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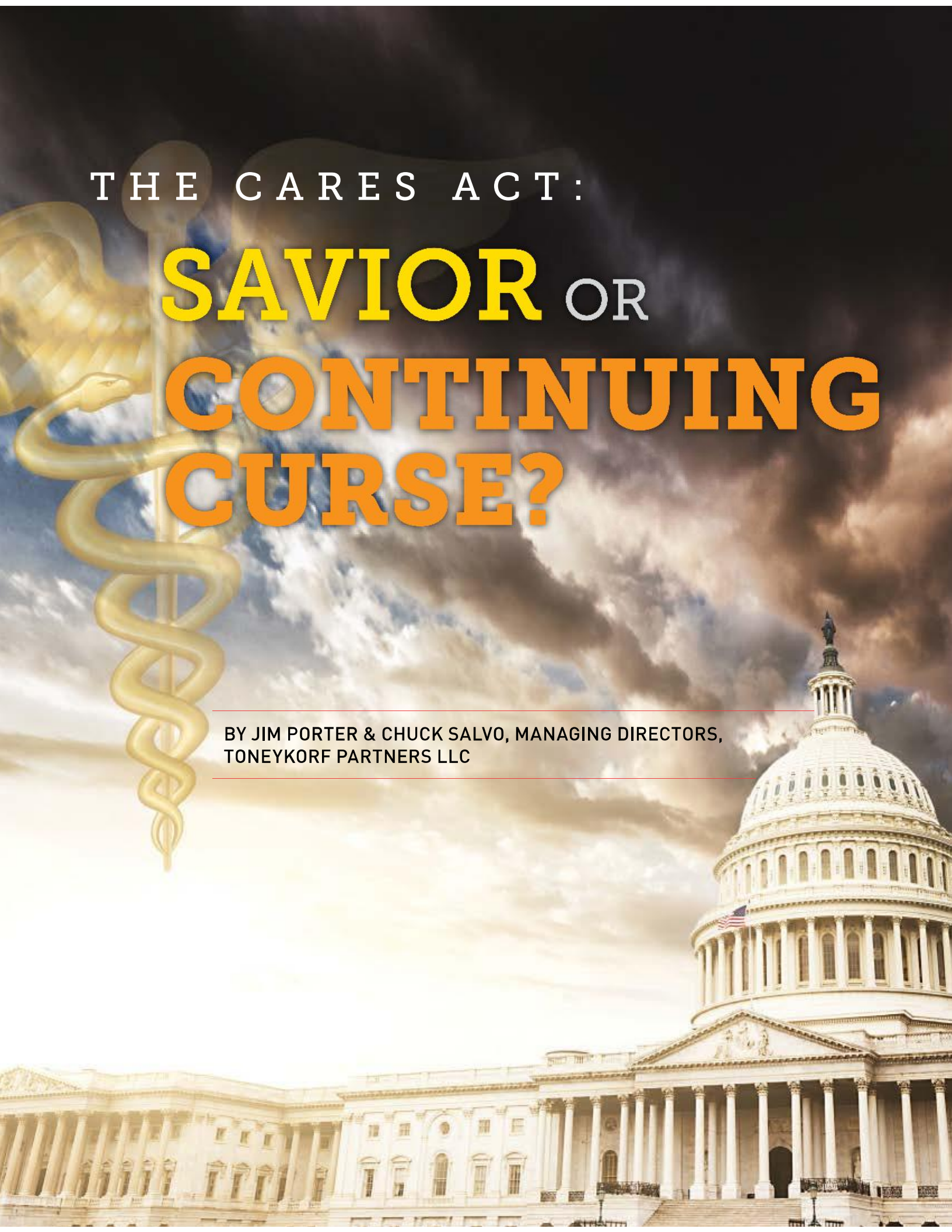

THE CARES ACT: SAVIOR OR CONTINUING CURSE?

BY JIM PORTER & CHUCK SALVO, MANAGING DIRECTORS,
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During the summer of 2021, the United States began to tentatively emerge from the COVID-19 pandemic, a dynamic that was supported thanks to hospitals nationwide benefiting from payments received in accordance with the Coronavirus Aid, Relief, and Economic Security (CARES) Act. As of April 2021, an estimated $178 billion in funds were available, and $146 billion had been distributed.

This funding was necessary during COVID-19 for several reasons. Routine healthcare delivery, such as elective cases and preventive in-person visits, evaporated overnight; non-emergent care was delayed; and balance sheet reserves for distressed and rural hospitals were insufficient to withstand their business coming to a standstill. Hospitals also needed the flexibility to prioritize patient care above the economics of their financially distressed situations. Unfortunately, these payments—although crucial for many hospitals to remain open during the pandemic—served to mask the growing financial underperformance in distressed and rural hospitals.

