McDERMOTT HEALTH 2023 ANNUAL REPORT

HOSPITALS AND HEALTH SYSTEMS 2023 OUTLOOK

McDermott Will & Emery

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SPECIAL REPORT

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INTRODUCTION

Historically viewed as recession-proof, 2023 is expected to be a challenging year for the healthcare industry as macroeconomic factors –inflation, high labor expenses, volatile markets, supply chain snarls and other issues – exert their influence in ways not previously seen.

In addition, healthcare providers – including hospitals and health systems – must grapple with the end of the COVID-19 public health emergency (PHE), which will require unwinding the multi-layered changes that were put into effect during the PHE.

Read on for the McDermott Health perspective on key topics impacting hospitals and health systems in the year ahead.

CONTEMPLATING MEGA-MERGERS: WHAT TO WATCH

Several mergers between health systems in different states successfully closed in the past year, and more of these "mega-mergers" are expected to follow as health systems pursue further economies of scale amid challenging financial headwinds. If a transaction does not present traditional horizontal consolidation concerns because the parties operate in different states or regions, stakeholders should consider whether the federal antitrust enforcement agencies may assert a "cross-market" theory of competitive harm.

Certain academic literature (see here and here) discusses the potential competitive effects of cross-market hospital mergers. A cross-market hospital merger is between hospitals that operate in distinct geographic areas. The merger does not eliminate any competition between the hospitals to attract patients since the hospitals service distinct patient populations. The literature suggests that this type of merger can nevertheless present competitive effects where the merging hospitals have common payor and employer customers and are competing to be in the same payor and employer networks.

Federal Trade Commission (FTC) staff previously announced the addition of cross-market theory questions to second requests in merger investigations. To date, however, the FTC has not formally challenged a hospital or health system transaction based on a cross-market theory of competitive harm. At a minimum, the FTC likely would have to show that the merging health systems had material overlapping payor customers. For mega-mergers between health systems in different states, the same payor would have to operate in multiple states or the parties would have to contract with payors for material national contracts. At least one state, California, has alleged these theories as well.

DEALS WITH DISTRESSED HEALTH SYSTEMS: NEW OPPORTUNITIES FOR EXPANSION

Distressed health systems likely will be at the center of an increasing number of transactions in 2023. Economic factors, the wind-down of COVID-19-related government spending and subsidies, governmental and third-party payor reimbursement pressures, and hits to investment portfolios have placed many hospitals and health systems in a vulnerable position. Many health systems are at risk for bond covenant violations and as a result are taking proactive steps to better position their organization, including reallocating resources towards the organization's core mission and strengths, eliminating underperforming service lines, and outsourcing operational and support functions. Many distressed health systems are also considering potential sales to third parties, including those outside the traditional healthcare ecosystem. Large healthcare retailers, technology and private equity investors are all venturing further into the healthcare space, and these companies may offer attractive deal terms for distressed organizations.

When looking to acquire or invest in distressed health systems, due diligence led by parties with deep experience in the business of healthcare is critical to determine whether the factors that led to distressed status can be remedied. In some cases, the Chapter 11 process may be appropriate to maximize benefits to the distressed health system and start the acquisition on more favorable terms. For example, the Chapter 11 process provides an opportunity to terminate certain contracts and leases that may be a drain on the distressed health system's performance.

Communicating with affected stakeholders is especially important when pursuing a distressed health system transaction, particularly when a distressed health system is the only healthcare provider for a community. Parties to a potential transaction involving a distressed health system should anticipate and develop a communications strategy to deal with potential negative responses from local governments, federal antitrust regulators, physicians, patients and the press, and should be prepared to highlight the benefits of the transaction to the community, particularly with respect to continued access to care that may not be possible absent the transaction.

VALUE-BASED CARE IN THE SPOTLIGHT

The coming year will see further divergence between health systems that embrace value-based care (VBC) and its opportunities (and make the necessary strategic moves and investments) and those that do not. This divergence will become more clear now that the debate over the primacy of fee-for-service versus VBC payment models is largely settled. A robust VBC and population health strategy is now table stakes and has been put into sharper focus by the Centers for Medicare & Medicaid Services and the Center for Medicare & Medicaid Innovation, commercial payors (both in terms of new modes of contracting and vertical integration plays, such as with risk-based physician practices), and the associated inevitable and significant site-of-care shifts from inpatient to ambulatory settings.

We expect to see a greater focus on establishing and shoring up system-sponsored risk-bearing physician networks (such as commercially integrated networks and Medicare and commercial accountable care organizations), as well as joint ventures between such networks and physicians, which can double as an opportunity to further those networks' potential as recruitment and retention vehicles. We also expect a new wave of consolidation among risk-bearing networks and risk-based physician practices as the VBC programs evolve, risk adjustment becomes more tailored and sophisticated, risk corridors narrow, exposure to shared losses increases, and the networks and practices get closer to bearing insurance-type risk. Finally, we expect to see a greater demand for service line divestures to, or joint ventures with, for-profit owners and operators of service lines relevant to lowering total medical expense, such as sub-acute, post-acute and behavioral care.

