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Pacific Business Group on Health

Supporting Health Care Re-engineering:
Provider Payment Issues and Reform Strategies

Background Materials and Glossary[1]
July 2006

Introduction

The members of the Pacific Business Group on Health are all too familiar with our health care system's promise and the "value chasm" that we see between quality shortfalls and rising costs. Regardless of your perspective, it is "our money" – whether that of PBGH's purchasers, public purchasing done by Medicare, or consumers' out-of-pocket spending – that is fostering waste and poor quality. One of the goals of the 2006 PBGH Board of Directors Strategic Planning Retreat was to inform and expand the thinking of key health purchasers in California and nationally on how payment strategies can support the delivery of higher quality, more cost effective care. The retreat looked at current payment systems, the promise of how care can be re-engineered, potential changes to provider reimbursement, and at strategies for engaging consumers in making better provider choices. Retreat participants recognized the following principles with regard to payment reform:

- Incentives in the provider payment landscape are often not aligned with our goal of promoting higher value;
- Efforts to re-engineer care to provide higher value are often contingent on changing payment structures;
- Changes must be made to payments from both private health plans and public payers, such as Medicare, beyond the current generation of "pay-for-performance" to promote value; and
- Engaged consumers must be agents for change by seeking out and using higher value providers.

The goal of this brief summary and background material was to help frame PBGH members' discussion of provider payment issues and reform strategies. Transforming payment systems that are a huge part of "the problem" is key to creating solutions that bridge the value chasm. We hope these materials will serve as a useful resource on this critical topic. This background summary is organized into the following areas:

1. The Cost of Poor Payment Design: Waste and Poor Quality
2. Re-engineered Care – A Real Possibility
3. Payment Today: Understanding the Current Models
4. Rewards-for-Performance In Practice: Examples and Evidence
5. Work-in-Progress: Varying Perspectives and Challenges for the Future

Attached to this summary is **Understanding Provider Payment: A Glossary of Health Care Terms and Acronyms**.

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[1] This summary document was originally prepared to support the Pacific Business Group on Health Board of Directors' Strategic Planning Retreat. The annual two-day retreat routinely focuses on important and timely issues relevant to purchasers collaborating on the common goals of moderated costs and improved quality in health care. The June 2006 retreat focused on provider payment reform and consumer engagement strategies as levers to promote re-engineered care delivery. For more information about PBGH, see www.pbgh.org.

Background

Most purchasers and consumers understand the concept of "you get what you pay for" relative to typical consumer goods and services. This is not conventionally true when dealing with health care. Since most payment systems pay for volume and have no consideration of either quality or efficiency, we reward quantity, including waste, and have been largely blind to quality. Payment systems and contract terms can vary considerably by provider type, service category and payor source – all of which contributes to the current misalignment of payment incentives and health care system improvement.

As early as 1999, PBGH's members engaged California's health plans in a challenge to reform their payments to directly incorporate quality and value into their payments to providers. Those efforts helped launch what has become the Integrated Healthcare Association's "Pay-for-Performance" initiative – the largest collaborative common measurement, public reporting and performance-based payment project in the country. PBGH and its members have been a national leaders encouraging reforms to Medicare to make the largest purchaser of health care a value-purchaser: supporting standardized measurement, public reporting and differential payments based on performance. These efforts are showing results. Legislation enacted in the beginning of 2006 calls on Medicare to expand its value purchasing in the hospital arena.

PBGH's members have always understood that rewarding performance is not just about payment – rewards to providers may come in the form of public recognition ("report cards") and more patients (channeled through "tiered" or "high performance" networks), as well as changes to payments. A core element of these rewards is that consumers need to be engaged – whether using quality information to select providers or decision support tools to make treatment choices. With the proliferation of information tools and resources, it is increasingly important to better understand how to best communicate with consumers and to position key information tools as "trusted" sources.

1. The Cost of Poor Payment Design: Waste and Poor Quality

The members of PBGH receive frequent material on the gaps in quality, geographic variability, and economic waste in care delivered today. These shortfalls are exacerbated by current payment systems and the disproportionate spending on high-intensity medical/surgical interventions and end-of-life care, in contrast to preventive care or counseling on behavior change and risk reduction. The articles below highlight some of the anomalies in current reimbursement systems and the opportunities for narrowing the "you get what you pay for" value chasm in health care.

