FEHB Program

All FEHB Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

Health Matters Newsletter: Telehealth

Newsletter No. 2022-01 **Date: July 14, 2022**

Background

Telehealth (TH) or Telemedicine is the delivery of healthcare services virtually by electronic communication without the requirement for patient and provider being in close physical proximity. Prior to the Public Health Emergency (PHE) declared by HHS on January 31, 2020,[1] TH was generally viewed by patients and providers alike as an adjunct to usual "in person" care for those living in rural locations, as a way of providing greater access to specialty care to those far away from urban centers, and as a more convenient way of accessing care for tech-savvy consumers. Prior to the PHE, traditional Medicare covered TH services for only beneficiaries living in defined rural areas. Providers, type of services received, and the place where these TH services were received were all limited by CMS.[2] More esoteric applications included medical care for researchers in remote Arctic and Antarctic bases.

Although TH services have been covered by some health plans and providers for many years, uptake prior to the PHE had previously been slow.[3] Healthcare and Insurance (HI) first encouraged expansion of TH services to Federal Employees Health Benefits (FEHB) Program members in its 2016 Call Letter[4] and reiterated support in the 2017 and 2021 Call Letters.[5],[6] With the COVID-19 PHE, however, TH gained rapid acceptance from both patients and providers with TH use stabilizing at about 38 times pre-pandemic levels as of February of 2021.[7] Similarly, in traditional fee-for-service Medicare, TH accounted for 0.1% of primary care visits prior to the PHE, but 40% at the peak.[8] Within the FEHB Program, Carriers self-reported a one-year TH median increase (from 2019 to 2020) of 2799% in primary care, 101% in urgent care,

[1] Secretary Azar declares Public Health Emergency
[2] Medicare and Telehealth: Coverage and Use During the COVID-19 Pandemic and Options for the Future
[3] Telehealth Rises to the Challenge During the COVID-19 Crisis
[4] 2016 FEHB Program Call Letter
[5] 2017 FEHB Program Call Letter
[6] 2021 FEHB Program Call Letter
[7] Telehealth: A quarter-trillion-dollar post-COVID-19 reality?
[8] Fad or future? Telehealth expansion eyed beyond pandemic

6325% in specialty care, 3449% in behavioral health, 2326% in behavioral health and 500% in remote monitoring.[9]

Increased use of TH has also been accepted by behavioral health care providers and their patients.[10] It has been shown to be as effective as in person visits, while decreasing costs, improving access, and decreasing stigma[11,12].

The Present

TH has the ability to provide advanced specialty services to patients who are physically distant from specialty sites. These include Telestroke services[13] where a patient may present to a smaller community hospital but has access to stroke specialists at distant centers of excellence. On a less emergent basis, programs such as Project Echo[14] provide a variety of specialty services to those living in rural locations in New Mexico.

The rapid acceptance of TH over the last two years has led many health care analysts[3] to predict that TH will continue to be widely accepted even once the PHE has resolved**. TH is currently in a highly fluid state.** It seems certain that future use will be higher than before the PHE, but unclear if use will remain as high, or if patients and providers will revert to old practice norms. TH does have limitations, most obviously the inability to conduct all but a limited physical exam. This limitation is more important in some medical specialties (e.g., orthopedics) and less so in others (e.g., behavioral health). Technology is also rapidly being developed that will allow more detailed physical exams, such as multipurpose scopes and cameras that allow examination of the ears and throat, devices that transmit heart and lung sounds and even devices that perform EKGs.[15] **Remote patient monitoring** of patients through Wi-Fi--connected glucose, blood pressure and weight scales are now a frequently used tool for monitoring patients with diabetes, hypertension and congestive heart failure respectively,[16] and have allowed more ill patients to receive care at home, reducing the need for inpatient care.

Cost, Quality and Reimbursement

The cost of TH to the overall healthcare delivery system is vitally important yet poorly understood. Pre-pandemic TH studies yielded conflicting results, with some showing a decrease

[9] OPM Healthcare and Insurance Automated Data Collection analysis, 2021
[10] Using Telehealth to Meet Mental Health Needs During the COVID-19 Crisis
[11] Telemental Health Care, an Effective Alternative to Conventional Medical Care: a Systematic Review
[12] How well is telepsychology working?
[13] Telestroke - Telemedicine
[14] Project ECHO - University of New Mexico
[15] The Virtual Physical Exam in the 21st Century
[16] The technology, devices, and benefits of remote patient monitoring in the healthcare industry

in healthcare cost because of **substitution** (using TH to substitute for in-person visits), while others showed an **additive** effect (using TH in addition to in-person visits).[17] More recent studies from data gathered during the pandemic have shown a more pronounced substitution effect, which suggest that TH may decrease healthcare costs.[18] Thus, viewed in aggregate, it is unclear to what extent TH will play a role in health care post-PHE, and what its effect on costs will be.

