



WHITE PAPER

**The COVID-19
Response: Differences
in Medicare
Advantage and Fee-
For-Service Medicare
in Meeting Beneficiary
and Provider Needs**

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BETTER MEDICARE
ALLIANCE



Executive Summary

The novel coronavirus (COVID-19) pandemic significantly disrupted the health care delivery system and dramatically altered how Medicare beneficiaries received care in 2020 and thereafter. In some geographies, the onset of the COVID-19 pandemic resulted in a wide variety of challenges for beneficiaries and providers. For beneficiaries, challenges included social isolation, practicing safety protocols, gaining comfort with virtual care, and accessing care. For providers, the COVID-19 pandemic caused challenges such as: surges in demand for hospital inpatient services; steep declines in outpatient surgical and outpatient office visits; the need to rapidly bolster safety protocols; implementing virtual care; and the need to navigate changes in coverage and payment policies.

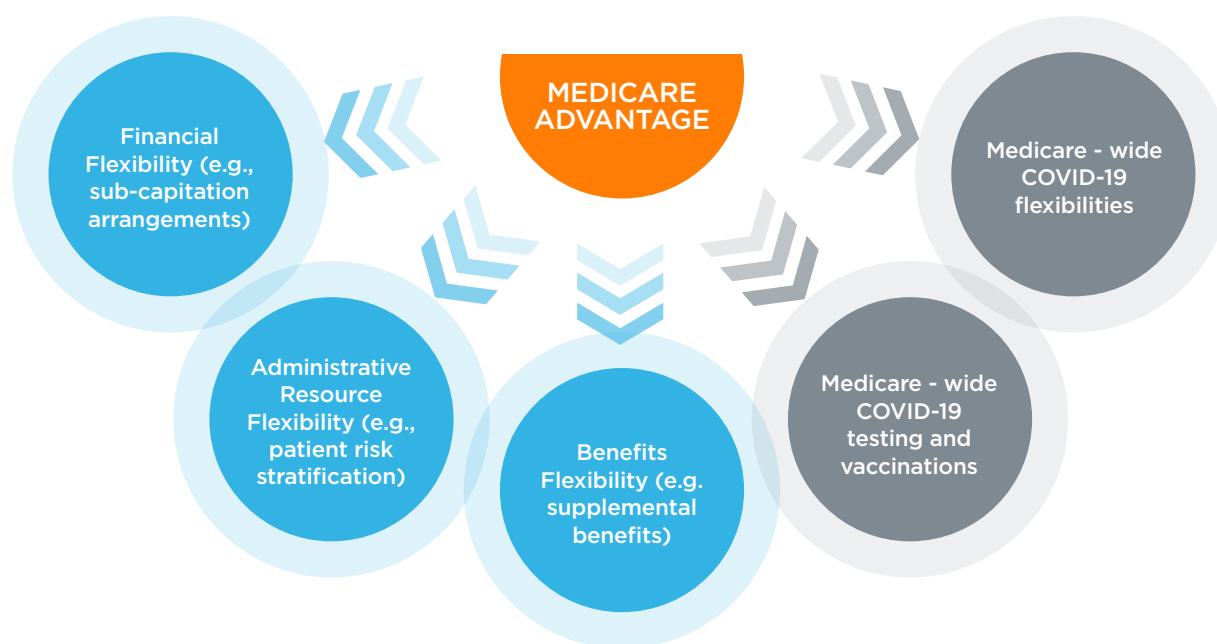
Federal policymakers, health care providers, and health plans quickly responded to mitigate these challenges. Congress and the Centers for Medicare & Medicaid Services (CMS) rapidly waived or changed existing Medicare regulations to provide new flexibilities for providers serving the Medicare population. Medicare Advantage plans adopted these flexibilities and leveraged key attributes of the Medicare Advantage model to further expand the support provided to beneficiaries and providers.

In an effort to identify the key differences between the responses of Fee-for-Service (FFS) Medicare and Medicare Advantage in 2020 when the nation was deep in a health care crisis caused by the pandemic, Better Medicare Alliance (BMA), in consultation with Health Management Associates (HMA), conducted interviews with representatives from Medicare Advantage plans and health care provider organizations. Through structured interviews, BMA and HMA identified the various challenges providers, health plans, and beneficiaries faced during 2020, the measures providers and health plans took to mitigate these challenges, and the role the Medicare Advantage program played in the response relative to FFS Medicare.

The findings from this study revealed both Medicare Advantage and FFS Medicare made extraordinary efforts to mitigate the various COVID-19-related challenges providers and beneficiaries faced during 2020. However, the analysis identified several key differences in the response of Medicare Advantage plans compared to FFS Medicare, which derive from the greater flexibility built into the Medicare Advantage program, in addition to the adoption of new flexibilities. Differences were categorized into three groups of flexibilities: financial, administrative resources, and benefits.

- **Financial:** The flexible financial mechanisms of the Medicare Advantage program allow health plans to enter into value-based payment arrangements and direct resources to support providers in times of financial strain, helping providers focus on safe and effective patient care. In particular, providers that have sub-capitated payment arrangements with Medicare Advantage plans stated that being free from the volume-based incentives of fee-for-service reimbursement enabled them to treat patients rapidly and as they needed. Providers also cited the ability of Medicare Advantage plans to offer their organizations advanced or enhanced payments as a great benefit during a time of financial stress.
- **Administrative Resources:** The administrative resources and care management infrastructure of many Medicare Advantage plans enabled them to deliver targeted education, outreach, and interventions to beneficiaries and providers. Providers and beneficiaries benefited from health plan efforts to identify at-risk beneficiaries, provide care management, and effectively communicate COVID-19 related information to beneficiaries and providers quickly.
- **Benefits:** The flexibility of Medicare Advantage plans to offer benefits beyond FFS Medicare was critical during the COVID-19 pandemic and distinguished Medicare Advantage plans from FFS Medicare. Providers consistently stated that when available, beneficiaries isolating at home benefited from supplemental benefit offerings such as home delivery of prescription drugs and groceries. In addition, several providers stated that Medicare Advantage plans were often quicker than FFS Medicare to cover and/or provide clear guidance about the coverage of audio-only telehealth visits and coverage of other forms of virtual care services (e.g., virtual check-ins, online portal visits, remote patient monitoring).

