HEALTHCARE REFORM CHAMPIONS KIT

Glossary of Key Terminology

Accountable Care Organizations (ACOs): Groups of doctors, hospitals, and other healthcare providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/

Bundled Payments: A type of healthcare reimbursement for providers that is based on anticipated costs for certain care.

http://www.aha.org/research/cor/bundled-payment/index.shtml

Capitation: Capitated payment systems are, as the name implies, based on a payment per person, rather than a payment per service provided. There are several different types of capitation, ranging from relatively modest per member per month (pmpm) case management payments to primary care physicians involved in patient centered medical homes, to pmpm payments covering all professional services, to pmpm payments covering the total risk for all services: professional, facility, pharmaceutical, clinical laboratory, durable medical equipments, etc.

http://www.ama-assn.org//ama/pub/physician-resources/practice-management-center/claims-revenue-cycle/managed-care-contracting/evaluating-payment-options/capitation.page

Coordinated Care: Care that is coordinated across all elements of the broader healthcare system. The goal of coordinated care is to make sure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

http://www.medicare.gov/manage-your-health/coordinating-your-care/coordinating-your-care.html

Diagnosis-Related Group (DRG): A diagnosis-related group (DRG) is a patient classification system that standardizes prospective payment to hospitals and encourages cost containment initiatives. In general, a DRG payment covers all charges associated with an inpatient stay from the time of admission to discharge. The DRG includes any services performed by an outside provider.

http://dev.hmsa.com/portal/provider/zav_pel.fh.DIA.650.htm

Discounted Fee-for-service: A financial reimbursement system in which a provider agrees to supply services on a fee-for-service basis, but with the fees discounted by a certain percentage from the physician's usual and customary charges.

http://www.pbs.org/wgbh/pages/frontline/shows/doctor/care/capitation.html

Episode Payment: A type of healthcare reimbursement for providers that is based on anticipated costs for certain care.

http://www.aha.org/research/cor/bundled-payment/index.shtml

Fee-for-service: Health care providers are paid for each service (like an office visit, test, or procedure).

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Fee-for-Service.html

Global Payment: Global payments are fixed-dollar payments for the care that patients may receive in a given time period, such as a month or year. Global payments place providers at financial risk for both the occurrence of medical conditions and the management of those conditions.

http://www.mass.gov/chia/docs/pc/2009-02-13-global-payment-c2.pdf

Healthcare-Acquired Condition: An undesirable situation or condition that affects a patient that arose during a stay in a hospital or medical facility.

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html?redirect=/HospitalAcqCond/

Health Information Technology for Economic and Clinical Health (HITECH) Act: Uses Health IT to provide necessary assistance and technical support to providers, aligns usage among numerous states and aims to ensure provider workforces are properly trained for new technology use.

http://www.healthit.gov/policy-researchers-implementers/hitech-act-0

Integrated Delivery Network (IDN): A network of facilities and providers that work together to offer a continuum of care to a specific geographic area or market. IDNs include many types of associations across the continuum of care.

http://www.healthcareitnews.com/directory/integrated-delivery-network-idn

Medicare Shared Savings Program: Reduces unnecessary costs among providers and improves quality of care for Medicare fee-for-service beneficiaries. In order to participate in the program, a provider must create or participate in an Accountable Care Organization (ACO).

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html

Operating Cost: The actual costs of providing services related to the delivery of health care, including the costs of procedures, therapies, and medications (also known as healthcare cost).

http://www.nlm.nih.gov/nichsr/edu/healthecon/glossary.html

Partial Capitation: Also known as blended capitation, this model allows only certain types of services to be paid on a capitated basis.

http://www.hci3.org/content/capitation-models

Patient Centered Medical Home (PCMH): Seen as a way to improve healthcare by changing the organization and delivery of primary care.

http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/pcmh_defining_the_pcmh_v2

Pioneer ACO Model: Allows provider groups to move from a shared savings payment to a population-base payment in a timely fashion, thus improving quality and health outcomes for patients across the ACO. However, this model works completes separate from the Medicare Shared Services Program.

http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/

Shared Savings Model: Typically broken down into two categories:

1. If the actual total costs of all care received by the patients assigned to a physician practice is lower than budgeted costs, the practice receives a percentage of the difference between the actual and budgeted costs (i.e., a "share of the savings").
2. If the actual total costs exceed budgeted costs, the practice is responsible for a percentage of the difference.

http://www.ama-assn.org//ama/pub/physician-resources/practice-management-center/claims-revenue-cycle/managed-care-contracting/evaluating-payment-options/shared-savings.page

Triple Aim: A framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which we call the "Triple Aim":

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx