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Healthcare

Impact of COVID-19 on Medical Groups: Key Strategies on the Road to Recovery

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COVID-19 continues to have a devasting impact on the overall healthcare ecosystem. While the stories of personal protective equipment (PPE) shortages and the need for additional hospital capacity in pandemic hot spots are widespread, there is another side of the impact that has been less publicized.

Seemingly overnight, health systems and physician groups have experienced drastic volume decreases caused by state-mandated stay-at-home orders, mandatory cancellations of all elective procedures, and patients canceling or delaying nonurgent visits and procedures to avoid potential exposure to COVID-19. In response, healthcare organizations are making swift and often painful decisions to aggressively manage expenses, including furloughing clinical (mostly ambulatory, outpatient, and procedural) and nonclinical staff, reducing executive pay, and stopping retirement contributions or bonuses.

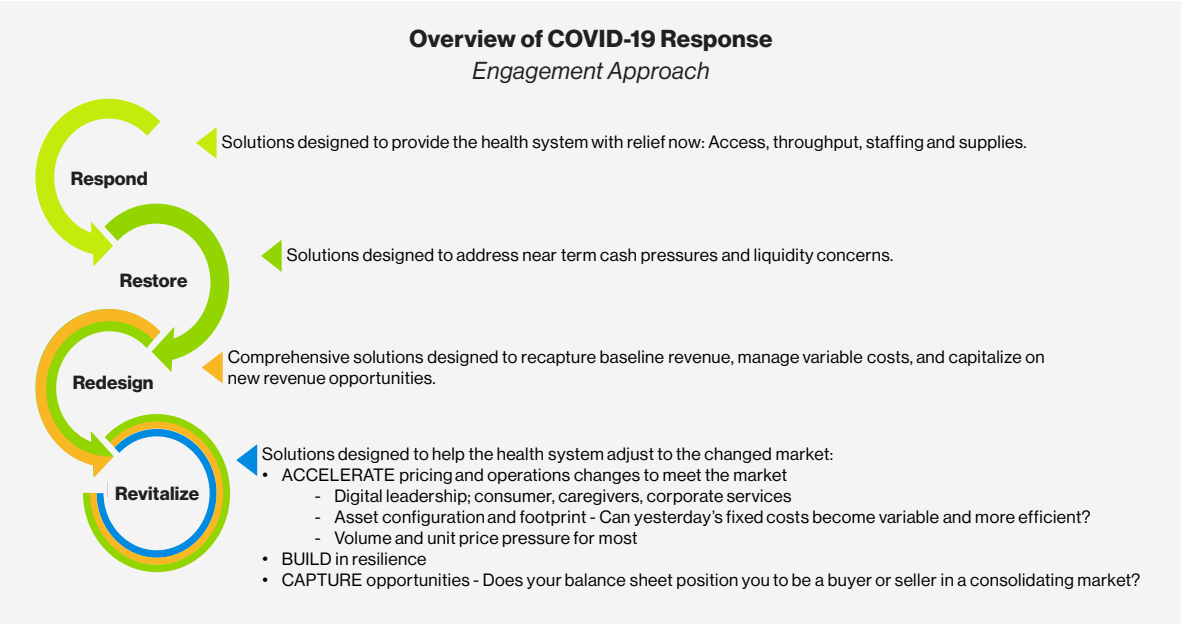
According to a Medical Group Management Association survey, medical groups have experienced a reduction of 55% of revenue and 60% of patient volume since the beginning of the COVID-19 crisis.[1] Similar to the range of geographical impacts of COVID-19, Guidehouse's experience is that medical groups are seeing a range of impacts to their volume and business based on specialties:

- Primary care: 30% to 50% reduction of volume; some organizations have been able to mitigate this with effective deployment of telehealth and video visits.
- Medical specialties (cardiology, neurology, rheumatology): 40% to 60% reduction of volume.
- Surgical/Procedural specialties: 60% to 80%-plus reduction of volume/ procedures.
- Hospital-based specialties: varies based on location; specialties tied to proceduralists listed above have seen similar decreases (e.g., anesthesia); Emergency departments have seen 30%-50% reductions; hospitalists/intensivists have seen similar decreases in most non-"hot spot" markets as hospitals have reduced volumes to prepare for potential COVID-19 patient surges.