Figure 1: Medicare Advantage plans relied on three areas of flexibility (Financial, Administrative Resources, and Benefits) built into the Medicare Advantage model to support providers and beneficiaries beyond what was offered within FFS Medicare during the COVID-19 pandemic in 2020.



Together these findings demonstrate the impactful role of Medicare Advantage in improving health care delivery, including during times of crisis, and points to the continued importance of advancing policies that support a more flexible Medicare Advantage model.



Introduction

Reflections on 2020 found that the novel coronavirus virus (COVID-19) pandemic and public health emergency (PHE) significantly disrupted the health care delivery system and dramatically altered how Medicare beneficiaries received care. In some geographies, the onset of the COVID-19 pandemic resulted in a surge in demand for hospital services and provider shortages. Across the country, the health care system experienced a sharp decline in the provision of non-urgent but needed health care services. In large part, disruptions were caused by efforts to treat patients infected with the virus and limit the transmission of the virus. These disruptions have disproportionately impacted Medicare beneficiaries who are older and more likely to have chronic conditions and therefore at greater risk of having severe complications related to contracting COVID-19.

Throughout 2020, federal policymakers, health care providers, and health plans quickly responded to mitigate these challenges. Congress and the Centers for Medicare & Medicaid Services (CMS) rapidly waived or changed existing Medicare regulations, which offered new flexibilities for providers in how they served beneficiaries under Fee-for-Service (FFS) Medicare. Using existing Medicare Advantage authorities and infrastructure, Medicare Advantage plans (or “health plans”) adopted many of these flexibilities, which expanded upon some of the existing coverage flexibilities generally provided to cover services beyond FFS Medicare coverage. For example, health plans developed targeted education campaigns to inform beneficiaries and providers about policy changes, deployed

their care management staff to engage at-risk beneficiaries, and leveraged their supplemental benefit offerings to address social isolation, improve access to nutrition, and offer safe transportation options during the pandemic. Through supplemental benefits and their general regulatory flexibility to expand coverage beyond FFS Medicare coverage, health plans were able to provide additional, critical services not available to beneficiaries enrolled in FFS Medicare.

Many in the health policy community believe COVID-19 created an opportunity to evaluate health care delivery in the Medicare program, and there is a specific interest in assessing the extent to which health care delivery has differed during the PHE under FFS Medicare and Medicare Advantage. To assess this specific interest, the Better Medicare Alliance (BMA), in consultation with Health Management Associates (HMA), engaged provider organizations and health plans in structured interviews to better understand their experiences during the PHE. BMA sought to identify potential differences between the COVID-19 response strategies of Medicare Advantage health plans and FFS Medicare. Interview participants were asked how these differences may have impacted the health care delivered to Medicare beneficiaries during 2020. While the work of BMA and HMA was focused on the most intense period of the COVID-19 pandemic in 2020, this analysis demonstrated that the challenges caused by the COVID-19 pandemic persist in 2021. To a certain degree, these challenges continue to be a focus of providers, plans, beneficiaries, and the Medicare program today.



Methodology

BMA and HMA conducted an extensive review of more than 70 publications and publicly available information to identify the challenges the health care delivery system faced in 2020. In addition, these publications provided information about common programmatic responses to the challenges of the pandemic. HMA used a robust list of terms to search Google Scholar for literature published from March 2020 through April 2021. This was supplemented with a targeted review of grey literature and public statements made by Medicare stakeholder organizations.

BMA and HMA requested and conducted interviews with representatives from Medicare Advantage plans and health care provider organizations to assess the challenges their organizations faced during the COVID-19 pandemic and the measures these organizations took to mitigate these challenges. Interviewees from Medicare Advantage plans were identified and selected from national and regional Medicare Advantage plans. Several of these plan interviewees represented plans affiliated with provider organizations. Interviewees from provider organizations represented local and multi-state organizations and also a wide variety of provider types, including: physician groups, hospitals and health systems, home health agencies, skilled nursing facilities, and behavioral health centers. A total of 18 interviews were conducted. Interviews occurred between April and June 2021, as pandemic restrictions were easing nationally and COVID-19 vaccinations were becoming widely available to the public. A complete list of interviewees can be found in Appendix 2.

BMA and HMA developed and implemented a structured interview guide to elicit the perspective of interviewees about the challenges posed by the COVID-19 pandemic, how they chose to mitigate those challenges, and how Medicare supported these efforts. Through these interviews, BMA and HMA also sought to better understand how providers implemented COVID-19 flexibilities and policy changes to meet beneficiary needs during the pandemic. The following overarching questions informed the interviews:

1. In light of the COVID-19 pandemic, what were some of the top challenges your organization faced in identifying beneficiary needs and delivering care during 2020?
2. To what extent did the flexibilities and/or policy changes implemented under FFS Medicare and Medicare Advantage mitigate the challenges you faced during 2020?
3. What were the key differences between the responses of FFS Medicare and Medicare Advantage in 2020?

Provider Challenges Experienced at the Onset of the COVID-19 Pandemic and the Impact on Medicare Beneficiaries

The literature review highlighted several challenges health care providers experienced in 2020 as a result of the COVID-19 pandemic. The challenges had a direct impact on the delivery of health care services in 2020. To a certain degree, many of the challenges for providers continue to impact the delivery of health care services as the COVID-19 pandemic persists in 2021. The following provider challenges were identified:

- Patient visit volumes declined, causing revenue and cashflow declines for providers.
- Rapidly changing Medicare policies caused confusion about how to record patient encounters and submit claims.
- Providers that were forced to temporarily close their offices due to the COVID-19 pandemic caused financial strain and reduced access to care for beneficiaries.
- Social distancing reduced demand for preventive care and chronic care management.
- Patient case complexity increased due to COVID-19-related stress and social isolation.
- Expanded infection control procedures increased administrative and medical burden on providers.
- Providers had to rapidly implement virtual care services.
- Providers experienced burnout and fatigue.

A more detailed summary of provider challenges identified in the literature is included in Appendix 1.



