



Telehealth and Alternative Payments Models: Implications for Health Disparities

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Health Innovations (B) Working Group

a charge from the Special (EX) Committee on Race and Insurance

... will evaluate mechanisms to resolve disparities through improving access to care, including the efficacy of **telehealth** as a mechanism for addressing access issues; the use of **alternative payment models and value-based payments** and their impact on exacerbating or ameliorating disparities and social determinants of health; and programs to improve access to historically underserved communities.



Related Reports

- Kelly D. Edmiston and Jordan AlZuBi, "An Overview of Telehealth and Its Implications for Health Disparities" (subject to revision)
- Kelly D. Edmiston and Jordan AlZuBi, "Issue Brief: Alternative Payment Models and Health Disparities" (forthcoming)



Telehealth and value-based payment systems have ***significant potential*** to improve health outcomes for the underserved and reduce socioeconomic and demographic disparities in health and healthcare, but ***they must continue to evolve for that potential to be fully realized.***

Telehealth

Key Takeaways





Key Takeaways - Telehealth

- Lack of access to healthcare invariably leads to worse health outcomes.
- Disadvantaged and marginalized populations are more likely to be ***physically isolated from healthcare providers*** and to have ***limited transportation options***.
- Telehealth has great ***potential to enhance access to healthcare*** in these cases.
- Telehealth also could provide ***access to culturally competent care*** that is not otherwise available.
- Among its applications, telehealth has been found to be especially effective in the management of chronic health conditions that disproportionately affect more vulnerable populations.



Key Takeaways - Telehealth

- But a **divide** in broadband access and digital literacy **limits telehealth's potential** to reduce these disparities in access to care.
- As is usually the case with the diffusion of new technologies, more advantaged populations are **better positioned** to benefit from increased utilization of telehealth.
- But increased telehealth utilization will **increase access to care for some underserved individuals**.
- Disparities **could** widen, but the end goal of reducing health disparities is "pushing up from the bottom" to **alleviate the burden of disease for the disadvantaged and underserved**.



Key Takeaways for Regulation – Telehealth

- Telehealth utilization will need to reach a **critical mass** before it is cost-effective in most cases.
- Telehealth has significant upfront costs, which means investments must be made. To continue to and further engage in telehealth, there will need to be some **certainty** around **coverage** and **parity**.
- Coverage of audio-only telehealth would likely lessen problems of the digital divide.
- Insurers could be incentivized to invest in broadband infrastructure through regulatory treatment.
 - Recent work by CIPR shows that insurance company investments in infrastructure-backed assets outperform other investments. ([Can Insurance Company Investments Help fill the Infrastructure Gap?](#) September 2021)

Alternative Payment Models

Key Takeaways



Key Takeaways – Alternative Payment Models (APMs)

- Traditional Fee-for-Service (FFS) payment models **incentivize overtreatment** and **disincentivize care for vulnerable populations**
 - Patients do not pay the full cost of their medical care, leading to ex-post moral hazard and likely inefficient use of limited healthcare resources.
 - Vulnerable populations disproportionately require **low-margin care** (e.g., management of chronic health conditions like diabetes, hypertension, and behavioral health issues).
- Common APMs also are largely **volume-based**. In the absence of **specific promotion** of high-quality, cost-efficient care, they have their own set of perverse incentives
 - Bundled care (e.g., post-1983 Medicare) and capitation plans (e.g., HMO) can **incentivize undertreatment** and **cream-skimming** [vulnerable populations typically have poorer health outcomes and often require more costly care, all else equal]



Key Takeaways – Alternative Payment Models (APMs)

- Our primary subject of interest is the set of APMs known as **Value-Based Payment (VPB) Models**.
- **“Value”** has a quality component and a cost component. The goal is maximum health benefit for the least total (opportunity) cost. VBP models ostensibly promote high-quality, cost-efficient care by **incentivizing value**.
 - Social Security Act (§1115A): DHHS can scale-up payment programs only if the expansion is expected to **“reduce spending . . . without reducing the quality of care” or “improve the quality of patient care without increasing spending.”**
- A VBP option can be a component of any reimbursement plan, including FFS.
 - Reward high quality and/or cost-efficiency with additional compensation and/or penalize the lack of it.
- In an ideal world, providers would respond to the VBP system by improving coordination and integration of care, which is **particularly effective for chronic disease management**.



The specter of disparities looms large over value-based payment. There are ***no convincing data that payment programs have reduced the inequity that affects marginalized populations***, such as racial and ethnic minorities and socioeconomically vulnerable individuals. Instead, ***payment models could worsen disparities for these groups***.