References:

The Care of Patients with Severe Chronic Illness: **A Report on the Medicare Program by the Dartmouth Atlas Project**. Center for the Evaluative Clinical Sciences, May 2006. Accessed at *http://www.dartmouthatlas.org/atlases/2006_Chronic_Care_Atlas.pdf*
The most recent in the work done as part of the Dartmouth Atlas project highlights the fallacy of the common belief that "more is better" and that a core part of the problem is the extent to which "resources are locked in by Medicare's reimbursement policy" – leading to misuse and waste.

The Medicare program could reduce current spending by at least 30%, while improving the medical care of the most severely ill Americans.

Tracking the Cost of Medical Procedures. Sarah Rubenstein, The Wall Street Journal, March 21, 2006. Accessed at *http://online.wsj.com/article/SB114286978816803021.html*
This article highlights both geographic variability and the difference between "list price" and that which is paid by health insurance and patients for selected medical procedures. In several instances, the list price is 2 to nearly 4 times the contracted amount, which can confuse the most

educated health care shopper. Selected plans and vendors, as well as Medicare, are beginning to make some of these pricing differences more transparent through Web-based tools.

Pay Method Said to Sway Drug Choices of Oncologists. Reed Abelson, New York Times, March 8, 2006. Accessed at *http://www.nytimes.com/2006/03/08/health/08docs.html?ex=1149220800&en=541506586b9771de&ei=5070*
The article reported on studies that found that oncologists' treatment choices were likely to include more expensive drugs because that resulted in higher reimbursement for the physician. Medicare recognized this problem and noted that in changing payments to be weighted to the services provided by the doctor and away from the drug prescribed they were seeking to "increasingly pay for quality, not just for services."

In the Treatment of Diabetes, Success Often Does Not Pay. Ian Urbana, New York Times, January 11, 2006. Accessed at *http://www.nytimes.com/2006/01/11/nyregion/nyregion special5/11diabetes.html?ex=1149220800&en=f8d2124404677e90&ei=5070*
The article and associated graphic on common medical diagnostic services and treatments detail how "good care = bad business" (with preventive care such as nutritional counseling for diabetics not reimbursed) while "bad health = good business" (with high profits from patients who "fail" to avoid office visits, hospitalizations and other expensive services).

2. Re-engineered Care – A Real Possibility

Retreat participants learned about two leading examples of re-engineering and the role payment reform must play to spur those efforts. **Gary Kaplan, MD, CEO of Virginia Mason** addressed their adoption of Toyota production methods to create administrative efficiencies and optimize resource utilization. Virginia Mason, a Seattle-based integrated health delivery system and medical center, has made measurable improvements in quality, efficiency, and patient satisfaction. Yet under current financial arrangements, reimbursements don't reward the desirable outcome of saved costs and improved outcomes. The lower payments do not offset the required investments to improve patient care. For more information, see Seeking Zero Defects: Applying the Toyota Production System to Medicine and the NCQA 2005 Annual Report. **Steve McDermott, CEO of Hill Physicians Medical Group** addressed their innovative approaches to provider compensation that place up to 20% of individual physician payment at risk for performance. Hill Physicians is the largest northern California multi-specialty independent physician association with more than 2,500 providers and affiliations with 34 hospitals. Hill aligns physician incentives with those of health plan pay-for-performance payments to the medical group, and has paid out more than $25 million in pay-for-performance rewards to providers. Key program goals are to promote a "results orientation" and to stress population management. Practices such as group visits and patient specific reporting for practitioners support physicians' performance on health plan-rewarded metrics. See the presentation here, or for more information see www.hillphysicians.com and 2005 Hill Physicians Annual Report: In Pursuit of a Balanced Life.

