



The Future of Acute Care: Treating Patients at Home

By **Travis Messina**, Founder and CEO, *Contessa*

The future is now for acute care providers. The so-called emerging trends the industry has watched for years—telemedicine, alternative sites of care, biometric monitoring, and others—have now fully emerged. Due to the pandemic, these offerings have gone from futuristic novelty to essential service nearly overnight for providers, in an industry unaccustomed to rapid, large-scale change.

But there's a reason these ideas were gaining attention even before COVID. For more than a decade now, payers and providers have felt increasing pressure to provide better care at a lower cost, without sacrificing patient satisfaction or risking provider burnout. And, perhaps most notably, patients continue to play a more active role in their care than ever before, starting a new race among competing providers for who can build a more consumer-centric model.

By now, most provider organizations have realized their traditional volume strategy—which can be flippantly characterized as “heads in beds”—is no longer the most efficient or effective way to meet most patients' needs. For hospital leaders who couldn't see the writing on the wall before 2020, the COVID-19 pandemic has made it plainly clear that the established model for providing acute care must, and will, change.

While there are dozens of reasons hospitals and health systems will increasingly focus on at-home care solutions, the most important reason may be the simplest: it's what patients want. In fact, 80 percent of American patients say they would likely use home-based hospital care—that is, acute care delivered inside their home—if it was covered

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by their insurance, according to a 2020 survey by Jarrard Inc. and Public Opinion Strategies.¹

And why wouldn't they? Americans have shifted many of their activities to their homes over the past 18 months. We have adapted (or, for some of us, are still trying to adapt) to working, learning, and socializing remotely.

Hospitals can't undo the momentum building behind today's innovative approaches to acute care. But they can adapt their delivery models to offer acute care in a way that

→ Key Board Takeaways

Questions to ask when determining if your organization is ready to deliver acute care at home include:

1. **What competition exists?** Assess the competitive landscape of high-acuity homecare services in your community. Are others (health systems or independent providers) offering services in the home? If not, there is an opportunity to be the first mover. If so, should you defend your market share?
2. **Are we already in patients' homes?** Do you have at-home care capabilities in place that can be leveraged to expand into a high-acuity homecare program?
3. **What resources do we have?** If you are unsure of the team's ability to expand to higher acuity homecare, do you have an expansive team that can dedicate sufficient time to design this service line or the capital needed to fund building out the clinical capabilities needed for this service line? If not, are there partners that you should evaluate as part of a "buy vs. build" exercise?
4. **How are our contracts structured?** Do you have a managed care strategy in place that incentivizes you to divert patients away from the inpatient setting while still being financially viable to the overall enterprise and not simply the P&L owner of this new service line?
5. **What can our tech platforms handle?** What technological capabilities will you need to replicate the services, monitoring, and turnaround times that a patient would experience on the floor of the hospital?

1 Jarrard Inc. and Public Opinion Strategies, [Coronavirus and Its Impact on U.S. Healthcare Providers](#), April 2020.

meets patients' care needs, lowers costs, prevents readmissions, and creates a better overall experience for patient and provider alike—all by treating patients in the home.

How It Works

The traditional hospital model is something we are all familiar with. A patient presents in the ER, gets admitted to the hospital and transferred to a quieter room, then is discharged to a post-acute setting (either the home or another post-acute facility). Multiple, confusing bills and a high rate of hospital-acquired infections typically follow.

Using a hospital-at-home model, the episode starts the same, but diverges dramatically from there. Once care in the ER is done, patients are evaluated and given the opportunity to spend the rest of their recovery time safely at home with their loved ones and creature comforts like pets and home-cooked meals. In our experience across multiple markets, more than 90 percent of eligible patients opt for this type of care when given the chance. And, on average, this significantly reduces the cost of the stay, the length of the stay, and the likelihood of readmission.

