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COVID-19 — Legal Guide for Medical Groups

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This COVID-19 – LEGAL GUIDE FOR MEDICAL GROUPS (“Guide”) provides a general discussion of legal issues confronting medical groups as a result of COVID-19, including employee protections, infection control, and reporting obligations, workforce management and related mitigation strategies, employee obligations, business and payor relationships, privacy and telehealth, Medicare changes, and strategic transactions.

This Guide is not exhaustive, and does not an attorney-client relationship with the reader. Readers are encouraged to consult legal counsel to address specific concerns for their business, particularly given the speed at which the COVID-19 situation is developing and varied degree and scope of responses by federal, local, and state governments. Things are changing quickly and there is no clear-cut authority or bright line rules for many of the topics addressed below. This is not an unequivocal statement of the law, but instead represents our best interpretation of where things currently stand. This Guide does not address the potential impacts of the numerous other local, state and federal orders that have been issued in response to the COVID-19 pandemic, but which are not referenced in this Guide.

1. EMPLOYEE PROTECTION AND INFECTION CONTROL MEASURES FOR COVID-19

Q. How do we respond if an employee informs us that he/she has symptoms of acute respiratory illness?

A. Employees who have symptoms of acute respiratory illness are recommended to stay home until

they are free of fever (100.4° F or greater using an oral thermometer), signs of a fever, and any other symptoms for at least 24 hours, without the use of fever-reducing or other symptom-altering medicines. CDC recommends that employees who appear to have acute respiratory illness symptoms at work be separated from other employees and sent home immediately. For healthcare personnel who have potential exposure in ahealthcare setting to patients with COVID-19, employers should follow the CDC's interim guidance: https://www.cdc.gov/ coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html.

Q: Do we have an obligation to report if a patient or employee tests positive for COVID-19?

A: Several states have included COVID-19 on their list of reportable communicable diseases. For example, California requires immediate telephonic reporting by health care providers knowing of, or in attendance on a case or suspected case of COVID-19. For patients, the medical group must make mandated reports to federal, state, and local public health authorities. For employees, however, unless the employer is the healthcare provider receiving the positive test result, the employer does not have a separate obligation to make a mandated report. Note, however, that the employer must record COVID-19 cases for workers in its OSHA 300 log per OSHA's Injury and Illness Recordkeeping and Reporting Requirements (i.e., if the case is confirmed to be COVID-19, "work-related" (as defined by 29 C.F.R. § 1904.5), and involves one or more of the general recording criteria set forth in29 C.F.R. § 1904.7 (i.e., time away from work, medical treatment)).

Q: What policies and procedures will best help us protect our patients and staff from COVID-19?

A. The CDC recommends establishing a plan of communication to promote situational awareness for staff, including infection control, healthcare epidemiology, leadership, occupational health, clinical laboratory, and frontline staff that addresses how to handle known or suspected COVID-19 patients. In addition, medical groups should consider third-parties who visit the medical office space and determine if their visit is essential to the business. If those relationships can be managed without in-person visits, that may be the safest approach.

Q. What infection control measures should we implement to protect our patients and staff in light of COVID-19?

A. If a group has the ability to provide certain services via telehealth, that is an optimal approach for infection control purposes. For in-person patient visits, medical groups can require infection control measures (e.g., washing hands, coughing etiquette, etc.), including wearing personal protective equipment ("PPE"), but must provide reasonable accommodations where needed (e.g., non-latex gloves). The CDC has printable posters and notices available for use in the workplace related to hand hygiene, respiratory hygiene, and cough etiquette. In addition to having appropriate PPE, medical groups should be performing routine environmental cleaning of common spaces and individual workstations. In a medical office, measures should be implemented before patient arrival, upon arrival, throughout the duration of the patient's visit, and until the patient's room is cleaned and disinfected.

If a patient has departed who is known or suspected to have COVID-19, personnel should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles. After this time, the room should undergo appropriate cleaning and

surface disinfection before it is returned to routine use. Preparedness and situational awareness (e.g., appropriate patient screening that allows providers to retain infected patients in a single room to reduce exposure) are prerequisites to an appropriate response. For additional and up-to-date information, the CDC's recommendations are available at https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html.

In addition, medical groups in California must comply with the state's Aerosol Transmissible Diseases ("ATD") standard to protect employees from diseases and pathogens transmitted by aerosols. The ATD standard requires medical groups to protect employees through effective:

• Written ATD exposure control plan and procedures;

• Training;

• Engineering and work practice controls;

• PPE;

• Medical services; and

• Laboratory operation requirements.

The California Division of Occupational Safety and Health ("Cal/OSHA") has issued guidance on the requirements of each of these factors, available at https://www.dir.ca.gov/dosh/Coronavirus-info.html.

Q. If an employee tests positive for COVID-19, should we share his/her identity with other employees so they may seek testing if they work or have been in contact with that employee?

A. No, an employer cannot reveal an employee's medical diagnosis. However, employer should generally communicate the exposure or potential exposure without providing information that would identify the individual employee.

Q. What if we suspect an employee has been exposed to COVID-19?

A. Medical groups have the right to take reasonable measures to protect: (1) the employee; (2) other employees/ staff; and (3) patients and their support persons. If there is a reasonable basis to suspect that an employee has been exposed to COVID-19, it is OK to ask him/her questions to determine if (and to what degree) he/she is experiencing symptoms to determine the possible threat level to others and/or need for self-quarantine. (Note that it is always OK to ask why an employee has been absent from work.) Current CDC guidelines state that a "reasonable basis" can be found if an employer has credible information suggesting:

• an employee may have been infected with COVID-19;

• an employee was exposed to an affected area or in close or extended contact with someone tested positive for COVID-19; or

• an employee has been in close or extended contact with someone who has recently visited a high risk location per CDC guidance.

If the employer determines there is a reasonable basis to suspect exposure to COVID-19 (as opposed to a common cold or flu virus), it is OK to send the employee home.

Q. Can we require our employees who have or are suspected to have COVID-19 to stay home?

A. It is generally considered reasonable to require an employee to stay home for at least the 14-day quarantine period recommended by the CDC if he/she meets the criteria set forth by the CDC for an acute respiratory infection; provided that the employer enforces all preventative measures and policies uniformly, consistently, and in a non-discriminatory manner. This applies even if the employee is paid on a productivity-basis

Q. Can we screen employees and/orrequire testing for COVID-19? Do we need to protect related information that we receive from employees?

