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HEALTH MANAGEMENT ASSOCIATES

*Analysis of the Financial Impact of COVID-19
on Hospitals in Washington, D.C.*

PREPARED FOR
DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION

BY
TOM MARKS, PRINCIPAL
MARY GODDEERIS, SENIOR CONSULTANT

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Executive Summary

The District of Columbia Hospital Association (DCHA) 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 Washington, D.C. HMA conducted interviews with hospital leaders representing six healthcare systems in the District and received actual financial results from five of the systems and forecasted financial results from four of the systems. HMA estimates that the financial disruption seen by hospitals in March and April and projections of the financial impact over the duration of the year will result in \$559 million in Districtwide margin shortfall.

On March 7, 2020, the District reported its first COVID-19 case. Pursuant to federal and Districtwide guidance and due to operational necessity, by mid-month, hospitals had begun to see significant impacts as they 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 resulted in significant revenue losses. Systems achieved expense savings associated with the slowdown in patient activity, but the savings were partially offset by pandemic preparedness expenses.

For the six-week period from mid-March through the end of April, the healthcare systems that provided data reported a 33% decrease in patient revenue. Operating expenses in March and April decreased by a reported 3% from expected levels. As a result of the patient care disruption, operating margins declined by an estimated \$185 million in March and April compared to expected amounts.

Hospitals continued to experience significantly reduced patient activity levels in May and into the first part of June. The restrictions on non-emergent services began to relax in May, and systems project some recovery of patient activity; however, May-June patient revenue is projected to be 26% lower than an average two months of fiscal 2019 patient revenue. Operating margins will decline by an estimated \$184 million in May and June compared to expected amounts.

Although the pandemic has been ongoing for over three months, there still remains much uncertainty regarding the length and scale of the remaining pandemic period, and systems are reticent to forecast results beyond June 30. However, there is agreement that the disruption will continue for the remainder of the year. Based on forecast and observations from the interviewees and past experience, HMA estimates an operating margin shortfall of \$190 million for July-December. The loss could be substantially larger if a new surge in COVID-19 cases occurs in the fall, as many experts predict.

Report Highlights	Districtwide Estimates*
Operating margin shortfall:	
March – April 2020	(\$185 M)
May – June 2020	(\$184 M)
July – December 2020	(\$190 M)
Total margin shortfall	(\$559 M)
*All figures are prior to the inclusion of federal and District relief funding and represent variances from expected amounts.	

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, \$87 billion has been allocated. Washington, D.C. healthcare systems have received \$205 million and expect to receive more from the remaining federal relief funds. In addition, the District has provided up to \$35 million in grants to help fund costs related to the public health emergency. In total, District hospitals and health systems have received \$240 million of federal and local relief payments and anticipate receiving more. Hospitals' pandemic-related losses will far exceed their share of available government relief payments, nationally and in the District.

As the COVID-19 disruption continues, hospital financial concerns about available cash to fund ongoing operations will grow. Medicare recently accelerated payments to hospitals across the District, but the repayment of these funds is scheduled to begin in late July—coinciding with a period of increased cash flow concerns that hospitals anticipate. Without a better understanding as to if, when, and how hospitals will be able to again recover patient volume, it is unclear whether all hospitals will be able to overcome the financial disruption caused by this crisis.

Introduction

As of June 28, 2020, medical professionals across the United States have diagnosed over 2.5 million cases and attributed 126,000 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 three 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, starting in mid-March hospitals cancelled non-emergency procedures, and many Americans continue to postpone 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 the nation's capital and therefore a place with a relatively transient population, Washington, D.C. has strongly felt the impact of the virus. Nationwide, the District ranks 5th in per capita diagnosed cases and 6th in per capita deaths. Maryland, a neighboring state and one whose residents also seek care in the District, ranks 9th in per capita diagnosed cases and 10th in per capita deaths.

¹ Pub. L. 116-136

² The New York Times. <https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html#states>. Accessed June 21, 2020.

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

Since early May, the District 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 certain what will occur in the near future. The unknown effects of the re-opening of businesses and the political unrest of recent weeks add to this uncertainty. As of May 29, 2020, the beginning of the District's Phase 1 re-opening, hospitals in Washington, D.C. are rescheduling surgeries and reopening ambulatory care 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 District guidelines for social distancing and other ongoing precautions, as well as public anxiety toward seeking care, hospitals will likely experience revenue losses for many months to come.

