



Model Memorandum of Understanding Between Hospitals during Declared Emergencies

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Introduction and Background. During a government-declared state of emergency, collaborations among healthcare entities (e.g., hospitals, nursing homes, clinics, rehabilitation facilities) can be vital to secure the health of individuals and populations. In particular, hospitals offering acute care services may benefit from sharing resources (e.g., personnel, equipment, supplies) and providing logistical support (e.g., continuity of communications) to meet patient surges during declared emergencies, disasters, or public health emergencies. Nationally, hundreds of acute care hospitals and other healthcare entities have executed memoranda of understanding (MOUs) or mutual aid agreements (MAAs) over the last decade to facilitate potential collaborative efforts.¹

As members of the Preparedness and Catastrophic Event Response (PACER) consortium, colleagues at the Johns Hopkins Center for Law and the Public's Health assessed model MOUs, MAAs, and other inter-hospital agreements, as well as select examples of agreements executed between healthcare entities in specific areas. Our review of these documents illustrates considerable inconsistencies in their purpose, content, scope, use, and conformance with principles set forth in the Department of Homeland Security (DHS) National Incident Management System (NIMS). Many of these agreements also do not reflect critical legal issues that may be implicated during declared states of emergency, disaster, or public health emergency.

An important issue related to existing examples of MOUs and MAAs is the extent to which they may constitute legally-binding contracts. Some MOUs are drafted as formal, binding contracts, or so closely resemble contracts in their style and content that courts would likely interpret them as formal contracts.² These documents often include clauses that attempt to dissolve liability between the signatories for specific acts or failures to act, but the actual utility of those exculpatory clauses is uncertain.³ Other MOUs or MAAs are drafted so as to not be construed as legally-binding contracts.⁴

Whether labeled as MOUs or MAAs,⁵ we have not identified any case law that definitively clarifies the legal enforceability of either MOUs or MAAs as binding contracts in the context of health care agreements. Emergency care hospitals and other entities that execute MOUs should assess whether the MOU constitutes a legally-binding contract under the laws of their specific jurisdictions. The potential for an MOU to be construed as a legal contract may impede the ability of hospitals to make real-time decisions during emergencies due to concerns of contractual liability or other factors. For this and other reasons, our understanding is that many hospitals prefer non-binding MOUs.

Project Objective. The primary goal of this project is to develop a model MOU for consideration by hospitals and potentially other healthcare entities within a specified healthcare system. An invaluable step toward this goal was the development of a draft blueprint outline of a model MOU. This blueprint was vetted among PACER colleagues and representatives of hospitals and other healthcare entities, public health authorities, emergency management officials, and other stakeholders. The resulting comments were considered, compared, and, to the extent possible, incorporated into a final blueprint outline. Based on the final blueprint outline and the underlying expert comments, the Center drafted and now presents below the following draft Model MOU for further review. As discussed above, this draft is not intended to constitute a legal contract consistent with the most common usage of the term "MOU."

**Model Memorandum of Understanding
Among Hospitals during Declared Emergencies**

This Memorandum of Understanding (MOU) is made and entered into as of this ____ day of _____ in the year _____, by and between

(list hospitals that are parties to the MOU)

Each of these hospitals is a party to this MOU and collectively they constitute the “Hospital Mutual Aid Network” for the purposes of this MOU.

NOW, THEREFORE, the parties agree as follows:

I. General Provisions

1.1 **Definitions.** As used in this MOU, these terms shall be defined as follows:

- (a) “**Contractor**” means a healthcare professional who provides healthcare services at a hospital, but is not under the direct control of the hospital and exercises independent judgment and discretion.
- (b) “**Designated representative**” means an individual and at least one alternative designee identified by a party as having the authority to issue, receive, and answer requests for resources pursuant to this MOU.
- (c) “**Emergency**” means an emergency, catastrophic event, disaster, public health crisis, or other exigency as defined in the jurisdiction(s) in which the parties are located.
- (d) “**Emergency declaration**” means the official declaration by an authorized government official of a state of emergency in the jurisdiction in which one or more parties is located.
- (e) “**Employee**” means a healthcare worker at a hospital who is employed to render healthcare services under the direct control of the hospital.
- (f) “**Healthcare services**” means the provision of medical treatment, care, advice, or other services, or supplies, related to the health of individuals or human populations.
- (g) “**Healthcare professional**” means an individual licensed under state law to provide healthcare services.

- (h) “**Healthcare surrogate**” means the parent, court-appointed legal guardian, or other individual lawfully authorized to make health care decisions for a minor or individual who lacks the legal capacity to make decisions on his or her own behalf.⁶
- (i) “**Healthcare worker**” means an individual, including a healthcare professional, who provides healthcare services.
- (j) “**Hospital Mutual Aid Network**” means the collective group of hospitals that are parties to the MOU.
- (k) “**Lending hospital**” means a party that considers requests and potentially provides personnel or other resources or provides resourced beds for transferred patients pursuant to this MOU.
- (l) “**License to practice healthcare service**” means the state authorization of an appropriately trained healthcare professional to provide healthcare services that would otherwise be unlawful without the authorization.
- (m) “**National Incident Management System (NIMS)**” means the federal coordinating program overseen by the Department of Homeland Security (DHS) requiring hospitals to formulate emergency plans including mechanisms to facilitate mutual aid in the event of inter-jurisdictional emergencies.⁷
- (n) “**Party**” means a hospital that has executed this MOU.
- (o) “**Prescribing Power**” means the authority to dispense prescription drugs for healthcare purposes pursuant to state licenses and institutional privileges.
- (p) “**Requesting hospital**” means a party that requests personnel or other resources or requests the transfer of patients pursuant to this MOU.
- (q) “**Scope of practice**” means the extent of the authorization to provide healthcare services granted by a license to practice healthcare services in the state in which the healthcare professional practices. Scope of practice may be further limited by privileging and credentialing requirements imposed by the state or the hospital in which the healthcare professional practices.
- (r) “**Standard of care**” means the degree of prudence and skill that a healthcare professional, healthcare worker, or healthcare entity must provide to a patient based on prevailing circumstances and existing best practices.
- (s) “**Volunteer health practitioner (VHP)**” means a healthcare worker licensed or registered in one or more states who is not an employee or contractor of a requesting hospital and who voluntarily provides healthcare services at a requesting hospital, irrespective of individual compensation.⁸

(t) “**Worker’s compensation**” means the government administered system for providing benefits to individuals injured or killed in the course of employment, regardless of fault.

1.2 **Construction.** This MOU is not a legal contract, and shall not be construed as a legal contract. Rather, this MOU expresses the intentions of the parties to provide mutual aid through procedures set forth herein.

1.3 **Activation of the Hospital Mutual Aid Network by Emergency Declaration.** An emergency declaration activates the terms of this MOU. The MOU does not govern the exchange of resources among the parties in non-emergency situations, but may be used to guide resource allocations during mock training exercises as agreed by the parties.

1.4 **Effect of Emergency Declaration and Relation to Other Laws.** An emergency declaration changes the legal environment in diverse and numerous ways that may impact the operation of this MOU. An emergency declaration may:

- (a) Suspend laws and regulations applicable to hospitals, including those that regulate the provision of healthcare services by healthcare workers;
- (b) Require hospital compliance with local, state, regional, and national emergency management agency directives and regional response efforts;
- (c) Initiate temporary licensure reciprocity through which healthcare professionals licensed in one jurisdiction are allowed to practice in another jurisdiction, often pursuant to various requirements such as advance volunteer registration or affiliation with an entity that deploys VHPs;
- (d) Provide enhanced liability protections to healthcare workers or VHPs for services that they render in responding to the emergency;
- (e) Extend workers compensation benefits to VHPs who would not otherwise qualify as covered employees;
- (f) Change the applicable standards of care;
- (g) Provide enhanced government emergency and disaster relief funding for ongoing response activities and reimbursement for rendered emergency and disaster services; and
- (h) Provide increased and expedited access to public entitlement programs, including through the waiver of enrollment requirements for Medicaid and Medicare.

