Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Inpatient Hospital Certified Public Expenditure Program

Substitute Senate Bill 5883, Sec. 213(1)(p); Chapter 1, Laws of 2017, 3rd Special Session PV

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Executive Summary

This report examines whether savings continue to exceed costs for the inpatient hospital Certified Public Expenditure (CPE) program. We've submitted this report as required by Substitute Senate Bill 5883 (2017), Section 213(1)(p):

> *The health care authority shall continue the inpatient hospital certified public expenditures program for the* 2017–2019 *fiscal biennium. The program shall apply to all public hospitals, including those owned or operated by the state, except those classified as critical access hospitals or state psychiatric institutions. The health care authority shall submit reports to the governor and legislature by November 1, 2017, and by November 1, 2018 that evaluate whether savings continue to exceed costs for this program. If the certified public expenditures (CPE) program in its current form is no longer cost-effective to maintain, the department shall submit a report to the governor and legislature detailing cost-effective alternative uses of local, state, and federal resources as a replacement for this program.*

We previously reported on this topic as directed by the Legislature in Engrossed Substitute Senate Bill 6052 (2015), Section 213 (1)(j) Visit our legislative reports webpage at https://www.hca.wa.gov/about-hca/legislative-reports to see previous reports.

The CPE program was implemented in the 2005-2007 biennium as a replacement for the Inter-Governmental Transfer (IGT) program. The statutory authority for this program is found in federal rule under 42 CFR 433.51 and state rule under WAC 182-550-4650 , 182-550-4670, and 182-550-4690.

We present this report in four parts. The first part provides a brief history of the CPE program, including the elimination of intergovernmental transfers (IGTs) and the resulting loss of federal funding. The second part describes how payments are determined. The third part provides a trended fiscal impact analysis. The final part provides information about the cost to buy out the program.

Based on our analysis, the CPE program continues to show savings exceeding costs through the 2017-19 biennium.

We defined terms in a glossary (Appendix A) at the end of the report.

Program History

The CPE program began with hospital inpatient admission dates on or after July 1, 2005. The following is a brief description of the program and the payment method it replaced.

Intergovernmental Transfers

Prior to state fiscal year (SFY) 2006, Washington State used intergovernmental transfers (IGTs) to fund supplemental Disproportionate Share Hospital (DSH) and upper payment limit (UPL) payments to public hospitals.

The United States (U.S.) Congress in 1981 created DSH to compensate hospitals for the added costs of serving a disproportionate share of low-income individuals who are either part of the Medicaid program or have no insurance at all. These payments are matched by the federal government based on each state's Medicaid match rate.

The IGT transactions netted approximately $80 million annually in revenue to Washington State for funding healthcare services. This was accomplished by sending the maximum amount of DSH payments to the hospitals using state and federal matching funds. The hospitals would then transfer most of the funds back to the State. The hospitals themselves retained only a very small portion of the payments. Prior to March 13, 2001 states could pay county-operated facilities far in excess of their costs as long as total payment were under the their upper payment limits (UPL). The excess payments would then be returned to the state.

Although these IGTs were used by several states and operated within federal law, the perception was that some of these practices inappropriately increased federal reimbursement to the Medicaid program. Two aspects of the IGTs were thought to be inappropriate. First, the IGTs may have inappropriately increased the amount of federal funds a state received by claiming matching funds for payments that were not retained by hospitals. Second, IGTs may have introduced "recycling," wherein a state used the federal funds received through IGTs to match federal funds a second time. Washington State used IGT revenue to fund health care services for low income persons, including those on General Assistance-Unemployable (GA-U), the Medically Indigent, and the Basic Health Program.

In the summer of 2004, the Centers for Medicare and Medicaid Services (CMS) notified Washington State that it must stop using these IGTs as of June 30, 2005. CMS also stated that no further State Plan Amendments (SPAs) would be approved until the State made this commitment.

Program Definition

With the loss of $80 million in revenue, Washington State needed to develop an alternative financing method that maximized non-state resources and maintained the same level of service. The State chose the Certified Public Expenditure (CPE) program. The CPE program is a payment methodology that applies to public hospitals, including government-owned and operated hospitals

that are not critical access or state psychiatric hospitals. The program's payment methodology applies to inpatient claims and Disproportionate Share Hospital (DSH) payments.

