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Medicare agency announces changes

On June 14, Secretary of Health and Human Services (HHS) Tommy Thompson announced a reorganization and a new name for the Health Care Financing Administration (HCFA). As part of an agency overhaul, HCFA will now be known as the Centers for Medicare and Medicaid Services (CMS)—which will actually be an umbrella for three centers, each appropriately named to clearly reflect what it does and how it serves millions of Americans.

- The Center for Beneficiary Choices will focus on the Medicare+ Choice program and will provide beneficiaries with information they need to make the best choice possible in selecting care.
- The Center for Medicare Management will focus on the traditional fee-for-service Medicare program.
- The Center for Medicaid and State Operations will focus on programs administered by the state, including Medicaid, the State Children's Health Insurance Program, and insurance regulation.

That same week, Secretary Thompson announced his intentions to reduce regulatory burdens in health care and to respond more quickly to the concerns of providers and state and local governments. HHS will create a cross-departmental Task Force on Regulatory Reform to steer ongoing review of HHS regulations and to oversee changes in regulations. The work of this group will include an expanded review of Medicare and Medicaid regulations, as well as a review of the extensive cost reports that Medicare hospitals are required to file with the agency. The Secretary also pledged to work with the members of Congress to reduce regulatory burdens through legislation.

Finally, the Secretary testified during a June 19 Senate Finance Committee hearing on Medicare governance that, before the end of the year, CMS will begin publishing a quarterly compendium of Medicare instruction changes. In addition, he said the agency would limit regulation publishing to once a month. The move is intended to help providers stay informed about new regulations and to reduce the time and effort they spend combing through the *Federal Register* for new policies that affect them.

MedPAC raises concerns about physician payment update

In its June report to Congress, *Medicare in Rural America*, the Medicare Payment Advisory Commission (MedPAC) reviewed CMS's estimate for the 2002 payment update for physician services. Although MedPAC believes that the agency's current estimate of a -0.1 percent payment update is reasonable, commission members commented that, for a number of reasons, the update for 2002 "may ultimately be lower—perhaps significantly lower—which could raise concerns about the adequacy of payments and beneficiary access to care." MedPAC also criticized the sustainable growth rate (SGR) system, which is designed to control overall spending for physician services in the Medicare fee-for-service program. In discussing the SGR, the commission stated that the system "fails to account adequately for changes in the cost of physician services and that policymakers should consider alternatives to the system if policies to control spending are necessary."

Medicare issues five-year review proposal

A proposed rule on the “five-year review” of the Medicare fee schedule physician work values, published in the *Federal Register* on June 8, predicts that many surgical specialties will receive modest payment increases in the coming year as a result of changes that are planned for the values assigned to some of their services. For example, it is estimated that average Medicare payments to cardiac surgeons will increase 6 percent; payments for thoracic surgeons will rise 5 percent; general surgery payments will go up 4 percent; and vascular surgery will increase 2 percent. The general surgery work value increases were based on a “building block” methodology developed by the College’s General Surgery Coding and Reimbursement Committee.

The precise impact of the new work values will become more clear later this summer, after CMS issues its proposed rule on the 2002 Medicare fee schedule. That draft regulation will include any planned changes in payment policies, as well as the fully implemented resource-based practice expense relative work value units.

HHS issues guidance on patient privacy protections

On July 6, HHS issued the first in a series of guidance material on new federal privacy protections for medical records and other personal health information. The material is intended to explain and clarify key provisions of the medical privacy regulation, which was published last December. Topics include patient consent, parental rights, marketing, medical research, and governmental access issues.

The guidance answers common questions about the new protections for consumers and requirements for doctors, hospitals, other providers, health plans, and health care clearinghouses. It also clarifies the meaning of key provisions of the rule. For example, the guidance states that hospitals do not have to build private, soundproof rooms to prevent overheard conversations about a patient’s condition as some mistakenly believed. The guidance also indicates that the rule allows a friend or relative to pick up a patient’s prescription at the pharmacy, as often occurs today.

Most covered entities have until April 14, 2003, to comply with the patient privacy rule; small health plans have an additional year to comply. HHS’s Office for Civil Rights will conduct extensive outreach to consumers and health care providers to explain what the rule means to them. The department also will provide technical assistance and further guidance to health care providers and other covered entities to help them comply.

A fact sheet summarizing the privacy rule’s rights and protections is available at <http://www.hhs.gov/news/press/2001pres/01fsprivacy.html>. More detailed information about the rule, including the initial guidance, is available at <http://www.hhs.gov/ocr/hipaa>.