State of Spine Surgery and Independent Practice

Richard N.W. Wohns, M.D., JD, MBA

Becker's 14th Annual Spine, Orthopedic and Pain Management-Driven ASC Conference
+ The Future of Spine
June 9, 2016

Disclosures

- Aqueduct Neurosciences – Board of Directors
- angelMD – Chief Medical Officer
- Nuvasive – Health Policy Consultant
- Consultant
  - Medtronic Streamlined Design Systems
  - Synthes Outpatient Cervical Surgery
  - Surgery Partners, Outpatient Spine Surgery
  - Spineology, Wenzel, Stryker

Independent Practice vs Direct Hospital Employment

- Growing trend for Direct Hospital Employment
  - Merritt Hawkins survey: doubled from 2006-2007
  - 2010: more than 50% of graduating residents
  - 2014: <10% of new recruits are independent/self-employed
- Physician factors
  - ↑financial pressure: ↑overhead + ↓reimbursement
  - Work-life balance
  - Administrative responsibilities of private practice
- Hospital factors
  - Physicians withdrew from ER and ICU coverage
  - "Hospitalists" provide emergency and inpatient care
  - Preferential hiring of certain lucrative specialties improve hospitals' bottom line
  - Hospital and medical group consolidation
  - ACOs require large physician panels

