

Via electronic mail

January 6, 2020

Ms. Courtney Avery
Board Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Floor 2
Springfield, Illinois 62761

Re: Response to Safety Net Impact Statement
Orthollinois Project No. 20-040 (the "Project")

Administrator Avery,

Please accept this letter as our "Response to the Safety Net Impact Statement" provided in accordance with Section 5.4 of the Illinois Health Facilities Planning Act. Orthollinois proposes to establish an ambulatory surgery center in Elgin. This new location would be right across the street from Advocate Sherman Hospital. This Response addresses the strong negative impact that the proposed Project will have upon the ability of Advocate Sherman Hospital to provide the Safety Net Services that our community needs and relies upon.

Statutory Requirement for Statement of Safety Net Impact Statement

When the General Assembly passed sweeping change of the Illinois Health Facilities Planning Act in 2009, one of the significant changes made was to create a mechanism for assessing the impact of a project upon Safety Net Services. Public Act 96-0031 created a new Section 5.4 that requires certain projects, such as this Orthollinois Project, to address the impact the proposed facility will have on other providers of safety net services:

(c) As developed by the applicant, a Safety Net Impact

Statement shall describe all of the following:

(1) The project's material impact, if any, on essential
safety net services in the community, to the extent that it
is feasible for an applicant to have such knowledge.

(2) The project's impact on the ability of another
provider or health care system to cross-subsidize safety
net services, if reasonably known to the applicant.

(3) How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Public Act 96-0031, Sec. 5.4.(emphasis added)

This Section 5.4 also granted the right for providers and other to file a Safety Net Impact Statement Response, which we are providing by this letter.

(f) Any person, community organization, provider, or health system or other entity wishing to comment upon or oppose the application may file a Safety Net Impact Statement Response with the Board, which shall provide additional information concerning a project's impact on safety net services in the community.

Id.

Unfortunately, the Orthollinois CON application does not even address the information required by the Planning Act and we believe that the application should not be considered until the applicants address this requirement. As addressed further below, the proposed Project seriously undercuts our hospital's ability to provide needed safety net services.

Background of Current Utilization of Existing Services

We are enthused that Orthollinois wants to expand services in our area. They have been good partners with the hospital and have served the community well. Many of the physicians involved with the Orthollinois project provide services at our Hospital and several had pledged their referrals to be part of the joint venture the Review Board approved as part of our Sherman Ambulatory Surgery Center which is still under development. We object that this new ambulatory surgery center, however only duplicates services at a critical time in our nation's history and would siphon away critical resources from our hospital, which is already struggling financially due to lower volumes and a worsening payer mix.

Many of the physicians listed in the application are already on staff at two nearby centers where they currently take cases: Algonquin Road Surgery Center in Lake In the Hills, Illinois, and Valley Ambulatory Surgery Center in Saint Charles, Illinois. Both centers are within 20 minutes of the proposed site in Elgin.

Impact on Ability to Provide Safety Net Services

Outpatient surgery is a critical service we provide to all patients in our service area, regardless of their ability to pay. It is also a service that contributes to our margin and allows us to offer safety net services that we would not otherwise be able to offer unless we had other services to subsidize them. This is especially important as the pandemic has seriously weakened our financial state. We're grateful for federal assistance but even that money does not come close to stemming our losses in 2020. In response, we are currently undergoing a significant leadership restructure which will help lower our expenses going into 2021.

Our net revenues 2020 are down by \$37M (-13%) and we are budgeting an operating loss for 2021, which is a significant deterioration in financial performance over past years. We continue to provide care to the uninsured and financially deprived individuals within our community. Our charity care and the amount uncollectible from patients is up by \$21M (53%). The proposed Orthollinois project directly undermines our ability to provide for these persons in need. Furthermore, this Project will do nothing to further the care for the underserved in our community. Unlike ambulatory surgery centers, Advocate Sherman Hospital cannot influence the payer mix of our emergency department nor do we screen out patients due to their insurance or uninsured status.

Orthollinois has Weak History of Serving the Medical Indigent

In its CON application emphasizes the problem when it states that "Ambulatory Surgical Treatment Centers are not providers of safety net service". CON Application, p. 275. By not providing safety net services, this means that other providers, such as Advocate Sherman Hospital, must provide these necessary services.

In its section of the Application addressing safety net services, the applicants tout the community services that its somewhat parent organization of Orthollinois has provided, such as charitable contributions to food banks. While laudable, this does not address the health care needs of medically indigent patients.

Proposed Project Negatively Impacts our cross-subsidization of Safety Net Services

We have attached two articles for the Board's review that raise concerns about hospital finances due to COVID-19. The American Hospital Association article note the following:

- Nationwide, hospitals are projected to lose \$323M
- The reimbursement for COVID patients does not cover the cost for caring for these patients
- Due to increased unemployment, hospitals across the country are seeing increased uncompensated care for insured patients (which further makes the point about Sherman's increasing bad debt)

As mentioned above, outpatient surgery serves as an important margin-generating engine for the hospital and allows us to offer important services into our community. Examples of programs that are subsidized at Advocate Sherman Hospital by profitable services include our Level II Trauma service, pediatric rehabilitation services, our Hispanic diabetic outreach program and Labor and Delivery. We are the only hospital in Elgin that performs deliveries and nearly 40% of those mothers are on Medicaid. Even in the best of financial times all of these services, which we believe important to provide our community, do not make money. As the attached Kaufman Hall article notes on page 7, "In the face of greatly eroded volume and revenue, and a long recovery period, many hospitals are confronted with extremely difficult about their paths forward as vital community assets."

