Data Note

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What Can We Learn from Telehealth Experience of Community Health Centers During the COVID-19 Pandemic?

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Community Health Centers and Telehealth: What We Know

For health care providers and patients alike, telehealth has grown from a promising innovation to become essential during the COVID-19 pandemic. News stories from around the country underscore the difficulties community health centers have experienced in maintaining key services, keeping sites open, and preventing staff furloughs and layoffs throughout the crisis. Because of where they are located and **whom they serve**, community health centers' ability to put telehealth to use will provide important insight into how well the modalities can be adapted to comprehensive primary health care for medically underserved populations, disproportionately low-income and at elevated social and health risk.

The latest **official data** from the federal government indicate that that, on average, 54 percent of health center visits are being conducted virtually during the pandemic, though the rate varies substantially by state (**Figure 1**). According to our calculations using data from the Department of Health and Human Services Uniform Data System (UDS), in 2018, the most recent year for which data are available, only 43 percent of health centers reported using telehealth services of any type; less than one-quarter of all centers (23 percent) used telehealth to reach patients at remote locations. Though this data is two years old, this statistic and the present survey data suggest that many centers may still need to implement telehealth capabilities during this present pandemic. Among health centers that provided some form of telehealth, the 2018 data indicate that 68 percent provided mental health services, while 30 percent provided primary health care. If this pattern holds in the present day, this finding suggests there still may be important differences in the availability of telehealth services by specialty (**Figure 2**). Twenty-one percent of those health centers that offered telehealth in 2018 provided care for chronic conditions; this suggests that for the present pandemic, some health centers could be challenged to offer care to those with an increased **likelihood of complications** due to underlying chronic health problems, and a greater need to observe distancing measures.

The Range of Issues Arising Under Telehealth Policy

Telehealth is complex, because it encompasses many types of synchronous and asynchronous activities. Telehealth is broader than **telemedicine**, as it can include non-clinical services. The type of services **may encompass** patient diagnosis, monitoring, and management, as well as patient and provider education, and provider consultations. The **means of technology** may include remote patient monitoring (the collecting, sharing, and interpreting of patient health data via electronic devices); store-and-forward transmissions (the sharing of health information such as medical scans, text-based patient information, or pre-recorded videos via secure data storage and sharing technology); mobile health apps; real-time audio/video encounters; and, during the COVID-19 pandemic, telephonic encounters. While there is a federal definition of telehealth under Medicare, under Medicaid, **states can choose** the range of covered services, eligible patient populations and providers, technology requirements, and reimbursement policies. These differences and operational complexities contribute to an intricate policy environment for the governance of telehealth.

Paying for Virtual Telehealth Visits

Among centers that reported not providing telehealth services in 2018, the most-cited barrier (35 percent) was

inadequate payment (**Figure 3**). In 2019, just 14 states reimbursed store-and-forward telehealth under Medicaid fee-for-service and only 22 reimbursed for remote patient monitoring, which is reflected in the low rates at which community health centers offered these types of services (**Figure 4**). Given the **catastrophic financial struggles** health centers have faced during the pandemic, it is essential that they earn adequate payments for their telehealth services as they shift toward greater reliance on this approach to care. The first step is ensuring that community health centers are eligible providers. **The Coronavirus Aid, Relief, and Economic Security (CARES) Act** temporarily allows Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to serve as eligible Medicare fee-for-service providers for telehealth services. Recently, **the Centers for Medicare & Medicaid Services (CMS)** also temporarily expanded Medicare telehealth eligibility for reimbursement, allowing Medicare to pay for a wider range of telehealth visits and eliminating numerous restrictions on qualifying patient types and originating sites, requirements for pre-existing patient/provider relationships and **qualifying provider types**.

The next step is ensuring adequate payment for telehealth services. Under the new guidance, Medicare will **pay the same rate for telehealth** as for traditional, in-person services and will allow providers to waive patient cost-sharing. Medicare will **pay $92 to RHCs and FQHCs** for distant site telehealth services per visit. Medicare Advantage (MA) plans had more flexibility than traditional Medicare with respect to telehealth location, modality and service types before the outbreak, **despite some limits** on the types of providers reimbursed. CMS has instructed Medicare Advantage Organizations that, for the duration of the outbreak, they can **expand telehealth services** beyond what is currently approved. Despite this flexibility to offer more expansive services, MA plans are only **required to provide the same services as Fee-For-Service plans**.

