Healthcare

Revenue Recovery

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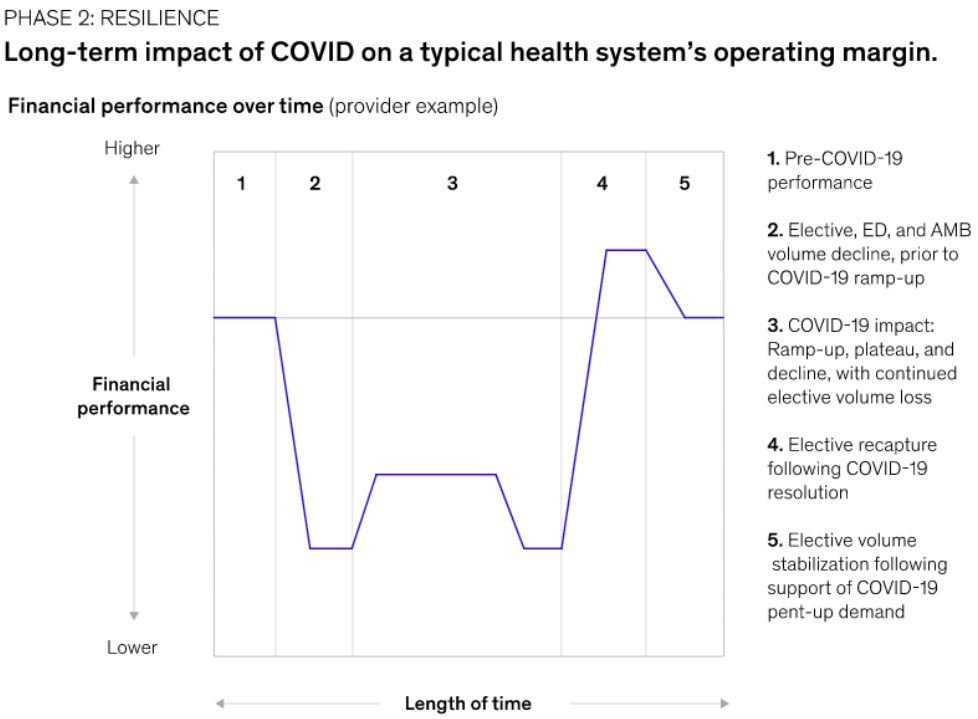
Any recovery of revenue will require two things: the return of non-COVID-19 healthcare delivery (medium-term), and realignment of operations to meet new healthcare needs (long-term).

1: Return of non-COVID-19 healthcare delivery

Non-COVID-19 care was the primary source of predictable cash flow for providers before the pandemic. Creating capacity for COVID-19 treatment, whilst critical, required suspension/delay of these services and was primarily responsible for significantly reduced cash flow. Hence, creating space for non-COVID-19 revenue sources is essential - where control of the pandemic allows.

McKinsey guidance on healthcare institutions' operational response to COVID-19 (Five stages: https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/from-wartime-to-peacetime-five-stages-for-healthcare-institutions-in-the-battle-against-covid-19)

Focus on phase 3: Return



Before moving into periods 4 and 5 (as identified by McKinsey) and regaining cash flow:

- Hospitals (and other providers) must ensure that testing/tracing/isolation takes place based on demand modelling (i.e. where epidemiological data indicates likely resurgence of COVID-19 cases)
- Providers should work with payers (e.g. insurance companies) to educate potential patients on available telehealth services and how to monitor symptoms
- Providers should also engage with government public health agencies to allow tracing of COVID-19 patients, and manage inflow of tracing information on other patients to guide future capacity planning
- Registration and billing for testing must be in place for providers and payers - this is crucial to ensuring some cash flow from testing.
- Payers should incentivise and reimburse providers in conducting testing/tracing/isolation, and help to create shared guidelines with providers to reinforce with patients. Where providers deliver COVID-19 care with alternative arrangements of staff/location, payers should support this financially
- Payers can also coordinate epidemiological data from different providers, to provide broader dataset to inform future demand modelling for COVID-19 care.

https://hbr.org/2020/07/how-hospitals-can-meet-the-needs-of-non-covid-patients-during-the-pandemic

PHASE 3: RETURN

Providers and payers can take steps across their organization to reactivate non-COVID capacity.

	Provider	Payer
Talent	• Establish proactive program for caregiver healing • Understand gaps in readiness to scale non-COVID capacity	• Engage in broad workforce renewal • Supplement talent in areas of emerging importance to next normal
Customers	• Reestablish the health system as a safe place for patients • Learn patients' preferences on new forms of healthcare	• Engage at-risk members • Promote a differentiated telehealth program
Operations	• Design operations to allow for flexible transition from/to COVID operations • Sequence return of non-COVID clinical volume	• Ensure appropriate payment for services offered during crisis • Double down on member communications, care/utilization management, and care navigation
Regulations	• Engage regulators to maintain crisis-driven changes in rules where patient care was improved • Coordinate on widespread testing and tracking initiatives	• Engage regulators to clarify and/or codify rules established in crisis • Shape the narrative on how next normal may be regulated
Finance	• Begin proactively utilizing new capabilities • Appropriately generate reserves	• Allocate capital to developing new capabilities • Ensure appropriate reserves

1. Innovate outpatient management to reduce demand at downstream bottlenecks.
2. Combine essential non-Covid inpatient services across hospitals.
3. Group hospitalized Covid-19 patients by their underlying clinical conditions.
4. Discharge patients into post-acute care based on Covid-19 status.

- HOSPITALS: Slowly resume some elective procedures and reduce capacity for COVID-19 surge, based on epidemiological data specific to hospital coverage area
    - Elective procedures were predictable source of cash flow, which had to be put on hold in favour of COVID-19 treatment - this only maintains revenue if cases surge and capacity is filled. In areas where social distancing has been effective in curbing the pandemic, this may not be as necessary.
- PHYSICIAN PRACTICES: Shift to telemedicine consults as far as possible, with priority given to potential stroke / chest pain / appendicitis / [other serious

condition] sufferers

- PAYERS (insurance companies): Encourage hospitals where possible to re-introduce some capacity for emergent care (e.g. trauma cases, which require rapid ER response) and non emergent care (e.g. joint replacements) - particularly in areas where social distancing has been effective and hospitals are better positioned to expand non-COVID capacity (see HOSPITALS)

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