Addressing the growth of ancillary services in physicians' offices

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What is the physician self-referral law?

- Prohibits physicians from referring Medicare/Medicaid patients for “designated health services” to a provider with which physician has financial relationship
- But in-office ancillary services exception permits physicians to provide most DHS in their offices (e.g., imaging, physical therapy, radiation therapy)

Potential benefits and concerns of providing ancillary services in physician offices

- Benefits
  - Enables physicians to make rapid diagnoses and initiate treatment during patient's office visit
  - Coordination of care
- Concerns
  - Could lead to higher overall volume through greater capacity, financial incentives
  - Studies find that physician self-referral associated with higher volume

Growth of ancillary services in physician offices

- Increase in imaging, lab tests, physical therapy, radiation therapy in physician offices
- Ancillary services account for significant share of Part B revenue for certain specialties
- CMS asked for comment in 2007 on whether certain services should no longer qualify for in-office exception

Comparing growth trends in ancillary services across settings

Average annual change in number of services per FFS beneficiary, 2003-2008

	Physician fee schedule	OPD and other settings
Diagnostic imaging	4.3%	0.4%
Outpatient therapy	9.4	5.1
Radiation therapy	3.2	-3.5

Note: OPD (hospital outpatient department). Outpatient therapy includes physical therapy, occupational therapy, and speech-language pathology services. In addition to OPDs, outpatient therapy is also provided in nursing homes, outpatient rehabilitation facilities, and other settings.
Source: MedPAC analysis of claims data for 100% of Medicare beneficiaries.

