

# EMBRACING VIRTUAL CARE

## 2020 Trends and the Path Forward

### EXECUTIVE SUMMARY

The response to COVID-19 caused a rapid shift from in-person visits to virtual care services including telehealth, phone, e-visits, and remote patient monitoring. Traditional providers in brick-and-mortar settings accelerated their adoption of technology to offer new virtual care programs and services as nonemergency in-person care stopped. Provider capacity was also supplemented by virtual-only providers, such as Doctor on Demand. A close examination of 2020 trends offers insight into how patients utilized those services and how virtual care may evolve going forward.

These data trends highlight opportunities to leverage virtual care to improve the consumer experience and improve outcomes coming out of the pandemic. Ultimately, the path forward does not center on choosing in-person care or virtual care, but rather how to integrate the two while giving patients options in care method and price point. Blue Cross and Blue Shield of Minnesota (Blue Cross) looks forward to working with providers, patients, and policymakers by translating our long-term support for effective virtual care into new opportunities to improve Minnesotans' health and reinvent care.

## OBSERVATIONS THUS FAR

- Virtual care claims increased dramatically from 2019 into 2020, with a year-over-year change of over 3,700 percent.
- Traditional providers' new virtual care offerings drove the majority of growth.
- Virtual-only provider usage doubled, yet grew at a lower rate than traditional providers' virtual offerings.
- Behavioral health had the most rapid adoption of virtual care and maintained a high utilization.
- Adoption patterns varied significantly by specialty. Some specialties, such as ophthalmology utilized almost no virtual care, and others, such as endocrinology, maintained a sizable percentage of virtual care throughout 2020.

## DEFINITIONS

TYPE OF SERVICE	DEFINITION
<b>Virtual care</b>	A broad term encompassing all digital tools and services that support a patient's health.
<b>Telehealth</b>	A type of virtual care where patients receive individually tailored clinical care and guidance remotely.
<b>Telephone</b>	The use of audio-only technology to support virtual care.
<b>E-visit</b>	Shorter, nonemergency virtual appointments for common health problems that are typically not with a patient's primary care provider.
<b>Virtual-only providers</b>	Providers who offer exclusively virtual services, used to supplement access to traditional providers.
<b>Claims</b>	Claims for services that are reimbursed by the plan. For the purposes of this paper, claims refer to services that could be offered in-person or virtually under the expanded list of medical service codes available since the start of the pandemic. Claims for procedures requiring in-person care (i.e., open heart surgery) are not included to more accurately measure virtual care utilization. Read more about methods in Appendix A.

*NOTE: Please refer to Minnesota statute for legal definitions of telehealth and other virtual health care terms.<sup>i</sup>*

