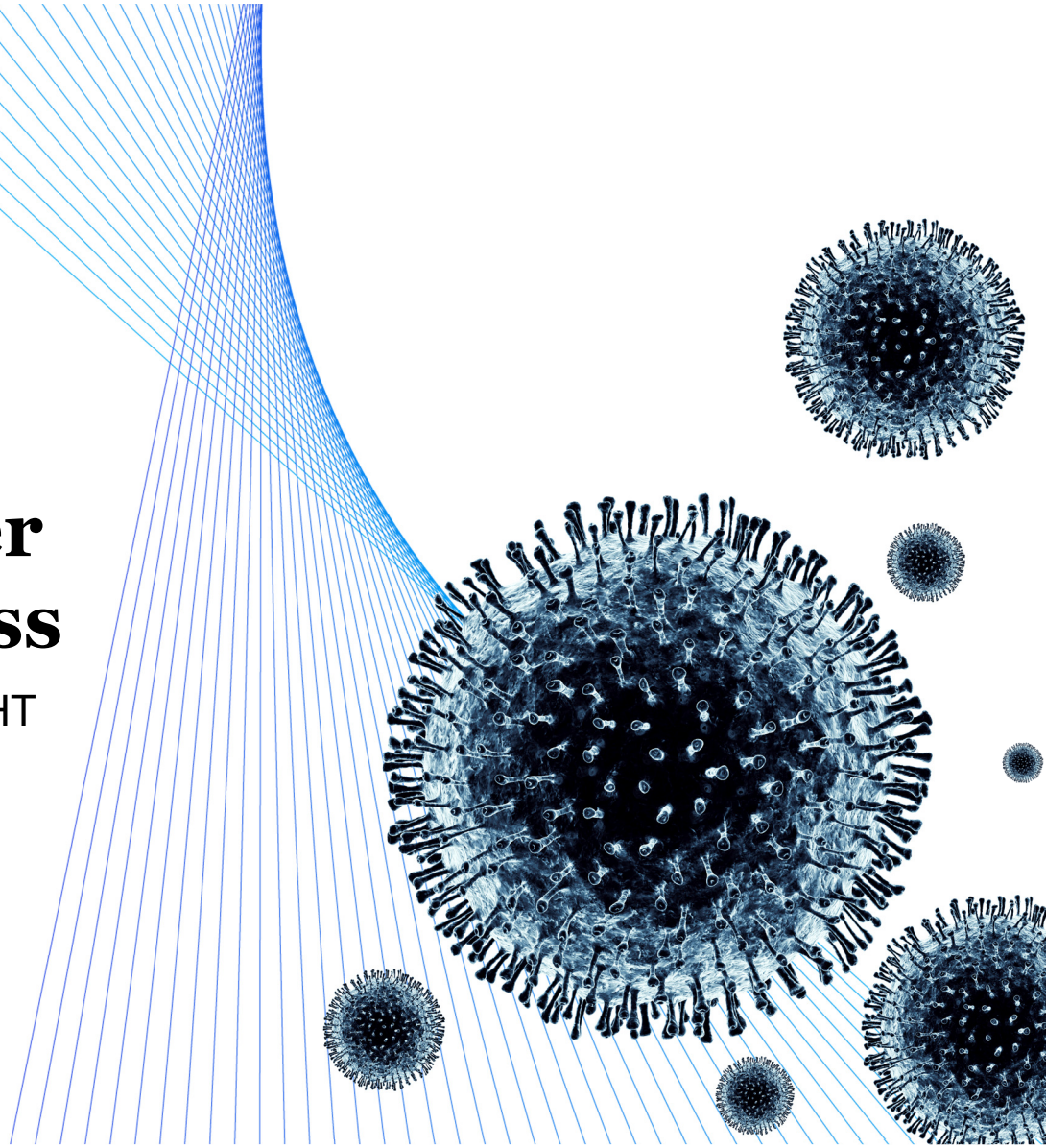
McKinsey & Company

COVID-19 Crisis: US Healthcare Provider and Payer Preparedness

DOCUMENT INTENDED TO PROVIDE INSIGHT AND BEST PRACTICES RATHER THAN SPECIFIC CLIENT ADVICE

Updated: March 18, 2020



Solving the humanitarian challenge is the top priority. Much remains to be done globally to prepare, respond, and recover, from protecting populations at risk, to supporting affected patients/ families/ communities, to developing a vaccine. To address this crisis, countries including the US will need to respond in an evidence-informed manner, leveraging public health infrastructure and proactive leadership.

This document is meant to help with a goal: provide a summarized fact base on the disease to date, insights on potential scenarios, and potential actions US healthcare providers and payers may consider.

In addition, we have developed a broader perspective on implications for businesses across sectors that can be found here: https://www.mckinsey.com/business-functions/risk/our-insights/covid-19-implications-for-business**.** This supplemental material discusses implications for the wider economy, businesses, and employment; and sets out some of those challenges and how organizations can respond in order to protect their people and navigate through an uncertain situation.

For all formal guidance, you can find **up-to-date information at CDC's COVID-19 website**, with a section specific to healthcare professionals: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html

Table of contents

COVID-19 appears to be more dangerous than the flu

Latest as of March 16, 2020

Features of the disease to date[1]

1.5-2x

Higher reproduction than the flu

Up to 20%

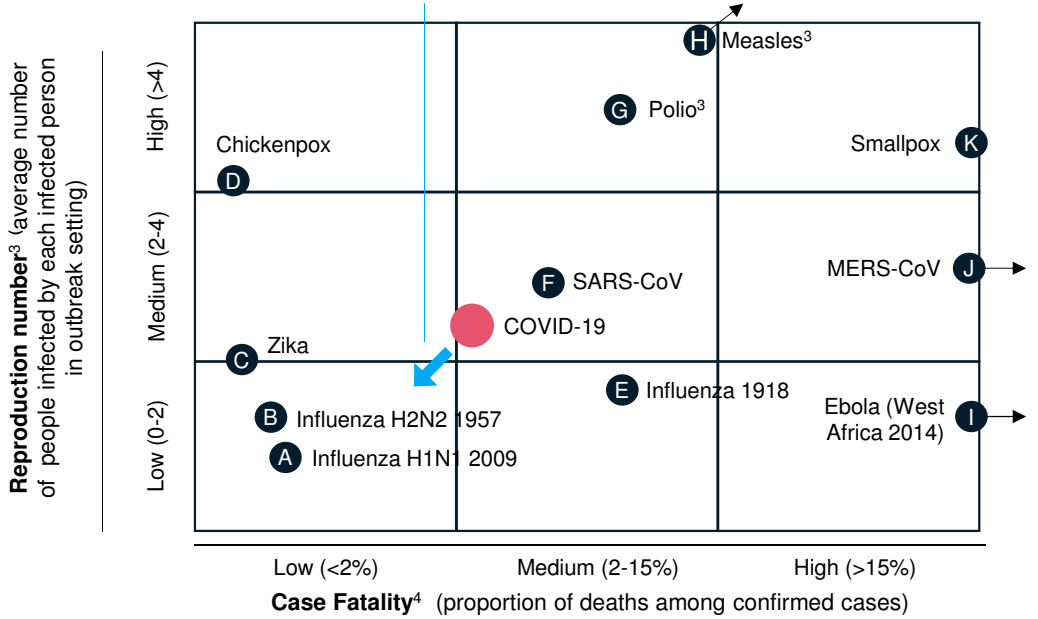
Of cases have a severe/critical form of the disease[6]

~0.9%

Case Fatality Ratio in South Korea after widespread testing. CFR appears higher where cases are missed and is higher when health systems are overwhelmed[2]

Comparison to other diseases[5]

Early identification of the disease, intensification of viral control, and treatment, when available, will reduce reproduction number and case fatality



1. Evidence on exact numbers are emerging, however expected to decrease as viral containment measures intensify and treatments are developed
2. WHO estimates the global average CFR at 3.4%, dependent on conditions such as patient age, community immunity, and health system capabilities. Latest case fatality ratios were calculated as death/ cases
3. In outbreak setting or the introduction of a new disease
4. Case Fatality numbers reflect outbreak settings and factors such as the patient's age, community immunity and health system capabilities
5. Estimates are very context and time-specific, however are provided from prior outbreaks based on academic lit review
6. WHO estimates 15% severe and 5% critical

The global spread is accelerating with more reports of local transmission

Latest as of March 17, 2020

1. Previously counted only countries; now aligned with new WHO reports; excluding cruise ship;
2. Previously noted as community transmission in McKinsey documents; now aligned with WHO definition

Sources: World Health Organization, CDC, news reports

Current as of March 17, 2020

Impact to date

>167,500
Reported confirmed cases

>6,600
Deaths

>150
Countries or territories with reported cases[1]

>80
Countries or territories with evidence of local transmission[2]

~40
Countries or territories with more than 100 reported cases[1]

