

VIEWPOINT

COVID-19: BEYOND TOMORROW

The Business of Medicine in the Era of COVID-19

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The United States will eventually get through the acute coronavirus disease 2019 (COVID-19) crisis but not without fundamental changes to the medical care system. Since the epidemic began, payment policy has stretched to remedy the bias of the health care system for in-person treatment provided by physicians. In response to the need for social distancing, new policies include broader payment for telemedicine, expanded scope-of-practice ability for nonphysician practitioners, and increased ability of physicians and nurses to practice across state lines. While these policy reforms address some of the immediate needs of this crisis, such as getting personnel to where they are most needed, they are not a complete solution to the COVID-19 crisis. How the aftermath of the current COVID-19 wave is handled will be just as important for the business of health care as what is happening now.

Two issues about the medical system after the current wave are particularly important: What type of organizations will be available to treat patients a few months from now? And how will those patients be most effectively served?

What Will the Health Care Landscape Look Like?

Hospitals and physicians treating most patients with COVID-19 have 2 financial challenges. The direct costs of caring for patients with COVID-19 are clear; many such patients are uninsured or require care that costs more than insurance pays. Likely much larger, however, is the financial effect of having postponed nonemergency care, ranging from office visits to elective surgery. These are the cases from which physicians and hospitals derive most of their profits. Elective care has declined across the country, with reductions in some services of 50% or more.

The good scenario for population health is also the good scenario for the business of medicine. It is possible that COVID-19 will be contained sooner than expected and that the economy will recover earlier rather than later. In that case, physicians and hospitals will fare well; indeed, there could be excess demand for services still deemed essential. But there could be pockets of concern even in this scenario. Will patients have concluded that some services are not so essential and thus not return for them? Will the rush of patients who do seek services lead to delays in scheduling and the rationing of capacity, both of which may lead patients to abandon valuable treatment out of frustration?

If the COVID-19 shutdown lasts for months or the normal business of health care does not resume until the fall, the implications for physicians and hospitals would be much more severe. In the past month, the response of many health care organizations to the reduction in primary and elective care has been to reduce staff provid-

ing those services. Employment in health care declined by an estimated 43 000 people from mid-February through mid-March¹ and has undoubtedly declined further since then. Approximately half the cost of primary care practices is attributable to salaries, so furloughs help ensure solvency.² But bills will have to be paid, and remaining costs cannot be reduced as much. The bank accounts of many practices are not large enough to absorb a long-term shutdown.

Some organizations are more vulnerable than others. In the hospital industry, rural institutions have lower margins than urban hospitals. This is particularly true in the South, where governors have been slow to enact stay-at-home measures and many states have not undertaken Medicaid expansion. Nearly 100 hospitals have closed in the South over the past decade.

Small primary care and specialty offices are also vulnerable because they are, in the end, small businesses: a significant share of primary care physicians work in practices with 1 or 2 physicians.³ If primary care or specialty visits are either deferred or foregone, the reduction in physician practice income could shutter some practices. It is unclear how effective the small-business loans that have been made available to many of these practices will be in ensuring they become operational again when social distancing ends.

This fall, and certainly into 2021, there could be additional consolidation of practices, both large and small. Smaller hospitals will look for capital infusions by merging with bigger hospitals, and physicians may find more security in larger groups. Several factors hasten these trends. Hospitals have started to work together to care for patients with COVID-19; merging may be a natural extension of that activity. Further, hospital personnel will be exhausted by caring for patients with COVID-19. Some clinicians will have become ill while caring for patients or will, in the worst circumstances, have succumbed to the virus. Additional physicians and nurses may thus be necessary. For services that do not come back, physicians in specialties that provide those services may need immediate job security.

The benefit of consolidation will be facilities that do not close and communities that maintain sources of care. But there are likely to be costs as well. Consolidation among hospitals and between hospitals and physicians significantly increases health care prices.⁴ This trend will further increase health care spending at a time when the lingering effects of the virus will already be raising private insurance premiums.

How Will Patients Be Served?

For physicians, COVID-19 may affect how they practice in even more fundamental ways. In response to the need to maintain social distance, many physicians have

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turned to telemedicine. In March, the federal government substantially eased restrictions it had previously placed on Medicare reimbursement for care provided via telemedicine. To support this move, federal and state governments also provided physicians with greater latitude to practice across state lines. In addition, nurse practitioners and other nonphysician clinicians were allowed greater ability to treat patients without direct supervision from physicians.

The substantial increase in the use of telemedicine during the crisis has been pervasive across health care systems. For instance, the Cleveland Clinic based in Cleveland, Ohio, reported being on track to complete more than 60 000 telemedicine for visits for the month of March compared with its prior average of about 3400 visits per month.⁵ Similarly, Jefferson Health in Philadelphia, Pennsylvania, has seen an increase in virtual visits on its JeffConnect telemedicine platform, from 60 visits per day before the pandemic to a recent figure of 2000 visits per day.⁶ These are but 2 examples of a much broader phenomenon.

The rapid growth of telemedicine and the broadening of clinician license raise the question of what becomes of these new approaches to treatment once the immediate COVID-19 crisis has passed. At this point, most of the easing of regulation has been temporary. What is not clear is whether, when, and to what extent these regulations will be re-established. There are many arguments for making these regulatory changes permanent. Just as telemedicine and the expansion of clinician capacity may help patients needing certain types of urgent care during this crisis, it may be a useful outlet to serve the wave of elective visits that is currently welling up. Further, it may also be helpful once the system returns to something approaching a "normal" level of volume. If keeping

older patients and those with chronic disease home is necessary in an epidemic, it also could be beneficial outside of an epidemic. Many long-standing efforts to reform the health care system have suggested that this may well be the case.

But the push for mergers and remote practice could go much farther, changing in a fundamental way what it means to be a physician and to practice medicine. Hospitals and medical practices have already reduced benefits and decreased hours for clinical staff.⁷ Might organizations decide that it is better to hire physicians on an as-needed basis rather than through employment? Emergency department care in the last decade offers a fitting analogy. Many hospitals, especially those with small volumes, found it difficult to staff a full-time emergency department. As a result, they turned to outside staffing companies. Having less to manage was good for hospitals, but the outsourcing of emergency care was identified as a key driver of the surprise billing phenomenon the nation is still addressing.⁸ To the extent that such practices become more widespread, new forms of regulation may be needed just as others are being relaxed.

Conclusions

Everyone hopes that medical care will return to normal in the coming months. But the new normal may be not as recognizable as some think. Some changes may be good, but the road is fraught with risk. It is possible, perhaps likely, that the painful process of reaching a new health care equilibrium will last well into 2021. Ideally, this time will allow for thoughtful discussion of how the intertwined forces currently affecting clinicians and other health care personnel, as well as hospitals, health care centers, and practices, can lead to sustained improvement of the overall system for delivering care.

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