or corporation involved in emergency management activities shall not be liable for the death of or any injury to persons or loss or damage to property resulting from an emergency management service or response activity, including the development of local emergency plans and the response to those plans. (VT. STAT. ANN. tit. 20 § 20(a))</p> <p>Any individual, partnership, association, corporation or facility that provides personnel, training or equipment through an agreement with the local emergency planning committee, the state emergency response commission or local emergency response officials is immune from civil liability to the same extent provided in subsection (a) of this section for any act performed within the scope of the agreement. (VT. STAT. ANN. tit. 20 § 20(b))</p>	<p>Any person owning or controlling premises who voluntarily and without compensation grants a license or privilege, or otherwise permits the designation or use of the whole or any part of such land and premises for the purpose of sheltering persons or animals or providing health-related services during a declared emergency or practice drill in cooperation with a federal, state, or political subdivision shall together with successors in interest not be civilly liable for negligence causing the death of or injury to any person on or about the land and premises or for loss of or damage to the property of the person during a declared emergency or practice drill. (VT. STAT. ANN. tit. 20 § 29)</p>	<p>Except in the case of willful misconduct or gross negligence... (VT. STAT. ANN. tit. 20 § 20(a))</p>

State	I. General Liability Protections	II. Explicit Liability Protections	III. Exceptions



Table 5 - Snapshot of Emergency Laws

This table indicates (via check marks (✓)) the existence of specific provisions across states' laws (see Tables 1-4 for more information).

Topic	CT	ME	MA	NH	RI	VT
I. Emergency/Disaster Declaration Authority (see Table 1)	✓	✓	✓	✓	✓	✓
II. Public Health Emergency Declaration Authority (see Table 1)	✓	✓	✓		✓	
III. Routine Licensure Reciprocity (see Table 2)	✓	✓	✓	✓	✓	✓
IV. Emergency Licensure Reciprocity (see Table 2)	✓	✓		✓	✓	✓
V. General Waiver Authority (see Table 3)	✓	✓	✓	✓	✓	✓
VI. Specific Waiver Authority (see Table 3)	✓	✓	✓	✓		✓
VII. General Liability Protections (see Table 4)	✓	✓	✓	✓	✓	✓
VIII. Explicit Liability Protections (see Table 4)		✓	✓	✓		✓

REFERENCES:

- ¹ James G. Hodge, Jr. & Evan D. Anderson, *Principles and Practice of Legal Triage During Public Health Emergencies*, 64 N.Y.U. ANN. SURV. AM. L. 249 (2008).
- ² AGENCY FOR HEALTHCARE RSCH. & QUALITY, ALTERED STANDARDS OF CARE IN MASS CASUALTY EVENTS: BIOTERRORISM AND OTHER PUBLIC HEALTH EMERGENCIES (2005).
- ³ James G. Hodge, Jr. et al., *Emergency Legal Preparedness for Hospitals and Health Care Personnel*, 3(S2) DISASTER MED. & PUB. HEALTH PREPAREDNESS S37 (2009).
- ⁴ Sara Rosenbaum et al., *State Laws Extending Comprehensive Legal Liability Protections for Professional Health-Care Volunteers During Public Health Emergencies*, 123 PUB. HEALTH REPS. 238 (2008).
- ⁵ Evan D. Anderson & James G. Hodge, Jr., *Emergency Legal Preparedness Among Select U.S. Local Governments*, 3(S2) DISASTER MED. & PUB. HEALTH PREPAREDNESS S1 (2009).
- ⁶ Gov. Charlie Baker of Mass., *Exec. Ord. No. 591*, Declaration of a State of Emergency to Respond to COVID-19 (Mar.10, 2020).
- ⁷ [COVID-19 State of Emergency](#), MASS.GOV (last visited July 21, 2021).
- ⁸ 42 U.S.C.A. §§ 5121-205 (West 2008).
- ⁹ 42 U.S.C.A. § 5122(1) (West 2008).
- ¹⁰ 50 U.S.C. §§ 1601–51 (2006).
- ¹¹ White House Office of the Press Secretary, *Declaration of a National Emergency with Respect to the 2009 H1N1 Influenza Pandemic* (Oct. 24, 2009).
- ¹² [COVID-19 Disaster Declarations](#), FEMA (July 6, 2021).
- ¹³ Memorandum to Extend Fed. Support to Governors' Use of the Nat'l Guard to Respond to COVID-19 and to Increase Reimbursement & Other Assistance Provided to States from Joseph R. Biden, President, U.S. (Jan. 21, 2021); Notice on the Continuation of the Nat'l Emergency Concerning the Coronavirus Disease 2019 (COVID-19) Pandemic from Joseph R. Biden, President, U.S. (Feb. 24, 2021).
- ¹⁴ 42 U.S.C. § 201 (2000).
- ¹⁵ James G. Hodge, Jr. et al., *Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP): Legal and Regulatory Issues*, HHS (2008).
- ¹⁶ James G. Hodge, Jr., *Global Legal Triage in Response to the 2009 H1N1 Outbreak*, 11 MINN. J.L. SCI. & TECH. 599 (2010).