Liao et al., 2021, JAMA



Key Takeaways - Alternative Payment Models (APMs)

- Under VBP, the highest-cost beneficiaries present the ***greatest opportunities for cost savings***, such as reducing ED visits for easily modified conditions.
- But VBP models have the ***potential to be harmful***.
 - Because vulnerable populations tend to have poorer health outcomes and require more costly care, ***the incentive inherent in VBPs is to avoid them***.
 - The causal factors for these disparities often are social determinants of health outside of providers' control, and providers should not be penalized for what they cannot control.
 - Social risk factors are in place to account for these factors, but many physician-researchers suggest they are ***not sophisticated enough to properly incentivize care*** for those at most risk for poor outcomes and high-cost care.
- But with ***optimal contract designs***, VBP hold much promise for better serving the health needs of the traditionally underserved.



Telehealth

**Telehealth and Alternative Payments Models:
Implications for Health Disparities**



What Do We Mean by “Telehealth”

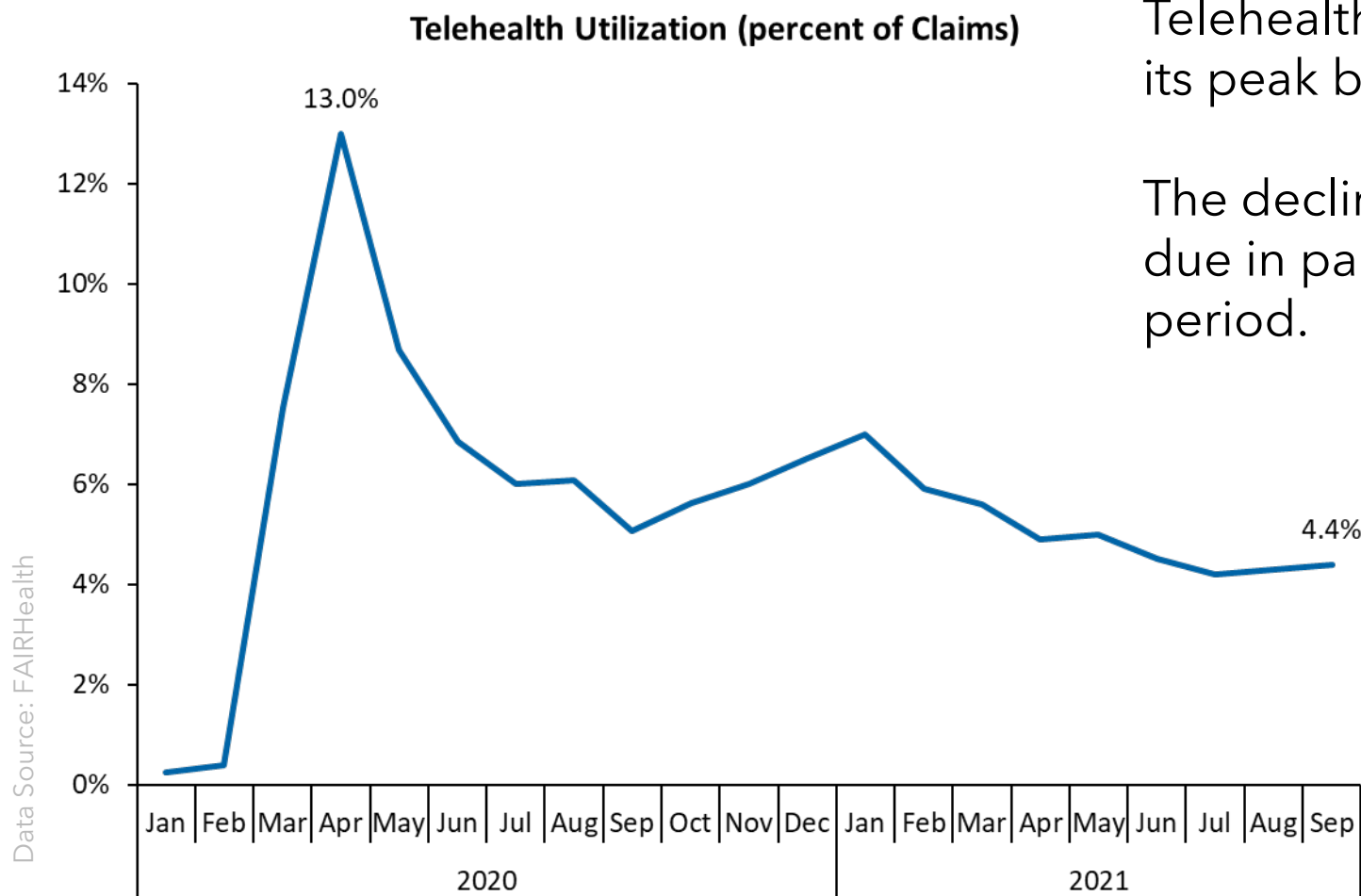
In general terms, “telehealth” refers to ***the use of medical information exchanged via electronic communications to support and provide health care.***

The key characteristics of telehealth are (1) it involves the use of information and communications technologies (ICTs) and (2) it is delivered outside of traditional facilities.

