



## The Society for Cardiovascular Angiography and Interventions

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# Rationale for ST-Elevation Myocardial Infarction Call Compensation by Healthcare Systems

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Radical changes to our nation's healthcare system will affect remuneration for both hospitals and interventional cardiologists yet these very same directives may allow for specific areas of synergy and collaboration toward the common good, for hospitals, physicians and most importantly for the patients we serve. Accordingly, the Society for Cardiovascular Angiography and Interventions (SCAI) supports a strategy of supplemental reimbursement for interventional cardiologists who participate in emergent call for patients suffering an ST-elevation myocardial infarction (STEMI).

While the practice of medicine is often considered an art, the delivery of healthcare is a business. In the

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1960s through the 1980s, these two ideologic cliffs were separated by a vast chasm, never to touch. However, for the past several decades the canyon between how medicine is practiced and how healthcare is remunerated has grown ever smaller. This started with the decision by Medicare in the late 1980s to pay hospitals based on Diagnostic Related Groupings (DRGs) rather than on a cost-per-case basis. This trend has grown since then to include outpatients (under the Ambulatory Payment Classification system) and similar methods have also been adopted by many, if not most, third-party payers.

The *Patient Protection and Affordable Care Act* ties formally the performance of providers directly to the payments made to hospitals (“pay for performance,” also known as value-based purchasing [VBP]). The ability of complex hospital accounting systems to adequately compensate interventional cardiologists for the intensity of STEMI care will be a daunting task, with several implications. Time and hospital system management strategies will likewise be important for optimizing patient outcomes and thereby will influence the VBP component of hospital reimbursement. Physicians must prioritize their daytime responsibilities for the care of patients already in their practices (whether hospital-employed, faculty, acquired or independent) versus the services they provide to their hospital for patients not previously under their care. Hospitals too must learn to prioritize the care of certain patients. A specific, time-sensitive case in point is the penalty that hospitals serving Medicare patients incur when not meeting the 90-minute door-to-balloon time mandate for patients presenting with STEMI. When the 90-minute limit is exceeded, there is a 2% payment penalty to the hospital across the board for any and all Medicare services. For many healthcare systems, millions of dollars are at risk.

Unfortunately, for many hospital systems, achieving the best door-to-balloon times will be difficult because there are a limited number of interventional cardiologists with the training and qualifications to perform such highly demanding, stressful, and time-sensitive procedures. Further, not only is the number of interventional cardiologists likely to decline in the next few years, but these highly skilled specialists currently represent a very small percentage of any medical staff. Thus, at a time when hospitals are in dire need of such services, the physicians able to provide them are becoming an increasingly scarce resource.

Additionally, to address the issue of timely transfer of STEMI patients to percutaneous coronary intervention (PCI)-capable hospitals, numerous regions have adopted a referral network where STEMI patients are brought directly to an appropriately credentialed hospi-

tal. The growth of hospitals wishing to provide this service has also placed a vastly increased time burden on interventional cardiologists. This burden, to be immediately available to the hospital while taking ER call, has required interventional cardiologists to forgo both their responsibilities to other patients during working hours and their families on weekends and nights.

Another factor that has placed pressure on interventional cardiologists is the proliferation of appropriate use criteria, which have helped to invert the relative percentage of the types of patients receiving PCI. Now, over 70% of all PCIs are performed on patients with STEMI, non-ST elevation myocardial infarction, and unstable angina, instead of patients with stable ischemic heart disease. When the burden of emergency PCIs was more manageable, most physicians considered such service their duty under the medical staff bylaws and as a part of their professional and ethical obligation to their communities. However, the care that interventional cardiologists provide in this regard is increasingly taxing. Interventional cardiologists on ER STEMI call must be available immediately to communicate with ER personnel or EMS and typically must arrive at the hospital within 30 min of notification—regardless of the time of day or night, weather conditions, or family and social obligations. As payments to hospitals have become tied to not just the performance but the perfection of these efforts and hospitals have sought to increase their volume of STEMI patients by seeking to provide care for those outside their immediate catchment area, SCAI believes strongly that it is appropriate for interventional cardiologists to be specifically remunerated for the time they spend prioritizing emergent STEMI call.

