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HEALTH MANAGEMENT ASSOCIATES

*Analysis of the Impacts of
COVID-19 on Pennsylvania Hospitals*

PREPARED FOR
HOSPITAL AND HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

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Executive Summary

The Hospital and Healthsystem Association of Pennsylvania (HAP) engaged Health Management Associates (HMA) to summarize the current and future impacts of the novel coronavirus (COVID-19) on hospitals in the Commonwealth. In August 2020, HMA conducted interviews with hospital leaders representing 12 health systems in Pennsylvania. We summarized the information and data shared to develop an analysis of ongoing challenges as a result of the public health emergency.

Patient volume plummeted and will remain well below pre-pandemic levels. From mid-March to the end of April, Pennsylvania state orders, in line with federal governmental guidance, severely restricted hospitals in performing non-emergent visits and treatment, effectively requiring hospitals to cancel or defer all elective services to prepare for a major surge in COVID-19 patients. The Commonwealth allowed for a phased approach to bring services back online beginning in May, and hospitals saw varying degrees of volume recovery in the following months. Although services have generally reopened, none of the health systems interviewed anticipate recovering all of their pre-pandemic activity levels in 2020. On average, interviewees forecast that inpatient discharges will remain 5% below historical levels, while emergency room visits and surgeries are estimated to be 13% below these hospitals' pre-pandemic experience for the second half of the year.

Large margin shortfalls occurred across the state, well in excess of federal relief payments. Between mid-March through July 2020, a 4.5-month period, Pennsylvania hospital systems incurred an estimated \$5.0 billion shortfall in operating margin from expected results, before federal relief fund payments. This represents a 24% drop from pre-pandemic revenues over a comparable period and significantly exceeds the estimated \$2.8 billion in federal relief funding received to date. Financial losses are expected to continue through 2020 and beyond, and while additional federal relief may occur, the net losses are expected to grow significantly across the industry.

The ongoing health crisis presents substantial challenges on many fronts. Hospitals are facing the potential for a second surge of COVID-19 infections that could surpass the March/April surge, concerns about workforce stability, and the impact on the population of a weakened economy.

- **Flu season and potential second surge:** Public health officials are becoming increasingly concerned with the intersection of the upcoming flu season and the pandemic, including a possible second surge. This double impact is likely to cause an increase in patient utilization, acuity, and cost of care, and the difficulty in initially differentiating between the two viruses will create enormous operational obstacles. A critical financial concern is whether a fall/winter surge would require hospitals to curtail non-emergency services, as was the case in March-April of 2020. If so, the revenues losses experienced in the first few months of the pandemic could be repeated, a scenario that would further worsen the financial stability of many hospitals.
- **Potential workforce shortages:** Health systems are very concerned that the flu and an increase in COVID-19 infections will deplete the workforce as staff contracting the flu virus or exposed to

COVID-19 will be unable to work. Hospitals are also beginning to see more early retirements or employees otherwise taking leave because of increased health risks, as well as childcare concerns as many schools are opting for virtual learning this fall.

- **A struggling economy:** A sharp decrease in economic output has caused many businesses to shut down or downsize and has led to high levels of unemployment. As people lose their jobs, they may also face loss of health insurance and inability to pay out-of-pocket costs. These outcomes have an increasingly negative direct impact on hospital financial performance through changes to payer mix and increasing levels of uncompensated care. Other impacts of a poor economy such as housing instability and food insecurity negatively affect population health and place more burden on hospitals' community support.

Investment in facilities, equipment and technology is being deferred. Operating margin shortfalls of the magnitude being experienced by Pennsylvania hospital systems threaten their ability to maintain facilities and infrastructure, invest in the equipment and technologies necessary to provide effective, high-quality care, and sustain their long-term financial viability. Some hospitals have reported they are only replacing equipment as it breaks or threatens patient safety. While a short-term solution, deferral of facility renovation and slowing proactive equipment replacement may result in costly repairs and disrupt patient care in the future.

