



Outpatient ancillary trends in the Medicare fee-for-service population: 2008-2012¹

By Milliman, Inc.

Summary and analysis by the American Medical Association

Background

Physicians recommend a wide range of services for their patients. In many cases, these recommendations involve the use of equipment or skilled personnel within those physicians' practices. This practice of "self-referral" for certain types of services has come under increased scrutiny in recent years, primarily over concerns that it may lead to over-utilization and higher overall health care costs. The U.S. Government Accountability Office (GAO) conducted several studies of self-referred services subject to the in-office ancillary services exception (IOASE) to the Stark Law, examining data from 2004 to 2010. Although none of the GAO studies suggested repealing the IOASE, proposals to eliminate it have been made by some members of Congress and the Administration.

To explore the issue in more depth, the AMA contracted for a study by the independent actuarial firm Milliman, Inc., to examine Medicare claims for several types of service that were the subject of recent GAO scrutiny, including advanced imaging, intensity-modulated radiation therapy (IMRT), physical therapy, and pathology or laboratory services. Milliman used claims from 2008 to 2012 from the 5 percent sample of Medicare fee-for-service enrollees to examine changes in spending and utilization for these services. They were able to include not just physician claims, but also claims from other relevant outpatient settings including hospital outpatient departments (HOPD), independent labs, and home health providers, and a much broader universe of procedure codes (and two more recent years of data) than GAO examined.

While this study does not distinguish between services that were self-referred and those that were referred by others in the physician office setting, the results can be examined for trends that could serve as potential markers for the impact of in-office referral. These markers include changes in spending and utilization for the affected services, trends in the percentage of enrollees receiving the services, and shifts in utilization between physician offices and other settings. Notably, during the period in question, the analysis also points to health status changes that would have been expected to increase spending for patients in fee-for-service Medicare.

In short, the data simply do not support the argument that self-referral encourages inappropriate utilization or increased Medicare spending. Instead, these results indicate that:

- **For most of the ancillary services, the proportion provided in physician offices compared to hospital settings is relatively small, suggesting that imposing pay cuts or**

¹ Damier and DeLilo, Milliman Inc., "Outpatient ancillary trends in the Medicare fee-for-service population: 2008-2012." December 18, 2014. Available online: <http://www.ama-assn.org/resources/doc/washington/x-pub/medicare-ancillary-services-report.pdf>.

self-referral restrictions on these services will not produce significant savings.

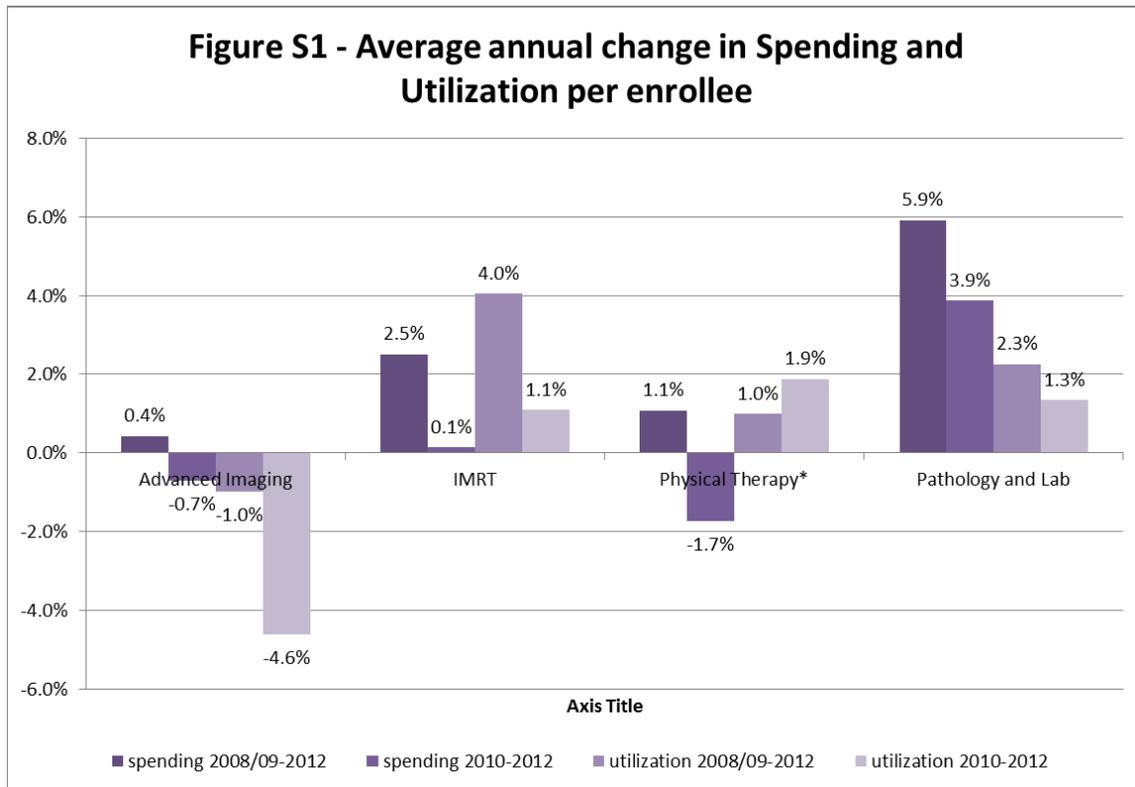
Physician offices account for less than 20 percent of outpatient physical therapy and laboratory services spending and less than 30 percent of advanced imaging spending (and a substantial percentage of these “office” services are provided through free-standing centers that rely on referrals from unrelated physician practices). Physician offices provide a more significant share of IMRT services, but that share dropped from 59 percent in 2008 to 53 percent in 2012, and again, much of that utilization is provided through free-standing centers that rely on referrals from unrelated physician practices. For physical therapy and laboratory services, physicians account for only 17 to 18 percent of total allowed charges.

