



RESEARCH REPORT

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

A Typology of Payment Methods

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April 2016





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Acknowledgments

This report was funded by the Robert Wood Johnson Foundation. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at www.urban.org/support.

A technical expert panel advised the project team and reviewed the reports at different stages. This team consists of **Michael E. Chernew**, Leonard D. Schaeffer professor of health care policy and director of Healthcare Markets and Regulation Lab, Harvard Medical School; **Francois de Brantes**, executive director, Health Care Incentives Improvement Institute; **Anna Fallieras**, program leader, Health Care Initiatives and Policy, General Electric; **Kate Farley**, executive director, Pennsylvania Employees Benefit Trust Fund; **Joseph J. Fifer**, president and chief executive officer, Healthcare Financial Management Association; **Robert Galvin**, chief executive officer, Equity Healthcare, operating partner, Blackstone, and former chief medical officer, General Electric; **Paul Ginsburg**, professor and director of public policy, Schaeffer Center for Health Policy and Economics, University of Southern California, and senior fellow and director, Center for Health Policy, Brookings Institution; **Stuart Guterman**, senior scholar in residence, AcademyHealth, and former vice president, Medicare and Cost Control, The Commonwealth Fund; **Vincent E. Kerr**, president, Care Solutions, National Accounts, UnitedHealthcare, and former chief medical officer, Ford Motor Company; **Peter Kongstvedt**, principal, P.R. Kongstvedt Company, LLC, and senior health policy faculty member, George Mason University; **Jeff Levin-Scherz**, assistant professor, Department of Health Policy and Management, Harvard University, and national coleader, Willis Towers Watson; **Robert Murray**, president and consultant, Global Health Payment LLC, and former executive director, Maryland Health Services Cost Review Commission; **Dave Prugh**, independent adviser and consultant, and former vice president of Reimbursement and Contracting Strategy, WellPoint, Inc.; **Simeon Schwartz**, founding president and chief executive officer, WESTMED Medical Group; and **Lisa Woods**, senior director, US health care, Walmart Stores Inc.

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. 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](#).

A Typology of Payment Methods

Typologies of Payment Approaches

One barrier to pursuing payment reform and reaching consensus on modifications to current payment methods and adoption of new ones is the inconsistent and often confusing terminology used to describe payment methods and the definitions of associated terms and concepts (Miller 2015). Both policy-makers and affected stakeholders find it difficult to determine whether to support a proposal if they do not understand the words used to describe it.

It is also difficult to reach agreement when the same words used by different people mean different things or when words are perceived to mean something different than what was actually intended. For example, policy-makers routinely refer to all current Medicare payment models as fee-for-service, meaning the unit of payment is each service a provider carries out. Yet, the various prospective payment methods in Medicare over the past 30 years represent a major departure from true fee-for-service. Payment can be made for an episode of care, such as an inpatient stay and a 60-day episode of

home health services, or for an inpatient day, regardless of the actual services provided, as is the case for rehabilitation hospitals or skilled nursing facilities.

The more accurate description of the current payment methods would be volume based, rather than fee-for-service, because, regardless of the particular unit of service or payment used, providers receive more revenues for more units of payment performed. Incorrectly labeling these legacy payment models “fee-for-service” unfortunately serves to diminish the substantial progress in payment methods and distorts considerations of the reforms needed to improve their performance.

To promote common understanding among researchers, policy-makers, and stakeholders about choices of alternative payment approaches, it is desirable to have a common typology of payment methods, to provide a useful conceptual framework for classifying payment methods along relevant dimensions and characteristics. A coherent classification system also would add clarity and consistency to considerations of the merits of payment models.

In some policy discussions about payment for acute care services provided by health professionals and hospitals, a dichotomy is made between “volume-based” and “value-based” payment. As alluded to above, *volume-based* is commonly used to connote payment models that provide larger payments as a function of more units of service provided, however that unit of service is defined.¹ The Department of Health and Human Services’ (DHHS’) categorization of payment methods considers value-based payment as requiring one of two elements: (1) that some payment is based on one or more quality measures to assess performance, or (2) that payment methods include incentives that reward providers for more prudent use of resources.²

While these differences may be appreciated by policy-makers and stakeholders, less well understood is that volume-based and value-based payment are not mutually exclusive approaches, as discussions often suggest. Indeed, most current alternative payment models layer value-based payment on top of volume-based payment—or, in the words of the DHHS framework, on a “fee-for-service architecture” (Alternative Payment Model Framework and Progress Tracking Work Group 2016), although the architecture is actually volume based, not fee-for-service.

A natural example relates to pay-for-performance (P4P) approaches that either reward or penalize providers based on their performance on specified quality or cost measures. P4P adoption must take into account that the incremental incentives involved may be overwhelmed by the much more powerful incentives in the base payment method underlying P4P. For example, providing a small P4P penalty for excessive readmissions may have an effect on hospital behavior. However, the impact will be small considering hospitals face powerful incentives with volume-based payment methods. The effect is an

empirical question and, in fact, penalties for excessive hospital readmissions are now the subject of a large natural experiment in Medicare.³

“Bundled payment” for an inpatient procedure is often referred to as a value-based approach. By combining separate payment streams to different providers, bundled payment might decrease fragmentation of care and promote greater collaboration in lowering costs when purchasing supplies and equipment. And bundled payment can extend the duration of care covered under a single-episode payment, thereby placing providers at risk for their related spending. This approach might incentivize providers to collaborate to reduce preventable emergency room visits and readmissions after initial hospitalization and to more effectively refer patients to the appropriate provider for postacute care services such as rehabilitation. However, bundled payment remains, in fact, volume-based as well, at least as commonly applied to payment for inpatient procedures. Bundled episodes include incentives for reducing costs. Yet, within bundled episode payment remain strong incentives to generate volume—although in this case, the unit of payment is the bundled episode rather than the individual service or procedure.

A logical typology should make clear that a bundled episode seeks to improve integration of care and increase prudent spending by extending the duration a fixed payment is meant to cover. Yet, a bundled episode, like other volume-based payment models, includes incentives to increase units of service, even though units of service are defined more broadly. Only through empirical testing in a variety of situations can we draw conclusions about the relative impact of conflicting incentives.

Nevertheless, how the payment method is defined and classified can highlight its advantages and disadvantages and how it might be designed to maximize the former and mitigate the latter. A typology of payment models can highlight issues to consider in their evaluation and illuminate how they may be designed to produce the desired effects.

Challenges to Constructing a Payment Typology

Although having clear and consistent terminology and a useful, formal typology of payment methods would improve communication and understanding in what has been a confusing, somewhat murky area of policy, there are challenges to doing so. One is conceptual, at least for now: when various payment methods are being proposed and tested, a fixed classification may falsely imply that payments are clearly separate when in fact they are largely on a continuum, without sharp lines separating related but different methods. Indeed, as our detailed examination of nine payment methods will demonstrate, the

payment designs can significantly alter the behavioral impact and administrative burden associated with adoption, with some implementation designs causing one method to blend into another.