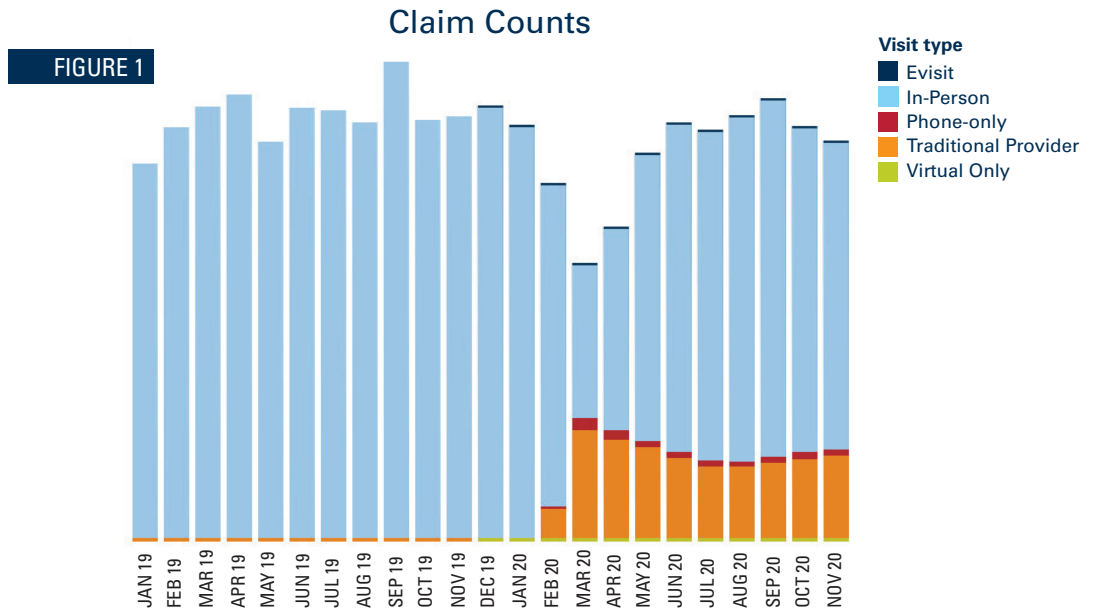
## 2020 VIRTUAL CARE TRENDS

**VIRTUAL CARE CLAIMS** increased dramatically from 2019 into 2020, with a year-over-year change of **OVER 3,700%**

As in-person visits and elective care rebounded through the summer and fall of 2020, **virtual member visits** remained a significant portion of care, stabilizing at nearly **1/5** of all claims.

### Patients opt for virtual over in-person care in early months of pandemic

Blue Cross witnessed many challenges and advancements for members and providers in 2020 virtual care trends. Patients chose to forego in-person care at the pandemic’s onset, as stay-at-home orders were put in place, clinics closed, and hospitals stopped treating elective procedures. Blue Cross saw a sharp decline in total in-person claims in April 2020—a 65 percent drop year over year as compared to 2019 claim numbers. [Figure 1]



As in-person visits dropped, virtual care visits grew rapidly. From 2019 into 2020, virtual care claims dramatically increased with a year-over-year change of over 3,700 percent. [Figure 1] Virtual care comprised nearly half of all claims in March and April 2020. As in-person visits returned and overall claim volumes rebounded through the summer and fall, virtual claims remained a significant portion of care, stabilizing at nearly one-fifth of all claims.

### Traditional provider virtual care offerings drive growth

Prior to 2020, virtual care represented a niche or specialized process, where virtual-only providers represented a large portion of care, including e-visits and phone visits. In response to safety concerns of COVID-19 transmission with in-person visits, traditional providers pivoted in 2020 by investing heavily in equipment, software, and training for virtual patient care. The results show that the traditional provider telehealth visits represented more than 95 percent of all virtual care visits from March to December of 2020.

## BEHAVIORAL HEALTH

had the **largest percentage of claims** as virtual care, as well as accounting for the **vast majority** of virtual care claims.

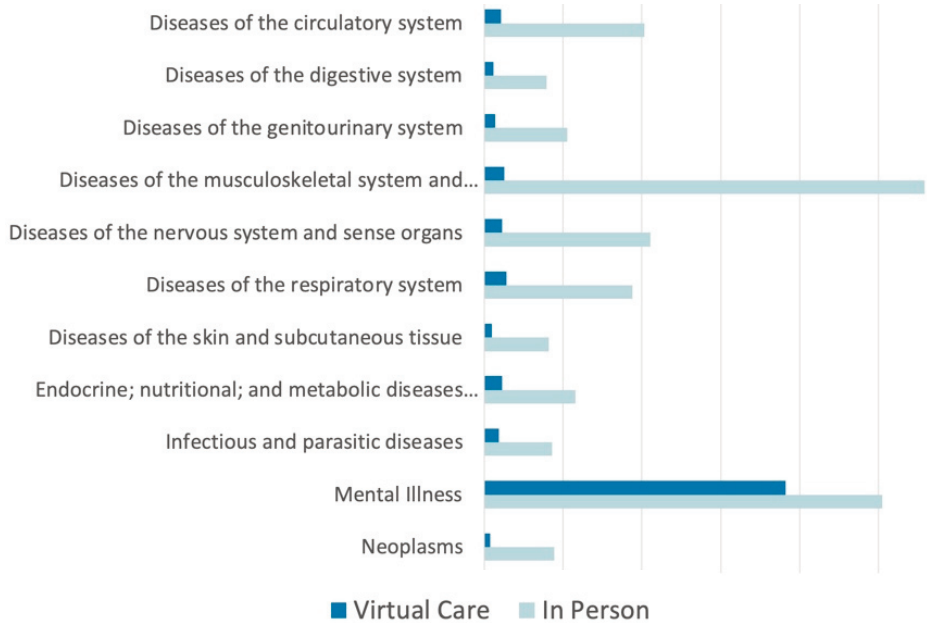
### Behavioral health adopts rapidly; maintains high utilization

Behavioral health providers pivoted most rapidly in the early stage of the pandemic. Unlike most other health diagnoses, those related to behavioral health did not have a drop in claims in the early months of the pandemic. For example, while musculoskeletal claims plummeted 38 percent in March and April 2020, mental health claims maintained normal volumes.

