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Reduced Reimbursement for Cardiovascular Services by the Centers for Medicare and Medicaid Services

Perspective From Interventional Cardiology

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The Centers for Medicare and Medicaid Services (CMS) recently released its proposed 2010 Medicare Physician Fee Schedule, which includes dramatic reductions in payments for cardiovascular services. However, the basis for these cuts is flawed in credibility and does not address the valid issues that demand health care reform. (J Am Coll Cardiol Intv 2009;2:894–6) © 2009 by the American College of Cardiology Foundation

The Centers for Medicare and Medicaid Services (CMS), since 1992, have paid for physicians' services under the Physician Fee Schedule (PFS), on the basis of national uniform relative value units, which are relative resources used in furnishing a service (1). Physician work (PW), practice expense (PE), and malpractice expense are components of the relative value unit system that are established on the basis of input from various sources: American Medical Association (AMA) Specialty Society Relative Value Update Committee for PW; Clinical Practice Expert Panel and AMA Socioeconomic Monitoring System (SMS) for PE; and commercial and physician-owned insurers from all states for malpractice expense (1). The SMS data, initially generated from a survey developed by the AMA in 1981, were discontinued in 1999 but later incorporated in 2002 by the CMS into the calculation of PE. However, the SMS data are dependent on survey responses from various specialties to provide accurate information on payroll expenses (clinical and administrative), office expenses (rent, mortgage, and utilities), medical material and equipment expenses, and other miscellaneous expenses (legal, accounting, and professional memberships) (1).

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The CMS recently released its proposed 2010 PFS (2), which includes dramatic reductions in payments for cardiovascular services, specifically invasive and interventional procedures (Table 1) (3). However, the basis for these cuts is flawed in credibility and does not address the valid issues that demand health care reform.

Poor Representation From a Small Sample Size

Medicine is held accountable by evidence-based practice, which is defined as the judicious use of current best evidence in making decisions about the care of individual patients. Evidence-based medicine, introduced as an emerging paradigm in 1992, deemphasizes intuition, unsystematic clinical experience, and pathophysiologic rationale as sufficient grounds for clinical decision-making and stresses the examination of evidence from clinical research (4). Current best evidence in medicine is derived from randomized clinical trials to avoid the possibility of bias in obtaining a specific result. A clinical practice guideline is never founded on experience from a single cohort study, because it would be plagued by inherent biases.

However, the CMS has employed a survey that generated a poor response rate, excluded greater than one-half of the responses received, and used input from just over 50 practices to influence a nationwide

Table 1. Medicare Fees for Common Invasive and Interventional Procedures

CPT Codes	Procedure Description	2009 Medicare Charge ($)	2010 Medicare Charge ($)	Change From 2009–2010 (%)
37205	Peripheral stent	445	426	−4
37215	Carotid stent	1,101	1,096	0
92974	Brachytherapy	171	151	−12
92978	Intravascular ultrasound	100	90	−9
92980	Intracoronary stent (single)	848	748	−12
92981	Intracoronary stent (additional)	236	208	−12
92982	Balloon angioplasty (single)	642	554	−14
92984	Balloon angioplasty (additional)	168	149	−12
92995	Coronary atherectomy	693	610	−12
93508	Coronary angiography	235	204	−13
93510	Left heart catheterization	249	216	−13
93526	Right and left heart catheterization	343	299	−13
93555	Imaging supervision, interpretation, and report (catheterization)	45	40	−10
93556	Imaging supervision, interpretation, and report (angiography)	46	41	−9

Adapted from National Medicare Fees for Common Invasive and Interventional Procedures (July 2010) (3).

health care policy decision. Moreover, no baseline characteristics of the respondents or practices used to generate the data have been revealed. The SMS data gathered from this relatively small and undisclosed group reflected a drop in cardiologists' PE by 33%, which subsequently led to exaggerated cuts to the PFS. At a minimum, the CMS should be obligated to have transparent reporting of actual complete survey results instead of a select fraction, because this is the accepted standard for the practice of medicine.

Compromise in Quality of Patient Care

Health care reform is a general platform used for discussing major health policy changes. The need for health care reform in the U.S. is evident and irrefutable and has been proposed since the early 1990s (5). The reason for reform is to broaden coverage, expand access, and improve quality of health care while curbing the rising cost of health care. The recent exposé in the *New Yorker* (6), evaluating the disparity in medical expenditure between 2 similar cities in Texas, attributes the growing costs of health care to overuse of services under a system that pays for quantity without incentives for quality.