The provisions of this MOU shall be applied consistent with these and other changing legal norms to the maximum extent possible during emergencies.

- 1.5 **Compliance with Federal, State, and Local Emergency Management Directives.** Parties shall actively follow directives from federal, state, and local emergency management agencies and accommodate these agencies in their efforts to oversee or direct the use of property or allocate health resources across impacted areas during an emergency.
- 1.6 **Federal Emergency Medical Treatment and Active Labor Act (EMTALA).⁹** EMTALA can impact the provision of healthcare services at hospitals, including medical triage, by requiring hospitals to screen and stabilize individuals requesting emergency treatment and prohibiting inappropriate transfer of patients. Under certain circumstances during declared emergencies, federal officials can suspend some of the requirements under EMTALA.¹⁰ If an EMTALA waiver is issued which covers one or more parties to this MOU, such parties shall immediately assess capacity to accept transferred patients and provide additional screening and stabilization services. As well, other parties shall be informed as soon as possible of:
- (i) the inception of the party's disaster protocol and the duration of the waiver's coverage;
 - (ii) any plans to suspend or modify patient screening and stabilization procedures; and
 - (iii) intended or expected needs regarding the transfer of existing patients, pursuant to Section 2.9 below.
- 1.7 **Identification of Designated Representative.** Each party agrees to identify a designated representative to communicate with other parties prior to and during a government-declared state of emergency and to ensure compliance with NIMS requirements (set forth in Section 1.8 below). The names and contact information for the designated representatives and alternate(s) are set forth in [Exhibit A](#). A designated representative must be available to act at all times.
- 1.8 **Effect of NIMS Requirements.** Parties shall integrate Hospital Incident System (HICS) principles and NIMS principles into their Emergency Response Plan including NIMS Implementation Activities for Hospital and Healthcare Systems¹¹ established by the NIMS Integration Center. Pursuant to this MOU, parties shall comply with the following:
- (a) **Structural requirements.** Parties shall implement an Incident Command System (ICS) as prescribed by current NIMS standards, including the development of a command hierarchy which facilitates communications between hospitals, government officials, and their communities. The designated representative shall be identified in the ICS hierarchy.
 - (b) **Collaboration.** Parties shall participate in Multi-Agency Coordination Systems (MACS)¹² and promote them with the public and private sectors and non-governmental organizations as appropriate and necessary. These agreements should be reviewed and executed annually as required by NIMS directives.¹³

Amendments to this MOU that enable efficient utilization of MACS may be considered and incorporated as future Exhibits.

- (c) **Resource typing.** To enhance emergency preparedness, parties shall follow the national typing protocol as prescribed by NIMS to describe available resources using category, kind, components, metrics, and type data.^{14,15}
- (d) **NIMS credentialing.** Parties shall comply to the maximum extent possible with NIMS requirements concerning baseline credentialing, certification, training,¹⁶ and education.
- (e) **Leadership NIMS certification.** Party administrators and healthcare workers likely to assume a supervisory or leadership position during a government-declared state of emergency shall complete prescribed NIMS compliance courses.¹⁷
- (f) **Compatibility of equipment and minimum requirements.** Parties shall acquire equipment that will perform in accordance with minimum standards as prescribed by NIMS so that equipment is interoperable with similar equipment used by other parties in the Hospital Mutual Aid Network and other hospitals.¹⁸
- (g) **Resource tracking.** Parties shall use an inventory system to track resources that may be available during a government-declared state of emergency, including any resources stored off premises.¹⁹ The inventory list shall be accessible to the designated representative during a government-declared state of emergency.