- ¹⁷ Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPPRA), Pub. L. No. 113-5, 127 Stat. 161.
- ¹⁸ *The Model State Emergency Health Powers Act: Table of State Laws*, NETWORK FOR PUB. HEALTH L. (Aug. 1, 2011).
- ¹⁹ CTRS. FOR L. & THE PUB.'S HEALTH AT GEORGETOWN & JOHNS HOPKINS UNIV., MODEL STATE EMERGENCY HEALTH POWERS ACT ([MSEHPA](#)) (2008).
- ²⁰ Evan D. Anderson & James G. Hodge, Jr., *Emergency Legal Preparedness Among Select U.S. Local Governments*, 3(S2) DISASTER MED. & PUB. HEALTH PREPAREDNESS S176 (2009).
- ²¹ Boston Public Health Act of 1995, Mass. Gen. Laws Ann. Ch. 111 App., § 2-1 (West); Boston Public Health Commission, [Declaration of a Public Health Emergency Relative to COVID-19 in the City of Boston](#) (Mar. 15, 2020).
- ²² [Press Release](#), Gov. Malloy Signs Ord. that will Assist the State's Emergency Response in the Event of a Confirmed Infection or Exposure to Ebola, Gov. Daniel P. Malloy of Conn. (Oct. 7, 2014).
- ²³ NETWORK FOR PUB. HEALTH L., [COVID-19 EMERGENCY LEGAL PREPAREDNESS PRIMER](#) (2020).
- ²⁴ [Wisconsin Legislature v. Palm](#), -- N.W. 2nd--, 2020 WI 42.
- ²⁵ During Hurricane Katrina, Louisiana initially declared a state of emergency on Friday, August 26, 2005, and then declared a state of public health emergency a week later on Friday, September 2, 2005.
- ²⁶ DEL. CODE ANN. tit. 20, § 3102(1) (West 2007); DEL. CODE ANN. tit. 20, § 3102(2) (West 2007); DEL. CODE ANN. tit. 20, § 3132(11) (West 2007).
- ²⁷ Pandemic and All-Hazards Preparedness Act, PL 109–417, §§ 101, 102 (2006).
- ²⁸ AM. COLL. OF SURGEONS, UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT ([UEVHPA](#)) (Feb. 27, 2014).

-
- ²⁹ AM. COLL. OF SURGEONS, UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT ([UEVHPA](#)) (Feb. 27, 2014).
- ³⁰ Daniel Orenstein, *When Law is Not Law: Setting Aside Legal Provisions During Declared Emergencies*, 41 J.L., MED. & ETHICS (Apr. 1, 2013).
- ³¹ VT. STAT. ANN. tit. 20, § 34(b), *amended by* H. 366, 2021 Leg., Gen. Assemb. (Vt. 2021).
- ³² 2020 Mass. Acts. Ch. 40
- ³³ James G. Hodge, Jr. & Evan D. Anderson, *Principles and Practice of Legal Triage During Public Health Emergencies*, 64 N.Y.U. ANN. SURV. AM. L. 249 (2008).
- ³⁴ Image adapted from [The EMAC Process](#).
- ³⁵ EMAC, 2005 HURRICANE SEASON RESPONSE: AFTER ACTION REPORT (Sept. 19, 2006), at EX-4.
- ³⁶ EMAC, [EMAC Legislation](#), PL 104-321, Art. V.
- ³⁷ EMAC, [EMAC Legislation](#), PL 104-321, Art. VI.
- ³⁸ EMAC, [EMAC Legislation](#), PL 104-321, Art. VIII.
- ³⁹ EMAC, [Deploying Private Sector via EMAC](#) (Oct. 2019).
- ⁴⁰ EMAC, EMAC PREPAREDNESS GUIDE & DEPLOYMENT [TIPS FOR STATE](#), LOCAL AND TRIBAL PUBLIC HEALTH AND MEDICAL PERSONNEL 3 (last visited July 21, 2021).
- ⁴¹ See EMAC, [EMAC Legislation](#), PL 104-321.
- ⁴² EMAC, [EMAC Reimbursement Process](#).
- ⁴³ EMAC, [EMAC Reimbursement Process](#).
- ⁴⁴ EMAC, [What is EMAC?](#) (last visited July 21, 2021).
- ⁴⁵ [Press Release](#), Letter to Emergency Managers Requesting Action on Critical Steps, FEMA Adm'r (Mar. 27, 2020).
- ⁴⁶ [Press Release](#), California Shares Lifesaving Ventilators with Hard Hit States through EMAC, EMAC (Apr. 9, 2020).
- ⁴⁷ [International Emergency Assistance Memorandum of Understanding](#), INT'L EMERGENCY MNGT. GRP. (July 2000).
- ⁴⁸ [S.J. Res. 13](#), 110th Cong. (2008).
- ⁴⁹ [Meeting Minutes: IEMAC Spring Meeting 2018](#), INT'L EMERGENCY MNGT. GRP. (July 3, 2018).