We focus on ***direct provider-to-patient interactions via videoconferencing*** (virtual visits, or telemedicine). But we also consider other forms of telehealth, such as ***remote patient monitoring.***



Recent Trends in Telehealth Utilization

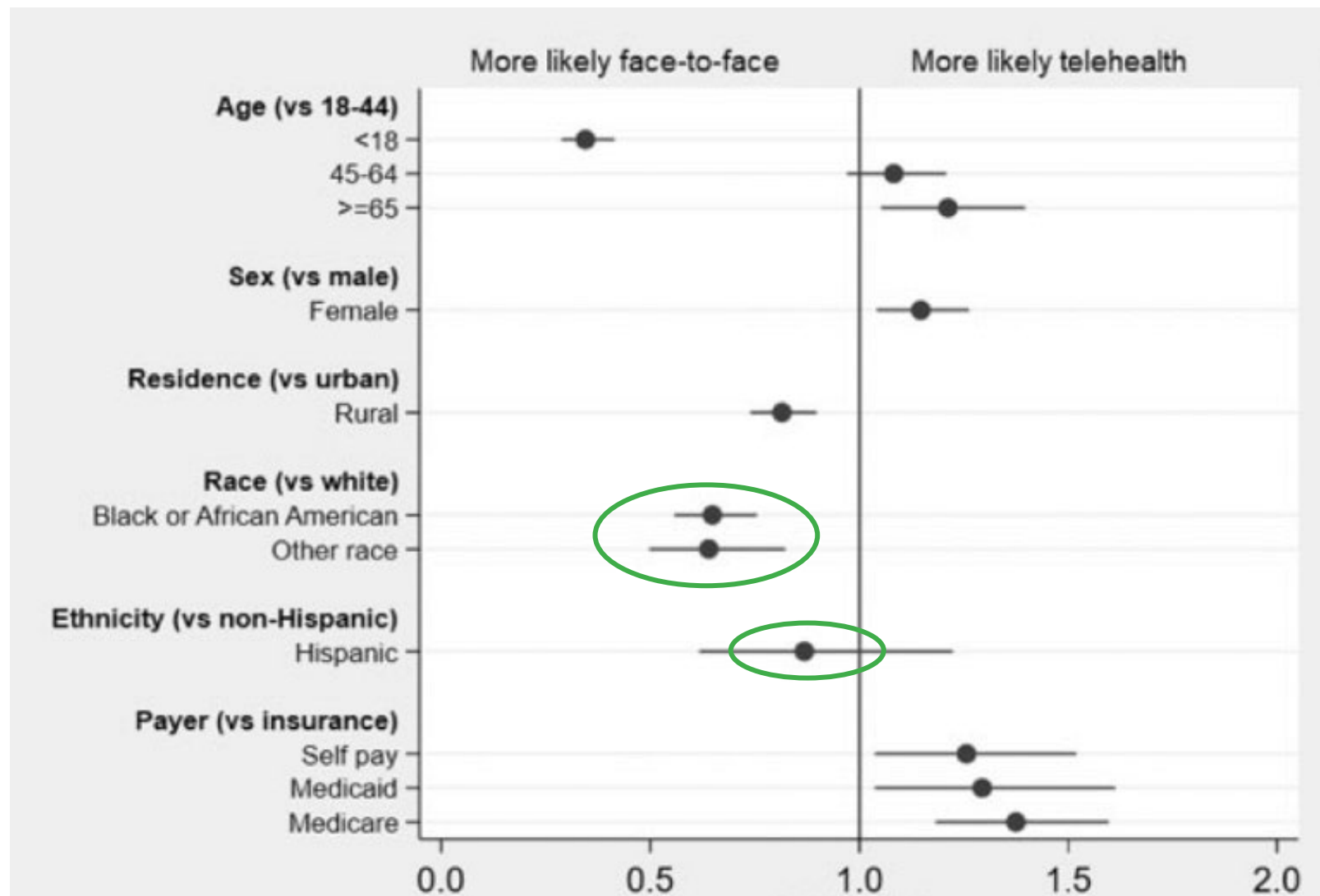


Telehealth as a share of claims is down from its peak but seems to have leveled off.

The decline in the share of claims is likely due in part to higher total claims in the later period.