For Medicaid patients, who make up the **largest payment group** among community health center patients, **states continue to have flexibility** around whether to utilize telehealth, the types of services covered, the types of practitioners eligible for delivering care via telehealth, and where telehealth services will be allowed. States **must submit plan amendments** if they wish to treat telehealth payments differently from traditional visit payments. **CMS requires** that states also submit such amendments to cover FQHC telephonic services at the existing prospective payment system (PPS) rate if their existing plan specifies face-to-face encounters only. If a service is within the scope of FQHC/RHC benefits, Medicaid must pay centers at least the PPS rate for telehealth services. Therefore, it is essential to ensure a comprehensive scope of benefits. Moreover, states can increase Medicaid payment rates or offer retainer payments to help offset provider losses via a §1115 waiver. In cases in which a state has a generous telehealth policy for community health centers, clear policy guidance becomes important; **centers report confusion** over the extent to which their states permit coverage and payment. States that alter their telehealth policies also could ensure rapid implementation of payment so providers can receive reimbursement for their services, as **providers have reported difficulty** receiving payment for their services as insurers adjust.

Technology Costs

The second most common barrier to providing telehealth services (cited by 23 percent) was funding for telehealth equipment, with training deficits, infrastructure and broadband issues cited as additional barriers. **CMS has temporarily allowed providers to use everyday communication technologies**, such as FaceTime, for telehealth services, waiving HIPAA violation penalties. Such a policy can facilitate treatment in cases in which patients and/or providers are not yet set up for telehealth. However, community health center patients are **largely low-income**, and low-income individuals are **more likely to lack access to broadband or smartphones** than the general population, potentially limiting the utility of these changes in communities served by health centers.

Because of the technology limits that affect health centers and their patients alike, it is important that states explicitly cover telephonic services at payment parity for community health centers. Some states **have begun taking such action** by establishing policies across a range of insurers and provider types, but anecdotal evidence suggests ongoing problems with parity across types of telehealth communication methods, especially payment for telephonic services. CMS has **broadened** the scope of covered telehealth services for Medicare, including patient education and behavioral health services by telephone, mandating parity for these visits with similar office or outpatient visits

retroactive to March 1, 2020. States **have the flexibility** to cover telephonic telehealth services under Medicaid and can apply for a special program waiver to provide case management telephonically. FQHC and RHC provision of telephonic services under Medicaid are eligible for federal financial reimbursement unless the approved state plan explicitly excludes the practice.

Additionally, health centers need financial resources to purchase telehealth equipment for patients and providers. **The COVID-19 Telehealth Program** could potentially provide health centers with such funding. Furthermore, states may apply to the federal government to adopt policy changes facilitating such purchases. Washington State, for example, requested in its **§1135 waiver** to use Medicaid financing, grants, or other resources to purchase equipment for patients and providers.

Adequate Telehealth Workforce

The third most common barrier to telehealth provision that health centers cited was lack of training for telehealth services. While insurance coverage and reimbursement of telephonic visits will help to address this issue, many centers are still dealing with staff shortages. Prior to the pandemic, many community health centers **did not have adequate staff to meet patient needs**. These staffing shortages are being exacerbated **under current conditions**. HRSA recently reported that **12 percent of health center staff** was unable to work during a one-week period. During the pandemic, CMS is allowing Medicare practitioners **licensed in a state** other than the patient's state of residence to practice telehealth. This practice helps to ensure an adequate supply of providers capable of providing telehealth services in regions with provider shortages. Additionally, policies that allow providers to use everyday communication technology on a temporary basis should reduce telehealth training needs. However, states and community health centers may also want to advocate for resources to help train providers on telehealth. For example, the COVID-19 Telehealth Program **does not allow** applicants to use its financial resources for training. CMS has released a **helpful checklist** for states to use when considering telehealth policy changes to enact. As states decide their policy response to COVID-19, they should consider how to best address the needs of community health centers and patients. The above-mentioned policies and funding sources are potential avenues to ensure the continued functioning of community health centers and optimize patient access.

