E-Briefings
A Bimonthly Governance Institute Newsletter
VOLUME 18 • NO. 4 • JULY 2021

The Long-Term Healthcare and Employment Law Effects of the COVID-19 Pandemic

By **Anjana D. Patel**, Member, **Denise Dadika**, Member, and **Olivia Plinio**, Associate,
Epstein Becker & Green, P.C.

The COVID-19 pandemic has resulted in a myriad of legal and policy changes to the healthcare industry. Since March 2019, numerous reactionary regulations, executive orders, administrative guidance, and the like have been issued in response to the pandemic, making it difficult for providers, boards, and senior leadership to keep up with not only what is required or permissible during the pandemic, but also which of these changes may become permanent in the near future. This article discusses some of the more noteworthy changes that are most likely to have widespread permanent impact in the future.

Telehealth Expansion

Perhaps the single most pervasive change and the one with the biggest impact on the industry is the expansion of telehealth. Various government agencies issued waivers and other regulatory changes in response to public demand and to encourage patients to continue seeking healthcare services during the pandemic.

CMS Waivers

CMS issued a series of blanket waivers involving telehealth in response to the pandemic and the resulting CARES Act. One such waiver involved the licensing of telehealth providers. Prior to the pandemic, practitioners billing Medicare for telehealth services were required to be licensed in the state where the services are provided, even if already licensed in another state. For example, a licensed State A physician treating a patient located in State B via telehealth would need to be licensed in State B—the location where the patient received the care. Under the waiver, this requirement is lifted for practitioners, with some conditions. For the waiver to apply, the practitioner must be enrolled in the Medicare program and

possess a valid license to practice in the state. The practitioner must also provide services in a state in which the emergency is occurring in order to contribute to relief efforts and cannot be affirmatively excluded from practice in any state.

Notably, this waiver only applies to federal healthcare reimbursement and has no effect on state or local licensure requirements. Practitioners are only able to take advantage of this waiver if the licensure requirements are also waived by their state for their type of practice. Some, but not all, states have implemented similar waivers, including Maryland, Mississippi, and Massachusetts. These states temporarily modified their professional licensure requirements to allow out-of-state licensed practitioners to provide services within their states, either by temporarily waiving licensure requirements (similar to the CMS waiver) or by modifying licensing requirements to make it easier for providers to obtain temporary licenses to practice in the state.

In addition to loosening the licensing requirements for providers, CMS also expanded the types of providers who may bill Medicare for telehealth services. Under authority granted under the CARES Act, CMS waived the requirements of section 1834(m)(4)(E) of the Social Security Act and 42 CFR § 410.78 (b)(2). These statutes specified the types of practitioners permitted to bill Medicare for telehealth services. The waiver allows all types of practitioners who are already eligible to bill Medicare for professional services to begin billing Medicare for distant site telehealth. New additions include physical therapists, occupational therapists, and speech language pathologists, amongst others. However, these providers are still

➜ Key Board Takeaways

Boards should consider the following questions:

- Is our organization keeping up with the most recent requirements for telehealth practice? How can we increase access for patients while remaining compliant?
- Are the board and senior leaders aware of the new OSHA and ETS mandates? Does our organization have a plan to implement these changes?
- How effective is our compliance program? Do we have a system in place to handle whistleblower complaints efficiently?

subject to limitations imposed by their state licensing board, which may limit their ability to practice, even with this waiver.

CMS also made changes to the provider–patient rules for telehealth services. In the past, telehealth was only available to Medicare beneficiaries if there was an already-established provider–patient relationship. Additionally, patients seeking telehealth services under Medicare were required to be in specific originating sites such as a physician's office, hospital, or other healthcare facility. However, CMS recognized the importance of limiting travel during the public health emergency, especially to healthcare facilities where patients could risk exposure to further illness. In response, CMS issued a waiver that would allow patients to access telehealth services regardless of their location (e.g., in the home, any healthcare facility, etc.) for the duration of the public health emergency. Additionally, HHS announced a policy of enforcement discretion where, if a requirement for a prior established provider–patient relationship existed, it would not be enforced and HHS would not conduct audits to confirm whether such a relationship exists.

