Watson Health®

Behavioral Health Telehealth Use During COVID-19

Application of IBM MarketScan research database

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Challenge

The COVID-19 pandemic interrupted in-person care for many health conditions, including behavioral health (mental health and substance use) treatment. Telehealth is a viable alternative to in-person care for many noninvasive health care services, such as psychotherapy. It is not surprising, therefore, that many health care providers rapidly pivoted to telehealth services when the Public Health Emergency (PHE) declaration temporarily suspended barriers to telehealth delivery and reimbursement.

A critical question is whether payers and policymakers should extend and potentially sustain these telehealth flexibilities after the pandemic. Some flexibilities have already been made permanent (such as reimbursement by Medicare for certain telehealth procedures),[1] but many are still set to expire when the PHE ends. Although telehealth may facilitate access to care, important questions remain about whether telehealth is an adequate substitute for in-person care, can be provided equitably, or could be overutilized in ways that compromise quality. Federal agencies need access to rapid analytic and reporting resources to identify trends, challenges, and opportunities in the use of telehealth services to guide policymaking. These data may be particularly important for mental health and substance use disorders given the increase in mental health conditions[2] and overdose deaths[3] during the pandemic and the need to evaluate the impact of changes in medication delivery protocols for opioid use disorder as part of the PHE.

Background

Prior to the PHE, access to behavioral health care already had severe gaps due to a lack of provider capacity to address behavioral health treatment needs. Telehealth offered a way to reduce those gaps. However, telehealth utilization was persistently low for these conditions for a variety of possible reasons, including patient and provider preferences, privacy and security concerns, broadband access and other technological barriers, and policy issues, such as lower reimbursement rates for these services.[4] With the PHE declaration, some of the policy barriers to providing behavioral telehealth care were lifted. These actions provided an opportunity to increase access to behavioral health care via telehealth—including, for example, allowing physicians to prescribe buprenorphine to patients with an opioid use disorder without an initial in-person visit. Given that these changes are recent, stakeholders lack data and analyses on their impact on access to and utilization of behavioral health treatment.

What we know

Little information is available about how telehealth has increased during the pandemic, whether utilization patterns differ between rural and nonrural areas, and whether there has been an impact on costs or health outcomes. To shed light on similar questions in a timely way that can be policy relevant, IBM Watson Health® has used trusted sources of data such as the IBM MarketScan® Commercial and the IBM MarketScan Multi-State Medicaid Databases to understand telehealth utilization. In work for the Substance Abuse and Mental Health Services Administration before the COVID-19 pandemic, we used the MarketScan Multi-State Medicaid claims data to analyze overall utilization, as well as specific differences in rural and nonrural Medicaid beneficiary populations.[5] This study found that rural beneficiaries were more likely than nonrural beneficiaries to receive telehealth treatment for behavioral health conditions, although underutilization persisted.

More recently, Watson Health® used MarketScan Early View Commercial and Medicare Supplemental data to produce timely analyses related to the trends in patterns of health care delivery, including the use of telehealth during the COVID-19 pandemic. In Figure 1, we show the proportion of selected behavioral health and general physical telehealth claims by major diagnostic category. The figure illustrates that telehealth claims for behavioral health conditions accelerated rapidly with the onset of the COVID-19 pandemic in the United States and, in contrast to trends for physical health conditions, did not attenuate in June 2020.

