

Medicare cardiology cuts of 31-48 percent since 2005 will increase costs, restrict patient access to care

Echo procedure reimbursement: down 48 percent. Stress echo: a 31.5-percent reduction. Nuclear testing: cut 37 percent. From 2005-2011, these drastic Medicare payment cuts for critical cardiology diagnostic tests have forced private Cardiology practices to lay off staff, close offices, shorten hours and reduce other services that patients desperately need. There are more cuts on the way as Medicare phases in additional reductions by 2013 for certain tests. This does not include the cuts by third-party payers, which set their reimbursement rates as a percentage of Medicare's.

The reimbursement reductions also have changed how Cardiology care is provided: almost half of all private practice cardiology groups are expected to be sold to hospital systems by the end of 2011 as a result of the financial pressures that independent cardiologists have faced since 2005. Yet cardiologists are needed now more than ever: more than 40 percent of the U.S. population will have some form of cardiovascular disease by 2030, and the cost of treating them will triple, according to a 2011 study by the American Heart Association.

The Cardiology Advocacy Alliance is concerned about the future of Cardiology as a specialty in the years to come, and how reimbursement cuts will affect both Medicare and its beneficiaries:

HIGHER COSTS FOR MEDICARE: A large percentage of private practices have recently/will be selling to their local hospitals. These integrations mean that Medicare will pay much more for the same test in the outpatient hospital setting as in the independent cardiologist's office.

HIGHER OUT-OF-POCKET COSTS FOR BENEFICIARIES: Patients, especially those in rural and inner city areas or those subject to physician/hospital integrations, will be directed to the hospital setting for diagnostic tests. This will increase their co-pays SIGNIFICANTLY since the hospital setting is twice as expensive—or even higher—than the physician office setting, and beneficiaries pay 20 percent of the fee.

PATIENTS NOT GETTING THE CARE THEY NEED: Closure of rural offices will mean that many patients will have to travel great distances and make multiple office and hospital visits, which will delay timely diagnosis. Some patients simply will not make the effort until their situation becomes desperate. Heart disease is among America's top killers, and although great strides have been made in reducing death and complications from cardiac disease, the constant cuts threaten the advances that have saved hundreds of thousands of lives.

CAA asks Congress to be alert to the crisis facing the Cardiology community and convey the concerns of heart patients and cardiologists to House and Senate Leadership. Further Medicare cuts to cardiology will have real and immediate repercussions for patient access to cardiac care, and will increase costs for Medicare and its beneficiaries.

READ ON FOR EXAMPLES OF HOW THE CARDIOLOGY CUTS HAVE AFFECTED PATIENTS, HEALTH-CARE WORKERS AND SMALL-BUSINESS PRACTICES NATIONWIDE. *(continued on reverse)*



CAA's mission is to support the sustainability of the cardiovascular professional regardless of practice setting. CAA educates the cardiovascular community about regulatory and legislative issues that affect its ability to provide all services necessary for high-quality cardiac care. CAA represents the common interests of the cardiovascular patient and professional on such issues and encourages its members to advocate for their patients and their practices.

From the front lines: practice administrators discuss the consequences of reimbursement cuts to patients, workforce

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ALABAMA “We have reduced all part-time help. We currently have an open nuclear position that we are trying not to fill. We have cut back hours of non-clinical staff by 7 percent. We eliminated three positions and did not replace three others prior to the end of 2009. We have budgeted for a significant reduction in physician salary.”

ARIZONA “We are in the midst of layoffs. Phase I will have 10% cuts of staff with a reduction of staff work weeks to 36 hours. Patients will wait longer for their appointments and the availability of same day appointments probably will be limited. Quality is a concern – more patients will be directed to the hospital where there are longer waits and delayed care, with higher patient co-pays. We are also starting to charge patients for non-clinical services that we used to do for free – thus passing more costs to the patients. Phase II will be more staff layoffs and potential closing of our rural practices. It is very concerning and it keeps me up at night worrying not only about the practice survival, but also how these layoffs will contribute to an economy that is already malnourished.”

ARKANSAS “We have discontinued mobile nuclear and ultrasound services to 11 outreach clinics in our rural area. We are cutting technical staff by one echo technician and one nuclear tech in our main office, plus the mobile services staff that we leased. We have begun discussions with the local hospital regarding practice acquisition—something my physicians NEVER would have considered before the 2010 cuts.”

CALIFORNIA (Practice A) “We are closing our nuclear department on Fridays and reducing nurse-practitioner support in the office by one day a week, which will slow down patient flow.” (Practice B) “We have reduced our nuclear schedule by eight hours per week (reducing patient access to care). We have reduced staff by 10 percent, eliminated a part-time administrator assistant position and laid off three full-time employees. We also restructured employee health insurance benefits to save money.”