- ⁵⁰ [International Emergency Assistance Memorandum of Understanding](#), INT'L EMERGENCY MGMT. GRP. (July 2000).
- ⁵¹ LARRY GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT (University of California Press, 3rd Ed. 2000).
- ⁵² BARRY FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS (West Academic Publishing, 8th Ed. 2018).
- ⁵³ [Reciprocity Packet](#), N.Y. STATE DEP'T OF HEALTH BUREAU OF EMERGENCY MED. SERVS. (Apr. 2013).
- ⁵⁴ [Reciprocity Packet](#), N.Y. STATE DEP'T OF HEALTH BUREAU OF EMERGENCY MED. SERVS. 2 (Apr. 2013).
- ⁵⁵ [Nurse Licensure Compact](#), NAT'L COUNCIL OF STATE BDS. OF NURSING (last visited July 21, 2021).
- ⁵⁶ [PSYPACT: 26 States Have Now Passed Laws Allowing Interstate Practice](#), AM. PSYCH. ASS'N SERVS., INC. (July 2, 2021).
- ⁵⁷ [About Us](#), PSYPACT (last visited July 21, 2021).
- ⁵⁸ EMAC, [Intrastate Mutual Aid Legislation](#), Art. V (March 2004).
- ⁵⁹ MODEL STATE EMERGENCY HEALTH POWERS ACT § 608(b) (2001).
- ⁶⁰ CONN. GEN. STAT. § 20-9(b)(5).
- ⁶¹ 32 ME. REV. STAT. § 3275(1)
- ⁶² 32 ME. REV. STAT. § 3278.
- ⁶³ R.I. GEN. LAWS § 23-1-17(b).
- ⁶⁴ [Order](#) of the Commissioner of Public Health: COVID-19 Public Health Emergency Order No. 2021-5, Mass. Dep't of Pub. Health (Aug. 20, 2021).
- ⁶⁵ [Order](#) Rescinding and Replacing the March 29, 2020 Order of the Commissioner of Public Health Maximizing Health Care Provider Availability, Mass. Dep't of Pub. Health (Apr. 3, 2020); [Order](#), Conn. Dep't of Pub. Health (Mar. 30, 2020).
- ⁶⁶ [Order](#) Allowing Out of State Practitioners to Render Temporary Assistance in Connecticut, Conn. Dep't of Pub. Health (Mar. 23, 2020).
- ⁶⁷ [What We License](#), R.I. DEP'T OF HEALTH (last visited July 21, 2021).
- ⁶⁸ AM. COLL. OF SURGEONS, UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT ([UEVHPA](#)) (Feb. 27, 2014).

-
- ⁶⁹ James G. Hodge, Jr. et al., *Volunteer Health Professionals and Emergencies: Assessing and Transforming the Legal Environment*, 3 BIOSECURITY & BIOTERRORISM 216 (2005).
- ⁷⁰ [U.S. States and Territories Modifying Licensure Requirements for Physicians in Response to COVID-19](#), FED’N OF STATE MED. BDS. (May 2020).
- ⁷¹ 42 U.S.C. § 1320b-5 (2006).
- ⁷² [Medicare FFS, Additional Emergency and Disaster Related Policies and Procedures That May be Implemented only with a §1135 Waiver](#), CTRS. FOR MEDICARE & MEDICAID (Mar. 15, 2019).
- ⁷³ [Medicare FFS, Additional Emergency and Disaster Related Policies and Procedures That May be Implemented only with a §1135 Waiver](#), CTRS. FOR MEDICARE & MEDICAID (Mar. 15, 2019).
- ⁷⁴ [1135 Waivers](#), U.S. DEP’T OF HEALTH & HUM. SERVS. (May 13, 2021).
- ⁷⁵ 42 U.S.C. § 1320b-5 (2006); [1135 Waivers](#), U.S. DEP’T OF HEALTH & HUM. SERVS. (May 13, 2021).
- ⁷⁶ [1135 Waivers](#), U.S. DEP’T OF HEALTH & HUM. SERVS. (May 13, 2021).
- ⁷⁷ MO. CODE REGS. ANN. tit. 19, § 30-20.021(2)(13) – (19) (2004).
- ⁷⁸ JCAHO, COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK GL-5 - GL-6 (2004).
- ⁷⁹ JCAHO, COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK GL-6 (2004).
- ⁸⁰ JCAHO, COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK GL-4 - GL 6, GL 19 (2004).
- ⁸¹ Mary E. O’Connor, *Medical Staff Appointment and Delineation of Pediatric Clinical Privileges in Hospitals*, 110 AM. ACAD. OF PEDIATRICS 414 (Aug. 2002).
- ⁸² JCAHO, COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK GL-4 (2004).
- ⁸³ Joint Comm’n, [Joint Commission FAQs](#), at EC-11 (last visited July 21, 2021).
- ⁸⁴ Joint Comm’n, [Joint Commission FAQs](#), at EC-11, MS-27 (last visited July 21, 2021).
- ⁸⁵ EMAC, [Intrastate Mutual Aid Legislation](#), Art. V (March 2004).