References:

Medical Errors in U.S. Hospitals		
Estimate of current annual level, nationwide	Benefit if rate were cut 50%	Benefit if rate were cut 90%
974,000 patients injured	487,000 patients avoiding injury	877,000 patients avoiding injury
44,000 to 98,000 deaths	22,000 to 49,000 lives saved	39,600 to 88,200 lives saved
$17 billion to $29 billion in costs	$8.5 billion to $14.5 billion saved	$15.3 billion to $26.1 billion saved

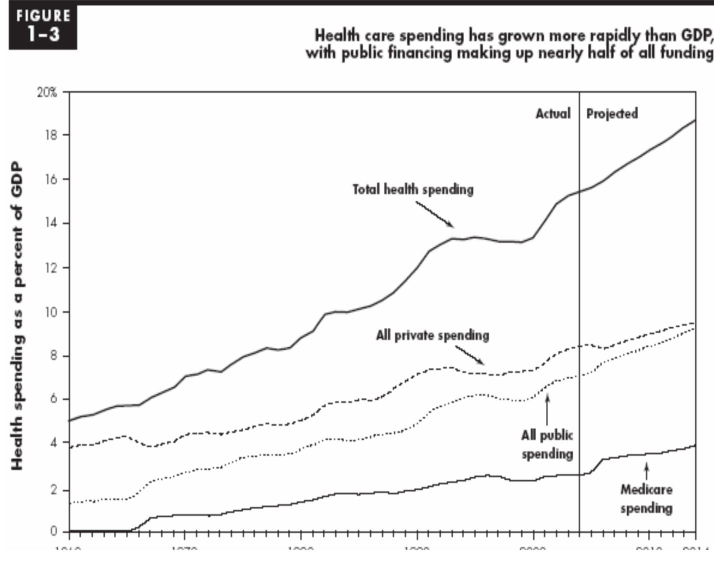
Fixing Health Care from the Inside, Today, Steven J. Spear, Harvard Business Review, September, 2005. Accessed at *http://harvardbusinessonline.hbsp.harvard.edu/hbrsa/en/archive/archive.jhtml*
This article speaks to the extraordinary opportunity to save lives and save money if health care organizations delivered "operational excellence" in the rapid assessment and adoption pattern to achieve "big gains through small changes" that has been well proven in manufacturing industries. Such rapid cycle quality improvement is at the core of PBGH's collaborative work with health plans and medical groups in the Breakthroughs in Chronic Care Program that is resulting in improved compliance with evidence-based practices and better service for patients through same-day appointments and other efficiencies. (See www.breakthroughcare.org).

***Stimulating the Emergence of a 60 Mile Per Gallon American Health Care System*,**
Arnold Milstein, MD, Medical Director, PBGH: Testimony before House/*Senate Joint Economic Committee, May 10, 2006.* Accessed at:
http://jec.senate.gov/index.cfm?FuseAction=Hearings.Hearing&Hearing_ID=86
Dr. Milstein's recent congressional testimony advocates greater physician performance transparency through access to CMS claims data to produce more broadly available and credible quality and efficiency measurement at the individual doctor level. Such information will help close the affordability gap between annual health care spending growth and GDP growth. He cites the well-documented experience of Pitney Bowes in Connecticut as well as more recent initiatives by the Massachusetts Group Insurance Commission (public employees).

Transforming Medical Care: Case Study of an Exemplary, Small Medical Group. Solberg, et al., Annals of Family Medicine, April 14, 2006. Accessed at: *http://www.medscape.com/viewarticle/529120*
This article complements the experience described at the Retreat of two large systems, highlighting what a small medical group can do in improving preventive services and care for the chronically ill. The article describes not only the attributes that made this group effective, but also notes that the group's "focus on quality improvement" was specifically influenced by payment incentives for better quality scores.

3. Payment Today: Understanding the Current Models

The United States spends far more dollars per capita on health care than does any other country, yet ranks well below many countries in health care quality. Current payment systems reward specialist and specialized services in comparison to primary care. Medicare reinforces this dynamic but at the same time, can help accelerate payment reform to promote value. (Note: for more information on the mutual objectives for payment reform shared by Medicare and private enterprise, see the website of the Consumer-Purchaser Disclosure Project, which has links to an array of background materials on the overhaul of payment systems (http://healthcaredisclosure.org)



References:

Context for Medicare Payment Policy, Medicare Payment Advisory Commission, Report to the Congress, Excerpt from Chapter 1, March 2006. Accessed at: http://www.medpac.gov/home/pubpdf.cfm?material_id=394
As a member of the Medicare Payment Advisory Commission, PBGH Medical Director Arnie Milstein brings the voice of private purchasers to the discussion on ways to reduce inappropriate use of physician services and improve quality for Medicare beneficiaries. This report provides background on the ominous trajectory of current health care spending and makes some critical recommendations to make better use of Medicare's financial resources: 1) conduct comparative-effectiveness analysis for new technologies, 2) pay differently among providers based on measures of quality and resource use (efficiency), and 3) introduce bidding approaches for purchased services to promote competitive markets.