Some members of the public have mistakenly believed that because the COVID-19 pandemic increased the need for health care services it has been beneficial for hospital's bottom line financial. As Review Board members know, the impact has instead been devastating to hospitals, including our own. The attached are only a few respected articles detailing the crippling financial impact upon hospitals.

This application will be heard in late January and many of our physicians and infectious disease experts are still expecting that we will continue to be in the middle of a COVID surge. Patients will still be nervous about seeking non-essential care, and I would suspect that many of our outpatient service volumes will continue to be depressed. This is happening nationwide and is not isolated to Sherman. Now is not the time to severely disrupt hospitals' financial lifelines.

Thank you for consideration of the impact on patients ability to access safety net services in the area as you deliberate and vote on this application.

Sincerely,



Mike Cavato
Director, Financial Services
Advocate Sherman Hospital

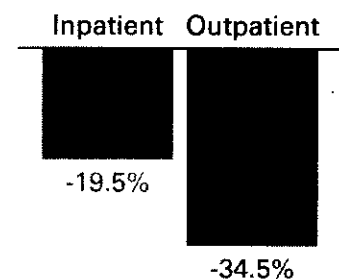
Introduction

The COVID-19 pandemic continues to take a heavy toll on America's healthcare infrastructure. While some parts of the country have started slowly phasing out stay-at-home orders and other restrictions, hospitals and health systems remain on the frontlines of this pandemic. Experts have warned that the recovery pace for hospitals and health systems will be slow and that normal hospital volume will not come back quickly even as states lift moratoriums on non-emergent procedures. There is still grave public concern that the risk of COVID-19 infection is high and a number of states continue to maintain certain restrictions. Coupled with this is the fact that many states continue to report increasing cases of COVID-19.¹ As recently as June 24th, state departments reported the highest number of new infections since the previous record set on April 25th.² These factors have led to historic reductions in hospital inpatient and outpatient volumes, which have in turn driven drastic reductions in revenues and margins – all of which can impact hospitals' and health systems' abilities to serve their communities.

Driving these reductions in volume and revenue are the costs of avoided and forgone medical care and additional costs borne by hospitals related to purchasing personal protective equipment (PPE) and other supplies and equipment. The American Hospital Association (AHA) previously estimated that the financial impact of COVID-19 on hospitals and health systems totaled \$202.6 billion in losses over a fourth-month period between March 2020 and June 2020.³ However, the slow recovery of inpatient and outpatient volumes to baseline levels, coupled with continued and increasing COVID-19 infection rates, has exacerbated these financial losses. As noted in AHA's prior report, as patients are hospitalized for COVID-19, hospitals' costs to treat these patients exceed expected reimbursement, which results in further financial losses.

To understand better the continued pressure hospitals and health systems face, the AHA conducted a survey of member hospitals on their current reductions in inpatient and outpatient volumes, as well as how quickly they expect to return to baseline patient volumes similar to 2019, if ever. This report describes the results of this survey and their use in projecting the financial impact of reduced hospital inpatient and outpatient volumes in 2020, assuming that patient volumes return to baseline levels by July 2021. The financial impact also takes into account the additional costs of acquiring PPE as patient volumes grow. Based on this analysis:

Hospitals' and Health Systems' Average Reductions in Volume from Baseline



Hospitals and health systems currently report average declines of **19.5% in inpatient volume and 34.5% in outpatient volume** relative to baseline levels.

The AHA estimates an additional **\$120.5 billion in total financial losses** from July 2020 through December 2020 should hospitals and health systems reach baseline patient volumes by July 2021, or an average of **\$20.1 billion per month. These estimates are in addition to the \$202.6 billion in losses the AHA estimated between March 2020 and June 2020 bringing the total projected losses to hospitals and health systems in 2020 to at least \$323.1 billion.**

Projected Losses to Hospitals and Health Systems in 2020

Projected Losses

March-June 2020

\$202.6B

July-December 2020

\$120.5B

Total Losses

\$323.1B

While the financial impacts estimated in this report are comprehensive, they may underrepresent the full financial losses hospitals will face in 2020. Importantly, the analysis does not account for currently increasing case rates in certain states, or potential subsequent surges of the pandemic occurring later this year. If the current surge trends continue, the financial impact on hospitals and health systems could be even more significant. The AHA's estimates also do not include all expenses, such as increased acquisition costs for drugs and non-PPE supplies and equipment. The financial impacts estimated in this report are above and beyond the \$202.6 billion in financial impact the AHA estimated in its prior report, highlighting the dire financial challenges that hospitals and health systems will continue to face for the foreseeable future. Though the federal government has continued to provide relief funds to hospitals and health systems, those funds still pale in comparison to the losses that hospitals and health systems have already incurred and will continue to face through the end of 2020 and likely into 2021.

