THE STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
WASHINGTON STATE MEDICAID

Inpatient Reimbursement System Study

Phase 1 Report – Executive Summary

DECEMBER 1, 2005

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Executive Summary

During the 2005 Washington State legislative session, Senate Bill 6090 mandated the Department of Social and Health Services ("DSHS") to procure a contractor to conduct an independent analysis of the current system for establishing hospital inpatient payment rates for services provided to the Medicaid population, and to submit recommendations for improvements to the current inpatient hospital reimbursement system. The purpose of this study was to inform State policymakers and lawmakers as they seek to identify and evaluate suitable enhancements to the current system.

DSHS awarded a contract to Navigant Consulting, Inc. ("NCI") in August 2005 to conduct this study. The NCI project team has extensive experience with the design, implementation, evaluation and modification of inpatient hospital prospective payment systems, and in particular, DRG-based systems.

Generally, the scope of this project, which is described in more detail later in this Phase 1 report, was to conduct an evaluation of the strengths and weaknesses of the existing fee-for-service ("FFS") Washington Medicaid inpatient reimbursement system, conduct a survey of other states' Medicaid reimbursement systems and make recommendations for potential changes to Washington's system. This process comprises Phase 1 of the project. The purpose of this report is to describe the results of this evaluation, and to present our recommendations.

The recommendations described in this Phase 1 report should be considered as preliminary. We have prepared recommendations without the benefit of a comprehensive fiscal impact model, which will be a key component of Phase 2 of this project. It is not possible at this point in time to understand with any certainty the fiscal impacts of the recommendations on the State and on the hospital providers, and it would be inappropriate to finalize decisions regarding our recommendations without the benefit of such an analysis.

It is also important to understand that one of the key directives given by DSHS for this project is that any changes to be implemented by DSHS resulting from this study must be budget neutral. In other words, payments in the aggregate resulting from the modified payment methodology must be equal to what payments would have been if the current payment methodology remained in place without change. Changes in the payment methodology may result in some sifting of payments between individual services or individual providers, but in the aggregate, payments must remain the same.

Finally, this study is not intended to evaluate the adequacy of funding for inpatient hospital services under the Medicaid (Title XIX) FFS program. While the analyses described in this report present information regarding payments received by hospitals, and estimates of the costs they have incurred, an evaluation of the adequacy of funding

must consider many other factors which are simply outside of the scope of this project. At the same time, it is important to understand that it is not our intent as part of this study to identify ways to reduce payments to hospitals in the State through modifications to the payment methodology.

In Phase 2 of this project, which will begin in December 2005, NCI consultants will carry the Phase 1 recommendations forward and conduct additional financial analyses and fiscal impact modeling to evaluate the impacts of the potential system changes. Based on these Phase 2 analyses, NCI will make final recommendations for changes to the system, and assist DSHS with implementing the changes.

We will finalize the recommendations in Phase 2 of this project, to a significant extent, based on the projected fiscal impacts to the State and the hospitals. It should be noted that many, if not all of the recommended methodology changes will be interdependent. In other words, recommendations or methodology changes should not be accepted or rejected individually. Making changes to some of the payment methodology features will be dependent upon other recommended changes. Accepting some, but not all recommended changes may result in unintended consequences, which might include not achieving budget neutrality, creating inappropriate incentives for providers and making payments that are not equitable.

Phase 1 Overview

In Phase 1, NCI consultants conducted a qualitative analysis of the current system based in part on comparisons to current practices of other states' Medicaid Programs, as well as our consultants' expert knowledge of payment systems for these programs and commercial payers. We enhanced our qualitative analysis through a comprehensive quantitative analysis of trends in utilization, payments, charges, estimated costs and acuity data for State Fiscal Years[1] ("SFY") 2002, 2003 and 2004, for all hospitals participating in the Medicaid Program in Washington State. Also, we received input from providers and other stakeholders, and considered this input as part of the evaluation process and formulation of potential recommendations.