4. Rewards-for-Performance In Practice: Examples and Evidence

There is a growing body of evidence that shifting provider payments is one essential component of an overall strategy for improving health care value. While fundamental payment reforms are needed, incremental steps are now being taken in the "rewards-for-performance" projects. PBGH and its members have been catalysts for change by: (1) setting expectations that plans and provider groups consider performance and value in their payments, (2) advocating use of standardized measures, (3) promoting accountability through public reporting and (4) fostering collaboration among purchasers, plans and providers. By rewarding performance, purchasers and plans can incent quality improvement and investments in infrastructure and health information technology.

References:

Major Studies Affirm Need for Value Purchasing in Medicare and Collaborative Efforts Chart Path for the Future. Pacific Business Group on Health, December 6, 2005. Accessed at http://www.pbgh.org
As part of our advocacy of thoughtful reform of Medicare payments, PBGH distributed the only summary highlighting existing evidence to Congressional leadership to inform the discussion that resulted in the historic passage of reforms to launch measurement, public reporting and performance-based payments for hospitals. The summary document highlights work by Dartmouth researchers to quantify variation in California hospital utilization and costs, with implications for Medicare spending; Rewarding Results (described below); Medicare Premier Hospital Quality pilot; and the Ambulatory Care Quality Alliance (AQA).

Rewarding Results
Aligning Incentives with High-Quality Health Care

Rewarding Results Pay-for-Performance Initiative: Ten Lessons Learned. The Robert Wood Johnson Foundation, November 15, 2005. Accessed at http://www.leapfroggroup.org/RewardingResults/pdf/RR-P4P-Top_10_Lessons.pdf
Rigorous assessment of seven "Rewarding Results" projects (including Blue Cross' California PPO pay for performance pilot) revealed that financial incentives do motivate change and that public reporting is a strong catalyst for providers to improve care. Provider engagement and education are critical as is performance feedback. However, more assessment is required to gauge ROI in many programs and P4P efforts need to be aligned with other incentives.

Advancing Quality Through Collaboration: The California Pay For Performance Program. Integrated Healthcare Association, February 2006. Accessed at http://www.iha.org/wp020606.pdf
The California IHA Pay for Performance program is the nation's largest with 225 participating physician organizations representing 35,000 physicians. This report highlights the program's history, including PBGH's support and participation in its launch and growth. Seven plans use common performance metrics, and with selected additional measures by carriers, over $100 million was paid to providers this past year. Two plans provide additional incentives to medical groups that pass rewards through to individual physicians. PBGH continues to support this effort through

health plan performance guarantees as well as providing technical expertise on integration of new measures.

5. Work-in-Progress: Varying Perspectives and Challenges for the Future

Provider payment reform continues to take shape in both the public and private sector. As noted above, MedPAC plays a critical role in instigating Medicare payment reform, which in turn has broad consequences for payments by private payors. At the same time, Medicare can draw lessons from innovative approaches that are launched in the private sector. There has been much recent progress in paying for performance. At this pivotal point, private and public purchasers should collaborate for comprehensive payment reform, including paying for performance of the right services at the right time by the right providers. The references that follow refer to an array of perspectives on the movement to pay-for-performance. For links to an array of advocacy positions more generally on payment reform, refer to the Consumer-Purchaser Disclosure Project website (http://healthcaredisclosure.org/).

References:

Pay-for-Performance: the MedPAC Perspective, Karen Milgate and Sharon Bee Cheng, Health Affairs, March/April 2006. Accessed at: *http://content.healthaffairs.org/cgi/reprint/25/2/413.pdf*
MedPAC has recommended that Medicare build financial incentives for quality into its provider payments, including hospitals, physicians, home health agencies, renal dialysis providers and the Medicare Advantage program. Their rationale lies in continuing evidence of quality gaps and the failure of resource-based payments to differentiate between high and low quality. MedPAC advocates use of evidence-based measures, readily available data, appropriate risk adjustment and quality metrics that can be improved upon by providers.