For example, a fee schedule is correctly considered a prototypical fee-for-service approach. The Medicare Physician Fee Schedule, which also is the basis for most Medicaid and private insurer physician payments, is based on more than 8,000 codes from the American Medical Association's Current Procedural Terminology manual. However, some codes describe services that extend over time as an episode payment would; many surgical services are for a 90-day "global" period, including all routine post-hospital visits related to the index procedure. Medicare is adding other episode-type payments to the fee schedule, so even the Medicare fee schedule is becoming less of a pure fee-for-service payment method over time.

Also, payment typologies can serve different purposes and might vary according to the purpose for which they are used. For example, operational managers at payer organizations are focused on the application to different provider types and therefore might want payment models sorted initially by provider type; policy analysts, though, are likely more interested in incentives that apply across provider types, and might want a higher-level organization of models that initially focuses on different incentive structures. However, producing different payment method classifications for different audiences may conflict with the objectives of greater clarity and consistency to decrease confusion and misunderstanding.

Another challenge arising from payment approaches being on a continuum is that as they continue to evolve, they might have to be moved to a different location in the classification scheme. A good typology would have a structure and category headings stable enough to accommodate payment method changes, without major reorganization.

A core decision in classifying payment methods is between "lumping" and "splitting." As our glossary indicates, at least eight kinds of capitation are in use, with variations based on the provider type to which it applies and the services included in a single payment. For classification, is it useful to lump them all under the term *capitation*, as they all provide a fixed per capita payment for a population regardless of the actual services provided? Or is it preferable to split them by the provider type and the specific way the per capita concept is achieved? Again, that decision might be different depending on the typology's specific purpose and likely user.

Our objective is to present a stable typology of payment methods that can be used for a range of purposes, that relies on precise terminology and definitions, and that reflects useful decisions about organization and placement of methods. We chose to build upon previous efforts to construct a logical

classification system that will facilitate better understanding of payment choices. In appendix B we present seven payment typologies found in our literature review. We next turn to considerations about the dimensions or sorting criteria that might be used in the typology construction.

Various Dimensions as the Basis for Classification

A *provider payment system* may be defined as the payment method combined with all supporting activities, such as contracting, accountability mechanisms, and management information systems. A *provider payment method* may be defined more narrowly as the mechanism used to transfer funds from the payer of health services to the providers (Langenbrunner, Cashin, and O'Dougherty 2016).

Previous efforts to create typologies have used various dimensions or parameters to sort the different payment methods in a payment method typology. The examples in Appendix B demonstrate a variety of dimensions that have been used. Here, we consider those (and others) that we propose be used as primary bases for categorizing payment methods:

- Base versus incremental payments
- The unit of payment⁴
- The provider recipient
- Fixed total versus activity-based payment (i.e., risk based versus activity based)
- Prospective versus retrospective payment
- Other dimensions of payment

Base versus Incremental Payments

An important distinction in sorting payment models is whether the payment method represents a base approach (in which close to 100 percent of revenues derive from payment) or an incremental approach (in which a small base payment is combined with rewards, penalties, or additional payments for specific purposes).

The difference between the base payment method in use and the incremental ones is usually easy to distinguish. For example, for hospitals, payers typically layer pay-for-performance bonuses (or

penalties) of at most a few percentage points of the total on top of the base payment—whether that is by per diems, diagnosis-related groups (DRGs), or percentage of charges—or some combination of these. Similarly, upside-only shared savings provide accountable care organizations (ACOs) an opportunity to achieve low single-digit bonuses, while the usual payments to the ACOs’ constituent providers continue as normal. However, many of the hybrid payment approaches being explored do not neatly fall into the base versus incremental payment dichotomy.

For example, the Danish system for paying primary care physicians provides about two-thirds of their revenues based on a physician fee schedule, with the actual fee schedule payment amounts adjusted by P4P, while the remaining one-third of the core base payment is determined by the size of the primary care physician’s patient rolls, capitation-style (Pedersen, Andersen, and Søndergaard 2012). It would be somewhat misleading to call the fee schedule the base payment and the capitation the incremental payment, given that an objective of the fee schedule/capitation split is to achieve incentive neutrality in the base payments, with fee schedule and capitation payments providing balanced incentives. Some might think that capitation should be considered the base and that the varying fee schedule payments for services rendered represent incremental payments. Others might consider the proportion of payment, rather than the intent to determine which is base and which incremental, such that in the Danish system, the fee schedule would be the base approach.

And while P4P has typically involved only a small percentage increase or decrease in payment, the Quality and Outcomes Framework in the United Kingdom provides as much as 25 percent extra payment based on performance, on top of the base method of primary care capitation (Campbell et al. 2009). MACRA, which repealed the sustainable growth rate formula applicable to the Medicare Physician Fee Schedule, has established the Merit-based Incentive Payment System (MIPS). This new payment method could provide up to a 36 percent swing in revenues based on physicians’ performance on quality, resource use, and other measures. Most physicians, however, will experience MIPS bonuses and penalties that are much smaller and truly “incremental.” All in all, for purposes of classification, it is correct to consider the MIPS an incremental payment method.⁵

The Unit of Payment

The payment unit is often used to classify payment models. Jegers et al. (2002) and Langenbrunner et al. (2005) define three alternative payment units that help classify payment models: time based, service based, and population based.

Although both studies describe time-based payment as paying providers according to the length of time spent providing services, perhaps a more precise description would be the time *commitment* to providing services, which distinguishes the approach from activity-based approaches that pay based on the actual time spent providing individual services.⁶ Salary is the prototype of a time commitment-based payment unit—the health professional is paid for his or her time commitment, which can be as short as a session or as long as an annual salary, classically independent of the activities the professional actually performs or the number of patients in his or her care. (However, some provider organizations have begun to adjust salary levels based on measures of productivity that include volume of services rendered.)

Service-based remuneration depends on activity—specific services provided and recognized for payment. The policy shorthand often states that under fee-for-service, providers get paid for each and every service they provide, needed or not. This is not strictly accurate. It is one reason we do not use the term fee-for-service in our typology. Some payment models for health professionals (e.g., physician fee schedules) actually only pay for services that have a payment code and one that the payer determines as covered for payment. In fact, much of some physicians' activity (up to 25 percent for primary care physicians; see Chen et al. [2011]) is not codified into payment codes or recognized for payment under standard fee schedule-based payment (Berenson and Horvath 2003).⁷ Fee-for-service in practice actually relies on the way services are coded and the charges submitted for payment—either by the provider himself or herself or by some average over a group of providers or all providers.