FFS Medicare Implemented Various Flexibilities to Expand Care for Beneficiaries

Between March 2020 and January 2021, Congress passed legislation and CMS used its regulatory authority to create approximately 250 temporary Medicare waivers that allow flexibility and enable providers to respond to beneficiary needs.¹ While these changes predominantly applied to beneficiaries in FFS Medicare, they also applied to beneficiaries enrolled in Medicare Advantage in many cases. Flexibilities provided by waivers and policy changes included key items such as: expanded virtual care services, relaxed clinical scope-of-practice and provider conditions-of-participation rules, modified payment rates for COVID-19 cases admitted for hospital care, and the clarification of payment rates for COVID-19-related services such as tests and vaccinations. To assist stakeholders in tracking these flexibilities, CMS provided details on their website.² In addition, CMS also developed a wide variety of provider-specific educational materials that provide information about eligibility for the flexibilities, dates of effectiveness, and instructions for billing and claims submission to reduce confusion and administrative burden.

Medicare Advantage Plans Leveraged their Unique Flexibilities and Organizational Capabilities to Support Providers and Beneficiaries During the COVID-19 Pandemic

While Medicare Advantage plans were able to leverage the flexibilities implemented by CMS for FFS Medicare during 2020, health plans also took various independent actions during this time to expand on the flexibilities, help beneficiaries get needed care, and reduce their risk of exposure to COVID-19. Early in the COVID-19 pandemic, several health plans voluntarily waived out-of-pocket patient costs for COVID-19 tests or vaccines before CMS issued the requirement. Many plans also waived beneficiary copayments for COVID-19-related hospitalizations.³ In addition, the financing mechanism characteristic of Medicare Advantage allowed health plans to offer additional items and services to address key challenges of the pandemic. For example, health plans established face mask donation programs to increase safety for beneficiaries and delivered care packages with health-related items like masks and hand sanitizer to increase protection for beneficiaries during the cold and flu season.⁴ Most health plans also expanded virtual care services, meal delivery services, companionship programs and other outreach efforts to engage beneficiaries and maintain ongoing care, particularly for those with chronic conditions.

HMA interviewed representatives from Medicare Advantage plans to better understand the challenges and opportunities described above as well as other strategies and innovations health plans applied during the pandemic. Interviews revealed common practices and unique approaches across health plans. Representatives of health plans cited the following key strategies.

Risk stratification methods enabled health plans to identify and engage beneficiaries with the most pressing needs.

Nearly all of the health plans interviewed indicated the implementation of risk stratification methods facilitated efforts to categorize beneficiary subpopulations by level of risk and prioritize outreach. Health plans leveraged access to internal beneficiary datasets to stratify patients, as this enabled them to prioritize outreach more efficiently to beneficiaries. Health plans stated their goal was to communicate with every beneficiary, and that beneficiary risk stratification methods ensured beneficiaries with the greatest risk of contracting COVID-19 or suffering the most severe complications were quickly identified and engaged through these stratification methods.

One regional health plan in the Northwest described an approach that categorized beneficiaries into three standard risk groups: high-risk, medium-risk, and low-risk. Case managers immediately reached out to beneficiaries in the high-risk category to ensure they had access to non-urgent services. Once these beneficiaries' needs were addressed, the case managers and other health plan staff reached out to those in the medium-risk and low-risk categories. In addition, one national health plan described taking a regional approach to risk stratification that enabled them to prioritize beneficiaries in parts of the country experiencing surges of COVID-19 infection. Using their risk stratification process, they were able to determine which populations were most likely to become infected and quickly initiate care management services.

Repurposing of health plan staff strengthened beneficiary outreach efforts.

Several health plans indicated they leveraged staff beyond case managers to broaden outreach efforts to beneficiaries. One regional health plan indicated that the organization's sales team was unable to conduct their regular responsibilities of holding events due to social distancing restrictions. The sales team was repurposed to conduct outreach to ensure all beneficiaries could be reached in a timely manner at the onset of the pandemic. The sales team also conducted additional outreach later in the pandemic to educate beneficiaries regarding the availability of providers who were once again seeing patients for non-urgent needs. In addition, a national health plan indicated that all external-facing staff from multiple teams within the organization joined case managers in making calls to at-risk populations. Further, a local health plan stated that in addition to case managers, members of the senior leadership team volunteered their time to support outreach efforts.

Additional payments and equipment from health plans eased providers' financial concerns and supported the development of new capabilities.

Nearly all health plans interviewed stated they have sub-capitated payment arrangements with provider partners. According to the health plans, the payment arrangements provided more predictable revenue streams to providers, leading to greater financial stability for the providers in 2020. However, many health plans also stated that these arrangements did not extend to all contracted providers and many providers that were reimbursed on a per-visit fee-for-service basis expressed concerns about their financial solvency. To help ease the financial burden faced by these providers and ensure beneficiaries had ongoing access to care, some health plans directed additional resources to certain providers outside of the contracted payment rates. For example:

- One regional health plan stated that to ensure the solvency of some providers in their network they provided advanced payments and enhanced reimbursement rates for primary care visits.
- One local health plan indicated that they provided lump-sum advanced payments on a quarterly basis to certain providers in their network to ensure these providers could sustain operations and pay their staff. In this case, the health plan gave the providers payments equal to their quarterly payments from the health plan from the previous year.

In addition, many of the health plans interviewed stated that in some cases they gave providers enhanced payments specifically for virtual care services. Health plans did so because they discovered some providers were not fully equipped to handle the volume of virtual care services demanded during 2020. While health plans provided enhanced payments for these services, many of the health plans interviewed also described efforts to give providers technological devices that enabled greater use of virtual care services, such as tablet devices.

Targeted education initiatives supported efforts to provide timely and accurate information to beneficiaries and providers.

All health plans stated it is important to ensure that both beneficiaries and providers have access to updated, comprehensive, and accurate information regarding changes in coverage policies, provider availability, COVID-19 testing and vaccine availability, COVID-19 safety protocols, and other necessary information.

