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HEALTH MANAGEMENT ASSOCIATES

*Analysis of the Financial Impact of COVID-19
on Hospitals in Rhode Island*

PREPARED FOR
HOSPITAL ASSOCIATION OF RHODE ISLAND

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Executive Summary

The Hospital Association of Rhode Island (HARI) engaged Health Management Associates (HMA) to complete a review of the financial impact of the novel coronavirus (COVID-19) on hospitals and healthcare systems in Rhode Island. HMA conducted interviews with hospital leaders representing all healthcare systems in the state. From the data shared, we developed statewide estimates of the financial disruption seen by hospitals in March and April and projections of the financial impact over the duration of the year.

Hospitals began to experience significant impacts starting in mid-March. Pursuant to federal and statewide guidance and due to operational necessity, hospitals began to cancel or reschedule all services determined to be non-emergent or unnecessary to preserve organ function or avoid further harm from underlying conditions or diseases. These impacts through mid-May result in very large revenue losses. For the six-week period from mid-March through the end of April Rhode Island healthcare systems experienced a 35% decrease in patient revenue. Operating expenses in March and April decreased by about 4% from expected levels. Systems achieved savings associated with the slowdown in patient activity, but the savings were partially offset by pandemic preparedness expenses.

As a result of the patient care disruption, operating margins declined by \$145 million in March and April compared to expected amounts.

Although there is much uncertainty regarding the length and scale of the remaining pandemic period, healthcare systems forecast significant losses for the remainder of 2020. These projections vary based on assumptions such as projected volumes of COVID-19 patients, timing of reinstating elective procedures, and shifts in payer mix due to the economic downturn. Aggregate estimates of the operating margin shortfall are \$121 million for May-June and \$174 million for July-December.

The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act¹ allocated \$100 billion in grant funding to all provider types and the most recent federal relief bill authorizes an additional \$75 billion for providers. Of the \$175 billion total, \$72 billion has been allocated and Rhode Island healthcare systems have received \$92 million. Federal authorities have not determined the distribution for the remaining \$103 billion, so it is unclear how much of the remaining funds will be distributed to hospitals in Rhode Island.

As the COVID-19 disruption continues, hospital financial concerns about liquidity will grow. Medicare recently accelerated payments to hospitals across the state, but the repayment of these funds is scheduled to begin in late July—coinciding with a time of expected cash flow concerns for hospitals.

Report Highlights	Statewide Estimates*
Operating margin shortfall:	
March – April 2020	(\$145 M)
May – June 2020	(\$121 M)
July – December 2020	(\$174 M)
Total margin shortfall	(\$440 M)
<i>*All figures are prior to the inclusion of federal relief funding and represent variances from expected amounts.</i>	

¹ Pub. L. 116-136

Without a better understanding of when and how hospitals will be able to again ramp up services, it is unclear whether many hospitals will be able to ride out the financial disruption caused by this crisis.

Introduction

As of May 29, 2020, medical professionals across the United States have diagnosed more than 1.7 million cases and attributed 101,600 deaths to the novel coronavirus (COVID-19).² With the most severe COVID-19 patients needing resource-intensive hospitalization in critical care units, along with invasive ventilation, hospitals across the country have spent the last two months preparing for and/or weathering an unprecedented public health crisis.

To increase personal and public safety across the country while conserving patient care capacity and supplies, hospitals have cancelled non-emergency procedures, and many Americans are postponing care as they shelter in place to stop the spread of the virus. The loss of revenue from cancelled and delayed services, coupled with a severe economic downturn resulting in an unprecedented increase in unemployment, has resulted in enormous financial challenges for hospitals. Based on a recent study by the American Hospital Association, the nation's hospitals and health systems will lose \$203 billion from March-June 2020.³

As with many other states on the East Coast, the population of Rhode Island has been hit hard by the virus. Nationwide, Rhode Island ranks 4th in per capita diagnosed cases and 6th in per capita deaths. Over the past three weeks, Rhode Island has seen a decreasing trend in new cases; however, models predicting the volume, peaks, and duration of COVID-19 infections and the variation by region are being revised continuously with no one is certain what will occur in the near future. As of mid-May, hospitals in Rhode Island have just begun reopening services, starting with the next level of emergent care and services requiring limited hospital recovery time. Nevertheless, due to the impact of factors such as federal and state guidelines limiting elective procedures and public anxiety toward seeking non-emergent care, hospitals will likely experience revenue losses for months to come.

