# COSTING VIRTUAL CARE

## Picking out what virtual care fee codes will do to physician services budgets is hard with COVID changing all aspects of utilization

BY ABIGAIL CUKIER

Technologies to deliver virtual healthcare have been around for decades, but Canada has lagged in providing widespread publicly insured virtual care, despite studies showing it can improve access to care and reduce costs.

Of course, the COVID-19 pandemic has profoundly accelerated virtual care. So what have we learned about how digital healthcare costs compare to costs for in-person care? It seems this question is not so easy to answer.

Before the pandemic, about 10% to 20% of medical care in Canada was virtual. That number was up to 60% within about six weeks of the start of the pandemic, according to Canada Health Infoway, an independent, federally funded, not-for-profit organization tasked with accelerating the development and adoption of digital health solutions. The organization says that so far in 2021, about 40% of care is being delivered virtually.

### IN ONTARIO

In Ontario for example, about eight million patients have received OHIP-insured virtual care since the onset of the pandemic, including about 33 million phone/video services. Physician services claimed using the pandemic virtual fee codes have accounted for about 13% of total physician payments since March 2020. In British Columbia, as of Feb. 15, 2021 there was a 1,222% increase in virtual family physician services and a 51% decrease in in-person family physician services when comparing March to December 2020 with the same time period in 2019.

Dr. Sacha Bhatia, chief medical innovation officer at Women's College Hospital in Toronto, says overall utilization of healthcare system resources is lower than before the pandemic, with an approximately 15% to 20% reduction in ambulatory visits in Ontario, as well as a reduction in hospitalizations, diagnostic testing and emergency room visits. Dr. Bhatia says this will inevitably lower the physician services budget, but other costs may be higher than usual.

"The confounder is the pandemic. It is pretty close to impossible to tease out whether the effect is due to virtual care or due to the COVID-19 pandemic," he said. "But it will be useful to look at this longitudinally, as people are vaccinated and levels of virtual care stay relatively high. We'll get a better sense around utilization and cost. We're not really going to know what's up until we really start to see a return to regular life."

The pandemic changed how physicians deliver healthcare and how they bill for their services. In response to the pandemic, provinces introduced temporary virtual care fee codes to allow patients to safely see their doctor by phone or video. These fees are generally equivalent to in-person fees. Provinces continue to extend the temporary codes, maintaining they will be reviewed after the pandemic. In June 2020, Alberta announced the fee codes introduced during COVID-19 would be permanent.

Prior to the pandemic, British Columbia had the most comprehensive approach to fee-for-service billing for virtual care. This included a video telehealth code so a physician could connect with another physician at an approved site to care for a patient, a code for telephone visits and one for email or text message medical advice to patients. These fees for family physicians were a weighted average of the age-based

Getty Images

in-person fees for these services. The temporary pandemic fee is the same rate as the corresponding in-person fees.

In Ontario, prior to COVID-19, physicians could bill for visits using the Ontario Telemedicine Network (OTN) platform for direct-to-patient video visits with fees equivalent to in-person care. The plan was to expand access to secure electronic messaging and phone calls and use of non-OTN technology.

Other provinces provided fees for some aspects of virtual care and pilot projects, limited to approved telehealth sites and focused around specific health system needs. In New Brunswick for example, virtual care occurred between two hospital or clinic facilities. There was no fee code for doctor to patient visits. At the onset of COVID-19, the province opened up one code for specialists and family doctors. It later added another for specialists, as well as psychiatry codes. After a couple of months, physicians were able to bill for fees equivalent to in-person codes.

"Ontario's schedule of benefits has thousands of codes. For family doctors, let's say there are 250. All of those have been distilled down to three codes," said Dr. Alykhan Abdulla, section chair for general and family practice at the Ontario Medical Association (OMA). "When you see a person in office, you do the assessment. That's one code. But if you do a Pap smear, that's a different code. If you do an ear syringe, that's a code. But now we're restricted to three specific codes."

There is also a code for specialists, and an hourly fixed rate for physicians working in a COVID assessment or vaccination centre. The province recently added a premium for performing high-risk procedures in-hospital and a virtual care code specifically for palliative care. The temporary codes also allow physicians to use applications such as Zoom, rather than just OTN.

Dr. Bhatia has spent years researching digital health innovations to help healthcare stakeholders decide which tools to adopt, with the aim of improving efficiency and increasing healthcare capacity and quality. He believes the pandemic virtual care fee codes have been a success. "The virtual care fee codes did exactly what we hoped they would," he said. "Though we had a modest decline in ambulatory visits, we were able to maintain volume and allow people to access their care provider."

