COVER STORY

THE *OTHER* LONG COVID

The pandemic has turned hospitals into their own toughest patients, as they attempt to resuscitate their fading bottom lines

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More than two years after Covid-19 appeared in Greater Washington, the region's health systems know how to care for their patients.

What they're still figuring out: how to stay healthy themselves.

Hospitals sustained serious injuries from the initial coronavirus surge. They shut down nonurgent services, which drove away patients – and crucial revenue – with lasting implications. They upped their investments, secured supplies and equipment, and made clinical and operational changes as they went. They put the money second to the medicine.

That scarred their income statements. Still, more surges followed, expenses soared and job vacancies mounted amid an industrywide exodus, as did the subsequent bills to fill those gaps. Not to mention, patients returned sicker after delaying care. Everything came with a greater cost.

Now in its third year, the pandemic continues to inflict pain on local hospital budgets. The federal relief that helped mask their revenue shortfalls has expired, the Great Resignation has intensified, supply chain delays and shortages have brought exorbitant price tags, and insurance reimbursements remain fixed, squeezing hospitals' already-thin margins until they bleed red.

In Maryland, where operating margins traditionally average 2% to 3% – lower than the 6% national average – the median margin dipped to negative terrain in October, crawling back up to 0.5% as of January. The public health emergency's initial onslaught in 2020 left Virginia hospitals with $1.8 billion in lost revenue, according to the Virginia Hospital and Healthcare Association. While the full impact is still being evaluated, projections from the region's hospital associations have put total revenue losses across D.C., Maryland and Virginia hospitals at more than $4.5 billion for 2020 alone.

This is their long-haul Covid-19.

The prognosis isn't pretty – indeed, most agree, it's financially unsustainable. Hospitals will need to "tap into the most creative minds and innovative thinking" to be able to adapt and function going forward, said Jacqueline Bowens, president and CEO of the D.C. Hospital Association.

"We really do need to think about, to some degree, what does a potential rescue plan look like for our industry," she said. "We are managing, but we are teetering."

'Financial double whammy'

The good news: Covid case numbers have fallen substantially since Omicron inundated hospitals with their highest volumes since the pandemic's start.

The bad news: Costs aren't following suit.

The first few months of 2022 have been the worst yet for fiscal health, industry leaders say. The new year welcomed "a financial double whammy" from a decrease in patient volumes and rising overhead expenses, said Julian Walker, vice president of communications for the VHHA. That's compounded by "outrageous" rates for staffing agencies as labor gaps grew and demand spiraled, said Deneen Richmond, president of Luminis Health Doctors Community Medical Center (LHDCMC) in Lanham.

For some, like Falls Church's Inova Health System, the Omicron period briefly brought more revenue, because its hospitals provided Covid care while continuing to run other services, unlike in 2020. "So we had a very strong fourth quarter, definitely to our surprise," said Dr. Stephen Jones, president and CEO of Inova. But now, he said, "it's exactly the opposite. Unfortunately, we're having a very difficult start to the year."

Inova is far from an exception. "It is going to be much more challenging this year to still be able to meet budget compared to where we ended last year," said Joe Perry, chief financial officer of Howard University Hospital in D.C.

Maryland counted 154 hospitalizations statewide as of April 18 and Virginia, 159 as of April 19, while D.C. said only 2% of its hospital beds were being used by Covid patients as of April 3 – all a fragment of the volumes seen at Omicron's peak. Columbia-based MedStar Health saw its cases plunge from 1,100 during Omicron to about 25 in

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► *Deneen Richmond oversees the Luminis Health Doctors Community Medical Center, a 190-bed community hospital based in Lanham.*

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mid-March. LHDCMC peaked at 90 Omicron cases, or 40% of its beds, before falling below four Covid patients nowadays.

During the peaks, the Lanham hospital worked with the National Guard to set up an outside testing site as a "pressure relief valve" for its overrun emergency department, Richmond said. But volumes across other service areas also decreased, she added, because the ER acts as "an important front door" for inpatient care.

That's had a lingering effect across the industry. Virginia's hospitals reported a 25% decrease in ER volumes and 10% slide in inpatient admissions in 2020 through the first half of 2021, the most recently available data, according to VHHA. D.C. hospitals haven't seen patient volumes fully return to pre-pandemic levels – down 32% in ERs, 20% for acute-care admissions and 25% for ambulatory surgeries this past January, compared with January 2020.