Behavioral health is also the leading service type observed in virtual care. Behavioral health represented nearly 60 percent of all virtual care claims in 2020—further, mental health claims had the largest virtual care percentage of claims. [Figure 2] Not only did psychiatrists and psychologists rapidly adopt to virtual care, but these providers also maintained a high utilization of virtual care. In fact, the percentage of claims delivered virtually by these specialties exceeded the percentage delivered in-person starting in April and remained significantly higher throughout the rest of 2020.

FIGURE 2

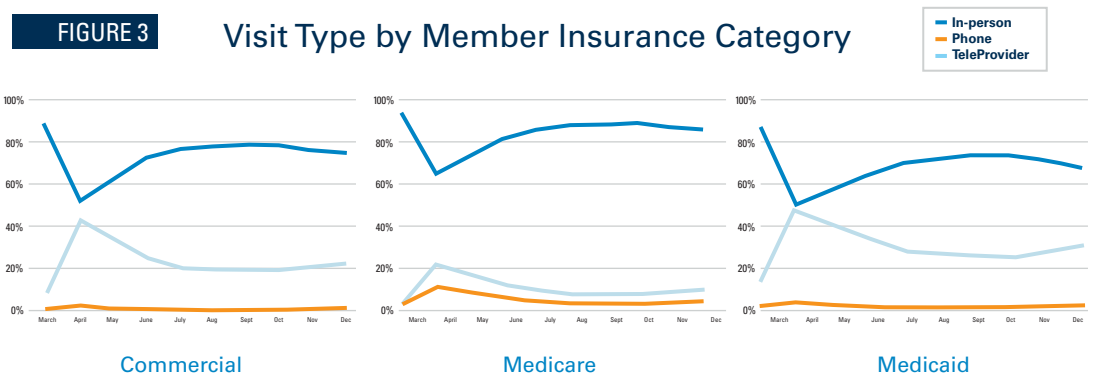
#### Virtual Care and In-Person Claims by Diagnosis 2020



NOTE: Please see Appendix A for a detailed description of the methods used to analyze trends in virtual care claims utilization.

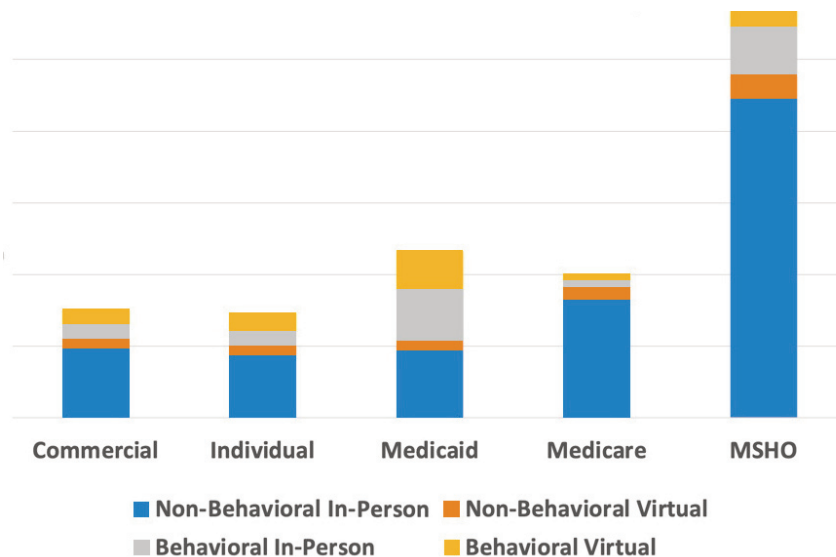
## DEEP DIVE: VIRTUAL CARE UTILIZATION VARIES ACROSS BLUE CROSS MEMBERSHIP

Utilization of virtual care in 2020 varied among Blue Cross members. Medicare members were much more likely to use the phone delivery method than other groups, following a very different pattern than Commercial and Medicaid members. Medicare members also returned to in-person visits more rapidly, and overall maintained a significantly lower percentage of virtual care utilization throughout the year.



