JTaylor™

Healthcare Consulting | Valuation

Healthcare Financial Planning During the COVID-19 Crisis

How to manage effectively through uncertainty

Kyle Kirkpatrick, FACHE
Principal - Consulting Services

The COVID-19 pandemic has caused massive disruptions to hospital and physician clinic patient volumes that has rendered 2020 budgets and financial plans obsolete during this time of the crisis. As healthcare administrators and managers know, budgeting and financial planning are an important part of managing any healthcare enterprise. In light of the unprecedented nature of the COVID-19 pandemic, predicting how healthcare consumers will respond after current lockdown and shelter-in-place orders are lifted will be difficult. In this brief, we present three scenarios that illustrate how the COVID-19 pandemic will impact future healthcare financial projections along with suggestions on how to approach your financial planning. The three scenarios are as follows:

1. Back to normal with a volume surge;
2. COVID-19 immunization as the pivot point; and
3. Telehealth wins!

After a synopsis of each scenario, we offer practical suggestions on financial planning and operational considerations.

Scenario One: Back to Normal with a Volume Surge

Most people want life to get back to normal. Sheltering in place has worn out its welcome for busy Americans, and most have a desire for normalcy – to get out of the house, to go to restaurants, even go to work. Our first scenario contemplates the "back to normal" scenario.

President Trump has issued new federal "Opening Up America Again" guidelines for opening the country[1], with heavy reliance on the states and regions to execute the plan. In fact, on April 17, Texas Governor Abbott issued an executive order that would begin to loosen restrictions on medical procedures beginning as early as April 22[2]. Asian and European countries are already opening up sectors of their economies in waves, with limited success. When COVID-19 infections peak and begin to decline and regions are able to reduce shelter in place restrictions, healthcare volumes may come back to pre-COVID-19 levels. Many have predicted a healthcare surge with physician-driven utilization – specifically, surgeons and proceduralists who have lost months of cases and revenues. Elective surgeries and procedures that were delayed may take place once the states enter Phase I, which allows outpatient surgeries, and continue during Phase II. In addition, pent up volumes in ancillary services like imaging and lab services as well as gastroenterology and pain procedures will rise when first allowed, then level off once patients have "caught up" on delayed services. Providers can add infection control precautions an enhanced safety protocols to give patients comfort that coming to a healthcare campus is relatively safe.

Administrators who plan for adequate staffing during the expected surge in volume, while remaining a good financial steward, will face a difficult challenge. Ramping staff back to normal levels over several months seems to be the most conservative choice. Ramping back to "normal" levels without fully knowing the precisely when the surge will occur or how long it will last is risky. Developing a creative schedule in your operating rooms and procedure rooms will challenge norms and preferences to a new level for providers. Our suggestion is to use your schedules creatively to maximize existing resources to avoid overstaffing to unsustainable levels.

A degree of public wariness will continue; however, the desire to live a normal life will likely outweigh fear of infection for many. Hospitals will remain vigilant against the ongoing threat of further COVID-19 cases. We expect to see higher utilization occurring in less acute, ambulatory settings such as ambulatory surgery centers, clinics, and imaging centers apart from acute care centers, as there may be a continued perception of the high-acuity hospitals as COVID-19 care centers that therefore carry a greater risk of exposure to the virus. As a result, the high-acuity hospitals may see continued lower margin non-critical cases in the short term. Healthcare volumes will flutter between waves of infections until an effective immunization and/or treatment is widely available.

[1] Andrew Restuccia, Michael C. Bener, Catherine Lucey, *Trump's Guidelines to Reopen Economy Put Onus Governors*, Wall Street Journal, April 16, 2020. (https://www.wsj.com/articles/trump-set-to-unveil-guidelines-for-lifting-coronavirus-restrictions-11587050541?shareToken=stcfb3a6e152104b31a66af8d8c8dbd8ee)

[2] Executive Order GA 15 (https://gov.texas.gov/uploads/files/press/EO-GA-15_hospital_capacity_COVID-19_TRANS_04-17-2020.pdf)

Scenario Two: "COVID-19 Immunization as a Pivot Point"

Stable healthcare volumes hinge on a worldwide immunization for the COVID-19 virus due to its novel nature.

