Key Payment and Delivery System Definitions

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Background: In August/September 2011, CIVHC staff and consultants conducted a literature search on key terms related to health care delivery redesign and payment reform for CIVHC's Payment Reform Operations Workgroup. Based on that search, staff presented suggested definitions to the Workgroup, which then reviewed, discussed and came to consensus on all definitions below.

A bibliography of sources used to develop these definitions may be found at the end of this document.

Payment Terms
- Fee-for Service Payment
- Enhanced Fee-for Service Payment
- Capitation
- Bundled Payment
- Global Payment
- Reference Pricing

Delivery System Terms
- Medical Home
- Accountable Care Organization
- Integrated Health Care Delivery System
- Fully Integrated Health Care Delivery System
- Chronic Care
- Inpatient Care
- Primary Care
- Specialty Care
- Acute Care
- Outpatient Care
- Care Management

Payment Terms

- **Fee-for-service payment**--A method of payment in which doctors and other health care providers are paid for many of the services performed; however, it is common for non-reimbursement of certain services, for example, telephone consults and email exchanges between patient and physician are frequently uncompensated.

- **Enhanced fee-for-service payment**--Fee-for-service payment that includes payment incentives for achieving or exceeding pre-established benchmarks for quality of care, health results and/or efficiency, such as incentives for chronic disease management. Enhanced payments can take many forms, including bonuses, case management payments, enhanced fee schedules and directing more enrollees to high-performing providers and health plans.[1] Enhanced fee-for-service payments are also known as *pay-for-performance payments* and *blended fee-for-service payments*.

[1] Committee member noted that this statement might be construed to take choice away from the patient. This is a larger issue that the committee will track on as an ongoing issue of concern.

- **Bundled payment**. A bundled payment is a method of reimbursing a provider, or a group of providers,[2] for providing multiple health care services associated with a defined episode of care for a specific illness, condition or medical event under a single fee or payment. Most episodes of care have a reasonably well-defined beginning and end, but for management of chronic conditions, episodes are defined as all of the condition-related services in a certain period of time (e.g., twelve months). Bundled payments can include responsibility for an allowance toward avoidable complications, can be severity-adjusted, can be tied to pay-for-performance and usually do not entail any insurance risk.[3]

  Categories of bundled payments include:
  - A total package price for the care cycle (e.g., all in-hospital care or all hospital, specialist and rehabilitative care) for a medical condition (e.g., heart attack) or event (e.g., knee replacement);
  - Time-based bundled reimbursement for managing chronic conditions; and
  - Time-based reimbursement for defined primary/preventative service bundles.

  Bundled payments are also known as *episode-of-care payments, case rates, evidence-based case rates, condition-specific capitation payments* and *episode-based bundled payments*.

- **Capitation** is a form of provider payment in which a provider or a group of providers receive a fixed amount for the provision of care to each enrolled person or group of enrolled individuals for a period of time. These payments can be risk adjusted.

- **Global payment**. A payment that prospectively compensates providers for all or most of the care that their patients may require over a contract period, such as a month or a year. The payment is usually adjusted based on the health (e.g. co-morbidities and severity of illness) of a risk-adjusted patient population and can also include quality-based pay-for-performance payments. The major difference between global payment and bundled payment is that bundled payments cover the episodes of care for patients with certain conditions, while global payment covers total care regardless of how many services are provided to patients.[4] Global payments are also known as *risk-adjusted capitation payments* and *bundled global payments*.

- **Reference pricing.** Reference pricing is a benefit design tool designed to encourage insured individuals to consider costs when choosing services, providers and pharmaceuticals. In general, this approach sets a maximum payment limit for certain procedures set by the employer or insurer. Limits are selected to incentivize the insured to choose a provider, service or drug with charges at or below the reference price. If the price is under the limit, insurance covers it all; if the price is over the limit, the insured individual pays 100 percent of the difference.

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[2] A provider is broadly defined as a an institutional provider of care (e.g. hospital, ambulatory surgery center, outpatient clinic) and a practitioner of health care services and includes but is not limited to a Medical Doctor, Doctor of Osteopathy, a Nurse Practitioner, a Physician's Assistant, a Registered Nurse, a Social Worker, a Psychologist, just to name a few. For the purposes of this definition, we consider a provider to be any health care professional that provides services with their scope of practice as defined by their professional accrediting body and the state and federal governments.

