# *Report to the Legislature*

# *Inpatient Hospital Certified Public Expenditure Program*

## *ESHB 1244, Section 209(8)*

## *October 2009*

***Department of Social & Health Services***
***Health and Recovery Services Administration***
***Division of Rates & Finance***
***PO Box 45500***
***Olympia, WA 98504-5500***
***(360) 725-1855***
***Fax: (360) 586-9551***

# TABLE OF CONTENTS

OVERVIEW & SUMMARY………………………………………………………………… 3

CPE PROGRAM HISTORY………………………………………………………………. 3

PAYMENT DETERMINATION…………………………………………………………….. 5

CPE TRENDED STATE FISCAL IMPACT……………………………………………… 9

GLOSSARY OF TERMS……………………………………………………………….. 10

## *Overview & Summary*

This report examines whether savings continue to exceed costs for the inpatient hospital Certified Public Expenditure (CPE) program. The report arises from instructions from the 2009 – 2011 legislatures.

> *ESHB 1244 Section 209 (8), in part: The department shall continue the inpatient hospital certified public expenditures program for the* 2009 – 2011 *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 department shall submit reports to the governor and legislature by November 1, 2009, and by November 1, 2010 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.*

The CPE program was implemented in the 2005-07 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 388-550-4650 , 388-550-4670 , and 388-550-4690 .

This report is presented in three parts. The first part provides a brief history of the CPE program including the elimination of intergovernmental transfers (IGT) and the resulting loss of federal funding. The second part describes how payments are determined. The final part provides a trended fiscal impact analysis.

Based on this analysis, the CPE program continues to show savings exceeding costs through the 2009-11 biennium.

A glossary of terms is included.

## *Part I: CPE 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.

### *A. 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.

DSH was 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 IGT transactions netted approximately $80 million annually in revenue to the 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.

Although these IGTs 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 (SPA) would be approved until this commitment was made.

## *B. Program Definition*

With the loss of $80 million in revenue, the State needed to develop an alternative financing method that maximized non-state resources and maintained the same level of service. The method chosen was the Certified Public Expenditure 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 payments.

This program allows public hospitals to certify their expenses as the State share in order to receive federal matching Medicaid funds, or Federal Financial Participation (FFP). In so doing, the State does not have to contribute the matching share of these expenditures saving the State an estimated $43 million for SFY 2010.

The basis for the CPE program is found in federal rule under 42 CFR 433.51, which states:

> *(a) Public funds 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 public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies (including Indian tribes) to the State or local*

*agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.*
*(c) The public funds 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 in order to receive federal match under this 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. Therefore, 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 nature of the way that hospital services are provided and billed, there is a lag of approximately two years between when the service is provided, when the hospital bills the State and when the information is available to calculate the actual cost of the service for a given service year. As such, 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 policy regarding the CPE program is that the State 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). An analysis is performed annually that compares 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.

So when determining whether the program is cost effective, a comparison must be made to what the State would pay if there was no Certified Public Expenditure program.

## *Part II: 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 the Centers for Medicare and Medicaid Services. 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.

## A. *Baseline Methodology*

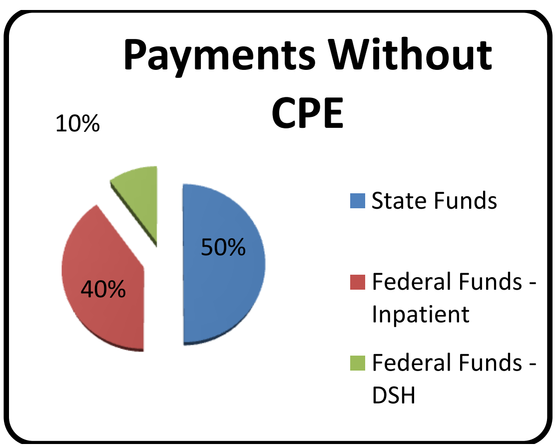
The baseline is the payment amount the hospital would have received if they weren't in the CPE program. When calculating baseline, we determine what the hospital would have been paid in state and federal funds for the inpatient fee for service claims and a DSH level directed by the legislature.