Therefore, a move by the CMS to cut reimbursement for high-quality specialized care does not help with coverage, access, or quality. Furthermore, it does not address the root cause for overuse of services, which would require payment reform to incentivize improvement in quality of care. Such actions from the CMS seem to be driven by short-term cost containment rather than the long-term value of performance and outcomes that are necessary for effecting health care reform (7).

Shift of Payments From Specialty Care

In the early 1990s, it was commonly believed that the U.S. was producing too many specialist physicians, including cardiologists. The rapid growth of managed care and obstacles to specialty services contributed to this belief. As a result, the number of first-year adult cardiology training positions fell by 20% by the late 1990s (8). The 35th Bethesda Conference in 2003 warned that the shortage of cardiologists would continue to increase and peak in the 2010s to 2020s as the "Baby Boomer" generation encounters heart disease and Baby Boomer physicians retire. Today, there is a deficit of more than 4,000 general, interventional, and pediatric cardiologists. If no effort is made to curb the shortage, the estimated deficit could reach 16,000 cardiologists by 2025 (9).

The CMS cuts to specialty services, under the current proposal, diminish patient access to high-quality specialized care. The need for primary care physicians is clear: the frontline of medical care for patients; the triage for referrals to specialists; and the face of continuity of care. However, shifting funds from specialty services does not treat the underlying problem but fuels the already large deficit of specialty services.

Burgeoning Medical Student Debt and Shrinking Physician Pool

According to the Association of American Medical Colleges, the average educational debt of medical school graduates in 2008 was $155,000, which was 11% higher than 2007 and 19% higher than 2006 (10). And because the cost of medical education is escalating and average medical student debt is mounting, options for deferment of accumulated loans during advanced training are dwindling. The Economic Hardship Deferment option has been eliminated as of June 30, 2009, which requires residents to make monthly payments during specialty training unless deferred under forbearance, which dramatically increases cost. The

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overall expensive training in specialized care is only made feasible by the compensatory income that follows upon completion, allowing repayment of an otherwise insurmountable debt.

The CMS cuts for reimbursement further balloons the average medical student debt without providing relief to increasing medical school tuition, decreasing student loan programs, and diminishing options for deferment of loans during advanced training. Such proceedings from the CMS threaten to multiply the shortage of specialized physicians in this country that has been so difficult to overcome.

Summary

There is an urgent need for major overhaul of the U.S. health care system; uncontrolled health care costs, inequitable access to care, concerns about quality, and bureaucratic chaos in administration of health insurance programs have evoked widespread interest in restructuring the health care system (5). The proposed CMS cuts for physician reimbursement are based on flawed data and do not address the valid issues that warrant health care reform. Moreover, they arrive at a critical time in the largest economic downturn in recent history and while the House of Representatives is already entertaining a health reform bill that focuses on physician payments and the sustainable growth rate: application of the sustainable growth rate formula would reduce physician payments by 21% in 2010 and 5%/year for the next 4 years. Together with the proposed CMS cuts, there could be as high as a 30% cut in physician reimbursement for cardiovascular services. Such dramatic reductions in payments for specialized services threaten the quality of health care that can be provided to patients without improving access to care. Furthermore, the concerns of growing medical student debt and a dwindling physician pool remain unaddressed.

Health care reform requires incentives for delivery of high-quality patient-centered care that meets the practice guidelines of disease management and satisfies the expectations of patients and peers. To this end, the American College of Cardiology (ACC), under its program of "Quality First" with current guidelines, consensus statements, appropriate use criteria, performance measures, and process measures, has led efforts to create a new standard of health care centered on increasing the quality of care and ensuring greater patient value (11). However, this cannot be achieved by drastic cuts in reimbursement but rather by payment reform that rewards quality of care and best practices including reduced hospital stays and stabilization of chronic illness.

The ACC and its partners across the cardiology community are heading an aggressive campaign to prevent implementation of policies that further burden the patient under the current medical system and to promote health care reform that is centered on improving the quality of patient care. Additional information regarding these critical issues that face the cardiovascular community and opportunities for members to participate can be obtained at the ACC/CardioAdvocacy Network website (12).

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