Background

Since the first case of COVID-19 was reported in the U.S. in January 2020, over 2.4 million individuals in the U.S. have been infected, with over 124,000 deaths.⁴ These grim statistics illustrate the breadth of the pandemic and its deleterious impact on communities. Despite certain local, state, and federal actions to ease restrictions, the pandemic has yet to show substantial signs of decline, and in fact is seeing increases in case rates in certain states.

As many states began reopening measures allowing for greater social contact, hospitals and health systems focused on safeguarding the health of their patients and staff, while also preparing for the uncertain future. This uncertainty has led many individuals to continue to postpone or delay their medical care, despite moratoriums on the provision of non-emergent care being lifted in most states. A May 2020 Kaiser Family Foundation (KFF) tracking poll found that 48% of respondents said they or a family member had skipped or postponed medical care in the last three months due to COVID-19 concerns.⁵ The same KFF survey found that 26% of respondents were willing to wait four months or more to seek previously forgone care.⁶

While states have begun easing restrictions on social contact, many restrictions and policies remain in place for hospitals and health systems to ensure public health. In some states, restrictions are being re-imposed after new increases in case rates. These policies include, but are not limited to:

- **Bed Capacity.** Many states are limiting hospital volume by requiring hospitals to maintain a certain number of vacant beds. For example, hospitals and health systems in Arizona cannot exceed 80% occupancy.⁷ At least 10 other states have imposed a similar policy, reserving between 20-30% of licensed or intensive care unit (ICU) beds in case the state experiences a surge in COVID-19 patients.⁸
- **PPE Reserves.** Many states are requiring hospitals and health systems to maintain a reserve of PPE. For example, Oregon is requiring large hospitals to maintain a 30-day supply of PPE, and small hospitals must maintain a 14-day supply.⁹ These requirements are intended to ensure the safety of hospital workers and patients, and limit the risk of transmission. This also means that hospitals may need to reduce the number of surgeries and procedures to maintain an adequate supply of PPE.

- **Screening for COVID-19 Among New Patients and Hospital Staff.** Many states are implementing policies that require hospitals and systems to screen incoming patients, as well as certain hospital staff for COVID-19. These requirements vary from temperature checks, to self-attestation of risk or exposure to COVID-19, and to lab tests for the virus. For example, Virginia and Colorado require that hospitals ensure staff or patients are tested prior to surgery.^{10,11}

Hospitals and health systems are committed to ensuring the safety of their patients and staff, as well as improving the health of our country. For this reason and in addition to state mandates, many hospitals and systems have moved to implement similar policies on their own.^{12,13,14} On the other hand, it's likely that these policies will extend financial recovery for hospitals and health systems, because of their effects on patient flow and hospital volumes.

Collectively, these new policies and insufficient demand for hospital services have led to sharp decreases in inpatient and outpatient volume. A recent study by Strata Decision Technology of their proprietary claims data found that inpatient volume was down 22% and outpatient volume was down 35% compared with the same time last year.¹⁵ The same study found that emergency department (ED) use fell 40% compared with the same time last year.¹⁶ This finding was reinforced by a KaufmanHall study that found a 43% decline in ED use compared with the same time last year.¹⁷ The Morbidity and Mortality Weekly Report released by the Centers for Disease Control and Prevention (CDC) also showed a 42% decrease in ED use after the U.S. declared a state of national emergency in March.¹⁸ Such drastic decreases in inpatient and outpatient volumes have resulted in declining hospital revenues and, sustained over several months, have hastened the decline of hospital margins well below normal levels. It also is important to note that COVID-19 hospitalizations have generated some level of inpatient and outpatient volume. However, as noted in AHA's prior report, the average cost of these hospitalizations exceed expected reimbursement, further exacerbating the financial challenges hospitals face.

Methodology

Surveying Hospitals on Reductions in Inpatient and Outpatient Volume

The AHA undertook a survey of hospitals to collect information regarding:

- Inpatient and outpatient volume reductions below baseline levels, as measured by the previous year's volume, and
- When hospitals expect to return to baseline inpatient and outpatient volumes.

Electronic survey results were compiled in early June. Responses representing 1,360 hospitals were received across 48 states, Washington D.C., and two U.S. territories. Approximately one-third of respondents represented hospitals and health systems in rural areas. Weighted averages were calculated for all survey data. Incomplete responses and any duplicate, inconsistent or otherwise unusable responses were excluded from the analysis.