- ⁸⁶ 210 ILL. COMP. STAT. 50/3.55 (2014); NAT’L HIGHWAY TRAFFIC SAFETY ADMIN., [NAT’L EMS SCOPE OF PRACTICE MODEL](#) 18 (2007); Ryan Oglesby, *Recruitment and Retention Benefits of EMT-Paramedic Utilization During ED Nursing Shortages*, 33 J. EMERGENCY NURSING 21 (2007).
- ⁸⁷ Gov. Martin O’Malley of Md., [Exec. Ord. No. 01.01.2009.15](#), Declaration of Emergency: Emergency Medical Services Staffing for Maryland’s H1N1 Influenza Vaccination Campaign (Nov. 6, 2009).
- ⁸⁸ [Remarks on the Opioid Crisis](#), Gov. Deval L. Patrick of Mass. (Mar. 27, 2014).
- ⁸⁹ Christian M. Wade, [State Expands Scope of Nurse Practitioners](#), SALEM NEWS (Mar. 27, 2020).
- ⁹⁰ [What’s the Difference Between Telemedicine and Telehealth?](#), AAFP (last visited July 21, 2021).
- ⁹¹ [Coronavirus Preparedness and Response Supplemental Appropriations Act](#), P.L. 116-123, 116th Cong. (Mar. 6, 2020).
- ⁹² [COVID-19 Information Page](#), U.S. DEP’T OF JUST. DRUG ENF’T ADMIN.: DIVERSION CONTROL DIV. (last visited July 21, 2021).
- ⁹³ [Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency](#), U.S. DEP’T OF HEALTH AND HUM. SERVS. (Jan. 20, 2021).
- ⁹⁴ [CONNECT for Health Act of 2021](#), H.R. 2903, 117th Cong. (Apr. 28, 2021).
- ⁹⁵ [Improving Telehealth for Underserved Communities Act of 2020](#), S.3998, 116th Cong. (2019-2020).
- ⁹⁶ [TREAT Act](#), S. 168, 117th Cong. (2021, 2022).
- ⁹⁷ [KEEP Telehealth Options Act of 2021](#), H.R. 1677, 117th Cong. (2021, 2022).
- ⁹⁸ [Advancing Telehealth Beyond COVID-19 Act of 2020](#), H.R. 7338, 116th Cong. (2019, 2020).
- ⁹⁹ [Private Payers & Telemedicine](#), eVISIT (last visited July 21, 2021).
- ¹⁰⁰ ME. REV. STAT. ANN. tit. 22, § 3173-H (2021), *amended by* S.P. 50, 130th Leg., 1st Reg. Sess. (Me. 2021).
- ¹⁰¹ CTR. FOR CONNECTED HEALTH POL’Y, [STATE TELEHEALTH LAWS AND REIMBURSEMENT POLICIES REPORT, SPRING 2021](#) (2021).
- ¹⁰² CTR. FOR CONNECTED HEALTH POL’Y, [STATE TELEHEALTH MEDICAID FEE-FOR-SERVICE POLICY](#) (2020).
- ¹⁰³ Tayla Holman, [How Do Telehealth Laws and Regulations Vary By State?](#), BARTON ASSOCS. (Sept. 3, 2019).
- ¹⁰⁴ Ctr. for Connected Health Pol’y, [Telehealth in the Time of COVID-19](#), CCHP (May 13, 2020).
- ¹⁰⁵ See, e.g., Gov. Christopher T. Sununu of N.H., [Emergency Ord. No. 8 Pursuant to Executive Order 2020-04](#), Temporary expansion of access to Telehealth Services to protect the public and health care providers (Mar. 18, 2020).

-
- ¹⁰⁶ Gov. Gina M. Raimondo of R.I., [Exec. Ord. 20-06](#), Fourth Supplemental Emergency Declaration – Expanding Access to Telemedicine Services (Mar. 18, 2020).
- ¹⁰⁷ Gov. Charles D. Baker of Mass., [Order Expanding Access to Telehealth Services and to Protect Healthcare Providers](#) (Mar. 15, 2020).
- ¹⁰⁸ [An Act Relating to Vermont’s Response to COVID-19](#), H.B. 742, 2019-2020 Leg., Gen. Assemb. (Vt. 2020).
- ¹⁰⁹ [President Trump Expands Telehealth Benefits for Medicare Beneficiaries During COVID-19 Outbreak](#), CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 17, 2020).
- ¹¹⁰ Eric Wicklund, [CMS Expands COVID-19 Telehealth Reimbursement to Therapists, Phone Services](#), MHEALTHINTELLIGENCE (May 1, 2020).
- ¹¹¹ Casey Ross, [‘I Can’t Imagine Going Back’: Medicare Leader Calls for Expanded Telehealth Access After Covid-19](#), STAT (June 9, 2020).
- ¹¹² [President Trump Expands Telehealth Benefits for Medicare Beneficiaries During COVID-19 Outbreak](#), CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 17, 2020).
