Dealing with Disruption

COVID-19 Strategic Reopening & Recovery Planning

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Dealing with Disruption: COVID-19 Strategic Reopening & Recovery Planning

COVID-19 has had a profound impact on every health system, health plan, and provider organization in the nation. We at BDC Advisors believe it is essential for health systems to start planning for their reopening and recovery at the same time they are taking immediate actions to respond to the crisis. There is still great uncertainty – how far the virus will spread, how many 'waves' will be experienced – but we do know that *COVID-19 is already taking a terrible toll on health system finances*, from the cost of ratcheting up ICU capacity and staffing, to cancelled elective procedures, patients voluntarily staying home, losses on investments, and more. While some patients will return when states reopen their economies, volume losses will persist, since consumers will remain fearful, and cautious employers will be slow to expand workforces during the recovery.

In addition to volume losses, health systems will also be hit by a deteriorating payer mix. The finances of the U.S. health system work only because commercial insurance subsidizes Medicare, Medicaid, and uninsured patients. Since the pandemic started, unemployment has skyrocketed: Over 26M people have lost their jobs and applied for unemployment insurance in the past five weeks—almost triple the ~9M who lost their jobs during the Great Recession. The low-paying service sector of the economy (retail, restaurants, leisure, etc.) has been especially hard hit, and many of these jobs will not come back for a long time. As a result, the long-term shift from commercial to government payers and uninsured patients, will accelerate. For the average health system, losing 5% of commercial volume translates to a 0.8-1.4-point reduction in operating margin (i.e., operating margin of 2% drops to 0.6-1.2%), so this shift in payer mix could add substantially to losses.

Overall, BDC Advisors projects that health systems could experience as much as a 35-point decline in operating margin this year under "moderate" assumptions about the severity and length of the pandemic (i.e., an operating margin of 5% could decline to -30%). Nationally, this represents a potential loss of $600B for the hospital and physician sectors and a decline of 130 days cash on hand for the average health system. The Coronavirus Aid, Relief, and Economic Security (CARES) and Paycheck Protection Program and Health Care Enhancement acts, which together earmark $175B for hospitals, does not come close to reimbursing the healthcare industry for this financial hardship.

What Can Health Systems Do to Recover?

While health system CEOs and COOs must be focused on responding to the COVID-19 crisis and stabilizing their operations today, at the same time they must also be preparing for what lies ahead. This means developing realistic scenarios for how the crisis will affect their systems and defining a range of reopening and recovery options. Then it requires deciding on an overall strategy for reopening services, including clear priorities, and drafting actionable recovery plans with timelines and triggers identified to deal with inevitable contingencies. The overall goal is to transform "unknown unknowns" into "known unknowns," so risks can be assessed and managed.

Reopening and recovery planning should have two time horizons: (1) *immediate* to organize short-term actions over the next *1-3 months* to prepare for reopening; and (2) *intermediate* to organize actions over the next *3-9 months* that will drive the longer-term recovery. The intermediate plan needs to anticipate structural changes in the way health care will be organized, financed, and delivered in the future and incorporate these into the recovery plan.

If health systems don't start planning their reopening and recovery now, the impact on their systems will be substantially greater and will last longer. The financial impact of the pandemic is highly sensitive to how quickly health systems reopen key services and recover lost revenue streams. Our financial projections indicate that by taking appropriate steps, a 35-point loss in operating margin could be cut to a 20-point loss, and a decline of 130 days cash on hand could be cut to 70 days. While severe, these losses are much more easily dealt with, especially if business recovers next year.

Reopening & Recovery Priorities

We believe health systems need to plan and implement initiatives in four priority areas to ensure a successful strategic reopening and recovery:

- **Develop a "SMART©" Reopening Plan**
- **Engage Payer Partners and Adapt Contracting Approach**
- **Rebuild Physician Partnerships**
- **Evaluate Partnership and Acquisition Opportunities**

Planning that needs to take place in each of these priority areas is discussed below.