Population-based payment varies as a function of the size of the population the provider serves, regardless of the number of patients actually receiving care or the level of activity by a health professional or a facility. Capitation—payment per capita—is the classic form of population-based payment. But some payment methods can have a combination of population-based and service-based payment. For example, Maryland has initiated an all-payer hospital demonstration program relying on global payments to hospitals based on the population each serves. However, given that patients can choose where to get hospital services, the Maryland Health Services Cost Review Commission administers a “volume shift adjustment” that permits the state to change global payment amounts based on significant volume shifts. Partial or global capitation payments to medical groups can have “carve-outs” or “bill-aboves” for particular activities for which fee schedule payments may be more appropriate. For example, immunizations may be paid on a fee schedule to encourage their availability and to reflect more accurate, timely pricing of vaccines (Kongstvedt 2013). In conceptualizing a payment method, one might seek to use capitation for often-overused services and fee-for-service for often-underused services that are also of high value.

A simpler example of how population based payment can be used with fee-for-service is found in the Medicare fee schedule. Renal physicians are paid a monthly amount for caring for patients with end-stage renal disease. However, since 2003, the payment amount has varied based on the number of face-to-face office visits provided the patient.⁸ Similarly, all routine visits that occur within 90 days after a major surgery are not separately paid but are rather included in a global payment, a form of episode-based payment applicable to the primary surgeon who performed the procedure. In short, the line between service-based and population-based payment is not always clear—elements of both can be present as the purer models move from theory to implementation.

The Provider Recipient

Payment typologies often sort methods by the type of provider typically receiving the payment. This serves two basic purposes: It provides a practical source of differentiation, in that one can readily look for all potential payments to hospitals, for example. In addition, the focus on the recipient rather than the payer (described below) permits consideration of payment methods that may be provided by an intermediary organization, such as a multispecialty group practice or a hospital, to which payers may make their payments.

The clearest example of a payment method available to intermediary organizations but not to payers is health professionals' salaries. Currently, more than half of practicing U.S. physicians are compensated primarily by salary (Boukus, Cassil, and O'Malley 2009), but the source of payment is the entity that employs them, not the third-party payer.⁹ Indeed, in the absence of a single payer, usually a government entity, it is virtually impossible for different payers in a multiple-payer health care system to use salary as a primary method to pay for physicians' services. Salary is typically available to the intermediary organization, which contracts with the payer and then is in a position to hire salaried health professionals.

The distinction between the payer, the intermediary organization, and the provider of services is important (Hillman, Welch, and Pauly 1992). It is particularly relevant with some newer payment models, such as shared savings. Such models directly maintain payer-generated payment flows to providers and also might maintain separate payment flows to the intermediary or separate ACO. Jaeger (2002) described this payment separation as “macro-level” and “micro-level” payment (Jegers et al. 2002). Many health care systems allocate resources for a population using one payment mechanism (macro-level), while compensation for individual care employs a different mechanism (micro-level). Further complicating matters, a constituent member can be a medical practice, not the individual

physicians within the practice, creating yet another tier of payer and payment recipient. In sum, there may be little relation between the incentives embedded in a payer's payment method and the incentives the service provider actually receives once the payment is dispersed.

One final classification issue is raised by the number of tiers of payment recipients. For example, in many European countries and increasingly in the United States, physicians are hospital employees. It is common in Europe to “bundle” facility and professional services into a single payment for all services provided. But some payment systems continue to make separate payments for professional and facility services, even when health professionals are hospital employees. For purposes of classification, the challenge is deciding whether a DRG payment represents a single payment for inpatient hospital services made to a hospital that employs health professionals, or alternatively, represents a bundled episode payment (an approach being tested now in the United States). In Europe, the employed physician's compensation is generally unrelated to the form and the amount of payment to the hospital, suggesting that this could be considered a straightforward hospital payment. In the U.S. Medicare context, there remain separate professional fees that are based on a fee schedule, then bundled. Whether the fees are actually combined with the hospital payment or not, this approach might properly be labeled a bundled episode. Using provider type as a sorting parameter has appeal because it is relevant to how the health care system is organized. Yet, the approach tends to freeze organizational distinctions, which is inconsistent with actual evolution of payment and delivery models. Increasingly, new payment methods are trying to break down organizational silos and replacing them with various forms of integrated care. Much of the activity in bundling services across provider types to promote integration cannot be well captured in a typology organized through classic differentiation of provider types—health professionals, hospitals, ambulatory facilities, and so on. Alternative classification approaches might focus more on incentives in the payment methods than on the provider recipient.

Fixed-Total versus Activity-Based Payment

Another frame for organizing payment models is based on whether providers receive additional revenues when they provide additional services. The practice of health care, like other industries, has fixed and variable costs associated with the delivery of services. In purely activity-based payment approaches, payments should be sufficient to cover both fixed and variable costs. Further, as long as the payment exceeds the variable cost of production, providers have incentive to produce additional services, creating the risk of overprovision. To counteract this incentive, activity-based payment approaches are sometimes supplemented by lump-sum payments to cover fixed costs, so that activity-

based payments can be lowered to approximate the marginal costs to the provider (Fujisawa and Lafortune 2008).

Indeed, there is a category of services that do not fit into the fixed-total versus activity-based dichotomy, called variously lump-sum payment or block grants. These payments are made independent of either services provided or the individuals for which the provider is responsible, but the payments are not based on time commitment, either. In the United States, an example is fixed-amount payments for providers adopting electronic health records that meet “meaningful use” criteria. In many European countries, hospitals receive *block grants*, contributions to budgets based on hospital size or type without specific regard to the number of or type of patients seen or services provided (Ellis and Miller 2008); block grants are provided to supplement hospitals’ main source of revenues, which are based on DRGs. In fact, unlike in the United States, in Europe DRG payments often exist within a global budget set at the hospital level, with DRG payments representing 60 to 85 percent of revenues and block grants or other additional payments for certain high cost services making up most of the remainder (Quentin et al. 2010).

In the United States, the common way that fixed total and activity-based payment is discussed is whether the payment involves risk-bearing. Fixed total payment would imply financial risk-bearing by the provider organization, whereas activity-based payment would be considered equivalent to volume-based payment with no risk-bearing. Of course, there can be partial risk-bearing—many payment methods reviewed in another publication of this project, *Payment Methods: How They Work* (Berenson et al. 2016), attempt to provide partial risk-bearing or otherwise provide incentives for reducing costs. Full-bore population-based payment, such as global capitation, would represent a fixed total payment, with the size of the payment determined though the size and mix of the population for whom the payment is made (or some other basis).