- ¹¹³ Madeline Guth & Elizabeth Hinton, [State Efforts to Expand Medicaid Coverage & Access to Telehealth in Response to COVID-19](#), KAISER FAM. FOUND. (June 22, 2020).
- ¹¹⁴ [Emergency Preparedness and Response for Home and Community Based \(HCBS\) 1915\(c\) Waivers](#), MEDICAID.GOV (last visited July 21, 2021).
- ¹¹⁵ Reed Abelson, [Is Telemedicine Here to Stay?](#), N.Y. TIMES (Aug. 3, 2020).
- ¹¹⁶ Fred Schulte, [Coronavirus Fuels Explosive Growth in Telehealth — And Concern About Fraud](#), Kaiser Health News (Apr. 22, 2020).
- ¹¹⁷ *Browning v. West Calcasieu Cameron Hosp.*, 865 So. 2d 795 (La. Ct. App. 3d Cir. 2003).
- ¹¹⁸ CONN. GEN. STAT. § 20-206kk (2013).
- ¹¹⁹ *Browning v. West Calcasieu Cameron Hosp.*, 865 So. 2d 795, 805–06 (La. Ct. App. 2003) (stating that protocols at issue “clearly provide the applicable standard of care” and that “EMTs’ failure to observe . . . established protocols is evidence of their obvious negligence.”).
- ¹²⁰ *Fagocki v. Algonquin/Lake-In-The-Hills Fire Protection Dist.*, 496 F.3d 623 (7th Cir. 2007).
- ¹²¹ W. Ann Maggiore, [Patient Abandonment: What It Is – and Isn’t](#), J. EMERGENCY MED. SERVS., (Oct. 3, 2007).
- ¹²² S.B. 2630, 191st Leg., Gen. Sess. (Mass. 2020); S.B. 2635, 191st Leg., Gen. Sess. (Mass. 2020).
- ¹²³ H.B. 5675, 2021 Leg., Gen. Assemb. (Conn. 2021); S.B. 538, 2021 Leg., Gen. Assemb. (Conn. 2021); S.B. 826, 2021 Leg., Gen. Assemb. (Conn. 2021).
- ¹²⁴ Jothan Sederstrom, [EMT Charged with Abandoning Child at Bronx Hospital After Forging Nurse’s Signature](#), N.Y. DAILY NEWS (Mar. 13, 2009) (EMT criminally charged after leaving 5-year-old child at hospital without completing patient care report or obtaining nurse’s signature).
- ¹²⁵ *People v. Jackson*, 938 N.Y.S.2d 726 (N.Y. Crim. Ct. 2011); [Charges Dropped Against EMT Accused of Letting Woman Die](#), CBS N.Y. (June 25, 2013); Al Baker, [Back on Duty, but Under a Cloud After a Death](#), N.Y. TIMES (Jan. 20, 2010).
- ¹²⁶ ARIZ. DEP’T OF HEALTH SERVS., [ARIZONA DEPARTMENT OF HEALTH SERVICES HEALTH REGULATORY BOARD ANALYSIS](#) (2017).
- ¹²⁷ CAL. HEALTH & SAFETY CODE § 1798.200(a)(6)(C)(1)-(12) (West 2011); N.Y. COMP. CODES R. & REGS. tit. 10, § 800.15-16 (2014).
- ¹²⁸ CAL. HEALTH & SAFETY CODE § 1798.200 (West 2011).
- ¹²⁹ N.Y. PUB. HEALTH LAW § 12 (McKinney 2008); N.Y. COMP. CODES R. & REGS. tit. 10, § 800.16 (2014).
- ¹³⁰ 42 U.S.C. § 1396r-2; [NPDB Mandatory Reporting](#), ARIZ. DEP’T OF HEALTH SERVS.
- ¹³¹ Linda Twardoski et al., [Professional Responsibilities for Treatment of Patients with Ebola: Can a Healthcare Provider Refuse To Treat a Patient with Ebola?](#), 97 R.I. MED. J. 63 (Oct. 2014).
- ¹³² CONN. GEN. STAT. § 20-206nn (2013)
- ¹³³ Mass. Nursing Ass’n, [Latest COVID-19 MNA Letter to Gov. Baker Sounds Alarm on Dangerous Decisions Being Made About Protective Equipment and Service Closures While Hospitals Layoff and Cancel Nurses Despite Extra Funding](#), PR NEWSWIRE (Apr. 14, 2020).
- ¹³⁴ Paul P. Murphy, [10 Coronavirus-Unit Nurses Are Suspended, Potentially for Weeks, for Refusing to Work Without N95 Masks](#), CNN (Apr. 17, 2020).
- ¹³⁵ 42 U.S.C. § 1983 (1996).
- ¹³⁶ *Davidson v. City of Jacksonville*, 359 F. Supp. 2d 1291 (M.D. Fla. 2005).
- ¹³⁷ *Williams v. Richmond County*, 804 F. Supp. 1561 (S.D. Ga. 1992).

-
- ¹³⁸ *Darling v. Charleston Cmty. Mem'l Hosp.*, 211 N.E.2d 253 (Ill. 1965).