In Phase 1, we examined the following areas and issues:

- The current Diagnosis-Related Group ("DRG")-based[2] payment methodology, including methods used to determine payments and rates under the methodology,

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[1] The Washington State Fiscal Year is the 12-month period ending on June 30th of each year. For example, Washington's SFY 2002 is the period from July 1, 2001 through June 30, 2002.
[2] The term "DRG-based" is used generically throughout this report to refer to the prospective payment methodology that relies on a patient classification system, or grouper, to assign a

- Determining payments for services using a Ratio of Cost-To-Charges ("RCC") methodology[3],
- The potential use of other payment options, such as a fixed per diem amount or fixed per case amount,
- The methodology used to identify outliers and make outlier payments for extraordinarily high cost cases,
- The appropriateness of allowing payments for individual claims under the current DRG-based methodology to exceed allowed billed charges submitted by the hospital for the claim,
- The methodology used to pay for psychiatric services provided in inpatient hospital settings,
- The current selective contracting program,
- The current centers of excellence program,
- The current critical access hospital ("CAH") payment program,
- The current trauma payment program, and
- Historical trends in utilization, charge and payment data.

We have described our detailed approach to this examination in the Phase 1 report. We have also presented recommendations resulting from this examination.

It should be noted that this study focused exclusively on reimbursement methods for inpatient hospital services. We did not examine reimbursement methods for outpatient hospital, physician, home health, skilled nursing, hospice or other types of services as part of this study.

Stakeholder Input

As mentioned previously, we received input for this project from various stakeholder groups, facilitated by DSHS and the Washington State Hospital Association ("WSHA"). We met three times with the WSHA Inpatient Hospital Advisory Committee, which is made up of representatives from a cross-section of hospital types. We met initially with this group to discuss the project scope and approach, and then again to discuss our

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payment to each inpatient discharge. Payment is generally determined by multiplying a fixed base rate, or conversion factor, by a relative weight, which is unique to each patient classification. Washington Medicaid currently uses the All-Patient Diagnosis Related Group, or AP-DRG patient classification system.

[3] Under an RCC payment methodology, payments are generally determined on a claim-by-claim basis by multiplying a claim's allowed billed charges by the facility's RCC.

progress with Phase 1. During this second meeting, we also received significant input from the providers regarding their concerns related to the current inpatient hospital payment system, potential changes to the system and other related issues. In the third meeting, we presented our Phase 1 draft report and recommendations to the group, and received their comments. We provided the Phase 1 draft report to WSHA prior to the third meeting, and WSHA distributed copies of the draft report to the Committee members prior to that meeting.

We also met separately with the Critical Access Hospital Subcommittee and the Psychiatric Subcommittee to discuss the current payment system related to services provided by these two groups.

The WSHA also provided us with a document entitled "Principles for Medicaid Payments to Washington Hospitals", which was created by the WSHA Inpatient Task Force. This task force is made up of chief executive officers from member hospitals that provide significant levels of inpatient care to Medicaid eligibles in the State. This document summarizes the providers' guidelines that they would like to State to consider as the State moves forward with modifying its inpatient payment methodologies. This document was considered by the Project Team as part of this study. A copy of this document is included in Appendix G to this report.

After our third meeting with the WSHA Inpatient Hospital Advisory Committee, the WSHA Medicaid Inpatient Task Force held a meeting to discuss our preliminary report and recommendations. This Committee prepared a formal response to the State regarding the draft report. A copy of the response is included in Appendix H of this report.

The State also prepared a letter commenting on the WSHA Inpatient Hospital Advisory Committee response, which is included in Appendix I of this report.

Input received from all parties has been considered as part of our evaluation of the current system, and the formulation of our Phase 1 recommendations.

Report Organization

The Phase 1 report is organized into the following sections:

- **Qualitative Analysis**. In this section, we describe our analytical approach to evaluating the current Washington Medicaid inpatient hospital reimbursement methodologies, and the results of our comparisons to other states' methodologies. We describe how states were selected for comparison, the survey questions used to gather information, how we completed the state

surveys, the evaluation criteria used to select exemplar states and the results of our evaluations.

- **Quantitative Analysis**. In this section, we describe our comprehensive trend and other analyses of SFY 2002, 2003 and 2004 paid claims data. We describe the process for receiving and uploading the data, adjustments made to the data, the analyses completed and significant observations resulting from the analyses.
- **Phase 1 Project Findings and Recommendations**. In this section, we provide an overview of our significant findings and recommendations resulting from our Phase 1 evaluation. We present our findings and recommendations by topic area. It should be noted that many of the recommendations provided in this section should be considered preliminary, and should be evaluated further as part of Phase 2 of this project.
- **Report Appendices**. The analyses completed for this Phase, both qualitative and quantitative, are significant. In the Appendix section of this report, we provide all of the supporting documentation and analyses generated during Phase 1.

