HOW COVID-19 WILL CHANGE THE PATIENT JOURNEY, REIMBURSEMENT, AND CARE DELIVERY

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Value-based care has led to much change in healthcare over the years, and COVID-19 is pushing change faster and even further. These changes forced by COVID-19 will have long-term effects on every aspect of care delivery; current healthcare tools and programs such as clinical pathways need to adjust to these changes to continue being helpful. Current shifts provide new opportunities with greater urgency for further change to aid in the evolution of the healthcare system.

COVID-19, with its stay-at-home requirements and restrictions on face-to-face interactions, has changed how care is delivered, and these changes will remain beyond this crisis. Indeed, actions by and learnings for all stakeholders (i.e., patients, payers, providers, policymakers) from the COVID-19 crisis will have long-term effects. These include changes to the entire patient journey from awareness to diagnosis to treatment and follow up—every aspect of care will be impacted. Clinical pathways are a fitting tool to accompany the new focus and collaborative mindset stakeholders have had (and must continue) to curate. Given how clinical pathways have evolved from simple treatment regimen guides to comprehensive guides for best practices along the entire patient journey, these shifts change everything, opening new opportunities with greater urgency.[1-4]

Government Increased Involvement

Payment has shifted from individuals to employer-based commercial insurance for most.[5] However, because of high unemployment caused by COVID-19, several changes are highly likely. These include a lowering of the Medicare age and increase in those receiving Medicaid coverage. While this is short of the government control of healthcare payments under a Medicare for All (M4A) system, it does represent movement toward significantly more government control of healthcare payments. Because the pandemic has slowed the Democrats' momentum in the presidential race, there was increased pressure to align around one candidate, i.e., former Vice President Joe Biden. Senator Bernie Sanders' withdrawal will not end the push toward M4A, but it will remove the primary leadership for this movement. In part to placate the Sanders/M4A supporters as well as alleviate the number unemployed, the Biden campaign proposed expanding Medicare coverage to those aged 60 years. The Medicare at 60 proposal is a health insurance option for early retirees who leave employment or who have been forced out of their jobs before the age of 65 years.[6] The proposal would provide Americans between the ages of 60 and 64 years with the option to buy into Medicare, the federal health insurance program for older adults. This would make around 20 million additional Americans eligible, which in turn could result in their early retirement and thus open up employment opportunities for others. This is especially needed given the high unemployment rate. The latest figures[7] show that approximately 16 million Americans have filed for jobless benefits since the writing of this piece, reaching an estimated national unemployment rate of 12% to 14%.

Depending on the duration of the national emergency, some estimate[8] that the national unemployment rate may reach as high as 20% and that Q2 gross domestic product may decline by up to 40%. In addition, this shift from private commercial insurance would likely decrease private insurance rates as well as decrease Medicare Advantage premiums, as this group represents both relative higher utilizers for commercial plans and lower utilizers for Medicare.

The other aspect of government coverage that will expand beyond that mentioned related to Medicare is Medicaid. With the uninsured numbers possibility increasing from 27 million to 40 million, with bigger impacts on non-expansion states, many will turn to Medicaid for health insurance benefits. Medicaid enrollment could grow by 5 million regardless of the number of people who lose their jobs, increasing from 71 million to 82 to 94 million.[9] These increases in both Medicare and Medicaid mean that the government will be responsible for an ever-increasing portion of healthcare payments. As a result, the government regulations will dictate every aspect of access restrictions. These factors would need to be addressed and accounted for in clinical pathways to ensure optimum outcomes, especially in the face of potential inappropriate restrictions.