Develop a "SMART©" Reopening Plan

COVID-19 has disrupted almost all aspects of operating a health system, especially patient flow, staffing, supply chain operations, and the system's relationship with its patients and consumers. Fortunately, there have also been some beneficial disruptors – e.g., waivers of some regulations, increased incentives for virtual care (telehealth), and greater flexibility in staffing to allow mid-level providers to operate closer to the top of their licenses. The crisis has also dramatically increased consumer acceptance of virtual care, which will have long-term benefits to industry costs.

Exhibit 1 summarizes immediate and intermediate service mix and operational planning activities needed to support strategic reopening and recovery. Every health system we work with has established a high-level crisis team to respond operationally to the COVID-19 crisis. We believe every health system also needs a dedicated, small, high-level planning team to organize its reopening and recovery efforts (we call this the SMART© Planning Team.) The objective of the SMART Planning Team is to define immediate and intermediate actions steps the system can take to bring capacity back online, restore trust and confidence with consumers / patients, rebuild relationships with physician partners and payers, and evaluate other partnership and acquisition opportunities.

Immediate priorities for reopening start with redesigning patient flows to isolate COVID-19 patients in dedicated units in order to control infection and provide a basis for assuring patients that the hospital is safe. Patient assurance needs to be the next priority. Until we have an effective vaccine in broad distribution, patients need to know they can come to hospitals and ambulatory facilities without risking COVID-19 infection. Health systems need to assess consumer sentiment about coming to their hospitals and ambulatory facilities for care. Systems then need to respond to these by: (1) reengineering patient flow and staffing to reduce patients' fears; and (2) communicating what they have done broadly through multiple marketing channels. The notion of a 'virus-free' facility, confirmed with antibody testing, could be compelling.

Once these risk-reduction and patient assurance actions have been taken, the other immediate priority is to develop service-specific plans and timelines to bring key services back online. To organize this, health systems need a Service Mix and Recovery Timeline or "SMART"© reopening plan. Many factors should be considered in developing these plans and timelines, as shown on Exhibit 1, but **restoring revenue and margin must be a principal goal** of the planning effort. Most health systems will want to examine different options for reopening services and analyze the financial impacts of these options. In particular, SMART reopening plans should assess new ways of distributing services across clinical assets to attract patients back quickly

Exhibit 1.

Develop a "SMART ©" Reopening Plan

DISRUPTORS

- COVID-19 patients requiring isolation, surge capacity
- Consumer fears about exposure to infection
- Increased consumer acceptance of virtual encounters
- Staff shortages, quarantines
- Increased staffing flexibility to operate at top of license
- Regulatory waivers
- Pricing transparency heightening competition
- Supply chain disruptions
- Service backlogs

IMMEDIATE ACTIONS
Now

Determine how risk of COVID-19 infection for patients and staff can be contained / controlled
- ➢ *What isolation options exist for dedicated COVID-19 units?*
- ➢ *How will testing impact this plan?*

Develop patient assurance strategies
- ➢ *What are consumer sentiments today?*
- ➢ *How can consumers be convinced we are safe?*

Evaluate options and develop a **Service Mix And Recovery Timeline ("SMART©")** reopening plan, based on:
- Clinical needs
- Staffing availability with new staffing models
- Backlogs and queues for patients
- Updated consumer preferences
- Potential site of service changes
- Physician support / enthusiasm
- Regulatory shifts
- Potential for near-term revenue and margin recovery for hospitals, MDs

INTERMEDIATE ACTIONS
Plan NOW to Deploy in Next 3-9 Months

Review strategic and financial plans against "new normal" realities, including:
- Updated performance vs. budget
- Target market positioning
- Changing consumer preferences
- Changing reimbursement trends
- Competitive shifts (e.g. acquisitions)

Develop service migration plan
- ➢ *How will sites of service change in your market? (IP ➔ ambulatory ➔ virtual)*
- ➢ *How should your system respond? What opportunities does this open?*

Develop new revenue streams – e.g., telehealth
- ➢ *What are current telehealth capabilities of your hospitals, PCPs, specialty groups?*
- ➢ *How has COVID-19 changed the economics of telehealth in your market? What opportunities does this open?*

Plan restructuring of core infrastructure:
- Facilities
- Virtual health
- Supply chain

Intermediate service mix planning should start with comprehensive reviews of current strategic and financial plans to determine where changes are needed to meet "new normal" marketplace realities. This planning needs to explore how changes in consumer preferences, reimbursement trends, and competitive factors are likely to interact with internal changes and constraints – e.g., budget performance and financial resources – in order to determine where adjustments are needed.

