ALTARUM
HEALTHCARE VALUE HUB

Glossary: Provider Payment Reform

Term	Acronym	Definition
Accountable Care Organization	**ACO**	A group of doctors, hospitals, and other health care providers working together to manage and coordinate a broad spectrum of care for a group of patients. ACO providers are financially rewarded if they meet cost and quality benchmarks.
Bundled Payment		A fixed payment that covers all services delivered by providers for all services to treat a given condition or provide a given treatment. Bundles can take different forms. See also *Capitation, Condition-Specific Capitation and Episode Based Payments.*
Bundled Payments for Care Improvement	**BPCI**	A Medicare bundled-payment initiative introduced in 2013.
Capitation		A fixed provider payment, made per person per month, designed to cover all care within a broad specified set of services. This payment covers medical and administrative costs without regard to the actual number of services provided.
Care Coordination		The coordination of services provided by different members of a health care team. The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.
Condition-Specific Capitation		A fixed payment to providers for the care that patients may receive for a specific condition or set of conditions (e.g., HIV/AIDS, cancer care, diabetes) in a given time period, such as a month or year. Non-specified conditions may remain reimbursed under fee for service or other payment method.
Diagnosis Related Group	**DRG**	A fixed payment, made per admission, for all hospital-provided services related to a specific diagnosis. DRGs are used by Medicare and many other payers to reimburse hospitals.
Episode-Based Payment		A fixed payment to providers for a clinically defined episode (such as a knee replacements) that may involve several practitioner types, care settings, and services or procedures over time. See also *Bundled Payment*.
Fee for Service	**FFS**	A payment model in which providers are paid for every unit of service delivered without considerations of quality, outcomes or efficiency.

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Fee-for-Value		Incentive payments added to fee-for-service reimbursement, paid when quality targets are met. See *Pay for Performance*.
Global Budgeting		Global budgets are annual targets for health care spending. A global budget can be established at a national level, a state level or for other subsets of spending. The goal is to both measure and constrain aggregate health care spending.
Medical Home		A patient-centered approach to primary care that features a partnership between the patient, family and primary care provider, is comprehensive and emphasizes care coordination. This model is often accompanied by reimbursement methods to incentivize new ways of collaborating and delivering care.
Medicare Shared Saving Program	**MSSP**	Shared savings arrangements differ, but in general they incentivize providers to reduce spending for a defined patient population by offering them a percentage of any net savings they realize. The Medicare Shared Savings Program—started in 2012—is the most well-known and standardized example of this model. See *Shared Savings*.
Negotiated Rate		The fee an in-network provider charges a health plan and its members for a specific medical service. This is determined by negotiations between the provider and insurance company.
Never Events		Never events are preventable medical errors that should never occur, such as wrong-site surgeries or death or injury caused by a medication error. Medicare, many state Medicaid programs and private insurers have adopted policies to no longer pay for additional costs associated with these preventable errors.
Patient-Centered Medical Home	**PCMH**	See *Medical Home*.
Pay for Performance	**P4P**	A reimbursement scheme in which providers are rewarded or penalized based on their performance on specific cost and/or quality measures.
Potentially Avoidable Complication	**PAC**	Unnecessary complications that could be avoided with proper care management including, but not limited to, preventable hospital readmissions, medical errors, unnecessary ER visits, and hospital acquired infections.
Preference-Sensitive Care		Refers to medical conditions that have more than one legitimate treatment option—each option having different tradeoffs for patients. This category of care is the subject of many interventions designed to help patients assess risks and benefits of treatment options to make informed decisions based on personal values and preferences. See also *Supply Sensitive Care*.

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Provider Reimbursement		Payments to providers such as doctors or hospitals for patient care from insurance companies, Medicare, or Medicaid.
Resource-Based Relative Value Scale	**RBRVS**	A system used by Medicare to determine payment for physician services. The system assigns a relative value to the procedures physicians perform based on three factors: physician work, practice expense and malpractice expense. This relative value, which varies by geography and procedure, is multiplied by a fixed conversion factor that changes annually ($35.75 in 2015) to arrive at the payment amount.
Risk Adjustment		Payment adjustments made to reflect differences in the underlying health (or other factors) in the patient population—for example, higher payments when the population is sicker than average.
Shared Savings		Shared savings arrangements incentivize providers to reduce spending for a defined patient population by offering them a percentage of any net savings they realize. See *Medicare Shared Savings Program*.
Sociodemographic Factors		These are factors outside the control of a doctor or hospital, such as patients' income, housing, education, even race—that can significantly affect patient health outcomes. There is a growing debate about whether to bring these factors into risk adjustment formulas.
Supply Sensitive Care		Refers to services where the supply of a specific resource has a major influence on utilization rates. This is believed to be a large driver of health care costs.
Total Cost of Care	**TCOC**	A single risk-adjusted payment for the full range of health care services needed by a specified group of people for a fixed period of time. Total cost of care payment is very similar to capitation, but may use more sophisticated risk-adjustment methodologies, limit on risk exposure and/or incorporate quality measurement.
Value-Based Purchasing	**VBP**	Payment incentives to providers that reward quality of care. Incentives may reward for (1) measuring and reporting comparative performance and/or (2) meeting performance targets.
Value-Based Reimbursement		See *Value Based Purchasing*.