Washington State Health Care Authority
Report to the Legislature

# Inpatient Hospital Certified Public Expenditure (CPE) program

Engrossed Substitute Senate Bill 5950; Section 211(15); Chapter 376; Laws of 2024

November 1, 2024

## Executive summary

This annual 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 Engrossed Substitute Senate Bill (ESSB) 5950 (2024), Section 211(15):

> The health care authority shall continue the inpatient hospital certified public expenditures program for the 2023–2025 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, 2023, and by November 1, 2024 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 ESSB 5187 (2023), Section 211(15). You can view previous reports on HCA's **legislative reports webpage**.

The CPE program continues to show savings exceeding costs through the 2023-25 biennium.

## Background

The CPE program was implemented in the 2005-07 biennium as a replacement for the Inter-Governmental Transfer (IGT) program. For the full program history, see the **2023 Legislative report**. 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.

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 $83 million for SFY 2023. The basis for the CPE program is found in federal rule (42 CFR 433.51).

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.

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. Additionally, 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.

# Payment determination

It is the state's policy to hold the hospitals harmless for the change to CPE, so participating hospitals will receive the greater of the payments under the baseline method or the cost-based CPE method. The

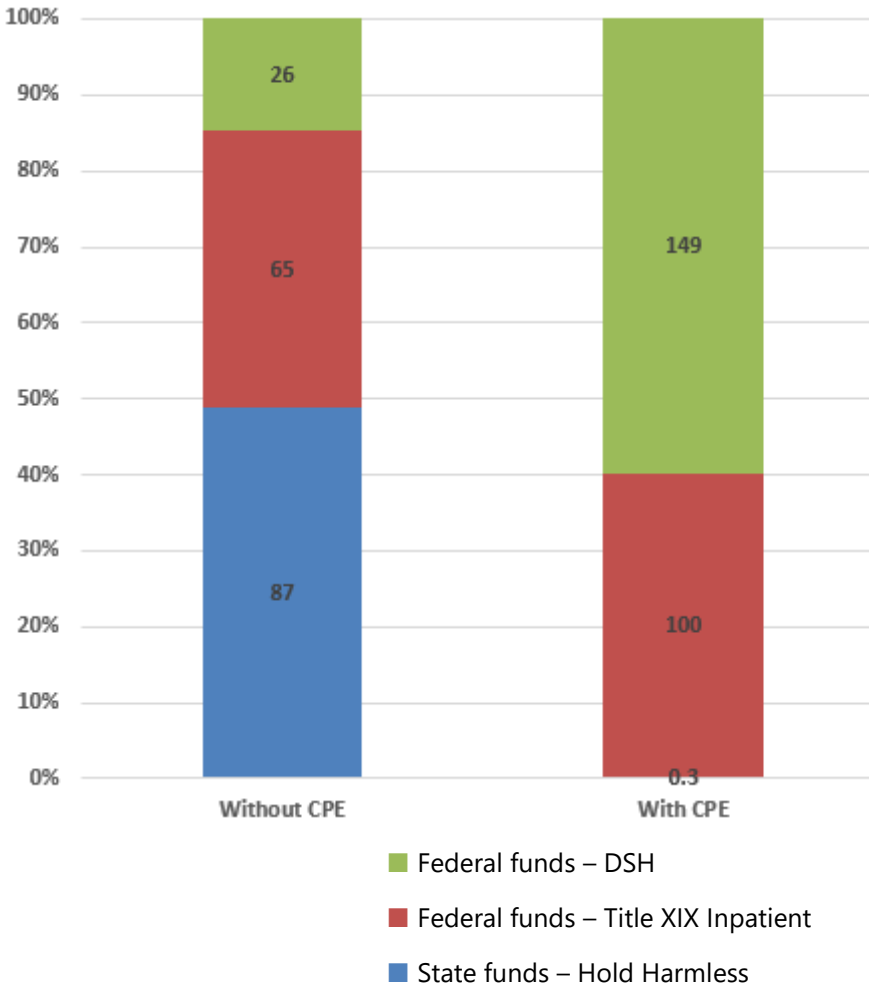
CPE program can be broken into broad categories of baseline, hold harmless, and cost settlement with CMS. The baseline and hold harmless grants relate to the payments a hospital receives from the state for inpatient services and uncompensated care. The CMS cost settlement reconciles the hospital payments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

## Baseline methodology

The baseline is the payment amount hospitals would have received if they were not in the CPE program. 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 as shown in Graph 1.

### Graph 1: State fiscal year 2023 fund comparison: with vs. without the Certified Public Expenditure (CPE) Program

All numbers are in millions.




If the payments for inpatient services and DSH combined are less than the 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, hospitals receive the same amount of funds as they did without CPE from different sources. As the chart illustrates, the CPE method allows the state to leverage 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 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 hospitals if the prospective grant payments are less than the interim and final calculated grant amounts.

## CMS cost settlements

CMS requires cost settlements to ensure that no CPE hospital is paid more than their actual costs. Hospitals participating in the inpatient CPE payment program must complete the applicable CPE Medicaid cost reports for the inpatient fee-for-service cost settlements. The state must repay CMS for any federal payments for services that exceed the federal share of the costs.