Telehealth Utilization Since the Onset of COVID-19



Heaviest users of telehealth are:

- Older
- Female
- **Urban**
- **White**
- **Non-Hispanic***
- Not privately insured

*not statistically different

Source: Pierce and Stevermer (2020)

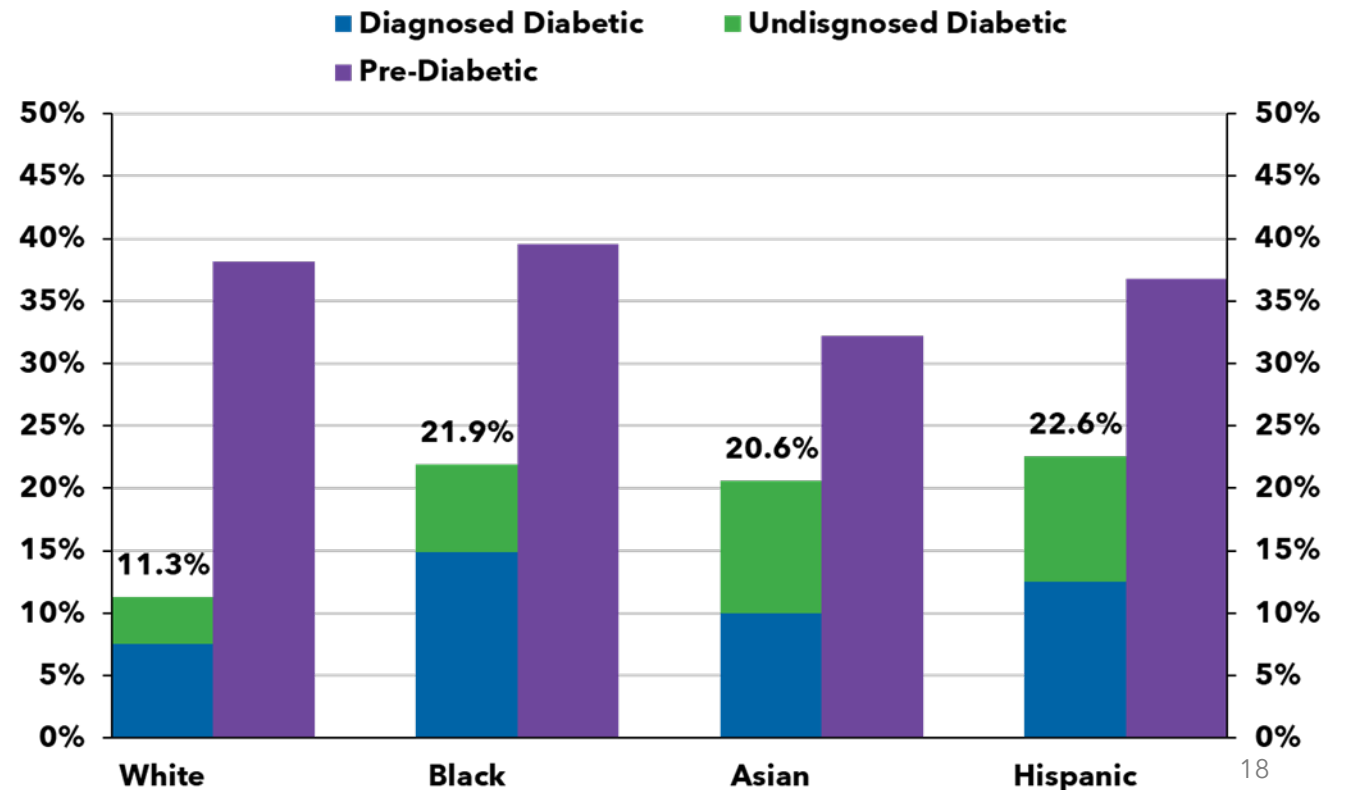


Cost-Effectiveness

- Telehealth can be as clinically effective or more clinically effective than usual care.
- But there is variance in efficacy across use cases and specific modalities.
- Due to implementation cost, some **threshold level of use must be met** for the technology to be cost-effective.

Disadvantaged and marginalized populations suffer disproportionately from these chronic conditions such as diabetes, hypertension, and mental health issues.

Research shows telehealth is particularly effective for monitoring and managing these chronic conditions.