- One national health plan stated that to assist providers and beneficiaries they focused on monitoring policy changes and keeping their websites up to date. For example, the health plan's team added a digital icon on their provider tracking web page if a provider began offering virtual care services. If there were provider closures or other provider status changes, the health plan's team updated the provider directory so beneficiaries could find and access care more easily.
- One local health plan described the implementation of a hotline used to walk beneficiaries through various technology-related concerns, such as how to setup an email account, access their health plan or medical group member portal, and complete a telehealth visit.
- One regional health plan described a website they created to support providers and beneficiaries in understanding where and how to access testing and vaccine services. Although testing and vaccination efforts were led by states, the health plan indicated the website helped reduce confusion for providers and beneficiaries that received information from a variety of sources.
- One national health plan reported providing "just-in-time" information to beneficiaries and providers when the organization learned there would be vaccines available in new locations.

Leveraging local community relationships and newly available supplemental benefit flexibilities addressed important non-medical needs.

Nearly all health plans reported many of their beneficiaries experienced unaddressed social needs that were exacerbated by the pandemic. The health plans interviewed used a variety of tools to address these needs. One local health plan stated that the organization leveraged strong relationships in the community to encourage donations for needed services. For example, the plan's case manager called the local pet store to provide donations for members with dogs that were either unable to travel for or unable to afford dog food. The same health plan stated that during the pandemic some of its case managers reached out to telecommunications companies to restore cable and internet service for beneficiaries whose service was terminated.

A different local health plan used administrative dollars to purchase toilet paper on behalf of beneficiaries that were unable to travel or were located in an area where toilet paper was unavailable. In addition, one national health plan described expansions or modifications to existing supplemental benefits to address changing beneficiary needs during the pandemic. For example, the health plan offered a social isolation benefit that enabled beneficiaries to access a companion virtually rather than in person. The same health plan also modified its fitness benefit to cover online courses.

Provider Perspectives: The Key Differences Between Responses in Medicare Advantage and FFS Medicare

Interviews with a range of providers revealed several differences between how Medicare Advantage and FFS Medicare responded to COVID-19 in 2020. First and foremost, providers stated that capitated payment arrangements from Medicare Advantage (when available) were extremely valuable in offering treatment flexibility. Second, providers reported many health plans were more effective than FFS Medicare at communicating critical information to beneficiaries and providers. Providers appreciated the quick action many health plans took to clarify coverage of virtual care services and key supplemental benefits helping beneficiaries remain safe and healthy in their homes. Providers also stated that Medicare Advantage offerings for 2020 and COVID-related initiatives benefited patients with other types of insurance coverage, including beneficiaries with FFS Medicare coverage.

Capitated payment arrangements and COVID-19-related advanced payments in Medicare Advantage offered providers flexibility and financial support during the pandemic.

All of the providers interviewed stated that during 2020 the capitated payment arrangements offered, or could have offered, their organizations increased flexibility to serve beneficiaries and enhanced their financial security. Providers receiving capitated payment from Medicare Advantage plans stated that when visit volumes and revenues declined during 2020, it was ideal to receive regular monthly payments or advanced payments from health plans. Providers who received capitation from health plans consistently described how these payments afforded them the flexibility to provide support to patients, enabled them to conduct more regular outreach to patients, and reduced their fears about revenue losses stemming from declines in visit volume. Providers who did not receive capitated payments from health plans stated that capitation would have been ideal during 2020 when visit volumes were unpredictable. Providers added that FFS Medicare payments tied to each patient encounter failed them during 2020

because there were several months where visit volumes were extremely low. Providers offered a variety of perspectives on this central theme:

The Chief Administrative Officer (CAO) of a multistate physician practice stated capitated payments were key to their financial survival in 2020. The CAO added that FFS Medicare reimbursement did not offer providers the incentive to carry out the treatment strategies providers must use when patients are in quarantine, such as frequent outreach and regular communication. This practice implemented “Love Calls” to patients during 2020, in which provider representatives called every patient periodically to check in on their health status and needs. Additionally, the CAO stated that capitated providers were better off during the pandemic than providers who relied solely on FFS reimbursement because capitated payments permitted providers to conduct frequent outreach to patients without worrying about not receiving payment for each individual encounter with the patient. In addition, capitation eliminated the provider’s concern about declining in-person visit volumes and the organization’s long-term sustainability.

The Vice President of Operations (VPO) at a large physician practice in Illinois stated it was substantially easier for the provider to remain financially solvent during 2020 when they knew they would be paid monthly by Medicare Advantage. The representative added that their organization maintains a mix of capitated and FFS payment arrangements with health plans, and under the capitated arrangements their organization received in 2020, they had a greater incentive to manage care more comprehensively. They added that due to the financing structure of Medicare Advantage, relative to beneficiaries in FFS Medicare, Medicare Advantage beneficiaries were typically seen sooner and had more immediate access to telehealth services.

The Chief Executive Officer (CEO) of a New England-based provider organization stated that some health plans they work with were willing to make advanced payments to support their organization’s long-term financial health. These advanced payments allowed the organization to focus on population health strategies to serve patients. The CEO also stated that capitation is highly beneficial during a public health emergency because providers receive payment quickly.

Health plan communication and education initiatives strengthened patient care and reduced burden on physician practices.

Several providers stated health plans assisted their efforts in treating beneficiaries during 2020 by regularly communicating details of coverage flexibilities and COVID-19-related public health information to providers and beneficiaries. Providers stated many health plans emailed or called providers with this information on a regular basis early in 2020, and the scope and detail of this communication exceeded that coming from CMS for FFS Medicare beneficiaries. A few providers even characterized the communications coming from CMS as inconsistent and confusing relative to Medicare Advantage communications, which were often easier to understand and digest.

Several physician practices stated health plans conducted outreach to providers and beneficiaries to educate them about COVID-19 public health guidelines, such as social distancing, mask wearing, testing, and vaccinations. Several providers also stated that these health plan communications to Medicare Advantage beneficiaries reduced the outreach they needed to provide and enabled them to focus their outreach to beneficiaries with FFS Medicare coverage. These plans also conducted educational outreach to beneficiaries to inform them of specific benefits that could be helpful during 2020, such as virtual care services, home-based services, and supplemental benefits involving social supports.

