



RESEARCH REPORT

Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care

# Per Diem Payments to Hospitals for Inpatient Stays

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Payment reform promises to substitute value for volume. Yet, value- and volume-based approaches typically are implemented together. All payment methods have strengths and weaknesses, and how they affect the behavior of health care providers depends on their operational design features and, crucially, on how they interact with benefit design. Those seeking greater value for their health care dollar are also turning to innovation in benefit design, which also typically involves the implementation of more than one approach at a time—each with its own strengths, weaknesses, and effect on consumer health care behavior. Although payment and benefit design each has received significant attention independently, the intersection between the two has received little if any. The Urban Institute partnered with Catalyst for Payment Reform to explore how established and proposed payment methods and benefit design options work on their own and together. We also examined how payment and benefit design can be blended to improve health care delivery. This chapter is one of the nine payment methods discussed in the report *Payment Methods: How They Work*. All reports and chapters can be found on our project page: [Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care](#).

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## Per Diem Payment to Hospitals for Inpatient Stays

Per diem payment for inpatient services provides a fixed amount for a patient day in the hospital, regardless of a hospital's charges or costs incurred for caring for that particular patient. In the most common arrangement in the United States, the payer negotiates per diem rates with the hospital and pays that rate without adjustment. If the payer and hospital can accurately predict the number and mix of cases, they can accurately calculate a per diem rate. All else equal, the larger the volume of cases applicable to a payer, the more predictable the average daily cost—and the per diem level—will be.

Often, however, hospitals want to exclude days in an intensive care unit or another specialized unit, unless there is a sufficient volume of regular medical-surgical cases to make the reimbursable costs predictable. Accordingly, multiple per diems are often negotiated on the basis of service type (e.g., medical-surgical, obstetrics, intensive care, heart surgery). Service-specific per diems diminish payers' need to formulate outlier provisions for unusually costly patients.

Per diem payment is often subject to carve-outs for particularly high-cost items and services, such as surgical implants and expensive drugs. The costs for these items can be passed through, sometimes with a markup for the hospital. Payers may also offer differential per diems for different days in the hospital; for example, the first day of a surgical stay would be paid at a higher rate than subsequent days, such that the later days are paid closer to the variable cost of the day rather than the average cost of all days.

Subject to a negotiated contract is whether the payer is obligated to pay for all days, regardless of their medical necessity. Private insurers are typically able to deny payment for days they deem unnecessary, using length of stay guidelines and performing either concurrent or retrospective review of clinical records to determine whether the billed days are medically necessary. Until recently, most U.S. insurers preferred per diems to DRG-based case rates because of their ability to deny days at the end of a hospital stay.

Recently, payers and hospitals have found DRG-based payment methods attractive because of their much stronger incentives and rewards for shorter stays and reduced costs. Yet some providers, especially ACO-like organizations that actively manage both who gets into the hospital and how they receive care, prefer to use per diems because they can directly control length of stay and do not need to provide hospitals payment for the average length of stay on which DRGs are calculated.

In some countries with health systems that rely on global hospital budgets, payers have combined budget targets with per diems as the billing units to provide cash flow.

## Key Objectives

Per diems represent an administratively straightforward way of modifying the inherently complex and inflationary approach of paying for each individual service hospitals provide. As a readily calculated metric, per diems provide straightforward payment negotiations between payers and hospitals. Per diems offer consumers the potential for cross-hospital cost comparisons, if such information is made transparent to the public (although hospital-specific variations for different service lines compromise that potential).

## Strengths

- Per diems, over more than 30 years, have led to straightforward administration and contracting. This payment method has facilitated administrative standardization, with supporting software to facilitate coding and billing.
- Per diems provide some constraints on cost-generating hospital behavior, because the payment amount per day is prospectively set (while the total actual payment is retrospective). Although hospitals have an incentive to generate longer stays to secure additional paid days, they should want to hold down costs per day.
- In contrast to both itemized individual services on the one hand and DRGs on the other, per diems can provide greater transparency for consumers to compare prices and lengths of stay among hospitals, as a surrogate for overall hospital costs.

