



**LESSONS
FROM VICTORY
AND
POSSIBILITIES
FOR REFORM:**

A recent history of Medicare advocacy efforts

by

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It was a hot July day in Washington, DC, when more than 350 members of the U.S. House of Representatives and more than two-thirds of the U.S. Senate united to pass significant changes to Medicare's physician payment system.

For surgeons who have closely followed developments in Medicare physician payment policy, the preceding account sounds much like this past July when Congress enacted the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (H.R. 6331)—the law that not only reversed a 10.6 percent cut in Medicare payments that took effect on July 1 of this year but also replaced a scheduled 5.4 percent cut in 2009 with a 1.1 percent increase. However, the same opening sentence could just as easily describe July 1997, when bipartisan majorities in the House and Senate passed the Balanced Budget Act (BBA) of 1997—the law that replaced Medicare's multiple volume performance standard (MVPS) with a new method of calculating reimbursement known as the sustainable growth rate (SGR). Unlike the MVPS, which based reimbursement on type of service, the SGR established a new method of calculating Medicare physician payments that sought to limit the annual growth in Medicare spending for physician services by linking reimbursement to growth in the gross domestic product and by requiring that any growth beyond that amount be recouped in future years.

It has been more than 11 years since the BBA was enacted, and the SGR has become the familiar shorthand that policymakers and physicians use to describe a Medicare payment system sorely in need of a drastic overhaul. Whatever logic may have guided the introduction of the SGR, policymakers of all stripes acknowledge the methodology has proven to be unsound.

From frustration to crisis

The SGR's problems were first felt in 2002 when the Medicare conversion factor was cut 5.4 percent. In 2003, the conversion factor was scheduled to be cut another 4.4 percent, but earlier that year, Congress passed legislation replacing that decrease with a 1.6 percent increase. Further cuts in 2004 and 2005—of 4.5 percent and 3.3 percent, respectively—were replaced with increases of 1.5 percent through the Medicare

Modernization Act (MMA) of 2003. Last-minute congressional actions prevented further cuts of 4.4 percent in 2006 and 5 percent in 2007 by freezing the conversion factor at 2005 levels. Although each of these actions was necessary to preserve Medicare patients' access to physician services, they only made the long-term scenario for Medicare physician reimbursement more precarious as the amount of dollars the SGR needed to recoup in future years grew precipitously—leading to projections of future Medicare cuts in excess of 40 percent over the next 10 years.

Needless to say, the annual threat of pending cuts has become a frustration not only for surgeons but for patients and policymakers as well. For surgeons, the possibility of payment cuts has compromised their ability to plan from one year to the next and has left surgeons wondering how they will continue to cover basic costs such as salaries and health insurance for employees. This uncertainty leaves employees worrying whether they will continue to have health insurance or even jobs. For patients, it has fueled uncertainty about whether a surgeon will be there when they need one. For policymakers, the SGR has become an impediment to focusing on Medicare reform and other health policy issues, consuming valuable time and forcing elected officials—on an almost annual basis—to address the issue in crisis mode before the end of the year. On multiple occasions, this has led to a year-end panic within the physician community, which has been compelled to dedicate considerable resources to lobbying lawmakers to step in and avert a payment cut.

Last year was no different, and, arguably, December 2007 marked a low point for efforts to stave off a reduction in Medicare payment. Indeed, physicians were facing the largest projected Medicare cut yet—a 10.1 percent decrease in 2008—and lawmakers were at an impasse about how to offset the costs of stopping the cut. Much of the disagreement centered on provisions that could affect payments to Medicare Advantage plans, which are offered by private insurers to beneficiaries as an alternative to traditional fee-for-service coverage.

Ultimately, Congress averted the cut and approved a 0.5 percent increase—the first Medicare payment increase in three years. However, these

provisions were scheduled to expire on June 30 of this year. So, for the first time since the SGR was created, physicians were facing a potential mid-year cut, and if Congress could not act within the following six months, this modest increase would be replaced with a 10.6 percent cut on July 1.

Hence, the usual year-end anxiety that accompanied the push to stop the looming cut was abruptly followed by an acute sense of uncertainty. The physician community not only was concerned about how Congress would come to

an agreement to stop a 10.6 percent reduction, but it was unsure what might happen if Congress could not come to an internal agreement or could not reach a compromise with the White House, which had indicated that any plan to decrease government funding for Medicare Advantage plans would be vetoed. What would happen if the 10.6 percent cut went into effect? How would physicians respond? Would physicians, for the first time ever, revisit their Medicare participation agreements? What would such an unprecedented scenario mean for patient access to care?

