

IMPENDING DEATH OF HOSPITALS: WILL YOUR ANESTHESIA PRACTICE SURVIVE?

Mark F. Weiss, Esq.

The Mark F. Weiss Law Firm, a Professional Corporation, Dallas, TX

How would *you* like to know exactly what's going to happen in the future so that you can prepare for and profit from it?

I have a crystal ball. Here, let me share it with you.

We're going to review some of the trends currently impacting, and soon to impact, hospitals that will, I predict, lead to their destruction, at least as we know them.

There is absolutely no question that these trends are going to have an impact on your anesthesia practice. Start preparing now.



Continued on page 6

► INSIDE THIS ISSUE:

Impending Death of Hospitals: Will Your Anesthesia Practice Survive?	1
The Evolving Relationships between Anesthesiologists and Their Hospitals and ASCs	2
The Perioperative Surgical Home: Our Partnership with the C-Suite	3
2016 Coding Updates for Anesthesia	10
"I'm Out Of Here!" Now What?	14
Confidentiality in the Peer Review Process: What Does it Mean and What is Covered? Part I	16
The Hospital is Your Practice's Client—Understand Client Satisfaction to Retain Your Contract	20
Event Calendar	24

Anesthesia Business Consultants is proud to be a

Anesthesia
Quality Institute 
PREFERRED VENDOR

MGMA®
Gold Affiliate





IMPENDING DEATH OF HOSPITALS: WILL YOUR ANESTHESIA PRACTICE SURVIVE?

Continued from page 1

TREND 1: HOSPITALS ARE GETTING BIGGER AND THAT IS A WEAKNESS

Government induces physician labor

Obamacare favors the growth of hospitals with its incentives for aligning physicians. Think Accountable Care Organizations (ACOs) and other incentives to coordinate care, meaning coordination via hospitals.

Although reports lag by several years, at least 20 percent to 30 percent of all practicing physicians are currently employed by hospitals. There was a 34 percent increase in hospital employment of physicians between 2000 and 2010.

In addition, an uncertain number of physicians, very likely a significant number of them, are controlled by hospitals through alignment relationships such as ACOs and foundation model medical groups.

Hospital merger mania

As hospitals gobbled up physician practices, hospitals began gobbling each other up as well.

In 2013 there were 105 hospital mergers. In 2014 there were fewer, approximately 100. Overall, since 2010, there has been a 44 percent increase in the pace of hospital mergers.

Hospitals merge because they think that there's strength in a larger entity. In other words, they believe that it brings so-called economies of scale. If that means that two hospitals merge and become one, and then one facility closes down, perhaps that's the case. But that's not the general trend. Instead, mergers are often used to build bigger hospital systems in which there are little to no economies of scale. It's often the case that when large entities merge, administrative costs go up.

In the 1990s, there was a similar wave of hospital mergers. Most merged hospitals failed. The same argument about economies of scale was made then: that merging would cut costs. But it didn't turn out to be true.

Hospitals are losing the economic bet on employed physicians

A 2014 study by the Kentucky hospital industry revealed that the cost

to hospitals of employing physicians is increasing.

A majority of hospitals reported increasing losses per physician; on average more than \$100,000 per employee and, for some specialists, more than \$200,000 per employee.

The larger the hospital and the larger the hospital system, the larger the losses.

Hospitals are losing the bet on integrated delivery networks

And, as to quality, a large study by the National Academy of Social Insurance "found little evidence that integrated delivery networks have reduced costs or improved the quality of care."

Fragility will lead to cascading failure

In the 1990s, if a hospital failed, chances were it failed alone. In other words, the physician practices associated with that facility were independent. Certainly, office-based physicians found privileges at another facility. Hospital-based physicians were impacted disproportionately in comparison to their office-based colleagues, but at least there were other hospitals to which to expand their services.

But now, if a hospital or a merger-bloated hospital system with its employed or otherwise tightly affiliated physicians fails, all of those physicians are out of a job.

So we have merger for the cure of high costs. And we have a history from the 1990s of a similar trend that resulted in the failure to cut costs resulting in hospital failures. But as opposed to what happened in the 1990s, today many of these merged hospitals not only have traditional hospital-side expenses, they have taken on the huge expenses of





employing physicians. Note that's not just physician labor expense, but the complete expense of operating the practices, from space to equipment to supplies to billing to staff and so on.

TREND 2: PHYSICIAN-OWNED FACILITIES

The growth of physician-owned facilities is a key disruptor of the traditional hospital business, shifting cases out of hospitals.

Ambulatory Surgery Centers

Ambulatory surgery centers (ASCs) pull cases—generally the better reimbursed cases—out of the hospital O.R. They offer a significantly cheaper alternative to Medicare, private payors and patients. They also make money for their physician owners.