This program allows public hospitals to certify their expenses as the State share to receive federal matching Medicaid funds, or Federal Financial Participation (FFP). By doing this, the State does not have to contribute the matching share of these expenditures, saving the State an estimated $93 million for SFY 2016.

The basis for the CPE program is found in federal rule (42 CFR 433.51):

> *(a) Funds from units of government may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.*
>
> *(b) The funds from units of government are appropriated directly to the State or local Medicaid agency, or are transferred from other units of government (including Indian tribes) to the State or local agency and are under its administrative control, or are certified by the contributing unit of government as representing expenditures eligible for FFP under this section. Certified public expenditures must be expenditures within the meaning of 45 CFR 95.13 that are supported by auditable documentation in a form approved by the Secretary that, at a minimum—*
>
> > *(1) Identifies the relevant category of expenditures under the State plan;*
> >
> > *(2) Explains whether the contributing unit of government is within the scope of the exception to limitations on provider-related taxes and donations;*
> >
> > *(3) Demonstrates the actual expenditures incurred by the contributing unit of government in providing services to eligible individuals receiving medical assistance or in administration of the State plan; and*
> >
> > *(4) Is subject to periodic State audit and review.*
>
> *(c) The funds from units of government are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.*

There are two primary requirements a state must meet to receive federal match under the CPE methodology. First, hospitals are required to expend local funds in lieu of state funds. Second, hospitals cannot be reimbursed for more than the cost of providing the service. So, the State's payments to participating hospitals equal the federal matching amount for allowable costs.

Under the program, hospitals are paid for the cost to provide hospital inpatient services to Medicaid recipients and for uncompensated care. Due to the way that hospital services are provided and billed, there is an approximate two-year lag between the date the service is provided, the date the hospital bills the State, and the date the information is available to calculate the actual cost of the service for a given service year. For this reason, payments for hospital inpatient services made during a given fiscal year under CPE are based on an estimate of costs for that year. The costs are

estimated using the hospital's most recent Ratio of Costs-to-Charges (RCC) which is typically based on data from two years prior.

Federal requirements mandate that payments made using CPE are cost settled once the actual costs for a service year can be calculated. This occurs once the RCCs are finalized, approximately two years after the service year.

Uncompensated Care or DSH payments are made up to the hospital's limit, as calculated according to federal requirements.

The State's CPE program will hold the hospitals financially harmless for the change to the CPE payment methodology. The hospitals will not be paid less under the CPE methodology than they would under the hospital payment methodology in place at the time services are rendered (baseline). We annually compare the total the hospitals would have received for inpatient claims and DSH payments under the baseline methodology to what they were paid under CPE. State *hold harmless* grants are paid to hospitals whose total payments are less under CPE.

When determining whether the program is cost effective, we must compare what the State would pay if there was no Certified Public Expenditure program.

Payment Determination

Since it is the State's policy to hold the hospitals harmless for the change to CPE, the participating hospitals will receive the greater of the payments under the baseline method or the cost-based CPE method.

The CPE program can be broken into broad categories of baseline, hold harmless, and cost settlement with CMS. The baseline and hold harmless grants relate to the payments a hospital receives from the State for inpatient services and uncompensated care. The CMS cost settlement reconciles the hospital payments to the costs of providing the services.

