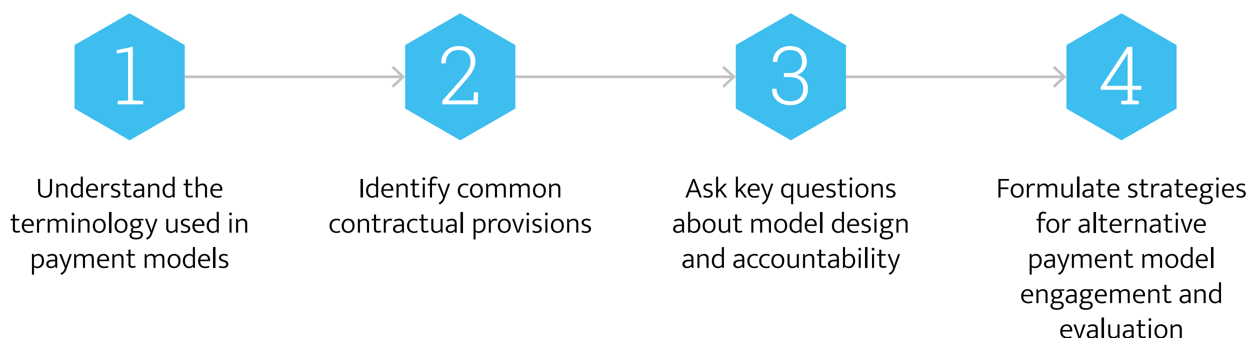
Physician Payment Models Guide

Payment models can often be confusing, and the available models are frequently changing. The following process flow can be helpful for physicians as they seek to understand the scope of the payment landscape.



While there are numerous options for physicians to review, the most common models fall into 3 main categories: core payment models, supplementary payment models, and organizational models.

Core Payment Models

The core payment models, or underlying payment models, can exist alone without other payment types.

Table 1. Core Payment Models

MODEL	DESCRIPTION
Fee-for-service (FFS)	Practices receive a flat fee per service unit for each visit, test, and procedure performed. In this model, practices achieve higher revenue with more patients and procedures each day. However, whether these revenues cover the physician's cost of providing the services depends on many factors. **More information:** • Centers for Medicare & Medicaid Services (CMS): Overview of the Medicare Physician Fee Schedule Search • CMS: Search the Physician Fee Schedule
Capitation	Practices receive payment to manage a patient's care and health conditions per patient per period, with the period typically being 1 month. The health plan will apply attribution rules to decide which patients are included in a given physician practice. **More information:** • Understanding Capitation • Effects of Health Care Payment Models on Physician Practice in the United States—Follow-Up Study (PDF) Basic definition: pp. 10–12; 32–33 Detailed overview: pp. 15–17; 37–39
Bundled or episode-based payments	Practices receive payment based on episodes of care as the payment base. Episodes are typically defined according to a set of diagnoses and services provided over a specified service time, especially for surgical procedures. These models may bundle hospital, physician, and post-acute care services together. These models allow practices to achieve higher revenue by avoiding complications, negotiating discounts, and choosing lower-cost settings for post-acute care. **More information:** • Evaluating bundled or episode-based contracts (PDF)

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Supplementary Payment Models

The supplementary payment models can coexist with 1 or more core payment models but cannot exist on their own.

Table 2. Supplementary Payment Models

MODEL	DESCRIPTION
Pay for Performance (P4P) ie, Medicare Merit-based Incentive Payment System (MIPS)	Physicians in the practice are compensated by the payer according to an evaluation of practice performance on defined metrics. These metrics could be based on the quality of care and/or measures of costs or utilization of care. Practices may receive an increase or a reduction in their fee-for-service compensation. **More information:** • Evaluating pay-for-performance contracts (PDF)
Shared Savings Program	Practices receive fee-for-service payments throughout the contract year rather than capitation payments before or during the year. At the end of the year, total costs of care for the attributed patient population are compared to a cost target, which triggers a lump-sum bonus or penalty. This is often compared to a practice's historical performance, and such targets may be recalibrated after a set amount of time. The shared savings bonus payments can only be distributed retroactively due to the calculation of actual costs. **More information:** • CMS: About the Shared Savings Program
Retainer-based payment	Practices receive capitation payments from the patient to the practice directly. Retainer-based payment models are commonly known as concierge or direct primary care. In this model, payments are typically made per patient per year or month as a membership fee. The fee covers a defined range of services. The membership can be supplemented by other payment arrangements, such as fee-for-service, typically billed to the patient's insurance (separate from the membership fee) for services, not within the range covered by the membership fee. **More information:** • Direct Primary Care: An Alternative Practice Model to the Fee-For-Service Framework (PDF)

Organizational Models

Organizational models for physician practices combine payment models to create additional payment models.