0.3%
China's share of new reported cases March 10th-16th

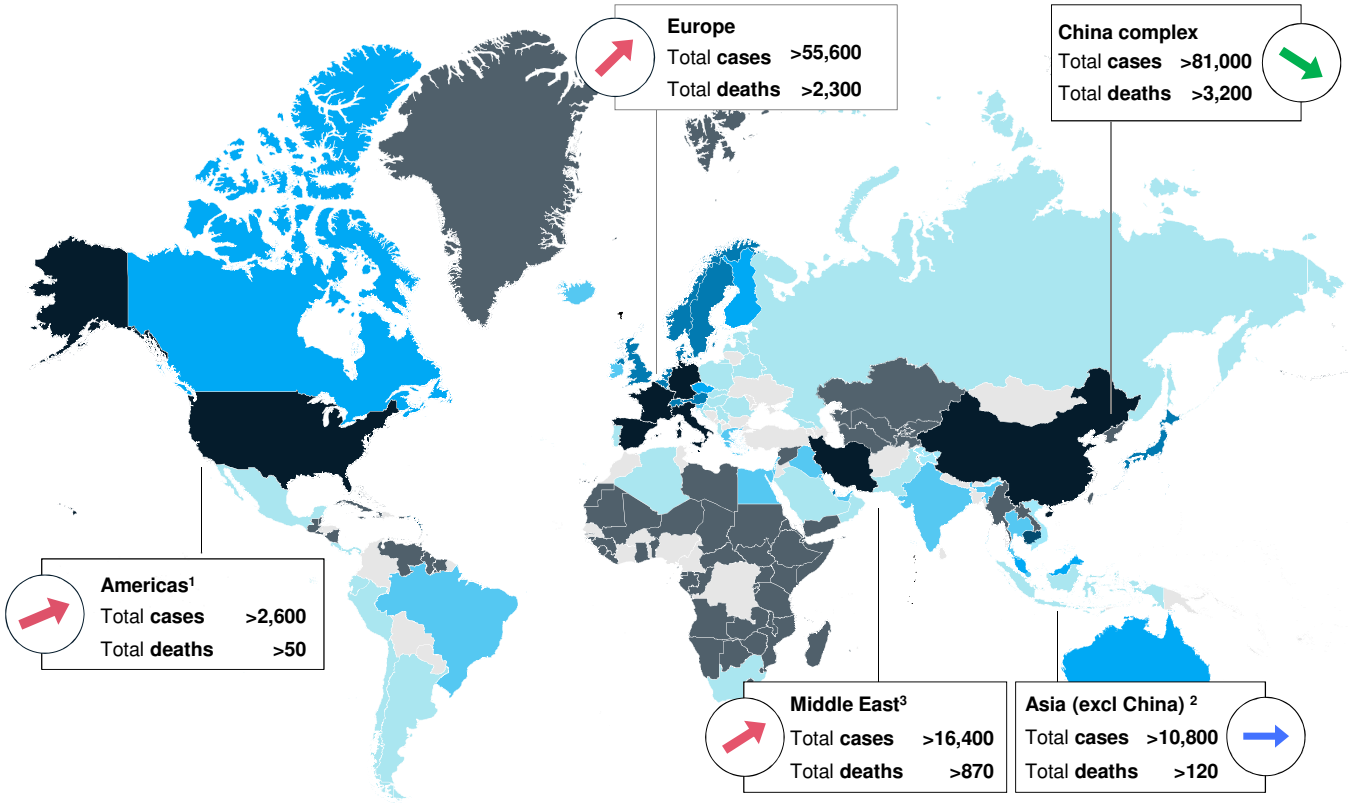
~75%
New reported cases on March 10-16th from Europe

>45
New countries with cases March 10th-16th

The virus is located in five major "transmission complexes"

A complex is an area with confirmed local transmission, and more than 100 confirmed cases, where it is difficult to prevent people's movement

- ↗ Propagation trend
- Mature/ on-going propagation
- Early propagation
- > 1000 reported cases
- 250-999
- 100-249
- 50-99
- 10-49
- <10



1.WHO data is lagging news reports for the US; In the US, CDC reports >3,400 cases; NYTimes reports >5,000 cases
2.Includes Western Pacific and South-East Asia WHO regions; excludes China; Note that South Korea incremental cases are declining, however other countries are increasing
3.Eastern-Mediterranean WHO region

Source: World Health Organization, team analysis

Progression varies widely among countries

Country				Status	Recent Actions
China	>81,000 Cases	>3,200 Deaths	~4.0% Case Fatality[2]	New cases at low levels throughout China	Strict containment and mandatory 14-day quarantine for inbound travelers Significant testing at facilities and in Hubei Construction of makeshift field hospitals
South Korea	>8,200 Cases	>70 Deaths	~0.9% Case Fatality[2]	New cases declined ~70% in the last week with potential decline or plateau[1]	Significant preparedness & rapid regulatory approval process for tests Rapid roll-out of diagnostics (e.g., drive-through tests) Hospitalization now available for lower-severity cases & significant hospital coordination
Italy	>24,700 Cases	>1,800 Deaths	~7.3% Case Fatality[2]	~3,500 new cases on March 16th – the highest in the world, corresponding to a ~140% increase in the last week[1]	Efforts initially focused on Northern Italy, but the country is now in nationwide lockdown Schools and non-essential businesses closed Accelerated medical training & graduation to relieve shortage of healthcare workers
US[3]	>1,600 Cases	>40 Deaths	~2.4% Case Fatality[2]	US cases are increasing daily, however official reporting may be lagging[3]	National emergency declared on March 13 with Congress aiming to provide testing free of charge 48 states have declared emergency with a range of actions including school and business closures, bans on gatherings, and large-scale testing plans Varied local responses at city and municipality levels

1. Number of new confirmed cases on March 16th compared to March 9th
2. Case Fatality calculated as (total deaths) / (total cases) – this rate is evolving and dependent upon several factors, including number of suspected cases that are tested
3. WHO data is lagging news reports for the US; In the US, CDC reports >3,400 cases; NYTimes reports >5,000 cases

Source: WHO situation reports, US CDC, press search

Overall, ~20% of cases are estimated to be severe/critical, requiring significant health capacity for testing and critical care infrastructure

Current as of March 13, 2020

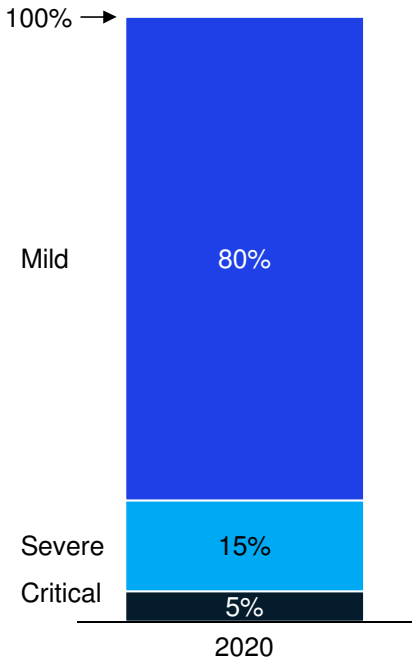
Context

WHO estimates ~20% of COVID-19 cases are severe (requiring oxygen) or critical (requiring ventilation)

This reflects a higher level of severity compared to influenza for instance

At a country level, mild cases may go undiagnosed

WHO estimated global distribution by severity of symptoms



Severity by country may vary

China

As of February 24, 2020 (~45K cases)

- Similar mix of mild / severe / critical confirmed cases to WHO estimate
- ~16K suspected cases were left undiagnosed, driven by testing limitations

Italy

JAMA

ICU admissions in first two weeks represented 16% of all patients who tested positive for COVID-19

News reports

March 3, 2020	March 10, 2020	March 12, 2020
56% of patients who tested positive for COVID-19 are hospitalized	ICUs almost at full capacity in Lombardy, region hardest hit by COVID-19	Northern regions trying to expand ICU capacity with and 230+ ICU spots added

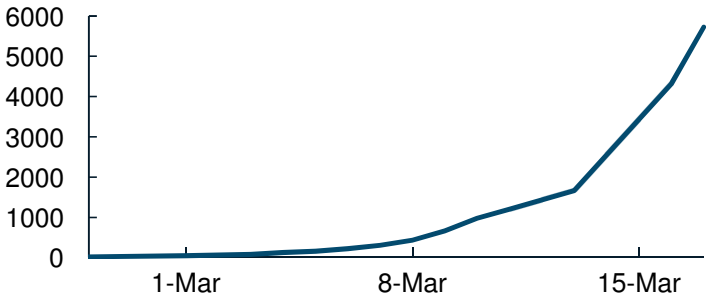
Source: JAMA, WHO, U.S. CSC, WSJ and associated press interviews with Italian physicians

