

Administration Proposes Large Medicare, Medicaid Cuts

The Bush administration's proposed FY 2008 budget calls for \$96 billion in health care entitlement cuts over the next 5 years. Of that amount, \$65.6 billion is reduced growth in Medicare spending and \$13 billion is reduced Medicaid spending.

Among the proposed Medicare cuts are (all figures are projected savings over 5 years):

- Reduce annual hospital updates to market basket minus 0.65% (\$13.8 billion).
- Phase out Medicare bad debt payments (\$7.2 billion).
- Eliminate SNF and inpatient rehab updates for FY 2008 and make annual updates market basket minus 0.65% thereafter (\$11.1 billion).
- Reduce annual outpatient updates to market basket minus 0.65% (\$3.4 billion).
- Eliminate home health updates through 2012 and reduce them to market basket minus 0.65% thereafter ((\$9.7 billion).
- Eliminate "duplicate" hospital IME payments for Medicare Advantage patients (\$4.4 billion).
- Set base payments for 5 post-acute conditions treated in SNFs and IRFs (\$2.9 billion).
- Increase premiums for high-income recipients (\$10.4 billion).

Proposed Medicaid cuts include limiting federal matching funds for administrative expenses to 50% (\$6.5 billion); reducing payments to drug manufacturers (\$2.2 billion); and reducing Medicaid spending through SCHIP authorization (\$1.8 billion).

If adopted, these cuts would hurt urban safety-net hospitals, so NAUH is opposing them. ♦

Administration to Circumvent Congress, Impose More Medicare, Medicaid Cuts

The Bush administration intends to use the regulatory progress to implement \$22.9 billion in Medicare and Medicaid spending cuts (over 5 years) over and above those it recently called for in its proposed FY 2008 budget. Regulatory changes do not require congressional approval.

Among the \$12.7 billion in Medicaid cuts, the administration will limit payments to government providers to cost (\$5 billion); eliminate selected school-based services (\$3.6 billion); eliminate federal matching funds for graduate medical education (\$1.7 billion); and "clarify" rehabilitation services (\$2.3 billion).

The administration proposes saving \$10.2 billion on Medicare by introducing new regulations designed to "improve Medicare efficiency, productivity, and program integrity."

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Congress Mulls Spending Alternatives

While congressional Democrats – now in the majority – have expressed considerable concern about many of the administration's recent Medicare and Medicaid proposals, they face a harsh reality as they move forward. Now that both the House and Senate have "PAYGO" (pay-as-you-go) rules, new spending must be offset with savings, which means that while Democrats may oppose some or even all of these recent proposals, they may need to accept at least some of them if they are to implement any of the changes they seek in both Medicare and Medicaid.

In addition, congressional Democrats must find money to pay for their plan to reauthorize and expand the SCHIP program and address the reduction in Medicare payments to physicians scheduled to take effect on January 1, 2008.

A possible alternative is for them to cut in areas other than those proposed by the administration.

Coincidentally, the Congressional Budget Office (CBO) recently released its every-other-year summary of possible spending alternatives. These

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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 Mulls Spending Alternatives (continued)

are proposals that have been made, or discussed, by policy-makers in both the executive and legislative branches as well as by CBO staff and the private sector. CBO's alternatives are not recommendations; they are just a compendium of options.

The Medicare options include (all figures are projected savings over 5 years):

- Revise the benchmark by which payments to Medicare Advantage plans are determined (\$64.8 billion).
- Remove IME money from private plans (\$5.2 billion).
- Reduce Medicare GME payments (\$5.9 billion).
- Reduce IME payments (\$21.6 billion).
- Equalize capital payments to teaching and non-teaching hospitals (\$2.3 billion).
- Convert DSH into a block grant program (\$11.2 billion).
- Reduce annual inpatient update factors (\$17.8 billion).
- Reduce inpatient capital payments (\$2.4 billion).
- Reduce payments for home health care (\$8.5 billion).
- Reduce annual updates for post-acute care (\$8.1 billion).
- Modify the formula for setting physician payments (\$24-65 billion).
- Increase Part B premiums (\$42.2 billion).
- Require more higher-income beneficiaries to pay higher Part B premiums (\$3.3-8.2 billion).
- Increase Part A and Part B cost-sharing (\$11.6 billion).
- Institute co-payments for home health care (\$12.9 billion).
- Institute cost-sharing for the first 20 days in skilled nursing facilities (\$9.6 billion).
- Institute deductibles and co-pays for clinical lab services (\$8.3 billion).

The CBO's collection of Medicaid cost-saving ideas also is daunting.

- Equalize the federal matching rate for administrative functions at 50% (\$8.4 billion).
- Restrict the allocation of administrative costs shared with the TANF and food stamps programs (\$1.8 billion).
- Cap administrative costs on a per-enrollee basis (\$4 billion).
- Convert payments for acute-care services to a block grant (\$65.7-87.2 billion).
- Convert DSH payments into a block grant (\$600 million).
- Limit allowable provider taxes (\$4.5 billion).

These options illustrate the challenge Congress now faces. While many members would like to reject large parts of the administration's budget proposal, they also want to put their own imprint on Medicare and Medicaid. To do so, however, they will need to find off-setting spending cuts – like those listed above or others – to pay for any changes as well as to reauthorize and expand SCHIP and address the Medicare physician payment problem. ♦

Administration to Circumvent Congress (continued)

The regulation to close the Medicaid upper payment limit loophole for public providers was published on January 18. By redefining “public provider” and preventing states from claiming Medicaid matching funds for payments to these providers that exceed 100% of their costs, NAUH believes this proposed regulation reduces the ability of states to draw down federal Medicaid funds, which would have serious implications for all providers and detract from the flexibility states need to direct their Medicaid resources where they believe they are most needed. It also relies on CMS's unreasonable definition of what constitutes hospitals' “costs.”

CMS is expected to issue several other new regulations in the near future, including new rules governing provider taxes; a regulation ending federal participation in Medicaid medical education funding; and a provision that would prevent states from pursuing third-party reimbursement for pharmacy costs already paid by state Medicaid programs and matched by the federal government.

Together, these changes further threaten the already inadequate stream of public payments from government to urban safety-net hospitals, which are much more dependent on Medicare and Medicaid than the typical American hospital. NAUH is currently working with other hospital groups to persuade members of Congress to oppose the administration's effort to make fundamental changes in these two national programs without consulting the legislative branch of government. ♦

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.