

Why are so Many Hospitals Going Bankrupt?

Several times in this discussion I've alluded to the financial troubles of many community hospitals. I've also hinted that this problem may be more wide spread than most people (even in the medical community) might think. The question is why? In a country in which so much money is being dumped into healthcare, why are hospitals being squeezed so hard?

To answer this question we should begin with some numbers.

-In 1985, there were about 7,000 hospitals in the U.S., now there are just under 5,800.

-In that time, the population in the U.S. has increased from 238 million to over 310 million and the median age has increased by about six years.

So, in 25 years our population has increased by 30%, aged six years (on average) but we have about 17% fewer hospitals to take care of us. Does this mean that the remaining hospitals are constantly filled to capacity with surgeries being performed in the hallways? Well... not exactly, or rather, not at all. I made some phone calls (or rather, my receptionist made some calls) to several local hospitals here in the San Francisco Bay Area to see how full they actually were. What we found was a little surprising.

On the morning of October 12, 2011:

-John Muir Hospital; a 572 bed hospital in the East Bay, had 301 patients (about 53% full).

-Alta Bates Hospital had 229 of their 527 beds occupied on that same morning (43% full).

-Summit Hospital had 195 of 399 beds occupied (49% full).

-California Pacific Medical Center in San Francisco had 231 of 382 beds occupied (60% full).

-Even Stanford Hospital had only 430 of 613 beds occupied that morning (70% full).

So in five hospitals in one metropolitan area about half of the beds in each hospital were occupied and over 1100 total beds were empty. To see if this were true with hospitals elsewhere she called a couple in Southern California the next morning.

-Huntington Memorial in Pasadena had 354 of 549 beds occupied (64% full).

-UCLA Hospital had 520 of 918 beds occupied (57% full)

I couldn't ask Heidi to call every hospital in the country (she'd quit) but I felt that the information I got from even these few phone calls reflected what I've been hearing and reading elsewhere: most hospitals are operating at about 50-70% capacity most of the time. So, in a country with fewer hospitals and more people, the remaining hospitals are only about half full. How is this possible? Are people no longer getting sick? And, if so, why do medical costs keep

rising? What's going on? To understand what's happening with hospitals now we must first go back in time.

A Bygone Era

If someone were to ask why a person were in the hospital in 1980 the simple answer would be "because he's sick" and the meaning of "sick" was pretty much anything the doctor said it was. A person could be hospitalized for a bad cold, a urinary tract infection or fatigue. If someone needed surgery, they would be admitted to the hospital days in advance to "prepare" them for the operation and they certainly wouldn't go home until they had "recovered" enough. Respite care was another favorite. If a family was about to go on a vacation and grandma or grandpa were too weak or infirm (or just not fun enough) to take with, no problem. Just drop them off at the hospital and they'll be admitted while everyone else goes to Disneyland.

It became the God-given right for anyone to stay in the hospital for any ailment, real or imagined, until the doctor decided it was time for them to go home. It was also the sworn duty of Medicare and the private insurance companies to pay for these hospitalizations without question or any interference in any decisions about medical care. Hospitals flourished and everyone was happy, but it couldn't last.

The Government Giveth and the Government Taketh Away

In 1983 Medicare instituted the policy of reimbursement only for certain Diagnostic Related Groups or DRGs. In this system, Medicare would only reimburse a fixed amount for each of the qualifying diagnoses listed in the DRGs. As you can guess, respite care, fatigue, bad colds and urinary tract infections did not make it on the list. The private insurance companies followed the example in rapid succession (as they always do) so, in a single move, Medicare eliminated a major source of income for most hospitals. It wasn't just that hospitals could no longer get paid to admit most of the patients they'd been admitting in the past; the patients they were left with were far less profitable. The patient population that they lost had cost almost nothing for their care but generated a lot of revenue.

Hospitals were left with fewer, more expensive patients who required a higher level of care but didn't provide nearly as much profit. With the profits disappearing, so went all motivation to build new hospitals and all of the old hospitals were hit with a sudden drop in income they couldn't make up. Over the next twenty years, more than one thousand hospitals found that they couldn't make ends meet with the new system and went bankrupt. By 2003 the number of hospitals in the U.S. leveled off to about where it is now but, the hospitals that remain are, by no means, having an easy time.

Among the many challenges hospitals now face are simple medical progress. Outpatient surgery centers perform minor surgeries that in the past would warrant a hospital admission. Advances in surgical techniques have transformed major surgeries into minor ones. Infusion centers now give

IV chemotherapies and transfusions that were formerly done in hospitals. People are no longer admitted to hospitals for radiation therapy either.