For Some, Telehealth Means Access to Care

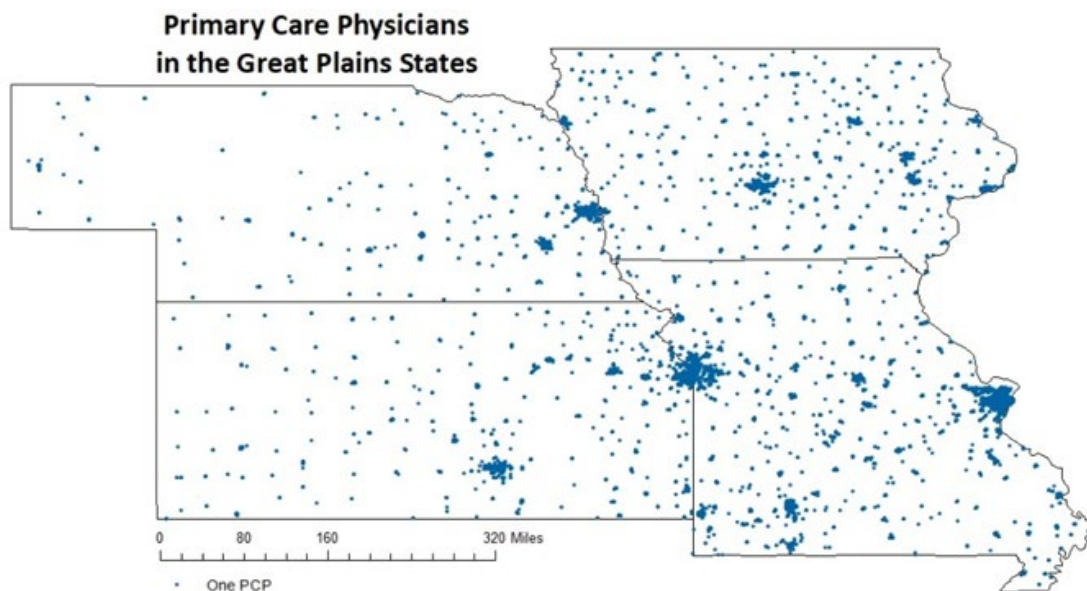
The greatest potential for telehealth to ameliorate disparities in health outcomes is to **improve access to healthcare**.

Those with the least (physical) access to care typically are among the most disadvantaged and marginalized.



