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Presented by: Katie Dru, Jodi Berlin,
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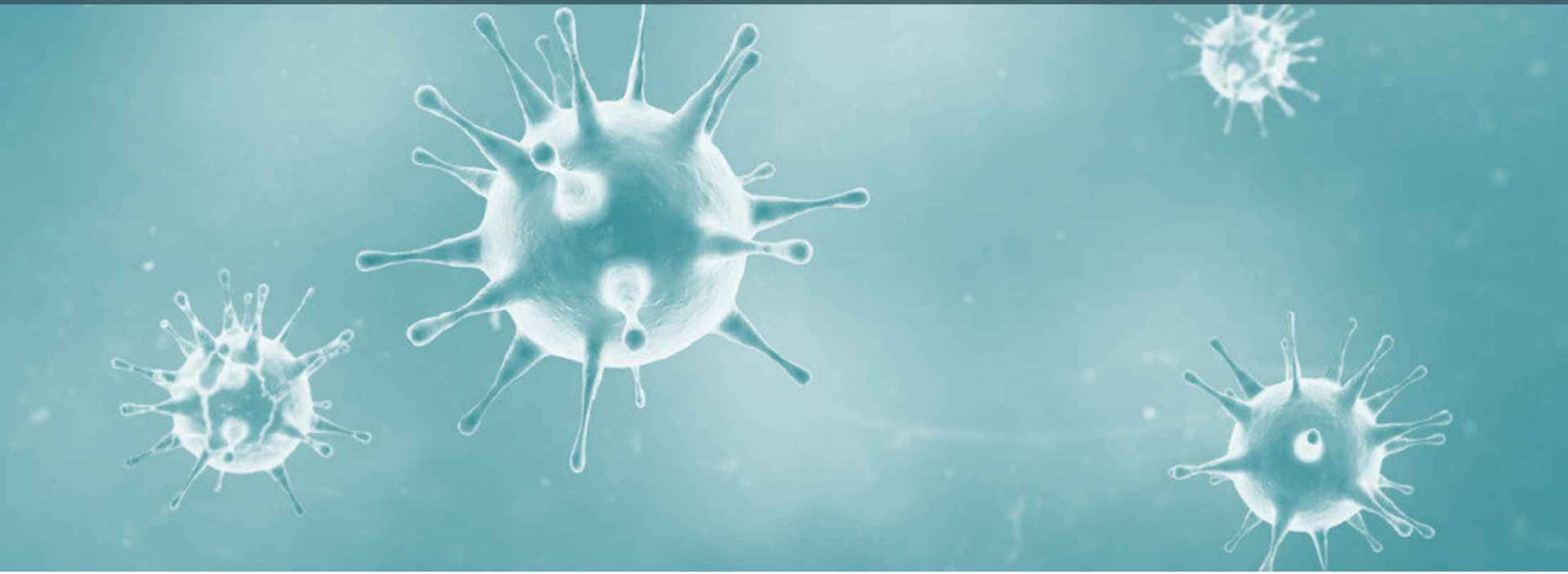
HLB Webinar | May 19, 2020 | 1:00 pm ET | 10:00 am PT

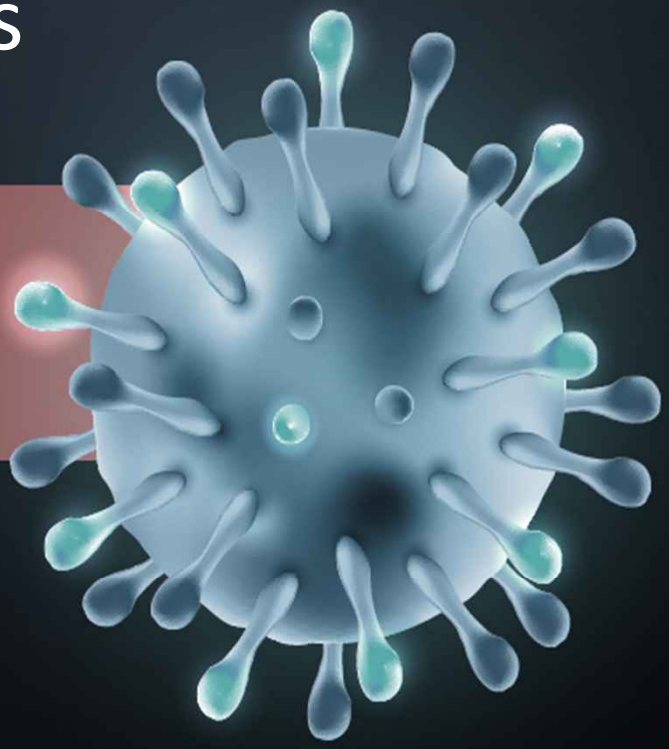


COVID-19 and Legal Changes to AHP and Medical Resident Practice:

Challenges in Redeploying Existing Healthcare Workforce During the State of Emergency and Beyond

Hooper, Lundy & Bookman's

Coronavirus COVID-19
Updates and Resources



www.hlbcovid19.com

Webinar "Roadmap"

- Federal Emergency Waivers and Rule Changes
  - CMS Blanket Waivers
  - Interim Final Rules
  - "Flexibilities" regarding medical residents
- Snapshot of state-level emergency rules and regulations
  - California, Colorado, Massachusetts, Maryland, Virginia
- Non-COVID-19 changes to AHP and medical resident practice
  - California:
    - Expanded PA practice authority (SB 697)
    - Changes to medical resident licensure (SB 798)
  - Colorado, Virginia, Maryland: Trend towards greater practice authority
- How can providers ensure payment for services furnished and ordered by AHPs and medical residents?

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Who Are Allied Health Practitioners and Medical Residents?

Who Is an Allied Health Practitioner?

- "**Non-Physician Practitioners**": Physician assistants, nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, certified nurse midwives, clinical social workers, clinical psychologists, and registered dietitians.
  - 42 C.F.R. § § 424.22(a)(1)(v)(A)(3)-(5), 40.70(f)(3)(ii)-(iv); 42 USC 1395u(b)(18)(C)
  - Group of practitioners constituting "Advanced Practice Providers"
- "**Allied Health Professionals**": "A health professional (other than a registered nurse or physician assistant)" who
  - (A) has a certificate or degree in a science relating to health care;
  - (B) shares in responsibility for delivery of health care services; and
  - (C) has not received an MD, DO, DDM, DVM, doctor of optometry, doctor of podiatric medicine, BS or doctor of pharmacy, graduate degree in public health or health administration, doctor of chiropractic, doctor of clinical psychology, or degree in social work or counseling
    - 42 USC 295p(5)

Who Is a Medical Resident?

- "For Medicare purposes, the terms 'interns' and 'residents' include **physicians participating in approved graduate training programs** and physicians who are not in approved programs but who are authorized to practice only in a hospital setting; e.g., **individuals with temporary or restricted licenses**, or **unlicensed graduates of foreign medical schools**."
  - (Medicare General Information, Eligibility & Entitlement Manual, Ch. 5, Sec. 70-7(A))
- "Medical and surgical services furnished by interns and residents within the scope of their training program are covered as provider services."
  - (Id., Sec. 70-7(B))
- Moonlighting: services provided by residents are covered as physicians' services *if:*
  - "not related to their training program, and are performed outside the facility where they have their training program" *or*
  - "performed in an outpatient department or emergency room of the hospital where they have their training program"
  - (Id., Ch. 5, Sec. 70-7(C))

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Federal Emergency Waivers and Rule Changes

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CMS Blanket Waivers and Interim Final Rules

Blanket Waivers and Interim Final Rules

- What is a "blanket waiver"?
  - Permitted by Sec. 1135 of the Social Security Act—Authority to Waive Requirements During National Emergencies
  - Purpose: to ensure availability of health care items/services and to exempt health care providers unable to comply with requirements from sanctions
  - Allows HHS to waive/modify Medicare, Medicaid, CHIP, and HIPAA requirements when a) President declares state of emergency, and b) HHS declares public health emergency (both prerequisites met on 3/13/20)
  - Health care providers do not need to request provider-specific waivers where CMS has issued a blanket waiver
- "[A] sweeping array of new rules and waivers of federal requirements to ensure that local hospitals and health systems have the capacity to absorb and effectively manage potential surges of COVID-19 patients."
- Retroactive to March 1, 2020; terminates upon end of emergency declarations, or 60 days after waivers first issued (subject to extensions)
- Interim final rules are another legal vehicle

(https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient)

First Round of Blanket Waivers, 3/30/20

- Waived requirement that CRNAs be under supervision of physician.
  - CRNA supervision to be at discretion of hospital and state law.
- Waived minimum personnel qualifications for CNSs, NPs, and PAs for critical access hospitals.
  - These providers must still meet state licensure requirements
- Waived physical presence requirement for physician supervision at CAHs
  - "This also allows CAHs to use nurse practitioners and physician assistants to the fullest extent possible, while ensuring necessary consultation and support as needed."