Baseline Methodology

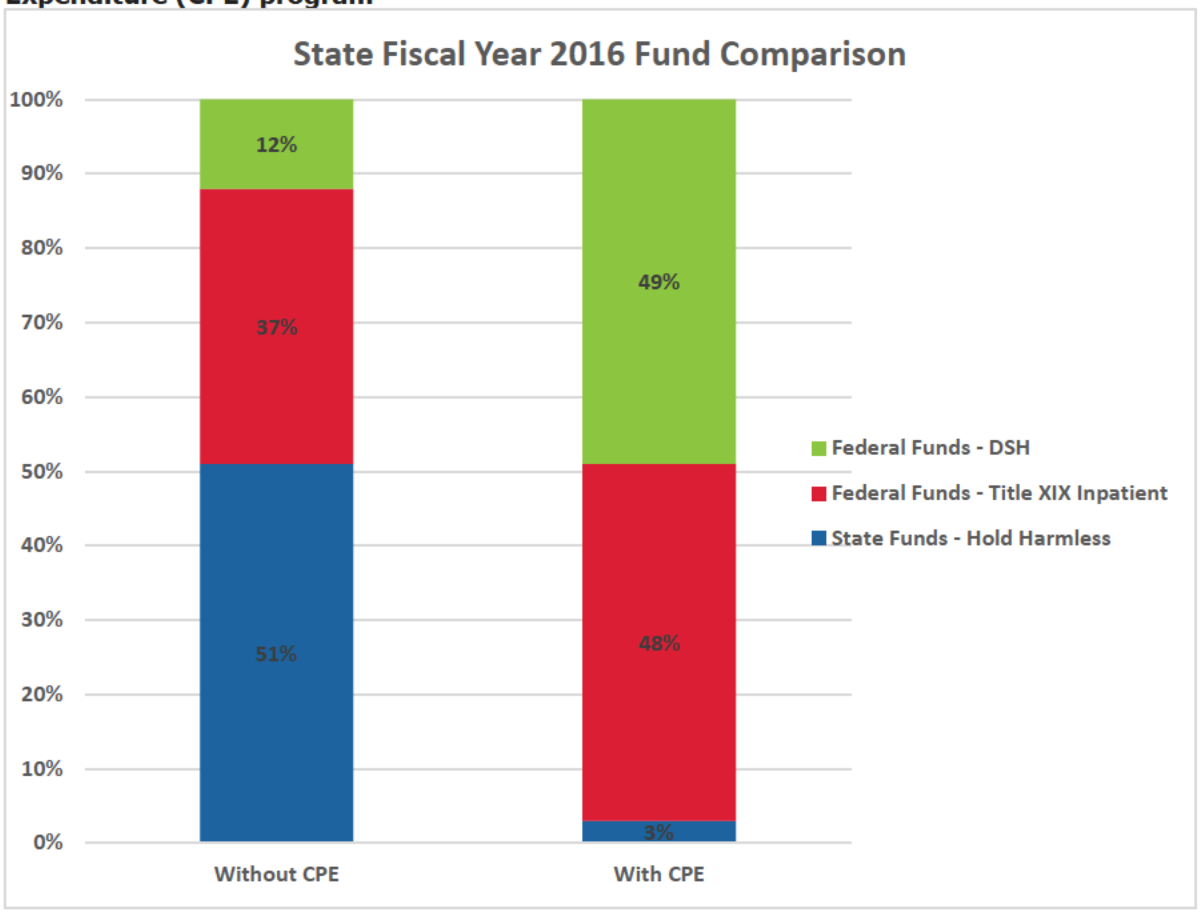
The baseline is the payment amount the hospital would have received if they were not in the CPE program.

Policy and other changes in programs and payment methodologies affect baseline calculations. Specifically, selective contracting ended on July 1, 2007 and an inpatient payment methodology developed by Navigant—a third party consulting firm—began on August 1, 2007. Effective July 1, 2009 the baseline was updated to exclude discontinued DSH programs as well as reductions to both non-rural and small rural indigent assistance programs. Inpatient rates were again rebased effective July 1, 2014.

Since hospitals receive at least as much funding under the CPE method as they would have without it, the comparison lies in the sources of funds.

The CPE hospitals receive the state and federal share of their inpatient claims and the state and federal share of DSH payments without the CPE program. The state share of these payments is charged to the State's general fund. Without CPE, DSH payments are limited by State match appropriations. The result: The State and federal governments' costs are roughly equal (see the *Without CPE* column in the table below).

Table 1: State fiscal year 2016 fund comparison: With vs. without the Certified Public Expenditure (CPE) program



However with the CPE program, the CPE hospitals are only paid the federal share of inpatient claims and DSH. The payments are an estimate of costs incurred, and the hospitals retain all of the payments until we perform cost settlements as required by CMS. The hospitals certify their expenditures, which allows those costs to qualify as the state portion. While the hospitals receive more in DSH payments because they can receive DSH funds up to their cap (as long as they provide local match), they receive less money for their inpatient claims because they don't receive the state share. As long as federal DSH allotment is available and hospitals have local match, these funds are available to pay the hospitals (see the *With CPE* column in Table 1).

