Telehealth and Value-Based Care Models:

Improving patient access and outcomes while reducing costs

California Telehealth Policy Coalition

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Background on Value-Based Care

Value-based care (VBC) models seek to reimburse providers according to the *quality of care* they provide rather than based upon the quantity of services provided to patients.[1] Instead of reimbursing for each individual service provided, these models give providers responsibility over the total cost of care (TCOC) and delivery of care, in which providers assume some or all of the financial risk associated with the costs of their patients' care. This incentivizes the reduction of health care costs and focuses delivery on outcomes and reimbursement on quality measures.

To be successful, providers need assurance that services are reimbursable to cover the month-to-month expenses associated with operating a medical practice. This was especially evident during the early part of the COVID-19 pandemic, when many practices laid off staff or closed altogether. Expanding and making permanent provider-side reimbursable services–particularly telehealth–empowers VBC providers to better engage patients with proactive, supportive care while covering their monthly expenses. Doing so alleviates the worry about coverage limitations on specific telehealth technologies. In this way, increased provider-side responsibility can reduce costly utilization of Emergency Department visits and hospital-based care, especially for high risk, older patients prone to chronic disease exacerbation. In addition, traditional concerns about expanded reimbursement (e.g., the risk of more reimbursements equating to more spending) are reduced or eliminated.

VALUE-BASED CARE (VBC)	TOTAL COST OF CARE (TCOC)[2]	ALTERNATIVE PAYMENT MODELS (APMs)
Health care delivery in which providers, including hospitals and physicians, are paid based on patient health outcomes or quality metrics. The 'value' in value based is a measure of quality relative to the cost of delivering care.	All payments from payers for health services made on behalf of individuals e.g., physician fees, facility fees, transportation, labs, etc. An example of an organization responsible for TCOC is an ACO.	Health care payment model and service delivery approaches that reward model participants for effectively delivering value-based care (providing high-quality and cost-efficient care).[3, 4]

1 What are the value-based programs? Centers for Medicare and Medicaid Services. Last updated March 31, 2022. Accessed June 17, 2022. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs

2 Health Care Payment Learning & Action Network. Alternative Payment Model: APM Framework. 2017. https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

3 Alternative Payment Models and the Quality Payment Program. Centers for Medicare and Medicaid Services. Last updated May 4, 2021. Accessed June 17, 2022. https://innovation.cms.gov/innovation-models/qpp-information#:~:text=The%20Centers%20for%20Medicare%20%26%20Medicaid,effectively%20delivering%20value%2Dbased%20care

4 Quality Payment Program: APMs Overview. Centers for Medicare and Medicaid Services. Accessed June 17, 2022. https://qpp.cms.gov/apms/overview

Telehealth and Value-Based Payment Models: *Supporting and Reinforcing the Other*

Telehealth coding under traditional fee-for-service models often changes and can be complex for providers to stay up to date on payer billing procedures. Moreover, under Medicare, telehealth coverage has been historically limited and even new audio-only allowances will be limited to certain mental health services after the COVID-19 public health emergency has passed.[5] This may increase inequitable outcomes, as older, minority, non-English speaking, and rural patients are more likely to need audio-only telehealth options.[6] A value-based payment model, with benefit enhancement (e.g., waivers) would help address this potential inequitable outcome, and complex coding rules, as providers could utilize the most appropriate, effective, and accessible means to assess and treat their patients when needed without concern for what may or may not be covered.

Telehealth can improve access to preventive and primary care, which in turn reduces potentially avoidable hospital visits and subsequent health care costs. In addition, telehealth allows for more frequent check-ins which provides a more holistic representation of a patient, resulting in more accurate provider assessments and more effective whole person care. Telehealth both helps lowers costs for providers participating in value-based care models and allows for visits to be more affordable and accessible to patients. More people are also preferring to be treated at home or in the community, which telehealth allows for while reducing utilization of more costly facility-based services. Lastly, payers often limit telehealth coverage due to concerns that increased telehealth coverage will result in increased costs. VBC payment models inherently address such concerns given the alignment of cost and outcome incentives on providers. VBC acknowledges that providers know when and how to use telehealth consistent with clinical appropriateness and the needs of their patients.

