

Practice Viability Threatened by Proposed Large-Scale Medicare Payment Cuts

By Vincent Bufalino, M.D., F.A.C.C.

By now everyone should be aware that the Centers for Medicare and Medicaid Services (CMS) has released a proposed rule for the 2010 Medicare Physician Fee Schedule that includes policies representing a grave threat to the ongoing viability of many cardiology practices. The good news is that the policies are subject to revision. However, achieving the positive changes will require not only the careful technical analysis and arguments we routinely apply to regulatory proposals, but also political pressure from each and every ACC member.

The following is an overview of the major provisions in the rule that affect the practice of cardiology.

Serious Impact on Patients

Practice Expense vs Payment

CMS has proposed incorporating the results of the American Medical Association's (AMA) Physician Practice Information Survey into its formula for calculating practice expense relative value units (RVUs). This proposed change would result in a 10 percent decrease in Medicare payments for the average cardiology practice and a 10 percent to 42 percent decrease in payments for many common cardiology services. While absolutely no one is untouched by the cuts, the devastating cuts proposed for echocardiography and nuclear cardiology procedures are by far the most problematic. A few key examples:

- Transthoracic echo with spectral and color flow Doppler (93306): **42 percent cut**
- Left heart catheterization (93510-26): **24 percent cut**
- EKG: **21 percent cut**

The ACC is fighting back regarding the validity of the AMA data, which showed a substantial drop in practice expense per hour for cardiology and a substantial increase in practice expense per hour for most other specialties. While the ACC contributed financially to the AMA survey and made great efforts to encourage members to participate, the practice expense per hour data that CMS

proposes to use is based on the responses of only 55 physicians. CMS did not review the new AMA data to determine if it passed the same precision tests required of past surveys.

To date, ACC leaders and staff have met extensively with CMS staff, the Obama Administration and members of

Cuts as massive as the ones proposed by CMS will have an enormous effect on the practice of cardiology — and not just on the practices. Patients will feel the effects also. While CMS may not have intended to reduce access to much-needed cardiovascular services, reduced access will happen if these cuts go through. Here's what the cuts could mean for patients —

1. REDUCED ACCESS. Practices won't be able to afford to provide certain services to patients, and patients will have to go to the hospital to receive necessary care. This will require more time off work for additional office visits and higher co-pays. In addition, the nearest hospital could be hours away for patients in more rural or low-access areas.

2. STAFF LAY-OFFS. With drastically reduced incomes, cardiology practices are going to have difficulty maintaining current staffing levels. This will have negative effects on the customer service offered to patients, as offices try to do more with less. In my practice alone, we would have to stop hiring new physicians and begin shrinking our staff base in order to remain fiscally sound. This would clearly affect our service and stop us from doing the free community work that we have become known for in the area.

3. REDUCED QUALITY. Rates for heart disease deaths have dropped 29 percent over the last eight years. This is because cardiologists are committed to quality. We're a leader in the creation of clinical guidelines and appropriate use criteria. Not to mention, our incredibly well-developed registries have proven to help improve patient care. Large numbers of us participate in quality improvement initiatives, and we use electronic health records at higher rates than other specialties. While we are a specialty committed to quality improvement, these activities often require a heavy administrative burden and up-front investments with minimal financial return in the short-term. Our ability to continue these efforts is threatened by our inability to afford the overhead.

Congress and will continue to do so. We also are working closely with our partner cardiovascular specialty societies and oncology in both our response to CMS and our efforts to bring political pressure to bear on the agency. On the regulatory side, ACC staff is preparing a substantive analysis and response to the CMS proposal.

Confusion with Consultations

CMS proposes to eliminate payments for consultations in order to end a long-standing debate over the definition of a consultation versus a clinically similar office or hospital visit. Under the proposed rule, services now reported with consultation codes would be reported using visit codes, and the RVUs associated with consultations would be redistributed across these visit codes. This change would result in at least a small decrease in payments, but because of the increase in payment for visits, it is unclear how much of an overall reduction would occur. The ACC is opposed to the reallocation given that it will create considerable coding confusion, while further reducing physician reimbursement. The AMA is also likely to challenge this issue, given that the CPT panel recently clarified the definition of a consultation.

