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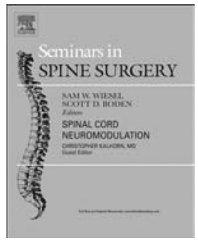

Financial considerations in outpatient spine surgery

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ABSTRACT

This paper aims to review the cost benefits of performing spine surgeries at an ambulatory surgery center or an outpatient hospital department. The potential for cost savings associated with ambulatory based surgery centers or outpatient hospital departments will likely continue to increase the number of spine surgeries performed at such locations. Several types of ownership structures for ambulatory based surgery centers or outpatients hospital departments exist, and can be broadly categorized into sole physician ownership, sole hospital ownership, physician-hospital joint ownership, physician-management service joint ventures. It can be argued that a sole physician ownership of these centers can cause potential conflicts of interests; however, it can also decrease costs for patients and improve physician satisfaction.

Healthcare spending has been rising at an increasingly unsustainable rate. In 2015, spending reached $2.8 trillion dollars, representing almost 18% of gross domestic product.[1–3] Spine surgery costs have been similarly rising with estimated aggregate national charges for spine conditions reaching approximately 250 billion dollars in 2011.[4]

Cost containment measures are being explored with a focus on increasing value in musculoskeletal care. One mechanism to rein in costs may be transitioning care to the outpatient setting. Several surgical subspecialties, including urology,[5] ophthalmology,[6] and orthopedic surgery,[7] have realized cost savings by performing certain procedures in outpatient surgery centers, including both hospital outpatient departments (HOPD) and ambulatory surgery centers (ASC). From 2005 to 2015, the number of outpatient spine procedures has continually increased and as of 2015, approximately 45% of all spine cases are performed on an outpatient basis.[8] Medicare has helped drive this growth by recently approving nine different codes that could be used for outpatient spine procedures as of 2015.[8]

Advocates of these outpatient centers cite increased patient satisfaction and decreased costs among the benefits.[9,10] Critics of these institutions claim that ownership structures at certain facilities may actually lead to costlier care and that the existence of outpatient centers may lead to financial loss for general hospitals.[11–14]

In this review, we will examine financial consideration in outpatient spine surgery including payment models currently in place and those being explored and ownership models at these centers. The pros and cons of these models will be explored with a closing section on the pros and cons of physician ownership in this arena.

1. Bundled payment/reimbursement

Any discussion of the potential conversion from inpatient to outpatient spine surgery, and the financial implications thereof, would be incomplete without mention of proposed or upcoming variations in physician-hospital reimbursement models. The Bundled Payments for Care Improvement initiative was rolled out in 2011 as a method to improve incentives for cost savings to Medicare.[15] Briefly, the bundled payment concept is a reimbursement mechanism wherein a flat,

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specific fee is paid for a procedure, with the intention of covering all costs associated with the surgery.[16–18] This bundled payment would provide for both physician and hospital fees, as well as any costs associated with post-operative complications or readmissions.[17] As will be discussed in the subsequent sections, there is strong evidence that utilization of HOPD and/or ASCs is associated with decreased length of stay and decreased costs for certain spinal procedures.[9,19–22] Thus, bundling payments for spine surgery may provide universal incentives to implement mechanisms to decrease cost for each episode of care that can be achieved via conversion to an outpatient setting. However, there is significant heterogeneity with regard to the potential application of bundled payments in spine surgery that may limit their utility for overall cost reduction.