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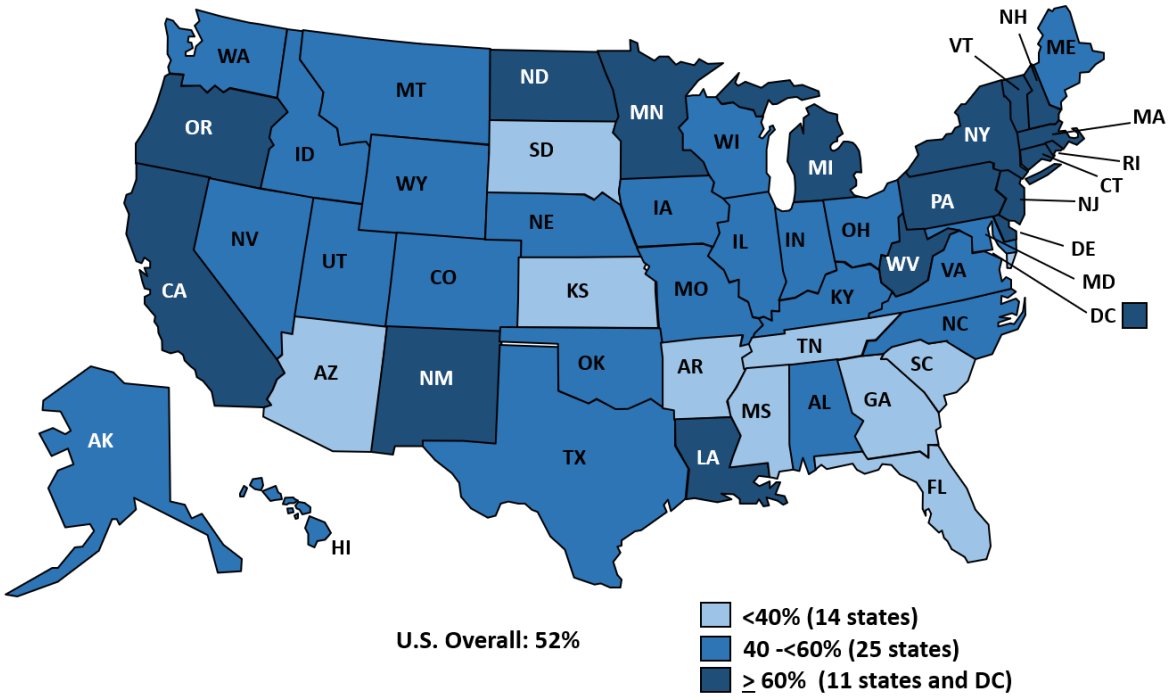
Conclusion

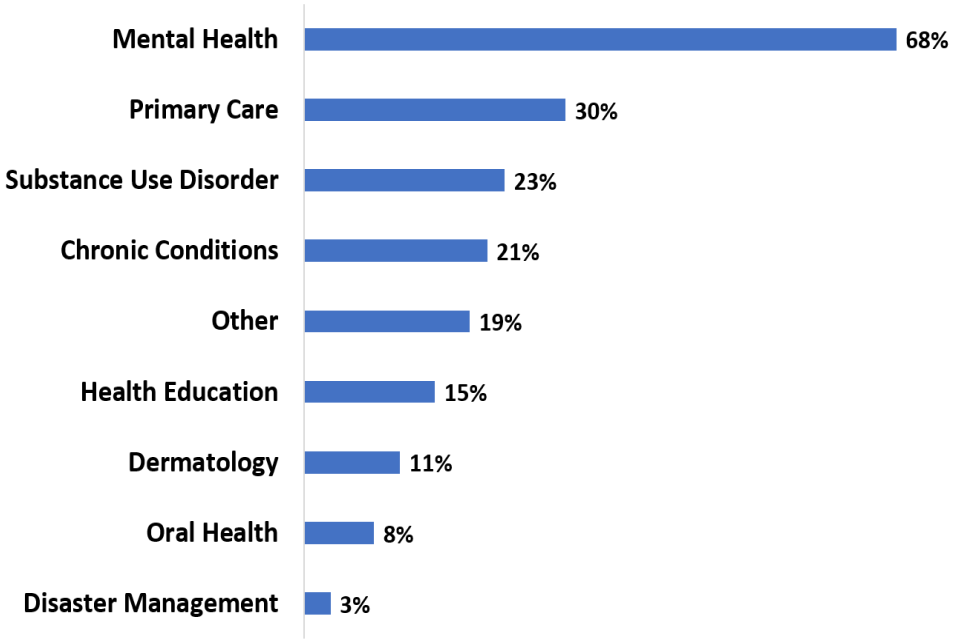
As the pandemic continues to claim such a heavy toll, telehealth as a means of ensuring access to health care will remain a front-and-center issue. This Data Note shows that community health centers are eager to expand their use of telehealth, but that they face substantial barriers related to payment, up-front investment, and staffing. Telehealth has the potential – not just during the public health crisis but on an ongoing basis – to ease access problems in medically underserved rural and urban communities. As policy implementation unfolds, health centers will be an important bellwether of progress.

