Federal Court Rules In Favor of Hospitals on Medicaid Rule

The U.S. District Court for the District of Columbia today ruled for the plaintiffs that the Centers for Medicare & Medicaid Services (CMS) violated a congressionally-imposed one-year moratorium by attempting to issue the public provider cost limit regulation in final form on May 25, 2007, the same day President Bush signed the moratorium into law. The final provider cost limit rule will be invalidated and sent back to CMS, giving Congress time to act on the Medicaid moratoria legislation that is part of the Iraq war supplemental appropriations bill. CMS must now decide whether or not to republish the provider cost limit rule – with or without changes – after May 25, when the current moratorium expires. If CMS does decide to republish the cost limit rule in final form, the rule would not be effective for 60 days from the date of publication. This past week Secretary Leavitt announced his intention to delay implementation of the provider cost limit and GME rules until August 1, although it is unclear how and when formal notification of that intention will occur. The Judge declined to rule on the substantive issues in the case because the final rule was vacated. [Source: NAPH Action-Alert—May 23, 2008].

IPPS Change Eliminating Capital IME Payment

According to the final rule with comment period, CMS seeks to eliminate the capital indirect medical education (IME) adjustment beginning in federal fiscal year (FFY) 2009. According to the rule, the IME adjustment would be reduced by 50 percent in FFY 2009 and eliminated altogether in FFY 2010 and beyond. If implemented, this decision would result in an annual aggregate payment cut to teaching hospitals of $375 million, of which University Health Care—Hospitals & Clinics would lose $1,265,470.

CMS Announces Demonstration to Encourage Collaboration Using Bundled Payments

CMS announced a new demonstration for hospitals to test the use of a bundled payment for both hospital and physician services for a select set of episodes of care to improve the quality of care delivered through Medicare fee-for-service. The goal of the Acute Care Episode (ACE) demonstration is to use a global payment to better align the incentives for both types of providers leading to better quality and greater efficiency in the care that is delivered. The demonstration will also test the effect that transparent price and quality information has on beneficiaries who, based on quality and cost, choose to receive care from the separate payment systems can lead to conflicting incentives that may affect decisions about what care will be provided. The select sets of procedures included in the bundled payment demonstration are 28 cardiac and 9 orthopedic inpatient surgical services. These elective procedures were selected because profit margins and volume have historically been high; there is sufficient marketplace competition to ensure interested demonstration applicants; the services are easy to specify, and quality metrics are available for them. This demonstration provides an opportunity for Value-Based Care Centers to develop efficiencies in the care they provide to beneficiaries through increasing market share, quality improvement in clinical pathways, improved coordination of care among specialists, and “gainsharing.” Gainsharing, or provider incentive programs, allow physicians and hospitals to share remuneration for implementing and coordinating improvements in efficiency and quality. This demonstration also provides an opportunity for Medicare to share savings achieved through the demonstration with beneficiaries who, based on quality and cost, choose to receive care from participating demonstration providers. [Source: CMS Office of Public Affairs].