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Healthcare Valuation Implications of COVID-19

As of March 31, 2020, more than 160,000 Americans have been diagnosed with the coronavirus (COVID-19) – the greatest number of confirmed cases of any country in the world – resulting in approximately 3,100 deaths.[1] The COVID-19 global pandemic has brought a time of grave uncertainty for U.S. healthcare and the greater economy. Both the legislative branch and the executive branch of the federal government have taken a number of unprecedented actions in an effort to stem the effects of the pandemic. Consequently, the uncertainty surrounding the resulting paradigm changes on the U.S. healthcare industry may have lasting and significant valuation implications – both now and in the future.

Recent Legislative Actions

During March 2020, the U.S. Congress has passed various pieces of legislation to combat both the surge in demand for healthcare services (and resulting shortages in healthcare workforce manpower and supplies) and the detrimental effects that the pandemic has had on the U.S. economy to date.

On March 6, 2020, President Trump signed the $8.3 billion *Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020*,[2] which authorizes several significant activities and expenditures by the U.S. government, including the following:

(1) The *Telehealth Services During Certain Emergency Periods Act* (TSDCEPA) of 2020, which gives authority to the Secretary of the *Department of Health and Human Services* (HHS) to lift some telehealth delivery restrictions;[3] and,

(2) $6.2 billion delegated to HHS for activities such as:

  (a) The *Public Health and Social Services Emergency Fund* (PHSSEF) – $3.4 billion in funding is delegated to: the *Biomedical Advanced Research and Development Authority* (BARDA) to research potential vaccines and therapeutics relating to coronavirus; contingency funding for vaccines and other therapeutics; and, the *Health Resources and Services Administration* (HRSA) to provide grants under the Health Center Program;

  (b) $1.9 billion delegated to the *Centers for Disease Control and Prevention* (CDC), to be directed to state and municipal response efforts relating to the pandemic and replenishment of the *Infectious Diseases Rapid Response Reserve Fund*;

  (c) $836 million delegated to the *National Institute of Allergy and Infectious Diseases* (NIAID), for the research of therapies and vaccines; and,

  (d) $61 million delegated to the *Food and Drug Administration* (FDA), to develop and review vaccines and other treatments to COVID-19.[4]

On March 15, 2020, Congress also passed the *Families First Coronavirus Response Act* (drafted by House Democrats and endorsed by President Trump), which provides for free COVID-19 testing, paid leave, enhanced unemployment insurance, expanded food security initiatives, and increased Medicaid funding.[5]

On March 27, 2020, Congress passed (and President Trump signed) a $2 trillion economic stabilization package, the *Coronavirus Aid, Relief and Economic Security (CARES) Act*, that provides funds to individuals, businesses, and states. The CARES Act will also provide direct funding to the healthcare industry through a number of additional measures, including:

(1) $100 billion to hospitals, for the purpose of reimbursing expenses and lost revenue related to COVID-19, plus an additional $250 million to increase their surge capacity;

(2) A 20% increase in Medicare payments to hospitals related to treatment of COVID-19 inpatients;

(3) A delay in disproportionate-share hospital (DSH) payments through November 2020, which will effectively increase reimbursement to those safety-net hospitals; and,

(4) A suspension of Medicare sequestration (which will effectively increase most Medicare provider reimbursement by 2%) through the end of 2020; and,

(5) Advance Medicare payments to critical access and other hospitals that request them to

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help balance out their cash flows (based on payments received in 2019), which may be paid back over a one-year period;

(6) An extension of several Medicare and Medicaid programs until November 30, 2020, which may allow Congress to revisit certain healthcare programs and policies (e.g., surprise billing, prescription drug prices) after the 2020 U.S. Presidential Election.

