

Practice Update

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For telehealth, 2019 is off to a running start. In the first four months of the year alone, the industry has seen confirmation of payment advances for Medicare Advantage beneficiaries and expansion of coverage under state legislative efforts, tempered by a substantial federal fraud initiative and prosecutions and new state licensure mandates. Below is a summary of the more significant developments.

Medicare Advantage Final Rule Confirms Payment Advances

On April 5, 2019, CMS filed the final rule for policy and technical changes to Medicare Advantage (MA) for fiscal years 2020 and 2021 (Final Rule).[1] The Final Rule confirms much of CMS' earlier November

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1, 2018, proposed policy and technical changes, allowing MA plans to offer “additional telehealth benefits” starting in plan year 2020, treating them as basic benefits, in addition to MA supplemental benefits not covered by original Medicare that are provided via remote access technologies and/or telemonitoring. The Final Rule estimates that the additional telehealth benefits are expected to produce \$557 million in savings for enrollees over 10 years, as well as a \$80 million transfer from the Medicare Trust Fund instead of out of the rebates (as supplemental benefits.) [2] As noted in the commentary, telehealth services have already seen a substantial uptick under MA plans with 88% of plans offering telehealth supplemental benefits in 2018 – a 77% increase from 2017.[3] CMS Administrator Seema Verma noted: “Today’s policies represent a historic step in bringing innovative technology to Medicare beneficiaries. With these new telehealth benefits, Medicare Advantage enrollees will be able to access the latest technology and have greater access to telehealth. By providing greater flexibility to Medicare Advantage plans, beneficiaries can receive more benefits, at lower costs and better quality.”

Prior to these changes, Medicare beneficiaries could only receive certain telehealth services if they lived in certain rural areas and met other limiting requirements. These limitations were not as significant for MA plans, which could offer more telehealth services as part of their supplemental benefits. With the Final Rule, MA plans can offer beneficiaries more telehealth services as additional benefits of the plan, expanding patients’ access to telehealth services through more providers and to more parts of the country than previously provided under Medicare. The change in financing (i.e. including the benefits in the capitated payment) makes it more likely to be offered by MA plans and utilized by beneficiaries.[4] CMS notes in its commentary its belief that “MA additional telehealth benefits will increase access to patient-centered care

by giving enrollees more control to determine when, where, and how they access benefits.”[5]

The detail of most of these changes is reflected in our prior summary of the Proposed Rule,[6] but the key points are itemized below:

- MA plans may offer Part B telehealth services as “additional telehealth benefits” and treated as basic benefits for purposes of bid submission and payment by CMS.
- All MA plan enrollees are eligible to receive telehealth services irrespective of where they live AND can receive these services in their home.
- Providers’ costs of infrastructure of the telehealth services (e.g. extra computers, wireless services, etc.) cannot be included in the providers’ payments.
- The MA Plan, not CMS, determines the services each year that are clinically appropriate to furnish as telehealth.
- Providers do have great flexibility through the definition of electronic information and telecommunications technology as to how the benefit is offered – secure messaging, store and forward, telephone, video conferencing, other internet-enabled technologies, and other evolving technologies as appropriate for non-face-to-face communication.
- The MA plan must notify its enrollees about the option to receive services via telehealth in its coverage document and identify any providers offering services for additional telehealth benefits.

Although not much changed between the Proposed Rule and the Final Rule,[7] the commentary to the Final Rule, which reflects review and response to 180 pieces of correspondences received by CMS regarding the Proposed Rule, does provide additional clarifications, the highlights of which are as follows:

- The provisions allowing for future technology under this benefit are not intended to conflict with the separate Medicare payment for traditional Medicare telehealth coverage or new “communication technology-based services” that are inherently non-face-to-face, paid under the Physician Fee Schedule, and not subject to the restrictions on Medicare telehealth services (such as RPM and remote interpretation of diagnostic tests, chronic care management services, transitional care management, and behavioral health integration services, virtual check-ins, remote evaluation of pre-record patient information, and interprofessional internet consultation).
- If a service is covered under Part B and provided through electronic exchange but otherwise does not comply with the requirements for basic benefits under an MA plan (e.g. is provided by an out of network healthcare provider), then it may be covered only as an MA supplemental telehealth benefit.
- In-person Part B services and services delivered via electronic exchange are delivered differently; as such, they can be treated differently from a cost-sharing perspective, with the caveat that any differential cost sharing must parallel the actual cost of administering the service and not to steer beneficiaries or inhibit access, which could lead to compliance or enforcement action.
- PPO plans will not be required to furnish MA additional telehealth benefits out of network, but if it wants to offer on an out-of-network basis, it may only cover as a MA supplemental telehealth benefit.