To date, there are potentially over 5,726 reported cases in the US

Growth in cases as of March 17, 2020

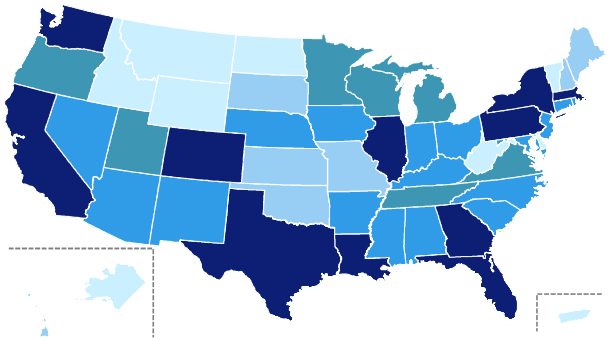
Approximate

Trend of confirmed COVID-19 cases in US



5,726+ total cases reported with significant growth in the last week

States with cases in the US[1]



100+ reported cases
51-100 reported cases
21-50 reported cases
10-20 reported cases
1-9 reported cases

1. Plus Washington, D.C., and three U.S. territories

Source: New York Times, Johns Hopkins CSSE, CDC

Current as of March 17, 2020

5,726+
Total cases

50
States with cases of COVID-19[1]

107+
Deaths due to COVID-19

US media sources appear in some instances to be ahead of official WHO / CDC case counts; we are showing the highest widely reported figure

Current as of March 17, 2020

US: Two scenarios for COVID-19 spread

US situation could evolve one of two ways, which can inform contingency planning

	Moderate[2]: Largest metro areas impacted	Severe[2]: Generalized spread
Degree and rate of spread[1]	**Several major clusters of disease (metro areas / regions) with less impact in other parts of the country.** Seasonality of the virus **leads to a peak in April and a plateau in new cases by end of Q2. Total cases 50K – 500K**	Case transmission is not contained, **accelerates in the near term, continues over a longer duration (>3months)** and becomes widespread - **ultimately reaches 500K – 10M+ cases** before plateauing towards end of 2020
Severity of disease	**Health systems challenged** by rising cases; significant acceleration in cases, **Mortality rate at ~0.75-1%**	**Health systems challenged** by exponential case growth**;** higher disruption in areas with lower care access and lesser prepared/equipped health systems; **Higher mortality upwards of 0.75-2%**
Affected regions	**5-7+ metro clusters see cases in the thousands -** low **hundreds of thousands**. More limited cases in other areas	Widespread throughout country, with **all major US cities experiencing a significant quarantine in March/April**, with some areas extending quarantine dependent on spread

As US data is reported, scenarios will be updated in real time

1. Rates and cases reported here represent confirmed cases, not symptomatic patients
2. These align to the 'Delayed Recovery' and 'Prolonged Contraction' scenarios as described on McKinsey.com: https://mckinsey.com/covid-19

How could this play out in a major metropolitan area?

Several factors to consider in major metropolitan cities for COVID-19 burden

1

Coastal cities and urban centers which have **high inbound and outbound travel** will likely host the largest growth in new cases

2

Local transmission (i.e., patients with no ties to international sources) becomes primary mode of spread in large urban centers where population density increases proximity to asymptomatic and mildly symptomatic patients. Local transmission is also possible in secondary town / rural areas

3

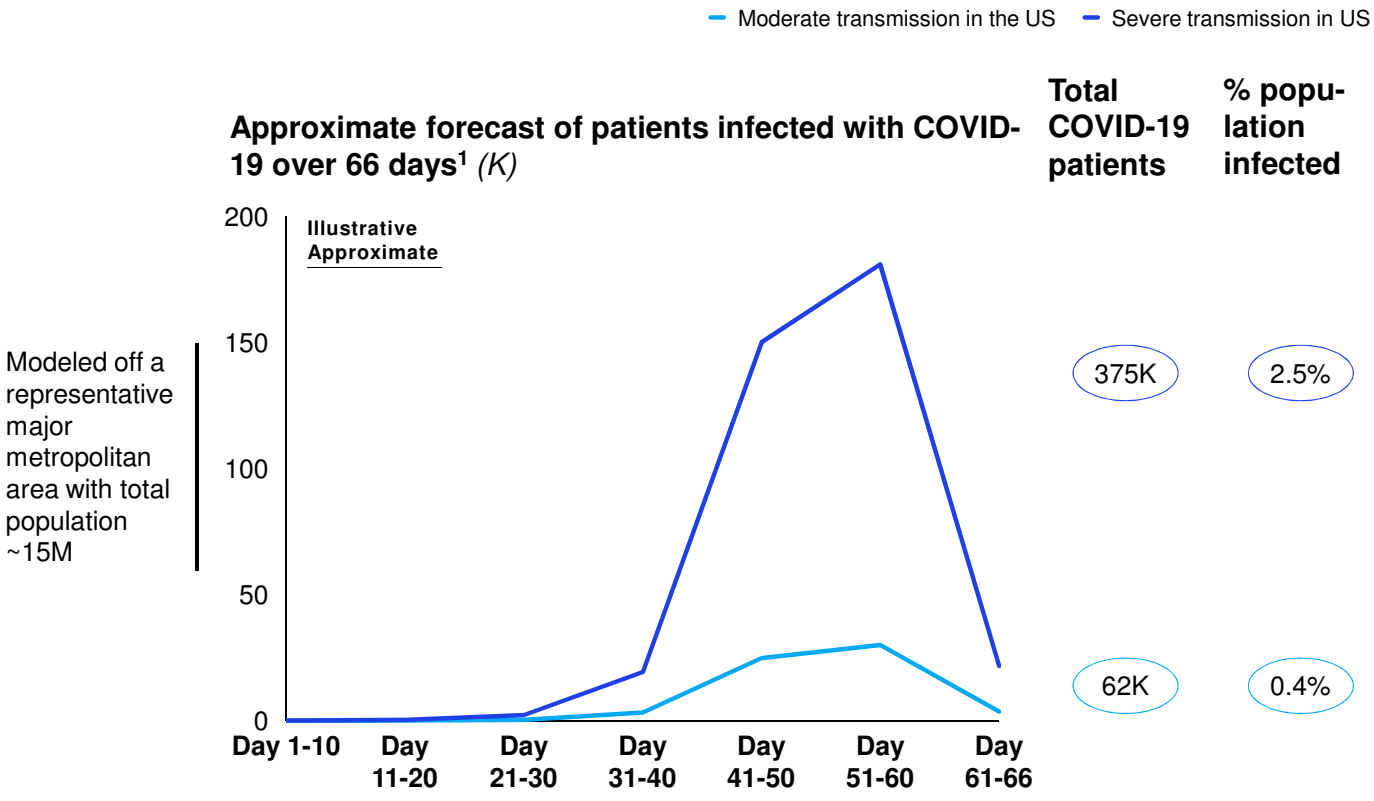
Public health measures such as social distancing and work from home recommendations are **likely to vary by city** based on local disease severity and population tolerance for restrictions

4

Access to healthcare will also vary with major metropolitan areas having the greatest access

Representative major metropolitan area: Scenario of COVID-19 disease burden

Scenario US disease spread based on China experience



1.Cumulative - line indicates the number of new COVID-19 cases predicted at each time step
2.Calculated as adult ICU beds + general medical/surgical adult beds + burn care beds + other special care beds + intermediate nursing care beds

Source: JAMA Characteristics of and Important Lessons From the Coronavirus Disease 2019 (COVID-19) Outbreak in China; https://jamanetwork.com/journals/jama/fullarticle/2762130

Key assumption:

Time course and percentage of infections over time mapped according to China experience as reported in JAMA

Multiple factors likely will make the US curve different:

1. Number of entry points
2. Public health containment procedures
3. Access to healthcare (including diagnostics)
4. Patient characteristics
5. No zoonotic event in the US

Table of contents

Current as of March 17, 2020

There are 10 major considerations for the US delivery system in response to the COVID-19 outbreak

Detail in appendix

Workforce readiness

1. Establish a multi-level, workforce-wide communication strategy utilizing CDC healthcare guidelines, including identifying who is eligible to treat COVID-19 patients and targeted, culturally sensitive communication for those at different levels of probable patient contact
2. Develop action / contingency plan for increased staffing demand (e.g., uptraining / cross-training personnel, recruiting, contract labor)
3. Establish protocol to monitor workforce health in the context of COVID-19 (e.g., burnout and other behavioral health, PPE-related pressure ulcers, staff infection) and establish systems to address needs, including childcare and designating safe quarantine areas for workers who may be exposed but live in high-density environments

Supply availability

4. Identify at risk supplies and understand current inventory and near-term ability to procure vs. projected demand
5. Implement detailed conservation protocols for critical supplies, identify acceptable alternatives in conjunction with infection control, and rigorously track inventory between sites for potential internal re-balancing

Surge capacity

6. Assess bed availability for infected and at-risk patients
7. Identify alternate sites for diagnosis/ triage (e.g., tents, parking lots/ vehicles, non-clinical space) and alternative diagnostic processes (e.g., diagnosis prior to waiting room entry, remote communication with patients requesting diagnostics/ exhibiting early symptoms)
8. Similarly, identify alternative treatment areas in case of surge (e.g., locations that can be converted into treatment wards - unstaffed floors, physical therapy space, outpatient health and non-healthcare facilities), options for patient transfer to regional referral centers
9. Establish systems/protocols to shift care of non-critical patients (e.g., patients primarily in need of social support) and establish proactive communication strategy for patients and staff about alternative options for treatment in non-acute scenarios (e.g., telehealth, home care), including access to telehealth outside of normal business hours