To quantify the projected total financial strain hospitals will endure through the duration of this crisis, the Hospital Association of Rhode Island (HARI) engaged Health Management Associates (HMA) to conduct interviews with hospital financial leaders representing all health systems across the state. This report contains a summary of the interview responses and analysis of the data supplied.

Approach

Between Wednesday May 13, 2020, and Friday May 15, 2020, HMA conducted interviews with hospital leaders representing all acute care hospitals and the major health systems in Rhode Island. These interviews captured information related to the following:

² The New York Times. <https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html#states>. Accessed May 18, 2020.

³ American Hospital Association, [Hospitals and Health Systems Face Unprecedented Financial Pressures Due to COVID-19](#), May 2020

- Operational changes and preparation to ready facilities and staff for the treatment of large numbers of COVID-19 patients
- Preliminary results of March and April operations, focusing on the impact of the crisis on the operating margins and revenue compared to budgeted estimates or the previous year
- Forecasted results including assumptions related to the projected length of the pandemic
- Estimated federal governmental support, including provider relief funding, short term advances, changes to public payer reimbursements, and disaster-related cost coverage
- Cashflow issues and potential solutions now and through the end of the crisis

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

COVID-19 Precautions and Industry Response

Beginning in early March, clinical and governmental leaders began to release guidance related to non-emergent medical care in hospitals and other medical sites. This guidance increasingly recommended restricting non-emergent visits and treatment, and by mid-March, this effectively required that hospitals in Rhode Island cancel all elective admissions, surgeries, and procedures, to make available hospital capacity to treat COVID-19 patients and to preserve scarce personal protective equipment (PPE). The term “elective” is used broadly to include to all services and procedures beyond ones necessary to save a life, preserve organ function, or avoid additional harms from an underlying condition. This guidance, along with additional surge preparation activities and safety precautions, typically resulted in the following operational changes across Rhode Island health systems:

- Consolidation and/or temporary closures of ambulatory care centers
- Repurposing medical/surgical hospital space as critical care space to allow for increased Intensive Care Unit (ICU) 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
- 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, including temperature checks, at hospital entrances for employees and visitors
- Standing up two field hospitals to increase treatment capacity
- Shifting as many services as possible to telehealth
- Procuring Personal Protective Equipment (PPE) and other equipment such as ventilators
- Revising and/or creating new policies in relation to hospital activities such as testing, cleaning protocols, staffing ratios, security, and visitation limits

Estimating the Impact

Given the radical changes in hospitals and health systems operations in the face of the pandemic, organizations have recently seen associated changes in financial performance —especially related to hospital revenues. Based on the information captured in the interviews, in the next section we estimate

the overall impact of the crisis on hospitals in Rhode Island. The information available to make these estimates is limited given that the disruption largely occurred over the last two weeks of March, and hospitals prepare financial statements on a monthly basis. Through the interviews, we have collected roughly a month and a half of reliable actual financial data along with observations about patient volume during the first half of May.

In addition to the actual data collected, we captured forecasted results for the remainder of 2020. Each organization provided a forecast for May-June and for the last six months of the year. Organizations described to us the various assumptions necessary to create forecasts in these uncertain times, including assumptions related to the following:

- Duration of the disruption to hospital services and the economy at large
- Rate at which patient volumes will return, including the effect of pent-up demand
- Impact of high levels of unemployment on insurance coverage
- Ability of hospitals to manage operating expenses given the uncertainties about patient volume
- Availability of federal disaster relief funding

None of the organizations' forecasts assumed a new surge in COVID-19 cases later in the year, as many believe will occur.

Analysis of Hospital Financials

Ten nongovernmental acute care hospitals operate in Rhode Island along with three nongovernmental specialty hospitals. Twelve of the hospitals are part of multi-hospital systems and one is independent. The facilities owned by two of the multi-hospital systems and the independent hospital are predominately located in the state. Three of the acute care hospitals and one of the specialty hospitals are part of national investor-owned healthcare companies and one of the acute care hospitals is part of a regional nonprofit health system.

The consolidated operations of the three in-state healthcare systems and the Rhode Island operations of the national/regional systems are included in this analysis. Consolidated operations include nonhospital services (such as physician groups, home care, and pharmacy) that are owned by the healthcare systems.

