

ASA Legislative Conference 2006

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The annual gathering of the ASA Legislative Conference convened at the J. W. Marriott Hotel in Washington, D.C., from May 1-3, 2006, attended by over 400 politically astute anesthesiologists from 45 states and Puerto Rico. Included in this number were over 50 inspired anesthesiology residents from across the country—but regretfully, none from California.

Washington is a city of many contrasts. The political climate in the Capitol is highly charged—Congress has appeared somewhat inert in this mid-term election year, with Democrats salivating over the potential for achieving majority control of the House of Representatives for the first time in 12 years, while the Republicans continue in their attempt to redefine entitlements such as Social Security, Medicare, Medicaid, and government oversight of business and the environment. Meanwhile, attendees at the Legislative Conference were treated to a well-conceived and informative program as well as spectacular warm, humidity-free spring weather. Leading the contingent of CSA officers, board members, and past presidents representing the interests of anesthesiologists and their patients in California were CSA President Edgar Canada, M.D., joined by Virgil Airola, M.D., Stanley Brauer, M.D., Michael Champeau, M.D., Paul Coleman, D.O., Christine Doyle, M.D., Thomas Joas, M.D., Norman Levin, M.D., Jack Moore, M.D., Rebecca Patchin, M.D., Kenneth Pauker, M.D., Johnathan Pregler, M.D., Michele Raney, M.D., Mark Singleton, M.D., Stanley Stead, M.D., Earl Strum, M.D., Narendra Trivedi, M.D., CSA's CEO Barbara Baldwin and yours truly.

Much of the credit for the success of this meeting is due to the consummate efforts of ASA's outstanding Washington office staff headed by ASA Director of Governmental Affairs Ronald Szabat, J.D., LL.M., and Associate Director for Legislative Affairs, Manuel Bonilla, M.S., in planning an outstanding and imaginative meeting. Contrary to previous conferences, which had produced a steady stream of members of Congress and representatives of the Executive Branch to address the conferees, only three members of the House spoke at this year's gathering.

State Issues, SGR, and P4P

The Conference kicked off with presentations by various ASA members from across the country. Topics familiar to all anesthesiologists included scope of practice, state “opt-outs” from Medicare’s physician supervision of nurse anesthetists requirement, assignment of benefit and balance billing controversies, Medicaid payment battles, and state medical board problems. The luncheon speaker for Monday was none other than California’s Rebecca Patchin who, as an AMA Trustee, discussed many of the legislative and organizational strategies that AMA is currently pursuing, as well as the dramatically improved health of that organization after years of financial and political strife. On Tuesday, ASA Vice President for Professional Affairs Alexander Hannenberg, M.D., provided a comprehensive review of the current and projected status of physician payment under Medicare. The use of the Sustainable Growth Rate Formula for physician payment updates (? downdates) remains in force and is projected to result in another 4.6 percent reduction in physician fees for 2007. Although Congress has passed legislation to prevent SGR-imposed fee reductions targeted for 2005 and 2006 by applying a freeze to current Medicare fees, the SGR will continue to be applied for annual adjustments, and it will eventually mandate reductions in payments totaling nearly 30 percent over the next several years unless Congress agrees to a legislative fix. Currently 50 percent of all Medicare dollars paid to physicians are for Evaluation and Management services. In the ongoing recarving of the physician payment pie according to the RBRVS methodology, adjustments in work and practice expense values are anticipated to favor E&M codes as opposed to the procedural codes for which most anesthetics are given. Over the past several years, ASA has worked tirelessly to convince CMS that the work values for anesthesia services are grossly undervalued. Some modest adjustments were realized a few years ago, but additional changes are unlikely. Currently, “work intensity” for anesthesia services as valued within RBRVS remains in the bottom 2 percent in comparison to all other physician services.

While ASA, AMA, and other physician specialty societies have continued to lobby Medicare and key Congressional health care committee members for the elimination of the SGR in favor of the Medicare Economic Index methodology used for hospitals and other health care providers, the introduction of a physician Pay for Performance program has gained broad support both in Congress and within the administration. Thomas B. Valuck, M.D., J.D., a Senior Adviser for the Centers for Medicare and Medicaid Services and a pediatrician by training, is Medicare’s guru on P4P. Dr. Valuck’s presentation of a detailed vision of the P4P program rekindled nightmarish recollections of the beginnings of managed care and HIPAA. The cornerstone of P4P is the development of quality measures that are evidence-based, valid and reliable, and reflect a

consensus among physicians. Theoretically, physicians would be rewarded for achieving such quality benchmarks. Many hospitals currently are rewarded with increased reimbursement of 2 percent to 4 percent for meeting various quality improvement measures; for them, the dollars received can be in the millions. And, no doubt, many large multispecialty practices might also benefit from P4P, but mostly it is the primary care fields that benefit. Driven by primary care specialists, AMA originally agreed to play along with this proposal in hope of removing the SGR as a trade-off in the adoption of a P4P program. Congress and CMS failed to act on SGR and P4P in 2005, and it is unlikely that any major change will be adopted this year. But the devil is in the details, and it is hard to imagine that substantial increases in physician payments will be realized under P4P. Of the numerous performance measures adopted so far by CMS, none is applicable to anesthesiology despite the ongoing efforts of Dr. Hannenberg and the ASA Washington staff.

