Anthem's prenotification process includes "pre-exam questions" for all echo services, even pediatric cases, no matter the indication for the test. These questions include each patient's current blood pressure, cholesterol values, smoking status, symptoms, "other cardiac risk factors," and the principal diagnosis for the requested service. All of these questions will be asked for every requested echocardiographic service. At present, responses to these questions are not mandatory except for stress echocardiography. These data will be entered into the patient's demographic information by AIM and will be in place for future requested services. AIM's rationale for collection of such data for transthoracic and transesophageal echocardiography is to "allow documentation of patient acuity in relation to coronary artery disease." After provision of an echo service, Anthem requires that notification be then given as to whether the result was abnormal, and as to whether the test result led to alteration of the patient's treatment.

The American College of Cardiology and the American Society of Echocardiography have raised concerns with Anthem regarding the burden such notifications will place on providers of echocardiographic services, and whether such an onerous process helps achieve the laudable goals of high-quality imaging, appropriate resource utilization, and cost containment. We have also expressed our opinion that collection of the aforementioned pretest data is irrelevant in patients undergoing non–stress echocardiograms. Nevertheless, Anthem is moving forward with the program.

We need to develop alternative methods of assuring delivery of quality, appropriate echo services. I invite you to contact me if you have ideas regarding this important issue. ■

Health Care Reform: The Implications for Cardiology

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It cannot have escaped the notice of any US cardiologist that the changes being implemented in the health care reform package currently passing through Congress and, separately, through the Centers for Medicare & Medicaid Services (CMS) will cause major upheavals in our ability to offer the kind of patient care that each of us would wish for ourselves and our loved ones. Although discussing moving targets such as these is fraught with uncertainty, I would like to attempt to outline the major issues and the California Chapter of the American College of Cardiology (CA ACC) response to these issues.

The first issue: the sustainable growth rate (SGR) formula. The problem arose because actual expenses for Medicare (ie, utilization, because Medicare payments are fixed and nonnegotiable) exceeded by a significant amount that which was predicted. Planners built into the legislation formulas that would increase payments if increases in spending fell below estimates, and decrease payments if they exceeded estimates. The increases have exceeded estimates each year, and the cumulative decrease in payments currently mandated by the legislation is 21.5% for every Medicare payment to every specialty.

Adjustments have not occurred because every year Congress has passed a 1-year fix, delaying implementation. CA ACC efforts have been directed toward the permanent repeal of this formula. The current House bill repeals the formula, but the Senate bill again contains a 1-year fix. This is now a $250 billion dollar

issue, and the House bill does not offer a means to pay for it. Due to the across-the-board disruptions it would obviously cause, it seems most unlikely me that it would ever be implemented.

The second issue: The attempt by radiologists to prevent cardiologists from having advanced imaging in their offices (something that has occurred in Maryland) has been taken off the table this year, but will return. We must gear up for a long-term battle.

CMS has long wanted to bundle codes for many procedures, and currently under attack are outpatient, office-based nuclear facilities (but not hospital-owned outpatient facilities). By using their bundling formula, reimbursement will fall 36% on January 1, 2010. The consequences of this are obvious. Many of our nuclear laboratories will be forced to close because high expenses will exceed reimbursement and the movement of these procedures to hospitals will increase the price per scan radically. Perhaps CMS figures that the decrease in the number of scans due to patient inconvenience will make up for the increased charges for each scan. Major efforts by ACC leadership are endeavoring to change this decision.

The second CMS area of attack is in echo imaging, which was originally scheduled for a 30% reduction on January 1, 2010. This has changed to a 4-year phase-in at 7.5% per year. This change came only due to intense political pressure, with which we had help from more than 100 congressional representatives from both sides of the aisle. State chapters and the national ACC office are crafting strategies, including suing CMS, to prevent these changes from taking place.

Whereas the nuclear decrease can be plausibly disguised as "simplification," that is not true of other imaging cuts. These have been justified by a practice expense survey conducted by the American Medical Association that purported to show that cardiology practice expenses have decreased by 30% in the past 5 years. This is not plausible. Due to the obvious falsity of this critically important survey as it applies to cardiology, legal remedies are being explored to halt the changes. Whether we will be successful is uncertain and cardiology practices should plan accordingly.

It is clear that the next immediate threats to our ability to care for patients come not from the health care "reform" effort from Congress, but from government bureaucracies and other groups that benefit from limiting our imaging abilities. The bill recently passed by the House (#3962) leans heavily toward large increases in coverage with extensive mandates that will increase insurance costs to all Americans. It does little to reform care or payment to incent effective and value-added service. The "savings" promised in the package will come from further payment cuts to us, and increased expenses to all. Despite this difficult political environment, people ultimately will demand high-quality evidence-based care. We as cardiologists are uniquely situated to deliver this and we have a proven track record.

In the long run, quality and hard work will win out over bureaucratic obtuseness and misrepresentation. I think we have a winning hand. ■