In-Office Ancillary Service Exception: Current Status and Advocacy Strategy

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New challenges faced by physician practices
- Decreased reimbursement
- Increased expenses
- Regulatory burden

THERE IS NO MONEY!
Market Response

- Two principal trends developing
  - Increased number of physicians being employed by hospitals
  - Practice acquisition
  - Direct hire from residency programs
  - Formation of large physician group practices
Advantages to Consolidation

- Economies of scale
  - Eliminate duplicated staff
  - More efficient operations
- Enhanced purchasing/negotiating ability
  - Vendors (i.e. medical supplies, EMR)
  - Third party payors
- Ability to acquire capital intensive services
  - Pathology
  - Diagnostic Imaging
  - Radiation Oncology
Advantages to Consolidation

- Ability to assume risk
  - Medicare
    - Form Accountable Care Organizations (ACOs)
    - Contract with multiple ACO’s
    - Participate in Shared Savings Programs
    - Create novel reimbursement models
      - Bundled payments
      - Case rates
  - Contract directly with third party payors
Historical monopolists are particularly vulnerable to market share shifts

- Minimal patient contact
- Rely on referrals
- Services are increasingly becoming commoditized
The Opponents

- Alliance for Integrity in Medicine
  - American College of Radiology
  - American Clinical Laboratory Association
  - ASTRO (Radiation Oncologists)
  - American Society for Clinical Pathology
Recent Threat

- GAO Report
  - Concluded that higher use of advanced imaging by providers who self-refer cost Medicare $109M per year ($1.1B over 10 years)
  - Flawed methodology and assumptions
    - Excludes hospital referrals
    - Appropriate referral rates not studied
- Report damaging politically
- Diagnostic imaging reimbursement severely cut
  - Did NOT recommend repeal of the IOASE
Fiscal Cliff
- There was an attempt to include language in the fiscal cliff bill repealing the IOASE
- Thwarted by advocacy efforts
Upcoming Threats

- **CBO Score**
  - CBO charged with “scoring” potential cost savings for repeal of IOASE

- **Sequestration**
  - Risk that repeal of IOASE could be part of strategy to avert across the board 2% Medicare reimbursement cuts

- **Problem:**
  - Urology accounts for only 2.3% of Medicare expenditures
  - Risk of becoming “collateral damage”
The Case for the IOASE

Must Customize Message to the Target Audience
The Case for the IOASE: Common

- Compliance & convenience
- Quality & coordinated care
- Cost & outcomes
Improves adherence to treatment plans and outcomes

- Elimination of duplicate paperwork
- Minimizing travel issues
- Easing insurance referral process
- Simplifying issues for patients
Quality and Outcomes

- Allows for better coordination of care between physicians
- Allows for the development of disease specific expertise
  - Recent publication: contamination rate of biopsy specimens significantly lower in pathology labs operated by urology practices significantly lower than in other sites of service*

Cost

- Utilization rates similar regardless of site of service
- Patients will simply seek services at alternative site of service
- Physician office is far less expensive than hospital
  - By law, under the Deficit Reduction Act all imaging services performed by physicians must be reimbursed at equal or less than the hospital rate
Pathology Utilization

- Jean Mitchell Health Affairs Study
  - Study funded by American Clinical Lab Association and College of American Pathologists
  - Concluded that physician owned labs took twice as many samples as control groups
    - Only a handful of urology groups in 11 arbitrarily selected counties
    - Groups were taking 12 rather than 6 cores
  - Positive biopsy rates of between 21 percent to 27 percent
    - 14% lower cancer detection than her control group
    - Used unproven and clearly flawed methodology to determine positive biopsy rate
Collaborated with Bostwick Laboratories

Obtained positive biopsy rate and vials/specimen directly from practice and patient source data

- Did not rely on arbitrary claims data methodology

LUGPA analyzed data from 2005-2011

Compared utilization data between urologists that used their own labs vs. those that sent specimens to a national reference lab

Pathology Utilization: LUGPA

- Urology practices
  - 29 urology practices representing 805 urologists nationwide
    - 179,681 patients with 1,866,775 specimens
  - National reference laboratory
    - 919 practices with 1513 urologists nationwide
    - 258,256 patients and 2,363,354 specimens
- Combined total of 2318 urologists (over 25% of all urologists in the US)
  - Total of 437,937 patients with 4,230,129 specimens
Pathology Utilization: LUGPA

- Average positive biopsy rate for LUGPA: 40.3%
- Average positive biopsy rate for reference lab: 40.3%
- These values are mathematically and statistically identical
From 2005-11, average difference in vials per biopsy between LUGPA and reference lab was only 1.2 vials per biopsy.

From 2009-11, the difference of 0.6 vials/biopsy was not significant.
Pathology Utilization: LUGPA

- There is no difference in either number of cores, positive biopsy rate or utilization trends between physician operated and reference labs
- No evidence of inappropriate incentive to biopsy based on site of service
- There can be no cost savings with elimination of physician operated pathology laboratories as these services will simply be performed elsewhere
Opponents of incorporation of radiation oncology services allege over-use of these services, particularly IMRT. Cite increase number of IMRT cases done by integrated urology groups. Absolutely NO objective data to support these claims.
Trends in Prostate Cancer Therapy

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EBRT: IMRT increasing, 3DCRT decreasing
IMRT Utilization: No correlation to number of urologists providing service

Number of Urologists in Groups with Integrated IMRT Services

- Urologists: 56, 193, 331, 484, 727, 845
- IMRT: 31060, 37280, 46660, 47060, 43580, 45460

y = 162.86x - 130.67
R² = 0.9903

y = 2608.6x + 32720
R² = 0.5848

Medicare Beneficiaries Receiving IMRT to Treat Prostate Cancer

- 2005: 0
- 2006: 56
- 2007: 193
- 2008: 331
- 2009: 484
- 2010: 727

- 2005: 0
- 2006: 31060
- 2007: 37280
- 2008: 46660
- 2009: 47060
- 2010: 45460
IMRT Utilization: Prostate vs. Non-Prostate

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Increased utilization of IMRT reflects changing clinical standards and is occurring in treating other disease states as well as prostate cancer;

The trend towards increased utilization of IMRT in the treatment of prostate cancer occurred prior to 2007, and thus predated the formation of integrated urology groups;

Trends in IMRT utilization to treat prostate cancer are similar regardless of whether the service is provided in the hospital or physician office setting;

There is absolutely no correlation between utilization of IMRT to treat prostate cancer and the number of urology practices offering these services.
The Case for the IOASE: Targeted

- Inappropriate interference with doctor-patient relationship and the practice of medicine
- Ability to develop alternative strategies to traditional fee for service medicine
Summary

- The IOASE is not a loophole, it is a provision deliberately inserted to improve access and enhance quality of services.
- Utilization patterns of GU services provided under the IOASE reflect changing clinical patterns and do not correlate with physician ownership.
- Legislative modifications in this arena would produce little or no cost savings and could adversely affect access to care.
Questions?