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Telehealth Integrity: An Overview of State and Federal Regulatory Frameworks

Overview: Telehealth has emerged as an essential and life-saving modality of care, broadening patient access nationwide. **The ATA and ATA Action advocate for normalization of telehealth services, emphasizing that practitioners must meet the same rigorous standards for education, licensure, background checks, credentialing, and clinical practices whether practicing via telehealth or in-person.** Federal and state governments have established comprehensive guardrails applicable to all healthcare providers, including telehealth, to prevent the entry of unqualified actors into healthcare. This document outlines the primary federal and state measures in place to maintain program integrity and protect against fraud, waste, and abuse (FWA). Telehealth is subject to both traditional scrutiny to prevent health care fraud, as well as targeted scrutiny specific to that modality.

Telehealth services are regulated with the same safeguards as in-person health services:

State Practice Acts and Licensure Boards: Each of the 50 states and the District of Columbia have Practice Acts, often encompassing telehealth specific language, that confer authority on their respective health professional licensing boards to perform the licensing of health care professionals, investigate complaints, enforce disciplinary actions for violations of state and federal laws and standard of care, and, when necessary, refer providers for evaluation and rehabilitation. These boards ensure that only qualified providers practice and uphold high standards of patient care. Providers, including those who provide telehealth services, are required to be licensed, registered, or otherwise authorized to deliver healthcare services in the state where the patient is located and must adhere to that state's laws and regulations.

United States Department of Health and Human Services Office of Inspector General (OIG): OIG within the U.S. Department of Health and Human Services (HHS) is tasked with the mission of fighting FWA in Medicare, Medicaid, and other government programs. In recent years especially, HHS OIG has specifically and actively overseen telehealth services, continuously assessing the benefits and potential threats of flexibilities introduced during the COVID-19 public health emergency. OIG also works with law enforcement partners nationwide to investigate individual FWA cases, and has participated in law enforcement takedowns of people who have sought to egregiously defraud the Medicare and Medicaid programs. Through ongoing audits and evaluations of healthcare organizations nationwide, the OIG publishes toolkits, research outcomes, and other critical resources. These efforts aim to highlight program integrity risks, offer guidance to Congress and stakeholders, and alert providers and patients to potential telemarketing fraud. OIG has identified a number of fraudsters in the space, but it is important to note that such fraudsters are just that, and are not practicing telehealth, but telemarketing, and OIG has not found significantly more fraud in the telehealth space than in traditional brick and mortar healthcare settings.

United States Department of Health and Human Services Centers for Medicare and Medicare Services (CMS): CMS administers the nation's major healthcare programs, including Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). CMS generally determines which services are covered by which providers through the annual fee schedule process as well as the national coverage determination process and other mechanisms. If geographic restrictions on telehealth were removed, that does not mean that every service would immediately be available via telehealth. CMS maintains the list of covered services based on clinical evidence and routinely updates which services are available using which modalities. CMS also requires provider enrollment and provider compliance with state and federal laws and regulations.

Federal Trade Commission (FTC): The FTC's core mission is to safeguard consumers and promote a competitive market, extending to healthcare sectors. For telehealth and virtual care platforms, the FTC focuses on health data regulation and mitigating privacy and security risks. This includes overseeing the use of online tracking technologies by healthcare websites and apps, ensuring they do not improperly disclose sensitive personal health information to unauthorized third parties.

Drug Enforcement Administration (DEA): The DEA regulates remote prescribing of controlled substances. Before the pandemic, the Ryan Haight Act mandated an in-person visit before prescribing controlled substances via telehealth. This requirement was waived during the pandemic and is set to end at the end of 2024. This has significantly increased access to essential treatments. After the current in-person waiver expires, the DEA could put in place a special registration process for the prescribing of controlled substances through telehealth. This process could verify providers' credentials and history to protect against misuse, allowing qualified providers to receive DEA approval for virtual prescribing.

Inappropriate Guardrails

The ATA strongly believes telehealth is health. Telehealth should be held to the same standard of care as in-person services. In-person care and telehealth can and should be used in conjunction to ensure a seamless, efficient, and effective healthcare journey. Telehealth should not be subject to arbitrary, unnecessary, and clinically inappropriate guardrails such as:

- **In-person requirements:** Embedding in law an in-person requirement before a telehealth visit lacks a clinical basis and undermines telehealth's value, especially disadvantaging underserved populations without access to transportation, childcare, or those in provider shortage areas.
- **Geographic requirements:** Limitations based on geography, such as restricting telehealth to rural areas, fail to recognize the universal applicability and benefits of telehealth, provided the provider is licensed appropriately.
- **Brick and mortar requirements:** Mandating a brick-and-mortar address for Medicare enrollment or telehealth service reimbursement ignores the virtual nature of telehealth and imposes unnecessary hurdles for providers and patients alike.
- **Requiring home address disclosure:** Mandating providers who render telehealth services to disclose their private residence addresses on public forms such as Medicare enrollment and billing forms, is a major security concern, especially for those providing mental and behavioral health services. Additionally, this type of requirement leads to burdensome administrative documentation and operational barriers for health systems and providers across the country.
- **Statutory restrictions on services or providers:** Imposing legislative constraints on the types of services or providers eligible for telehealth overlooks the need for clinical discretion and the capacity of entities like CMS to adapt services and provider eligibility based on clinical evidence and technological advancements.