(https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf)

First Round of Blanket Waivers, 3/30/20

- Waived requirement that NP, PA, or CNM be available to furnish care at least 50% of time that RHC or FQHC operates.
- Waived physician supervision requirement of NPs in RHCs and FQHCs (to the extent permitted by state law).
- Waived prohibition on physicians in SNFs delegating tasks that must be performed personally.
  - Enables physician to delegate any tasks to PAs, NPs, CNSs (to the extent permitted by state scopes of practice).
- Waived requirement that SNF physician must visit patients personally
  - Enables visits to be done by PAs, NPs, CNSs (to the extent permitted by state scopes of practice).

(https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf)

Second Round of Blanket Waivers, 4/30/20

- Second set of waivers following questions from healthcare providers and enactment of CARES Act
- Goals:
  - "[T]o remove barriers for hiring and retaining . . . to keep staffing levels high."
  - "[C]utting red tape so that health professionals can **concentrate on the highest-level work they're licensed for**."
- Additional waivers:
  - Waived requirement that home health services must be certified by a physician
    - NPs, CNSs, PAs now able to order home health services, establish plan of care, and certify/re-certify patients as eligible
  - Will permit PTs and OTs to delegate maintenance therapy services to PT and OT assistants in outpatient settings
  - Expanded categories of providers who can furnish telehealth to include PTs, OTs, and speech language pathologists (in addition to MDs, NPs, and PAs)
    - Includes all practitioners eligible to bill Medicare for professional services

(https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid)

Interim Final Rules

- Two rounds: 3/26/20 and 4/28/20
- Revised definition of "direct supervision" by physician or non-physician practitioner to allow for virtual (real-time) supervision
  - Change is only to *manner* of supervision; does not change underlying payment or coverage policies
- Change also to general supervision
- Most other changes addressed in 1135 waivers

(https://www.cms.gov/files/document/covid-final-ifc.pdf and https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf)

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CMS "Flexibilities to Fight COVID-19" for Teaching Hospitals/Physicians and Medical Residents

CMS "Flexibilities to Fight COVID-19" for Teaching Hospitals/Physicians and Medical Residents

- Teaching physicians may meet requirement of presence during "key portion" of service/procedure through virtual means
- Residents may provide expanded services: Levels 4/5 E/M visit, telehealth, etc.
  - However, "flexibilities" **do not** apply to surgical, high risk, interventional, or complex procedures, service performed via endoscope, or anesthesia
- Expanded moonlighting to include **inpatient services** at hospital where resident has training program
  - Previously limited to outpatient department or ED if at hospital where training
  - Services still must be "not related to their approved GME programs" to be separately billable
- Teaching hospitals can claim DGME/IME payments for services furnished by medical residents in their own homes/at patients' homes
- Teaching hospitals that send residents to other hospitals in response to COVID-19 will continue to receive DGME/IME payments for those residents
  - Presence of residents in non-teaching hospitals will not trigger penalties

(https://www.cms.gov/files/document/covid-teaching-hospitals.pdf)

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State Emergency Rules/Regulations

State Emergency Rules/Regulations

- Historic measures to address healthcare practitioners during state emergencies:
  - Emergency Management Assistance Compact – 1996
  - Nurse Licensure Compact – Created 1997, Implemented 2000 /Enhanced Nurse Licensure Compact 1/19/18
  - Uniform Emergency Volunteer Health Practitioner Act -2006
  - Interstate Medical Licensure Compact – 2013
  - APRN Compact – 2015. Not yet implemented

States Challenges and Responses

- Challenges:
  - Lack of national response to historic legislation.
  - Ongoing barriers to mobilizing health care practitioners:
    - rigidity in licensing laws;
    - inconsistency in scopes of practice;
    - reduced supply of healthcare professionals.