Other intermediate planning actions the SMART Planning Team should pursue include:

Developing a service migration plan to rebalance service mix and volumes. The pandemic is likely to accelerate the long-term shift from inpatient to ambulatory care and is certain to expand virtual care significantly.

Developing new revenue streams to replace or augment pre-COVID revenue sources. In the era of COVID-19 and beyond, the ability to provide patients at home, in nursing homes, and other locations virtual access to many healthcare services will be essential. Health systems must assess their current telehealth capabilities, identify services that can be provided virtually, predict lasting changes in consumer behavior in their markets, and understand the changing economics of telehealth to identify revenue growth opportunities. Telehealth will also encourage health systems to focus more on segmenting the market and customizing consumer experience for different segments.

Planning restructuring of core infrastructure. Once future service mix changes are understood and agreed to, the planning team needs to assess the implications of these changes on core system infrastructure – e.g., facilities, supply chain, IT resources – and the financial resources needed to bring infrastructure in line with the "new normal."

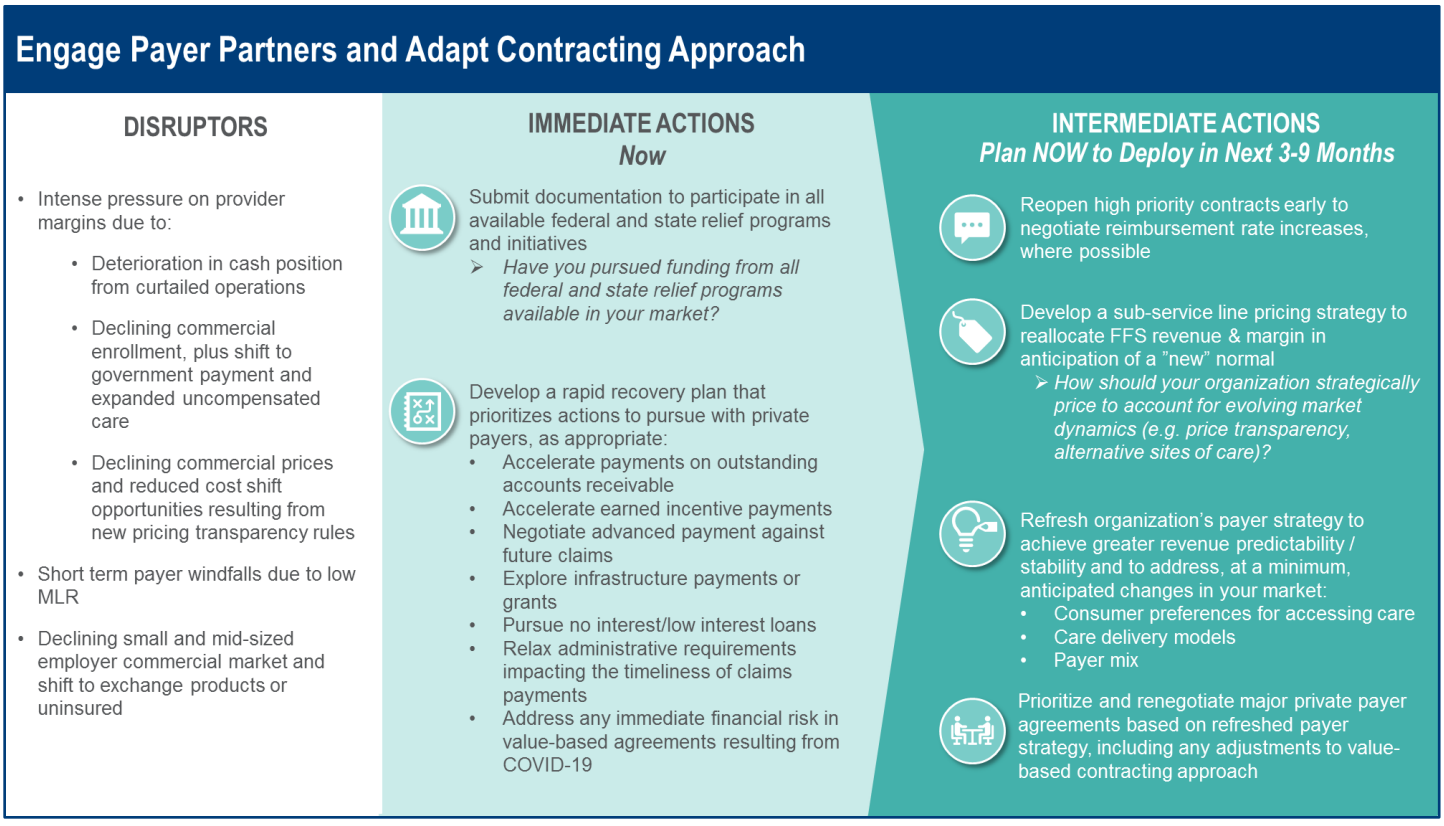
Engage Payer Partners and Adapt Contracting Approach