A. Because the CDC and state/local health authorities have acknowledged community spread of COVID-19 and issued attendant precautions, employers may measure employees' body temperature, but currently cannot require that employees be tested for COVID-19. Employers must still maintain all information about an employee's illness as a confidential medical record in compliance with the ADA, the federal Family and Medical Leave Act ("FMLA"), and state law equivalents. In California, if an employer is subject to the California Consumer Privacy Act ("CCPA"), the employer must provide a CCPA-Compliant notice prior to or at the time that it collects this information. Managers/supervisors should not handle medical information or inquire about diagnoses of employees. If an employee voluntarily provides medical information to a manager, the manager should provide HR the information immediately.

Q. When should medical groups allow employees who have had or been quarantined on suspicion of having had COVID-19 to return to work?

A. Medical groups can request medical certifications before an employee returns to work. As a practical matter, however, doctors and other health care professionals may be too busy during and immediately after a pandemic outbreak to provide fitness-for-duty documentation. Therefore, new approaches may be necessary, such as reliance on local clinics to provide a form, a stamp, or an e-mail to certify that an individual tests negative for COVID-19. Additionally, medical groups may impose other reasonable requirements to help ensure the employee is not infected (e.g., by requiring that he/she attest to being symptom free during the incubation period or, where the employee was symptomatic, that they be symptom free for at least a certain number of days without medication, and/or requiring that he/she test as afebrile before returning to work).

Q. Can the Group prohibit employees/staff from travelling?

A. While medical groups cannot dictate where employees travel for personal reasons, medical groups may ask employees where they have travelled and suggest that they review the CDC's Traveler's Health Notices and educate them on the consequences of traveling to CDC-designated high-risk areas (e.g., government a/or Company-mandated quarantine for 14-days). Finally, employers may require that employees disclose personal travel prior to return to work (especially to affected areas or other international travel).

2. WORKFORCE MANAGEMENT DURING THE COVID-19 CRISIS AND RELATED RISK MITIGATION STRATEGIES

Q. Can we require employees to come to work, even if there are legitimate fears about possible exposure to COVID-19?

A. Employers can still require employees to come to work (assuming the employee has not reported COVID-19 related symptoms, have not likely been exposed, and are currently not caring for a sick child/parent/family member). Generally, employees cannot refuse to come to work based on a general fear of the virus. In addition, the American Medical Association mandates that a physician's ethical duties to patients are constant, even in light of greater than usual risk to the provider's health; provided, however, that physicians should take measures to protect themselves and their ability to care for patients go-forward. We note, however, that employers should be mindful that there is some risk associated with taking action against employees, particularly non-physicians, who elect to stay home in order to avoid potential exposure, and should consult with counsel before proceeding with any related measures.

Q. Can we require employees to come to work, even if a "shelter-in-place" order is in effect where we operate?

A. While there are some jurisdictions currently covered by shelter-in-place orders (and more that are likely to come), health care is an "Essential Business" and health care workers are exempt from such orders. Employers should remind employees to carry their business cards/IDs in order to demonstrate their exemption if necessary.

Q. Is there legal risk if an employee becomes infected with COVID-19 in the course of his/her job duties?

A. The Occupational Safety and Health Act governs infectious disease under its "general duty" clause. If there is a recognized work hazard like exposure to COVID-19, employers must take reasonable steps to prevent and abate the hazard (e.g., by providing PPE, workplace sanitation and, if there is credible threat of infection, quarantine). To mitigate risk, medical groups should implement infection control and adequate communication plans regarding COVID-19, and ensure that employees have access to necessary PPE to perform their job duties safely.

For guidance on efficient use of respirator supplies, please review California Division of Occupational Safety and Health's Interim Guidance available at https://www.dir.ca.gov/dosh/Use-of-Respirator-Supplies.html.

Q. Must we provide work from home accommodations to our employees in light of COVID-19?

A. Only qualified disabled employees have a right to a reasonable accommodation such as a work from home arrangement, provided there is no undue hardship and that the accommodation does not pose a "direct threat" (as defined by the federal EEOC) to the safety of self or others. Currently, COVID-19 is not a"disability" requiring an accommodation under state or federal law. However, the DOL has encouraged employers to be flexible during this time because work-from-home can be used for purposes of infection control. Medical groups should consider possible work-from-home solutions that may be possible (e.g., telehealth visits,remote EMR completion, etc.).

Q. If we allow employees to work from home, do we need to reimburse them for cell phone,

internet, and other related expenses?

A. If an employee who does not regularly work remotely needs to do so during the COVID-19 pandemic, an employer may need to reimburse him/her for additional related expenses incurred during that period. The DOL has not stated that employers must reimburse employees, but advised that if an employer requires a non-exempt employee to work from home, the employer may not require him/her to pay for related business expenses if doing so reduces his/her earnings below the required minimum wage or overtime compensation. We note that employers should evaluate state wage and hour laws to ensure they do not have additional requirements and/or guidance during this time.

Q: Our group cannot keep up with the demand for services. What are our options?

A: There are several options available that require careful consideration before implementation, including increasing providers' existing workloads, leveraging advanced practice clinicians within their scope of practice, floating providers across specialty areas, and seeking additional help from providers currently practicing (or even those who have retired). For current physician and non-physician providers, it is important to be mindful of contractual provisions that may limit the medical group's ability to call on providers to render additional services. For providers who may be asked to float among departments or specialties, those persons must have the appropriate credentialing and skillset to render care safely in each area.

If a medical group reaches the point where it may request that retired physicians assist on an ad hoc basis to help with the COVID-19 workload, the group will need to confirm that the person has valid licenses/permits, up-to-date continuing medical education, professional liability coverage (or eligibility therefor, whether on a slot coverage basis or otherwise), and, if applicable, appropriate medical staff credentialing.

Medical groups should also be mindful that some license requirements are being relaxed to address the current pandemic. For example, out-of-state medical personnel entering California for the limited purpose of addressing COVID-19 can request temporary recognition of an out-of-state license from the Director of California's Emergency Medical Services Authority. In the telehealth context, such licensure waivers can be used in conjunction with CMS's relaxation of reimbursement requirements (discussed below) to seek reimbursement for telehealth services provided by out-of-state physicians. Because licensure requirements vary by state, groups should consult with legal counsel to determine what options are available.

Q. Our group does not have sufficient workflow to use all of our employees. Do we furlough our employees or should we opt for a termination/layoff?