The opportunity to choose a virtual care visit varied across membership in 2020. Members in Medicare and Commercial groups, for example, showed differences in both the intensity of virtual care use and the types of virtual care employed.

**FIGURE 4** Average Number of Claims per Member Broken into Virtual and Behavioral Health Groups



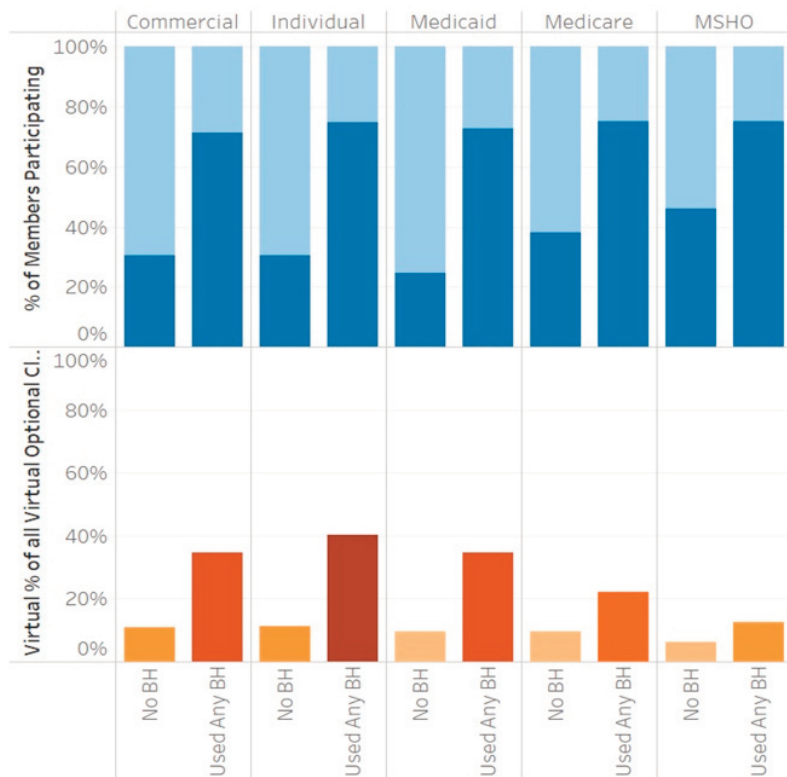
Blue Cross members' **NEEDS VARY ACROSS** lines of business.

While **Medicare** and **MSHO** members were more likely to **HAVE** a visit as **VIRTUAL**, **Medicaid** and **Commercial** members were more likely to **CHOOSE** **VIRTUAL** care when given the option.

Members eligible for both Medicare and Medicaid (“Dual Eligible” or “MSHO”) averaged nearly four times the number of claims with virtual as an option than Commercial and Individual members. As behavioral health was the area with the most intensive use of virtual care over the year, these claims represented a greater potential for virtual care utilization.

FIGURE 5

Participation and Concentration of Virtual Care



Medicare and Dual Eligible members were more likely to have tried virtual care in 2020 than Commercial, Individual, and Medicaid members, but less likely to use it for a large percentage of their visits.

For members with any behavioral health claims, the participation rates were fairly consistent across all lines of business—over 70 percent of members tried at least one virtual visit. For members with no behavioral health claims, MSHO and Medicare had the highest participation rate with over 40 percent of members trying a virtual care visit.

However, the intensity of virtual care use followed a different pattern. When given the option, Commercial and Medicaid chose virtual care at a much higher percentage compared to Medicare and MSHO members. So, while Medicare and MSHO members were more likely to have a visit as virtual, they didn’t prefer it in the same way as many of the members in other lines of business.

## CURRENT TRENDS & THE VALUE OF VIRTUAL CARE

### PRELIMINARY 2021 TRENDS

- Behavioral health visits remained greater than 50 percent virtual through May of 2021.
- The convenience of virtual care remains a key driver for members to continue using virtual care options to access health services.
- Virtual care increases access to health care services by connecting members to specialty health services in communities without any local options.
- By not restricting virtual care policy and payment, there are additional opportunities to collaborate with providers to integrate virtual care into inventive care strategies, rather than as a one-to-one replacement of in-person visits.
- Savings from a virtual strategy will evolve beyond lower cost e-visits to a reduction in member long-term health care costs, as greater emphasis is on shifting from emergency care to increasing and improving proactive outpatient management.