Joe Perry

Few remedies in sight

The end of health care relief funding adds salt to those raw wounds.

The CARES Act, which gave hundreds of billions of dollars to hospitals to remain in the black and offset costs of labor and supplies, is now running out with little to take its place. It's the same with other pandemic-era forms of support, including from the Centers for Medicare & Medicaid Services, which allowed prepayment on some future Medicare claims, "a huge benefit to our balance sheet," Perry said.

Many advocate for more federal funding, but none actually expects it. The Maryland Hospital Association is instead pushing for more state support – and seeing results. In a recent win, the Maryland General Assembly and Maryland Gov. Larry Hogan appropriated a combined $80 million in grants for hospitals' recruitment and retention efforts. And Maryland's unique payment system, which gives its hospitals annual global budgets and the ability to adjust rates accordingly, "acted as a nice shock absorber" in the ear-

OPERATING ON SLIM MARGINS

The pandemic squeezed already tight margins at local hospitals as expenses soared. This chart shows operating incomes and margins for local players that report financials, some still unaudited, through the Municipal Securities Rulemaking Board for their most recent financial reporting periods. Federal CARES Act funding helped many stem financial bleeding in 2020 — and, for Luminis, into 2021, with a constant level of surgeries there that year as well. But most started feeling the pain of sinking margins in 2021.

ly days by temporarily increasing those rates, said Bob Atlas, president and CEO of the MHA.

But that structure is a double-edged sword, said Dr. Norvell Coots, president and CEO of Silver Spring's Holy Cross Health, part of Michigan-based Trinity Health. "Where other health systems across the United States can increase volume to increase revenue to offset the cost of labor and supplies, we can't do that because volume means nothing to us," he said. "Our rate is set."

The state's providers say they hope the Maryland Health Services Cost Review Commission (HSCRC), the agency that regulates hospital budgets, will consider solutions to help them survive in the face of fixed revenue and inflation.

The agency said it's finalizing its revenue update, which considers prices and volumes, as well as inflation projections and other factors. Commissioners will vote on final recommendations in June, but officials voiced the need to also prevent heavy markups at hospitals for their drug or medical procedure pricing.

Dr. Norvell Coots

"We will do our very best to have an update factor that is responsive to the needs of the hospitals to make sure that they are resourced to operate," said HSCRC Executive Director Katie Wunderlich. "We also have a duty to the public and to payors to contain the growth of costs, and not have charges that are out of line with what actually is happening at the hospital."

Necessary changes in store

Bridging that gap gets far tougher in the face of other mounting expenses, from nationwide shortages of supplies like crutches, to a greater need for stronger cybersecurity defenses, to the soaring rates for fuel.

"The cost of hospital business has outpaced inflation even as inflation has gotten higher," now hovering around 7% to 10%, Atlas said. "That's upending a lot of normal budgeting assumptions."