Bills discussed in this article

For the text of the bills mentioned in this article, visit the following sites:

- **The Medicare Improvements for Patients and Providers Act of 2007.** Public Law No: 110-275. (H.R. 6331). 110th Congress. Available at: http://thomas.loc.gov/cgi-bin/toGPObss/http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_public_laws&docid=f:publ275.110.pdf.
- **The Balanced Budget Act of 1997.** Public Law No: 105-33. 105th Congress. Available at: http://thomas.loc.gov/cgi-bin/toGPObss/http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=105_cong_public_laws&docid=f:publ33.105.pdf.
- **The Medicare Prescription Drug, Improvement, and Modernization Act of 2003.** Public Law No: 108-173. 108th Congress. Available at: http://thomas.loc.gov/cgi-bin/toGPObss/http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_public_laws&docid=f:publ173.108.pdf.
- The Board of Trustees, Federal Hospital Insurance, and Federal Supplementary Medical Insurance Trust Funds. *The 2008 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.* Available at: <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2008.pdf>.
- U.S. Senate. Committee on Finance. Max Baucus, Chairman. News release. Memorandum re: Update on Medicare negotiations. May 21, 2008. Available at: <http://www.senate.gov/~finance/press/Bpress/2008press/prb052108.pdf>.
- **The Children's Health and Medicare Protection Act of 2007.** H.R. 3162. 110th Congress. Available at: http://thomas.loc.gov/cgi-bin/t2GPO/http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:h3162eh.txt.pdf.
- **The Medicare Improvements for Patients and Providers Act of 2007.** S. 3101. 110th Congress. Available at: http://thomas.loc.gov/cgi-bin/t2GPO/http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:s3101pcs.txt.pdf.
- **The Comparative Effectiveness Research Act of 2008.** S. 3408. 110th Congress. Available at: http://thomas.loc.gov/cgi-bin/t2GPO/http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:s3408is.txt.pdf.
- **The Medicare Physician Payment Reform Act of 2007.** H.R. 3038. 110th Congress. Available at: http://thomas.loc.gov/cgi-bin/t2GPO/http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:h3038ih.txt.pdf.

Uncertainty in uncharted territory

As lawmakers returned to Washington in early 2008, attention focused on the Senate, whose cloture rule requires 60 votes in order to end debate and proceed to a final vote on a piece of legislation. In addition, attention shifted to the Senate because it had been only a few months since the House had passed the Children's Health and Medicare Protection (CHAMP) Act of 2007, which included provisions to replace scheduled Medicare payment cuts in 2008 and 2009 with 0.5 percent increases in both years. The payment provisions were part of larger legislation to reauthorize and expand the State Children's Health Insurance Program (SCHIP). Whereas the House bill had included Medicare provisions, the Senate's version of the bill had focused solely on SCHIP. During negotiations between the House and Senate, the Medicare provisions were removed from the legislation, meaning the Senate did not consider the Medicare payment provisions in the CHAMP Act. This back-and-forth set the stage for the temporary measure passed in December 2007.

With House leaders pointing to the CHAMP Act as their marker, attention was squarely on the Senate and the Senate Finance Committee. Finance Committee Chairman Max Baucus (D-MT) forged ahead with an effort to craft a Medicare package that would stop the payment cut in July and in 2009, and from early on, discussions included Senator Baucus; Sen. Charles Grassley (R-IA), the Committee's Ranking Member; the two senators' respective staffs; and the White House.

From the beginning of 2008, the advocacy staff for the American College of Surgeons was an active participant in meetings with Senator Baucus and Senate Finance Committee staff to discuss the legislative effort to stop the Medicare payment decrease. As spring approached, ACS staff and representatives from other physician and allied health associations participated in a meeting with Senator Baucus, during which he outlined his initial thoughts on the legislation.

Senate negotiations on Medicare legislation commenced early in the legislative session, but as time passed, it became apparent that the Senate Finance Committee would not have an oppor-

tunity to consider Medicare legislation before receiving consideration by the full Senate. Even so, discussions continued through the spring, but in late May, Senate negotiations reached an impasse, which culminated in a statement from Senator Baucus indicating his intentions of working with fellow Democratic senators over the Memorial Day recess to craft a package that would stop the scheduled Medicare payment cuts through the end of 2009. The plan would be slated for Senate consideration in early June, with Republican support very much in doubt.

