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Making Medicare Reimbursements Work for Higher-quality, Lower-cost Health Care Delivery: Paying for the Right Care

Using the A3 tool, which is a standard problem-solving tool used in lean management, we analyze the problems with the current Medicare IPPS reimbursement formula, and offer goals to advance solutions.

Define the Problem

The current formula discourages the delivery of high quality, low cost health care services—a key factor in effective reform. The formula actually encourages providers to drive costs higher and to expand services and facilities. It offers very few, if any, incentives to deliver high quality care and positive health outcomes for patients.

Many providers are diligently working to improve quality care, that is, care that is assessed by patient health outcomes. Importantly, successes show that quality care improvements do not have to cost more. In fact, when providers use proven processes to improve patient outcomes, the results also include significant cost savings.

Background

Medicare IPPS reimbursement payments are derived through a series of adjustments applied to separate operating based and capital based payment rates. The base rates are updated annually, and unless there are policy changes, the updates proportionately raise all payment rates.

The operating base payment rate includes labor related and non-labor related shares. The labor related share is adjusted by a wage index to reflect area differences in the cost of labor. If the area wage index is greater than or equal to 1.0, the labor reimbursement share equals 68.8 percent. The law requires the labor reimbursement share to equal 62 percent if the area wage index is less than 1.0.

The wage index incorporates a number of elements, including legal and professional fees, pension costs, home office personnel, bonuses, severance payments, overtime hours, employee physicals and other factors.

The capital base payment rate covers costs for depreciation, interest, rent and property-related insurance and taxes.

The wage index is applied to the labor-related portion or labor share of the operating base rate, which reflects an estimated portion of costs affected by local wages and fringe benefits. Additionally, the wage index is applied to the whole capital base rate.

Finally, the payment is reduced when a Medicare patient has a short length of stay and is transferred to another acute care hospital, or in some cases, to a post acute-care setting.

Current State
Several elements of the formula create the problem: the wage index, capital payment rates and the discharge penalty.

Although the wage index is intended to account for regional variations in the cost of doing business, it actually encourages higher spending on wages and wage-related expenses. These costs are markers of inefficiency. They incent higher wages, not better quality, efficiency or outcomes.

While the adjustments for capital payment rates are intended to promote the use of appropriate new technologies and recognize the burden certain hospitals bear in treating a disproportionate share of disadvantaged patients, the formula also rewards health care expansion and over-capacity. And since the wage index is applied to the entire capital base payment, it further supports expansion and higher wages.

The flawed formula results in the misallocation of resources. New hospitals are built in areas where existing hospital services already meet the needs of patients. Expensive technology that already exists in the local market is purchased anyway. The acquisition of independent physician practices to capture market share and drive volumes at the newly-constructed hospital facilities continues. Dartmouth data clearly demonstrate that markets with more hospital beds and more physicians, especially specialists, have higher costs and lower quality care.

Goals

1. Review and revise the Medicare IPPS reimbursement formula to encourage health care providers to deliver high-quality, low-cost care. The formula should include both quality and cost.
2. Stop penalizing lower-cost providers for using resources well. Costs should be assessed through actual costs of delivering quality care to patients, and providers should be encouraged to manage those costs in keeping with quality outcomes. In Wisconsin, we look to the Wisconsin Health Information Organization (WHIO) to track and measure costs. WHIO is moving our state toward a comparative process, where payers can evaluate providers' costs for comparable care.
3. Include quality indicators together with cost assessments in the IPPS formula. Better health care does not have to cost more. Providers around the nation demonstrate this every day as they use proven methods for eliminating waste, reducing errors and improving patient safety. They are delivering better care, and it's costing them less. We can offer another Wisconsin resource to support identifying and measuring quality: The Wisconsin Collaborative for Healthcare Quality (WCHQ). The Collaborative offers patients, providers and payers the opportunity to compare outcome measures around care delivery. It is possible to measure and assess quality. Medicare's reimbursement formula must account for this critical component of care delivery.
4. Revise the length of stay transfer factor in the formula. Incorporate both quality and cost factors when looking at LOS. Many efficient providers are discharging patients sooner, and discharging them to more appropriate settings. The formula should not penalize the delivery of care that gets patients better faster and home sooner.

The Medicare IPPS payment formula should be revised to reimburse high-quality, low-cost care and the efficient use of health care resources. These priorities are also the ultimate goal of any successful healthcare reform initiative.