Gaithersburg's Adventist HealthCare, for example, is see-

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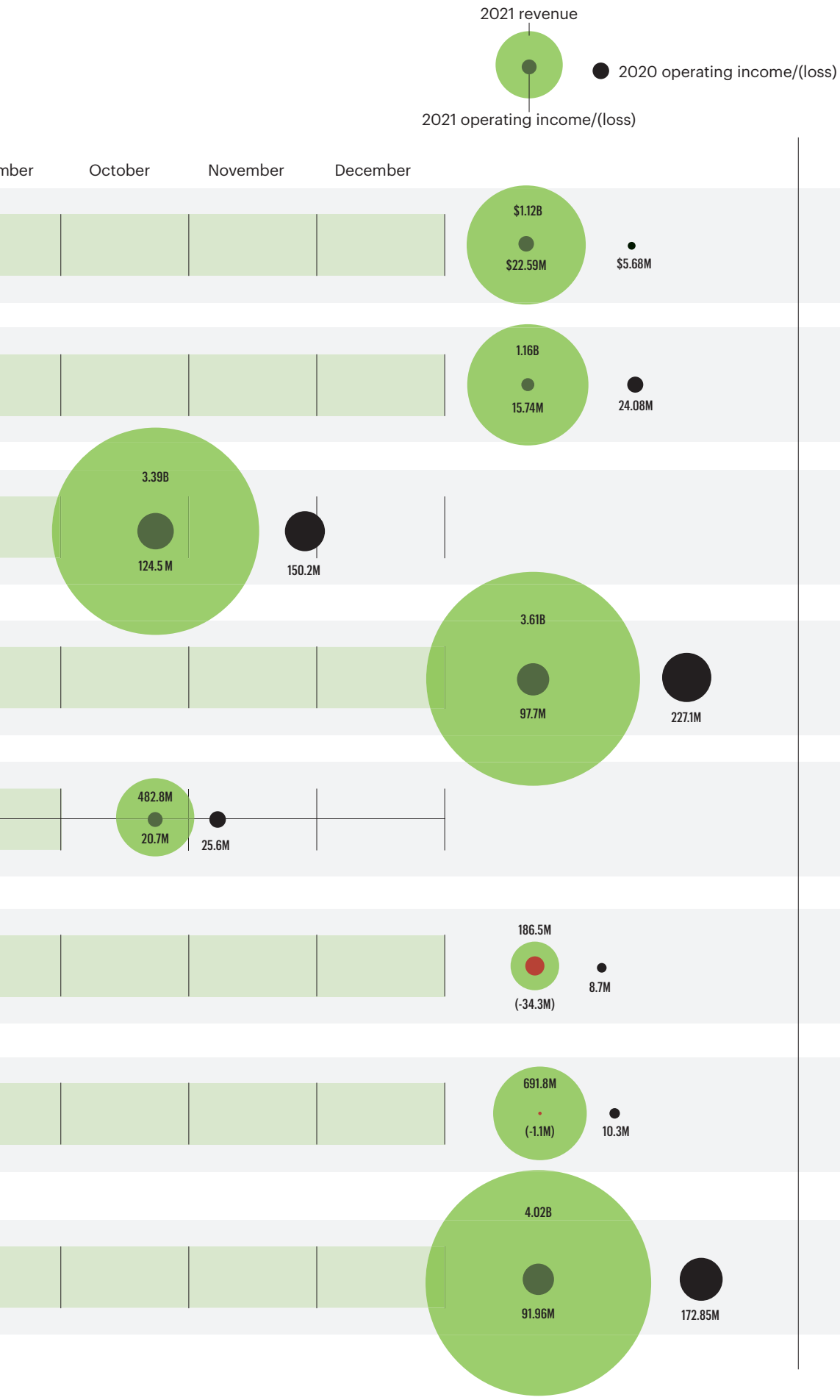

Operating margin
(for the same time period at left)

2020	2021
0.54%	2.02%
2.46%	1.36%
5.10%	3.70%
6.80%	2.70%
6.10%	4.30%
4.20%	-18.39%
1.60%	-0.20%
4.50%	2.30%

CARES Act funding 2020-2021
(for the same time periods for each year)

$82M
$100.6M
$131.5M
$253.1M
$32.8M
$55.2M
$80.2M
$151.8M

For the period from July 2019 to June 2021

SOURCE: The hospitals, financial statements reported to EMMA

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ing 16% to 25% increases each month in year-over-year costs. And with rising wages, utility prices and supply costs, "it could be very well over 8% to 10% permanent cost increases that the health systems may experience," said Adventist President and CEO Terry Forde.

So the staff is working with Medicare, Medicaid and commercial payors to try to increase reimbursement. They're going after more grant dollars to diversify revenue streams. They're ramping up fundraising campaigns for philanthropy and creating new funds to support operations. They're negotiating contracts with their suppliers, many of whom passed onto hospitals their own increased costs due to shortages. They're searching for vendors beyond their current supply chains, "which doesn't put us always on the favorable contracted rate," said Perry of Howard hospital.

The complicated art of the supply chain means shortages plague different items at different times, said Sarah Swank, a D.C. health care attorney with Nixon Peabody LLP. Some, like Annapolis-based Luminis Health, are using data to buy more efficiently, but without overbuying, said Kevin Smith, its chief financial officer. The system is working with its distributors to bundle shipments differently to limit the administrative burden on hospital staff.

