The Powers Report Podcast

Episode 24

Don't Use Covid-19 as an Excuse to Bail-Out the American Hospital System

Welcome to The Powers Report Podcast. I am your host, Janis Powers. The show brings you candid, unique and data-driven perspectives on the health care industry. I believe that any solution that is going to positively impact the American health care system has to satisfy two major criteria: financial viability and behavioral incentive alignment. In other words, access to high quality care can only be achieved if we can afford it, and if we behave in ways that optimize our health. Please subscribe to our show on iTunes or on your preferred podcasting platform and connect with us on social media. Again, this is Janis Powers, and welcome to The Powers Report Podcast.

Please don't bail out the American hospital industry. With the dramatic rise in cases and hospitalizations due to the Covid-19 pandemic, a bailout is going to get very, very tempting. The government will likely do it because, well, during crises they've done it before. During the Great Recession, billions of dollars were given to companies in the financial service and insurance industries. They were deemed "too big to fail." The rationale was that the general public would suffer if these companies couldn't extend credit or pay out claims. So the government bolstered the companies, which in turn shielded consumers. Some of the companies paid the money back. Lots of executives were paid handsomely.

Economists, financiers, investors and the general public can argue about whether or not this was a good idea. I say it wasn't. No one should be too big to fail.

Also back in the day, there were bailouts for the auto industry. But not all car companies got the same deal. The ones in the worst financial straits were recipients of more money. General Motors and Chrysler got TARP funds, but Ford got loans too. The money was paid back. But the terms were different. And here we are, about ten years later, and the same car companies are potential recipients of more bailout money.

If your company can't figure out how to maintain profitability over a ten-year span, you deserve to go out of business. The auto industry's problem isn't Covid. It's Tesla. Tesla just reported its fourth consecutive quarter of profitability, positioning it for inclusion in the S&P 500. The company isn't even 20 years old. It was founded in 2003. Ford, the oldest American car brand, was founded 100 years before Tesla, in 1903. It's time for the legacy auto makers to evolve or die.

I am getting to the health care industry. Bear with me.

Covid-19 is impacting the airline industry much more than the auto industry. Airlines have already received funds, but they are all over the map with regard to debt and cash on hand. Arguably, the airline that's most exposed is American Airlines. Full disclosure: I love American Airlines. I became a Million Miler over 20 years ago and have lifetime status on American. I go out of my way to fly the airline because I get preferential treatment in boarding, checked bags and oftentimes, going through security. Whatever I can do to mitigate the pain of airline travel in a post-9/11 and Covid-19 world, well, I'm going to do it.

That's why it's hard for me to say that American Airlines may need to fail. It won't. But it should. If demand for airline travel continues to stay down, and it will, all airlines are going to have trouble. Yes, at some point in the future airline travel will get back up to the levels it's at now. But we don't know when that's going to happen. Perhaps in the interim there are other players who will step up and do airline travel more efficiently. A free market celebrates this idea. Bail-outs don't.

Which brings me to the hospital industry. Hospitals are archaic monoliths. They are outdated sites of care. I encourage you to take a listen to two of my earlier podcasts about hospitals to learn more about my perspectives on them (1, 2). There are some themes that I repeat in podcasts because they need to be said, over and over. Like…

Much of the care that used to be done on an inpatient basis in a hospital can now be done in the outpatient environment. It's safer and cheaper to do things on an outpatient basis, yet many hospitals still do these surgeries and procedures on site. They want to preserve their revenue.

The government has caught on and is shifting its payment philosophy to a "site-neutral" model. They are moving to providing the same reimbursement for care – assuming similar patient profiles and procedures – regardless of where the care is delivered. Meaning a hospital would get paid the same as an ambulatory surgery center for doing surgery on 50-year-old healthy man who needs a hernia repair. The surgery center makes more money on the case because their cost structure is much lower than that of a hospital. In some cases, hospitals lose money on these cases. But if a hospital isn't the cheapest place to perform the care – assuming the same quality outcomes – then the care shouldn't be done in the hospital.

Some cases have definitely shifted out of the hospital. That creates excess capacity on site. Instead of shuttering or heaven forbid demo'ing the space that was formerly used for inpatient cases, hospitals typically retain it. This space gets turned into storerooms for creepy old medical equipment, medical records or offices or some other such nonsense that drives up carrying costs, utilities, etc. Hospitals need a dramatic physical downsizing.

Downsizing would be great because hospitals are old. The oldest hospital in the country is Bellevue, which is now part of New York City's hospital system. My mother was a nurse at Bellevue in the 1950s. It was a prestigious job. The original Bellevue was founded before the Revolutionary War, in 1736. Obviously, the site has moved around a lot. But hospitals have

always been a central component of a community. The older the community is, the longer a hospital has been in town. And as hospitals age, they retain some of the germs from the patients who've been treated there. Prior to Covid-19, many hospitals have had chronic problems which staph and MRSA and other nasty viruses and bacteria. It's one reason why being in a hospital is one of the worse places to be if you're sick.

