A Silver Lining of COVID-19: Telehealth and the Appalachian Healthcare Landscape

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A Silver Lining of COVID-19: Telehealth and the Appalachian Healthcare Landscape

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In 2020, the COVID-19 pandemic truly altered the world around us. Many things have changed, but not all of these changes are necessarily bad. If there is a silver lining, it might be the way the world has come together through innovation. One such innovation, though not entirely novel, is the unprecedented adoption and growth of Telehealth in America.[1]

Telehealth, or the exchange of medical information through electronic telecommunication to improve patient health, has flourished as a way to maintain social distance and increase the availability of health services.[2] This virtual method of health care delivery reduces the potential for Coronavirus exposure and transmission while maintaining continuity of medical care.[3] The development and implementation of Telehealth programs has also served to expand general access to health services to those that might typically lack ready access (e.g., historically medically underserved populations).[4]

The Appalachian region, specifically, maintains some of the greatest health disparities in the country.[5] Even before COVID-19, Appalachia has long faced dramatic health challenges as the region lacks sufficient access to primary care providers, and is plagued with higher rates of illness, mortality, and poverty. In whole, Appalachian residents have "a greater proportion reporting no health insurance or being underinsured, greater geographic isolation, less public transportation, and fewer physicians, clinics, hospitals, and cancer centers per capita."[6]

Commentators have posited that the adoption and utilization of Telehealth practices in the region could help improve health outcomes and bridge the health divide between Appalachia and the rest of the nation.[7] In the wake of COVID-19, significant steps have been taken to rapidly expand Telehealth utilization. [8] The U.S. government has acted to remove, at least temporarily, several anti-fraud 'guardrails' and to generally relax policy guidelines regarding Telehealth regulations.[9] In so acting, various relief funds and other forms of financial assistance were authorized and distributed to promote these new policies.[10]

It remains to be seen whether these flexible Telehealth policies will remain post-COVID.[11] Many providers considering offering Telehealth services are understandably wary in light of this uncertainty. This unprecedented relaxing of anti-fraud and other regulatory guidelines has allowed for providers to, at least temporarily, step out of their comfort zone and expand their services. However, experts are cautioning that physicians and healthcare providers who have taken advantage of Telehealth's expansion might find themselves at risk for fraud allegations post-COVID.[12]

The government has historically prioritized fraud enforcement efforts and the deterrence of fraud. This can be seen clearly by looking at the impressive number of False Claims Act (FCA) cases being brought each year.[13] Enforcement efforts have been oriented to "business practices that target vulnerable segments of the nation's population, such as elderly and veterans, and those that the government perceives as contributing to the nations opioid epidemic."[14] This long-standing priority will not disappear merely because of a national health emergency. As a result, it is to be expected that there will be a surge in healthcare—specifically in Telehealth-related healthcare—fraud allegations following the pandemic.[15]

The regulatory risk surrounding Telehealth services is compounded even further by the current uncertainty regarding the application of the falsity component required in FCA claims.[16] A viable claim under the FCA must have four elements established: falsity, intent, materiality, and causation. [17] Currently, the Circuits are split as to what is required to establish falsity.[18]

Some Circuits maintain that there must be a showing of "objective falsehood" for a claim to be considered false under the Act, and others hold that a "mere difference of opinion" is sufficient to satisfy the falsity requirement.[19] Based on which standard is employed, there could be a dramatic effect on a physician's willingness to undertake the heightened risk associated with practicing Telehealth.[20] It will be much easier for an FCA claim to survive beyond the summary judgment phase in a jurisdiction where only a "mere difference of opinion" is needed. Thus, the risk associated with offering services, like Telehealth, where fraud accusations are likely, is dramatically higher in these jurisdictions.

As it stands, providers are largely unable to properly evaluate the risks involved in expanding their Telehealth services.[21] Legislative or judicial action is needed in order to preserve the newfound healthcare access and other benefits being enjoyed from the recent promotion and expansion of Telehealth. Absent some directive, physician willingness to implement Telehealth practices is likely to wane and these newfound healthcare innovations, that have so greatly expanded accessibility, will be threatened. The Appalachian region, in particular, would suffer greatly from this loss.

The health gap between Appalachia and the rest of the country is wide and growing wider each day. Clarity concerning the proper FCA falsity standard and the anticipated Telehealth regulatory scheme post-COVID would be a significant step in bridging this gap.