ASA's Legislative Agenda

There is a plethora of issues before the Congress that impact all physicians and some that are directly related to the specialty of anesthesiology. It was the intent of the Legislative Conference to educate ASA's political activists on all such issues, but attendees were asked to focus on only one or two key issues that directly affect its members during their visits to Congressional offices. This year the two issues that members were asked to discuss during visits with their senators and representatives were the Medicare Anesthesiology "Teaching Rule" and the extension of the "Rural Pass-Through" to anesthesiologists.

Medicare's Anesthesiology Teaching Payment Rule

In 1994, Medicare implemented a provision in its physician payment rules whereby faculty anesthesiologists in teaching programs, when supervising two residents administering surgical anesthesia concurrently, are paid 50 percent of the prevailing Medicare fee for each case—even if such cases overlap by only a few minutes. For academic departments in California, this means being paid less than \$9 per unit! This provision is applied to no other specialty but anesthesiology. For instance, academic surgeons can supervise more than one operation at a time as long as they are present for the key elements of each procedure. Primary care faculty can supervise as many as four residents simultaneously. Medicare claims that the anesthesia teaching rule is consistent with the "medical direction" rules that apply to physician supervision of nurse anesthetists. However, in the teaching situation, Medicare pays only half; whereas under "medical direction," half of the fee goes to the supervising anesthesiologist and the other half goes to the nurse anesthetists. For the 120 academic programs in the United States, this rule has resulted in an average loss of

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\$400,000 per department, and as much as \$1 million to some programs. The cost of correcting this inequity is estimated to be \$30 million to \$40 million.

ASA has addressed this issue for the last three years. During the tenure of Michael Scott, J.D., ASA's previous Director of Governmental Affairs, and with the support of many key members of Congress, the Washington office was assured by CMS that a correction would be included by means of a regulatory change. However, in each of the last two years, CMS has failed to include such a change in its annual update package. To complicate matters, the American Association of Nurse Anesthetists has actively lobbied against this correction as they believe that it will negatively impact their own training programs—despite the fact that the number of nurse anesthetist trainees has nearly doubled in the last six years to roughly 2,000 graduates per year! Thanks to the support of Congressman E. Clay Shaw, R-FL, and Congressman Pete Sessions, R-TX, a bill addressing the H.R. 5246 problem was introduced on April 27. It would specify that "... in the case of teaching anesthesiologists involved in the training of physician residents in a single anesthesia case or two concurrent anesthesia cases, the fee schedule amount to be applied shall be 100 percent of the fee schedule amount otherwise applicable under this section if the anesthesia services were personally performed by the teaching anesthesiologist alone. ...” It is extremely unlikely that a single-issue bill such as this one would be passed by the Congress and signed into law. However, by generating enough broad support among the members of Congress, it is hoped that this language would be included in the anticipated year-end Medicare correction legislation.

On a positive note, following his Tuesday morning address to the Conference, Congressman Fortney H. “Pete” Stark, D-CA, expressed his willingness to support H.R. 5246. Mr. Stark has always been a friend to our specialty, most

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significantly in his support of the ASA Relative Value Guide by which “time” remains a component of anesthesia payments under Medicare. Thus his positions on anesthesia-related issues within the Medicare system are highly

valued. However, much of the thanks for Mr. Stark's spur-of-the-moment decision to support H.R. 5246 belongs to a timely visit to the microphone by CSA's Dr. Ken Pauker. Following his speech, Mr. Stark solicited questions from the audience. Dr. Pauker asked for his thoughts on the Teaching Rule. As the Congressman expressed his unfamiliarity with the issue, Ken provided a brief synopsis, and then asked for the Congressman's support. The give and take

was quick and to the point—almost theatrical. Mr. Stark agreed to support the bill, and the assembled anesthesiologists roared their approval with a standing ovation. Because it was so unexpected, it was truly the highlight of the meeting! Since that time, Pete Stark has introduced his own identical legislation supporting the elimination of the “Teaching Rule,” H.R. 5348, the Medicare Anesthesiology Funding Restoration Act of 2006. His version will make it easier for Democrats to add their support.

