Chip Kahn (00:12):

Hello, and welcome to another episode of Hospitals In Focus. I'm your host Chip Kahn. COVID-19 is a human tragedy that has spawned a healthcare and economic crisis in the United States and across the world. In recent episodes, we have examined the impact of COVID on health care delivery. Today, we will focus on the economic implications of COVID for hospitals and health systems. We will look at the financial problems COVID has caused, the mitigation undertaken by the Congress and the administration and the implications of both the problems and this mitigation for the future of patient care in hospitals and health systems. But before we get started with our conversation, I want to ask you to take a minute to rate, review, and subscribe to Hospitals In Focus. Rating us five stars will help us to keep creating content, which I hope you find informative and worth your time.

COVID has imposed an unprecedented triple whammy on hospital care [inaudible 00:01:16] a significant toll that has immediate and possible longterm implications for hospitals and health systems and the patients and communities that we serve. First, throughout the nation under instructions from governors and local officials, hospitals basically shut down for all, but the most essential services. They had to stop most non-emergency scheduled procedures like cancer treatments, placement of cardiac stents and joint replacements.

Second was mandated preparations for the pandemic. It meant hospitals had to gear up for a surge of COVID-19 patients, including buying PPE often at outrageous cost and building out alternative ICU and additional patient care areas, which has had implications for staffing also.

And third, are those communities that have the experience of actually being a COVID hotspot. Hospitals in these areas are dealing with very sick patients, straining resources, stressing staff and frankly, having long and difficult patients stays, often ending in death.

All of this has had staggering financial effects on hospitals and health systems. The very survival of healthcare services as we've known them is now a potential question in many communities. Our guest today is particularly well suited to comment on the present and future state of healthcare financing and delivery. J.B. Silvers is a renowned healthcare financial expert who recently wrote an important op-ed that appeared in MarketWatch. In the piece he compared the current state of hospitals with that of banks during the 2008 financial crisis. Long story short, J.B. sees parallels for today's hospitals and health systems due to COVID with what occurred to the banking industry more than a decade ago. We will discuss this and his thoughts of what is necessary going forward. I am pleased to have J.B. with us today. How are you doing J.B.?

J.B. Silvers (03:23):

Great. Thanks for inviting me Chip.

Chip Kahn (03:26):

J.B. you currently hold several distinctive teaching positions and you also have extensive experience with health systems and managed care. Can you talk a bit about your career, where you are focused now and why you are uniquely positioned to understand the current and quite unique forces impacting health care and facility financing?

J.B. Silvers (03:47):

Well, I started as an engineer and then a professor of finance, but I was grabbed by the issues in healthcare while I was on the Harvard Business School faculty many, many years ago. So for most of the rest of my time, largely here at Case Western Reserve, I studied and taught a lot about healthcare

finance payment and policy issues. But along the way, I've wandered around the health system in a variety of ways, serving on the what's now MedPAC. It was ProPAC called then, ran a health insurance company for a while, 12 years in the Joint Commission Board and now vice chair of a hospital, [inaudible 00:04:27] medical center safety net, as well as doing research and such. Most of the time I've been concerned about financial risk in healthcare, how we measure it, how we manage it, how we absorb it and then how we react to these kinds of choices that we have.

Chip Kahn (04:44):

J.B. in your op ed that I cited, you made the comparison between the banks during the 2008 financial crisis and hospitals and health systems today facing the pandemic. Will you explore that comparison and discuss the implications?

J.B. Silvers (05:00):

Well, it's interesting on both cause and the effect. In 2008, the problem there came from a mistaken assumption about how diversification and risk work. How could all those mortgages go bad at the same time and threaten the whole system? We never built that into our models. So when it happened, it was a big issue. In 2020, we didn't really anticipate the threat of a virus that would get everyone seriously ill at the same time, with much of the same threat to this vital part of our society. So action to save the financial system in 2008 was really critical and had to be done, or the system would have gone down and society would have suffered. And I think there's a parallel and there's a need for action to save the healthcare system now in a similar way.

Chip Kahn (05:48):

Your op ed focused on hospital liquidity, the effects of massive revenue loss from hospitals and health systems, basically shutting down vast lines of service, all while meeting at the, at least the second point I made and sometimes all three levels of this triple whammy I talked about in my introduction. Will you describe what this has meant for institutions which pre-COVID were full of patients, and also those in rural America or elsewhere who were already facing fiscal issues?

J.B. Silvers (06:24):

Well, as many of your listeners may know, most hospitals are lucky to break even on Medicare and Medicaid. It's the commercial payments that allow them to survive on relatively small margins. This is not a big margin business, but when elective and non-emergent cases are gone, which they just immediately disappeared once the government acted, this delicate balance is really upset. So without some external help, the losses are huge from an accounting point of view and the cash needs amount very quickly. The threat is both insolvency, that is you can't pay your bills right now and ultimate bankruptcy when you can't pay your debts. So it's a mounting issue that's very serious.

Chip Kahn (07:13):

The Federal Government has responded in a coordinated fashion by passing the CARES Act and the later bill, which created a $175 billion provider relief fund. And they've also offered advanced payments for Medicare through a program called the Medicare Accelerated Advanced Payment Program. Is this response sufficient to meet the immediate challenge? If it is only a start, where do we have to go next?

J.B. Silvers (07:45):

Well, it sounds good, but there are two problems with what the government's done. The first, the CARES Act program are grants, they're gifts, they're given to the system, but they're targeted at COVID related services. So these are things that you have to do to meet the immediate crisis, the payment for testing and such and backup capacity. But they don't offset enough of that loss business to make you whole. The accounting losses are going to be massive. There's just no question. American Hospital Association assumes about $50 billion losses every month. So the first is it's not enough to replace the revenue that you lost. So that that's the bankruptcy threat.

The solvency question was addressed to some extent by the Accelerated Advanced Payment, which is really borrowing against future Medicare revenue. So you're borrowing against future billings for Medicare services assuming they will show up again when this is over. But the problem is you have to pay it back. So effectively, we've postponed the crisis from a cash point of view for three months until the fall. So we're going to have major trouble when Medicare revenue comes back, but is immediately taken away to pay back these short term loans.

Chip Kahn (09:14):

Let's look beyond this immediate action and assume hopefully that most of this liquidity that's been provided is sufficient to keep hospitals and health systems afloat for the next few months. If we look back to the 2008 financial crisis, not all the financial institutions survived, there was a lot of restructuring. So once we get past this short term liquidity issue, what's next? What are the implications for institutional solvency, that's a little different from immediate liquidity? And from a public policy standpoint, what is the role of government, do you believe in terms of dealing with the possible restructuring that we might anticipate occurring?

J.B. Silvers (10:00):

Well, that's where it gets really interesting Chip. We had to do what we did right now to keep the hospitals afloat this summer, during the spring and summer because otherwise they would have just closed down. You just can't take away all the business and expect them to stay afloat. But when you violate long covenants and you can't make the payroll, then decision shifts to others, and that's largely what happened in 2008. 2008, it was largely the bank regulators and the Fed who rescued the system, they provided the financing, but they also restructured it. They rescued some, they merged others and they let some financial institutions close. So we have all sectors of the financial structure that aren't there anymore. And a whole bunch of others that are merging them with somebody else. So something similar might happen here for the marginal providers.

And that's where it's interesting to speculate what might happen. The issue is how to help those that are critical parts, the ones you really can't let fail, the too big to fail, or in this case too important to fail, while helping others to transition to some other status. We don't have anything, unfortunately like the Fed that would let that happen. For the financial structure, we had a large institution, large government agency who supervised it so that we could do it in an orderly fashion. In this case, we might just result in the old fashioned capitalism with big winners and big losers based on market forces. And that may be pretty chaotic. I think we've got some tough times ahead in sorting this all out.

Chip Kahn (11:47):

Let's just take a community. How do you see that sorting process taking place? Maybe we shouldn't have names, but if you could sort of describe one or two cities that you know, and maybe illustrate for us what the implications are of this. And I guess ... I don't want to get off on a separate tangent before you answer that. But one of the issues that we haven't, I think come to grips with, and we don't know is

what if we get back into a situation in the fall where we're again, emptying hospitals of conventional normal service to prepare for a second wave of COVID, and what does that all imply?

J.B. Silvers (12:32):

Well, that's the doomsday scenario, obviously, and it's a very real threat. In 2008, we managed to get rid of, or neutralized most of the underlying problem. We did the TARP program, we bought out mortgages, we made massive guarantees. We basically made the problem go away. You can't do that with a virus. There's nobody out there that's going to neutralize the virus unless, and until, we get us a vaccine. So the only real solution for this thing is to deal with that. But the problem is vaccines are, and the viruses have a nasty way of changing over time. And so it's pretty predictable this'll happen again. We're going to have another rogue virus out there that will affect us. So I think we need to think in the longer term, as well as short term. And that means we may restructure the system in multiple ways.