So now, moving into the recovery stage and beyond,[1] the question becomes, "What does this funding mean to those who will manage through the disruption accelerated by COVID-19?" This article looks at the factors that led to today's situations, then outlines strategies that hospital management teams and boards must deploy for their organizations to succeed.

Pre-Pandemic Healthcare

Leading up to the pandemic, many hospitals were already in the midst of a fundamental change in their economics based on the increasing shift of care outside of the inpatient setting. COVID-19, however, hastened that transition. For example, over the past two decades, there has been movement from hospital-based services to physician offices, ambulatory surgery centers (ASCs), urgent care centers, and in-home care, including telemedicine. A report on patterns of outpatient growth noted that the aggregate share of outpatient services in total hospital revenue grew from 28% in 1994 to 48% in 2018.[2] Value-based care is another trend promoted largely by insurers and government payors to chase value and improve quality, driving the shift in the location of care away from the hospital setting, including to intensive outpatient programs and ASCs.

Continued advances in telemedicine have led to improved patient access to innovative, high-quality critical care, such as the Milford-Yale Tele-ICU, which provides care remotely to critically ill patients through audio and video conferencing and remote monitoring of data. This model allows the ICU team to care for patients across multiple hospital locations with real-time efficiencies.

There is also a trend in closures and consolidations. Merger and acquisition deals dipped in 2019 to 85, compared to 116 in 2018, and declined further in 2020, when 79 transactions occurred.[3] Pre-COVID, 47 hospitals closed in 2019,[4] compared with 21 hospitals in 2020.[5]

The healthcare market had a flurry of new entrants in 2019, disrupting incumbent providers and raising the competitive bar. Nimble, tech-enabled, and well-funded organizations like SynaptoGenix, Oscar Health, and Clover Health quickly established themselves, and patients responded favorably. Other newcomers included healthcare ventures funded by private equity (PE).

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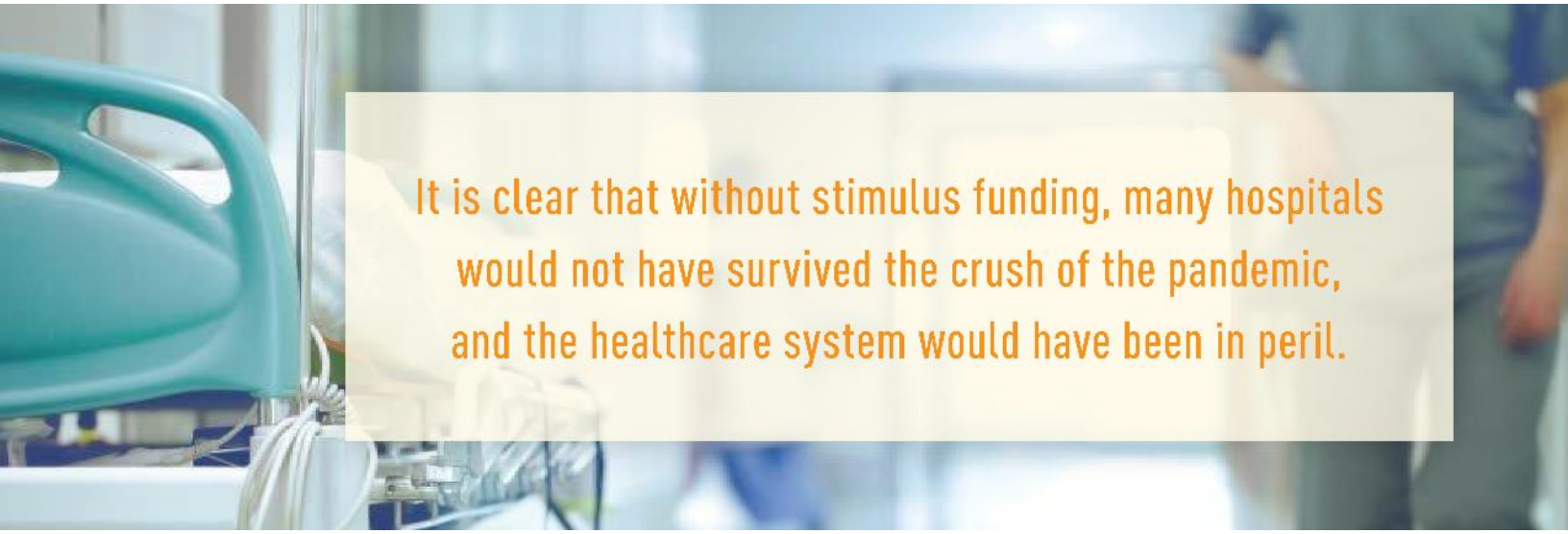

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PE funding reached record levels in 2019[6] —estimated annual deal values surged from $41.5 billion in 2010 to $119.9 billion in 2019—and the rate is only expected to increase in coming years.