- 1.9 **Communications.** Parties shall adopt a plan to enable efficient communication during declared emergencies when prevailing modes of communication may be unavailable or compromised. The plan may specify a process for utilizing alternate communication media (e.g., radio, web-based resources). Implementation and maintenance of such plans should be regularly tested in periodic exercises.

II. Mutual Assistance

2.1 Mutual Assistance Obligations and Duties.

- (a) **Good faith obligation to provide mutual assistance.** Parties shall provide mutual assistance as set forth in this MOU to the maximum extent possible. Decisions about providing mutual assistance pursuant to this MOU shall be made by:
 - (i) objectively assessing whether and which resources can be feasibly shared and the degree to which patients can be safely transferred or received;
 - (ii) clearly conveying capacity for mutual assistance to other parties; and
 - (iii) striving to ensure transparency, honesty, and fairness in all phases of mutual assistance.

(b) **Duty concerning mutual assistance requests.** Parties shall confirm receipt of verbal or written requests for mutual assistance and provide responses within 24 hours when possible.

2.2 **Requesting Resources – Role of the Designated Representative.** All requests for resources must be directed to the designated representative who is authorized to agree to provide requested resources.

2.3 **Requesting Resources - Procedure for Communicating Requests.** After an emergency declaration is made, the requesting hospital's designated representative may initially request personnel or resources from the lending hospital's designated representative verbally. This request must be confirmed in writing within 24 hours, or as soon as possible, and must employ NIMS data-types where possible. The requesting hospital shall set forth in the written request to the lending hospital the following:

- (i) the type and number of requested personnel and resources;
- (ii) an estimate of how quickly personnel and resources are needed;
- (iii) the location where the personnel should report or the resources should be delivered; and
- (iv) an estimate of how long the personnel or resources will be needed.²⁰

2.4 **Prioritization Scheme for Multiple Requests.** If this MOU involves more than two hospitals, the parties must agree to a prioritization scheme for handling multiple requests for resources. This may be accomplished by designating "priority partners"²¹ in which parties agree to prioritize the requests of their priority partners over requests from other parties. A prioritization scheme agreed to by the parties is attached as [Exhibit B](#) and is incorporated herein by this reference.

2.5 **Transfer of Personnel.** During emergencies there are often critical shortages of healthcare workers. Accordingly, the following personnel may be transferred between parties subject to limitations set forth below:

- (a) **Employees.** Lending hospitals may allow or encourage the voluntary transfer of employees to a requesting hospital under the terms of this MOU. No employee may be ordered to transfer to a requesting hospital if the employee is not willing to be transferred. Each party shall maintain a list of current employees who may be willing to transfer to a requesting hospital during an emergency.
- (b) **Contractors.** Parties may allow the transfer of contractors to a requesting hospital. All transferred contractors provide their services to the requesting hospital voluntarily. Whenever possible, contractors with a prior or existing relationship with the requesting hospital should be transferred first.
- (c) **In-State VHPs.** Volunteer registration systems across the nation, including ESAR-VHP state-based systems, Medical Reserve Corps programs, and hospital-specific registries facilitate rapid deployment of vetted VHPs to meet surge capacity needs in hospitals. Whenever the use and deployment of VHPs through such registries

can be accomplished without compromising the provision of healthcare services to patients, parties shall do so before requesting employees or contractors from other parties.

- (d) **Inter-state VHPs.** A number of federal and state laws allow the deployment of VHPs who hold out-of-state licenses during an emergency. Similar provisions exist under the Emergency Management Assistance Compact (EMAC)²² and many regional MOUs. Parties to this MOU that are located in different states²³ shall identify and agree on the mechanisms for accepting inter-state VHPs. These mechanisms and any rules governing the deployment of inter-state VHPs are attached in [Exhibit C](#) and incorporated herein by reference.
- (e) **Credentialing and privileging.** The lending hospital shall ensure that the records of all transferred healthcare workers comply with requirements applicable to the lending hospital, including licensure and accreditation requirements for healthcare professionals. To the maximum extent possible, the lending hospital shall provide the requesting hospital with copies of deployed healthcare professionals' credentialing documents to facilitate the granting of emergency staff privileges.
- (f) **Transfer of personnel limitations.** Resident physicians, students, or healthcare workers who are not fully-trained shall only be transferred with the agreement of the requesting hospital, which shall closely supervise their activities. Deployment of any VHP must comply with Joint Commission Standard H.R. 125.²⁴