Estimating the Financial Impact of Inpatient and Outpatient Volume Decreases

The AHA estimated the financial impact of current reductions in inpatient and outpatient volume reaching baseline levels over time by using results from the survey and applying that to historical inpatient and outpatient revenues. Since AHA's prior report projected financial impacts through June 2020, this study projects financial impacts starting in July 2020 through December 2020. However, the majority (67%) of respondents indicated that volume would not return to baseline in 2020. Experts have also suggested that the pandemic is likely to continue for at

least another 12 months.¹⁹ Therefore, the AHA assumed a return to baseline patient volume by July 2021. Although under this scenario hospitals will continue to incur losses from reduced volume into 2021, this report focuses on the estimated losses through the end of 2020 given the high level of uncertainty regarding a number of future factors, including but not limited to, potential subsequent COVID-19 surges and changing trends in insurance coverage as a result of an economic downturn.

Annual inpatient and outpatient gross revenues were taken from the 2018 AHA Annual Survey Database (ASDB) and were inflated to 2020 dollars using the increase in hospital care expenditures as reported in the National Health Expenditure Accounts²⁰, and then converted to monthly figures. The weighted average of current inpatient and outpatient volume decreases from baseline, taken from the survey, were then applied to the monthly inpatient and outpatient gross revenues. To account for the expected month-to-month increase in inpatient and outpatient volume until baseline was achieved in July 2021, the AHA applied a negative compound annual growth rate (CAGR) to each of the inpatient and outpatient gross revenue losses on a monthly basis until baseline was achieved. Monthly inpatient and outpatient gross revenue losses were summed to yield a total monthly gross revenue loss. This number was then converted to a net patient revenue loss based on 2018 ASDB data. The monthly net revenue losses were then summed from July 2020 through December 2020 resulting in a cumulative financial impact figure.

Estimating the Additional Cost of Acquiring Sufficient PPE

Data from the Society of Healthcare Organization Procurement Professionals (SHOPP) were used to determine the relative increase in total PPE acquisition cost per bed per day due to COVID-19.²¹ These increases in costs took into account both increases in unit cost of PPE and increases in volume of PPE required to meet new guidelines established by the CDC. This increase in cost per bed per day was scaled to all U.S. hospitals by the total number of U.S. hospital beds. To project increases in PPE costs as inpatient and outpatient volume reach baseline in July 2021, the AHA applied the same monthly CAGRs used to estimate increases in inpatient and outpatient volume over time. These monthly CAGRs yielded estimates of the increased PPE cost per bed per month and those were summed from July 2020 through December 2020 to generate a cumulative financial impact figure.

Results

The AHA estimates **\$120.5 billion** in total financial impact from July 2020 through December 2020, or an average **\$20.1 billion per month**, should hospitals and health systems reach baseline patient volumes by July 2021. **These estimates are in addition to the \$202.6 billion in losses the AHA estimated between March 2020 and June 2020, bringing total financial losses for hospitals and health systems in 2020 to at least \$323.1 billion**, not including the impact of currently increasing COVID-19 case rates. If the current surge trends continue, the financial impact on hospitals and health systems could be even more significant. These figures were derived based on the following findings:

Survey Results on Inpatient and Outpatient Volume Reductions

Hospitals reported significant reductions in current inpatient and outpatient volume relative to their baseline. The weighted averages of current inpatient and outpatient volume reductions were 19.5% and 34.5%, respectively.

Hospitals also were asked when they expected to achieve baseline. Overall, 67% indicated that they did not think they would achieve baseline by the end of this year. However, nearly 30% of hospitals reported that this timeframe was "unknown" or that they "never" expected to return to baseline volumes.

Financial Impact of Inpatient and Outpatient Volume Reductions

Based on projections using these survey data, the AHA estimates \$116.7 billion in financial impact from July 2020 through December 2020 should hospitals and health systems reach baseline patient volumes by July 2021. This figure does not include the PPE costs that are described separately below. The figure also does not include the impact of currently increasing COVID-19 case rates or any subsequent waves of the pandemic.

Financial Impact of Acquiring Additional PPE

The AHA estimates that the cost of acquiring additional PPE would be \$3.8 billion from July 2020 through December 2020 should hospitals and health systems reach baseline patient volumes by July 2021. As the COVID-19 pandemic continues, the demand for PPE remains high relative to normal operations. This high demand is further heightened as inpatient and outpatient volumes return to baseline levels over time and additional PPE is needed. In addition, some states are requiring hospitals to maintain two weeks or more of PPE reserves in the event of a surge in COVID-19 hospitalizations. Collectively, these factors are increasing the need for and expense on PPE for hospitals.

Discussion

The nation's hospitals and health systems, which remain on the frontlines as the COVID-19 pandemic continues, are increasingly financially vulnerable and in need of additional support. The AHA estimates that hospitals and health systems will experience at least \$120.5 billion in total financial losses from July 2020 through December 2020 due to current reductions in patient volumes and additional expenses associated with acquiring PPE. These financial impacts are in addition to the \$202.6 billion in losses the AHA estimated between March 2020 and June 2020. In total, the AHA estimates that hospitals will incur at least \$323.1 billion in losses through the end of this year. Though these analyses already indicate the immense financial challenges hospitals and health systems face, they likely under-represent the total financial impact. This is because some cost factors contributing to the total financial impact are not included in the analyses due to limited available data. In addition to the impact of currently increasing COVID-19 case rates in many states, other costs not included in this analysis include:

- **Drug Acquisition and Shortage Costs.** As hospitals continue to treat COVID-19 patients in addition to patients with other conditions, the demand for certain drugs has increased (e.g., antibiotic agents, sedatives, etc.), while supply for these drugs has decreased due to fractured pharmaceutical supply chains. This has led to significant shortages for many drugs and created upward pressure on prices, resulting in hospitals acquiring these drugs at higher prices.²² These higher drug prices have increased overall costs for hospitals, with one study showing a 62% year-over-year increase in drug costs per adjusted discharge.²³
- **Wage and Labor Costs.** With COVID-19 cases continuing to rise across the nation, hospital and health systems continue to experience staff shortages and increased hours for some hospital workers. This has led hospitals to implement bonus pay and other similar measures to compensate workers, increasing overall wage costs. In addition, staff shortages have forced hospitals to hire staff from professional staffing firms, many of whom have raised their rates due to increased demand. With no sign of the pandemic subsiding soon, the AHA expects that hospitals will continue to experience increased wage and labor costs.
- **Uncompensated Care Costs.** One of the unfortunate consequences of this pandemic has been the sharp rise in unemployment in this country, which has led to an increase in the number of uninsured and underinsured. One study has suggested that there could be an increase of over 15 million uninsured Americans due to

COVID-19 alone.²⁴ As the number of uninsured and underinsured grow and many are forced to seek hospital care due to COVID-19 infections or other conditions, hospitals and health systems will need to incur higher uncompensated care costs to treat these individuals. In addition, these costs are likely to increase the longer the pandemic endures and as more patients return to hospitals for non-COVID-19-related care.

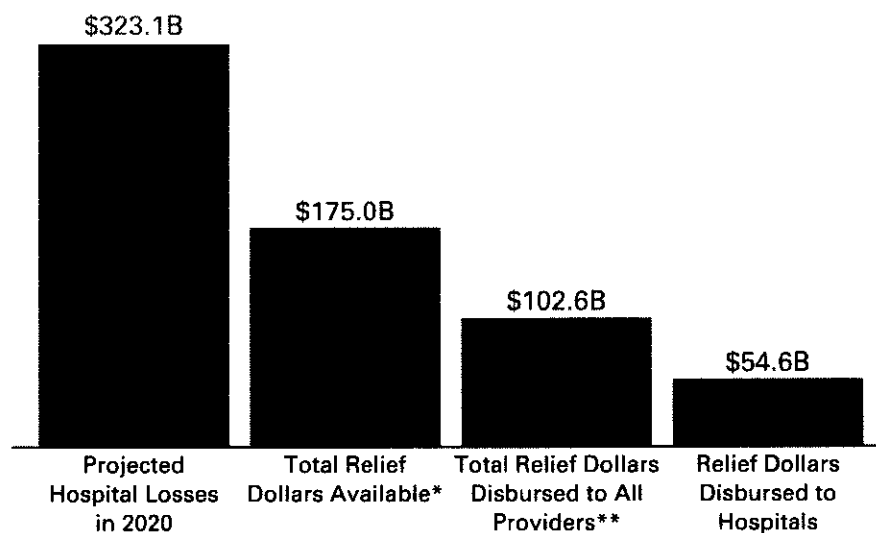
- **Non-PPE Medical Supplies and Equipment Costs.** As current reductions in inpatient and outpatient volume subside over time and COVID-19 patients continue to be seen, hospitals will need to incur more costs to acquire the necessary medical supplies and equipment (e.g., ventilators, surgical tools, syringes, medical scopes, etc.) to meet increased patient demand.
- **Capital Costs.** Many hospitals and health systems have already invested heavily in expanding bed capacity and providing additional space for testing and triaging of COVID-19 cases. As COVID-19 surges continue in different parts of the country, hospitals will need to expend further resources to address the need for additional treatment capacity.

The totality of these expenses in combination with the financial impacts estimated by the AHA in this report and its prior report, illustrate the significant financial burden being shouldered by our nation’s hospitals and health systems. In addition, this report does not attempt to quantify additional losses from currently increasing COVID-19 case rates, subsequent COVID-19 surges or changing trends in insurance coverage as a result of an economic downturn this year or beyond 2020.

While Congress and the Trump Administration have worked to deliver funds to hospitals and health systems with the goal of mitigating these financial impacts, the efforts have been inadequate to address the crisis. The Coronavirus Aid, Relief, and Economic Security (CARES)

Act allocated \$100 billion and the Paycheck Protection Program and Health Care Enhancement Act allocated an additional \$75 billion. However, these funds were intended for all healthcare providers and suppliers, not just hospitals. As of June 2020, the AHA has estimated that hospitals have received approximately \$54.6 billion of the \$102.6 billion in CARES Act relief funds that have been disbursed by the U.S. Department of Health and Human Services (HHS) based on the information HHS has released regarding the methodologies they have used. Though significant, this amount represents just a fraction of the total financial losses already experienced by hospitals, and

Hospital Losses Compared to CARES Act and PPP Provider Relief Fund



Sources: <https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html>; <https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/data/index.html>; AHA estimates using Medicare Cost Reports, CMS Provider Specific Files, Provider of Services Files, and other public use files. The \$54.6B figure includes payments that hospitals and health systems received, or expect to receive, from the general distribution, and the targeted allocations to providers in high impact areas, rural providers, skilled nursing facilities, tribal hospitals, clinics and urban health centers, and safety-net providers.

