Best's Insurance Law Podcast

What Claims and Telemedicine Professionals Should Know About the COVID-19 Public Health Emergency Transition - Episode #201

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John Czuba: Welcome to "Best's Insurance Law Podcast," the broadcast about timely and important legal issues affecting the insurance industry. I'm John Czuba, Managing Editor of *Best's Insurance Professional Resources*.

We're pleased to have with us today Mary Kate McGrath and Adam Fulginiti from the law firm Marshall, Dennehey, Warner, Coleman and Goggin. Mary Kate McGrath is a shareholder at Marshall Dennehey, where she co-chairs the Telehealth and Telemedicine Practice Group.

She has extensive experience in the defense of healthcare providers, hospitals, health systems, rehabilitation centers and skilled nursing facilities from the onset of a client's involvement in a case through the appellate level. She also handles compliance matters, including defending and advising healthcare clients regarding government payment programs, electronic discovery, and privacy matters.

Adam Fulginiti is also a shareholder at Marshall Dennehey, where he, along with Mary Kate, co-chairs the Telehealth and Telemedicine Practice Group.

Adam also has extensive experience with defending healthcare providers as well as social welfare agencies throughout the Commonwealth of Pennsylvania. Through Adam's work with the Telehealth and Telemedicine Practice Group, he helps clients navigate the intersection of healthcare technology and the law.

Together, he and Mary Kate have published and presented their studies regarding the trends and practicalities of telemedicine to the legal and medical communities at both the local and national level.

John: Mary Kate and Adam, we're very pleased to have you both with us today.

Mary Kate McGrath: John, thank you so much. We're big fans of your podcast and we're thrilled to be here.

Adam Fulginiti: Thanks, John. We're very excited to have this opportunity and we appreciate being able to come on and talk about an issue that's of great importance to us, and as we're going to be discussing, great importance to the industry as well.

John: Thank you, Adam and Mary Kate. It's always great working with your firm. Today's discussion is going to be on the conclusion of the COVID 19 Public Health Emergency and what telemedicine providers and claims professionals need to know.

Adam, we're going to start the questioning off with you today. What is the Public Health Emergency, or PHE, and how does it impact telemedicine?

Adam: That's a great question, John. Technically speaking, the PHE derives from the Public Health Service Act, and essentially, the provision of the Act that we're going to be dealing with.

It provides the secretary of the Department of Health and Human Services the ability to make a determination and ultimately a declaration that some kind of disease or disorder presents a public health emergency.

The Act also empowers the secretary to make such a declaration and put this into effect for a period of 90 days. If the circumstances persist beyond the conclusion of those 90 days, the office can then renew the PHE.

If you've been keeping track over the last few years, we've had a number of 90-day renewals since the inception of the COVID 19 pandemic. How does this impact telemedicine?

The PHE declaration allows, amongst other things, the secretary to either waive or modify certain requirements that are imposed by Medicare, Medicaid, HIPAA, and other laws that govern the provision of healthcare services. Telemedicine is no exception here.

What we've seen throughout the PHE is that the PHE status has incorporated and implemented a pretty vast array of flexibilities and relaxations regarding how telemedicine is implemented and executed, starting with how it can be practiced, who can practice it, where they can practice it, and ultimately, the reimbursement structure.

There are a number of other issues that have been impacted, but those are some of the main highlights.

Generally speaking, it's fair to say that the PHE has created a very large footprint on how telemedicine has been practiced throughout the past few years.

John: Adam, what is the current status of the PHE, and how does its impending expiration impact the practice of telemedicine?

Adam: John, this is an issue that is hot off the presses. Literally, just a little over a month ago, on January 30, the Biden Administration announced that it would end the PHE effective on May 11 of 2023. A little over a month from now, we are going to see the end of the PHE. There is not going to be another 90-day renewal.

When I talked a moment ago about the increased flexibilities that the PHE has created within the medical industry and certainly within telemedicine, the expiration of the PHE is going to have a significant effect on those modifications and those relaxations that we've seen over the past few years.

Just to name a couple of examples, the expiration of the PHE is going to impact how controlled substances can be prescribed via telemedicine. It's going to impact how out of state providers can treat patients in states where they may or may not be licensed.