Advances in primary care have also cost hospitals much needed business. Every day I treat high blood pressure, high cholesterol and diabetes with powerful medicines that prevent my patients from having strokes or heart attacks that would result in hospitalizations. Peptic ulcers often required major surgery in the past. Now they are easily treated with over the counter antacids. Newer antibiotics are very potent even in pill form. This reduces the need to hospitalize patients for IV antibiotic therapy for many acute infections.

These are just a few of the many innovations that, although good for society, leave hospitals with a declining patient population (and lower overall healthcare costs). The few patients that continue to need hospitalization are the ones who require the greatest number of resources and are therefore the most expensive to treat.

How else are hospitals being hurt?

In 2003 Congress passed “The Medicare Prescription Drug, Modernization and Improvement Act”. Among other things, this bill allowed seniors to buy into prescription drug plans that resulted in their being overcharged for most of their medications (see Medications I). The act also contained a provision creating the Recovery Audit Contractors or RAC. Their job was to go into hospitals, review the charts for the last three years and retrieve any perceived overcharges.

That’s fair enough on the surface. Medicare has a right to fight overcharges, as much as, anyone else. The problem was the RAC was paid entirely on commission (25-30%) up front so the more “overcharges” they found, the more they were paid. Hospitals had to appeal each individual “overcharge” one at a time (costing them money to fight each appeal) and, originally, the RAC didn’t even have to refund commissions made from cases that were overturned.

In other words, they could cite any chart with a perceived irregularity and collect their commission with no penalty for being wrong. In the meantime, the hospital in question would have to spend even more money (\$1,000-\$2,000) to fight EACH fine. In 2009 hospitals won some concessions from the Center for Medicare and Medicaid Services (CMS) in that they agreed that there was a serious conflict of interest in how the RAC was paid. The system of auditing was revised so that auditors would only get paid AFTER a case against the hospital was won. This made the RAC far less predatory but, by then, the damage was already done. More than \$120 MILLION was “recovered” from California hospitals ALONE.

Now each hospital employs a whole team of case managers who go over each chart every day to make sure that criteria are met for each patient to stay in the hospital. Their job is to insure that no patient ever stays longer than would be reimbursed. They also have to forward chart notes and other clinical evidence to the insurance companies to verify that a patient still belongs in the hospital every day. Obviously, it costs money to have these case managers doing this and that adds to the overall cost of a hospitalization.

If I want to admit a patient to the hospital, I have to verify one of two things in advance: Either the patient needs a treatment for a medical condition that can only be provided in the hospital or the patient needs to be observed in the hospital for a condition that might soon kill him if he were to go home. It's not always easy to verify these conditions in an office setting since I often won't know until I get the results of certain tests. Even in an Emergency Room, it might not be obvious after initial testing whether someone is really sick enough to warrant hospitalization by the strict criteria we have now.

No matter, we now have a whole list of "observation" criteria to cover us while we're determining if a person really needs to be in the hospital. Observation means that the patient can stay in the hospital up to 48 hours while tests are being run to see if he really belongs there. These pseudo-admissions don't pay the hospital as well as a regular admit (a few hundred dollars a day versus a few thousand for a regular admission) but that's the price the hospital has to pay for our not knowing everything at a glance.

These criteria for observation-versus regular admission-versus just send them home with aspirin are extremely detailed and numerous enough to fill a book. One such book is "InterQual Level of Care Criteria 2011" and is put out not by the government or an insurance company but rather by a medical supply company called McKesson. In it, there are 272 pages of very detailed criteria for assigning the level of care a patient should get. This book also has a disclaimer in the beginning (as do most medical texts). The disclaimer states that ...it "cannot alone either resolve medical ambiguities... or provide the sole basis for definitive decisions". I find that quote interesting since the criteria in that book do provide almost the sole basis for insurance reimbursement.

On occasion, a patient will appear in my office or the ER with a condition that is far too severe to send them home, but who doesn't quite meet the strict criteria spelled out in the book to qualify for hospitalization. I find it annoying that, even in this enlightened age, there are still diseases that haven't taken the time to read all of our text books. No matter. Hospitals now contract full time legal teams to defend the hospital's decision to admit such a patient. This also adds to the overall cost of a hospitalization.

So, as you can see, we've come full circle. Thirty years ago a doctor could admit patients for any reason and keep them in the hospital as long as he wanted without being questioned. Now, my opinion as a doctor means absolutely NOTHING. If I think that a patient should be in the hospital I have to present absolute proof of the necessity in advance. In an ambiguous case, I do have up to 48 hours to prove the patient qualifies. If I don't make my case, it's the hospital that gets docked not me. I am paid about the same amount each day for an observation as I am for a full admit. It's the hospital (who's resources I use for my patient's work-up) that gets about 90% less money if the patient ends up not being "sick enough".

