
Aaron Mauck, Ph.D.
Our Presenter


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Learning Objectives

At the end of this session, participants should be able to:

1. Explain the potential impact of Covid-19 on the healthcare sector.
2. Discuss strategies that employers, health plans and providers are using to manage revenue and control spending.
3. Describe the changes taking place in healthcare delivery strategies.
A fearsome foe, risen from the mat
As cases and hospitalizations rise, resource shortages threaten anew

Daily Covid-19 deaths and positive tests
From March 26 to July 5

U.S. Covid-19 inpatient bed and ICU bed utilization
From March 26 to July 5

Positive tests
Daily deaths
Inpatient bed utilization
ICU bed utilization

Source: "US Historical Data," The COVID Tracking Project.
What will the new normal look like?
New questions emerge as others come into focus

Known quantities:
1. How deep is the initial drop in utilization?
2. How long do we stay at the bottom before beginning to reopen?
3. How fast is the operational rebound as supply returns?

Outstanding questions:
4. How does utilization fall and rise in the medium to long term?
5. Is the “new normal” baseline different than before?
Consumer mindsets and circumstances suddenly reshaped
Covid-19 to have lasting—and potentially permanent—impacts on behavior

Profile of the “peri-Covid” consumer

More fearful
70% of consumers are very or somewhat concerned about contracting Covid-19 at a health care facility1

Financially insecure
36% of consumers have experienced a change in employment status due to Covid-192

More experienced
19% of consumers who used a virtual visit during the pandemic were new to telehealth2

Sicker
15% of consumers with a chronic condition lost insurance coverage due to Covid-192

More likely to self-ration?
45% of healthy consumers say they are skipping their annual physical due to Covid-193

Certainty of impact
Permanence of impact


1. As of April, 2020.
Resilience is not a zero-sum game
Efficient, flexible, agile and equitable strategies bridge the gap

Delivery system needs
- Durable
  - Capacity
  - Clinical staff
  - Stockpiles
  - Reserves

Purchaser demands
- Affordable
  - Taxes
  - Budget obligation
  - Benefit costs
  - Claims payments
  - Delivery costs
  - Consumer expenses

Resilient
Efficient | Flexible | Agile | Equitable
For purchasers, Covid-19 amplifies preexisting pressures
Purchasers all facing budget pressures but with widely variable urgency, tool sets

To what extent will Covid-19 shift purchaser motivation and ability to control health spending?

**Medicare**
Despite spending trillions of dollars on Covid-19 relief, the federal government has more flexibility than any other purchaser

**Medicaid**
Need to balance state budgets offers a clear mandate; solution set limited but also straightforward

**Employers**
Despite substantial revenue pressure, deferred care means health care costs trending below budget—for now

**Health Plans**
Short-term dynamics favor insurers, but looming uncertainty around pricing, revenue, future utilization make correct strategy extremely difficult to judge
Medicare spending continues to accelerate
Per-capita spending overtakes enrollment as primary driver of spending growth

Medicare-eligible seniors make up an increasing share of the population...
Percent of U.S. population ages 65+

...and every year the amount that Medicare spends on each enrollee grows
Per capita Medicare beneficiary spending

No Medicare price cuts in 2021
But CMS will continue to pursue other cost savings levers

CMS does not opt for provider reimbursement cuts during acute phase of pandemic...