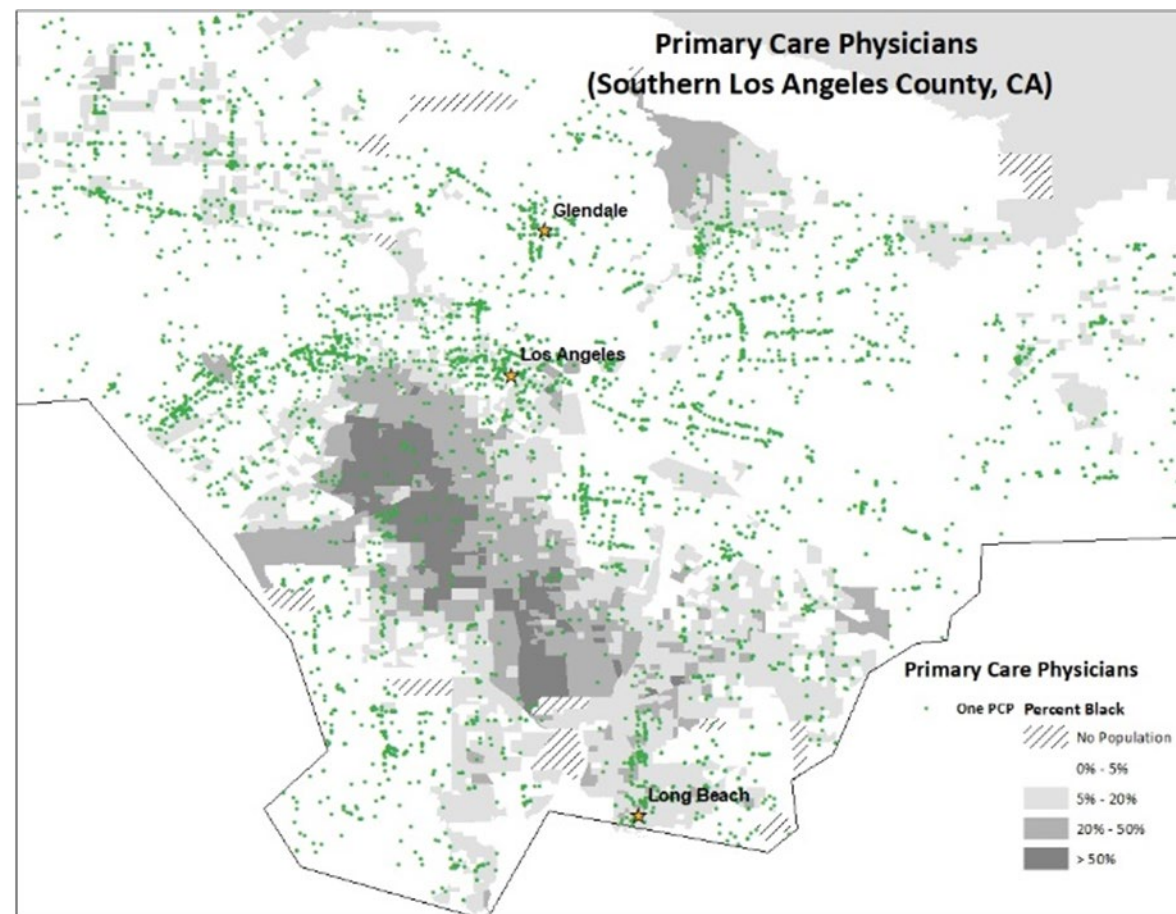
Access to Care

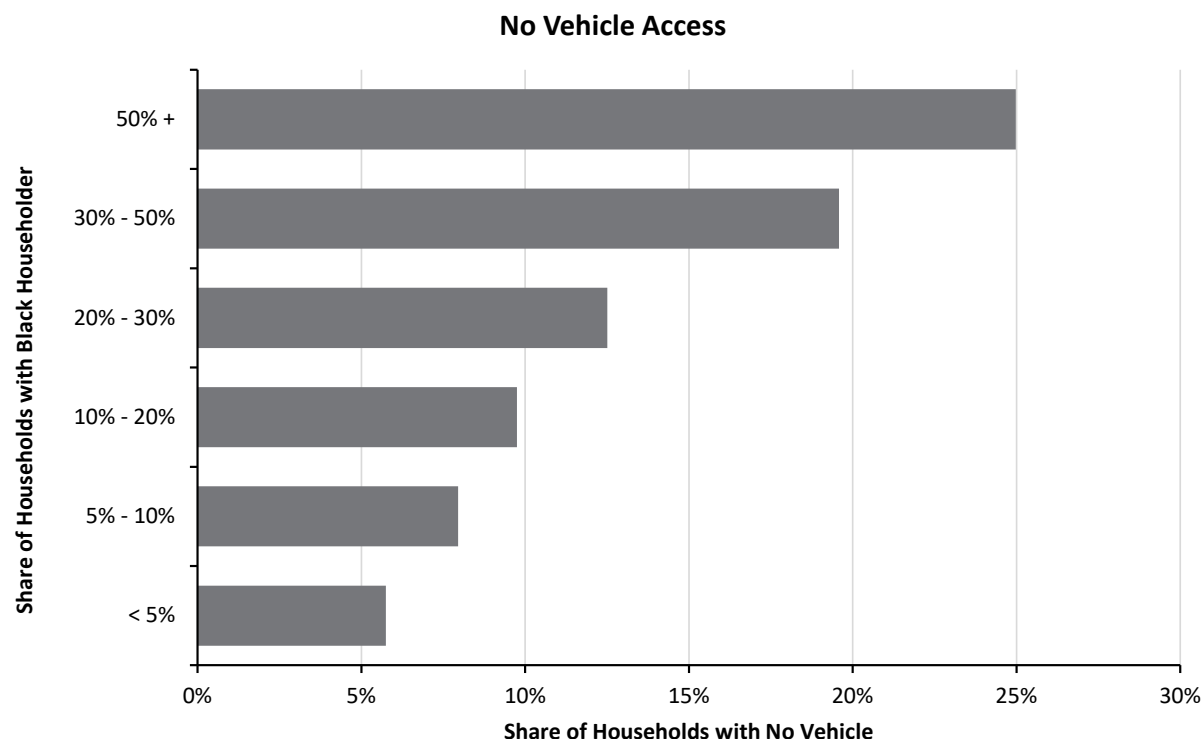
Primary care physicians are sparsely located in most rural areas



Some counties have no primary care physicians. Many others 1 PCP per 1,000 - 2,000 residents.

Primary care physicians are sparsely located in areas where minorities are concentrated





Transportation

Walking or using public transportation to receive healthcare is a **significant, independent predictor of not having a regular source of care**. Patients who do not use private transportation are **significantly more likely to delay receiving healthcare**.

Urbanicity	No Vehicles	1 Vehicle	< 2 Vehicles	2+ Vehicles
Urban	4.9%	28.1%	33.0%	67.0%
Suburban	5.9%	33.0%	38.9%	61.1%
Rural	14.0%	38.0%	52.0%	48.0%



Other Aspects of Access to Care

Often vulnerable populations have access to healthcare *ipso facto*, but they lack access to ***culturally competent care***.

