August, 2022

CASE STUDY: CARE ANYWHERE

Protecting Access to Quality Care

An Integrated System Multiplies the Value of Telehealth

Introduction

Baylor Scott & White Health Plan (BSWHP) is the nonprofit, community health plan of Baylor Scott & White Health, the largest nonprofit, fully integrated delivery system in the state of Texas with over 50 hospitals, 7,000 physicians and 1,000 clinical sites. Based in Temple, Texas, BSWHP has approximately 400,000 Medicaid, Medicare, exchange, non-exchange and commercial members across 171 of Texas' 254 counties.

History of Digital Care

Pre-Pandemic Digital Care

While digital care modalities (e.g., telemedicine, telehealth, e-visits) have been on the market for decades, minimal demand for telehealth services from health plan members existed prior to the pandemic. Governmental policies that restrict telehealth and telemedicine, as well as slow technological adoption by providers, contributed to this limited marketplace.

Many state governments only recently relaxed regulatory impediments to the delivery of telehealth services. Texas removed the requirement of an in-person visit prior to virtual visits in 2017— one of the last states to do so. Due to these impediments, the evidence base for the outcomes and effectiveness of telehealth and telemedicine is still in development.

Pandemic Digital Care Expansion

When the pandemic disrupted care delivery, stakeholders turned to digital care to maintain patient access without risking exposure and further burdening hospitals.

As part of the pandemic response, BSWHP contracted with providers to furnish telehealth or virtual visits. BSWH launched a robust video visits platform within the delivery system's virtual platform, MyBSWHealth, adding onto its original capabilities of telephonic visits and e-visits. With 2.2 million accounts and over 2,000 new accounts added daily, patients and providers use the application over 700,000 times monthly.

Due to pandemic-related regulatory flexibilities, the health plan made the necessary configurations to accommodate provider billing and payment for virtual visits. BSWHP covered telehealth with a $0 copayment, whether the service was provided through in-network physicians on MyBSWHealth or through MDLIVE.

What is an e-visit?

Patients with certain low-acuity visits (e.g., acute sinusitis) and COVID-19 triaging (i.e., a provider recommends seeking a test or other care pathway) are eligible for an e-visit.

Patients complete an online five-to-ten-minute adaptive interview about symptoms.

Baylor Scott & White Health providers respond to patient messages within one hour.

Patients can send any applicable prescriptions to their preferred pharmacy.

Benefits of Integration on Telehealth

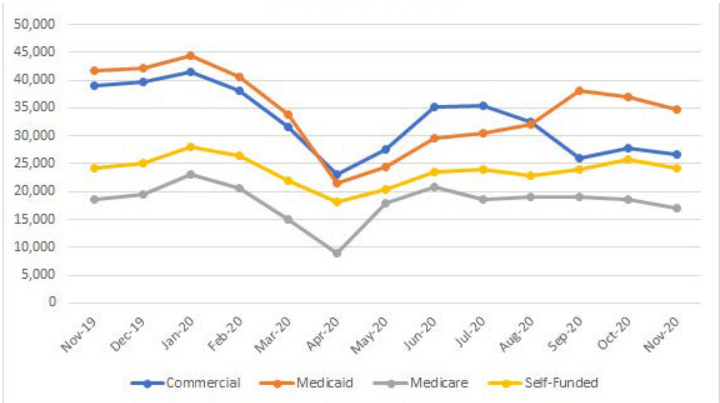
Integrated systems that pair the payer and clinical model are ideally situated to provide digital health services. As part of an integrated delivery system, BSWHP members have virtual access to the delivery system's physicians through MyBSWHealth. This virtual platform, which had been in place since 2017, allows all BSWHP members and delivery system patients to manage their entire care experience virtually—from identifying networked physicians, to scheduling and conducting a visit, to payment. BSWHP used its list of contracted providers furnishing telehealth services to assist members in finding virtual care. Additionally, the health plan reviewed members' records for any gaps in care that could be covered by telehealth options and educated members on scheduling virtual visits.