- State Responses to COVID-19:
  - Temporary emergency measures to increase supply of healthcare professionals to meet demands of the virus.
    - States declaring states of emergency
    - Provisions authorizing or directing Departments of Health and Nursing Licensure Boards to act
    - Enacting Uniform Emergency Volunteer Practitioners Act
    - Waiving/suspending requirements for collaboration/supervisory requirements
    - Waiving fees

A Snap Shot of Various State Responses

California

- Actions following 3/30/20 Executive Order:
  - Suspended radiology technician and EMS licensing, certification, and training requirements.
  - May waive professional licensing requirements and amend scopes of practice for healing arts practitioners
    - "Professional licensing requirements should be interpreted broadly to effectuate the purposes of this executive order."
- Dept. of Public Health All Facilities Letters:
  - Suspended enforcement of Certified Nurse Assistant staffing ratios for SNFs (3/30/20).
  - Suspended professional certification requirements for CNAs (4/5/20) and for home health aides (4/24/20).
  - Suspended regulatory requirements for CNA training programs (4/14/20).

Department of Consumer Affairs - Orders

- Nurse Practitioners (4/14/20)
  - Suspended physician supervision limit when furnishing or ordering drugs or devices.
- Physician Assistants (4/14/20)
  - Suspended physician supervision limit;
  - Suspended requirement for practice agreement or written delegation of services agreement to perform medical services;
  - Suspended requirement to limited extent that it requires practice agreement to furnish or order drug or device.
    - PA may only furnish/order Schedule II or III controlled substance with patient order approval by treating/supervising physician;
    - PA must render services under supervising physician; /surgeon; be competent to perform medical services, and have necessary education, training, experience.

Department of Consumer Affairs - Orders

- Nurse-Midwife (4/14/20)
  - Suspended physician supervision limits.
- MFT, Professional Clinical Counselors, and Clinical Social Workers (4/14/20)
  - Suspended “face to face” mental health services to complete required training;
  - Allow Associate MFT, CSW and Professional Clinical Counselors to be supervised via two-way, real time videoconferencing irrespective of work setting.

Colorado

- Existing statutory authority for emergency nursing assistance:
  - Nurse Practice Act – rendering of nursing assistance in emergency - “Good Samaritan law” (C.R.S. § § 12-255-127(1)(c));
  - Nurse Aide Practice Act – nurse aide services in emergency (C.R.S. § 12--260-120(1)(c)).
- Actions following 3/11/20 Executive Order:
  - Waived nursing licensing requirements and rules to allow late renewals, reinstatements, and reactivations for volunteer nurses and other “qualified licensed providers” from out of state;
  - Allowed nursing student instruction to continue via simulation;
  - Suspended physician supervision limit for PAs and allowed remote PA supervision;
  - Suspended requirement for demonstration of continuing competency for PAs.

Massachusetts

- Actions following 3/17/20 Executive Order:
  - Extended expiring registrations of RNs, LPNs, pharmacists, and PAs “in good standing” during state of emergency until 90 days following termination of emergency;
  - Implemented expedited credentialing procedures for licensed independent practitioners for medical facilities.
- 4/3/20 DPH Order “maximizing health care provider availability”:
  - State to issue Mass. license to health care providers in good standing in other states;
  - Previously-licensed health care providers in good standing to have licenses immediately renewed or reactivated upon request;
  - Applies to RNs, LPNs, APRNs, PAs, respiratory techs, social workers, etc.

Specific AHP Orders

- 3/18/20 Order for Physician Assistants
  - May designate a new supervising physician as needed to maximize health care provider available if certain conditions met regarding licenses, consent, records of designation, competency of PA; ability to provide supervision and designation is in order to maximize provider availability to respond to COVID-19 spread.
  - If supervising physician designated pursuant to this Order is unable or unavailable to be principle decision maker, another licensed physician must be designated to assume temporary responsibilities of the PA.

Specific AHP Orders

- 3/26/20 Order for APRNs

  - Allow prescriptive practice without physician supervision and written guidelines for APRN (except CNM) with at last 2 years supervised practice experience or equivalent.

  - APRN who collaborates with different physician for supervision of prescriptive practice during state of emergency are exempt from written guidelines if applicable licenses are current and in good standing; collaboration is based on need to maximize provider availability for COVID-19 response; and physician and APRN consent to the collaboration and have written document evidencing consent, specific dates of collaboration and supervision of prescriptive practice.