If the payments for inpatient services and DSH combined are less than baseline, the State pays the difference to the hospital in the form of a hold harmless grant using state funds. Therefore, with the CPE program in place, the initial cost to the State is the amount paid in hold harmless grants. With CPE, the hospitals receive the same amount of funds as they did without CPE from different sources. As can be seen in the chart, the CPE method allows the State to use federal funds in lieu of state funding.

Hold Harmless Settlements

For a given fiscal year, there are three calculations made to hold CPE hospitals harmless:

- Baseline the prospective payments;
- Interim adjustment; and
- Final adjustment.

Under the State's policy, the hospitals must repay the State if the prospective payments are greater than the interim or final calculated grant amounts. Likewise, the State will owe the hospitals if the prospective grant payments are less than the interim and final calculated grant amounts.

Prospective Hold Harmless Grant Payments

Estimated hold harmless grant payments are made to CPE hospitals during the service year based on historical data and trended forward to the current year. For example, the hold harmless payments for SFY 2016 were based on SFY 2014 hospital claims data trended forward to SFY 2016 using producer price indices and state forecast information. The payments were paid monthly throughout the state fiscal year and were subject to change as additional data became available. The intent was to pay the hospitals only what they needed to be held harmless. Some hospitals did not need grants, as the payments under the CPE methodology exceeded those under the baseline.

Interim Adjustment

We complete an interim analysis approximately one year after the end of the state fiscal year when mature claims data are available. For example, we completed the SFY 2015 interim analysis in December 2016. We compared the result of this analysis to the total grant payments made to the hospitals for the state fiscal year, resulting in a payments of $3,202,589.

Final Adjustment

The final adjustment is made at least two years after the interim adjustment to include additional final paid claims. The final adjustment coincides with the final CMS cost settlement.

CMS Cost Settlement

While baseline and hold harmless relate to payments made to hospitals for services provided, the CMS cost settlement reconciles these payments to the hospitals' costs for providing the services.

CMS requires cost settlements to ensure that no CPE hospital is paid more than their actual costs. We use required interim and final Medicare Cost Reports to make this determination. The State must repay CMS for any federal payments for services that exceed the federal share of the costs. We calculate interim cost settlements using "as filed" Medicare cost reports and additional Medicaid schedules approved by CMS. The interim settlement for SFY 2015 resulted in a net payable to CMS of approximately $10.8 million and $18.3 million receivable to the State for hold harmless grants. The SFY 2016 interim settlement is approximately $18.2 million payable in federal payments and $10.1 million receivable for hold harmless grants. In SFY 2015, Harborview and University of Washington Medical Center were overpaid hold harmless funds; Harborview was overpaid hold harmless funds in SFY 2016.

The final Medicaid cost reports schedules are not completed until the Medicare Intermediary has audited the Medicare Cost Reports, usually two years after the hospital fiscal year. This means the final cost settlement with CMS for the CPE program is at least two years beyond the service year. In addition, our internal nurse auditors must review the inpatient claims paid through the state's Medicaid Management Information System—Provider One—for medical necessity and length of stay. When the audits are done, the hospitals complete a final cost report for both the CPE inpatient and CPE DSH final settlement amounts. Then, the final hold harmless adjustment is completed.

Risk

Under the CPE program both the state and the hospitals assume some risk. Again, the hospitals are paid whichever amount is higher—baseline or costs. If a hospital's costs are less than their baseline payments, the state must repay the difference to CMS.

If a hospital receives payments above baseline that are not supported by their costs, the hospital must repay the difference to the state. DSH payments above baseline are subject to available federal DSH funds even if the hospital certifies the additional costs.

Trended State Fiscal Impact

We use the best available data and apply a trending factor to estimate the state fiscal impact of the CPE program.

In the first year of the program (2006), cost settlements with CMS were not included in the budget. In 2007, the Legislature approved a supplemental budget for approximately $12 million to cover the projected 2006 cost settlement with CMS.

Changes in savings over 2007-2008 are linked to changes in payment methodologies, such as ending selective contracting and starting the Navigant inpatient payment methodology. Changes during this time period also reflect fluctuations in reported hospital costs.

Beginning October 1, 2008 the State received federal stimulus funds for Title 19 (Medicaid) claims. With the increase of Title 19 payments to the hospitals, the state saw additional savings.

