

Medicaid Regulation Moratorium Advances

The House has overwhelmingly passed legislation aimed at blocking the implementation of seven new Medicaid regulations.

Over the past year, the administration has proposed seven Medicaid regulations that would reduce federal Medicaid spending an estimated \$17.8 billion over the next five years. Last year Congress imposed a moratorium on the implementation of some of these regulations, but those moratoriums end next month; others regulations are scheduled for implementation soon as well.

Among the pending regulations are measures that would limit state Medicaid payments to public hospitals, which in turn would reduce federal funding of state Medicaid programs; narrow the services for which the federal government would provide Medicaid matching funds; and prohibit federal matching funds for the cost of transporting Medicaid-eligible children to school and providing care in schools.

Other regulations would narrow the types of rehabilitation services for which the federal government would provide matching funds; end federal matching of Medicaid graduate medical education payments; narrow the scope of outpatient services eligible for federal Medicaid matching funds; and limit the taxes that states can use to raise their share of Medicaid revenue.

State governments maintain that these regulations would increase their share of Medicaid costs. Hospitals fear that this shifting burden would result in Medicaid payment reductions at the state level. Because of their large numbers of Medicaid patients, urban safety-net hospitals would be especially vulnerable to payment reductions.

House Republicans, initially skeptical about the bill, rallied around the measure after the addition of an amendment that would enhance asset verification as part of determining Medicaid eligibility and save enough money

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Administration Proposes Medicare Inpatient Payment Changes

The Bush administration has proposed revising some Medicare inpatient payments next year.

In its newly proposed, 1205-page Medicare inpatient prospective payment system regulation for FY 2009, the Centers for Medicare & Medicaid Services (CMS) proposes raising Medicare inpatient rates by 2.1 percent for hospitals that comply with quality data reporting requirements (0.1 percent for those that do not).

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Medicare Bill in the Works

Congress is again considering developing Medicare legislation with potential implications for many urban safety-net hospitals.

Last year the House attempted to address a number of Medicare issues in its Children's Health and Medicare Protection Act (CHAMP), and now, the Senate is mulling possible Medicare legislation. At the heart of discussions in the Senate is the desire to prevent the scheduled reduction in Medicare payments to physicians from taking effect on July 1. Instead, lawmakers are talking about raising physician payments 0.5 percent for six months, beginning on July 1, and then raising them another one percent for the year beginning January 1, 2009.

Congress also is considering revising the Medicare physician payment formula to increase payments to primary care physicians. Because such a change would have to be budget-neutral, any increase in primary care physician payments would need to be

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MedPAC Mulls Gainsharing

The Medicare Payment Advisory Commission (MedPAC) will recommend that Congress direct Medicare to experiment with bundling hospital and physician payments for care provided to hospitalized Medicare beneficiaries.

The federal agency, which advises Congress on Medicare payment issues, voted to make the recommendation at its April 2008 meeting. MedPAC will formally offer the recommendation in a report it submits to Congress later this year. – 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.

Administration Proposes . . . (continued)

The proposed regulation also calls for keeping indirect medical education (IME) adjustments at their FY 2008 level; paying only 50 percent of the customary IME adjustment to Medicare capital payments; reducing the outlier threshold from the current \$22,185 to \$21,025; and extending the application of the post-acute transfer rule in situations in which patients are discharged from the hospital before the mean length of stay for the DRG in question from the current three days to seven days.

CMS also proposes several changes that could affect hospitals' Medicare area wage index. For hospitals seeking reclassification, the threshold for comparability of wages with surrounding areas has been raised from 84 to 88 percent for individual urban hospitals and from 85 to 88 percent for urban hospitals applying for group reclassification. In addition, CMS is proposing a new formula for calculating rural floors for individual states, and this change would lower the rural floors, and possibly reduce wage indexes, for some urban hospitals in California, Connecticut, Iowa, Massachusetts, New Hampshire, New Jersey, North Dakota, and Vermont.

Finally, CMS is proposing increasing the number of quality measures on which hospitals must report to qualify for full payment updates from the current 30 measures to 73 measures beginning in FY 2010. Hospitals that fail to meet quality data reporting requirements would receive updates two percentage points less than a full update. In addition, CMS proposes denying Medicare payments to hospitals for selected medical conditions that are generally thought to be the fault of the hospital – eight such conditions in all, including infections, bedsores, and objects left in patients' bodies after surgery. CMS also proposes adding to this list of conditions in the future.

For further information about these and other aspects of the proposed inpatient rule, please contact NAUH at info@nauh.org. ♦

Medicaid Regulation Moratorium . . . (continued)

to offset the cost of the year's delay in implementing the regulations. The House voted 349-62 in favor of the bill – a veto-proof majority.

Senate Republicans, on the other hand, are not thought to be as supportive of the measure, so while the moratorium is likely to pass in the Senate as well, it may not do so with a veto-proof majority. The White House has already indicated – twice – that President Bush will veto the bill if it reaches his desk.

The Senate is expected to take up the moratorium in earnest next month. ♦

Medicare Bill in the Works (continued)

offset by reductions in payments to specialists. The anticipated Medicare bill also is expected to address wage index issues. Specifically, section 508 wage index classifications, introduced as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, are currently set to expire at the end of the current fiscal year (September 30). Many observers expect Congress to extend these reclassifications, under which many urban hospitals currently are paid, for at least another year.

In addition, any Medicare bill this year is expected to seek to extend a number of Medicare provisions that govern the reimbursement of rural hospitals. Anything the Senate passes will then go to a conference committee to be reconciled with last year's House bill. Because of the importance of the physician payment issue, passage of some sort of Medicare bill appears almost certain by mid-June or shortly thereafter. ♦

MedPAC Mulls Gainsharing (continued)

Under the MedPAC proposal, Medicare would experiment with paying hospitals a single fee for caring for inpatients with specific medical problems. This fee would be a "bundle" that would include money both for the hospital and physicians participating in a given patient's care. Hospitals and physicians would need to negotiate how they would split the fee and share risk and reward – a practice often referred to as "gainsharing."

In MedPAC's view, bundling Medicare payments should make providers more efficient and more quality-oriented by giving them a direct financial stake in the quality of patients' care while rewarding physicians by enabling them to share the financial benefits of the efficiencies they contribute to patient care. At the same time, participants would be penalized financially for readmissions considered avoidable.

Currently, there are numerous legal obstacles to physician gainsharing that would need to be addressed as part of any effort to institute the practice.

MedPAC is expected to recommend that Congress implement a voluntary pilot program to test the viability of gainsharing. While the agency's recommendations are not binding on Congress and there is little reason to believe Congress will act quickly on such a recommendation, MedPAC's recommendations generally are respected by Congress and frequently end up being implemented in some manner after a period of gestation. ♦

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.