COLORADO “We cut staff by 11 percent –technicians, billing, and accounting. We moved some of those who remain to 36-hour weeks or mandate furloughs during low-volume periods. There will be no wage increases for 2010. We’ve torn up our five-year growth plan, admitting that all physician recruitment and the opening of another office location is not in our foreseeable future. This decision was met by much exasperation by the patients and community we’d hoped to serve with the expansion. Expense-side cuts continue with all major capital spending on hold. Vendors and folks that sell us stuff are feeling the pinch too. Worst of all, our patients are feeling the squeeze with higher fees for no-shows, letters, and much less access to staff and docs for uncompensated phone care.”

FLORIDA (Practice A) “We are not closing, but we are selling to the local hospital.” (Practice B) “We sold to our local hospital in December, 2009. A big reason was the 2010 reimbursement cuts.” (Practice C) “We have had to reduce staff by 20 percent (25 people laid off), cut remaining staff salaries by 10 percent, reduced physician salaries by 40 percent, reduced health insurance contribution to staff by \$100 per month, and had to modify equipment leases to reduce monthly payments over a longer term. We reduced schedules for nuclear tests from five to three days per week.”

GEORGIA “We eliminated eight FTEs (roughly 10 percent) of clinical, mid-level and business support staff in advance of the 2010 fee cuts. We aren’t renewing any leases for more than one or two years so that we can shutter sites that no longer are economically feasible (typically our outreach sites).”

KENTUCKY “We’ve laid off staff, cut employee hours and reduced the staff payroll by 15 percent. Physicians took a 15-percent pay cut two weeks ago.”



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MARYLAND “We reduced our total number of employees by 10 percent from last year, and will either close or downsize two offices with anticipated layoff of three to 15 additional employees. We postponed replacement (or purchase) of more than \$1.4 million in medical equipment. We postponed the hiring of three new physicians. We backed away from supporting two regional underserved hospitals, canceled the expansion of one office and canceled the opening of a new satellite office. We implemented a second year of salary freezes for staff. We moved to a high-deductible HMO healthcare plan where the employees have to pick up 30 percent of the plan and 50 percent of the in-network deductible, and reduced employee 401K contributions by 30 percent in 2009 and another 35 percent in 2010.”

MASSACHUSETTS “We eliminated 17 FTEs by layoff and cutting hours. We expect to cut eight more in the first quarter of 2010. We likely will pull back from outreach satellite offices. We had no staff merit increases in 2008 and 2009; none are anticipated in 2010. Our retirement plan was partially funded in 2008 and eliminated in its entirety in 2009.”

MINNESOTA “In 2009, we reduced our staff by 8 percent, froze wages, eliminated Continuing Medical Education funds, reduced hours at two rural clinics and mandated furloughs for all staff. In 2010, if we don’t integrate with the local hospital, we will reduce staff by another 14-18 percent; pull back from at least two other rural communities; stop physician recruitment despite growing demand (which will affect patient access); and shorten visit times to address the patient access issue, which means less face time with the patient.”

MISSOURI “We are in the process of integrating with the hospital, which includes a sell of all cardiac diagnostic services. With that sell we also will most likely stop providing cardiac and vascular ultrasound services at our satellite and outreach offices at five locations throughout rural Missouri. Many of these patients will be forced to travel anywhere from 50 to 100 miles to receive the service, since we are the only provider in the area.”

NORTH CAROLINA “We have reduced office hours by 10 percent and reduced staff size by 10 percent. Additionally, we have reduced the number of mid-level providers we use by 1.5 FTEs and decided to not re-hire a physician. We have drastically reduced all benefits, reduced retirement contributions and virtually eliminated raises. The group health insurance deductibles have increased three-fold. In 2010, we will likely close our satellite clinics in our outreach areas, reduce mid-level providers by another FTE, not replace another physician ready to retire in a couple of years, eliminate 100 percent of charity work and charitable contributions to the community, and reduce both our workforce and office hours by another 10 percent.”

NEW JERSEY (Practice A) “We halted the upgrading of all equipment and as leases expire and machines fail, we will evaluate the need to keep services. We reduced our billing/support/nursing staff by close to 10 percent. We have initiated integration discussions with our local hospital. We have stopped physician recruitment, even though 10 of my 25 physicians are over the age of 50. We just cannot afford to add a new physician.” (Practice B) “Our practice has had an electronic medical record for 10 years. We got no reward for helping lower medical costs through this innovation. We have a clinic for patients with congestive heart failure and have reduced hospitalizations for these patients by 65 percent, saving thousands of dollars. We got no reward for helping lower medical costs for this either. Instead, we have had to reduce all salaries by 9 percent due to the 2010 fee schedule cuts.”