## Weaknesses

- Hospitals have no incentive to avoid unnecessary days during a hospitalization.
- Per diems do not provide much transparency about hospitals' actual clinical activities, in contrast to DRGs. Thus, although per diems may facilitate length of stay comparisons, they do not permit comparisons among hospitals on activities or on outputs produced.
- Efforts to control costs may require third parties that monitor per diems to determine medical necessity through aggressive "continued stay" medical review. This introduces administrative complexity and sometimes inappropriate intrusion into clinical care, especially if the length-of-stay criteria are not supported by strong evidence.

## Design Choices to Mitigate Weaknesses

The most common approach to addressing the incentive for unnecessary admissions and longer-than-needed stays is through precertification of hospitalization and concurrent or retrospective medical review to deny medically unnecessary days. Payers will have to weigh the benefits of this regulatory approach and perhaps vary its application depending on their assessment of a hospital's proclivities toward excessive stays.

Operationally, whether per diems are calculated for different service units or service lines can vary. Payers can adopt a sliding-scale per diem approach: they will either pay a lump-sum settlement at the end of the year or withhold an amount from the final payment for the year to effectively reduce the per diem, depending on total bed days or admissions in the year. These reconciliations could be made more often than annually if hospital volume is high enough. And payers can attempt by contract to reduce how much hospitals benefit financially from payments for pass-through costs and from outlier payments.

## Compatibility with Other Payment Methods and Benefit Designs

For many decades, per diems had become the dominant approach for payer-hospital contracting for inpatient services because of relative administrative simplicity and modest incentives to reduce hospital costs per day, if not per stay. Starting in the mid-1980s with an inpatient prospective payment system, however, Medicare introduced an alternative with stronger cost-containing incentives because it provided hospitals with a fixed payment for the entire hospital stay. Payers able to deny days through continued stay oversight tended to prefer per diems, although some evidence shows that contracting has moved more toward case rates using DRGs, to be compatible with Medicare.

With the current growing interest in global payment, there is a rationale for medical groups bearing risk to prefer per diems to DRGs. Medical groups at risk for inpatient hospital services now have direct interest not only in avoiding inpatient care through more vigilant and higher-quality ambulatory care, but also in using less-intensive and less-costly sites of service. In addition, medical group personnel can actively manage their patients as inpatients and accomplish early discharges supported by strong transition programs, rather than rely on the hospital and separate clinical staff, for a high-quality, “early” discharge, thereby addressing the incentive for unnecessarily long hospital stays.

Per diems are compatible with procedure-based, bundled episodes for care provided during an inpatient stay, because providers can benefit from reduced stays. In contrast, paying a full DRG amount even when length of stay is reduced makes it more difficult for the parties receiving the bundled episode payment to generate savings for themselves. As with global payment, providers receiving a condition-specific bundled episode payment might prefer per diems to DRGs. Per diems impart a direct interest in controlling the use of and the length of inpatient hospital stays, and so providers might spend less under per diems than under DRGs.

Per diem payment for inpatient services is compatible with benefit design approaches that limit consumers' access to services through precertification and continued stay review, with the attendant strengths and weaknesses of that form of utilization management. Some commercial payers and hospitals have shown interest in instead moving toward DRGs, suggesting that they would rather rely on DRGs' stronger cost-reducing incentives than on a "regulatory" approach of denying days they pay for.

## The Focus of Performance Measurement

As noted, per diems give little information on clinical activities a hospital performs, particularly not the output per unit cost and the distribution of clinical services by condition. Separate data must be collected for measurement. Hospitals have incentive under per diem payment to generate both inpatient admissions and longer-than-necessary stays. Thus, measures of hospital-specific admissions for ambulatory care-sensitive conditions and of preventable readmissions would be particularly useful to assess—especially to see how hospitals are responding to perverse effects.

## Potential Impact on Providers' Prices and Price Increases

Nothing intrinsic in the per diem payment approach affects hospitals' prices or their incentives to increase prices. Hospitals with pricing power in their negotiations can seek higher per diem rates beyond their actual costs and can sustain a high cost structure. They also are in a position to avoid the cost discipline imposed by per diems ) by having service lines and outlier cases revert to payment of charges or discounts off of charges, rather than the negotiated per diems, resulting in higher payments.

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A [technical expert panel](#) advised the project team and reviewed the reports at different stages.

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