Maryland

- Actions following 3/11/20 Executive Order
  - Interstate reciprocity with valid, unexpired license from another state.
  - Activation of inactive practitioners if conditions met.
  - Expanded scope of practice if need to meet required staffing ratios or ensure safe care, and have qualified supervisory personnel at health care facility.
- Board of Physicians Notice 3/24/20
  - Suspended requirement that PA wait until Board receives delegation agreement before assuming duties.
  - Suspended physician supervision limit for PAs in all settings.
  - Suspended requirement to meet requirements to reactivate license while working at health care facility if necessary to meet staffing ratios/provide continued and safe delivery of health care services.

Maryland

- Board of Nursing Notice 3/24/20
  - Allow RNs and LPNs with current active license from another state to render nursing care for more than 30 days.
  - Allows inactive licensees to apply for reactivation without meeting minimum reactivation qualifications.
  - Suspended time limit in which a Nursing Graduate may practice before being licensed.
  - RNs/LPNs may delegate tasks to unlicensed personnel in accordance with COMAR 10/27.11.01-06.
  - Allow delegating nurse case manager to perform supervising onsite visit every 60 days during emergency.

Virginia

- Actions following 4/23/20 Amended Executive Order for Licensing of Health Care Professionals:
  - Active licenses to health care practitioners licensed in another state and in good standing if engaged by hospital, licensed nursing facility, dialysis facility, physician's office or other health care facility to assist with emergency response.
  - Temporary licenses for clinical psychologist, professional counsel, MFT and CSW if licensed in good standing in another state;
  - Health care practitioners with active license by another state may continue to provide care to current patients who are Virginia residents through telehealth services;
  - NPs licensed in Virginia (except CRNAs) with 2 or more years of clinical experience may practice in their practice category and prescribe without written or electronic practice agreement.

Virginia

- PA licensed in Virginia with two or more years of clinical experience may practice in their area of knowledge and expertise and may prescribe without a written or electronic practice agreement;
- Interns, residents, and fellows with active temporary training licenses may practice in a hospital without supervision of a licensed physician. Level of supervision determined by training program.
- Senior fourth year medical students may practice in a hospital without direct tutorial supervision by licensed physician member of medical staff. Level of supervision established by institution in coordination with hospital where practice occurring.
- Individuals completing accredited respiratory care program may practice respiratory therapy and for 90 days thereafter or until passed licensure exam and issued a license or failed exam, whichever occurs first.

Virginia

Additional Medical Board Measures:

- Temporary waiver to reinstate or reactivate license for MD or DO, PA or respiratory therapist who held unencumbered license within past 4 years.
- Expedited licensure process for medicine and surgery; osteopathic medicine and surgery, PA, podiatry and respiratory therapy.

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Non-COVID-19 Changes to AHP and Medical Resident Practice

Changes to PA Supervision Requirements Under California SB 697

SB No. 697 (Eff. Jan. 1, 2020)

- Most significant changes:
  - Requiring a "practice agreement" with an organized health care system (as opposed to delegation agreement with supervising physician)
  - Eliminates specific supervision requirements for PAs
  - Permits PAs to prescribe drugs without specific physician supervision or physician contact info on the prescription

Replacing Delegation of Services Agreement with Practice agreements

- **Before**:
- PAs were required to enter into delegation of services agreements that named “each supervising physician”
- Each PA’s scope of practice was limited by the specific tasks delegated to him or her as stated in the delegation of services agreement

- **Now**:
- Practice agreements are required
  - Defines the medical services the PA is authorized to perform
  - Developed through collaboration among physicians/surgeons and physician assistants
  - Grants approval for physicians/surgeons on the staff of an organized health care system to supervise one or more physician assistants in the system

Cal. Bus. & Prof. Code, §§ 3501(k), 3502.3.