The Chief Operating Officer (COO) of a chain of midwestern community mental health centers stated health plans provided them with frequent emails containing information about FFS Medicare's rapidly changing and confusing coverage flexibilities. The health plans summarized the confusing information coming from CMS, easing the implementation of these new flexibilities for providers.

The Senior Director of a post-acute care provider system in Pennsylvania stated that one of the health plans they work with allowed them to use the plan's learning management system (LMS) to educate beneficiaries and train the providers' staff during 2020. By allowing the provider to use its LMS, the health plan increased the speed and depth of the dissemination of information to beneficiaries and provider staff. Further, this enabled the provider to combat staff shortages and reduce the time required to get new staff trained and up to speed on COVID-19 protocols.

Medicare Advantage's rapid expansion of coverage for virtual care services enhanced provider capacity to serve beneficiaries, increased access to care, and bolstered providers' financial solvency.

While all of the providers interviewed stated Medicare's expanded coverage of virtual care services was essential during 2020, several also stated Medicare Advantage was quicker than FFS Medicare to expand coverage of these services early in the PHE. Providers indicated that in the initial months of the pandemic, CMS' virtual care coverage rules were slowly released and confusing while health plans were quicker to clarify for providers that telehealth visits, which is one form of virtual care, would be covered and reimbursed. This included telehealth visits from the patients' residence, when conducted from urban or rural areas, through audio-only communication, and provided to patients with whom they did not have an existing clinical relationship.

Throughout 2020, several types of providers relied on virtual care services to remain connected to both Medicare Advantage and FFS Medicare beneficiaries and extend access to needed services to new patients in their community. Hospitals and health systems interviewed stated they relied on Medicare's expansion of virtual care services to extend the reach of their outpatient clinics and access to physician specialists and enabled attending physicians to supervise resident physicians remotely from their residences. All of the physician practices interviewed stated Medicare's expanded coverage of virtual care services was essential for staying connected with existing patients and offering access to care to new patients.

Several providers also stated that in the early weeks and months of the pandemic, CMS' guidance on the expansion of coverage for virtual care services was confusing. This confusion caused uncertainty among providers about whether or not they would be reimbursed for the virtual care services. Several providers stated that in March and April of 2020, many health plans gave specific assurance that office visits conducted with audio-only technology and virtual care services provided to beneficiaries in their homes would be covered and reimbursed. These providers elaborated that audio-only telehealth visits were critical early in the pandemic for serving both low-income beneficiaries without access to smart phones and elderly beneficiaries who were not comfortable with the video technology necessary for a more traditional video telehealth visit.

Two examples clearly describe how Medicare Advantage plans swiftly responded to the need for expanded access to virtual care services during the COVID-19 pandemic, including in the early part of 2020 when it was needed most. First, the COO of a chain of midwestern

community mental health centers stated in the spring of 2020 some health plans began covering a larger range of mental health services when conducted via virtual care than FFS Medicare. The COO stated they regularly used this additional coverage to serve all of their beneficiaries and it was particularly useful for those with severe mental illnesses requiring regular contact with clinicians. Second, the VPO at a large physician practice in Illinois stated that in early 2020 some health plans expanded coverage of virtual care services rapidly and communicated the details to providers well, while guidance from CMS was frequent but confusing and contradictory. The VPO elaborated that Medicare Advantage routinely educated the provider about the scope of virtual care services available, including coverage for audio-only services. As a result, the Medicare Advantage beneficiaries served by this provider received more audio-only services than beneficiaries in FFS Medicare.

Supplemental benefits offering social supports enhanced provider capacity to serve beneficiaries.

Several providers stated in interviews that Medicare Advantage supplemental benefits enhanced their capacity to serve socially isolated patients during the pandemic. Providers identified grocery delivery, prescription drug delivery, and the ability for plans to refer and connect beneficiaries with state and local social service organizations as the most beneficial supplemental benefits offered by health plans. These supplemental benefits are not covered by FFS Medicare, and therefore, providers stated they were only able to utilize these services for beneficiaries enrolled in Medicare Advantage. Providers consistently stated that when available, supplemental benefits such as those above made it easier to serve beneficiaries in their homes and reduced the need to bring them into the clinical office setting, which was limited and considered a risk to their health during the pandemic.

Three examples speak specifically to the value of supplemental benefits during 2020. First, the CAO of a multistate physician group stated that Medicare Advantage supplemental benefits were extremely helpful to patients. They stated that the most impactful supplemental benefit was one which enabled the provider to schedule home delivery of prescription drugs. The representative stated these services improved patient care at a time when they were doing everything they could to connect with beneficiaries while keeping them at home. Second, the VPO at a large physician practice in Illinois stated prior to the COVID-19 pandemic, their organization did not utilize the supplemental benefits offered by health plans but began doing so in 2020. Supplemental benefits enabled the practice to connect their patients to social service agencies, which was extremely helpful for their most isolated and elderly beneficiaries. Third, the Vice President of a large health system in New York, which owns a Medicare Advantage plan, stated that their plan's supplemental benefit offerings included at-home grocery delivery and connection to state agency social supports. During 2020, both benefits were extremely popular with beneficiaries and enabled beneficiaries to remain at home and mitigate the risk of exposure to COVID-19.

Care management services augmented providers' beneficiary outreach initiatives.

Providers stated health plans with strong patient care management services enabled them to focus their outreach efforts on beneficiaries who did not have access to such services, such as those in FFS Medicare. The CEO of a large network of independent providers in New England stated that Medicare Advantage beneficiaries were more likely than FFS Medicare beneficiaries to have access to care management services. They added that during 2020, the presence of Medicare Advantage care management services enabled their own care managers

to focus on beneficiaries without other care management supports. Knowing that many received outreach from certain health plans, providers were able to avoid redundancy of care and better target their own outreach to beneficiaries most in need. Therefore, the presence of Medicare Advantage care management services had a positive impact on Medicare Advantage beneficiaries as well as those in FFS Medicare and people with other forms of insurance or no insurance.

Faster claim payment reduced concern about declining revenues.