Telemedicine Expansion

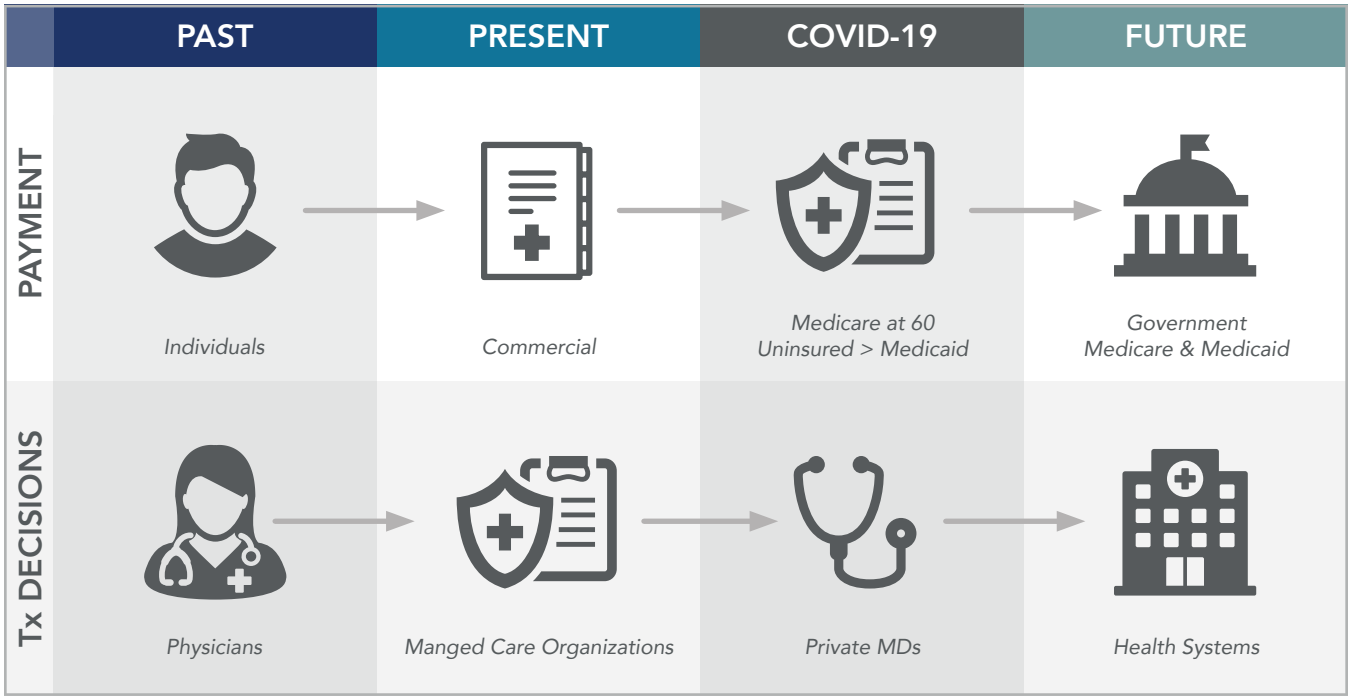

Image 1: How reimbursement and market arrangements are evolving.

Telemedicine is getting a boost from COVID-19—you hear it discussed across nearly all media sources. Demonstrating that is Teledoc's Q1 2020 results that show a 40% year over year growth in the first quarter.[10] These increases come from environmental demands for non-face-to-face care and are supported further by the administration's actions to enable greater use of telehealth to deliver care in the home. These actions include the Centers for Medicare & Medicaid Service's (CMS's) clarification that Medicare Advantage plans can submit for risk-adjusted payments for diagnoses that are from telehealth visits when the visits meet all criteria for risk-adjustment eligibility (i.e., face-to-face encounter and allowable service).

Additionally, the COVID-19 Telehealth Program application portal opened on April 13, 2020.[11,12] The program provides $200 million to help healthcare providers provide connected care services to patients at their homes or mobile locations in response to the COVID-19 pandemic. There are six funding applications totaling $3.23 million for providers in some of the hardest hit areas (as of the time of this article publication).[13] The Federal Communications Commission is evaluating applications and will distribute additional funding on a rolling basis. CMS has issued guidance on rural health clinics and federally qualified health centers to furnish distant site telehealth services to Medicare beneficiaries during the public health emergency.[14]

Because use of telemedicine will continue long after the COVID-19 pandemic has past, clinical pathways need to account for this shift in site and timing of care, as diagnosis and treatment could be either made earlier or delayed if not managed appropriately. Clinical pathways can help guide this change in care delivery.

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The Growth of Nonphysician Providers

The shortage of primary care physicians is especially noticeable in dealing with the COVID-19 pandemic. As a direct result, CMS is opening up the pathway for expanded use of nonphysician providers. For example, CMS is waiving certain requirements so that physicians can delegate tasks to physician assistants, nurse practitioners, and clinical nurse specialists (within the limits of state law).[15] CMS is also waiving the requirements around physician visits to allow them to be conducted by nurse practitioners, physician assistants, or clinical nurse specialists. Both of these waivers still require physician supervision but now allow for expanded use of nonphysician providers in certain settings.