Health systems must also prioritize which investments to make and which to put off to manage their cost lines. For Howard, that includes waiting to update areas of its aging facility – a replacement hospital is still years out – and adding months to the timeline on a multimillion-dollar effort to connect the hospital's electronic health record with that of Adventist, its operator.

"Every hospital looks to improve efficiencies, to do better purchasing, more efficient use of all resources," Atlas said. "But there's only so much inefficiencies left to squeeze out."

'The greatest challenge'

None of those efforts matter if hospitals don't have the people they need to function. That's also not cheap.

"Staffing is, no doubt, the greatest challenge in our industry right now," said Jones of Inova. "That proverbial 'What keeps you up at night?' – it's exactly that."

Shortages in key positions worsened through the Covid crisis, with infections hitting staff, employees retiring or opting for work outside of a hospital, and nurses taking positions with travel agencies for higher pay. And their replacements ratchet up the expenses, to the tune of nearly 8% hikes in hourly earnings for hospital workers for fiscal 2022, per the Bureau of Labor Statistics – costs that are embedded into budgets for years to come. "Their salaries have gone up, but the reimbursement's not necessarily there to accommodate the increases in salaries right now," Swank said.

That has meant "millions of dollars over budget every month," Coots said, given that labor represents at least half of a hospital's budget. In Maryland, monthly contract labor spending shot up, from about $15 million prior to Covid to nearly $100 million today. Some D.C. hospitals face agency costs that exceed budgets by 40%, or in Howard hospital's case, as high as 200% more than pre-pandemic.

Virginia counts more than 9,000 open permanent nursing jobs, and about a quarter of Maryland's nursing positions are vacant. Holy Cross, which employs about 6,000 staff and physicians at its Silver Spring and Germantown hospitals, has about 400 openings, one-third of which are nursing positions. It's fewer than the health system's 700 vacancies earlier in the pandemic, but it's still too much, Coots said.

The need is becoming more dire, as patients who deferred care now return in poorer condition, requiring more intensive, and more expensive, treatments. In response, health systems are turning more to technology to help eliminate time spent on documentation, for instance. LHDCMC is working to shorten length of stay, to "take care of that many more patients with the same fixed expenses that we have," Richmond said. "Not only is it good for our bottom line, but it's good for our patients."

The treatment plan for staff turnover: to make wages more competitive for current workers – and to reduce reliance on temporary agency work, which can cost triple or quadruple a staff paycheck. Inova invested an incremental $300 million in its pay and benefits in recent years, Jones said. The Baltimore-based University of Maryland Medical System has offered $100 million in upped hourly rates and incentive bonuses in the last six months, said Jania Matthews, a spokesperson for Prince George's County's University of Maryland Capital Region Health. Luminis is pouring $29 million into a new recruitment and retention initiative, even as it expands its nursing residency program.

Adventist, meanwhile, has launched an in-house nursing track and developed programs to assist with student debt. It's also recruiting internationally, aiming to hire about 250 nurses in the next 18 months from Korea, Jamaica, the Philippines and countries in Africa, Forde said. But experts agree immigration restrictions must loosen up for such strategies to succeed more widely.

Once employees are on board, the next challenge is to keep them engaged and give them enough balance. "The health and well-being of the health care workers is the No. 1 issue," said MedStar President and CEO Ken Samet. "And you can't simply buy your way out of that."

