

Federal Budget to Bring Pain for Urban Hospitals

While it could have been worse – there apparently will be no reductions in Medicare disproportionate share (DSH) and medical education payments – the federal budget reconciliation bill that Congress is expected to pass shortly after it reconvenes at the end of January will most likely include a number of provisions that will hurt urban safety-net hospitals.

Among the Medicaid measures that would affect urban hospitals are a new federal Medicaid default rate for some emergency care; the potential for new, unprecedented cost-sharing requirements for Medicaid recipients; and the phased elimination of managed care provider taxes.

Medicare changes in the bill that would affect urban hospitals include the elimination of a previously proposed reduction in physician payments and a previously proposed increase in home health payments; reduced reimbursement for skilled nursing facility bad debt; and more.

On the whole, the pharmaceutical industry, rather than hospitals, appears to have borne the brunt of this plan to reduce federal health care spending by \$11.3 billion over five years – a far cry from the Bush administration's original proposal to reduce Medicaid spending alone by \$60 billion over 10 years.

Here is a closer look at the changes that are expected to affect urban safety-net hospitals when Congress finally puts to rest the 2006 fiscal year budget.

The reconciliation bill would impose a default rate on payments to hospitals that provide emergency care to members of Medicaid managed care plans with which individual hospitals have no contracts. The proposed default rate would be individual states' Medicaid fee-

- Continued on Page 2

The National Association of Urban Hospitals advocates for adequate recognition and financing of the nation's private, urban, safety-net hospitals, which serve America's needy urban communities.

For further information about the Association, or the information presented in this document, please contact Ellen Kugler at 703-444-0989.

MedPAC Suggests FY 2007 Adjustments

The Medicare Payment Advisory Commission (MedPAC) has finalized its recommendations to Congress for Medicare payment updates for fiscal year 2007.

For both inpatient and outpatient services, MedPAC will recommend updates of 0.45 percentage points less than a full market basket increase, which is expected to be four percent. That would make its recommendation about 3.55 percent. While federal law calls for full market basket updates, a MedPAC staff member explained at the agency's January 10 meeting that the increase should be "market basket less half of expected productivity growth" – growth that MedPAC concludes is 0.9 percent.

Physicians, MedPAC will suggest, should receive an increase of 2.8 percent.

For inpatient rehabilitation facilities, skilled nursing facilities, long-term-care hospitals, and home health agencies, MedPAC will recommend to Congress no increases at all in their Medicare reimbursement. CMS has already endorsed the no-increase recommendation for long-term-care hospitals.

MedPAC's recommendations, officially made in March, are usually given serious consideration by Congress – especially when they call for anything less than a full market basket update. ♦

MedPAC Looking at Wage Index

The Medicare area wage index system has a significant impact on the Medicare revenue of urban safety-net hospitals. Most of those hospitals are located in higher-cost parts of the country and rely on their wage index adjustments to help them pay competitive wages to in-demand health care professionals.

The wage index system has become increasingly controversial, with many observers believing that changes in the system in recent years have been more politically oriented than policy-based. This has piqued MedPAC's interest, and for the last year or so, it has begun to take a closer look at the system. The

- Continued on Page 2

Federal Budget to Bring Pain for Urban Hospitals (continued)

for-service rate (this would be slightly different in California). To take effect on January 1, 2007, this measure would appear to give those managed care plans little reason to negotiate fees with hospitals in good faith.

The bill also would give individual states unprecedented flexibility to change their basic Medicaid benefits packages and impose deductibles, co-pays, and even premiums on some Medicaid recipients – and to do so without seeking federal approval. Such cost-sharing would be “nominal” – the bill’s term – for recipients who earn less than the federal poverty level but could be much greater for those who earn above that level. Groups that would be protected from most cost-sharing include children under the age of 18, the terminally ill receiving hospice care, women with breast or cervical cancer, and inpatients required to spend all but a minimal amount of their income to become Medicaid-eligible. States also would be permitted to charge co-payments to some beneficiaries who use hospital emergency rooms for non-emergency care when a reasonable alternative is available – with the onus on hospitals to inform patients of such alternatives.

The final major Medicaid provision with a potential impact on urban hospitals calls for the phase-out of provider taxes on Medicaid managed care organizations; several states currently impose such taxes to raise Medicaid revenue. New provider taxes levied selectively – only on Medicaid managed care organizations but not all managed care organizations – would be banned immediately and states that currently employ such taxes would be able to continue doing so only until October of 2009.

The proposed Medicare changes appear to be less damaging. The previously announced 4.4 percent cut in physician fees would be eliminated, with fees to remain the same as in 2005, but home health payments, previously scheduled for a full market basket update, also would remain at their 2005 levels, with no increase at all. Medicare also would reduce its bad debt reimbursement to skilled nursing facilities from the 100 percent of bad debt for which it reimburses those facilities now to just 70 percent of their bad debt.

Other Medicare changes with a potential impact on urban safety-net hospitals include an end to the moratorium on beneficiary spending caps for outpatient therapy provided in non-hospital settings; the elimination of the rental option for recipients who need durable medical equipment for extended periods of time; and a five-fold increase in the penalty for failure to provide quality data to the Centers for Medicare & Medicaid Services (CMS).

The bill does offer a few positive provisions for urban hospitals. Phase-in of the long-debated 75 percent rule for rehabilitation hospitals would be extended an additional year, until July 1, 2008. Other measures include the extension of the moratorium on new specialty hospitals for another eight months, pending the Department of Health and Human Services’ submission to Congress of a plan that addresses the challenges that such hospitals pose; gainsharing demonstration projects, beginning next year, to explore how hospitals might share with physicians any savings they generate as a result of physicians’ actions; and a change in how hospitals calculate their Medicare DSH patient percentage in which acute care inpatient days attributable to patients eligible only for drug coverage under a section 1115 waiver would be included, for the first time, in the Medicaid patient-days figure.

The bill has several other interesting clauses, including a requirement for Medicare to implement a pay-for-performance program by fiscal year 2009. It also proposes an experimental approach to addressing hospital-acquired infections in which hospital care for selected diagnosis codes, when accompanied by secondary diagnosis codes that reflect conditions that could have been prevented through the use of “evidence-based” guidelines, would be reimbursed as if the patient did not have the condition that resulted from the secondary diagnosis code. CMS would select at least two diagnosis codes for this demonstration project, which would begin on October 1, 2008.

Members of Congress left Washington in December without finalizing the reconciliation bill, but the House already has scheduled a February 1 vote in which it is expected to endorse the Senate version of the bill and send the measure to the president for his signature. ♦

MEDPAC Looking at Wage Index (continued)

subject arises now at every public MedPAC meeting, and although the agency’s examination is still in its early stages, more can be expected in the coming year.

Because any changes in the Medicare area wage index system could have a potentially dramatic effect on urban safety-net hospitals, NAUH will follow this issue closely in the coming months. ♦

For further information about the news and views presented in NAUH Update, or to learn about membership, please contact Ellen Kugler, executive director, at 703-444-0989.