Physician Self-Referral and Health Care Utilization

A DISCUSSION FEATURING:

Jean Mitchell, PhD
Professor
Georgetown Public Policy Institute

Brent Hollenbeck, MD
Professor
University of Michigan

Rita Redberg, MD
Professor of Medicine
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FORUM SESSION ANNOUNCEMENT

FRIDAY APRIL 1, 2011
11:45AM–12:15PM—Lunch
12:15PM–2:00PM—Discussion

LOCATION
Reserve Officers Association
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
(Across from the Dirksen Senate Office Building)

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Physicians are responsible for the majority of health care spending in this country, both directly by providing health care services, and indirectly by referring their patients for other services such as tests, therapies, and procedures. Payers have long grappled with how to control the number, type, and site of these services without inappropriately interfering with the practice of medicine. One particular area of concern has been physician referrals for services that financially benefit the physician because the physician has an ownership interest in the practice or facility that provides the referred service. Research has demonstrated that physician self-referral contributes to higher use of certain services. Some argue, however, that physician ownership arrangements can enhance the quality and continuity of care, improve patient convenience, and help ensure access to services. The complexity of these issues was recently illustrated by a *Wall Street Journal* investigative report on a sophisticated (and expensive) radiation therapy for prostate cancer, which has focused renewed attention on the ability of physicians to refer their patients to their own treatment facilities.\(^1\)

The Medicare program has limited the ability of physicians to directly benefit financially from certain referrals, although the complex relationships among physicians and facility providers makes the elimination of any financial benefit difficult and possibly inadvisable. The Ethics in Patient Referral Act, commonly referred to as the Stark law (after Congressman Pete Stark, the chief congressional sponsor), prohibits physician self-referral for certain designated health services. That is, Medicare will not pay for certain services if the referring physician has a financial interest in the facility where it is provided. Enacted in 1989 and expanded in 1993, the Stark law specifically exempts in-office ancillary services. Physicians are allowed to refer their own patients for ancillary services, such as laboratory tests and therapy, that are provided in their offices. Physicians may also refer their patients to ambulatory surgery centers (ASCs) in which they have an ownership interest. The relationships between physicians and ASCs are governed by other laws, including the anti-kickback statute, intended to prevent physicians from soliciting or receiving financial or other rewards for patient referrals.

A growing body of research has examined whether financial interests affect physician decision-making regarding services needed by their patients.\(^2\) Some of the early work, for example, indicated that physical therapy and rehabilitation visits were 39 to 45 percent higher in facilities that were owned in part by physicians.\(^3\) An analysis by the General Accounting Office demonstrated that owners of MRI
scanning equipment referred their patients for MRI scans twice as often as non-owners. More recent studies indicate that ancillary service use is higher for patients of physicians with an ownership interest in the service. In some cases, patients who receive services in an ASC or specialty hospital that is partly owned by the referring physician are less severely ill (or less costly to treat) than the patients who receive those services in a hospital outpatient department or another facility provider.

The limits to physician self-referral try to balance concerns about escalating service use and possible inappropriate utilization with the desire to promote patient and provider convenience, as well as to encourage innovation in the delivery of health care. As a result, the investment arrangements for physicians that have developed to ensure compliance with the Stark and anti-kickback laws have become increasingly complex. At the same time, the ability to provide self-referred services continues to rise with expanded in-office ancillary capacity and steady increases in the number of ASCs. Spurred by technological innovations that have made certain types of equipment less costly and easier to use, more and more services have moved out of the inpatient hospital setting.

The Medicare Payment Advisory Commission (MedPAC) and others have considered options to address inappropriate utilization of health care services that may be encouraged by the financial advantages of self-referral. Focusing on the in-office ancillary exception, the Commission examined three types of options to address the growth of ancillary services: limiting the services or physician groups exempted from the Stark law, reducing payments or improving payment accuracy for ancillary services, and adopting a limited prior authorization requirement. More broadly, MedPAC and others have endorsed more encompassing payment reforms, such as the use of larger payment bundles or accountable care organizations (ACOs), to reward more appropriate use of services while improving quality of care. Such reforms may deal with the concerns originally addressed through the Ethics in Patient Referral Act. Given the magnitude of current fiscal pressures and the long time frame for these more sweeping delivery reforms, however, it may be appropriate to reconsider the latest evidence on physician self-referral and its consequences.

SESSION

At this Forum session, researchers will present some of the latest findings on the relationships between physician financial interests
and referral patterns. **Dr. Jean Mitchell**, economist and professor in the Georgetown Public Policy Institute, began examining the relationship between physician self-referral, utilization, health care spending, and quality in the early 1990s. She will describe the history of research in this area and her latest work, which includes examining the in-office ancillary exception. **Dr. Brent Hollenbeck**, a urologic oncologist and professor at the University of Michigan will discuss his research on physician ownership interest in ASCs and utilization of outpatient procedures and surgeries. **Dr. Rita Redberg**, cardiologist and professor of medicine at the University of California, San Francisco, will discuss some of the latest innovations in the practice of cardiology, their incorporation into office practice, and the utilization of services. **Dr. Allen Taylor**, professor of medicine at Georgetown University, will describe the appropriate use criteria initiative of the American College of Cardiology to introduce voluntary quality improvement standards to guide imaging decisions in cardiology practices.

**KEY QUESTIONS**

- How have the exceptions under the Stark law contributed to innovation in health care technology? Health care delivery? What are the advantages to having a growing share of ancillary services and surgeries performed out of the hospital setting? What are the disadvantages?

- How has the mix of patients at ASCs and hospital outpatient departments changed with the growth in ASCs? How has the mix of patients receiving imaging services from radiology practices changed with the growth in other specialties providing in-office imaging? How has the quality of care changed with these developments? How has the cost of care changed?

- How do quality assurance measurement and monitoring differ at physician offices and hospital outpatient departments? At ASCs and hospital outpatient departments? Have quality assurance mechanisms kept up with the change in service settings?

- What kinds of legislative and regulatory changes can be made to limit self-referrals for services that may not be necessary? Are there other types of policy changes that should be considered? With expanded use of bundled payments and the advent of ACOs, will self-referrals for financial gain go away?
ENDNOTES


