

HEART OF THE MATTER

Dodging the Bullet

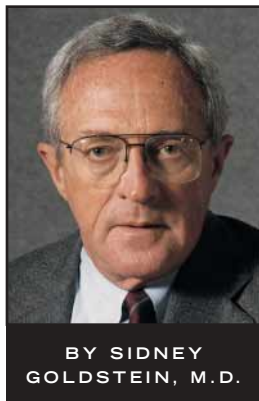
The forces that control health expenditure are progressively and irrevocably moving in a direction that makes Medicare administrators increasingly uneasy.

The spread between planned growth and real growth in health care costs continues to expand, leading to the need to squeeze Medicare payments to doctors and hospitals. A starry-eyed Congress passed legislation a decade ago that proposed that payments to doctors and hospitals would level off and in fact decrease over time.

Through the sustainable growth rate established in the law, the spending limits would be controlled by the rate of overall economic growth. Instead, even with the small increases in physician fees that have occurred in the last decade, the Medicare expenditures have far exceeded the proposed doctors' payments. At the same time, the development of new technology and devices has led to large increases in hospital costs.

The most recent attempts at limiting hospital expenditures proposed draconian cuts in payments to hospitals for a number of cardiac procedures, including implantation of implantable cardioverter de-

fibrillators and coronary drug-eluting stents of 24% and 33%, respectively. But, as reported in this issue of *CARDIOLOGY NEWS*, ("Inpatient Cuts Far Less Severe Under Final CMS Rule," p. 1) these cuts have been pulled back, awaiting a new payment system that will be based on hospital costs rather than charges.



BY SIDNEY GOLDSTEIN, M.D.

In the planning phase is a hospital payments system, in which the current diagnosis-related groups (DRGs) will be adjusted to patient characteristics and disease severity, rather than the current system where payments are the same regardless of severity and are based upon

diagnosis alone.

This payment system may eventually make reimbursements more equitable for the general hospital and specialty hospitals, since those specialty centers appear to have more stable and less severely ill patients.

The proposed changes are not intended to decrease the \$125 billion paid out by Medicare to 5,000 hospitals annually, but to redistribute those payments. The initiation of the new DRG is expected in the next year. The delay in the implementation of the programs has been a result of intense lobbying by device and hospital

representatives who have a large stake in this issue. Payment schedules initiated by Medicare will have a significant influence on private insurers and Medicaid.

The other issue is the continuing battle over physician payments. The current proposal by CMS is to decrease physician fees by 5.1% ("Medicare Proposes 5.1% Physician Pay Cut in 2007," p. 6). This, in addition to other mandated cuts, will result in an approximately 7% decrease in payments to cardiologists. Many physicians indicate that they will not accept Medicare patients in the future. Cardiologists have little choice in the matter since most of our patients are well within the Medicare age span. We will have little option in this regard.

These reimbursement changes could have a widespread effect on the availability of health care to the Medicare patients if physicians continue to limit the number of Medicare patients they treat in their practice.

In addition, the changes in hospital costs could have a major effect on the viability of many hospitals, large and small alike, and increase the competition among hospitals. The largesse of the cardiology profit center in the general hospital is spread across many other specialties that could also suffer.

Cardiology centers have also promoted growth of many community hospitals. Witness the media-advertising blitzes of

many hospitals to attract cardiology patients. All of this could change if the Medicare redistribution of payments is actually carried out. The changes will face major opposition by the hospital and device industry before they can be implemented. ■

DR. GOLDSTEIN, *medical editor of CARDIOLOGY NEWS, is professor of medicine at Wayne State University and division head, emeritus, of cardiovascular medicine at Henry Ford Hospital, Detroit.*

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