- **In general, five-year annualized utilization and spending trends for these services show declining and even negative growth rates in office settings.** For most, the downward trend was even more remarkable in 2011 and 2012. Growth rates for these services in hospital outpatient departments also moderated but it was less pronounced than in physician offices.
- **Taken together, these trends indicate that concerns about potential cost and utilization related to physician ownership are unwarranted.** In fact, the evidence suggests that rather than increasing, the share of these ancillary services provided in physician offices is generally declining. Notably, all major categories except physical therapy have experienced a decline in the proportion provided in physician offices.
- **In addition, per unit costs of these ancillary services are generally less when delivered in the physician office than in the hospital.** A prime example can be seen in advanced imaging, where Medicare payment in 2014 was 36 to 53 percent higher in the hospital outpatient department than in the office.
- **There is a real risk that policies intended to preclude or discourage physician investment in ancillary services could backfire by accelerating their movement out of physicians’ offices where Medicare and its beneficiaries often pay less than when the identical services are provided in the hospital.**

Following is a summary of key findings from the Milliman analysis.

Trends in utilization and spending

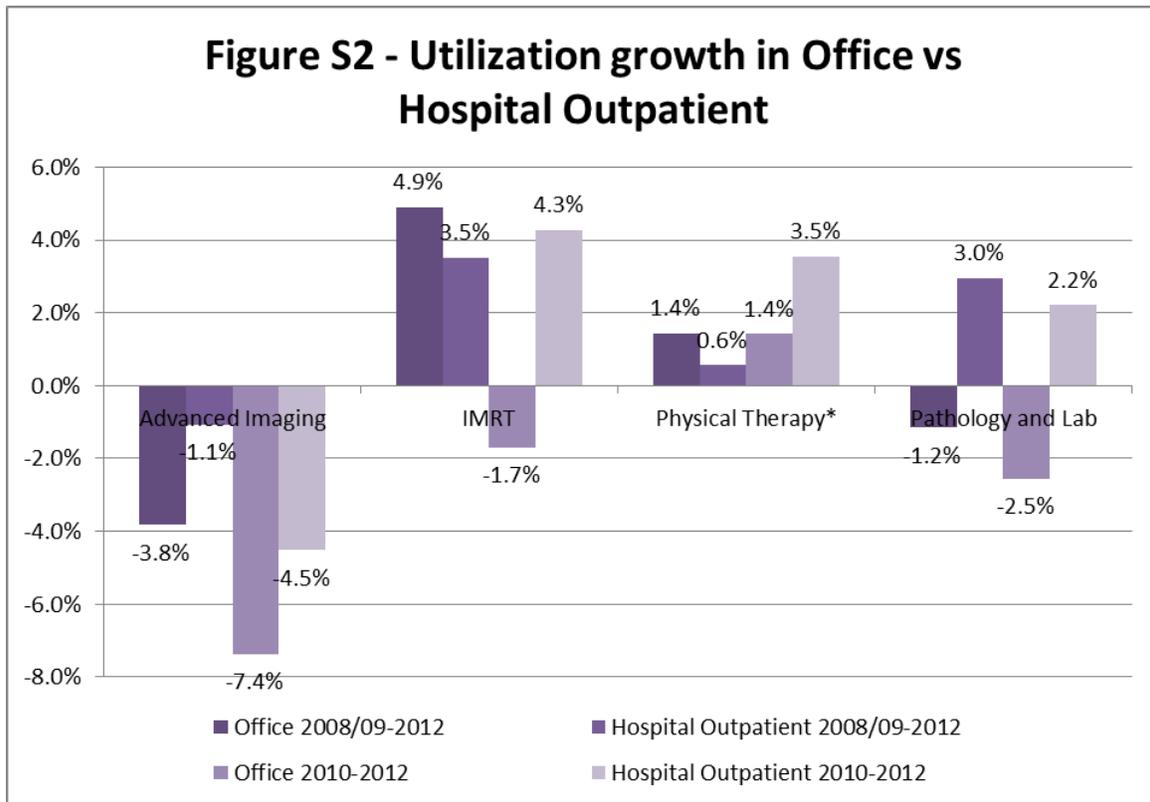
Figures S1 to S3 summarize Milliman’s results on growth in spending and utilization per enrollee across outpatient settings, which include the physician office and hospital outpatient departments for all the service categories shown (as well as home health for physical therapy and independent laboratories for pathology).