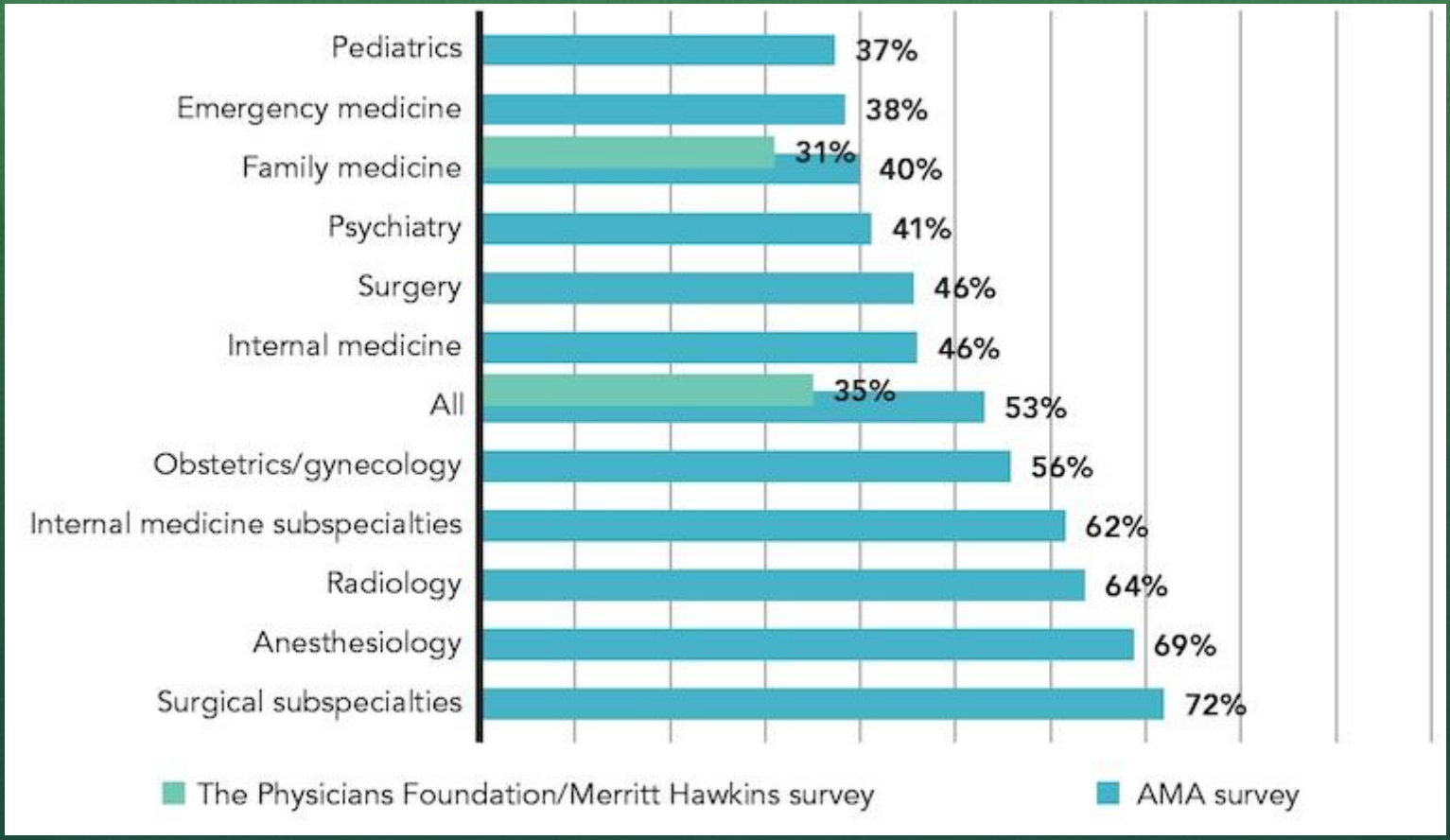
Direct Hospital Employment

- AMA 2012 *Practice Benchmark Survey:* a slight majority (53%) of physicians owned their practices, down from 61 percent in 2007/2008; 42% of physicians were employees, and 5% were independent contractors.
- AMA 2014: 50.8% of physicians were owners of their practices; 43% were employees of their practice, 6.2% were independent contractors.
  - More physicians worked directly for a hospital or in practices that had at least some hospital ownership in 2014 than in 2012 (32.8% vs 29%)

Independent Practice

- Independent private practice physicians are becoming extinct

Physicians as Owners by Specialty



Direct Hospital Employment - Issues

- Employed physicians see 17% few patients per day than independent physicians (Merritt Hawkins 2014)
- Direct hospital employment involves many other **ISSUES** faced by employed physicians, hospitals, patients, and government regulatory agencies

Issues

- Corporate Practice of Medicine Doctrine
- Fiduciary duty to serve hospital employer
- Conflict of interest between ethical duty to care for patients and fiduciary duty to serve hospital employer
- Conflict of interest related to medical-legal liability
- Whether direct hospital employment improves or adversely affects access to care in urban areas vs rural communities
- Employment contracts
- Financial integration between physicians and hospitals has been associated with higher commercial prices and spending for outpatient care

Corporate Practice of Medicine Doctrine

- Prohibits corporations from providing professional medical services
- Bars employment of physicians by hospitals
  - States which prohibit direct employment of physicians: CA, CO, IO, OH, TX
  - Not-for-profit and for-profit hospitals are exempt from prohibition of CPOM in most states
- Created by AMA to protect public as well as doctors
- Divided loyalty and impaired confidence between interests of corporation and needs of patient
  - May lose freedom to make decision based on patients' needs
- Prevents Sherman Anti-Trust violations and limitation in patient choice
  - When hospitals directly employ physicians, they are generally required to perform procedures, order tests, and make referrals within their place of employment.
- Outside competition and patient choice may suffer
- Hospitals may unfairly terminate non-employed physicians' privileges to push a hired arrangement

Corporate Practice of Medicine Doctrine

- Overriding public policy concern is to ensure that "lay persons are not influencing the professional judgment and practice of medicine by physicians."
- "Physicians sole interest is ethically to their patients. They don't have a legal duty to make the hospital money, and that's what we want to avoid."
  - Brett Michelin, Associate Director of Government Affairs, California Medical Association (AMA News, Aug. 3, 2009)

Conflict of Interest: Ethics

- Inherent conflict of interest between ethical duty to care of patients and fiduciary duty to serve hospital employer
- Physician employment increases cost of care
  - "The most expensive piece of medical equipment …. is a doctor's pen. And, as a rule, hospital executives don't own the pen caps. Doctors do."
  - Hospital executives understand this and desire to harness this expensive piece of medical equipment to provide financial security to the hospital.

Conflict of Interest: Ethics

- Direct employment allows control of physicians
  - Increase in opportunity for financial factors to drive referrals, tests, procedures, imaging studies, surgeries
- Financial gain could supplant needs of patient despite ethics of physician to primarily be caregiver, not profit center
- Mayo Clinic recognized this conflict and eliminated financial barriers by pooling all physician and hospital revenues, and paid all employees a salary. Goal was to eliminate possibility that doctors would do anything to try to increase their income and to promote financially blind patient care decisions →ACO

Higher Costs

- Financial integration between physicians and hospitals has been associated with higher commercial prices and spending for outpatient care, but not inpatient
  - Nesprash et al, Association of Financial Integration Between Physicians and Hospitals with Commercial Health Care Prices, JAMA Intern Med. Doi:10.1001/jamainternmed.2015.4610
- Study design, setting and participants:
  - Physician-hospital integration, measured using Medicare claims data as the share of physicians in an MSA who bill for outpatient services with a place-of-service code indicating employment or practice ownership by a hospital.
  - Annual inpatient and outpatient spending per enrollee and associated use of health care services, with utilization measured by price-standardized spending (sum of annual service counts multiplied by the national mean of allowed charges for the service).
  - 7,391,335 enrollees in 240 metropolitan statistical areas

