

# The Impending Death of Hospitals: How to Help Your Clients Survive

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By Mark F. Weiss, JD

Major trends are changing the health care industry, trends that will shake the anticipated future of the government-health care complex to its core, trends that will impact your health care clients' businesses and, perhaps, your own.

As any Texas CPA with health care industry clients will attest, the business of health care has become increasingly "hospital-centric:" organized around hospitals and their associated health care systems. But at the same time, due to the convergence of the major trends that we'll address, those same hospitals, at least as we know them today, are dying or dead; they just don't know it yet.

Some will mourn their death. Some are afraid of a future without them. Others see tremendous opportunities and profit, both on the facility and provider sides: The services and patient care that hospitals and their aligned physicians once provided are being distributed to a wide range of outpatient facilities and provider practices. Others are being dematerialized as patients-as-consumers take, and demand, more control and involvement, thus opening lines to new ways for professionals to provide value.

Hospitals will shrink or close. Independent outpatient facilities will predominate.

How will your clients fare in this new world? How will you?

## No Crystal Ball Needed

Although we sometimes like to feign that we have a crystal ball, this view of the future is open to all to see if you pay attention to the signs. For example, Mount Sinai Health System, based in New York City, has announced its plan to close its 865-bed Mount Sinai Beth Israel hospital and sell the property upon which it's located. Up to 700 employees will lose their jobs. The size of the replacement facility to be located elsewhere in the community? *70 beds.*

On the following pages, we're going to review some of the trends currently impacting, and soon to impact, hospitals that, I predict, will 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 clients' facilities, medical practices and health care businesses. They must start preparing now.

## Trend 1: Hospitals are Getting Bigger and That is a Weakness

**Government induces physician labor.** The Affordable Care Act favors the growth of hospitals with its incentives for aligning physicians. Think 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 accountable care organizations (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 a few less, 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

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“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.

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. However, as opposed to the 1990s, many of these merged hospitals today 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 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.

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

Currently, there are more than 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.

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. A prime example is the explosion of interventional radiology procedures now being performed from outpatient facilities and the attendant birth of the irASC.

**HOPD payment differential will backfire.** Although recent federal budget legislation has reduced some of the benefit of operating an outpatient facility as a hospital outpatient department (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.

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.** 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 to create teamwork and provide coordinated care, it is “bad.” But if hospitals own physicians to create teamwork and

provide coordinated care, it is “good.”

This nonsensical argument will eventually lose traction. Even if physicians are prevented from owning hospitals that qualify to treat federal health care 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 Health, which is a clear indication of where they believe health care is going. Other examples are the plethora of urgent care and even emergency care facilities built in strip centers, at heavily traveled intersections à la fast food franchises, and at other ease-of-access locations.

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 that are going to push for it; it's patients who are going to demand it.

**Updated house calls.** It's 7 a.m. on a Wednesday morning and you feel like death warmed over. When you call your doctor's office (not open until 9 a.m.), 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

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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 health care* resulted in lower costs to the consumer. In health care, however, all technology did was increase costs.

This history of technology also fed the growth of hospitals. Who could afford to buy the technology except large facilities? Wasn't it cheaper and more efficient to 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. 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 prize for a tool capable of capturing key health metrics and diagnosing a set of 15 diseases. In April 2017, two teams were declared winners. Both exceeded requirements for user experience and nearly met the benchmark of diagnosing 13 diseases. Final Frontier Medical Devices received \$2.5 million as the highest performing team and Dynamical Biomarkers Group received \$1 million for 2nd place.

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 lead to less invasive surgery and to implantable devices that allay more surgery. It's also bound to lead to more procedures that 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 health care businesses (e.g., CVS Health, 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: patients 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.

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 Physicians and Other Providers

If your physician clients think that hospital employment or close alignment is safe, they should think again. Physicians, other providers and their groups can't ever be dependent upon a single hospital relationship. In the past, the concern was that a facility might terminate their contract. In the near future, the concern will be that the hospital might not survive.

Certainly, some hospitals will survive to provide services to the sickest patients and for the most complicated procedures. There will continue to be some reduced need for physician and other professional services at those facilities.

However, the majority of providers must plan for an out-of-hospital future for themselves and for perhaps all of their patients. That means work in, investment in and even the formation of freestanding ASCs and other facilities, which will be the future of facility-based care.

Your physician clients must adopt practices, both patient-centered and electronic, to empower patients who seek to monitor and manage their own health. Providers can no longer view those self-help actions as heretical to a hierarchical physician-patient relationship. Instead, they must view the relationship with their patients as collaborative in the same manner that any other expert consultant interfaces with the ultimate client.

Ultimate physician bottom line: Physicians will be impacted by two major thrusts. More and more patient care, including procedures, will move out of the hospital setting into freestanding and other locations, including patients' homes. Technology will enable patients to receive diagnostic information independent of traditional physicians' offices. Enterprising physicians will see the opportunities in these tectonic shifts. Others will fear them, with good reason. ■

**Author's Note:** This article is based in part on my book *The Impending Death of Hospitals: Why You Must Plan Your Medical Practice's Survival*.

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