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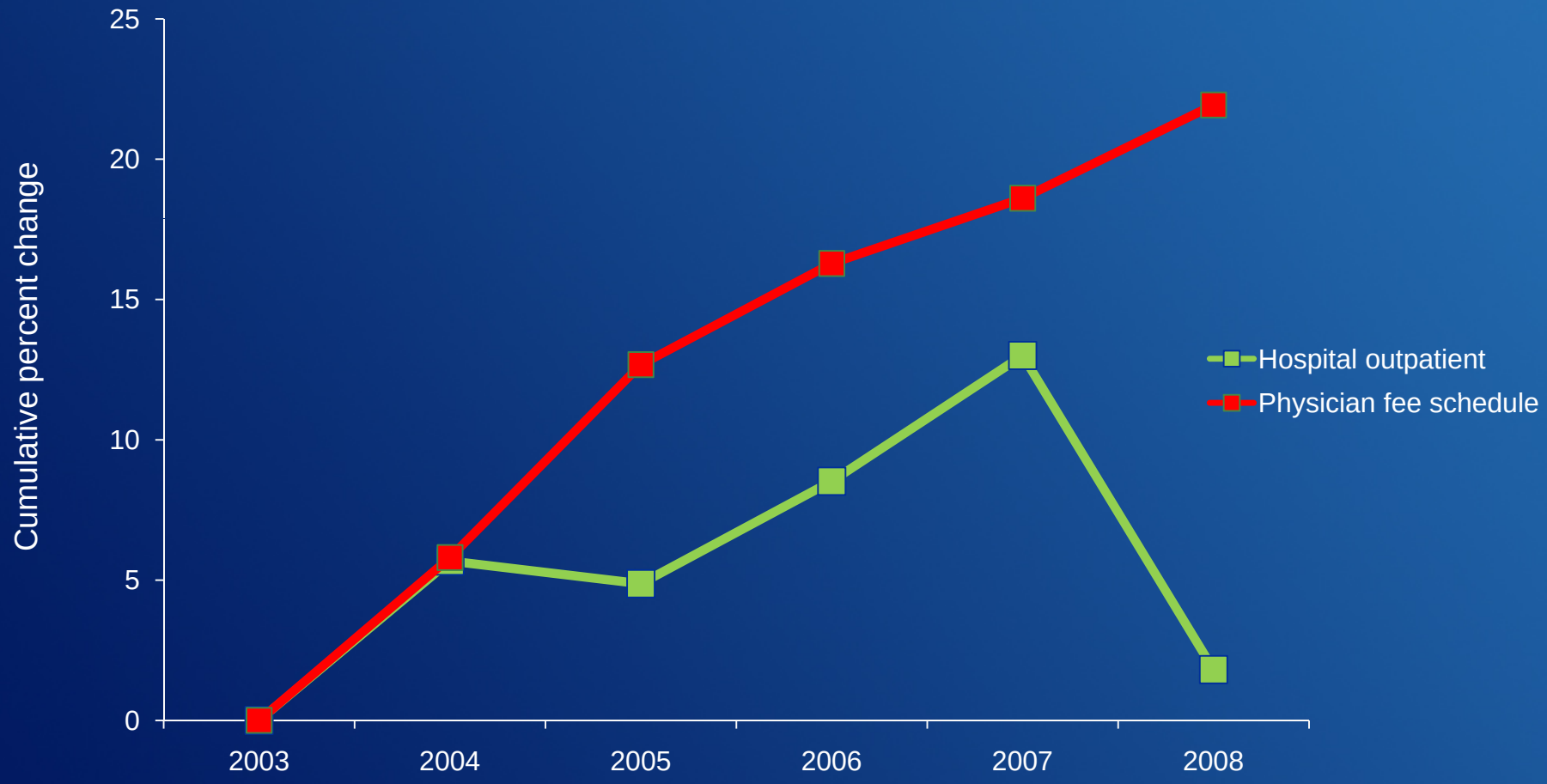
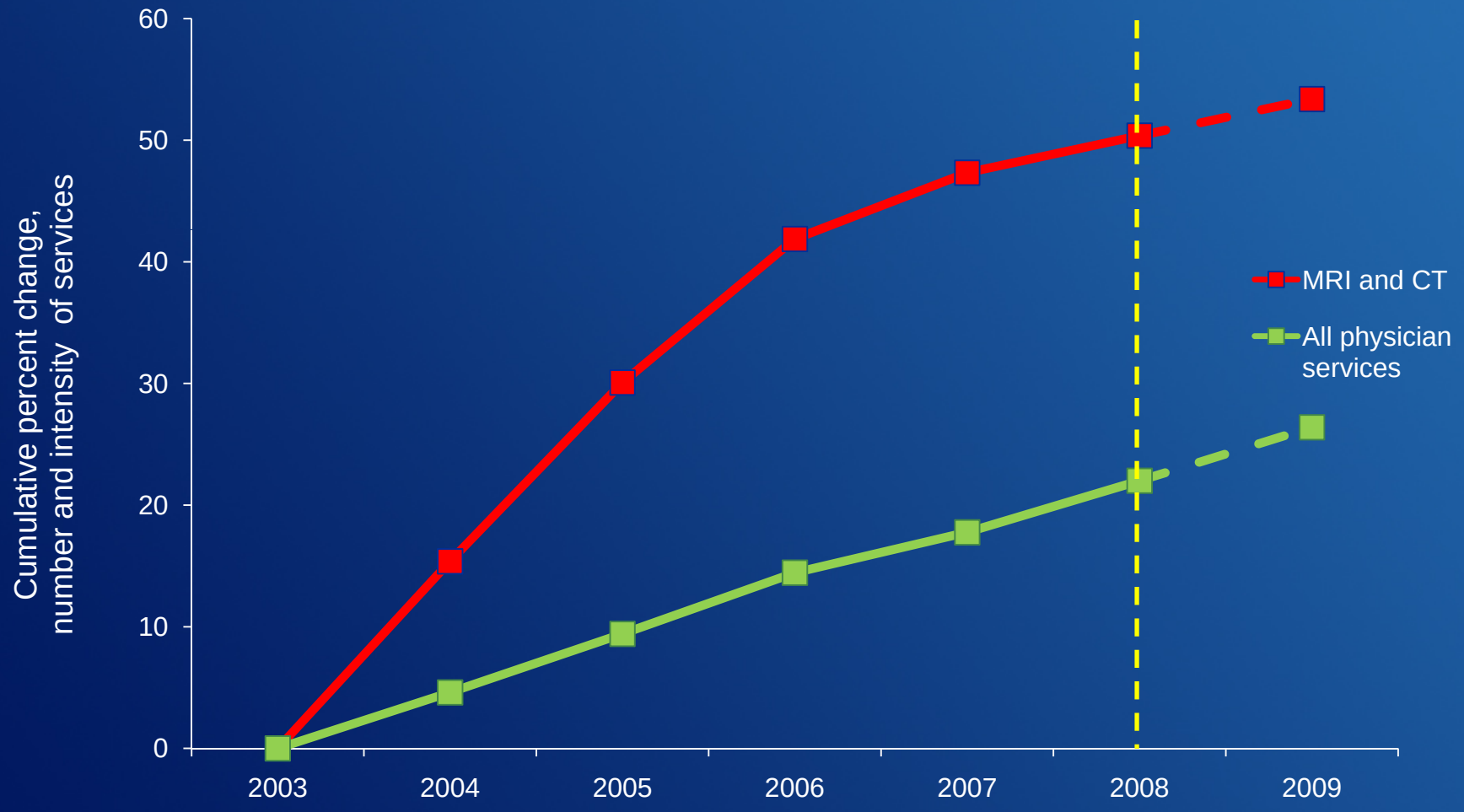
Cumulative growth in the number of diagnostic imaging services, by setting (per FFS beneficiary)