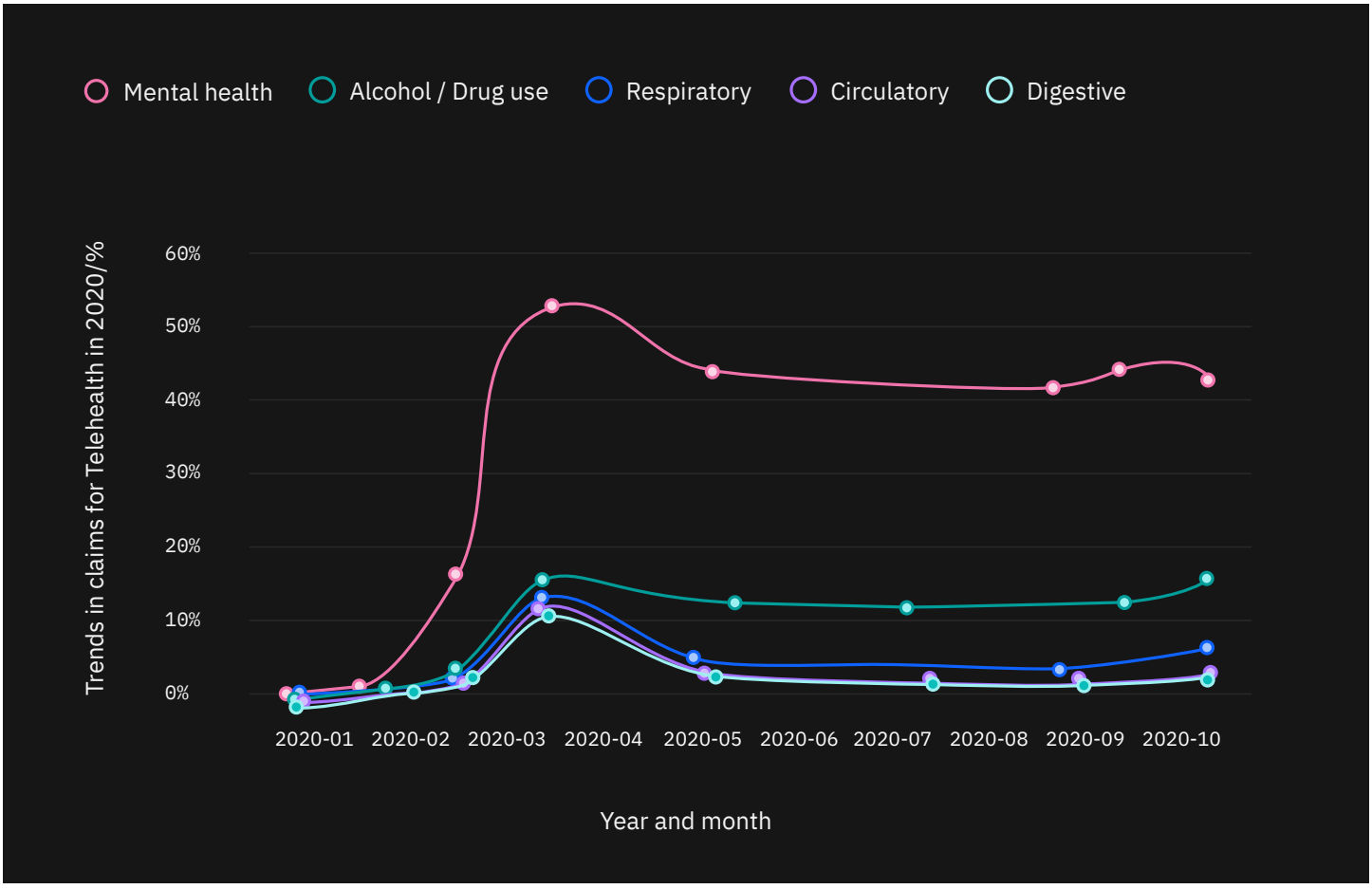

Figure 1. Trends in claims for telehealth in 2020—by selected diagnostic categories

Figure 2 demonstrates a similar pattern, with a large increase in telehealth claims filed by behavioral health providers following the onset of the pandemic in March 2020. Claims for general physical health conditions also jumped in April and May, although these claims did begin to attenuate in June, again in contrast to trends for behavioral health providers. However, for both behavioral health and general health providers, the proportion of telehealth claims did not return to prepandemic levels. These findings suggest that demand for health care delivery overall via telehealth will persist as the COVID-19 pandemic recedes. For behavioral health, the large increase in utilization suggests a fundamental transformation in the delivery system.