2.6 **Scope of Practice.**

- (a) **Authorization and supervisory power.** The requesting hospital shall clarify the relevant procedures concerning authorization, scope of practice, and supervision for transferred personnel that arrive at the requesting hospital pursuant to the terms of this MOU.
- (b) **Prescribing power.** The requesting hospital shall clarify the prescribing powers of transferred personnel to ensure consistency with jurisdictional prescription laws. If parties are located in different states, they shall set forth guidance about prescribing power through [Exhibit D](#), incorporated herein by reference.

2.7 **Transfer of physical resources.** Any physical resources may be shared between parties including pharmaceuticals, medical equipment, non-medical equipment, and basic supplies. Parties shall continuously monitor the availability of physical resources for potential transfer during a government-declared state of emergency.

2.8 **Recall.** The lending hospital may recall its personnel and resources from a requesting hospital through a formal request for recall consistent with Section 2.3 above. Recall requests may be made by the lending hospital at any time in its discretion. Requesting hospitals shall honor the lending hospital's request for recall at the earliest opportunity possible without significantly and irreversibly harming existing patients, and must

immediately begin to arrange for the acquisition of comparable personnel or resources from other parties, agencies, or facilities.

2.9 **Transfer of patients.** Transferring patients during a government-declared state of emergency raises numerous medical, legal, and ethical challenges. Contingent on existing laws, including EMTALA (see Section 1.6 above) the transfer of patients shall be facilitated consistent with the following:

(a) **Resourced beds.** Transfer of patients shall be considered in terms of “resourced beds.” The designated representatives of the parties shall monitor the availability and make transfer requests in terms of specific types of resourced beds. Classifications of resourced beds, depending on the capacities of the parties, may be identified in [Exhibit E](#), incorporated herein by reference.

(b) **Process for transferring existing patients.** A requesting hospital seeking to transfer patients must:

- (i) determine that the patient cannot receive adequate healthcare services at the hospital because of circumstances arising from the emergency and that the potential harm to the patient from the transfer does not outweigh the potential harm from staying at the requesting hospital state of healthcare services at the requesting hospital;
- (ii) seek patient consent to the transfer unless such consent is impossible due to the exigencies of the emergency or the inability of the patient or a surrogate to consent due to legal incapacity, incompetence, or unavailability of the healthcare surrogate;
- (iii) make all reasonable efforts to either directly notify the patient, the patient’s healthcare surrogate, or next of kin of the transfer including the time of transfer and the location of the lending hospital, or share patient lists to enable these persons to locate transferred patients; and
- (iv) transport the patient or ensure that appropriate transportation is provided to ensure patient safety to the maximum extent possible given the exigencies of the emergency.

(c) **Process for transferring (pre-screened) individuals.** A requesting hospital seeking to transfer individuals prior to being screened must determine that the potential benefits from the transfer outweigh the potential harms from remaining at the requesting hospital considering the state of healthcare services at the requesting hospital.

(d) **Surveillance and reporting.** Parties shall comply with all preexisting government public health surveillance and reporting requirements to the maximum extent possible.

- (e) **Health information privacy and data access.** The parties recognize the importance of maintaining the privacy of patient identifiable health data to the maximum extent possible consistent with national or regional health information privacy protections without compromising the provision of critical healthcare services during a government-declared state of emergency. Although these protections may be modified or waived during a government-declared state of emergency, parties shall agree on a procedure for securely sharing identifiable health data concerning transferred patients.