IPA$1 rate increase remains steady

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final rule</td>
<td>1.45%</td>
<td>2.76%</td>
<td>2.93%</td>
</tr>
</tbody>
</table>

…but other cost savings options are still moving forward

- Site-of-care shifts
- Value-based care programs


1. Inpatient Prospective Payment System.
Medicare policy continues to impel site-of-care shift
Momentum growing across wider range of services

Recent changes to Medicare reimbursement favor moving patients out of the hospital

- **Inpatient to outpatient**
  - Example: Total hip arthroplasty removed from inpatient only list

- **Provider-based setting to home**
  - Example: Reimbursement for infusions delivered at home

- **Outpatient to ambulatory**
  - Example: Three PCI procedures added to ASC covered procedures list

- **Bricks-and-mortar setting to virtual**
  - Example: Expanded telehealth reimbursement

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1. Percutaneous coronary intervention.
Medicare price cuts still on the table if other measures fail
Depleted Trust Fund approaching levels that have triggered firmer action in past

The longevity of the Medicare Hospital Insurance (HI) Trust Fund has fluctuated since its inception

Number of years projected until HI Trust Fund insolvency

1997: BBA reduces provider payments, increases premiums
1997: BBA increases payroll tax revenue, implements Medicare productivity adjustments
2010: ACA increases payroll tax revenue, implements Medicare productivity adjustments

Covid-19 relief could force Congress to take action sooner
Accelerated Payments and 20% Medicare add-on payment for Covid-19 patients will further deplete HI Trust Fund

Medicaid a massive state budget item—and a massive target
States’ efforts during last recession portend even more focus this time

A clear target in 2008 recession
Percent change in state Medicaid spending

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>5.8%</td>
</tr>
<tr>
<td>2009</td>
<td>-10.9%</td>
</tr>
<tr>
<td>2010</td>
<td>-4.9%</td>
</tr>
</tbody>
</table>

While state spending decreased in 2009 and 2010, total spending grew due to increased Federal Medical Assistance Percentage.

Likely to be an even bigger target this time around
State budget expenditures, FY 2019

- Medicaid: 28.9%
- Transportation: 33.4%
- Primary and secondary education: 19.5%
- Higher education: 10.1%
- Other: 8.1%

The average share of a state’s budget going toward Medicaid increased from 19.1% in 2000 to 28.9% in 2019.

DATA SPOTLIGHT
12.7M
Estimated number of individuals who became eligible for Medicaid between March 1 and May 2, 2020 due to unemployment.

All things considered, Medicaid price cuts likely
State strategies likely to revisit tactics deployed during Great Recession

Majority of states were forced to turn to price cuts during last recession

States reporting at least one provider rate cut or freeze

Only 18 states made cuts to optional benefits like physical therapy, medical supplies or dental coverage

[The looming crisis facing Medicaid programs] is going to be the ’09 recession on steroids. It’s going to hit hard, and it’s going to hit fast.”

Matt Salo, Executive Director
NATIONAL ASSOCIATION OF MEDICAID DIRECTORS

Employers unlikely to reuse Great Recession playbook
Cost-shifting opportunity not completely exhausted, but less attractive now

Common employer benefit changes post-2008 recession
Percent indicating likely or very likely to make or keep changes after economy recovers, 2009

n=329 human resources professionals

- Increase employee share of health coverage costs: 62%
- Combine leave into PTO bank: 35%
- Reduce pension plans: 33%
- Reduce retirement contributions: 31%
- Reduce health coverage for dependents: 30%
- Eliminate paid relocation: 26%
- Reduce leave annual carryover: 26%
- Reduce leave accruals/balances: 22%

Critical distinctions between employer landscape in 2009 vs. 2020

- Employers have already pursued easy savings opportunities and additional progress will require significant time and effort
- Optics of cutting health care benefits during a pandemic are poor
- Typical employer savings due to canceled elective procedures through First Half 2020: 3-5%

Referral management increasingly a top priority
Consumers now more tolerant of managed care—if the price is right

Cost sharing increased acceptance of managed care
Percent of people who report cost- or coverage-related features as the most important aspects in a health plan

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost-related (%)</th>
<th>Coverage-related (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>33</td>
<td>60</td>
</tr>
<tr>
<td>2018</td>
<td>26</td>
<td>59</td>
</tr>
</tbody>
</table>