The political lines had been drawn and a sense of apprehension gripped the physician community as the likelihood of the 10.6 percent cut taking effect seemed to grow with each passing day. In response, ACS staff and colleagues at other physician organizations participated in separate meetings with staff to Senators Baucus and Grassley to discuss their respective efforts. In addition, ACS staff was included in meetings with these senators and the Senate Democratic and Republican Leadership, including Senate Majority Leader Harry Reid (D-NV) and Senate Minority Leader Mitch McConnell (R-KY).

Overcoming defeats, achieving victory

By early June, it had become clear that Senator Baucus' legislation, the MIPPA of 2008 (S. 3101), would become the legislative vehicle for averting the payment cut on July 1. The College and most of the physician community fully supported the effort to enact the legislation. However, the fate of S. 3101 was far from certain because of Medicare Advantage provisions opposed by both the White House and many Republican senators. In addition to limiting certain payments to these plans, S. 3101 also would require certain Medicare Advantage plans, known as private fee-for-service plans, to develop networks and negotiate contracts with physicians and other providers. ACS advocacy staff—along with colleagues at the American Medical Association (AMA), surgical societies, and other physician organizations—engaged in an intense campaign to pass MIPPA, meeting with advisors to numerous Republican senators and asking for their support of S. 3101.

On June 6, Senator Baucus and Sen. Olympia

Snowe (R-ME) introduced S. 3101, which included measures to stop the pending 10.6 percent payment cut in July and replace a scheduled 5.4 percent cut in 2009 with a 1.1 percent increase. In a June 9 letter to Senator Baucus, ACS Executive Director Thomas R. Russell, MD, FACS, expressed the College's commitment to achieving passage of S. 3101. That same day, Dr. Russell issued what would be the first of 10 e-mail alerts over the next seven weeks, calling upon ACS Fellows to contact their senators and ask them to allow a vote on S. 3101. In spite of a considerable response from Fellows, on June 12, the effort to invoke cloture and proceed to a vote on S. 3101 fell five votes short of the mandated 60 needed, with 55 senators—45 Democrats, nine Republicans, and two Independents—supporting the motion, and 38 senators, all Republicans, voting against cloture. The final vote was 54 yeas to 39 nays¹ because Senator Reid, who originally supported the motion, changed his vote to allow himself the right as Majority Leader, under Senate rules, to revisit the vote in the future.

Although the failure to invoke cloture was disappointing, it also provided a glimpse of hope. If all senators had been present, the motion would have passed. Yet, with one of the absent senators, Edward Kennedy (D-MA), severely limited by his illness, it appeared that the best possibility for passing MIPPA would be to secure additional Republican support.

At this point, it also was uncertain what action the House might take, if any at all. The House had previously indicated that its position was contained in the CHAMP Act and for months gave few indications of modifying its stance. Yet, as the week following the Senate cloture vote drew to an end, the House changed course, and on June 20, Ways and Means Chairman Charlie Rangel (D-NY) and Energy and Commerce Chairman John Dingell (D-MI) introduced a slightly modified version of MIPPA, H.R. 6331. On the following Monday, in a June 23 letter to Representatives Rangel and Dingell, Dr. Russell expressed ACS support for H.R. 6331, which retained the bill's original provisions to stop the Medicare cuts through the end of 2009. On the same day, Dr. Russell called on Fellows to call their representatives and urge them to support H.R. 6331.

Uncertainty now centered on whether the House would be able to garner the support needed to pass H.R. 6331. House Democratic leaders made plans to bring MIPPA to the floor for consideration under a procedure known as suspension of the rules, which allows for expedited consideration of legislation but also requires a two-thirds majority for passage. Drama surrounded the events of the day, as the House Republican leaders pressed members to oppose the bill, citing the Medicare Advantage provisions as their primary disagreement with H.R. 6331. Rumors were circulating that some Republican members were privately speaking against their leaders and intending to support the bill, in particular because of its provisions to stop the Medicare payment cuts. On June 24, the House passed H.R. 6331 in an overwhelming 355 to 59 vote.²

With the House's resounding vote as the backdrop, on June 26, Senate Democratic and Republican leaders reached an agreement to combine the votes for cloture and final passage on H.R. 6331, meaning that if MIPPA could garner the 60 votes needed for cloture, it would pass. Again, Dr. Russell summoned Fellows to call on their senators and ask them to stop the imminent Medicare cut that was but days away. Meanwhile, advocacy staff for the ACS and other physician groups renewed the push for Republican votes. On the evening of June 26, the final Senate vote was 58 to 40,³ with Senator Reid again changing his vote at the last minute to reserve his right to bring the bill up again following the July 4 recess.