- ¹³⁹ *Tallahassee Mem'l Reg'l Med. Ctr., Inc. v. Meeks*, 560 So. 2d 778 (Fla. 1990).
- ¹⁴⁰ Maya Atrakchi & Jason Gavejian, [Vermont Court Finds Patient Can Sue Hospital and an Employee for Breach of Confidentiality](#), JD SUPRA (June 6, 2019).
- ¹⁴¹ 6 MATTHEW G. DORE, BUSINESS ORGANIZATIONS § 40:16 (2020).
- ¹⁴² *MCG Health, Inc. v. Nelson*, 606 S.E.2d 576, 579–80 (Ga. App. 2004).
- ¹⁴³ *Green v. City of N.Y.*, 465 F.3d 65 (2d Cir. 2006).
- ¹⁴⁴ *Green v. City of N.Y.*, 465 F.3d 65 (2d Cir. 2006) (citing *Coon v. Town of Springfield*, 404 F.3d 683 (2d Cir. 2005); *Amnesty Am. v. Town of W. Hartford*, 361 F.3d 113 (2d Cir. 2004); *Patterson v. County of Oneida*, 375 F.3d 206 (2d Cir. 2004); *Kern v. City of Rochester*, 93 F.3d 38 (2d Cir. 1996); *City of Canton v. Harris*, 489 U.S. 378 (1989)).
- ¹⁴⁵ Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327.
- ¹⁴⁶ Rehabilitation Act of 1973, Pub. L. No. 93-112, 87 Stat. 355.
- ¹⁴⁷ *Bragdon v. Abbott*, 524 U.S. 624 (1998).
- ¹⁴⁸ ME. REV. STAT. ANN. §§ 8101–18; RESTATEMENT (SECOND) OF TORTS § 895B (1979).
- ¹⁴⁹ RESTATEMENT (SECOND) OF TORTS § 895B (1979).
- ¹⁵⁰ ME. REV. STAT. ANN. §§ 8101–18
- ¹⁵¹ *Velazquez v. N.Y. City Health and Hosp. Corp.*, 65 A.D.3d 981 (N.Y. Sup. Ct. 2009).
- ¹⁵² ARIZ. REV. STAT. ANN. § 12-982 (1997) (West).
- ¹⁵³ Federal Volunteer Protection Act of 1997, Pub. L. No. 105-19; 42 U.S.C. § 14501 (2004).
- ¹⁵⁴ The CARES Act, Pub. L. No. 116-136 (2020).
- ¹⁵⁵ 1950 Mass. Acts Ch. 639 § 12.
- ¹⁵⁶ CONN. GEN. STAT. § 19a-131i.
- ¹⁵⁷ ME. REV. STAT. tit. 22 § 816-2.
- ¹⁵⁸ Gov. Ned Lamont of Conn., [Exec. Ord. No. 7U](#), Protection of Public Health and Safety During COVID-19 Pandemic and Response – Protection from Civil Liability for Healthcare Providers and Billing Protections for Patients (Apr. 5, 2020).
- ¹⁵⁹ [Attorney General Opinion No. 2020-01](#), Att’y Gen. Gordon J. MacDonald of N.H. (Apr. 22, 2020).
- ¹⁶⁰ [New Hampshire Good Samaritan Law](#), N.H. RSA § 508:12 (2015).
- ¹⁶¹ *Willard v. Vicksburg*, 571 So. 2d 972 (Miss. 1990) (declining to interpret a Good Samaritan statute, but recommending that the legislature review and amend the statute to clarify application to those with a duty to provide care).
- ¹⁶² *Leang v. Jersey City Bd. of Educ.*, 969 A.2d 1097 (N.J. 2009) (Good Samaritan Act did not apply to situations where care or transportation was provided to a person who was not the victim of an accident or emergency as envisioned by the legislature in passing the Act).
- ¹⁶³ ME. REV. STAT. tit. 14, § 158; see also ME. REV. STAT. tit. 14, § 158-B(1)
- ¹⁶⁴ ME. REV. STAT. tit. 14, § 158-A(2).
- ¹⁶⁵ 42 U.S.C. § 247d-6d (2013).
- ¹⁶⁶ Pandemic Influenza Vaccines – Amendment, [75 Fed. Reg. 10,270–10,271](#) (Mar. 5, 2010).
- ¹⁶⁷ 42 U.S.C. § 247d-6d (2013); [The Public Readiness and Preparedness Act \(PREP\): What You Need to Know](#), MICH. DEP’T OF CMTY. HEALTH (2010).
- ¹⁶⁸ Ebola Virus Disease Vaccines, [79 Fed. Reg. 73,314](#) (Dec. 10, 2014).
- ¹⁶⁹ [Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19](#), [85 Fed. Reg. 15,198](#) (Mar. 17, 2020).
- ¹⁷⁰ JOSEPH R. BIDEN, [NATIONAL STRATEGY FOR THE COVID-19 RESPONSE AND PANDEMIC PREPAREDNESS \(2021\)](#).
