ADVISORY E-ALERT

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Maybe Not 2020, But This Vision's In Focus

As the year draws to a close, it's time to think about the next decade of the 2000's, the 2020s.

Other than 2020 being the best year *ever* for advertising ophthalmology, optometry, and optical services, the 2020s promise to deliver on a number of trends, some continuing and others now coming into focus.

Let's look at a few. As you read, think what each might mean for you and how you might profit from it or because of it.

Continued Growth of ASCs

There's been a steady expansion in the number of ambulatory surgery centers (ASCs) over

the past several decades due to a near perfect storm of technology, the ability of physicians to legally profit, and aligned payor and patient preferences. Combined, they pushed procedures out of hospitals and into ASCs.

And then, in a bizarrely shortsighted move, the American Hospital Association lobbied Congress to incorporate into Obamacare near complete prohibitions on physician investment in hospitals. The result was "protecting" the dying hospital business by pushing those who can influence referrals to refer their patients elsewhere: to ASCs. In 2019 alone, well over 200 new centers opened.

As I've written many times before, any procedure that *can be* performed on an outpatient basis *will be* performed on an outpatient basis. And, with Medicare quickly moving to payment parity (reducing HOPD reimbursement to ASC levels) it's only a matter of time until hospital outpatient departments are as hard-to-find as kangaroos in Kansas.

This trend portends success for those willing and able to invest, physicians and lay investors alike, in the ownership of ASCs. It also bodes well for facility-based providers such as anesthesiologists and CRNAs who focus on supporting ambulatory surgical services.

Additionally, due to recent additions by Medicare of dozens of new interventional CPT codes to its list of approved ASC procedures, “surgery-like" specialists, interventional cardiologists and interventional radiologists, will have even greater ability to shift their practice focus to the ASC setting.

And, of course, the huge growth in the sector presents opportunities for lay investors, both those investing in ASCs themselves and in ASC management companies.

Imaging Insight

Similar to the reasons supporting the shift to outpatient surgery, following the lead of Anthem, carriers will continue to force the shift of outpatient imaging to freestanding, non-hospital-owned imaging facilities for reason of their value competitiveness.

Obviously, this is a growth opportunity for radiology groups who control their own facilities.

And, similar to the opportunities in the ASC market, radiology facilities can be owned by lay investors and, of course, managed by companies with or without physician involvement.

Larger Cracks in Hospitals and Healthcare Systems

The shift toward outpatient care combined with the built-in fragility of large systems will continue to weaken hospitals and health systems, especially those with employed or closely aligned physicians. [If you haven’t already, download a copy of my book, The Impending Death of Hospitals.]

The result of the trend to outpatient facility care is that lower and “no” reimbursement cases will remain in the hospital while better reimbursed cases will flow out, drastically destroying hospitals’ payor mix.

Although hospitals attempt to protect their economic flank by way of employing, directly or indirectly, physicians in order to capture referrals, the combined very large expense of supporting both money-losing facilities and compensating captive physicians will take an increasing toll on hospitals and health systems.

Thought to be safer than private practice, physicians should consider that large healthcare systems, with fewer business options and little to no ability to quickly shift directions, might, in reality, be no more immune to disaster than large ships -- remember the Titanic?

And, as discussed above, at the same time, cases that deliver value *to physicians* and *to freestanding facilities*, as well as to patients and payors, will be permitted to “drive themselves” to physician and investor owned facilities. I call this concept Value Based Buying™.

Increased Anti-Kickback, Stark Law, and Other Compliance Scrutiny

Because the Feds make money on compliance (as do whistleblowers) you can count on ever-increasing compliance scrutiny.

Look at it this way: Even Warren Buffett can’t get the return on investment that the Feds generated from 2015 to 2017 as a result of coordinated Department of Health and Human Services and Department of Justice healthcare anti-fraud operations, stuffing $2.6 billion into federal coffers. And, it’s 100% leveraged, i.e., 100% other people’s (taxpayers’) money.

Plus, in 2017 alone, the DOJ obtained 639 criminal conviction for healthcare fraud-related crimes. And that's just the DOJ.

The joint DHHS/DOJ Medicare Fraud Strike Force brought charges against an additional 478 defendants, negotiated 290 guilty pleas and obtained convictions against another 40 defendants. 305 individuals went off to prison for an average sentence of more than 50 months behind bars.

If you know federal prosecutors, their currency in trade is convictions, including guilty pleas. And, in healthcare, getting them appears to be almost as easy as shooting fish in a barrel.

Healthcare compliance is a big business. Policing it is a big bureaucracy. Both will get bigger in the 2020s.

For physicians, other healthcare providers, and facilities, this necessitates far more active and effective compliance programs.

It also presents even greater opportunities for investors of all types in coding, auditing, and compliance ventures serving providers and facilities.

*Continued Consolidation In Physician Services and Other Healthcare Sectors**

The major trend is toward continued consolidation in most medical specialties. This is certainly the case in connection with ophthalmology, gastroenterology, dermatology, plastic surgery, urology, and orthopedic surgery, in which valuation multiples are, in general, rising. The same trend is mirrored in dentistry.

Although much of the activity is driven by private equity, PE is *not* by any means the sole driver of consolidation.