PRIORITIZING INNOVATION INVESTMENT

Leading health systems will continue to make strategic investments in companies and technologies that enable them to tackle operational issues and develop more efficient care delivery models. Increasingly, health systems are making these investments through innovation entities or funds that they launched independently or in partnership with other organizations. Focusing investment activity through a centralized innovation strategy can provide a forum for the health system, clinicians and third parties to suggest and evaluate new technologies or modified clinical processes that address self-identified problems in healthcare delivery. Innovation investments can also create new revenue streams for health systems by allocating capital—either independently or through partnerships with venture capital or private equity funds—to promising early-stage companies. As hospitals navigate financial, reimbursement and staffing challenges, prioritizing innovation investments will better equip hospitals to impact the development of more efficient clinical processes and diversify how and where they provide care.

FORGING NON-TRADITIONAL PARTNERSHIPS

Preparing for a post-pandemic future requires health systems to engage in outside-the-box thinking to improve outcomes while lowering costs and addressing supply chain and workforce issues. Many health systems are navigating the unconventional nature of these challenges by entering into non-traditional partnerships or service arrangements.

Health systems have seen value in working with technology companies to analyze data for the purposes of improving clinical and administrative workflows and achieving better patient outcomes. These initiatives will likely continue with an increased focus on how technology may reduce the administrative burden imposed on physicians and their support personnel, such as through the use of artificial intelligence to better direct patients to more appropriate sources of health information or treatment locations.

Health systems are also expected to continue developing alternatives to traditional group purchasing organizations in an effort to enhance supply chain resiliency and better integrate purchasing activity with clinical needs. Such alternatives may include supply chain joint ventures with geographically diverse health systems or relationships with prominent retailers for non-medical supplies.

Finally, health systems are collaborating with payors in efforts to address social determinants of health. In 2022, for example, Blue Cross Blue Shield of Massachusetts entered into contracts with leading health systems to align reimbursement with health equity goals. Similarly, in California, Medi-Cal is working with health systems, other providers and community organizations to reward coordination of physical, developmental, behavioral and dental health needs with social supports such as housing assistance.

PREPARING FOR THE END OF THE COVID-19 PHE

On January 30, 2023, President Biden announced that the federal public health emergency and national emergency declaration that have been in place since the earliest days of the COVID-19 pandemic will terminate on or shortly after May 11, 2023, while other emergency acts pertaining to liability protections (*i.e.*, the PREP Act covering medical countermeasures, and emergency use authorization authorities for testing, vaccines and other medications) would continue for a longer period. The announcement of the PHE's end date fulfilled the Biden Administration's 2022 promise to provide at least 60 days' notice before the PHE comes to an end.

Since their initiation in March 2020, the federal waivers and flexibilities afforded to healthcare providers as part of the PHE (collectively, waivers) have been viewed as vital components of pandemic response. Even as the PHE continued (renewed a dozen times as the COVID-19 pandemic ebbed and flowed in unrelenting waves), state-level emergency orders and related state law regulatory flexibilities have been slowly rolled back across the country. As of the date of this writing, only eight states still have emergency orders in place, and even where they survive state-level flexibilities have started to wind down.

Covering a broad range of regulatory requirements, the waivers affected myriad aspects of hospital and health system operations, including the following:

- Operational requirements and conditions of participation via "blanket waivers" and individual waivers

- Telehealth requirements
- Enhanced payment for treating patients with COVID-19
- Vaccination and testing at no charge to patients.

The provision of ample notice that the PHE is ending and identification of a specific end date recognizes the level of complexity involved in unwinding the multi-layered changes that were put into place by healthcare facilities and providers—including hospitals and health systems—during the PHE. Because the waivers have been in place for almost three years, their availability has been the norm for the duration of some healthcare providers' careers and, as such, some healthcare facility staff may know of no other way to operate.

CMS recently released updated waiver fact sheets for various provider types, including hospitals and critical access hospitals. Fact sheets for other provider types may be accessed here.

How efficiently facilities can end the use of waivers and return a pre-pandemic norms will vary. In some cases, hospitals and health systems may not have tracked their use of waivers to know what aspects of their operations need to change. Some facilities may need to undertake internal audits or other actions to root out and resolve any remaining practices that will no longer be permissible once the waivers have terminated. Others may have already begun the process of returning to pre-pandemic operations.

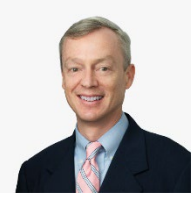
Even if hospitals can identify the waivers under which they have operated and identify a path to return to pre-pandemic operations, certain issues are likely to be in flux up to the PHE's end date as Congress weighs the possibility for legislation to make some of the waivers permanent beyond the PHE. Certain flexibilities, such as those related to aspects of telehealth and continuation of acute care hospital-at-home programs, were already extended via legislation into 2023–2024, although in some cases related provisions were not continued and could complicate ongoing compliance if further action is not taken.

Hospitals and health systems will be challenged to undertake the additional task of winding down reliance on waivers and returning to pre-pandemic operations in a time of staffing and resource concerns. Coordination with a multidisciplinary team at the individual hospital or system level, including input from internal and external advisors, is an important first step to prepare for the PHE's end date.

YOUR PARTNER IN THE YEAR AHEAD

It's during times of difficulty that market leaders emerge, applying their innovative mindsets to overcome the hurdles facing their systems and deliver improved financial outcomes and patient experiences. At McDermott Will & Emery, we work with hospitals and health systems around the country to find creative solutions to their most complex problems – and nothing begets creativity like a challenge.

AUTHORS



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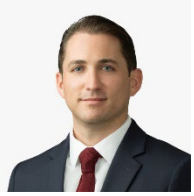

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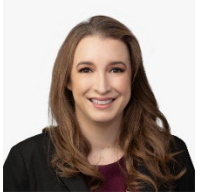

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