The long-term viability of some hospitals is threatened. Several hospital systems had accumulated financial reserves to help them withstand operating losses, but several hospitals have experienced years of inadequate operating margins and entered the pandemic with relatively weak balance sheets. In 2019, the Pennsylvania Health Care Cost Containment Council (PHC4) found that 34% of Pennsylvania general acute care hospitals operated with negative margins. To the extent that the COVID-19 related margin shortfalls of these hospitals exceed their share of federal provider relief payments, their ability to serve their communities and possibly their existence is in jeopardy.

Introduction and Scope

As of September 2, 2020, medical professionals across the United States have diagnosed over 6.1 million cases and attributed 186,000 deaths to the novel coronavirus (COVID-19).¹ In late February, there were just a few dozen known cases in the United States, most of them linked to travel. However, by mid-March confirmed cases were identified in several states and by early April more than 30,000 cases per day were being reported. To mitigate the spread of the virus, most states implemented stay-at-home orders and required temporary closures of all non-essential businesses. These measures brought the reported case rates down, but as states began to relax their restrictions in May-June, case counts began to rise sharply again. By late July, over 60,000 new cases per day were reported. The trend has

¹ National and Pennsylvania COVID-19 data is from The New York Times Coronavirus Outbreak site. <https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html#states>. Accessed September 3, 2020.

moderated in August but remains at an alarmingly high rate, and there are grave concerns about additional surges as schools attempt to reopen and as fall/winter flu season begins.

The northeast region of the country including Pennsylvania, was the first to experience significant outbreaks of the disease. Pennsylvania had very few cases until mid-March, but over the next three weeks the daily cases counts rose dramatically and peaked at nearly 2,000 on April 9th. Daily case counts began to decline in mid-April and in spite of a more modest increase in July have remained at levels well below the April peak. Since the initial surge, the Commonwealth has been more successful than most states in controlling the infection; over the course of the pandemic the state ranks 14th and 9th in lowest confirmed cases and deaths per capita, respectively.

With severe COVID-19 patients needing resource-intensive hospitalization in critical care units, public health officials were deeply concerned about the capacity of hospitals to manage the surge. To conserve patient care capacity and supplies and increase personal and public safety, starting in mid-March hospitals cancelled most non-emergent patient care. Lost revenue from cancelled and delayed services, large expense increases to address public and employee safety, costly treatment of infected patients, and a severe economic downturn, have resulted in enormous financial challenges for hospitals.

Despite several months of experience with the virus, the future remains uncertain. States have largely relaxed limitations on hospital elective procedures; however, additional restrictions may be required if a second major surge of infections were to hit. Additionally, hospitals continue to feel the impacts of the public health emergency in the form of lower patient volumes, higher expenses due to necessary operational changes, as well as workforce challenges. One thing is clear, the negative impact of COVID-19 on hospital financials is ongoing and will likely continue until the virus is controlled.

To summarize the current and future impacts of COVID-19 on hospitals, the Hospital and Healthsystem Association of Pennsylvania (HAP) engaged Health Management Associates (HMA) to conduct interviews with leadership and collect data from several hospital systems across the commonwealth. This report contains a summary of the interview responses and analysis of the data supplied.

In August 2020, HMA conducted interviews with hospital leaders representing twelve health systems in Pennsylvania. The participating health systems covered a variety of hospitals types including large urban academic health centers, multi-hospital systems, and small community and rural providers. In total, the participating systems represent about 28% of Pennsylvania acute care revenue. These interviews captured information related to the following:

- Steps hospitals have taken and continue to take to safeguard patients and staff and provide care to patients suffering from COVID-19
- The previous and ongoing impact of the pandemic on inpatient and outpatient volumes
- Steps taken to manage expenses, given the changes in patient volume and uncertainty about the future
- Financial impact to date
- The impact of the spike in unemployment on uncompensated care and Medicaid enrollment

- Longer-term impacts of the pandemic including patient care delivery and volumes, capital and strategic plans, workforce concerns and community needs

This report contains summarized information based on these interviews. Identifiable information at the hospital or health system level will remain confidential.

