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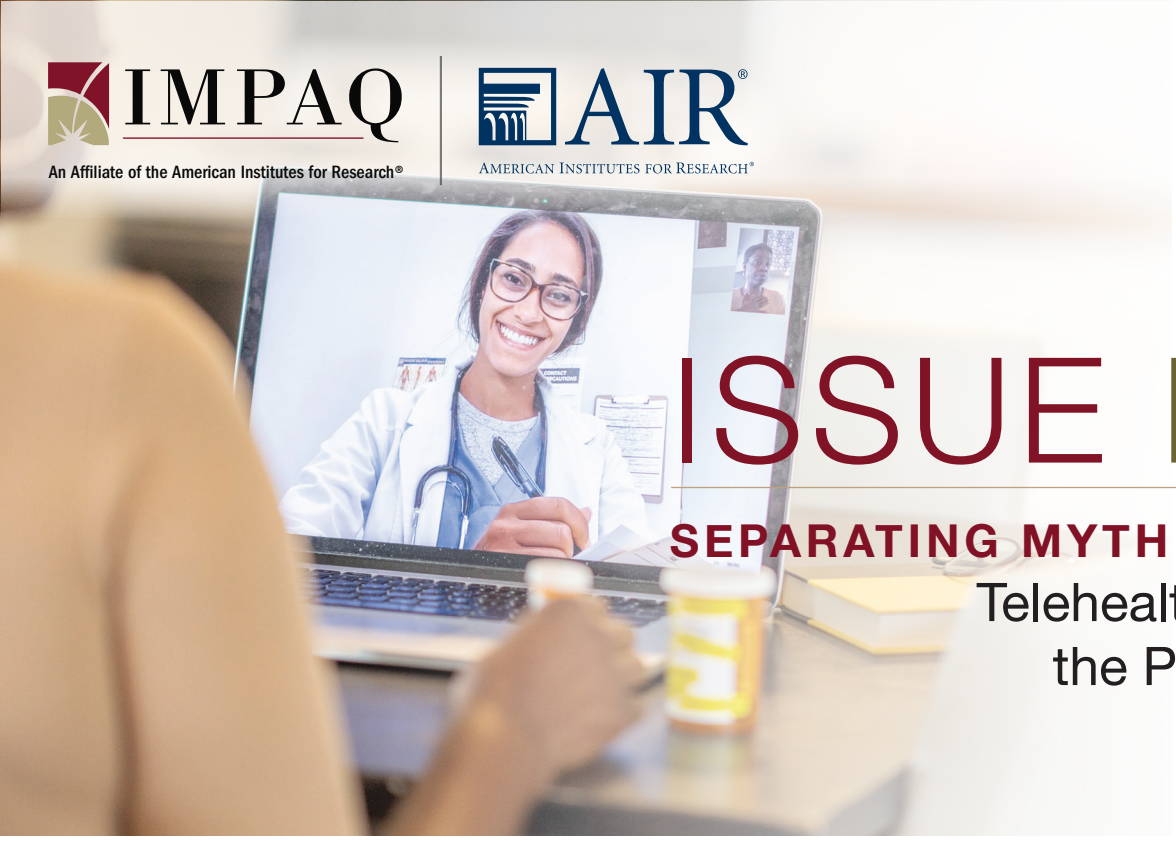

ISSUE BRIEF

SEPARATING MYTH FROM REALITY

Telehealth Expansion and the Potential for Fraud

Health policy researchers from IMPAQ, Index Analytics, and the American Institutes for Research reviewed the accuracy of claims that increased use of telehealth is likely to increase fraud and abuse. This brief

- Reviews findings from federal investigations of telehealth utilization,
- Synthesizes insights from health systems providing telehealth services during the COVID-19 pandemic, and
- Identifies strategies that will enable the appropriate and effective use of telehealth.

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To ascertain whether increased use of telehealth during the COVID-19 public health emergency has been associated with the unnecessary or excessive use of healthcare, we (1) reviewed relevant studies from the U.S. Office of the Inspector General (OIG) and the U.S. Government Accountability Office (GAO); (2) conducted interviews with staff from national health systems and with healthcare providers; and (3) identified strategies to increase the integrity of telehealth programs as the use of virtual care becomes more prevalent. Our findings demonstrate that telehealth can be used to deliver timely, person-centered care; generate cost savings; enhance care coordination; and be effectively employed to improve algorithms to detect fraud and ensure program integrity.