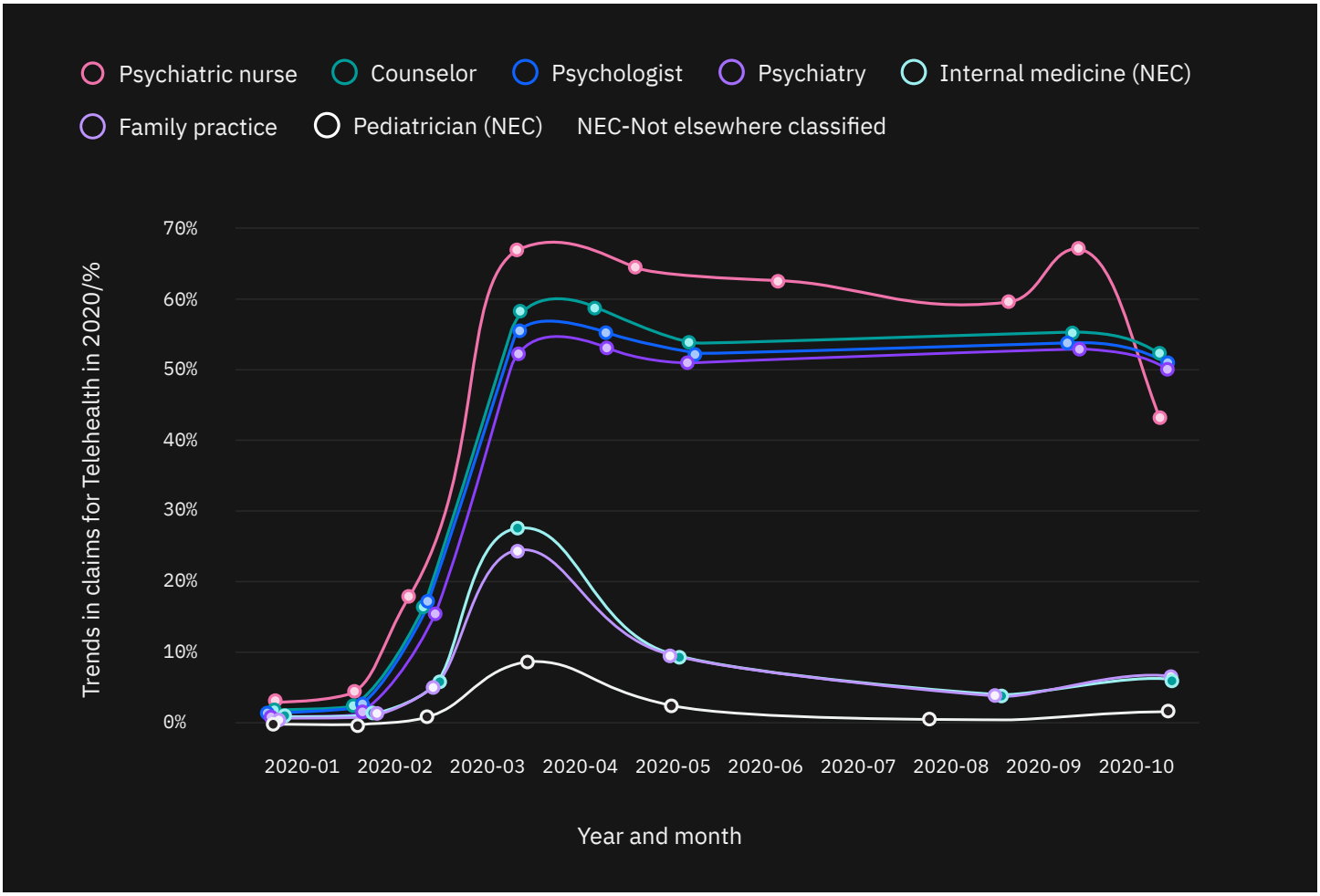

Figure 2. Trends in selected provider types with a telehealth claim in 2020

We also examined patterns for behavioral health utilization among commercial and Medicare enrollees, comparing rural and nonrural trends. As illustrated in Figure 3, we observed person-level utilization patterns that were similar to the overall claims-level analyses across time. Interestingly, although the proportion of rural and nonrural telehealth use for behavioral health conditions was almost identical in the first 2 months of 2020, the acceleration in telehealth use was higher among nonrural enrollees through the rest of 2020. Patterns of attenuation over time were similar across the two population groups.