Financial Impact of the Pandemic, to Date

Patient Volume and Revenue

From mid-March to the end of April, Pennsylvania state orders, in line with federal governmental guidance, severely restricted hospitals in performing non-emergent visits and treatment. This effectively required that hospitals cancel or defer all elective admissions, surgeries, and procedures, to make available hospital capacity for a potential major surge in COVID-19 patients and to preserve scarce personal protective equipment (PPE). The term “elective” was used broadly to include to all services and procedures beyond services that would be emergent or urgent to save a life, preserve organ function, or avoid further harms from an underlying condition or disease.² After the confirmed case rate began to decline and officials concluded that COVID-19 patients could be managed without such severe restrictions, the Commonwealth allowed for a phased approach to bring services back online beginning in May.

All hospitals that we interviewed experienced large declines in patient volume from mid-March until the end of April, and while systems reported that significant portions of the volume losses have gradually reversed, there remains a significant shortfall in most areas including inpatient admissions, surgeries, and outpatient (emergency and ambulatory) encounters. There is general agreement that surgical procedures and emergency room (ER) visits were most greatly impacted by the mid-March order and are the slowest to recover. March-July surgeries and ER visits were below expectations by 36% and 29%, respectively.

Expenses

From the beginning of the public health emergency, federal and state guidance along with additional surge preparation activities and safety precautions resulted in significant operational changes and additional investments across health systems in the commonwealth, including:

- Procuring and maintaining adequate inventories of PPE and other equipment such as ventilators
- Repurposing medical/surgical hospital space and reopening offline beds to allow for increased intensive and critical care capacity for COVID-19 patients
- Redirecting staff to areas most in need of resources and providing all necessary training to ensure staff are prepared and safe

² Pennsylvania Department of Health. Guidance on Hospitals’ Responses to COVID-19. <https://www.health.pa.gov/topics/Documents/Diseases%20and%20Conditions/Guidance%20on%20Hospital%20Responses%20to%20COVID-19.pdf>

- Restructuring hospital space to allow for increased social distancing as well as safe separation of COVID-19 diagnosed or suspected cases from other hospital patients
- Instituting health screening for employees and visitors and staffing entrances to enforce strict visitation policies
- Shifting as many services as possible to telehealth
- Investing in additional tools and equipment for COVID-19 testing
- Purchasing technological tools, such as those to track exposure and to manage the labor pool
- Revising and/or creating new policies in relation to hospital activities such as testing, cleaning protocols, staffing ratios, security, and visitation limits

All hospitals we interviewed indicated that the expense increases associated with surge preparation and safety precautions were extensive, and many of these additional costs continue.

Generally, systems achieved some expense savings associated with the slowdown in patient activity. Salaries and benefits comprise over half of hospital expenses. Many hospitals had workforce reductions in the March-May period, whether through reduced staffing hours or voluntary furloughs. Some organizations had extensive involuntary furloughs. There were also savings in employee health expense, because employees' use of health care services decreased during the period that nonemergency services were limited. However, due to the need to be ready for a potential surge, the uncertainty about when the patient volumes would return, and concerns about staff retention, none of the health systems reported labor cost savings commensurate with the losses in patient volume.

Smaller savings were achieved in nonlabor expenses. Reducing surgical procedures generated reductions in medical devices and supplies expense and closing ambulatory sites saved some facility costs. All systems implemented discretionary spending. However, many of the non-workforce related expenses are fixed and therefore do not decline with lower volume.

Nonacute Care Services

All of the hospital systems have non-hospital patient care services as part of the delivery system, including physician practices, home health agencies, nursing facilities and various provider specialties. It is important to note that the patient volume reductions and pandemic-related expense pressures apply to these types of services as well and contribute to the financial losses incurred by the hospital systems.