As independent or health system-owned medical groups prepare to respond to the current crisis and the ongoing challenges that will be present over the coming months, we recommend that they consider organizing their actions into the following four "R" phases:

- **Respond:** immediate actions that an organization needs to take to remain solvent during the initial months of the pandemic
- **Restore:** address near-term cash pressures by accessing advances and grants
- **Redesign:** ramp up practices and take appropriate steps to deal with potential surge of pent-up demand
- **Revitalize:** implementing changes to adjust to the "new normal," adjusting the cost structure to deliver services that patients require at a lower expense point

1. Medical Group Management Association, "COVID-19 FINANCIAL IMPACT ON MEDICAL PRACTICES," April 2020, https://www.mgma.com/getattachment/9b8be0c2-0744-41bf-864f-04007d6adbd2/2004-G09621D-COVID-Financial-Impact-One-Pager-8-5x11-MW-2.pdf.aspx?lang=en-US&ext=.pdf.



Respond

Before an organization can begin to plan what actions to take, they first must understand the initial impact that COVID-19 may have on their organization; for example, are they in a "hot spot" and expecting a surge, or are they addressing volume decreases due to stay-at-home orders and cancellation of elective cases? Furthermore, many organizations need to make immediate decisions to reduce expenses.

Identify best- and worst-case financial scenarios

In order to begin to understand the potential financial impacts of COVID-19, medical groups will need to evaluate multiple scenarios to calculate the range of impact from best to worst. Unfortunately, this is new territory and there is no playbook or history lesson that can predict how long volumes may be impacted or what consumer behaviors will be in the new normal. Questions to consider include:

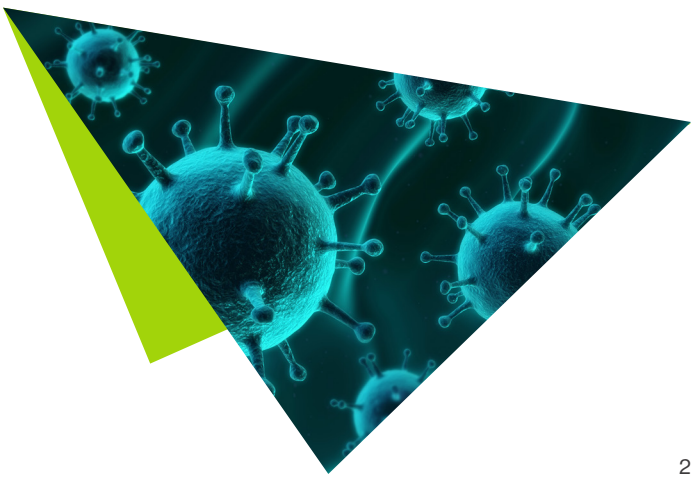
- How much have volumes dropped already and how long will they remain at that level?
- What will happen with volumes when stay-at-home orders are lifted (surge from pent-up demand, gradual return to historical volumes, or gradual return to lower-than-historical volumes)?
- How much business will be delivered virtually and how will that change over the coming months?
- How many months will it take for volumes to return to pre-COVID-19 levels? Will they ever return to pre-COVID-19 levels?
- What happens if there is another spike in local cases when stay-at-home orders are lifted?
- What impact will the economy and unemployment have on volumes (reduction of elective care, payer mix shifts, higher bad debt, higher volume in the ED, etc.)?
- What changes can be implemented to reduce costs in the short and long term?
- How much of a loss can we afford to carry, and for how long?

As mentioned in the introduction, where a group is located at and its specialty mix will impact the answers to these questions. We are seeing many of our clients model volume and revenue impacts into late 2020, even 2021. Once an organization has a grounding in the best- and worst-case scenarios, it can then start to identify incremental actions that can be taken to further reduce expenses.

Adjust capacity and labor expenses to deal with short-term reduction in demand

Health systems and large medical groups nationwide are consolidating practices, furloughing employees, closing ambulatory surgery centers, and taking other steps to immediately reduce labor expenses and to more appropriately match staffing to current volume levels. In addition, the reduction of face-to-face visits and consolidation of staff (often separating nonpatient-facing staff in "closed practices" and keeping only clinical staff in "open practices") are steps organizations can take to minimize the risk of community transmission.

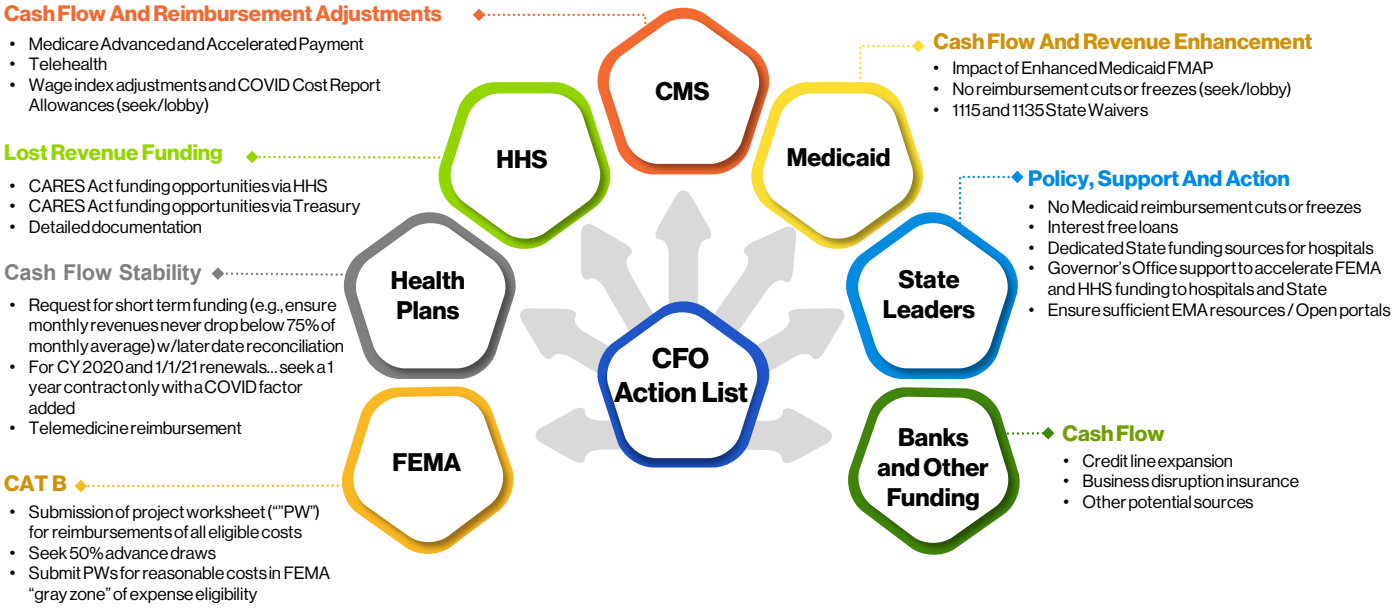
Furthermore, some organizations are establishing respiratory clinics and funneling all potential COVID-19 patients to centralized locations while caring for non-COVID patients in other locations. While organizations have implemented multiple solutions, they continue to act quickly to reduce these expenses.



Restore

In this phase, organizations need to take action to access funding to offset some of the financial impact of the pandemic. Further changes to reduce expenses continue to occur during this phase.