In fiscal year 2019, these organizations collectively had operating losses of \$23.2 million on \$4.3 billion of operating revenue.⁴ Inpatient discharges and outpatient visits in fiscal year 2018 totaled 121,000 and 2,200,000, respectively.⁵

Rhode Island also has a state-owned psychiatric hospital and a Veterans Administration hospital that are excluded from this analysis.

⁴ From HARI analysis of audited financial statements for fiscal years ended in 2019.

⁵ From American Hospital Association DataQuery, compiled primarily from a survey of its hospital members.

March and April 2020 results

For the month of March, consolidated operating results for the state based were an estimated **\$58 million** below expectations.⁶ For the month of April, the first complete month of pandemic-related results, consolidated operating results for the state were an estimated **\$87 million** below expectations. This estimate is before considering funding from federal relief legislation.

The negative variances were the result of precipitous declines in patient revenue, which fell by 35% from mid-March through April compared to an average 1.5 months of revenue in fiscal 2019. Inpatient discharges decreased significantly as the reduction of nonCOVID-19 inpatients far exceeded the number of COVID-19 admissions. Outpatient volume fell more significantly, as surgical procedures, ER

After canceling or delaying all elective procedures and services in mid-March, hospital operating margins in March-April dropped by an estimated \$145 million compared to expectations.

encounters, and outpatient and other provider visits were drastically reduced. The decreases are primarily due to the abrupt cancellations and deferrals of elective and scheduled procedures, treatments and diagnostic tests. Hospitals began voluntarily reducing volume in mid-March consistent with federal and state government and clinical guidance. The volume declines are also attributed to the shutdown of many economic and social activities as well as patients deciding to forgo medical care.

Patient revenue decreased by even larger percentages than patient volumes. Surgeries and complex tests and treatments that were canceled or delayed generate more revenue per encounter than the emergent and other medical services that are not subject to the restrictions. In addition, initial results suggest that revenue losses from elective and complex surgeries are more heavily concentrated in the loss of commercial business and Medicare procedures having higher reimbursement.

Overall, operating expenses in March and April decreased by about 4% from expected levels. Generally, systems achieved savings associated with the slowdown in patient activity, but the savings were partially offset by pandemic preparedness expenses. Salaries and benefits comprise over half of hospital expenses. Many hospitals had workforce reductions in March and April, whether through reduced staffing hours or voluntary and involuntary furloughs. However, due to the need to be ready for a potential surge and the uncertainty about when the patient volumes would return, 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 generates savings in medical devices and supplies, and closing ambulatory sites saves some facility costs. However, many of the non-workforce related expenses are fixed (they do not increase or decrease with volume).

All health systems incurred significant costs from pandemic preparedness activities such as procuring supplies and equipment, implementing testing, and other activities discussed earlier. Due to increased

⁶ Many systems used a comparison of actual results to budget to present the variance from expected results, while some used average operating results for the first eight months of the fiscal year and others used March 2019 for the comparison.

demand, some supply costs have skyrocketed, and some additional costs were incurred to replace staff that were self-quarantined due to known exposure.

May-December results

Most of the organizations have forecasted operating margins through the remainder of 2020 and the variance from expected performance. For one organization, financial projections were provided through September and HMA estimated its projected results for the 4th quarter of 2020 based on the weighted average of the other five organizations.

May to June

Generally, organizations expressed a reasonable degree of confidence in predicting their financial results through June 2020, and there is a much higher degree of uncertainty about the last two quarters of the year. Accordingly, we summarized and present financial projections in two parts: the two-month period ending June 30 and the six-month period ending December 31, 2020.

For May and June of 2020, forecasted statewide operating margins are **\$121 million** below expectations (an average of \$61 million per month). This estimate is before considering any funding from federal relief legislation.

Estimated operating margin shortfall for May to June 2020 totals \$121 million statewide.

The forecasting methods and assumptions vary considerably from system to system depending upon several factors.

Patient volume is the most important variable, and there are two major uncertainties. First, the number of COVID-19 cases and the extent of COVID-19 hospitalizations are unknowns, and estimates vary about the effect on hospital inpatient units and emergency rooms. Second, and more significant, is the timing of elective and scheduled procedures, tests and treatments. Current restrictions have already begun to loosen, but operational obstacles and public anxiety will dampen the speed of the ramp up. Additionally, it is unknown at what point care that is currently being deferred will become urgent.