A. A furlough is an unpaid leave of absence, or a "pause" in an employee's services, although he/she will still be considered to be an employee. For that reason, the employer should communicate in a notice to the employee that the employment relationship is continuing and that the furlough is not a termination. A furlough does not generally trigger notice requirements under the federal WARN Act. If an employee is furloughed, he/she may, but is not required, to use accrued paid-time off to cover any part of their furlough period. During the furlough period, health benefits may continue, and we recommend that groups review their benefit plans and discuss with any 401K administrators in order to clarify how the furlough will impact the employer and employees.

A termination or layoff ends the employment relationship, even if it is temporary and the employer

intends to later re-hire the employees. This action would trigger any termination clauses in an employment contract and may subject the employer to specific notice requirements and/or additional pay, including accrued paid time off if there is an applicable employer policy or requirement under state law. If an employee's employment is terminated, the employer would not be required to re-hire him/her, whether to fill his/her prior position or otherwise. Note that a termination or layoff may trigger the federal WARN Act (described below) if the layoff is anticipated to be more than six (6) months. With the COVID-19 pandemic, if the employer expects to rehire individuals (or, even simply hope to), its termination notice should clarify that it anticipates that the layoff is temporary and that it hopes to re-hire the employees within six (6) months. If the company has not re-hired employees after four (4) months, it should re-evaluate whether a WARN Act notice is going to be needed and develop that notice.

Q. What do we need to do for our employees if we are required to shut down by the government, or decide to shut down ourselves?

A. The federal Worker Adjustment and Retraining Notification Act ("WARN") is designed to give employees notice of certain mass layoffs. WARN notices are not required for government-mandated shutdowns. However, for a voluntary shutdown, the WARN Act may be implicated if an employer meets the threshold criteria: more than 100 full time employees, a temporary shutdown if the shutdown will (i) affect 50 or more employees at a single site of employment; and (ii) result in at least a 50% reduction in hours of work of individual employees during the month of the shutdown. Employers are usually required to provide 60 days' notice in these circumstances; however, if there are unforeseen business circumstances, an employer is required to provide as much notice as possible to the affected employees. The state equivalents to the WARN Act may have additional criteria or requirements.

Q. Do employers pay employees during a shutdown?

A. Generally, they are not required by law to do so. As described herein, employees, on a federal level, are not entitled to any pay for work they do not perform. Specifically, hourly employees will receive compensation only for hours worked. Salaried employees will receive their salary only for any week in which they perform any work. Employees who are entitled to productivity bonuses likely should be given prorated bonuses, contingent on the terms of the bonus plan. Employees who have "earned" commissions prior to the shutdown should be paid such commissions in a timely manner. Q. If we have to shut down or layoff employees, can we waive their non-competition promises to our group during the COVID-19 emergency so that they can find work elsewhere? A. Yes, but the group should make sure that any such waiver is documented in writing and clear that it is temporary and applies only during the pandemic.

Q: Does our group need to maintain a focus on continuing education and license renewals for employees at this time?

A. Yes, although states may be considering easing license renewal terms and continuing education requirements for certain healthcare providers. For example, in Illinois, the Secretary of the Department of Financial and Professional Regulation ("Department") has taken steps to extend licensees' renewal periods for those whose licenses expire between March 1, 2020 through and including, July 31, 2020 through September 30, 2020 (provided that licensees otherwise comply with applicable requirements). The deadline for those licensees to complete their required continuing education coursework was also extended through September 30, 2020, and they may complete their continuing education coursework on a remote learning basis. Licensees should check the

announcements of their applicable licensing agencies' websites and monitor their communications from those agencies to see if similar variances may be applied by their relevant jurisdiction(s).

3. EMPLOYEE BENEFITS FOR COVID-19

Q. Can we require an employee to use PTO if he/she refuses to come to work?

A. Unless otherwise governed by an employee's contract, medical groups can require employees to take available paid-time off ("PTO"), vacation time, and sick days for time away from work. If the employee does not have available PTO, he/she may take paid leave under applicable policies and procedures. In addition, employees may potentially be eligible for unpaid leave under state and federal family and medical leave laws. Finally, sick employees and employees caring for family members may be also be eligible for paid sick leave under applicable local or state laws.

Q. What are the pay considerations for employees who need to stay home under existing law?

A. Exempt employees who may be required to stay home due to COVID-19 issues may be able to continue working while at home, and if this is an option, they should be paid their usual salary. Generally, if an exempt employee works for any period of time during the workweek, they must be paid their full salary.

Pending any future updates or developments, non-exempt employees must only be paid for hours worked. The Department of Labor ("DOL") Wage and Hour Division's COVID-19 guidance reminds employers that nonexempt employees will only be paid for time worked. This means that if an employer must close their business and/or send non-exempt employees home, they are not required to pay those workers, even if they were previously scheduled to work. In such situations, employees may be entitled to unemployment compensation and other state benefits. Employers should evaluate any applicable state wage and hour laws to ensure they do not have additional requirements and/or guidance during this time. Continued pay may be required for an employee (whether or not exempt) who is quarantined through different channels, including:

• They may be eligible for pay for other qualifying reasons, such as school closure or care for a child who is sick with COVID-19 or any other illness;

• Pay may be available based on company business disruption protocols and/or • Pay may be available under local sick leave laws if a pandemic is declared locally. Q. Does the federal Families First Coronavirus Act (the "Act") change our obligations to our employees with respect to pay or sick leave? How can we tell if we are bound to follow the Act? A. It depends on your number of employees, and may depend on the type of medical services that your group provides to patients. For clarity, two paid leave provisions of the Act apply to employers with fewer than 500 employees, unless they meet an exception: (1) the Emergency Family and Medical Leave Expansion Act; and (2) the Emergency Paid Sick Leave Act (each described below).

Q. How do we know if we have 500 or fewer employees?

A. The Act amends the FMLA, and so, while the Act does not define how an employer should measure whether or not they have 500 employees, and the federal Department of Labor has not yet issued guidance on that issue, we recommend that employers use the current measuring standards used for determining employer size under the FMLA. Under the FMLA, multiple entities may be considered as one employer if the entities meet the "integrated employer test." When determining

whether to treat separate entities as a single employer, individual determinations are highly fact-specific and are based on the totality of their relationship, considering (i) interrelation of operations, i.e., common offices, common record keeping, shared bank accounts and equipment; (ii) common management, common directors and boards; (iii) centralized control of labor relations and personnel (i.e., hiring/firing of employees); and (iv) common ownership and financial control. Importantly, if an employer takes the position that it is an" integrated employer" for purposes of avoiding the requirements of the Act, it could implicate future "joint employer" claims in future litigation.