Strategies to Manage Financials
Across Various Sources and Entities



Apply for available funding opportunities to recoup expenses and stabilize cash flow

Since the pandemic was declared a national emergency on March 17, several funding opportunities have been made available to health systems to cover expenses related to COVID-19 and to stabilize cash flow. Many of these opportunities are also available to employed and independent physician groups.

For groups that are employed and are wholly owned under a health system's tax identification number, most of these opportunities will flow through the health system's finances. For independent nonprofit groups, eligible expenses incurred "but for COVID-19" can be reimbursed through Federal Emergency Management Agency (FEMA) Public Assistance Category B funding.[2] These dollars are made available by FEMA and administered through an application process at the state level. Reimbursement is available to cover at least 75% of eligible expenses incurred. This program is not available to for-profit groups.

In addition, all medical groups that have billed Medicare in the previous 180 days can request an advance payment of up to 100% of three months of historical Medicare payments through the Centers for Medicare & Medicaid Services Accelerated and Advanced Payment Program.[3] This funding is not a grant and currently requires payback beginning 120 days after dollars are received. As part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, independent medical groups are eligible for a portion of the allocated $50 billion based upon a combination of 2019 Medicare fee-for-service revenue and 2018 net patient revenue. Finally, independent medical groups can apply for several loan programs, including the Paycheck Protection Program and Economic Injury Disaster Loans. Both programs are administered through the Small Business Administration and have varied repayment considerations.

Evaluate benefit changes to improve short-term cash flow position

When a temporary reduction of workforce is not enough, organizations are also looking at benefit reductions as a next step. This is often done to avoid reductions to provider base compensation; however, some groups have been unable to avoid this impact and have already implemented reductions to provider compensation. Benefit reductions that groups are taking include:

- Suspending any employer matches on 401(k) or 403(b) plans, employer-funded defined contribution/benefit plans (e.g., 401(a)), or other employer-funded non-qualified plans.
- Delaying or eliminating any other pension/retirement contributions.
- Eliminating any CME/travel.
- Temporarily eliminating any provider paid time off benefit.
- Forgoing quarterly/annual bonuses or other performance-based payouts.

2. FEMA, "Coronavirus (COVID-19) Pandemic: Eligible Emergency Protective Measures," March 19, 2020, https://www.fema.gov/news-release/2020/03/19/coronavirus-covid-19-pandemic-eligible-emergency-protective-measures.
3. Centers for Medicare & Medicaid Services, "FACT SHEET: EXPANSION OF THE ACCELERATED AND ADVANCE PAYMENTS PROGRAM FOR PROVIDERS AND SUPPLIERS DURING COVID-19 EMERGENCY," April 2020, https://www.cms.gov/files/document/accelerated-and-advanced-payments-fact-sheet.pdf.

Redesign

As an organization begins to see stay-at-home orders lifted and volumes increase, medical groups need to quickly adapt and respond to consumer demands for access. Further evaluation of expenses, including areas such as provider compensation and the long-term impacts of COVID-19, should be evaluated.

Monitor volumes and scheduling demand daily

The transition to the new normal will not take place uniformly across the country, and consumers in diverse markets and age demographics are likely to respond differently. Thus, it is important for each medical group to track their demand/volume daily. As volumes begin to return to normal there will be a significant opportunity for medical groups to capture market share if they are able to offer access when their competitors are not. However, this may require medical groups to consider offering access in ways they have never done previously.

After a few (or perhaps more) months putting off physician visits, consumers will be looking for immediate access to care, which can "clog" the system. Practices should carefully manage schedules, office hours, and new and established appointment lag times, and quickly act to see as many patients as possible. Actions that may be required to take place are extended evening hours and weekend hours, as well as expanded telehealth visits. Of course, these changes in demand may not impact one multispecialty group uniformly. For this reason, we suggest that groups develop a command center-type approach to evaluate demand and manage resources and capacity at the specialty/practice level.