### **Virtual care presents opportunities to improve patient outcomes, patient satisfaction, and provider satisfaction.**

#### **Virtual care services allow patients to access care conveniently from wherever they are.**

Virtual care brings the health care provider to the patient, whether the patient is at home, work, or on vacation. Accessing care has become easier and allows those with limited access or mobility barriers, college students, parents, older adults, and patients in rural areas to fit health appointments into their lives.

**Patients are keeping their scheduled appointments for services.** Some local providers have shared that the number of missed appointments has decreased since virtual care became a more prominent option. Empowering patients with options of how to access care allows patients to choose virtual care when transportation, work schedules, long drives, or public stigma could be a barrier to an in-person visit.

**Flexibility empowers consumer choice.** Virtual care provides increased flexibility to consumers, providing options for how they access care, from whom, and at what price point (e-visits and phone calls are less expensive than a scheduled telehealth or in-person visit).

**Reconsidering reimbursement policies can help reduce health care costs for patients.** Allowing flexibility for plans to negotiate with providers on reimbursement policies will enable providers to innovate and integrate virtual care within their in-person visit care model. Providers will be able to offer more frequent and meaningful interactions with members to decrease downstream, high-cost utilization of emergency and inpatient services. Further data analysis should occur to understand the impact of state law requiring that telehealth services be reimbursed at the same rate as in-person visits.

**Remote patient monitoring services allow providers to be innovative and offer more meaningful interactions with patients.** These touchpoints can promote effective management of chronic illness and ultimately intervene before higher levels of care are necessary, helping to keep patients at home.

## THE PATH FORWARD

### KEY INSIGHTS FOR POLICY MAKERS

- **Enhance the patient experience by meeting patients where they are.** Providers should continue to provide flexibility in care methods to patients, allowing them to drive their care journey. Part of eliminating access barriers is the recognition that providers should be incented to reduce the total cost of care by working toward reimbursement structures that are more affordable for patients.
- **Maintain the cost saving potential of telehealth by reconsidering payment models.** Virtual care visits do not always require the same level of intensity, same amount of time, or the same equipment as in-person visits and thus should not be required to be reimbursed equally. Traditional providers need to be able to offer virtual care at various price points and have the ability to contract with different payers to compete with virtual-only providers and disrupters in the market.
- **Allow innovative programs to expand access and reduce costs.** Allowing many types of providers to deliver services through virtual care is a key part of expanding access. By providing virtual care options at different price points, more patients can access services that fit their needs and their budget.

### Supporting members through remote patient monitoring

In effort to provide members with better quality and access to care, Blue Cross is actively working with provider organizations to apply virtual care options to chronic illness management. One provider partner is piloting an option that allows remote patient monitoring between scheduled visits for high risk, high-cost patients without requiring any expensive devices or broadband. Additionally, Blue Cross is working with providers to explore opportunities in which nurse visits and care management check-ins can be performed through telehealth, allowing video (face-to-face) interactions between scheduled appointments. To support providers in building out their telehealth services and strategies and to align with the new Minnesota state law, Blue Cross permanently included many telehealth services in commercial coverage for provider reimbursement.

### Normalizing virtual care for providers and patients

Stakeholders continue to adjust to the proliferation of virtual care and the provider community is developing longer-term strategies. Providers are eager to know how virtual care services will be reimbursed by health plans, but the technology and reimbursement policies required for telehealth are only part of creating a successful strategy. Normalizing this new method of care for patients will take time. Up to this point, patients have been required to receive care in an office room with basic medical equipment such as an exam table, education booklets, a blood pressure cuff, oximeter, and an otoscope. The nurses and doctors will take the patient's vital signs and likely perform a physical exam. Virtual care now asks that patients accept and pay for care that occurs mostly through dialogue, self-exam, and video, and is not within a setting that has always been deemed necessary for care.



Instead of using telehealth and e-visits as a one-to-one replacement,

**VIRTUAL CARE WORKFLOWS**

should be integrated into the brick-and-mortar long-term health care delivery model.