For hospital-based medical specialties such as anesthesiology, radiology, and emergency medicine, which were early to begin consolidating, opportunities still abound. However, in general terms, valuations are lower. Some original PE sponsors have already exited, and others seek to exit. In essence, these specialties are entering into second order consolidation: the consolidation of consolidators.

For those same hospital-based specialties, there will likely be a concurrent, hospital-by-hospital countertrend in which hospitals which shifted early in the consolidation wave from contracting with independent groups to contracting with regional/national groups, seek to re-establish contracts with local groups over which they can exert more control and receive greater loyalty.

In the broader sense, most business sectors within healthcare remain ripe for acquisition as well as for divestiture. In addition to physician and dental practice entities, ASCs, imaging facilities, clinical laboratories, medical coding companies, compliance auditing firms, and revenue cycle management companies are examples of hot M&A activity.

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* Some information courtesy of our affiliate, Steering Advisors, LLC, the Dallas-based national healthcare M&A advisory firm – steeringadvisors.com.

Wisdom. Applied. 133 - Tastes Like Chicken. Smells Like Fraud.

What appears to the unknowing and unsuspecting to be a normal day-to-day business transaction is really something quite different.

All Things Personal

Dateline: Last week, first class on American, 30,000 ft above who knows where.

She had to use the restroom.

But just when I got up to let her into the aisle, the flight attendant wheeled the beverage cart to block the way. “Just a minute, please, the pilots need to use the lavatory.”

So she sat back down.

Pilot one comes out, uses the lavatory, and a minute or two heads back into the cockpit.

Pilot two comes out, uses the lavatory, and a minute or two later comes back out . . . and proceeds to chitchat with three flight attendants for close to 15 minutes. Laughter. Smiles. Ha ha ha.

Did they care that the passenger next to me, or any other, needed to pee?

Did they understand that they’re in the customer service business, not in the chatting business?

What might your employees, or worse, your partners, be doing to send the signal that they don’t give a shit? That it’s all about them and not about the customer, whether you call them customers, patients, or guests.

It doesn’t take four morons to ruin your reputation. One is enough.

If you have one and something’s not done to either correct the behavior or fire the moron, then it’s no longer the moron’s problem, it’s a management issue.

Podcast Compilation Greatest Hits - Strategy Edition 1.0

We've curated our most popular podcasts on strategy into our first compilation album.

Sit back, enjoy, and think about your future.

Listen here.

Come listen to Mark speak in sunny Las Vegas on January 17, 2020, at the American Society of Anesthesiologists Conference on Practice Management.

Recent Posts

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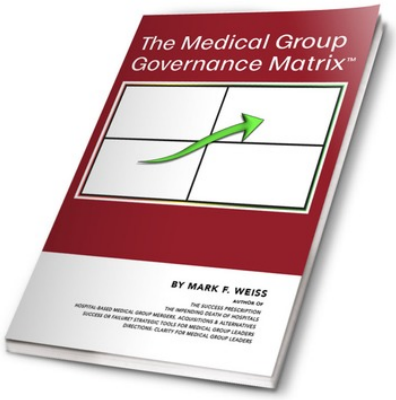
- 2020 New Year's UnResolutions
- Tastes Like Chicken. Smells Like Fraud. – Rebroadcast – Podcast
- Why You Need to Adopt the Contingency Mindset – Rebroadcast – Medical Group Minute

Published Articles

- The Good, The Bad and The Ugly: Why Some Negotiations Succeed, Fall 2019, Communique.
- Fair and Balanced Views: The Pros and Cons of Selling Your Anesthesia Group, Fall 2019, Sentinel.
- What's the Lifetime Value of a Patient? Published in the July 2019 issue of Outpatient Surgery.

Books and Publications



We all hear, and most of us say, that the pace of change in healthcare is quickening. That means that the pace of required decision-making is increasing, too. Unless, that is, you want to take the "default" route. That's the one is which you let someone else make the decisions that impact you; you're just along for the ride. Of course, playing a bit part in scripting your own future isn't the smart route to stardom. But despite your own best intentions, perhaps it's your medical group's governance structure that's holding you back. In fact, it's very likely that the problem is systemic. The Medical Group Governance Matrix introduces a simple four-quadrant diagnostic tool to help you find out. It then shows you how to use that tool to build your better, more profitable future. Get your free copy here.

Whenever you're ready, here are 4 ways I can help you and your business:

1. Download a copy of The Success Prescription. My book, The Success Prescription provides you with a framework for thinking about your success. Download a copy of The Success Prescription here.

2. Be a guest on "Wisdom. Applied. Podcast." Although most of my podcasts involve me addressing an important point for your success, I'm always looking for guests who'd like to be interviewed about their personal and professional achievements and the lessons learned. Email me if you're interested in participating.

3. Book me to speak to your group or organization. I've spoken at dozens of medical group, healthcare organization, university-sponsored, and private events on many topics such as The Impending Death of Hospitals, the strategic use of OIG Advisory Opinions, medical group governance, and succeeding at negotiations. For more information about a custom presentation for you, drop us a line.

4. If You're Not Yet a Client, Engage Me to Represent You. If you're interested in increasing your profit and managing your risk of loss, email me to connect directly.