*The \$175B in total relief funds available come from \$100 billion allocated through the CARES Act and an additional \$75 billion from the Paycheck Protection Program and Health Care Enhancement Act.

**All providers include hospitals as well as physicians and other practitioners, pharmacies, clinics, laboratories, testing and imaging facilities, etc.

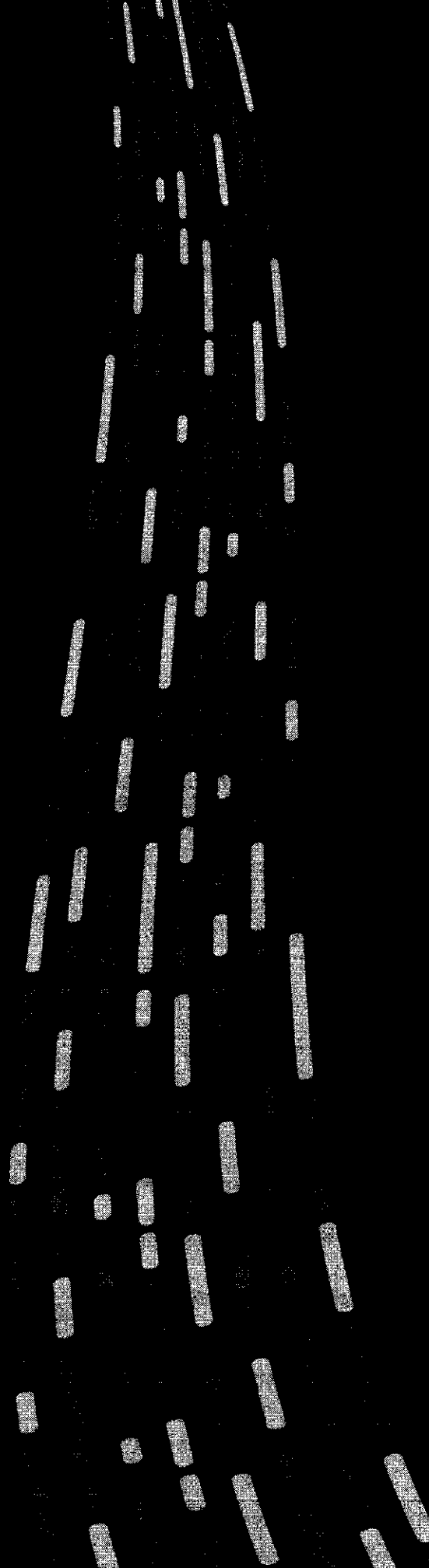
these losses are likely to continue to grow. **Therefore, more financial support is urgently needed to safeguard America's hospitals and health systems.**

The AHA urges policymakers and other stakeholders to carefully consider the unprecedented financial pressure faced by our nation's hospitals and health systems. **These losses put hospitals' survival at serious risk.** As the country continues to confront the unique and perilous challenges of COVID-19, communities across America cannot see hospitals close and access to life-saving treatment be restricted – action is needed urgently to support our nation's hospitals and health systems and their front-line staff.

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The Effect of COVID-19 on Hospital Financial Health



KaufmanHall

Exceptional Partners. Exceptional Performance.

Hospitals Require a Positive Margin to Serve Their Communities

For any organization, a positive operating margin is essential for long-term survival. Few organizations can maintain themselves for an extended period when total expenses are greater than total revenues.

For hospitals, positive financial margins allow them to invest in new facilities, treatments, and technologies to better care for patients, and to build reserves to meet unexpected expenses or revenue shortfalls.

Before COVID-19

Compared with other industries, healthcare margins typically have been very thin. Even before COVID-19, a number of U.S. hospitals struggled with negative margins—in other words, they were losing money on operations. In fact the median hospital margin was a very modest 3.5%.

This situation has been a serious threat to the future viability of many of America's hospitals.

The Effect of COVID-19 on Hospital Margins

When the COVID-19 pandemic emerged, hospitals had to stop all but the most urgent non-COVID care. The result was a dramatic slowdown in volume of patients and in revenue, while expenses remained high. To date, no one knows when and to what degree these patients will return. The result has been an unprecedented impact and an uncertain future about the ability of hospitals to serve their communities and remain financially viable.

At the request of the American Hospital Association, Kaufman Hall presents our analysis of the critical question of how COVID-19 could affect hospital margins during 2020.

The Path of COVID-19 Remains Unpredictable

This analysis is based on two broad scenarios for the COVID-19 virus.

