

2009 Fact Sheet:

Hospital cost controls

THE BACKGROUND

Faced with the state's drastic decline in revenues for the upcoming biennium, the Health and Recovery Services Administration assigned a series of steering committees to review the Medicaid program's purchasing practices. Overall, the teams were able to develop purchasing strategies that will let the administration save more than \$200 million a year – taxpayer dollars that will help the state avoid cuts in vital services and health care during the coming biennium. Hospital purchasing changes below are expected to save the state more than \$56 million over that period.

TIMELINE FOR HOSPITAL PURCHASING STRATEGIES

Start date and Dollar savings (est.)	Purchasing strategies
July 1, 2009 \$7.8M	Prorating length-of-stay in “Diagnostic Related Grouping (DRG)” payments when patients are transferred to a post-acute care setting. Medicaid currently pays the full DRG for a claim even when a patient is transferred before the end of the average length of stay to a skilled nursing facility, nursing home, hospice, or other post-acute care setting. In these situations, Medicaid is essentially paying the daily cost of care in duplicate. Under the new calculation, Medicaid will pay a pro-rated amount for a DRG paid hospital claim if a post-acute care transfer occurs before the end of the average length of stay for the DRG plus one day...
July 1, 2009 \$ 4.5M	Move to the Outpatient Prospective Payment System (OPPS) methodology for all hospitals, taking advantage of standardation in billing and consistency of reporting.
July 1, 2009 \$ 42M	Reduce inpatient and outpatient payments: Targeted across-the-board percentage reduction in payment rates will enable the state to achieve a reduction in hospital payments.
July 1, 2009 \$500 K	Reduce potential inpatient DRG upcoding: New software and technical applications will allow screening of hospital billings, with edits that can detect incorrect upcoding.
July 1, 2009 \$1.5M	Increase clinical audit staff to identify and assist in the recovery of medical assistance overpayments.
July 1, 2009 TBD	Eliminate third year allowance for claims adjustments. Medicaid currently gives hospitals one year after date of service to submit claims – and allows up to three years after date of service for a claim adjustment. This means hospitals are encouraged every three years to mine their previous claims, looking for opportunities to adjust existing claims for higher rates of reimbursement. DSHS is proposing to reduce the three-year period – an extremely long period by national standards – to two years.
April 1, 2009 \$2.0M	Reduce C-section rates for Medicaid births to a statewide average of 18% by lowering the rates paid for non-emergent C-section to be equal to vaginal delivery. <i>(The C-section changes are outlined in detail on the next page.)</i>

BACKGROUND OF C-SECTION REDUCTIONS

Like the rest of the United States, Washington State's health-care system has cast a worrisome eye on the increasing rate of elective Cesarean sections – so-called “C-sections,” or surgical births – over the past two decades. The state's C-section rates have jumped 60 percent in low risk mothers, adding 2,600 more C-sections than the national Healthy People 2010 goal. In fact, Washington State overall is approaching a 30 percent surgical birth rate. Of even more concern is the wide variation in C-section rates between hospitals. The rate varies between 15% and 48% at different hospitals without a good understanding of why. Patient safety is the paramount concern since rising C-section rates are running parallel to the rise in costs for neonatal care of newborns. The problem is fourfold:

BY THE NUMBERS

The growth in C-sections is a national phenomenon.

- Nationally, the U.S. has seen a 50 percent increase in C-sections since 1996.
- Only 8 percent of women with a previous C-section delivered vaginally in 2006.
- Just under 1 percent of the women with a previous C-section experienced a ruptured uterus during a subsequent vaginal birth.

-- Time Magazine, March 2, 2009

- First, the increase has occurred despite the concern it raises about patient safety. Although high-risk births require C-sections, those that are elective in nature, especially when the baby is taken early, pose higher risks for mothers and newborns (*New England Journal of Medicine – Jan 2009*).
- Second, the C-sections themselves are forcing a second growth rate – a trend in which obstetricians are wary of recommending vaginal births for women who have already experienced a C-section. Data shows that women who have undergone a C-section face a risk of a ruptured uterus during subsequent vaginal births. The old slogan in medicine --- “once a C-section, always a C-section” – appears to be proving true. Studies show that many women, once educated on the risks, may wish to have a vaginal birth after Cesarean (VBAC) yet are denied the option because of the liability concerns. (*British Medical Journal 2008*)
- Third, C-sections represent significantly higher costs for health insurance payers – they easily run double or more the cost of vaginal births in Washington. Private insurance carriers are concerned about the expenses; so are public health-care systems like Medicaid, Basic Health or state employee health plans. Additionally, elective C-sections often result in an expensive intensive care stay for the child. Babies delivered as a vaginal delivery are much more likely to be placed in the normal nursery. (*Pediatric Critical Care Medicine, Nov 2004*)
- Fourth, the recent set of octuplets in California points to the growing trend of OB doctors to implant two or more eggs in a woman seeking *in vitro* fertilization - commonly referred to as IVF. Each time a woman continues a pregnancy with two or more eggs increases the chances of both a C-section and increases the birth risk putting the mom and baby at risk. (*Journal of Perinatal Neonatal Nursery, April-June 2005*)

A LEGISLATIVE APPROACH

The 2009 Legislature is looking at the increased C-section rate with an eye toward savings, patient safety and good evidence-based practice. Legislation (ES2992) would allow for patient decision aids, helping educate patients, physicians and hospital birth centers about the need to control C-section recommendations and to understand the role of surgical deliveries. This educational approach will help new mothers understand their stake in vaginal delivery, improving patient voice, lower provider liability, and reducing costs to the state.

EVIDENCE-BASED MEDICINE AND PATIENT SAFETY

When used for appropriate indications, C-section is a safe and effective intervention to improve infant or maternal outcomes. However, C-sections also result in increased morbidity and costs and should not be used solely for convenience of doctor or patient. Variation in use of C-sections across communities and hospitals suggest that avoidable C-sections continue to occur in Washington and can provide guidance for carefully focused efforts to prevent unnecessary surgical deliveries.