Governance

Critical enabler

10. Prepare for a “medium-term” COVID-19 management strategy - establish a Emergency Operations Center
    - People: Designated COVID-19/ emergency response program lead (with back ups identified in case of burnout/clinical need)
    - Performance: Dashboard for continuous monitoring of key operational (e.g., beds, volumes), financial (e.g., supply cost variability/ advance purchasing, elective volume declines) indicators
    - Top management: clarify key new responsibilities for top teams in context of potential epidemic

Key questions to ask leaders in your organization

Detailed checklist of actions in appendix

Chief Operations Officer (or equivalent)	Do we have an up-to-date understanding of **facility and workforce capacity,** and daily ability to monitor/ adjust? Do we have **relevant supplies in stock** and an approach to rapidly sourcing **and distributing** in the case of shortages? Do we have effective **plans for managing patient volume (e.g., delaying elective volume; addressing increased behavioral health demand, including via telehealth) if required**? Have we established inpatient / ED clinical **operational workflows** to handle the specialized needs of COVID19 patients?
Chief Administrative Officer (or equivalent)	Do we have the right **safeguards and policies for employees**, including right frequency and rigor of updates? Have we established a best in class **communication cadence** with our employees, both caregivers and non-caregivers? Do we have a strategy for **hiring or temporarily contracting** staff to support expanded telemedicine, telephonic and other capabilities?
Chief Financial Officer (or equivalent)	Have we **pressured tested our financials** (including P&L and working capital) given potential scenarios, identified **strategies if required to mitigate risk (e.g., credit)**, and prepared appropriate **investor messaging** on biggest areas of exposure (e.g., softening elective volume)? Have we evaluated the potential **financial implications** of increased patient utilization of telemedicine? Have we thought about the potential financial implications associated with **reduced elective volume**, and strategies to mitigate that?
Chief Information Officer (or equivalent)	Have we established systems for the real-time **collection and analysis of data** to rapidly capture and integrate learnings? Have we established **data sharing agreements** with local, state and / or national public health agencies?
Chief Nursing Officer (or equivalent)	Do we have a clear plan to address **to address workforce shortages and increased care demand**, including sourcing from other network providers, contracting and cross-training?
Chief Medical Officer (or equivalent)	Have we considered **dedicated clinical workforce teams** for COVID-19 patients as a potential strategy to handle increased demands? Are all providers aware of the **latest CDC guidelines** for treatment of potential COVID-19 patients? Have we developed **protocol and processes for reducing elective volume to help address and mitigate capacity concerns** (e.g., elective PCI, orthopedic surgeries, gastroenterological procedures)? Are we actively planning for **remote/virtual care** protocols?
Chief Patient Safety Officer (or equivalent)	Do we have clear **protocol and systems to assess adherence to clinical safety** and quality guidelines (e.g., appropriateness of COVID-19 diagnostic testing)?
Chief Executive Officer (or equivalent)	Do we have the right **communication strategies with patients and providers** and, as necessary, external constituents (e.g., public health authorities, employers)? Do we have the **right systems and dashboard setup** to continuously monitor key operational, administrative and epidemiological indicators? Given **potential reductions in outpatient elective volume** as well as selective inpatient service line volume increases, have you developed **strategic initiatives to mitigate these forces in real-time or downstream** when COVID-19 burden drops? Have we developed **partnerships with payers, vendors and local businesses and community agencies** to effectively execute on latest clinical and operational recommendations?

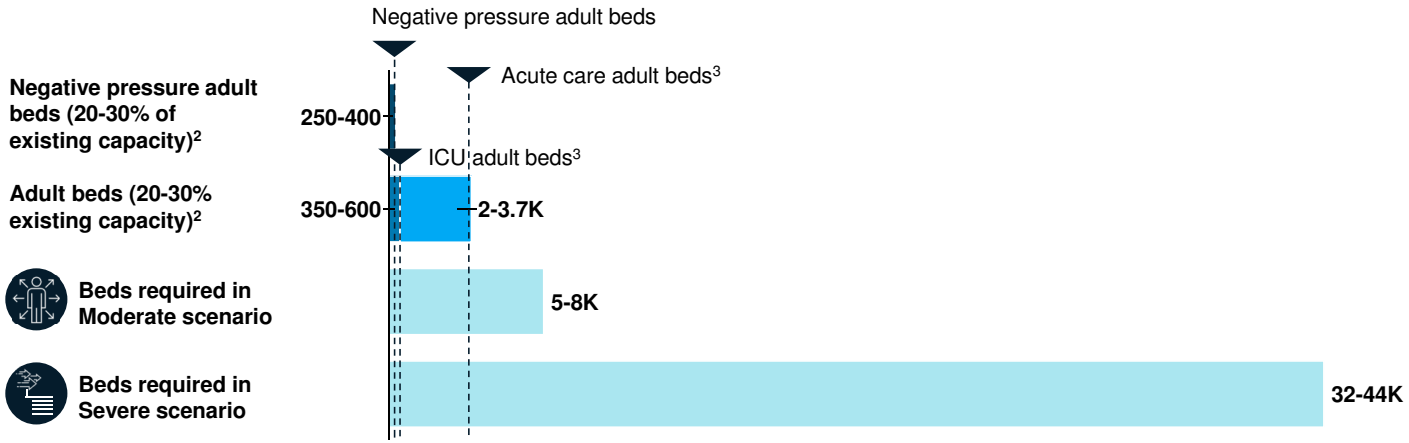
Source: Expert interviews

Contents

Current as of March 17, 2020

Representative major metropolitan area: Given disease burden and CDC recommendations, providers could experience capacity constraints

US representative major metropolitan area bed availability and requirement given each COVID-19 potential scenario[1]



Given this, implications on workforce, supply chain, and facility (bed) capacity should be considered and proactively planned for

1.Calculated based on approximate peak time/number of hospitalized patients across 66 day period of COVID-19 outbreak in a representative major area in the US, this approximation provides a slight underestimate because it takes an average patient volume over 10 days and does not factor for patient overlap between 10 day periods (i.e., patients that stay in the hospital for more than 10 days)
2.In representative major area in the US - Assumes hospitals can free up 20-30% capacity of all bed types
3.Calculated as per AHA 2018 reported bed counts: ICU beds = medical/surgical intensive care beds + cardiac intensive care beds + other intensive care beds | acute care beds = general medical/surgical adult beds + burn care beds + other special care beds

Source: CDC; AHA 2018 bed data; JAMA - Characteristics of and Important Lessons From the Coronavirus Disease 2019 (COVID-19) Outbreak in China; JAMA - Positive RT-PCR Test Results in Patients Recovered From COVID-19 - https://jamanetwork.com/journals/jama/fullarticle/2762452;

Key assumptions:

1. Evaluates peak infection period only where the most patients will need to be cared for at the same time
2. 20-30% of bed capacity in each category of beds can be freed up to care for COVID patients

With an impending shortage of hospital beds accompanying the COVID-19 pandemic, hospitals must consider options to expand capacity

Current as of March 17, 2020

Levers to increase hospital capacity	Deploy mobile hospitals	Bring in unlicensed beds	Explore additional areas in hospitals	Utilize attached specialty hospitals	Convert existing post-acute care facilities	Partner with outpatient clinics	Use non-health care facilities	Partner with a local VA or military hospital
Examples	Temporary mobile solutions (i.e., vans, trailers, etc.) serve as sites of care Vanguard Health Solutions (UK) offers mobile hospital wards with 6 bed-capacity and overhead oxygen[1] and Aspen Medical (AU) offers 100 bed units assembled onsite in 72 hours[2]	Place additional beds in hallways or other free areas to extend capacity NYP employed this strategy during Hurricane Sandy[3]	UCLA has placed tents in the parking lot to increase ED capacity[4] NYP converted space in an open atrium to an interim ED during Hurricane Sandy[3]	Cancel elective surgical cases at specialty hospitals (i.e., ophthalmologic institutes and orthopedic surgery centers) and convert to hospitals for COVID-19 patients	Utilize capacity of post-acute care facilities such as SNFs, LTACs and rehabs for extra bed space	Cancel non-essential office visits and convert to hospital space for COVID-19 patients	New York Governor Anthony Cuomo has recommended converting facilities such as military bases and college dorms into temporary medical centers[5]	The Department of Veterans Affairs is reported to be preparing to absorb COVID-19 patients The department has surplus beds in many of its 172 hospital centers and rooms equipped to support patients with breathing disorders[6]

1. Vanguard Health Solutions, https://www.vanguardhealthcare.co.uk/fleet/hospital-ward/
2. Aspen Medical, https://www.aspenmedical.com/health-services/deployable-mobile-hospitals
3. McKinsey expert interview
4. NBC's Meet the Press
5. New York Times, https://www.nytimes.com/2020/03/15/opinion/andrew-cuomo-coronavirus-trump.html
6. New York Times, https://www.nytimes.com/2020/03/15/us/politics/veterans-affairs-coronavirus.html