Recognizing that this may be considered a controversial issue for some hospitals, SCAI offers the following insights on questions frequently asked:

- **What stops non-cardiology physicians already taking ER call from requesting similar call – linked, supplemental reimbursement?**

Pay for ER call should be based on a transparent process that quantifies the relative burden of the call compared to the direct benefits the hospital receives when the call duties are satisfied. Heart attacks are unfortunately a common occurrence and door-to-balloon mandates are rigid at 90 min, as defined by a careful set of clinical guidelines based on a robust body of evidence. Time decrees like those for STEMI call are rare in guidelines-directed, evidence-based documents outside of cardiology. Certainly one exception would be for trauma call. Thus, STEMI call is

more burdensome on interventional cardiologists compared to other physicians whose responsibilities may only require availability by phone or making arrangements to see a patient in the office the following day. Importantly, not only do hospitals benefit directly from this pay for performance (VBP) metric, but the hospital's market share also benefits from reputable, high-quality and efficient STEMI care as well: patients brought emergently to the STEMI hospital from outside the typical catchment area usually stay for continued care. The paybacks for STEMI call have an obvious and hefty value to the healthcare institution.

- **If our medical staff bylaws already require interventional cardiologists to cover our ER without compensation, why should we pay for it?**

In the case of STEMI call, having physicians compensated to align directly with the objectives of the hospital creates synergy and working relationships that are difficult to legitimately develop in other ways. This synergy could also aid in reaching or surpassing national quality and outcome standards. In addition, although bylaws may require such coverage, they are deemed voluntary in many hospitals, and physicians may need to prioritize their own practice over the hospital's needs. Incentivizing STEMI call creates a win-win-win (patient-hospital-physician) scenario that benefits the overall reputation of the hospital, its patients and the community it serves. Done correctly, it contributes to the fiscal viability of the hospital and the sustainability of the cardiology practices in its community.

- **Why is compensation needed?**

Interventional cardiologists, like all specialists, recognize the special role they play in the care and well-being of their patients, and are grateful for the opportunity to care for patients and families when they are most in need. However, despite a desire by most physicians to keep the practice of medicine separate from its economics, this is simply not practical considering new healthcare legislation. Physicians are facing rising costs in the overhead needed to maintain their

practices. This has led to a significant percentage of those in private practice leaving for an employed position in a hospital system. Moreover, physicians also face declining reimbursement. It is not reasonable to expect an interventionalist in practice to forgo revenue-generating activities while on STEMI call while he or she must still contribute to an ever-increasing overhead under the pressure of work relative value unit (RVU) metrics. The absence of STEMI call pay is no longer financially reasonable especially in light of the recent ~18% cut in reimbursements for PCIs.

- **Is such an agreement legal?**

Yes. While the Anti-Kickback Statute (AKS) forbids unlawful kickback payments in any form, it does not compel physicians to provide on-call services for free. Consistent with this, a recent survey by hospital executives showed that almost half were already paying interventional cardiologists to participate and prioritize STEMI call at their hospital. Such compensation must be set at fair market value and cannot in any way reflect past or future referrals. The OIG issued Advisory Opinion 07-10 providing guidance in this regard.

- **Is this a new concept? Are there any hospitals doing this?**

A survey conducted by the American College of Physicians Executives in 2005 found that 46.6% of respondents' hospitals paid specialists to take ER call. While 44.5% indicated they were not then paying for ER call, nearly half of these reported they had considered the matter recently.

In conclusion, SCAI believes that all hospitals providing emergent STEMI primary angioplasty services will benefit from an optimal program, run by high-quality interventional cardiologists, whether faculty, hospital-employed, or in independent private practice, who prioritize this arduous yet vital duty. Toward this end, initiating a supplemental reimbursement policy for time on call will align both financial and clinical interests across the hospital, physician, and patient community.