[3] Committee member noted that Medicare does not severity adjust its payments under the Acute Care Episode (ACE) Demonstration project.

[4] In the Prometheus model, payers take responsibility for all probability risk (costs of episodes and severity and complexity of a patient's condition) and providers assume the technical risk for the costs of all potentially avoidable conditions PACs. A committee member noted that a global payment to a provider shifts both insurance risk and technical risk to the provider(s), while risk adjusted bundled payments shifts only the technical risk to the provider.

Delivery System Terms

- **Medical Home (also known as health care home, primary care medical home, patient-centered medical home and advanced primary care)**—A model of enhanced primary care, centered around the patient's needs and characterized by each patient having a personal provider[5] responsible for coordinating and providing or arranging for all of his/her care; care coordination across all settings and practitioners by a provider-led team of health care professionals; expanded health care access for patients (e.g., after-hours care); evidence-based care; collaborative patient involvement in all care decisions, with adequate information provided to patients to support decision making; an emphasis on quality and safety; and provider-specific assessments of care efficiency and quality.

- **Accountable Care Organization (ACO).** A local, provider-led entity comprised of a wide range of collaborating providers. ACOs monitor, manage and coordinate acute and chronic care across multiple or all care settings (e.g., physician practices, clinics, outpatient settings and hospitals) and are accountable to health care payers (e.g., Medicaid, Medicare or private insurers) for the overall cost and quality of care for a defined population. An ACO can be an independent nonprofit organization formed specifically to serve as an ACO, an independent practice association, a multi-specialty group, a hospital-medical staff organization, a physician-hospital organization or a fully integrated health care delivery system. Providers in an ACO share some financial risk for meeting or exceeding performance goals across all providers and patients and may earn less if benchmark goals are not met.

- **Integrated health care delivery system**--A network of health care providers and organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the clinical outcomes and health status of a defined population served. Coordinated care for patients may take many forms, ranging from collaborating networks of providers to formally constituted integrated (or merged) organizations. Integrated health care delivery systems are also known as *integrated care systems*.

- **Fully integrated health care delivery system**—An integrated care system in which the providers are part of a single organization that has a common bottom line. A fully integrated system includes the full range of providers (e.g., primary care physicians, specialists and hospitals), and is responsible for providing all services, including delivery of care, payment and risk management, needed to care for a defined population of patients

- **Chronic Care –** Care for a condition that has lasted or is expected to last twelve or more months and has resulted in functional limitations and/or the need for ongoing medical care.

- **Inpatient Care –** Care for services delivered to a patient who needs physician care for more than 24 hours in a hospital.

- **Primary Care --** Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings. Primary care is performed and managed by a provider often coordinating with other health professionals, and utilizing consultation or referral as appropriate. Basic or general health care traditionally provided by doctors trained in: family practice, pediatrics, internal medicine, and occasionally gynecology.

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[5] A medical home can also be led by a nurse. For an article reviewing the history of nurse-led medical homes, see http://www.medscape.com/viewarticle/743197. Through state and federal level advocacy, language has been amended from the use of "physician" to "clinician" – a broader term that includes nurses and is now accepted by the National Committee for Quality Assurance and in a variety of federal legislation in recent years. There is not unanimity on the idea of a nurse-led medical home. For another perspective on the medical home, see the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association's joint statement on the principles and components of a medical home. For more, see http://www.medicalhomeinfo.org\downloads\pdfs\jointstatement.pdf.

- **Specialty Care --** Specialized consultative care, usually on referral from primary or secondary medical care personnel, by physicians whose training focused primarily in a specific field, such as neurology, cardiology, rheumatology, dermatology, oncology, orthopedics, ophthalmology, and other specialized fields.

- **Acute Care** – Short-term treatment for a severe injury or episode of illness and the opposite of chronic care. It entails stay in a short term facility such as a hospital or ambulatory surgery center.

- **Outpatient Care** – Care that does not require an overnight stay or hospitalization. It may be performed in a clinic, medical office, hospital or any other number of facilities.

- **Care Management** – Coordination of care in order to reduce fragmentation and unnecessary use of services, prevent avoidable conditions, and promote independence and self-care.

  This is sometimes used interchangeably with case management.

  Others differentiate the two terms. Care management can refer to a global approach to medical care from prevention through treatment and recovery while case management can refer to coordination of services to help meet a patient's health care needs, usually when the patient has a condition which requires multiple services from multiple providers.

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