Some have portrayed the continuum of payment methods starting with no risk-bearing and moving to full risk-bearing evolving through intermediate steps, including bundled episodes, one-sided shared savings, and two-sided shared savings, and ending in full population-based payment, such as capitation (appendix B). In terms of risk assumption, this is an instructive portrayal. But along other parameters, such as whether primary care or specialty providers are most involved, this particular continuum may be less helpful. For example, there is disagreement over whether procedure-specific bundled episodes actually promote additional movement toward population-based payment and, if so, whether that is a desirable evolution. Some would want to stop at bundled episodes as preferred to population-based payment to avoid promoting larger, consolidated provider organizations. Others would want to proceed to implement population-based payment without first adopting bundled episodes, feeling that some

forms of bundled episodes remain firmly volume-based and are targeted inappropriately to specialists rather than to primary care physicians.

Prospective versus Retrospective Payment

Whether payment is prospective or retrospective depends on whether the payment to providers is *determined* before or after services are rendered; the actual payment may be made before or after services are provided (Jegers et al. 2002). Thus, a fee schedule is prospective when rates are set in advance and they determine the subsequent payment when claims for services are submitted. However, payment based on a percentage of physician's charges would be retrospective, because the submitted charges determine the payment amount.

The actual level of payment may be determined via fixed total payment or variable payment. For example, some government payers set per diem rates or hospital budgets at the beginning of a given year. This prospective payment may be fixed or activity-based. If the government sets a "hard cap" on the hospital budget over which there will be no additional payment, then the prospective system is truly fixed. However, in some countries with a "soft cap," the government's hospital budget may be partially adjusted based on the level of activity or the number of patients served, and the following year's budget may be adjusted based on the current year's activity. In this case, hospitals have the incentive to increase overall costs to qualify for additional funding in the following year (Lorenzoni and Pearson 2011). Prospectively set rates are, by definition, activity based, because although the rates per unit of payment are fixed, the total payment depends on the level of activity.

Other Dimensions of Payment

Other dimensions that could be used to categorize payment models include whether payment is based on inputs or outputs, breadth of payment and granularity of payments, and compatibility with consumer and patient payments (Langenbrunner et al. 2005).

Inputs refers to the recurrent costs of providing services, while *outputs* refers to what was produced as a result of activity (e.g., cases treated, bed-days provided). An example of input-based payment is where a provider is paid according to a budget to cover operating costs. In disaggregated output-based payment systems, each individual service (or output) is considered separately (which ultimately becomes fee-for-service).

Breadth refers to how broadly or narrowly provider services are aggregated, with a continuum extending from payment for very discrete service elements up to global payment for most health care services over an extended period. Because payment methods fall along a continuum, without sharp dividing lines, breadth would not constitute a useful basis for classification, but it is an important characteristic of any payment model.

In all payment systems, a granular approach is one with many different payment codes, while a coarse one involves few codes. For example, Medicare's Healthcare Common Procedure Coding System, which relies on the American Medical Association's Common Procedural Technology coding system, has more than 8,000 codes, whereas Taiwan's and Korea's fee schedules are coarse, with very few fee categories (Fujisawa and Lafortune 2008). Similar variations exist for different DRG models and even for population-based payment such as capitation, in which granularity refers to the number of categories in the risk-adjustment method. Relative granularity is a characteristic of all payment methods and does not seem to provide a clean dividing line for use in the structure of a payment typology.

Finally, another potential dimension for classifying payment methods relates to their compatibility with payments made by consumers (in premiums when selecting a health plan) and patients (at the point of service in various forms of cost sharing). For purposes of a payment typology, we do not think issues involving consumer payments help us sort among payment options. Issues of deductibles, co-payments, co-insurance, waived cost-sharing, and so on, very much affect payment and the payment incentives that influence service use, but in our view these fall properly under the purview of benefit, rather than payment, design options.

The Payment Typology

Based on considerations described above, we have developed a payment method typology that centers more on the incentives inherent in payment methods, deemphasizing primary classification based on the type of provider receiving the payment. This approach is consistent with the desired trend in payment policy toward promoting integration of services and breaking down organizational silos that may be reinforced with provider-specific payments. This approach is also most relevant to policy analysts and policy-makers, who may put less emphasis on the technical details of payment methods and more on their ultimate effect on the organization and the delivery of health care.

In contrast to prior payment typologies, we make a categorical distinction between “base” payment and “incremental” payment, accepting that the differentiation may not always be clear-cut, especially as designers consider hybrid payment methods that attempt to balance contrary incentives. This classification approach assumes, then, that many payment reform methods considered to be value based are actually placed on top of a range of underlying base-payment methods, many of which are volume based.

The next level of classification considers the broad payment unit the method relies on, grouping all base payment models into three categories—fixed, activity based, and population based—representing three sets of incentives that are fundamentally different because of the different payment units used.

Volume-based payment has become a ubiquitous term, but we prefer the less pejorative “activity based.” This term is used more in other developed countries to connote payment that increases with activity, that is, more services provided—whether the actual payment units are at the level of individual services or are more aggregated cases or episodes. Population-based payment methods differ fundamentally from activity-based ones in that the unit of payment is the population the provider is responsible for, regardless of the volume of services provided to them.

Most current payment methods fit into one of these two categories. Some payment methods pay a fixed amount determined by factors other than activity or size of population, although these factors may produce variations in the actual payment levels used. A prototype of a fixed payment is salary for health professionals, which in essence pays based on the time commitment the professional agrees to work.

Finally, after consideration of the payment unit and the incentives the various units represent, we drill down by provider types, recognizing the reality that some payment methods do apply only to particular provider types. Of note, consistent with the focus on payment units and related incentives independent of provider type, all the incremental payment methods can be considered generic by payment method regardless of provider type and not specific to particular provider types the way some base payment methods are. (In addition to the typology based on the payment methods we developed an additional, alternate typology organized by provider type in appendix A. Seven other payment typologies found in the literature are presented in appendix B.)

Some payment typologies include only payment approaches from the perspective of third-party payers—insurers. Because insurers typically do not have employment relationships with health professionals or exclusive relationships with hospitals or other facilities, some payment methods may not be relevant to them (for example, fixed salaries to health professionals or line-item or global

budgets to hospitals). However, the focus of this typology is the recipient of payment, whether the source is the third-party payer or the intermediary organization that receives payment and in turn pays its constituent providers. This approach is broader and reduces the payment method variations that result from different macro-level health system differences.

We acknowledge that the classification system adopted here involves some arbitrariness, especially as the various methods are made operational and evolve over time. For example, it has become common to adjust salary levels based on activity-based productivity. Yet, the essence of salary remains payment for time commitment to work. A condition-specific (or bundled episode) case rate is partially driven by case finding (volume-based payment) but also has aspects of population-based payment, such as specialty capitation. In the end, every payment method has unique attributes, with specific advantages and disadvantages that can vary based on the specific payment method design and payment levels adopted.

A Typology of Payment Methods for Paying Providers

This typology is organized by payment method, emphasizing the inherent payment incentives regardless of the provider type to which the method would apply.