*Due to a data anomaly for 2008, the study period for physical therapy is from 2009 to 2012.

Spending growth overall is declining or has gone negative for most of these services (Figure S1). From 2008 to 2012, Medicare spending growth per fee-for-service enrollee for advanced imaging, IMRT and pathology averaged 0.4 percent, 2.5 percent and 5.9 percent, respectively. Growth in spending per enrollee for physical therapy averaged just 1.1 percent per year from 2009 to 2012. And, spending growth rates for all these services were notably lower in more recent years, from 2010 to 2012, with an outright decline in spending per enrollee for advanced imaging and physical therapy and a virtually flat growth rate for IMRT. These changes came at a time when the risk adjusters Medicare uses to measure beneficiaries' need for medical care rose by almost 5 percent. During the same period, overall Medicare spending growth per enrollee averaged 2.1 percent from 2008 to 2012, and 1.2 percent from 2010 to 2012.

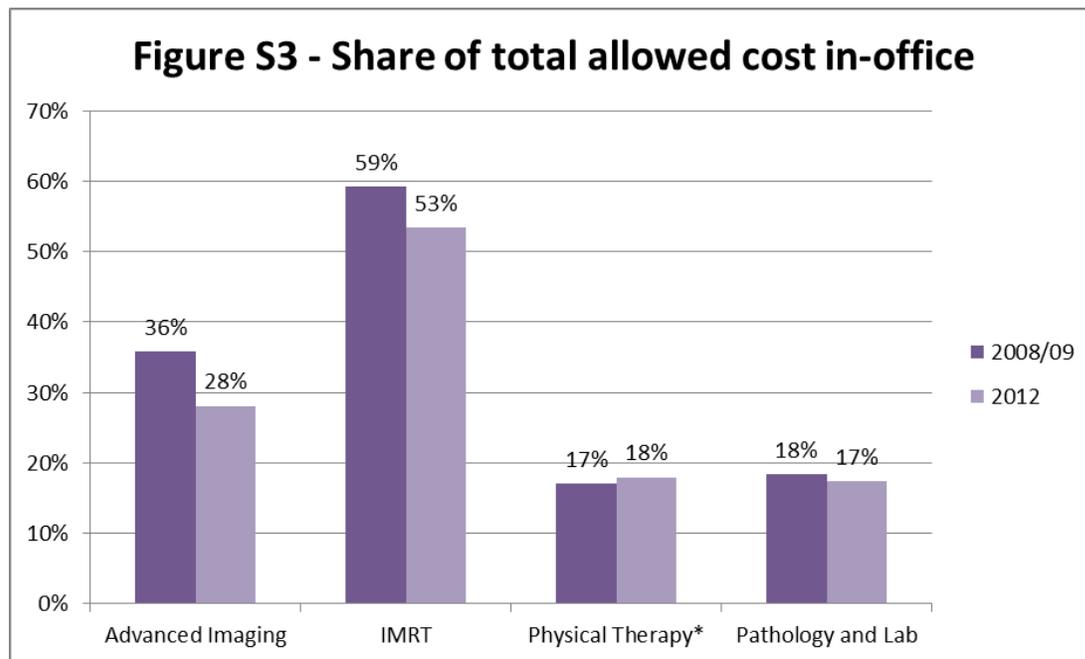
Utilization growth has also been low or negative (Figure S1). Utilization of advanced imaging services per enrollee declined by an annual average of 1.0 percent per year from 2008 to 2012, and experienced negative growth (-4.6 percent) per year from 2010 to 2012. Growth in use of IMRT and pathology averaged 4.0 percent and 2.3 percent per year, respectively, from 2008 to 2012, and then dropped to about 1 percent from 2010 to 2012. Growth in use of physical therapy per enrollee averaged 1.0 percent from 2009 to 2012, increasing to 1.9 percent average growth for 2010 to 2012. It should be noted that utilization was measured as the number of units of service, which does not capture changes in the intensity of service use.



