Using Telehealth to Enhance Current Strategies in Alternative Payment Models
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The coronavirus disease 2019 (COVID-19) pandemic has driven clinicians and organizations around the country to expand their telehealth capabilities. Video and audio services were critical early in the pandemic, when individuals delayed in-person care and health care practitioners halted nonurgent services, actions that collectively plummeted clinic and hospital visits. Although in-person care recovered in the following months, telehealth has remained a critical tool while clinicians faced multiple waves of COVID-19 surges. These dynamics highlight how telehealth will remain a key element of patient care going forward, both in future waves and after the pandemic ultimately subsides.

In particular, telehealth may play an increasingly important role in alternative payment models (APMs) that are designed to improve quality and contain costs through better coordination. Telemedicine increases clinicians’ ability to work together and with patients to coordinate care—an overarching goal of APMs. Policy experts have increasingly recognized telemedicine’s potential impact on APMs, with groups like the Physician-Focused Payment Model Technical Advisory Committee and the Medicare Payment Advisory Commission dedicating time to the topic in recent meetings. In this article, we use 3 examples to illustrate this potential, highlighting how telehealth can enhance strategies that have shown promise or established benefits in APMs.

Improving Primary Care Access

Between 2012 and 2016, Medicare used the Comprehensive Primary Care (CPC) initiative to encourage practices to implement 5 functions of comprehensive primary care, including access and continuity. Although a formal evaluation of CPC did not demonstrate cost savings or quality improvements in many areas, practices participating in CPC did exhibit slower growth in emergency department visits than nonparticipating practices.1

While exact mechanisms remain unclear, existing evidence supports the possibility that lower emergency department visits could be associated with expanded access, a benefit observed in primary care innovations in the United States and the United Kingdom.2,3 In future APMs, policy makers can use telehealth to explore the promise of reducing acute care utilization via expanded primary care access.

Historically, efforts to increase access have been resource intensive, requiring expanded staffing and operations. Telehealth strategies, such as on-demand visits, text-based symptom surveillance, and remote monitoring, could expand access more cost efficiently. Telehealth could also expand access in ways that are more upstream (eg, identifying patient symptoms before they become severe enough to require in-person care) and patient centered (eg, increasing access without rearranging schedules, finding transportation, and making appointments).

To achieve this potential, APMs must create quality measurement and incentives around telehealth, not simply encourage its use. Even though CPC provided participants with the flexibility to use telehealth, it was not featured prominently in the program. One way would be to emphasize telehealth among individuals for whom evidence of benefit is greatest, such as among those with mental health conditions or chronic disease and high risk of acute care utilization.4,5 Another way would be to tie telehealth to financial incentives, such as a portion of a per-member-per-month
payment. Both strategies would also require the creation of specific telehealth-based metrics for access, patient experience, and appropriateness.

Improving Quality Through Population Health Management

During the last decade, Medicare has scaled up accountable care organizations (ACOs) as a type of APM that seeks to increase value through population health management. Although ACOs are designed primarily with cost savings in mind—success has generally been defined by reduced spending—they have also demonstrated quality improvements in Medicare and commercial programs.

Telehealth could build on ACO infrastructure and personnel investments, using audio-based or video-based visits to enhance quality improvements generated from population health management. For instance, increased quality in the Blue Cross Blue Shield of Massachusetts’ Alternative Quality Contract included chronic disease management measures (eg, blood pressure control for patients with hypertension, glucose control for patients with diabetes). Both measures could be improved through real-time or asynchronous virtual visits and monitoring, strategies that reduce barriers to patient-clinician communication and the ability to monitor symptoms and coordinate care.

Containing Costs by Redesigning Discharge Decisions

Discharge decisions have been a source of cost savings in prior APMs. For instance, under population-based payment models such as ACOs, cost reductions were driven in part by reduced skilled nursing facility use. Similarly, episode savings observed under surgical bundled payments were due in part to changes in discharge decisions and shifts away from institutional postacute care and toward discharge home. To date, APM participants have achieved cost reductions by increasing clinical integration between hospitals and other health care practitioners, including postacute care facilities (eg, joint training, cross-staffing, the creation of preferred networks).

Telehealth could enhance the effectiveness of these integration strategies. For example, teleplatforms can allow more rapid, cost-effective ways to conduct joint training between hospital and postacute care teams. Telehealth could also reduce barriers to cross-staffing (eg, hospital-based physicians can conduct televisits with patients admitted to postacute care facilities) and communication between hospitals and postacute care facilities.

The Challenges Ahead

Despite these potential benefits, policy and practice leaders must overcome several challenges to effectively use telehealth within APMs. First, patients must be able to access these services—no small task given the digital divide between individuals who have digital literacy, internet coverage, and technology access and those who do not. Neglecting these issues could exacerbate health care disparities.

A second challenge is ensuring that clinicians have requisite telehealth infrastructure. While many have rapidly built capacity due to COVID-19, telehealth infrastructure could still vary based on the type (eg, phone-only vs video) and purpose (eg, preventive counseling vs acute illness diagnosis) of services delivered. A particular concern is ensuring patient privacy and data security via Health Insurance Portability and Accountability Act–compliant telehealth applications.

Third, leaders must monitor for fraud and other inappropriate telehealth use, issues that may be more problematic for telehealth than in-person services. To overcome these barriers, policymakers also need more data about how different types of telehealth affect outcomes and disparities.
Conclusion

There are no silver bullets in health care transformation. Telehealth is also not a panacea: it has limitations and does not obviate many in-person services. Nonetheless, by enabling more convenient, cost-efficient communication and care coordination, telehealth is poised to improve payment reform by enhancing strategies identified through prior or current APMs.

ARTICLE INFORMATION

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