Base Payments

FIXED PAYMENTS

- Salary for a health professional
- Historically or geographically (or territorially)—based for a hospital
- Line-item budget for a hospital
- Lump-sum payment to a hospital or a health professional

ACTIVITY-BASED PAYMENTS

Fee-for-service

- Straight charges for a hospital and health professional
- Discounted charges for a hospital and a health professional
- Usual, Customary, Reasonable (UCR) fee for a health professional
- Fee Schedule for a physician or other health professional
- Per diem payment to a hospital for an inpatient stay
- Ambulatory care groups or similar for an outpatient hospital service

Case rates

- Diagnosis Related Groups (DRGs)- based payment to a hospital for an inpatient stay
- Episode based payment for a hospitalization and some posthospital period
- Multiprovider bundled episode payment around an inpatient hospitalization

POPULATION-BASED PAYMENTS

- Retainer payments to a health professional
- Multiprovider episode payment based on one or more conditions
- Partial capitation to an organization or a health professional
 - » Primary care capitation
 - » Specialty capitation
 - » Contact capitation
- Global budget to a hospital
- Global capitation to an organization
- Percentage of premium payment to an organization

Incremental Payments

- Shared savings
 - Shared risk
 - Pay-for-performance
 - Gainsharing between a hospital and physicians
 - “Nonvisit functions”—monthly payments for care coordination activities for particular patients
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Glossary

ambulatory patient group (APG). A system of classifying patients into categories based on their expected relative use of outpatient hospital services and other ambulatory care services. The APGs system was developed and is maintained by 3M Information Systems. It was originally designed for, but not used in the implementation of, Medicare’s Hospital Outpatient Prospective Payment System. (*Ambulatory payment classifications* were used instead.) APGs are primarily based on procedures rather than diagnosis, and they are designed to risk-adjust payments for services to reflect the relative anticipated costliness of the patient.

ambulatory payment classifications (APCs). A methodology used by the Centers for Medicare & Medicaid Services (CMS) for payment to facilities for ambulatory services. In this model, each APC is composed of services that are similar in clinical intensity, resource use, and cost. APCs also provide a mechanism for “packaging” hospital outpatient services. APCs are not a risk-adjustment system, since they do not differentiate spending or performance levels based on patient characteristics (independent of the services actually delivered). APCs form the core of the Hospital Outpatient Prospective Payment System (HOPPS) used by Medicare to pay most large acute care hospitals for outpatient services. HOPPS bases payments on the same codes are used in the Medicare Physician Fee Schedule, but the payment amount is based on the ambulatory patient classification to which the code is assigned.

bundled episode. A prospective payment made for all care a patient needs over the course of a specified clinical episode or a period of management, instead of payment for discrete services under a fee schedule or for all care a patient receives. Bundled episode payment is here distinguished from episode payment in that the former covers all care for a defined clinical condition—across multiple providers of patient care—bundled into a single payment. Episode payment here refers to payment that only covers care by a single provider, whether a health professional or a facility. Bundled episodes can cover payment related to procedures for a short period after the procedure and to clinical conditions extending over an extended period.

capitation. Fixed, prospective payment made to cover the cost of care for a defined population over a specified time period. A specific dollar amount per member per month (or per year) is paid to providers, and in return they provide whatever quantity of services is needed to meet defined patient population’s health needs. (The term *capitation* means that the payment is made per person, or per capita, rather than per service.) Variants of capitation include the following:

- a. **condition-specific capitation.** A form of capitation designed to cover only services provided for care of a particular health condition or a combination of conditions. Condition-specific capitation can be considered a type of condition-based bundled episode payment—one in which a single payment or a single monthly payment is made for each patient who has the condition.
- b. **contact capitation.** A form of capitation that is triggered by a patient’s initial visit to a particular provider (usually a specialist and through referral from a primary care physician) and is intended to cover all services delivered by that provider for a period of time or for all services associated with the condition for which the patient is seeking care. Contact capitation systems that were used in the 1990s paid a specific per patient amount to a physician group for all services provided to a patient for a particular health problem.
- c. **global capitation.** A form of global payment typically made to an integrated care entity or a large physician group for each patient that is intended to cover all services the patient needs for all of his or her health problems. In other words, this payment system (applicable to all hospital, all physician, and most other services but sometimes not prescription drugs) combines into a single capitated payment the services delivered by different providers or at different levels of care.
- d. **partial capitation.** A form of capitation in which some services, but not all, are to be delivered in return for a capitated payment, while other services are paid through another payment mechanism. For example, professional services capitation is a form of partial capitation in which a physician group or independent practice association accepts a capitated payment to cover all professional services delivered by its physicians, including physician services delivered in hospitals, but the hospitals are paid separately for their portion of hospital stays.

The term also has been used to characterize two related but somewhat different payment models, which may cause some confusion: (1) providers can accept full financial risk on a limited set of services, for example, for professional services but not for institutional services; or (2) providers can accept partial financial risk for all services, using risk corridors to limit both profits and losses. We prefer to use *partial capitation* for the former.

- e. **percentage of premium.** A method of setting global capitation amounts for payments made by a health insurance plan to a provider based on a pre-defined percentage of the insurance premiums collected for the health plan members assigned to the provider – thus directly reflecting competitive factors in the particular market.

- f. **primary care capitation.** A per patient payment made to a primary care physician to cover all services delivered by that physician, but not to cover any services delivered by other providers. Under most primary care capitation systems, the primary care practice receives a monthly payment for each patient enrolled with the practice and does not bill separately for individual office visits with those patients. It is similar to the method used in health maintenance organizations (HMOs), whereby patients enroll with a particular primary care physician who in turn is responsible for all routine nonemergency referrals. Since this approach involves risk-bearing by the physician, it is subject to state regulations applicable to HMOs and is generally permitted only in HMOs.
- g. **professional services capitation.** A form of partial capitation in which the payment for each patient only covers professional services delivered by physicians or other clinicians, not services delivered by hospitals or other institutional providers.
- h. **specialty capitation.** A form of partial capitation, as with primary care capitation, whereby a fixed payment per member per month is made for services provided a defined population of members. The capitation amount is calculated based on the expected volume of referrals, and their average cost.

case rates. A generic term describing a single payment for all or most services a provider delivers for a particular patient “case”(i.e., care associated with a particular condition or procedure). For example, a single payment for a hospital stay (such as the DRG payments made in the Medicare Inpatient Prospective Payment System) and a global surgical fee are typically described as case rates.

diagnosis related groups (DRGs). A clinical category classification system that uses information about patient diagnoses and selected procedures to identify patients who are clinically similar and expected to have similar costs during a hospital stay. One version of DRGs, called MS-DRGs, is used as part of the Medicare Inpatient Prospective Payment System to pay hospitals for inpatient admissions of Medicare beneficiaries. A version called APR-DRGs is used by many commercial health insurance plans to pay hospitals for admissions of their members. Each DRG is assigned a weight that reflects the relative cost of caring for patients in that category relative to other categories, and is then multiplied by a conversion factor to establish payment rates that are a form of case rates.

discounted charges. A contract under which the hospital or physician submits claims in full, and the plan pays that amount discounted by an agreed-upon percentage. This fee-for-service-based method has two variants. One is a simple discount (say, 20 percent) on charges; the other is a sliding scale discount based on volume.

episode payment. A form of payment that covers a defined group of services over a specified period of time. This period can cover a range of care episodes, such as hospitalization and any care the patient may need up to 30 days after hospitalization for a specified number of months; this period could even be a year for an episode based on a condition. Episode-based payments, paid prospectively or retrospectively, can be made to a single provider or to more than one provider involved with the care episode, in which case the payments can be referred to as bundled episodes.

