

MedPAC Questions Key Payments

The Medicare Payment Advisory Commission (MedPAC), which advises Congress on Medicare payment issues, has cast a critical eye on a number of supplemental Medicare payments that urban safety-net hospitals consider vital to their financial well-being.

Among the payments MedPAC addressed at its September and October meetings are those for disproportionate share (DSH), indirect medical education (IME), capital, and outliers. It also is taking a closer look at the Medicare area wage index.

MedPAC's starting point is a troubling one from the perspective of urban safety-net hospitals. Looking only at inpatient Medicare margins, MedPAC staff believes that large urban and teaching hospitals are doing quite well financially. A contrary view, offered by one MedPAC commissioner, is that inpatient margins are an incomplete measure of hospitals' financial performance and that when overall Medicare margins are considered, many such hospitals are actually losing money and the Medicare margins of the group as a whole are lower than those of other non-urban, non-teaching hospitals.

MedPAC members have questioned whether the current levels of DSH and IME payments are "appropriate" and have hinted that the formulas for both could be rewritten. Members would like to link DSH payments to uncompensated care but concede that they are probably two years away from having adequate data on hospitals' provision of uncompensated care.

The commissioners also questioned whether Medicare really needs separate operating and capital payments and whether the three percent add-on for hospitals in large urban areas is justified.

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Congress Adjourns, Will Return to Tackle Medicare Physician Payments

Congress has adjourned until after the November elections without adopting any changes in Medicare or Medicaid. Members intend to return to Washington after the elections for a lame-duck session amid promises to fix the Medicare physician payment problem.

Medicare physician payments are scheduled to be reduced 5.1 percent beginning on January 1, 2007. Many in Congress, including the Speaker and the chairman of the House Energy and Commerce Committee, have indicated that they want to prevent this reduction and hope to address it before the 109th Congress ends.

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Still No Medicaid Changes

Summer has come and gone, but the Centers for Medicare & Medicaid Services (CMS) still has not delivered the Medicaid changes it promised – or, from the perspective of many urban safety-net hospitals, that it threatened – in the spring.

As part of the administration's proposed budget, CMS proposed changing a number of Medicaid practices, including limiting allowable costs, reducing permitted provider taxes from six percent to three percent, and limiting allowable costs for targeted case management. When Congress failed to adopt the administration's proposals, CMS said it would implement them unilaterally, through a rule to be published by the end of August. That plan prompted many members of Congress to write to CMS and ask that it not circumvent Congress by changing Medicaid without congressional input and participation.

In response to those letters, recently departed CMS administrator Dr. Mark McClellan indicated that he intended to move forward as planned, regardless of congressional concerns.

That has not happened – yet. Many observers now believe that CMS will wait until after the November election and then publish the regulation making its desired changes official. ♦

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.

Congress Adjourns . . . (continued)

This is an important issue for urban hospitals, many of which employ physicians and do not want to see a 5.1 percent reduction in their payments for caring for Medicare patients.

On the other hand, preventing the reduction will cost an estimated \$14 billion over the next 10 years. Many lawmakers believe that the only way to pay for this would be to take money out of other parts of the Medicare program. Among the approaches that have been discussed are taking money out of the special pool of funds set aside as an incentive for Medicare managed care plans, reducing the Medicare update factor, reducing bad debt reimbursement, and others. Some of the possibilities would be more damaging than others to urban hospitals.

Complicating the widespread desire to address this issue before the end of the year is the nature of post-election sessions of Congress. These lame-duck sessions typically are characterized by tumult and uncertainty, and it is not clear what, if anything, Congress will be able to accomplish during this period – even on an issue such as this one that both parties agree is a priority. ♦

CMS Still Pursues Severity-Based DRGs

When CMS's annual Medicare inpatient prospective payment system rule published in the spring proposed introducing new, severity-based DRGs, the hospital industry responded with an avalanche of protest – including from NAUH, which has long supported the concept of severity-based DRGs but opposed the manner in which CMS proposed implementing them. CMS subsequently released the final version of the rule without completely revamping the DRG system – but it has not given up on the concept.

Instead, it hired two new consultants, the RAND Corporation and RTI International, to examine severity-based DRG systems other than the system that incurred the hospital industry's wrath when proposed earlier this year. Both companies were given short-term contracts and are expected to work quickly. CMS has indicated that it intends to address this issue again in next year's inpatient prospective payment system rule. ♦

MedPAC Questions Key Payments (continued)

Outliers, too, have been the subject of recent MedPAC interest. With Medicare expected to adopt severity-adjusted DRG payments at some point in the near future, MedPAC commissioners believe that now may be an appropriate time to review Medicare outlier policy.

MedPAC has been discussing new approaches to the Medicare wage index since the spring. It would like to simplify the formula and reduce or eliminate the need for reclassifications (currently, nearly one-third of all hospitals are reclassified). The agency is considering a number of new approaches, but its staff warns that change – even budget-neutral change – will create winners and losers. The likely losers, based on MedPAC's current reform ideas: hospitals in areas with wage indexes of 1.2 or more – in other words, those in larger cities.

MedPAC plans to continue discussing all of these issues at its November and December meetings and to present its recommendations to Congress about DSH, IME, capital, and outliers in January. It will continue to examine the wage index in 2007.

While MedPAC's recommendations are highly respected by Congress, they are not binding on that body. ♦

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.