In the days of bow-and-arrow warfare, the most effective target for an arrow was the heart. The federal government recently revived that concept by targeting cardiovascular care for payment cuts that ultimately will become fatal to the practice of cardiology. In 42 years of practice, I have not witnessed such disdain as our own government expresses for cardiologists, nor have I witnessed such animosity among medical specialties.

The disdain seems to come from concerns about cost. The government blames cardiologists for overuse and driving excess cost in health care. However, cardiovascular disease constitutes more than 40% of Medicare costs. What our legislators forget is that cardiovascular disease is the greatest cause of hospital admissions in the country, the highest cause for mortality, and the disorder that has seen the most improvement in survival over the past 30 years (with nearly 30% mortality reduction since 1995) (1). The reduction in mortality is not by chance. We have significantly improved outcome through a combination of robust treatment and prevention programs to lower cardiovascular risk, and through interventions like coronary artery bypass grafts, percutaneous coronary interventions, implantable cardioverter-defibrillators, pacemakers, new heart valves, and so on. We created thrombolytic therapy for acute myocardial infarction, the door-to-balloon emergency percutaneous coronary intervention concept that has saved innumerable lives (2), implantable cardioverter-defibrillator and cardiac resynchronization therapy for end-stage heart failure, and many other new therapies that have kept patients alive with a high quality of life for many years beyond prior life expectancies. We have been pioneers in developing evidence-based guidelines and performance measures to provide the best quality care for our patients. None of this therapy comes without a cost, and in terms of the benefit measured in quality-adjusted life-years, all of these therapies have been accepted by medicine and society as being cost-effective. Eliminating this level of cardiology care may reduce the cost of health care in the short term, but at the risk of greater mortality and less innovation. The end result may, in fact, be an increase in cost as many of the office-based imaging procedures are moved into a hospital setting with often more than double the cost.

The most egregious effort at damaging cardiology comes from recent decisions by the Centers for Medicare and Medicaid Services (CMS) to accept without question spurious data from the American Medical Association Physician Practice Information Survey (3). Based on this data, the CMS 2010 Physician Fee Schedule would reduce cardiology reimbursement to levels that would destroy most private practices. Medicare leads this effort, but private insurers will follow when they see an opportunity to increase profits. Indeed, this is already happening in some areas of the country where insurers are harassing cardiologists to the point that it is impossible to obtain “permission” to perform needed studies for good care. The insult is compounded by the requirement for a physician to converse about the complexities of care with insurance representatives whose lack of expertise can delay effective care.

The American Medical Association survey data showed that cardiology practices have experienced a significant reduction in practice expense over the past 5 years, when in fact...
several surveys (4) have demonstrated a 4% to 5% annual increase. It is clear that the survey data was flawed. Only one-third of the submitted surveys were acceptable for data analysis, and although we cannot review the surveys, it appears that some of the practices that responded may not have been representative of most private cardiology practices, as it is hard to believe 20% of cardiology practices do not employ nurses (3). During the survey process, we were not permitted to provide explanations of the survey’s structure to our members, but it is apparent that other societies managed to provide some guidance to their members. The CMS accepted the survey data and did not question it, thus fostering their agenda of redistribution of funds to increase support for primary care. This is clearly the administration’s agenda. The survey data, however, also provide considerable increases in reimbursement for dermatology, ophthalmology, and anesthesia—clearly not the primary care practices in need of revenue.

Responses
The task ahead of us is to inject reality into the practice expense information so that proper allocations of cost can be made. We support increased reimbursement for primary care, but to reward primary care by eliminating private practice of cardiology is the wrong methodology, particularly when both the House and Senate health care reform bills contain 5% to 10% increases for primary care.

Our approach is multipronged. First, we are demonstrating the distinct value of cardiology care. This is an essential concept, as primary care physicians alone cannot accommodate the increase in the elderly population with their high incidence of heart disease. Prevention of cardiovascular disease has been a major focus of cardiology practice for many years and will continue to be one of the prime goals of cardiologists. While prevention is espoused by primary care for lowering costs, it will take many years to show a benefit. Many economists believe that prevention will not lower the cost of health care (5)—patients live longer and need more care. The benefit is in longevity and quality of life, not in cost.

Second, we are aggressively working to have the CMS delay implementation of the rule for 2010 until proper survey data can be obtained. The response to our efforts to date has been a decision by the CMS to spread the reduction over 4 years so that the full impact of the cost shift will not be felt immediately. This delays the failure of cardiology practices by a few years, but the end result is still the same. The CMS also implemented a very large cut in reimbursement for nuclear imaging. This was based on a revision of nuclear imaging codes, and the claim that they therefore represent a new procedure. Phase-ins apply only to existing codes, as they are intended to reduce the year-to-year variation in payments for services, and new services neither have established payment nor are they widespread enough to have a significant impact on physician practices. Thus, the CMS did not apply the 4-year phase-in to nuclear imaging under its new code, resulting in a major 36% hit for this service in 2010. This clearly is a thinly veiled attempt to further cut cardiology reimbursement. Does anyone in the CMS believe that single-photon emission computed tomography imaging began in 2009? It was performed on Medicare beneficiaries more than 3 million times in 2007 (6).

Third, we are taking our case to Congress. The CMS makes policy based on congressional mandates. We only achieved the 4-year phase-in through an unprecedented grassroots advocacy effort by American College of Cardiology members to encourage more than 120 members of Congress to write letters to CMS, urging them to reconsider the proposed cuts to cardiology. The ultimate solution is to produce legislation that will force the CMS to provide transparency and appropriate oversight and use truly statistically significant and powered, valid, realistic, precise, and reproducible data.

Finally, if all else fails, we will consider legal action to block the flawed data from harming the public and prevent the rule from being implemented this year. While such an avenue is long, arduous, and expensive, with an uncertain outcome, we owe it to our members and their patients to try.

The plans are set. All of these activities require funding, so this is the time to become politically active by contributing to the American College of Cardiology political action committee. What is at stake is not only the survival of the private practice of cardiology, but also the incredible gains we have achieved in the battle against heart disease. What is at stake is the delivery of office care and accessibility of needed studies. What is at risk is the prevention of long hospital queues for patients for an echocardiogram or single-photon emission computed tomography study. An investment now will have a tremendous impact on our success. We can demonstrate our commitment to lowering cost by following appropriate use criteria to avoid overutilization, and by using guideline-based care and performance measures to improve outcomes and efficiency.

We have done our job by improving cardiovascular care and reducing mortality. Now is the time to defend our accomplishments, our practices, and our patients.

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REFERENCES


