

Dateline Washington

prepared by the Washington Office, Health Policy and Advocacy Department

Senate prepares to debate managed care reform

Following Sen. James Jeffords' (I-VT) decision to change his party affiliation, the new Democratic majority announced plans to expedite Senate consideration of patients' rights legislation. Two principal bills are pending in the Senate: the Bipartisan Patient Protection Act introduced by Sens. John McCain (R-AZ), Edward Kennedy (D-MA), and John Edwards (D-NC); and the Bipartisan Patients' Bill of Rights introduced by Sens. Bill Frist, MD, FACS (R-TN), John Breaux (D-LA), and Jeffords.

Both bills include managed care protections that have wide support on Capitol Hill, including a ban on "gag clauses," ensured access to specialty care, and independent external review of insurance denials. Another patient protection sought by many physician and patient groups—the right to sue health plans—is more controversial and is treated differently in the two bills. The McCain bill includes a \$5 million cap on punitive damages for health plans, while the Frist bill includes a \$500,000 cap on noneconomic damages and bans punitive damage awards. Neither bill places any limits on physician liability.

The McCain bill is very similar to the Norwood-Dingell bill that passed in the House of Representatives last congressional session. However, President Bush has publicly announced that he will veto that bill if it reaches his desk, citing the \$5 million cap on punitive damages and the absence of a noneconomic damages cap as particularly problematic. Working in consultation with a number of national medical and surgical specialty societies, including the College, Senator Frist and others drafted an alternative bill that the President has since endorsed. After some particularly objectionable sections were removed, the College sent a letter of support to Senators Frist, Jeffords, and Breaux when the new bill was formally introduced on May 15, specifically noting the critical importance of gaining President Bush's support for the effort. A follow-up letter to the Senate sponsors was sent on June 4, outlining remaining concerns with some of the bill's more technical details.

Medicare approves new coverage expansions

The Health Care Financing Administration (HCFA) announced on May 25 that Medicare coverage of liver transplants will be expanded to include certain patients with primary hepatocellular carcinoma. This will be the program's first movement towards transplant coverage for a liver malignancy. Although HCFA does not anticipate a large number of Medicare transplants for this disease, the procedure is viewed as extremely important because there are few alternative therapies for these patients. HCFA officials also said that a technology assessment would be sought for other types of malignancies in an effort to further expand coverage. Details of the May 18 decision memorandum are available at www.hcfa.gov/coverage/8b3-rr.htm.

Also of interest, Health and Human Services (HHS) Secretary Tommy Thompson announced on May 3 that Medicare will expedite coverage of pneumatic compression pumps to make it easier for Medicare patients with lymphedema to take advantage of the technology. The new coverage policy eliminates language that made these devices the treatment "of last resort" for beneficiaries suffering from the often debili-

Health plans rarely report to the NPDB

tating condition. Instead, pumps will be covered if a beneficiary first undergoes an initial therapy of conservative care that includes elevation, exercise, and the use of a compression garment for at least four weeks without results. The new policy eliminates the need for patients to purchase a more expensive, custom-made garment before becoming eligible to receive a pump. Details of the coverage decision are available at www.hcfa.gov/coverage/8b3-z.htm.

According to a report issued by the HHS Office of the Inspector General (OIG) in May, managed care organizations rarely submit reports to the National Practitioner Data Bank (NPDB) on adverse actions they take against physicians and other health professionals. Between September 1990 and September 1999, managed care plans reported a total of only 715 adverse actions to the data bank; 84 percent of plans made no reports at all. The report, *Managed Care Organizations Nonreporting to the National Practitioner Data Bank, A Signal for Broader Concern*, concluded that the two most likely causes of low reporting levels were a limited focus on clinical oversight by managed care organizations and reliance on hospitals, physician practice groups, and state licensure boards to monitor quality matters.

The report is available on the OIG's Web site at <http://www.oig.hhs.gov/oei/reports/a521.pdf>.

Many changes foreseen at HCFA

Thomas A. Scully, confirmed by the Senate as the new HCFA Administrator on May 25, and HHS Secretary Thompson recently discussed plans for implementing a variety of changes and reforms at the agency. For example:

- HCFA soon will make more use of newspaper advertisements, the Internet, and toll-free telephone numbers to market Medicare program and benefits. In particular, it is reported that plans are under way to conduct an aggressive advertising campaign targeted toward enrolling 30 percent of Medicare beneficiaries in the program's managed care plans by 2005.

- HCFA staff were invited to participate in a "Rename the Agency" contest to help establish a new identity that better describes the agency's mission and responsibilities. The results were announced on June 14 by HHS Secretary Thompson, who said that HCFA will now be called the Centers for Medicare and Medicaid Services (CMS). The name change and restructuring will also allow for more effective management of Medicare's managed care and fee-for-service programs.

- Most controversial, the agency tentatively announced plans to develop new "scorecards" for every Medicare provider. Comprised of numerical ratings for a limited number of criteria, such as medical credentials, staffing levels, and patient satisfaction, the scorecards are expected to be issued four times a year. Details of the proposal are still being developed, but it is reported that nursing homes would be the first provider group to receive ratings, followed by dialysis clinics, hospitals, and physicians. Officials believe that a new rating system could not only help Medicare patients make more informed choices, but also encourage improvements in quality of care.