Flush with Cash

COVID-19 patients, either anticipated or actual, drove a shift in hospital revenue models. Revenue came from COVID patient discharges, advances from the federal government on future Medicare payments, and stimulus money designed to cover COVID-related costs like personal protective equipment (PPE), telehealth, additional clinical staffing, and testing supplies.

This influx of cash enabled hospitals to ride out even the most expense-laden months of the pandemic by funding unexpected expenses, such as setting up and staffing COVID testing sites and isolation areas and tapping into staffing agencies to help cover additional shifts that their own staffs could not. The influx of funding delayed the need for layoffs in 2020, but staff reductions are now being seen across the country. Becker's recently identified seven hospitals or systems that have announced layoffs or job cuts.[7] Further, according to Kaufman Hall's National Hospital Flash Report, discounting CARES funding, hospitals experienced declines in median operating margins for 2020 of 55.6%, along with declines in volume and increases in expenses.[8]

Additional factors contributed to no net gains during this time. Beginning in March 2020, private health plans were required under the CARES Act to eliminate co-pays, deductibles, and claim denials for COVID-19-related diagnoses and care. Around this same time, the Centers for Medicare and Medicaid Services enacted provisions to ease regulations to allow hospitals to quickly ramp up their telehealth services, leading to a sharp increase in adoption. For example, the One Brooklyn Health System, a safety net hospital in Central Brooklyn, rolled out video-enabled visit capabilities in less than one week at the onset of the pandemic.

While telehealth visits were integral to maintaining continuity of care for patients with chronic conditions, Medicaid payments typically do not cover the full cost of services. The Kaiser Family Foundation estimates that New York Medicaid reimburses providers approximately 48% of the Federal Medicare rate for a primary care visit.[9] Layering on direct costs for telehealth software and indirect costs for IT support, training, and hardware upgrades would not have been possible without CARES Act funding.

CARES Act funding, after various modifications to the proposed legislation, was designed to result in a no loss, no gain financial outcome for facilities. The result? In the short term, most hospitals experienced no gains in net revenue but also little to no cash losses, which sustained their balance sheets heading into 2021.

The Downside of Advances and Stimulus

Previously, economically stressed hospitals experienced some breathing room on their balance sheets thanks to the initial injection of COVID funding, and one could assume this would give them time to adjust and prepare for whatever the next crisis might be. However, once the initial surge of COVID patients subsided, it became evident that non-COVID patient volumes were behind pre-pandemic levels. Now, in the fall of 2021, this decrease is eating into hospitals' newly found balance sheet assets.

To put this into context, one hospital reported that during COVID it averaged 300 emergency department visits per day; by spring of 2021, that volume declined to 180 patients per day. This same hospital had received $40 million in stimulus funding, but by early 2021 was $5 million below its historic revenue. From a cash perspective, this put the facility back to the pre-pandemic level. However, revenues have declined below those at the onset of COVID, which will impact future cash flow. Absent changes to operations, funding would be depleted within the year.

The CARES Act provided much-needed funding to hospitals and included conditions designed to avoid "double-dipping," meaning the funding is intended to be used on COVID-related spending only. At this stage, few facilities appear to have considered reorganizing or restructuring. Yet, this is precisely when hospitals need to evaluate their role in the community and execute a strategy for sustainability.

As of this writing, the June 30 deadline for repayment of unused stimulus funding had passed. The ability or inability to repay further magnifies the underlying economic chasm that exists among hospitals. It is clear that without stimulus funding, many hospitals would not have survived the crush of the pandemic, and the healthcare system would have been in peril.

For facilities that were experiencing negative cash flow from operations before the pandemic and that used advance funding, the repayment period creates additional drains on cash flow. Given that the mechanism for payment is offsetting future Medicare payments, working capital is negatively impacted. Provisions are in place, though, for extended repayment terms of up to five years for Medicare advances, which is welcome news, especially for hospitals and long-term care facilities.

Further, many organizations provided employees with "hazard" or "recognition" pay during the pandemic. As the pandemic waned and hospitals ended these programs, front-line worker morale took a hit, as did employee support for administration. This negative impact resulted in lower cooperation, higher sick time call outs, and increased turnover.

Strategies for a Positive Future

Hospitals and health systems are now emerging from the beating they took since the onset of the pandemic. Providers should focus on the future while drawing lessons from the past, understanding that their new normal is lower volume. The COVID-19 stimulus funding and other external financial support meant to get them through the pandemic is in the past. History shows that during any disruptive event, there are those who adapt and those who do not, and in the case of hospitals, some institutions will fail.

