



Inpatient hospital certified public expenditure program

Engrossed Substitute Senate Bill 6168; Section 211(14); Chapter 357; Laws of 2020

November 1, 2020

Washington State
Health Care Authority

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Executive summary

This annual report examines whether savings continue to exceed costs for the inpatient hospital Certified Public Expenditure (CPE) program. We have submitted this report as required by Engrossed Substitute Senate Bill 6168 (2020), Section 211(14):

The health care authority shall continue the inpatient hospital certified public expenditures program for the 2019–2021 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, 2020, and by November 1, 2021 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 6032 (2018), Section 213(1)(q). Visit our legislative reports webpage at hca.wa.gov/about-hca/legislative-reports to see previous reports.

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 42 CFR 433.51 and state rule under WAC 182-550-4650, 182-550-4670, and 182-550-4690.

Based on our analysis which compares what the state would pay if there was no CPE program, the CPE program continues to show savings exceeding costs through the 2021–23 biennium.

Program history

Prior to state fiscal year (SFY) 2006, Washington State used IGTs to fund supplemental Disproportionate Share Hospital (DSH) and upper payment limit (UPL) payments to public hospitals, which netted approximately \$80 million annually in revenue to Washington State for funding healthcare services.

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.

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 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 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 \$72 million for SFY 2019. 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. 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. 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

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.

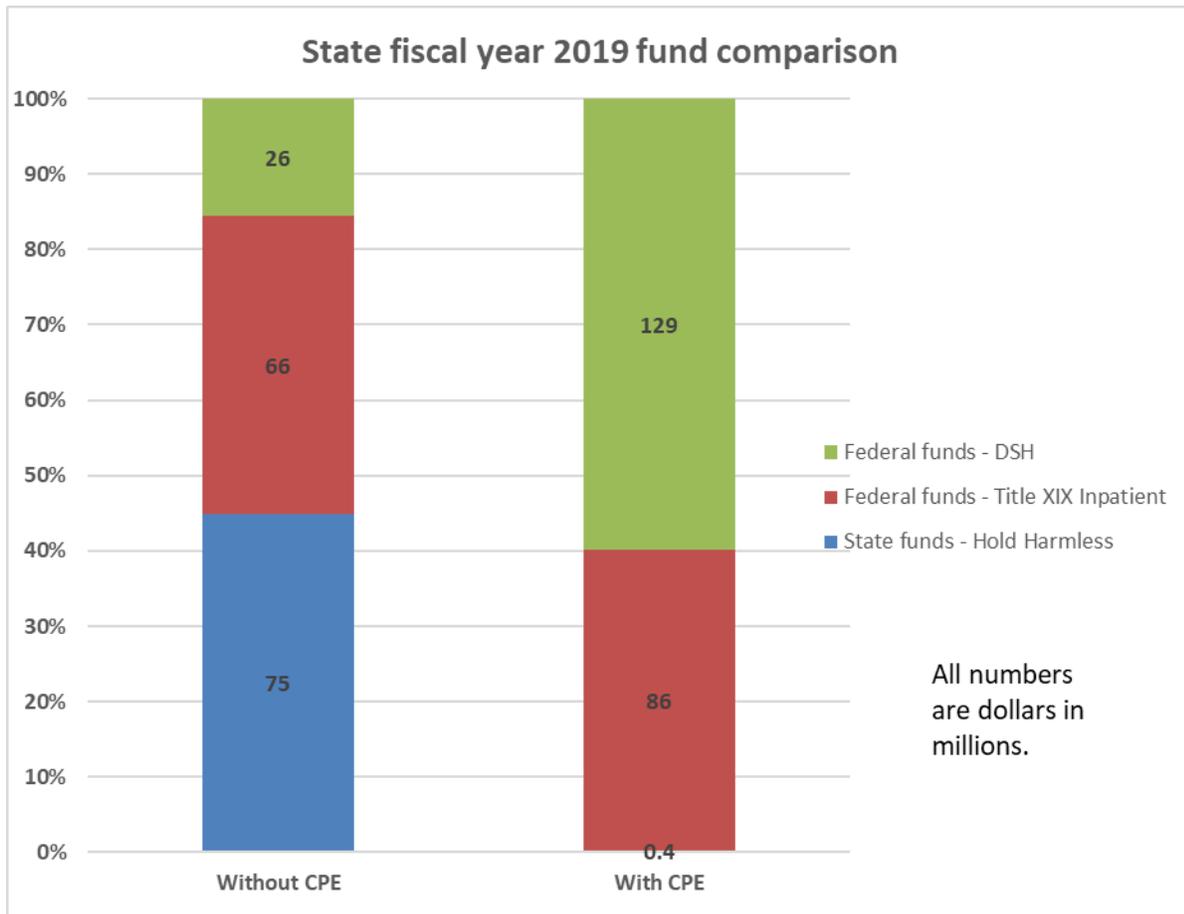
The CPE program can be broken into broad categories of baseline, hold harmless, and cost settlement with CMS. The baseline and hold harmless grants relate to the payments a hospital receives from the state for inpatient services and uncompensated care. The CMS cost settlement reconciles the hospital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