BACKGROUND

Before the declaration of the COVID-19 public health emergency, the use of telehealth was growing slowly but steadily. Although Medicare reimbursement for telehealth services has been subject to many restrictions—including requirements that limited eligible services to rural areas,[1] approved care delivery sites, and specific providers—the list of services that are eligible for reimbursement has grown over time. For example, in 2019, the Centers for Medicare and Medicaid Services (CMS) made enhancements to telehealth coverage as a result of the Bipartisan Budget Act of 2018 (BBA). These changes expanded access to telehealth for patients. In addition, the advent of innovative payment and service delivery models like Accountable Care Organizations allowed providers to offer telehealth services under a shared savings payment model. Total Medicare spending on telehealth services provided by physicians rose from less than 0.1 percent prior to the pandemic to more than 16 percent in April 2020 but was limited to only a few service categories. In 2020, CMS further expanded Medicare coverage for telehealth by authorizing reimbursement for non-face-to-face, patient-initiated communications through an online patient portal. CMS also implemented statutory changes that enabled Medicare Advantage plans to offer telehealth

1. The States of Alaska and Hawaii already had authorization to deliver telehealth services in non-rural communities.

services as appropriate under a capitated payment rate. In the private sector, the volume of claims for telehealth services more than doubled from 17 percent in February 2019 to 38 percent in February 2020.

TELEHEALTH DURING COVID-19

The COVID-19 public health emergency significantly expanded the scope of telehealth services covered under Medicare. In addition to adding 135 new allowable services, CMS also provided a number of waivers, including the ability to provide telehealth services in non-rural communities and in any setting, including the patient's home. These waivers also allowed providers to bill for telehealth services at the same rate as in-person care, provide care to patients outside of the State where a clinician is licensed, provide audio-only care using cell phones and other personal devices, and use digital platforms that may not meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA), such as Facetime.

Key Temporary Changes to Medicare Telehealth Coverage Authorized Under the Public Health Emergency

- 135 additional allowable services
- An expanded list of approved providers
- No geographic restrictions
- No clinical setting restrictions
- Reimbursement parity and waived co-payments
- Flexibility in allowed digital devices and platforms

Telehealth use also increased dramatically at the start of the COVID-19 public health emergency. From mid-March 2020 through mid-June 2020, more than 9 million Medicare beneficiaries received a telehealth service. In April 2020, nearly half (43.5 percent) of all Medicare primary care visits were telehealth visits. Within the Medicare population, evaluation and management visits—which are usually in-person office visits—have been the most common form of telehealth services provided during the public health emergency, with nearly 5.8 million Medicare beneficiaries receiving these services. Telehealth has also been widely used to facilitate behavioral health services, with approximately 460,000 Medicare beneficiaries (or 60 percent) receiving psychiatric care or counseling through telehealth. Among Medicare beneficiaries, more than one-third of all telehealth visits were conducted using the telephone.

PREVIOUS RESEARCH ON FRAUD AND ABUSE IN TELEHEALTH

As the number of telehealth services increased during the COVID-19 public health emergency, so did concerns that such expansion may lead to an increase in fraud and abuse, particularly within the Medicare program. This is not the first time that concerns have been raised about fraud and abuse in telehealth. CMS has gradually expanded Medicare reimbursements for telehealth services, which has resulted in payments increasing from $61,302 in 2001 to $17.6 million in 2015. This rapid increase in reimbursement for telehealth services prompted concerns regarding the legitimacy of these claims. In 2016, the Department of Health and Human Services' (HHS) OIG investigated the appropriateness of Medicaid claims for telehealth provided in the State of Texas and concluded that the services aligned with Medicaid requirements. In April 2017, the GAO investigated telehealth and remote patient monitoring use in Medicare and select federal programs. The GAO concluded that **the use of telehealth and remote patient monitoring in Medicare was likely to expand if clinicians used them to achieve the goals of the new Merit-based Incentive Payment System, which pays clinicians based on quality and resource use.**

Suspected Telehealth Fraud and Abuse Concerns

1. Inappropriate billing
2. Illegitimate diagnostic tests and prescriptions
3. Overuse of medical care
4. Kickbacks to telehealth vendors

