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The Medicare Improvements for Patients and Providers Act of 2008: Reflections on the Political Process

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As most CSA members are aware, on July 15 the United States Congress voted to override President Bush's veto and enact the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. This law retroactively reversed the Sustainable Growth Rate (SGR)-mandated 10.6 percent across-the-board reduction in Medicare payments to physicians that had gone into effect on July 1 and instead provided for small increases over the next 18 months. While cries of "Victory!" were heard from some corners of organized medicine, it is difficult to characterize the prevention of a 10.6 percent reduction in an already unacceptably low payment rate as an unmitigated triumph for anesthesiologists. However, there are aspects of this legislative battle in which organized anesthesiology should take some heart, and some pride.

How We Got to Where We Are

The SGR provision was enacted as part of the Balanced Budget Act of 1997, replacing the similarly intended Medicare Volume Performance Standard. The purpose of both provisions was to limit the growth of federal spending for payments to physicians under the Medicare program. In the SGR iteration, the provision calls for total Medicare spending for physicians to grow each year at no more than an economically "sustainable" rate, hence its name.

Each year, this "sustainable" growth rate is calculated by the Centers for Medicare and Medicaid Services, and the total amount paid to physicians is allowed to increase by only that amount. Thus, if utilization remains constant from one year to the next, the payment rate to physicians, i.e., the conversion factor, is allowed to increase by the same percentage as the SGR. But if utilization increases at a greater rate than the SGR, then the conversion factor must be reduced to bring total projected spending in line with the "sustainable" amount.

Although well intended, the system has major flaws. Rapid growth in Medicare utilization, some of which is the direct result of screening tests mandated by Medicare, and the inclusion of factors in the SGR calculations over which

physicians have no control, such as the costs of outpatient pharmaceuticals, have rendered the provision unworkable. Without Congressional intervention, the Medicare conversion factors for all physicians would have decreased substantially in each of the last two years.

Although this reduction in conversion factors was clearly the intent of the 1997 legislation, Congress understood the practical consequences of actually cutting payments that physicians already perceived as unacceptably low. Fearing significantly reduced access to physicians by Medicare beneficiaries, Congress passed measures in late 2006, and again in late 2007, that temporarily “fixed” the SGR problem, granting physicians trivial increases in conversion factors rather than the prescribed cuts. Because the most recent “fix” in late 2007 was only a six-month reprieve, and because the temporary “fixes” did not actually change the methodology, physicians were scheduled to feel the full 10.6 percent impact of the accumulated SGR cuts on July 1, 2008.

The newest “fix,” the MIPPA of 2008, once again provides a reprieve from the SGR-mandated cuts, although this time for 18 months. Although legislators claim that this provision will allow sufficient time for thorough study of—and a permanent fix for—the SGR problem, no doubt the issue will remain un-resolved until such time as the newest fix is, once again, due to expire.

A REAL Victory for Anesthesiology

Now, let's go back to the good news. First, unbeknownst to almost everyone other than anesthesiologists, the legislation contains one **outright victory for organized anesthesiology**: correction of the onerous “anesthesia teaching rule.” For the past several years, the ASA had made relief from this blatantly unfair regulation its number one legislative priority.

Promulgated by CMS in 1992, and in effect since 1994, the rule mandated a 50 percent reduction in payments from CMS to teaching anesthesiologists supervising residents in two operating rooms if the cases overlapped by even a single minute. This rule applied only to anesthesiologists, and did not affect surgeons supervising residents on overlapping cases or other physicians supervising multiple residents in a clinic setting.

Initial attempts to effect change administratively within CMS failed due to the agency's persistent refusals, and, as a result, ASA undertook a long, well-organized campaign to achieve the desired changes legislatively. In each of the last two Congresses, ASA supported the introduction of legislation, most recently H.R. 2053, authored by California's own Rep. Xavier Becerra (CA-31),

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and S. 2056, authored by Senators Jay Rockefeller (D-WV) and Jon Kyl (R-AZ), that would specifically overturn this rule. Although ASA knew that these bills would not see the light of day as stand-alone pieces of legislation, they helped the issue "gain traction" with legislators and attracted over 150 co-sponsors.

