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COVID-19 Issues for AMCs

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American academic medical centers (AMCs) are on the front lines of the fight against COVID-19, providing care through tertiary and quaternary medical centers with highly trained, cross-disciplinary teams, developing new diagnostic tools, and discovering new ways to treat the illness. At the same time, AMCs face unique challenges given their tripartite mission, making rapid decisions with a broad base of stakeholders and managing significant financial pressures, all in an uncertain environment. This alert focuses on:

- Undergraduate medical education,
- Graduate medical education, including reimbursement and Medicare funding,
- Liability considerations, and
- Impacts on institutional funding.

Undergraduate Medical Education

LCME Endorses Flexibilities in Undergraduate Curriculum

As COVID-19 has upended regular class schedules and clinical rotations, the Liaison Committee on Medical Education (LCME) has issued guidance allowing medical education programs to shift instruction online and has encouraged academic institutions to be flexible in the event of cancelled clinical clerkships.

If clerkships are unavailable for fourth-year students, LCME suggests that schools examine the objectives of these clerkships and determine whether those objectives have been addressed earlier in the student's education. For third-year students, LCME suggests that medical schools identify segments of the clinical curriculum that can be delivered virtually, though LCME will not allow for entirely virtual clinical clerkships.

Requirements for Medical Student Volunteer Opportunities

LCME has encouraged medical schools to suspend patient care activities through April 14, 2020, including through clinical rotations.[1]

While recommending suspension of patient contact for medical students, LCME has issued guidelines for medical schools that make volunteer opportunities available to students during the COVID-19 crisis. LCME permits schools to make volunteer opportunities available to students so long as:

1. There is a genuine need for volunteers;

[1] Interim Guidance on Medical Students' Participation in Direct Patient Contact Activities: Principles and Guidelines, ASS'N OF AMERICAN MEDICAL COLLEGES (Mar. 30, 2020), https://www.aamc.org/system/files/2020-03/meded-March-30-Interim-Guidance-on-Medical-Students-Clinical-Participation_0.pdf

2. Students are informed of all risks associated with volunteering with COVID-19-infected patients;
3. No core curriculum credit is provided and, if elective credit is provided, non-direct patient care opportunities to obtain elective credit are also provided;
4. There is adequate training;
5. The opportunities are based on the abilities and competencies of the students;
6. Student health services directors screen potential volunteers for student's health status, including the presence of conditions that could pose a safety risk; and
7. The academic institution clearly communicates that students are not expected to volunteer and should not feel pressured to do so.[2]

Regional Accreditation Organizations Have Relaxed Policies in Response to COVID-19

Regional accreditation organizations are also issuing guidance for changes to medical education in response to the pandemic. For example, the Middle States Commission on Higher Education (MSCHE) has waived its requirements for distance education. However, MSCHE is requiring updated information from each institution "related to any temporary distance education operations, temporary agreements with other institutions, as well as any impact on the academic calendar."[3] While MSCHE has suspended in-person site visits, virtual site visits will go forward.[4] The Southern Association of Colleges and Schools Commission on Colleges (SACSCOC) by contrast, has postponed all on-site visits until summer 2020 and has extended the accreditation cycle for 12 months for any school in the group of 28 that did not have a site visit this spring. The SACSCOC also requires affirmative requests for waivers for institutions not currently authorized to offer 50% or more of an approved program remotely. These two examples are just a sampling of the regional variation in approaches to modifying accreditation requirements in response to the COVID-19 epidemic.

Graduate Medical Education (GME)

Sponsors of residency and fellowship programs are experiencing a wide range of challenges in supporting programs, from ensuring adequate training experience for residents and fellows in a number of programs, to meeting supervision requirements, altering rotations and entering into emergency GME agreements, and obtaining reimbursement for services as appropriate.

Accreditation Council for Graduate Medical Education (ACGME) Has Suspended Accreditation Activities for All Sponsoring Institutions and Participating Sites

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[2] *Id.*
[3] Updates Relating to the Coronavirus (COVID-19, MIDDLE STATES COMM'N ON HIGHER EDUC. (Mar. 9, 2020), https://go.msche.org/20200309-Institutions-Memo-Coronavirus-Updates.
[4] Flexibility for Spring 2020 Visits, MIDDLE STATES COMM'N ON HIGHER EDUC. (Mar. 13, 2020), https://go.msche.org/20200313-Info-for-Chairs-and-Institutions-w-Visits (Virtual visits may adhere to the time frame of the original on-site visit dates if possible. If it is not possible to conduct the virtual visit during the original dates, depending on the date of the rescheduled visit, the Commission may not take action following the rescheduled visit until November 2020. If a team or an institution is unable to commit to a virtual visit, the visit will need to be delayed due to extraordinary circumstance.)