**Technology** and **reimbursement policies** required for telehealth are only

**one ASPECT** of creating a **successful strategy.**

Patient and provider **EDUCATION IS CRITICAL**

to delivering effective, high-quality virtual care visits.

The new expectations for virtual care visits will develop over time, and clinicians and patients should strive for a care experience where both parties' needs are met. For example, a doctor may have received all the information he or she needed to determine next steps for the plan of care, but the patient may wonder whether the doctor received all the information needed without being physically examined.

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**“Webside manner”** training can help providers ensure intentional and empathetic communication in virtual environments.

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There is a great opportunity for providers, plans, and patient advocacy groups to begin creating education materials that normalize the virtual care experience to allow patients to understand what to expect from virtual care versus an in-person visit. Providers also require more training regarding “webside manner,” since giving empathy and compassion over a computer is different than in-person and requires more intentional actions and communication.

Providers can also help patients to determine if an e-visit or telehealth visit is needed. Quality organizations can support patients by helping providers to adapt to high quality and evidence-based guidelines to the virtual realm. Various forms of media can be used for positive public service announcement messaging to help normalize virtual care by sharing what happens in a virtual care visit and how the visit can be beneficial without a physical exam.

Managing expectations for patients is critical and offering ongoing training to providers to give high quality and valuable virtual services is also key. Provider organizations can explore how virtual care allows new opportunities to care for patients between in-person office visits and the ability to support more proactive and meaningful interactions. Instead of using telehealth and e-visits as a one-to-one replacement, providers are positioned to consider how to integrate virtual care into the brick-and-mortar long-term health care delivery model.

Blending in-person and virtual care within the patient’s journey can allow for a more **COORDINATED & CONNECTED EXPERIENCE** with a **better outcome.**

At Blue Cross, ensuring the member has a **POSITIVE experience** and has their **needs met** is the **number one PRIORITY.**

**EXAMINING patient and member SATISFACTION** in the different areas of **virtual care** is a key area for further assessment and one that is **actively being explored.**

### Supporting value-based agreements through virtual care

Blue Cross has been at the forefront of value-based care agreements in Minnesota, which are designed to reward providers for improving cost of care and health outcomes while focusing on delivering patient-centered care, rather than payment-centered care. This approach to providing better health care at an affordable price is highly compatible with virtual care. Providers may perform better in their value-based contract through utilization of less intense virtual care visits, as opposed to traditional office visits or even urgent care and emergency department visits.

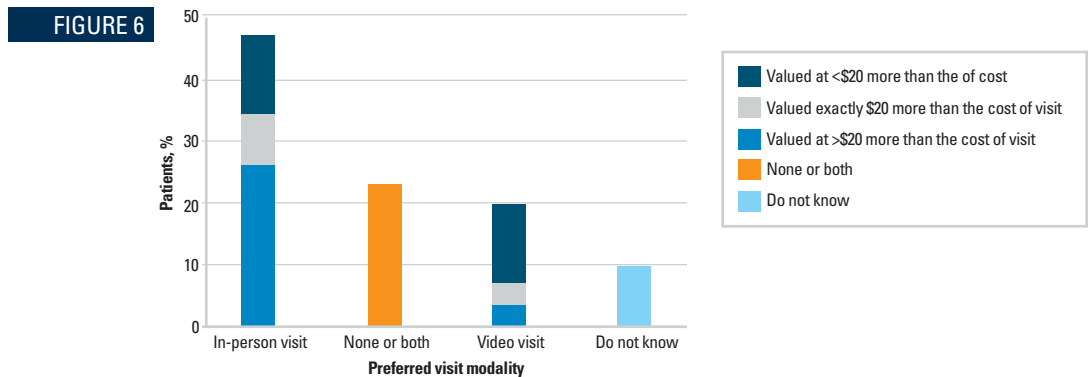
Allowing multiple methods to access care and supporting providers to think of how to offer meaningful care between scheduled appointments is where virtual care has great opportunity to change how care is delivered and decrease expensive emergency and inpatient care. If designed correctly, blending in-person and virtual care within the patient’s journey allows for a more coordinated and connected experience with a better outcome.