In general, patterns were also similar over time for mental health and substance use disorder telehealth utilization, although higher utilization was evident for mental health both in rural and nonrural enrollees. These trends suggest that barriers to telehealth utilization for behavioral health conditions are lower overall in nonrural areas. However, the persistence of high telehealth utilization in both rural and nonrural areas indicates that the availability of these services after the pandemic will be important in both settings.

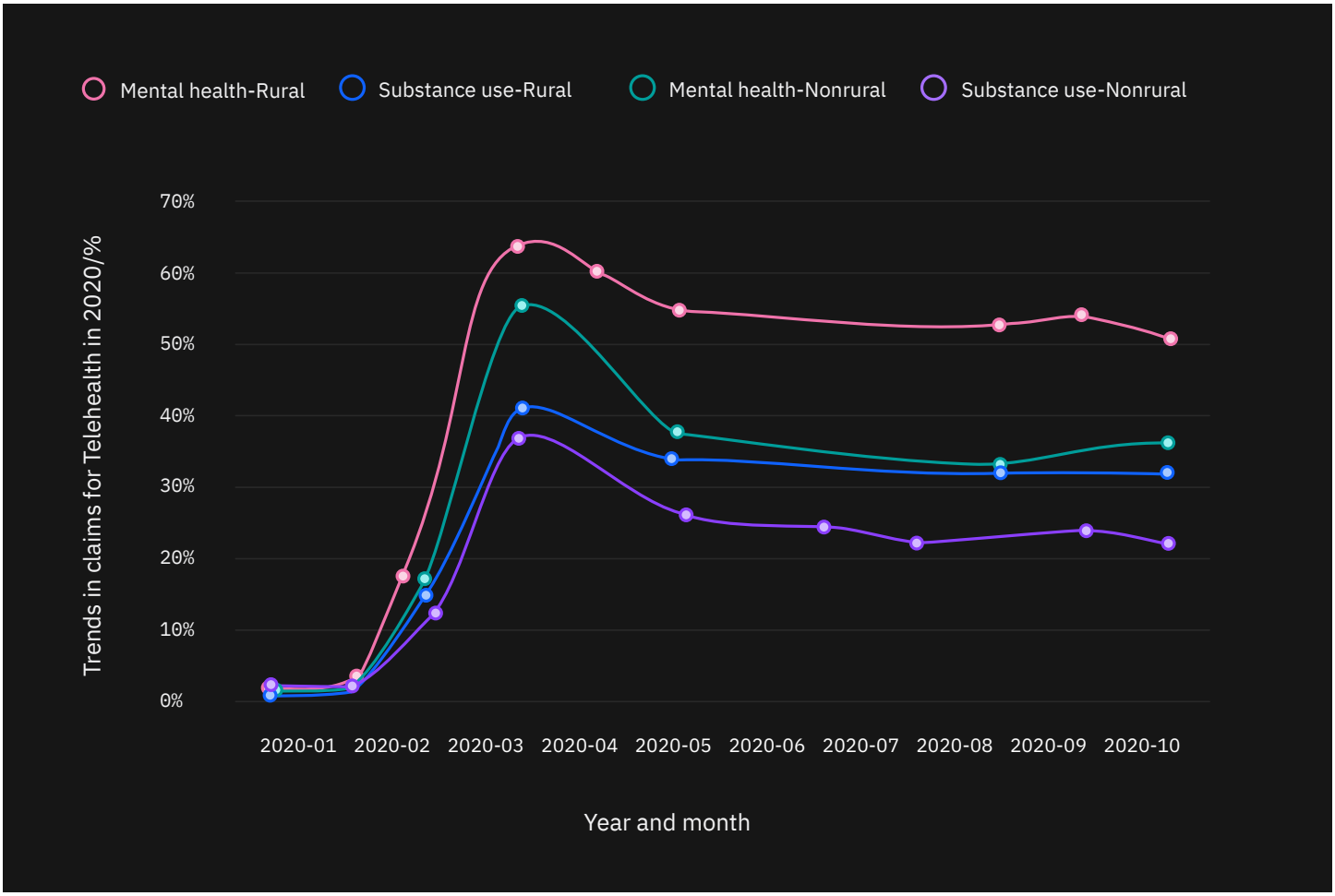

Figure 3. Trends in month-to-month utilization of Telehealth by enrollees for behavioral health conditions in 2020, Rural versus Nonrural

What we could learn

Watson Health has the data assets, analytic capabilities, and subject matter expertise to provide immediate answers to critical questions about telehealth use that can help guide federal policy decisions. In addition to the MarketScan Commercial data highlighted in analyses in this paper, we also have access to the following data sources for timely analyses of COVID-19 impacts:

- → Medicaid data (IBM MarketScan Multi-State Medicaid Database): Medicaid claims data from a subset of states, with early view information available from January-June 2020
- → Electronic health record (EHR) data (IBM Explorys® EHR Database): EHR data including more than 71 million patients from 30+ health systems, 400 acute care facilities, and 400,000 providers, updated weekly
- → Household survey data (PULSE®/PRIZM®): Watson Health PULSE Survey combined with PRIZM block-level market segmentation data from 2020

Analyses drawing from these data resources—as well as technical specifications and code that can be used with these and other data sets—are available to federal clients to help inform key current policy questions and others that will emerge after the PHE, such as the following:

- → To what extent did mental health and substance use disorders increase during the COVID-19 pandemic? How did providers respond to this increased need for services? How did telehealth fill these gaps in care?
- → What are the outcomesfor those with behavioral health conditions who switched to delivery of care via telehealth during the COVID-19 pandemic?
- → Should the flexibilities for delivery of medication to those with opioid use disorder that were initiated during the PHE be sustained following the pandemic?