In an e-mail following the vote, Dr. Russell told Fellows, "When forced to make a choice between a position that was supported by almost every physician group...and another position that was supported by the health plans and the President of the United States, 39 senators voted with the health plans and the President.... As a result, for now, the 10.6 percent cut in Medicare reimbursement to physicians will go into effect on July 1. The full arsenal of ACS advocacy resources will continue to be employed in the coming days in order to ensure that Congress passes legislation to retroactively stop the 10.6 percent cut. We must not give up or give in."

Over the course of the week of July 4, as senators returned to their home states, Fellows did not give up or give in, and neither did their colleagues.

Instead, they vocally expressed disappointment with the senators who had voted against H.R. 6331 and asked that they change their vote when the bill would be revisited.

When Congress returned from the July 4 recess, all eyes remained on the Senate to see whether the support for MIPPA would hold and whether the bill's supporters could gain the vote needed to secure cloture and passage. If that one vote could be secured, it was widely believed that additional votes would follow, and the two-thirds majority needed to override a widely anticipated presidential veto would likely be secured as well.

On July 9, Senator Reid called for the Senate to revisit the vote on H.R. 6331. In anticipation of the vote, the ACS, along with others in the physician community, continued to reach out to senators and ask for their support. In addition, Dr. Russell issued yet another call to Fellows to contact their senators.

What began as a normal Senate vote, with legislators milling around the floor in conversation, soon transformed into an almost euphoric atmosphere as Senator Kennedy, who had missed the previous votes, triumphantly entered the chamber to cast the critical deciding vote to secure Senate passage of H.R. 6331. In spite of its often partisan tone, the Senate is still a fairly collegial body, and even Senator Kennedy's political foes could be seen welcoming him and applauding his return. With Senator Kennedy's return and passage no longer in doubt, the anticipated additional votes followed, and the bill ultimately passed with a veto-proof majority of 69 to 30.⁴

Even with the bill's passage in the Senate, it now faced a veto threat from President Bush, which ultimately became reality on July 15. Wasting no time, the House took up the bill the same day and, this time in a 383 to 41 vote,⁵ overrode the President's veto; a few hours later, the Senate would follow in a 70 to 26 vote⁶ and enact MIPPA over the President's objection.

Reasons to celebrate, lessons learned

This victory was achieved largely as a result of the time and energy that Dr. Russell, ACS staff, and, most importantly, the Fellows of the College dedicated to this effort. Although it is impossible to measure the number of calls placed by Fellows

to Capitol Hill, anecdotal evidence suggests that this legislative effort generated a response unlike any other in recent memory. Thousands of phone calls were made to Senate and House offices asking for support of MIPPA. These efforts, combined with those of colleagues in other specialties, led to a tide of support that ultimately overwhelmed the opposition.

Passage of MIPPA was gratifying for several reasons. First, it marked the longest Medicare payment provisions secured since 2003 when the MMA secured payment increases of 1.5 percent for 2004 and 2005. Second, it meant that physicians would receive their largest payment increase since 2005. Lastly, it demonstrated the influence that the College, the surgical specialties, and the physician community as a whole can wield when working together.

In addition, the legislation included other provisions of interest to surgery. For example, the law addresses how Medicare values the work involved in certain surgical services. Under the Medicare physician fee schedule, there is a requirement that any changes be administered across the spectrum of services in a budget-neutral fashion. Following the AMA/Specialty Society Relative Value Update Committee's completion of the five-year review of the work values of the resource-based relative value scale in 2006, the College and the rest of the physician community requested that CMS apply the budget neutrality requirement to the Medicare conversion factor. Contrary to this request, CMS applied this budget neutrality requirement to work values in 2007 and 2008. MIPPA changes this policy, and, in 2009, Medicare's budget-neutrality requirement will be applied to the conversion factor as opposed to the work values assigned to physician services, meaning additional payment increases for some surgical services.

Nonetheless, much work remains to be done. If Congress does not act in 2009, the SGR will again require a cut in Medicare payments—this time in excess of 20 percent for 2010. But the efforts of the past year have been helpful and instructive, providing insights into possible payment reforms the Congress will consider in 2009.