III. Liability, Costs, and Compensation

3.1 **Liability of Hospitals and Healthcare Workers.** During an emergency, potential liability can be a major concern for hospitals and healthcare workers. While exposure to liability cannot be fully eradicated, it can be significantly minimized through the clear expression of the expectations of the parties. The parties recognize the following principles concerning liability:

- (a) **Changing standards of care.** Emergency declarations may lead to alterations or changes in the standard of care that healthcare workers are obligated to adhere to in the treatment of patients. These changing standards of care may impact potential claims of liability to the extent that they provide varying expectations of the duties healthcare workers or hospitals owe to patients in the provision of personnel or resources.
- (b) **Use of VHPs.** Parties may minimize their potential exposure to liability and workers' compensation costs relating to personnel by utilizing registered VHPs. VHPs may be legally protected from liability claims and entitled to governmental coverage for workers' compensation benefits and costs during declared emergencies (subject to specific laws). Use of VHPs may also decrease the need for the transfer of employees and contractors whose acts may not be similarly protected from liability or entitled to workers' compensation coverage via government.
- (c) **Employees.** A requesting hospital may normally be responsible for all liability claims, disability claims, litigation costs, and other foreseeable costs incurred by transferred employees involving third parties except in instances arising from gross, willful, or wanton misconduct of the transferred employee. Transferred employees shall not be principally liable to a requesting hospital, including through indemnity actions, for their actions taken in good faith.
- (d) **Contractors.** The requesting hospital also shall be responsible for all liability claims, malpractice claims, disability claims, attorneys' fees and other foreseeable costs incurred by transferred contractors except in instances arising from gross, willful, or wanton misconduct of the transferred contractor. A contractor who agrees to be transferred shall not be contractually liable for failing to fully discharge the terms of employment at the lending hospital provided that the lending hospital agrees in writing to the transfer.

- (e) **Lending hospitals: Vicarious liability.** A lending hospital shall not be held vicariously liable for the actions of transferred employees, contractors, or VHPs, except in instances of gross, willful, or wanton misconduct of the lending hospital personnel in assuring the credentials of transferees.
- (f) **Failure to respond or inadequacies.** Parties are not bound to a specific course of action for which the failure to act constitutes an actionable claim for breach of contract or equitable relief, except with respect to the credentialing of transferred personnel. Execution of this MOU shall not result in any liability or responsibility for failure to respond to any request for assistance, inefficiency in answering such a request, or for the inadequacy of equipment or skills of the responding personnel.
- (g) **Workers' compensation coverage.** Transferred employees and contractors shall be considered "employees" of the requesting hospital for the purposes of workers compensation coverage in the event that an injury or death of the employee or contractor occurs in the scope of the work at the requesting hospital.

3.2 **Financial Obligations**

- (a) **Compensation and reimbursement for borrowed resources.** A lending hospital shall be reimbursed by a requesting hospital for transferred personnel and resources. The lending hospital shall also be reimbursed for services rendered, including salaries of the transferred personnel at their normal pay rate as if those personnel were being paid by the lending hospital. Reimbursement shall be for actual costs, but shall not include ancillary expenses, such as administrative costs or loss of revenues.
- (b) **Responsibility for insurance.** Parties shall maintain and demonstrate their existing professional liability, property, workers' compensation, or other insurance coverage and affirm their intention to retain such coverage at all times as a party to this MOU.

IV. Miscellaneous

- 4.1 **Amendments and Modifications.** All modifications and amendments to this MOU must be formally agreed to by the parties in writing. Modifications can occur through direct amendment or by incorporation by reference of Exhibits.
- 4.2 **Mediation and Dispute Resolution.** This MOU is not intended to provide the basis for post-emergency litigation. However, to the extent that litigation could result from the acts of the parties in carrying out the MOU (e.g., claims related to actual costs of reimbursement pursuant to Section 3.3(a)), parties agree to submit any actionable claim to arbitration and dispute resolution (or an analogous mechanism) prior to the inception of litigation.
- 4.3 **Good Faith Attempts to Clarify and Fulfill Understandings.** In the event that a portion of this MOU is impossible to fulfill, the parties agree to attempt to comply with

the remainder of the MOU to the maximum extent possible. If any party withdraws from the MOU, the remaining parties shall continue to recognize and honor the MOU.

