

VIEWPOINT

COVID-19: BEYOND TOMORROW

COVID-19 and the Financial Health of US Hospitals

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Supplemental content

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The rapid growth in the number of patients with coronavirus disease 2019 (COVID-19) threatened to overwhelm hospital and intensive care unit capacity.¹ The pandemic also raises questions about the ability of hospitals to remain financially solvent amid unprecedented changes in care delivery and billable services. To limit the spread of disease and create additional inpatient capacity and staffing, many hospitals are closing outpatient departments and postponing or canceling elective visits and procedures. These changes, while needed to respond to the COVID-19 pandemic, potentially threaten the financial viability of hospitals, especially those with preexisting financial challenges and those heavily reliant on revenue from outpatient and elective services.

A 2014 report from the Agency for Healthcare Research and Quality suggested that elective admissions accounted for more than 30% of total inpatient hospital revenue.² Elective procedures, especially orthopedic and cardiac surgical procedures, are among the most profitable services for hospitals.³ By one estimate, hospitals earn \$700 more for elective admissions than for admissions through the emergency department.⁴ Furthermore, for many hospitals, outpatient revenue now equals inpatient revenue, elective or otherwise.⁵

Although reduced outpatient and elective revenue may be partially offset by higher hospital and intensive care unit occupancy during the COVID-19 pandemic, and by an increase in services after the pandemic ends, this may not mitigate losses (particularly given the need for surge personnel and resources) or be evenly distributed across hospitals. Hospitals in some regions will experience both greater revenue due to COVID-19 hospitalizations and greater costs related to additional staff and resources, whereas other hospitals will experience mostly lost revenue due to state or federal guidance to minimize nonessential services. Moreover, at baseline, some hospitals are much better positioned financially to contend with pandemic-related reductions in revenue. Many large hospital systems, for example, have had consistently positive operating margins in recent years, while many smaller and rural hospitals have experienced major financial challenges. A 2019 analysis found that 1 in 5 rural hospitals is at risk of closure because of financial difficulties.⁶

Recognizing this strain, Congress recently passed the Coronavirus Aid, Relief, and Economic Security (CARES) Act⁷ and the Paycheck Protection Program and Health Care Enhancement Act,⁸ which together provide \$175 billion in emergency funding for hospitals and other health care organizations. On April 10, the Department of Health and Human Services began disbursing this funding to any health care facility or physician practice that received Medicare payments in 2019. It is not

yet clear, however, how the majority of the funds will be disbursed or whether the funds will be allocated to those most in need. Moreover, it remains uncertain if this level of funding will be sufficient or if additional funding will be required in subsequent legislation, which is likely if the pandemic continues for an extended period.

In this Viewpoint, we describe the financial health of US hospitals and how financial performance measures vary by hospital characteristics. Data from 4 measures of financial liquidity and 2 measures of sources of revenue for short-term, general, nonfederal hospitals in the US are presented. This information may be helpful to inform state and federal policy designed to support hospitals during the COVID-19 pandemic.

Many hospitals have limited liquid assets and may not be capable of absorbing large financial shocks while also mobilizing sufficient resources to respond to the pandemic (eTable 1 in the Supplement). Based on data from 2018, across US hospitals, the median operating margin (defined as the difference between revenue and operating expenses, divided by revenue) was 2.0% and median asset-to-liability ratio (a measure of a hospital's ability to pay its short-term debt obligations) was 2.1 (a ratio greater than 1 indicates that a hospital has the assets needed to cover its liabilities). The median hospital had 53.4 days cash on hand (defined as the number of days a hospital can continue to pay its operating expenses) and 49.2 days in net accounts receivable (defined as how long payment is outstanding before it is collected). Many hospitals were in a considerably worse financial position: those in the 25th percentile, for example, had -4.4% operating margins and only 7.6 days cash on hand. Some hospitals do have substantial endowments, particularly teaching hospitals associated with major academic medical centers, but most do not and many of those funds are restricted.

