RESCUING HOSPITALS BY RESUMING CARE FOR ALL PATIENTS

By Sanjay B. Saxena, MD; Brett Spencer, MD; Natasha Taylor; and Colleen Desmond

As the US seeks to progressively reopen the economies of cities and states, hospitals and health systems face a unique challenge: even as they continue to treat COVID-19 patients, they must resume caring for patients with unrelated health problems. They must return to providing the full portfolio of patient care services in order to preserve their own financial health, while at the same time maintaining their critical role in winning the fight against COVID and meeting the health care needs of their communities.

Before the COVID crisis, 20% of hospitals and health systems faced material financial risk. Today, our estimates suggest that almost two-thirds of all hospitals and health systems are in that same precarious situation. The US health care system, particularly in already underserved areas, will be immeasurably harmed if facilities and medical practices curtail operations significantly or go out of business altogether.

The compounding effect of delaying a full reopening cannot be overstated. By the second week of April, 66% of US consumers had postponed primary care appointments and 58% had postponed routine therapies at the hospital, according to a BCG survey. Beyond the economic implications, further delays in critical care—including elective procedures, preventive and maintenance care for chronic conditions, and important diagnostics and screenings—will have profoundly detrimental impacts on health outcomes.

Health Care Economics Take a Turn for the Worse

The COVID-19 pandemic is a paradox for hospitals and health systems. It creates increased demand, strains resources (in both preparing for a surge and responding to one), and raises operating costs. But unlike other industries (such as consumer staples) that are benefiting from surging crisis-related demand, health care providers face significant financial distress because of the crisis.

To understand the impact, consider the ba-

sic elements of conventional provider economics. Commercial health insurance cross-subsidizes less well-reimbursed Medicare and Medicaid patients, and higher-margin outpatient and elective procedures offset lower-margin inpatient services. At the same time, institutions have high fixed costs for infrastructure and labor and rely on investment income to offset weak performance in down-years. Almost universally, overall margins are low—indeed, approximately 50% of health systems have negative operating margins.

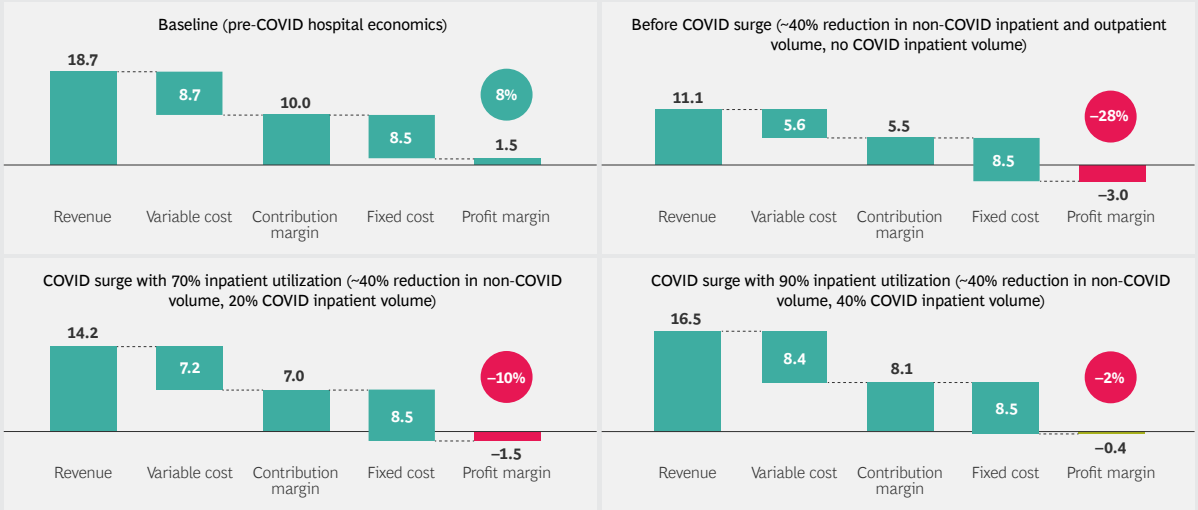
The COVID pandemic has undermined the positive aspects of this model and worsened the negative ones. Since early March, the crisis has created a demand cliff, as nearly all commercial, higher-margin volume has disappeared. For four to six weeks and counting, health systems have deferred urgent, semielective, and elective procedures. But many have not had a corresponding increase in COVID patients to partially offset this loss. Even in early COVID hotspots, such as Washington and Northern California, there is significant unused hospital bed, ICU, and clinical capacity.