Contents

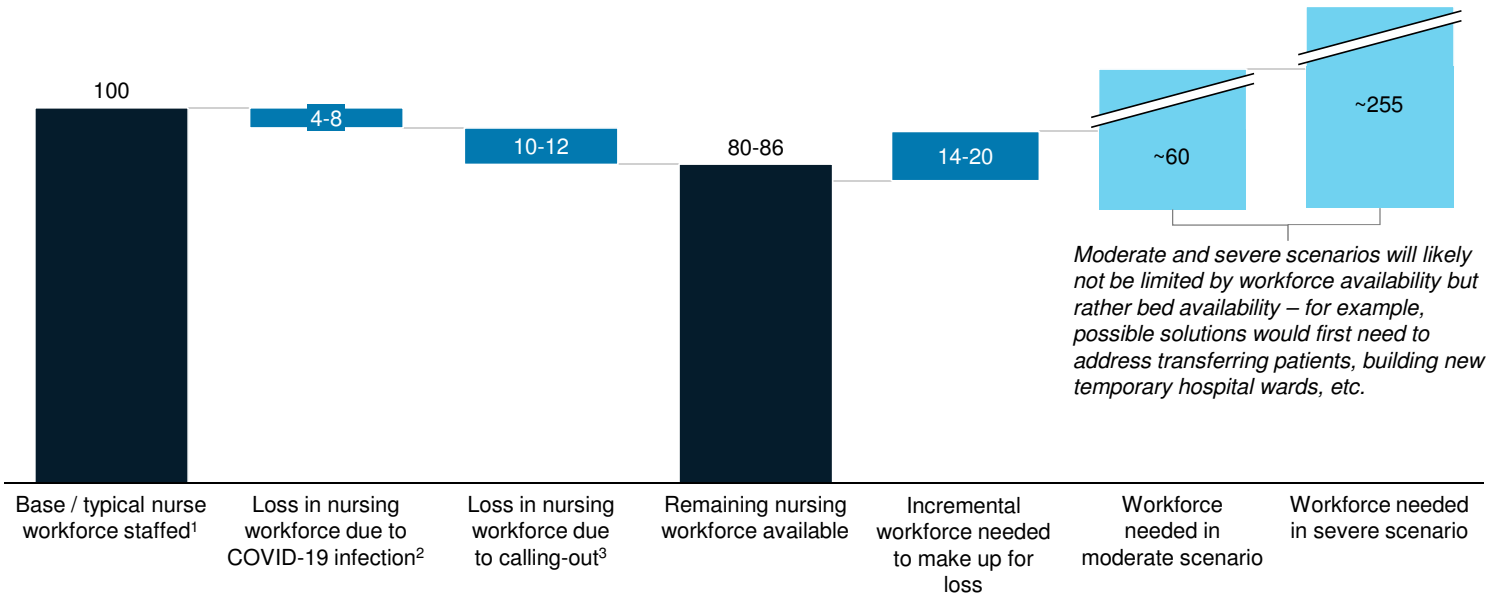
- Care (bed) capacity
- **Clinical workforce**
- Clinical operations
- Supply chain

Hospitals will likely need to plan for increased staff based on reduced nursing workforce and increased patient burden

Scenario of representative medium sized hospital (300-500 beds) during peak period of COVID-19 epidemic

Nurse FTE reduction due to factors related to the COVID-19 epidemic (per 100 productive[4] FTE nurses)

Workforce needed to care for patients during the peak of the epidemic[5]
(per 100 productive[4] FTE nurses)



Potential methods for increasing workforce to meet new demand include (non-exhaustive):

- Request overtime shifts
- Hire additional agency workforce
- Collaborate with surrounding hospitals to share workforce in high/lower effected geographies areas and/or transfer patients
- Reschedule elective procedures / admissions

Additional mitigating factors detailed on next page

1.Assuming a hospitals full workforce is staffed at 80% bed capacity, all workforce measured in full time equivalents (even if the workforce includes some part time employees)
2.Assuming a 3.8% health care personnel infection rate - same rate as China as of 2/24/2020; Assuming an additional ~4% health care personnel quarantine rate due to unprotected exposure
3.Assuming a call-out rate of 10-12% (give that a normal call-out rate is ~5%) due to inability to care for COVID-19 patients due to caregiver or childcare needs, immunocompromised status, etc
4.Productive workforce (e.g., not including training, sick days, etc.)
5.Given mild scenario is no longer viable, these numbers assume all hospitals in a health system will serve COVID-19 patients (i.e., even distribution of COVID-19 patients)

Current as of March 17, 2020

Healthcare workforce is complex and different groups of employees will have different needs during this time

The impact of disruption and potential strategies to mitigate will differ by group

Group	Description	Key considerations
Group 1: COVID Caregivers	Workers who are fulfilling the need for current health system **demand related to COVID-19** (e.g., hospitalists, critical care physicians, ICU RNs, security at the hospital, lab technicians, care managers)	**Demand is high**: Creating additional capacity is critical, through flexing up, contract labor, activating cross-trained personnel **Supply is strained**: Large increase in strain on workforce with childcare, quarantine and other factors Must ensure there are strategies in place to **avoid burnout**
Group 2: Other Caregivers	Workers who are caring for patients / other populations **not related to COVID-19** (e.g., speech language pathology techs, orthopedic surgeons, clinic receptionists)	Many patients will still require life-saving and critical maintenance care, requiring **healthcare workers to continue working but potentially in creative ways** (e.g., more telehealth, sanitization efforts in care sites, home care support) Physician and others' **productivity will be impacted** which may raise questions and concerns around areas such as **compensation** Some caregivers' skills may be **useful in COVID-19 support** and all hands on deck approach may be needed with some **flexing** / **re-skilling**
Group 3: Workers with likely reduced demand	Workers who are potentially **under-employed or unable to work their usual jobs** because of COVID-19 (e.g., researchers in closed labs, food workers at closed site, home health workers)	**High anxiety over job security**, ability to make living wages (especially among hourly employees); **clear messaging will be needed** to manage panic and show support Need to be creative in thinking through **how to mobilize some of these employees in a productive way** (e.g., supporting community programs, trainings etc.)
Group 4: Workers who must work differently	Workers **who are less impacted** by COVID-19 directly (i.e. can do same work done from home) (e.g., administrators, coders etc.)	**Tools to complete work and new ways to stay connected** will be needed; likely reduction in productivity can be expected in several areas Considerations around **how to flex staff** and ensure some of "business as usual" continues so support functions can continue to operate

Current as of March 17, 2020

Preparedness to address a set of unique challenges in workforce readiness is critical during the COVID-19 crisis

Across a spectrum of healthcare workers

Non-exhaustive

	Workforce shortages	Workforce readiness / flexing	Workforce morale / "burnout"
Challenges	**Increasing capacity: unsuitability of traditional methods** such as travelers (e.g., travel restriction, global demand); **difficulty in rapidly engaging non-traditional sources** (medical students, IMGs, retired HCPs) due to regulatory, legal, patient safety issues **Reducing losses: expected COVID-19 infection** of HCPs (~10-20%); **burnout** / **fatigue** of frontline workers; **non-clinical imperatives** for workers (childcare, elderly care etc.)	**Guidance and communication:** rapidly **evolving evidence-base** for COVID-19 with new information daily; non-centralized, **disparate communication on roles** **Flexing and re-skilling: shift restrictions** (hourly and weekly restrictions); **licensure ceilings** (e.g., who can work in ICUs**); time and resources for re-skilling** (needed to train in ventilator mgt.); **lack of readiness for using tech** in pandemic situations (e.g., e-ICUs, management of moderate symptoms by phone etc.)	**Work-related: over work and fatigue** (e.g., staying in-hospital for extended periods); **anxiety** from infection risk for self and others; **resource constraints** / difficult work environment (e.g., re-using of PPE); **patient losses** and "war-like" decision-making needs (e.g., which patients to triage for limited ICUs) **Systemic: Increase in other duties** (child care, sick care etc.); **lack of community support** (e.g., in prevention of infection, reducing burdens etc.); **loss of productivity** from change in structure (e.g., WFH)
Solutions	**Policy changes** to increase pool of providers (e.g., rapid license issuing) **Prioritizing of infection control** (e.g., PPEs, public education etc.) Working with **FEMA** / **support organization** for systemic response **Structure support systems** for childcare, eldercare etc.	Centralized information from **nerve center** **Re-structuring shifts** to improve efficiency Identifying and flexing providers **who can move to group 1** (e.g., double boarded physicians, nurses with ICU experience etc.) Creating **rapid re-skilling materials** (e.g., e-learning for vent mgt.) **Optimizing virtual health** Identify senior medical and surgical **residents who can be transitioned to independent practice**	**Support for HCPs in-house** (e.g., food, childcare, online resources on working in this environment etc.) **Community support for HCPs** – for childcare, grocery pick-up, etc. **Proactive mental health support** for HCPs
Workforce focus	**Group 1**	**Group 2, Group 3**	**All Groups**

