

August 27, 2010

Mr. Glenn M. Hackbarth, J.D.
Chairman
Medicare Payment Advisory Commission
601 New Jersey Avenue, NW, Suite 9000
Washington, DC 20001

Dear Chairman Hackbarth,

On behalf of the undersigned organizations, we are writing to express our serious concerns about Chapter 8 of the Medicare Payment Advisory Commission's (MedPAC) June 2010 Report to Congress, entitled "Addressing the growth of ancillary services in physicians' offices."

We share MedPAC's goal of guarding against inappropriate utilization of medical imaging services. Our organizations are committed to a broader goal: ensuring the quality and appropriateness of diagnostic imaging services provided to Medicare beneficiaries. Unfortunately, the policy options outlined in the report would not contribute to that goal.

We believe that policies similar to those outlined in the Report may interfere in the efficient and effective delivery of in-office imaging services, limit patient access, reduce competition, and increase overall Medicare costs by driving services into higher cost hospital settings. Therefore, we discourage the Commission from developing formal recommendations to implement such policies and recommend that MedPAC instead focus on policies that would facilitate and reward the provision of high quality, clinically appropriate diagnostic imaging services.

The analysis and policy recommendations presented in Chapter 8 rests on several faulty and out of date assumptions:

1. Imaging continues to grow faster than physician services generally;
2. Self-referred services account for a large proportion of imaging services and, in particular, inappropriate imaging services;
3. The major benefit of the in-office ancillary service exception is patient convenience and
4. Excess profits built into payment rates drive overutilization of imaging by self-referring physicians.

Background

The "Background" section of the Report leaves the impression that the proportion of "self-referred" advanced imaging services provided under the in-office ancillary services exception to the Stark Law is substantial and has grown significantly in recent years; that this growth has occurred primarily in physician offices; and that advanced imaging services are continuing to grow rapidly. Significantly, however, the available data does not appear to support these conclusions.

In fact, while it is true that the proportion of advanced imaging services provided in non-hospital settings has grown, MedPAC itself has found that much of this growth historically has taken place in Independent Diagnostic Testing Facilities, not physicians' offices. Indeed, the report itself cites evidence that the proportion of advanced imaging services provided by "self-referring" physician practices has remained relatively constant. Therefore, self-referral clearly was not the "driver" of the volume increases in diagnostic imaging noted from 2003-2007.

It is also significant that the diagnostic imaging services that have the lowest utilization rate increases historically have the highest rates of self-referral (e.g. x-ray and ultrasound), and those with the highest historical rates of increase have had the lowest rates of self-referral (MRI, CT and PET). For example, a GAO report of June 2008 indicated that spending on advanced imaging modalities increased almost twice as fast, at an average annual rate of 17 percent, as other imaging services. (GAO-08-452 Medicare Part B Imaging Services: Rapid Spending Growth). Thus the extent of self-referral does not appear to be the major driver of utilization growth. And while the Report cites studies that raise questions about the clinical appropriateness of some diagnostic imaging services, it fails to note that the study undertaken by the American College of Cardiology Foundation and United Healthcare found more inappropriate studies ordered by primary care physicians outside the practice than by "self-referring" cardiologists.

Nor does the report consider other potential consequences of driving imaging services out of physician offices and into hospitals. Medicare beneficiaries incur substantially higher copayments for imaging services provided in hospital settings. And hospitals, which are paid considerably more than physicians' offices for many diagnostic imaging services and which increasingly own physician practices, have a strong financial incentive to increase imaging utilization—in effect, to "self refer." In short, the relationship between self-referral and utilization is far more complex and nuanced than the Report suggests.

Perhaps most importantly, based on 2008 and 2009 data, the rate of volume growth for diagnostic imaging services overall is now generally LOWER than the rate of growth for other medical services covered by the SGR, a significant development that barely receives mention in the MedPAC report. Based on 2008 and 2009 Medicare data from CMS, volume growth for services covered under the physician fee schedule was 3.6% in both years while the volume of diagnostic imaging services rose by 3.4% in 2008 and 2.2% in 2009. This data suggests that further limitation on physician self-referral of diagnostic imaging certainly is not critical to maintain the financial integrity of the Medicare Program, as the Report implies.

Policy Recommendations

We also have significant concerns about a number of the policy options described in the Report:

- **Modifying the Definition of "Group Practice" under the federal self-referral law.**

The Report suggests that the group practice exception could be limited to physician practices that are "clinically integrated." Specifically, MedPAC suggests that each physician in the group could be required to provide a substantial share of his or her services –such as 90 percent—

through the group. We believe this change is unwarranted and potentially disruptive and should not be included in any MedPAC recommendations on the Stark Law regulations.

The Stark Law is among the most complex provisions of the Medicare Act, having spawned hundreds of pages of implementing regulations and preamble language over the past twenty years during the course of numerous rulemaking proceedings, each of which has further complicated health care transactions. While many of the changes made over the years have been necessary because of the unanticipated consequences of prior Stark Law rules, each set of changes has resulted in significant disruption of existing arrangements. It is particularly telling that many of the most sensitive and controversial regulations are those implementing the “ancillary services” exception—the very exception that is now the focus of MedPAC’s attention.

In particular, over the years, many comments were submitted regarding the group practice definition. CMS carefully balanced the need to guard against “sham” group practice arrangements and the need to allow group practices the flexibility to meet patient needs. A requirement along the lines suggested in the Report—requiring each physician in the group to provide at least 90% of his or her services through the group-- would fundamentally preclude a group from, for example, hiring a subspecialist on a part time basis, to serve the needs of a subset of the group’s patients. We strongly urge MedPAC to refrain from tampering with the group practice definition, in light of the complexities of the issues involved, all of which have been considered at length, and repeatedly, by CMS.