## HIT PHYSICIAN PAY

But the decrease in healthcare utilization did affect physician pay. Without patients coming into the clinic and a delay in virtual care fees, fee-for-service physicians, who only get paid if they are seeing patients, were hit hard. Physicians in alternative payment arrangements, such as capitation, where physicians are paid a flat fee for each patient in their roster, could transition to virtual care without having to wait for fee codes. Community-based specialists were hit harder than those under academic-based or salaried payment models. While some specialists, such as psychiatrists, could provide virtual care, others could not.

Dr. Abdulla, who is medical director of the Kingsway Health Centre in Ottawa, works under capitation. He believes every doctor should have this opportunity. "Capitation has to be the way moving forward. You want some guarantee that doctors are going to be working all the time," he said. "You probably want capitation for surgeons. You want capitation for anyone who works in a hospital. You want academic alternate funding plans, which guarantee that you are going to get paid. If you can't do an operation, we will give you something else to do."

As the OMA continues to negotiate with the Ontario government for its new physician services agreement, Dr. Abdulla says there must be a willingness to scrap the way things used to be and work together for a better way forward. "There is going to be a balance between in-patient and virtual care. We need to plan for that future. You also want to make sure physicians have some level of stability. And we're not talking about more money. We are talking about better use of that money," he said, adding that there is a need for more virtual care codes; increased video, telephone and messaging options; and opportunities for alternate funding arrangements.

While all of these issues will affect how healthcare is delivered, they will also influence costs. So we are still left with the question, will virtual care increase or decrease healthcare costs? After years of international research, Simon Hagens, senior director of performance analytics at Canada Health Infoway, says there are no definitive answers. "At the health system level it's really hard to figure out. There is give and take on both sides," he said. For example, virtual care may provide access to citizens who might otherwise not get it, avoiding possible health complications and saving costs. But costs may go up with increased access or if a virtual visit doesn't resolve the complaint and an in-person visit is still needed. "The really important question is how do you build the right mix of virtual care and in-person services and reimbursement systems to incent the right type of care in the right situation?"

Canada Health Infoway released a study in 2017 comparing patients who had virtual visits to patients seen in person. "The early indication was that there might be an opportunity to reduce costs in primary care with virtual care. Also, for the most part, people in the virtual care group did not have additional followup visits. But the big limitation is that the data set at the time was insufficient, due to low volumes," Hagen said.

"It will be a long time before we actually know the long-term health of patients seen virtually and the costs. It often takes months or years for a course of treatment to play out and see how a virtual intervention compared to an in-person visit."

There are two areas where Hagens is certain digital health saves costs. An analysis of the Infoway Telehomecare Program, which provides remote monitoring for patients with COPD and congestive heart failure, found that for every $1 invested in these programs, the health system sees $4 in value, through reduced inpatient admissions and ER visits.

Another Infoway study examined direct patient access to their lab results. Almost 60% of patients with online

**"The really important question is how do you build the right mix of virtual care and in-person services and reimbursement systems to incent the right type of care in the right situation?"**

access visited their physician to receive or discuss results, while 83% of patients in a comparison group visited their doctor for that reason. In addition to reducing healthcare costs, this also benefits patients, who often have to miss work, pay for parking or find childcare to see their doctor.

In fact, Infoway's 2019/20 annual report shows that in 2019, virtual care saved patients 11.5 million hours by not having to take time off work to attend in-person appointments; avoided $595 million in travel costs to primary care visits for rural patients who used telehealth; and reduced 120,000 metric tonnes of carbon dioxide emissions when used for primary care visits and rural telehealth. Those numbers reflect the savings pre-pandemic (10% to 20% of care delivered virtually). The report states that if the number of virtual care visits increased to 50%, it would save 103 million hours, $770 million in expenses for Canadians and 325,000 metric tonnes of $CO^2$ emissions.

"We are increasingly looking at the benefits to Canadians being a central pillar of how we talk about virtual care and trying to convince governments that if you're saving constituents time and money, it's worth the investment and it also has a good economic spinoff," Hagens said.

Hagens calls the pandemic the first opportunity for real-world experience with virtual care. "We've had this gradual increase in the quality of the technology and of course, citizens having phones in their hands. So the conditions are right and this appears to have been the spark," he said. "So now the big question is, how do we take what's best about virtual care and make that the norm in healthcare?"

## HYBRID MODEL OF CARE

Dr. Bhatia believes most patients want a hybrid model of care. "We have to figure out what that right mix is and that's going to be through a combination of clinical appropriateness and further research on healthcare quality and cost."

He cautions against making bold policy changes around remuneration and is wary of early calls for certain costs for an in-person visit vs. a video or telephone visit. "Let's look at optimal models of clinical care first, and have the reimbursement follow them, rather than build the financial model first. What's going to happen is, people are going to tailor their practice to the reimbursement model.

"I wouldn't want us to create incentives to pick one modality of communication with patients over another. I think we should resist temptation to make arbitrary funding decisions. We should first figure out what the models look like and ensure that the reimbursement follows the optimal models of care." **MP**