Analysis

Quality

Immediately before the pandemic, Baylor Scott & White Health had completed a peer-reviewed statistical analysis of its e-visit program to ensure the program was of equal quality to an in-person visit.[1] Specifically, the retrospective analysis examined the rates of misdiagnosis, defined as a change in diagnosis that occurred in a 10-day window following the initial visit, for in-person encounters versus e-visit encounters. The analysis found diagnostic accuracy for low-acuity illnesses in this population was equivalent between e-visit and in-person encounters, with 3.8 percent of in-person and 5.5 percent of e-visit diagnoses being revised—a statistically insignificant difference.

FIGURE 1: Cumulative Office/Clinic Visits

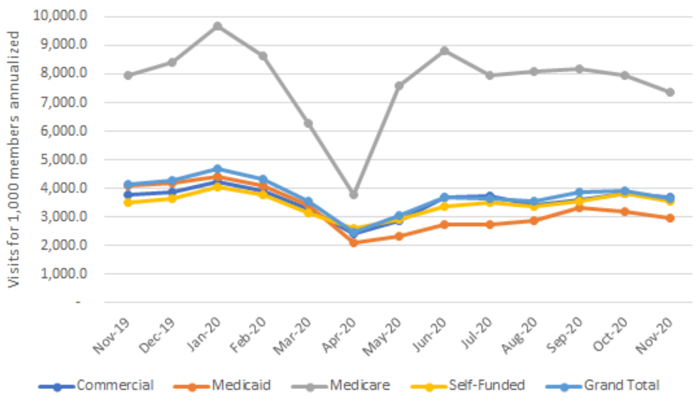


Utilization

BSWHP analyzed demand for in-person office and clinic visits compared to telehealth visits (video, telephone and e-visit) from November 2019 to November 2020 across Medicare, Medicaid, commercial and self-insured products using a sample of BSWHP claims data.

In addition to the total number of in-person visits across product types (Figures 1 and 3), BSWHP examined rates per 1,000 members (Figures 2 and 4) to understand how utilization compared across the health plan's products and with changes to membership throughout the pandemic.

FIGURE 2: Rate of Office/Clinic Visits, per 1,000 members



1. Rhonda Hertzog, et al. "Diagnostic Accuracy in Primary Care EVisit: Evaluation of a Large Integrated Health Care Delivery System's Experience." Mayo Clinic Proc. June, 2016. V94, I6. P 976 -984. https://pubmed.ncbi.nlm.nih.gov/31171135/.

FIGURE 3: Cumulative Telehealth Visits

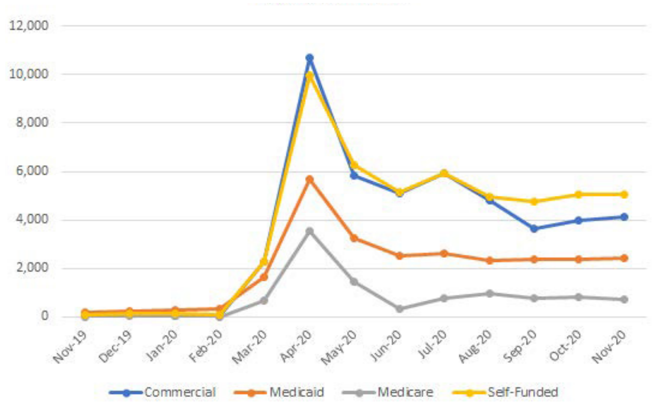
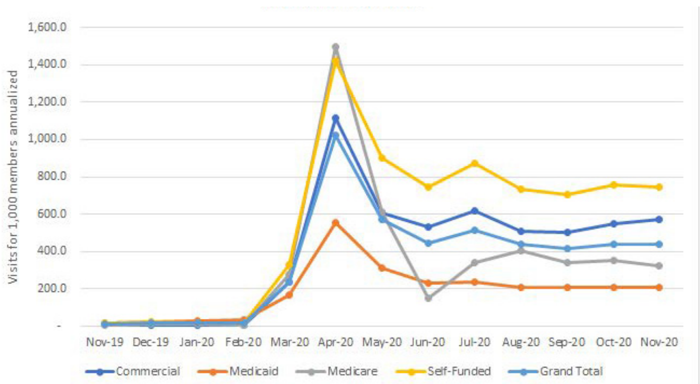