Consolidated Appropriations Act

In a similar vein, the Consolidated Appropriations Act of 2021 (CAA), Section 123 established a similar, but more permanent waiver for mental-telehealth originating sites. Under the CAA, Medicare will accept claims for patients seeking mental health services via telehealth without geographic restriction (whether they are home, at a health facility, etc.). This rule will become permanent after the public health emergency, with some restriction. Specifically, eligible patients must have an existing in-person relationship with a provider, defined as at least one in-person visit during the previous six months before the telehealth visit. This requirement will only apply to patients seeking treatment from aforementioned newly eligible originating sites. Patients seeking treatment via telehealth from already-eligible originating sites (e.g., rural areas) will not be required to comply with the in-person requirement.

Prescribing Opioids

The effects of the COVID-19 public health emergency have intersected with another public health emergency, the ongoing opioid crisis. Under the Controlled Substances Act, providers are normally required to conduct in-person patient evaluations before they are permitted to prescribe controlled substances, such as opioids. This broad categorical requirement also encompasses buprenorphine, a drug used in opioid use disorder treatment. The federal government recognized that this requirement

for an in-person evaluation during a pandemic could serve as a significant roadblock to those seeking treatment for opioid use disorder. In response, the DEA issued guidance to waive the in-person evaluation requirement. The waiver allows providers to prescribe controlled substances without an in-person evaluation, so long as the prescription is for a legitimate medical purpose, any telemedicine communication is conducted using audio-visual, real-time, two-way interactive communication, and the provider acts in accordance with any applicable federal and state laws. However, without universal adoption by the states, this waiver has limited effect in some states.

Privacy Changes

With the overwhelming need for telehealth services in the pandemic, providers were forced to adapt quickly to meet the needs of their healthcare populations. In response, HHS Office for Civil Rights (OCR) announced that it would exercise enforcement discretion, not perform audits, and waive penalties for HIPAA violations in respect to telehealth platforms. Telehealth platforms are typically required to comply with HIPAA's security requirements. Under the waiver, healthcare providers who serve patients in good faith using everyday communications technologies, such as FaceTime or Skype, will not be penalized under HIPAA during the public health emergency. Providers will also not be penalized for lack of a Business Associate Agreement (BAA) with a technology platform vendor. However, the breach notifications are not waived, and providers should still have policies in place and be prepared to notify individuals in the event of a breach of PHI.

In addition to the privacy changes for providers, OCR also announced changes for business associates in response to the COVID-19 public health emergency. Under these changes, business associates are temporarily allowed to share PHI with public health and oversight agencies in accordance with certain HIPAA exceptions. This expansion is significant in light of the pandemic as it allows business associates to transmit immunization information between public health entities and providers. Beyond the scope of the pandemic, the expansion will allow public health and oversight agencies greater insight into the activities of business associates and the providers with whom they contract, improving public health surveillance, payment integrity, and healthcare interoperability.

Increased Health and Safety Measures

The COVID-19 pandemic has required healthcare employers to enhance their workplace health and safety protocols to protect workers from the virus and comply with the myriad of federal, state, and local legislation and guidance. Most recently, on June 10, the Occupational Safety and Health Administration (OSHA) issued a long-awaited Emergency Temporary Standard (ETS) for healthcare employers.[1] The ETS mandates virus protections in healthcare workplaces, defined as "all settings where any employee provides healthcare services or healthcare support services," with several exceptions. OSHA published a flow chart to help employers determine if they are covered by the ETS,[2] as well as several fact sheets[3] and FAQs[4] regarding the ETS. The ETS took effect on June 21, although some of the requirements have a 14-day or 30-day window for compliance.