Phase 1 Project Findings and Recommendations

Generally, we found Washington State Medicaid's prospective payment system for inpatient hospital services to be a robust system that was carefully developed to address specific issues at the time it was designed. While we have identified some payment system features that are still effective and consistent with best practices, we found other features to be somewhat outdated and in need of modification.

We identified a number of recommendations as a result of this Phase 1 study. As mentioned previously, it should be noted that many of these recommendations are somewhat preliminary, and we have developed them without the benefit of a comprehensive fiscal impact analysis, which is anticipated as part of Phase 2 of this project. We do not believe that it would be appropriate, in most instances, to finalize our recommendations without fully understanding the fiscal impacts of the recommendations to the State, and to the individual providers in the State. As such, these recommendations should be viewed as options to consider further as part of the fiscal impact modeling in Phase 2. These recommendations will not become final until Phase 2 is completed.

Our recommendations are provided below, by topic area:

DRG Methodologies and Related Issues

- The State should update the version of the AP-DRG grouper that it is using. There are substantial improvements in the AP-DRG groupers developed after version 14.1. The most current version (version 23.0) should be implemented. In addition, the State should consider establishing a regular schedule for updating the AP-DRG grouper version, along with relative weights, conversion factors and other payment system components. Regularly scheduled updates would help to maintain the integrity of the system over time.
- The State should bring as many services as possible into the DRG-based payment methodology, to the extent that there are sufficient numbers of claims available to calculate stable relative weights. The State pays for significant volumes of services using other payment methods, and many of these services can be appropriately paid under the DRG-based methodology. The State also excludes provider types from the DRG-based methodology that could also be paid appropriately using this methodology.
- The State should reconsider the need to maintain peer groupings for purposes of establishing ceilings for payment, and if necessary, evaluate peer grouping criteria to be consistent with other adopted methodology changes.
- The State should also consider whether peer group or statewide conversion factors could replace the current facility-specific approach. If adopted, such an approach should also consider the necessary adjustments to reflect appropriate differences in costs between providers, such as regional differences in wages, the costs of maintaining trauma programs, the costs of supporting graduate medical education programs, the costs associated with providing specialized children's services and high-risk neonatal services, and others.
- The State should consider modifying the indirect medical education factor used in cost calculations to reflect the most current Medicare-based formula.
- The State should analyze the costs of DRG-based transfer claims to determine if costs of services are more intensive in the first few days of a transfer. If so, the State should consider adjusting the transfer-out payment policy to better reflect the higher intensity of costs in the first few days of a patient's stay. For example, the state should consider following Medicare's approach of adding an additional day of stay for purposes of calculating payment for the transferring hospital, or use 200 percent of the per diem for the first day.

Per Case and Per Diem Payment Methods

- Overall, the State should consider transitioning from its RCC payment approach and move to a prospective per discharge or per diem payment methodology for services currently paid under the RCC method.
- The State should consider a per diem approach for payment of psychiatric services, rehabilitation services, and acute services that are categorized into AP-DRGs that do not have enough historical claims volume to support the calculation of stable relative weights. The State should analyze the costs of providing psychiatric and rehabilitation services in freestanding psychiatric and rehabilitation hospitals, distinct part units and in acute care hospitals without distinct part units to identify variations and evaluate whether the variations should be accounted for in the per diem payment methodology.
- For new per diem services, the State should consider the need for a cost outlier policy. The State should conduct analyses during Phase 2 of the project to determine the significance of potential outliers.
- If the per diem methodology is expanded to more services, the State should consider implementation of concurrent utilization review and limitations on cost components (consistent with those adopted for the AP-DRG methodology, if applicable). To the extent that the utilization review functionality is expanded for related services, the State should also take into consideration the potential increased costs associated with such expansion.
- If the per diem methodology is expanded to more services, the State should consider adjusting the costs used for setting AP-DRG conversion factors to exclude the costs of services to be paid under the per diem methodology.
- The State should consider establishing a consistent schedule for updating and rebasing per diem rates. Updating and rebasing per diem rates should be done concurrently with updating and rebasing of all other payment system components, such as conversion factors.