Hospitals are doing exactly this to prepare for the potential surge in inpatient volume. This work should expand to the ambulatory environment and these same tools and data should be utilized to predict when practices should reopen and the cadence at which they should open. By carefully monitoring visit demand and volume, an organization can effectively make the decision when it is appropriate to reopen practice locations.

Strategies for Medical Groups to Ensure Organized Practice Reopenings

- Incorporate at least a two-week lead time to make sure schedules can be filled as much as possible and it's fiscally appropriate to reopen a location.
- Allow scheduling staff to start two-weeks prior to the practice reopening to begin to get patients on the schedule and ensure financial clearance on all patients prior to arrival.
- Have all staff on-location a week prior to ensure rooms are cleaned and stocked and to review any new COVID-19-related workflows for the practice.

This planning will also allow organizations to monitor estimated volumes and adapt operating hours if required to deal with higher- or lower-than-normal patient volumes. Once open, access should be carefully tracked, and swift action taken to proactively add additional capacity at locations or provide alternative sites for consumers to receive care. Regardless of the reopening strategy, proactive communication across the practice and panels can help inform consumers of their options (extended hours, access to virtual care, etc.) and set appropriate expectations.

Evaluate and implement short-term (next quarter) and longer-term (year) provider compensation changes that are required

Based on recent experience with large multispecialty groups, we've found that 50% to 60% of all medical group expenses are for provider compensation and benefits. It will be extremely challenging to remain financially sustainable and address the significant revenue and volume decreases without adjusting provider compensation. After an organization takes some of the necessary actions around benefits described above, they should focus on provider compensation.

Some organizations (mostly hospital-owned groups) have been looking to keep providers "whole" during this time, or guaranteeing their existing salaries. Other groups are beginning to implement reductions of 10% to 30% or more, and others may elect to do nothing and allow the reduced wRVUs to result in lower compensation. Since numerous compensation models exist, it is important to understand how the volume changes will impact compensation in your model and if your group needs to make any changes — either to further support your providers who are on compensation per wRVU models and experienced significant reductions in volume or to adjust compensation downward.

If an organization is looking to guarantee current compensation levels, we recommend avoiding "socializing the downside and privatizing the upside." This ensures that when volume ramps back up, the physician doesn't immediately benefit from any surge volume that may be over the baseline. One way to think about holding the physician compensation consistent through the initial reduction of volume is that an organization is paying an advance to the physician and future wRVUs need to be paid back prior to the physician benefiting from any production incentives.

Other recommendations that groups should consider when making changes to compensation models are:

- Adjust compensation based on new shift requirements/demands (primarily for shift-based providers).
- Consider the impact to specialty when making groupwide reductions (adjustments may be made at the specialty level incorporating volume impacts from COVID-19).
- Avoid making multiple "reductions" or compensation adjustments (better to make one large conservative adjustment than several small "tweaks").
- Use COVID-19 as a catalyst to change your compensation model.

Medical group executives understand there are very few issues that are more political or important for the group culture than provider compensation. It is important for organizations to balance both the legal requirements of current contracts and remaining financially viable, effectively "threading the needle" of affordability and market-competitive compensation. Groups must also ensure that these changes do not polarize or isolate providers, which can increase provider turnover, and that they continue to allow the organization to be market-competitive while helping the group grow once the major impacts of the pandemic are behind us.

Revitalize

With the initial response over, medical groups need to focus on further expansion of virtual care to better compete in the post-COVID-19 marketplace. Consumer engagement strategies and sound revenue cycle processes will be key to maximizing performance through this phase.