- → Does the increase in telehealth utilization in rural areas effectively fill gaps in care for mental health and substance use disorders in those communities? To what extent do these modalities continue to fill gaps in access after the pandemic?
- → What are the financial implications for continuing to use telehealth for behavioral health conditions? Are there cost savings or increases in the long term? How should federal agencies assess the costs and benefits of various levels of reimbursement for telehealth?

Additional analyses will allow federal agencies to (1) better understand pandemic-related changes to the utilization of behavioral telehealth services and (2) use data and analytics to inform decision-making. Through a better understanding of trends over time, federal agencies can be agile and responsive to health care need s due to the PHE and continue to address access barriers to behavioral health care.

About IBM Watson Health

IBM Watson Health is a data, analytics, and technology partner for the health industry. Supported by the innovation of IBM and intelligence of Watson, we are committed to helping build smarter health ecosystems. Through the combination of our deep industry expertise in health, data and analytics, actionable insights, and reputation for security and trust, Watson Health is working together with its clients and partners to help them achieve simpler processes, better care insights, faster breakthroughs, and improved experiences for people around the world.

Footnotes:

1. Centers for Medicare and Medicaid Services. *Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients*. Press Release. December 1, 2020. https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment
2. Czeisler MÉ , Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic—United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1049–1057. DOI: http://dx.doi.org/10.15585/mmwr.mm6932a1
3. Centers for Disease Control and Prevention, National Center for Health Statistics. *Vital Statistics Rapid Release: Provisional Drug Overdose Death Counts*. Page last reviewed March 17, 2021. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.html
4. Creedon TB, Schrader KE, O'Brien PL, Lin JR, Carroll CD, Mulvaney-Day N. Rural-nonrural differences in telemedicine use for mental and substance use disorders among Medicaid beneficiaries. *Psychiatric services*. 2020;71(8):756-764. https://doi.org/10.1176/appi.ps.201900444
5. Creedon et al. 2020. Op. cit.

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