Modern hospital-level care delivered at home is not new—the idea has been around for at least 30 years—but it is becoming increasingly advanced. Contemporary hospital-at-home models combine all the critical elements of inpatient care, the comfort and convenience of the home, and the latest technology and monitoring capabilities.

Supported by modern health informatics platforms, these models enable provider organizations and health plans to deliver excellent care to patients with non-life-threatening conditions—anything from urinary tract infections to pneumonia to dehydration.

With hospital-at-home, patients receive:

- Remote health monitoring
- A custom treatment plan
- Screenings and treatment
- Daily nurse visits
- Physician telehealth consultations

All this means providers achieve cost savings, improve patient outcomes and satisfaction, and set a new standard for alternative site acute care delivery.

How It's Evolving

While the hospital-at-home model has been in the works for some time, its capabilities have shifted significantly in recent years. Companies providing hospital-at-home services responded to the pandemic in kind. For example, amid a looming capacity crisis, Mount Sinai Health System knew it needed to act fast to avoid a catastrophic situation. Third-party partner Contessa Health helped Mount Sinai rapidly adjust its at-home care model—which typically helps patients avoid hospital admissions altogether—into a model that could also provide coordinated, at-home health services for patients who had already begun treatment inside the walls of the hospital. Mount Sinai patients were moved out of the hospital and into their homes within 10 days of the first call, and they continued to receive the care they needed in a much safer, calmer environment: their homes.

Giving providers the capability to deliver care more broadly through alternative care sites is essential to evolving our health system. Data show that risk of infection decreases, patient comfort and satisfaction increases, and the costs to the patients, providers, and payers decrease when appropriately treating patients virtually in their home. Not to mention the contingencies allowed by freeing up bed space in the event of a public health emergency.

Taking care of patients from their location of choice is highly effective in normal times, but it's even more important under today's unique circumstances.

How It's Scaled

In order for hospital-at-home to truly revolutionize healthcare, it must be widely adopted. For that to happen, hospitals need to clear several hurdles, a few of which are listed below.

Managed Care Contracting

While some administrators may see fewer “heads in beds” and assume lost revenue, hospital-at-home models have proven that's simply not the case, thanks to their ability to contract with managed care organizations (MCOs). Finally, providers of at-home care can offer hospitals and health systems a means for receiving reimbursement for this care where previously there was none. Contracting also introduces opportunities to refer a broader range of patients into the program, rather than just traditional Medicare patients, ultimately increasing the organization's capacity. As MCOs prove

more receptive to this type of contract, providers will continue to see the value these programs can deliver, while also improving patient satisfaction and outcomes.

The Right Technology

In order to receive full reimbursement, hospitals and health systems need to provide care to patients who meet the criteria to be admitted into their facility. That means patients need to receive the same level of service as they would receive on the general medicine floor—including 30-minute turnaround times and high-quality care. This requires specialized technological solutions to pull off.

Needed Resources

Whether you build from the ground up or form a partnership such as a joint venture, home hospital care requires a significant commitment of financial and organizational resources. Hospitals and health systems across the country are playing out this decision right now: whether to spend tens of millions of dollars to create and control a hospital-at-home program, or spend hundreds of thousands of dollars with a partner and still retain a decent majority of the revenue generated. The right upfront investments—in technology, credentialing, education, and more—can easily (and quickly) provide good returns when leadership is bought in and determined to make this work.

What's Next

The COVID-19 pandemic forced hospitals and health systems to embrace hospital-at-home purely out of necessity. But now that we know it can be done, and that hospitals and health systems aren't confined to physical buildings, the possibilities are expanding rapidly.

Instead of just moving the general medicine floor to the home, more hospitals are looking at other services that can be provided there, like skilled nursing and palliative care. They can become much less sensitive to patient fluctuations, able to expand and decrease capacity with ease. And, in the long run, they can avoid high-cost projects like building additions or facility acquisitions.

