Washington State
Department of Social
& Health Services

2007 Fact Sheet:

Medicaid hospital rate study

THE BACKGROUND

Navigant Consulting has completed Phase 2 of a legislatively mandated review of Washington Medicaid inpatient reimbursements. The study, delivered to the Legislature on November 15, 2006, was prompted by complaints that the current methodology is inefficient, unfair and out of date. Hospitals also complain that Medicaid payments, especially psychiatric care, are underfunded. The upshot of the complaints is that it is difficult to understand why hospitals are paid certain rates under the current methodology – it is clear that the system needs improvement.

Navigant's two-year study has validated some of the hospital arguments: The current system is based on outdated data, and it does not take current technology or efficiencies into account. It also lacks incentives for hospitals to control costs. This may be one reason that hospital inpatient costs have been increasing at a faster rate than any other Medicaid service.

STUDY RECOMMENDATIONS INCLUDE:

1) Update the hospital data used to calculate rates by an up-to-date DRG (Grouper).
2) Devise payment methodologies that reward efficient behavior and that show why one hospital is paid differently from another.
3) Significantly reduce ratio of cost to charges (RCC) payment methodology and replace with per diem.
4) Propose regular state updates of hospital rate increases and rebasing.
5) Implement the changes within current budget projections on a statewide basis.
6) Plan for changes to take effect on July 1, 2007, with a one-year transitional payment.

IMPLEMENTATION BENEFITS

Recommendations in the study provide significant benefits to the state's Medicaid program:

- Payment methodologies will be closer to those used by the Health Care Authority and the Department of Labor & Industries
- Virtually eliminate payment methodologies that no other state uses to the extent Washington does (e.g. RCC)
- The state's ability to control inpatient expenditures is enhanced.

IMPLEMENTATION RISKS

Certain hospitals may not be satisfied with the outcome if their payments drop or if they disagree with the way the new payments are calculated.

- Some of hospitals that thought they were low cost and would receive more payments under the new methodology. These hospitals could see payments drop instead.
- Evidence clearly indicates that state-only programs are under-funded, especially psychiatric inpatient programs. Psychiatric services show a loss under the proposed system when the current payment is projected from SFY05 to SFY08 and compared to payments under the proposed system. The Governor's budget increases non-Medicaid psychiatric rates to 86% of Medicaid rates.

FOR MORE INFORMATION, CONTACT:
Susan Lucas, HRSA, 360-725-1828, LUCASSL@dshs.wa.gov

- Implementation of the new system coincides with other billing changes required as ProviderOne is implemented. This will add another layer of complexity for hospitals and HRSA's claims processing system.
- Certain programs are paid differently in the new methodology and may experience payment changes (e.g. CUP, rehab, Children's)

WHAT HRSA CAN DO

The study's methodology more clearly states the basis for payments and comparison of payment to cost estimates. This information has been shared with hospitals affected by the recommendations. The analyses include:

- Cost coverage under the new methodologies.
- Differences in payment under the new methodology versus the old.
- Why and how reimbursement calculations vary in different parts of the state.

OTHER PROPOSALS

The study includes several other recommendations:

- Annual evaluation of hospital rate increases based on factors such as national medical inflation, known cost increases in the industry, and factors established and used by CMS in calculating the payments for Medicare. These increases will ensure that hospital funding does not further erode below cost.
- HRSA will re-evaluate the reimbursement calculations on an annual basis, and we intend to rebase the system every three years. This process will avoid the out-of-date system we currently have.
- Selective contracting for hospitals is eliminated. This recommendation does not prevent the State's use of selective contracting in the future.
- Out of state hospitals are paid in state rates if they are deemed critical hospitals. Other hospitals are paid at the lowest in-state rate.