When examining the events of the past year, it becomes apparent that lawmakers view the College as a leader on health policy issues. Not only was ACS staff in regular contact with legislators

on Capitol Hill, the College was among a select group of physician organizations to be included in all physician group meetings with Democratic and Republican leaders in the Senate and House to discuss efforts to craft and enact legislation to avert Medicare cuts. Instrumental support for these efforts was provided by Fellows who reached out to their legislators.

Fellows contributed in other ways as well: For example, in January, Josef E. Fischer, MD, FACS, then-Chair of the ACS Board of Regents, traveled to Washington to meet with Senator Baucus as well as staff to Sens. Grassley and Kennedy to discuss the effects of declining reimbursement on the surgical workforce; and in April, Charles F. Rinker II, MD, FACS, a general surgeon from Bozeman, MT, met with Senator Baucus to highlight the effects of Medicare reimbursement on access to surgical care in rural areas. Dr. Rinker also authored an opinion piece highlighting these issues in the April 5 edition of the *Billings Gazette*.^{*} Thomas Foley, MD, FACS, of Marshalltown, IA, authored an article describing the effect of declining Medicare reimbursement and the challenges posed to Iowa's surgical workforce in the March 21 edition of the *Des Moines Register*.[†] With the payment cut approaching, Charles D. Mabry, MD, FACS, Chair of the ACS Health Policy Steering Committee, testified regarding the effects of declining Medicare reimbursement and the threat that the pending Medicare cut could pose to small surgical practices and the patients and communities they serve.[‡]

Possibilities for reform

The lessons from this experience are especially important because Congress will need to revisit the Medicare payment issue again in 2009. In its effort

^{*}Rinker C. General surgeon shortage looms. *Billings Gazette*. April 5, 2008. Available at: <http://billingsgazette.net/articles/2008/04/05/opinion/guest/70-shortageslooms.txt>. Accessed October 10, 2008.

[†]Foley T. Now hiring in rural Iowa: General surgeons. *Des Moines Register*. March 21, 2008. Available at: <http://search.desmoinesregister.com/sp?skin=100&aff=1117&keywords=foley&pubDate=&author=foley>. Accessed October 10, 2008.

[‡]Mabry C. Medicare physician fees: Can small practices survive? Committee on Small Business. U.S. House of Representatives. May 8, 2008. Available at: <http://www.facs.org/ahp/testimony/mabry0508.html>. Accessed November 3, 2008.

to stop the 20-plus percent cut in 2010, Congress is likely to consider much broader reforms. MIPPA provides helpful insight into the likely direction of Medicare policy and larger-scale health reforms Congress will consider in 2009:

- *Quality incentives:* MIPPA included an extension of the Physician Quality Reporting Initiative (PQRI) through 2010 and an increase in PQRI bonus payments from 1.5 percent to 2 percent in 2009 and 2010. By May 2010, the Secretary of the U.S. Department of Health and Human Services (HHS) must submit a report to Congress that includes a plan to transition to value-based purchasing. MIPPA also will establish a Physician Feedback Program in 2009 to provide physicians confidential information about their resource use in caring for Medicare patients.

- *Health information technology:* Although the bill did not include requirements for health information technology systems, MIPPA establishes a mandate for e-prescribing in 2011. Non-compliant physicians will face a penalty assessed on Medicare charges in the following year. The penalty starts at 1 percent in 2012 and phases up to 2 percent in 2014 and future years. To promote e-prescribing, MIPPA provides bonuses of 2 percent for e-prescribing in 2009 and 2010, with bonuses gradually phasing out by 2014. Exempt from the e-prescribing mandates are physicians for whom e-prescribing is associated with less than 10 percent of Medicare charges and physicians who issue less than a certain number of prescriptions under Medicare's drug benefit.

- *Imaging and accreditation:* As imaging is one of the fastest growing service areas in Medicare, policymakers have often discussed options for limiting the growth of unnecessary and low-quality imaging. Under MIPPA, starting in 2012, Medicare payment for the technical component of advanced imaging services—excluding X ray, ultrasound, and fluoroscopy—will be limited to physicians and others who have been accredited by an organization designated by the HHS Secretary.

With private insurers often looking to Medicare's lead, each of the preceding factors is viewed as an important component of efforts to control rising health care costs. Furthermore, comparative effectiveness research, which stud-

ies the relative effectiveness of various treatment options, is increasingly viewed as a critical component of these efforts to promote quality care, to achieve the best value for patients, and to ultimately restrain rising costs. To this end, on July 31, Senator Baucus and Senate Budget Committee Chairman Sen. Kent Conrad (D-ND) introduced the Comparative Effectiveness Research Act of 2008, which would provide federal funding to promote comparative effectiveness research.

