

Telehealth Mythbusters for Health Centers to Consider

Initial stay-at-home orders, fears of contracting COVID-19, and increasing unemployment rates have led many patients to forgo in-person health care visits, propelling telehealth to the forefront of health care services. While 96% of health centers are currently offering telehealth services compared to just 43% in 2019, there are persistent misconceptions about the effectiveness, quality, and breadth of these services.

Myth #1 – Patients and Providers Prefer In-Patient Care

While in-person care will remain critical, patients and providers support medically appropriate telehealth services, with systematic reviews showing that they can increase quality of care and patient satisfaction.^{1,2} 2019 data reflects that patients prefer telehealth visits because of convenience, while over 52% of clinicians found these visits were more efficient.³ Increased telehealth care during the pandemic has highlighted these sentiments, with a recent survey showing 75% of patients were very satisfied and wanted to incorporate more telehealth into their care routine.⁴ The American Medical Association (AMA) also expressed support for virtual care with the launch of The Telehealth Initiative, helping providers implement virtual services more broadly.⁵

Myth #2 – Telehealth Provides Lower Quality Care

The pandemic exacerbated existing barriers for vulnerable populations, including people experiencing financial constraints and homelessness, people with disabilities, and residents in rural areas. New telehealth opportunities, like audio-only visits and broader access to multilingual providers, have ensured access to care while increasing cultural competency by broadening the range of approaches to care. In the 2020 Telehealth Impact Physician Survey, 75% of respondents said telehealth allowed them to provide quality COVID-19 care, 80% noted that care was provided in a timelier manner, and 60% reported improvements in patient health.⁶

Myth #3 – Telehealth Ensures Equitable and Culturally Competent Care

Telehealth promotes equity through increased care options, and the pandemic has expanded reimbursement flexibilities, including audio-only visits. However, these flexibilities will end with the Public Health Emergency (PHE), threatening equitable and culturally competent care. While many states have passed legislation to maintain these flexibilities, the national landscape is inconsistent.^{7,8,9} Studies highlight a lack of payment parity from insurers towards audio-only care will negatively hurt health centers serving populations disproportionately affected by the pandemic.^{10,11} Equitable telehealth care must be available and properly reimbursed for.

Myth #4 – Telehealth Will Not Outlast the COVID-19 Pandemic

Advancements in telehealth services since the start of the pandemic have permanently transformed health care delivery. The Centers for Medicare and Medicaid Services (CMS) already gives states significant flexibility in how they cover Medicaid telehealth services, and all 50 states plus the District of Columbia and Puerto Rico have taken advantage of additional COVID-19 flexibilities.¹² Health centers, and those they serve, have greatly benefited from these new opportunities, and want to continue this progress after the PHE rather than rolling back services. Many states echo this sentiment, and have already implemented, or are pursuing, telehealth legislation to make flexibilities permanent, including audio-only visits, distant sites, and payment parity.^{13,14}

Myth #5 – Audio-Only Telehealth Is Not Effective

Prior to the pandemic, CMS did not reimburse for audio-only services, despite 2017 data highlighting that while only 6.5% of the US was without access to broadband, that number increased to 32% in tribal lands and 26% in rural areas.¹⁵ A 2021 article examining 43 different health centers in California utilizing this new flexibility found that 49% of primary care visits and 63% of behavioral health visits were conducted telephonically.¹¹ Former Administrator Verma underscored this trend in the Medicare space, stating 3 million, or one-third, of beneficiaries participated in a telehealth visit telephonically during COVID-19.¹⁶

Myth #6 – Telehealth is Not Critical to the Delivery of FQHC Patient Services

In April 2020, 1,643 health centers temporarily closed due to the pandemic.¹⁷ Between revenue loss and the costs of new COVID-19 response expenses, the financial impact for health centers between then and June 2021 is expected to reach \$10.77 billion. However, telehealth has allowed 96% of FQHCs to continue serving patients.¹⁸ While below normal, 87% of visits are still held at health centers, up from 54% at the onset of the pandemic, with a large portion attributed to telehealth services.¹⁸ Telehealth may come with opportunity costs, but these services are critical to health centers and those they serve.

