Physician ownership of specialty spine hospitals

ROBERT E. TIBBS, JR., M.D., STANLEY PELOFSKY, M.D., ERIC S. FRIEDMAN, M.D., AND KEVIN BLAYLOCK, C.P.A.

Neuroscience Specialists, P.C., Oklahoma Spine Hospital, Oklahoma City, Oklahoma

Patients expect and deserve quality medical care. Physicians, by nature, want what is best for their patients. With the advent of specialty hospitals, physicians can own, run, and control a superior center designed to deliver the highest quality health care. Neurosurgeons who manage their own hospital may set the standards for medical excellence, with patient satisfaction as their primary focus.

KEY WORDS • physician ownership of specialty spine hospitals • neurosurgery • spine

Patients expect and deserve quality medical care. Physicians, by nature, want what is best for their patients. With the advent of specialty hospitals, physicians can own, run, and control a superior center designed to deliver the highest quality health care. Neurosurgeons who manage their own hospital may set the standards for medical excellence, with patient satisfaction as their primary focus.

Only a few generations ago, physician-owned hospitals were common. Over time, surgical and medical diagnostic and treatment options increased exponentially, often made possible by costly technology. Consequently, hospitals continuously expanded in size and complexity. The administrative burden of dealing with third party payers grew ever more difficult once Medicare and later managed care were introduced. To concentrate on practicing their craft, doctors eventually ceded the responsibility of owning and managing hospitals to others. As decades passed, hospitals became big business, controlled by professional administrators who often lacked medical experience. To the detriment of both doctors and patients, this phenomenon grew, and was accompanied by diminished interest in physician input. Lately, however, there is a trend toward physician control once again.

Over the past 20 years, during which less invasive procedures have been performed in outpatient settings, the

ambulatory surgery center became popular. Ownership of these centers empowered surgeons, providing opportunities for enhanced productivity and additional earning power. Very few neurosurgical procedures, however, are appropriate for an ambulatory surgery center, which by definition does not provide inpatient treatment.

In the 1990s a few physician-owned, full-service hospitals were opened, although they met with little success. More recently, physicians have participated in the development of single-specialty hospitals in partnership with majority-owner nonphysician investors. These facilities include orthopedic and cardiac hospitals. Usually, the nonphysician partners are either publicly traded corporations or established large general hospitals. Even though the physicians are only minority owners, these specialty hospitals have at least been generally good investments for doctors. Unfortunately, their influence over daily operations and decision making is often still minimal.

Finally, we are now seeing the development of completely physician-owned, single-specialty, hospitals specifically tailored for neurosurgeons—spine hospitals. These facilities are designed to provide advanced medical and surgical treatment to patients suffering from diseases of the spine and chronic pain. For the physician control and decision-making power translate into a more satisfy-

ing and rewarding professional life in conjunction with increased revenues in a time of declining medical reimbursement.

In today's complex and fast-paced society, people in the United States desire efficiency and simplification of services. Medical services are no exception. Patients' expectations are higher, demanding personalized quality medical treatment especially when it involves specialty care and/or surgery. The ideal spine hospital offers the benefit of "one-stop shopping." Everyone involved in the facility is dedicated to the care of patients with spinal problems. Pain management specialists complement neurosurgeons and orthopedic spine surgeons. In-house diagnostic services further enhance capabilities. On-site computerized tomography and magnetic resonance imaging lessen the anxiety of patients already suffering from a painful condition, as well as expediting care. Appropriate neuroimaging can be performed the same day as a patient's initial appointment, and the results are immediately available for the physician to review. Should additional diagnostic studies or nonsurgical treatments be needed, a referral can be made and the procedure undertaken in the facility that same day.

For provision of inpatient services, a specialty spine hospital permits superior patient care. Every staff member is focused solely on the care of the patient requiring spine-related treatment. Staff includes nurses, operating room personnel, and ancillary services. Each person involved becomes a spine specialist in his or her area of expertise.

Ultimately physicians determine the hospital's success because their decisions determine policy and procedure. The physician owners control the clinical operations of the hospital. They make purchasing decisions, have final approval over the hiring of staff, and determine the surgery schedule. By controlling the operative scheduling, the spine surgeon may better improve overall time management, becoming more efficient and allowing a larger case-load. The added benefit of always having a team of spine specialists in the operating suite increases the quality of care for the patient and the quality of life for the surgeon.

Even ancillary support physicians are hand picked to be on staff. Should a patient require medical services not directly available at the spine hospital, these specialists (cardiologists, pulmonologists, and others) who have been granted privileges can be quickly consulted for assistance. If necessary, transfers to facilities that are more equipped to handle these problems can be made safely and efficiently.

By outsourcing certain support functions such as billing or other administrative services, the clinical staff's commitment to patient care becomes more focused. Lacking the constant administrative oversight typical of a traditional hospital, they are encouraged to devote their energy to streamlining operations. Because little bureaucracy is involved in decision making, appropriate rapid changes in policy are facilitated. New equipment can be obtained without the usual red tape. Rarely are meetings necessary.

Although administrative and other support services may be centralized offsite, these employees will still specialize in spine hospital services. If a patient calls with a business-related question, the administrative staff, functioning as a seamless extension of the spine hospital, can effectively respond.