Further, the US Department of Health and Human Services (HHS) announced that licensed pharmacists can order and perform COVID-19 tests, including serology tests that have been granted an emergency use authorization (EUA).[16] The Food and Drug Administration has granted an EUA for one serology test thus far, Cellex Inc's qSARS-CoV-2 IgG/IgM Rapid Test.[17] So far though, HHS remains silent on whether pharmacists can bill for their services related to COVID-19 tests. This will likely aid in the push for pharmacists to finally gain provider status.

These type of expansions of nonphysician providers means that clinical pathways need to incorporate the skill set and availability of these providers into pathways, as they are different from physicians. Increased availability balanced against a different skill set means expanded opportunities around earlier diagnosis and referral to specialist. This guidance can be provided through clear patient-journeyed clinical pathways.

"Payviders"

Finally, beyond the increase in government as the primary payer of health care and use of telemedicine and nonphysician providers, there is also a COVID-19-accelerated growth in "payviders."[18] The prevalence of payviders, the combining of payer and providers either from traditional payers acquiring providers or health systems becoming payers, is being accelerated from COVID-19, as many private practitioners find it impossible to survive independently. As many small businesses are finding in this climate, support from larger, well-financed organizations is needed to survive. A survey found that 97% of independent medical group practices have been negatively impacted as a result of COVID-19.[19] Practices reported a 60% decrease in patient volume, a 55% decrease in revenue since the beginning of the public health emergency, and that 70% of medical practices have already been forced to lay off and furlough staff. In response, HHS has started distributing emergency funding included in the Coronavirus Aid, Relief, and Economic Security (CARES) Act to health care providers through two different streams:

- More than $51 billion has been paid out in accelerated payments to hospitals and other healthcare providers. Providers must apply through their Medicare Auditor Contractor.[20]
- $30 billion of the $100 billion COVID-19 provider relief fund is now being directly deposited into providers' accounts. Payments are based on a provider's historic Part A and Part B Medicare fee-for-service payments. The funds do not need to be repaid. Providers must acknowledge receipt and agree to the terms and conditions within 30 days. Providers must also agree to not balance bill patients for coronavirus treatment and must charge patients in-network rates even if they are treated out of network.[21]

Private insurers are also attempting to assist. UnitedHealth Group announced that it is providing up to $125 million in small business loans to OptumHealth's clinical partners.[22]

Despite this aid, many private providers are moving to operating under payers or health system rather than remaining private. Given the strain COVID-19 has placed on physician practices, we should expect more consolidation as one fallout from the pandemic. One example of this is Altais, a division of Blue Shield of California, who announced the acquisition

of San Francisco-based Brown & Toland Physicians, a multispecialty network of 2,700 physicians serving 350,000 patients.[23,24] The clinically integrated network is known for its risk-based contracts. Again, expect the trend that started before the crisis, i.e., payer acquisition of physician practices, to accelerate.

COVID-19 Implications for Clinical Pathways

As illustrated above, much has changed over the years and COVID-19 is pushing change even further, at a rate never seen before. Payment is increasingly government controlled in Medicare and Medicaid programs. These changes necessitate increased guidance for stakeholders, and they should be addressed within clinical pathways to ensure optimal outcomes, especially in the face of potential inappropriate restrictions. While government may be the primary payer, they continue to shift certain oversight and responsibilities to commercial payers. These commercial payers are increasingly acquiring providers and, again, this has been accelerated by COVID-19. The growing prevalence of payer-acquiring providers, termed payviders, in the market will change relationship dynamics, thus such alterations must also be reflected in adapted clinical pathways, as pathways can serve as a tool for stakeholders to assist in and guide processes.

As noted above, the faces of these providers are changing as well, from physicians to nurse practitioners, physician assistants, clinical nurse specialists, and pharmacists. The type of expansions of nonphysician providers means that clinical pathways need to incorporate the varying skill set and availability of these providers in pathways. Increased availability balanced against a different skill set means more opportunities around earlier diagnosis and referral to specialists.

Conclusion

These changes forced by COVID-19 will have long-term effects on every aspect of care delivery; current healthcare tools and programs such as clinical pathways, need to adjust to these changes (perhaps taking advantage of accelerated evolutions thrust upon stakeholders) to continue being helpful.

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