Addressing the liquidity crisis while caring for the nation’s pandemic patients

Across the US, hospitals and health systems face serious liquidity crises as they treat the nation’s COVID-19 patients. Before the pandemic, many providers already were operating on thin margins, with enough cash and patient receivables to cover only three to four months of operations, according to an analysis of hospital finances by PwC’s Health Research Institute (HRI).

Now deferred procedures and visits have led to depleted revenues and the payer mix is shifting because of swelling unemployment; fixed costs, however, remain static. Many solutions that worked in the past—rethinking service mix, bumping up capacity—are ineffective in the COVID-19 period. The American Hospital Association (AHA) estimates that hospital losses between March 1 and June 30 of this year will total $202.6 billion.

But hospitals can take practical steps now to rapidly address their cash crises in the short term while shoring up finances for the medium term and post-COVID-19 period. These actions could include:

- Using targeted models to understand the short- and medium-term implications of the pandemic on liquidity and economic recovery planning;
- Addressing capital structure by dealing with covenant breaches, creating headroom in existing facilities and raising new capital;
- Carefully rolling out strategies to preserve cash and minimize costs so efforts undertaken now don’t hamper business down the road;
- Considering their workforces with care and forethought;
- Taking advantage of funding and other opportunities available under the CARES Act and other federal and state aid efforts, and;
- For hospitals, exempt and for-profit, considering tax strategies that can free up liquidity now and bolster finances in the long term (see Figure 1).
The COVID-19 pandemic is a historic event with profound implications for Americans, the economy and the US healthcare industry. The liquidity crisis is not unique to healthcare, although its effects could have important ramifications for the nation’s ability to weather the crisis. In a periodic survey on COVID-19 of CFOs across all industries conducted by PwC and published on April 13, 75% of respondents named financial impacts—including effects on the results of operations, future periods, and liquidity and capital resources—as a top three concern.

Eighty percent of respondents to a survey published on April 27 told PwC that they continue to expect a decline in revenues, profits, or both in 2020. Asked how long it would take to get back to “business as usual” if the pandemic were to end today, 48% of business leaders surveyed by PwC said it would take more than three months.

Healthcare providers, in particular, have been challenged financially even as they scrambled to prepare for surges in COVID-19 patients. Adjusted discharges are down 13% year over year for March, a month that included just a few weeks of state shutdowns, according to the AHA. Between March 1 and June 30, hospitals likely will lose an estimated $37 billion due to the treatment of COVID-19 patients alone, the organization projects. Canceled hospital services likely will result in the loss of another $161 billion over the same four-month period. At the same time, these providers will spend nearly $5 billion on personal protective equipment and additional resources. The AHA notes that its estimates do not include other possible increased expenses, such as boosts in wage and labor costs and expenditures associated with building temporary structures for the pandemic.

Since early February, hospitals from Massachusetts to Kentucky to Oregon have announced furloughs, pay cuts, layoffs, and cuts in executive pay. The Bureau of Labor Statistics reported a loss of 43,000 jobs in healthcare in March; the industry had added 374,000 jobs in the previous 12 months.

Federal aid through the Families First Coronavirus Response Act, the CARES Act, the Paycheck Protection Program and Health Care Enhancement Act, and other federal actions have sent tens of billions of dollars in grants and loans to providers. Still, the money likely will not make up for the billions in lost revenue.

Some rural hospitals, with less than two months’ cash on hand, fear they may have to close their doors. “If we’re not able to address the short-term cash needs of rural hospitals, we’re going to see hundreds of rural hospitals close before this crisis ends,” Alan Morgan, who runs the National Rural Health Association, told Modern Healthcare.