Myth #7 – No Further Changes are Needed to Telehealth Reimbursement Policies

The fact that many telehealth flexibilities will end with the termination of the PHE has led to increased uncertainty. As of February 2021, only 14 states have passed true payment parity allowing providers to be reimbursed for telehealth services at the same rate as in-person visits.¹⁹ Flexibilities and reimbursement should be protected in all states after the PHE concludes. Congress must support the CONNECT for Health Act, which modernizes Medicare policy and recognizes health centers as distant and originating sites, allowing for telehealth reimbursement. CMS must also act to clarify that states have the maximum flexibility to adopt audio-only and payment parity policies in Medicaid. Without congressional and agency action, health centers will be unable to provide efficient, equitable, and quality care to patients after the PHE.

Myth #8 – Telehealth Will Lead to Increased Over-Utilization and Possible Fraud

While Medicare and Medicaid have expanded telehealth policies, it has not led to overutilization. In 2001, when Congress expanded Medicare telehealth, the Congressional Budget Office estimated a \$150 million increase in spending over the first five years. However, from 2001-2014, Medicare telehealth spending increased by just \$57 million.²⁰ Related to possible fraud, the Office of the Inspector General (OIG) noted in a February 2021 letter the critical differences between telehealth fraud and “telefraud,” the latter of which involves the use of telemarketing to defraud patients.²¹ In many publicized cases, the OIG noted that “the criminals did not bill for the sham telehealth visit, ” an important distinction that otherwise unfairly impugns critical telehealth services.

If you have any questions, please contact The NACHC State Affairs team at state@nachc.org.

¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5723163/>

² <https://effectivehealthcare.ahrq.gov/products/telehealth-acute-chronic/research>

³ <https://www.ajmc.com/view/patient-and-clinician-experiences-with-telehealth-for-patient-followup-care>

⁴ <https://www.kyruus.com/news/new-survey-reveals-patients-have-been-overwhelmingly-satisfied-with-virtual-care-during-the-covid-19-pandemic-and-want-greater-access>

⁵ <https://www.ama-assn.org/practice-management/digital/survey-physicians-laud-telehealth-s-value-still-find-barriers>

⁶ <https://c19hcc.org/static/catalog-resources/telehealth-physician-survey-analysis-c19hcc.pdf>

⁷ <https://www.manatt.com/insights/newsletters/covid-19-update/executive-summary-tracking-telehealth-changes-stat>

⁸ <https://leg.colorado.gov/bills/sb20-212>

⁹ http://gencourt.state.nh.us/bill_status/billText.aspx?sy=2020&id=1180&txtFormat=html

¹⁰ <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774488>

¹¹ <https://jamanetwork.com/journals/jama/article-abstract/2776166>

¹² <https://www.nachc.org/wp-content/uploads/2020/11/Resource-Guide-on-State-Telehealth-Coverage-in-Medicaid-Oct-27-2020.pdf>

¹³ <https://www.cchpca.org/sites/default/files/2020-10/CCHP%2050%20STATE%20REPORT%20FALL%202020%20FINAL.pdf>

¹⁴ <https://www.jdsupra.com/legalnews/executive-summary-tracking-telehealth-8692451/>

¹⁵ https://bipartisanpolicy.org/wp-content/uploads/2020/07/Health_InfoGraphicBPC_Final-Files-1.pdf

¹⁶ <https://www.healthaffairs.org/doi/10.1377/hblog20200715.454789/full/>

¹⁷ <https://www.nachc.org/research-and-data/health-centers-on-the-frontlines-of-covid-19-the-first-6-months/>

¹⁸ <https://www.nachc.org/research-and-data/research-fact-sheets-and-infographics/infographics-national-findings-on-health-centers-response-to-covid-19/> *Updated Weekly

¹⁹ <https://www.foley.com/en/insights/news/2021/02/pandemic-virtual-care-adoption-50-state-survey>

²⁰ <https://www.politico.com/story/2015/12/telemedicine-fans-point-to-cbos-history-of-cost-overestimates-216915>

²¹ https://oig.hhs.gov/coronavirus/letter-grimm-02262021.asp?utm_source=oig-web&utm_medium=oig-covid-policies&utm_campaign=oig-grimm-letter-02262021