MORE OPTIMISTIC:

a slow but steady decrease in COVID-19 cases

- ▶ This scenario assumes a continued increase in patient confidence and associated return to the hospital setting
- ▶ This scenario assumes a higher likelihood of a long slog than a quick return, given current COVID-19 case projections.
- ▶ We give this scenario 40% weight in our analysis

LESS OPTIMISTIC:

periodic surges in COVID-19 cases

- ▶ This scenario assumes that patient demand will be affected by incremental surges in cases, and by associated government and public health interventions, such as enhancing social distancing requirements or re-enacting stay-to-home orders
- ▶ This scenario includes the possibility of both secondary and seasonal surges beginning in the summer and extending through the Fall of 2020.
- ▶ We give this scenario 60% weight in our analysis

For more information about our methodology, see [page 8](#).

COVID-19 Is Expected to Drive Median Hospital Margins from Positive to Negative

COVID-19 has created immediate and significant damage to hospital margins, as well as great uncertainty about the path forward toward financial stability.

Funding from the CARES Act distributed in April and May—along with estimated distribution in June—is mitigating that impact to a certain degree. Median margins are forecast to drop to -3% in the second quarter of 2020; however, those margins would have been -15% without CARES Act funding.

Our forecast shows that, without further government support, margins could sink to -7% in the second half of 2020. This is an unsustainable level for America's hospitals.

Adjusted Operating Margin Index
Median by Quarter



The Degree of Margin Damage Could Vary Depending on COVID-19's Path

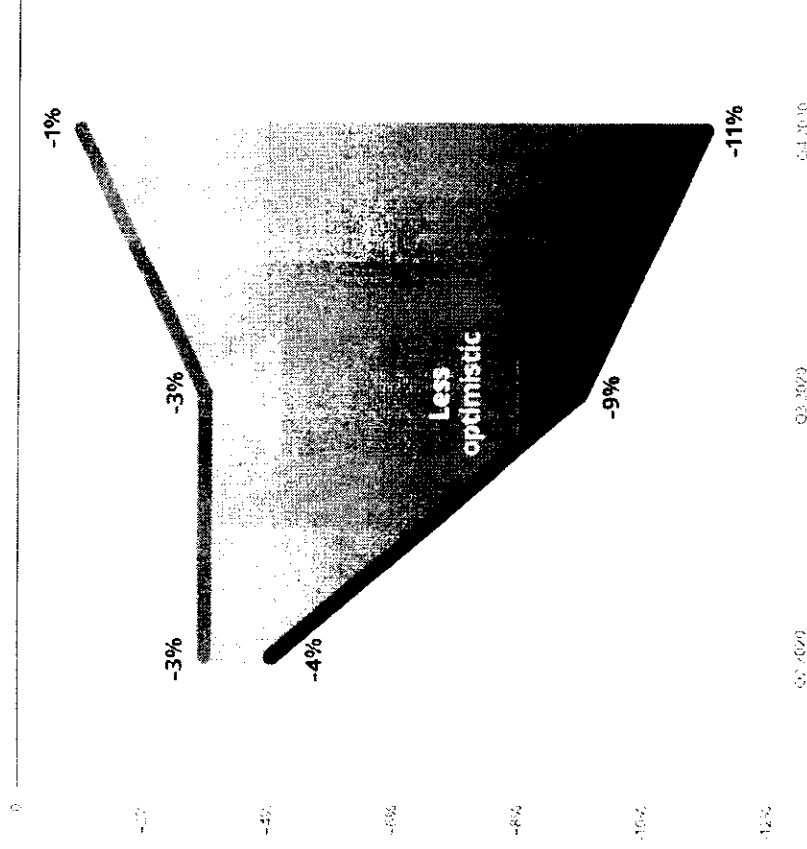
COVID-19's path—whether we see a gradual recovery or new surges—will affect the degree of damage to hospital margins for the remainder of 2020 and into the future.

In the most optimistic scenario, median margins could be -1% by the fourth quarter of the year. In a less optimistic scenario, margins could sink to -11%.

Both of the scenarios shown are possible. Both would undermine the ability of hospitals to serve their communities while COVID-19 continues and in the post-COVID-19 environment.

CARES Act funding delayed a more devastating financial impact of COVID-19. However, without further government assistance, the financial picture will quickly worsen, no matter COVID-19's path.

Adjusted Operating Margin Index*
Median by Quarter



* Margins in Q3 are different points because the two different scenarios are applied to the forecast for June 2020.