The requirements of the ETS include, but are not limited to, the following actions by healthcare employers:

- Develop a COVID-19 plan to mitigate the spread of the virus in accordance with the parameters established by OSHA; for workplaces with more than 10 employees this plan must be in writing.
- Designate a safety coordinator to oversee implementation of the COVID-19 plan.
- Screen patients and anyone else before they enter the workplace.
- Provide respirators for workers when exposed to people with suspected or confirmed COVID-19 infection.
- Conduct regular health screening of employees and provide notice of positive cases of COVID-19.
- Require six feet of separation between people when indoors.
- Install solid barriers at each fixed workstation in non-patient care areas where employees are not socially distanced.
- Ensure ventilation systems operate at their designed specifications.
- Follow standard practices for cleaning and disinfection of surfaces and equipment in accordance with CDC guidelines in patient care areas, resident rooms, and for medical devices and equipment.

1 See "COVID-19 Emergency Temporary Standard."
2 To view the flow chart, see OSHA, "Is Your Workplace Covered By the COVID-19 Healthcare ETS?"
3 To view fact sheets, see OSHA, "COVID-19 Healthcare ETS."
4 See OSHA, "COVID-19 Healthcare ETS—Frequently Asked Questions."

- Support COVID-19 vaccination for each employee by providing reasonable time and paid leave (e.g., paid sick leave or administrative leave) to each employee for vaccination and any side effects experienced following vaccination.
- Provide training related to COVID-19 transmission, policies, and procedures.

The ETS exempts fully vaccinated employees from the facemask, physical distance, and barrier requirements in well-defined areas if the employer determines there is no reasonable expectation that another person with suspected or confirmed COVID-19 will be present and the written COVID-19 plan includes policies and procedures to determine the employees' vaccination status.

Finally, the ETS prohibits retaliation against employees for exercising rights available under the ETS and requires employers to provide training on anti-retaliation rights.

Healthcare employers, boards, and senior leaders should closely review the ETS and continue to monitor federal, state, and local developments to ensure they are complying with the latest requirements.

Enhanced Compliance Programs

Workplace safety whistleblower claims have surged during the pandemic. There has been an uptick in OSHA complaints, as well as whistleblower litigation filed in federal and state courts. To minimize the filing of external retaliation complaints, healthcare employers should review and enhance their compliance programs by doing the following:

- Ensure that their health and safety practices and policies are compliant with the latest federal, state, and local regulations and guidance; train employees on those safety practices; and monitor for, and address, noncompliance.
- Revisit policies governing the reporting of suspected violations to ensure they provide for a range of reporting channels that are accessible 24 hours a day, 365 days a year. Employers should regularly encourage and train their employees on such policies, reporting channels, and the employer's investigation process. They should also ensure that their investigators, whether internal or external, are properly trained and possess the skills to thoroughly conduct and document investigations. In addition, creating a playbook that includes a list of potential stakeholders who may need to be consulted, as well as procedures for collecting and preserving data, conducting interviews and preparing interview summaries, and crafting an investigative report that documents the steps taken and the basis for the investigation findings, will

assist in standardizing and providing a fair and thorough process and record. Also, communicating the results of the investigation and any next steps to complainants and protecting the complainants from retaliation are paramount in fostering the trust and transparency that is essential for an effective compliance program.

- Make it clear that the compliance program is supported, and adhered to, by senior management. Commitment from the top is critical in creating an environment where employees trust their complaints will be addressed without fear of retaliation.

While institutions cannot prevent employees from filing external complaints, boards and senior leadership can minimize external complaints by prioritizing effective compliance programs from the top, providing employers the opportunity to quickly address employee concerns and potential workplace safety violations.

The Governance Institute thanks Anjana D. Patel, Member, Denise Dadika, Member, and Olivia Plinio, Associate, Epstein Becker & Green, P.C., for contributing this article. *They can be reached at adpatel@ebglaw.com, ddadika@ebglaw.com, and oplinio@ebglaw.com.*