ACGME has suspended all self-study activities; accreditation site visits; Clinical Learning Environment Review Program site visits; and surveys of residents, fellows and faculty for all institutions. While all in-person site visits have been suspended, ACGME indicated its intent to begin virtual site visits on March 23, 2020 to a limited number of sponsoring institutions and programs based on Review/Recognition Committee priorities.

Additionally, ACGME has acknowledged there will be challenges for residents and fellows to achieve the minimum number of visits and cases set for accredited programs, and has clarified that the numbers were not "designed to be a surrogate for the competence of an individual program graduate."[5] Regarding accreditation, ACGME acknowledged that the volume of specialty visits will be impacted by the pandemic and has indicated "visits/Case Logs of a program's graduates who were on duty during this pandemic (particularly those in their ultimate or penultimate years) will be judiciously evaluated in light of the impact of the pandemic on that program."[6] ACGME has not clarified how pandemic-based changes in volume will be evaluated, but will likely provide clarification of its standards in future guidance.

Despite the pressures of responding to the pandemic, ACGME expects sponsoring institutions "to maintain strict compliance to the work hour, supervision, and education/training requirements" and plans to develop "mechanisms to monitor adherence in these important areas."[7] ACGME requires sponsoring institutions to enforce these guidelines even as states such as New York relax state law limitations on work hours.[8]

ACGME has Implemented "Staged" Guidance that Provides Greater Flexibility for Institutions and Sites Depending on the Degree of Disruption

ACGME has also recognized that different sponsoring institutions and participating sites will be impacted differently at different times. ACGME guidance categorizes sponsoring institutions and participating sites into three groups:

- Those in "Stage 1" (referred to as "business as usual") have not experienced significant disruption in patient care and educational activities and are required to comply with all applicable ACGME program requirements.
- Those in "Stage 2" will have suspended some educational activities and shifted some residents or fellows to patient care duties. At such institutions and sites, fellows may immediately work as attending physicians; fellows and residents may be reassigned to other rotations or forms of clinical work; and graduation is permitted for residents and fellows even if the original curriculum as planned is not completed based on individual ability.
- Those in "Stage 3" will have shifted most or all residents and fellows to patient care and suspended the majority of educational activities. In Stage 3, sponsoring institutions can declare "Pandemic Emergency Status," suspending all common and specialty-specific program requirements except for work hour limit requirements, resources and training requirements, supervision requirements, and the requirement that fellows be allowed to function in their core specialty.

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[5] ACGME Response to the Coronavirus (COVID-19), ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC. (Mar. 18, 2020), https://acgme.org/Newsroom/Newsroom-Details/ArticleID/10111/ACGME-Response-to-the-Coronavirus-COVID-19.
[6] *Id.*
[7] *Id.*
[8] *Id.*; The ACGME Common Program Requirements and COVID-19, ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC. (Mar. 27, 2020), https://www.acgme.org/Newsroom/Newsroom-Details/ArticleID/10169/The-ACGME-Common-Program-Requirements-and-COVID-19.

Flexibility for Residents/Fellows to Use, and to Be Supervised Through, Telehealth

For all stages of the pandemic, ACGME has altered its policies to allow residents and fellows to provide care using telemedicine, accelerating a change in program requirements originally intended to go into effect in July 2020. In addition, ACGME has modified its definition of Direct Supervision to contemplate scenarios in which "the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology."[9] This change will allow institutions to more flexibly deliver care, supervise residents, and conserve on-site resources for the most ill patients who cannot be treated remotely.