Practice Agreement Requirements

Must include:

- Types of medical services a PA is authorized to perform
- Policies and Procedures to ensure adequate supervision
- Methods for continuing evaluation of PA's competency and qualifications
- Furnishing or ordering of drugs/devices

PA Supervision Requirements

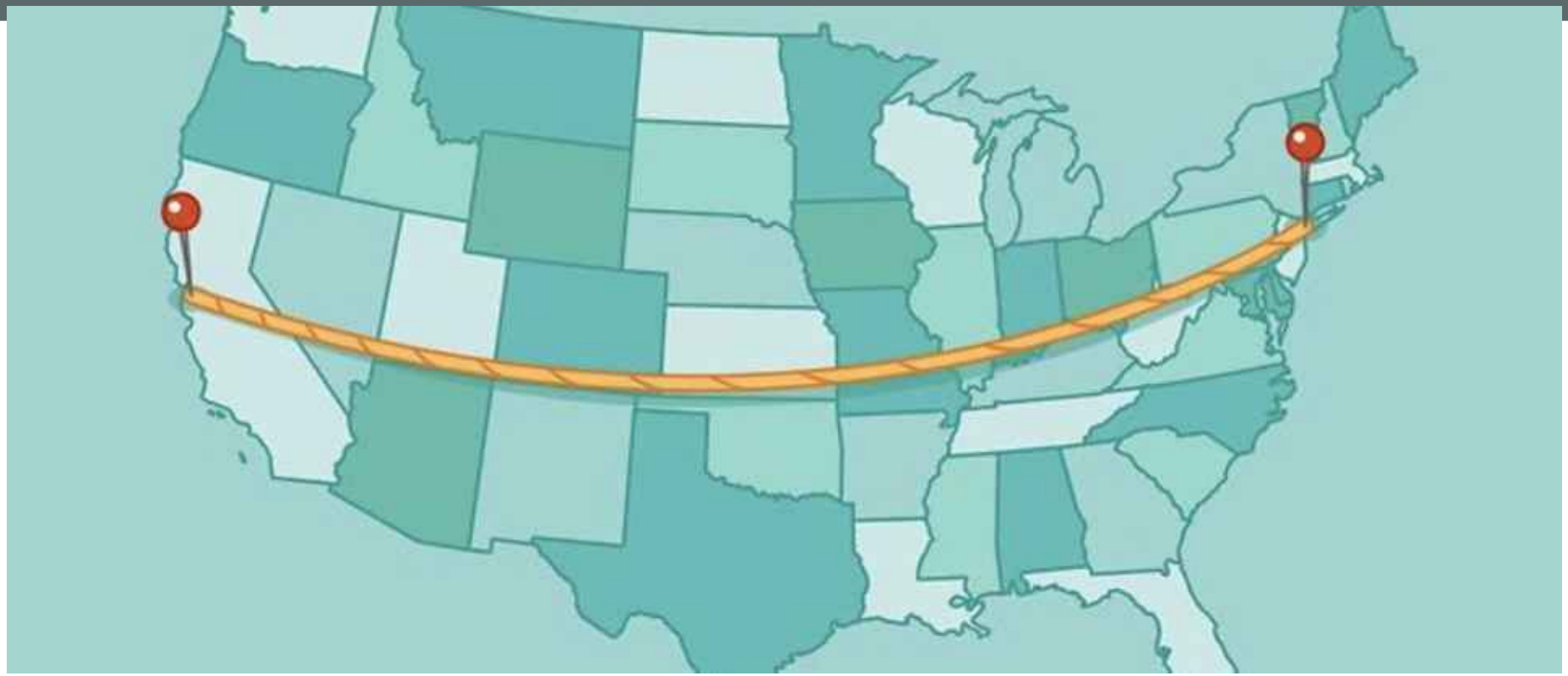
Before:

- PAs were supervised by physicians in 1 of 4 ways:
  1. A supervising physician must examine the patient the same as care is rendered by the PA
  2. Countersignature and dating required for all medical records written by the PA within 30 days
  3. Development of protocols governing the performance of a PA for some or all tasks
  4. Other mechanisms approved in advance by the Board

Now :

- Supervision does not require physical presence of the physician, but does require:
  - Adherence to adequate supervision as agreed to in the practice agreement
  - The physician and surgeon being available by telephone or other electronic communication method at the time the PA examines the patient

Cal. Bus. & Prof. Code, § 3501(a)(6)(f)).



