

# Specialty hospital CEO takes up arms against Obamacare restrictions

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TULSA – With his hands folded against his chin, his eyes drooping from weariness, Terry Woodbeck leaned forward in his chair with all the resolve of a man backed against a wall.

On the table before him sat two piles of paper, more than 1,500 sheets reaching almost to his wrists. “If you add this report, it’s about 25,000 pages,” he said, tapping a small summary printed out from Medicare’s [DataView](#) system.

The ominous stacks demonstrate his own research, a report comparing 100 specialty hospitals to 100 general hospitals operating in the same markets across the nation. Woodbeck, chief executive officer of [Tulsa Spine & Specialty Hospital](#), compiled the data this winter in his spare evenings and weekends.

“Probably 400 hours,” he estimated, rubbing his eyes when thinking about the work.

With this issue paper as his lance, this modern-day Don Quixote intends to give a copy of his report to every U.S. congressman as part of his one-man crusade against President Barack Obama’s health care initiative.

But unlike that troubled knight, or Frank Capra’s comparative working-man equivalent in *Mr. Smith Goes to Washington*, Woodbeck has a firm understanding of what he’s up against.

“The purpose of this was to show the impact on Medicare if physician-owned hospitals were to close and all the inpatient cases currently done at each facility were taken to another for-profit or not-for-profit facility in the same town that the physician-owned hospital was located,” said Woodbeck, who will go to Washington in April.

His findings indicate Medicare costs could rise by \$3 billion to \$5 billion over five years – a sizable factor even to that towering government institution. But Woodbeck hopes the real message gets delivered to lawmakers seeking to clamp down on specialty hospitals.

"If you limit the amount of physician-owned hospitals, it will cost Medicare and the taxpayers more," he said.

While different federal policymakers have debated potential restrictions for years, voicing fears that specialty hospitals siphoned off the healthiest and best-paying patients from government-supported and other general hospitals, the pressure heightened in 2003 as Medicare placed an 18-month moratorium on physician-owned hospital expansion to study that issue.

"Their published report said they could find no evidence of overall cherry-picking," said Woodbeck, whose position demonstrates his stand on the issue. "In fact, they said dollar for dollar, when you take into account taxes paid and indigent care provided, that the physician-owned hospitals actually provided more indigent care than the larger facilities, dollar for dollar, when scaled back for their smaller size."

Although follow-up Medicare studies also charted the effectiveness and customer satisfaction with specialty hospitals, lingering economic concerns led Obama's reform-minded Congress to put a freeze on physician-owned hospital growth. Those 2009 actions, a potentially crippling blow for new facilities or those under construction when the December 2010 moratorium kicked in, now face challenges in court.

Woodbeck took up arms in 2009, completing his first specialty hospital study. He decided to do it again last fall to update his financial figures and add Medicare's customer satisfaction survey results.

"Our goal now is to take that report in summary and on CD and take it out and distribute it to the congressmen and senators to give them a basis for making decisions as new health care legislation develops," he said.

Many observers seemingly have forgotten that physician-owned hospitals evolved in the '70s and '80s as business-minded efforts to reform increasingly institutionalized health care. Woodbeck said many lawmakers also do not understand Medicare payment systems.

"That's one of the things we're working on because we have so many new senators and congressmen," he said. "We want to try and educate them a little bit about the Medicare program, about physician-owned hospitals, so that when they make these decisions they're making educated ones."

Woodbeck started his research by using all the members of the Physician Hospitals of America that were old enough to generate Medicare data. He then added specialty hospitals from around the nation to reach the 100 plateau.

"I did not eliminate a facility because I found it was more advantageous to get rid of the facility than keep the facility," he said.

He appreciated the fact that the report often demonstrates specialty hospitals' comparative operating efficiencies, lower costs or higher customer satisfaction results, but he sees that as a secondary benefit.

"That wasn't our objective," he said with a smile.

By demonstrating the lower rates paid to specialty hospitals for the same procedures, the report also suggests a bottom-line operational judgment.

"I think you can assume they're profitable," Woodbeck said with a note to the specialty hospitals' ages, although he didn't delve into their finances.

His research ended up sampling providers from 30 states.

"Usually the states that will have physician-owned hospitals are states that do not require a CON – certificate of need – which says you have to go in front of the Legislature or an advisory board and justify why you need additional beds," he said. "That's kind of like if we wanted to open a new Walmart, you would have to bring in Kmart and all the other stores would have an opportunity to say why they can handle the business and there isn't a need for another Walmart or Krogers or whatever."

Naturally Woodbeck doesn't expect one provider to bear the full brunt of a shuttered specialty hospital. But since Medicare reimburses individual hospitals at different rates, depending on their market, local carrier determinations and other circumstances, he used one comparative hospital to provide the clearest example of cost differences and savings.

Woodbeck acknowledged some role in the report's outcomes through his choice of which multipurpose hospitals he used for comparison. But he said they were not weighed for best results.

"I just picked one," he said. "I tried to stay as much as possible with not-for-profits or university teaching hospitals or something like that. I also tried to find one that was geographically close to where the physician hospital was located."

Not counting his time and effort, Woodbeck said distributing the report to each U.S. senator and representative will cost about \$2,000. With all the time and effort involved, he's not contemplating an update.

"A lot will depend on where health care goes," he said. "When I commit to doing this, the first thing I do is I cringe and say, 'OK, where are you going to find the time to do something like this?'"

"I have done two studies," he added. "Both studies have basically come out and shown basically the same result. Both studies have shown an additional \$3 (billion) to \$4 (billion) to \$5 billion additional cost to Medicare. If I do it again, it's just going to come out the same way. It's another stack of paper and another study, but it should come out to be about the same thing because the reimbursement methodology has not changed."