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Dr. Kapoor explains support of self-referral exception

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Dr. Kapoor

In a May 19, 2015 letter to the editor in the *JAMA*, LUGPA Chairman of Health Policy Deepak A. Kapoor, MD, pointed out what urologists might find to be glaring omissions published online in a *JAMA* Viewpoint Jan. 12 that supported repeal of the in-office ancillary services exception (IOASE) to the Stark law.

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In their Viewpoint, authors Ely Y. Adashi, MD, MS, of Brown University in Providence, RI, and Robert P. Kocher, MD, of the University of Southern California, Los Angeles, explained why they thought failure to repeal the IOASE "would constitute a costly missed opportunity."

Among their points: "Observations on self-referrals of IMRT services for the treatment of prostate cancer were particularly disconcerting. The utilization of self-referred IMRT services increased by as much as 356 percent at a time when the utilization of the non-self-referred variety decreased by 5 percent."

The authors cite findings from four recent Government Accountability Office (GAO) reports and suggest Congress could close dozens of loopholes that have allowed physicians to increasingly refer patients for medical services to enterprises in which they have a financial stake.

In a telephone interview, *Urology Times* asked Dr. Kapoor to comment on his rebuttal.

UT: *Is preserving the IOASE LUGPA's position?*

Dr. Kapoor: Actually, preservation of the in-office ancillary service exception is part of the common legislative platform for all of organized urology. As such, preserving the IOASE is a priority not only for LUGPA, but also the AACU and the AUA as well.

UT: *How would urologists in private and group practices be impacted if IOASE were to be repealed?*

Dr. Kapoor: The three services that urology groups perform to the largest degree are pathology, radiation oncology, and advanced imaging. All of those are at risk by the repeal of the exceptions.

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UT: *In their Viewpoint, Drs. Adashi and Kocher singled out self-referrals of IMRT services for the treatment of prostate cancer and how utilization of self-referred IMRT services increased by as much as 356% while utilization of non-self-referred services actually decreased. How do you respond?*

Dr. Kapoor: Unfortunately, the authors cherry-picked information from the GAO report that supported their premise. The GAO report actually found that from 2007 to 2010, overall use of IMRT was virtually unchanged; all increases in IMRT use by urology groups was directly offset by decreases in utilization by hospitals and free-standing radiation centers.

To really understand IMRT use, you need to look beyond the GAO report. The literature shows that the largest increase in IMRT use occurred prior to 2007, during which time virtually no urology practices owned IMRT technology. Even then, looking at IMRT in a vacuum is deceptive; increased IMRT use was associated with a simultaneous decrease in both 3-D conformal radiation therapy, as well as seed implantation.

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The end result is that hospitals and free-standing radiation centers were losing market share for IMRT technology, and being unable to compete on either cost or access, have sought relief via legislative fiat—efforts that have, to this point, not gained traction in Congress.

Next: Dr. Kapoor - independent physician's office most cost-effective site of service

UT: *You noted in your letter that Drs. Adashi and Kocher failed to note that the independent physician's office—not the hospital—is the most cost-effective site of service. The authors disagreed with you on that.*

Dr. Kapoor: They say they disagree and then, if you read the balance of their response, they acknowledge that my statement is true. In fact, in the following paragraph, they acknowledge repeal of the IOASE may force patients to go to a more expensive and less convenient site of service.

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That said, there is no question that independent data support the notion that care at hospitals is more expensive than at a doctor's office. Specifically regarding IMRT, the GAO report cited by the authors also noted that from 2007 to 2010 although IMRT use in the physician office setting increased 14.1%, expenditures at this site of service decreased 6.1%; simultaneously, hospital expenditures for IMRT increased 3.1% despite a 17% decrease in utilization of IMRT services at this site of service.

These cost differentials go beyond radiation. Literature that I cited in my response clearly illustrate that point. The study by Robinson et al analyzed the utilization patterns in a fee-for-service model and found that hospitals were about 10.3% more expensive than physician groups at delivering care. If you look at hospital systems, the costs are 19.8% more expensive. This cost differential extends to risk-sharing arrangements. An analysis by McWilliams et al from Harvard of 4.29 million Medicare beneficiaries enrolled in Pioneer ACOs determined that not only were physician groups less expensive overall, they performed better on quality metrics as well.

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Another excellent article that I didn't cite in my rebuttal is from Stanford and published in the May 2014 issue of *Health Affairs*. According to the study, costs go up when hospitals acquire physicians. In fact, the authors suggest hospitals acquire physicians specifically to redirect the use of more expensive ancillary services to their institutions.

Next: What's the solution?

UT: *What, then, do you think is the solution?*

Dr. Kapoor: I'm not sure there every really was a problem, but given the changes in health care, utilization issues are certainly not our most pressing issue going forward.

The recently passed SGR reform bill encourages the development of alternative payment methodologies. Physicians are encouraged to perform a minimum of 25% of their services under alternative payment models (APMs) within the next 3 years; eventually, this is to increase to 75% APM use by 2023. Under these APMs, providers assume financial risk for services they utilize; therefore, ancillary services no longer generate revenue but become costs that must be controlled. The studies we discussed earlier show that in risk-sharing models, physician groups are less expensive in every ancillary service category—as much as 34% less expensive for radiation and Medicare Part B medications.

The notion that on the one hand we are encouraging people to take risk by going to alternative payment methodologies and on the other hand simultaneously eliminate from the market what has been demonstrated to be the most efficient site of service makes utterly no sense. To the contrary, the competitive counterbalance provided by physician group practices should be nurtured and expanded.