Many hospitals likely were operating on thin margins when the pandemic hit. An HRI analysis of financial data primarily from fiscal 2018 and 2019 collected by the American Hospital Directory on 4,688 hospitals found that the national mean operating margin was less than −3%, with enough cash plus net patient accounts receivable to cover an average of nearly four months of operations (see Figure 2).
Hospitals’ financial situations varied by region and by type. Focusing on days cash on hand, urban providers, which experienced some of the nation’s earliest, highest caseloads, could cover an average of about 45 days of operations in the fiscal years before the pandemic. Meanwhile, rural providers tended to have slightly more, an average of nearly 70 days cash on hand, according to HRI’s analysis. Rural hospitals, HRI found, tended to have much lower operating margins than their urban peers. They also tended to have less ability to cover debt.

Across most regions, private for-profit hospitals tended to have the lowest days cash in the fiscal years before the pandemic, as did urban and teaching facilities. On the debt side, HRI also found that large, national for-profit health systems and some academic medical centers maintained relatively large levels of undrawn revolving credit compared with their peers. And private, for-profit hospitals appear best equipped to service their debts, with coverage ratios greater than 1 or positive and among the healthiest operating margins. Other hospital systems tended to have debt service coverage ratios near or below zero, according to HRI’s analysis.

Some of the hardest-hit cities are served by hospitals that may have been operating on less than one month of cash on hand when the pandemic struck. Hospitals in New York City, an early US epicenter, held, on average, about 31 days cash on hand in the fiscal years before the crisis (or 75 days when including net patient accounts receivable), according to HRI’s analysis. Hospitals in Detroit and New Orleans in particular averaged fewer than 20 days cash on hand (and about 60 days cash plus accounts receivable). Hospitals in Miami averaged about one month of cash on hand (see Figure 3).

<table>
<thead>
<tr>
<th>Region 1: New England</th>
<th>Average days cash on hand</th>
<th>Average days cash on hand plus net patient accounts receivables</th>
<th>Average debt service coverage ratio</th>
<th>Average operating margin</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>53.6</td>
<td>103.6</td>
<td>0.1</td>
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<td>Region 2: NY &amp; NJ</td>
<td>56.3</td>
<td>113.3</td>
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<td>Region 3: Mid-Atlantic</td>
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<td>Region 4: Southeast</td>
<td>46.9</td>
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<td>117.7</td>
<td>0.4</td>
<td>-0.9</td>
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<tr>
<td>Region 6: South</td>
<td>55.2</td>
<td>119.0</td>
<td>0.2</td>
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<tr>
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<td>121.7</td>
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<td>Region 10: Northwest</td>
<td>61.8</td>
<td>121.6</td>
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</tbody>
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Source: PwC Health Research Institute analysis of American Hospital Directory data pwc.com/hri
Acute care and teaching hospitals tended to have higher Medicare case mix indices, which signal costlier populations and procedures and therefore likely greater losses of revenues, as these organizations canceled nonessential procedures and clinician visits in March and April, HRI’s analysis found.

Some hospital systems could face increased pressure on bonds, some of which are due as early as this spring, HRI found. Hospitals also may find it harder to use municipal bond issuances as an immediate source of cash, according to Modern Healthcare.

As the crisis unfolds, hospitals are scrambling to focus on their patients, their workers’ safety, and a post-COVID-19 future serving thousands of Americans waiting out the pandemic at home. These institutions’ financial crises cannot be set aside until the pandemic fades. Thankfully, hospitals can take steps to strengthen their financial positions now and in the near and more distant future.

Implications:

Understand liquidity requirements. Providers facing a liquidity crisis should start with a short-term cash flow forecast and then work to update business plans, budgets, and forecasts. They should identify downside case scenarios due to the pandemic and find cost reduction levers to improve their liquidity positions, such as canceling nonessential orders or rationalizing work shifts. Healthcare providers should consider reaching out to stakeholders about flexibility in payment and pricing terms. In addition, they should analyze whether their reporting tools and systems are adequate. What are these tools’ strengths and weaknesses, and are they capable of real-time reporting across different locations?

As providers resume nonessential procedures and services, they should not assume that patients will return in the same numbers as before, at least not right away. Patients may continue to fear being infected with SARS-CoV-2, the virus that causes COVID-19, at the hospital or doctor’s office, and some may continue to defer care because of financial considerations.