NEW MEXICO “Our 40-year history of independence and physician-led healthcare is on the line. We elected not to hire an excellent electrophysiologist even though there are only 11 electrophysiologists in New Mexico for 2.4 million people. New patient appointments have been pushed out. More urgent cases are seen in the higher-cost Emergency Department versus the lower-cost office setting. We are not replacing two non-physician providers. Inpatients are not discharged as early as before. We have eliminated several professional and technical positions, and anticipate losing people with many years of experience and value to our organization. We are not staffing rural clinics at levels necessary to eliminate auto trips of up to three hours for elderly patients, frequently in bad weather. We foresee a drop-off in compliance with follow-up care for our sickest patients who are unable or unwilling to travel to our permanent offices. It is reasonable to assume they will not get their medications filled, either.”

NEW YORK “We have scaled back two employees out of eight in one office and two out of seven in another location. We have had employee attrition of 26 that we have not replaced.”

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OHIO “We are re-starting integration discussions with two local hospital systems because we are unsure if we can manage financially. In June when our leases are up on our nuclear cameras, we will shut down one lab. We have also cut hours for technicians—they are now 32 hours per week and we still reserve the right to cut their hours/call them off for low volume. If the total impact is really unmanageable, we will close one location and have only one remaining location. Last year we cut all excess staff so at this point we have a skeleton crew.”

PENNSYLVANIA “We closed an office last year and consolidated with another in the vicinity. We just moved out of the large space we rented from the hospital and consolidated into our catheterization lab suite. We have allowed attrition, moves, changes in staffing and other initiatives to decrease our total overhead over the past 12 months by more than \$1 million, and have left many positions open and have been on a general hiring freeze since last year.”

SOUTH CAROLINA (Practice A) “We have closed two offices and decreased the hours of coverage at two outreach clinics. We have eliminated 35 FTEs—18 percent of our work force.” (Practice B) “We have let 10 percent of our staff go and have reduced hours that attribute to another 10 percent of remaining staff. We have stopped traveling to two rural areas for cardiology coverage.”

TEXAS (Practice A) “We have cut all our salary staff pay by 5 percent and have gone to a 36-hour work week for hourly staff, thereby limiting times we can see patients. Physicians will take a 20-percent cut on top of the 15-percent cut they took last year and we definitely are not on the high end in terms of physician salaries.” (Practice B) “We are in the process of closing one office. Patients will need to drive 70-120 miles for their cardiac services. We are considering closing another full-time office in a rural, underserved area and have laid off approximately 10 percent of staff. We have closed our outpatient catheterization laboratory. Patients are currently scheduled as outpatients in the hospital, which has increased the patient’s deductibles and markedly increased their hassle factor. We have cut regular hours from 40 to 36.”

VIRGINIA “We are reducing staff through attrition and we are already understaffed. We will close an office which will eliminate four FTEs and we will also eliminate a nurse practitioner position in the hospital—she is non-billable but this will devastate the level of service and timeliness of care for families and patients. We have reduced our contribution to employee health premiums and for the first time ever staff will have to pay a percentage of HMO costs. We have eliminated our 401K match and did not make discretionary contributions to retirement plans for staff and physicians. All of this is happening while we are taking on a huge expense to implement Electronic Health Records. We could just go under entirely if we don’t get some relief.”

WASHINGTON (Practice A) “We have committed to, and accelerated, the pace of integration discussions. This is entirely out of concern for our economic viability due to the 2010 reimbursement reductions and increases in administrative costs due to regulation and hyper scrutiny of common diagnostic modalities by payers. When I joined this group one year ago, the commitment was to remain independent.” (Practice B) “We did not replace one of our billers and will continue to make cuts through attrition. We were planning to explore a new satellite clinic in a rural setting, but have decided this is not the time due to the 2010 PFS cuts. We have also decided to stop all recruitment efforts even though the population and need for more cardiologists is evident.” (Practice C) “We have reduced staff and nuclear office hours by 20 percent, which affects patient access to care. We are sending patients to the (higher cost) hospital instead.” (Practice D) “We haven’t replaced three physicians and a physician assistant. We have reduced patient nuclear services by 40 percent and eliminated staff in that department. We have reduced staff by 6 full-time positions, including technicians and nurses.”

Please protect patient access to cardiac care: no more Medicare cuts



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