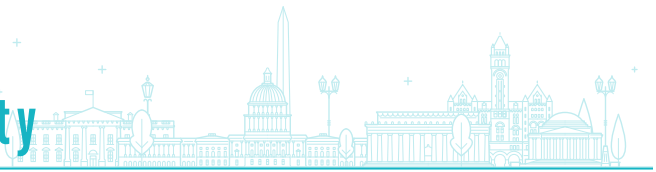


Telehealth and Program Integrity



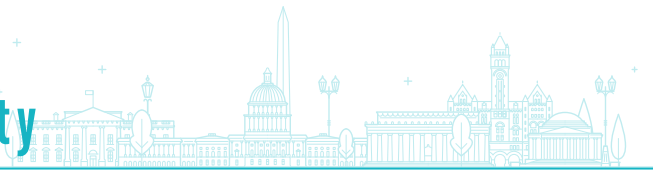
Millions of Americans turned to live audio and video visits with healthcare providers during the COVID-19 pandemic, and Congress needs to make decisions that will affect how Americans, in particular Medicare patients, may access these telehealth services on a permanent basis. Live audio and video interactions are an increasingly important part of healthcare services for every demographic in a broadening set of care scenarios. However, although the U.S. Department of Health and Human Services (HHS) has existing mechanisms in place to address overutilization, fraud, waste, and abuse, policymakers rightfully seek to better understand how removing statutory barriers to telehealth coverage might impact the fiscal stability of Medicare. We believe removal of those statutory barriers is the most fiscally responsible course of action for a number of reasons.



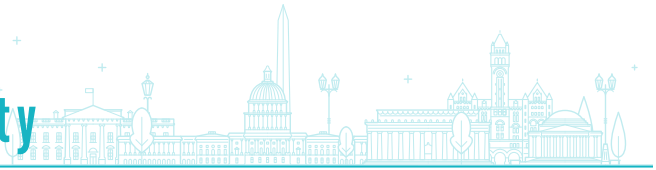
In terms of program integrity, it is important to note that nearly all recent U.S. Department of Justice (DOJ) actions are related to telemarketers—not physicians using technology—attempting to unnecessarily prescribe durable medical equipment (DME), genetic testing, pharmaceuticals, or other medical equipment. Historically, improper billing of Medicare for telehealth services is low and is similar to improper billing of face-to-face care.

- Analysis of Medicare telehealth services claims data from the PHE indicates that **fears of overutilization are overstated:**
 - An analysis of Medicare fee-for-service (FFS) claims data indicates that new patient office visits conducted via telehealth accounted for just 3.6 percent of all FFS Medicare telehealth spending when the pandemic first shocked the U.S. healthcare system—and when 1834(m) restrictions were first generally waived—between March 16 and June 30 of 2020.
 - Accordingly, claims data **also indicate that after an initial spike, telehealth usage has subsided as a percentage of ambulatory visits and is flattening out** as the pandemic wears on.
 - *Findings based on claims data **weigh heavily against predictions of dramatic uptake** by new Medicare telehealth users exerting uncontrollable fiscal pressure on the Medicare system.*

Telehealth and Program Integrity



- HHS already has strong mechanisms to deal with various kinds of Program Integrity (PI) concerns with Medicare telehealth services:
 - Improper Billing:
 - Audit records from HHS' **Office of Inspector General (OIG) 2018 report** evaluating telehealth payments prior to the public health emergency (PHE) suggest that the primary source (**over 63 percent**) of improper telehealth payments were from Medicare beneficiaries being outside the statutory geographic limits set in Section 1834(m).
 - From this data, OIG determined that improper payments for telehealth services were at least **partially the result of claim forms omitting a designated field for originating-site location and practitioners being unaware** of various telehealth requirements.
 - *If statutory geographic restrictions are lifted, the data here suggest that **the bulk of improper payments for telehealth services are:***
 - **Unlikely to expand** with increased access to telehealth services; and
 - **Unlikely to be addressed by continuing geographic restrictions on coverage, or by imposing an in-person requirement, which would more likely cause the billing friction leading to improper payments to persist.**
 - OIG proposed **a number of measures to prevent future improper billing events** involving telehealth services and HHS is implementing those now.
 - Kickbacks and Other Illegal Arrangements:
 - DOJ ramped up enforcement of the Anti-kickback Statute and Stark Law, and OIG expects to release a report this year on “Medicare Telehealth Services During the COVID-19 Pandemic: Program Integrity Risks.” In one recurrent fraud scheme, **fraudsters contact target patients via telephone, pay kickbacks to providers to write unnecessary prescriptions for durable medical equipment (DME)**, and then send the equipment to target patients while billing Medicare.
 - DOJ and HHS OIG have the tools they need—including partnership with the U.S. Postal Service—to **detect these schemes** and **stop them**.



- In addition to all Medicare coverage and payment and fraud and abuse authorities applying to telehealth services just as they do any other Medicare covered service, the existing Medicare claims process allows **the Centers for Medicare and Medicaid Services (CMS) to effectively track and audit all telehealth services billed to Medicare via a specific modifier code (Modifier 95)**. The Modifier 95 describes “synchronous telemedicine services rendered via a real time interactive audio and video telecommunications system” and is applicable for all codes listed in Appendix P of the CPT manual. The Modifier 95, along with listing the Place of Service (POS) equal to what it would have been for the in-person service, is also applicable for telemedicine services rendered during the COVID-19 Public Health Emergency. The requirement to code with the Modifier 95 enables CMS to properly track and audit telemedicine services and is a powerful tool for rooting out fraud, waste, and abuse.
- Telehealth can help reduce long-term costs by enabling caregivers better access to patients to employ preventive measures and avoid costly escalation events:
 - This **compendium of research includes** a variety of studies confirming that responsible use of telehealth services facilitates cost-effective care.
 - The University of Virginia’s (UVA’s) care coordination and remote patient monitoring program, which relies on telehealth visits among other digital health tools, **reduced hospital readmissions by 40 percent**, regardless of payer, since it began in 2012.
 - *Hospital readmissions impose outsized costs—about \$26 billion annually—on the Medicare system, and reducing them through the use of telehealth is a smart investment.*