A few providers stated that during the PHE, Medicare Advantage continued to pay claims faster than FFS Medicare. Concerned about declining revenues stemming from declining patient visit volumes, providers stated they were acutely aware of which payors were paying claims on time. The Chief Medical Officer of a large hospital system in Illinois stated they had no payment-related delays from either Medicare Advantage or CMS during the PHE. However, a few physician practices stated that Medicare Advantage typically paid claims faster than FFS Medicare and this was beneficial to them during 2020. Providers added that knowing Medicare Advantage would pay claims rapidly reduced their concern about their overall solvency.

CMS' COVID-19 coverage flexibilities were beneficial to providers of various types.

Providers stated emphatically that several of the coverage flexibilities offered by CMS and Medicare Advantage during 2020 were critical to caring for beneficiaries isolated at home. Providers identified flexibilities like expanded coverage of virtual care services, site of service flexibilities that allowed beneficiaries to be at home, and nursing scope of practice flexibilities as the most beneficial.

Providers observed no difference between Medicare Advantage or FFS Medicare regarding the provision of COVID-19 testing and vaccinations.

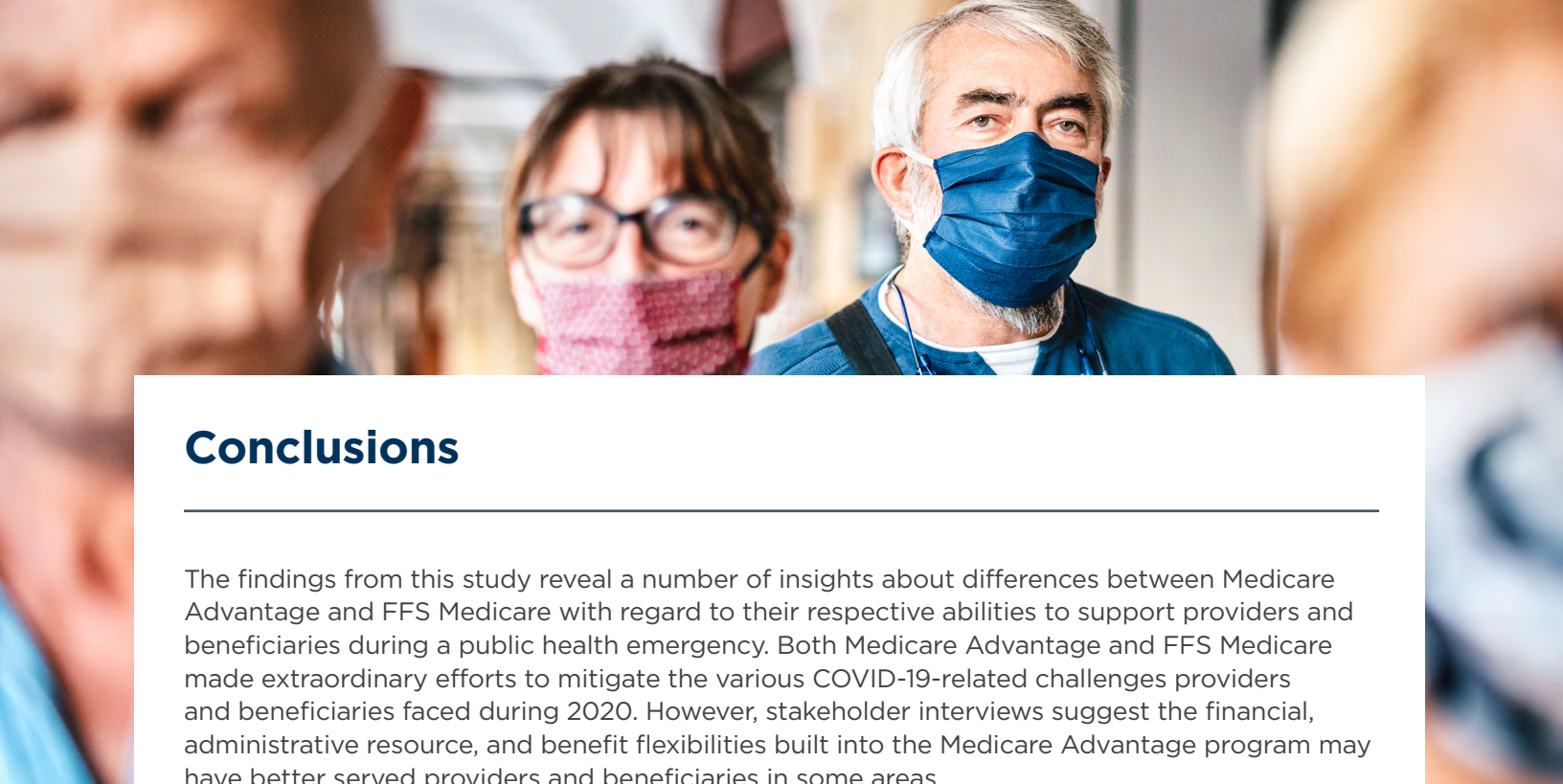
COVID-19 testing and vaccination distribution services were largely handled by state and local public health departments. These services for all Medicare Advantage and FFS Medicare beneficiaries were paid for by the Medicare program generally. Providers therefore did not observe differences in Medicare Advantage and FFS Medicare for COVID-19 testing and vaccination services. Providers did state that health plans discussed the importance of testing and vaccination in their communications and guidance to providers and beneficiaries.

Provider Suggestions: Medicare Reform for a Future Public Health Emergency

During interviews, providers offered several suggestions for CMS in which Medicare Advantage and FFS Medicare could be improved to better support providers and beneficiaries in the event of a future public health emergency. Providers stated that:

- CMS should move more rapidly towards payment system transformation that creates population-based payment and/or capitated reimbursement because providers under capitated reimbursement structures had greater flexibility during the COVID-19 pandemic to serve beneficiaries and did not struggle with the volume-based incentives of FFS reimbursement.
- The federal government should create a national dataset of patients to aid plans, providers, states, and local governments with coordinating vaccination implementation, population health management, and case management.
- CMS should improve its methods of directly communicating to beneficiaries with FFS Medicare coverage and providers to ensure all stakeholders are informed of changing policy and agency guidance.
- CMS should coordinate reimbursement billing instructions and billing codes across Medicare and Medicaid to relieve providers of administrative burden.
- Congress should consider efforts to close coverage gaps and extend access to coverage and care to all individuals without insurance on a temporary basis during any subsequent PHE.
- CMS should modify its Medicare Advantage risk adjustment model because the current model fails to capture the detailed unbillable activities providers commonly conduct to assist beneficiaries.