Likely employer strategic approach post-Covid-19

Network alignment
- Hyper-narrow networks
- Dedicated (or owned) providers

Price incentives
- Value-based cost sharing
- Advance price information
- Reference pricing

Referral management
- HMO gating
- Virtual visit-based triage
- Second opinion service

At first glance, Covid-19 a windfall for insurers
Insurance one of few industries with short-term financial shelter during pandemic

Early data shows stable finances

DATA SPOTLIGHT

30%
Decrease in non-elective procedures

-$101B to -$10B
Net cost impact on health plans in 2020 at a baseline infection rate of 20%

11% increase
Q1 revenue of the seven largest health insurers over same time period in 2019

“It very well could be that under the circumstances, deferrals of services outweigh COVID-19 costs,”
United HealthGroup,¹ Q1 2020 Earnings Call

“As for medical cost, we expect somewhat offsetting impacts from elevated COVID-19 claims cost and lower medical costs from deferred procedures.”
Cigna, Q1 2020 Earnings Call

“As a result of the higher unemployment rate in the U.S., the suspension of eligibility redeterminations and our product mix, we are increasing our total revenue guidance by an additional $4 billion…”
Centene, Q1 2020 Earnings Call


¹. Advisory Board is a subsidiary of UnitedHealth Group. All Advisory board research, expert perspectives, and recommendations remain independent.
Premium pricing subject to considerable uncertainty
Plans unsure of total impact—or even direction—to future rates and margins

Factors influencing future premium pricing

Expected utilization
- Deferred care
- Covid-19 treatment
- Covid-19 testing
- Covid-19 vaccination

Revenue shifts
- Premium discounts
- Membership changes
- Risk coding accuracy
- Rate increase approvals

Provider reimbursement
- Supportive payments
- Risk-based surplus sharing
- Consolidation impacts on rate negotiation

Financial adjustments
- Available reserves
- Medical loss ratio rebates
- Reinsurance premiums
- Risk mitigation policies
Covid-19 has not prompted fire sales, but long-term outlook still unclear

Physician outlook not (yet) as dire as some headlines suggest

Media predicts extinction of independent physicians

247wallst
“American Doctors Will Go Out of Business by the Thousands”

Bizjournal
“Expect exodus of physicians from health care after Covid-19 pandemic, survey says”

Washington Post
“The coronavirus is bankrupting primary care doctors”

Variety of structures propping up practices (for now)

Government loans and grants
CARES act advanced payments and small business loans have provided temporary relief

Advanced payments from health plans
Some insurers have followed the government’s lead in advancing payments to physicians

Loosened telehealth restrictions
Have enabled practices to maintain revenue streams with relatively minimal investment

Voluntary pay cuts, furloughs, PTO
Physician shareholders have opted to take a short-term hit in hopes of maintaining viability
Covid-19 will drive some physicians to seek or switch partners
Nature of deals will depend on underlying physician motivation, post-Covid finances

<table>
<thead>
<tr>
<th>Prevalence</th>
<th>Small groups seeking financial support</th>
<th>Disgruntled individuals seeking new home</th>
<th>Big influential groups making strategic plays</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ex: Small primary care and single specialty practices</td>
<td>Ex: Employed physicians with adjusted compensation</td>
<td>Ex: Large multispecialty groups, risk-based primary care groups</td>
</tr>
<tr>
<td>Time frame</td>
<td>Near-term (need immediate capital infusion)</td>
<td>Medium-term (“wait and see”)</td>
<td>Longer-term (considering their options)</td>
</tr>
<tr>
<td>Agency in deal-making</td>
<td>Compromising when necessary</td>
<td>Depends on strategic value of individual physician / specialty</td>
<td>Can afford to be choosy</td>
</tr>
</tbody>
</table>
Hospital consolidation hitting a rough patch before Covid-19
Exhibiting either cold feet or prudent restraint, leaders second-guessing rush to scale