In response to the increasing volume of Medicare claims for telehealth, in 2018, the OIG conducted a study to investigate CMS payments to practitioners for telehealth claims that did not meet Medicare requirements at that time. They analyzed a random sample of 100 telehealth claims filed between 2014-2015 and found that more than two-thirds were legitimate claims. **Among claims that were not legitimate, the OIG determined that the claims were not attributable to intentional fraudulent activities.** In many cases, the claims were not allowable because the beneficiaries received services in a clinical setting that was not located in a rural area. Other claims were determined to be inappropriate because they were submitted by providers who were not eligible to provide telehealth services

under CMS' restricted list of approved providers. The OIG concluded that CMS should employ remediation procedures similar to those recommended for claims adjudication for in-person encounters, namely improved oversight of payments. Specifically, the OIG recommended that CMS authorize Medicare contractors to conduct periodic post-payment reviews for telehealth claims. OIG also recommended that CMS expand education and training to Medicare providers on telehealth requirements.

OIG found that the increased utilization of telehealth services yielded significant public benefits, and that its continued use and expansion was unlikely to increase costs to federal payers beyond what is paid for the same services when provided in person.

Concerns regarding the appropriateness of using telehealth to deliver behavioral healthcare prompted a 2019 investigation by the OIG. The study focused on behavioral health services provided in New Mexico and **found that telehealth is an effective strategy to improve access to behavioral health services** in areas with provider shortages. In response to growing concerns regarding the potential for telehealth fraud and abuse, OIG issued a policy statement in March 2020 in support of increased telehealth flexibilities during the COVID-19 pandemic. In February 2021, the OIG issued the following statement in a letter: **"We are aware of concerns regarding enforcement actions related to 'telefraud' schemes and it is important to distinguish those schemes from telehealth fraud."** The letter further confirmed that the OIG has not identified any substantiated findings of telehealth fraud in any of its investigations to date.

"TELEHEALTH CAN BE AN IMPORTANT TOOL TO IMPROVE PATIENT ACCESS… OIG RECOGNIZES THE PROMISE THAT TELEHEALTH AND OTHER DIGITAL HEALTH TECHNOLOGIES HAVE FOR IMPROVING CARE COORDINATION AND HEALTH OUTCOMES."

Christi Grimm, HHS-OIG Principal Deputy Inspector General, February 26, 2021

The OIG is currently conducting audits of telehealth use during the COVID-19 pandemic. Findings will likely be released in late 2021 and will provide valuable insights that can be used to inform decision making on future Medicare reimbursement and delivery policies related to telehealth. Reviewing these findings will be essential in making evidence-based decisions regarding telehealth regulatory policy.

BENEFITS AND UTILITY OF TELEHEALTH IDENTIFIED THROUGH DISCUSSIONS WITH HEALTH SYSTEMS

Although telehealth may not be appropriate for all types of medical services, it is important to recognize its utility and role in facilitating access to care after the pandemic. To that end, our team conducted interviews with half a dozen healthcare leaders and clinical providers representing major healthcare systems and clinical practices across the United States.

Appropriate, patient-centered care

All respondents noted that the waivers for telehealth granted during the COVID-19 public health emergency allowed their patients to receive care that would otherwise have been deferred or inaccessible. These waivers also enabled providers to triage patients to determine the need for in-person care, address acute conditions in a timely manner, and offer a lifeline to patients in need of essential services. The ability to conduct virtual visits allowed clinicians and patients to identify the best clinical site for in-person followup care. Respondents described a program established in 2019 that employs virtual triage services to reduce the spread of influenza. This model was repurposed for COVID-19. For example, providers directed patients who needed emergency care to separate entrances of the emergency department to avoid potential exposure to patients with COVID-19.

Respondents from a southern health system noted that only 10.5 percent of 1,100 telehealth urgent care patients needed to be seen in person.

Neurologists from a large midwestern academic medical center (AMC) found that their telestroke initiative allowed patients to receive care at local health clinics, rather than requiring ambulance or helicopter transportation to the AMC.

This effort was critical given the need to appropriately allocate resources for the delivery of emergency care when the AMC was overwhelmed with COVID-19 patients. Similarly, a women's health clinic in the upper Midwest and a midwestern AMC mental health counseling clinic noted that without telehealth services, patients would have had to travel many miles to receive care due to the limited number of providers in their service areas. In many cases, they surmised that a number of these patients may have chosen to forego needed care. When used appropriately, telehealth promotes access to care and encourages the delivery of care that meets the diverse needs of patients.