These data also indicate that hospitals varied substantially in the extent to which they rely on surgical revenue (both essential and elective procedures) and on outpatient revenue, which may affect their financial stability during COVID-19-related restrictions on hospital services. In 2018, hospitals in the 25th percentile received 49.9% of their revenue from outpatient services, and those in the 75th percentile received 76.9%. Similarly, hospitals in the 25th percentile of surgical volume performed 19.7 surgical procedures per 100 hospital discharges, and those in the 75th percentile performed 55.8 procedures per 100 discharges. These differences suggest that some hospitals will sustain much larger losses due to recommended or mandated cessation of outpatient and surgical services.

Financial performance and sources of revenue also varied by hospital characteristics, which may inform

decisions about where extra resources should be targeted to support hospitals during the COVID-19 pandemic (eTable 2 in the Supplement). A composite measure of financial performance was created to reflect the mean of the standardized 4 measures of financial liquidity described above and a composite measure of revenue source to reflect the mean of the standardized outpatient revenue and surgical volume measures described above. Based on 2018 data, hospitals with lower financial liquidity (higher financial vulnerability) were more likely to be small, rural, have lower occupancy rates, and have critical access status. By contrast, those with high liquidity were more likely to be nonprofit hospitals, teaching hospitals, and affiliated with health systems. Similarly, hospitals that received a higher share of revenue from outpatient services and had higher surgical volume (and were thus at highest risk for financial challenges due to COVID-19–related restrictions) were small, rural, and critical access hospitals; those less reliant included teaching hospitals, hospitals with high occupancy rates, and hospitals affiliated with health systems.

While payment reforms occurring over long periods allow hospitals to adapt by changing their underlying cost structure, the rapid evolution of the COVID-19 pandemic, characterized by sharp reductions in elective and outpatient revenue, has created unprecedented financial challenges for hospitals. Threats to hospitals' financial stability may lead to a number of negative health and economic outcomes. Financially insecure hospitals may be less capable of investing in COVID-19 response efforts, and differential financial strain may worsen differences in outcomes for patients treated at resource-poor hospitals. In addition, financial challenges may make it difficult for hospitals to maintain appropriate staffing levels at a time when more hospital capacity is needed. Many hospitals have already been forced to place workers on leave.⁹

The CARES Act includes several provisions that support hospitals identified as vulnerable in this analysis. For example, the legislation increases Medicare payment rates for COVID-19–related

admissions by 20% and delays reductions in disproportionate share payments, which support hospitals caring for large numbers of Medicaid beneficiaries and uninsured patients. Further, at least \$10 billion of the \$175 billion emergency fund will target hospitals in areas most affected by COVID-19, and another \$10 billion will go to rural health clinics and hospitals. The initial \$50 billion disbursed under the CARES Act, however, was allocated to hospitals, physician practices, and other health care facilities in proportion to their 2018 net patient revenue from all payers, an approach that is unlikely to ensure the most vulnerable hospitals receive adequate support because this does not reflect the variable nature of COVID-19–related utilization.

Going forward, targeted financial support for hospitals could take several forms and should change over time to support surge vs ongoing operations as the pandemic evolves. First, lump-sum payments should be provided to help hospitals prepare and respond to the surge in COVID-19 cases in the areas most affected. Second, funds should be disbursed to offset hospitals' approximate losses due to reduced elective and outpatient revenue, after accounting for their ability to recoup losses in the future when normal operations resume. Third, state governments should use funding separately allocated by the CARES Act to further support individual hospitals, based on local assessments of the negative financial consequences of COVID-19. Because many hospitals are already struggling financially, the Department of Health and Human Services should disburse funds quickly and on a rolling basis as needs arise.

The COVID-19 pandemic represents an unprecedented medical and economic challenge for the US health care system. In the absence of robust and sustained governmental support, almost all hospitals will experience financial difficulties. But hospitals that are smaller, independent, rural, and have critical access status are particularly at risk. Policymakers should provide dedicated support to these hospitals to access CARES Act funds and consider allocating additional funding to them during the COVID-19 pandemic.

ARTICLE INFORMATION

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