Federal Relief Funding

Four major pieces of federal legislation have been passed since March to provide disaster relief and economic stimulus. Two of the bills authorize the Department of Health and Human Services (HHS) to make direct payments to hospitals and other providers totaling \$175 billion that is referred to by HHS as the CARES Act Provider Relief Fund.³

³ Congress allocated \$100 billion for provider relief in the Coronavirus Aid, Relief, and Economic Security (CARES) Act, and added \$75 billion to the relief fund in the Paycheck Protection Program and Health Care Enhancement Act

Approximately \$125 billion of the \$175 billion total has been allocated to hospitals and other providers, and hospital systems in the Commonwealth received an estimated \$2.8 billion⁴. A total of \$50 billion of direct provider relief funding remains unallocated. Pennsylvania hospitals and healthcare systems are likely to receive additional provider relief payments; it is uncertain how the remaining funds will be distributed, but it is possible that Pennsylvania hospitals will receive a lower share of the remaining funds than they have received from funds already allocated.

Also, the Federal Emergency Management Agency (FEMA) will reimburse 75% of the costs of “eligible emergency protective measures taken to respond to the COVID-19 emergency at the direction or guidance of public health officials”.⁵ However, no estimate of FEMA reimbursement is available. FEMA reimbursement is meant as a payer of last resort and requires a complex process for determining what costs are eligible for reimbursement given the other federal funding streams.

Results

From mid-March through July 2020, a 4.5-month period, Pennsylvania hospital systems incurred an estimated \$5.0 billion shortfall in operating margin from expected results, before federal relief fund payments. The margin shortfalls include losses from consolidated physician groups and other nonacute care services owned by the systems. The estimated margin shortfall was 24% of pre-pandemic revenues over a comparable period.

As explained below, most hospitals anticipate that operating margin shortfalls will continue for the remainder of the year, and well into 2021. The next section of the report identifies several reasons for this concern.

Uncertainties and Challenges

Based on the information captured in the interviews, in the next sections we discuss many of the current impacts of the crisis on hospitals in Pennsylvania and concerns for the near future. Every hospital system is facing unique challenges and as such, this will not be a comprehensive account of all obstacles faced; however, this analysis is meant to provide an overview of common themes shared.

Ongoing Patient Volume Declines

Patient volume losses, compared to pre-pandemic levels are occurring nearly four months after hospitals were permitted to “reopen”, and all of the systems we interviewed believe that the negative impact on patient volume will remain until the virus is no longer a major public health concern.

⁴ HHS’ CARES Act Provider Relief Fund website includes links to reports that list all providers receiving general allocation funds and summaries by state of the targeted distributions. Pennsylvania hospital systems’ share of the general allocation was estimated by HAP and HMA using 2% of hospital patient revenue and a factor to consider non-hospital providers’ funding included in hospital systems. See <https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html>

⁵ <https://www.fema.gov/news-release/2020/03/19/coronavirus-covid-19-pandemic-eligible-emergency-protective-measures>

Each of the hospital systems was asked to predict their patient volume shortfalls for the remainder of the calendar year. While there was variability in the forecasts, none of the systems we interviewed anticipate recovering all of their pre-pandemic activity levels in 2020 and most expect significant shortfalls. HMA calculated the weighted average of these forecasts.

Inpatient discharges are estimated to remain 5% below historical levels, while emergency room visits and surgeries are estimated to be 13% below these hospitals' pre-pandemic experience.

Experience varied across health systems, and hospital executives made the following observations to explain why patient volumes have not fully recovered and are not expected to recover in the near term:

- Patients are hesitant to visit emergency rooms and clinics, and are opting to forego or delay care they may have otherwise sought
- Precautions being taken by hospitals and other providers affect volume and throughput – shorter hours, additional pre-visit screening, extra time taken for cleaning, and social distancing adversely affect patient throughput and decrease staff productivity
- Process lags: once a site is reopened there is a lag in filling the schedules; until surgical and procedures are performed there is a lag in demand for post-operative care
- Telehealth has replaced many onsite provider visits, and there likely will be fewer orders for tests and specialty referrals from this mode of patient care
- Fewer organized activities (e.g. sports) results in fewer injuries

The full impact of foregone or delayed services is still yet to be seen, but there is concern that they will have lasting impacts on the health of the population as a whole in the form of late detection of disease and unmanaged illness.