Figure 1. Average Percent of Virtual Health Center Visits in the Last Week, by State (as of April 10)



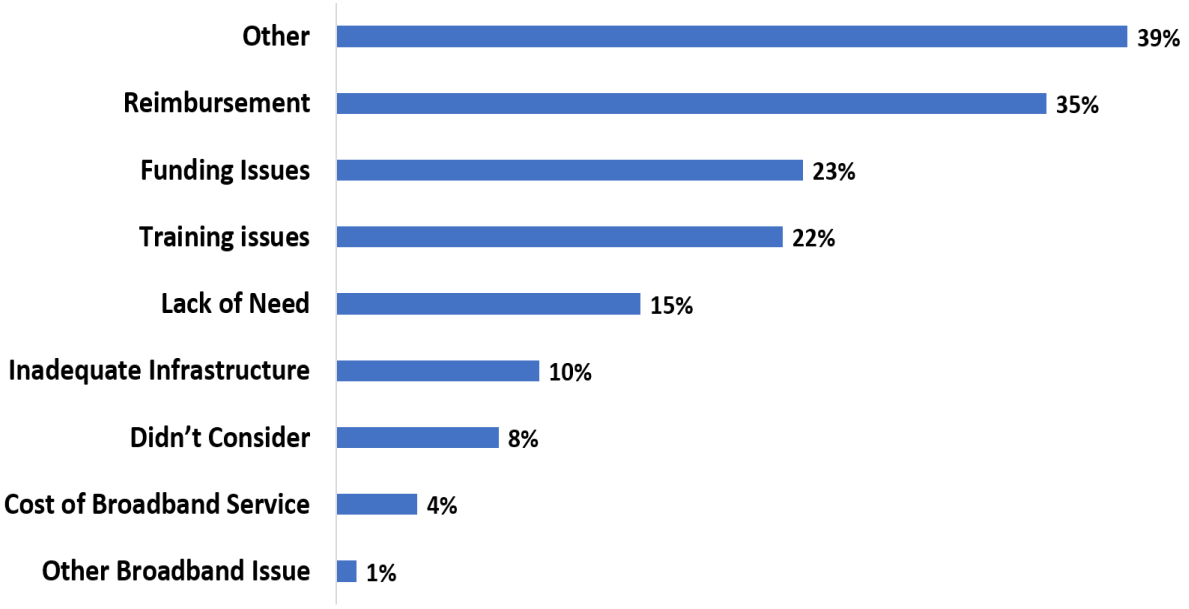
Notes: U.S. overall percentage includes health centers in U.S. territories.
Source: HRSA COVID-19 Survey (data as of April 10), published April 17, 2020. https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data

Figure 2. Telehealth Services Offered by Community Health Centers in 2018



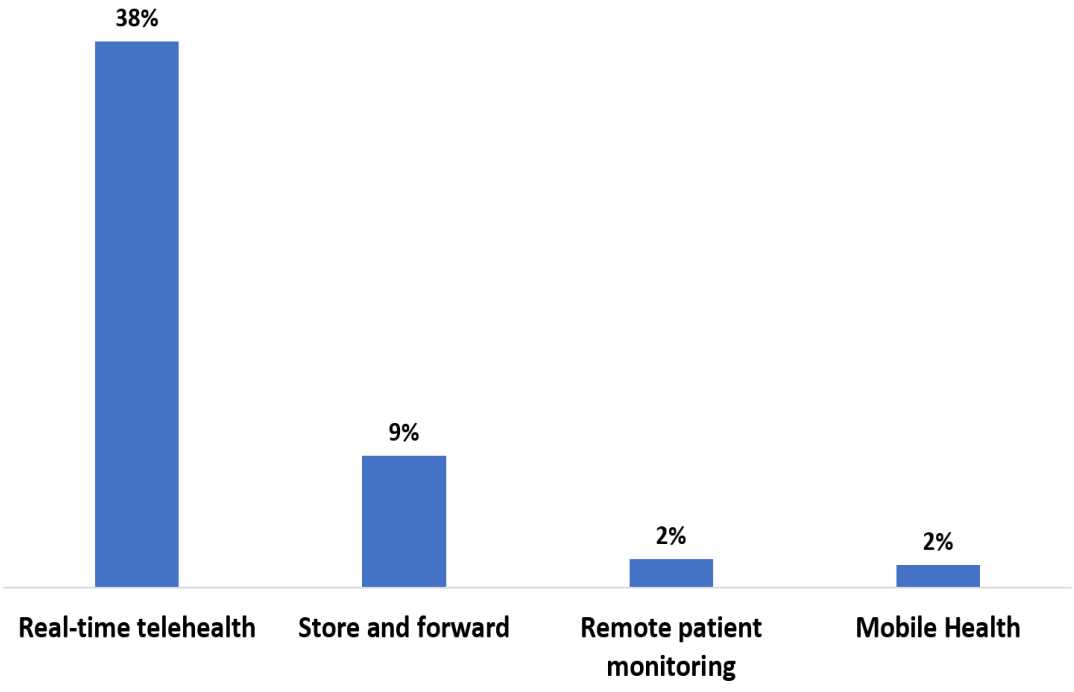
Source: GW analysis of 2018 Uniform Data System data

Figure 3. Barriers to Telehealth Implementation Reported by Community Health Centers in 2018



Source: GW analysis of 2018 Uniform Data System data

Figure 4. Telehealth Technologies Used by Community Health Centers in 2018



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