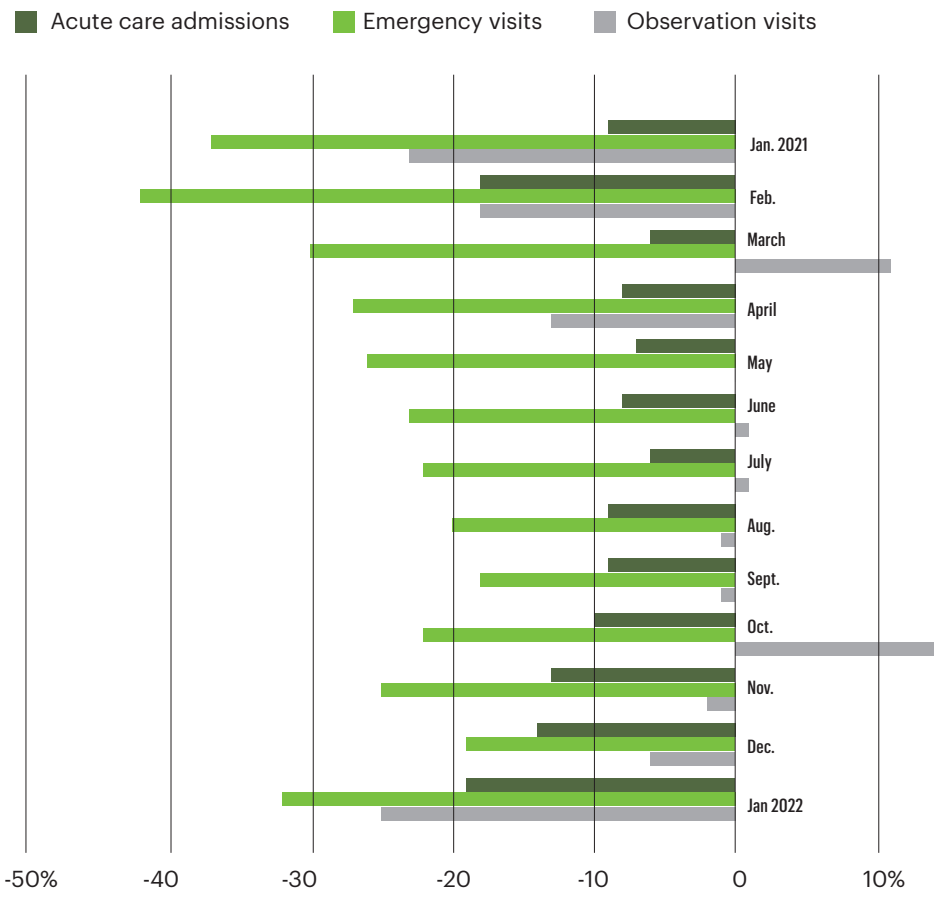
Where to go from here

At this turning point, health leaders say, the answer often lies in big-picture care delivery models – not cutting the cost of an X-ray or an hourly wage, but identifying which X-rays and positions are necessary in the first place.

It's investing in primary and preventive care, and making that care equitable and accessible – closer to home in an outpatient

D.C.'S DECLINING VOLUMES

Hospital traffic remained considerably down in D.C. in the past year — and got worse as 2021 wore on, into this past January — when compared year-over-year with 2020 figures. Those in for acute care and shorter observations fell to their lowest levels in a year.



Source: D.C. Hospital Association Monthly Utilization Report, January 2022

Sarah Swank

Ken Samet

THE REGULATORY REVERBERATIONS

Health care providers must also brace for a likely increase in federal regulatory enforcement, said Nixon Peabody LLP attorney Sarah Swank. Those areas include:

Telehealth: Virtual care was covered as a Medicare and Medicaid benefit during Covid. Congress and the Centers for Medicare & Medicaid Services are now considering how to expand that going forward. But the Office of Inspector General, part of the Department of Health and Human Services, also added review and audits of providers' telehealth services to its OIG Work Plan "because of the potential program integrity risk," Swank said.

Federal relief: Hospitals that received CARES Act funding must report the use of that money and repay unused funds. They must also be prepared for the possibility of governmental audits and congressional oversight, including possible civil and criminal penalties.

Government payors: Medicare and Medicaid, as well as other federal programs, are likely to see increased enforcement.

Cybersecurity: On the other side of enforcement, "hospitals have been and are likely to be targeted as victims of malicious cyber activities, threats and ransomware," Swank said. "The FBI has warned of hospitals being targeted in 2020 and has done so again in 2022."

setting or, even, in the home itself. That may drive down emergency room and inpatient volumes, which cuts into the overall revenue mix. ER care is inherently more expensive than urgent care, but insiders say it doubles down on an important shift that began before Covid dawned.

"We need to do the right thing from a care standpoint first," Samet said. "We then need to think through: How do we reset the foundation of the organization from a business/financial standpoint to stay strong and allow us to continue to go forward?"