Source: MedPAC analysis of claims data for 100% of Medicare beneficiaries

Cumulative growth in physician fee schedule services: MRI and CT vs. all physician services (per FFS beneficiary)



Source: Data for 2003-2008 from MedPAC analysis of claims data for 100% of Medicare beneficiaries. Data for 2009 from AMA analysis of claims data from CMS.

June 2010 report: discussed policy options

Radiation therapy & outpatient therapy	Diagnostic imaging & lab tests
Exclude from in-office exception	Exclude from in-office exception unless provided on same day as visit
Exclude from exception unless practice is clinically integrated	Exclude from exception unless practice is clinically integrated
	Reduce payment rates for tests performed by self-referring physicians
	Prior authorization program for advanced imaging
Combining services into larger units of payment (e.g., bundling)	Combining services into larger units of payment (e.g., bundling)

Consultations with stakeholders

- Staff met with groups representing cardiologists, radiologists, pathologists, clinical labs, neurologists, urologists, oncologists, dermatologists, physical therapists
- Received letters from AMA, MGMA, AMGA, AAO, AANS, AAOS, ACR, ASN, ASE, ASNC, others

Option: Exclude outpatient therapy and radiation therapy from in-office ancillary exception

- Physician investment in therapeutic services may influence decisions about treatment
- Therapeutic services are generally not ancillary to an office visit
- Would affect clinically-integrated cancer groups that include medical and radiation oncologists

Option: Limit the exception to practices that are clinically integrated

- Balance risks of higher volume with potential benefits of integrated care
- Two possible criteria for defining clinical integration
  - Require each physician in the group to provide substantial share (e.g., 90%) of his/her services through the group
  - Require group to have EHR technology and use it for specific purposes (perhaps based on meaningful use criteria for incentive payments)

Option: Limit the exception to practices that are clinically integrated (cont.)

- Should this approach be applied only to therapeutic services or also applied to diagnostic tests?
- Even integrated groups have incentives to drive volume under current FFS payment systems
- Eventually, need to hold providers accountable for costs and quality

Option: Exclude diagnostic tests not usually provided on same day as office visit from exception

- One of key rationales for exception is that it enables physicians to provide ancillary services during office visit
- But certain tests rarely done on same day as visit
- CMS could set threshold for how frequently tests would need to be provided on same day as visit (e.g., 50%)
- Tests that fall below threshold would be excluded from exception

Option: Reduce payment rates for diagnostic tests performed by self-referring physicians

- Evidence that self-referral of imaging and lab tests associated with increased volume
- Lower payment rates for self-referring physicians would offset some of additional Medicare spending
- Size of payment reduction could be based on
  - Empirical estimates of effect of self-referral on volume
  - Activities that may be duplicated when tests are ordered and performed by same physician (e.g., reviewing records, discussing findings with referring physician)
  - Normative standard

Option: Prior authorization program for physicians who self-refer for advanced imaging

- Focus on self-referring physicians who order more studies than their peers
- Would target inappropriate use of imaging without prohibiting self-referral
- Concerns
  - Administrative costs for Medicare and providers
  - Medicare needs to have transparent criteria
  - Are decision rules based on sound evidence?
  - Lack of independent evidence that prior authorization has long-term impact on spending

Option: Combining multiple services into larger unit of payment (packaging or bundling)

- Could encourage efficient use of ancillary services
- Would not prohibit self-referral arrangements
- But much analytic work needs to be done to identify and price cohesive bundles of services

Illustration of how to combine strategies

Exclude services from in-office ancillary exception, unless

- Physician group meets criteria for clinical integration, or
- Group participates in accountable care organization, or
- Services are part of bundled payment

For Commissioner discussion: Which strategies should we pursue?

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