Providers are under intense pressure to secure additional funding quickly in order to preserve their cash position and compensate for volume reductions and payer mix shifts. To compound the problem, new CMS price transparency rules coming into effect January 2021 threaten to intensify price competition and reduce margins on commercial business.

While providers are suffering, the pandemic has created a windfall for many health plans, which are benefitting from reduced utilization and medical costs. Most private payers recognize the importance of maintaining the stability of provider networks and many are in a financial position to provide near-term financial assistance. Moreover, some payers may be at risk of not adhering to the ACA's Medical Loss Ratio (MLR) provision, which requires health plans to allocate a specific portion of their revenue to the provision of care. Specifically, health plans that do not meet MLR requirements must provide rebates to members, employer clients or the federal government. Payers with large commercial books of business may find that the reduction in elective care has created a risk of this requirement being triggered, making them more willing to provide short-term financial assistance that would be included as medical expense, such as advance payments and one-time recovery payments. Financially stable payers that are not at risk of falling short on their MLR requirements may be willing to extend low-interest or no-interest loans to providers. In fact, payers in several markets are already offering financial support to selected providers to keep them afloat.

Exhibit 2 summarizes immediate and intermediate planning activities that health systems should pursue with major payers.

Exhibit 2.



Most health system CFOs have already taken the immediate action of pursuing the federal and state relief programs designed to pay for COVID-19-related costs. Beyond this, health systems need to develop **rapid recovery plans** for each major private payer. Provider organizations have numerous paths to increasing short-term revenue from payers as listed in Exhibit 2, and these should be explored now.

Payers that represent a significant portion of a provider's revenue, that have large commercial fully insured books and strong balance sheets, and with whom providers have durable relationships may be the best organizations to approach regarding unique COVID-19 revenue solutions. These solutions can take many forms, such as no interest / low interest loans or advanced payments against future claims. As with many provider-plan contracting issues, convincing payers to increase provider payments, even with the MLR incentive, is a delicate dance that may require bringing outside political pressure to bear on health plans to share surpluses.

Intermediate recovery activities with payers may be more productive for health systems over the long run. Health systems should plan on reopening high priority contracts as soon as possible, in order to bring them in line with their "new normal" operations and financial needs. COVID-19 will accelerate many trends – e.g., the uptake and expansion of virtual care, the acceptance of non-traditional provider players, the desire to access care in non-hospital settings. In this environment, a thoughtful pricing strategy, developed at the sub-service line level, that is sensitive to the needs of consumers and the rise of transparency, is imperative. Calibrating rates for the right services and locations can address existing exposures and grow commercial volume.

Beyond specific contracts, health systems should take the opportunity of the pandemic to refresh their overall payer strategy to incorporate new consumer preferences (e.g., virtual care), new care delivery models and payer mix shifts in major payer contracts. A comprehensive payer strategy captures not only price positioning by segment, but also specifies target fee-for-service vs. value-based revenue mix, target market share by consumer segment, potential payer partners for innovative offerings, product participation decisions (e.g. narrow networks), and employer engagement approaches.