CMS Flexibilities for Resident Services

On March 30, 2020, CMS released guidance relaxing in-person resident supervision requirements for Medicare billing purposes. Medicare regulations and administrative guidance generally allow payment for residents' services in a teaching setting only if a teaching physician is physically present.[10] CMS defines "physically present" in administrative guidance as when the "teaching physician is located in the same room . . . as the patient and/or performs a face-to-face service."[11] During the COVID-19 emergency, CMS will allow teaching physicians to provide services with medical residents virtually through "audio/video real-time communications technology."[12] CMS will not provide payment for virtual supervision for "surgical, high risk, interventional, or other complex procedures, services performed through an endoscope, [or] anesthesia services."[13]

Additionally, CMS issued an interim final rule allowing for reimbursement for services provided outside hospital premises. For the duration of the public health emergency, when a hospital is paying a resident's salary and fringe benefits for the time that the resident is at home or in the home of an existing patient of the physician or hospital, but performing duties within the scope of the approved residency program and physician supervision requirements are met (including through remote or virtual supervision), a hospital can claim that resident time for indirect and direct GME payment purposes.[14]

CMS further modified existing law to allow for reimbursement of resident moonlighting services. Resident moonlighting services can be billed under the physician fee schedule if (1) the services are identifiable physicians' services and meet generally applicable requirements for physician services; (2) the resident is fully licensed to practice medicine,

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[9] ACGME Response to the Coronavirus (COVID-19), ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUC. (Mar. 18, 2020), https://acgme.org/Newsroom/Newsroom-Details/ArticleID/10111/ACGME-Response-to-the-Coronavirus-COVID-19.
[10] 42 C.F.R. §§ 415.170(b) and 415.172(a); Medicare Claims Processing Manual, Chapter 12, Section 100.
[11] Medicare Claims Processing Manual, Chapter 12, Section 100.
[12] Teaching Hospitals, Teaching Physicians and Medical Residents: CMS Flexibilities to Fight COVID-19, CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 29, 2020), https://www.cms.gov/files/document/covid-teaching-hospitals.pdf
[13] *Id.*
[14] Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency Part X (Interim Final Rule with Comment Period issued Mar. 26, 2020), https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-06990.pdf.

osteopathy, dentistry, or podiatry by the state in which the services are performed; and (3) the services are not performed as part of the approved GME program.[15]

CMS Will Require GME Agreements for Adjustment to Residency Caps Based on Slot Transfers

While hospitals have flexibility to share resident slots via GME agreements, including emergency GME agreements in the case of declared disasters, many institutions had been hoping CMS would provide more general flexibility to temporarily increase residency slot caps. However, CMS has insisted that "hot spot" hospitals that wish to take on additional residents beyond their cap must do so through an emergency GME agreement in order to receive the additional federal funding for those slots.

Liability Considerations

Relocation of residents, fellows and other professionals to other sites or organizations, and use of professional and nonprofessional volunteers, require that AMCs revisit insurance policies to determine the scope of professional liability coverage and legal requirements relating to such coverage. Maintaining continuous coverage is critical, as many states require physicians to maintain liability insurance in order to practice and bill for care provided. Furthermore, state and federal immunity provisions will not cover all professionals and students recruited to help manage COVID-19 patients.

Section 3215 of the CARES Act insulates licensed health care professional volunteers (*i.e.*, who do not receive any monetary or non-monetary compensation) from liability for any act or omission in providing health care services within the scope of the professional's license during the national emergency, except for gross negligence or other misconduct. Because residents receive stipends, they do not qualify for the immunity extended to volunteers in Section 3215 of the CARES Act. Immunity is not guaranteed for medical student volunteers under the CARES Act unless states temporarily provide licenses for these medical students. In New York, for example, under Governor Cuomo's Executive Order No. 202.10, medical students within accredited training programs may become licensed to act as health care professional and thus fall within the scope of CARES Act immunity.[16]

The CARES Act preempts state law unless state law provides greater protection than federal laws.[17] In New York, Governor Cuomo has modified Good Samaritan laws to provide that "all physicians, physician assistants, specialist assistants, nurse practitioners, licensed registered professional nurses and licensed practical nurses shall be immune from civil liability for any injury or death alleged to have been sustained directly as a result of an act or omission by such medical professional in the course of providing medical services in support of the State's response to the COVID-19 outbreak, unless it is established that such injury or death was caused by the gross negligence of such medical professional."[18] California provides immunity to physicians licensed in any state who provide services during an

[15] *Id.* at Part O.
[16] Governor Andrew Cuomo, Exec. Order No. 202.10 (Mar. 23, 2020), https://www.governor.ny.gov/news/no-20210-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency.
[17] CARES Act § 3215(c) (2020).
[18] *Id.*

emergency with the exception of willful acts or omissions.[19] Other states might follow suit to provide broader immunity protections as their COVID-19 case counts rise.