- ¹⁷¹ JOSEPH R. BIDEN, [NATIONAL STRATEGY FOR THE COVID-19 RESPONSE AND PANDEMIC PREPAREDNESS \(2021\)](#).
- ¹⁷² James G. Hodge, Jr., *The Intersection of Federal Health Information Privacy and State Administrative Law: The Protection of Individual Health Data and Workers’ Compensation*, 51 ADMIN. L. REV. 117 (1999).
- ¹⁷³ U.S. CHAMBER OF COM., ANALYSIS OF WORKERS’ COMPENSATION LAWS (2004); 2 WILLIAM R. SCHNEIDER, THE LAW OF WORKMEN’S COMPENSATION (2012).
- ¹⁷⁴ LEX K. LARSON, ET. AL, [WORKERS’ COMPENSATION LAW: CASE, MATERIALS AND TEXT](#) (6th ed. 2018).
- ¹⁷⁵ U.S. Chamber of Commerce, *2004 Analysis of Workers’ Compensation Laws*, 2004.

-
- ¹⁷⁶ LEX K. LARSON, ET. AL, [WORKERS' COMPENSATION LAW: CASE, MATERIALS AND TEXT](#) (6th ed. 2018); JACK B. HOOD ET AL., *WORKERS' COMPENSATION AND EMPLOYEE PROTECTION LAWS IN A NUTSHELL* (3rd ed. 1999).
- ¹⁷⁷ James G. Hodge, Jr., *The Intersection of Federal Health Information Privacy and State Administrative Law: The Protection of Individual Health Data and Workers' Compensation*, 51 ADMIN. L. REV. 117 (1999).
- ¹⁷⁸ LEX K. LARSON, ET. AL, [WORKERS' COMPENSATION LAW: CASE, MATERIALS AND TEXT](#) (6th ed. 2018).
- ¹⁷⁹ LEX K. LARSON, ET. AL, [WORKERS' COMPENSATION LAW: CASE, MATERIALS AND TEXT](#) (6th ed. 2018).
- ¹⁸⁰ BRETT GIROIR & ROBERT KADLEC, [RAPID EXPERT CONSULTATION ON CRISIS STANDARDS OF CARE FOR THE COVID-19 PANDEMIC](#) (2020).
- ¹⁸¹ INST. OF MED. OF THE NAT'L ACADS., *GUIDANCE FOR ESTABLISHING CRISIS STANDARDS OF CARE FOR USE IN DISASTER SITUATIONS: A LETTER REPORT* (Bruce M. Altevogt et al. eds., 2009); Lawrence O. Gostin & Dan Hanfling, *National Preparedness for a Catastrophic Emergency: Crisis Standards of Care*, 302 J. AM. MED. ASS'N 2365 (2009).
- ¹⁸² INST. OF MED. OF THE NAT'L ACADS., *GUIDANCE FOR ESTABLISHING CRISIS STANDARDS OF CARE FOR USE IN DISASTER SITUATIONS: A LETTER REPORT* (Bruce M. Altevogt et al. eds., 2009).
- ¹⁸³ INST. OF MED. OF THE NAT'L ACADS., *CRISIS STANDARDS OF CARE: A SYSTEMS FRAMEWORK FOR CATASTROPHIC DISASTER RESPONSE* (Dan Hanfling et al. eds., 2012).
- ¹⁸⁴ INST. OF MED. OF THE NAT'L ACADS., *CRISIS STANDARDS OF CARE: A SYSTEMS FRAMEWORK FOR CATASTROPHIC DISASTER RESPONSE* (Dan Hanfling et al. eds., 2012).
- ¹⁸⁵ Rukmini Callimachi, [Paramedics, Strained in the Hot Zone, Pull Back from CPR](#), N.Y. TIMES (May 10, 2020).
- ¹⁸⁶ [State Crisis Standards of Care Web Resources](#), NETWORK FOR PUB. HEALTH L. (June 14, 2013),
- ¹⁸⁷ 42 U.S.C.A. § 247d(a)(2) (West 2011).
- ¹⁸⁸ [Termination of the Emergency Use Authorization \(EUA\) of Medical Products and Devices](#), CDC (June 24, 2010).
- ¹⁸⁹ [Expiration Dating Extension](#), FDA (July 12, 2021).
- ¹⁹⁰ [Press Release](#), Coronavirus (COVID-19) Update: FDA Issues Emergency Use Authorization for Potential COVID-19 Treatment, U.S. Food & Drug Admin. (May 1, 2020).
- ¹⁹¹ [Emergency Use Authorizations for Medical Devices](#), FDA (Mar. 1, 2021).
- ¹⁹² [Johnson & Johnson Announces Submission of Application to the U.S. FDA for Emergency Use Authorization of its Investigational Single-Shot Janssen COVID-19 Vaccine Candidate](#), JANSSEN (Feb. 4, 2021); [Johnson & Johnson COVID-19 Vaccine Authorized by U.S. FDA for Emergency Use – First Single-Shot Vaccine in Fight Against Global Pandemic](#), JOHNSON & JOHNSON (Feb. 27, 2021).