It's also going to impact a lot of the privacy requirements and how those requirements are ultimately enforced under HIPAA and relevant laws. It's also going to impact where telemedicine can be practiced, who can provide it, and who it can be provided to.

There's also going to be a shift in the requirement for in person visits. Over the past few years, the PHE has given us quite a bit of flexibility within the telemedicine sphere with respect to when and where in person visits can take place. Those are going to shift once the PHE expires.

These are just a few examples of where we're going to see shifting sands in the industry once the PHE ultimately comes to a close in May.

John: Thank you, Adam. Mary Kate, we'll go over to you now. Can you tell us what are waivers, and how do they affect the practice of telemedicine?

Mary Kate: Sure, John. Waivers exist at federal and state levels, and they're enacted during public health emergencies like our COVID 19 current PHE. They waive administrative requirements to increase access to medical services.

When you have a PHE, the government essentially decides to cut red tape so the good doesn't become the victim of the perfect. Requirements are relaxed or removed as long as the PHE exists.

At the federal level, the Social Security Act has created a provision in Section 1135, which, as Adam was discussing, gives authority to the Department of Health and Human Services to enact waivers during the time of a national emergency. Specifically, with the COVID PHE, scores of waivers were approved, especially and including waivers on telemedicine.

The states tend to mirror what's happening at a federal level on a state level as well. There are blanket waivers that extend to all covered entities, and then there are specific waivers that someone could petition for.

Essentially, with the federal in state waivers regarding telemedicine, they made adjustments so that patients were allowed to receive telemedicine, for example, using their home as the originating site, which wasn't always approved before.

Patients were allowed to use different types of modalities and communication platforms that had not been approved prior to the COVID PHE. New medical specialties were permitted to provide care via telemedicine.

You don't necessarily naturally think of nephrologists with their dialysis patients as being telemedicine providers, but the emergency required that certain adjustments be made. Physical therapists, at home nursing providers, we could go on and on.

Patients were allowed to have their first visit with the new provider via telemedicine, which, prior to COVID, was not permitted. You had to have an established relationship with the provider in most cases before you could move forward. Also, a really important one was parity of pay for telemedicine visits.

Prior to the COVID PHE, there were many services where a telemedicine visit would not be compensated or billed out at the same rate as an in person visit. That was withdrawn and rolled back during the COVID PHE.

These waivers are temporal in nature, so when the PHE ends, the waivers end. Remember that we're now looking at May 11, 2023, as the end of the COVID 19 PHE. Providers need to be aware of what's coming down the pike next.

John: Thanks, Mary Kate. To what extent will telemedicine waivers remain in place after the expiration of the PHE in May?

Mary Kate: John, during the PHE, the government was communicating that it would create a bridge and they would give healthcare providers a good understanding of, "We'll give you a few months to a year," with rolling out protocols and procedures that comported with the waivers, but wouldn't necessarily comport with post public health emergency living.

On December 23rd of 2022, Congress passed the Consolidated Appropriations Act of 2023, which President Biden signed into law on December 29. They are continuing many telehealth related flexibilities for Medicare patients. Some of these flexibilities are permanent, some of them are extended on a temporary basis.

The government is continuing to revisit what's working. If it's not broken, they're not going to fix it. They are considering making some of the temporary changes permanent down the road. As of right now, there are permanent changes.

For example, a big one is behavioral and mental telehealth services will be continued to be delivered using audio only communication platforms if that is necessary at the time, which is important. There have been rollbacks on a permanent level saying that Medicare patients may continue to receive behavioral mental telehealth services in their homes.

With rural patients, rural hospital emergency departments are going to be accepted permanently as originating sites. When we say originating site, we mean that's where the patient is located. The originating site where the provider is located is the distant site. Those are permanent changes.

We're having some temporary changes that are extended right now through December 31st, 2024. Those temporary extensions under the Appropriations Act include that Medicare patients can receive telehealth services authorized in the calendar year 2023 Medicare physician fee schedule.

In person visits within six months of an initial behavioral or mental telehealth visit will not be required, and telehealth services can continue to be provided by a physical therapist, an occupational therapist, speech language pathologists, other specialties.