What do you think is going to happen to hospitals now that they've had Covid-19 patients all over the place? Think not just about the hospital beds and mattresses. Think about the equipment. Can gallons of disinfectant really clean an MRI? Or a surgical suite? What about the HVAC system? What's in the air ducts? How long can the virus survive? Use your imagination. The reality is probably worse.

Everyone likes to be a Monday Morning Quarterback. Now I'm in "I told you so" mode. Sometimes it's not all good to be right. Now is one of them.

A few podcasts ago, I talked about how hospitals wanted to retain Covid patients because of the potential reimbursement they'd receive for treating them (3). The billing and reimbursement is going to be very complex especially because early on, we didn't know how to treat the virus. We're still struggling, but thanks to the hard work of many in health and research, we're getting better. That said, we still don't have good testing capabilities to quickly diagnose patients, so hospitals may have treated many Covid patients without even realizing it.

Hospitals, whether they will admit it or not, were incented NOT to do the right thing. The right thing would have been for all Covid patients to have been sent to one Covid-designated facility away from everyone else. This magical Covid site – and didn't necessarily have to be a hospital – should have been staffed with people who'd already been exposed to the disease. It would have been terrific if this had been a federal mandate. But even local government could have made the demand. That didn't happen. As a result, Covid patients in hospitals infected other patients and of course, staff and physicians.

How did this strategy work for hospitals? Fantastically. This week, HCA, the largest for-profit hospital system, announced earnings. Amid the pandemic, HCA had a net income of over a billion dollars for the last quarter (4). And guess what. They got $822 million in stimulus relief from the CARES Act. So we taxpayers funded about 75% of HCA's profits, causing their stock to surge.

There is something really wrong with this.

You can guarantee that hospitals, who are treating more and more Covid patients, are going to demand another cash infusion. The damage is being done right now. Hospitals are reporting that they are at capacity levels – especially in Texas, where I live. Of course I need to note that it's tragic that so many people have gotten and continue to get sick. We're fortunate to have dedicated doctors and staff who are working diligently to take care of people. The issues I'm

talking about are not related to their hard work. We have a systematic issue related to hospital over-capacity that I hope Covid will highlight and potentially address.

I already talked about excess capacity at hospitals because so much care has shifted to the outpatient environment. Now, with a surge of patients due to a generational pandemic, we're seeing hospitals at capacity levels. Why does it take a pandemic to highlight overcapacity? Think about it. If there were no Covid, hospitals would have lots of empty beds. That breeds inefficiency. I can't stand inefficiency.

So let us back up a moment and talk about these overcapacity claims. Back in my consulting days, I performed capacity analyses for merging hospitals. We'd look at patient demand in the area where two or more hospitals were thinking about merging and we'd figure out how much capacity was needed to service the patients. We designed the hospitals to be at about 80% capacity. We knew there would be surges in demand, especially in the winter. The hospitals needed to be just big enough to deal with the surge. Any larger, and there would be waste. We'd recommend shutting or selling a hospital or at least re-purposing it if there was too much capacity in the system.

So let's look at some numbers! The CDC reports on Covid-related hospitalization rates (5). As of July 11, 2020 reporting, the cumulative rate of Covid-related hospitalizations was 113.6 per 100,000 people. That means 113.6 people (as if there is a .6 of a person) get hospitalized for every 100,000 people. On a percentage basis, that's .11%. That's just the rate for Covid patients. You have to add on normal hospitalizations.

So what is the hospitalization rate during normal – or non-pandemic – times? Well, data for 2018 from the CDC is 257.7 per 100,000 people (6). If we add 257.7 per 100,000 to the 113.6 per 100,000 during the pandemic, we're bringing in an extra 44% of Covid-related hospitalizations into the mix.

If hospitals were running at close the capacity that they should, they should only have 20% excess capacity during normal times. (This was the idea that a hospital should target 80% occupancy and have 20% to spare for spikes in need.) But here we are, adding 44% more hospitalizations. And hospitals can handle it. That means there's too much capacity.

Now you could argue that we can't use the normal hospitalization rate because most communities where there's a surge of Covid cases have pushed off any elective care. This certainly impacts the outpatient environment more than the inpatient. Yet there are reports that people are avoiding the hospital for things like chest pain and heart attacks for fear of getting Covid. So hospitals probably have fewer cases than normal.

But here's the data issue. Occupancy rates are calculated based on available beds. Meaning, if you have 80 patients that need a bed and you have 100 beds available, you have an 80% occupancy rate. It's how hospitals designate "available beds" that makes the numbers fluffy. There are at least three buckets of beds that can be used for the calculation.

One is licensed beds. When a hospital is built, they have to show that there's community demand for the beds. At least if they want Medicare reimbursement. Since many hospitals were built decades ago, these licensure requirements were based on demand for inpatient care that is completely outdated. Many hospitals are probably licensed to build more beds than the community needs today. So right there is a potential overcapacity problem.

Not all hospitals build to the license. Some hospitals build maybe 80% of the beds for which they are licensed and then they reserve space to build the rest of the beds later on. To me, this is the most accurate figure for available beds. The licensed number is meaningless if the hospital hasn't built the bed.