All of this adds up to an extremely optimistic view of healthcare delivered in the home. As I said, the future is now for providers—it's becoming less a question of "if" and more about "when." But developing a home hospital care program is an organizational shift that comes with a significant set of challenges that require time,

resources, and expertise to solve. When considering integrating a home hospital care component into a hospital or health system, the primary question board members should think through as they consider their specific needs and resources is whether it makes more sense to build from scratch or partner with a proven company that has shown the ability to scale this type of care.

Either way, when done properly, hospitals and health systems can save money while still providing the highest levels of care. And patients enjoy their experience more, spending less time in the hospital and more time at home with their families. Hospital-level care at home is a win-win across the board, and it's no longer a futuristic fantasy. It's a reality that's here to stay.

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The Long-Term Healthcare and Employment Law Effects of the COVID-19 Pandemic

By **Anjana D. Patel**, Member, **Denise Dadika**, Member, and **Olivia Plinio**, Associate,
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The COVID-19 pandemic has resulted in a myriad of legal and policy changes to the healthcare industry. Since March 2019, numerous reactionary regulations, executive orders, administrative guidance, and the like have been issued in response to the pandemic, making it difficult for providers, boards, and senior leadership to keep up with not only what is required or permissible during the pandemic, but also which of these changes may become permanent in the near future. This article discusses some of the more noteworthy changes that are most likely to have widespread permanent impact in the future.

Telehealth Expansion

Perhaps the single most pervasive change and the one with the biggest impact on the industry is the expansion of telehealth. Various government agencies issued waivers and other regulatory changes in response to public demand and to encourage patients to continue seeking healthcare services during the pandemic.

CMS Waivers

CMS issued a series of blanket waivers involving telehealth in response to the pandemic and the resulting CARES Act. One such waiver involved the licensing of telehealth providers. Prior to the pandemic, practitioners billing Medicare for telehealth services were required to be licensed in the state where the services are provided, even if already licensed in another state. For example, a licensed State A physician treating a patient located in State B via telehealth would need to be licensed in State B—the location where the patient received the care. Under the waiver, this requirement is lifted for practitioners, with some conditions. For the waiver to apply, the practitioner must be enrolled in the Medicare program and possess a valid license to practice in the state. The practitioner must also provide services in a state in which the emergency is occurring in order to contribute to relief efforts and cannot be affirmatively excluded from practice in any state.

Notably, this waiver only applies to federal healthcare reimbursement and has no effect on state or local licensure requirements. Practitioners are only able to take advantage of this waiver if the licensure requirements are also waived by their state for their type of practice. Some, but not all, states have implemented similar waivers, including Maryland, Mississippi, and Massachusetts. These states temporarily modified their professional licensure requirements to allow out-of-state licensed practitioners to provide services within their states, either by temporarily waiving licensure requirements (similar to the CMS waiver) or by modifying licensing requirements to make it easier for providers to obtain temporary licenses to practice in the state.

In addition to loosening the licensing requirements for providers, CMS also expanded the types of providers who may bill Medicare for telehealth services. Under authority granted under the CARES Act, CMS waived the requirements of section 1834(m)(4)(E) of the Social Security Act and 42 CFR § 410.78 (b)(2). These statutes specified the types of practitioners permitted to bill Medicare for telehealth services. The waiver allows all types of practitioners who are already eligible to bill Medicare for professional services to begin billing Medicare for distant site telehealth. New additions include physical therapists, occupational therapists, and speech language pathologists, amongst others. However, these providers are still subject to limitations imposed by their state licensing board, which may limit their ability to practice, even with this waiver.