Currently, there are nearly 6,000 ASCs in the United States. There has been a slowdown in the net addition of ASCs during the last two years. In large part this is due to the fact that hospitals are attempting to remove the competition by purchasing ASCs in the local market, closing some and converting

others to hospital outpatient departments (HOPD).

Notwithstanding that buying spree, it's unlikely that hospitals will be able to stop the shift of cases to the ASC setting.

Procedures that only a few years ago were inpatient are now being performed on an outpatient basis. And, in some specialties, new surgical codes enable cases to be brought to ASCs, thus opening the specialty to fostering ASC development.

HOPD payment differential will backfire

Although recent federal budget legislation has reduced some of the benefit of operating an outpatient facility as a HOPD sooner or later the payment differential will play itself out to disrupt hospitals' futures. There's little justification for paying more to hospitals for the same procedure that can be performed in a hospital-free, that is, ASC, setting.

But even if the differential continues to be paid, physicians will continue to invest in and take cases to ASCs and payors will continue to want access to their more cost efficient services.

It's unlikely that hospitals will be able to garner the political support to put the same roadblocks on ASCs that they've managed to place on physician-owned hospitals.

Physician-owned hospitals

In order to protect their near monopoly, the investor-owned and non-taxpaying hospitals (many of which are busy employing and otherwise aligning physicians) have claimed that if physicians own hospitals in order to create teamwork and provide coordinated care, that is bad. But if hospitals own physicians in order to create teamwork and provide coordinated care, that is good.

This nonsensical argument will eventually lose traction.

Even if physicians are prevented from owning hospitals that qualify to treat federal healthcare program cases, they will continue to invest in smaller facilities focused on private payor cases. They will be able to avoid the low reimbursement that comes from governmental programs and the "no reimbursement" that comes from complete charity care.

TREND 3: NEW CLASSES OF COMPETITORS

New business models are disrupting the flow of patients, patients who were formerly destined to be referred into a hospital's "world."

Walk right in

These models include walk-in clinics of the type opening at retail stores such as Walgreen's, Rite Aid and CVS. In fact, CVS, until recently known as CVS Pharmacy, is now known as CVS Healthcare, which is a clear indication of where they believe healthcare is going.

Other examples are the plethora of walk-in and urgent care facilities built

Continued on page 8



IMPENDING DEATH OF HOSPITALS: WILL YOUR ANESTHESIA PRACTICE SURVIVE?

Continued from page 7

in strip centers and other ease-of-access locations. In fact, in Colorado, Texas and a number of other states, free-standing emergency rooms—often located near or at intersections close to acute care hospitals—siphon off patients headed to the hospital's OR based on their accessibility and their near zero wait times.

The point here is that these types of facilities signal a trend: non-traditional ventures are disrupting the flow of patients to physicians' offices and to hospital emergency rooms. More importantly, because this trend has an exponential impact, patients don't have the same emotional barriers to obtaining medical care outside of the physician office or hospital setting that they had 20 years ago.

In other words, if care can be obtained in a less intense, less costly, more convenient setting, it's not just insurance carriers who are going to push for it, it's patients who are going to demand it.

Updated house calls

It's 7:00 a.m. on a Wednesday morning and you feel like death warmed over. When you call your doctor's office (not open until 8:30) you know that you'll be told that they might be able to fit you in on Friday. You're lucky, because the average waiting time in the U.S. works out to more than 18 days.

But why bother, especially when a growing number of services will send a physician or nurse practitioner to see you now, at a cost that's probably one-third to one-half less than what your own physician would charge for an in-office appointment.

And, if you don't have to see a physician, or even a nurse, in person, why see one? Why not stay at home and simply



transmit the same information about your condition to a physician or another provider via telemedicine?

It's not difficult to see that both house call services and telemedicine are disruptive to traditional medical practitioners. In fact, in some states, primary care physicians are exerting pressure on state regulators to make it more difficult for telemedicine and other telehealth companies to operate. Eventually those anticompetitive efforts will fail as patients demand those services. After all, pushing for regulation is the death gasp of any profession or industry; if they can't compete on their own, they turn to the government, and especially to bureaucrats, to protect them.

It requires only slightly more foresight to realize that, in the end, those and other new classes of competitors will not only disrupt traditional office practice, they'll disrupt hospitals as well.

Patients will no longer be following the normal route of (1) go to a primary

care doctor in an office building on or near a hospital campus, (2) be referred by that physician to a specialist on staff at the same hospital for more detailed diagnosis and care and (3) receive diagnostic services and treatment at the hospital.

TREND 4: THE ROLE OF TECHNOLOGY

We're at a technological tipping point and tech is the fuel for the fire of the demise of hospitals as we know them.