Preparing for a Fall/Winter Surge

The Directors of the US Centers for Disease Control (CDC) and the World Health Organizations and many public health experts have issued warnings about what is frequently referred to as a “second surge” of COVID-19 cases in the last quarter of 2020 and first quarter of 2021. A major concern is that the upcoming flu season coupled with a significant increase in COVID-19 spread could overwhelm the health care delivery system. In the US, there were 410,000 to 740,000 flu hospitalizations during the 2019-2020 flu season, which ran from October to April, according to the CDC. With hundreds of thousands of patients already filling up hospital rooms, there is less room for COVID-19 patients. During a recent interview, CDC Director Robert Redfield said a virus surge, along with the upcoming flu season, could create the “worst fall” that “we’ve ever had.”

As discussed above, surge preparation activities and safety precautions resulted in significant operational changes and additional investments across health systems in the Commonwealth. All hospitals we interviewed indicated that expense increases associated with surge preparation and safety precautions were extensive, and most of these additional costs continue today and may again need to be ramped up with an increase in cases. Hospitals that saw higher numbers of COVID-19 patients after

the restrictions on elective procedures were lifted did not face capacity issues, which is in part due to the hospitals' ongoing preparation activities to maintain readiness.

In addition to operational changes and expenses, the double impact of COVID-19 and the flu is likely to cause an increase in patient utilization, acuity, and cost of care. Both viruses can cause life-threatening harm to the respiratory system and contracting one may leave patients more vulnerable to the other. Because both viruses display similar symptoms, it will be difficult to rule out COVID-19 in a patient with the flu without waiting on test results. This will mean increased PPE usage rates, higher numbers of patients to be segregated from the COVID-negative hospital areas, and increased testing, all likely to increase the cost of caring for these patients.

Testing is an issue that the Commonwealth and most other states have been struggling with for months. The need for more testing is hampered by shortages in instrumentation and supplies, and test results are often not available timely. The testing issues will be exacerbated during flu season, as hospitals will have to administer tests for several possible viruses (COVID-19, Flu A, Flu B, and Respiratory Syncytial Virus) rather than only testing individuals for a subset of those viruses. This will increase costs, and unless the turnaround time is greatly reduced, will further complicate clinical decision-making.

The combination of the flu and COVID-19 is also expected to take its toll on the workforce. As hospital workers contract or are exposed to COVID-19, they must self-quarantine for several days. As staff begin to contract the flu virus, an even more limited workforce will be available to handle what could be increased volumes of patients with respiratory ailments.

A critical question for hospitals, and perhaps the most important question financially: Will a fall/winter surge require hospitals to curtail non-emergency services, as was the case in March-April of 2020? If so, the revenue losses experienced in the first few months of the pandemic could be repeated, which would make a very challenging financial situation worse for most hospital systems.

Maintaining the Workforce

Hospital leaders are very concerned about the future of the hospital and health system workforce.

All of the systems we interviewed discussed their workforce challenges during the early months of the pandemic. As patient volumes and revenues plummeted, each hospital faced difficult decisions about how best to respond. As noted above, many hospitals and health systems had workforce reductions in the March-May shutdown of elective procedures period, whether through reduced staffing hours or voluntary furloughs. Some organizations had extensive involuntary furloughs, although many staff were brought back as services reopened. A growing concern is workforce retention and availability.

Several interviewees noted that they have already begun to see clinical staff move up retirement plans or otherwise choose to leave the workforce. Older staff or those part of other more vulnerable populations have expressed that the increased health risk has factored into their decision to leave.

Another workforce issue is related to the availability of behavioral health services. Hospitals expressed concern that demand for these services is increasing, which will require locating, recruiting, and hiring

new behavioral health professionals and possibly competing with other providers over a limited supply. This concern is supported by a Kaiser Family Foundation health tracking poll that has found 53% of July 2020 participants “say they feel that worry or stress related to coronavirus has had a negative impact on their mental health”, up from 32% in March.⁶ Additionally, staff has been exposed to extraordinary amounts of suffering throughout this pandemic; they have had to make difficult decisions about resource allocation and have been unable to connect dying patients with their families in their last moments. For these reasons and more, it is expected that they may also require increased access to behavioral health supports as the pandemic drags on.