Strategies for Improving Surgical Quality – Should Payers Reward Excellence or Effort?
Nancy J.O. Birkmeyer, Ph.D., and John D. Birkmeyer, M.D., New England Journal of Medicine, February 23, 2006. Accessed at *http://content.nejm.org/cgi/reprint/354/8/864.pdf*
This article highlights a provider perspective on pay for performance, citing interest in "pay for participation" and rewards for effort (both surgeons and hospitals), rather than just results. Part of their argument stems from the variability of measurable results in different specialty areas (notably, this is rapidly evolving through efforts of the AMA and medical specialty societies) and the concern that "results" may not be immediately evident. The authors note that "centers of excellence" models may lend themselves to rapid implementation, but they may not motivate broad-based systemic improvements.

Pay for Performance: A Decision Guide for Purchasers. R. Adams Dudley, M.D., M.B.A. and Meredith Rosenthal, Ph.D., Agency for Health Care Research and Quality, April 2006. Accessed at *http://www.ahrq.gov/qual/p4pguide.pdf*
The AHRQ guide examines the decisions public and private purchasers of health care services must make in designing and implementing pay-for-performance programs. The guide lists 20 questions in four phases: contemplation, design, implementation and evaluation. Each question reviews the possible options, potential effects and consequences, and offers evidence from empirical evaluations and economic theory to help purchasers make informed decisions.

Can Money Buy Quality? Physician Response to Pay for Performance. Thomas Bodenheimer, Jessica H. May, Robert A. Berenson and Jennifer Coughlan, Center for Studying Health System Change. Accessed at *http://www.hschange.org/CONTENT/807/807.pdf*
This article summarizes different P4P approaches and highlights the impact of two major programs in Orange County, CA, and Boston, MA. Early observations on physicians' response to P4P

highlight successes among larger medical groups (note small provider group re-engineering article under Tab 2), while the majority of medical practices have fewer than five physicians. To the extent that improved performance requires data repositories, chronic illness registries, and other quality-enhancing innovations, plans and purchasers must consider the possibility of a widening performance gap between small physician practices and larger groups. At the same time, P4P holds the promise that it will catalyze physicians to make infrastructure investments or join larger groups that do make the investments.

Understanding Provider Payment:
A Glossary of Health Care Terms and Acronyms

Term	Definition
Allied Health Professional (AHP)	AHPs are individuals trained to support, complement, or supplement the professional functions of physicians, dentists, and other health professionals in the delivery of health care to patients. They include physician assistants, dental hygienists, medical technicians, nurse midwives, nurse practitioners, physical therapists, psychologists, and nurse anesthetists.
Allowable Charge	The maximum charge for which a third party will reimburse a provider for a given service. An allowable charge is not necessarily the same as either a reasonable, customary, maximum, actual, or prevailing charge.
Ambulatory Care	Health care services provided to patients on an ambulatory basis, rather than by admission to a hospital or other health care facility. The services may provided at a hospital or a free-standing facility.
Ambulatory Payment Classification (APC)	This is the method used by CMS to implement prospective payment for ambulatory procedures. APC clusters many different ambulatory procedures into groups for purposes of payment.
Ambulatory Surgery Center (ASC)	Surgery performed on an outpatient basis, either hospital-based or performed in an office or surgicenter.
Any Willing Provider Laws	Any willing provider laws take many different forms, but they typically restrict the ability of managed-care organizations to use a closed panel of physicians, hospitals, or other providers.
Average Wholesale Price (AWP)	Average Wholesale Price of brand-name pharmaceuticals, as stated by the manufacturer, is used as a basis for determining discounts and rebates.
Capitation	Capitation pays the provider a fixed amount for each of the patients for whom he agrees to provide care, regardless of whether those patients seek care or not. Payment is typically based on a set number of dollars "per member-per month."
Care Management Protocols (CMPs)	Care Management Protocols specify utilization and treatment standards for various diagnoses.
Certificate of Need (CON)	A certificate issued by a governmental body to an individual or organization proposing to construct or modify a health facility, or to offer a new or different service. The process of obtaining the certificate is included in the term.
Certification	Certification is a voluntary system of standards that practitioners can choose to meet to demonstrate accomplishment or ability in their profession. Certification standards are generally set by non-governmental agencies or associations.
Chronic Illness	Diseases which have one or more of the following characteristics: they are permanent, leave residual disability, are caused by nonreversible pathological alteration, require special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation, or care.
CMS	Centers for Medicare and Medicaid Services.
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1986.
Coinsurance	The percentage of the costs of medical services that is paid by the patient. A characteristic of the indemnity and PPO plans.