Because these bills were unlikely to make it to the floor on their own, ASA needed an appropriate piece of legislation into which the language of H.R. 2053 and S. 2056 could be inserted. Enter H.R. 6331, the MIPPA of 2008. Crafted primarily as an eleventh-hour solution to the undesired, yet SGR-mandated, cuts in payments to physicians, the bill presented the ideal legislative vehicle for correction of the teaching rule. After years of behind the scenes effort, language from H.R. 2053 was successfully included in H.R. 6331, and became law when Congress overrode the President's veto.

CSA members, ASA members from other states, and ASA's Washington staff together spent thousands of hours lobbying Congress on this issue. As a direct consequence of these efforts at both the national and state level, payment parity with other teaching specialists was achieved.

Every academic anesthesiologist in California owes a debt of gratitude to organized anesthesiology for its efforts on his or her behalf. As a result, I believe that it is incumbent upon every academic anesthesiologist in the state who is not yet a member of the ASA and CSA to go online today, or to pick up the telephone and call the CSA office, and submit an application for membership in these organizations.

Strength in Numbers

This story illustrates my oft-repeated point that, while there is no single issue of importance to all anesthesiologists, our chances of success in the struggles with those who seek to define our role and our worth are greatly enhanced when we speak with one voice. Clearly, most CSA members are not teaching anesthesiologists. But without organized anesthesiology, the individual anesthesiologist has no voice. By banding together and pooling our resources, we can make our voice heard on matters of interest to our patients, our society and ourselves.

Something to Feel Good About

A second noteworthy aspect of this story, and one in which I believe we can take no small measure of comfort as physicians, was the final showdown between Congress and the President. Interestingly, President Bush's veto of this

legislation was based not on his belief that the 10.6 percent cuts were warranted, but rather on the source of the funding for the reinstated payments.

The Congress had designated that the funding for the increased payments to physicians come from the Medicare Advantage Program which includes both HMOs and the nefarious private commercial fee-for-service programs for Medicare beneficiaries. The government itself (in GAO and MEDPAC studies) has identified these schemes as being *more* costly per beneficiary than the traditional Medicare fee-for-service program. President Bush claimed he wanted to preserve the Medicare Advantage option for America's seniors, but the point that the Medicare Advantage programs are particularly profitable for the health insurance industry was not lost on anyone. Many saw this vote as a test of allegiance: Was one with the insurance companies, or the physicians? The final vote wasn't even close.

A Duty to Support Your Profession

An important corollary of the teaching rule victory is **the importance of political involvement**. As physicians, all of us must recognize that "politics" is part of politics, and we should understand that we ignore "political" activity such as campaigns, fundraisers and the like at our peril. **CSA members need to be involved in the political process, and one part of that includes providing financial support to candidates and political action committees, at both the state and federal levels, that share our interests.** Building relationships with lawmakers at the campaign level is just as important as building relationships with them at the policy level. In accordance with federal law and basic ethical principles, the two activities must always be separate and distinct, but they are equally important.

GASPAC, our CSA political action committee for candidates for California office, is one way for our members to become involved in the political process. It deserves our support, and every person reading this can easily afford to contribute \$200 to this fund. Speaking from personal experience, I know the exercise of opening one's wallet for political contributions can be painful the first time around. Like most California anesthesiologists, I thought that the general appeals for political contributions somehow just didn't apply to me. After becoming more involved with the CSA, I realized the importance of these contributions. Like any exercise, opening the wallet becomes less painful with each repetition. To contribute to GASPAC, go to https://www.csahq.org/donation_pay.php. Collectively, we can have a meaningful influence on our state and federal legislatures.