Pre-immunization Financial Planning for Healthcare Entities

Growing volumes in this interim stage will require mitigating efforts of high infection control procedures, marketing for "essential" services, and capturing additional volume because patients believe the services are essential and cannot wait until the risk of contracting COVID-19 is significantly reduced and state and local governments give the "all clear" to resumption of normal activities. We suggest working with your physicians and clinical teams to plan essential services and optional services by CPT and DRG, if possible, in order to have interim financial plans based on future necessities prior to the "all clear" declaration.

To date, the negative volume impact due to the pandemic has been catastrophic to many health-related businesses – which for many has been somewhat offset by the CARES Act stimulus funds provided in the U.S. Currently, only essential services are occurring in healthcare entities, which encompass COVID-19 care and other life-sustaining care that must continue regardless of the pandemic. Non-essential or optional volume has mostly disappeared for now across the country. Some volume during the interim period will include procedures that have been delayed thus far but cannot be delayed forever, and will therefore at some point need to move to the essential category. That conversion capture rate will be difficult to predict and is the reason we encourage a deep dive on your planning efforts to estimate essential vs. optional services during this interim period. Staffing and expense management will need to follow the results of your planning efforts for the short and long term. In other words, if your interim planning efforts show your facility will have a 40% reduction in volume, your staffing and expense management should reflect that expected decline in utilization for this period.

Volume exists at acute care centers that are taking on COVID-19 and other high-acuity patients and providing life sustaining treatments and procedures. However, these providers have also experienced major volume declines as elective procedures that provide high margins have been all but eliminated. The overnight shift to telemedicine services along with receiving reimbursement for those services is a new phenomenon that is unlikely to go away in any scenario. Many practices have ramped up their telehealth capabilities and presence over the past few weeks since the CARES Act relaxed telemedicine billing standards. Facility fees are not part of these telehealth fees, which will cause a financial hit to most healthcare providers.

The remainder of the healthcare continuum including the vast majority of clinics, physician practices, ambulatory surgery centers, urgent care clinics, freestanding emergency departments, pre- and post-acute care, and other access points that provide in-person non-critical care have all suffered as a result of the pandemic. Most ambulatory clinics, non-essential services and even emergency departments have seen dramatic volume declines.

The hope is that many practices and services can re-open after Phase I or Phase II are achieved; however, this is unpredictable since the virus has no bias to victims or geographies. Regardless, nimble operators will have to use all their resources and creativity during this time period to manage limited volumes in a high stress, constantly changing environment. This includes marketing to your patient base that your infection control protocols limit virus exposure risks.

After the *"All Clear"*

Work is ongoing around the world to develop a COVID-19 vaccine. Once this is widespread, which may be twelve to eighteen months away, a general ramp-up should occur for healthcare utilization other than the telemedicine volume impact. Surgeries, cath labs, GI procedures, ASC and imaging center volumes, ancillary work, and even medical/surgical volume should rise back to pre-pandemic levels and grow from there.

Long term, we expect that some things will be permanently changed – such as the adoption of telemedicine. Most healthcare service providers will need to evaluate how the 2020 pandemic will change their service delivery going forward. A broad adoption of telehealth could have a negative financial impact on American healthcare facilities unless the facility fee can be renegotiated into commercial payor contract terms.

Our best guess is that after COVID-19 immunization is widespread, healthcare volumes will see a ramp back to pre-pandemic levels over a six-month period, with the exception of what has converted to telehealth services.

Scenario Three: Telehealth Wins

The big winner out of the pandemic is the widespread adoption of telemedicine. Due to necessity, patients are now able to access care providers remotely, and those providers are able to be reimbursed for those services in most cases. State Medicaid programs will lag behind. Integration with EMR's and billing systems will have glitches and workarounds for months and potentially years; however, telehealth will become more widespread. The only exception is in rural areas without broadband service. However, funding through the CARES Act to promote telehealth may help even rural areas prepare for telehealth services through programs administered by the Federal Communications Commission (FCC).

Financial forecasts must incorporate the impact a much broader conversion to telemedicine services will have on revenue. New marketing approaches will need to be deployed to ensure your patient base remains plugged in to your providers. Additionally, consideration must be given to the infrastructure that may be needed to maintain telehealth services once the privacy requirements that were relaxed during the emergency period are tightened back up again. This could include investments in a more robust telemedicine platform that is HIPAA-compliant.

We are all looking for positive things coming out of the pandemic. The move to telemedicine provides a convenience for patients and families that is welcome.