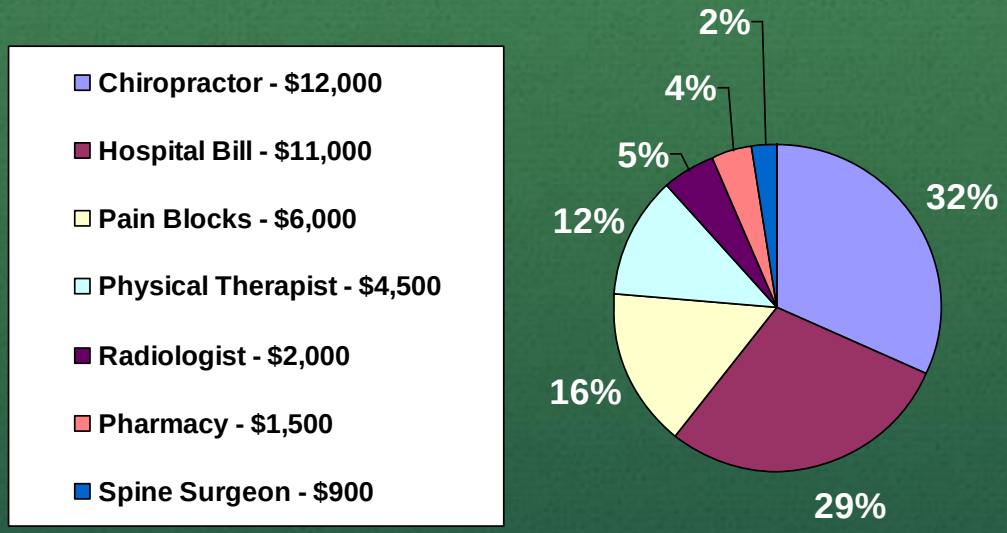
Higher Costs

- Increase in physician-hospital integration was associated with a mean increase of $75 per enrollee in annual outpatient spending ($p<.001$) from 2008 to 2012
- This increase in outpatient spending was driven almost entirely by price increases as associated changes in utilization were minimal

Devaluation of Spine Surgery

- Spine surgeons are now at the bottom of the food chain
- The care for spine patients yields much greater financial benefits to many other providers than the surgeon
- These factors have contributed to more and more spine surgeons becoming hospital employees

Care for Typical Lumbar Disc Patient



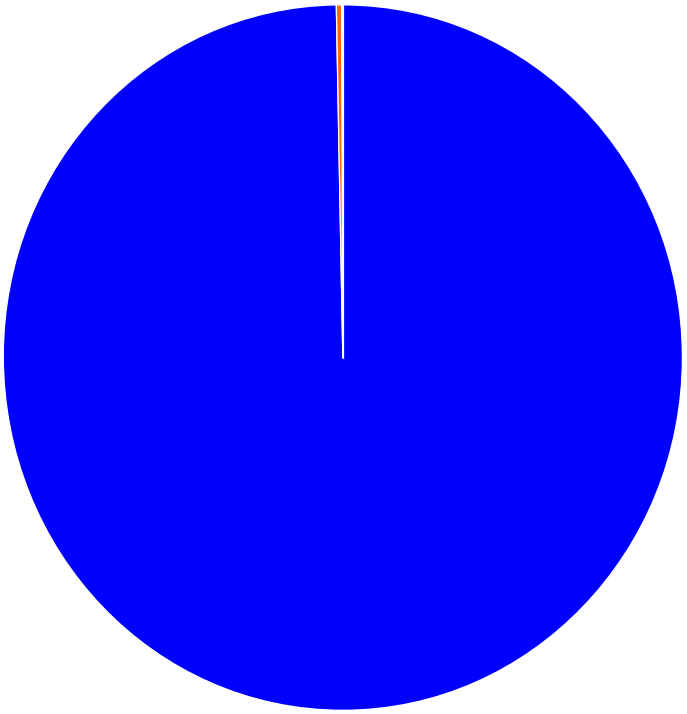
Spine Surgeons currently receive $900 for performing microdiscectomy, a curative, definitive, procedure requiring the most training, and carrying the most liability.

How to Remain Independent

- Problems: Employment opportunities + devaluation of spine surgery = fewer independent spine surgeons
- Solution: Develop boutique practice with best in class reputation for quality, service, and price
- Solution: Develop ancillary revenue streams
  - Outpatient spine surgery center
  - Imaging center
  - Interventional pain management
  - Electrodiagnostics
  - Physical Therapy
  - DME