In recent weeks, the situation has gone from bad to worse. A number of leading health systems have reported record losses, announced significant furloughs, and curtailed most capital expenditures for the remainder of this year and 2021. And our revised estimates indicate that the picture has further deteriorated from our earlier bleak estimates. Even on a contribution margin basis (which controls for the high-fixed-cost base of hospitals and health systems), the economic impact of COVID is extremely challenging. Our estimates suggest that treating COVID patients (including additional staffing and PPE) pushes hospitals' variable costs higher by as much as 10%. Indeed, regardless of whether a health system experiences a significant COVID surge, a mild surge, or no surge at all, it faces an enormous financial downside. (See Exhibit 1.)

Independent physician practices are likewise facing dire economic consequences, many having stopped nearly all work without any offsetting COVID surge. Some practices (such as primary care and behavioral health) have been able to convert a portion of their business to digital or virtual care.

EXHIBIT 1 | COVID Has Put Severe Pressure on Margins

Weekly impact for a representative $1 billion US health system ($millions)



Sources: American Hospital Association; Ambulatory Surgery Centers Association; BCG COVID PLAN model; BCG analysis.
Note: This analysis is as of April 15, 2020, and represents only potential scenarios based on discrete data from one point in time. It is not intended as a prediction or forecast.

Although this has allowed them to maintain continuity with patients—which is important for restoring business after the crisis—the economic loss is devastating and is accelerating the decline of physician practices.

The Road to Recovery

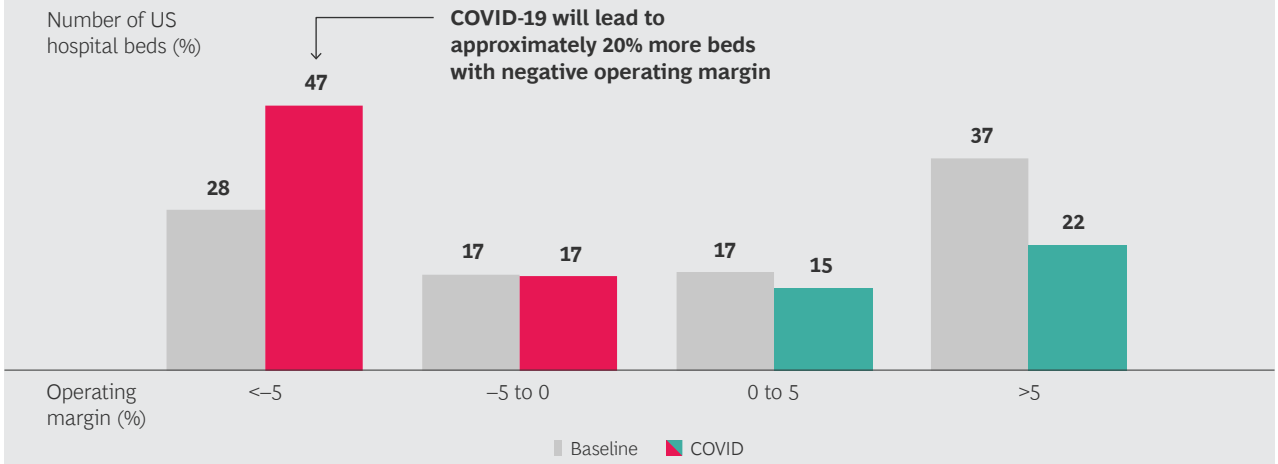
Plans to reopen parts of the US and restart the economy have largely focused on where the COVID curve has flattened and cases have presumably peaked. Public health and government officials have also highlighted the importance of ensuring hospital bed, ICU, and PPE capacity as key criteria for reopening. Others have set out benchmarks, such as a 14-day decline in COVID cases, that must be met before normal hospital operations can resume.

Our financial analysis suggests that hospitals and health systems do not have the luxury of waiting much longer before their future sustainability is threatened. The COVID crisis has reduced system-wide operating margin by approximately 5% and made an additional 20% of US hospital beds unprofitable. (See Exhibit 2.) More important, providers need to return to caring for *all* patients, many of whom cannot afford to continue deferring critical treatments and procedures. How organizations resume operations will largely depend on the COVID-specific situation in their communities.

Situation 1. The peak has passed, and no major constraints exist. Hospitals and health systems in this situation should focus on a safe and expedited rebound. This means solidifying the physician network (the referral base for elective procedures), maintaining a strong connection with consumers (quickly converting virtual cases to physical cases), offering extended operating hours to accommodate pent-up volume, and restoring consumer confidence. Stronger systems should also pressure test their existing strategic plan, explore potential M&A and partnership opportunities that may have emerged, and accelerate critical investment priorities (such as digital and telehealth solutions).

