Overview of Hospital Payment Systems

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Medi-Cal Payment to Hospitals

- Medi-Cal pays a “per diem” rate hospitals
- A flat rate per day in a hospital
Medicare pays “Diagnostic Related Groups”, or “DRG” rate to hospitals

A flat rate per case admitted to a hospital
In the old days, private plans pay hospitals by procedures

“Fee-for-services” or “FFS”

Payment based on “usual and customary” charges

Hospitals develop their own “chargemaster” and update that frequently

There is no systematic way of how hospitals update their charges
Managed care rose since the 1980s
Began to form network providers and pay differently
- Discounted FFS - heavily discounted rates off “charges”
- **Per diem** – a flat rate per day
- DRG – a flat rate per admission, Medicare rates
- Case rate - a flat rate per admission, private rates
- Capitation – a flat rate per patient, all inclusive
Private Payment for Out-of-network Hospitals

- Chargemaster to hospitals is like appendix to human beings
  - It was once useful but is no longer functional today

- With 2 exceptions, where insurance contract is not binding
  - Hospitals bill uninsured full charges, until recently
  - Out-of-network hospitals bill plans full charges. Patients have to pick up what plans do not pay (except for emergency care)
Incentives Under Different Payment Methods

- FFS
- Discounted FFS
- Per Diem
- DRG
- Capitation

Degree to which reimbursement reflects costs:
- High
- Low

Incentives to provide care:
- Over-provide
- Under-provide
Issues Related to Switching from Per Diem to DRG

- Upcoding
  - Code patients toward DRGs that pay more

- Unbundling
  - Inpatient spending is reduced
  - Spending for non-hospital care increases (such as rehab, skilled nursing, and home health services)

- Cost-cutting vs cost-shifting
  - Lower DRG payments $\rightarrow$ hospitals cut cost, if they do not have market power
  - Lower DRG payments $\rightarrow$ hospitals raise payments for private plans, if they have market power
Issues Related to Switching from Per Diem to DRG

- Payment adequacy
  - Higher payment for high-cost cases (outlier payment)
  - Very low DRG payment may hurt access and quality of care provided to beneficiaries

- Pay for quality
  - DRG/prospective payment has not encouraged better quality
Hospital spending have been growing rapidly since 1999 (7% per year), unclear what the major drivers are.

Huge variation in prices paid to hospitals that is not related to cost or quality.

Some evidence that hospital market power is related to higher payments in several markets.
Cumulative Growth in Hospital Payment, 2001-2007

Net Patient Revenue

CPI
Cost and Payment for Cardiac Valve Replacement Surgery in CA, 2008

- **Cost per case:** $19,263
- **Payment per case:** $27,052
- **Multiplier:** $172,087 / $27,052 = 6.3

The diagram illustrates the cost and payment comparisons for cardiac valve replacement surgery in California in 2008.