Prominent deals called off

- Partners HealthCare
- Care New England
- Gundersen Health System
- Marshfield Clinic
- Baylor, Scott & White Health
- Memorial Hermann Health System
- Sanford Health
- UnityPoint Health
- Beaumont Health
- Summa Health
- Jefferson Health
- Einstein Healthcare Network

Why have deals been falling through? Hint: FTC approval isn’t always the barrier

1. Conflicts and disagreements between leadership teams lead to dissolution of deals
2. Premature mergers motivated by defensive moves rather than true organizational alignment
3. Acknowledgement that gains beyond pricing leverage are practically challenging and empirically rare
M&A likely to remain slow through 2020, but not indefinitely
New motivations for deal-making may emerge

Factors contributing to a **near-term slowdown**

- Management teams actively redeploying resources and investing time to manage Covid-19 crisis
- Reduced cash on hand as a result of delayed and cancelled care
- Organizations waiting for health care demand to stabilize before committing to mergers and acquisitions

Possible drivers of **long-run M&A acceleration**

- **Mounting financial challenges** ("have-to" scenarios)
  Will financial pressure from Covid-19 force previously unwilling partners to seek shelter in scale?

- **New returns to scale** ("want-to" scenarios)
  Will the emerging competitive landscape offer organizations new opportunities to find value in scale and achieve true "systemness?"

- **More regulatory freedom**
  Will regulators accept new (or old) arguments for the benefits of consolidation and permit M&A where they had not before?
Put to the test: Were larger systems more resilient?
Some systems able to reap rewards of systemness (not just scale)

**CLINICAL ADVANTAGE**

**Montefiore Medical Center**
11 hospitals • Bronx, NY

Created a command center to enable critical care physicians to provide virtual support to staff across the system; enabled the system to manage with a 1:50 critical care physician ratio

**STRUCTURAL ADVANTAGE**

**NorthShore University HealthSystem**
5 hospitals, 140+ practices • Evanston, IL

- Transformed a single hospital campus into a dedicated Covid-19 treatment center for the system
- Allowed the system to triple its ICU surge capacity

**OPERATIONAL ADVANTAGE**

**Novant Health**
15 hospitals, 350+ practices • NC, SC, VA

- Built an interactive, real-time dashboard at the system, region, facility, and clinic levels to preempt supply shortages and shift resources across system
- As of June, no Novant facility had experiences shortfalls in ventilators, PPE or other resources

**TRANSFORMATIONAL ADVANTAGE**

**UC San Diego Health**
2-hospital academic system • San Diego, CA

- University engineers developed a monitoring platform for Covid-19 patients to recover at home using a wearable device and an app
- System is being tested by patients in a clinical trial at the health system

Stay-at-home economy opens new frontier for site-of-care shift
Covid-19 exposes more patients to benefits of home care

Factors encouraging increased utilization of home care during pandemic

- Patients feel safer getting care at home rather than going to a health care facility
- Patients experience convenience of receiving care at home during Covid-19 lockdown
- Patients are getting comfortable using technology for virtual care and remote monitoring
Many pushing for transition of senior care into the home
Bleak funding outlook for SNFs\(^1\) intensifies focus on home-based care

Advocates rally for more funding in facility-based care…

$4.9 billion vs. $200 billion

First federal Covid-19 relief funds specifically assigned to skilled nursing facilities in late May

Federal relief funds allocated to hospitals by the end of April

…but others instead propose a shift toward the home

I’m encouraged that HHS is finally recognizing the need to respond to the severity of this crisis in our nursing homes and assisted living facilities. **However, this amount is still far short of the funding desperately requested** by our long-term care facilities and their advocates”

—U.S. Representative Abigail Spanberger (D-VA)

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1. Skilled Nursing Facilities.