Several health systems interviewed also own long-term care and home care providers, and in addition to overcoming obstacles at the hospital level, systems have had to manage resources and staffing across the health care spectrum. With the severe hit of COVID-19 in nursing homes earlier this year, facilities are facing staffing shortages and concerns about increased health risks to staff. To help better prepare the staff in place, some health systems have allocated hospital resources to help train staff at other facilities on PPE usage and other infectious disease protocols, noting that it is not enough to ensure that facilities have the right equipment, they must also be trained in how to use it. Others have worked to streamline patient care and minimize the movement of patients across the health system by helping to bring more resources to the patient. This all requires close management of staffing and thoughtful deployment of resources.

Addressing Childcare Needs of Employees

Heading into the fall, childcare for school aged children is a growing concern. Although the Commonwealth has released recommendations for at least partial in-person instruction in areas with lower incident rates⁷, individual school districts have already put in place plans to rely on virtual learning for at least the first several weeks of classes, including the largest three public school districts: Philadelphia City School District, Pittsburgh Public Schools, and Central Bucks School District. Hospital leaders interviewed expressed concerns that employees will have to make tough decisions to ensure children have proper care and supervision, which may lead to at least a temporary exit from the workforce. Because this is essentially a supply problem, hospitals are considering, and some have already begun, making plans to provide supervised childcare to enable parents to work. Some hospitals already provide on-site childcare options and are looking to expand. For others, this would be a new cost and employee benefit.

These issues will continue to strain hospital financial performance. As workforce supply decreases, competition for staff will increase, with corresponding staffing costs such as higher wages, increased hazard pay if a fall/winter surge occurs, and increased benefits in the form of sick pay or other paid time off.

⁶ Kaiser Family Foundation Health Tracking Poll, March-July 2020. Accessed August 17, 2020.

<https://www.kff.org/coronavirus-covid-19/report/kff-health-tracking-poll-july-2020/>

⁷ Pennsylvania recommendations on instructional models and levels of community transmission. Accessed August 17, 2020. <https://www.education.pa.gov/Schools/safeschools/emergencyplanning/COVID-19/SchoolReopeningGuidance/ReopeningPreKto12/Pages/DeterminingInstructionalModels.aspx>

Facing Increased Medicaid Enrollment/Uncompensated Care

As a result of closing most businesses deemed nonessential in order to mitigate the spread of the virus, the US economy experienced an unprecedented decline. Real gross domestic product decreased at an annual rate of 32.9% in the second quarter of 2020⁸ and the unemployment rate is at 10.2% at the end of July⁹. The unemployment rate skyrocketed to 14.7% at the end of April 2020 and has improved over the last three months as many businesses were permitted to reopen.

The unemployment rate in Pennsylvania is higher than the national average. At the end of June 2020, the US Bureau of Labor Statistics reports 821,000 Pennsylvania residents are unemployed, representing 13% of the workforce.

Economic downturns and high levels of unemployment have a significant impact on hospitals and health care. Contrary to a view that some hold, health care is not “recession proof”. Many insured patients will decide to delay or forego care when their financial resources do not permit them to manage their deductibles and copays. Further, when economic stress is high there are more issues with housing and food, important determinants in population health, and these factors intensify responsibility for hospital programs to support the community.

The most significant financial impact of high unemployment is loss of private insurance. People that have been laid off may lose employer health coverage, and those purchasing insurance on the individual exchange may no longer be able to afford the premiums.

When people lose private insurance coverage, they may qualify for Medicaid. If those losing private insurance do not qualify for Medicaid, they will likely require uncompensated care.

