THREE KEY THINGS IN HEALTH CARE

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- **Hospitals should plan for upcoming changes to the Medicare Conditions of Participation ("CoPs") in the health information exchange arena.**
  - In a prior issue we addressed the final rule from the Office of the National Coordinator for Health Information Technology ("ONC"), focusing on the huge shift that the rule's information blocking provision will bring about by *mandating* access, use and disclosure of certain electronic health information under some circumstances.
  - A companion final rule issued by the Centers for Medicare & Medicaid Services ("CMS") sets forth CMS's initial policies focused on advancing interoperability and patient access to health information. It promises to impact a wide variety of stakeholders, including hospitals.
  - In particular, hospitals need to be aware of updates to the medical records services CoPs that are designed to advance information exchange and, ultimately, care coordination. The updated CoPs will require acute care, psychiatric and critical access hospitals to send an electronic patient event notification for each patient admission, discharge and/or transfer ("ADT") to designated recipients.
    - For example, hospitals subject to the ADT requirements must demonstrate they have made reasonable efforts to ensure the transmitting system sends messages to all applicable post-acute care providers and suppliers, and to certain specified categories of practitioners and entities.
    - The ADT requirements apply to patients registered in a hospital's emergency department ("ED") and to inpatient care admissions (whether subsequent to an ED visit or otherwise).
      - According to CMS, "a hospital's system would be expected to send one notification when a patient is first registered in a hospital's ED or as an observational stay (that is, in both of these cases, the patient would be considered an outpatient and not an inpatient at this point in time), and a second notification if the same patient was then later admitted to a hospital inpatient services unit (for example, medical unit, labor and delivery unit, telemetry unit, neurology unit, surgical unit, intensive care unit (ICU), etc.), or if the same patient was admitted for inpatient services, but was being boarded in the ED while waiting for an inpatient unit bed." The hospital also would be expected to send an additional notification of a patient's discharge or transfer from the hospital, whether from the ED, an observational stay, or an inpatient admission.
  - CMS expects to issue interpretive guidelines prior to the updated CoPs' effective date. The original effective date has been extended to May 1, 2021, in light of the COVID-19 public health emergency.
  - **Key Takeaway**: Any hospital using an electronic medical records system or other electronic administrative system conformant with the HL7 2.5.1 content exchange standard set forth at 45 C.F.R. 170.205(d)(2) will need to demonstrate compliance with the updated CoPs for ADT notifications as of the effective date. Affected hospitals should begin assessing now the steps they need to take to come into compliance.
- **Telehealth may be the care delivery model of the future, but telehealth providers should tread carefully in this rapidly evolving landscape.**

- With the onset of the COVID-19 crisis and subsequent social distancing mandates, the use of telehealth has skyrocketed.
- Following the President's emergency declaration, the Centers for Medicare & Medicaid Services (CMS) broadened payment for telehealth services on a temporary basis to ensure Medicare beneficiaries receive needed services while limiting potential exposure to and transmission of COVID-19.
- CMS has announced that it is exploring whether such telehealth flexibilities should remain in place following the COVID-19 crisis. CMS will conduct two reviews based on Medicare Parts B and C data.
  - CMS's announcement provides, "[t]he first review will examine the extent to which telehealth services are being used by Medicare beneficiaries, how the use of these services compares to the use of the same services delivered face-to-face, and the different types of providers and beneficiaries using telehealth services. The second review will identify program integrity risks with Medicare telehealth services to ensure their appropriate use and reimbursement during the COVID-19 pandemic."
- States have not remained on the sidelines. Some states that implemented their own telehealth flexibilities during the COVID-19 crisis are moving to make those changes permanent. For example, Colorado recently barred insurers from requiring that patients have a pre-established relationship with a telehealth provider or imposing additional location, certification or licensure requirements on providers as a condition for telehealth reimbursement.
- As federal and state requirements continue to evolve, telehealth providers must pay close attention to statutory and regulatory changes that affect their practice. It is not safe to assume that all flexibilities implemented during the COVID-19 pandemic will remain in effect in perpetuity. Moreover, telehealth providers may face increased scrutiny for compliance with Medicare billing and coding requirements, as well as with the requirements of the various fraud and abuse laws that may be implicated by telehealth arrangements.
- **Key Takeaway**: Utilization of telehealth services has boomed as a result of the pandemic. CMS and state governments have implemented certain temporary flexibilities that allow patients to access valuable health care services remotely. The permanency of these flexibilities is currently under debate at both the federal and state levels, and telehealth providers should not assume that all such flexibilities will remain in place indefinitely. Providers must remain vigilant, monitor changes in this area and modify their practices accordingly.

- **Virginia is implementing an emergency standard on COVID-19 infectious disease prevention ("Emergency Standard") applicable to "every employer, employee and place of employment" subject to the Virginia Occupational Safety and Health program. This includes health care providers.**
  - The federal Occupational Safety and Health Administration ("OSHA") has declined to issue an emergency temporary standard on infectious diseases in connection with the COVID-19 pandemic, and last month the U.S. Court of Appeals for the District of Columbia Circuit rejected a lawsuit brought by the AFL-CIO seeking to require OSHA to do so.
  - In the absence of federal action, the Virginia Safety and Health Codes Board ("SHCB") is reviewing draft language for an Emergency Standard recommended by the Department of Labor and Industry, as well as proposed amendments thereto prepared by several SHCB members.

    - The discussion is scheduled to continue at an electronic meeting on July 15, 2020, beginning at 9:15 am. Written materials are available here.

- The Emergency Standard would be the first of its kind in the country, and "is designed to establish requirements for employers to control, prevent, and mitigate the spread" of COVID-19 "to and among employees and employers."
- The Emergency Standard is organized around exposure risk levels (very high, high, medium and lower), and all employers must "classify each job task according to the hazards employees are potentially exposed to and ensure compliance with the applicable sections of [the Emergency Standard]."
    - "Very high" risk workplaces include those in which aerosol generating medical procedures are performed and where direct access to COVID-positive patients occurs.
    - "High" risk workplaces include other medical care settings involving patient care and exposure to potential COVID-positive patients.
- A single place of employment may have hazards or job tasks in more than one risk level.
- All employers are subject to certain requirements, without regard to risk level, including conducting hazard assessments of COVID-19 risks in the workplace; informing employees of symptoms and exposure risks for COVID-19; having flexible sick leave policies for COVID-19, a notice process for employees if a co-worker tests positive and return to work protocols for employees who test positive; and implementing social distancing policies, or proper personal protective equipment if distancing is not feasible.
- In addition to the foregoing, specific engineering controls, administrative and work practice controls, PPE requirements, Infectious Disease Preparedness and Response Plan development and employee training requirements apply based on risk level.
- **Key takeaway:** Although the Emergency Standard is likely to be time limited, more permanent standards are likely to follow if the pandemic persists. Virginia health care providers should monitor carefully the evolving draft and be prepared to devote significant resources toward implementing the final standard once approved by the SHCB – compliance will be no simple task. Providers in other states should be aware of the action being taken in Virginia because it may well serve as a model for similar standards in other jurisdictions.

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