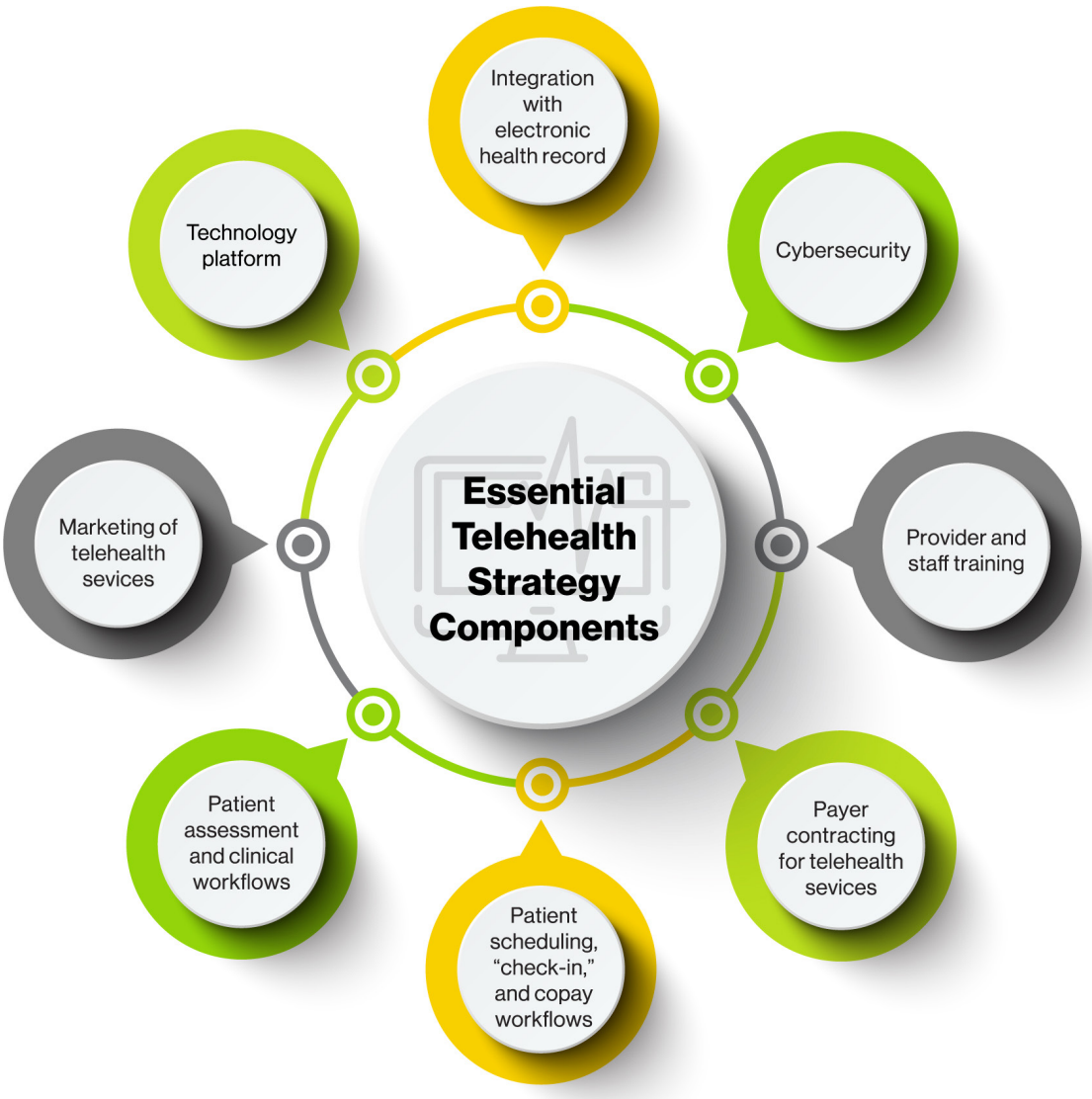
Build out telehealth capabilities to expand access options

One positive outcome of COVID-19 has been the acceleration of acceptance for telehealth services. In light of the outbreak, government and commercial payers are now covering telehealth services that were not previously covered. Similarly, consumers may now be more willing to engage in a video/telehealth visit than previously. During the pandemic, the increased uptake of virtual care has been driven by a lack of conventional access, not just concerns over contracting a potentially deadly disease. Whether this consumer behavior continues after the pandemic will be dependent upon the value proposition that the practice presents.

