ATTACHMENT E: Intergovernmental Transfer (IGT) Protocol

Washington State Medicaid Transformation Project Section 1115(a) Medicaid Demonstration
Approved January 9, 2017

I. Preface

a. Medicaid Transformation Project – Intergovernmental Transfers

On January 9, 2017, the Centers for Medicare and Medicaid Services (CMS) approved Washington State's request for a Section 1115 Medicaid demonstration entitled *Medicaid Transformation Project*. The Special Terms and Conditions (STC) of the demonstration set forth in detail the nature, character, and extent of federal involvement in the demonstration, the state's implementation of the expenditure authorities, and the state's obligations to CMS during the demonstration period.

As part of this demonstration, the Delivery System Reform Incentive Payment (DSRIP) program is to provide incentives for Medicaid providers to create and sustain an integrated, high performing health care delivery system that can effectively and efficiently meet the needs of Medicaid beneficiaries and low income uninsured individuals in their local communities by improving care, improving health and reducing costs. The non-federal share of these payments will come from intergovernmental transfers (IGT) from public hospitals, other local government or tribal funds, or funds that the state has earned by claiming federal match on expenditures for Designated State Health Programs (DSHP).

In accordance with STC 87(d), the state may use IGTs to the extent that such funds are derived from state, tribal, or local monies and are transferred by units of government, which can include a governmentally operated provider, within the state.

The IGT protocol (this document, Attachment E) describes the methodology and guidelines by which the state may use IGT as a source of funding for the non-federal share of demonstration expenditures.

II. IGT Process and the Role of the Accountable Communities of Health (ACH)

Under this demonstration, the state will make performance-based funding available to regionally-based ACHs and their partnering providers with the goal of transforming the delivery system for Medicaid beneficiaries. The ACHs will be responsible for coordinating the efforts of partnering providers in their community to create and implement regional project plans to transform the Medicaid delivery system. The project plans will be reviewed by a third-party Independent Assessor, who will make recommendations to the state as to whether the plans should be approved.

Approved project plans that meet the milestones outlined in the project will be eligible for incentive payments under the demonstration. A component of the non-federal share of these payments will come from IGTs. The responsibility of the Financial Executor includes distributing earned funds in a timely manner to participating providers in accordance with each ACH's budget plan.

DSRIP payments are made twice per year and are always paid using the same process. The payment amounts are determined by two reporting periods per demonstration year, where ACHs report the metrics and milestones achieved by their transformation projects. The state, with support from the Independent Assessor, will review reports to calculate the incentive payments earned by the ACH. Once incentive amounts are calculated, the state will calculate the non-federal share amount to be transferred by an IGT contributor based on ACH budget plans in order to draw the federal funding for incentive payments related to the achievement of milestones and metrics. Within 14 calendar days after notification by the state of the identified non-federal share amount, the IGT contributor will make an intergovernmental transfer of funds. The state will pay an amount equivalent to the non-federal and federal shares of the incentive payment to the ACH and its partnering providers. The state will then draw the federal funding based on those disbursements. If the IGT is made within the appropriate 14-day timeframe, the incentive payment will be disbursed within 30 calendar days. The total computable incentive payment must remain with the ACH partnering providers and will not be returned to or retained by the state.

III. IGT Funding Conditions

IGTs from governmentally operated providers must be in an amount not to exceed the non-federal share of title XIX payments. No pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

An agreement will be executed between the Health Care Authority (HCA), Washington's Medicaid agency, and each IGT contributing entity. The agreement will identify the annual estimated commitments by each IGT contributor. Funds will be transferred from each IGT contributor and will be under the administrative control of HCA.

IGT contributions for purposes of DSRIP are eligible for a 50 percent federal match. The IGT contributor will, by signature, attest that the IGT contribution is not derived from Federal receipts and that they will maintain records to document the source of non-federal share and furnish those records to HCA and CMS as necessary.

Additionally, the IGT contributor must identify the allowable funding source, over the course of a given DSRIP Year, to support the IGT commitment for DSRIP.

IGT funding as described under this demonstration does not have any interaction with existing provider assessment arrangements, with regard to the federal 6% cap. Additionally, IGTs will not interact with existing Certified Public Expenditure (CPE) arrangements or any upper payment limit requirements with governmental (public) hospitals as long as the IGTs are not considered an expenditure for the provision of a hospital service for hospitals that CPE. CPEs are expenditures made for the provision of a Medicaid service and certifying providers can receive no service payments above their certified costs. The IGTs are the expense of financing the non-federal share for other Medicaid purposes, and the public hospitals may not claim the transfer of funds to the Medicaid agency as a Medicaid

uncompensated hospital service cost under the State Plan or the waiver since their service costs are fully satisfied.