Changes Across the Country:

A Trend Towards Greater Practice Authority

Changes Across the Country

Colorado

- HB 19-1095 revised the MPA
  - Licensed physician can be responsible for supervision of up to 8 PAs at a time
  - Licensed physician shall not be made responsible for more than 4 PAs unless physician agrees to assume responsibility
- PAs must be operating under either a Supervisory Plan (new PAs) or a Practice Agreement

Virginia

- HB 1952/SB 1209
- Authorizes PAs to practice in collaboration and consultation with patient care team physicians
- Deletes references to a "delegated scope of practice" and permits PA scope of practice to be determined by the patient care team

Maryland

- HB 591/SB 549
- Authorizes PAs to prepare and dispense medications they can already prescribe within their scope of practice
- Removes dispensing limitations on PA practice

Recent Changes to Postgraduate Training & Licensure Requirements

SB No. 798

(Eff. Jan. 1, 2020)

- Within 180 days after enrollment in a board-approved postgraduate training program, all medical school graduates must obtain a physician and surgeon's postgraduate training license ("PTL").
- PTL will be valid until 90 days after the holder has successfully completed 36 months of board-approved postgraduate training.
- To be eligible for a physician's and surgeon's certificate, a graduate must have successfully completed a minimum of 36 months of approved postgraduate training with at least 24 consecutive months in the same program.

Cal. Bus. & Prof. Code, §§ 2064.5(a), (b), 2065(e).

California's Requirements Are the Most Stringent

- To date, California is the only state to require 36 months of graduate medical education("GME") for full licensure of MDs and DOs
- Only 2 other states—Maine and Nevada—have 3-year GME requirements but with certain exceptions
- 33 states and Washington, DC require MDs to have 1 year of GME for full licensure
- 12 states require MDs and DOs to have 2 years of GME before obtaining full licensure

See Rose Raymond, *California to Require Three Years of GME for Full Physician Licensure*, To Do (Sept. 11, 2019), https://thedo.osteopathic.org/2019/09/california-to-require-three-years-of-gme-for-full-physician-licensure/; *see also* Federation of State Medical Boards, *State Specific Requirements for Initial Medical License*, https://www.fsmb.org/step-3/state-licensure/.

- A physician and surgeon's postgraduate training licensee may engage in the practice of medicine only in connection with his or her duties as an intern or resident physician in a board-approved program, including its affiliated sites, or under those conditions as are approved in writing by the director of the residency program.

  Cal. Bus. & Prof. Code, § 2064.5(b).

- Accordingly, a resident or intern holding a training license may moonlight with written authorization from the residency program director.

  See id.

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Ensuring Payment for Services Ordered and Furnished by AHPs and medical residents

Medical Residents

- Resident services furnished within the scope of training program—
  - Covered as *provider* services paid through DGME and IME payments
  - No Medicare Physician Fee Schedule Payment
- Moonlighting Exception
- Teaching Physicians
  - Must be identified as the teaching physician on claims
  - Meet documentation guidelines
  - GC modifier (Except GE modifier for primary care exception)

Non-Physician Practitioners: Facility Fee

- Therapeutic outpatient services
  - Services provided by NPP
  - Incident-to services furnished by hospital nursing staff under the supervision of the NPP
  - NPPs
    - Clinical psychologist
    - Licensed clinical social worker
    - Physician assistant
    - Nurse practitioner
    - Clinical nurse specialist
    - Certified nurse midwife
- Diagnostic outpatient services
  - Ordering
  - Supervising

Non-Physician Practitioners: Professional Fee

- Not separately payable if NPP is included in the hospital cost report
- May be payable if salary is excluded from Medicare cost report
  - Payment reassigned to hospital
  - Billed under NPPs NPI and generally payable at 85% of the Medicare physician fee schedule
  - Only for services personally performed by NPP
- Split/Shared E/M Visits
  - NPP and physician are in the same group practice
  - Both NPP and physician provide face-to-face portion of the E/M encounter
  - Contributions of both the NPP and physician may be considered when coding the E/M visit and visit may be billed under the physician's NPI.

Professional Billing for Incident-to Services

- Not available in Hospital Setting
- Incident-to Services:
  - Are an integral part of the patient's normal course of treatment when the listed practitioner personally performed an initial service and remains actively involved in the course of treatment.
  - Are commonly furnished without charge or included in the listed practitioner's bill.
  - Are an expense to the listed practitioner.
  - Are commonly furnished in listed practitioner's office or clinic.
- Supervision—Services billed only by the supervising practitioner
  - Generally direct supervision
  - General supervision for services and supplies incident to Transitional Care Management (TCM) and Chronic Care Management (CCM)

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Thank You.

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