HMA recently produced a model¹⁰ that estimates changes in enrollment nationally and by state under three scenarios – moderate, heavy, and severe. The following table shows projected changes from Quarter 1 2020 to Quarter 4 2020 for the moderate and severe scenarios:

Change in Coverage, 2020 Q1 to Q4	National	Pennsylvania
Medicaid increase	5 to 17 million	286,000 to 1,091,000
Uninsured increase	5 million	(66,000) to 126,000
Private insurance decrease	(5 to 22) million	(220,000 to 1,217,000)

To the extent that these shifts occur, hospital systems will experience further erosion of their net revenue. Private insurers reimburse hospitals at significantly higher rates than public payers. A 2018 publication from the American Hospital Association estimates that on average, hospitals receive 144% of

⁸ United States Bureau of Economic Analysis, July 2020

⁹ United States Bureau of Labor Statistics, August 2020

¹⁰ Health Management Associates. COVID-19 Impact on Medicaid, Marketplace, and the Uninsured. May 2020. <https://www.healthmanagement.com/wp-content/uploads/HMA-Updated-Estimates-of-COVID-Impact-on-Health-Insurance-Coverage-May-2020.pdf>

cost from private payers compared to 87% for Medicare and 88% for Medicaid.¹¹ A 2019 study of Pennsylvania hospitals concluded that in 2016, Medicaid and uninsured patient payments to hospitals covered only 81% of the cost.¹² A shift from private insurance to Medicaid results in lower reimbursement for the same services, and as patients become uninsured, virtually all services to this population will be uncompensated care. While some interviewees did report modest changes to payer mix to date, it is likely that hospitals and health systems have yet to experience the full impacts of these shifts. It is likely that temporary furloughs will become layoffs the longer businesses continue to struggle and as extended employer health coverage expires.

Sustaining Community Support

In addition to fighting the pandemic within the walls of their facilities, the hospitals and health systems interviewed emphasized a commitment to supporting public health within their communities. One form of this support is through contact tracing efforts. Public health departments in rural regions have limited staff and resources to respond to this somewhat unprecedented public health emergency, and hospitals have stepped in to supplement those efforts. Although some facilities have secured federal dollars to support contact tracing within the community that they serve, that relief is time-limited, and hospitals are concerned about needing to sustain these efforts into the longer term.

Hospitals also have reported needing to increase call center staff not just to handle increased scheduling requests resulting from the reopening of services, but also to respond to community questions. Hospitals are often seen as a reliable source of public health information, and hospitals and health systems have reported hearing from individuals and local businesses looking for answers. Not only does this increase the number of staff necessary to answer these calls, it also changes the skillsets needed to respond to the inquiries. Hospitals also reported working directly with local businesses to help guide the restructuring of workspaces to maximize employee and customer safety.

As unemployment remains high and the public health emergency continues, the level of community support needed is expected to increase. Hospitals play a critical role in supporting the needs of the communities they serve. Emergency federal funding has provided protections for people out of work, but that federal support is expiring. In addition to the impact of losing health coverage, many residents are facing and will continue to face challenges meeting their basic needs such as food and housing, and hospitals' community support will grow accordingly.

Maintaining Future Patient Access to Care

Hospital systems have incurred very large losses to date and expect continuing significant losses through the end of 2020. Additionally, all hospital systems believe the negative financial impact will continue well into 2021. Restrictions likely will remain in place on vital parts of the economy, patients will still have reservations about seeking care, PPE and operational safeguards will remain a driver of cost

¹¹ American Hospital Association, 2018 Trendwatch Chartbook

¹² "The Adequacy of Medicaid Program Payments to Hospitals in the Commonwealth of Pennsylvania", Dobson DaVanzo & Associates, 2019

increases, and other disruptive impacts of the virus, such as staff and patient quarantines, will continue to adversely affect productivity.

Hospitals require positive operating margins over the long term to enable them to maintain facilities and infrastructure, to keep up with the rapid changes in medical equipment and information technology to provide effective and high-quality care, and to invest in programs needed by the communities they serve. Operating margin shortfalls of the magnitude being experienced by Pennsylvania hospital systems threaten their ability to achieve these goals and weaken their long-term sustainability. An operating loss in any given year can be overcome in subsequent years, but the losses incurred in 2020 (and potentially beyond) will be very challenging to overcome.

The direct consequence of the current operating margin shortfalls is a decrease in cash and investments.

Most of the hospital systems we interviewed have curtailed capital spending in response to their lost revenue, and instead have reported replacing equipment as it breaks or threatens patient safety. This type of deferral of facility renovation and halting of proactive equipment replacement may result in costly repairs and disrupt patient care in the future. In addition, a slowdown or suspension of clinical expansion and investment in new technologies may adversely affect the hospital's ability to meet the needs of the community for access and quality care. Several interviewees indicated that their future capital plans have been suspended or modified. While the need for these projects may still exist, the timeline may need to be extended or designs reworked to account for things like social distancing or increased reliance on telehealth services.

