One thing is clear in this time of economic uncertainty—Medicare reimbursement continues to go down. Especially this year! Propelled by a payment system that fails to adequately account for actual physicians’ costs and that has been compromised by projection errors made by the Centers for Medicare and Medicaid Services, the latest round of Medicare payment cuts were far deeper than anyone expected. Even the most informed observers of American health policy and politics were surprised by their severity. For cardiologists, the average fee reduction was 8.6%. Several specific cardiac tests and procedures fared even worse. Today, in this challenging context, virtually every doctor, practice group, and medical center in the nation is looking at ways to reduce expenses—again. These circumstances have forced many physicians to reflect not only on how they provide their services but to whom.

Some doctors, mainly primary care physicians at this point, have begun to make tough decisions based on the practical implications of steadily increasing costs and decreasing Medicare reimbursement. They’re not taking any new Medicare patients. The New York Times ran a front-page story on the problem when many of us were in Atlanta recently for the American College of Cardiology (ACC) Annual Scientific Session. “I love my elderly patients,” Brooklyn family physician Mark Krotowski told the Times. “But they are very sick. They need a lot of attention, a lot of medications, and a lot of time. Medicare reimbursement has not kept up with inflation or the cost of providing care to the elderly.” (1).

The problem has resonated from coast to coast. A recent survey of physicians in Washington state reflected the impact of this latest round of reductions. The state medical society found that 57% of respondents indicated that the cuts had led them to reduce the number of Medicare patients they see or to stop seeing them altogether (2). The ACC is listening and acting. Speaking directly to the Medicare issue, my predecessor, Doug Zipes, sent a letter to every member of the College in January and devoted his February President’s Page to the subject (3). Every 2002 issue of Advocacy Weekly (available in the advocacy section at www.acc.org) has covered the evolving story and the College’s responses. Medicare reimbursement is still and will remain the College’s top advocacy priority. Why? Because so much is at stake for our profession and for our patients.

Although concerns about homeland security have understandably marginalized most health care issues recently, the federal government must renew its resolve to explore options and seek solutions to the Medicare crisis that is undermining the care of older Americans. Homeland security must mean more than protection against terrorist acts and weapons of mass destruction. My daughter lives in lower Manhattan, so I applaud the measures our leaders have taken to protect our cities and our nation. But the catastrophic and incomprehensible events of September 11 shouldn’t diminish our dedication to delivering high-quality health care to our older citizens. More than 2,600 Americans die every day as a result of cardiovascular disease—almost 1 million a year (4)! Older persons—those insured through Medicare—are especially vulnerable. They are the ones most likely to have symptomatic or silent cardiovascular disease, and they are now at greater risk because they may not have timely access to prompt and accurate diagnosis and proven therapies.

I don’t want to oversimplify the complex issue of Medicare reimbursement or pretend that cardiovascular specialists and their College have all the right answers when it comes to health care delivery. But I do know that we chose a specialty that focuses on older patients and that the future of our field is filled with promise. Over the years, the ACC has worked hard to broadcast the value of specialty care and to lobby for fair reimbursement for services. We’ve had some critical successes such as the reinstatement of separate payment for ECG interpretation. And our voice contributed significantly to the public outcry that demanded access to specialists.

These outcomes were in the best interest of patient care, something that became increasingly evident as alternatives were analyzed, argued, and acted upon. Solving the ACC’s most acute advocacy problem—the Medicare mess—will require a skillful blend of old and new strategies. Because there are so many demands on finite resources, we must articulate our concerns in concise, clear, and compelling ways. If we hope to engage Congress and the Bush administration, we need allies not just in Washington but throughout the nation. Moreover, when patients add their voices to those of their physicians, the sound can be deafening. That’s what it takes to be heard today in
Washington, when there are so many compelling issues and competing agendas.

The administration has acknowledged many problems with Medicare and has proposed investing $190 billion to "modernize the program." A recent letter from HHS Secretary Tommy Thompson to federal lawmakers, however, included some sobering statements. Writing to Representative Nancy Johnson, Republican from Connecticut, and Representative Bill Thomas, Republican from California, two influential congressional advocates for Medicare payment reform, Thompson declared, "We have no compelling evidence that there is a problem with the overall adequacy of provider payments, although we acknowledge that recent short-term adjustments have been substantial in the system Medicare uses to pay physicians." (5)

Fortunately, representatives Johnson and Thomas and some other members of Congress take a different view of this thorny issue and are acting on their beliefs. Representative Johnson just introduced legislation that reflects the Medicare Payment Advisory Commission's recommendation to set the 2003 fee update using a 2.5% increase rather than the 5.4% decrease (that will result from continued use of the current formula). As Secretary Thompson's letter illustrated, however, the Bush administration has decided that any changes in payments to providers must be "budget neutral" (in both the short and long term). This means that any upward adjustment to specific physician payments must be balanced by cuts in payments to other Medicare providers. It's naive to ignore the complexities of the Medicare crisis or minimize the cost implications of any proposed changes. And no one thinks that a logical, fair, and fiscally sound solution is just waiting to be discovered by some bright economist or bureaucrat. One thing is certain: the outcome will have profound implications for many physicians and patients.

A more fundamental question at the center of the current Medicare crisis will become increasingly evident. Just how much is the U.S. willing to spend on health care for our older citizens? And don't forget the troubling fact that almost 40 million Americans are uninsured. In 2000, total health care spending was $1.3 trillion, about 13% of the gross domestic product (6). Is this too much or too little? As a society, we have yet to decide. Meanwhile, research and development continue to produce new and effective ways to help cardiac patients get well and stay well. But creating new knowledge and translating it into practice is expensive. Our leaders will continue to face many tough choices. The ACC is working hard to inform the debate.

To amplify our voice, the College recently helped create the Coalition for Fair Medicare Payment, made up of 13 medical societies whose members were most affected by the latest round of Medicare cuts. The coalition hired a prominent Washington lobbying firm (led by former Senators Bob Dole and George Mitchell) to promote legislation that would ensure a more rational approach to determining annual physician payments—one that reflects the actual cost of practicing medicine.

Although partnerships and lobbyists are helpful, nothing influences lawmakers and legislation more than a concerted and consistent grassroots campaign. The ACC, with 25,000 domestic members who care for millions of older Americans, has enormous potential to draw attention to the Medicare mess that threatens our senior citizens. I say potential because it will take active member involvement to transform rhetoric into reality. To catalyze and sustain the effort, the College will continue to provide up-to-date information and useful tools to help cardiovascular specialists become informed advocates. Visit www.acc.org today and click on the icon that reads "Fight Medicare Fee Cuts!" This special resource and the entire advocacy section on the ACC web site contains a wealth of current information and useful links to other sites.

Effective advocacy depends on accurate information, influential allies, adequate access, and optimal timing. In Washington, it takes a critical mass of constituent concern to catalyze change. To begin with, tell your elected representatives how these unrelenting Medicare cuts have and will affect your practice and your patients. Personal stories are compelling. As this message resonates, it will hopefully create a wave of support for legislation to fix the current system. We need a more rational approach to determining annual fee updates—one that acknowledges the increasing costs of providing quality care to older Americans.

When the time is right, the ACC advocacy division at Heart House will contact you by e-mail or fax to ask you to contact your elected representatives in Washington to urge them to support a specific piece of legislation. The voices of thousands of physician-constituents—in unison and at the right time—will help convince Congress to act. But don't wait until then to get informed and get involved. If you do, it may well be too late.

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