COVID-19 Could Leave Half of America’s Hospitals With Negative Margins

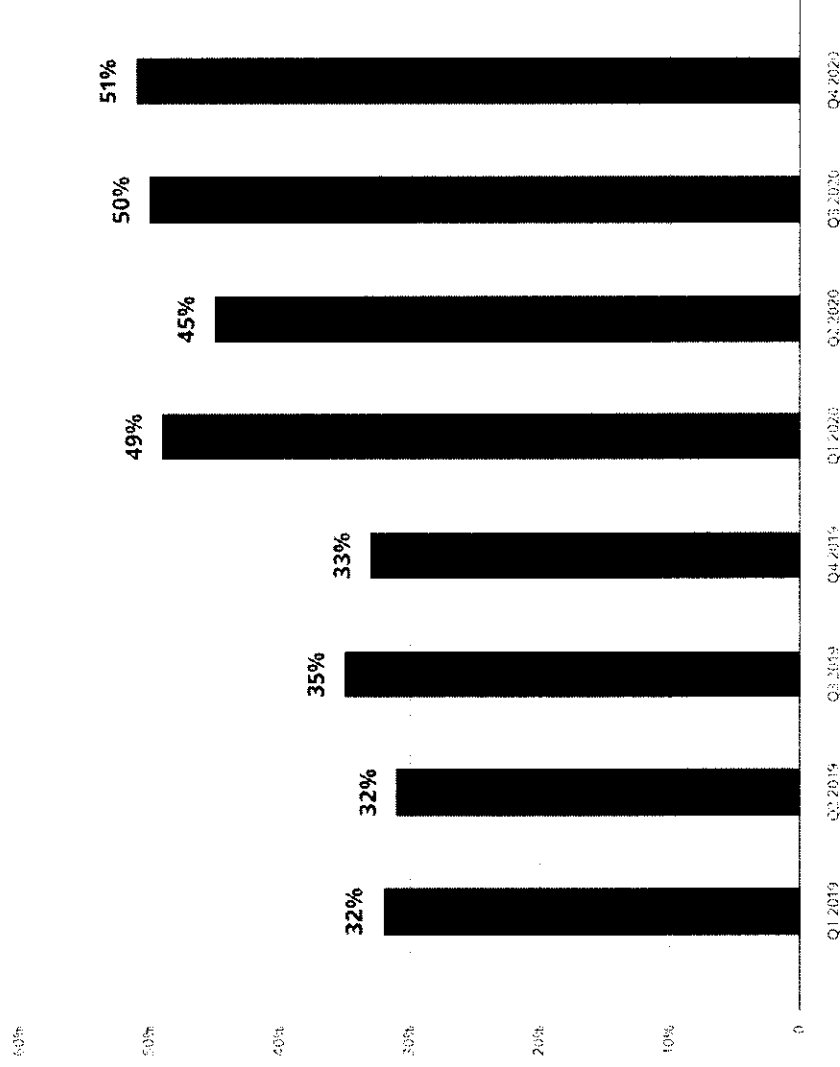
Prior to COVID-19, in 2019, a number of hospitals already had a negative margin—an indicator of the economically fragile state of the industry.

In the second quarter of 2020, when we experienced COVID-19’s initial impact, we saw almost half of America’s hospitals with negative margins—a figure that was far worse prior to distribution of CARES Act funds.

However, even as COVID-19 recedes, our analysis shows half of America’s hospitals will remain with negative margins without any further support.

This is a dire and unsustainable outlook for a major portion of the country’s hospitals and communities.

Quarterly % Hospitals with Negative Margin



The Possible Long-Term Impact of COVID-19 on Hospitals

To date, the financial impact of COVID-19 has been significant, even with Federal emergency funding, and the financial damage is likely to continue.

Adding to this financial impact is the unpredictability of COVID-19's trajectory, and the pace and degree of patients' return to hospitals.

In the face of greatly eroded volume and revenue, and a long recovery period, many hospitals are confronted with extremely difficult choices about their paths forward as vital community assets.

Now more than ever, hospitals will need support from governments, and will need to rethink their strategic-financial plans for what is likely to be a highly challenging environment even as COVID-19 cases diminish.

Methodology

Several variables were considered to create projections of hospital operating margins.

Demand

- This is considered the most significant factor and primary driver of margin projection moving forward.
- Kaufman Hall wrote about four potential scenarios for scheduled procedure resumption, including: optimistic, long slog, secondary surge, and seasonal surge – all of these scenarios are considered in the projections, as explained on [page 3](#).
- Surveys indicate a growing proportion of patients are willing to return in the next 3 to 6 months.
- External projections show wide variation in outcomes relative to COVID case modeling, hospital bed demand, and pace of secondary surges.

Expenses and CARES Act Impact

- Response varies across hospitals with regard to labor and non-labor expense categories; many hospitals have significant fixed and de facto fixed cost structures.
- For projection purposes, we assume organizations will continue to manage expenses in a similarly prudent fashion as during the initial onset of COVID from March to May of 2020. Further analysis in this area is warranted and ongoing.
- We include the offsetting impact of CARES funds received to-date in April & May, along with an estimated offsetting impact for June.

COVID-19 Margin Impact

- Margin impacts from COVID-19 have been broadly similar across geographies, hospital sizes, and other variables such as case mix index and inpatient/outpatient revenue mix
- For projection purposes at a national level, we assume these generalized trends will continue.

About Kaufman Hall

For more than 30 years, Kaufman Hall has been providing organizations in Healthcare, Higher Education, and Financial Institutions with independent, objective insight and financially-centered software tools that support decision making and enable the development and execution of sustainable strategies and goals.

Kaufman Hall currently provides consulting services and software to 80 of the 100 largest health systems in the United States.

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