Recent Executive Branch Actions

In addition to the various laws passed by the U.S. Congress, the president and various government agencies have taken a number of steps to ameliorate the crisis. On March 11, 2020, President Trump announced aggressive measures to combat the spread of coronavirus, including:

(1) Instructing the *Internal Revenue Service* to allow high deductible health plans (HDHP) to provide health benefits associated with testing and treatment of COVID-19 without application of the deductible or below the deductible amount without losing tax status as an HDHP thus allowing tax-favored contributions to health savings accounts (HSA) by patients;[6]

(2) Collaborating with national health insurers to cover all American patients' COVID-19 testing and treatment, without copayments;[7] and,

(3) Instructing the *Department of Treasury* to defer tax payments for individuals and businesses impacted by COVID-19.[8]

On March 13, 2020, President Trump officially declared the COVID-19 pandemic a national emergency.[9] This proclamation allows for greater flexibility for healthcare providers and access to additional resources for states. Following the proclamation, the *Centers for Medicare & Medicaid Services* (CMS) issued a number of waivers for healthcare providers and announced other, additional measures, which are active for the duration of the pandemic:[10]

(1) The *skilled nursing facility* (SNF) three-day rule (which requires Medicare beneficiaries to have a three-day hospital stay before Medicare pays for SNF services) has been waived;

(2) *Critical access hospitals* (CAHs) are no longer required to (a) limit the number of beds to 25; or, (b) limit patient length of stay to 96 hours;

(3) The requirement that acute care hospitals house acute care patients and psychiatric patients in distinct units separate from the rest of the hospital has been waived;

(4) Lost or damaged durable medical equipment (DME) may be replaced without a face-to-face patient encounter;

(5) Providers already licensed in one state may now practice in another state without a license;

(6) Providers (both physicians and non-physician practitioners) may receive expedited temporary Medicare billing privileges, waived application fees, and waived background checks;

(7) States may apply for section 1135 waivers, which would allow their Medicaid programs to relax various restrictions, including:

(a) Reimburse out-of-state licensed providers under the state's Medicaid program;

(b) Authorize providers to provide care in alternative settings; and,

(c) Suspend prior authorization requirements.[11]

Recent Federal Reserve Actions

In response to the economic instability, the Fed (a governmental agency) has also made a number of drastic moves to offset the greater market panic resulting from COVID-19:

(1) On March 15, 2020, the federal funds rate was reduced 1% to between 0.00% and 0.25%;[12]

(2) On March 15, 2020, the Fed directed the Open Market Trading Desk (the Desk) to increase holdings to $500 billion in Treasury securities, and $200 billion in mortgage-backed securities in the coming months;[13] and,

(3) On March 17, 2020, a lending facility was established to support short-term commercial debt markets (similar to what was used during the *Great Recession*).[14]

These unprecedented measures are the most aggressive since the *Great Recession*, the most significant economic downturn since the Great Depression, which lasted from December 2007 to June 2009.[15] Subsequently, on March 23, 2020, the Fed announced additional, broader measures, including:

(1) Removal of the March 15 limit on the purchase of treasury securities and mortgage-backed securities. The Open Market Trading Desk will make purchases in "*the amounts needed*" to support smooth market functioning and effective transmission of monetary policy to the broader economy;

(2) Establishment of new credit programs to support up to $300 billion in financing to employers, consumers, and businesses;

(3) Establishment of two facilities to support credit to large employers – the *Primary Market Corporate Credit Facility* to provide new bond and loan issuance, and the *Secondary Market Corporate Credit Facility* to provide liquidity for outstanding corporate bonds;

(4) Establishment of the *Term Asset-Backed Securities Loan Facility* to support credit to consumers and businesses;

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(5) Expansion of the *Money Market Mutual Fund Liquidity Facility* to include additional securities, including municipal variable rate demand notes and bank certificates of deposit, in order to facilitate the flow of credit to municipalities; and,
(6) Expansion of the *Commercial Paper Funding Facility* to include high-quality, tax-exempt commercial paper and reduction of facility pricing.[16]

Despite these measures, financial market conditions have remained volatile:[17]

(1) As of March 16, 2020, the Dow Jones Industrial Average, the Standard and Poors 500, and the Nasdaq indices have all entered bear market territory (a fall of more than 30% from recent highs);[18]
(2) Selloffs in the S&P 500 have triggered multiple trading halts;
(3) All 11 sectors of the S&P 500 have seen considerable stock price declines;
(4) Stocks of airline and cruise industries have tumbled more than 20%;
(5) International financial markets have seen precipitous declines;
(6) Most multinational corporations project a decline in earnings due to the pandemic;
(7) The U.S. dollar has surged against all major currencies, an indication of stressful market periods;[19] and,
(8) A record number of Americans, 3.28 million, filed for unemployment benefits the week ending March 26, 2020.[20]

Valuation Implications

The financial market conditions above will impact valuations performed on or after December 31, 2019.[21] Previous *Black Swan Events*, i.e., an unpredictable event that is beyond normal expectations for a situation and has potentially severe consequences (such as the *Great Recession*),[22] as well as evaluation of current events and market conditions, can help provide guidance for the impact upon the valuation of healthcare enterprises, assets, and services.

