



The Society for Cardiac Angiography & Interventions

Society News

SCAI Advocacy Efforts Pay Off!

As the summer of 2003 drew to a close, the Society for Cardiovascular Angiography and Interventions received word that its intensive work in advocacy had achieved some success. In mid-August, the Centers for Medicare and Medicaid Services (CMS) indicated, through a new proposed rule, that interventional cardiologists will see an increase in Medicare practice expense (PE) payments for cardiac catheterization services in 2004. The rule also indicates that the decline in overall Medicare reimbursement for catheterization may ease significantly in 2004.

If this holds true in the final rule, this victory, though just a small step toward rectifying problems with the Medicare fee schedule, is the result of painstaking efforts by SCAI in partnership with other concerned organizations. Here, two SCAI past presidents and current leaders of SCAI's Advocacy Committee, Drs. Joe Babb and Carl Tommaso, discuss the Society's efforts on behalf of interventional cardiologists and their patients. They are joined by Randy Fenninger, whose lobbying firm MARC Associates worked tirelessly along with SCAI leaders, members, and staff on behalf of interventional cardiologists and their patients.

Q: SCAI has been very active in key issues affecting the practice of interventional cardiology. What are some of the most important of those?

Dr. Babb: One of the biggest issues we face is declining Medicare reimbursement, and the effect it has on health-care quality and patient access to medical care. There are only so many patients you can see in a day and properly take care of. You get to a point where you're really in a bind. That's why SCAI began its advocacy program – to



Joseph Babb, MD, FSCAI

ensure that the concerns of invasive and interventional cardiologists are aggressively expressed.

Dr. Tommaso: The other main focus right now is litigation reform. A number of states have put caps on economic damages and developed reasonable ways of determining which malpractice cases go to court. On the other hand, 18 states are on an AMA "watch list" because they have exceedingly high malpractice costs. When you compound increases in overhead because of malpractice costs with reductions in Medicare reimbursement, you're soon heading for a major healthcare crisis. We're already seeing physicians retiring early, dropping Medicare re-

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imbursement, and opening boutique practices. That's not good for patients.

Mr. Fenninger: In fact, the problems of liability insurance are no longer regional; they have become national in scope. SCAI recognized this change and has worked aggressively with other medical societies to push national legislation to relieve the liability insurance crisis. The House of Representatives has already passed a good bill, and SCAI is pleased that the Senate Republican

leadership seems committed to pursuing the issue this year. SCAI grassroots activities have been a key part of this effort.

On the payment front, SCAI volunteers devoted countless hours to collecting and analyzing practice expense information. They worked closely with experts in our firm to organize and present the data successfully.

Q: What specific advocacy steps has SCAI taken?

Dr. Babb: When CMS was determining reimbursement for intravascular brachytherapy, we advocated for adequate payment before the Relative Value Update Committee, or RUC (an advisory committee to CMS). This is a very arcane process, and it's difficult to make your case and get awarded a fair value. Well, SCAI did that, and we've done it for other procedures as well. Another example: Because the Medicare reimbursement system did not recognize (or pay for) the time spent by cardiology office staff supporting cardiac catheterization procedures in a hospital setting, SCAI advocated for an increase in practice expense payments for these services. SCAI surveyed its members, collected the data, analyzed it, and presented it to the Practice Expense Advisory Committee, or PEAC—and CMS approved the additional reimbursement. A quirk in CMS rules held up payment this year, but we made them aware of the problem, and we should get it in 2004. The Society is also a member of the Cardiovascular RUC. This body brings cardiologists together to discuss difficult reimbursement issues within the house of cardiology before we take them to the house of medicine. SCAI has a seat at that table, along with representatives from the other subspecialty societies, and we've been very effective at that table. Several of us also spent time last year visiting legislators on Capitol Hill, talking specifically about medical liability reform and Medicare drug coverage.

Dr. Tommaso: The Society has given significant support to members involved in statewide issues as well, in particular in Florida, New Jersey, Ohio, and Illinois. SCAI has responded to whatever agency was involved, whether the issue was Blue Cross reimbursement for outpatient procedures, or efforts to inappropriately institute clinical guidelines into law.

Mr. Fenninger: SCAI has made a major commitment on behalf of its membership to represent the specific interests and concerns of interventional cardiology. The Society's leadership recognized the need for SCAI to speak directly for its members and has taken important steps to make sure that they are at the table on *every* important issue. The support from the membership has been terrific, and the grassroots programs continue to grow and improve.

Q: What can SCAI members themselves do to advocate for interventional cardiology?

Dr. Tommaso: Our advocacy efforts are young. We need to get our membership more involved at the grassroots level. We'd like members to be in touch with their Congressional Representatives and Senators. If they know them personally, we'd like them to develop liaisons, and if not, to write letters and be in contact with their offices. When any of our members are in Washington, we'd be happy to set up visits for them to meet their legislators or their healthcare representatives. We can prep them on what the issues are, what our stance is, what their particular legislator's stance might be, and we give them some talking points.

Mr. Fenninger: Members of Congress need to know what is happening in their states and districts. They want to be responsive and helpful, but if they don't hear from home, then they *can't* act. This is where individual SCAI members can play a crucial role. They must be actively involved, building the kind of relationships with Representatives and Senators that ensure the flow of information from home to DC. SCAI has already demonstrated that grassroots efforts can be successful, but there is no such thing as too much grassroots activity.

Dr. Babb: It's imperative that legislators understand how key issues are affecting our practices and, through our practices, how healthcare is delivered to patients in their districts. That usually gets the message through. *The bottom line: working together, we CAN make a difference!*

New CMS Rule Shows How SCAI Gets Things Done

The proposed new rule by CMS gives every indication that interventional cardiologists will see an increase in

Medicare payments for cardiac catheterization practice expense (PE) services in 2004. For SCAI, the rule is evidence that hard work on advocacy initiatives can yield results. Society leaders and staff worked for months to collect and present the solid data that persuaded the AMA's Practice Expense Advisory Committee, or PEAC, that the services of interventional cardiologists and their staffs were misunderstood and, therefore, undervalued. SCAI led this effort, working closely with the ACC and other partner organizations.

PEAC, a multispecialty committee that advises CMS, had based previous practice expense values for cardiac catheterization on a flawed assumption that the interventional cardiologist's clinical office staff was not involved in the delivery of services. The SCAI gathered data from its members and presented it to PEAC, demonstrating that the staff provides essential support services, including scheduling the cath lab and equipment, obtaining prior approval and informed consent, and instructing patients. After PEAC eventually accepted these data, the Society turned its sights on the CMS, which had to be convinced to accept the recommended values. The proposed rule for 2004 represents a 20 to 30 percent increase in PE values for CPT codes 93508–93533. The estimated dollar value for the change is relatively modest, a sign that the SCAI's job as the advocate for interventional cardiology is far from done—but proves that, through hard work, we can make significant progress.

This rule is now subject to comment. The Society does not expect any changes to the proposal; however, the final 2004 Medicare fee schedule will not be available until later this month. Further developments will be communicated to SCAI members via eNews (e-mail updates) and via www.scai.org.