The words *bundled* and *episode* tend to be used interchangeably in health care payment policies and programs. While bundling of services is not a new concept (e.g., global periods in surgeries), *present-day* innovation efforts involving bundled payments include bundling for services *across providers* as well. This can create confusion between an episode payment and a bundled episode payment. Thus, for definitional precision, we propose defining an episode payment as a payment for an episode that covers a range of care episodes provided by a single provider, while a bundled episode payment would refer to situation in which payment for the care episodes are made to more than one provider.

fee schedule. A comprehensive list of service codes and accompanying prices used by a third-party payer to pay providers, based on historic physician charges, resource costs (as in Medicare), or other basis. It is a list of a plan's allowances for specific services, which providers have agreed to accept for services to enrollees. Typically, the payer pays either the physician's charge or the fee schedule allowance, whichever is lower.

fee-for-service. A payment approach in which a specific amount is paid when a particular service is delivered; generally, the payment amount differs depending on which discrete service is delivered. Payments are made only for services that are codified and determined by the payer to be approved for payment. Although fee-for-service payment systems are criticized for "rewarding volume over value," many alternative payment models are also volume based. Although some would consider various volume-based payment methods, such as diagnosis related groups, to be forms of fee-for-service, we reserve fee-for-service for payments made for discrete services, rather than for cases or episodes.

gainsharing. An arrangement between hospitals and physicians whereby a hospital agrees to share with physicians any reduction in the hospital's costs for patient care attributable in part to the physicians' efforts. Common examples of gainsharing include initiatives on standardizing purchasing decisions for prosthetics or stents, which can lower prices for some high-cost specialty services such as orthopedics and cardiology by leveraging larger discounts or shifting purchases to lower-price items. Gainsharing is restricted by the Civil Monetary Penalties law, which prohibits hospitals from rewarding physicians for

reducing services to patients. However, CMS is engaged in demonstrations that test gainsharing with quality protections in place.

global budget. Usually applied to hospitals, this is a prospective annual budget, generally with no external stipulation of the amount to be spent on each cost category or service line. The scope of services included and the method for enforcing budget caps varies. An example of a global budgeting system for hospitals combined with an all-payer rate setting system is the payment reform being implemented in Maryland. Global budget can also refer to constraints on total health care system spending.

line-item budget. A form of payment in which hospitals receive an annual budget with the amounts for particular expenses (such as salaries or equipment) already specified. Line-item budgets may be soft (sometimes called indicative) or hard; in the former, hospitals may transfer funds between budget lines, in the latter, budget lines are fixed.

lump-sum payment. A basic payment system that consists of a payment to physicians that is intended to cover the fixed costs of a practice or to finance a particular capital expenditure, independent of any activity or population served by the physician.

no payment. The cases in which a payer typically refuses to pay a hospital, and the hospital may not bill the patient for the remainder. Examples include costs associated with inefficiencies or nonclinical errors and those associated with serious medical errors, including “never events,” that is, those that should not occur under any circumstances.

packaging. Used in the hospital outpatient setting, packaging establishes a single payment rate to provide various services in a single encounter. These include, for example, ancillary services, such as laboratory tests, in addition to the primary service, such as an office visit, in the same encounter with the patient. CMS, through HOPPS, packages payment for multiple interrelated items and services into a single payment to create incentives for hospitals to furnish services most efficiently and to manage their resources with maximum flexibility.

pay-for-performance (P4P). A payment model that includes financial incentives based on the ability or inability of the provider or provider organization to meet certain performance standards. A P4P system can provide rewards (upside), penalties (downside), or both upside and downside. A bonus or penalty can be implemented either retrospectively (a bonus is paid or a penalty is imposed at the end of a performance period) or prospectively (future payments to the provider are higher or lower based on performance in a prior period). P4P can include a “value-based” component to payment, so that

providers respond by improving performance on both quality and spending. An example is Medicare's Value-Based Purchasing program for hospitals. The Medicare Access and CHIP Reauthorization Act of 2015 introduced the Merit-Based Incentive Payment System, which will combine three different Medicare P4P programs into one P4P program for physicians.

payment for “nonvisit” functions. In its simplest form, this model is a per member per month payment, layered on top of another form of payment like fee-for-service. Providers typically receive this payment to help them manage their patients' care and to support their coordination with other providers in the patient-centered medical home.

per diem. A per diem payment is a payment that is made for each calendar day on which services are provided to a particular patient. For example, if a payer pays a hospital on a per diem basis, the total payment to the hospital for an individual patient would depend on how many days the patient spent in the hospital before being discharged, but not on how many services were delivered on any of those days. Rates can be based on historical cost data or negotiation between the hospital and the payer, as well as on length of stay, and may be adjusted by service volume or the severity of the patient's illness. The amount of the per diem payment thus need not be the same for all days and all patients. For example, Medicare pays inpatient psychiatric facilities on a per diem basis, but the per diem payments are higher for earlier days in a patient's stay than for later days, and the per diem payment on any day varies from patient to patient based on the patient's characteristics.

retainer fee. An upfront fee paid by patients to join the “retainer” practices and physicians in order to receive access to physician services and amenities, sometimes in lieu of insurance-covered services and sometimes in addition to covered services.

salary. A form of remuneration wherein physicians are paid for specified units of time. The amount of payment is usually independent of the volume of services or the number of patients cared for. Rather, it is based on the time commitments adjusted by the physician's qualifications and task profiles. However, in some cases, salaries can vary based on considerations of productivity or another desired performance.

shared risk. Shared savings models can involve either one-sided or two-sided risk. Two-sided or upside/downside models—referred to as *shared savings and shared risk* or just *shared risk*—require providers to share in payers' financial risk by accepting some accountability for costs that exceed their targets. Two-sided models often give providers an opportunity to receive proportionately larger bonuses in exchange for this additional financial risk. This is in contrast to one-sided or upside-only

models that entail no performance risk to providers, even if they experience higher costs or if they do not achieve quality performance goals.