“Operation Brace Yourself” Signals Attention to Fraud

Four days following CMS’s filing of the Final Rule, the U.S. Department of Health & Human Services’ Office of Inspector General (OIG) and collaborative enforcement partners[8] announced charges against

24 defendants, including the CEOs, COOs, and others associated with five telemedicine companies (including Videa Doctor USA, Afforded, Web Doctors Plus, Integrated Support Plus and First Care MD)[9], the owners of dozens of durable medical equipment (DME) companies, and three licensed medical professionals, for their alleged participation in healthcare fraud schemes involving more than \$1.2 billion in losses; the execution of over 80 search warrants in 17 federal districts; and adverse administrative action against 130 DME companies that submitted over \$1.7 billion in claims and were paid over \$900 million.

This timing does not seem to be coincidental, and, in fact, in issuing the indictments, the government highlights the long-recognized concern that, by expanding access to telehealth benefits, it is increasing the potential for fraud in telehealth. As such, by the operation and indictments (much like in its action in 2017 pursuing a \$32,000 settlement against a psychiatric provider in Connecticut for non-telehealth services billed as telehealth services), it clearly sends a message to the industry that law enforcement is watching and will aggressively prosecute any company or individual that seeks to commit a fraud in this arena. Indeed, in unsealing the indictments, the government demonstrated that the alleged fraudsters would not only be prosecuted for healthcare fraud, which carries a maximum sentence of ten years and a fine of \$250,000 (18 USC §§ 1347, 3571), but will also seek to include counts for money laundering and mail fraud which carry maximum sentences of 20 years and penalties of \$500,000 or \$250,000 respectively (18 USC §§ 1956, 1341).[10] The charges result from a fraud strike force initiative aptly named “Operation Brace Yourself.”

Generally described, the alleged scheme involved payment of illegal kickbacks and bribes by DME companies in exchange for the referral of Medicare beneficiaries by medical professionals working with telemedicine companies for medically unnecessary back, shoulder, wrist, and knee braces. Some of the

defendants allegedly controlled an international telemarketing network that lured over hundreds of thousands of elderly and/or disabled patients into a criminal scheme that crossed borders, involving call centers in the Philippines and throughout Latin America. The defendants allegedly paid doctors to prescribe the DME, either without any patient interaction or with only a brief telephonic conversation with patients they had never met or seen. The proceeds of the fraudulent scheme were allegedly laundered through international shell corporations and used to purchase exotic automobiles, yachts, and luxury real estate in the United States and abroad. In addition to the charges brought against the defendants, the OIG has issued a beneficiary alert to the scheme, which includes both information describing the scheme and steps for reporting any illegal behavior.[11]

Specifically, the alleged masterminds behind the scheme owned a call center, which aired television and radio advertisement for orthotic braces covered by Medicare and made direct calls to beneficiaries to offer “free or low cost” orthotic braces. In turn, the call center confirmed the beneficiaries’ coverage with Medicare and transferred them to a telemedicine company for a physician consult and prescription for the orthotic braces. The physician under contract with the telemedicine company generated a prescription for the orthotic brace without regard to medical necessity, and often without either any patient interaction or with only a brief telephonic conversation with patients they had never met or seen. The call center paid the telemedicine company and its physician for the prescription, which was submitted to the call center rather than directly by the physician to the DME company without charge. The call center subsequently sold the prescriptions to the DME company, the DME company sent braces to beneficiaries, and the DME company billed Medicare for the brace and received payment between \$500-\$900 per brace, approximately \$300 of which it paid to the call center owners.[12]

In commenting on the indictments, the Assistant Attorney General Brian Benczkowski of the Justice Department's Criminal Division sums up the conundrum for telemedicine perfectly: "These defendants — who range from corporate executives to medical professionals — allegedly participated in an expansive and sophisticated fraud to exploit telemedicine technology meant for patients otherwise unable to access health care."

New State Legislation

Since the proverbial New Year's Eve ball dropped at the start of 2019, we have seen quite a bit of state legislative activity on the telehealth front.

- **Arkansas:** Arkansas lawmakers passed legislation that includes telemedicine or other remote technology as a viable source of mental health treatment for those who are deaf or hard of hearing. AR Legis 644 (2019).
- **Florida:** The Florida legislature passed House Bill 23, which provides a telehealth tax credit for tax years beginning on or after January 1, 2020 and authorizes telehealth providers to use telehealth to provide a patient evaluation and prescribe certain controlled substances. FL Legis HB 23 (2019).
- **Georgia:** The Georgia legislature recently passed SB 115, which would provide for telemedicine license for physicians licensed in other states wanting to provide telemedicine services to Georgia license. To do so, the bill proposes amending the Georgia Medical Practice Act to allow out-of-state physicians to provide telemedicine services to patients in Georgia via a telemedicine license. Eligibility for such a license would require the physician to (1) hold a full and unrestricted license to practice medicine in another state; (2) not have any disciplinary or other action taken against him or her by any other state or jurisdiction; and (3) meet such other requirements established by the board as deemed necessary by the board to ensure patient safety.