Extending the “Rural Pass-Through” to Anesthesiologists

Anesthesia services for Medicare beneficiaries, whether provided by anesthesiologists or by nurse anesthetists, are covered under Medicare B. There is a unique provision within the Medicare system that allows low surgical volume hospitals to contract with anesthesia providers; the hospital can then recoup that expense under Medicare A on a reasonable cost “pass-through” basis. The low-volume threshold for this application is no more than 800 surgical cases in the facility—no more than 2,080 anesthesia work hours per year. Usually such contracts exceed significantly what a provider could otherwise earn through professional billings when taking care of Medicare and Medicaid beneficiaries. This provision allows hospitals in underserved, usually rural, areas to ensure the adequate availability of anesthesia services. Oddly enough, this provision is available only to nurse anesthetists!

For years, ASA has tried to level the playing field on the rural “pass-through” issue. It is only reasonable to think that needy rural hospitals should have the option to recruit fully trained anesthesiologists, especially when many of them are caring for sicker patients undergoing more complex procedures. But CMS has been unwilling to include anesthesiologists in this provision, although, oddly enough, anesthesiologist assistants are included! In 2002, when CMS proposed a change of the threshold from 500 to 800 surgical cases, ASA requested that the rule change also include anesthesiologists in the rural pass-through exemption. CMS declined, stating that it would require a statutory change. ASA expects to have legislative language drafted soon that would address this inequity.

Each year, the “House of Medicine” has several issues that warrant Congressional attention. The ASA shares many of the regulatory concerns that physicians in other specialties have, and, likewise, there are many issues that are unique to our specialty. There is no doubt that the changes to the Medicare Fee Schedule and its SGR-driven update formula are critically important to all physicians, especially when many commercial payers are attempting to use the Medicare model as a standard for private pay. Likewise, ASA remains committed to achieving parity with other specialties under the Medicare Fee Schedule

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as payments for anesthesia services remain at 30 percent to 40 percent of private fees whereas other specialties receive 50 percent to 80 percent of their usual and customary charges. Additionally, tort reform has not been realized in many states and Congressional action is seen as the only way of overcoming the influence of lawyers in many state legislatures. However, this year ASA leadership felt that it was necessary to confine our lobbying efforts to two easily correctable and seemingly reasonable issues.

ASA Excellence in Government Award

Each year, the Committee on Governmental Affairs selects from a list of nominees two individuals to receive the ASA's Governmental Affairs Award. The award is intended to recognize two individuals: an ASA member for outstanding contributions to the Society's governmental affairs efforts at the state or national level, as well as an elected or appointed individual for extraordinary leadership in legislative or regulatory affairs of interest to the Society. The Award is traditionally presented at the annual ASA Legislative Conference. This year L. Charles "Chuck" Novak, M.D., the former director from the state of Washington and the former distinguished Chair of the ASA Committee on Economics, and Senator Mike DeWine, a persistent voice of reason in support of the Medicare requirement for physician supervision of nurse anesthetists, were so honored.

The ASA Lansdale Public Policy Fellowship

Two years ago, the ASA created a fellowship for one of its members to work in a Congressional or federal executive branch office for up to one year with financial support from the Society not to exceed \$80,000. The first Lansdale Public Policy Fellow has been William G. Horton, M.D., a former ASA Board member from the State of Washington. As he nears the end of his one-year stint, he has conveyed his impressions on the superb experience he has had during the past year.

The ASA is currently seeking applicants for this nonclinical position designed for an anesthesiologist interested in health policy issues. Inquiries should be directed to the ASA Washington office. Applications must be submitted by January 31, 2007. Next year, the Lansdale Fellowship will be administered under the AAAS, a Congressional Science and Engineering Fellowship Program, which has an established structure to facilitate this activity more effectively.

ASAPAC/Alabama Cup

Capitalizing on its extraordinary success in raising money for the ASA's Political Action Committee (ASAPAC), the Alabama Society of Anesthesiologists donated a decorative cup to be awarded to the state component society that excels in ASAPAC contributions. It is called the ASAPAC/Alabama Cup. In 2005, Alabama raised over \$86,000 from 203 donors (compared to California's \$51,425 from 284 donors). The challenge has been issued from Alabama to match its success. Of note is an engraving on the ASAPAC/Alabama Cup that recognizes the individual who proposed the resolution to the ASA House of Delegates that led to the creation of the ASAPAC. It states, "In recognition of the important contribution made to the medical specialty of anesthesiology by Tom Joas, M.D., in bringing forth the resolution calling for the creation of the ASAPAC."



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