FIGURE 4: Rates of Telehealth Visits, per 1,000 Members



As displayed in Figures 1 and 2, between November 2019 and April 2020, in-person office visits declined 42 percent. BSWHP's largest covered population, Medicaid members, accounts for much of the decreased volume (Figure 1). On an annualized per 1,000-member rate basis (Figure 2), however, Medicare Advantage (MA) members were more likely to halt in-person care, with a 50 percent decline, due to elderly populations' risk-adverse attitude with COVID and the Centers for Medicaid and Medicare Services advice to use telehealth.

While demand for in-person care has rebounded since April 2020, it has not returned to pre-pandemic levels. Across all populations, in-person visits continue to lag approximately 17 percent compared to pre-pandemic levels.

Although the MA population is BSWHP's smallest population in terms of covered lives, the population has the slowest return to in-person care, or 7 percent fewer visits monthly between November 2019 and 2020.

As seen in Figures 3 and 4, telehealth utilization increased approximately 71 percent across all populations between November 2019 and April 2020. Regardless of product line—Medicare, Medicaid, large commercial, or self-funded—consumers demanded virtual care. MA members appeared most likely to substitute in-person care for telehealth during the early months of the pandemic, with a 73 percent increase on a per 1,000-member basis from November 2019 to April 2020.

While telehealth utilization has declined since the April 2020 peak, all populations continue to use virtual care services. November 2020 telehealth visit rate levels for both Medicaid and Medicare populations represent a 10- and 69- fold increase from pre-pandemic levels. Much of the overall increase in demand is related to behavioral health and prenatal care. Additionally, across all populations, telephone, audio-only visits account for most visits during the early stages of the pandemic.

After peak utilization, patients covered by Medicare and Medicaid used telehealth at lower rates than those in commercial or self-funded plans. This was likely related to historically restrictive policies related to reimbursement, standard of care and the inability to use telehealth data for risk adjustment, among other factors. Access to telehealth via broadband or other technologies, especially for rural and low-income populations, is likely another significant determinant for service utilization. Overall, it appears that BSW members had robust access to care through video and telephone modalities, especially for behavioral health services.

Telehealth served to replace care during the pandemic and was well received and adopted by a significant portion of the BSWHP membership, but virtual services did not completely make up the loss of deferred in-person care. In April 2020, BSWHP conducted 29,000 virtual visits, but experienced 65,000 fewer in-person visits compared to pre-pandemic rates. This demonstrates that increased telehealth access does not lead to supply-induced sharp increases in overall health care utilization and costs.

ACHP and BSWHP Recommendations

The future of telehealth, especially for Medicare and Medicaid populations, will largely be driven by governmental policies—continued reimbursement for video and/or audio-only visits, removal of site-of-service and geographic restrictions and allowing plans to use telephone-only data for risk-adjustment purposes. These policies will determine the entire health care system's approach to and integration of telehealth—both in the public and private sectors.

The pandemic showed that digital modalities play a critical role in access to behavioral health services, where a physical exam is often not necessary, as well as care for remote and underserved patients. Without permanent policy changes, meeting this critical role will be challenging. Ultimately, the burden will be placed on providers to determine who can receive virtual care as allowed by insurers, or on patients left to defer and decline care without access to telehealth services. Successful expansion of telehealth in the public and private sectors hinges on government action solidifying regulations surrounding virtual health care.