There is consensus among the systems that the enormous decreases in volume experienced in the latter part of March and through April will continue. Most of the organizations believe there will be a modest improvement in the second half of May, as the disruption begins to loosen and there will be continued improvement through June, although there are no consensus assumptions around pace of these improvements. In aggregate, patient revenue is projected to decrease by 18% in May-June compared to an average two months of fiscal 2019 patient revenue, ranging from 7% to 38% of fiscal 2019.

Another important variable in these forecasts is the potential savings from workforce reductions. Along with the decline in patient volume, there has been a net reduction of work in providing and supporting patient care. The response to the reduction varies considerably. Many organizations have repurposed staff to perform other work such as implementing the new safety measures, delivering testing, and cleaning. All organizations have either furloughed staff or reduced staffing hours.

All of the healthcare systems are monitoring the situation closely; hospitals cannot be caught short-handed if a COVID-19 surge comes and no one wants to be understaffed as normal activity resumes.

Finally, changes in insurance coverage will affect financial performance. As unemployment rates are skyrocketing across the country, millions may lose employer-based health care coverage and some with individual coverage may not be able to continue to pay the premiums. There will be a shift from private insurance to Medicaid and uninsured. HMA recently produced a model⁷ that estimates changes in enrollment nationally and by state :

Change in Coverage, 2020 Q1 to Q4	National	Rhode Island
Medicaid increase	5 to 17 million	16,000 to 86,000
Uninsured increase	5 million	2,000 to 11,000
Private insurance decrease	(5 to 22) million	(18,000) to (97,000)

Note: The Rhode Island private insurance decreases represent 3% to 12% of non-Medicare residents

To the extent that these shifts occur, hospital systems will experience further erosion of their net revenue. Medicaid payment rates are significantly lower than private insurance rates, and most care to the uninsured will be uncompensated. Three of the organizations we surveyed accounted for an expected shift in payer mix in their forecasts, while the others did not. As a result, the negative variance for the two-month period could be greater.

After June 2020

Predicting the financial impact of the pandemic after June 2020 is far more uncertain than forecasting results through June. Just as there will be a gradual easing of stay-at-home and social distancing requirements, there will be a recovery of surgeries, diagnostic testing, treatments, and clinic visits and emergency room activity. Some believe the rate of recovery may be faster than other sectors of the economy because of pent-up demand for healthcare services, while others have more conservative views.

For the six-month period from July through December 2020, forecasted statewide operating margins are **\$174 million** below expectations (an average of \$29 million per month). This estimate is before considering any funding from federal relief legislation.

Estimated operating margin shortfall for July to December 2020 totals \$174 million statewide.

Each of the organizations believe there will be a significant return of patient activity in the second half of the year, although there are no consensus assumptions around pace of the recovery. In aggregate, patient revenue is projected to decrease by 8% from July to December compared to an average six months of fiscal 2019 patient revenue, ranging from 6% to 18% of fiscal 2019. Notably, none of the

⁷ 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>

organizations expected a full recovery of pre-pandemic patient volume during this period because of continued impact of social distancing and other precautions.

Notwithstanding the previous comments, there is significant concern among some healthcare experts that a respite of COVID-19 activity during the summer months could be followed by an aggressive return and corresponding increase in COVID-19 cases in the latter part of the calendar year and early 2021.

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 health care providers.

- The first, referred to as the CARES Act, includes \$100 billion that is referred to by HHS as the CARES Act Provider Relief Fund.
 - \$50 billion is a general allocation available to all health care providers with Medicare revenue who agree to certain HHS terms and conditions. Most of the general allocation has been distributed, including \$72 million to hospitals in Rhode Island.
 - \$22 billion has been allocated and paid to hospitals impacted by a high number of COVID-19 admissions, and rural hospitals and clinics. One Rhode Island hospital received \$19.8 million from these allocations.
 - The remaining \$28 billion will be distributed to reimburse healthcare providers at Medicare rates for COVID-related treatment of the uninsured, and some providers will receive further, separate funding, including skilled nursing facilities, dentists, and providers that solely take Medicaid.
- An additional \$75 billion is authorized in the most recent federal relief package signed into law on April 24, to reimburse eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus. At this time, no guidance on the use of this funding has been provided by HHS.