Appendices

[to be developed by parties]

Exhibit A – Designated Representative

[Provide contact data (e.g., name, address, telephone, fax, and email information) below for the Designated Representative and at least one alternate designee]

Exhibit B – Prioritization Scheme for Multiple Requests

[Provide plan for how to prioritize varying partners during declared states of emergency pursuant to this MOU]

Exhibit C – Acceptance of [Inter-state VHPs](#)

[If parties to this MOU are located in different states, provide plan below that addresses the mechanisms and any rules for deploying and accepting inter-state VHPs].

Exhibit D – Restrictions on Prescribing Powers

[If parties to this MOU are located in different states, the requesting hospital shall clarify below the prescribing powers of transferred personnel to ensure consistency with jurisdictional prescription laws].

Exhibit E – Designated Resourced Beds

[Provide below a classification of resourced beds that, depending on the capacities of the parties, may be identified for the purposes of patient transfers. Examples of resourced beds include, for example:

- (i) acute trauma care*
- (ii) burn care*
- (iii) obstetrics*
- (iv) pediatric care*
- (v) cardiac care*
- (vi) intensive care unit (ICU)*
- (vii) isolation*

REFERENCES:

¹ As of August 2003, the GAO reports that nearly 70% of urban hospitals have agreements with other hospitals to share resources in the event of bioterrorism. U.S. Gov't Acct. Off., Hospital Preparedness: Most Urban Hospitals Have Emergency Plans But Lack Certain Capacities For Bioterrorism Response, GAO-03-924, at 13 (Aug. 2003), available at <http://www.mipt.org/pdf/gao03924.pdf>.

² It is not necessary for an agreement to be labeled a contract for a court to interpret it as a contract. A court can determine that a contractual relationship exists based on almost any written or oral exchange that meets certain criteria, namely the presentation of an offer, an acceptance of the offer, consideration, and some degree of mutual assent.

³ Established principles of contract law offer mixed guidance as to the enforceability of agreements that otherwise look like contracts, but that include clauses claiming that contractual liability does not result from the agreement. Traditionally, an agreement only creates contractual liability in instances when the parties demonstrate "mutual assent." To establish mutual assent, the parties must clearly manifest their intention to be bound by the terms of the agreement. Whether the parties express an intention to be bound is judged by the objective standard of whether a reasonable person would interpret the party's actions as indicating an intention to be contractually bound. *Hotchkiss v. National City Bank*, 200 F. 287, 293 (S.D.N.Y. 1911). Additionally, each party must honestly and reasonably believe that the other party intends to be bound. *Lucy v. Zehmer*, 84 S.E.2d 516 (1954). Together, these principles suggest that the form of an agreement is not as important as the question of whether the parties convey with sufficient clarity an intention *not* to be bound. In such instances, no legally enforceable obligations can result. Corbin on Contracts § 34 (1963); Williston, A Treatise on the Law of Contracts § 21 (W. Jaeger 3d ed. 1957). As a consequence, so-called "gentlemen's agreements," enforceable only by moral obligation, rather than the processes of law, are possible. Corbin on Contracts § 34. Nevertheless, contracts that include "no-binding-effect" clauses are not always followed by courts and have sometimes been ignored on public policy and other grounds.

⁴ See PACER Model MOU Briefing Book, September 14, 2007.

⁵ Memoranda of Understanding are common in business transactions such as stock-brokering, corporate acquisitions, financing and loan agreements, and real estate transactions. These documents frequently include no-binding-effect clauses. Sometimes courts enforce the obligations expressed in these MOUs; sometimes they do not. The underlying analysis is often based on common practices in the respective business communities. Our research uncovered no cases that discuss the enforceability of these agreements in the context of hospital mutual aid.