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DATA SPOTLIGHT

Family members say they plan to substitute in-home care for facility-based care even after the pandemic

67%

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Plenty of practical barriers remain
Patient preference is not the factor preventing transition to the home

**Clinical limitations**
- Many patients have multiple comorbidities
- Requires access to high-licensure staff
- Necessitates 24/7 monitoring, therapy and nursing support

**Environmental constraints**
- Patient needs frequent access to equipment not easily available in home
- Patient’s home has stairs or other obstacles reducing navigability

**Reimbursement barriers**
- Lack of specific codes to bill for under Medicare fee-for-service
- Non-provider caregivers cannot bill for services

**Personal and family challenges**
- Patient lacks caregiver at home
- Patient faces housing instability
- Patient has limited health literacy

Advisory Board interviews and analysis.
Telehealth adoption off the charts during shutdown
Investment boom a big opportunity for Big Tech?

Huge increase in amount of virtual care provided

3,500% Increase in telehealth claims at Blue Cross Blue Shield of Massachusetts between February and March 2020

1,300 New providers added to NYU Langone Health's telehealth platform during crisis

1.7M Medicare fee-for-service beneficiaries received telehealth services in the last week of April

Significant telehealth investments made in 2020

$788M Venture capital funding raised by telehealth companies in Q1 2020; over three times more than raised in Q1 2019

1,818% Amwell files for IPO

168% YTD increase in Teladoc valuation

168% YoY increase in funding for remote patient monitoring startups


1. Year-over-year.
Future telehealth utilization likely to land on middle ground
Providers must take advantage of fleeting experience, flexibility and urgency

Telehealth visits are on the decline
Weekly average of daily telehealth visits at Crestone Health System

Advisory Board perspective: It is unrealistic to expect telehealth use to maintain its unnatural peak achieved during widespread shutdowns, but also to expect it to drop back to pre-crisis levels.

No-regrets telehealth investments

1. Implement telehealth platform that could withstand reinstatement of security regulations
2. Seize opportunity to build “healthy habits” for appointment scheduling
3. Engage all providers, not just early champions, in telehealth use
4. Make believers of patients through positive, supported experience
5. Collect outcome and cost data to prepare case for favorable reimbursement, regulatory posture, stakeholder adoption
Federal stance on telehealth beginning to come into focus
But complex interplay of interests and authority may slow progress

What’s likely to stay?
- Covering telehealth when patients are in their homes or other facilities (i.e., SNF, hospice)
- Permanently including telehealth reimbursement for home health providers
- Expanding the number of services Medicare reimburses as telehealth visits

What’s likely to go?
- Reimbursement parity for telehealth services as if they were delivered in-person
- Allowing hospitals to bill facility fees for out-patients treated in their homes
- Suspending HIPAA enforcement to allow providers to use unsecured services such as Skype

Who controls what?

Congress
- Where patients must be located to receive services
- Which practitioners can bill for telehealth care
- Whether facility fees will be permitted

CMS
- Which telehealth services will be covered
- Whether risk adjustment can continue virtually
- What reimbursement rates will be

Covid-19 forces a closer look at hospital operating models
Tension between durability and affordability especially clear during crisis

“There was this notion that for true change to happen in health care, it had to come from outside of the industry… But Covid-19 has convinced me even more that we have a moral obligation—as well as a path forward—to be the ones transforming health care from within.”

Dr. Gianrico Farrugia, President and CEO
MAYO CLINIC

Covid-19 prompts executives to rethink the largest components of hospital cost structure

1. Supplies
   • How much money do we have to spend to get access to future PPE?
   • Should we rationalize our ambulatory office space?

2. Physical infrastructure
   • Do we need to build flexible inpatient rooms?
   • Should we change how our staff get paid?

