House Votes to Delay Bush Plan to Cut Medicaid Payments to States

Defying repeated veto threats, the House voted Wednesday to pass a bill that would block Bush administration Medicaid rules. The bill (HR 5613), sponsored by Rep. John D. Dingell, a Michigan Democrat, passed 349-62. The question now is whether supporters in the Senate will be able to muster enough votes to overcome a presidential veto in that chamber as well. 

Lawmakers debated the bill Tuesday, but House leaders decided to delay the vote to give members who were campaigning in the Pennsylvania primary time to return to cast their votes — placing them on record in agreement with criticism back home that the new rules would push more Medicaid costs on the states. Medicaid is a joint federal-state health insurance program for the poor. Currently, the federal government pays 57 percent of the program’s costs — an estimated $204 billion in fiscal 2008. There has long been tension between states and the federal government over who should bear more of the burden. The administration argues that states are unfairly gaming the system to wring extra dollars out of the federal government and, in some cases, using the money for non-Medicaid purposes. House Democrats and state governors say the states have addressed those problems and the new rules would unfairly deprive them of funds. The seven proposed Bush administration regulations would narrow certain services provided by Medicaid, limit some state services eligible for federal reimbursement, and limit certain Medicaid accounting maneuvers by the states. The legislation’s fate now will rest on whether the Senate can duplicate the support shown in the House. For Senate Democrats, success could depend on not burdening the legislation with riders that might give otherwise supportive Republicans second thoughts. The Congressional Budget Office estimates that the Dingell bill’s one-year delay of the regulations would cost about $1.8 billion over five years.

[Source: Congressional Quarterly—April, 2008]

Proposed IPPS Rule

⇒ CMS projects that the market basket update used to adjust hospital payments will be 3.0 percent.
⇒ CMS is proposing to set the outlier threshold at $21,025 in FY 2009, down from $22,185 in FY 2008.
⇒ In FY 2007, CMS began a three-year transition in the determination of DRG relative weights, moving to cost-based weights from weights based on charges. Beginning in FY 2009, the third year of the transition, CMS is proposing to base relative weights 100 percent on costs.
⇒ The post-acute transfer policy would apply to 273 MS-DRGs, the same number as were subject to the policy in the FY 2008 IPPS final rule. Of these, 24 MS-DRGs qualify as special pay post-acute transfer DRGs. Under the general post-acute transfer policy, the transferring hospital will be paid 50 percent of the total IPPS payment plus the average per diem for the first day of the stay. For the special pay MS-DRGs, the transferring hospital will also receive 50 percent of the per diem amount for each subsequent day of the stay, up to the full MS-DRG payment amount.
⇒ In order for technology to qualify for an additional payment beyond the payment for the associated MS-DRG, the applicant must demonstrate that the medical service or technology: 1) is new; 2) meets a defined cost threshold; and 3) offers substantial clinical improvement over existing services or technologies.

[Source: CMS Office of Public Affairs—April 14, 2008]

New Regulatory Education Committee

University Hospital has created an education team responsible for directing and coordinating regulatory updates to all appropriate persons within the hospital and clinics. The goal of the committee is to establish consolidated responsibility for disseminating regulatory updates to hospital entities. The committee (chaired by Barb Viskochil) consists of reps from Admitting, HIM, HIM/ITS, M-M Services, and PBFS. The committee will call upon adjunct members from Case Management, Contracting, Compliance, hospital entities, etc. when necessary to educate all areas.

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