⁶ This definition is taken from the § 1-102 (31) of the Turning Point Model State Public Health Act. For more information about the Act, see <http://www.publichealthlaw.net/ModelLaws/MSPHA.php>.

⁷ For more information on the National Incident Management System, see the National Integration Center at the Federal Emergency Management Agency at <http://www.fema.gov/emergency/nims/index.shtm>.

⁸ This definition is set forth in the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA), Section 2(15) (2007). The UEVHPA definition does not include a practitioner who receives compensation pursuant to a preexisting employment relationship with a host entity or affiliate which requires the practitioner to provide health services in the state, unless the practitioner is not a resident of this state and is employed by a relief organization providing services in this state while an emergency declaration is in effect.

⁹ 42 U.S.C. § 1395dd (2003).

¹⁰ These waivers, which can be issued retroactively, are operative for 72 hours after a hospital in a designated area institutes its disaster protocol, except during emergencies involving pandemic infectious diseases, in which case the waivers remain operative for 60 days. 42 U.S.C. § 1320b-5.

¹¹ National Integration Center at the Federal Emergency Management Agency. http://www.fema.gov/pdf/emergency/nims/imp_act_hos_hlth.pdf. (Implementation Activity 1)

¹² National Integration Center at the Federal Emergency Management Agency. http://www.fema.gov/pdf/emergency/nims/imp_act_hos_hlth.pdf. (Implementation Activity 3)

¹³ National Integration Center at the Federal Emergency Management Agency. http://www.fema.gov/pdf/emergency/nims/imp_act_hos_hlth.pdf. (Implementation Activity 8).

¹⁴ National Integration Center at the Federal Emergency Management Agency, http://www.fema.gov/pdf/emergency/nims/nims_doc_full.pdf. (Appendix B), http://www.nimsonline.com/docs/Resource_Typing_Definitions_II.pdf.

¹⁵ National Integration Center at the Federal Emergency Management Agency. http://www.fema.gov/pdf/emergency/nims/imp_act_hos_hlth.pdf. (Implementation Activity 16)

¹⁶ National Integration Center at the Federal Emergency Management Agency.
http://www.fema.gov/pdf/emergency/nims/imp_act_hos_hlth.pdf. (Implementation Activities 7, 12, 13, 14)

¹⁷ National Integration Center at the Federal Emergency Management Agency.
http://www.fema.gov/pdf/emergency/nims/imp_act_hos_hlth.pdf. (Implementation Activities 9-11).

¹⁸ National Integration Center at the Federal Emergency Management Agency.
http://www.fema.gov/pdf/emergency/nims/imp_act_hos_hlth.pdf. (Implementation Activities 9-11).

¹⁹ National Integration Center at the Federal Emergency Management Agency.
http://www.fema.gov/pdf/emergency/nims/imp_act_hos_hlth.pdf. (Implementation Activity 15).

²⁰ This provision is based on the Model Memorandum of Understanding Regarding the Sharing of Personnel during a Disaster created by the New York City Department of Health and Mental Hygiene (2004), at p 2, section 5 (on file with authors).

²¹ For example, in the American Hospital Association Model MOU (adapted from the D.C. Hospital Ass'n) available at http://www.nimsonline.com/docs/mutual_aid_aj.pdf, one of the general principles of understanding is that each hospital has the option of linking to a designated partner or "buddy" hospital as the hospital of "first call for help" during a disaster.

²² See Emergency Management Assistance Compact information available at <http://www.emacweb.org/>.

²³ See related Joint Commission standards mentioned earlier for requirements, specifically H.R.1.25 and MS.4.110.

²⁴ Joint Commission Standard 1.25 requires that volunteer practitioners must at a minimum present a valid government photo ID and at least one of the following:

- Current hospital picture ID
- A current license or certification
- Primary source verification
- Identification from a DMAT, MRC, or ESAR-VHP
- Identification by a current organization member who possesses personal knowledge regarding the practitioner's qualifications