Policy and other changes in programs and payment methodologies affect baseline calculations. Specifically, selective contracting ended on July 1, 2007 and the Navigant inpatient payment methodology began on August 1, 2007. Effective July 1, 2009 the baseline was updated to exclude discontinued IGT DSH programs.

## B. *Payment Method Comparison*

Since CPE 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.

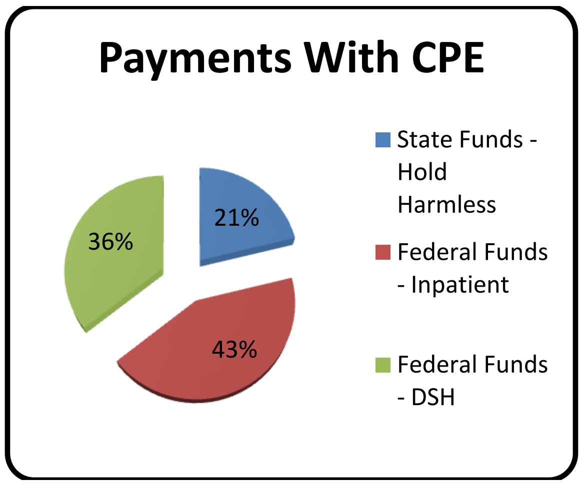
Without CPE, the CPE hospitals receive the state and federal share of their inpatient claims and the state and federal share of DSH payments. The cost to the State is the state share of these payments. Under this method, the State and the federal government roughly share the costs.




With CPE, hospitals are only paid the federal share of inpatient claims and DSH. The payments are paid as an estimate of costs incurred and the hospitals retain all of the payments until a cost settlement is performed as required by CMS. The hospitals certify expenditures that qualify as the state portion. The hospitals receive less money for their inpatient claims because they don't receive the state share but, receive more in DSH payments because they can receive as much DSH as they can provide local match. Without CPE the State is limited in the DSH payments it can make due to the limits on the state match appropriated. As long as federal DSH allotment is available and hospitals have local match, these funds are available to pay the hospitals.

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.

So 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, just from different sources. As can be seen from the pie charts, the CPE method is currently allowing the State to leverage federal in lieu of state funding.




## *C. Hold Harmless Settlements*

For a given fiscal year, there are three calculations made to hold CPE hospitals harmless to baseline: the prospective payments, the interim adjustment and the 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.

### *a. Prospective hold harmless grant payments*

Estimated hold harmless grant payments are made to CPE hospitals during the service year based on historical data trended forward to the current year. For example, the hold harmless payments for SFY 2010 are based on SFY 2008 hospital claims data trended forward to SFY 2010 using consumer price indexes and state forecast information. The payments are paid monthly throughout the state fiscal year and are subject to change as additional data become available. The intent is to pay the hospitals only what they need to be held harmless. Some hospitals do not need grants at all.

***b. Interim Adjustment***

An interim analysis is performed approximately one year following the end of the state fiscal year when mature claims data is available. For example, the interim analysis for SFY 2008 was performed in June 2009. The results of this analysis were compared to the total grant payments made to the hospitals for the state fiscal year, resulting in a net recovery of $420,000.

***c. Final Adjustment***

The final adjustment is made at least one year after the interim adjustment to include additional final paid claims.

## D. 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. Interim and final Medicare Cost Reports are required to make this determination. Federal payments made by the State for services that exceed the federal share of the costs of the services must be repaid to CMS. Interim cost settlements are calculated using "as filed" Medicare cost reports and additional Medicaid schedules approved by CMS. The interim settlement for SFY 2008 resulted in a payment to CMS of approximately $4.8 million.

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. At this time no final cost settlements have been performed.

## E. Risk

Under the CPE program both the State and the hospitals assume some risk. Again, the hospitals are paid the higher of 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. Payments above baseline are subject to available federal DSH funds even if the hospital certifies the additional costs.