- **Nebraska:** The Nebraska legislature enacted a law providing for a credential holder under the Uniform Credentialing Act to establish a provider-patient relationship through telehealth, and to prescribe the patient a drug if the credential holder is authorized to so prescribe under state and federal law. NE Legis 29 (2019).
- **New Mexico:** The New Mexico legislature passed a bill requiring a number of health insurers to provide coverage for services provided via telemedicine to the same extent that the group health plan covers the same services when those services are provided via in-person consultation or contact. NM Legis 255 (2019).
- **South Dakota:** The South Dakota legislature passed an act for the utilization of telehealth by a healthcare professional. Under the act, any healthcare professional treating a patient in the state through telehealth must be licensed to practice in the state or employed by a licensed healthcare facility, an accredited prevention or treatment facility, a community support provider, a nonprofit mental health center, or a licensed child welfare agency, and subject to any rule adopted by the applicable South Dakota licensing body. A provider-patient relationship must be in place if a provider is treating a patient through telemedicine, and a healthcare professional using telehealth to provide medical care to any patient located in the state shall provide an appropriate face-to-face examination using real-time audio and visual technology prior to diagnosis and treatment of the patient, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telehealth. SD Legis 156 (2019).

The South Dakota legislature also passed an act to provide for the payment of claims for covered services provided by a healthcare professional via telehealth, which disallows a health insurer from excluding a service for coverage solely because the service was provided through telehealth and

not provided through in-person consultation between a healthcare professional and a patient. SD Legis 211 (2019).

- **Utah:** In Utah, the legislature amended provisions regarding reimbursement for telemedicine services, requiring the Medicaid program to reimburse for certain telemedicine services at rates set by the Medicaid program, requiring the Public Employees' Benefit and Insurance Program to reimburse for certain telemedicine services at commercially reasonable rates, and amending telemedicine reporting and study requirements. The act requires the Medicaid program to reimburse for telemedicine services at the same rate that the Medicaid program reimburses for other healthcare services. UT Legis HB 392 (2019).
- **Virginia:** In Virginia, lawmakers passed an act providing for the payment of medical assistance for medically necessary healthcare services provided through telemedicine services, which now include remote patient monitoring services. VA Legis 219 (2019).

This flurry of state legislation demonstrates the expansion of telehealth services and payment at the state level with the counterbalancing licensing controls as another means of attempting to ensure a caliber of quality control for these services.

In summary, these developments herald the continued expansion of coverage of telehealth services in 2019; however, the spectres of fraud and licensure enforcement serve as a powerful reminder that these services will not go unmonitored.

[1] <https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-06822.pdf>. A summary of the 2019 Proposed Rule can be accessed at <https://www.akerman.com/en/perspectives/the-future-of-telehealth-in-2019.html>

[2] Final Rule at 8.

[3] Final Rule at 12.

[4] Final Rule at 14.

[5] Final Rule at 5.

[6] This summary can be accessed at
<https://www.akerman.com/en/perspectives/the-future-of-telehealth-in-2019.html>

[7] Id.

[8] Federal agencies participating in the initiative include the OIG, the Health Care Fraud Unit of the U.S. Department of Justice's Criminal Division's Fraud Section, its Medicare Fraud Strike Force (MFSF)(a partnership among the Criminal Division, U.S. Attorney's Offices, the FBI and HHS-OIG), and the U.S. Attorney's Offices for the Districts of South Carolina, New Jersey and the Middle District of Florida, with participation from the IRS-Criminal Investigation, and the Center for Medicare Services' (CMS) Center for Program Integrity (CPI). First established in March 2007, MFSF teams currently operate in the following areas: Miami, Florida; Los Angeles, California; Detroit, Michigan; Houston, Texas; Brooklyn, New York; Baton Rouge and New Orleans, Louisiana; Tampa and Orlando, Florida; Chicago, Illinois; Dallas, Texas; Washington, D.C.; Newark, New Jersey/Philadelphia, Pennsylvania; and the Appalachian Region.

[9] <https://www.justice.gov/usao-nj/pr/seven-people-charged-new-jersey-massive-health-care-fraud-scheme-involving-telemedicine>

[10] It is noteworthy that, in this operation, the defendants were only charged with money laundering conspiracy (18 USC § 1956(h)), which only carries a maximum ten year sentence.

However, by including such a charge, the government has signaled that, if the facts exist in the future, a straight money laundering count will be included.

[11] <https://oig.hhs.gov/fraud/consumer-alerts/alerts/bracescam.asp>

[12] For a user friendly pictorial of the alleged scheme, which the OIG is using in its alerts to beneficiaries and others of the scheme, see https://oig.hhs.gov/fraud/consumer-alerts/alerts/brace-scheme_infog-horz.png