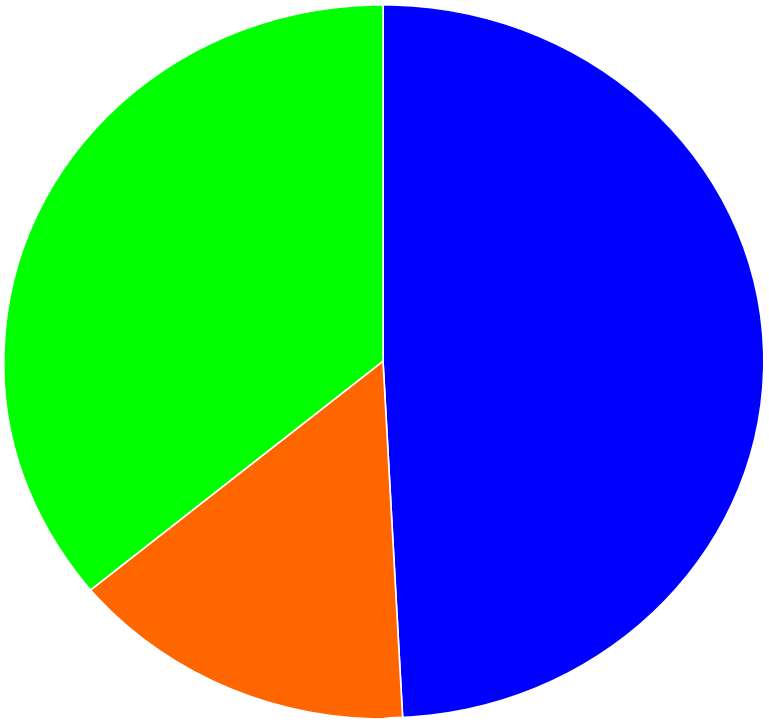
Net Revenue by Profit Center

2008



Professional Fees

2015



Professional Fees

Surgery Center

MRI

"To Build" or "Not to Build" … that is the question!

Why build?

Case Study #1: Lumbar HNP, Single Level
Revenue from patient with commercial insurance

Practice Management and EMR Software

Clinic → $ 132 — 99203 New Patient Office Visit (low)

Diagnostics → $1,400
- MRI
- C-Arm
- EMG/NCV

Treatment Facility → $2,598 — 63030 or 63042 or 63056 {1 level lumbar}
- ASC
- P/T & Rehab

4 Visits

Professional Staff → $1,236 — 63030 or 63042 or 63056 {1 level lumbar}
- Neurosurgery
- Non-operative Tx
- Pain Management

"To Build" or "Not to Build" … that is the question!

Why build?

Case Study #2: Cervical HNP, Single Level
Revenue from patient with Commercial insurance

Practice Management and EMR Software

Clinic → $ 132 — 99203 New Patient Office Visit (low

Diagnostics → $1,479 — 72141 {cervical spine w/o contrast}
95860 & 95903 & 95904 {EMG & NCV}

- MRI
- C-Arm
- EMG/NCV

Treatment Facility → $4,950 — 63020 or 63040 or 63075 {1 level cervical}
4 Visits

- ASC
- P/T & Rehab

Professional Staff → $1,860 — 63020 or 63040 or 63075 {1 level cervical}

- Neurosurgery
- Non-operative Tx
- Pain Management

"To Build" or "Not to Build" … that is the question!

Why build?

Case Study #3: lumbar disc, 2 level
Revenue from patient with commercial insurance

Practice Management and EMR Software

Clinic → $140 — 99214 Established Patient - moderate

Diagnostics →
- MRI
- C-Arm
- EMG/NCV

$1,480 — 72158 {lumbar spine w & w/o
95861 & 95903 {EMG & NCV}

Treatment Facility →
- ASC
- P/T & Rehab

$3,415 — 63042 & 63035 {2 level lumbar}
6 Visits

Professional Staff →
- Neurosurgery
- Non-operative Tx
- Pain Management

$1,988 — 63042 & 63035 {2 level lumbar}

What was the question?

	Center	No Center
Case Study #1: Lumbar HNP, Single Level Revenue from patient with commercial insurance	$5,366	$1,368
Case Study #2: Cervical HNP, Single Level Revenue from patient with commercial insurance	$8,421	$1,992
Case Study #3: lumbar disc, 2 level Revenue from patient with commercial insurance	$7,023	$2,128

Ancillary Revenue Streams Promote Independence

- Ancillary revenue streams allow neurosurgeons to impact the quality of care in a more complete fashion
- Makes economic sense and provides a financial substrate that supports independence
- Legal constraints on the practice of medicine need to be focused on conflicts, oversight, and due process within vertically integrated hospital systems that directly employ physicians
- Goal is to guarantee patient access and rights to care, unaffected by corporate or contractual interference with medical decision making
- Risks of lay control of medical decisions and divided loyalty should not be tolerated
- It is necessary to protect ethical patient care and the integrity of the medical profession
- The increase in health care costs related to financial integration between physicians and hospitals needs to be transparent
- Transparency promotes independent practice