Accreditation Standards for Advanced Imaging

The proposed rule would move forward with a requirement that providers of the technical component of advanced imaging (CT/MR/nuclear) be certified by certain designated organizations. Under the rule, organizations would

continued on next page

Wanted: Strength in Numbers

The ACC has launched a massive campaign to stop the CMS cuts. Every single ACC member is encouraged to make use of the tools outlined below:

1. Call, e-mail or visit with your lawmakers to point out the serious consequences of the proposed rule. The ACC has talking points, patient materials and a sample letter available on www.acc.org/can. Advocacy staff can help you schedule appointments with your lawmakers, which will be especially effective if you visit during the August recess when they are back in their districts. For more information contact jbeland@acc.org or mnichels@acc.org.

2. Attend this year's Legislative Conference, Sept. 13 – 15, in Washington, D.C. Don't miss this opportunity to help educate Congress about the effects of these cuts and the need for overarching health reform. Go to www.acc.org for more information.

3. Take part in the ACC's "Cut the Cuts Roadshow." The ACC has developed a PowerPoint presentation about the cuts and ways to get involved that can be shared with your practice and/or hospital. In addition, a video presentation featuring ACC's presidential team is also available. The video focuses on the cuts and the need for overarching health reform done the right way. E-mail qualityfirst@acc.org for more information.

4. Give to the ACC Political Action Committee if you have not already done so. For more information on the PAC, visit www.accpacweb.org.



Payment Cuts

continued from page 3

be requested to nominate themselves in 2009, with accreditation to begin in 2012. The ACC continues to work with CMS on defining these regulations, which are based on legislation that the College strongly supported last year. (See also page 25 for information about the Intersocietal Accreditation Commission.)

Changes to Equipment Use Formula

CMS proposes adopting the Medicare Payment Advisory Commission's (MedPAC) recommendation to change the agency's formula for calculating the per-procedure cost of medical equipment worth more than \$1 million. The proposal would assume that all equipment with an acquisition cost greater than \$1 million is used 90 percent of the time that an office is open, thus driving down the practice expense RVUs for services using that equipment. Within cardiology, cardiac MR, cardiac CT and non-hospital cardiac catheterization services would see payment cuts as a result of this change.

Malpractice RVUs

CMS proposes to update the malpractice RVUs with data from a new survey of specialty-level malpractice premiums. In addition, CMS has proposed a new method for determining malpractice RVUs for technical component services. The proposed new malpractice RVUs would reduce cardiology payments by 1 percent.

Good-bye to SGR?

As required by law, CMS proposes to implement a 21.5 percent reduction in the conversion factor as a result of the flawed Sustainable Growth Rate (SGR) formula. The ACC continues to work with Congress to stop these cuts and find a long-term solution for the SGR. On a more positive note, CMS does propose eliminating retroactively the inclusion of physician-administered drugs in the SGR calculation. While this does not impact payments this year, it significantly reduces the accumulated debt and reduces the cost of Congressional reform of this issue. The ACC has long supported the removal of drugs from the calculation.

Some Positive News for e-Prescribers

In a bit of positive news, CMS has proposed simplifying the electronic prescribing (e-prescribing) incentive program to encourage greater participation. The agency has proposed giving successful e-prescribers bonuses equal to 2 percent of total estimated allowed charges for all covered Medicare services provided in 2010. Physicians would report only one code (G8443) at least 25

Alfred A. Bove, M.D., Ph.D., F.A.C.C.
President

Ralph G. Brindis, M.D., M.P.H., F.A.C.C.
President-Elect

David R. Holmes Jr., M.D., F.A.C.C.
Vice President

John G. Harold, M.D., F.A.C.C.
Secretary

Richard A. Chazal, M.D., F.A.C.C.
Treasurer

Aaron Kugelmass, M.D., F.A.C.C.
Marc Shelton, M.D., F.A.C.C.
Mary Norine Walsh, M.D., F.A.C.C.
W. Douglas Weaver, M.D., M.A.C.C.
Medical Advisers

Publisher
John C. (Jack) Lewin, M.D., CEO

Executive Editor
Alicia Sokol

Editor
Anne Dees

Associate Editors
Shalen Fairbanks
Autumn Strass
Peggy Tresky
Emily Zeigenfuse

Design
Tony Ciccolella

Director, Creative and Branding
Morgan Bramlet

Advertising Manager
Keith Dillon

Cardiology
is published monthly by the
American College of Cardiology,
2400 N Street NW
Washington, DC 20037-1153.