Contents

- Care (bed) capacity
- Clinical workforce
- **Clinical operations**
- Supply chain

Current as of March 17, 2020

There are implications for clinical operations along 3 phases of the patient journey

Patient population

Pre-diagnosis (prior to seeking care)

Patient population that providers should be **proactively engaging remotely** to educate, assess risk if relevant, and provide guidance / precautions on visiting sites of care

Diagnosis

Patients initially screened (remotely or in person) and **identified for need to undergo COVID-19 diagnostic testing**

Includes patients undergoing diagnostic testing in ED and outpatient setting (e.g., primary and urgent care)

Confirmed positive

Patients with confirmed positive test results via local and/ or CDC lab testing

Includes patients whose **symptoms are sufficiently severe to warrant hospitalization and concerning history to warrant isolation** (excludes home quarantine patients)

Across each phase, providers should also consider developing standardized protocols for proactively engaging patients' families, caretakers and employers throughout their care journey

These perspectives are intended to build from CDC and other guidance based on operations and management experience. Please continue to consult CDC, state health department, and medical societies for the most up-to-date guidance. These perspectives are not intended as a substitute for professional medical advice, diagnosis or treatment. Any actions impacting clinical decisioning should be vetted by the appropriate quality committees within your organization.

Current as of March 17, 2020

For patients not diagnosed, providers can establish a number of offerings to minimize unnecessary exposure to sites of care

Five elements to establishing a strategy to prevent overcrowding sites of care

Pre-diagnosis > Diagnosis > Confirmed

Establish COVID-19 telephonic support / care navigation	Designate a dedicated **COVID-19 patient advice line** Establish proactive **multi-channel communication options** for patients to express concerning symptoms Via phone and text communications, push **patient portal registration** to access updates and tools Develop protocol to **screen** scheduled patients before they arrive to a care site for a visit Develop and implement protocol to identify and route patients who need **behavioral health support**, in addition to or in lieu of medical services
Develop COVID-19 web- and app-based resources/ care navigation	Develop a library of CDC-aligned COVID-19 **educational resources** Design a COVID-19 patient **self-assessment tool**[1] based on the latest local and CDC public health guidelines Establish a process to alert providers if patients have positive self assessment results; engage in **proactive outreach**
Strengthen telemedicine services where appropriate	Offer **telemedicine options** to patients who do not need to be seen at sites of care Leverage existing **remote patient monitoring capabilities** for patients suspected positive, quarantined at home and not needing hospitalization Increase access to **behavioral health telemedicine** options to address increased demand due to crisis and social isolation
Prepare and leverage home health services	**Uptrain home health vendors** on CDC guidelines and how best to engage with patients Establish protocol with home health vendors / services to **proactively screen patients for COVID-19 prior to visits** Consider ability to **develop program to provide supportive care** to suspected and confirmed COVID-19 patients in-home Partner to enable **in-home specimen collection**, when it becomes available
Engage local agencies and payers	**Establish relationships with local employers, businesses, community agencies, and primary care provider networks** (e.g., retail clinics) to enable scaled access your services Work with payers to **cover telehealth services** at parity in the short term, where currently not covered

Given urgency, providers should prioritize strengthening existing offerings and deploying them as quickly as possible and limit investments in new capabilities

1.Continuously monitor whether the CDC or other third party vendors have developed app- or web-based screening assessment tools

These perspectives are intended to build from CDC and other guidance based on operations and management experience. Please continue to consult CDC, state health department, and medical societies for the most up-to-date guidance. These perspectives are not intended as a substitute for professional medical advice, diagnosis or treatment. Any actions impacting clinical decisioning should be vetted by the appropriate quality committees within your organization.

Source: CDC, Expert interviews, Press search

Current as of March 17, 2020

For suspected COVID-19 patients, providers can establish a series of operational systems and controls

Ambulatory and emergency service operations can be enhanced to control spread of suspected COVID-19

Pre-diagnosis **Diagnosis** Confirmed

Outpatient / ambulatory services	Consider designation of separate COVID-19 **ambulatory testing sites** Develop protocol based on pre-diagnostic criteria to **route patients** to designated diagnostic testing sites Consider establishing **dedicated staff** to operate testing sites; train staff on appropriate collection and handling of specimen, per CDC / public health guidelines • Establish a combination of **engineering and administrative controls** to minimize patient and workforce exposure to suspected cases Establish protocol to route patients to the nearest available **emergency room or other designated clinical sites** based on clinical guidelines as set by the CDC Develop protocol and partnerships with **out-of-network providers** (e.g., retail clinics, urgent care) to address the needs of patients who have concerning symptoms and require hospitalization Reschedule non-urgent OP visits as necessary
Emergency room / pre-triage services	Consider establishing a separate **diagnostic area outside core facilities** (e.g., tent outside ED) to perform screening and clinical assessments; also consider ways to rapidly triage and discharge patients that do not require emergency care but remain practicing within EMTALA guidelines Consider **redesigning the ED to establish a separate section for COVID-19 triage / assessment,** including designated entrance, triage area, staff, lavatory, supplies and color-coded bedding/linen/scrubs – all to be separate from rest of patients Establish protocol with **emergency medical services** (EMS) to ensure drivers contact receiving EDs or facilities to flag at-risk incoming patients Develop and train staff on protocol for **appropriate handling** of suspected COVID-19 patients; consider assigning **dedicated staff** to support at-risk patients **Isolate suspected** COVID-19 cases Discharge suspected COVID-19 patients not requiring hospitalization **home** (in consultation with state / local public health authorities) as appropriate

Providers should aggressively monitor the availability of the latest COVID-19 diagnostic tools to help improve diagnostic cycling

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Source: American Academy of Emergency Medicine, American Board of Internal Medicine, American College of Physicians, American College of Surgeons, American Medical Association, American Nurses Association, Anesthesia Patient Safety Foundation, CDC, Infectious Disease Society of America, Society for Academic Emergency Medicine, Society for Healthcare Epidemiology for America, Society of Critical Care Medicine,, Society of Hospital Medicine

Current as of March 17, 2020

For confirmed COVID-19 patients, providers should adhere to a series of medical society recommendations

Pre-diagnosis · Diagnosis · **Confirmed**

General inpatient medical care	Per CDC / society recommendations: Maintain **patient isolation** with strict adherence to CDC / public health guidelines for infection prevention and control; consider **color-coded bedding and linen for patients** Given current guidelines that suggest maximizing in-room / portable testing, plan for likely **operational bandwidth constraints** across likely impacted departments / supplies (e.g., radiology technicians, x-ray machines etc.) Establish protocol for **discharging patients** according to the latest CDC guidelines Reschedule non-urgent IP procedures as necessary
Surgical / procedural / anesthesia inpatient care	**Minimize, postpone, or cancel elective surgeries** as per ACS guidelines Per CDC / society recommendations: Develop a **contingency plan** in anticipation of **likely reductions in block utilization** due to need for COVID-19 patients to recover in operating rooms (ORs) Develop a plan to address likely need for **increased post-anesthesia care unit** (PACU) **nurse coverage** to support COVID-19 patient recovery in ORs Establish processes for **transport of COVID-19 patients** from the OR to floors/ICUs Consider establishing **designated ORs** / **procedure rooms** to treat patients; train staff / procedural / OR teams accordingly
Workforce and environmental considerations	Consider identifying **dedicated staff (e.g., hospitalist team)** to care for COVID-19 patients; ensure dedicated staff are easily identifiable by other workforce (e.g., color-coded attire) Deliver **education** / **training** to clinical and nursing workforce to prevent transmission of COVID-19, including refresher training on latest CDC / public health guidelines Regularly **clean and disinfect environmental surfaces**, as well as non-dedicated, non-disposable medical equipment, with EPA-registered hospital-grade disinfectant, per CDC recommendations Establish a **contingency plan for low-supply specialties** (e.g., pediatric neurosurgery) in the case of reduced capacity

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Current as of March 17, 2020

Health officials are urging providers to use digital and telehealth to triage, and some providers/ payers are responding

The use of virtual channels will be a particularly valuable lever to help prevent overcrowding

Not exhaustive

The Center for Disease Control and World Health Organization are urging hospitals and clinics to look at **expanding uses of virtual health services to help triage the sick and keep the worried out** of already crowded medical facilities

Blue Cross of North Carolina started to **cover telehealth services** the same as in-person provider visit (at parity) starting March 6	BlueCross BlueShield of North Carolina
UnitedHealthcare **covers 24/7 telemedicine services** delivered through Teladoc, American Well and Doctor on Demand across the United States	UnitedHealthcare
UCSF Health's Existing flu **digital health tools** are being used to triage for coronavirus Hospital is proactively reaching out to patients with scheduled visits for flu and cold symptoms to do **video calls** instead	UCSF Health
One Medical established its **virtual health program** in response the Swine Flu / H1N1 in 2009, enabling 24/7 care over video chat	one medical
Vendors are **using CDC guidelines to screen users** for coronavirus	amwell, buoy
China is **moving many services online** that were once done physically, to ensure continuity of care (e.g., prescription refills) Seeing a **spike in the use of virtual services** – vast majority are healthy people trying to stay out of the hospital	