A payer strategy refresh should also address risk contracts and health systems' risk exposure. In the near term, the COVID-19 crisis will likely have a favorable financial impact on providers' performance in commercial risk arrangements due to the postponement and cancellation of many elective clinical services. Performance in the Medicare segment may also be favorable, but this is less clear. A provider's risk-based contract performance, in any case, is dependent on key terms of the risk-based contract, including benchmark methodology. Some providers may find that certain contract terms are not adequately or appropriately structured given the current health care landscape will require adaptation. Beyond these specifics, COVID-19 has underscored the uncertainty and risk surrounding provision of medical services and the importance of achieving greater predictability and stability of revenue. The pandemic serves as an important reminder for providers to ensure they have appropriate contract terms to weather such storms in the future.

Rebuild Physician Partnerships

The financial condition of independent medical groups is a major disruptor in today's market. While almost half of physicians are employed by health systems or medical groups, nearly one-third remain in private practice and distribute all (or the vast majority) of their cash at the end of the year.[1] Currently, these private practitioners are hanging on from payments for work performed in January and February, but they see the cliff looming ahead. Those with the most prepaid revenue (e.g. capitation) are currently in the best shape, but many fee-for-service providers are anticipating major hits to their top and bottom lines. Even though most are exempted from "shelter in place" regulations, many are already cutting hours and laying off staff.

This situation creates a major instability in the market, one that is likely to be exploited by insurance companies (which, as discussed above, are in much better shape financially), national physician organizations like Optum, and other major players – e.g., CVS. These companies have deep pockets and long-time horizons and will likely be offering medical groups "deals they can't refuse." This instability has the potential to disrupt existing provider networks, even for physicians and groups currently employed by health systems.

In this environment, it is critical for health systems to reach out to their physician community to help stabilize their financial situation. Exhibit 3 summarizes some of the immediate and intermediate action steps health systems should pursue to rebuild their physician partnerships in this time of change.

Exhibit 3.

[1] Jacquline LaPointe, "Less Than a Third of Docs Owned Independent Practices in 2018", *RevCycleIntelligence,* September 20, 2018. https://revcycleintelligence.com/news/less-than-a-third-of-docs-owned-independent-practices-in-2018

Health systems can strengthen their relationship with physician communities immediately by reaching out aggressively, assessing their needs, and offering cash flow assistance, education, and advocacy support with government and private payers. Some may need help in applying for CARES and Paycheck Protection program loans and grants or negotiating for faster collections and/or supplemental payments from private insurers. Some may need help restructuring their practices to reduce costs or in keeping their offices up and running. While most risk contracts should be relatively healthy in a time of lower utilization, some practices may have contracts that are under-water and need help restructuring them. It is in the interest of health systems to keep their physician partners seeing patients full-time.

Health systems also need to act now to understand broad physician market dynamics. What insurers, national medical groups, or other competitors are "sniffing around" looking for bargain acquisitions? What medical groups are distressed enough to be looking for a new owner? What medical groups are moving to exploit COVID-19-driven changes in care delivery – e.g., growth of telehealth? In addition to collecting valuable intelligence, asking these questions is likely to identify practices that could be acquisition candidates in the intermediate phase.

In the intermediate timeframe, health systems should pursue two types of initiatives: (1) Incorporating the market intelligence gleaned in the immediate phase and the implications of "new normal" care delivery models into physician alignment strategies; and (2) Working with physicians to restructure their practices to fit these new models.

Based on what systems learn about the physician market, they need to review and revise their physician alignment strategies (in parallel with their other strategies). For example, what changes in alignment strategy are needed to keep financially healthy physician groups out of the arms of competitors? Are clinically integrated networks enough, or do we need stronger "hooks" to align with physicians?

Health systems also need to start acting on these new strategies in the intermediate term. This means, for example, negotiating with practices that are open to being acquired, if acquiring them fits revised alignment strategies. It could also mean developing or expanding joint risk contracts with independent physician partners. Some Stark law constraints have been lifted (perhaps temporarily), and the implications of these changes for physician networks need to be understood and utilized where appropriate. For employed physicians, changes in practice economics may indicate the need to recalibrate compensation plans to modify levels and incentives.