Savings increased during the 2009-2011 biennium due to a combination of state policy changes and increased federal funds for both DSH and inpatient payments through the American Recovery and Reinvestment Act (ARRA). Through ARRA funds, the Federal Medical Assistance Participation (FMAP) increased to a high of 62.9 percent for Title 19 claims, and the DSH allotment increased for federal fiscal years (FFY) 2009 and 2010. On the policy side, supplemental Graduate Medical Education (GME) payments to Harborview Medical Center and the University of Washington Medical Center (UWMC) were eliminated and baseline DSH levels were reduced to reflect current DSH programs only. Beginning in SFY 2010, additional reductions to DSH programs further reduced the hold harmless grants. As reflected in Graph 1, the savings generated by the CPE program in SFY 2011 were lower than SFY 2010 (with the reduction of ARRA FMAP during the year).

For SFY 2014 through SFY 2016, state savings increased due to the Affordable Care Act expanding eligibility to a new eligible adult group. Through this expansion, the federal government funded 100 percent of the coverage costs of *newly eligible* individuals for the first three years and will phase down gradually to a permanent rate of 90 percent in 2020.

Inpatient Buyout and Findings

The State's costs to buy out the CPE program are determined by calculating the state share of the baseline payments and then deducting the cost to the State for the continuation of the CPE program. The state costs for continuing the program are limited to the hold harmless grants paid to the hospitals and the federal cost settlements with CMS.

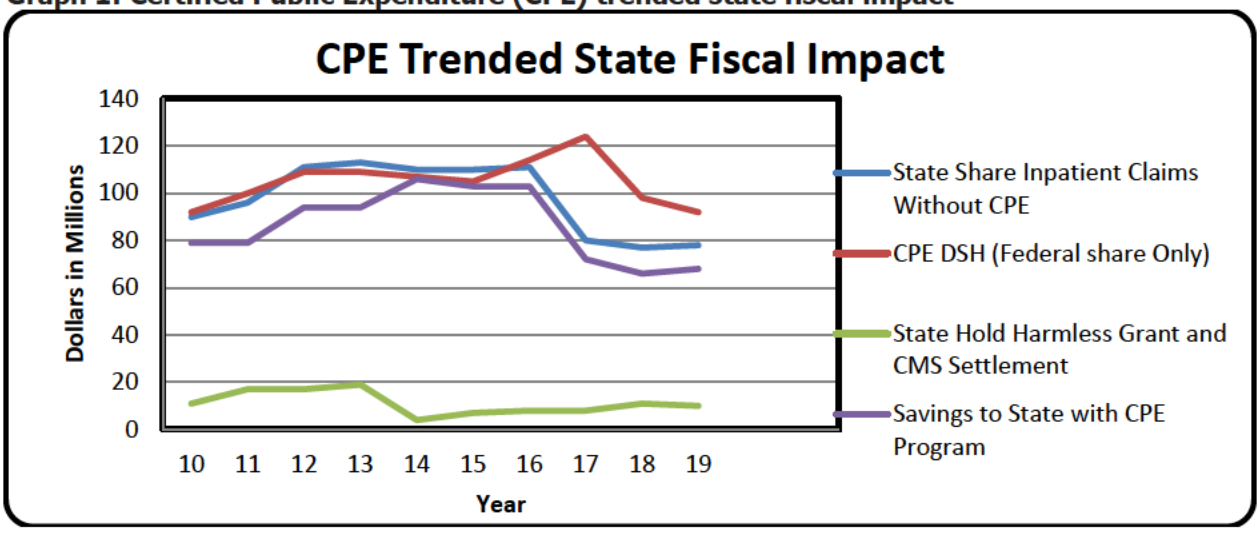
By buying out only the inpatient portion of the CPE program, the CPE hospitals may still certify uncompensated care costs and receive the maximum available DSH payments. The hospitals would not receive hold harmless grants and would be at risk for the DSH cost settlements.

Using the most recently available re-priced claims data for SFY 2016, the net cost to the state would have been $93 million to buy out the CPE inpatient program in SFY 2016. Included in this amount is the $26 million state share of inpatient managed care premiums carved out for the blind/disabled population paid as fee for service (FFS) to CPE hospitals.

Hospitals incur less FFS and uninsured care costs as more individuals are covered by health insurance; however, managed care costs are expected to continue increasing with the reduction of FFS clients.

