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How telehealth adoption may drive increase in value-based care adoption

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The health care industry has continued to evolve, including its transition from a fee-for-service model to a value-based care model during the COVID-19 pandemic.

The Centers for Medicare and Medicaid Services (CMS)[1] defines value-based care programs as those that reward health care providers with incentive payments for the quality of care provided to Medicare members and rewards providers for both efficiency and effectiveness, which supports CMS's 3-part aim of better care for individuals, improved health for populations and lower costs.

Digital health technologies, including telehealth, have exploded into prevalence, especially in the wake of the COVID-19 public health emergency (PHE), and have proved to be a driver of value-based care models.

Health care providers implementing telehealth technologies are able to reach patients facing transitions in care, close patient gaps in care and track adherence for patients with chronic health issues. By implementing telehealth technologies support, health care providers are able to offer greater access to lower-cost care for low-acuity patient encounters, thereby benefitting from value-based care models.

There are varying definitions as to what constitutes "telehealth" at the federal and state legislative levels.

At the federal level, the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS)[2] defines "telehealth" as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education and public health and health administration.

Technologies generally include synchronous audio-video, store-and-forward imaging, streaming media and landline and wireless communications.

Meanwhile, telehealth services reimbursed by Medicare are the services defined in Section 1834(m)[3] of the Social Security Act and are furnished via real-time, interactive communication technology.

States vary on what constitutes telehealth, but it can include all types of technologies and modalities of care, including synchronous audio-video, asynchronous modalities, audio-only, remote patient monitoring, exchange of data and images.

Observations during the COVID-19 public health emergency

While the health care industry embraced the adoption and utilization of telehealth technologies prior to the PHE, federal waivers and statewide emergency order declarations that allowed for flexibility and relaxed requirements relating to licensure, modality of care and more favorable reimbursement for telehealth vastly increased the adoption of telehealth across the country.

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Specific subspecialties have seen a particular increase in the utilization of telehealth. For example, telehealth use among Medicare Advantage enrollees soared among primary care practices with value-based payment models.

Behavioral health providers also saw an increase in utilization and claims activity during the PHE. According to data from McKinsey & Company,[4] psychiatry visits increased by 50%, and substance use treatment visits increased by 30%.

It's anticipated that the increased utilization and reliance on telehealth technologies will continue after the expiration of the PHE. A recent JAMA study[5] found that most study participants were willing to use video visits in the future.

In the same study, it was noted that when presented with the choice between an in-person or a video visit for nonemergency care, most preferred in-person care, highlighting telehealth utilization as a supplement (rather than a replacement) to traditional care delivery.

Notably, willingness to pay for preferred visit modality was higher for those who preferred in-person care, and those who preferred video visits were more sensitive to out-of-pocket costs.

Similar to the observations with telehealth adoption during the pandemic, value-based care models also saw increased utilization and adoption.

For example, according to a Spyglass Consulting Group report,[6] 88% of health systems and hospitals surveyed have invested or plan to invest in remote patient monitoring solutions to support their organizational transitions to value-based care.

Notwithstanding the push to value-based care, several obstacles to an increased adoption of value-based care models remain.

For example, a recent American Medical Association (AMA) article[7] described various challenges relating to contracting models for value-based care arrangements, including that more employers are entering into direct contracts with physician practices, health systems and others, targeting annual total cost of care and shared costs with doctors and their administration. Meanwhile, pharmacy and behavioral health are becoming progressively integrated with other costs.

Relatedly, an increased adoption of alternative payment models is expected post-PHE.

For example, Health Payer Intelligence[8] discussed a recent study in which 91% of payers predicted alternative payment model activity increases in the coming years. Nearly all health plans surveyed (95%) strongly agreed that such adoption would improve care coordination and 97% thought that it would bring about higher quality care, according to the article.

The article also noted several challenges to adoption of alternative payment models, including concern regarding providers' willingness to accept additional financial risk and whether there is a willingness amongst providers to adopt alternative payment models more generally.

Notably, in addressing the challenges of value-based care models, some physician practices revised their payer contracts to mitigate downside risk or shift some risk to partners, including hospitals or device manufacturers.

Notwithstanding the challenges to the increased adoption of value-based care models, the health care industry saw significant growth and adoption of these models during the pandemic. Telehealth adoption has proved to be a catalyst for value-based care models as telehealth enables providers to offer preventive care in the lowest-cost care settings and avoid worse health outcomes in the future.

As the PHE expires and most states continue ending their emergency orders, there remain obstacles to increased adoption and continued growth of both telehealth and value-based care. Addressing these obstacles, such as the adoption of expanded modalities of care and risk allocation in payer contracts for value-based care arrangements, will be critical in the future adoption and growth of these models.

Notes

[1] https://go.cms.gov/3Nw0QkO

[2] https://bit.ly/3xbVKTH

[3] https://bit.ly/3Q3BgoS

[4] https://mck.co/3tHnjUb

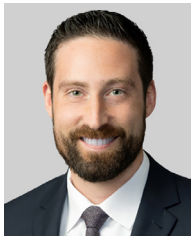
[5] https://bit.ly/3miYael

[6] https://bit.ly/3aycLja

[7] https://bit.ly/3xdDd9r

[8] https://bit.ly/3Q3CGQe

About the authors



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