

Paying Less for High-Value Care— Are You Kidding Me?

Recently, the CMS announced plans to lower another physician fee schedule, starting in 2016. This time it's the gastroenterologists at the end of the stick. The plans are to cut reimbursement for colonoscopy and other endoscopy procedures: not just a little, but a whopping 19%! Now, I confess I know very little about the details of the business plan for a gastroenterology procedural practice and exactly what this would mean for the practice. But I do know that a near 20% cut in reimbursement for a common service in any medical practice would be a difficult pill to swallow.

Putting the economics aside, one has to question why CMS would devalue such an important procedure as colonoscopy. The decline in both the incidence and mortality rates of colorectal cancer is one of the greatest success stories in modern medicine. Of course, like anything, the interventions are probably multifactorial, and colonoscopy can't take all the credit. Primary prevention through diet, exercise, and NSAIDs probably contributes greatly. But we can't forget the role of colonoscopy for screening. Not only is it proven useful in detecting early-stage cancer, but also incidental precancerous polyps can be removed, contributing further through secondary prevention.

We hear a lot about the high cost of cancer care and especially the high cost of drugs. We are even developing models now for value-based reimbursement. Doesn't the same apply here? Reducing the burden of colorectal cancer in society appears pretty high value to me. I'm sure an economist could model the savings through avoidance of treatment or increased productivity in the workforce. But it seems to me that the statistics showing continuously declining incidence and mortality speak volumes.

I won't argue that we are doing everything perfectly. Not everyone who needs screening colonoscopy gets it, and it is also sometimes overused. There is a need to better understand tailored screening programs and to define better, less-invasive biomarkers. But for heaven's sake, let's not throw the baby out with the bathwater!

How this happened is a mystery to me. But the American Gastroenterological Association (AGA) Web site tells the story. According to the AGA, the American College of Gastroenterology, and the American Society for Gastrointestinal Endoscopy, who are all working together, the blame falls clearly on the Relative Value Scale Update Committee (RUC) in the AMA. The societies insist they provided ample data on colonoscopy to the RUC, but instead, the RUC used time and intensity for another specialty procedure to calibrate and establish this new reimbursement payment. Frankly, I've never understood well how any reimbursement rate gets established. No doubt we could use a better, more transparent process for this, too.

This has also been a long fight for our colleagues in gastroenterology. For 2 years now, they have been able to stall plans to cut reimbursement for this critical set of procedures. Fortunately, there is still time. The new ruling is posted for public opinion, and CMS can still reverse its plan. Let's hope that happens. We need our colleagues back at home helping our patients, not marching in Washington.



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What do you think? Please e-mail correspondence (include contact information) to JNCCN@nccn.org.