New York City Independent Budget Office

Focus On:
The Preliminary Budget

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Medicaid Waiver Funds May Not Be a Great Deal for the City

New York State's ammended waiver from some federal Medicaid regulations has been hailed as a savior for financially distressed hospitals throughout the state. The waiver amendment, informally agreed to by the federal government, would allow the state to retain $8.0 billion of federal savings from the state's Medicaid reform initiatives. But what the funds can actually be used for has not been well understood. Even less understood have been the impacts that the waiver may have on the Health and Hospitals Corporation (HHC) and the New York City budget. Especially in the latter case, these consequences may not be entirely positive.

New York State first submitted a proposal to the U.S. Centers for Medicare and Medicaid Services (CMS) to amend its existing Medicaid waiver in August 2012.[1] Specifically, the state sought to have the federal government allow the state to hold onto $10.0 billion in future federal Medicaid savings. The funding was to be reinvested into the state's health care system over the course of five years. New York had recently enacted a series of Medicaid reforms and state officials argued that they should be allowed to retain a portion of the approximately $17 billion in federal savings they expected from the changes. CMS rejected several aspects of New York's original proposal and the state submitted a revised application. Last month, the state and CMS reached an agreement in principle on $8.0 billion in federal reinvestment over five years. Specific details about how the money will be spent are unknown, as the state is still awaiting formal approval. Still, the revised application offers some clues.

The updated proposal includes three components, the largest of which is a Delivery System Reform Incentive Payment (DSRIP) plan worth $7.4 billion, or almost 75 percent of the $10.0 billion requested.[2] DSRIP is an existing mechanism to disburse Medicaid waiver dollars and foster quality improvements, which is currently being used in several other states. The primary goal of New York's DSRIP plan would be to reduce avoidable hospitalization statewide by 25 percent over five years. The secondary goal would be to stabilize and transform the state's health care safety net. As proposed, the state's DSRIP plan would include 25 different programs, all of which require clearly defined outcome measures related to reducing avoidable hospitalizations. Some examples include: the implementation of care coordination and transitional care programs; the development of co-located primary care services in emergency departments; and the development of community-based strategies to improve cancer screening.

The state has proposed a four-step process to distribute DSRIP funds to specific providers. The first step would occur when New York formally receives its statewide funding allocation from CMS. The statewide allocation would then be split into two pools, one for public hospitals and the other for private, safety-net hospitals and other providers. Next would be the project allocation, with each project scored for elements such as avoidable hospitalization and quality objectives, potential cost savings, number of Medicaid members impacted, and the applicant's financial viability. Each project's overall score would determine the size of its allocation from either the public or private pool. The last step would be performance allocation, which would link payouts to project performance in terms of milestone attainment, reduction in preventable hospitalizations, financial sustainability, and other project-specific outcome metrics.

The state's revised application aims to allocate the first funds to approved planning projects in May. This was based, however, upon the state obtaining formal approval from CMS by March 3, which did not occur. More broadly, the state is planning on spreading project funding over five years.

The Mayor's Preliminary Budget assumes that HHC will receive $400 million in Medicaid waiver funding in each

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year from 2015 through 2018.[3] These projections are far from certain. One major concern is that federal waiver funds, like all Medicaid funding, require a one-to-one match. The state's current plan to produce the match involves the use of both intergovernmental transfers and designated state health programs. These designated programs are state or local expenditures on existing public health services that CMS certifies as counting towards the state's match. Exactly which programs and how much spending will be eligible for this certification is unknown, but the designated programs will likely account for only a minority of the total state commitment. Rather, based on very preliminary estimates released in December, the state Department of Health (DOH) expects the lion's share of the match to come from intergovernmental transfers from public hospitals throughout the state. Specifically, DOH would assign each participating public hospital a transfer amount and then pool all these funds to draw down the federal match. DOH would then divide the combined funding into public and private pools, and from there distribute the money to individual projects.

This funding process could be problematic for HHC and the city several reasons. First, HHC's intergovernmental transfers would likely be signifigant given it is the largest public hospital system in the state. Second, hospitals are required to pay for their intergovernmental transfers with nonstate, nonfederal operating revenues—a very small pool of funds for HHC. In 2013, fully 77 percent of HHC's operating revenues came from Medicaid or Medicare—including supplemental funds from the Disproportionate Share Hospital and Upper Payment Limit programs—and as such would be ineligible for this purpose. Another 8 percent came from the indigent care and other pools, which are partially funded with Medicaid disproportionate share dollars. Given that much of HHC's remaining operating revenues are city funds, the city could end up paying for all or much of HHC's intergovernmental transfer obligation. This could occur using city funds already in the HHC budget or, considering HHC's challenging fiscal outlook, by the city increasing its subsidy so that HHC is able to draw down Medicaid waiver dollars.

Over Three-Quarters of HHC Operating Revenues from Medicaid and Medicare
Dollars in millions

	2012		2013	
	Amount	**Share**	**Amount**	**Share**
Medicaid Fee-for-Service & Managed Care	$2,309	40%	$2,105	37%
Disproportionate Share Hospital & Upper Payment Limit Payments	1,317	23%	1,402	25%
Medicare Fee-for-Service & Managed Care	986	17%	862	15%
Indigent Care and Other Pools	438	8%	446	8%
Other Patient Reimbursements	389	7%	360	6%
Grants, City Funds	245	4%	339	6%
All Other Revenue	65	1%	116	2%
Total Revenue	**$5,749**	**100%**	**$5,631**	**100%**

SOURCE: Health and Hospitals Corporation
NOTE: Amounts are on a cash and not accrual basis.
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Another concern is that if payments are performance-based, they become dependent on whatever outcome metrics the state uses. An example of how this could play out can be observed in two federal policies tying Medicare reimbursements to quality of care that took effect in October 2012. IBO's analysis of these two programs last spring found that HHC facilities fare worse than other hospitals in the city overall and specifically in terms of penalties and bonuses that were assessed based on adherence to clinical standards and patient surveys. HHC facilities do better than other hospitals in avoiding penalties for readmissions, however.

Lastly, while the state's application to CMS calls for waiver funds to be used for both public and private hospitals, the exact split between the two groups and the eligibility criteria for participating private providers is still being determined. HHC serves the most uninsured and Medicaid patients in New York, but there is intense pressure on state DOH to use waiver funds for other providers too. Upstate legislators are calling for the money to benefit hospitals outside of the city, which serve fewer needy patients, and downstate advocates are calling for funds to bail out struggling private providers in Brooklyn. The end result may be that HHC does not receive the equivalent of its entire intergovernmental payment plus a one-to-one federal match in Medicaid waiver funds. Were this to occur, HHC's payment, likely funded with city dollars, would be used in part to draw down federal dollars subsidizing other public or private hospitals throughout the state.

Endnotes

[1]Under the 1115 waiver program—1115 refers to a specific section of the Social Security Act—states can apply to try out a new approach to delivering or financing Medicaid services. If approved, CMS may waive certain federal requirements and/or approve funding for populations and services not typically covered by Medicaid.
[2]The other two components of the state's revised proposal are Managed Care Contract Payments worth $2.1 billion and a State Plan Amendment worth $525 million.
[3] Unless otherwise indicated, all years refer to city fiscal years.