[1] Ty Howard & Janus Pan, *Telehealth's Moment: The Effect of COVID-19, First Wave Enforcement Actions, and What Lies Ahead for Compliance and Enforcement in Healthcare's Hottest Area* (Dec. 30, 2020), https://www.bradley.com/-/media/files/insights/publications/2020/12/sup-materialsarticle-telehealths-moment-the-effect-of-covid19-first-wave-enforcement-actions-jan-2021.pdf.

[2] Centers for Medicare & Medicaid Services, *Medicare Telemedicine Health Care Provider Fact Sheet,* CMS.gov (Mar. 17, 2020), https://go.cms.gov/38cQdzY.

[3] Center for Disease Control, *Using Telehealth Services,* CDC.gov (June 10, 2020) https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html.

[4] Tasha Woodall, Melinda Ramage, John T. LaBruyere, William McLean, & Casey R. Tak, *Telemedicine Services During COVID-19: Considerations for Medically Underserved Populations,* 37 J. Rural Health 231, 231 (2021).

[5] *See generally* Appalachian Regional Commission, *Key Findings: Appalachian Kentucky Health Disparities,* ARC (January 17, 2020) https://www.arc.gov/wp-content/uploads/2020/07/KYHealthDisparitiesKeyFindings8-17.pdf.

[6] *Id.*

[7] *Id.*

[8] *See id.*

[9] Fred Schulte, *Coronavirus Fuels Explosive Growth in Telehealth – and Concern About Fraud,* Modern Healthcare (April 22, 2020 12:53 PM) https://www.modernhealthcare.com/technology/coronavirus-fuels-explosive-growth-telehealth-and-concern-about-fraud.

[10] *See e.g.*, Lawrence Vernaglia, Alexis Bortniker, Rachel Goodman, Jessa Boubker, *Hhs Provider Relief Funds and the Strings and Risks Attached: What Compliance Officers Need to Be Thinking About Now,* 22 J. Health Care Compliance 5, 7–8 (2020).

[11] *See generally id.*

[12] Ayanna Alexander, *Doctors Cashing Telehealth Paychecks Run Fraud Risk After Virus,* Bloomberg Law (July 7, 2020 5:47 AM) https://news.bloomberglaw.com/health-law-and-business/doctors-cashing-telehealth-paychecks-run-fraud-risk-after-virus.

[13] The FCA is the government's primary litigative tool for combatting healthcare fraud. *See* Melissa E. Najjar, *When Medical Opinions, Judgments, and Conclusions Are "False" Under the False Claims Act: Criminal and Civil Liability of Physicians Who Are Second-Guessed by the Government,* 53 Suffolk U. L. Rev. 137, 141 (2020); Press Release, U.S. Dep't of Justice, *Justice Department Recovers Over $3 Billion from False Claims Act Cases in Fiscal Year 2019* (Jan. 9, 2020), https://www.justice.gov/opa/pr/justice-department-recovers-over-3-billion-false-claims-act-cases-fiscal-year-2019.

[14] *Id.*

[15] See Susan Gaertner & Jackson Hobbs, *Just What the DOJ Ordered: Telehealth Enforcement Actions Are Here to Stay*, Lathrop GPM, (Dec. 2, 2020), https://www.lathropgpm.com/newsroom-alerts-Just-What-the-DOJ-Ordered-Telehealth-Enforcement-Actions-Are-Here-to-Stay.html.

[16] See Tricia L. Forte, *Resolving the Circuit Split: Pleading Healthcare Fraud with Particularity*, 25 Roger Williams U. L. Rev. 16, 18 (2020).

[17] 20151115 AHLA Seminar Papers 7.

[18] Robert S. Salcido, *When Can Opinions Be "False" And Result In False Claims Act Liability: Three Circuit Courts Provide Conflicting Guidance*, Mondaq (Nov. 25,2020).

[19] *Id.*

[20] *Id.*

[21] Thomas E. Fraysse, *Relaxation of Telemedicine Rules Post-COVID-19 Opens Door to Fraud,* Managed Healthcare Executive (August 24, 2020) https://www.managedhealthcareexecutive.com/view/relaxation-of-telemedicine-rules-post-covid-19-opens-door-to-fraud.

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