STAT News

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STATE UPDATE: Medicaid Waiver Terms Finalized

The New York State Department of Health announced on Monday (4/14) the federal government's final approval of the terms and conditions of the $8 billion Medicaid waiver. The Centers for Medicare and Medicaid Services (CMS) and the state reached an agreement in principle in February. The state anticipates $17.1 billion in total Medicaid savings to accrue as a result of the dozens of reforms outlined by the state's Medicaid Redesign Team (MRT) in February 2011 and then adopted by the state legislature. The governor charged the multi-stakeholder MRT to find ways to reduce costs, while ensuring access to quality care for the state's Medicaid beneficiaries. Seventy-eight recommendations resulted and were adopted by the legislature. Those reforms, mostly focused on better care coordination, are now being implemented. Moving all Medicaid patients into managed care plans is one major reform and it is already reaping savings. Waiver funding will also help stabilize safety-net providers. Safety-net providers are those hospitals that service a disproportionate number of poor, uninsured, and underinsured patients. The waiver allows the state to reinvest over a five-year period $8 billion of the $17.1 billion in federal savings generated by the MRT reforms. The Medicaid program's costs are shared by the state and federal governments. Waiver money will flow mostly to New York and its eligible Medicaid providers through a competitive program – the **D**elivery **S**ystem **R**eform **I**ncentive **P**ayment (**DSRIP**) Plan worth $6.42 billion. Providers must choose from among a list of approved DSRIP programs. The waiver's emphasis is on local, yet broad-based partnering as a means to transform the delivery system with the ultimate goal of saving money and delivering better and more appropriate care to Medicaid patients. The waiver seeks to reduce avoidable hospitalizations (inpatient and ER admissions) in New York by 25 percent over five years. This percent reduction in avoidable admissions will be a tough one for already fragile hospitals to absorb, especially the safety-net providers that already predominately serve a Medicaid population. However, the waiver provides a $500 million Interim Access Assurance Fund, which is temporary, time-limited funding to ensure safety-net providers can fully participate in the competitive DSRIP transformation process without disruption. Other waiver money will support health home development, investment in long-term care, workforce, and behavioral health services. DSRIP letters of intent are due May 15, 2014 and the DSRIP planning applications are due late in June.

FEDERAL UPDATE: Hospitals Challenge Federal CMS

New York hospitals were among the parties to a suit filed in federal court earlier this month with support from the Healthcare Association of New York State, the American Hospital Association, other state and regional hospital associations and a few hospital systems. The suit addresses CMS' "two-midnight" inpatient admissions criteria and related policies. Hospitals contend that the 0.2 percent payment cut for all inpatient services is unlawful and arbitrary. CMS imposed the cut because it believes more patients will be admitted rather than placed on less costly outpatient-based observation care. Some months ago, the agency released guidance about what constitutes observation level care vs. inpatient care. It determined that a valid inpatient stay must span two full midnights. The rule does not consider the medically complex patients, even some ICU patients, who do not need to stay in a hospital for two midnights, but nonetheless need inpatient care. Historically, hospitals placed patients on observation level care as opposed to admitting them for short-inpatient stays because the CMS had ramped up its auditing of short-inpatient stays. Recovery Audit Contractors, known as RACs and hired by CMS, often and without substantiating evidence denied these short stays. Observation status allowed physicians and the care team to diagnose and treat patients without worry of short-stay denial. Patients on observation care, however, are liable for outpatient-based co-pays and deductibles. These costs add up and are often a surprise to Medicare beneficiaries. **Permission to reprint articles granted. Attribution to this publication required.*

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