Valuation Approaches for Healthcare Enterprises, Assets, and Services

The impact of the financial market conditions above on the valuation of healthcare enterprises, assets, and services will partially depend on the valuation approach utilized. The three general classifications of valuation approaches are:

(1) Income approach-based methods:

Income approach-based methods seek the present value of anticipated future economic benefits that will accrue to the willing buyer of the business, asset, or service. In addition to estimating the future economic benefits of post-transaction ownership, an appropriate discount rate, risk-adjusted for the property interest, by which the benefits are discounted to present value, must also be developed.

(2) Market approach-based methods:

Market approach-based methods are premised on the foundation that actual transactions of similar property interests guide value. The efficient market hypothesis posits that prices derived from well-functioning, publicly traded markets are reflective of all pertinent information available to the participants in the market, i.e., a price derived from market transactions represents the market consensus present value of the expected future economic benefit to be received from the ownership of the enterprise, asset, or service by a willing buyer.

(3) Asset/Cost approach-based methods:

Asset/cost approach-based methods seek an indication of value by determining the cost of reproducing or replacing an asset or providing a service.

No matter which valuation methodology is selected, economic value is quantified as the expectation of future economic benefit to be derived from the ownership or receipt of the property or service, respectively.

Impact on the Valuation of Healthcare Enterprises and Assets

Hospitals and other healthcare enterprises will see significant financial impacts from the cancellations of financially vital procedures. In a recent survey of orthopedic surgeons, interventional cardiologists, and anesthesiologists, 23% of responding physicians noted an increase in deferrals or cancellations of procedures, and 55% of responding physicians expected that deferrals and cancellations will continue to increase.[23] While the cancellations of elective procedures have been primarily initiated by patients, the need for additional inpatient capacity at healthcare facilities could drive a further reduction in elective procedures,[24] especially given the direction from the *Centers for Disease Control and Prevention* (CDC) that hospitals in affected regions cancel non-urgent procedures for an indefinite amount time[25] and the recommendation from professional societies such as the *American College of Surgeons* that hospitals be prepared to call off all elective surgeries during the pandemic.[26] Cancellations of profitable cardiac and orthopedic elective surgeries will undoubtedly hurt hospital margins. In addition to the loss of revenue from elective procedures, there will also be increased costs related to space, supplies, and staffing needed to respond to COVID-19 cases. According to *S&P Global Ratings*, hospitals could see up to a 20% decline in admissions for up to six months.[27] *S&P Global Ratings* has lowered its financial outlook for hospital companies *LifePoint* and *Tenet Healthcare* due to the pandemic and the effects on revenue.[28]

These factors could lead to a negative impact on the short-term economic benefits that would be derived from ownership in healthcare enterprises and assets, even with current legislative actions.

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The long-term impact of the COVID-19 outbreak on U.S. economic growth and the U.S. healthcare industry is currently uncertain. This uncertainty may also present significant opportunities for healthcare providers, especially for providers that are providing telehealth services.[29] In fact, the temporary roll-back of regulations has increased demand for telemedicine services 10- to 20-fold.[30]

In addition to adoption and provision of telehealth services, there is an increase in the use of additional tools and technologies to help manage patient outcomes, such as remote clinical observation and disease management; improved communication tools; self-service diagnostics and self-care tools; predictive analytics and knowledge management; artificial intelligence; informational chatbots; cross-industry collaborations; and, innovative care models.[31] Those companies and providers that can make this transition, or already have, may differentiate themselves from their competition and guideline comparables (which may lead to a higher indication of value based upon market approach based methods), and/or provide enhanced economic benefit of ownership with reduced uncertainty (which may increase value under income approach based methods), both of which may warrant a positive impact on value. In addition, those companies and providers that have already spent the resources, time, and funds may increase value under a cost approach based method.