Relatedly, many hospitals have been struggling financially for years and entered the pandemic period with weak cash and investment positions. The recent financial stress may be greatest for rural, safety net and independent community hospitals. The Pennsylvania Health Care Cost Containment Council (PHC4) found that in fiscal year 2019, more than one third of Pennsylvania general acute care hospitals (34%) operated with negative margins, and another 29% reported operating margins of zero to 4%.¹³ The margins cited in the report exclude physician and other nonacute services owned by the hospitals, which frequently generate additional financial losses. To the extent that the COVID-19 margin shortfalls of these hospitals exceed their share of federal provider relief payments, their existence is in jeopardy.

Unplanned hospital closures adversely affect the communities they serve in two important ways. First, access to patient care is affected. Residents must find alternate sites for services and may suffer from terminating their relationship with providers and clinical programs, and in rural and small communities, residents may have to travel prohibitively long distances to receive care if their local hospital closes. Second, hospitals are often the largest or among the largest employers in their communities, and the job loss from a hospital closure can have significant negative effects on the local economy.

¹³ Pennsylvania Health Care Cost Containment Council Financial Analysis Fiscal Year 2019.
<http://www.phc4.org/reports/fin/19/>

Conclusions

Hospitals and health systems across the Commonwealth experienced unprecedented drops in volumes and revenue in the spring due to the shutdown of elective services; however, the end to the shutdown did not signal the end to their challenges resulting from the COVID-19 pandemic.

Nearly four months after reopening of services, hospitals continue to experience patient volume losses, compared to pre-pandemic levels, and all of the systems we interviewed believe that the negative impact on patient volume will remain until the virus is no longer a major public health concern. Ongoing, and potentially increasing, concerns related to the struggling economy and high unemployment rates, workforce shortages, and needs for community support continue to cloud the future of hospitals and health systems. Direct federal relief has helped offset the operating margin losses; however, a significant and growing gap remains.

The upcoming intersection of COVID-19 and the annual flu season will further strain providers. Cost of care is expected to increase as heightened testing and PPE usage is expected to be necessary to care for the two viruses with overlapping symptoms. A repeated concern expressed in the interviews is that a fall/winter surge could require hospitals to curtail non-emergency services, as was the case in March-April of 2020. If another shutdown occurs, the revenues losses experienced in the first few months of the pandemic almost certainly would be repeated, further undermining the financial stability of many hospital systems.

Further, operating margin shortfalls of the magnitude being experienced by Pennsylvania hospital systems threaten their ability to maintain facilities and infrastructure, invest in the equipment and technologies necessary to provide effective, high-quality care, and weaken their long-term sustainability.

Finally, many hospitals have experienced years of inadequate operating margins and entered the pandemic with relatively weak balance sheets. To the extent that the COVID-19 related margin shortfalls for these vulnerable hospitals exceed their share of federal provider relief payments, their ability to survive and serve their communities is jeopardized.

Appendix: Methodology for Estimating Financial Results

Each of the organizations we interviewed was asked to provide summary financial results and patient volume information for March-July 2020.

- Revenue, expenses, operating margin and key patient volume measures were reported based on the variance from expected amounts. Systems used a comparison of actual or forecasted results to budget, preceding year, or pre-pandemic forecasts to present the variance from expected.
- Revenue excludes federal provider relief payments. As explained below, hospitals received significant payments from federal relief funds. These payments were excluded from revenue to enable a comparison of losses before federal relief to the amount of federal relief received.
- The systems' consolidated operations are included in this analysis. Consolidated operations generally include nonhospital services (such as physician groups, home care, and pharmacy) that are owned by the healthcare systems.

The hospital systems represented in our interviews account for an estimated 28% of patient revenue across the Commonwealth. Using this relationship, we have extrapolated our combined survey results to estimate statewide numbers.