You need to look to what the specialty is and whether or not the waivers are going to be rolled out on a permanent or a temporary basis**.**

John: Thanks, Mary Kate. Adam, back over to you now. Are there PHE waivers that affect how patient privacy is handled within telemedicine, and how will these waivers change when the PHE expires?

Adam: Thanks, John. Privacy is a big issue here. As Mary Kate mentioned, as we pivot and see the light at the end of the tunnel with the end of the PHE, there are going to be some changes in a number of areas, and privacy is absolutely one of those areas.

To answer your first question, yes, there are PHE waivers that affect how patient privacy is handled. These waivers have affected patient privacy protections and enforcement.

This came down fairly early on in the COVID 19 pandemic from the Office of Civil Rights or OCR, which is the governmental entity here in the U.S. that is in charge of investigation and enforcement of patient privacy and HIPAA privacy protections.

The OCR issued what was called a notice of enforcement discretion. That's basically what it sounds like. It was a notice that was sent out to the country that told providers that the OCR was going to exercise some discretion over how they were enforcing HIPAA requirements as the COVID 19 pandemic progressed.

This was contingent upon the existence of the PHE. Why did they issue this? I'm sure we all recall, at the beginning of the pandemic and throughout a significant portion of it, there was a fairly large curtailment of in person medical treatment.

A lot of providers simply were not able to see their patients in an in person setting. There was this huge and sudden increase in demand for virtual healthcare, in effect, telemedicine services. In order to meet that demand as quickly as possible, the whole purpose of that notice was to effectively give providers the benefit of the doubt.

The bottom line was this, what that notice said was that if the providers were making a good faith effort to comply with the HIPAA privacy requirements, if a HIPAA violation occurred through the use of some type of newer technology that the providers were using for telemedicine services, that violation would not necessarily be subject to sanctions.

In effect, the OCR would have discretion to prosecute that. As we pivot towards the end of the pandemic, what your listeners should be aware of is there is going to be a little bit of hangover with this and with certain areas of audio only telemedicine.

For the most part, we are going to do a full stop 180 when the PHE expires. For all intents and purposes, this is going to revert to that pre COVID setting, that pre COVID level of enforcement and compliance.

Providers and their insurers do need to be aware that once that PHE expires, that the providers are utilizing proper technology through which to implement and provide telemedicine services and they are taking the proper precautions to protect not only the patients with respect to their privacy, but in effect, themselves as well.

John: Adam, thanks again. Mary Kate, last word of the day rests with you, a final question. One of the most significant issues applicable to telemedicine is the capability or at least the possibility of providing medical services across state lines.

How might the expiration of the PHE affect this particular area of telemedicine?

Mary Kate: John, if we could have a "Danger, Will Robinson" sign flashing, this would be one of the biggest topics for everyone to be aware of. As we were talking about earlier, where the patient is located is the originating site.

As a matter of law, care via telemedicine is provided at the originating site, or wherever the patient is located, and not at the distant site, which is where the provider is located. Providers must be aware of the location of the patient and must confirm that he or she is authorized to practice medicine in that jurisdiction where the patient is located.

Note that we're saying authorized to practice medicine, not necessarily licensed, because what authorized means depends on the state and the jurisdiction where the patient is. There are some states that permit registered practitioners to provide care.

These are practitioners who aren't necessarily licensed, but they've jumped through some administrative hoops and have gained approval to become registered and can therefore practice medicine.

During the PHE, there were waivers that were enacted that opened borders so that practitioners could come into new jurisdictions and provide care. If a practitioner was licensed or registered under a waiver, then that is a temporal permission, and that will expire, in most cases, at the end of the PHE.

Providers need to know, "Am I still authorized to provide care in that jurisdiction?" If I got my green light via a waiver, then I need to go back to the drawing board and start from square one to seek authorization, whether it's licensure or registration, in a way that isn't underneath the umbrella of an actual waiver.

John: Mary Kate and Adam, thank you both very much for joining us today.

Mary Kate: Thanks so much, John. It's been such a pleasure.

Adam: John, thanks again. We appreciate it.

John: You've just listened to Mary Kate McGrath and Adam Fulginiti from the law Marshall, Dennehey, Warner, Coleman, and Goggin. Special thanks to today's producer, Frank Vowinkel.

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I'm John Czuba, and now this message.

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