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Navigating Through Uncertain Times

Focus on stability as economy and healthcare providers face headwinds

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As the corona virus pandemic has taken hold and governments world-wide have issued stay at home orders for significant numbers of their populations, unprecedented changes have occurred in the world economy. As noted in a recent Wall Street Journal Article, economists estimate that up to 14.4 million jobs will be lost in the U.S. in the coming months and the unemployment rate may rise to 13% by June, up from a 50-year low of 3.5% in February.[i] As it relates to the healthcare industry specifically, it is predicted that April job losses for ambulatory healthcare services could top 1.5 million[ii]. Hospitals and physician clinics are feeling a financial squeeze as they see sharp declines in routine doctor visits and emergency room visits. In addition, elective surgeries have been canceled or delayed under orders from state and local officials in order to conserve personal protective equipment and keep hospital space available for COVID-19 patients.[iii] Major health systems and medical practices of all sizes are furloughing administrative and some clinical staff, while other large providers are curbing expenses and delaying capital projects[iv]. In this environment, we expect there to be a slowdown in transaction activity until the COVID-19 crisis passes and the economy can get started again. As providers and healthcare investors cope with the challenges of managing their entities through this crisis, we at JTaylor have turned much of our attention to helping providers remain financially strong so they can successfully emerge from the current turbulence.

During the COVID-19 crisis our firm has been focused on four areas as we help our clients navigate the current uncertainty. These four areas are as follows:

(1) The CARES Act;

(2) Provider Revenue Streams;

(3) Physician Compensation; and

(4) After the Crisis.

The sections below will discuss each of these focus areas in more detail.

The CARES Act

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was enacted into law on March 27, 2020. This Act provides a variety of funding sources to address the significant financial needs resulting from the pandemic. Much of the aid is directed at healthcare providers, who are uniquely impacted by rising costs and revenue disruptions associated with responding to patient needs during the crisis while also maintaining long-term financial stability. Additionally, the Act provides increased flexibility to allow healthcare providers to more effectively serve patients during the crisis.

Public Health & Social Services Fund

A sizeable portion of the fund ($100 billion) was designated to reimburse eligible healthcare providers for healthcare related expenses or lost revenues attributable to coronavirus. Funds from this program may be used for:

- Building or construction of temporary structures;
- Leasing of properties;
- Medical supplies and equipment, including testing supplies and personal protective equipment (PPE);
- Increased workforce and training;
- Emergency operation centers;
- Retrofitting facilities; and
- Surge capacity.

On April 10, The Department of Health and Human Services (HHS) began making distributions of an initial $30 billion from this fund to all providers based on their relative share of total 2019 Medicare fee-for-service (FFS) reimbursements.

The remaining $70 billion of this fund is expected to be allocated through targeted distributions focused on providers in areas particularly impacted by the COVID-19 outbreak, rural providers, and providers of services with lower shares of Medicare reimbursement or who predominantly serve the Medicaid and uninsured population. Furthermore, HHS has indicated that this fund will be utilized to provide reimbursement at Medicare rates for providers treating uninsured coronavirus patients.[v]

Hospital Inpatient Prospective Payment System Add-On Payment

During the emergency period, the weighting factor that would otherwise apply to the diagnosis-related group (DRG) to which a patient's discharge is assigned shall be increased by 20% for Medicare patients diagnosed with COVID-19. State Medicaid agencies are authorized to make the same adjustment, even if they have received a 1115A Waiver. **No action is necessary on the part of enrolled hospitals to receive the additional payments.**

Delay of Medicare Sequestration

During the period May 1, 2020 through December 31, 2020, Medicare sequestration will be temporarily suspended. This will result in a 2% increase in Medicare reimbursement on claims for services provided during that period. Sequestration will be extended through fiscal year 2030 (rather than expiring as scheduled in 2029) to recover those funds. **No action is necessary on the part of enrolled providers to receive the additional payments.**

Paycheck Protection Program

The CARES Act authorized up to $349 billion in forgivable loans to small businesses to pay their employees during the COVID-19 crisis. While the Paycheck Protection Program (PPP) is not an option for large hospitals or health systems, this program may be advantageous for qualifying medical practices and other smaller healthcare providers who are experiencing significant disruptions to their normal patient volumes. Eligible entities, which include not-for-profit entities, sole proprietorships, and self-employed individuals, generally must have fewer than 500 employees. Businesses may borrow up to 2.5 times average monthly payroll costs, not to exceed $10 million, and funds may be used to pay payroll costs (including benefits), mortgage interest, rent, and utilities during the 8-week period following receipt of the loan.

Loan amounts are forgivable to the extent the number of employees during the 8-week period is maintained at historical levels, and salaries and wages for individual employees are not reduced by more than 25%. It is anticipated that no more than 25% of the forgiven amounts may be for approved non-payroll related expenses.