Conclusions

The findings from this study reveal a number of insights about differences between Medicare Advantage and FFS Medicare with regard to their respective abilities to support providers and beneficiaries during a public health emergency. Both Medicare Advantage and FFS Medicare made extraordinary efforts to mitigate the various COVID-19-related challenges providers and beneficiaries faced during 2020. However, stakeholder interviews suggest the financial, administrative resource, and benefit flexibilities built into the Medicare Advantage program may have better served providers and beneficiaries in some areas.

Providers acknowledged the equivalent responses to the COVID-19 pandemic by Medicare Advantage and FFS Medicare with regard to the various COVID-19 coverage flexibilities implemented by CMS, as well as with issues related to COVID-19 testing and vaccinations. Medicare Advantage and FFS Medicare offered equal assistance to providers in terms of temporarily expanding site of service locations, expanding clinician scope of practice rules, and covering virtual care services. Further, Medicare Advantage and FFS Medicare similarly covered COVID-19 testing and vaccinations. Providers were appreciative of all these efforts. Overall, the COVID-19 pandemic raised awareness of the importance of the flexibility to respond to the immediate and evolving needs of the Medicare population.

By contrast, providers stated Medicare Advantage offered their organizations more support during 2020 than FFS Medicare due to the unique design of the Medicare Advantage program. This unique design enabled health plans to support providers and beneficiaries in ways that were different than FFS Medicare. The differences are categorized into three groups of flexibilities: financial, administrative resources, and benefits.

- **Financial:** The flexible financial mechanisms of the Medicare Advantage program allow plans to enter into value-based payment arrangements and direct resources to support providers in times of financial strain, which help providers focus on providing safe and effective patient care. In particular, providers with sub-capitated payment arrangements with health plans stated that being free from the volume-based incentives of FFS reimbursement enabled them to treat beneficiaries rapidly and as needed. Providers also cited the ability of health plans to offer their organizations advanced or enhanced payments as a great benefit during a time of financial strain.
- **Administrative Resources:** The administrative resources and care management infrastructure enabled health plans to deliver targeted education, outreach, and interventions to beneficiaries and providers. Providers and beneficiaries benefited from health plan efforts to identify at-risk beneficiaries, provide care management, and effectively communicate COVID-19 related information to beneficiaries and providers quickly.

- **Benefits:** The flexibility of Medicare Advantage to offer benefits beyond FFS Medicare was critical during the COVID-19 pandemic and distinguished Medicare Advantage from FFS Medicare. Providers consistently stated that when available, beneficiaries isolating at home benefited from supplemental benefit offerings, such as home delivery of prescription drugs and groceries. In addition, several providers stated that Medicare Advantage was often quicker than FFS Medicare to cover and/or provide clear guidance about the coverage of audio-only telehealth visits and coverage of other forms of virtual care services (e.g., virtual check-ins, online portal visits, remote patient monitoring).

Together, these findings demonstrate the impactful role Medicare Advantage had for beneficiaries and points to the continued importance of Medicare maintaining a more flexible Medicare Advantage program. Providers acknowledged the various benefits the Medicare Advantage program offers to providers and beneficiaries during a public health emergency when beneficiaries were unable to access their providers through their normal pathways. For the health policy community, the experience gained while responding in the initial months of the pandemic offers a deeper understanding of the role of Medicare Advantage in addressing both the clinical and social needs of beneficiaries, including those who are chronically ill and at high risk of social needs that impact health status. Therefore, at a time when the Medicare delivery system is in crisis, the flexibility of the Medicare Advantage program enables providers to better serve beneficiaries.

Appendix 1: Provider Challenges Experienced at Onset of the COVID-19 Pandemic and the Impact of Beneficiaries

The literature review highlighted several challenges health care providers experienced in 2020 as a result of the COVID-19 pandemic. These challenges had a direct impact on the delivery of health care services in 2020. To a certain degree, many of these challenges continue to impact the delivery of health care services as the COVID-19 pandemic persists in 2021. These challenges include:

Patient visit volumes declined, causing revenue and cashflow declines for providers.

Historic levels of decline in health care utilization among Medicare beneficiaries during the first half of 2020 posed substantial revenue gaps for providers. During the first three months of the COVID-19 pandemic (March-May 2020), Medicare outpatient hospital and physician claims declined 51 percent and 42 percent, respectively, from 2019 to 2020.⁵ Literature points to three specific causes of this decline: reduced patient demand for care, the cancellation of elective surgeries, and the postponement of non-urgent visits. As a result of this volume decline, provider revenues for these lines of business declined by similar degrees, posing solvency concerns for many providers.

Rapidly changing Medicare policies caused confusion about how to record patient encounters and submit claims.

Early in the COVID-19 pandemic, Medicare made numerous modifications to policy and guidance related to medical coding and billing for COVID-19 cases, coverage, and reimbursement. These changes, and the rapid pace at which they were released, caused confusion for providers and plans. Specific challenges included obtaining accurate clinical documentation and coding for COVID-19 cases, changes to the Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding System (HCPCS) code sets, and policy

changes finalized in Medicare's 2021 Physician Fee Schedule regulations.⁶ Among the various concerns cited by providers within the Healthcare Financial Management Association's (HFMA) Pulse Survey were increased workloads as a result of confusion over coding changes related to COVID-19 and unpredictable claim volumes.⁷ Other medical billing experts noted that rapidly changing billing requirements during 2020 were likely to lead to coding and billing errors, claim denials, and revenue losses for providers.⁸ Further, the confusion of plans and providers in this regard was augmented by providers and plans transitioning their operations from in-office to remote locations.

Providers that were forced to temporarily close their offices due to the COVID-19 pandemic caused financial strain and reduced access to care for beneficiaries.