Consider MedStar, which acquired urgent care clinic network Righttime Medical Care in late 2020 and instantly grew to 33 urgent care sites now handling more than 500,000 visits a year. Howard University Hospital is hiring physicians in select specialty areas, including surgery, to increase access for patients. VHC Health, formerly Virginia Hospital Center, is building more ambulatory care sites miles from its Arlington campus, but closer to its patients.

All of the health systems view telemedicine as an essential piece of the puzzle to help prevent readmissions and increase access; MedStar alone saw its virtual visits rise to 10% of its physician activity systemwide. But outside of some Covid-era exceptions, insurers have historically reimbursed telehealth at lower rates, carrying its own cost considerations.

Swank said the key is to stay in contact with state and local governments in what she described as a "very effective" pandemic-era approach. "Keeping those connections going and those discussions going, even now, will be important to lay the groundwork for future needs."

Ultimately, the goal is to reach sustainable operating margins once again – around 4% to 5% at least for Adventist HealthCare, Forde said, though "we're going to be pressed hard for probably one to three years to try and recover and get back to that."

Barring that outcome, the fiscal consequences can turn rather dire for some hospitals, perhaps forcing consolidation. Or the loss of entire service lines they can no longer afford.

"The worst-case scenario is you start pulling some of those levers that you don't want to pull, and you consolidate down," Coots said. "You always keep the apocalyptic course of action in your hip pocket in case you ever have to activate it, but knowing that is a last-ditch effort. That is not what you want to do."

THE BIG NUMBERS

With nearly 10% wage inflation and the end of federal relief funds, Maryland's health systems are now feeling "some of the harshest effects" of Covid-19, said Bob Atlas, president and CEO of the Maryland Hospital Association, which shared the unaudited operating margins below across member providers in recent years. By January, nearly half of Maryland's hospitals were operating in the red, and more than half of hospitals posted a loss each month from October to January, he said. "No hospital can stay open over the long term if it's losing money constantly. The notion that hospitals can stay open on philanthropy is long gone," Atlas said, dubbing the current margins statewide as "below acceptable."

2018
3.60%

2019
2.17%

2020
>3%

2021
>3%

Seven months leading up to January 2022
0.50%

SOURCE: Maryland Hospital Association

WBJ ILLUSTRATION / GETTY IMAGES

INFLATION INFLAMMATION: HEALTH'S BIG HIT

Inflation, while not unique to health care, has its own set of implications for the industry.

Most businesses can pass on a bump in expenses to their users. But health providers must pass the cost increases to the insurance companies, who pass the same increases to the employers — and that creates a messy ripple effect.

A restaurant, for example, can increase the prices on its menu or stop serving lunch altogether to offset higher wages. But "we can't close for lunch," said Ken Samet, president and CEO of MedStar Health. And Medicare, Medicaid and the commercial insurers, he said, are "not absorbing enough of this increase."

So hospitals are "effectively paying surcharges for goods and services" despite those static reimbursement rates, said Julian Walker, vice president of communications for the Virginia Hospital and Healthcare Association.

The cherry on top: Health systems don't get paid equally for everything they do.

"In the entirety, at the end of the day, you have to assure that the business has enough revenues to cover the fact that you're going to do a lot of things that you will be either uncompensated for or undercompensated for," said Dr. Stephen Jones, president and CEO of Inova Health System.

The yearslong shift from fee-for-service (getting paid per procedure) toward what's called value-based care (getting paid based on population health, care coordination and overall outcomes) has helped, equitably improving access to care and prioritizing better health at a more amenable long-term price tag, experts said.

But it doesn't help mitigate inflation on its own because of the preset, negotiated price of a hospital's procedures and care with insurers. "You already know in advance what you're going to get paid, and you really have no way of managing that if your costs are going to continue to go up on the other side, unabated," said Jacqueline Bowens, president and CEO of the D.C. Hospital Association. "That's the reality of what we're dealing with right now."

So jurisdictions are looking for other ways to manage and meet budgets, said Sarah Swank, a D.C. health care attorney with Nixon Peabody LLP. Maryland's reimbursement system differs from most others across the country with a budget regulator structure; the state's hospitals are given an annual global budget and the ability to adjust their rates up or down by 5% to help meet budget if volume slips. And it "has been a model for other states trying to do payment reform," Swank said, "as an example what needs to be changed in payments into the future." *– Sara Gilgore*