- Language

- Non-gender-conforming

- Historical mistrust of the medical profession by some African-Americans



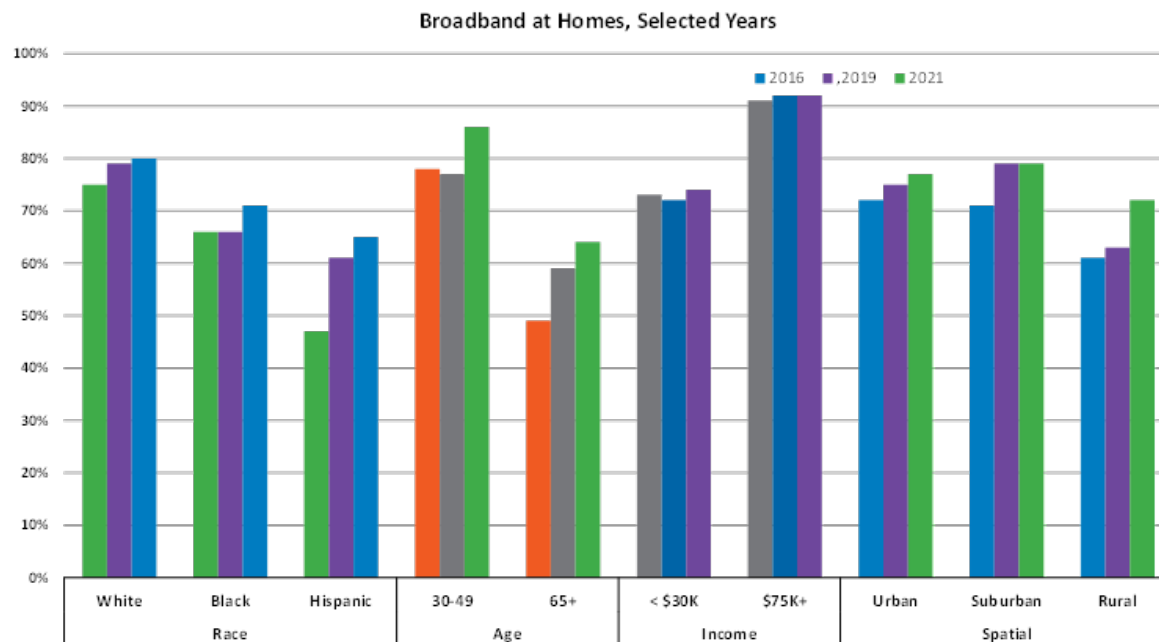
Limitations of Telehealth to Ameliorate Disparities

The major limitation to gaining access to care through telehealth for disadvantaged and underserved groups is the **digital divide**.

This divide includes disparate **access to broadband at home**, necessary for private provider-to-patient videoconferencing, and disparities in **digital literacy**.



Underserved populations are less likely to have access to broadband at home.



Research finds disproportionately low digital literacy in the health context among the less educated and members of racial or ethnic minority groups.