From the \$72 billion of provider relief already allocated, Rhode Island healthcare systems received \$92 million. A total of \$103 billion of direct provider relief funding remains unallocated. Hospitals and healthcare systems in Rhode Island are likely to receive additional provider relief payments, but it is uncertain how the funding will be distributed.

The CARES Act also included two Medicare payment changes, increasing the payment rates by 20% for COVID-19 inpatients, and eliminating the 2% sequestration for the last eight months of the year. The revenue increases from these changes are, for the most part, already included in the health systems' forecasts.

In addition, 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”.⁸ A FEMA fact page provides a listing of costs that may be reimbursable, if not otherwise funded from other sources.

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.

Federal relief payments offset the operating margin shortfalls discussed in previous sections. Because of the uncertainties about the allocation of federal provider relief funding and FEMA recovery, no reasonable estimate of the total impact of federal relief can be made at this time.

Cash

Financial losses of the magnitude discussed above have several negative consequences to hospitals and health systems. The most immediate and pressing concern is whether providers have sufficient cash to remain in business.

The margin shortfalls described above are likely to result in significant reductions in cash and readily available investments. Hospitals that did not enter the pandemic period with strong balance sheets may not be able to absorb the losses.

The Centers for Medicare and Medicaid Services (CMS) used its emergency authority to offer accelerated Medicare payments to providers. All of the systems took advantage of this program and have received Medicare advances. These advances will help ensure that hospitals and health systems have the liquidity they need for the short-term. However, under the conditions of the program, the advances must be repaid after 120 days. Beginning in early August, providers will have all Medicare payments withheld until the advance is recovered. Consequently, cash receipts will be significantly reduced over the last five months of 2020 as the Medicare advances are effectively repaid. and the advance provides only temporary relief.

All of the organizations we interviewed are taking additional steps to provide sufficient liquidity. Capital expenditures (buildings, equipment and information technology) are being delayed where possible. Lastly, during the pandemic emergency, essential businesses are allowed to defer employer contributions to social security and hospitals are taking advantage of this temporary savings as well.

Other Concerns

Several related financial concerns were raised during the interviews, including the following:

- Equity market values declined significantly in March. Many hospitals have significant holdings and pension assets in market-sensitive investments and the recent loss of value further weakens the hospitals’ financial position.

⁸ <https://www.fema.gov/news-release/2020/03/19/coronavirus-covid-19-pandemic-eligible-emergency-protective-measures>

- Debt financing concerns. Sustained operating losses and weakened balance sheets could have adverse implications for current and future borrowings. Many hospital borrowings are made under agreements that include financial provisions (often called covenants) imposed by the lenders requiring the borrower to maintain specified levels of net income or cash. Failure to meet debt covenants may result in a default, and the amount borrowed becomes immediately due and payable. This scenario often leads to bankruptcy or closure. In addition, the deteriorating financial position will adversely affect the credit worthiness of some hospitals and make it more difficult and more expensive to obtain future financing.
- The financial data presented in this report does not include the effects on affiliated physicians and physician group practices that are not owned or employed by the health system. These independent physicians are experiencing the same financial strains as hospital-controlled physicians and their ability to weather the current crisis is critical to the hospitals.

Conclusions

The current pandemic is resulting in a dramatic disruption of patient care and large financial losses for most hospitals. Forecasting the financial impact of the crisis is challenging given that we only have six weeks of relevant financial results and highly volatile predictions about the extent and duration of the disruption.

We obtained information about the bottom-line impact from each of the Rhode Island health systems for March and April 2020 and their forecasts for the two months ending June 30, 2020. From March through June, hospitals and health systems could incur a shortfall of **\$266 million** before federal relief payments.

The current restrictions and operational limitations on non-emergency patient care and requirements for social distancing are beginning to loosen in May but the changes will be gradual and a full return to normalcy will probably not occur until 2021. The systems forecast an additional margin shortfall of **\$174 million** from July through December 2020.

These margin shortfalls are partially offset by federal emergency funding. To date, \$92 million has been received by hospitals and health systems in Rhode Island from the March 2020 CARES Act. Remaining CARES Act funds and provider relief funding in the April 2020 federal relief package are likely to result in more payments to Rhode Island providers and additional relief is available from FEMA reimbursement. Reasonable estimates of federal relief cannot be made at this time.

In total, the systems project a \$440 million margin shortfall from the pandemic in the last ten months of 2020, before considering federal relief funding. For context, this amount represents about 12% of operating revenue at pre-pandemic levels.