3. Workforce
   • How can we engage clinicians that put their lives in danger for our patients?

Source: “Mayo Clinic CEO Gianrico Farrugia on why he doesn’t want to go back to a pre-pandemic world,” At the Helm, Advisory Board, July, 2020.
The supply chain paradox
Supply chain lacking in resilience—but also not particularly efficient

Historical approach to supply chain management

- Laser-like focus on lowering the unit cost for commodities and PPI\(^1\)
- “Just in time” inventory management to minimize holding costs and waste
- Insufficient line of sight into the contracting and purchasing activities of third parties (such as GPOs and distributors)

Net result of supply chain initiatives

- Lacking resilience
  - No transparency to identify shortfalls in supply chain and proactively implement changes
  - Inability to access or produce the increased quantities of supplies needed to respond to Covid-19

- Lacking efficiency
  - Despite low unit costs on specific supplies, other components of the supply chain remain inefficient
  - Severe lack of transparency inhibits efficient use of supplies once purchased

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1. Physician preference items.
2. Group purchasing organizations.
Visibility a necessary component of the solution
Transparency the critical factor in building a more flexible and agile supply chain

Problems with the current U.S. supply chain

Sourcing and manufacturing
Manufacturers rely on the same sources for raw materials, creating potential for large scale shortages across product categories

Logistics and distribution
Tendency to hold limited reserves, instead favoring “just-in-time” purchasing

Purchasing and product use
Inability to accurately forecast demand to predict spikes

Solutions
Visibility into shared sources enables manufacturers to shift practices to avoid significant production interruptions
Visibility into upstream product availability, location of products, and how quickly they can be distributed to care facilities
Visibility into the quantity and location of inventory and individual purchaser demand

Advisory Board Insight
Effective communication between IT teams, supply chain workers, and vendor organizations will be vital to building a more resilient health care supply chain
Cleare sightlines can redefine what’s possible
Shared cost, inventory, forecast data unlock collaboration, savings opportunities

Health systems and distributors
• Distributors can more easily anticipate and accommodate demand spikes
• Systems can “see” their allocated stock within distributor-managed service centers

Distributors and suppliers
• Suppliers can alert distributors more quickly to emerging threats to production volumes
• Distributors (and third-party trading platforms) can increase purchaser awareness of smaller, pre-approved new suppliers

Health systems and clinicians
• Clinicians gain confidence that right products will be available at right time
• Health systems gain greater clinician compliance with contracts and formularies

Health systems and suppliers
• Suppliers can help customers reduce spend on expedited shipping
• Health systems can reduce amount of wasted, unused, or expired product

Clearer sightlines can redefine what’s possible
Fixed cost structure not keeping pace with clinical efficiency
Despite reduction in bed count, U.S. still maintains more excess capacity

Inpatient beds per capita, average occupancy, and average length of stay, by country

962,301
Number of acute care beds in the U.S. in 1992

789,197
Number of acute care beds in the U.S. in 2016

**Inpatient beds per capita, average occupancy, and average length of stay, by country**

<table>
<thead>
<tr>
<th>Country</th>
<th>Beds per 1,000 people</th>
<th>Occupancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>91.6%</td>
<td>2.0</td>
</tr>
<tr>
<td>France</td>
<td>75.6%</td>
<td>3.1</td>
</tr>
<tr>
<td>Germany</td>
<td>79.8%</td>
<td>6.0</td>
</tr>
<tr>
<td>Italy</td>
<td>78.9%</td>
<td>2.6</td>
</tr>
<tr>
<td>Japan</td>
<td>75.5%</td>
<td>2.9</td>
</tr>
<tr>
<td>Netherlands</td>
<td>65.4%</td>
<td>2.4</td>
</tr>
<tr>
<td>Spain</td>
<td>75.3%</td>
<td>3.6</td>
</tr>
<tr>
<td>Switzerland</td>
<td>82.0%</td>
<td>2.1</td>
</tr>
<tr>
<td>U.K.</td>
<td>90.7%</td>
<td>2.4</td>
</tr>
<tr>
<td>U.S.</td>
<td>64.0%</td>
<td></td>
</tr>
</tbody>
</table>