Source: Press search, CDC, WHO, https://twitter.com/RahulRajkumar11/status/1235299478657261568

Current as of March 17, 2020

To reduce risk of exposure in the healthcare setting, providers should enable a number of restrictions

Visitor restrictions

Reduce the number of visitors to all patients

Example policies:

- Adult patients: One adult visitor
- Pediatric and newborn patients: Two visitors, but only parents or guardians. No siblings or extended family
- No children under 16 will be allowed to visit, except under exceptional circumstances

Reduce visitation hours

Shorten duration of time allowed for visits

Screen all visitors and staff at entry's

Screening for fever, at risk travel, and exposure to COVID-19

Reduce the number of entry points for visitors and staff

Identify essential entry points and close others

Source: CDC, Expert interviews, Press search
https://www.uofmhealth.org/news/archive/202003/michigan-medicine-announces-visitor-restrictions-hospitals
https://www.ucsf.edu/news/2020/03/416911/ucsf-health-expands-visitor-restrictions-hospital-and-clinics-amid-covid-19
https://www.sfchronicle.com/bayarea/article/Bay-Area-keeps-shutting-down-as-coronavirus-cases-15131898.php
https://kstp.com/news/mayo-clinic-limiting-hospital-visitors-during-coronavirus-covid-19-threat/5674724/
https://boston.cbslocal.com/2020/03/14/coronavirus-boston-hospitals-childrens-brigham-womens-limit-visitors-precautions/
https://www.vumc.org/coronavirus/latest-news/covid-19-patient-and-visitor-policy-hospitals-and-clinics
https://stanfordhealthcare.org/for-patients-visitors/visiting-hours.html

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Contents

- Care (bed) capacity
- Clinical workforce
- Clinical operations
- **Supply chain**

Healthcare provider supply chain preparedness

Solutions to consider as COVID-19 impacts medical and pharmaceutical supply lines

Overview

As COVID-19 cases increase, **providers will face pressure** in supplying key protective and treatment items

Protocols, visibility and collaboration are key to mitigating supply chain risk

Centralized Buying, Inventory Balancing and Distribution

Control buying at system level and ensure supplies reach greatest point of need

Prioritize at-risk supplies and pharmaceuticals for increased tracking; pursue alternative buying and maintain continual line of sight for key products and expected inflow of supply

Develop a system for proactive rebalancing and internal distribution system involving one (or more) of the following components:

- Current patient inventory days on hand against current burn rate
- Expected inflow of MedSurg and Rx supplies
- Expected epidemiological outlook, site maximum capacity and critical access hospital status

Continued open dialogue with suppliers, distributors and public agencies critical for contingency planning[2]

Clinical Conservation and Supplies Security

Promote conservation and establish clinical scenario plans

Establish clinical protocols around the use of at-risk supplies by situation:

- Develop tiers of clinical scenario planning against supply levels
- Communicate plans to clinical site leaders and ensure all care providers are aware and adopt

Ensure distribution of at-risk items is controlled (i.e. by supply chain group) and limited to clinicians and patients only

Explore alternative product use and sourcing when possible

Home Health and Alternative Points of Care

Prepare distribution plans as care delivery methods evolve

Create distribution strategy to emerging care delivery response models – these include shift to home health and new clinical sites (i.e. gyms, parking lots, community centers)

- Collaborate with clinical leaders to understand expected care delivery and alternative site plans
- Engage local supply chain operators to discuss receiving and stocking (i.e. linked to local hospital, new PARs)
- Proactively engage key distributors to ensure they adjust delivery accordingly
- With physician input, create standard supply packages for home health

Increased and constant stakeholder collaboration between providers, suppliers and public agencies will promote the success of the above

1. Recommended to begin with critical PPE supplies and subsequently scale to larger list of items listed on Supply Chain Job Aid (PXX)
2. E.g. coordinating on emergency supplies and public response

Tactical steps to consider on supply chain with COVID-19 response

Appoint a single lead to oversee all COVID-19 response and represent supply chain organization at enterprise meetings (leaving head of organization to organize business continuity)

Establish supply chain organization critical response team integrating stakeholders from sourcing, distribution, supply chain operations, communications and project management

Integrate supply chain and logistics critical response team to overall enterprise emergency response (i.e. ensure single lead above speaks as single representative for organization)

Ensure resiliency of procure-to-pay system in reduced productivity scenarios (e.g. work from home) to ensure critical supply orders received and dispatched through crisis response

Engage critical vendors to promote collaboration and visibility early and throughout situation

Connect with local, state and federal stakeholders and promote open line of communication

Prepare remote (i.e. work from home) contingency plans and inform to ensure all leaders prepared

Table of contents

Federal actions

On Jan 31, Health and Human Services (HHS) Secretary Alex Azar declared the 2019 novel coronavirus a public health emergency

Vice President Mike Pence leads the Coronavirus Task Force, with Ambassador Debbie Birx serving as the White House Coronavirus Response Coordinator, and Secretary Azar as its chairman

HHS have separate collaborations with Regeneron, Sanofi and Janssen (part of J&J) to develop therapeutics and vaccines

The Trump administration asked for at least $2.5B funding for the coronavirus on Feb 26, which was followed up by Congressional authorization of $8.3B total – though additional Congressional efforts and relief are currently being considered, particularly focused on economic relief

On March 11 and 14, President Trump announced travel restrictions for foreigners traveling from Europe (now including the U.K.) into the U.S. and announced several financial relief measures to mitigate the effects of COVID-19

On Mar 13, President Trump declared a state of national emergency due to COVID-19. The declaration frees up $50B in federal disaster relief funding and grants the HHS more authority to waive certain Medicare, Medicaid, and Children's Health Insurance Program Requirements

Various government agencies have also taken action:

- **CMC waived certain** Medicare, Medicaid, and Children's Health Insurance Program **requirements** to increase testing and treatment
- **CDC has implemented its pandemic response plans** and is developing tests and issued clinical guidelines
- **FDA has issued emergency authorizations** for different diagnostic companies to **develop tests** as well granted **permission from certain laboratories to begin testing patients**
- **BARDA and ASPR have partnered with industry**, including Sanofi and Janssen (part of J&J) **to develop therapeutics and vaccines** against COVID-19

Funding level for bill, $B		**Uses**
Federal Disaster Relief Funding	50.0	Various efforts by states and U.S. territories to assist individuals affected by COVID-19
Public Health and Social Services Emergency Fund	3.1	Develop vaccines and countermeasures, give grants to HRSA health centers ($100M)
Center for Disease Control	2.2	Give states, localities, tribes etc. grants for surveillance, epidemiology, lab capacity, infection control etc.; use for detection and response
Dept of State, USAID, Bilateral Economic Assistance	1.3	Maintain consular operations, reimburse evacuations, and fund global health programs, international disaster assistance, and support for economic, security, and stabilization requirements
National Institutes of Health	0.8	Fund research, provide worker-based training to reduce exposure
Purchase of vaccines and therapeutics	0.3	Purchase vaccines and therapeutics
Food and Drug Administration	0.1	Develop vaccines and medical countermeasures, manufacture advanced medical products, monitor supply chains
Small Business Administration	0	Administer disaster loan program

Resources

Communities, schools and businesses: https://www.cdc.gov/coronavirus/2019-ncov/preparing-individuals-communities.html

Healthcare providers: https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html

Health departments: https://www.cdc.gov/coronavirus/2019-ncov/php/index.html

Source: H.R. 6074 and Congressional Budget Office estimate for H.R. 6074; Wall Street Journal ('U.S. Weighs Paying Hospitals for Treating Uninsured Coronavirus Patients', 3 March 2020), CNBC ('Trump signs $8.3 billion emergency coronavirus spending package'), Modern Healthcare "Trump declares COVID-19 emergency…", CNBC, Agencies websites

President Trump's national emergency declaration over COVID-19 provides additional funding and aims to remove several obstacles to delivering care

Current as of March 16, 2020

Context

On 3/13 President Trump declared a national emergency over COVID-19. The declaration was preceded by several travel restrictions and financial relief measures. At the time of the declaration, there were 1,701 confirmed COVID-19 cases and 40 deaths. The declaration has two components: (1) **National Emergency Act**, which formalizes the emergency powers of the president and equips the government with additional resources to deal with COVID-19, and (2) **The Stafford Act**, which coordinates the administration of disaster relief resources and assistance to states (FEMA funding), and is the same authority used by President Clinton to address West Nile Virus outbreaks in 2000

Measures announced in response to the declaration

Freeing up $50B in emergency relief funds, available to federal, state, and local governments

Asking hospitals to activate their emergency plans

Asking states and local governments to activate their Emergency Operation Centers