*Due to a data anomaly for 2008, the study period for physical therapy is from 2009 to 2012.

By the end of the study period, utilization growth in hospital outpatient departments was outpacing growth in physician offices for all four categories of ancillary services (Figure S2). In physician offices, both advanced imaging and pathology had negative five-year annualized utilization growth rates of -3.8 percent and -1.2 percent, respectively. In hospital outpatient departments, use of advanced imaging services declined by a more modest -1.1 percent while pathology and lab services increased by 3 percent. Over the five-year period, average annual growth for use of IMRT and physical therapy was somewhat higher in the office setting (4.9 percent and 1.4 percent) than in the outpatient department (3.5 percent and 0.6 percent). In the latter years of the period, however, the relationship reversed with IMRT dropping by almost 2 percent a year in the office and rising by about 4 percent in the outpatient department, while physical therapy grew less than half as fast in the office as in the outpatient department. While utilization in physician offices was declining for three of the four ancillary service categories (all but physical therapy) by the end of the study period, it fell for only one category (advanced imaging) in the outpatient department.

Also of note, some services are frequently provided in settings other than the hospital outpatient department or physician office. For example, utilization for pathology and laboratory services increased even faster in the independent laboratory setting (3.6 percent) than in the hospital outpatient department (3.0 percent) because of use by physician practices that do not self-refer.



*Due to a data anomaly for 2008, the study period for physical therapy is from 2009 to 2012.

Lower growth of utilization and expenditures in physician offices has led to a decline in the share of spending in physicians' offices for all but one of the studied service categories (Figure S3). As a share of the total in all outpatient settings, physician office spending over the course of the study period rose slightly (from 17 to 18 percent) for physical therapy and fell slightly (from 18 to 17 percent) for pathology. The in-office share of total spending for IMRT showed a larger decline from 59 percent in 2008 to 53 percent in 2012 and was most dramatic in advanced imaging where it dropped from 36 percent of the total in 2008 to 28 percent in 2012.

Less in-office use may increase overall Medicare spending. When provided in a hospital outpatient department, Medicare reimbursement for some services will include both a facility payment under the outpatient prospective payment system and a professional payment under the physician fee schedule. This total often significantly exceeds the in-office payment. For example, the average 2014 Medicare allowed amount for "CT abdomen & pelvis w/contrast" was \$482.91 when performed in the hospital outpatient department, compared to \$327.42 in the office. In fact, among the top five advanced imaging services, the 2014 national average Medicare hospital outpatient department payment was 36 to 53 percent higher than the in-office amount.

In summary, the Milliman analysis clearly refutes the arguments of those who wish to limit physician investment in ancillary services that have become an integral part of the services they provide. Cutting payments for these services or targeting them for referral restrictions would disrupt multispecialty practice models, discourage delivery system innovation, and reduce continuity of care for Medicare beneficiaries with no discernible benefit to the Medicare program. As shown in this analysis, the cost and utilization trends for the services in question do not support arguments that physician ownership of the services leads to overutilization and increases Medicare spending. In fact, they suggest that to the contrary, efforts to discourage availability of these services in physician's office could actually increase costs to Medicare and its beneficiaries.