How can hospitals manage to remain afloat following this crisis? The critical component for success is communication—among management, their peers, regulators, boards, physicians, employees, and advisors. Experience with distressed organizations suggests that not everyone in a business will be on the same page regarding a recovery plan. Each stakeholder and department will have its own priorities. Management must be reminded that the end goals are to achieve better patient outcomes, preserve market share, and be prepared for further disruption.

With strong communications as a foundation, successful solutions involve:

- **Acknowledging the need for change.** Management and boards must first acknowledge the need for change in certain areas, whether in technology, costs, or new partnerships. Leadership should also understand that there is no single opponent disrupting the organization but rather a series of factors and a number of competitors impacting specific areas of the continuum of care, including consumer trends, PE-backed organizations, government interventions, and changes in technology.

- **Establishing partnerships.** Partnering with proven entities or specialists who are the best in their fields enables hospitals to leverage advantageous payment methods, reduce clinical capital intensity,

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and manage scarce human capital needs. Understandably, aligning with profit-motivated partners or even competitors may feel counter to the organization's mission, but it is important to focus on the potential outcome—the positive patient experience.

- **Embracing and encouraging strong public policy and coordination of resources.** Healthcare organizations should leverage all government (state and local) health departments. These agencies have the bigger chessboard and should be trusted to assist with appropriate decisions. Collaboration upfront may result in favorable treatment down the road. Health departments can broker better coordination between larger systems and smaller safety net hospitals. This can be mutually beneficial, as safety net hospitals tend to be the focus destination for Medicaid patients, whose financial contribution is low. Absent these safety net institutions, the communities' healthcare dependency will shift to the larger systems. Conversely, systems tend to have broader in-house capabilities and connections that can be leveraged to improve the stability of safety net providers.

- **Shedding underperforming services and managing overhead.** Shedding low-volume or underperforming services is one step toward staying afloat. Instead of providing all services to everyone, hospitals should focus on their strengths and seek alternatives for low-volume, mission-related services. Decoupling the institution's mission from its existing stakeholders (employees, boards, health departments, and community) may be controversial but necessary for survival.

Managing overhead and high-cost areas, such as the workforce, is critical. There are more acceptable alternatives to layoffs, such as retraining employees or offering early retirement packages for select personnel. In January, NYU Langone Health announced that a significant portion of its physician billing service would be relocated to Nevada.[10] Technological advancements allow organizations to decentralize services and take advantage of larger labor pools in lower-cost markets. Collaboration and open dialogue are necessary with employees, especially where labor unions are involved.

- **Investing in technology and refocusing on improved patient outcomes.** Ongoing margin erosion, the result of revenue declines and cost increases, has long driven the need for continuous reengineering in healthcare delivery. The pandemic has simply magnified the differences between organizations that have adopted new technologies and those that have not or have made minimal investments in that regard. Those with the ability to invest and leverage innovative technology can benefit from improving the patient experience, redesigning the revenue cycle, and allowing better interpretation of data.

By harnessing "big data," organizations like United Health Group can predict what types of care individuals will need and proactively guide them to lower-cost options. Alternatively, by placing a greater financial burden on those members who use the wrong care provider (*e.g.,* using an emergency room for a minor burn), payors are pursuing behavioral changes and higher profits. Hospitals must redesign their service models and create a more cost-effective manner or risk becoming obsolete. This perpetuates the "arms race" pitting providers against payors, and the payors always have an edge.

- **Lobbying for forgiveness of existing advances.** State and local lawmakers recognize the importance of the healthcare industry in their communities. Hospitals and all who work there have been hailed as healthcare heroes, and the goodwill that has been built up from the pandemic can be leveraged. Hospitals can and should investigate whether repayment of funding, especially Medicare advances, can be forgiven. A hospital can argue that it needs to retain the advances received to shore up its infrastructure to be prepared for another potential pandemic or to adapt to the rapidly changing market.

Over the past 18 months, hospitals have experienced unprecedented challenges on all possible fronts. Dealing with the pandemic required hospital boards and management to necessarily focus on the immediate needs of patients, staff, and operations. This resulted in the majority of their time being focused inward. Now is the time to take a step back, reassess, and reach out. Engaging the skills and knowledge of the board, legal counsel, and outside advisors who can help assess balance sheets and overall operational needs will help organizations look to 2022 with a fresh, hopeful, and optimistic perspective.

Conclusion

Healthcare organizations, including many hospitals, are struggling. Ultimately, some will close. The pressures from health-tech, payors, and new clinical delivery models will siphon off all but the sickest and the poorest patients from traditional acute care hospitals. Large, fully integrated systems have the greatest likelihood of extending the lifespan of traditional care access in some communities. Stand-alone community, rural, and safety net hospitals are at the highest risk in the U.S. healthcare system.

However, organizations that acknowledge the need for change, embrace partnerships, utilize strong public policy, maximize limited resources, and resolve to improve patient outcomes will be best positioned to survive. J

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