Please refer to the discussion regarding psychiatric services for additional recommendations regarding the adoption of a per diem approach for psychiatric services. Also, please refer to the discussion regarding centers of excellence for more discussion of payment alternatives for transplant services.

RCC Payment Methodology

- The State should consider eliminating the use of RCCs in most cases. Many services currently paid based on the RCC methodology could be paid based on the AP-DRG methodology, or a per diem methodology. Such a change would result in greater incentives for cost effectiveness, and enhance predictability of expenditures for the State.

Outlier Policy

- The State should consider eliminating the day outlier policy. If hospitals do not incur additional costs for outlier cases, normally, there is no need to pay for long lengths-of-stay[4].
- The State should consider adopting a regular interval for updating the high-cost outlier threshold. There is also a need to regularly review the outlier policy to determine whether it is effective. Updates to the outlier policy could be made coincident with updates to conversion factors.
- The State should consider implementing a policy where the outlier threshold is set at a level so that only those cases with extraordinarily high cost are identified as outlier cases. This policy should be reevaluated on an annual basis.
- The State should consider implementing a policy where the outlier threshold is set at a level that results in a targeted outlier payment percentage of AP-DRG based payments, similar to CMS's policy for Medicare outlier payments. The threshold policy should be reevaluated on an annual basis so that resulting outlier payments remain within the States targeted amount.
- The basis for identifying outliers and determining outlier payments should be revised so that outliers are identified based on estimated costs and outlier payments are based on a percentage of estimated costs that exceed the outlier threshold (estimated costs determined by multiplying the RCC by the billed allowed charges). Under the current methodology, outliers are identified based on billed allowed charges, and outlier payments are based on a percentage of the billed allowed charges that exceed the outlier threshold. This leads to increases in outlier payments when a hospital increases its charges.
- The State should consider eliminating the facility-specific outlier set-aside amount. While it is important to consider and adjust the cost basis for conversion factors to reflect the costs of outlier claims, such adjustments could be accomplished at the statewide or peer group level. If the set-aside amount is retained, the calculation of the cost outlier set-aside amount should be modified to be consistent with revisions to the outlier payment policy. As described above, under the current policy, increases in charges tend to increase the outlier payments disproportionately. As a result, the set-aside amount tends to increase, thereby lowering the conversion factor, which in turn tends to further reduce the outlier threshold and increase outlier payments even more. The current methodology leads to ever-increasing levels of outlier payments.

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[4] Some states have maintained a day outlier policy for children's services to meet OBRA requirements. However, other states have successfully demonstrated that the use of cost outliers is sufficient to meet OBRA requirements without a separate day outlier policy.

Critical Access Hospitals

- The State should streamline the cost settlement process, and perform only one cost settlement. The current RCC methodology, if retained, should provide for sufficient reimbursement on an interim basis, until a final settlement can be completed. If a single cost settlement process is adopted, the State should consider allowing for exceptions in certain circumstances if a CAH can demonstrate that its costs are significantly different from the interim payments received.

Border Hospital Payment Methodology

- The State should re-evaluate the appropriateness of border hospital definitions, considering the access needs of Washington Medicaid clients relative to the provider services available in state, and those specific out-of-state hospitals that will enhance overall access to services.
  - For those hospitals identified as critical border-area hospitals in the above recommendation, maintain the current policy of payment based on the methodologies used to pay in-state providers.
  - For those hospitals identified as non-critical border-area hospitals, consider simplifying the payment methodology to make payments based on the same method used for in-state hospitals, using averages of in-state providers' rates (average conversion factors or per diem rates, which could be based on peer group designations, and average RCC for outlier payment determination). Amounts could be discounted if determined appropriate.
- For both non-critical and non-border-state hospitals, consider exclusion of payments related to medical education costs (direct and indirect).
- For out-of-state hospitals, consider exclusion of disproportionate share hospital payments. As part of the evaluation of this option, consider disproportionate share hospital payments by other states to Washington hospitals.