Looking at Graph 1 below, the savings were $103 million in SFY 2016 and decreased to $72 million in SFY 2017. Estimated savings projections for SFY 2018 are $66 million. The decrease in savings to the state is due to the reduction of DSH funds available to the hospitals starting FFY 2018 and continuing through FFY 2025. With the reduction of DSH funds, some hospitals qualify for additional hold harmless funds. These estimates are based on historical data; actual results will vary. In conclusion, the savings from the CPE program continues to exceed the costs for the program.

Graph 1: Certified Public Expenditure (CPE) trended state fiscal impact



Appendix A: Glossary of Terms

American Recovery and Reinvestment Act of 2009 (ARRA)–Economic stimulus package enacted by the 111th United States Congress. One provision of the ARRA allows for increased FMAP for certain Medicaid payments.

Baseline payments–The total payments that would have been retained by the hospital had the Certified Public Expenditure (CPE) Program not been enacted. The baseline payments are determined by adding the Legislature-designated level of Disproportionate Share Hospital (DSH) payments for the hospital to the re-priced inpatient claims for the CPE state fiscal year to determine the baseline payments. The re-priced claims are calculated by the payment method in effect, such as Diagnosis Related Group (DRG), Ratio of Costs-to-Charges (RCC), and reduced RCC or per diem rates for non-CPE hospitals. In SFY 2010, the Legislature directed baseline DSH to equal one half of the indigent assistance DSH retained by the hospitals in 2005 and all other DSH retained by the hospitals in 2005 for other DSH programs still in existence in the 2009-11 biennium.

Centers for Medicare and Medicaid Services (CMS)–Previously known as the Health Care Financing Administration (HCFA). CMS is a federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.

Disproportionate Share Hospital (DSH) Allotment (Cap)–The maximum amount of DSH funds available to a state during a federal fiscal year as set forth by the federal government as an annual DSH allotment. Additionally, each qualifying hospital has an annual hospital-specific cap which cannot be exceeded using DSH funds.

Disproportionate Share Hospital (DSH) Program–A federal program created by Congress in 1981 to compensate hospitals for the added costs of serving a disproportionate share of low-income individuals who either are part of the Medicaid program or have no insurance at all. These payments are matched by the federal government based on Washington's Medicaid match rate. The Health Care Authority (HCA) makes DSH payments to eligible hospitals according to federal law, legislative direction, and established payment methods. See 1902(a)(13)(A)(iv) of the Social Security Act. See also WAC 182-550-4650, 182-550-4670, and 182-550-4690.

Federal Financial Participation (FFP)–The dollar amount of federal financial participation based upon FMAP.

Federal Medical Assistance Participation (FMAP)–The percentage of federal matching funds allocated annually to eligible social and medical programs. For example, in FFY 2016 the FMAP was 50 percent. So, for every dollar Washington spent on eligible programs, the federal government contributed another dollar.

Hold Harmless–Provision under WAC 182-550-4670 providing hospitals eligible for payments under the Certified Public Expenditure (CPE) program to receive no less in combined state and federal payments than would have been received had the CPE program not been implemented. Hold Harmless grants are made to hospitals that receive CPE payments that are less than baseline payments.

Inpatient Services–Healthcare services provided directly or indirectly to a client after the client's inpatient hospital admission and prior to discharge.

Intergovernmental Transfer (IGT)–Public funds transferred from other public agencies.

Medicare Cost Report–The Medicare cost report for hospitals (Form 2552-96), or successor document completed and submitted annually by a hospital provider to:

- Medicare intermediaries at the end of a provider's selected fiscal accounting period to establish hospital reimbursable costs for per diem and ancillary services; and
- Medicaid to establish appropriate DRG and other rates for payment of services rendered.

Navigant Consulting, Inc–Contractor that provided analysis and recommendations for HCA hospital inpatient payment methods implemented on August 1, 2007 and July 1, 2014.

Ratio of Costs-to-Charges (RCC)–A method used to pay hospitals for some services exempt from the Diagnosis Related Group (DRG) payment method. It also refers to the factor or rate (costs and charges) applied to a hospital's allowed covered charges for medically necessary services to determine estimated costs, as determined by HCA, and payment to the hospital for some DRG-exempt services.

State Plan–The plan filed by HCA with CMS, Department of Health and Human Services (DHHS), outlining how the State will administer Medicaid and State Children's Health Insurance Program (SCHIP) services, including the hospital program.