Q. What is the Emergency Family and Medical Leave Expansion Act?

A. This provision of the Act gives eligible employees the right to take up to 12 weeks of job-protected leave under FMLA for certain reasons related to the COVID-19 pandemic. An employee is deemed eligible if: (1) he or she has been employed for at least 30 days and (2) is unable to work (or telework) due to a need to care for minor children who is unable to go to school or child care program that has been closed or the child care provider is unavailable due to a public health emergency. An eligible employee is entitled to 10 days of unpaid leave (the employee may choose to substitute accrued paid time off or other medical or sick leave during this period) and 10 weeks of paid leave at a rate of two-thirds of the employee's regular rate of pay, at the number of hours that the employee is regularly scheduled to work. Paid leave, however, cannot exceed $200 a day or $10,000 in total.

Q. What is the Emergency Paid Sick Leave Act?

A. This provision of the Act also provides eligible employees of employers with fewer than 500 employees with up to 2 weeks (80 hours) of paid sick leave. Employees, regardless of length of employment, are entitled to immediate paid sick leave if they are unable to work (or telework) for the following reasons:

1. The employee is subject to a Federal, State, or local quarantine or isolation order related to COVID-19;

2. The employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19;

3. The employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis;

4. The employee is caring for an individual who is subject to an order to quarantine or self-isolate or has been advised by a health care provider to self-quarantine due to concerns related to COVID-19;

5. The employee is caring for a son or daughter of such employee if the school or place of care of the son or daughter has been closed, or the child care provider of such son or daughter is unavailable, due to COVID-19 precautions; or

6. The employee is experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor. The Act states that paid sick time shall not exceed: (i) $511/day and $5,110 in the aggregate for employees utilizing the leave for reasons (1) – (3) listed above; and (ii) $200/day and $2,000 in the aggregate for employees utilizing the leave for reasons (4) – (6) listed above. For reasons (1) – (3), the pay must be provided at an employee's regular rate of pay (which must equal or exceed minimum wage); for reasons (4) – (6), the rate of pay must be no less than two-thirds of the employee's regular rate of pay or the minimum wage (whichever is greater). The Secretary of Labor

is required to issue regulations regarding how paid leave should be calculated under the Act. Q. Do any exceptions to the Act apply to us? If so, how do we notify our employees? A. The Act has an exception for “an employer of an employee who is a health care provider or an emergency responder may elect to exclude such employee from the application of this subsection.” However, currently, this exception does not appear to be a blanket exception for the healthcare industry because the Act includes a request that the Secretary of Labor the authority to issue regulations exempting (1) certain health care providers and emergency responders from taking leave under the bill and (2) small businesses with fewer than 50 employees if compliance would jeopardize the viability of the business. Conservatively, we recommend that a medical group seek to comply with the Act, unless exigent circumstances require the group to mandate that its providers be at work as much as possible to combat the COVID-19 epidemic. Currently, the Secretary of Labor has not provided employers with notices to post regarding the Act’s requirements, and there is no formal notice that needs to be given, or guidance as to how employers should inform employees that they are not covered.

Q. If we need to comply with the Act, what is the deadline?

A. The Act will take into effect no later than April 2, 2020 (15 days after presidential approval) and expire on December 31, 2020.

Q. Will we get any tax credits if we have to comply with the Act?

A. Yes. The Act provides for tax credit to help reimburse employers for wages paid while employees are on paid sick and paid FMLA leave. The paid FMLA leave credit for each employee is limited to $200 per day, up to a maximum of $10,000. The paid sick leave credit is equal to the wages actually paid, up to a maximum of $511 per day while an employee is on paid sick leave to care for themselves, and $200 per day if the employee is on paid sick leave to care for a family member or child. The credit is also limited to 10 working days per employee. Both credits are refundable to the extent they exceed the amount the employer owes in payroll taxes. Q. Do we need to be aware of state or local equivalents to the Act? A. We recommend confirming with counsel whether or not your group may need to comply with additional state or local requirements. For example, San Francisco’s Workers and Families First Program funds certain extended sick leaves agreed to by employers. For more insights, see: https://www.laboremploymentlawblog. com/2020/03/articles/coronavirus/san-francisco-provide-paid-sick-leave-covid-19/.

4. BUSINESS DECISIONS,CONTRACTUAL OBLIGATIONS, INSURANCE POLICIES,PAYOR RELATIONSHIPS

Q: Our group compensates some or all of our providers on a productivity basis. What are our options?

A: COVID-19 has had wide-ranging impacts on the healthcare system. While self-quarantines, social distancing, shelter in place ordinances, and reductions in the volume of elective procedures may substantially decrease productivity within certain specialties, other specialties, including emergency services, intensive care, anesthesia and telehealth may see spikes in demand. Some physician employment or independent contractor agreements may account for adjustments to compensation in the event of pandemic disease outbreaks, but many may not. As a result of COVID-19, some physicians who are compensated on a productivity-basis may be concerned about a loss in compensation, and, depending on their practice areas, medical group employers may be concerned not only about a loss of revenue but also about the well-being of their physician employees. Many

groups may seek to modify compensation to benefit productivity-based employees to reduce the negative impact they may face as a result of decreased productivity. In doing so, groups need to be mindful of existing contractual obligations with their physicians, and third-parties, such as a management entity or, in California, a non-profit foundation that operates certain outpatient clinics. In addition, groups also need to be mindful that any adjustments to compensation comply with the federal fraud and abuse laws (i.e., the Stark Law and Anti-Kickback Statute), and any related state laws (such as PORA in California). If a medical group desires to make these changes, we recommend conferring with counsel to ensure any contemplated change complies with contractual or regulatory requirements. Q. Can medical groups avoid obligations under contracts with “force majeure”clauses? A. A “force majeure” clause in an agreement exempts a party from having to perform obligations that it otherwise has promised to another party because doing so would be impossible, impracticable, or illegal. While it is possible to invoke these clauses, a party seeking to enforce one must meet a high bar in court, and the law varies by state. For example, in California, courts may find that a party is excused from performing its obligations if (X) that party (i) did not exercise reasonable control over the excusing event; (ii) did not assume the risk; (iii) suffered more than mere economic hardship; and (Y) there was an insurmountable interference to the contract that the parties could not have prevented by prudence, diligence and/or care. If a medical group anticipates or knows that it may not be able to perform under an agreement (e.g., a medical group that is obligated to staff a clinic or hospital outpatient department but has insufficient available staff due to COVID-19), it may rely on a force majeure clause to avoid any related damages. However, given the high bar for that exemption, if a group is concerned it may breach its obligations, it may be preferable for the group to engage with counsel and impacted third parties to address issues and identify potential solutions to avoid a breach and/or related dispute.