Further, it is important to note that when considering income-based valuation methods, up to 75% of the value could exist in the terminal period (i.e., period beyond the short-term discrete projection of economic benefits).[32] The long-term impact of the COVID-19 outbreak on the valuation of healthcare enterprises and assets remains to be seen. However, the long-term prospects of those companies who are positioned to deliver care in a high quality, cost-effective manner in the post-COVID-19 world may outweigh any short-term negative impact on valuations from COVID-19.

Impact on the Valuation of Healthcare Services

The majority of compensation arrangements have not factored in compensation during extreme public health crises such as the current COVID-19 outbreak. Regulatory guidance will continue to change around compensation arrangements that are revised or entered into during and after the COVID-19 outbreak.

Currently, there is strong demand for essential services in the emergency departments and intensive care units at the epicenter of the COVID-19 outbreak, and hospitals are attempting to redeploy specialists who do not typically treat infectious diseases to meet the excess demand.[33] There may be a need to change compensation arrangements to provide payment to these providers for working extra hours and facing additional risk. The amount of hazard pay that providers would qualify for would depend upon the selection of an appropriate proxy for the determination of the hazard pay premium and would likely vary on a case-by-case basis as some providers may already work in inherently dangerous environments and some amount of compensation may already be factored into existing arrangements. Certain qualitative factors may also impact the necessity for hazard pay, such as situations where there is insufficient personal protective equipment for providers, which would require providers to reuse equipment and increase risk of infection.[34]

Physicians and non-physician providers providing non-essential services under provider services agreements (PSA) will likely experience a near-term decline in productivity due to the limitation or cancellation of elective procedures. Hospitals may consider converting affected specialists to a fixed salary or stipends to temporarily stabilize their income and minimize the impact to these specialists.

On March 30, 2020, CMS published "*Blanket Waivers of Section 1877(g) of the Social Security Act*," wherein the HHS Secretary waived certain requirements under the Stark Law (subject to certain conditions), including:

(1) Remuneration between an entity and a physician (or the physician's immediate family member) that is above or below fair market value for:
   (a) "*services personally performed by the physician (or the immediate family member of the physician) to the entity*;"
   (b) "*items or services purchased by the entity from the physician (or the immediate family member of the physician)*;"
   (c) The use of premises or for items or services purchased, medical staff incidental benefits;
   (d) Nonmonetary compensation that surpasses the current Stark Law limit of $300 per year; and,
   (e) Remuneration resulting from a loan with an interest rate below fair market value; and,

(2) Rental charges between an entity and a physician (or the physician's immediate family member) that is above or below fair market value for the lease of office space or equipment.[35]

CMS provided specific examples wherein these blanket waivers may apply, including a hospital compensating a physician above the contracted rate in recognition of "*particularly hazardous or challenging environments*."[36]

While these waivers provide needed relief to healthcare providers, this does not eliminate the need for a fair market value analysis in order to comply with fraud and abuse laws. Fair market value of these arrangements will vary on an individual basis and adequate documentation for the necessity of these arrangements will reduce regulatory risks should the arrangement be subject to scrutiny in the future.

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Fair market value of compensation arrangements will vary on an individual basis and adequate documentation for the necessity of these arrangements will reduce regulatory risks should the arrangement be subject to scrutiny in the future.[37] Further, documenting the commercial reasonableness of these arrangements may prove vital to substantiating the extraordinary circumstances of the change in compensation, as a commercial reasonableness opinion may serve to set forth the qualitative aspects of such an arrangement and provide the reasoning behind compensation changes.

In addition to the above, existing pay-for-performance compensation models may require normalizing adjustments for the period impacted by COVID-19.

Future physician compensation arrangements will need to take into consideration normalizing adjustments to industry normative benchmark compensation data for 2020. Some healthcare systems are temporarily reducing non-essential physician compensation, which may impact the compensation reported in the industry normative benchmark compensation data for 2020.[38]

Conclusion

While the focus of healthcare providers and regulators is, appropriately, on the access to and delivery of care to those impacted by the COVID-19 outbreak, the regulatory scrutiny related to fraud and abuse issues will persist. This current uncertainty creates a plausible scenario wherein a valuation professional may be required to deviate from industry normative benchmark data to account for those specific facts and circumstances related to a given transaction. As a result, valuation professionals opining on these transactions should utilize an evidence-driven methodology that includes both qualitative and quantitative assessments of the specific facts and circumstances related to the transaction; document their consideration of these facts and circumstances; and, articulate their ultimate applicability to the transaction in support of their opinion.

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