CMS also made changes to the provider–patient rules for telehealth services. In the past, telehealth was only available to Medicare beneficiaries if there was an

→ Key Board Takeaways

Boards should consider the following questions:

- Is our organization keeping up with the most recent requirements for telehealth practice? How can we increase access for patients while remaining compliant?
- Are the board and senior leaders aware of the new OSHA and ETS mandates? Does our organization have a plan to implement these changes?
- How effective is our compliance program? Do we have a system in place to handle whistleblower complaints efficiently?

already-established provider–patient relationship. Additionally, patients seeking telehealth services under Medicare were required to be in specific originating sites such as a physician’s office, hospital, or other healthcare facility. However, CMS recognized the importance of limiting travel during the public health emergency, especially to healthcare facilities where patients could risk exposure to further illness. In response, CMS issued a waiver that would allow patients to access telehealth services regardless of their location (e.g., in the home, any healthcare facility, etc.) for the duration of the public health emergency. Additionally, HHS announced a policy of enforcement discretion where, if a requirement for a prior established provider–patient relationship existed, it would not be enforced and HHS would not conduct audits to confirm whether such a relationship exists.

Consolidated Appropriations Act

In a similar vein, the Consolidated Appropriations Act of 2021 (CAA), Section 123 established a similar, but more permanent waiver for mental-telehealth originating sites. Under the CAA, Medicare will accept claims for patients seeking mental health services via telehealth without geographic restriction (whether they are home, at a health facility, etc.). This rule will become permanent after the public health emergency, with some restriction. Specifically, eligible patients must have an existing in-person relationship with a provider, defined as at least one in-person visit during the previous six months before the telehealth visit. This requirement will only apply to patients seeking treatment from aforementioned newly eligible originating sites. Patients seeking treatment via telehealth from already-eligible originating sites (e.g., rural areas) will not be required to comply with the in-person requirement.

Prescribing Opioids

The effects of the COVID-19 public health emergency have intersected with another public health emergency, the ongoing opioid crisis. Under the Controlled Substances Act, providers are normally required to conduct in-person patient evaluations before they are permitted to prescribe controlled substances, such as opioids. This broad categorical requirement also encompasses buprenorphine, a drug used in opioid use disorder treatment. The federal government recognized that this requirement for an in-person evaluation during a pandemic could serve as a significant roadblock to those seeking treatment for opioid use disorder. In response, the DEA issued guidance to waive the in-person evaluation requirement. The waiver allows providers to prescribe controlled substances without an in-person evaluation, so long as the prescription is for a legitimate medical purpose, any telemedicine communication

is conducted using audio-visual, real-time, two-way interactive communication, and the provider acts in accordance with any applicable federal and state laws. However, without universal adoption by the states, this waiver has limited effect in some states.

Privacy Changes

With the overwhelming need for telehealth services in the pandemic, providers were forced to adapt quickly to meet the needs of their healthcare populations. In response, HHS Office for Civil Rights (OCR) announced that it would exercise enforcement discretion, not perform audits, and waive penalties for HIPAA violations in respect to telehealth platforms. Telehealth platforms are typically required to comply with HIPAA's security requirements. Under the waiver, healthcare providers who serve patients in good faith using everyday communications technologies, such as FaceTime or Skype, will not be penalized under HIPAA during the public health emergency. Providers will also not be penalized for lack of a Business Associate Agreement (BAA) with a technology platform vendor. However, the breach notifications are not waived, and providers should still have policies in place and be prepared to notify individuals in the event of a breach of PHI.

In addition to the privacy changes for providers, OCR also announced changes for business associates in response to the COVID-19 public health emergency. Under these changes, business associates are temporarily allowed to share PHI with public health and oversight agencies in accordance with certain HIPAA exceptions. This expansion is significant in light of the pandemic as it allows business associates to transmit immunization information between public health entities and providers. Beyond the scope of the pandemic, the expansion will allow public health and oversight agencies greater insight into the activities of business associates and the providers with whom they contract, improving public health surveillance, payment integrity, and healthcare interoperability.

Increased Health and Safety Measures

The COVID-19 pandemic has required healthcare employers to enhance their workplace health and safety protocols to protect workers from the virus and comply with the myriad of federal, state, and local legislation and guidance. Most recently, on June 10, the Occupational Safety and Health Administration (OSHA) issued a

long-awaited Emergency Temporary Standard (ETS) for healthcare employers.¹ The ETS mandates virus protections in healthcare workplaces, defined as “all settings where any employee provides healthcare services or healthcare support services,” with several exceptions. OSHA published a flow chart to help employers determine if they are covered by the ETS,² as well as several fact sheets³ and FAQs⁴ regarding the ETS. The ETS took effect on June 21, although some of the requirements have a 14-day or 30-day window for compliance.