Thirty-two percent of respondents to a consumer survey conducted by HRI in early April said they had already made or were planning adjustments to their spending on healthcare visits as a result of COVID-19. Seventy-eight percent of these consumers said they would skip at least one visit such as a well visit, maintenance visit for a chronic illness, elective procedure or recommended lab test, or screening. Scenario planning and engagement with patients to understand attitudes around trust, finances, and prioritization should help generate insights.

Deal with the capital structure. Providers should not delay when it comes to reaching out to financial institutions. Engage early and support any requests with robust documentation. Providers should review flexibility within loan agreements: Is there room to change interest periods? Can amortization payments and timing be adjusted? Providers seeking to access existing liquidity lines should examine the representations and warranties required to draw on existing facilities. They should review loan agreements for permitted debt incurrence and security baskets. They should examine whether the system can finance assets, such as property and inventory. Finally, they
should consider raising new capital. What are the options for raising incremental capital from existing financial stakeholders or, possibly, new ones?

**Identify working capital and cost management options.** Providers should set up a central point of control and visibility. They should prioritize and focus the efforts of operational teams by using analytics to support cash collection. They also should examine customer risk in all initiatives. Will any actions taken today undermine the organization’s future? Providers should consider offering early payment discounts and set up new ways to collect payment. In an HRI survey of provider executives in 2019, just 50% said their health systems offered patients payment plans without interest.

Providers also should challenge every uncommitted spend: What value will it deliver? They should consider temporary operational cuts and examine supply chains.

What are the short-term replenishment triggers? What are the controls in the face of lead time and demand volatility? Are there supply and substitution options that make sense? What would be the impact of changing inventory requirements because of potential delays, lead time changes, and variation to the surety of supply?

Providers should make the most of the explosion in telehealth after years of slow adoption by providers and consumers. HRI’s April consumer survey found that 5% of polled adults said they or a family member had attended their first telehealth visit during the pandemic. The Centers for Medicare and Medicaid Services (CMS) has announced that it will reimburse telehealth visits on par with in-person visits, a temporary policy that might be extended beyond the crisis period. Some payers have announced that they, too, will pay for telehealth visits during the pandemic at the same rates as in-person visits, but it remains unknown when or whether those policies might change. Hospitals should review whether coding is accurate and documentation is robust, especially as payer decisions are made about levels of visits.

Providers also should confirm that coding is set up to capture the Medicare add-on for COVID-19 treatment. The CARES Act offers providers a 20% boost for COVID-19 treatment reimbursements for Medicare patients.

Providers also should take advantage of accelerated payments. Qualified facilities can ask CMS for an up to six-month lump sum or periodic payment. The advance payment would be based on net reimbursement represented by unbilled discharges or unpaid bills. Most hospital types could elect to receive up to 100% of the prior period payments; critical access hospitals can request up to 125%. Hospitals do not have to pay down the loan for four months and have 12 months for total repayment at no interest. Payers have also announced that they will accelerate payments to providers in some cases.

Billions of dollars in loans and grants through the CARES Act and other federal aid packages contain many potential opportunities for additional funds in the short and medium terms. Providers should examine all options and apply for these funds early.

**Consider short- and medium-term tax strategies.** Providers should consider the availability of the employee retention tax credit. Under the CARES Act, eligible employers can use a new temporary refundable payroll tax credit for 50% of qualified wages paid to certain employees after March 12, 2020 through Dec. 31, 2020.

In general, the credit is available to employers, including nonprofits, whose operations have been subject to full or partial suspension due to the COVID-19 emergency as a result of a government order limiting commerce, travel or group meetings. It is also available for employers whose gross receipts have significantly declined because of COVID-19, defined as a reduction in gross receipts of more than 50% when compared with the same quarter in the prior year. Employers may offset the employee retention credits against payroll taxes, including employee income tax withholding. The amount of qualified wages eligible for the credit with respect to any individual employee is limited to $10,000, subject to certain reductions.

