HCCA
HEALTH CARE COMPLIANCE ASSOCIATION

Compliance TODAY

October 2015

A PUBLICATION OF THE HEALTH CARE COMPLIANCE ASSOCIATION

WWW.HCCA-INFO.ORG

Combating healthcare fraud in New Jersey

an interview with Paul J. Fishman

United States Attorney for the District of New Jersey

See page 16

27

Final rule for Accountable Care Organizations: Enabling technologies, Part 1

Paul R. DeMuro

35

Narrow network health plans: New approaches to regulating adequacy and transparency

Michael S. Adelberg

43

OIG offers new guidance for healthcare governing boards

Paul P. Jesep

49

Telemedicine arrangements: Trends and fair market value considerations

Jen Johnson and Mary Fan

by Jen Johnson, CFA and Mary Fan, CVA

Telemedicine arrangements: Trends and fair market value considerations

» Telemedicine is real-time, store-and-forward, or remote monitoring.
» Arrangements commonly exist between hospital-provider or hospital (hub)-spoke.
» Compensation structures may include equipment, activation, and/or availability fee.
» Value drivers include consult volume, reimbursement risk, availability, and more.
» More than 50% of all US hospitals utilize some form of telemedicine.

Jen Johnson *(jenj@vmghealth.com) is managing director and* ***Mary Fan*** *(maryf@vmghealth.com) is senior analyst with VMG Health in Dallas.*

Compensating physicians or hospitals for telemedicine service has become a new challenge for health systems across the country. Attempting to evaluate a highly fragmented reimbursement setting, a multi-practitioner-and-patient relationship, and the various services and technology involved highlight the complications for establishing these payments. Based on regulatory guidance and the inherent referral relationship within most of these arrangements, compensation between hospital and physician, as well as between two hospitals, must be set at fair market value (FMV).

Industry overview

According to the American Telemedicine Association, telemedicine refers to the exchange of medical information from one site to another through electronic communications. More than half of all hospitals in the United States utilize some form of telemedicine as of May 2014. As illustrated below, a study on digital health markets published by Frost & Sullivan indicates that home and disease management/remote patient monitoring and video telemedicine are top growth areas throughout the next four years (see Figure 1 on page 50).

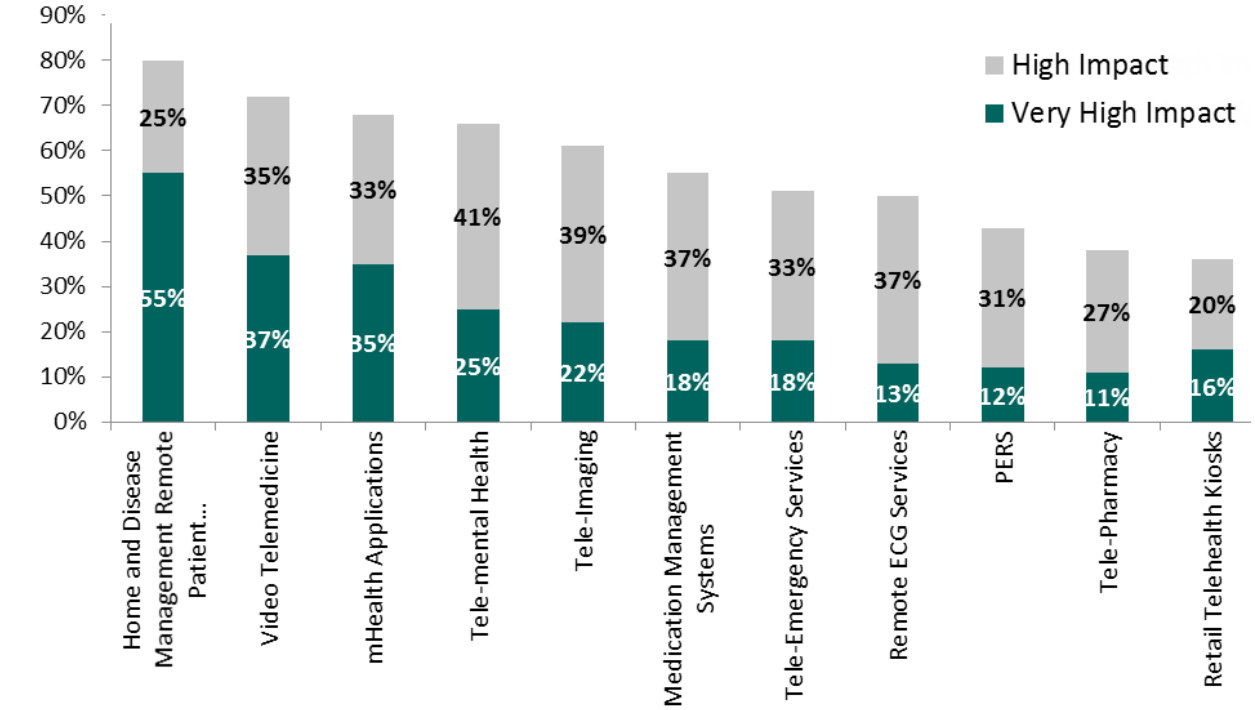
Johnson

Fan

In general, telemedicine can be classified as real-time ("synchronous telemedicine"), store-and-forward ("asynchronous telemedicine"), or remote monitoring.[1] Synchronous telemedicine requires live communication amongst all parties via videoconferencing, whereas asynchronous telemedicine involves the gathering and transmission of medical data, such as sending a medical image to a medical practitioner for interpretation. Remote monitoring consists of an external monitoring center for healthcare providers to monitor a patient remotely. All of the aforementioned services are often used interchangeably with "telehealth," which represents the broader umbrella under which telemedicine resides.