Q: Will any downturn in our revenue be protected by our insurance policies?

A: We recommend that medical groups check with their broker to confirm whether any relief is available under their insurance policies (whether business interruption or otherwise). Business interruption insurance covers business income losses directly caused by a covered peril. This coverage is generally sold as an add-on to a company’s underlying commercial property insurance. To be covered, a claim needs to fit within the designated cause of loss in the policy, and often, policies require a direct physical loss in order for an insured to claim a covered loss. However, certain policies may extend “civil authority” business interruption coverage for losses arising from orders from a governmental authority that impair or prohibit access to an insured’s premises or property as a result of physical damage (although voluntary shut-downs without a governmental order will likely not fall within the scope of this coverage).

Q: We have risk-based reimbursement contracts with Medicare Advantage and/or other health plans. Are we protected from losses associated with the COVID-19 pandemic?

A: Groups should review their risk-based contracts to check for protective provisions, which may include limitations on losses attributable to catastrophic or outlier claims. In addition, contracts may include other stoploss protections (or require that a group obtain other stop-loss protections under its insurance policies). Q: We are having trouble obtaining prior authorizations from payors due to their call center staffing shortages and/or difficulty absorbing high call volumes as a result of COVID-19. Is there risk associated with providing services to beneficiaries without pre-authorizations from the applicable plans?

A: There is always some risk that a plan may not reimburse the medical group for services rendered by its providers without a plan’s required pre-authorization. It is always best, if possible, to confirm

with a plan in advance as to how it may be relaxing, expediting or waiving pre-authorizations given the substantial strain on providers and insurers in response to COVID-19. For example, CMS has advised Medicare Advantage plans that they may waive prior authorization requirements. CMS has also authorized plans to lift limits on prescription refills, relax restrictions on home delivery of prescription drugs, expand access to certain telehealth service, and waive or reduce cost-sharing for coronavirus tests and treatments delivered in doctor's offices, emergency departments or via telehealth. Given the circumstances, it is possible that other commercial plans may take a similar approach.

Notwithstanding the foregoing, we note that the Families First Coronavirus Act requires that group health plans and issuers of individual and group health insurance plans (including grandfathered plans) provide coverage without cost-sharing or pre-authorization or other medical management requirements for (i) FDAapproved testing for COVID-19 and the administration of such testing, and (ii) items and services furnished to an individual during office visits (including in-person and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of a test for COVID-19. The mandate applies only to the extent the items and services relate to the furnishing or administration of the test or to the evaluation of the individual for purposes of determining the need for testing. Coverage from original Medicare for such testing will be paid at 100%, and the Medicare coinsurance and deductible will not apply. Similarly, Medicare Advantage organizations must also cover such testing without cost-sharing or pre-authorization or other medical management requirements.

5. PRIVACY AND DISCLOSURE OF INFORMATION; CHANGES TO RULES FOR COVID-19 RESPONSE

This Section assumes a basic familiarity with federal and state privacy laws, and contains specific information about certain rules applicable only in California. Because there are already changes occurring with respect to enforcement in connection with telehealth, and may be more to come as the COVID-19 situation evolves, we note that medical groups should confirm with counsel that they have the most up-to-date guidance in this area when implementing new policies and procedures.

Q. What patient information may a covered entity disclose to a public health authority for public health purposes?

A. Reporting on confirmed cases and testing statistics is a critical component of public health efforts and is permitted without patient authorization to public health authorities authorized to receive such reports. The Office for Civil Rights ("OCR") of the U.S. Department of Health and Human Services issued a bulletin about HIPAA privacy standards and COVID-19 in February 2020. The bulletin clarified that covered entities are Page 10 www.sheppardmullin.com permitted to disclose PHI without patient authorization to public health authorities legally authorized to receive such reports. A public health authority is an agency or authority of the United States, a state, or political subdivision of a state authorized by law to collect or receive information to prevent or control disease, injury, or disability. Public health authorities include the Centers for Disease Control and Prevention ("CDC"), the Occupational Safety and Health Administration (OSHA) and state and local health departments. Generally, HIPAA requires that a covered entity limit the information it discloses to the minimum necessary to accomplish the public health purpose. However, the minimum necessary standard does not apply to disclosures made pursuant to an individual's authorization or a disclosure required by other law. The OCR bulletin clarified that a covered entity may rely on representations from a public health authority that the requested information is the minimum necessary. For example, "a covered entity may rely on representations from the CDC that the [PHI] requested by the CDC about all

patients exposed to or suspected or confirmed to have [COVID-19] is the minimum necessary for the public health purpose."

Q. May a medical group disclose patient information to another person potentially exposed to COVID-19?

A. To prevent or control disease, a covered entity may disclose PHI to a person potentially exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease, as long as the disclosure is otherwise authorized by law. However, covered entities must only disclose the "minimum necessary" information to accomplish the public health purpose. If possible, health care providers should provide a general notice to a potentially exposed person and refer them to CDC guidance on how to conduct an assessment of their potential exposure, without disclosing the identity of the infected individual(s).

Q. May a medical group disclose information about an infected employee to coworkers who may have been exposed to COVID-19?

A. While HIPAA permits covered entities to disclose patient information to individuals potentially exposed to communicable diseases, the federal Americans with Disabilities Act ("ADA") prohibits employers from disclosing employees' confidential medical information, including the identity of an employee confirmed to have a communicable disease. However, the federal Occupational Safety and Health Administration ("OSHA") requires that employers take reasonable efforts to maintain a safe work environment for employees free from hazards that cause or are likely to cause death or serious physical harm. To balance these competing interests, medical groups should inform employees of their possible exposure to COVID-19 and refer the coworkers to CDC guidance on how to conduct an assessment of their potential exposure, without disclosing the identity of the infected individual(s).

Q. May a medical group release patient information to the public or media regarding COVID-19 cases?

A. Under HIPAA, a medical clinic may disclose certain limited patient information to the media or the public under the following conditions: • The request must contain the patient's name. • The medical clinic must inform the patient in advance of the proposed disclosure to the media or the public and the patient must have the opportunity to agree to or prohibit the disclosure. • If the patient has not requested that information be withheld, the medical clinic may release the patient's condition "described in general terms that do not communicate specific medical information about the individual," such as "good," "fair," "serious," "critical," etc. • No additional information may be provided to the media or public without written authorization from the patient or his/her legal representative.

