

VIEWPOINT AND COMMENTARY

The Practice of Cardiology and Healthcare Reform

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As reimbursement policies and healthcare reform legislation add pressure onto the independent practice of cardiology, many cardiology groups seek refuge in hospital employment. This has implications for healthcare costs and the future of the practice of cardiology, especially in the age of accountable care organizations. (J Am Coll Cardiol 2011;57:000-0) © 2011 by the American College of Cardiology Foundation

The private practice of cardiology has been under assault since well before the Affordable Care Act (ACA) was signed into law in March 2010 (1,2). White House healthcare advisors recently described the administration's vision of the practice of medicine in the era of the ACA in the *Annals of Internal Medicine* (3). While itemizing the desirable objectives of the ACA, they drew a road map for physician survival that excludes anything other than organization into a large group or hospital employment. They called this *vertical organization*.

Since 2007, the Centers for Medicare and Medicaid Services (CMS) has systematically reduced Medicare allowable fees for outpatient cardiovascular imaging performed in a physician's office. From 2007 to 2010 in Tennessee, CMS has reduced office-based myocardial perfusion imaging fees by 23% and echocardiographic fees by 31% (4). The elimination of Medicare's reimbursement for consultation codes in 2010 has inflicted further financial harm to cardiology. Meanwhile, CMS has increased reimbursements for hospital-based outpatient myocardial perfusion imaging by 31% and echocardiographic imaging fees by 22% during the same interval (4), and thus has created a large disparity in payments for identical services performed in different venues (Tennessee 2010 Medicare allowable fees for echocardiography global [93306] in office \$231.42, and in hospital \$495.29; myocardial perfusion imaging [78452] in office \$417.98, and in hospital \$809.75 [4]). The resulting economic stress on private cardiology practices has caused them to run for the shelter of hospital employment in droves. So, hospitals have not only been immune from these fee reductions but see an opportunity for revenue increase by the purchase of cardiology groups and redirection of previously lost imaging studies back to the hospital at increased reimbursement levels.

Remarkably, it has been the large cardiology groups that have been most sensitive to this economic stress while smaller groups have continued to thrive, albeit by implementing austere cost-containment strategies. This observation casts doubt upon the truth of "economy of scale," but also reveals a paradox about the economics of this movement. When physician groups are purchased by hospitals, the imaging studies ordered by the newly employed physicians will be performed by the hospital and reimbursed at higher fees than had been reimbursed previously. Unless there is a large-scale reduction in the number of studies performed (is there really that much savings to be had by redefining the self-referral incentive from group employment to hospital employment?), the cost to the healthcare system of these imaging studies will increase. Therefore, it would seem that CMS's reimbursement policies and the incentives introduced by the ACA have the potential to transform the practice of cardiology from a low-cost cottage industry into a higher-cost, but vertically organized, big business.

The push toward hospital employment raises an even more important concern. Having practiced interventional cardiology for two decades, I have been fortunate to participate in the introduction of numerous new technologies that represented proven advances in patient care, such as coronary and peripheral vascular stenting, rotational ablation, carotid stenting, abdominal aortic aneurysm stent grafting, and drug-eluting stenting. Without exception, each of these new technologies has resulted in increased costs to the hospital, and without exception, each has been met with resistance from hospital administrators. On one occasion, a hospital administrator naively but honestly reported that the administration opposed the adoption of rotational ablation simply because it would "increase their costs." On another, the administration of a not-for-profit community hospital decided it would save money in the late 1990s by forcing all invasive cardiology procedures to use Renografin (Bracco Diagnostics Inc., Princeton, New Jersey) rather than a more expensive nonionic and lower osmolality contrast agent.

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**Abbreviations
and Acronyms**

ACA = Affordable Care Act

CMS = Centers for
Medicare and Medicaid
Services

Only after an epidemic of life-threatening arrhythmias in the catheterization laboratory did the administration relent and allow cardiologists to use their choice of contrast agents. On yet another occasion, and years before the existence of any legitimate

controversy about the safety of drug-eluting stents, the chief executive officer of a for-profit hospital distributed a corporate office-generated white paper to all cardiologists titled “Drug Eluding [sic] Stents,” wherein grave concerns about their efficacy were raised in stark financial terms.

Hospital administrators must be concerned with their costs. That is their fiduciary duty. However, it is one thing to be concerned about institutional costs and another to be concerned about global healthcare costs. One determines hospital profitability and the other healthcare system sustainability. We should not confuse decreasing hospital costs with savings to the healthcare system.

If hospital administrators appropriately protect the profitability of the hospital, who will protect the medical interest of the patient when the two are in conflict? That has been, and must remain, the responsibility of the physician. That is his or her fiduciary duty. When hospital and physician are separate economic entities, there is some balance of authority. When there is employment and consequent loss of autonomy, will the physician be able to champion the patient’s interest effectively?

I agree with the Obama administration’s view that reform of the healthcare system is not optional—it is mandatory. The United States cannot compete in a global economy while it spends 16% of its gross domestic product on health care with vast numbers of uninsured citizens, compared with other industrialized countries that spend an average of 9% of gross domestic product (5) with virtually no uninsured citizens. Therefore, I have been a wary supporter of the administration’s healthcare reform efforts, a lonely position among physicians in the South. However, as CMS reimbursement policies dictate, and as White House officials

articulate the intent of the ACA, and thus the two give shape to the practice of medicine for the future, I am left wondering: Why should vertical organization be a synonym for hospital employment? Does hospital employment really translate into healthcare cost savings? Should small but efficiently operated cardiology practices be discouraged from forming ad hoc relationships with hospitals into accountable care organizations? Or, would not independent provider associations provide the same vehicle to accomplish the laudable objectives of the ACA such as integration of care, data sharing, and efficiency? Yet, to date, the Federal Trade Commission has considered independent provider associations guilty of violating antitrust laws. Must our healthcare system recognize only one model of delivery, that of hospital employment? Without expanding the definition of vertical organization, the days of the independent cardiologist are limited. Thus, the voice advocating for the patient becomes weaker, whereas cost savings are far from assured.

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