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Congressional proposals introduced to limit Medicare cuts

Legislation introduced in November to limit scheduled 2002 reductions in Medicare physician payments received strong support from medical and surgical specialty societies and among Members of Congress. The Medicare Physician Payment Fairness Act of 2002 was introduced November 8 by Sens. Jim Jeffords (I-VT) and John Breaux (D-LA), and on November 28 by Reps. Michael Bilirakis (R-FL) and Sherrod Brown (D-OH). The bill would have significantly reduced to -0.9 percent the -5.4 percent Medicare physician payment update that took effect January 1, 2002. It also would have required the Medicare Payment Advisory Commission to conduct a study and prepare a report by March, offering its recommendations for replacing the sustainable growth rate system that is used to determine the physician payment update. Unfortunately, Congress failed to act on the bill before adjourning on December 20, despite endorsements from a majority in both chambers.

For additional information on 2002 Medicare payments and the sustainable growth rate system, see "What surgeons should know about the 2002 Medicare fee schedule" on page 8.

Regulatory relief bill passes House

By a unanimous vote, the House of Representatives passed legislation on December 4 that, if also passed by the Senate, would grant significant regulatory relief to physicians. The Medicare Regulatory and Contracting Reform Act of 2002, H.R. 3391, would provide important protections to physicians who are audited. It also would streamline the regulatory process by requiring proposed or final regulations to be published on one specific business day a month and a regular timeline to be set by the Secretary of the Department of Health and Human Services for the publication of final regulations. The legislation also would prohibit retroactive applications of substantive regulatory changes. Also of interest, the Centers for Medicare & Medicaid (CMS) would be required to develop a new advanced beneficiary notice process that would allow both beneficiaries and providers to obtain predetermination of coverage before a service is delivered.

In addition to these and other regulatory reforms, the broad bill addresses Medicare contractor reforms, education and outreach programs, appeals and recovery processes, and other issues.

On November 28, Sen. John Kerry (D-MA) introduced S. 1738, the Medicare Appeals, Regulatory, and Contracting Improvement Act of 2001. The legislation, which is not as sweeping in scope as the House bill, already has the support of 21 co-sponsors, including Sens. Max Baucus (D-MT) and Charles Grassley (R-IA), the chair and ranking member of the Senate Finance Committee, respectively. At press time, the Senate had not yet acted on this legislation.

House votes to delay compliance deadline

Also on December 4, the House unanimously approved H.R. 3323, legislation that would delay for one year the October 2002 compliance deadline for standard electronic formats for exchanging health data. The bill was introduced in response to concerns expressed by state legislators and others that health care providers, payors, and clearing-

CMS sets forth plans to improve

houses do not have enough time to comply with the current law's deadlines. Similar legislation, S. 1684, passed the Senate on November 27. The House bill, however, differs in that it requires covered entities seeking an extension to submit their plan for achieving compliance before the current October 16 deadline. Differences between the two bills must be reconciled by a conference committee.

The CMS, on November 2, issued a request for comments on its efforts to become more open and responsive to the needs of Medicare and Medicaid beneficiaries and to those who are involved in their care. More specifically, the agency proposes to:

- establish a series of open-listening forums across the country to hear directly from constituents about the impact that regulations and policies are having on them;
- work closely with state and regional officials to troubleshoot and resolve disputes involving Medicaid and the State Children's Health Insurance Program;
- form in-house expert teams across program areas to develop ways to reduce administrative burdens and simplify policies and regulations;
- issue quarterly provider updates that list regulatory documents and program instructions of interest;
- enhance provider training systems; and
- reduce correspondence response time.

Some elements of the plan are now being implemented. Most notably, several open-listening forums have already been held.

Final rule issued on hospital outpatient PPS

Final regulations setting policies and rates for the Medicare outpatient prospective payment system (PPS) in 2002 were issued on November 30 by CMS. Most significantly, the rule reduces so-called pass-through payments for new medical devices, drugs, and biologicals by 68.9 percent in order to meet a congressionally mandated spending limit. As a result, payments for a number of oncology drugs and biologicals will be significantly reduced.

The new technology pass-through was created by Congress when the new outpatient payment system was first proposed in 1997, because of fears that inadequate data on these innovative products would lead to underpayment for outpatient services. To constrain spending growth, however, the total amount of such payments was capped at 2.5 percent of total PPS payments. The pass-through rate reduction for 2002 reflects recent significant increases in payment for new technology since the PPS was implemented on August 1, 2000.

Concerns about the impact these reductions could have on patient access to these technological innovations caused CMS to issue a notice on December 31 delaying the effective date of the new rates until no later than April 1, 2002. Revised rates and an effective date will be announced in a new final rule. Other provisions of the November 30 rule took effect as scheduled on January 1.