Q. Are there special information security considerations during public health emergencies like the COVID-19 pandemic?

A. Yes. As more employers are allowing or requiring employees to work from home, in order to contain the spread of the virus, it is important that medical groups, and particularly those offering new or expanded telehealth services, consider information security risks associated with a remote workforce. Covered entities must reinforce information security policies and procedures intended to safeguard the organization's data, including multi-factor authentication and connecting through a virtual private network (VPN) or similar method. Medical groups should stay vigilant and ensure information security teams are prepared to respond immediately to suspicious activity and take

reporting and corrective action steps using the entity's incident response plan.

Q. When is a medical group required to disclose to public health authorities in California?

A. Like HIPAA, California law requires medical groups to disclose medical information to a local health department to prevent or control disease, injury, or disability. California law requires health care providers and administrators to report known or suspected cases of diseases, including "novel virus infections with pandemic potential" to the local health officer for the jurisdiction where the patient resides. Notification must be made immediately by telephone. Reports must include: • Name of the disease or condition; • Date of onset; • Date of diagnosis; • Name, address, telephone number, occupation, race or ethnic group, Social Security number, gender, pregnancy status, age, and date of birth for the case or suspected cases; • Date of death if death has occurred; and • Name, address, and telephone number of the person making the report.

Q. Are there special considerations in California regarding the release of information from facilities governed by the Lanterman-Petris-Short Act and the Confidentiality of Alcohol and Drug Abuse Patient Records?

A. Yes. The California Lanterman-Petris-Short Act ("LPS") and the federal Confidentiality of Alcohol and Drug Abuse Patient Records Act ("substance abuse regulations") provide special privacy protections for certain patients. LPS applies to disclosures of information created at mental health treatment facilities, wards, clinics, and certain community mental health programs. Treating providers, facilities, clinics, and programs must still report cases of communicable diseases, like COVID-19, to public health authorities, as such reports are required under California law and permitted by HIPAA, but may not release identifiable patient information to the public or media without an individual's written authorization.

6. CHANGES TO MEDICARE TREATMENT OF TELEHEALTH FOR COVID-19

Q. Under Fee-for-Service ("FFS") Medicare, what services can be provided to beneficiaries without coming in to the office in person for a full visit?

A. Under a waiver published on March 17 (the "COVID-19 Waiver"), FFS Medicare pays for office, hospital and other visits furnished via telehealth regardless of where the patient is located (i.e., the patient does not have to be in a rural area or in a facility). This waiver builds on existing policies that already allow "virtual check-ins" as well as "e-visits." Together these three (3) options offer beneficiaries easy ways to remain at home and avoid exposure to others when seeking treatment of the Coronavirus (COVID-19). More details are provided below. In addition, the Office for Civil Rights has published an FAQ on telehealth and HIPAA during the crisis: OCR Telehealth/HIPAA FAQs.

Q. What does the new COVID-19 Waiver allow practitioners to do that they could not do before?

A. Prior to this waiver, FFS Medicare only covered telehealth when the patient was located in an "originating site." More specifically, the patient previously had to be located in a medical facility, such as a doctor's office, hospital, skilled nursing facility, within a designated rural area. Most patients currently seekingtreatment would not meet these originating site requirements. The waiver removes these restrictions and allows the patient to be located anywhere in the country, including in their own

home. Beneficiaries must receive services using a device allowing real-time audio and video communication, for instance a smart phone with video chat functionality, with a remotely located doctor or certain other types of practitioners.

Q. When is the COVID-19 Waiver effective and how long will it last?

A. The COVID-19 Waiver is effective retroactively for services starting March 6, 2020, and will remain in place for the duration of the COVID-19 Public Health Emergency.

Q. What is the payment rate for services furnished under the COVID-19 Waiver? Do providers have to collect this payment?

A. Visits furnished under the COVID-19 Waiver are considered the same as in-person visits and are paid at the same rate as regular, in-person visits. FFS Medicare coinsurance and deductible payments apply to these services. That is, beneficiaries pay 20% of the Medicare-approved amount for doctors' services, and the Part B deductible applies. However, pursuant to a Policy Statement published by the Office of Inspector General ("OIG") also issued on March 17, physicians and other practitioners will not be subject to administrative sanctions for reducing or waiving any cost-sharing obligations Federal health care program beneficiaries may owe for telehealth services so long as the Public Health Emergency continues. This Policy Statement is significant because ordinarily, routine reductions or waivers of costs owed by Federal health care program beneficiaries, including cost sharing amounts such as coinsurance and deductibles, potentially implicate the Federal antikickback statute, the civil monetary penalty and exclusion laws related to kickbacks, and the civil monetary penalties that prohibit inducements to beneficiaries. Under the new Policy Statement, providers can forgo collecting cost-sharing payments for telehealth services without risking sanction.

Q. What CPT Codes can be billed for and what Place of Service ("POS") code should be used when billing under the COVID-19 Waiver?

A. Medicare telehealth services include office visits, psychotherapy, consultations and certain other medical or health services that are provided by an eligible provider who isn't at the beneficiary's location using an interactive 2-way telecommunications system (like real-time audio and video). The full list of CPT codes payable under the Medicare Physician Fee Schedule when furnished via telehealth is available at: Covered Telehealth Services CY 2019 and CY 2020. Telehealth services claims should be submitted using the POS code of "02" for Telehealth, to indicate that the billed service was provided from a distant site. Q. Can the COVID-19 Waiver be used for new patients? Can the COVID-19 Waiver be used for all patients, including those with no COVID-19 symptoms? A. Per a Fact Sheet published by CMS, the COVID-19 Waiver is available for new or established patients. Notably, to the extent existing law requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this Public Health Emergency. The COVID-19 Waiver is available without regard to the diagnosis of the patient.

Q. Can the COVID-19 Waiver be used for all patients, including those with no COVID-19 symptoms?

A. Yes, the COVID-19 Waiver is available without regard to the diagnosis of the patient.

Q. Can we use telehealth to provide face-to-face visits required by home health, hospice and

DME regulations?

A. While CMS' guidance does not specifically address this question, the guidance indicates that telehealth visits will be treated in the same way as in-person visits. Therefore, telehealth office visits should be allowed to meet requirements for physician face-to-face visits with patients.

Q. Outside of telehealth visits, may we bill FFS Medicare for my communications with patients during the COVID-19 emergency?

