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Limits Weighed on Physician-Owned Hospitals

Lawmakers Seeking Curbs on Specialty Facilities Want to Attach Provision to Medicare Bill

By [Christopher Lee](#)
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An end-of-the year push in Congress to stave off a 10 percent cut in the fees [Medicare](#) pays doctors has revived political interest in another thorny issue: whether physicians should be able to own the hospitals they send their patients to.

Lawmakers who previously have sought tighter scrutiny of physician-owned "specialty hospitals" say there is a small chance that Congress will address the issue as part of legislation to wipe out the fee cut, scheduled to take effect Jan. 1. The [American Medical Association](#) and other doctors' groups strenuously oppose the cut and have succeeded in putting it off for several years.

[Sen. Charles E. Grassley \(Iowa\)](#), the top Republican on the [Senate Finance Committee](#), said: "My motivation for seeking reforms over a long period of time is the effect that specialty hospitals have on community hospitals when specialty hospitals pass the buck on emergency care and cherry-pick based on profits rather than patient needs." Grassley, a key player on both issues, said it's "not clear" whether specialty hospitals can be dealt with in the year-end Medicare bill.

The debate has been contentious for years, with traditional hospitals complaining of lost business and conflicts of interest, and backers of doctor-owned hospitals saying they promote competition and improve quality of care. Congress, lobbied heavily by both sides, imposed a temporary moratorium in 2004 on establishing new doctor-owned hospitals, but did not ban them. The moratorium has since expired.

Interest surged again in August when the House passed a measure sponsored by [Rep. Pete Stark](#) (D-Calif.) that would limit physician investment in existing doctor-owned hospitals to 40 percent, and individuals' stakes to no more than 2 percent. Under the bill, no new physician-owned hospitals could be created. The restrictions would apply only to hospitals that treat Medicare patients, but that program's reach means all would be affected.

The [Congressional Budget Office](#) estimated that the provision would reduce Medicare spending by \$2.9 billion over 10 years, because fewer services would be performed.

Whether the Senate will go along is unclear. The Medicare fees bill is caught in Washington's polarized political atmosphere, leaving negotiators struggling just to achieve its main goal.

Critics say that when doctors steer patients to a hospital they own, it gives them an incentive to put profits above the patient's health by ordering more tests or procedures than are necessary. They argue that physician-owned hospitals siphon off the most lucrative, easy-to-treat patients, leaving more complex and costly cases, as well as the poor and uninsured, to community hospitals. That can prompt community hospitals to curtail vital but expensive services, such as comprehensive emergency room care, which specialty hospitals generally do not provide.

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"The major hospitals are more or less being cannibalized," said Stark, chairman of the [House Ways and Means](#) health subcommittee. "It's pretty hard to build a case for these specialty hospitals."

Supporters say the hospitals offer high-quality care, tend to have more nurses, pay taxes (unlike nonprofit institutions), and, most important, offer a choice. Doctors care more about patients' welfare than do the large chains that operate some hospitals, say supporters, who suspect that what community hospitals really object to is having to

fight for business.

"To say that competition in the hospital business is bad goes against all the factual information that we have," said William G. Plested III, immediate past president of the AMA, which opposes ownership restrictions. "We have all kinds of data that show that if you have a specialty hospital open up, the first thing that the general hospital will do is to try to improve their quality to compete."

Physician-owned hospitals began to proliferate in the 1990s, often specializing in services such as cardiac care and orthopedic surgery. There are about 180 such hospitals operating or in the later stages of development, up from 110 in 2001, according to Physician Hospitals of America, a trade association. About 155 are specialty facilities, while the rest are general hospitals, the group said. Most are west of the [Mississippi](#) in states that do not require hospitals to demonstrate a need for their services before they open.

In a 2005 study, the Medicare Payment Advisory Commission found that physician-owned hospitals were no more efficient than traditional hospitals, generally admitted patients who were less severely ill and therefore more profitable, and saw fewer people on [Medicaid](#), which serves the poor. The commission found that the rate of cardiac surgeries in an area tended to increase after a doctor-owned heart hospital opened. And it found that most community hospitals were able to compensate for lost revenue by cutting staff, raising some prices, and expanding profitable services such as imaging.

At the same time, the Centers for Medicare and Medicaid Services concluded in a separate study that care at doctor-owned cardiac hospitals was "as good as or better" than at traditional hospitals, and that patient satisfaction was "very high" in cardiac and orthopedic hospitals.

One of the most fertile regions for such facilities is the [Wichita](#) area, where at least six new hospitals, most of them specializing in limited services such as cardiology, have opened since 1995.

"We've been sort of a hotbed," said Sam Serrill, chief operating officer of Wesley Medical Center, a 540-bed general hospital owned by [Nashville](#)-based Hospital Corporation of America. "You see almost an overnight reduction in admissions to the [general] hospital from . . . owners of a physician-owned hospital."

From 2001 to 2002, revenue from Wesley's cardiovascular services program dropped from \$18 million to \$2 million, Serrill said. The hospital had to raise salaries and pay bonuses to keep key staff from leaving. Administrators made up for the lost money by closing the occupational medicine program, shuttering an electron microscopy lab, and pulling out of a pharmacy research program. But the hospital, a major trauma care center, never considered curtailing its emergency room hours, Serrill said. And Medicaid recipients still account for about 15 percent of the hospital's patients.

"We really sort of buckled down," he conceded. "We don't have any trouble with competition. That's fine. Our issue is the self-referral and the conflict-of-interest that it creates."

But Badr Idbeis, chief executive of Kansas Medical Center, a 58-bed doctor-owned general hospital that opened in October 2006 near Wichita, said traditional hospitals also use their muscle to lure patients, by negotiating exclusive agreements with insurers, pressuring doctors not to send patients elsewhere, or other tactics.

Idbeis, a co-founder of Kansas Heart Hospital and president of Cardiovascular Hospitals of America, said physician ownership will lure the best minds to medicine and ensure that patient care trumps bureaucracy. Kansas Medical Center has at least one nurse for every four patients, he said, and the hospital has comparatively little administrative overhead. About 5 percent of its patients are on Medicaid.

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"All of our money goes into clinical services," Idbeis said. "I see Mrs. Jones every day. Do you think I'm going to cut her care and see her tomorrow, suffering? No chance. That daily renewal of contact is what makes physicians more capable of delivering health care the way it should be."

Last year, the Centers for Medicare and Medicaid Services devised a plan to adjust Medicare reimbursement rates in an attempt to level the financial playing field for hospitals. Idbeis said he would not object to proposed requirements that doctor-owned hospitals publicly report on their ownership structure, but the government would be wrong to regulate them out of existence.

"America made its greatness allowing the market to decide what works and what does not work," he said. "Obviously patients are getting very good care in our hospitals. We should let the market decide what's good and what's bad."

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