



STATE UPDATE: Feds Claim Medicaid Overpayment

If New York State's plan to appeal the recent Centers for Medicare and Medicaid Services' (CMS) request that the state repay \$1.26 billion in Medicaid overpayments is not successful, the state says it will take the bold step of suing the federal government. The alleged overpayment dates back to fiscal year 2010-2011. A CMS audit concluded that overpayments for Medicaid claims for certain services for developmentally disabled individuals occurred. CMS' request holds ramifications for both providers and patients. Repayment of such a large amount would put pressure on the state's budget, and the state could look to further reduce Medicaid payments to hospitals to offset this unprecedented disallowance. Medicaid patients would inevitably feel the pinch and such a move would also disrupt the state's Medicaid transformation plans. Further, CMS has indicated that it may audit additional years. The overpayment number could climb higher. The hospital industry is in the midst of redesigning the way Medicaid services are delivered, and it has been an active and willing partner in the state's ambitious effort to overhaul and streamline the Medicaid program. In this regard, the state's support as hospitals move through this transformation process must remain intact.

Medicaid Redesign Grant Awards

On August 6, 2014, the state awarded \$21.6 million in Delivery System Reform Incentive Payment (DSRIP) project design grants. These planning grants will help emerging Performing Provider Systems (PPS) prepare their final competitive DSRIP Project Plans, which are due December 16, 2014. Suburban Hospital Alliance applicants were granted \$4.64 million - \$ 2.3 million (Long Island region) and \$2.34 million (Hudson Valley region). These grants are just another step in the long process toward overhauling New York's Medicaid system – the second costliest in the nation.

FEDERAL UPDATE: Watching the “Two-Midnight” Rule

Congressional representatives are back in their home districts and will return to Washington after the Labor Day holiday, but work in the regulatory realm of Washington DC continues at a measured pace. For the hospital industry that means steadfast vigilance concerning CMS' “two-midnight” rule. At the present time, CMS has opened the door to further discussion about a short-stay payment methodology that would address the inadequacies of the “two-midnight” rule that have cropped up when high-need patients do not cross the “two-midnight” threshold to qualify as inpatients, but nonetheless require expensive, inpatient level 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 these short stays. CMS-hired Recovery Audit contractors (RACs), often and without substantiating evidence, denied these short stays. In response to hospitals' and patients' pleas for equity, CMS has delayed the start of enforcement of the “two-midnight” rule and has extended hospitals' “probe and educate” transition period – a span of time in which very limited audits are conducted to help the hospital industry acclimate itself to the rule. Meanwhile, the hospital industry's suit against CMS and the “two-midnight” rule is pending. It was filed in April 2014 by the American Hospital Association, the Healthcare Association of New York State, and other regional hospital associations. Further, the Medicare Diagnosis Related Group (DRG) global payment mechanism established in the 1980s is constructed to account for low-end and high-end patient acuity. The short-stay mechanism could disrupt this balance because the high-end acuity patients would disrupt the balance of the formula and consequent reimbursement given to hospitals.

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