Relevant Research

- Over 95% of Medicare beneficiaries received telehealth services only from providers with whom they had an established relationship.[1]
- This OIG report describes providers' billing for telehealth services and identifies ways to safeguard Medicare from fraud, waste, and abuse related to telehealth. A very small proportion of providers (1,714 providers out of approximately 742,000) billed Medicare inappropriately, indicating that the measures put in place to safeguard against fraud, waste, and abuse related to telehealth worked well to maintain program integrity.[2]
- OIG released a report that found during the first nine months of the public health emergency -- March 2020 to November 2020 -- Medicare practitioners correctly billed for telehealth evaluation and management services in 95% of cases. The 5% of services that were billed incorrectly were primarily clerical errors or the inability to access records.[3]
- In a meta-analysis of 127 articles, researchers found that the risk of all-cause hospitalization decreased significantly by 18 hospitalizations per 1000 patients when telehealth was used as compared to usual care.[4]
- OIG conducted an audit of Montana and Medicaid providers to assess compliance with Federal and State requirements when claiming Medicaid reimbursement for telehealth services during the COVID-19 pandemic.[5] The audit covered 440,003 Medicaid telehealth paid claim lines, totaling $43.2 million.[6] The audit revealed that Montana and Medicaid providers generally complied with Federal and State requirements when claiming Medicaid reimbursement for telehealth services during the COVID-19 pandemic.[7] Over 99.9% of the paid claim lines OIG reviewed complied with Federal and State requirements.[8]
- The OIG conducted an audit of Illinois as well. Illinois generally made telehealth payments that were in accordance with Federal and State requirements. Of the 584,492 Medicaid fee-for-service telehealth payments (totaling $21,052,452 ($13,980,157 Federal share), 583,960 (99.9%) of the payments were in compliance with the requirements.[9]

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[1] Most Medicare beneficiaries received telehealth services only from providers with whom they had an established relationship 10-18-2021 OEI-02-20-00521 (hhs.gov)

[2] Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks OEI-02-20-00720 09-02-2022 (hhs.gov)

[3] Beavins, E. (2024, March 1). OIG: Medicare Telehealth Did Not Increase Fraud, Waste, Abuse In 2020. InsideHealthPolicy.

[4] Peters GM, Kooij L, Lenferink A, van Harten WH, Doggen CJM. The Effect of Telehealth on Hospital Services Use: Systematic Review and Meta-analysis J Med Internet Res 2021;23(9):e25195
doi: 10.2196/25195

[5] Office of Inspector General. (2023, May 17). Montana Generally Complied With Requirements for Telehealth Services During the COVID-19 Pandemic. https://oig.hhs.gov/oas/reports/region7/72103250.asp

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] Office of Inspector General. (2022, Dec. 21). Illinois Generally Complied With Requirements for Claiming Medicaid Reimbursement for Telehealth Payments During COVID-19.https://oig.hhs.gov/oas/reports/region5/52100035.asp

- A study was conducted to assess the effects of eLongTermCare (eLTC), a telehealth program implemented by an integrated health system in 45 nursing homes across the Midwest, on the use of acute hospital services and total expenditures for Medicare residents. For long-term care residents, the eLTC program led to an estimated reduction of 73 emergency department visits per 1000 beneficiaries over the two-year follow-up period. For skilled care residents, the program was associated with an estimated reduction of 85 emergency department visits per 1000 beneficiaries.[10]
- In a literature review of published articles on PubMed from January 2017 to December 2020 about telehealth interventions in rural communities in the United States, the studies reported positive outcomes and experiences of telehealth use in rural populations including acceptability and increased satisfaction; they also noted that technology is convenient and efficient. Other notable benefits included decreased direct and indirect costs to the patient (travel cost and time) and health care service provider (staffing), lower onsite health care resource utilization, improved physician recruitment and retention, improved access to care, and increased education and training of patients and health care professionals.[11]

About the ATA

As the only organization completely focused on advancing telehealth, the American Telemedicine Association (ATA) is committed to ensuring that everyone has access to safe, affordable, and appropriate care when and where they need it, enabling the system to do more good for more people. The ATA represents a broad and inclusive member network of leading healthcare delivery systems, academic institutions, technology solution providers and payers, as well as partner organizations and alliances, working to advance industry adoption of telehealth, promote responsible policy, advocate for government and market normalization, and provide education and resources to help integrate virtual care into emerging value-based delivery models. For more information, please email info@americantelemed.org.

[10] Suhui (Evelyn) Li PhD, Mynti Hossain MPP, Boyd Gilman PhD, Lauren V. Forrow MS, Katie M. Lee MPP, Randall Brown PhD. (2022, Jan 18). Effects of a nursing home telehealth program on spending and utilization for Medicare residents. https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13936

[11] Butzner M, Cuffee Y. Telehealth Interventions and Outcomes Across Rural Communities in the United States: Narrative Review.J Med Internet Res 2021;23(8):e29575. https://www.jmir.org/2021/8/e29575/