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

Approach

Between Monday June 1, 2020, and Thursday June 4, 2020, HMA conducted interviews with hospital leaders representing six health systems in the District. HMA received actual and projected financial results from five of the organizations, which account for the large majority of Districtwide FY 2019 operating revenue. HMA captured information related to the following:

- Operational changes and preparation to ready facilities and staff for the treatment of large numbers of COVID-19 patients
- Results of March and April operations, focusing on the impact of the crisis on the operating margins and revenue compared to pre-pandemic estimates.
- Forecasted results including assumptions related to the projected length of the pandemic
- Estimated federal and local governmental support
- Information about the effect of margin shortfalls on cash, and steps taken to mitigate the negative impacts.

Based on the financial data captured, we estimated the overall impact of the crisis on District hospitals. This report contains summarized information and extrapolations based on these interviews and data received. 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 Washington, D.C. 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 those 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, resulted in the following operational changes and additional investments across health systems in the District:

- 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
- Refurbishing offline beds to increase 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 at hospital entrances for employees and visitors
- Staffing entrances to enforce strict visitation policies
- Shifting as many services as possible to telehealth
- Procuring PPE and other equipment such as ventilators
- Investing in additional tools 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

Analysis of Hospital Financials

Seven acute care hospitals operate in the District along with five specialty hospitals. Eleven of the twelve hospitals are part of multi-hospital systems with six systems represented in the District. Four of the hospitals are part of national investor-owned healthcare companies, and five of the hospitals are owned or managed by a regional nonprofit health system.

The consolidated operations of the District-only healthcare system and the District operations of the national/regional systems 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.

Districtwide inpatient discharges and outpatient visits in fiscal year 2018 totaled 120,000 and 2,600,000, respectively.⁴

Washington, D.C. also has a District-owned psychiatric hospital and a Veterans Administration hospital that are excluded from this analysis.

Five of the organizations, which account for the large majority of Districtwide revenues, provided March and April financial results and projections for May and June. The projections for May and June were made as hospitals were completing their May financial statements and preliminary May results were

⁴ From American Hospital Association DataQuery, compiled primarily from a survey of its hospital members.

considered in these projections. The aggregate results were extrapolated to estimate Districtwide results by using fiscal 2019 operating revenues as the base for extrapolation.

March and April 2020 Results

For the month of March, consolidated operating results for the District were an estimated **\$64 million** below expectations.⁵ For the month of April, the first complete month of pandemic-related results, consolidated operating results for the District were an estimated **\$121 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 33% 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 \$185 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 local 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 cancelled 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 3% 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, in limited instances, 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 and therefore do not decline with lower volume.

⁵ Systems used a comparison of actual results to budget or pre-pandemic forecasts to present the variance from expected results.

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

Forecasting

For revenue forecasting purposes, 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. As previously noted, the loosening of restrictions on businesses, the recent political unrest, and potential fluctuations due to weather patterns have the potential to cause future waves of cases. 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 recovery. Many hospitals noted reluctance by significant numbers of patients to reschedule delayed services at the first opportunity. Additionally, it is unknown at what point care that is currently being deferred will become urgent.

May to June Results

For May and June 2020, forecasted Districtwide operating margins are **\$184 million** below expectations (an average of \$92 million per month). This estimate is before considering any funding from federal relief legislation.

Estimated operating margin shortfall for May through June 2020 totals \$184 million Districtwide.

There is consensus that the enormous decreases in volume experienced in the latter part of March and through April continued through most of May. Organizations experienced a modest improvement in the second half of May, and there will be continued improvement through June. In the aggregate, patient revenue is projected to decrease by 26% in May-June

compared to an average two months of fiscal 2019 patient revenue.

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 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. Expenses are estimated to decrease by 5% in May-June compared to an average two months of fiscal 2019 expenses.