Impact on Institutional Funding

All of the parties within an AMC will experience financial shocks throughout the pandemic. Teaching hospitals will experience a spike in expenses along with a simultaneous drop in revenue from elective procedures. Affiliated faculty practice plans will also experience significant lost revenues and may need to consider dramatic steps to reduce expenses. The academic institutions that provide medical education are dependent on financial support from affiliated clinical institutions in financial distress and from governments directing available resources to COVID-19 response, and will be affected simultaneously by decreased liquidity and declines in investment values.

External resources that AMCs may be considering include the following:

- *Public Health and Social Services Emergency Fund:* In the CARES Act, Congress appropriated $100 billion to "public entities, Medicare or Medicaid enrolled suppliers and providers, and [others] as the Secretary may specify . . . that provide diagnoses, testing, or care for individuals with possible or actual cases of COVID–19." The funds may be used for "health care related expenses or lost revenues that are attributed to coronavirus," provided that the expenses and losses are not reimbursed by other sources, and with some present uncertainty, notwithstanding the law's reference to "lost revenues," as to whether funds in fact must be dedicated to incurred expenses or also may cover at least some categories of lost revenue.[20] The Department of Health and Human Services (HHS) has not published standards for application as of the date of this publication, and the law does not provide any criteria for distribution of these funds. HHS will review applications for funding on a rolling basis.
- *Federal Government Loans:* AMCs may consider applying for Economic Injury Disaster Loans under the Small Business Act, which Section 1110 of the CARES Act increased from $2 million to $10 million for nonprofits of all sizes. Congress set aside $10 billion for these loans, and applicants are eligible for advances of $10,000 within three days of submitting an application. Additionally, nonprofits with 10,000 employees or fewer are eligible for loans under the Federal Reserve lending program.[21]
- *Geriatric Training Grants:* The CARES Act provides funding to support training in geriatric medicine, which could bolster efforts to care for the influx of elderly patients disproportionately affected by COVID-19.[22] Grants will be disbursed to ensure equitable geographic distribution.
- *Medicare Advance Payment:* The CARES Act and subsequent CMS action have expanded the Medicare Accelerated Payment Program to extend to all Medicare Part A and B providers and suppliers, providing an opportunity to receive, within seven days of request, an amount equal to three months' projected Medicare payments.

[19] California Emergency Services Act § 8659 (2020).
[20] CARES Act § 743.
[21] CARES Act § 4003.
[22] *Id.* at § 753.

- *Deferral of Social Security Tax.* The CARES Act allows all business, including nonprofits such as AMCs, to defer payroll taxes at this time (assuming that the employer does not receive a loan under the Paycheck Protection Program, which is restricted to smaller businesses).[23]
- *Expanded Hospital Reimbursement.* CMS promulgated an interim final rule that allows hospitals to obtain hospital-level reimbursement for services that are provided in alternate settings during the pandemic, provided that state law permits this manner of reimbursement.[24] This flexibility could allow AMCs to obtain hospital-level reimbursement for services that, during the pandemic, can be provided in faculty practice plans or other ambulatory settings.
- *Private Agreements:* Universities, AMC affiliates, or adjacent institutions may also be entering into hurried lease, license and construction arrangements to provide overflow space and capacity. In some cases—*e.g.*, for leases of spaces financed with tax-exempt bonds or subject to mortgages or other encumbrances—these arrangements of course must be carefully structured to comply with legal requirements.

Assessing how to solve these funding issues in many cases will require joint decision-making and problem-solving across the entire academic-clinical ecosystem. Some AMCs have already established decision-making bodies that consider the interests of all parties in AMCs. Institutions without these structures in place may be considering creating these bodies quickly to respond to the related financial and operational pressures of the pandemic.

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AMCs continue to innovate and to leverage brilliant faculty and students to confront the crisis, all while educating and training the next generation of clinical leaders. As the COVID-19 pandemic continues, accrediting organizations and governmental authorities will continue to release guidance affecting institutions, medical students, residents, and fellows. Among many competing demands, AMCs will need to continuously assess opportunities to support, and provide flexibility needed to support, their joint academic and clinical missions.

[23] CARES Act § 2302.
[24] Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (Interim Final Rule with Comment Period issued Mar. 26, 2020), https://www.cms.gov/files/document/covid-final-ifc.pdf.