For employers with more than 100 full-time equivalent employees, qualified wages are defined as wages paid to employees who are not performing services because of suspension of the business or reduction in gross receipts. If the eligible employer averaged 100 or fewer full-time employees in 2019, qualified wages are all wages during the quarters that the business is closed or limited, or during the period of significant decline in gross receipts. IRS guidance should be consulted as to the complexities for the new credit, including limitations for employers receiving funds under the Paycheck Protection Program.

Providers should consider tapping donors, as donation limits have been increased. The CARES Act raises the annual cap on deducting cash charitable contributions for individuals who itemize, raising the limit to 100% of adjusted gross income for cash contributions made in 2020 to public charities (which generally include charitable tax-exempt hospitals), but not to supporting organizations or donor advised funds. Corporations can give cash donations of 25% of annual taxable income for 2020 (up from 10%). Further, non-itemizers may claim an “above the line” deduction up to $300 for qualified cash charitable contributions made in 2020 to public charities.

Providers should consider deferring payment of the employer share of payroll tax to the extent allowed under the CARES Act. The law allows a delay in payment of the applicable 2020 employer portion of Social Security taxes from March 27, 2020 through Dec. 31, 2020. Half of the deferred tax is to be deposited by Dec. 31, 2021, and the remainder by Dec. 31, 2022. IRS guidance should be
consulted, including limitations for employers receiving funds under the Paycheck Protection Program.

Organizations should consider delaying payment of income tax to help preserve cash to the extent allowed under IRS Notices. The IRS has postponed filing and payment of federal income taxes in some cases.

For-profit organizations should weigh utilizing losses and amending prior-year returns. Before the CARES Act, net operating losses (NOL) were subject to a taxable-income limitation and could not be carried back to reduce income in a prior tax year. The CARES Act relaxed the limitations on a company’s use of losses. The law provides that an NOL arising in a tax year beginning in 2018, 2019 or 2020 can be carried back five years. The CARES Act also temporarily removes the taxable income limitation to allow an NOL to fully offset income. These changes can allow companies to utilize losses and amend prior-year returns, which can provide critical cash flow and liquidity during the COVID-19 emergency.

For-profit hospitals and healthcare organizations also should analyze the availability of new interest expense deductions. The CARES Act temporarily increases the interest expense that businesses may deduct on their tax returns by raising the 30% limitation to 50% of taxable income, with adjustments, for 2019 and 2020. As businesses look to weather the storm of the current crisis, this provision may allow them to increase liquidity with a reduced cost of capital.

Other aspects of the CARES Act may also be beneficial. These include suspension of the aviation excise tax, technical corrections affecting depreciation of qualified improvement property, the ability to accelerate refunds of alternative minimum tax credits, and provisions involving contributions to single-employer pension plans.

Think through a workforce strategy. Health systems already are asking themselves what can be done to manage workforce costs. They should reevaluate and set up continuous processes to adjust based on volume as COVID-19 continues to drive uncertainty from a demand perspective. They should consider how roles should evolve to fit the current environment. Can changes be made to rewards programs, such as 401(k) contributions? Employers should consider the impact of union or employment agreements on how the workforce may be restructured. They also should examine whether employees are willing to discuss changes to their contracts.

Throughout the emergency period, health systems should communicate with employees often and clearly to keep them engaged and productive. Health systems that furlough or terminate employees should set up communications systems to keep connected.

Evaluate reporting requirements. Healthcare companies should evaluate financial reporting needs and resources earlier than usual.

About this research: Data provided by the American Hospital Directory, based on Medicare Cost Reports (MCR) and other sources. MCR figures do not necessarily equate to those in audited financial statements, which include financials from nontreatment activities such as research, related third-party transactions, and any other efforts not directly related to patient care. The final sample size of providers excludes nonreporting facilities and those with extreme outlying values for days cash on hand or operating margin, for example. Additional sources used for research include data reported from S&P Capital IQ and Fitch.
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