Graph 1: State fiscal year 2019 fund comparison: with vs. without the CPE program



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 but from different sources. As can be seen in the chart, 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 the hospitals if the prospective grant payments are less than the interim and final calculated grant amounts.



CMS cost settlement

CMS requires cost settlements to ensure that no CPE hospital is paid more than their actual costs. We use 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.

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

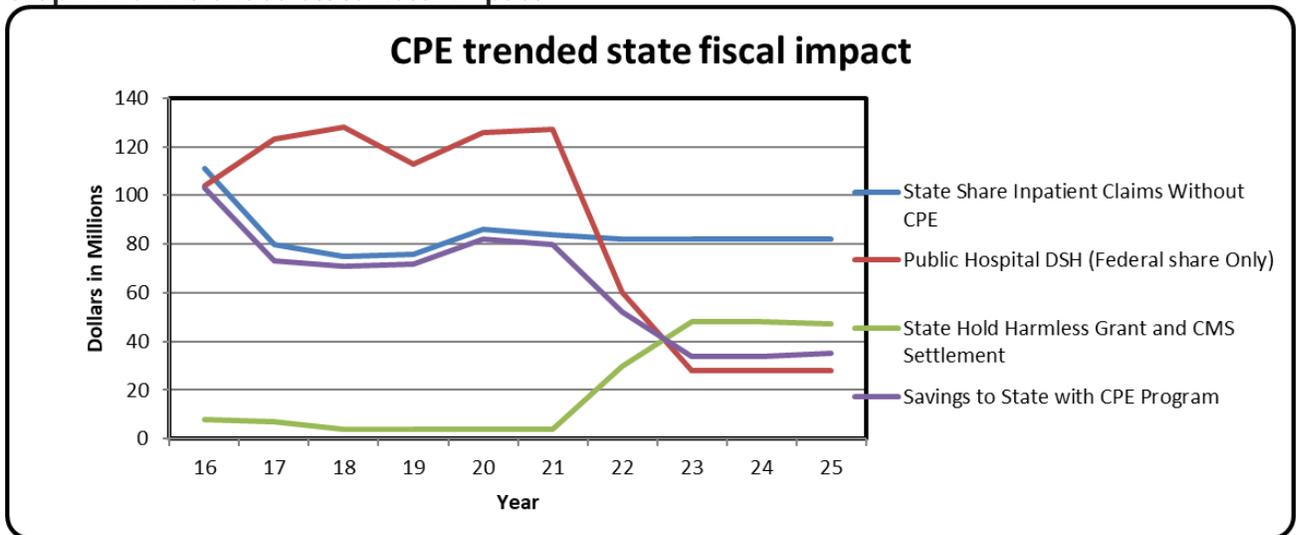
We use the best available data and apply a trending factor to estimate the state fiscal impact of the CPE program.

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.

The Affordable Care Act requires aggregate reductions to state DSH allotments annually beginning with federal fiscal year (FFY) 2018. However, H.R. 8337, Continuing Appropriations Act, 2021 and Other Extensions Act of 2020 delays the start of these reductions until December 11, 2020. Should the proposed reductions take place in FFY 2021, the CPE program is projected to save the state an estimated \$80 million as shown in Graph 2 below.



Graph 2: CPE trended state fiscal impact



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