Cost savings

Obtaining timely care using telehealth translates to better outcomes and contributes to cost savings by preventing adverse or acute events. This is especially true for emergency services where timely care can have a significant impact on clinical outcomes. For example, in the case of stroke or heart attack management, clinicians can use telehealth services to assess the patient's status and provide timely and often lifesaving treatment. Telehealth can also reduce costs by facilitating access to disease management services that may not be readily available in a patient's community or are not prioritized because of competing priorities such as work and childcare. For example, offering telemental health counseling to vulnerable populations—who have shouldered a significant portion of the burden caused by the loss of interaction during the COVID-19 pandemic—will be instrumental in mitigating the co-occurring mental health crisis in the United States. Similarly, missed appointments affect care coordination, which can result in the need for more costly treatment. During the pandemic, providers reported a reduction in no-show rates and increased utilization of behavioral health services, particularly among low-income and underserved populations. Clinicians at a behavioral health practice in the Northwest noted an 85 percent increase in patient participation in medication management consultations—a clinical visit which, historically, had high rates of missed appointments. They attributed this increase in appropriate use of care to the reduced travel burden on patients and the reduced stigma associated with waiting in a public waiting room. Clinicians were optimistic that higher levels of compliance with required routine care will lead to a decrease in adverse outcomes, resulting in cost savings and better coordination of care. In addition, telehealth will be instrumental in reducing the expected burden of deferred chronic care.

Deferring care can exacerbate chronic conditions and can increase costs. A May 2020 survey of 1,263 respondents reported that

- **53 percent of seniors have delayed care,**
- **60 percent of patients with chronic conditions have delayed care, and**
- **38 percent of patients plan on delaying care in the near future.**

Enhanced care coordination

In recent years, the number of free-standing clinics located in pharmacies, urgent care centers not affiliated with a specific hospital, and direct-to-consumer telehealth consults has grown considerably. Although these services increase access to timely care, they may compromise care management. Providers delivering care through these models may not have access to patients' complete medical histories and will have to rely on the information that is shared, or can be recalled, by the patient at the time of the encounter. During the COVID-19 pandemic, patients have discovered that the same convenience offered by freestanding clinics, urgent care centers, and direct virtual consults is available from their regular clinicians through telehealth. Increasing access to timely telehealth services through a regular and trusted source of care improves care coordination, minimizes unnecessary or duplicate services, and reduces the likelihood of adverse outcomes that may occur because of uncoordinated medical care such as having incomplete information about a patient's medical history and any allergies to medication.

Fraud mitigation

Our interviews also found that telehealth can act as a **preventive** modality in mitigating fraud, waste, and abuse. For example, developing options like a telehealth triage system can direct patients to appropriate care settings, which helps to

- Minimize inappropriate service use,
- Reduce the volume of unnecessary tests and labs, and
- Efficiently manage the allocation of hospital resources.

Bringing care teams together to develop telehealth workflows strengthens fraud prevention initiatives because of the need to have multiple touchpoints for setting up appointments and troubleshooting connections for video visits with providers, as well as the proliferation of digital markers for medical information that are associated with electronic health records and integrated into telehealth platforms. Although telehealth is a different modality of care, the same algorithms that CMS uses to detect fraud for in-person care are also applicable to telehealth, which provides the same services as those delivered in person.

ADVANCING TELEHEALTH PROGRAM INTEGRITY

Future models of healthcare are likely to involve a hybrid approach that uses both in-person and virtual methods to deliver tailored, person-centered care. Given the increased use of and reliance on technology to deliver appropriate and timely care, policymakers and stakeholders should consider the following measures to further strengthen the integrity of telehealth programs and reduce the potential for fraud and abuse:

1. **Policymakers should establish data standards** for telehealth to facilitate interoperability across telehealth platforms, which can improve data collection and help to prevent and track potential fraud, waste, and abuse.
2. **Payers should consider adapting existing algorithms** that are used to identify fraud in in-person care to detect outliers in telehealth utilization following the pandemic.
3. **Congress should provide the financial resources and personnel** necessary to protect the expansion of telehealth from fraud attempts as telehealth becomes a larger part of healthcare delivery.
4. **Researchers can conduct additional studies** that can help determine how the combination of telehealth and in-person care impacts the quality and costs of care in the Medicare program. The results of this research can inform future policy decisions regarding how to optimize care delivery and access.
5. **Public and private payers should analyze the available data on the use of telehealth services in non-rural areas** to gain a more comprehensive understanding of how telehealth is being used in order to develop insights to tailor fraud, waste, and abuse algorithms.

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