For decades, the cost of technology in almost every industry *other than healthcare*, resulted in lower costs to the consumer. But in healthcare, all technology did was increase costs.

This history of technology also fed the growth of hospitals. Who, but large facilities, could afford to buy the technology? Wasn't it cheaper and more efficient to, in essence, spread the cost of that technology by locating it in a central location, the hospital, for access by those in the community, both physicians and other providers, as well as by patients?

Thus came the centralizing of technology (read that as medical equipment) from imaging to monitoring to operating rooms themselves.

But today, the cost of technology has shifted. Instead of being more expensive, it is less. In fact, in many cases it's become so much less that it is, or soon will be, affordable at the consumer level, bypassing completely the ASC and physician level.

And, importantly, the size (sometimes there is, effectively, no size at all) of new equipment has shrunk.

Technology is quickly becoming the enabler for devices and for services that permit the disruption of the centuries-old doctor-patient relationship.



Star Trek in your home

Remember the “tricorder” from Star Trek, the handheld medical diagnostic device? Now, it’s time for the real one.

The Qualcomm Tricorder XPRIZE is a \$10 million dollar prize for a tool capable of capturing key health metrics and diagnosing a set of 15 diseases. As of this writing, there are seven finalists.

Consider the OtoHOME device from Cellscope. It’s an iPhone device that allows parents to examine their child’s ears and record the result. It then connects them to a doctor for an immediate response. Dozens of other smartphone and wearable devices exist, each of which will reduce visits to traditional primary care doctors. Referrals to specialists (including all of those employed by hospitals) will be reduced, as will diagnostic procedures performed at hospitals.

Tech will also lead to less invasive surgery and to implantable devices that allay more surgery.

It’s also bound to lead to the fact that more procedures can be performed in either smaller, specialty hospitals or in outpatient settings. Hospitals will no longer need to provide everything to everyone. Procedures will move out of general hospitals into specialty ones and eventually will move out of hospitals altogether into ambulatory facilities.

THE BOTTOM LINE FOR HOSPITALS

Hospitals have expanded to become “full service” and have “bought” physicians to capture patients into the system. They claim that by closely aligning physicians they can deliver better care at a lower cost. But they are losing money on employed physicians and there’s no evidence that close alignment of physicians results in better care.

At the same time, patients are increasingly taking more control of their own diagnosis (and in some cases care) via technology.



Both technology and new classes of healthcare businesses (e.g., CVS Healthcare, Teladoc, etc.) are enabling patients to bypass traditional brick and mortar facilities (e.g., hospitals and physicians’ offices).

Patients don’t care as much as before whether they see a doctor, a nurse practitioner or some type of technician. And, for hospitals this is the big one, they don’t care as much if they obtain care from someone within the hospital’s patient acquisition funnel, or if they get surgery at an ASC or some other non-hospital site. As medicines improve (medicine as the future of surgery) and as miniaturization permits more procedures to be performed outside of the hospital, non-hospital facilities will syphon off a larger and larger percentage of hospital business.

Or perhaps patients won’t receive care at any facility—perhaps the facility will come to them: care in a “pod” inside or outside of your house?

ULTIMATE HOSPITAL BOTTOM LINE

Hospitals will shrink. They will be for the sickest people only. They might become monitoring stations for patients receiving care at home. Many will fail.

THE BOTTOM LINE FOR ANESTHESIOLOGISTS AND CRNAs

If you think that hospital employment or close alignment is safe, think again.

Anesthesia groups can’t ever be dependent upon a single hospital relationship. In the past, the concern was that that facility might terminate your contract. In the near future, the concern will be that the hospital might not survive.

Certainly, some hospitals will survive but they will be only for the sickest patients and the most complicated procedures. There will continue to be some—reduced—need for anesthesia services at those facilities.

ULTIMATE ANESTHESIA BOTTOM LINE

Freestanding facilities, even mobile ones, will be the future of the huge bulk of surgical care. If your practice isn’t already heavily focused on freestanding facility care, begin pivoting in that direction. ▲

[Author’s Note: This article is an abridged adaptation of my upcoming book *Impending Death of Hospitals: Why You Must Plan Your Medical Practice’s Survival*, due to be released in early 2016.]

Mark F. Weiss, Esq. is an attorney who specializes in the business and legal issues affecting physicians and physician groups on a national basis. He served as a clinical assistant



professor of anesthesiology at USC Keck School of Medicine and practices with The Mark F. Weiss Law Firm, a firm with offices in Dallas, Texas and Los Angeles and Santa Barbara, California, representing clients across the country. He can be reached by email at markweiss@advisorylawgroup.com.