Allowing US Health Secretary and other health officials the permission to waive laws and license requirements to give healthcare providers more flexibility (e.g., Medicare, Medicaid, and Children's Health Insurance Program requirements)

Increasing the number of COVID-19 tests available through both private labs, vaccine developers, and healthcare providers

Engaging in several agreements with private companies to facilitate testing for COVID-19

Waiving interest in student loans

Instructing the Department of Treasury to provide relief from tax deadlines to American affected by the COVID-19 emergency

Implications of the measures

Looser regulations will speed up and increase testing, which will help officials track the spread of the virus

Reduced requirements for hospitals *(e.g., allow providers to obtain a license to work in other states, increase access to telemedicine, and lower restrictions on where patients can be treated within a hospital)* **to increase patients' access to treatment**

Additional funding provides flexibility for the government to **provide additional financial relief** to help state and localities as well as individuals affected by COVID-19

Eases financial burden for individuals across the US, increasing spending potential and minimizing economic fallout

Source: Modern Healthcare "Trump declares COVID-10 emergency, asks hospitals to activate emergency plans", BBC "Trump declares national emergency over coronavirus", Politico "Trump declares national emergency in latest bid to combat coronavirus"

Payers: Federal government actions and implications

	Federal action	Potential implications
Prevention	**All payers** • National Institute of Allergy and Infectious Diseases (NIAID) launched first US clinical trial of a COVID-19 vaccine • BARDA and ASPR have partnered with industry, including Sanofi and Janssen (part of J&J) to develop vaccines against COVID-19 **MA payers:** • CMS gave flexibility for MA/Part D plans to enable seniors to access care and treatment quickly while socially distancing (e.g., relaxation of prescription refill limits, increased access to telemedicine, removing prior authorization requirements), and has given state Medicaid/CHIP agencies ability to extend similar provisions, which would be particularly helpful for dual populations	**All payers** • Planning for to incorporate vaccine coverage as soon as widely available **MA payers** • Coordinated response across member service, provider/pharmacy relations to ensure seniors are receiving appropriate care and medication while at home • Potential need to expand access to telehealth services
Testing	**All payers** • The government expects to distribute 1.9 million tests by the end of the week, for use by 2000 commercial labs with high-speed testing capabilities as well as by pod-based "drive-through" testing sites with expected capacity of 2-4k tests a day **MA payers** • CMS issued two FFS billing codes for COVID-19 testing with implications for MA tracking • CMS gave flexibility to MA/Part D plans to waive cost-sharing for testing	• Update claims adjudication logic to incorporate new tests/sites of care • To the extent possible, track community level test results and plan for implications
Treatment	**All payers** • BARDA and ASPR have partnered with industry, including Sanofi and Janssen (part of J&J) to develop therapeutics for COVID-19 **MA Payers** • CMS announced special requirements for MA payers, including coverage and in-network cost-sharing for A, B, and C services at non-contracted facilities and waiving gatekeeping referrals • CMS gave flexibility to MA/Part D plans to waive cost-sharing for treatment of COVID-19 • CMS gave an extension of all MA and Part D appeals **Medicaid managed care payers** • CMS has allowed state Medicaid/CHIP agencies to expand presumptive eligibility **Individual payers** • HHS has released guidance that treatment of COVID-19 (including hospital-based quarantine) is considered an essential health benefit for individual exchange plans	**All payers** • Update claims adjudication logic to incorporate therapeutics as soon as widely available • Coordination with all provider systems (in-network and out-of-network) in coverage area **Medicaid managed care payers** • May see increased enrollment as a result of presumptive eligibility

Current as of March 16, 2020

Providers: Federal government actions and implications

	Federal action	Potential implications
Prevention	President Trump has asked hospitals to activate emergency response plans (e.g., minimizing elective procedures) National Institute of Allergy and Infectious Diseases (NIAID) launched first US clinical trial of a COVID-19 vaccine CMS has expanded allowed telehealth services reimbursed by Medicare/Medicaid CMS has provided targeted provider facility guidance: • Guidelines for nursing homes to restrict visitors, non essential personnel, and communal activities • Instructions for prevention of COVID-19 transmission in Outpatient Hemodialysis Facilities (e.g., policies, PPE, and patient placement techniques)	Larger clinical trials if first trial appears safe and effective- wider availability may be 12-18 months away Providers (PCPs, specialists, etc) can move some practice to video Specific provider facilities will need to adapt policies and procedures to align to guidance
Testing	The government expects to distribute 1.9 million tests by the end of the week, for use by 2000 commercial labs with high-speed testing capabilities as well as by pod-based "drive-through" testing sites with expected capacity of 2-4k tests a day	Hospitals may have increased access to tests, but may still need to limit to most vulnerable populations and healthcare staff
Treatment	Provider staffing measures • CMS has relaxed Medicare provider enrollment screening requirements and established provider enrollment hotline • CMS will allow licensed providers to practice out of state (Medicare/Medicaid) Bed capacity measures • Allows for Medicare reimbursement of SNF stays without 3-day qualifying stay when related to emergency (e.g., discharged early from a hospital to make room for COVID-19 patients) and extends benefits for patients who have exhausted SNF benefits • CMS has waived requirements that Critical Access Hospitals limit stays to 96 hours and total beds to 25 • CMS has enabled greater flexibility in bed allocation by allowing acute care inpatients to be housed in non-acute care beds, and for psychiatric patients and rehabilitation inpatients to be housed in acute care beds where appropriate • CMS allows long-term care hospitals to exclude emergency admits/discharges from the 25 day average length of stay requirement CMS declared masks which protect from splashes and sprays can act as an acceptable and temporary alternative to respirators for most medical services until demand for respirators lessens, while eliminating requirement for state surveyors to validate last test of N-95 masks CMS has suspended non-emergency facility survey inspections Administration and billing • CMS established new billing codes for services related to treatment/diagnosis of COVID-19 • CMS has allowed state Medicaid/CHIP agencies to expand presumptive eligibility	Provider staffing measures create flexibility for provider systems to increase staffing as needed using out-of-state providers or providers not currently enrolled with Medicare Bed capacity measures allow more flexibility for provider systems to reallocate patients between units and facilities (including to SNFs/other non-acute care settings) as is clinically appropriate Personal protection equipment (PPE) regulatory changes enable provider systems to ease supply burden by substituting masks for respirators where necessary and minimizing discarded masks Suspension of non-emergency facility inspections allow providers to focus on serious health and safety threats including infectious disease and abuse Administration and billing changes enable better tracking and ease financial burden of COVID-19 treatment on providers

Current as of March 17, 2020

Deep dive: COVID-19 testing

Background

- When the first cases of COVID-19 were reported in the US, only **two labs at the CDC were permitted to conduct COVID-19 testing** using a **test developed by the agency's own researchers**
- When CDC tried to expand testing by providing its test kits to state and local public health labs, there were **issues with the initial versions of the** kits, requiring rework and delaying the supply
- The delay, along with growing number of cases, prompted the **FDA to expand its approval criteria on 2/29** to allow any **qualified lab to develop its own test**
- Two of the largest diagnostic commercial labs, **Quest Diagnostics** and **LabCorp**, **quickly began developing their own tests** and had to take time to build up capacity, but are now carrying out an expansive number of tests
- As of March 11, CDC state and public health labs had conducted **more than 11,000 tests since mid-January**. By comparison, **South Korea** has tested **more than 200,000 people** since January (and only has a population of 51M)

Current and future supply

- According to the March 17th CDC update, **31,878 tests have now been carried out in the US** and **supply is increasing**
- HHS announced March 13th it is funding two companies, DiaSorin Molecular and QIAGEN, for the development of **rapid diagnostic tests** which would provide results within an hour. Development is targeting completion within 6-12 weeks
- The FDA has **given states such as NY the authority to approve labs for coronavirus testing without waiting for federal approval** – NY is contracting with 28 private labs to increase testing capacity
- As of March 17th, the government is working to distribute **1.9 million more tests by the end of this week** for use by **2,000 commercial labs with high-speed testing capabilities**
- The federal government, using **FEMA and the Public Health Service Corps**, is **supporting state efforts** to develop and run pod-based "drive-through" testing sites with **expected capacity of 2-4k tests a day.** As of March 17th, more than 10 states have implemented their own "drive-through" testing sites
- Looking ahead, **2 million tests are expected to be available next week** and at least **5 million the week thereafter**

SOURCE: https://www.whitehouse.gov/briefings-statements/remarks-president-trump-vice-president-pence-members-coronavirus-task-force-press-briefing-2/; https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/testing-in-us.html; https://www.propublica.org/article/how-south-korea-scaled-coronavirus-testing-while-the-us-fell-dangerously-behind; https://time.com/5801790/coronavirus-testing-us/; https://www.modernhealthcare.com/politics-policy/covid-19-testing-delays-shine-light-lab-developed-test-regulation-debate; https://www.whitehouse.gov/briefings-statements/remarks-president-trump-vice-president-pence-members-coronavirus-task-force-press-briefing-2/