Also lacking is robust data on quality outcomes using TH. While a critical adjunct to care during the PHE, it is unclear in which clinical situations TH will be able to substitute for in-person visits, and when the necessity of an in-person visit with a complete physical exam is critical for good care.

In addition, as TH broadens from dedicated TH providers (e.g., Teladoc, Amwell) to brick-and-mortar medical practices adding TH into their routine services the cost structure of TH will change as existing practices invest in IT infrastructure, remote monitoring equipment and broadband access, while still requiring sufficient revenue to cover the **high fixed costs** (e.g., rent, utilities, cleaning services, insurance, etc.) associated with their physical practice. While there may be some decreases in clinical personnel costs associated with increased use of TH, the magnitude of these decreases depends on the degree to which TH becomes a substitute for in-person visits as opposed to additional utilization. This may be specialty dependent.[17] Orthopedic surgery practices are likely to have minimal need for TH services, while general pediatric practices may make extensive use of TH. The **aggregate** effect on the national health system is currently unknown.

With the declaration of the PHE, CMS elected to pay for TH visits at the same rate as in-person visits (i.e., payment parity)[19] to minimize disruptions to care and to ease financial burdens on practices. The 2021 Medicare Physician Fee Schedule made coverage for many TH services permanent[20]. Many health plans followed CMS' lead during the pandemic and reimbursed TH visits at the same rate as in person visits. Some health policy analysts are concerned that once the PHE has ended, payment for TH visits may decrease.[21,22]

---

[17] Direct-To-Consumer Telehealth May Increase Access To Care But Does Not Decrease Spending
[18] NCQA - Findings and Recommendations - Telehealth Effect on Total Cost of Care
[19] Medicare Telemedicine Healthcare Provider Fact Sheet
[20] Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients
[21] Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond
[22] JAMA - Implications for Telehealth in a Post pandemic Future

Accreditation Standards

The Joint Commission[23], the National Committee for Quality Assurance (NCQA)[24] and URAC[25] all have quality standards in place and offer accreditation to practices and organizations offering TH services. JCAHO is focused on hospital-based programs, NCQA on payer and medical home programs (both primary and specialty care), and URAC on both provider and payer programs. These standards seek to ensure that TH is integrated into usual care, that it is evidence-based, and provides appropriate privacy and security to patients. These standards will likely continue to evolve over time as TH and remote monitoring technology evolve.

Telehealth and the FEHB Program

OPM has encouraged the provision of coverage for TH services as early as 2016[26] and reiterated its importance as a way of improving access for behavioral health services[27] and medical services during the pandemic.[28]

As Carriers are aware, in the FEHB Program Call Letter[29]and Technical Guidance[30] for 2023, OPM encouraged Carriers to take the following actions:

1. Leverage TH services to improve health equity. This can be accomplished by mitigating transportation difficulties for both rural and urban populations, making complex care more available to populations with limited transportation for both emergent (e.g., stroke) and non-emergent services (e.g., liver specialists).

2. Take steps to assist providers with coordinating care between free-standing TH providers and those who have ongoing medical relationships with members. OPM believes that it is important that Carriers support the efforts of brick-and-mortar practices to incorporate TH into their repertoire of services. OPM also encourages Carriers to continue supporting the efforts of providers to furnish TH to their patients by continuing reasonable agreements on reimbursement.

3. Leverage TH for the provision of mental health and substance use disorder services. Studies have shown that patients can be more comfortable receiving such services in their

[23] Telehealth and the Joint Commission
[24] NCQA Telehealth Accreditation
[25] URAC Telehealth Accreditation and Certification
[26] 2016 Call Letter encouraging the expansion of Telehealth Services
[27] 2021 OPM Carrier Letter encouraging coverage for Telehealth services as part of mental health care
[28] 2021 OPM Carrier Letter encouraging coverage of Telehealth Services during the COVID Pandemic
[29] FEHB Call Letter for Calendar Year 2023
[30] FEHB Technical Guidance for Calendar Year 2023

homes through TH.[31,32] Thus, TH has the potential to both alleviate network scarcity issues by making providers more broadly available and improving the patient experience.

4. Support the expansion of remote monitoring capabilities, which can also improve the quality of care for those with chronic diseases.

TH services, including remote monitoring, offer the ability to provide enhanced services to FEHB members in a more convenient and patient-centered fashion. These services improve access for members who are geographically isolated or have mobility and/or transportation difficulties. Carriers should therefore consider developing a strategic vision and implement a plan that incorporates appropriate high-quality TH into multiple areas of clinical practice, an OPM looks forward to working with Carriers to improve TH services to FEHB members as the technology for TH services continues to improve.

This edition of the FEHB Program Health Matters Newsletter was edited by Ron Kline, MD. Please direct questions or comments to FEHBHealthMatters@opm.gov

[31] Telebehavioral Health - An Effective Alternative to In Person Care

[32] American Psychological Association - How Well is Tele-Psychology Working?