The requirements of the ETS include, but are not limited to, the following actions by healthcare employers:

- Develop a COVID-19 plan to mitigate the spread of the virus in accordance with the parameters established by OSHA; for workplaces with more than 10 employees this plan must be in writing.
- Designate a safety coordinator to oversee implementation of the COVID-19 plan.
- Screen patients and anyone else before they enter the workplace.
- Provide respirators for workers when exposed to people with suspected or confirmed COVID-19 infection.
- Conduct regular health screening of employees and provide notice of positive cases of COVID-19.
- Require six feet of separation between people when indoors.
- Install solid barriers at each fixed workstation in non-patient care areas where employees are not socially distanced.
- Ensure ventilation systems operate at their designed specifications.
- Follow standard practices for cleaning and disinfection of surfaces and equipment in accordance with CDC guidelines in patient care areas, resident rooms, and for medical devices and equipment.
- Support COVID-19 vaccination for each employee by providing reasonable time and paid leave (e.g., paid sick leave or administrative leave) to each employee for vaccination and any side effects experienced following vaccination.
- Provide training related to COVID-19 transmission, policies, and procedures.

The ETS exempts fully vaccinated employees from the facemask, physical distance, and barrier requirements in well-defined areas if the employer determines there is no

1 See [“COVID-19 Emergency Temporary Standard.”](#)

2 To view the flow chart, see OSHA, [“Is Your Workplace Covered By the COVID-19 Healthcare ETS?”](#)

3 To view fact sheets, see OSHA, [“COVID-19 Healthcare ETS.”](#)

4 See OSHA, [“COVID-19 Healthcare ETS—Frequently Asked Questions.”](#)

reasonable expectation that another person with suspected or confirmed COVID-19 will be present and the written COVID-19 plan includes policies and procedures to determine the employees' vaccination status.

Finally, the ETS prohibits retaliation against employees for exercising rights available under the ETS and requires employers to provide training on anti-retaliation rights.

Healthcare employers, boards, and senior leaders should closely review the ETS and continue to monitor federal, state, and local developments to ensure they are complying with the latest requirements.

Enhanced Compliance Programs

Workplace safety whistleblower claims have surged during the pandemic. There has been an uptick in OSHA complaints, as well as whistleblower litigation filed in federal and state courts. To minimize the filing of external retaliation complaints, healthcare employers should review and enhance their compliance programs by doing the following:

- Ensure that their health and safety practices and policies are compliant with the latest federal, state, and local regulations and guidance; train employees on those safety practices; and monitor for, and address, noncompliance.
- Revisit policies governing the reporting of suspected violations to ensure they provide for a range of reporting channels that are accessible 24 hours a day, 365 days a year. Employers should regularly encourage and train their employees on such policies, reporting channels, and the employer's investigation process. They should also ensure that their investigators, whether internal or external, are properly trained and possess the skills to thoroughly conduct and document investigations. In addition, creating a playbook that includes a list of potential stakeholders who may need to be consulted, as well as procedures for collecting and preserving data, conducting interviews and preparing interview summaries, and crafting an investigative report that documents the steps taken and the basis for the investigation findings, will assist in standardizing and providing a fair and thorough process and record. Also, communicating the results of the investigation and any next steps to complainants and protecting the complainants from retaliation are paramount in fostering the trust and transparency that is essential for an effective compliance program.

- Make it clear that the compliance program is supported, and adhered to, by senior management. Commitment from the top is critical in creating an environment where employees trust their complaints will be addressed without fear of retaliation.

While institutions cannot prevent employees from filing external complaints, boards and senior leadership can minimize external complaints by prioritizing effective compliance programs from the top, providing employers the opportunity to quickly address employee concerns and potential workplace safety violations.