Health systems also need to work with physicians in the intermediate term to change practices to fit "new normal" market realities. This begins with assessing shifts in consumer preferences about inpatient care, ambulatory care, and virtual care and using this data to develop new approaches to care. This will attract more patients on the front end and strengthen the health system's overall market position. A related trend is greater use of mid-level practitioners, and health systems may be able to help physician partners adapt their practices to use them more effectively to leverage valuable physician time.

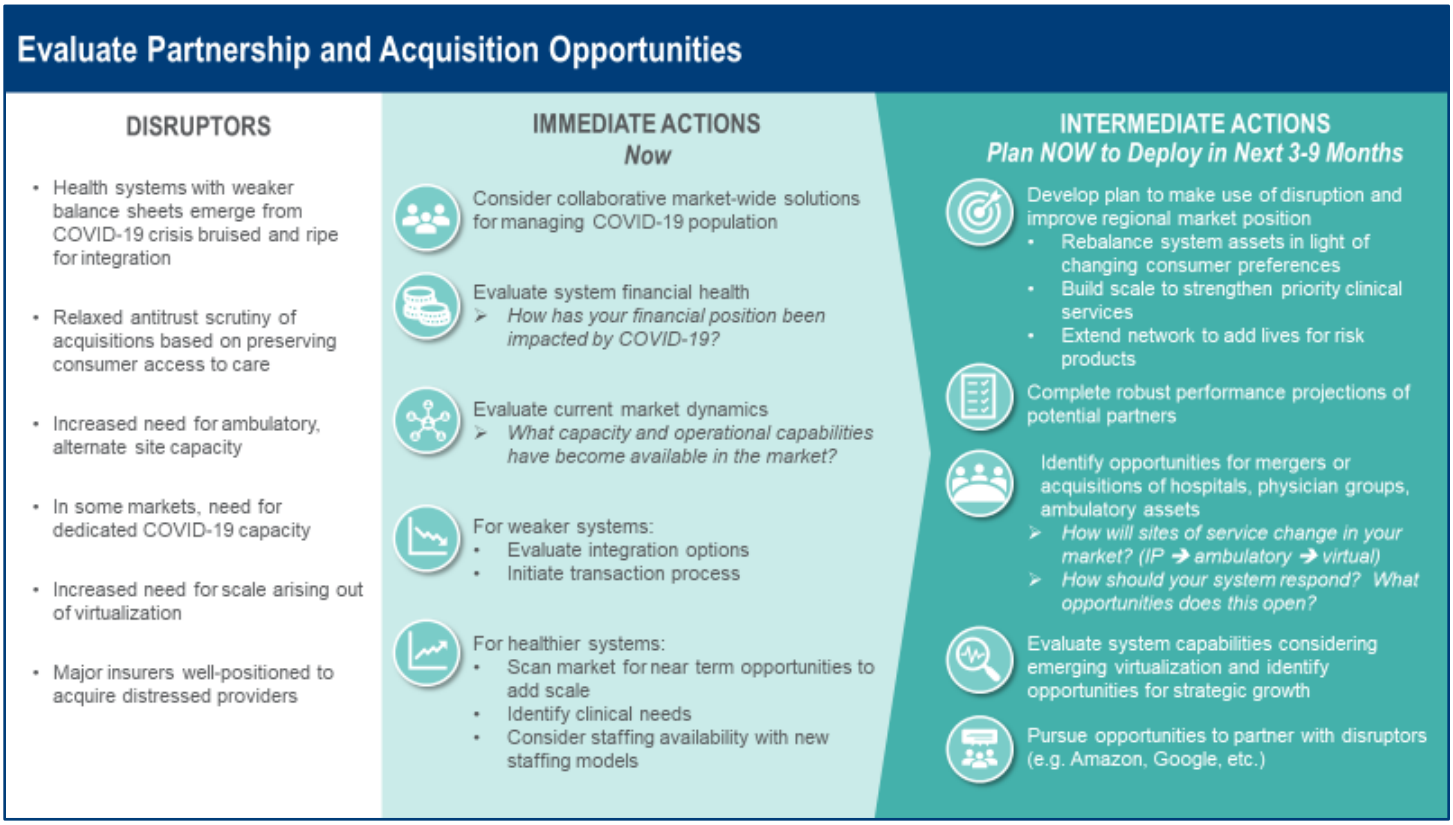
Evaluate Partnership and Acquisition Opportunities