Collective Bargaining	Collective bargaining refers to bargaining by union members, which is authorized by the NLRA, or non-unionized physicians' attempts to obtain the right to bargain collectively.
Computerized Physician Order Entry (CPOE)	Computer physician order entry (CPOE) is an electronic prescribing system. With CPOE, physicians enter orders into a computer rather than on paper. Orders are integrated with patient information, including laboratory and prescription data. The order is then automatically checked for potential errors or problems.
Coronary Artery Bypass Graft (CABG)	Surgical therapy of ischemic coronary artery disease, achieved by grafting a section of saphenous vein, internal mammary artery, or other substitute between the aorta and the obstructed coronary artery distal to the obstructive lesion.
Critical Loss Analysis	A two step analysis is used to perform a critical loss analysis. The first step identifies, for any given price increase, the amount of sales that can be lost before the price increase becomes unprofitable. The second step considers whether or not the actual level of sales lost due to the price increase will exceed this amount.
Diagnosis Related Group (DRG)	DRGs form the cornerstone of the prospective payment system. A DRG is a cluster of diagnoses that are expected to require comparable hospital resources and lengths of stay.
Discounted Fee for Service (FFS)	A financial reimbursement system whereby a provider agrees to supply services on an FFS basis, but with the fees discounted by a certain percentage from the physician's usual and customary charges.
Durable Medical Equipment (DME)	Devices which are very resistant to wear and may be used over a long period of time. DME includes items such as wheelchairs, hospital beds, artificial limbs, etc.
EMTALA	Emergency Medical Treatment and Active Labor Act of 1986.
End-Stage Renal Disease (ESRD)	An irreversible and usually progressive reduction in renal function in which both kidneys have been damaged by a variety of diseases to the extent that they are unable to adequately remove the metabolic products from the blood and regulate the body's electrolyte composition and acid-base balance. Chronic kidney failure requires hemodialysis or kidney transplantation.
ERISA	Employee Retirement Income Security Act.
Exclusive Provider Organization (EPO)	Uses a small network of providers and has primary care physicians serving as care coordinators (or gatekeepers). Typically, an EPO has financial incentives for physicians to practice cost-effective medicine by using either a prepaid per-capita rate or a discounted fee schedule, plus a bonus if cost targets are met. Most EPOs are forms of POS plans because they pay for some out-of-network care.
Experience Rating	The process of setting rates partially or in whole on evaluating previous claims experience for a specific group or pool of groups.
Fee-for-Service (FFS)	In FFS, a provider is paid based on the number and type of services that are performed.
Formulary	A list of approved drugs for treating various diseases and conditions.
Group Purchasing Organization (GPO)	A shared service which combines the purchasing power of individual organizations or facilities in order to obtain lower prices for equipment and supplies.
HIPAA	Health Insurance Portability and Accountability Act of 1996 .
Health Plan Employer Data and Information Set (HEDIS)	A set of standardized performance measures designed to ensure that purchasers and consumers have reliable information with which to compare the performance of MCOs.