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Rightsizing Your Lease Agreements: Options for Healthcare Boards

By **Matthew Tarpley**, Vice President, *H2C Securities, Inc.*

Even before the pandemic, many hospitals and health systems found themselves in unfavorable lease arrangements. These agreements, often structured several years ago, have exceeded market rental rates, prevented healthcare organizations from leaving undesirable space, and allowed competitors to move in nearby.

Now, as the impact of COVID-19 on hospital volumes and expenses strains healthcare organizations' finances—and as medical office buildings continue to show remarkable resilience in pricing and cost of capital remains low—healthcare boards must consider: Should we renew or renegotiate our lease agreements? Or, is now the time to purchase the properties we lease?

It's also important to evaluate the impact of new lease accounting standards—which require hospitals to report leases longer than 12 months on their balance sheets—on the organization's leverage position. Recently, we have seen instances where the operating lease liability reported by health systems is much higher than what the rating agencies' projection of the debt equivalent of the health system's leases had been. In one instance, a health system's outlook was revised from “stable” to “negative” in part because the health system's leverage metrics weakened when lease liability was added to the balance sheet.

Understanding the Healthcare Lease Landscape

While health systems own \$1 trillion in real estate—most of it in inpatient facilities (42 percent) and clinical care facilities—H2C Securities, Inc. estimates that 35 percent of health-system occupied space is leased nationwide.¹ Real estate occupancy and lease agreements account for 8 to 12 percent of hospital costs annually.²

1 Based on H2C's review of the Top 100 largest health systems in the United States.

2 “Investors Remain Bullish as Technology, Consumerization, and Mergers Further Transform the Healthcare Landscape,” Colliers International, 2019.

Real estate investors view medical office buildings (MOBs) as a “safe haven.” These assets have long-term leases, attract investment-grade tenants with big balance sheets, and are recession-resistant. Other trends driving interest in MOBs include the “retailization” of medical office space, the steady rise of Baby Boomers aging into Medicare, and the accelerated move toward “off-campus” MOB locations, with MOBs situated away from the immediate surrounding areas of large hospitals.

In 2019, private equity investors accounted for the majority of MOB investment volume, with \$7 billion in transaction volume.³ Real estate investment trusts (REITs) had been net acquirers of MOBs for four years, accounting for 22 percent of MOB dollar volume in 2019.⁴ Demand for MOBs was so high that small assets and small individual properties increased in appeal due to the shortage of portfolios or larger MOBs to meet acquisition goals.

Over the past four years, MOB vacancy was low—and rents began to rise. Nationally, MOB vacancy totaled 8.2 percent in 2019, while rents climbed 3.6 percent.⁵ Historically, the annual average rent increase for MOBs had totaled 0.2 percent.⁶

→ Key Board Takeaways:

Rightsizing a hospital or health system’s lease agreements could benefit the organization by reducing rent/lease liability, achieving real estate tax savings, or restricting competitive tenancy in the same building. There are four questions board members should ask in determining whether the time is right to restructure lease agreements:

- Does our organization own or lease the majority of its real estate?
- If we lease, how do our lease rates compare to the market?
- Why do we own certain assets versus leasing them (and vice versa)?
- Is there an opportunity to achieve tax savings by restructuring lease agreements?

3 “REITs Cap Off Active Year for MOB Acquisitions,” H2C, February 4, 2020.

4 *Ibid.*

5 Colliers International, 2019.

6 *Ibid.*

Top 10 Markets: Vacancy Rate and Asking Rent

Market	MOB Vacancy %	Direct Gross Asking Rent PSF
Atlanta	10.3%	\$24.03
Boston	5.7%	\$30.71
Chicago	12.4%	\$22.45
Dallas-Fort Worth	14.8%	\$25.90
Houston	12.2%	\$25.31
Los Angeles	8.2%	\$33.94
Miami	8.6%	\$34.16
New York	7.6%	\$75.62
Philadelphia	9.1%	\$22.43
Washington D.C.	10.4%	\$27.83

Source: U.S. Research Report, 2019 Healthcare Marketplace, Colliers International.