Much of the evidence examining bundled payments and reimbursement is for total joint arthroplasty,[16,18] particularly as more of these procedures are performed as outpatients. With regard to spine surgery in an outpatient surgical setting, while there is evidence supporting utilization of ASCs or HOPDs for lumbar decompression/discectomy, there is also evidence that anterior cervical discectomy and fusion (ACDF) can be performed safely and effectively in this setting.[19] Sullivan et al.,[16] explored the benefits and disadvantages of bundled payments in spine surgery, writing that with the potential cost savings, "a shift in case volume will continue towards ambulatory surgery centers," as changing reimbursement models in this way would help control costs for common surgical procedures.[16] In a survey of 12 large spine centers examining reimbursement models, Kazberouk et al., [17]found that while traditional fee-for-service models remained at all surveyed organizations, a majority had some form of bundled payment initiatives in place. Many of the respondents to the survey cited the opportunity afforded by bundled payments for physicians to "share in savings from efficiency improvement efforts" as a reason to implement the initiatives.[17] There is also the suggestion that bundling payments will drive innovation and cost savings in other ways. As the flat bundled fee does not change, there will be new incentives for hospitals or physicians to negotiate implant and graft prices with industry.[16,17] Development of new minimally invasive techniques, which could potentially be performed effectively in an outpatient setting, would also decrease 90-day costs and would be viewed favorably by payers in a bundled model.[16]

However, Sullivan et al also note that "patient comorbidities, socioeconomic factors, and payment inconsistencies limit universal application of these models".[16] As there is a shift in financial risk with a change in the reimbursement mechanism, patient selection and risk management based on demographics and comorbidities will become even more paramount than currently. Indeed, as reported in their analysis of outpatient ACDF utilizing the National Surgical Quality Improvement program (NSQIP) database, McGirt et al.,[19] noted that "inpatient surgery will always be more appropriate for some patients, and surgeon judgment is necessary in these cases." Inherent in this statement is the selection bias innate in determining which patients are suitable for outpatient or ambulatory surgery; under bundled payment models, this selection pressure will only become more prevalent. There is a risk, therefore, that necessary procedures will be denied, or appropriate treatment options will be avoided in favor of less expensive alternatives.

Generally, the literature appears to support limited application of outpatient surgical procedures for the treatment of some spinal conditions. As more institutions implement payment bundling programs, the potential cost savings associated with ASC or HOPD utilization will become more attractive, and the trend towards an increasing number of spine surgeries performed in an outpatient setting will likely continue.

2. Ownership models

Two types of outpatient surgery centers exist: hospital outpatient departments and ambulatory surgery centers. To qualify as a HOPD, the site must be within 35 miles of the hospital.[23] A specialty hospital, although not necessarily affiliated with a general hospital, can be considered a category of HOPD and can bill as one too.[24] Governmental agencies define a specialty hospital as a facility in which a proportion of its inpatients, typically between 45% and 66%, fall into no more than 2 major diagnostic categories.[24] Prior to January 1, 2017, the Center for Medicaid and Medicare Services (CMS) had differential pay for each type of center. ASCs were reimbursed at just 67% of fees paid to HOPDs.[25] The higher reimbursements at the HOPD incentivized physician recruitment and from 2007–2013, the number of physicians working at these centers doubled.[26] Moreover, an Avalere Health report found an increased rate of additional procedures (above the primary procedure) performed in HOPD compared to when the same procedure was performed in other settings.[26]

The GAO estimated that Medicare and its beneficiaries could save $1–2 billion annually by equalizing reimbursement rates at HOPDs with those at ASCs or at physician offices.[26] Congress passed the Bipartisan Budget Act of 2015 which specifically addressed this issue and per section 603 of the bill, as of January 1, 2017, "payments for most items and services furnished at an off-campus department of a hospital that was not billing as a hospital service prior to the date of enactment will be made under the applicable non-hospital payment system."[25] The new payment schedule may influence the trajectory of future and current HOPD.

Outpatient surgery can be a source of profits for ownership and increasing physician participation reflects this potential. Several ownership structures exist. These can broadly be categorized into four types: sole physician ownership, sole hospital ownership, physician-hospital joint ownership, physician-management service joint ventures. Hospital partnership and non-health care business investors (corporate-partnered) are the most common types of joint ventures.

Partnership ventures provide several advantages over solo ownership. Primarily, there is risk mitigation through shared financial risk and there is the possibility of increased efficiency and productivity by melding the strengths of each partner. Alternatively, these same advantages can be disadvantages as the profits are shared (leading to diminished returns) and management styles may conflict leading to decreased satisfaction and productivity.