Can Costs Be Contained? Ask the Doctor

I was asked to give a keynote lecture at the recent Cardiovascular Research Technologies (CRT) meeting in Washington, DC, and the assigned title was, “What does the future hold for interventional cardiology?” This seemed a rather easy assignment, since a host of new technologies are headed our way, especially in structural heart disease. But then I read on and saw that my subtitle was, “Appropriateness, guidelines, credentialing, and reimbursement.” Okay, the first two were not a great challenge, as the American College of Cardiology (ACC) guideline process has tried to go into high gear and the appropriateness emphasis is now center stage for our catheterization laboratories (1). Credentialing presented a bit more of a problem, as the rapidly expanding technology demands training and activity to maintain competence, and all procedures are not going to be performed by all operators. So, how extensive should the experience be for each procedure, and how do hospitals allow procedures to go forward in the best hands without unduly restricting practice. That one, indeed, was tougher. The last point, however, was a killer. What is going to go on with reimbursement? Everyone is worried. The doctors and the hospitals are circling the wagons in order to be indispensible and therefore able to negotiate the best contracts with managed care. The Centers for Medicare and Medicaid Services (CMS) rules are changing so that in 2011, all codes for catheterization have been collapsed into one, and some would contend that the reimbursement has been collapsed as well. Coming soon is the International Classification of Diseases (ICD)-10 coding process. Here, the 24,000 codes are being expanded to 140,000 codes, and if the correct documentation for the specific code is not provided, the reimbursement will not be either. It is anticipated that there will be an increased demand for ICD-10–educated coders, and the pressure to increase their pay will be great. Some of my physician colleagues have asked how one applies for a job as a coder. I have no real insight into the future of reimbursement or how effective our efforts to maximize it will be. But, I cannot help hearing daily that federal, state, and municipal budgets are deeply in the red and that the private economy continues to struggle. We hear pronouncements of how to slash spending on discretionary items, such as education, police, firefighters, research, and other “unnecessary items,” but then we are told that there is really not enough money there to solve the deficit. Of course we can raise taxes, an approach we will eventually accept but not as long as we can deny that it will help. No, in order to reduce the deficit, the pundits tell us that the three buckets with the most money in them must be looked at. They are: social security, the military, and health care.

So, where will the cuts come from? For this deliberation I will consider that the United States is a democracy of sorts and, therefore, the voters may have a say. Since most voters are getting social security or are paying into it and plan to get it, few will support doing anything about it, even though the old age 70 is the new 65. What about the military? Some cuts will occur, but Eisenhower’s admonition to watch out for the military industrial complex has been ignored for all of these years, and until we get some other countries to sign on as the world’s police force, there seems to be little voter support for severely slashing here. As for health care, however, most voters are not sick and many of the younger ones do not plan to get sick and, in fact, object to paying for others who get sick (even if those sick people might make them sick). It is very likely that healthcare expenditure will not continue its historic climb. Advocacy efforts to increase reimbursement will have a hard time succeeding, regardless of legislative outcome of healthcare reform. If less is to be spent, where will the savings come from? Much
of it will come from hospitals and physicians, and despite the fact that these two classes of providers have had different business interests in the past, the rush to employment models has put them in the same boat. Is it time for the physicians to play a greater role in planning how to provide more effective health care at less cost? Should all of this be left to healthcare economists?

These thoughts were in my mind when I was participating in a Food and Drug Administration think tank on a new study of radial versus femoral approaches to catheterization in percutaneous coronary intervention (PCI) in women. The trial is very interesting since it uses the ACC’s National Cardiovascular Data Registry as the entry port for a randomized trial. Dr. David Cohen, in discussing the economic analyses in the trial, pointed out that the impacts are viewed very differently by the physician, the hospital, the payer, and the patient. It occurred to me that by concentrating on reimbursement, we leave the field of cost reduction to others. Who knows better how to provide safe and effective care at a reduced cost than the physician? Radial access may result in lower complications and lower costs, but is that the end of the story? Since the majority of catheterizations and PCIs are done by the femoral approach, should we also concentrate on other aspects of procedures that might reduce costs and complications, including equipment and ancillary medications, and take a careful look at the appropriateness of performing the procedure?

The reality that societal costs of health care cannot continue to go up may mean that there will be measures taken to hold them down. Everyone looking at the problem has his or her own agenda. The payers will reduce reimbursement. The hospitals and doctors have been viewing reimbursement and costs from different perspectives, but now the incentive will be to get them on the same team. The welfare of the patient must remain our primary goal, but physicians should play a major role in developing methods to contain costs. If we do not do it, it will be done to us.

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