Psychiatric Services

- The State should evaluate the best way to pay for inpatient psychiatric services if they revert to fee-for-service in any of the regions. To accomplish this, the State should analyze the costs of providing psychiatric services in specialty psychiatric hospitals, distinct part units and in acute care hospitals without distinct part units to identify variations in costs and to understand the reasons for such variations. This analysis will support a determination as to whether there should be different methodologies based on the provider

type (i.e., acute care hospital, distinct part unit, free-standing psychiatric hospital).

- The State should evaluate the feasibility of implementing a system based on Medicare's Inpatient Psychiatric Facility Prospective Payment System. Implementing a system based on Medicare's psychiatric and prospective payment systems would allow Washington Medicaid to pay for psychiatric services using a variable per diem approach that accounts for patient characteristics, such as age and comorbidities, that affect resource utilization. Concurrent utilization review would be necessary to assure that all days of a client's stay were medically necessary, but since per diem payment decreases as length-of-stay increases under the Medicare Inpatient Psychiatric Facility Prospective Payment System, the approach would create less incentive for longer lengths-of-stay. Also, as mentioned previously, the State should consider the potential additional cost associated with expanding the utilization review function related to this change.
- If the State determines that the Medicare approach is not appropriate, it should consider evaluating the implementation of a fixed per diem payment system with concurrent utilization review. The design of a fixed per diem payment system will depend on the results of the analysis recommended above[5].

Selective Contracting

- The State should evaluate the need for selective contracting in the current environment and whether there are less administratively burdensome ways to achieve the State's health care access and cost containment goals. Consider discontinuing the Selective Hospital Contracting program.

Centers of Excellence

- The State should evaluate the need for Centers of Excellence in the current environment and whether there are less administratively burdensome ways to achieve the State's health care access and cost containment goals. The State should consider this issue in conjunction with the evaluation of the Selective Contracting program. If Selective Contracting is maintained, the Centers of Excellence program may be a way to better define those facilities that can participate in Selective Contracting.

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[5] Most commercial payers use a fixed per diem payment method for inpatient psychiatric services. A small number of commercial payers use a percentage of charge payment method for these providers.

- Consider adopting an alternative payment methodology for services currently covered under the Centers of Excellence program. For example, consider establishing fixed price payments for transplant services based on the payment levels currently in place for the Medicare program. Amounts could be adjusted to take into consideration the differences in resources between the Medicare and Medicaid population, and to meet the State's objectives for expenditures.

Trauma Care Program

- The State should assess the extent to which total Medicaid payments for trauma services (DRG- or RCC-based payments and supplemental trauma care payments) cover estimated hospital costs over time.
- Washington Medicaid should collaborate with the Department of Health to conduct a study of uncompensated trauma care (Medicaid and other payers) to determine which trauma care providers (e.g., hospitals, physicians, ambulance providers and others) incur the greatest unreimbursed trauma care costs and use the results of this study to asses the current trauma care payment distribution (Medicaid and non-Medicaid) methodology.

DRG-Based Payments Exceeding 100 Percent of Billed Charges

- We do not recommend making a change to the payment methodology to limit payments to billed allowed charges. We believe that the potential for abuse of the current DRG-based payment system through inappropriate coding can be better addressed through other measures.
- The State should consider a policy that establishes a threshold, based on payments compared to billed charges, and based on length-of-stay; claims that exceed this threshold should be either suspended for payment and require a manual review, and potentially a medical record review by the State's Provider Review Organization prior to payment, or be flagged for review without suspension.

Conclusion

As mentioned previously, we found Washington State Medicaid's prospective payment system for inpatient hospital services to be a robust system that was carefully developed to address specific issues at the time it was designed. While we have identified some payment system features that are still effective and consistent with best practices, we found other features to be somewhat outdated and in need of modification.

It is clear in our evaluation that DSHS was very thoughtful in its development of the current system. Rates and relative weight calculations are well documented, and

accurately determined. Significant detailed attention was given to all rates and rate component calculations.

Our recommendations focus primarily on potential changes to make the existing payment methodology and related rates more reflective of the current costs of providing services. This is not to suggest that payments are either adequate or inadequate, but that conversion factors, relative weights and other payment system components have not been updated for several years, and as more time passes, the relationship between payments and costs becomes less significant. Our recommendations also focus on potential changes that will make the system more prospective in nature, which if implemented, will make payments in future periods more predictable not only for the State, but for the providers.