- ¹⁹³ [Johnson & Johnson COVID-19 Vaccine Authorized by U.S. FDA for Emergency Use – First Single-Shot Vaccine in Fight Against Global Pandemic](#), JOHNSON & JOHNSON (Feb. 27, 2021).
- ¹⁹⁴ Jessica R. MacNeil et al., [Updated Recommendations from the Advisory Committee on Immunization Practices for Use of the Janssen \(Johnson & Johnson\) COVID-19 Vaccine After Reports of Thrombosis with Thrombocytopenia Syndrome Among Vaccine Recipients](#), 70 MORBIDITY & MORTALITY WKLY. REP. 651, 651 (Apr. 30, 2021).
- ¹⁹⁵ Jessica R. MacNeil et al., [Updated Recommendations from the Advisory Committee on Immunization Practices for Use of the Janssen \(Johnson & Johnson\) COVID-19 Vaccine After Reports of Thrombosis with Thrombocytopenia Syndrome Among Vaccine Recipients](#), 70 MORBIDITY & MORTALITY WKLY. REP. 651, 651 (Apr. 30, 2021).
- ¹⁹⁶ [Press Release](#), FDA Approves First COVID-19 Vaccine, U.S. Food & Drug Admin. (Aug. 23, 2021).
- ¹⁹⁷ Sarah Elizabeth Adler, [What Full FDA Approval of the COVID-19 Vaccines Will Mean](#), AARP (July 16, 2021).
- ¹⁹⁸ Project Bioshield Act of 2004, Pub. L. No. 108-276, § 564(a)-(b).
- ¹⁹⁹ Project Bioshield Act of 2004, Pub. L. No. 108-276, § 564(c).
- ²⁰⁰ U.S. DEP'T OF HEALTH & HUM. SERVS., [EMERGENCY USE AUTHORIZATION OF MEDICAL PRODUCTS AND RELATED AUTHORITIES: GUIDANCE FOR INDUSTRY AND OTHER STAKEHOLDERS](#) (2017).
- ²⁰¹ [Emergency Use Authorization](#), U.S. FOOD & DRUG ADMIN. (Apr. 2009).
- ²⁰² Project Bioshield Act of 2004, Pub. L. No. 108-276, § 564(e).
- ²⁰³ Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA), Pub. L. No. 113-5, 127 Stat. 161; 21 U.S.C. § 360bbb-3 (2013).

-
- ²⁰⁴ U.S. DEP'T OF HEALTH & HUM. SERVS., [EMERGENCY USE AUTHORIZATION OF MEDICAL PRODUCTS AND RELATED AUTHORITIES: GUIDANCE FOR INDUSTRY AND OTHER STAKEHOLDERS](#) (2017).
- ²⁰⁵ 42 U.S.C. § 300hh-11(e)(3); *see generally* 44 C.F.R. § 206.43 (2004).
- ²⁰⁶ 38 U.S.C. § 4312 (2002).
- ²⁰⁷ 38 U.S.C. § 4316 (2002).
- ²⁰⁸ ALA. CODE 1975 § 36-1-9; ARK. CODE ANN. § 12-85-101, et seq. (2005); DEL. CODE ANN. § 6001, et seq. (2005); GA. CODE ANN., § 38-3-91, et seq. (2005); 5 ILL. COMP. STAT. 335/1, et seq. (2005); IOWA CODE ANN. § 70A.26 (1999); KAN. STAT. ANN. § 75-5546, et seq. (2004); KY. REV. STAT. § 65-395 (2005); MO. ANN. STAT. § 105.267 (West 2005); N.C. GEN. STAT. § 166A-30, et seq. (2005); N.D. CENT. CODE § 54-06-14.3 (2003); R.I. GEN. LAWS § 28-49-1, et seq. (2004); UTAH CODE ANN. § 34-43-101, et seq. (2005).
- ²⁰⁹ [Rhode Island Disaster Service Volunteer Leave Act](#), 28 R.I. GEN. LAWS ANN. § 28-49-3 (West).
- ²¹⁰ [CT GEN. STAT. § 5-249 \(West 2018\)](#).
- ²¹¹ [Paid Sick Leave](#), NAT'L CONF. OF STATE LEGISLATURES (July 21, 2020).
- ²¹² [Medical Assistance](#), U.S. DEP'T OF HEALTH & HUM. SERVS. (May 14, 2021).
- ²¹³ JOINT COMM'N, [EMERGENCY MANAGEMENT HEALTHCARE ENVIRONMENT CHECKLIST](#) (2020).
- ²¹⁴ Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (1996).
- ²¹⁵ [COVID-19 & HIPAA Bulletin: Limited Waiver of HIPAA Sanctions and Penalties During a Nationwide Public Health Emergency](#), U.S. DEP'T OF HEALTH & HUM. SERVS. (Mar. 2020).
- ²¹⁶ CDC, *HIPAA Privacy Rule and Public Health: Guidance from the Centers for Disease Control and the Department of Health and Human Services*, 52 (Supp.) MORBIDITY & MORTALITY WKLY. REP. 1 (2003).