Herfindahl-Hirschman Index (HHI)	The Herfindahl-Hirschman Index is a commonly accepted measure of market concentration. It is calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers. The HHI takes into account the relative size and distribution of the firms in a market. The HHI increases both as the number of firms in the market decreases and as the disparity in size between those firms increases.
Independent Practice Association (IPA)	IPAs are networks of independent physicians that contract with MCOs and employers. IPAs may be organized as sole proprietorships, partnerships, or professional corporations.
Inpatient Prospective Payment System (IPPS)	Medicare's payment system for inpatient hospitals and facilities. The specific amount that is paid is based on the DRG for the hospital admission.
Licensure	A mandatory system of state-imposed standards that practitioners must meet to practice a given profession.
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
Managed Care Organization (MCO)	MCOs integrate, to varying degrees, the financing and delivery of health care services.
Maximum Allowable Cost (MAC)	Maximum Allowable Cost, or Charge. The maximum that a vendor may charge for something. This term is often used in pharmaceutical contracting.
Medicare + Choice (M+C)	Also known as Medicare Part C. The Balanced Budget Act of 1997 (BBA) established the Medicare+Choice program. Under this program, an eligible individual may elect to receive Medicare benefits through enrollment in a Medicare+Choice plan, which generally takes the form of a MCO.
Medicare Advantage (MA)	As of 2003, the new name for Medicare+Choice (M+C).
Medicare Payment Advisory Commission (MedPAC)	The Commission was created by the BBA through a merger of the Prospective Payment Assessment Commission and the Physician Payment Review Commission. MedPAC reviews payment policies under Medicare Parts A and B and the effects of Medicare Part C. MedPAC also evaluates the effect of prospective payment policies and their impact on health care delivery in the US.
Medigap	A supplemental health insurance policy sold by private insurance companies that is designed to pay for health care costs and services that are not paid for by Medicare and any private health insurance benefits.
Metropolitan Statistical Areas (MSA)	Standard metropolitan statistical areas are defined by the U.S. Census so that institutions and individuals gathering statistics on urban areas can use a common definition.
Most Favored Nation (MFN)	A "Most Favored Nation" (MFN) clause is a contractual agreement between a supplier and a customer that requires the supplier to sell to the customer on pricing terms at least as favorable as the pricing terms on which that supplier sells to other customers. These clauses are sometimes found in the contracts health insurers enter into with providers.
Outpatient Prospective Payment System (OPPS)	Medicare's system for payment to outpatient departments of hospitals and other outpatient facilities. The specific amount that is paid is determined by the relevant APC.
Patient Flow Data	Patient flow data identifies the zip code of each patient discharged from a hospital.
Payment for Performance (P4P)	Payment for Performance pays providers based on their success in meeting specific performance measures.

Pharmacy Benefit Manager (PBM)	A company under contract with managed care organizations, self-insured companies, and government programs to manage pharmacy network management, drug utilization review, outcomes management, and disease management.
Physician-Hospital Organization (PHO)	A PHO is a joint venture between a hospital and some or all of the physicians who have admitting privileges at the hospital.
Point of Service (POS)	A health insurance plan in which members do not have to choose how to receive services until they need them. The most common use of the term applies to a plan that enrolls each member in both an HMO (or HMO-like) system and an indemnity plan. These plans provide different benefits, depending on whether the member chooses to use plan providers or go outside the plan for services.
Preferred Provider Organization (PPO)	A health insurance plan with an established provider network ("preferred providers) that provides maximum benefits when members use a preferred provider.
Risk Adjustment	A statistical method of paying managed care organizations different capitated payments based on the composition and relative healthiness of their beneficiaries.
Quality Improvement Organization (QIO)	Organizations that contract with CMS to review care provided to Medicare beneficiaries.
Resource-Based Relative Value Scale (RBRVS)	The RBRVS determines the rate at which Medicare reimburses physicians on an FFS basis. The RBRVS is calculated based on the cost of physician labor, practice overheads, materials, and liability insurance. The resulting figures are adjusted for geographical differences and are updated annually.
Single Specialty Hospital (SSH)	Specialized hospitals that provide treatment relating to a single specialty (e.g., cardiac or orthopedic services). Many of the physicians who refer patients to an SSH have an ownership interest in the facility.
State Action Doctrine	First articulated in *Parker v. Brown*, the state action doctrine shields certain anticompetitive conduct from federal antitrust scrutiny.
State Board of Medical Examiners	State Boards of Medical Examiners are typically responsible for licensure and promulgate regulations governing physicians and AHPs.
State Children's Health Insurance Program (SCHIP)	Also referred to as Children's Health Insurance Program (CHIP). A program created by the federal government to encourage states to provide insurance coverage for children. SCHIP is funded through a combination of federal and state funds, and administered by the states in conformity with federal requirements.
Telemedicine	Telemedicine involves the use of electronic communication and information technologies to provide or support clinical care at a distance.
Third-Party Administrator (TPA)	A firm that performs administrative functions (e.g., claims processing, membership) for a self-funded plan or a start-up MCO.
Utilization Review	An organized procedure carried out through committees to review admissions, duration of stay, professional services furnished, and to evaluate the medical necessity of those services and promote their most efficient use.

Primary Sources: The National Library of Medicine's (NLM) controlled vocabulary database, Medical Subject Headings (MeSH), *at* http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=mesh, and Peter R. Kongstvedt, *Glossary of Terms and Acronyms*, *in* Essentials of Managed Health Care (Peter R. Kongstvedt ed., 4th ed. 2003).