Policymakers also have shown an interest in promoting primary and preventive care. In response, MIPPA provides an additional \$100 million to expand Medicare's current medical home demonstration project if the HHS Secretary determines that these health systems are useful in improving quality of care for patients and in achieving cost savings. In addition, the Medicare Payment Advisory Commission (MedPAC) has recommended that Congress increase payments to primary care physicians using a budget-neutral mechanism, which would result in Medicare payment cuts for all other physician services, including major surgical procedures.⁷ Of the 17 Commissioners, only two opposed the recommendation: Karen Borman, MD, FACS, and William Scanlon, PhD. In a May 16 letter to MedPAC Chairman Glenn Hackbarth, the College and 13 surgical specialty societies expressed strong opposition to MedPAC's recommendation, noting that primary care is not the only specialty facing significant reimbursement and workforce challenges. The letter was copied to leaders on the Senate Finance, House Ways and Means, and House Energy and Commerce Committees.

In light of this strong interest in promoting primary care, the surgical community must work with the Congress and the primary care community to ensure that these efforts do not compromise patient access to surgical care. It is in this spirit that the College has joined forces with the American Osteopathic Association (AOA) to offer a proposal to reform Medicare's physician payment system. The proposal, which was highlighted in the December 2006 *Bulletin* (Friesen S. Surgery's future under Medicare? The College proposes effort to reform Medicare payment structure. 2006;91[12]:14-17.) would replace the SGR with a system called the service

category growth rate (SCGR). Under the SGR, when Medicare spending exceeds the SGR target, Medicare payments for all physician services are cut, regardless of whether a particular type of service has been growing beyond the limits of the SGR. As the SCGR name implies, the ACS/AOA proposal would eliminate the blunt across-the-board SGR target and would replace it with separate targets based on type of service, including a category for major surgical procedures. With the creation of new targets based on type of service and with the elimination of the SGR's blunt payment cut, the SCGR would enable policymakers to dedicate additional dollars to promote certain services, such as primary and preventive care, without penalizing other specialties. The proposal would also provide policymakers with an opportunity to examine services that have experienced higher growth, such as imaging and office-based procedures, and to determine whether the growth is appropriate; if policymakers conclude that the growth is appropriate, they can dedicate additional dollars to those services as well.

The positive, collaborative efforts of the College and the AOA embodied in the SCGR proposal have been well received by lawmakers, and the proposal has generated significant interest in Congress. The ACS/AOA proposal was first introduced by Rep. Pete Sessions (R-TX) as the Medicare Physician Payment Reform Act of 2007 (H.R. 3038), and a modified version of the proposal was included in the CHAMP Act. Following the passage of the CHAMP Act, Rep. Lincoln Davis (D-TN) and Representative Sessions led a bipartisan coalition of 140 House members in sending a letter, dated December 8, 2007, to Speaker of the House Nancy Pelosi (D-CA) and Republican Leader John Boehner (R-OH) expressing support for measures that would both increase Medicare payments in 2008 and 2009 and replace the Medicare payment formula with a system that establishes separate service category targets starting in 2010. By either voting for the CHAMP Act or signing the Davis-Sessions letter, 279 members of the House have expressed support for separate service category targets. Furthermore, the service category approach is often mentioned by policymakers as a starting point for the Medicare

physician payment reforms that Congress will consider next year.

Looking ahead

Whatever reforms are introduced, lawmakers have clearly indicated their desire that Medicare legislation should have bipartisan support. Of course, as the SGR has shown, bipartisanship in Congress on any particular issue does not necessarily guarantee positive results. Furthermore, legislation's potential future consequences—both intended and unintended—must be closely studied, not only by lawmakers but by those whom the legislation stands to affect most directly. For this reason, the College will closely monitor the final details of any proposal, even if it is modeled after the SCGR, and continue to actively partner with lawmakers, the surgical community, and the larger physician community to ensure that Medicare does not simply exchange one broken payment system for another.

The success of this past July can be a helpful guide for the year ahead and for future advocacy efforts well beyond Medicare. The past year's experience demonstrates that the legislative process must be viewed as just that—a process. Sometimes, as was the case with MIPPA, it is a process that lasts only a few months, but more often, as in the case of the Medicare payment reform effort, it is one that can take much longer before the desired end is ultimately achieved. If meaningful reform for patients and surgeons is attained, it will be through the same spirit that together the Fellows and the College marshaled in this year just past—by holding firm and remaining resolute until victory is secured. □

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