Situation 2. The peak has passed, but constraints remain. In some regions, government leaders are taking a cautious stance toward reopening their economies as they seek to avoid a second COVID surge. Here health systems will need to find creative ways to restore their pre-COVID

EXHIBIT 2 | The COVID Crisis Makes an Additional 20% of US Hospital Beds Unprofitable



Sources: American Hospital Association; BCG analysis.
Note: Based on sample of approximately 670,000 US hospital beds. Assumes 40% revenue loss during a three-month COVID crisis and 50% variable cost. This analysis is as of April 15, 2020, and represents only potential scenarios based on discrete data from one point in time. It is not intended as a prediction or forecast.

demand and financial health. In addition to pursuing many of the measures appropriate to situation 1, health systems should consider maintaining COVID-only locations, developing concrete frameworks for prioritizing across their portfolio and within distinct service lines, and developing regional capacity solutions to share the risk with other providers. They should also be prepared to screen and test large numbers of people when potential surges are detected (such as during flu season).

Situation 3. The peak is pending. Some regions, particularly in rural areas, may not have seen a peak in COVID cases yet. Hospitals and health systems in these areas can still take steps to resume relatively normal services. These may include accelerating the recent shift of patient volume out of the inpatient setting wherever possible, designating COVID and non-COVID treatment locations, maximizing telehealth and virtual care for continuity with patients, relocating simple diagnostics to maintain the referral pool, prioritizing service lines (on the basis of acuity, margin, or brand) if testing capacity is limited, and investing in PPE.

Transform Operations and Cost Structure

Rapidly restoring non-COVID volume in the coming weeks—particularly for outpatient, elective, and high-margin procedures—is absolutely paramount, but hospitals and health systems will need to radically transform their operations and find ways to survive with less.

With unemployment reaching levels not seen since the Great Depression and unlikely to return to normal in the near term, providers will experience significant shifts from commercially insured volume to Medicaid, subsidized health insurance exchanges, and uninsured patients. Moreover, patients who retain their employer-sponsored insurance could have higher deductibles and copays, along with more limited network options, as employers look to rein in their premium costs during the upcoming annual open-enrollment period in the fall—potentially resulting in decreased demand for providers.

The magnitude of the impact will vary depending on an individual system's starting cost position and geographic exposure. However, all organizations will need to reduce their cost base significantly in order to break even at Medicare reimbursement levels (or even lower, depending on the extent of unemployment in their markets). They will no longer be able to rely on the traditional playbook of using higher commercial reimbursements to offset shortfalls incurred from treating Medicare, Medicaid, and uninsured patients.

In addition, like other businesses, health systems will need to adjust staff activities and reconfigure their administrative and nonclinical spaces (from registration desks to patient waiting rooms to hospital cafeterias) to ensure patient and employee safety. They will need to optimize clinical operations and supply chains to allow for greater flexibility and capacity in case of localized spikes in COVID cases. Across the board, clinical and nonclinical staffing levels will need to be adjusted to reflect reduced productivity and lower operating efficiencies. The net result will be significant additional ongoing costs that health systems will have difficulty offsetting.

To address these issues effectively, organizations will need to increase cooperation across the health care infrastructure—including more capacity sharing and greater collaboration on ways to triage and balance spikes in COVID volume. However, the current ecosystem is not currently set up for this type of cooperation.

Capabilities for Thriving in the New Environment

Regardless of situation, hospitals and health systems will need to make meaningful, if not radical, changes to their capabilities in order to thrive as the COVID crisis persists and we eventually transition to the postcrisis world. In the new environment, scale will be especially critical to enabling separate services for COVID and non-

COVID patients. Having a large physician network may also confer an advantage. Side projects, such as developing provider-sponsored plans, may need to be put on hold. Given the need for belt-tightening, leaner SG&A costs will be essential. Hospitals and health systems should also identify ways to differentiate themselves for competitive advantage, such as through superior digital and virtual care.

EVEN MORE ACUTELY than businesses in other sectors, hospitals and health systems face long-term financial pressure, including the loss of critical revenue streams and changes in the revenue mix. They must reimagine how they conduct business in order operate under new constraints, rebuild consumer confidence, treat patients when they need care, and, ultimately, maintain the health of the communities they serve. Unfortunately, they do not have the luxury of time as they plan for the new normal. Every day and week that passes means more financial instability and additional delays in the delivery of critical care to non-COVID patients in need. To prevent devastating consequences for the health of our society, hospitals and health systems must act at lightning speed to restore their own well-being.

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