But if it has built it, then it needs to be counted in the denominator. Oftentimes, it's not. We're seeing more and more of a "staffed beds" figure in the denominator. A staffed bed means that the hospital is only counting beds that have staff to service them. There could be an entire wing of available beds with no patients in it. From an operational perspective, it makes no sense to pay for staff to work there because there are no patients. So hospitals will present occupancy figures based on staffed beds, knowing that staff fluctuates based on patient census.

Given that Covid has had a deleterious impact on health care workers, many facilities are struggling to find staff. If they can't get staff to work the beds, the denominator shrinks. And that makes the occupancy rates look terrifying, like hospitals are overflowing and there's nowhere for patients to go.

I've read stories where patients are backed up in the emergency room and there are no hospital beds available. If this is happening right now, someone in charge needs to be replaced with someone else who has some strategic operational capabilities. We've seen what surges can do. There is capacity. We need staff. We should be quarantining Covid patients. Here in Austin, they've opened up the Convention Center as a Covid site. Great idea. Houston's Astrodome should have been repurposed a month ago.

What does this mean? We need to let some hospitals go out of business because there's obviously too much capacity in the system. No bail-out.

Now, one could argue that cutting funds to hospitals will make it hard on rural hospitals to stay afloat. I totally agree. Rural hospitals have already seen way too many closures and they are oftentimes the only game in town. I think they deserve funding to stay in business because we have real access problems to health care in rural America.

Covid has disproportionately hit urban centers. This is great for the no-funding rationalization strategy. Urban hospitals are being hit hardest, climbing towards so-called capacity. That means there's too much capacity in urban centers. A no bail-out for hospitals approach will help consolidate hospitals in urban centers.

Keep in mind that many city-dwellers are abandoning the urban environment for the suburbs. One should expect many cities so see a population dip. Fewer people means less demand. And that reinforces the need for fewer hospitals.

Now, I'm sure the hospital community, certainly as represented by their lobbying arm the American Hospital Association, would not agree with me. I'm sure they're bumping elbows in DC right now trying to drum up support for more hospital funding.

This is extremely ironic, because right now they are also engaged in legal action against the federal government. You may have heard that a recent Trump administration ruling requires that hospitals disclose rates that they negotiate with different insurers for services. Put simply, hospital prices are supposed to go public. Hospitals appealed the decision. The decision was upheld. And now the hospitals are appealing it again. I mean…what is the point of making an appeal and having it get shut down only to appeal again? It makes me wonder if the legal system is worse than the health care system.

Anyway, the American Hospital Association doesn't want hospitals to have to make these disclosures because then all the insurers – with whom hospitals negotiate separately – will have the same playbook. It will put hospitals at a significant disadvantage. The hope is that making the pricing public will force prices down. At the very least, those educated in this pricing stuff can analyze the information and help the public better understand how the health care system works. I am 1,000 percent for the pricing disclosure.

Hospitals claim that disclosing the pricing is an undue burden. Here's a great quote from a *Wall Street Journal* article about this issue: "Complying would require spreadsheets with hundreds of thousands of columns, the hospitals said in the lawsuit. They also said such files could crash most standard computer systems." (7)

There is something really wrong with this.

Pricing for hospital-based care is so complex that it requires hundreds of thousands of spreadsheet columns to capture the information. It's no wonder that about a third of health care costs in the America are attributable to administrative expenses. If it's so darned complicated to compile, why aren't hospitals asking for a simpler payment system? Heck, why aren't WE asking for a simpler payment system? Anything has to be better than hundreds of thousands of spreadsheet columns worth of pricing information.

A lot of hospital reimbursement is based on DRGs or Diagnostic Related Groups. These were adapted by Medicare in 1983. There have been changes to DRGs and there are other coding mechanisms used. Yet we're still using a system developed about 50 years ago.

I know it's insane to think that maybe we could get something simpler. After all, electronic medical records have been built around the current payment system and if we trash the payment system, then the billions spent on EMRs would be all for naught. Not like most doctors

would have a problem with that since EMRs are so labor intensive they're a major source of physician burn-out.

But couldn't we make a goal of cutting the codes we already have in half? Can't we find a way to simply consolidate some of the details? I'm not saying that would cut administrative costs in half, but it could use the system currently in place and cut some of the nonsense out.

As for Covid, given the complexity of pricing, do we have any faith that the government is going to be able to come up with a simple way to reimburse hospitals for care? Highly doubtful. Some of the bailout money that has been distributed to hospitals was based simply off the Medicare charges that a hospital incurred. Using that as a baseline assumes there's some correlation between Medicare spending and Covid spending. Sure, the elderly are more susceptible to Covid, but the logic isn't perfect. Then again, if you're using hundreds of thousands of pricing elements, nothing's going to be perfect. So maybe the Medicare ratio is good enough.

Actually, the simplest thing would be to not reimburse hospitals at all. That would be my plan.

This is The Powers Report Podcast. Please subscribe to our show and please follow me, Janis Powers, on social media. Please see our website at powersreportpodcast.com to submit questions and ideas on the Contact page. I look forward to hearing from you. Thanks so much for listening!

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