shared savings. A form of payment in which a provider or a provider organization shares generated savings with the payer when actual spending for a defined population is less than a target amount. Under shared savings—also referred to as one-sided or upside-only—the recipient is not at risk for overspending. Under current shared savings models in the United States, organizations are usually eligible for shared savings only if they meet both specified cost and quality targets. Spending targets in current approaches to payment for accountable care organizations have typically been organization specific, commonly based on the organization’s recent historic spending trended forward. However, shared savings targets can be determined using ways other than historic costs, for example, the local or national average, or some combination of organization specific and normative standard.

usual, customary, reasonable (UCR). A payment method used since the 1950s by insurers, which found its way to Medicare in 1965 where it was referred to as CPR—customary, prevailing and reasonable”—translating to the lowest of (1) the physician’s billed charge for the service; (2) the physician’s customary charge or the physician’s median charge for the service over a 12-month period; or (3) the prevailing charge for that service in the given geographic community. Many payers used the UCR payment system to pay physicians before the creation of the resource-based relative value scale (RBRVS). It is still used in some jurisdictions to set balance billing limits for out-of-network services.

value-based payment. A generic term used to describe a payment model in which the amount of payment for a service depends in some way on the quality and/or cost of the service delivered. Most value-based payment methods being considered are layered on top of existing volume-based payment approaches. According to the framework adopted by the U.S. Department of Health and Human Services, health care payment is categorized according to how providers receive payment for care: category 2 refers to fee-for-service models with a link of payment to quality, category 3 to alternative payment models built on fee-for-service architecture, and category 4 to population-based payment approaches. (Category 1 refers to fee-for-service models with no adjustment for quality.)

volume-based payment. Commonly used to connote payment models that provide larger payments as a function of more units of service provided, however the unit of service is defined. This approach to payment is sometimes called activity-based payment.

Glossary Sources

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Appendix A

The Operational Payment Model Typology for Health Professionals and Hospitals

Base Payments

FOR HEALTH PROFESSIONALS

- Salary
- Charges based (whether by insurer or by direct payment from patient)
 - » Straight charges
 - » Usual, customary, reasonable (UCR)
 - » Discounted charges
- Fee schedule
- Capitation
 - » Primary care capitation
 - » Specialty capitation
 - » Contact capitation
- Retainer fee
- Episode-based

FOR HOSPITALS

- Budget
 - » Line-item budget
 - » Global budget
- Activity-based
 - » Straight charges
 - » Discounted charges
 - » Per diem for inpatient care
 - » Diagnosis-related groups(DRGs) for inpatient care
 - » Ambulatory care groups or similar for outpatient care
- Population served
 - » Capitation
 - » Percentage of premium payment

CONSOLIDATED/INTEGRATED PHYSICIANS AND HOSPITALS

- Bundled episode payment
- Partial capitation
- Global capitation or global payment

Incremental Payments

- Shared savings
- Shared risk
- Pay-for-performance
- Gainsharing between a hospital and physicians
- Lump sum (independent of activity or population served)
- No payment

Appendix B

TABLE B.1

Literature Review of Provider Payment Typologies

Source	Berenson, Robert A., Jonathan H. Sunshine, Arkaprava Deb, Julia A. Doherty, Ellen T. Kurtzman, Elizabeth S. Richardson, Noah S. Kalman, et al. 2012. <i>The Effect of Provider Payment Systems on Quality, Cost and Efficiency, and Access: A Systematic Literature Review</i> . Warsaw, PL: InterQuality Research Project.		Kongstvedt, Peter R. 2012. "Provider Payment." In <i>Essentials of Managed Health Care, 6th ed.</i> , edited by Peter R. Kongstvedt. Burlington, MA: Jones & Bartlett Learning.
Typology	<p>Payment systems for physician care</p> <ol style="list-style-type: none"> 1. Salary 2. FFS 3. Capitation 4. Other physician payment systems: <ol style="list-style-type: none"> a. DRG-based payments b. Episode-based payment c. Informal payments d. Lump-sum payments <p>Payment systems for hospital care</p> <ol style="list-style-type: none"> 1. Budget-based payments <ol style="list-style-type: none"> a. Line-item budgets b. Global budgets 2. Activity-based payments <ol style="list-style-type: none"> a. Per diem payment b. FFS for inpatient care c. DRG, or per stay payment <p>Payment systems for integrated physician-hospital care</p> <ol style="list-style-type: none"> 1. Bundled-episode payment 2. Global or integrated capitation 3. Mixed or blended systems of payment <p>Marginal payments</p> <ol style="list-style-type: none"> 1. Shared savings 2. Pay-for-performance 	<p>Nonrisk physician payment</p> <ol style="list-style-type: none"> 1. FFS <ol style="list-style-type: none"> a. Straight charges b. UCR c. % discount on charges d. Fee schedule e. RVS f. RBRVS g. % Medicare RBRVS h. Special fee schedule on RVS multiplier i. Facility fee add-on 2. Case rates and global fees <p>Risk-based physician payment</p> <ol style="list-style-type: none"> 1. Capitation <ol style="list-style-type: none"> a. Variation factors (age, sex, acuity, other) b. PCP only (w/ and w/o a withhold) c. Individual vs. pooled risk d. Specialist e. Global f. IPAs g. Contact capitation 2. At-risk FFS <ol style="list-style-type: none"> a. Fee % withhold b. Budgeted FFS 	<p>Common hospital and facility payment methods</p> <ol style="list-style-type: none"> 1. Straight charges 2. Discounted charges 3. Per diem 4. Diagnosis-related groups 5. MS-DRGs (Medicare severity DRGs) 6. Percent of Medicare 7. Case rates—facility only or bundled with professional 8. Capitation (HMOs only) 9. Ambulatory surgical center rates under HOPPS 10. Ambulatory payment classifications 11. Ambulatory payment groups 12. Ambulatory care groups 13. Average sales price for drugs and devices