The financial crisis created by the COVID-19 pandemic and shutdowns of elective procedures is unprecedented in our industry. Many health systems with weak balance sheets will be forced to seek stronger systems to acquire them, or they will close. Rural providers are especially vulnerable: without federal support, many are likely to go out of business, creating significant gaps in care. In the face of growing care gaps, federal regulators are likely to relax antitrust enforcement and permit distressed hospitals to join larger systems.

Systems with strong balance sheets should try to consolidate with high quality organizations that improve their portfolios. Mid-size systems that have long looked at their neighbors and wondered, "Should we be joining together?" may now realize this is the best course of action. Many smaller systems and stand-alone hospitals will not have the reserves to sustain the toll of COVID-19; they need to complete a clear-eyed financial forecast. If that forecast looks tough, now may be the time to identify points at which the board would trade 'independence' for ensuring the community has a strong health care resource for the next generation.

Exhibit 4 summarizes some of the immediate and intermediate action steps health systems should take to evaluate partnership and acquisition opportunities over the next nine months.

Exhibit 4.



One immediate action all health systems should take (that has little to do with long-term trends) is search for collaborative solutions to the COVID-19 crisis. The pandemic has already created unprecedented cooperation between providers across the country. The conversion of the recently closed St. Vincent Medical Center into the Los Angeles Surge Hospital ("LASH") by Kaiser Permanente and Dignity Health is a perfect example of what can be done to organize care for COVID-19 patients in a way that centralizes expertise and offers protection to existing systems.[2]

The other immediate step health systems should take to begin assessing partnership opportunities is to conduct a dispassionate assessment of your system's financial health and the resources you have to survive and/or deploy in new partnerships. If you believe you need to find a larger partner, you should conduct a preliminary assessment of potential partners. If you believe you have the resources to take on a partner, you will need to scan the market to identify potential assets, identify potential competitors for them, and decide which, if any deserve further exploration. At this early stage, your scan should be broad, encompassing ambulatory facilities, medical groups, post-acute care, and virtual health resources. Some of these probably have multiple owners. In fact, your health system may already have ownership interests in some potentially attractive assets, which is usually a good place to start your search.

The intermediate timeline should encompass two main thrusts: (1) Further evaluation and pursuit of specific partnership and acquisition opportunities, with the potential for execution of an agreement; and (2) Strategic planning to identify future potential partnerships based on longer-term trends unleashed by the pandemic. There are many approaches to evaluating and pursuing partners (reach out to "best fit" partner; conduct an RFP or RFI process, etc.), and this process is relatively well known. Your system's mission, strategic vision, and goals should inform your evaluation, and the pace at which you proceed should be driven by financial exigencies and the degree of competition you expect for partners or assets you might acquire. However, don't dawdle. Discontinuities like this don't happen very often, and as soon as the initial shock of COVID-19 dissipates, valuable assets (or potential partners) are likely to be hotly contested.

Longer-term planning of potential partnerships should start with trends the pandemic is driving and answer this question: What kind of partners do we need in the future to exploit these trends? The answer may include other providers, health plans, niche technology companies, and aggregators / disrupters (e.g., Amazon, Google, Microsoft). This question is best answered in the context of a robust strategic planning process, rather than on its own.

Conclusion

There is never a time when health systems can focus only on caring for their communities and for their patients. Health system leaders must always have one eye on the present and one eye on the horizon, and this is especially important in times of major change. While difficult, it is essential for leaders to rise above, "How will we manage the current crisis?" and think about your organization's reopening and recovery strategy: how to re-open key services, how to engage differently with your payers, how to support your physician community, and what partnership or acquisition opportunities could position your system better for the future.

[2] California Health & Human Services Agency, "Los Angeles Surge Hospital to Begin Accepting COVID-19 Patients," April 6, 2020, https://www.chhs.ca.gov/blog/2020/04/06/los-angeles-surge-hospital-to-begin-accepting-covid-19-patients/.