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 paying premiums. There will be a shift from private insurance to Medicaid and potentially the uninsured, although Washington D.C. has generous Medicaid eligibility policies. HMA recently produced a model⁶ that estimates changes in enrollment nationally and by state and within the District:

Change in Coverage, 2020 Q1 to Q4	National	Washington, D.C.
Medicaid and uninsured increase	5 to 22 million	7,000 to 44,000
Private insurance decrease	(5 to 22) million	(7,000) to (44,000)

Note: The Washington, D.C. private insurance decreases represent 1% to 7% 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 for the uninsured will be uncompensated. Some organizations we surveyed accounted for an expected shift in payer mix in their forecasts, while other did not. As a result, the negative variance for the two-month period could be somewhat 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 Districtwide operating margins are **\$190 million** below expectations (an average of \$33 million per month). This estimate is before considering any funding from federal relief legislation.

Estimated operating margin shortfall for July to December 2020 totals \$190 million Districtwide.

The organizations believe there will be a return of patient activity in the second half of the year, although there are no consensus assumptions around pace of the recovery. In the aggregate, patient revenue is projected to decrease by 9% from July to December compared to an average six months of fiscal 2019 patient revenue. Notably, none of the organizations expected a full recovery to pre-pandemic patient volume during this period because of the continued impact of social distancing and other precautions.

Notwithstanding the previous comments, there is significant concern among many experts that a respite of COVID-19 activity during the summer months could be followed by an aggressive return and

⁶ 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>

corresponding increase in COVID-19 cases in the latter part of the calendar year and early 2021. Hospital losses in the second half of the year could be substantially larger if a new surge in COVID-19 cases occurs.

Federal and Local Relief Funding

A total of \$240 million in direct payments has been allocated to District hospitals from federal and District government relief programs.

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. 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. Approximately \$87 billion of the \$175 billion total has been allocated:

- \$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 \$106 million to hospitals in the District.
- \$37 billion is for targeted allocations: hospitals impacted by a high number of COVID-19 admissions through April 10th, safety net hospitals, rural hospitals and clinics, and skilled nursing facilities. District hospitals received \$68 million from these allocations.

HHS has designated \$25 billion that has not yet been allocated. An additional \$10 billion will be paid to hospitals with high numbers of COVID-19 patients, and District hospitals are likely to receive a portion of this fund. Also, \$15 billion is designated for providers not eligible for the first general allocation; District hospitals are not expected to benefit from this fund.

From the \$87 billion of provider relief already allocated, healthcare systems in the District received \$205 million. A total of \$88 billion of direct provider relief funding remains unallocated. Hospitals and healthcare systems in the District are likely to receive additional provider relief payments, but it is uncertain how the remaining funds 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.

Through June 18, 2020, the D.C. Department of Health Care Finance has allocated \$35 million in grants to hospitals to support D.C. hospitals in preparing for the medical surge caused by the COVID-19 emergency.

Finally, 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”.⁷ 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 partially 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. Most 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.

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 hospital financial positions.
- 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

⁷ <https://www.fema.gov/news-release/2020/03/19/coronavirus-covid-19-pandemic-eligible-emergency-protective-measures>

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.
- The District has several academic medical centers (AMCs). The medical education and research arms of these AMCs typically receive significant funding from patient care operations. The expected margin shortfall will impact the ability of hospitals and physician faculty group practices to support the academic mission at expected levels.

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 the highly variable predictions about the extent and duration of the disruption.

In total, HMA estimates a **\$559 million** margin shortfall from the pandemic in the last ten months of 2020, before considering federal relief funding. For context, this amount represents about 10% of operating revenue at pre-pandemic levels.

We obtained information about the bottom-line impact from several Washington D.C. 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 **\$369 million** before federal relief payments.

The current restrictions and operational limitations on non-emergency patient care and requirements for social distancing began to loosen in May but the changes will be gradual and a full return to normalcy will probably not occur until 2021. We forecast an additional margin shortfall of **\$190 million** from July through December 2020. The margin shortfall in the second half of the year could be substantially larger if a new surge in COVID-19 cases occurs.

These margin shortfalls are partially offset by federal and local emergency funding. To date, \$205 million has been received by hospitals and health systems in the District from federal provider relief funds, and up to \$35 million has been allocated from the District for surge-related costs. Remaining federal provider relief funding is likely to result in more payments to Washington D.C. providers, and additional relief is available from FEMA reimbursement. Reasonable estimates of additional federal relief cannot be made at this time.

Despite federal and local fiscal relief efforts to date, District hospitals expect to incur pandemic-related losses far in excess of available government relief payments.