A. Yes, under certain circumstances. Since 2019, Medicare has allowed providers to bill for qualifying "virtual check-ins" and, since 2020, has allowed providers to bill for "e-visits" with patients. Requirements for these services are explained below. These types of services may be particularly useful in communicating remotely with patients during the COVID-19 emergency

Q. What is a virtual check-in?

A. Officially titled "Brief Communication Technology-Based Service," a virtual check-in is defined as a "[b]rief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management ("E/M") services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion." In other words, to be reimbursable, the "virtual check-in" cannot relate to evaluation or management (E/M) services provided to the patient in the prior seven (7) days, nor can it relate to an E/M service or procedure in the ensuing 24 hours. Since 2019, these virtual check-ins have been billable to FFS Medicare. Virtual check-ins allow beneficiaries to talk to their doctor or certain other practitioners, like nurse practitioners or physician assistants, using real time audio-only telephone interactions in addition to synchronous, or two-way audio interactions that are enhanced with video or other kinds of data transmission, without going to the doctor's office. The doctor or other practitioner can respond to the patient using the following tools: • Phone • Audio/visit • Secure text messages • Email • Use of a patient portal

Q. Who can deliver virtual check-ins?

A. Virtual check-ins can be delivered only by those practitioners authorized to furnish E/M services. Only physicians and qualified health care professionals, such as nurse practitioners or physician assistants, are allowed to bill for these services.

Q. How do the time limitations associated with virtual check-ins work?

A. If the virtual check-in originates from a related E/M service provided within the previous seven (7) days by the same physician or other qualified health care professional, then the service is considered bundled into that previous E/M service is not separately billable. If the virtual check-in leads to an E/M service with the same physician or other qualified health care professional within the next 24 hours or soonest available appointment, then this service is considered bundled into the pre- or post-visit time of the associated E/M service, and also would not be separately billable.

Q. What type of consent is required from the beneficiary?

A. The beneficiary must verbally consent to using virtual check-ins and the consent must be

documented in the medical record prior to the patient using the service.

Q. What is the cost of a virtual check-in to the beneficiary?

A. The Medicare coinsurance and deductible would apply to these services. That is, the beneficiary pays 20% of the Medicare-approved amount for the doctor or practitioners' services, and the Part B deductible applies. Q. How do health care providers bill Medicare for virtual check-ins? A. Physicians and qualified practitioners may bill for these virtual check-in services using the HCPCS Code G2012 for several communication technology modalities, such as telephone, and the HCPCS Code G2010 for captured video or image.

Q. Are there any beneficiary restrictions?

A. CMS limits these services to established patients only. With regard to what constitutes an "established patient," which generally means a patient who has received professional services from the physician or qualified health care professional or another physician or qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past 3 years.

Q. Are there any beneficiary location requirements?

A. No. The beneficiary need not be located in a rural area or any specific originating site. The beneficiary can be at home.

Q. What is an e-visit?

A. According to the Calendar Year 2020 Medicare Physician Fee Schedule, e-visits are non-face-to-face "patientinitiated digital communications that require a clinical decision that otherwise typically would have been provided in the office." E-visits are intended to cover short-term ("up to 7 days") evaluations and assessments that are conducted online or via some other digital platform. Evaluations and assessments that extend beyond the 7-day maximum may constitute remote patient monitoring. Q. Which health care providers can perform and bill for e-visits? A. Physicians and other health care practitioners that can directly bill Medicare E/M codes can bill for e-visits using CPT Codes 99421-99423. CMS created HCPCS codes G2061, G2062 and G2063 for non-physician practitioners who are unable to bill E/M services but who will be providing e-visits. Practitioners who may furnish these services include physicians, nurse practitioners; physician assistants; and, in specific circumstances; LCSWs, clinical psychologists, and therapists.

Q. Which Medicare beneficiaries can use e-visits?

A. In order for a health care provider to bill Medicare for an E-Visit, a patient must be "established," meaning, as above, that the provider must have an existing provider-patient relationship with the patient.

Q. What is the cost of a virtual check-in to the beneficiary?

A. The Medicare coinsurance and deductible would apply to these services. That is, beneficiaries pay twenty percent (20%) of the Medicare-approved amount for your doctors' services, and the Part B

deductible applies.

Q. Are there any waivers for prescribing controlled substances via telehealth?

A. Under the Ryan Haight Online Pharmacy Consumer Protection Act (the "Act") a prescription for a controlled substance issued by means of telehealth (aka telemedicine) must generally be predicated on an in-person medical evaluation unless an exception applies. One such exception occurs when the Secretary of HHS has declared a public health emergency and the DEA takes further actions with respect to the Act in response to the emergency to designate patient locations and the types of controlled substances waived. Secretary Alex Azar declared a public health emergency with regard to COVID-19 on January 31, 2020, and on March 17, 2020, the DEA took further actions to specify the locations and type of controlled substances waived on its website.

Specifically, per the COVID-19 waiver, for as long as the Secretary's designation of a public health emergency remains in effect, DEA-registered practitioners may issue prescriptions for all controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

• The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice;

• The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and

• The practitioner is acting in accordance with applicable Federal and State law. Provided the practitioner satisfies the above requirements, the practitioner may issue the prescription using any of the methods of prescribing currently available and in the manner set forth in the DEA regulations. Thus, the practitioner may issue a prescription either electronically (for schedules II-V) or by calling in an emergency schedule II prescription to the pharmacy, or by calling in a schedule III-V prescription to the pharmacy. Notably, if the prescribing practitioner has previously conducted an in-person medical evaluation of the patient, the practitioner may issue a prescription for a controlled substance after having communicated with the patient via telemedicine, or any other means, regardless of whether a public health emergency has been declared so long as the prescription is issued for a legitimate medical purpose and the practitioner is acting in the usual course of his/her professional practice.

Q. Are there special waivers from HIPAA for telehealth?

A. Yes. In light of the COVID-19 nationwide public health emergency and need for expanded telehealth services, HHS announced on March 17 that it would not enforce penalties for non-compliance with the regulatory requirements under HIPAA in connection with the good faith provision of telehealth services (the "HIPAA Waiver"). For instance, providers may rely on communication platforms that do not fully meet HIPAA requirements to communicate with patients without penalty. The notification is effective immediately.

Q. What kind of platform can a provider use under the HIPAA Waiver?

A. Providers may use any audio or video communication platform, as long as the communication is non-public facing. HHS stated that providers may use applications like Apple FaceTime, Facebook Messenger video chat, Google Hangouts or Skype. Providers may not, however, use public-facing

platforms like Facebook and TikTok. Providers are encouraged to notify patients about potential privacy risks and enable encryption and privacy settings when available. HHS points out that if providers are seeking platforms with additional privacy protections for their patients, they should use vendors who represent themselves as HIPAA compliant and are willing to enter into business associate agreements ("BAAs") in connection with providing the telehealth services.

