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HEALTHCARE MANAGEMENT ADVISORS

COVID-19 and Hospital Finances: Assessing the Impact

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COVID-19 is a tsunami for hospitals—the waters pulling back as beds are emptied, then an overwhelming and uncontrollable surge wave. Like an actual tsunami, this one may have multiple surges. But even with several waves, an actual tsunami is over quickly and recovery returns you to a former baseline. With COVID, it is likely that successive waves will have an extended timeframe, and that while hospitals will regain stability, it will not be at the former "normal."

Each of the phases of the COVID tsunami will have its own set of financial impacts, some of which overlap, some of which trigger sequential impacts, and some of which are separate and distinct.

These are the key elements that drive each of these phases:

PRE-SURGE

During the pre-surge, patient volumes decline as hospitals delay elective procedures. System's employed physician networks experience declines in patient office visits as patients stay home and cancel appointments for non-urgent medical needs. Physicians, both employed and some independent, begin meeting some patient needs through virtual meetings and telehealth solutions.

Hospitals deploy cash for emergency purchases of supplies, equipment, and facility conversions, to prepare for the anticipated needs of COVID-19 patients at peak volumes. Supply chains dry up due to the significant demand from competing health systems and business interruptions due to stay-at-home orders.

Hospitals may need to draw down Investment holdings to fund operational and capital needs, right at the point when a market crash has reduced fund balances.

SURGE

The surge hits different geographic areas at different times and with varying intensities. It continues to force profitable elective procedures to extremely low volumes, and even to prevent some patients from seeking potentially life-saving emergency care. Employed physician networks judiciously bolster their telehealth capabilities, resulting in some revenue streams, though these are insufficient to offset deep and growing operating losses.

COVID-19 patients now fill Inpatient beds. While patient acuity increases, it is likely that reimbursement, even with expected increases in Medicare payments for COVID-19 patients, is not sufficient to offset both increased lengths of stay and greater acuity, higher ICU utilization, and labor and non-related expenses associated with demand-driven wage growth, critical PPE and medication shortages, and physician call fees and income supplements. During this time, clinical staff contract the virus at high rates, thus further driving the need for contract labor at increased costs, where such labor can be found at all.

As inpatient volumes outpace capacity, the utilization of observation beds as de facto COVID inpatient beds becomes a reimbursement issue. In some markets, bed counts that exceed typically licensed numbers may also result in at least short-term reimbursement issues.

POST-SURGE: THE "PULSED RECOVERY"

Though potentially catastrophic, the pre-surge and surge impacts are to some degree predictable. In contrast, it's hard to predict how the post-surge phase will develop. The most likely scenario is a series of successive, smaller surges as distancing measures are released and re-applied—with some degree of recovery occurring in pulses between these smaller surges.[1] The overall Covid-19 related timeframe is likely to encompass 18 to 24 months with longer term financial recovery and return to "normal" taking, perhaps three years or more. The uncertainty of this phase is perhaps its most critical aspect:

- How long will it take for the revenue cycle to recover to predictable patterns, and how will secondary surges affect this?
- Will supplemental revenue streams from the CARES Act materialize? When and to what degree?

[1] A vaccine or effective treatment would short circuit these timeframes, but even once found, would take months to years to apply broadly. Achieving herd immunity could take 2-3 years to reach if we continue to work to prevent hospitals from being overwhelmed, although widespread testing might modify this.

- To what degree can future expenses be reduced and managed to a lower level, given the likelihood of successive smaller surges?
- Will pent-up demand for “elective” cases, physician and specialist business offset the negative impact of the two prior phases?
- How long will it take to return to normal physician productivity and scheduling levels, and how will this be affected by long-term changes in practice patterns (e.g. telehealth)?
- How will the loss of employment and the emerging recession impact patient insurance coverage and patient volume demand?
- How will short-term capital support measures (e.g. bridge financing) influence longer-term expenses and debt capacity?

The cumulative impact of these phases will affect net income, cash flow (and hence, financial position and debt capacity) differently for each hospital provider, depending on the intensity of surges and timing of governmental controls in each geographic location, the hospital’s degree of pre-surge preparedness, and the demographic and socio-economic characteristics of the hospital’s market. While some of the post-surge/recovery factors are out of hospital control, utilization and financial projections and sensitivity analyses based on those factors both within and beyond hospital control will be essential in shaping the way forward. How well a hospital responds to those projections will play a critical role in determining the hospital’s financial position upon the completion of all COVID-19 phases.