## Risk

Under the CPE program, both the state and hospitals assume some risk. Again, hospitals are paid whichever amount is higher — baseline or costs. If a hospital's costs are less than its 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

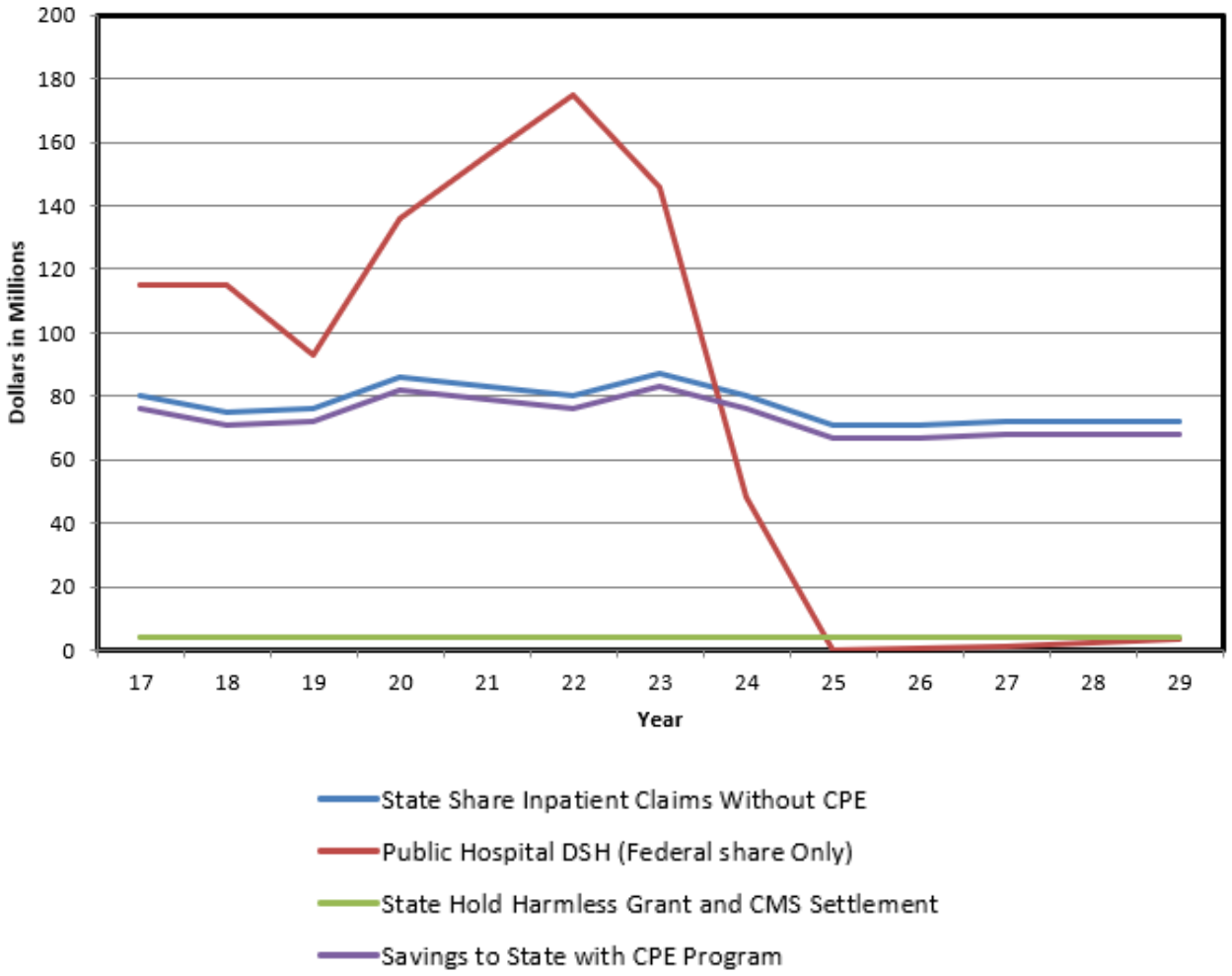
Payments in this program are based on the amount of uncompensated care incurred by the hospital during the most recently reported fiscal year (usually two years prior) trended forward to the year of payment.

The outpatient and inpatient directed payment programs benefiting the University of Washington and Harborview, as well as the designated public hospital directed payments under the hospital safety net program, have impacted uncompensated care for each hospital and reduced their public hospital DSH cap.

State savings increased due to the Affordable Care Act expanding eligibility to a new eligible-adult group. The federal government funded 100 percent of the coverage costs of *newly eligible* individuals in SFY2014 through SFY2016, gradually decreasing to 90 percent in 2020 and each year thereafter.

The 2024 Consolidated Appropriations Act, H.R. 4366, eliminated DSH reductions up until January 1, 2025, followed by the reduction in payments, in an amount equal to $8 billion for each fiscal years. It will start in the fiscal year January 1 through September 30, 2025, and continue in fiscal years 2026 and 2027. T**he CPE program is projected to save the state an estimated $67 million as shown in Graph 2.**

### Graph 2: Certified Public Expenditure (CPE) trended state fiscal impact

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