As of April 16, 2020, the initial $349 billion of this program has been exhausted and lawmakers on Capitol Hill are negotiating to add additional funds to the program.[vi]

Medicare Accelerated / Advance Payment Program

For the duration of the emergency period relating to COVID-19, Medicare Part A and Part B providers may request accelerated payments on a periodic or lump sum basis for up to 100% (or up to 125% for critical access hospitals) for up to a 6-month period. Eligible providers include inpatient acute care hospitals, children's hospitals, specialized cancer hospitals, critical access hospitals, and Part B providers such as ambulatory surgical centers, physicians, and durable medical equipment (DME) suppliers. Hospitals shall have up to 120 days before claims are offset against the advance to recoup the accelerated payments. The outstanding balance must be paid in full within 12 months of the date of the first advance.

Subsequent to the enactment of the CARES Act, CMS issued a press release indicating that the accelerated payment program has been expanded to all Medicare providers throughout the country, including hospitals, doctors, DME suppliers, and other Medicare Part A and Part B providers and suppliers who have billed Medicare for claims within 180 days prior to making the request.

For providers or suppliers to receive Accelerated / Advance Payments under this program, they must submit a request to their designated Medicare Administrative Contractor (MAC). It is anticipated that approved payments will be issued within 7 days of the submitted request.

COVID-19 Telehealth Program

The CARES Act appropriated $200 million to the Federal Communications Commission (FCC) to support efforts of healthcare providers to address the coronavirus pandemic by ramping up their use of telehealth. This program will provide funding for costs related to telecommunications services, information services, and devices necessary to enable the provision of telehealth services during the emergency period. As a result of this authorization, the FCC has established the *COVID-19 Telehealth Program* (Program).

The Program is open to eligible healthcare providers in both rural and non-rural areas, providing support for Program recipients to purchase telecommunications, information services, and connected devices to provide telehealth services on a temporary basis in response to the coronavirus pandemic, whether directly for treatment of coronavirus or for treatment of other health conditions during the emergency period. Rewards under this program will provide full funding for eligible services and devices, but it is anticipated that awards to any single applicant will not exceed $1 million. Funding received from the Program may be used for any necessary eligible services and connected devices, and additional funding may be requested after initial funds are exhausted.

The Program will be limited to nonprofit and public health providers that fall into the following categories:

1. Post-secondary educational institutions offering healthcare instruction, teaching hospitals, and medical schools;
2. Community health centers or health centers providing healthcare to migrants;
3. Local health departments or agencies;
4. Community mental health centers;
5. Not-for-profit hospitals;
6. Rural health clinics;
7. Skilled nursing facilities; or
8. A group of healthcare providers consisting of one or more entities falling into the first seven categories.

Provider Revenue Streams

Hospitals and physicians have experienced significant disruptions to their patient volumes due to the suspension of most elective surgical procedures as well as patients choosing to delay doctor visits as they follow shelter in place orders and avoid visiting medical facilities where they face potential exposure to COVID-19. This abrupt change in volume and service mix is putting a strain on hospitals, since much of their profit is derived from surgical procedures and outpatient visits. Physician groups are experiencing similar revenue declines as patients avoid office visits and specialists are unable to perform surgeries that usually comprise a significant part of their practice.

While the CARES Act has implemented changes to Medicare payment levels and reimbursement policies to help account for some volume disruptions and service mix changes, we know that these measures are not enough to fully address the revenue losses providers are experiencing as a result of the pandemic. To further protect revenue

streams, providers should work with commercial managed care payers to ensure their contracted rates account for these same changes. Payer negotiations should include both short-term and long-term considerations to enable providers to be fairly compensated for the services they provide.

Hospitals and Health Systems

Hospitals and health systems should reach out to their largest commercial payers and work towards rebalancing their contracted rates to enhance payments for medicine services over surgical services. This can be accomplished in a couple of ways.

For DRG based contracts, providers should make sure that the updates that the Center for Medicare and Medicaid Services (CMS) makes to DRG weightings to effectuate the 20% increase for COVID-19 related DRGs are also adopted in the DRG weight tables used by commercial payers. Some payer contracts automatically follow CMS DRG weights, but many contracts use custom weight tables or DRG weights fixed to a specific year. It is important for providers to ensure their contracts reflect any weight enhancements implemented by CMS.

Hospitals could also examine year over year volume changes to determine how COVID-19 has impacted their service mix, then negotiate with payers for a one-time payment to make up for the difference in revenue that is attributable to the service mix change. Contracted rates and associated insurance premiums are established based on historical utilization patterns. The COVID-19 disruption represents a material volume shift from historical patterns that could not have been predicted. Accordingly, providers should work with payers to account for such a dramatic shift in volume and service mix.

Physician Groups

Multi-specialty physician groups that contain a mix of primary care physicians and specialists should examine their commercial contracts and pursue a similar rebalancing by shifting dollars from surgical procedures to evaluation and management (E&M) services. Enhanced E&M rates could be implemented on a temporary basis (i.e., through the duration of the emergency declaration), and the enhancement removed after the COVID-19 crisis passes.