- ***Excluding Imaging Services That Are Not Provided with Office Visits from the In-Office Ancillary Services Exception***

MedPAC is also considering a recommendation that would exclude from the exception imaging services that are not commonly performed at the same time as an office visit. Such an approach would be extraordinarily difficult to implement, since the list of services subject to the Stark Law is updated each year, and shifting practice patterns may result in a procedure’s periodic appearance on and disappearance from the list, making it virtually impossible for physician practices to plan their provision of in-office diagnostic imaging services effectively.

Even more importantly, though, subjecting a procedure to Stark Law restrictions based solely on whether or not it is commonly performed at the same time as an office visit assumes that the sole rationale for the group practice exception is to limit patient inconvenience. In fact, the purpose of the group practice exception is considerably broader: The exception helps assure that in-office diagnostic imaging can be performed and supervised by the patient’s physician or another group practice member so that test findings can be integrated effectively and expeditiously into the patient’s plan of care. Considerably more than a return trip to the doctor is at stake.

- ***Further Reducing Medicare Payment for Diagnostic Imaging.***

MedPAC is also considering an option that would selectively reduce Medicare payment for self-referred diagnostic imaging services, presumably to decrease the incentive for physicians to provide them. However, Medicare payment for diagnostic imaging services already has been slashed, not only by the Deficit Reduction Act caps, but also by multiple procedure reductions

and changes in the equipment utilization rates used to establish technical component payment rates. In addition, the 2010 Physician Fee Schedule includes significant additional reductions in Medicare payment for diagnostic imaging. Under this rule, by 2013, Medicare payment for the technical component of the most common CT procedures will be in the range of \$ 140-165, and Medicare payment for the technical component of MRIs will be in the range of \$240-\$260.¹ By 2013, Medicare payment for the technical component of the most common cardiovascular imaging procedures likewise will fall to about 37% below 2009 levels. Since diagnostic imaging facilities have relatively high fixed costs, they cannot sustain such massive payment cuts without adversely affecting quality.

Medicare payment for diagnostic imaging already has been cut to the bare bones and additional cuts in imaging payments are called for in the proposed 2011 physician fee schedule rule. Even without these additional cuts, Medicare data establishes that the amounts paid for these services will barely cover the direct costs involved (equipment, supplies, and clinical personnel), and will not cover any indirect costs (e.g. facility, overhead, administrative costs). For example, the CMS database indicates that the equipment, clinical personnel, and supply costs alone for the technical component of one of the most common CT services (CT of the abdomen, with contrast) is in the range of \$220, while the total Medicare allowance for this procedure is in the same range, leaving little or nothing to cover the facility, radiation safety, administrative, and other considerable indirect costs involved in providing this service. Under these circumstances, we strongly urge MedPAC to discard the notion that Medicare “mispricing” of these services is driving self-referral of inappropriate studies.

Pre-Authorization

Another course of action that is under consideration is requiring pre-approval of self-referred advanced diagnostic imaging services—a course of action that has the potential to result in substantial patient and provider inconvenience. Again, we caution against precipitous action, in light of the substantial administrative cost of such an approach for both providers and the Medicare Program. In addition, there is insufficient data demonstrating that pre-authorization saves money over the long term, after providers have had an opportunity to become conversant with the process.

Conclusion

In light of the extent of current regulation, the recent “leveling off” of growth trends in diagnostic imaging, the sharp reductions in Medicare payment for physician-office imaging, the significantly higher prices and co-pays for these same services when they are performed in hospital-owned settings, and the limited extent of physician ownership of advanced imaging services, we strongly urge the Commission to refrain from recommending any of the options discussed above. We ask, instead, for your support of policy options that actively promote and reward the adoption of strategies for improving the quality and appropriateness of diagnostic imaging services provided to Medicare beneficiaries.

¹ These rates may increase somewhat as the result of certain provisions in the Health Care Reform legislation.

MedPAC has recommended that Medicare transition away from fee-for-service to another payment system for physicians' services, such as episodes of care, capitation through Accountable Care Organizations, or other risk-sharing methods. These payment systems will put pressure on providers to reduce use of diagnostic imaging, to the extent that inappropriate under-utilization could become a concern. We plan to continue to monitor the extent and impact of physician ownership of health care facilities, and hope to share additional data with the Commission in the near future. In the interim, we hope that MedPAC will objectively re-evaluate the current utilization trends for diagnostic imaging and the extent of physician ownership of diagnostic imaging services, based on a careful analysis of the Medicare claims files. In addition, we would suggest that, prior to making any recommendation on this topic, MedPAC seriously consider the increased costs to the Medicare program and the impact of increased beneficiary copayments that result from shifting in-office imaging to hospital settings.

We appreciate your serious consideration of this most important issue.

Sincerely yours,

American Academy of Neurology
American Academy of Otolaryngology – Head and Neck Surgery
American Association of Neurological Surgeons
American Association of Orthopedic Surgeons
American College of Cardiology
American College of Rheumatology
American Medical Association
American Medical Group Association
American Society for Neuroimaging
American Society of Echocardiography
American Society of Nuclear Cardiology
American Urological Association
Association of Black Cardiologists
Cardiovascular Advocacy Alliance
Congress of Neurological Surgeons
Heart Rhythm Society
Medical Group Management Association
Society for Maternal-Fetal Medicine