For physicians who independently contract with independent telemedicine companies (e.g., Teladoc, American Well, Doctor on Demand) on a part-time basis, they will likely be compen-

Figure 1: Digital Health Markets — Highest Impact on Healthcare in the Next 5 Years



Source: Nancy Fabozzi. "Pulse of Telehealth 2014," Presented by Frost & Sullivan during the 2014 American Telemedicine Association (ATA) Annual Meeting.

sated on a per visit, per member, or periodic flat fee basis. For contractual arrangements between a hospital and physician, or a hospital and a smaller/rural hospital, the compensation structures include but are not limited to: uncompensated on-call coverage (i.e., part of employment agreement or on-call provisions), per-use/click fee, hourly or daily availability fee (i.e., unrestricted call coverage), per Emergency Department (ED) visit fee (with the potential of a tiered structure based on increased ED volume), and compensation per work relative value unit (RVU). By definition, work RVUs reflect the relative level of time, skill, training, and intensity to provide a service or procedure.[2] Finally, telemedicine arrangements could either take on a physician-to-patient or physician-to-physician relationship depending on the nature of the service. With a multitude of structures, complexity of service combinations, and new reimbursement environment, determining the appropriate payment for telemedicine services has proven to be challenging.

FMV standard

FMV is the standard which is pertinent for arrangements between hospitals and physicians, as well as arrangements between two hospitals. As defined by the International Glossary of Business Valuation Terms, FMV refers to "the price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arm's length in an open and unrestricted market, when neither is under compulsion to buy or sell and when both have reasonable knowledge of the relevant facts." It is important to note that determining compensation under healthcare regulations may not always be consistent with generally accepted appraisal standards and may include additional guidelines. For example, a notable definition for compensation set at FMV as stated in the Stark law includes:

"The compensation must be set in advance, consistent with fair market value,

and not determined in a manner that takes into account the volume or value of referrals or other business generated by the referring physician."[3]

These guidelines are important to consider when establishing compensation for any telemedicine arrangement to maintain compliant with regulatory guidelines. In summary, the methodology and data points for determining FMV may not consider other referral relationships. This further complicates the process for establishing FMV.

Arrangement examples

The parties associated with telemedicine relationships can vary, amongst which the two most common types of arrangements exist between a hospital and a provider or a hospital and a spoke facility. Under the first scenario, the provider is being compensated to provide on-call services through either a synchronous or asynchronous fashion by the hospital.

The second arrangement is alternatively known as the "hub-spoke" model, whereby a hospital that is generally located in an urban area ("hub facility") provides services to one or more facilities either located in a rural area or in an urban setting lacking a particular specialty ("spoke facility").[4] Under this arrangement, the payment is from the spoke facility to the hub facility's provider(s) for supplying services to the spoke facility.

In any of the above noted arrangements, the following value drivers are typically considered in determining FMV:

- Volume of consults (i.e., video, telephonic);
- Response time requirements;
- Ability to collect from patients and commercial/governmental payers;
- Reimbursement/payer mix;
- Severity level of patients;
- Supply and demand of similarly specialized providers; and/or
- Equipment expense.

Bottom line

As illustrated above, many facts and circumstances must be considered when determining FMV for a telemedicine arrangement. Both internal and external factors should be taken into account, including the providers' services, availability, and access to equipment. The critical components to compliance include documenting factors to accurately reflect the burden of telemedicine services and following the regulations that surround telemedicine arrangements. The roots of telemedicine may have stemmed primarily from wanting to improve the access of care for rural patients, but now it faces an inevitable future in non-rural areas due to its key benefits of convenience, cost effectiveness, and rapid care.

1. "Telehealth Modalities", Center for Connected Health Policy: The National Telehealth Policy Resource Center, 2015. Available at http://bit.ly/1gUkzdP
2. Stark II, Phase II, FR Vol. 69, No. 59. Available at http://bit.ly/1EeT21T
3. "Introduction to Relative Value Units and How Medicare Reimbursement in Calculated", American College of Radiation Oncology. Available at http://bit.ly/1JoxBx8
4. Bart M. Demaerschalk, et al."Stroke Telemedicine," US National Library of Medicine: National Institute of Health, Jan 2009; 84(1): 53-64. Available at http://1.usa.gov/1hKKNA7