### Virtual care in the eyes of the consumer

Research suggests that the benefits of virtual care are mixed for both patients and providers. According to a recent *New York Times* survey conducted by *Psychology Today*, most behavioral health professionals reported that telemedicine had made their jobs easier by increasing access to therapy for patients and providing useful glimpses into a person’s home life. However, many clinicians raised concerns about virtual visits, discussing how it had made caring for patients more difficult due to barriers such as missing important body language cues.<sup>ii</sup>

For consumers, attitudes toward virtual care preferences are also mixed. A 2021 *JAMA Network* survey of U.S. adults found that most respondents were willing to use video visits in the future, but when presented with the choice between an in-person or a video visit for nonemergency care, most preferred an in-person visit. Specifically, the study found that “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 cost.”<sup>iii</sup> [FIGURE 6]

Preferred Visit Modality and a Perceived Relative Value (Weighted)



### Questions for further exploration

- **Convenience vs. value: what is most important to members?** Further research is needed regarding patient satisfaction and what makes patients choose a virtual care option—is it because they are receiving better care or because it is most accessible and convenient to them? Ultimately, are patients willing to sacrifice their traditional, in-person experience for the convenience of virtual care?
- **Is virtual care providing members with a high value of care?** As virtual care normalizes, its effectiveness and impact on patient outcomes should be closely measured. Innovative and new virtual care strategies that prioritize consumer experience should be explored in order to ensure patient needs are met.
- **Does the addition of virtual care options help decrease the total cost of care?** If virtual care is being used in innovative ways, such as for chronic illness management and remote patient monitoring, it's possible to examine its effectiveness in decreasing emergency room utilization, and thus the cost of care. Further considerations might include how to reimburse services like nurse visits and video call check-ins.

## CONCLUSION

In moving toward a post-COVID health care system, virtual care will continue to provide patients with an additional way to access care that is vitally important. Ultimately, the path forward does not center on choosing in-person care or virtual care, but rather how to integrate the two while giving patients options in care method and price point. While there are recently updated provisions in place for telehealth, these should be reviewed in a post-pandemic environment to ensure a long-term, sustainable solution is in place to strengthen care and advance price transparency. The solution must allow increased access while balancing quality outcomes and affordability for our customers, while allowing for flexibility for rapidly changing technologies and payment options.

## CONTACT

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## APPENDIX A: DATA TREND METHODS

### Methods

To analyze the trends in virtual care claims utilization, analysts first had to identify the group of claims for comparison. They selected what is referred to as “claims.” These are all claims that have a Current Procedural Terminology (CPT) code found in the expanded list of CPT codes now billable as virtual for reimbursement. Note that prior to February of 2020 only a subset of those claims was available for virtual reimbursement. However, it provided the best population for a level comparison with post-expansion utilization so the change in the number of virtual care claims could be examined while accounting for overall volume changes in those CPTs by looking at the percentage of claims delivered virtually. It also avoided measuring the impact of virtual care on care delivery in situations where it isn’t feasible. For example, the change in virtual delivery of thoracic surgery CPTs was not examined.

### Virtual Care Identification

After all claim lines with reimbursable CPTs were collected, virtual care claims were flagged and categorized into five categories. A claim was first checked against a list of virtual-only provider National Provider Identifiers (NPI) and matches were identified as a virtual-only provider claim. Remaining claims with specific *e-visit* CPTs were put into the *e-visit* category and claims with specific phone call CPTs labeled as *phone*. Claims with *procedure* or *modifier* codes specifying virtual delivery and not already in a category were identified as *traditional provider virtual claims*. These are claims where traditional providers delivered care virtually.

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<sup>i</sup> Parker Pope, T., Caron, C., & Cordero Sancho, M. (2021, December 17). Why 1,320 Therapists Are Worried About Mental Health in America Right Now. The New York Times. <https://www.nytimes.com/interactive/2021/12/16/well/mental-health-crisis-america-covid.html>

<sup>ii</sup> Predmore Z.S., Roth E., Breslau J., Fischer S.H., & Uscher-Pines L. (2021). Assessment of Patient Preferences for Telehealth in Post-COVID-19 Pandemic Health Care. JAMA Netw Open, 4(12):e2136405. <https://doi.org/10.1001/jamanetworkopen.2021.36405>

<sup>iii</sup> Minnesota Session Laws – 2021, 1st Special Session, Laws of Minnesota § 7-6-1 (2021). <https://www.revisor.mn.gov/laws/2021/1/Session+Law/Chapter/7/>