This brings us to the strange world of doctor versus hospital billing (if it hasn't already been strange enough for you). Very few doctors are actually employed by hospitals. We work as independent providers with hospital privileges. We use the hospitals to treat our patients but we

are paid in an entirely separate manner. It's not just that we bill the insurance companies separately, we bill separate divisions of each insurance provider. This means that our reimbursement is not directly tied to the hospital's reimbursement.

Every day that I see a patient in the hospital, I inform the insurance provider that I saw them (with a billing and a diagnosis code) and they pay me. I realize that in the section on office billing I went on for some time about how much trouble they take NOT to pay me. Still, compared to what a hospital has to go through, my tormentors are strictly bush league. My wife learned to chew them up and spit them out years ago. They still try but, mostly, we prevail with them.

The hospitals have a far more sophisticated group of seasoned professionals to deal with. A favorite technique of theirs is to make sure that no reimbursement goes for any medical problem that wasn't documented precisely by the doctor in exactly the way that they (the insurance providers) want it. In other words, it's the duty of the doctor to make sure that every medical diagnosis is documented in exactly the right way or the hospital doesn't get paid. No amount of objective evidence (lab values, treatment,

documented patient response, etc...) is good enough. If the doctor didn't chart it in EXACTLY the right way, it didn't happen.

What makes this so clever is that the attention to detail that's required in the hospital chart doesn't affect the doctor's pay at all. When I bill for seeing a patient in the hospital I'm asked one question: Did you see that patient today? If the answer is yes, I am paid. All of this "perfect charting" that is expected of us is purely for the benefit of the hospital.

Most doctors have little understanding or interest in how or whether the hospital they're affiliated with gets paid. Remember, most of us doctors are blissfully unaware of how WE get paid. The hospital's finances are far less of a concern for us. This makes even more work for the case managers. They not only have the responsibility of going through each chart to make sure that each patient meets the criteria to still be in the hospital. They also have to chase doctors around and gently remind them to mention a certain condition in a certain way or ask them to clarify what they mean by certain statements.

Most Doctors don't enjoy having others look over their shoulders. This is especially true for the older ones who were trained in a time when they could do practically anything without question. As you can imagine, doctors and case managers aren't always on the best of terms with each other.

So, to summarize some of the problems hospitals are facing today:

-Almost all hospitals in the U.S. were built in an age before the invention of the personal computer.

-They were built with the intention of taking care of a patient population that would never be hospitalized today.

-The number of patients who need hospitalization has fallen steadily over the years due to increasing restrictions and medical innovations.

-The patients who continue to need hospitalization are, by far, the MOST expensive to take care of.

-Hospitals have to fight harder each year and spend more money to justify the admissions they have and to be paid ANYTHING to take care of them.

-When they are paid, the profit obtained is increasingly diminished.

-The people most responsible for doing what it takes to secure the hospitals reimbursement (doctors) have little knowledge of, or interest in, what the hospital makes.

Considering all of these challenges, I may have asked the wrong question in the title of this section. Instead of asking “Why are hospitals going bankrupt?” maybe I should have asked “Why are any hospitals still left open?” And will there be any in five years?

Hospitals continue to serve a vital function in our society and it would be hard to imagine practicing medicine without them. I wrote this section as an epilogue because, unlike the rest of my website, it didn't deal with the specific medical costs to patients. Instead, it deals with the potential cost to society as a whole. It's unlikely that many new private hospitals will be built any time soon. The enormous cost of building one mixed with the abysmal profits they now provide almost guarantee that almost none will be added to what we have now. Still, the hospitals that remain do an admirable job of taking care of our sickest patients (in spite of the challenges).

It's unlikely that the number of patients that need hospitalization will continue to decline. Medical innovation, for all of its wonders can only postpone the inevitable for so long. As the population in this Country continues to increase and age, we will again begin to fill up all of the hospital beds that were emptied by the recent restrictions and innovations. The question is: Will the hospitals still be there? No business can survive if each service it provides results in a net loss. As hospital finances become increasingly more toxic, and the average reimbursement for taking care of a patient declines, the likelihood of a cascade of hospital closures becomes very real.

In the section on hospital billing, I went to great lengths to demonstrate the bizarre methods that hospitals use to collect what they're owed. This continues to be a problem since the opaqueness, apparent deception and flagrant overcharging in the current process will continue to alienate the very people that hospitals were built to serve. This process needs to be reformed if only because hospital can't afford any more enemies. It's easy to make an argument that hospitals deserve most of their troubles but the fact remains we can't afford to lose them either. Simply waiting for this crisis to unfold (as we have with every other crisis in the past) will only cost us more.