# *Part III: CPE Trended State Fiscal Impact*

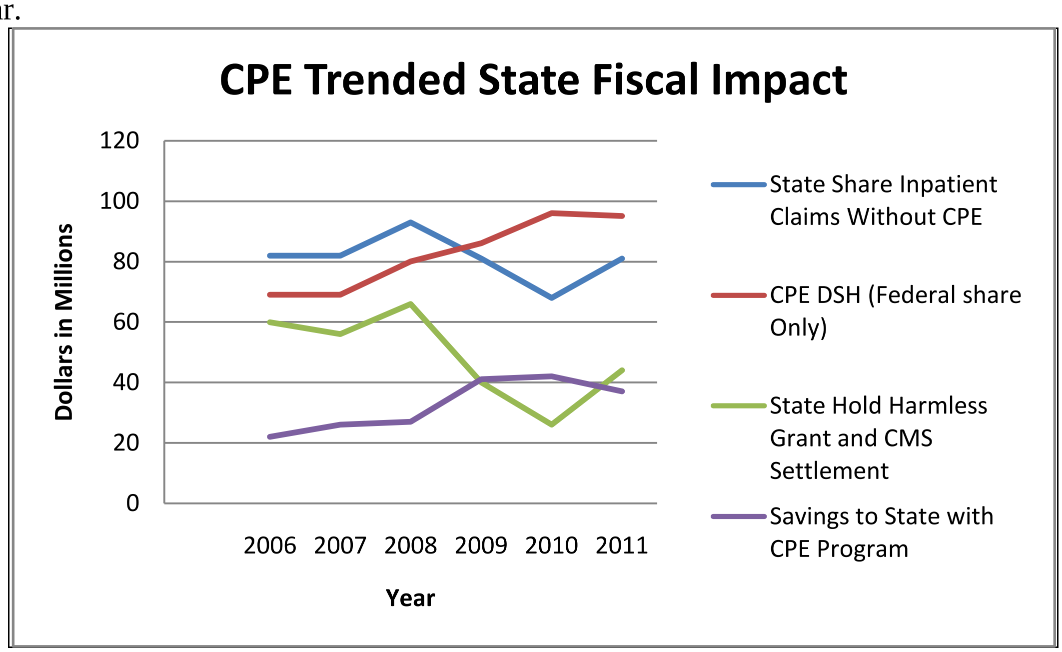
The fiscal impact to the State is trended forward using best available data.

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

Changes in savings over 2007 – 2008 are linked to changes in payment methodologies, such as elimination of selective contracting and implementation of 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 claims. This reduced state expenditures in the form of the hold harmless grant and altered the CPE trend. Only two hospitals needed hold harmless grants in SFY 2009. However, the cost settlement for SFY 2009 should require higher repayment to CMS, since federal payments exceeding costs must be returned to CMS. The higher share of federal payments increases the liability to the state.

We anticipate savings to increase to $42 million in 2010. This increase is due to a combination of state policy changes and increased federal funds for both DSH and inpatient payments. We expect state savings will continue through SFY 2011. Reductions in federal funding will increase state costs to maintain the baseline payment level. As reflected in the graph below, the savings in SFY 2011 will trend lower than SFY 2010 with the loss of stimulus funds half-way through the year.



## *Glossary of Terms*

**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 2005 retained 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 that was in effect, such as Diagnosis Related Group (DRG), Ratio of Costs to Charges (RCC), reduced RCC or selective contracting for non-CPE hospitals. In SFY 2010, baseline DSH changed 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 to the same extent that those DSH programs exist 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 and Recovery Services Administration (HRSA) makes DSH payments to eligible hospitals in accordance with federal law, legislative direction and established payment methods. See 1902(a)(13)(A)(iv) of the Social Security Act. See also WAC 388-550-4900 through 388-550-5400.

**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 2007 the FMAP was 50%. So, for every dollar Washington spent on eligible programs, the federal government contributed a dollar.

**Hold Harmless –** Provision under WAC 388-550-4670 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 subsequent to 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 (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
- To Medicaid to establish appropriate DRG and other rates for payment of services rendered.

**Medicare Upper Payment Limit (UPL) –** 42 CFR 447.253(b) requires that the Medicaid agency find that the estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services than the amount that the agency reasonable estimates would be paid for the services under the Medicare principles of reimbursement.

**Navigant Consulting, Inc. –** Contractor that provided analysis and recommendations for DSHS hospital inpatient payment method implemented on August 1, 2007.

**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 DSHS, and payment to the hospital for some DRG-exempt services.

**State plan -** The plan filed by DSHS with the Centers for Medicare and Medicaid Service (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.