In the short term, I think that we've accelerated a lot of existing trends. We've had maybe 25% of the hospitals that are in weak financial position to begin with. And they might've hung on for a while and then ultimately closed. I've done that in my early part of my career here in Cleveland. I followed hospitals that closed. They closed because nobody went there anymore and we're going to have that happen a lot. People will not want to go to hospitals that are marginal where they think they might come out worse than they did when they went in. We're going to still have postponed surgeries and people avoiding it. So the question is where and how, and what kind of health care access do we need. And I think, much like this is a bit of a tangent, but I think it's important, much like tele-health has been accelerated probably 10 years by this last three month experience. And that was happening anyway. We were using the internet for everything. That's going to happen with the restructured system.

So some of those marginal hospitals that were out or on the edge are going to close. There's no question about that. And the question is, what do we replace them with? Distance medicine is going be a big chunk of that. Transition to being able to get the patients to the right place at the right time, we now sort of have gotten past the hump where I think we can think of some significantly large ways to do it. You ask about specifics, in Cleveland and the board of the hospital I'm on, MetroHealth, we're rebuilding the whole campus. And the interesting thing about that, it's a large academic medical center. We're going to have half the beds on the campus that we started with.

It's going to be building a new hospital to academic standards with all the healthcare and safety stuff you'd want, but with a much smaller footprint on the main campus, because people don't need to go to the main campus. They're going to have ambulatory care, now they're going to have distance care and it's going to be distributed. So I think that the nature of the system is going to change and we've just accelerated that pretty dramatically, I think in the last three months.

Chip Kahn (15:48):

Before we close out, J.B. I'd like to ask actually a drill down question and get your advice on it. We talked a bit about the Medicare Accelerated Advanced Payment Program and the stiff terms that program now has if Congress doesn't otherwise change it, where after a number of months, actually for many hospitals it'll happen this summer, they will have their Medicare payment garnished until the advanced payments they received are paid off. Do you think that there's a level 20, 25%, that could be garnished rather than 100, that would still be sustainable for hospitals in terms of paying this debt back? Is that reasonable? What's your view on that?

J.B. Silvers (16:36):

Well, that's a question for spreadsheet analysis and I don't have an off the top answer. Yeah, they could be. I would see it even more, there's even a more interesting policy approach Chip. And I think much like if you go back, at the end of the 40s and 50s, so we did the Hill-Burton Program when we needed to rebuild the whole health care system. And that was basically a form, most of the summer grants, most of them were loans. But we didn't have to pay them back as long as you met the conditions and the conditions were largely, you had to take care of the uncompensated care, you had to take care of poor people. This was before Medicare and Medicaid, and that worked pretty well. So those loans got paid off in kind over a period of time. I think we have an interesting opportunity given the fragmented system we've got to provide an incentive for hospitals to get together and think ahead collectively about how we're going to deal with the next crisis that's coming along, because it will come along.

How do we decide how much standby capacity we need to have? How many ventilators, if you want to go to that simplistic measure? How much bed capacity we need to have? All the things we're talking about right now, but more importantly, how do we coordinate that care? What do we do as a contingency plan the next time around? And where are we going to put those patients when they show up? And maybe even more important, how do we do the testing and the prevention care that we need to do? If we could organize a way, a policy approach that said, look hospitals, if you can meet these standards, you're going to have X% of your loan forgiven over Y time period. And maybe X and Y are in, first, large percentages are small, maybe they're over months or maybe over years. But maybe we have a lever here to get into the healthcare system.

We actually have a chance to do a national approach, or at least a regional approach to what is obviously a problem that goes to the population, not to an individual provider. I would love to see a policy discussion on that one. I think that might have some really interesting possibilities.

Chip Kahn (18:54):

That's great J.B. Thank you so much for your insights. And we really appreciate you joining us today on Hospitals In Focus, and we hope that our audience found our discussion useful and informative.

J.B. Silvers (19:08):

Great, thanks.

Chip Kahn (19:09):

Join us next time as we speak with experienced leaders on new ideas about healthcare, delivery and financing. Please listen, rate and subscribe wherever you get your podcasts. And if you haven't already, you can follow the Federation on social media at FAH Hospitals and me at Chip Kahn. This was Hospitals In Focus, I'm Chip Kahn. Thanks again for listening.