Source	Langenbrunner, Jack, Eva Orosz, Joe Kutzin, and Miriam Wiley. 2005. "Purchasing and Paying Providers." In <i>Purchasing to Improve Health Care Performance</i> , edited by Josep Figueras, Ray Robinson, and Elke Jakubowski. Berkshire, UK: McGraw Hill Open University Press.	Schneider, Eric C., Peter S. Hussey, and Christopher Schnyer. 2011. <i>Payment Reform: Analysis of Models and Performance Measurement Implications</i> . Santa Monica, CA: RAND Corporation.	Quinn, Kevin. 2015. "The 8 Basic Payment Methods in Health Care." <i>Annals of Internal Medicine</i> 163 (4): 300–306.	Miller, Harold D. 2007. <i>Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform</i> . New York: The Commonwealth Fund.
Typology	<p>Individual practitioner</p> <ol style="list-style-type: none"> 1. Time based: salary 2. Service based <ol style="list-style-type: none"> a. Fee-for-service b. Fee for patient episode (e.g., admission) c. Target payments 3. Population based <ol style="list-style-type: none"> a. Per capita payment b. Territorial payment <p>Medical institution</p> <ol style="list-style-type: none"> 1. Time based: fixed budget (based usually on historic allocations) 2. Service based <ol style="list-style-type: none"> a. Fee-for-service b. Fee per hospital day (per diem) c. Fee for patient episode d. Budget based on case mix/utilization 3. Population based: block contract 	<p>Payment methods for primary care physicians</p> <ol style="list-style-type: none"> 1. Line-item budget 2. Fee-for-service <ol style="list-style-type: none"> a. Fixed fee schedule b. Bundling of services 3. Fee-for-service (no fixed fee schedule) 4. Per capita <p>Hospital payment methods</p> <ol style="list-style-type: none"> 1. Line-item budget 2. Fee-for-service <ol style="list-style-type: none"> a. Fixed fee schedule b. Bundling of services 3. Fee-for-service (no fixed fee schedule) 4. Per diem 5. Case-based 6. Global budget 	<p>Classified by unit of payment</p> <ol style="list-style-type: none"> 1. Per time period (budget and salary) 2. Per beneficiary (capitation) 3. Per recipient (contact capitation) 4. Per episode (Case rates, payment per stay and bundled payments) 5. Per day (per diem and per visit) 6. Per service (fee-for service) 7. Per dollar of cost (cost reimbursement) 8. Per dollar of charges (percentage of charges) 	<p>Types of payment methods</p> <ol style="list-style-type: none"> 1. FFS 2. Per diem 3. Episode-of-care payment 4. Multi-provider bundled episode-of-care payment 5. Condition-specific capitation 6. Capitation

Source	Alternative Payment Model Framework and Progress Tracking Work Group. 2016. <i>Alternative Payment Model (APM) Framework: Final White Paper</i> . Baltimore: Health Care Payment Learning and Action Network.	
Typology	<p>Category 1 Fee-for-service—no link to quality</p> <ul style="list-style-type: none"> ▪ Traditional FFS^a ▪ DRGs not linked to quality^a <p>Category 2 Fee-for-service—link to quality and value</p> <p>A. Foundational payments for infrastructure and operations</p> <ul style="list-style-type: none"> ▪ Foundational payments to improve care delivery, such as care coordination fees, and payment for investments in HIT <p>B. Pay for reporting</p> <ul style="list-style-type: none"> ▪ Bonus payments for quality reporting ▪ DRGs with rewards for quality reporting ▪ FFS with rewards for quality reporting <p>C. Rewards for performance</p> <ul style="list-style-type: none"> ▪ Bonus payments for quality performance ▪ DRGs with rewards for quality performance ▪ FFS with rewards for quality performance <p>D. Rewards and penalties for performance</p> <ul style="list-style-type: none"> ▪ Bonus payments and penalties for quality performance ▪ DRGs with rewards and penalties for quality performance ▪ FFS with rewards and penalties for quality performance 	<p>Category 3 APMs built on fee-for-service architecture^b</p> <p>A. APMs with upside gainsharing</p> <ul style="list-style-type: none"> ▪ Bundled payment with upside risk only ▪ Episode-based payments for procedure-based clinical episodes with shared savings only ▪ Primary care PCMHs with shared savings only ▪ Oncology COEs with shared savings only <p>B. APMs with upside gainsharing/downside risk</p> <ul style="list-style-type: none"> ▪ Bundled payment with up-and downside risk ▪ Episode-based payments for procedure-based clinical episodes with shared savings and losses ▪ Primary care PCMHs with shared savings and losses ▪ Oncology COEs with shared savings and losses <p>Category 4 Population-based payment^b</p> <p>A. Condition-specific population-based payment</p> <ul style="list-style-type: none"> ▪ Population-based payments for specialty, condition, and facility-specific care (e.g., via an ACO, PCMH, or COE) ▪ Partial population-based payments for primary care ▪ Episode-based, population payments for clinical conditions, such as diabetes <p>B. Comprehensive population-based payment</p> <ul style="list-style-type: none"> ▪ Full or percent of premium population-based payment (e.g., via an ACO, PCMH, or COE) ▪ Integrated, comprehensive payment and delivery system ▪ Population-based payment for comprehensive pediatric or geriatric care <p><i>Capitated payments not linked to quality^d</i></p>

Notes: ACO = accountable care organization; APM = alternative payment model; DRG = diagnosis related group; FFS = fee-for-service; HMO = health maintenance organization; HOPPS = hospital outpatient prospective payment system; IPA = independent practice association; PCP = primary care physician; RBRVS = resource-based relative value scale; RVS = relative value scale; UCR = usual, customary, reasonable.

^a These payment models are not linked to quality, so they do not count toward the APM goal.

^b Category 3 includes “risk based payments not linked to quality,” which will not count toward the APM goal. Category 4 includes “capitated payments not linked to quality,” which will not count toward the APM goal.

Notes

1. The commonly used term in Europe for volume-based payment is “activity-based payment,” a term with a more positive connotation than “volume-based.”
2. Centers for Medicare and Medicaid Services, “Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume,” press release, January 26, 2015, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html>.
3. “Readmissions Reduction Program.” Baltimore: Centers for Medicare and Medicaid Services, accessed April 28, 2016, <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html>.
4. We do not use the term *reimbursement*, although it is commonly used to refer to transfer of funds from a health care payer to a provider. The term is misleading because the provider has not actually made payments to other parties for which it is seeking the same amount as a reimbursement. It is especially misleading to characterize forms of population-based payment, such as capitation, as reimbursement. The payment clearly does not represent even a loose notion of reimbursement for activities performed, let alone for outlays made to providers.
5. MACRA also called for development and implementation of “alternative payment models,” some but not all of which would be base payment alternatives to the Medicare Physician Fee Schedule.
6. For example, some have recommended that payment for office visits in a fee schedule should be based on the time the clinician spends in the encounter.
7. These findings are from practices oriented to fee-for-service payment; under other base payment methods, such as capitation, perhaps a much higher percentage of primary care activities would be ineligible for fee schedule payment. Understandably, not every discrete physician activity is eligible for third-party payment. Reasons include administrative complexity, program integrity concerns, and likely higher health spending, especially for services that would not necessarily require patients to participate in face-to-face office visits, with the attendant time costs and inconvenience.
8. Centers for Medicare and Medicaid Services. “Medicare Carriers Manual: Part 3—Claims Process.” Change Request 2622, July 25, 2003. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1810B3.pdf>.
9. Sometimes the payer and the intermediary organization that directly pays health professionals and other providers are one and the same. The classic example is the staff-model HMO, in which physicians are paid directly by the insurer, often by salary. More commonly in the group-model HMO, the insurer may pay the contracted medical group or groups a capitation. The group then determines its own method for compensating its employed members.

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