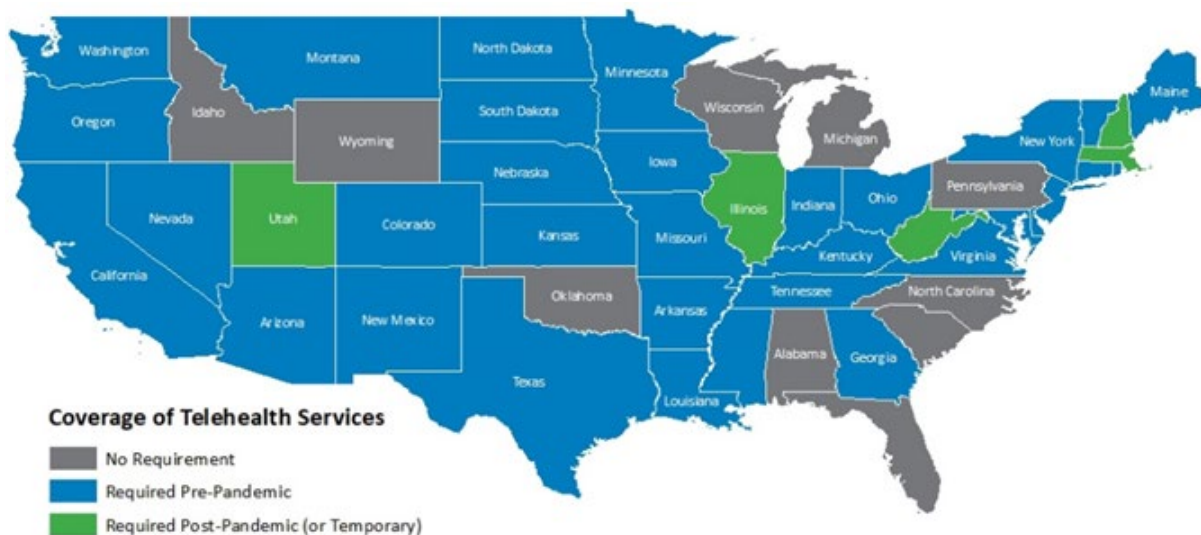


Photo: doctordisability.com

Trends in Telehealth Insurance Regulation Telehealth



As of March 2021



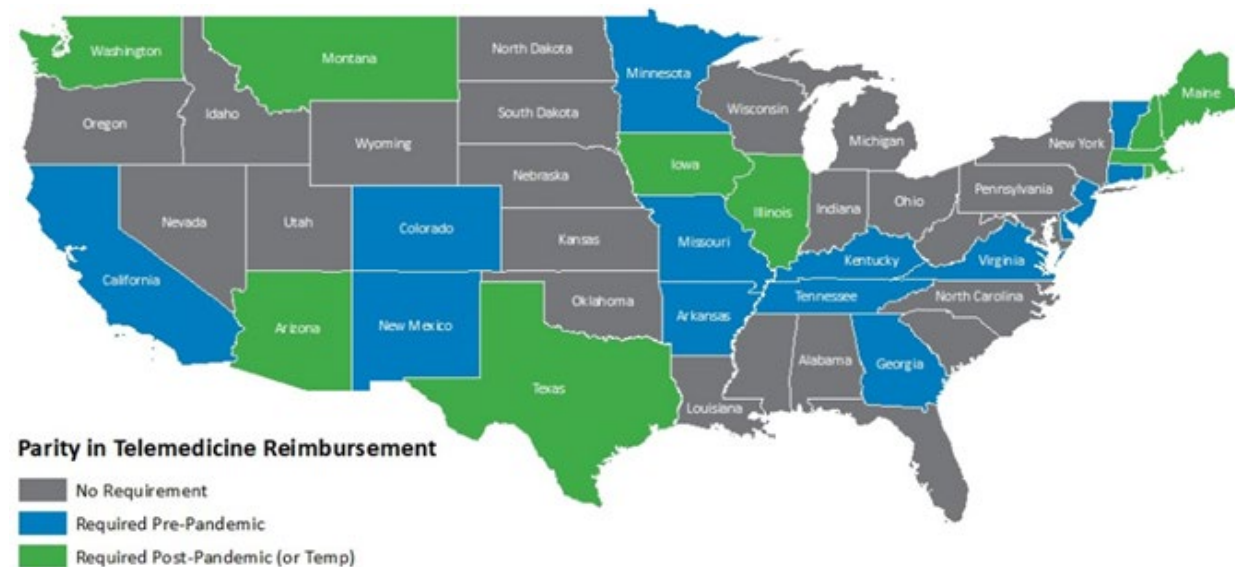
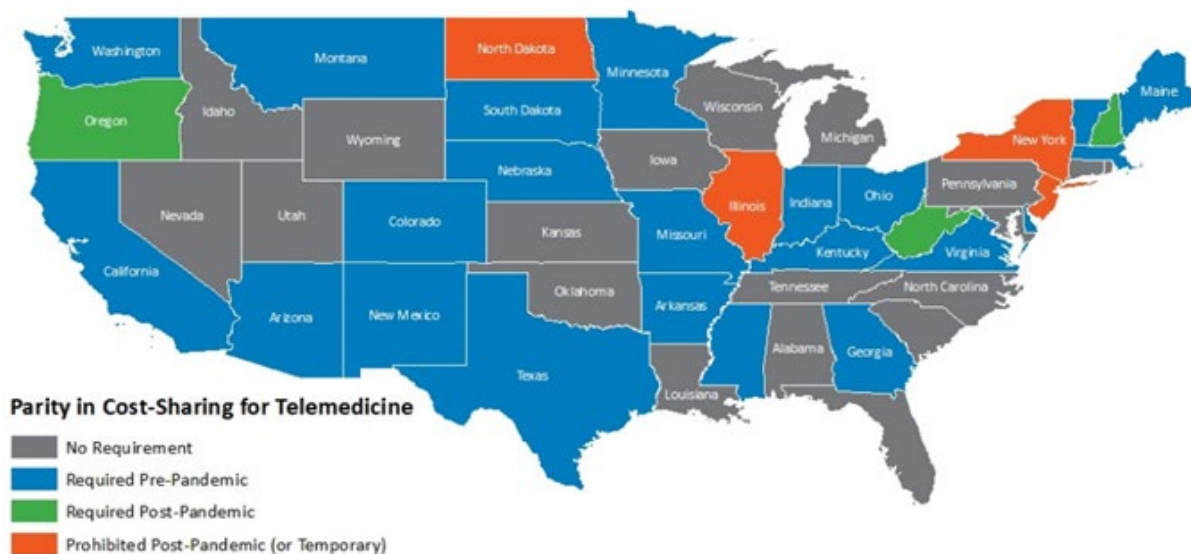
Most states required telehealth coverage before the pandemic.

Few states required coverage of audio-only visits before the pandemic, but numerous states implemented this regulation after the pandemic's onset.



As of March 2021

Several states required parity in cost-sharing before the pandemic, but half still do not.



Many states required parity in cost-sharing before the pandemic, but a significant number of states still do not.



Trends in Telehealth Insurance Regulation

- There is significant ***diversity across states*** in the regulation of insurers' coverage of telehealth.
- Several states have temporary requirements in place with ***near-term sunset dates***.
 - To date, requirements have been extended in most states when sunset has been reached, but rarely have they been made permanent.
- With many temporary requirements in place, there is ***significant uncertainty around telehealth regulation***.
- Requirements unrelated to insurance coverage, including licensing issues, privacy concerns, and prescribing restrictions add to the uncertainty around insurance regulation.
- A transition to telehealth requires ***substantial upfront costs in technology and training***, and ***investment is highly sensitive to uncertainties***.

Please reach out with question or for additional information.

Our work is fluid - feedback and ideas are always welcomed.

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