MEDICARE PART B IMAGING SERVICES:

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National Health Policy Forum
(November 13, 2008)
Presentation Based on the Following GAO Reports

• Medicare Part B Imaging Services: Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices (GAO-08-452)

• Medicare: Trends in Fees, Utilization, and Expenditures for Imaging Services before and after Implementation of the Deficit Reduction Act of 2005 (GAO-08-1102R)
Methodology

• Analyzed Medicare Part B claims data from 2000 through 2007, in aggregate, and by six categories of imaging services
  • CT, MRI, and nuclear medicine services ("advanced" imaging)
  • Ultrasound, x-ray and other standard imaging, and procedures that use imaging ("other imaging")
• Expenditures include two components of imaging services paid under the Medicare physician fee schedule
  • Technical component, or provision of the imaging examination
  • Professional component, or interpretation of the imaging examination
• Interviewed experts and other knowledgeable individuals
First Report
(June 2008)
From 2000 to 2006, Medicare Part B Expenditures for Imaging Services More than Doubled, As Use of Advanced Imaging Services Grew

- Medicare imaging expenditures under the Part B physician fee schedule more than doubled from 2000 through 2006.

- Expenditures increased across all imaging categories, but grew almost twice as fast for advanced imaging services (CT, MRI and nuclear medicine).

- Advanced imaging accounted for 54 percent of total imaging expenditures in 2006 compared to 43 percent in 2000.
Increased Volume and Complexity Accounted for Most of the Growth in Expenditures, 2000 through 2006

Factors affecting growth

- Volume and complexity (RVUs): 77%
- Number of Medicare beneficiaries: 11%
- Separately billed ancillary items (no RVUs): 7%
- Medicare physician fee increase: 5%

Source: GAO analysis of Medicare Part B claims data.
Several Spending Trends Associated with In-Office Imaging Raise Concerns about Incentives for Physicians to Overuse Services

- Increasing share of imaging services provided in physicians’ offices.
  - Physician office settings accounted for about two-thirds of spending (about $9 billion) in 2006 compared to 58 percent in 2000.
  - Physicians in specialties other than radiology accounted for an increased share of in-office spending—68 percent in 2006 compared to 64 percent in 2000.
- Substantial geographic variation in imaging spending per beneficiary, ranging from $62 in Vermont to $472 in Florida in 2006.
Physicians Deriving Increasing Share of Revenue from In-Office Imaging

Percentage of total Medicare Part B revenue

<table>
<thead>
<tr>
<th>Physician specialty</th>
<th>2000</th>
<th>2006</th>
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<tbody>
<tr>
<td>Cardiology</td>
<td>23.2</td>
<td>36.0</td>
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<tr>
<td>Vascular surgery</td>
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<tr>
<td>Orthopedic surgery</td>
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<tr>
<td>Primary care</td>
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</tr>
<tr>
<td>Urology</td>
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</table>

Source: GAO analysis of Medicare Part B claims data.

*Includes general and family practitioners and internists.
Substantial Variation of In-Office Imaging Use Across Geographic Regions, 2006

Office-based imaging services per beneficiary

- $1 to $99
- $100 to $199
- $200 to $299
- $300 to $399
- $400 to $499

Source: GAO analysis of Medicare Part B claims data, Map Resources (map).
To Manage Imaging Expenditures, Private Health Plans in our Study Use Certain Prospective Practices

- The plans in our study reported that prior authorization, which requires physicians to obtain some form of plan approval before ordering a service, was the practice most important to managing physicians’ use of imaging services. Sixteen of the 17 plans used a radiology benefits manager to administer their prior authorization program.

- Seven of 17 used privileging by which a plan limits its approval for ordering certain imaging services to physicians in certain specialties.

- Eight of the 17 plans used physician profiling, which entails a statistical analysis of medical claims data measuring an individual physician’s use of services relative to a desired benchmark.

- As a result of these strategies, the plans reported decreased utilization and decreased growth rates.
CMS’s Imaging Management Activities Rely on Retrospective Strategies

- CMS administers, through its claims administration contractors, an array of retrospective safeguards designed to achieve payment accuracy.

- CMS has contracted with a firm to develop efficiency measures for certain imaging services to determine whether appropriate evidence-based guidelines were adhered to.
Recommendation

To address the rapid growth in Medicare Part B spending on imaging services, we recommended that CMS examine the feasibility of adding more front-end approaches, including prior authorization and privileging.

HHS raised concerns about the applicability of using prior authorization for the Medicare program.
Second Report
(September 2008)
Congress Acted to Address the Rapid Growth in Spending on Imaging Services

- Under a provision in the Deficit Reduction Act of 2005 (DRA), Medicare fees for certain imaging services covered by the physician fee schedule (PFS) may not exceed what Medicare pays under the hospital outpatient prospective payment system (OPPS).

- The DRA provision—known as the OPPS cap—applies only to the fee physicians receive for performing (as opposed to interpreting) an imaging test.

- The OPPS cap was implemented for imaging tests performed on or after January 1, 2007.
Extent to Which Fees for Performing Imaging Tests Were Affected by the OPPS Cap in 2007

- The OPPS cap resulted in fee reductions for about one in four imaging tests, with a larger impact on more costly advanced tests than other less expensive tests.

- Of the 65.9 million physician imaging tests performed in 2007, about 23 percent were paid at the OPPS rate.

- Fees for about 65 percent of the 13.3 million advanced imaging tests were paid at the OPPS rate.
Percentage of Physician Imaging Tests Paid at OPPS Rate and PFS Rate in 2007

Source: GAO analysis of Medicare Part B claims data and physician fee schedule data.
After Years of Growth, Imaging Expenditures Declined in 2007

- Total Medicare expenditures for physician imaging services declined nearly 13 percent in 2007.

- The OPPS cap was the largest of several factors that caused the decline in expenditures. Changes in enrollment, fees and volume also impacted expenditures.

- On a per fee-for-service beneficiary basis, total imaging expenditures declined 10.5 percent. Expenditures for advanced services declined more than expenditures for other services.
Imaging Expenditures per Medicare FFS Beneficiary, 2000-2007

Expenditures per beneficiary in dollars

Source: GAO analysis of Medicare Part B claims data.
The Volume of Imaging Tests Continued to Increase in 2007

• The volume of tests per beneficiary increased 3.2 percent in 2007, which continued the upward trend from previous years.

• The growth in volume of tests subject to the OPPS cap was almost four times higher than the growth in volume for tests not subject to the cap.
Imaging Tests per Medicare FFS Beneficiary, 2000-2007

Number of tests per beneficiary

<table>
<thead>
<tr>
<th>Year</th>
<th>Total tests</th>
<th>Other tests</th>
<th>Advanced tests</th>
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Source: GAO analysis of Medicare Part B claims data.
Provisions Related to Imaging from the Medicare Improvements for Patients and Providers Act, July 2008

Requires the Secretary of HHS to:

- Establish an accreditation program for Medicare providers of advanced imaging tests.

- Conduct a demonstration project to determine the appropriateness of advanced imaging services provided to Medicare beneficiaries.
Issues Touched on by the Medicare Imaging Controversy

- Rapid spending growth, coupled with substantial geographic variation
- Lack of consensus, evidence-based guidelines
- Physician self-referral
- Fee-for-service incentives for volume and complexity
- Development and diffusion of medical technology
- Achieving savings without jeopardizing access or quality