It stands to reason that medical groups that had a telehealth platform and could quickly scale it have fared better than providers without such a platform during the initial weeks of the crisis. Furthermore, some organizations are seeing it as a strategic imperative and even an opportunity to attract (and hopefully maintain) new market-share after COVID-19. Any ability to increase market share during this time will only accelerate an organization's return to pre-COVID-19 financial levels.

With the acceptance of telehealth increasing and new programs in development to fund telehealth investments, we believe that every medical group should look at how they can implement a telehealth program/strategy.

It is also important for medical groups to continue to monitor any future regulation changes by government and commercial payers to continue to ensure that these services will be reimbursed and are financially viable to offer. We believe that every medical group should look at how they can implement a telehealth program and strategy (see image below).



Monitor accounts receivable and other revenue cycle impacts closely

Now more than ever, it will be important that medical groups collect what they are owed. As volumes begin to return to normal, we recommend each organization revisit policies and procedures related to financial clearance, payment plans, time-of-service collections, and even consider offering additional training to front office staff about how to collect prior balances or time-of-service payments while maintaining compassion and empathy.

Economists are estimating that upward of 30 million individuals may lose their job as a result of COVID-19. This will lead to a drastic increase in uninsured patients and medical groups should ensure that they are actively verifying insurance prior to all visits and offering financial counseling for patients who are in challenging financial circumstances. Monitoring financial clearance rates and insurance eligibility is a leading revenue cycle indicator that reduces denials and important days in accounts receivable while waiting to hear from a payer that the patient no longer has coverage through them. It is necessary for an organization to ensure their front office staff have the tools, training, and policies to support how the medical group is going to serve patients who may find themselves newly uninsured.

Medical Group Assessment — Patient Self-Pay Approach

Following are questions that can indicate process and policy updates that may be required as medical groups begin to address rising uninsured rates and increasing patient balances.

- What is our self-pay discount and how does it compare to what we collect from third-party payers?
- Do or should we offer a prompt-pay discount?
- Do we have a charity care policy and how is a patient eligible?
- What elective services do we offer and how do we communicate patient responsibility for payment for those services?
- Do we accept new patients without insurance and, if so, what is the policy?
- What is our process to schedule/collect from existing patients who are now uninsured and need follow-up care?
- What payment plan options do we offer patients?
- Do we partner with a credit card company for our patients to finance the care they receive from us?

4. Eric Morath, Harriet Torry, and Gwynn Guilford, "A Second Round of Coronavirus Layoffs Has Begun. Few Are Safe," The Wall Street Journal, April 14, 2020, https://www.wsj.com/articles/a-second-round-of-coronavirus-layoffs-has-begun-no-one-is-safe-11586872387.

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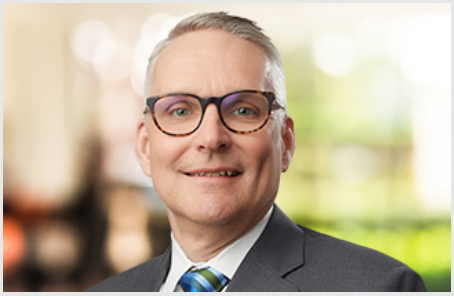

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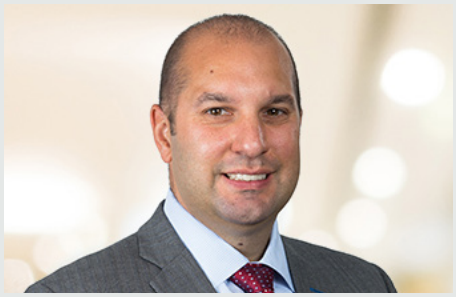

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