[5] 86 Fed. Reg. 221. Published November 19, 2021. https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf.

[6] Rodriguez JA et al. Differences in the Use of Telephone and Video Telemedicine Visits During the COVID-19 Pandemic. Amer. J Managed Care 2021;27(1):21-26. https://www.ajmc.com/view/differences-in-the-use-of-telephone-and-video-telemedicine-visits-during-the-covid-19-pandemic

Examples of Value-Based Care Payment Models

PAYMENT MODEL	DESCRIPTION	VALUE-BASED PAYMENT MODELS	CONNECTION TO VALUE-BASED CARE
Accountable Care Organization (ACO)	Network of physicians, hospitals, and other providers who volunteer to work together to achieve more coordinated and high-quality care for Medicare beneficiaries.[7]	**Medicare Shared Savings Program (MSSP)** **ACO Realizing Equity, Access, and Community Health (REACH)**	Participants share in any savings they achieve from reduced healthcare costs. Providers experience financial loss if their costs exceed the agreed-upon amount.
Primary Care Transformation (Patient-Centered Medical Homes)	Place primary care at the center of coordinating patient care through team-based approaches.[8]	**Primary Care First**	The coordination of care through a team-based, patient-centered approach allows for proper understanding of and addressing patients' needs.
Medi-Cal Managed Care	California Department of Health Care Services negotiates with a health plan to procure a monthly fixed rate per member that is then used to cover all Medi-Cal services for the member.[9]	**County Organized Health System (COHS), Two-plan model, Geographic Managed Care**	The health plans internalize some of the risk, incentivizing them to delegate risk to providers and prioritize primary and preventive care.
Medicare Advantage (MA)	Medicare Advantage is an all-encompassing alternative to Original Medicare where patients have an out-of-pocket annual limit and generally confront lower costs with extra benefits.[10]	**Health Maintenance Organization (HMO) Plans, Preferred Provider Organization (PPO) Plans**	Since patients have an out-of-pocket annual limit, health plans have an incentive to coordinate care effectively and efficiently while prioritizing preventive care.
Other Per-Member Per-Month (PMPM)/ Capitated Models for Dual Eligibles	The state, CMS, and a health plan negotiate a given "per member per month" capitated rate for the provider to provide coordinated care.[11]	**Program of All Inclusive Care for the Elderly (PACE), CityBlock Health**	Health plans are incentivized to assess their patients' needs holistically to prevent costly avoidable hospitalizations and illnesses.

[7] Accountable Care and Accountable Care Organizations. Centers for Medicare and Medicaid Services. Accessed June 17, 2022. https://innovation.cms.gov/key-concepts/accountable-care.

[8] Defining the PCMH. Agency for Healthcare Research and Quality. Published September 2021. Last updated September 2021. Accessed June 17, 2022. https://www.ahrq.gov/ncepcr/tools/pcmh/defining/index.html.

[9] Tatar M, Chapman A. The Medi-Cal Program: An Overview. California Health Care Foundation 2019. https://www.chcf.org/publication/medi-cal-program-overview/.

[10] Centers for Medicare and Medicaid Services. Understanding Medicare Advantage. November 2020. https://www.medicare.gov/Pubs/pdf/12026-Understanding-Medicare-Advantage-Plans.pdf.

[11] Medicare-Medicaid Coordination: Capitated Models. Centers for Medicare and Medicaid Services. Last updated April 6, 2020. Accessed June 17, 2022. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/CapitatedModel.

The California Telehealth Policy Coalition

The coalition is the collaborative effort of over 150 statewide organizations and individuals who work collaboratively to advance California telehealth policy. The group was established in 2011 when AB 415 (The Telehealth Advancement Act) was introduced and continues as telehealth becomes integral in the delivery of health services in California. Convened by the Center for Connected Health Policy, the coalition aims to create a better landscape for health care access, care coordination, and reimbursement through and for telehealth.

Visit the coalition online at **www.cchpca.org/about/projects/california-telehealth-policy-coalition.**