Q. Does a provider need a BAA with a telehealth vendor during the COVID-19 public health emergency?

A. No. OCR will not impose any penalties against covered health care providers for not having a BAA with telehealth vendors or "any other noncompliance with the HIPAA Rules that relates to the good faith provision of telehealth services during the COVID-19 nationwide public health emergency."

Q. Does the expansion of telehealth services only apply to conditions related to COVID-19?

A. No. HHS guidance applies to telehealth services provided for any reason, regardless of whether the service is related to the diagnosis and treatment of conditions related to COVID-19. Services may be provided for the evaluation of an injury, dental service, psychological evaluation, or other conditions.

Q. Are state licensure requirements for providers rendering telehealth services waived?

A. CMS has waived requirements that out-of-state providers be licensed in the state where they are providing services when they are licensed in another state for the purposes of Medicare and Medicaid. At this time, however, health care providers must still comply with state telehealth laws and regulations, including, but not limited to, professional licensure, scope of practice, standard of care, patient consent, and medical information privacy/security requirements. Some states may allow licensed practitioners to apply for a temporary emergency license. In addition, state governments may take a similar approach in light of the national emergency and their own declarations of emergencies. However, at this point, providers should use caution regarding state law compliance.

7. MEDICARE ENROLLMENT, APPEALS, AND FRAUD ANDABUSE COMPLIANCE DURING COVID-19

Q. Will CMS make it easier to enroll in Medicare during the emergency?

A. Yes. CMS has established a toll-free hotline for non-certified Part B suppliers, physicians, and practitioners to enroll and receive temporary Medicare billing privileges. For these temporary privileges, CMS will waive application fees, criminal background checks, and site visits. CMS is also postponing all revalidation actions, expediting pending and new applications, and allowing licensed providers to render services outside of their state of enrollment.

Q. How will COVID-19 affect Medicare appeals?

A. For appeals in Medicare FFS, Medicare Advantage, and Part D, CMS will grant extensions to file an appeal and waive timeliness for requests for additional information to adjudicate an appeal. It will also process appeals even with incomplete Appointment of Representative forms and that don't meet the required elements, using the information available. CMS will use all flexibilities available in the appeal process as if good cause requirements are satisfied

Q. Will state Medicaid requirements be waived?

A. Because Secretary Azar has declared a Public Health Emergency, states are empowered to request permission to waive state Medicaid requirements. Some states have already requested and been granted waivers. Other waiver requests are still in process, and other states have not yet submitted requests.

Q. Has the OIG waived the application of the AKS or CMPL as related to COVID-19?

A. Partly. Pursuant to a Policy Statement published by the OIG issued on March 17, physicians and other practitioners will not be subject to administrative sanctions for reducing or waiving any cost-sharing obligations Federal health care program beneficiaries may owe for telehealth services so long as the Public Health Emergency continues. This is significant because ordinarily, routine reductions or waivers of costs owed by Federal health care program beneficiaries, including cost sharing amounts such as coinsurance and deductibles, potentially implicate the Federal antikickback statute, the civil monetary penalty and exclusion laws related to kickbacks, and the civil monetary penalty law prohibition on inducements to beneficiaries. This new Policy Statement allows providers to forgo the coinsurance deductible payments as it relates to telehealth services without that act (on its own) being viewed as an inducement likely to influence future referrals. In addition, on March 13, the HHS has announced that it will waive Sanctions under the Stark Law "under such conditions and in such circumstances as the Centers for Medicare & Medicaid Services ("CMS") determines appropriate." It is not yet clear what the details of this waiver will entail. Besides the Policy Statement and the Stark waiver, the OIG has not issued any additional waivers yet. Nonetheless, the current statutory and regulatory safe harbors and exceptions continue to be available. Programs motivated by and designed to address the outbreak may not, if properly structured, create risk of violating these laws.

Q. Do cost-sharing waivers for privately insured patients create legal risk?

A. Cost-sharing waivers for privately insured patients may, under some circumstances and in some jurisdictions, violate state laws and/or be the basis for fraud or breach of contract claims. However, risk associated with such waivers may be mitigated by adopting certain safeguards, for instance, fully disclosing the waivers to affected insurers. We are available to advise on the risks associated with particular cost-sharing waiver programs.

Q. Has CMS implemented any waiver of Stark Law restrictions?

A. No. HHS has issued a waiver of sanctions under the Stark Law "only to the extent necessary, as determined by the CMS, to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the Medicare, Medicaid and CHIP programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of these requirements as a result of the consequences of the 2019 Novel Coronavirus…pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance." Although this waiver has retroactive effect to March 1, CMS has not issued any related guidance; therefore, it is unclear what – if any – Stark Law sanctions CMS would consider it necessary to waive.

Q. Has CMS implemented any waiver of EMTALA requirements?

A. No. HHS has issued a waiver of sanctions under EMTALA "only to the extent necessary, as

determined by CMS, to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the Medicare, Medicaid and CHIP programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of these requirements as a result of the consequences of the 2019 Novel Coronavirus…pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance." Although this waiver has retroactive effect to March 1, CMS has not issued its own guidance adopting a broad waiver of EMTALA sanctions. CMS has noted that, should it "receive complaints alleging either inappropriate transfers by a sending hospital or refusal of a recipient hospital to accept an appropriate transfer, it will take into consideration CDC guidance and State or local public health direction at the time of the alleged noncompliance" as well as "any clinical considerations specific to the individual case(s)."

8. IMPACT OF COVID-19 DURING STRATEGIC TRANSACTIONS

Q. Our group is involved in or considering a strategic transaction. How can we expect that COVID-19 will impact that process?

A. For any medical group involved in or considering a strategic transaction, COVID-19 has introduced unanticipated elements to the process. For example, a group involved in a sale may be facing heightened scrutiny from representation/warranty insurance carriers who are concerned about how the business may be impacted by the pandemic and how the group's representations/warranties could suffer a breach as a result. Unsurprisingly, for groups involved in transactions that expect to use representation/warranty insurance coverage, but for whom the underwriting process has not yet started or is in the early stages, should expect broad exclusions for losses resulting from COVID-19. In addition, buyers may be concerned about a target's future in the market and could seek to rescind or delay the transaction on the basis of a "force majeure" or material adverse effect claim. Finally, practical considerations, such as closing of state and federal agencies, could delay the ability of parties to a strategic transaction to make necessary filings, and/or to complete diligence involving publicly available materials, such as lien and litigation filings.

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