Average length of stay

| Country       | 6.8 | 9.9 | 8.9 | 7.8 | 28.2 | 10.8 | 7.3 | 8.1 | 6.9 | 6.1 |


1. In-patient.
Ambulatory, administrative facilities getting a closer look
Virtualization of care, commerce suggests opportunity for lighter footprint

Virtual care could shrink **ambulatory footprint**—but savings likely modest

**SPOTLIGHT**

Lincoln Medical Group\(^1\) calculated reduction in demand for physical exam space if visits shifted virtually

- Reduction in facility space needed if **one third** of visits and procedures done virtually, despite 20% reduction in exam rooms
- Determined there wasn’t enough justification to scale down office footprint—especially given rate of ambulatory growth

8%

Rationalization of **administrative footprint** more likely

- Encouraging continued telecommuting on a regular and permanent basis
- Cutting back on a portion of offices when existing leases are renewed
- Consolidating administrative offices that require workers to maintain in-person presence
- Canceling new construction of administrative offices, eliminating footprint altogether

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1. Pseudonymed 600-physician medical group.
A agreement for the crisis (and beyond)
Mutual sacrifice unavoidable—challenge is in mutual understanding

I need you to….
• …trust that our workplace is safe.
• …be productive while I’m making cuts.
• …be more flexible.
• …be comfortable with ongoing uncertainty.

In return, I will…
• …address disengagement and burnout.
• …invest in diversity and inclusion.
• …ensure fair compensation.
• …sufficiently staff the mission.
Clinical labor to remain an indispensable asset
Underlying demographics guarantee critical role for constrained resource

Clinical labor market

<table>
<thead>
<tr>
<th>Aging population</th>
<th>First baby boomers reaching age of 75</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sicker population</td>
<td>Growing incidence of chronic conditions</td>
</tr>
</tbody>
</table>

Decreasing workforce supply

<table>
<thead>
<tr>
<th>Retirement wave</th>
<th>Baby boomer clinicians approaching retirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience gap</td>
<td>Tenured clinicians replaced by new and/or recent grads</td>
</tr>
</tbody>
</table>

Potential impact of Covid-19

↓ Depressed demand due to Covid-19 fears, financial fears
↑ Increased patient complexity due to deferred care
↑ Increased patient complexity due to Covid-19 complications
↑ Increasing behavioral health needs and comorbidities

↑ Deferred retirement due to Covid-19-induced financial concerns
↓ Accelerated retirement due to Covid-19-induced burnout
↓ Interruption of education and clinical rotations
↓ Variable volumes limiting opportunities to get hands-on practice
Don’t take goodwill for granted
Dramatic improvement in perceptions after 9/11 also dramatically brief

Negative view of health system mostly holds steady

*Is the U.S. health care system today in a state of crisis, has major problems, has minor problems, or it does not have any problems?*

n= 1,015 adults in all 50 states


DATA SPOTLIGHT

23/25

How health care industry is rated by consumers, compared to 25 other major industries

Source: Advisory Board interviews and analysis.
Assessment Question 1

Which of the following represents an example of the impact Covid-19 is having on revenue across employers, health plans, and providers?

a. Deferral of healthcare services
b. Loss of insurance coverage due to unemployment
c. Employer savings due to canceled elective procedures
d. All of the above
Assessment Question 2

To alleviate the impact of COVID-19, which of the following state or federal tactics are being used?

a. Medicaid provider rate cut or freeze  
b. Decreased reimbursement for telehealth  
c. Reimbursement for infusion services delivered in the home  
d. Both A and C
Assessment Question 3

Which of the following strategies are emerging ways in which providers are delivering care?

a. Shifting site-of-care to home healthcare
b. Expansion of telehealth
c. Increased transparency related to product availability
d. All of the above
References

33. Mayo Clinic CEO Gianrico Farrugia on why he doesn’t want to go back to a pre-pandemic world,” At the Helm, Advisory Board, July, 2020.
Thank you...

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