Telephone: (800) 992-7224
or (202) 375-6000

Fax: (202) 375-7000

E-mail: cardiologyeditor@acc.org

Web site: www.acc.org

To subscribe or report a change of address,
call (800) 253-4636, ext. 5603,
or e-mail resource@acc.org

All contents ©2009,
American College of Cardiology.

Send correspondence and letters to the
editor to cardiologyeditor@acc.org.

Opinions expressed in *Cardiology* are those
of the identified authors and do not necessarily
reflect the opinions or policies of the
American College of Cardiology.

Also, paid advertisements do not reflect an
endorsement of a product or program by the
ACC. All advertisements are subject to review
and approval by the ACC. The ACC reserves
the right to decline, withdraw or modify
advertisements at its discretion.

For questions regarding advertising in
Cardiology please contact:

For Display Advertising
Pharmaceutical Media, Inc., 30 East 33rd St.,
New York, N.Y. 10016-5337; Tim Wolfinger,
(212) 904-0379, twolfiner@pminy.com and
Gina Bennicasa, (212) 904-0362,
gbennicasa@pminy.com.

For Classified Advertising
Ariel Medina, Elsevier, 360 Park Ave. South,
New York, NY 10010-1710;
Direct: (212) 633-3689;
Fax: (212) 633-3850;
a.medina@elsevier.com

times during the year, indicating at least one prescription was generated for that office visit. In addition, data could be submitted through claims, a qualified registry or qualified electronic health record (EHR) system. CMS proposes to report publicly the names of successful e-prescribers in 2011 after the 2010 payments are made.

Additionally, CMS is offering group practices the option to participate in a combined incentive program that includes both the e-prescribing and the Physician Quality Reporting Initiative (PQRI). Interested group practices would be required to

However, in an effort to move physicians away from claims-based reporting and towards registry and EHR-based reporting, many of the new measures, some of the old measures and both new cardiology measures groups could only be reported through a registry. While the cardiology measures groups were recommended by ACC, it was not anticipated that so many measures would be registry-only. As the PQRI program moves towards a registry or EHR model, the ACC is working to determine where its IC3 Program® and other tools best fit in the PQRI reporting world for

...the time has come for every ACC member to become an activist on these issues. It is critical that Congress and the administration hear first-hand from ACC members, their support staff and patients about the impact of these cuts.

submit a self-nomination letter to CMS that includes how the practice will report data (whether through claims, registry or EHRs). Under this proposal, the group practice would need to report at least one electronic prescription for at least 2,500 patient visits. However, individual physicians could not report data separately to earn bonus payments.

PQRI Update

The proposed rule includes a number of new cardiology measures for Physicians Quality Reporting Initiative (PQRI). In addition, the agency has proposed creating two new measures groups for cardiology — one for heart failure and one for coronary artery disease. These measures would allow physicians to report on 30 patients rather than 80 percent of cases throughout the year and the 30 patients would no longer need to be consecutive.

practicing cardiologists.

The ACC leadership and staff are working hard to resolve many of issues with the CMS proposed rule. However, the time has come for every ACC member to become an activist on these issues. It is critical that Congress and the administration hear first-hand from ACC members, their support staff and patients about the impact of these cuts. Every member is being encouraged to phone, e-mail or personally visit his or her legislators to point out the serious consequences of the proposed rule. Patient materials and sample letters are available at www.acc.org/can.

You can help shape your future in health care, but only if you participate in the dialogue.

Bufalino is co-chair of the ACC Advocacy Committee