One common—and expensive—issue for healthcare organizations: above-market rental rates, driven by preset annual lease payment increases that exceed the consumer price index. One Southwest surgery center discovered it was paying rent that was 20 percent higher than the market rate. A not-for-profit healthcare provider that entered into a master lease agreement for several properties in 2008 saw its rent rise at 3 percent per year, a rate that was significantly above market. A factor that may contribute to the lease rates being over market is that many healthcare providers have improved their financial position and “credit” since leases were originally signed, and in today’s marketplace could justify lower yield-to-costs on new developments.

Other issues commonly faced by hospitals and health systems that entered into lease agreements years ago include:

- Unfavorable control provisions (e.g., no competitive leasing restrictions)
- Lease obligations coming onto the balance sheet as liabilities in excess of expected obligations
- Escalating real estate tax pass-throughs

Evaluating Your Organization’s Options

Every lease is different. Conducting a thorough review with the help of a qualified healthcare real estate firm will enable boards to understand their options and make the right moves for their organization.

This process—typically led by the CFO—starts by understanding the status of current lease obligations compared with “market rent” and the ways in which the utility of select assets has increased or decreased since the organization entered into the lease agreement. It also includes an examination of control provisions that have negatively affected the hospital or system. From there, the board should examine the costs and potential savings associated with each option, with careful evaluation of asset locations, long-term utility, and value. The sensitivities related to a potential purchase of an asset or restructuring of a lease also should be taken into consideration.

Typically, healthcare boards find that they have a number of options at their disposal, even in a COVID-19 environment. Options commonly fall into four categories. The CFO will review the pros and cons of each option and make a recommendation to the board.

Purchasing leased facilities. During the pandemic, some health systems are acquiring real estate they have leased, taking advantage of low interest rates and investor demand in the bond market to finance the acquisitions. Health systems often have purchase options within lease agreements that allow them to acquire leased real estate at favorable pricing. By acquiring MOB in which health systems lease the majority of space and/or look to expand, in some instances, these systems can realize savings by avoiding paying rent and real estate taxes because the cost of the debt issued to acquire the MOB is less than the rent they pay to occupy.

Restructuring lease agreements. Restructuring a lease agreement and renegotiating lease terms can help hospitals and health systems reduce rent as well as operating expense. At a time when organizations may be considering a partnership with a larger system due to the financial impact of COVID-19, this approach may also increase the pool of potential buyers.

Acquiring and repurposing non-medical buildings. Health systems may find themselves acquiring assets and land and then redeveloping properties for their use. In 2020, several health systems acquired former retail stores to repurpose them for clinical use to capitalize on the visibility of retail locations. Often, there is a large spread between the costs expended and the potential market value.

Developing new property. Consolidating space into a newly constructed MOB can lead to reduced long-term costs and more efficient care delivery. For example, in 2020, one large, not-for-profit system with multiple leases across 26 facilities

discovered it could save \$20 million in rent by consolidating spaces into a new, single facility built by the system.⁷

There is no one-size-fits-all approach to rightsizing a health system's lease agreements. That's why it's important to carefully consider your options from a number of perspectives—including the impact of COVID-19 on landlords. For example, some landlords may be more amenable to lease restructuring or renegotiation of terms during the pandemic to keep healthcare tenants in place long term.

By carefully considering the options from a number of angles, healthcare boards can better position their organization to navigate negotiations with landlords and determine the right path forward.

The Governance Institute thanks Matthew Tarpley, a Vice President for the real estate division of H2C Securities, Inc., for contributing this article. He can be reached at mtarpley@h2c.com.



7 "Health Systems Make Strategic Moves in Second Full COVID-19-Impacted Quarter," H2C, October 29, 2020.