Additionally, as CMS has expanded the use of telemedicine services by approving reimbursement for previously unreimbursed services, commercial payers should follow suit. Providers should work with commercial payers to ensure reimbursement rates for telemedicine services are equal to the rate for an equivalent service performed in a non-telehealth setting.

Physician Compensation

Changes in volume have also impacted compensation for the many physicians who are compensated based on work RVU production models or collections-based models. These physicians are directly impacted as volume shifts occur as a result of directives to halt elective procedures, patients choosing to delay routine visits, shortages of PPE required to safely provide care, and other shifts in resources as hospitals are dealing with severe financial constraints brought on by the COVID-19 crisis.

This circumstance is forcing hospital administrators to think creatively to ensure physicians are incentivized to provide services where they are most critically needed, while minimizing losses in other areas of the health system. Some creative

ways to address physician compensation issues include:

- Increasing compensation for physicians working directly with COVID-19 patients;
- Reassigning qualified physicians as "hospitalists" in geographies heavily impacted by COVID-19 activity, and adjusting compensation accordingly;
- Extending compensation guarantees or implementing base salaries for key physicians who are negatively impacted by current volume disruptions but will be required for the health system to maintain adequate care for the community after the crisis subsides; and
- Temporarily reducing compensation for non-critical physicians whose volumes and associated collections have been negatively impacted by the disruptions.

Any changes to physician compensation levels should be made in a manner to ensure adjusted amounts remain at fair market value for services rendered, or the adjustment qualifies for one of the eighteen blanket stark waivers issued by CMS on March 1, 2020[vii]. While the waivers allow increased flexibility to allow health systems to address the unique impact of the crisis on their organization and the local community, adequate documentation remains important from a regulatory compliance standpoint.

After the Crisis

While the focus of providers has understandably been on determining how to weather the storm in the present moment, it is critical for the long-term financial health of their organizations they also keep an eye towards the future and what it will look like when we emerge from the COVID-19 crisis.

After honestly evaluating their current financial position, providers should begin planning for their cash needs when the crisis passes and a new normal takes hold. In addition, providers need to assess their ability to serve pent-up demand once directives are lifted and surgical volumes begin to return. Providers should plan for varying volume and staffing scenarios since it is unclear if volumes will return immediately, or whether there will be slow build as patients remain tentative about undergoing medical procedures – either from continued fear of exposure to COVID-19 or due to financial constraints resulting from the economic downturn.

Until there is a COVID-19 vaccine, protocols and safety measures must be implemented to ensure the continued safety of patients and staff. All planning should take these enhanced safety measures into account, including developing appropriate processes and procedures as well as procuring required supplies and equipment.

The increase in telemedicine activity accelerated an already existing trend, and this change will impact facility needs and staffing needs for providers. Telemedicine and technology should factor into a provider's plan for future operations.

Finally, the crisis has forced everyone in the healthcare industry to think differently about how care is delivered and what types of contingencies need to be planned for. The government has made available hundreds of millions of dollars in an attempt to bridge the funding gap during the crisis. The U.S. (and much of the world) has experienced a forced shutdown of its economy at a scale that is unprecedented in our lifetime. In the chaos of the present, the seeds of new opportunities

are being planted that will drive new alliances, new ventures, and new ways of working. It is important that entities do all they can to remain stable and strong through the current uncertainty so they will be positioned to engage in new opportunities when they arise.

Endnotes

[i] Eric Morath, Harriet Torry and Gwynn Guilford, *A Second Round of Coronavirus Layoffs Has Begun. Few Are Safe,* Wall Street Journal, April 14, 2020, (https://www.wsj.com/articles/a-second-round-of-coronavirus-layoffs-has-begun-no-one-is-safe-11586872387?shareToken=st665e0339f9004e0e90948a8738b07192)
[ii] Ibid.
[iii] Anna Wilde Mathews and Melanie Evans, *Hospitals, Doctors Feel Financial Squeeze as Coronavirus Sweeps U.S.,* Wall Street Journal, April 1, 2020, (https://www.wsj.com/articles/hospitals-doctors-feel-financial-squeeze-as-coronavirus-sweeps-u-s-11585768706?shareToken=std1ad4c906d6a44fe930a907107ca04aa)
[iv] Ibid.
[v] CARES Act Provider Relief Fund, (https://www.hhs.gov/provider-relief/index.html)
[vi] Andrew Duehren, *Funding Exhausted for $350 Billion Small-Business Paycheck Protection Program*, Wall Street Journal, April 16, 2020, (https://www.wsj.com/articles/funding-exhausted-for-350-billion-small-business-paycheck-protection-program-11587048384?shareToken=st325fa01462664bff9cd33cb780eddca8)
[vii] Details for waivers may be found on the CMS website, (https://www.cms.gov/files/document/covid-19-blanket-waivers-section-1877g.pdf)