Table 3. Organizational Models

MODEL	DESCRIPTION
Medical home	Most practices following the medical home payment model receive fee-for-service payments as their primary revenue source. Medical homes often receive additional payments in enhanced fee-for-service payment rates, per-month patient care management fees, and pay-for-performance payments for high performance on measures of quality, patient experience, or cost. Physicians may also be subject to payment reductions if they miss cost and quality savings targets. **More information:** • Patient-Centered Medical Home (PCMH) Model
Accountable Care Organization (ACO)	ACOs are large health systems or collections of physician practices that jointly enter an ACO contract with a payer. Typically, ACO contracts pay via fee-for-service but can receive shared savings at the end of the year if it performs well on quality and patient experience measures and holds the total costs for its population of attributed patients below a defined target. The bonus is paid as a lump sum for the previous year, but other payment bases are possible. Physicians participating in ACOs may also be liable for shared losses if spending exceeds the benchmark. **More information:** • Accountable Care Organizations (PDF)

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Physician Payment and Risk

As health care moves from volume-based models to value-based models, there needs to be a focus on the quality of care and potential risk-sharing between physicians and payers.

Risk in Payment Models

Before accepting risk-based contracts, physicians need a broader understanding and education of the risks, rewards, and the underlying cost of doing business. A physician who makes such an agreement takes on the risk and assumes responsibility for delivering or arranging health care services to patients when the total payment for providing those services can be greater or less than the total cost for such services.

The AMA guide, Key Considerations in Forming, Operating or Joining a Clinically Integrated Network (PDF), is invaluable when a practice is assessing readiness to join risk-based payment models.

Table 4. Types of Risk and Their Definitions

TYPE OF RISK	DEFINITION
Downside risk[1]	Downside risk occurs when a physician could potentially incur costs greater than payments received for services.
Insurance risk[2]	Insurance risk is related to the health status beyond the physician's control, such as age, gender, and acuity differences.
Patient risk adjustment[3]	Patient risk adjustment uses a statistical process to calculate the health status of a patient into a number, called a risk score, to assist in the prediction of health care costs.
Nominal risk[4]	Nominal risk is contained in the Medicare Access and CHIP Reauthorization Act (MACRA), Advanced Alternative Payment Model (APM) states that participants must assume negligible risk or take the risk of an amount that is less than optimal but substantial enough to drive performance.
Performance risk[2]	Performance risk is the potential for higher costs from delivering unnecessary services, inefficiently delivering care, or committing errors in the diagnosis or treatment of a particular condition.
Full risk	Full risk is a two-sided risk that can subject health care providers to responsibility for 100% of health care costs for a population of patients but typically also provides an opportunity for higher shared savings gains.
Upside risk	Upside risk gives physicians a chance for a financial upside but no downside risk. The risk comes from the uncertainty that there will be a positive margin and its size.
Shared risk	Shared risk is a method where the physician and payer agree to share responsibility when payment differs from the cost of care.
Utilization risk	Utilization risk relies on the physician to take steps to limit unnecessary care.

Risk in patient populations

As the payment model landscape shifts from payment for each service provided to payments that vary according to costs and quality measures, physicians would benefit from a clear understanding of their patient population and its health risks. This understanding directly correlates to the financial risks of your practice.

Insurance companies and government payers use diagnosis coding to make comparisons of quality, cost, and estimations of resource use. To accurately capture patients' severity of illness, physicians will want to be aware of specific diagnosis coding. ICD-10 diagnosis coding will help payers assign appropriate insurance risk and position your practice for value-based payment by accurately reflecting individual patients' health or severity of illness. Higher risk assignment may also equate to higher pay for care management or under a capitation model. Risk adjustment methods have some significant limitations, however. They generally use historical information about patient diagnoses, so it may not lead to adequate compensation for the services patients need when they need them.

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Further Reading

AMA–RAND Effects of Health Care Payment Models on Physician Practice in the United States

AMA–RAND Follow-Up Study (PDF)

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