Physician practices, hospitals, and providers in rural locations closed or consolidated during 2020 as a result of financial challenges posed by the COVID-19 pandemic.⁹ In many cases, the COVID-19 pandemic worsened pre-existing financial complications for some providers.¹⁰ However, COVID-19 pandemic-related volume declines caused financial strain for providers that were not under equivalent financial strain prior to the pandemic. A 2020 survey by the Physician's Foundation found that 8 percent of physicians closed their practices (approximately 16,000 practices) and an additional 4 percent of physicians planned to close their practices within the next year (approximately 8,000 practices).¹¹ Experts assert these physician practice closures will reduce access to care and worsen disparities in access to care.¹²

Social distancing reduced demand for preventive care and chronic care management.

The early impact of the COVID-19 pandemic threatened the health and wellbeing of patients, especially Medicare beneficiaries, and altered how or if beneficiaries sought care. Avoided or delayed care in 2020 was widely reported. Survey data from CMS suggests the most common types of foregone care in 2020 among all beneficiaries were dental care, regular check-ups, treatment for an ongoing condition, and diagnostic or medical screening tests.¹³ The CMS survey also concluded 41 percent of Medicare beneficiaries avoided or delayed care out of concern for being in a medical facility where COVID-19 was present, and 21 percent of beneficiaries reported needing care not related to COVID-19 but decided against seeking treatment.¹⁴ Foregoing care is a particular concern for Medicare beneficiaries who are older and tend to have more chronic conditions than the non-Medicare population. Some experts assert that avoided preventive services by Medicare beneficiaries may spawn additional crises for the health care system and the Medicare program in the future.^{15,16}

Patient case complexity increased due to COVID-19-related stress and social isolation.

In 2020, Medicare beneficiaries experienced worsening health caused by isolation and the stress of the COVID-19 pandemic. From the provider and plan perspective, this increased the case complexity of Medicare beneficiaries. A Kaiser Family Foundation study found that close to half of older adults in the US reported in July 2020 that worry and stress related to the coronavirus had had a negative impact on their mental health, up from 31 percent in May 2020.¹⁷ In addition, a recent survey of Medicare beneficiaries concluded that one-third of beneficiaries reported feeling less socially connected since the start of the COVID-19 pandemic due to practicing social distancing during the COVID-19 pandemic.¹⁸ Beneficiary health was further complicated by food insecurity during the COVID-19 pandemic. The social isolation and economic challenges of the COVID-19 pandemic worsened food insecurity issues for many Medicare beneficiaries, including those also eligible for Medicaid.^{19,20}

Expanded infection control procedures increased administrative and medical burden on providers.

Throughout 2020, medical facilities and offices were required to implement a wide variety of COVID-19-related infection control procedures in order to reduce the spread of the COVID-19 virus. These procedures involved the acquisition and use of personal protective equipment (PPE), the implementation of social distancing rules, and many other requirements. Many facilities and offices were unprepared for this challenge and were required to devote substantial resources to meeting required state and county standards for protection. Infection control procedures varied by provider type, including congregate, acute care, office, and home care settings.^{21,22} Further, the COVID-19 pandemic highlighted the issues of the less stringent infection control practices and workforce safety issues that increased risk to COVID-19 exposure.²³

Providers had to rapidly implement virtual care services.

Prior to the COVID-19 pandemic, many providers lacked substantial virtual care services infrastructure, and social distancing requirements during the pandemic forced providers to rapidly commit to expanding their capacity to provide these services to patients.²⁴ Providers struggled to establish these lines of service, redeploy and train staff to use these services, and integrate virtual care services into their business model.²⁵ During 2020, providers also faced rapidly changing coverage and guidance from CMS related to virtual care services.²⁶ Beneficiaries were similarly unprepared for the expanded use of virtual care services by providers, as many lacked the technology or technological experience necessary to engage in the services.²⁷ A longstanding issue known as the digital divide, the barriers to access virtual care, such as access to smartphones and broadband internet, were amplified early in the pandemic when virtual care services were rapidly adopted.²⁸ The lack of access to virtual care services further exacerbated health disparities and inhibited access to care for disadvantaged populations and lower-income communities.^{29,30} Thus, while telehealth proved highly valuable to many, it was not universally accessible or usable for all Medicare beneficiaries.³¹

Providers experienced burnout and fatigue.

Many reports have highlighted the toll the COVID-19 pandemic has taken on providers and administrators. In 2020, providers endured stress, fatigue, burnout, and post-traumatic stress disorder (PTSD).³² In particular, primary care physicians noted rising levels of burnout and exhaustion for themselves and staff as a result of the COVID-19 pandemic.³³ Key factors for staff burnout include longer hours and longer shifts, and the stress of becoming infected with the virus, or fear of spreading the virus to others.³⁴ Several other factors likely contributed to increased provider burnout, including; patient deaths and the severity of patient illness, individual financial strain, individual feelings of helplessness, and the fear of being reassigned to departments outside their scope of practice to assist in treating COVID-19 patients.³⁵ Provider burnout can have immediate and long-term consequences for beneficiary access to care and the quality of care being provided.^{36,37}

Appendix 2: Health Plan and Provider Interviewee List

Plans		
Organizational scope	Geographic Location	Plan Type
1. Local	California	Medicare Advantage
2. Regional	Minnesota and Wisconsin	Medicare Advantage
3. National	Multi-state	Medicare Advantage
4. Local	Washington	Medicare Advantage
5. Local	Ohio	Medicare Advantage
6. National	Multi-state	Medicare Advantage
Providers		
Organization scope	Geographic Location	Provider Type
1. Large local	Indiana	Behavioral Health Group
2. Small local	New York City	Health System
3. Large local	Illinois	Physician Group
4. Large local	Texas	Physician Group
5. Large national	Multi-state	Physician Group
6. Large local	Illinois	Health System
7. Small local	Illinois	Physician Group
8. Large national	Multi-state	Behavioral Health
9. Regional	Connecticut and Massachusetts	Physician Group/Clinically Integrated Network
10. Large local	Pennsylvania	Skilled nursing care, home health, hospice and palliative care
11. Large local	New York City	Home health, hospice and palliative care; Medicare, Dual- Eligible
12. Large local	Massachusetts	Physician Group



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