Now What?
Suggestions for Financial and Operational Planning:

- Prepare multiple short- and long-term scenarios based on how people are responding in your area, the magnitude of current cases, and the specific phase of Opening Up America Again where you reside.
- Move to lean operations in anticipation of an extended low volume period.
- Work with your physicians and clinical team to plan "essential" services and "optional" services by CPT and DRG, if possible, to have financial plans based on future necessities prior to the "all clear" being issued by state and local authorities.
- Assess your telehealth position and how you can effectively move into this space. Your market position could be at risk from someone who will provide telehealth services more readily than you and your providers.
- Maintain a readiness state for a second wave of COVID-19 infections later in 2020 and into 2021 prior to an immunization being available.
- Move elective services to ambulatory settings where possible.
- Estimate revenue implications in the following areas:
    - Telemedicine growth and resultant declines in related facility fees;
    - Shifts to ambulatory settings;
    - Decreased volumes across all services until after an immunization;
    - CARES Act cash infusions;
    - COVID-19 related premiums on care provided to infected patients.
- Re-evaluate your capital plans and re-prioritize in light of less capital available. Consider equipment and/or software that may be required to continue providing telehealth services in a HIPAA-compliant manner.
- Actively pursue stimulus funds where available.
- Be proactive with payors (both commercial and governmental) – communicate with them frequently pursuing value for essential services which have been medically focused.
- Be opportunistic with competitor changes that may help you gain long-term market share through collaborations.
- Create a "safe" environment for your patients to enable volume to grow. This would be driven by infection control/safety leaders enabling social distancing, regular cleaning, and other methods to provide confidence to patients and families that they will be safe coming to your facilities.
- Proactively market your infection control and safety precautions to your patients and providers**.**

Conclusion

The COVID-19 pandemic is a signature event in our lives. It has been compared to the Spanish Flu of 1918; however, most of us were not alive to experience that. Planning for near- and long-term healthcare volumes will require creativity and nimbleness from all of us. Scenario planning requires us to be thoughtful about multiple future scenarios. Then, as circumstances change and we monitor them closely, we will be better prepared to react quickly and appropriately. If life as normal returns quickly, all of us will be relieved. As planners, however, we must consider an elongated time period of providing only essential services until an "all clear" is given in a particular area.

Like everyone, we hope that positive healthcare innovations will result from how providers and patients alike adapted to the pandemic out of necessity. Times of uncertainty, while challenging, also present remarkable opportunities. Best of luck to us all as we navigate the current challenges, with continued commitment to providing quality care to patients as our top priority.

JTaylor™
Healthcare Consulting | Valuation

4800 Overton Plaza | Suite 360
Fort Worth, Texas 76109
P. 817.924.5900
F. 817.924.5915
Toll Free 888.811.8877
Email: info@jtaylor.com

Kyle Kirkpatrick, FACHE

Principal - Consulting Services
214.675.3608
kkirkpatrick@jtaylor.com

Kyle is an experienced advisor serving healthcare clients across the country for over 25 years. He can add perspective from his experience as hospital CEO, real estate developer, strategist, financial planner, podcaster, rancher, and beekeeper.

Herd Midkiff, CVA

Partner - Director of Consulting Services
hmidkiff@jtaylor.com

Herd Midkiff serves a variety of non-profit and investor-owned healthcare clients. His fields of expertise include managed care business enterprise and compensation valuation, contract strategy and negotiation, capital planning and expansion projects, and merger and acquisition due diligence. Herd's list of clients includes large multi-hospital health systems, private equity owned enterprises, entrepreneurs, and attorneys.

Courtney McKay, CPA

Partner - Director of Quality
cmckay@jtaylor.com

Courtney is a founding member of JTaylor in 1999. She has an expertise in business enterprise valuations, physician compensation valuation and plan design, and litigation support and damage assessments. Courtney has helped clients with strategic planning, including joint venturing, business acquisition, buy/sell agreements and due diligence services.

Jim Berend, CPA

Executive Consultant - Consulting Services
jberend@jtaylor.com

Jim is a senior healthcare financial executive with broad-based and deep experience in virtually every major delivery mode in the care continuum. During his 35 years of client service, he has consulted with academic medical centers, children's hospitals, health insurers, pharmacy benefit managers, surgery centers, skilled nursing facilities, imaging centers, CCRCs, cancer centers, hospice and home health agencies, laboratories, lithotripsy companies, air and ground ambulance entities, and LTAC, among others.