Although specialty spine hospitals are still in their infancy, the concept is growing rapidly, being quickly embraced by physicians and patients alike. There is presently at least one specialty spine hospital in operation, and others are in various stages of development. The impetus for involvement in these ventures is clear: improved patient care and physician lifestyle.

Currently, the states that are home to the most specialty hospitals are Texas, Oklahoma, California, and Ohio. At present, only a few states do not require a Certificate of Need to build a specialty hospital: Arizona, Arkansas, California, Colorado, Idaho, Indiana, Kansas, Louisiana, Minnesota, Montana, Nebraska, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Texas, Utah, Wisconsin, and Wyoming. In a few more states the Certificate of Need laws are flexible enough that developing a new hospital can sometimes be accomplished with minimal difficulty.

Unlike many health services, physician-owned hospitals are not prohibited by the Stark Act,¹ provided certain conditions are met, including: 1) the referring physician owner is authorized to perform services at the hospital, and 2) the ownership is wholly of the hospital and not merely as a subdivision of the hospital.² Legislation, however, has been introduced in the House of Representatives, which would, for all practical purposes, eliminate the hospital exception to the Stark Act for all investments acquired by doctors after the effective date.³ The issue has been referred to the General Accounting Office for study (Congressman Bill Thomas and Congressman Jerry Kleczka, personal communication, July 19, 2001). Even with an exception to the Stark Act, one must still be mindful of the Medicare Fraud and Abuse and Anti-kickback Law.⁴ Because it relates to physician investment in a hospital, this law essentially requires the investment be structured in such a way as not to constitute a means of giving remuneration in exchange for referrals. Some states have enacted their own self-referral and anti-kickback laws similar to the federal statutes. Experienced legal counsel is required to ensure compliance with these statutes.

Unfortunately, the development of a physician-owned hospital is not a simple task. It is, in fact an arduous, complex, and expensive matter. Physicians who want their own facility must engage expert consultants with extensive experience in developing specialty hospitals. There are few such consultants and are best identified by contacting other physicians who have (or are in the process of developing) their own hospitals.

Finally, more important than accommodating laws, retaining experienced attorneys, and engaging expert consultants is the organization of a "critical mass" of physicians who are willing to accept the challenge and substantial risk of owning a hospital. Even a specialty hospital is an extremely capital-intensive business with very high fixed costs. To absorb the cost of the necessary support and ancillary functions, a surgery-oriented hospital must have at least two (preferably more) operating rooms. The key factor for success is the number of surgeons who own and practice in the hospital.

Operating rooms in a spine hospital can average three surgeries per day. The length of stay for each patient will be approximately 2 days. Therefore, a spine hospital should have five or six patient rooms for each operating

room. If three cases each day undergo surgery in each operating room of a three–operating room hospital, 2,250 cases per year can be treated based on a 5-day-a week, 50-week-a-year schedule. If one surgeon averaging 200 spine cases per year can perform half of those surgeries at his own facility, then the optimum number of spine surgeon owners in this scenario would be approximately 22. A hospital with three operating rooms, 15 to 18 patient rooms, one or two procedure rooms for pain management cases, diagnostic neuroimaging facility, and required support functions will range in size from 40,000 to 60,000 square feet. This size depends primarily on the extent of off-site outsourcing that can be achieved. Construction costs will be between \$150 and 200 per square foot, according to geographical region and the quality of finish. Land cost, of course, will vary greatly depending on location, but it could range from \$3 to 10 per square foot. With parking and green spaces, a surgical hospital will need at least 5 square feet of land per square foot of building. Equipment, instruments, furniture and fixtures will run between 75 and \$100 per square foot of building space, depending in large part on the mix of diagnostic neuroimaging technologies included. Finally, startup costs, opening inventories, and operating capital can be estimated to range from 20 to 25% of fixed costs. This makes the total investment required to develop a spine hospital from approximately \$11,000,000 at the low end to approximately \$23,000,000 at the high end. Assuming 20 equal physician owners, each would bare a risk of between \$550,000 and 1,150,000. In the right circumstances, the vast majority of the investment can be financed. Still the

sheer magnitude of such a risk is sobering. In a favorable market, however, an investment in a spine hospital can be expected to produce a 10% annual return and in some cases substantially more.

Owning a specialty spine hospital does not guarantee success. With a market capable of supporting such a facility, however, ownership leads to benefits never before imagined. Ultimate administrative control permits tailored settings both for spine patients and physicians. Managing such matters as operative scheduling greatly lessens the surgeon's daily burden. This efficiency, in turn, permits a larger caseload, allowing the physician to increase productivity substantially. Specialty spine hospitals should be physician owned, physician run, and physician controlled. They will set the standard for medical excellence for years to come. Neurosurgeons can take the lead in controlling their future by developing, managing, and investing in their own spine hospitals.

References

1. 42 U.S.C. § 1395 nn, et seq.
2. 42 U.S.C. § 1395 nn (e) (3)
3. H.R. 2490, 107th Cong. (2001)
4. 42 U.S.C. § 1320 a–7b

Manuscript received February 22, 2002.

Accepted in final form March 19, 2002.

Address reprint requests to: Stan Pelofsky, M.D., Neuroscience Specialists, 4120 West Memorial Road, Suite 300, Oklahoma City, Oklahoma 73120.