CENTERS for MEDICARE & MEDICAID SERVICES
Center for Medicare & Medicaid Innovation

Value-Based Healthcare Video Series

What Every Clinician Should Know

Glossary of Terms

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Glossary of Terms

ACO (Accountable Care Organization) - Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to a population of patients they serve. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program (U.S. Centers for Medicare & Medicaid Services/CMMI, 2019).

Alternative Payment Model (APM) - A value-based payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a patient population (U.S. Centers for Medicare & Medicaid Services/QPP, 2019).

Advanced APM – Advanced APMs (AAPMs) are alternative payment models that include both up- and down-sided risk. AAPMs are a track of the Quality Payment Program that offer a five percent incentive for achieving threshold levels of payments or patients through Advanced APMs (U.S. Centers for Medicare & Medicaid Services/QPP, 2019).

Attribution - The process that commercial and government payers use to assign patients to the physicians who are held accountable for their care (Fiesinger, 2016).

Beneficiary - The name for a person who has health care insurance through the Medicare or Medicaid program (U.S. Centers for Medicare & Medicaid Services/Glossary, 2006).

BPCI, Advanced (Bundled Payments for Care Improvement, Advanced) - BPCI-Advanced is a voluntary episode payment model that aims to support healthcare providers who invest in practice innovation and care redesign to better coordinate care, improve quality of care, and reduce expenditures, while improving the quality of care for Medicare beneficiaries. The goals of BPCI-Advanced include care redesign, health care provider engagement, patient and caregiver engagement, data analysis/feedback, and financial accountability (U.S. Centers for Medicare & Medicaid Services/CMMI, 2019).

Bundled payment - Models of care which link payments for the multiple services beneficiaries receive during an episode of care (U.S. Centers for Medicare & Medicaid Services/CMMI, 2019).

Capitation - A specified amount of money paid to a health plan or doctor. This is used to cover the cost of a patient's health care services for a certain length of time (U.S. Centers for Medicare & Medicaid Services/Glossary, 2006).

Comprehensive Primary Care Plus (CPC+) - A national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States (U.S. Centers for Medicare & Medicaid Services/CMMI, 2019).

Co-Pay - A fixed amount you pay for a covered health care service after you've paid your deductible (U.S. Centers for Medicare & Medicaid Services/HealthCare.gov, 2019).

CRM (Customer Relationship Management) - A comprehensive strategy and process of acquiring, retaining, and collaborating with selected customers to create superior value for the organization and

the customer. It involves the integration of customer service-related functions of the organization to achieve greater efficiencies and effectiveness in delivering customer value (Navimipour & Soltani, 2016).

CPT Code - The Current Procedural Terminology (CPT®) codes offer doctors and health care professionals a uniform language for coding medical services and procedures to streamline reporting, increase accuracy and efficiency (American Medical Association, 2019).

Direct Contracting (DC) - A set of three voluntary payment model options aimed at reducing expenditures and preserving or enhancing quality of care for beneficiaries in Medicare Fee-For-Service. The payment model options available under DC create opportunities for a broad range of organizations to participate with CMS in testing the next evolution of risk-sharing arrangements to produce value and high quality health care. The payment model options are anticipated to appeal to a broad range of physician practices and other organizations because they are expected to reduce burden, support a focus on beneficiaries with complex, chronic conditions, and encourage participation from organizations that have not typically participated in Medicare FFS or CMS Innovation Center models (U.S. Centers for Medicare & Medicaid Services, 2019).

Downside Risk – Downside risk in healthcare refers to assuming risk for actual costs of care. If the cost of care falls below the targeted costs, the practice will share in savings. If the cost of care exceeds the targeted or budgeted costs, the practice will be responsible for a portion of the difference between actual total costs and targeted or budgeted costs (American Academy of Pediatrics, 2019). Downside risk puts providers at financial risk in the event that added resources are needed to care for a patient (in situations where additional care could have been avoided). The most common examples apply to hospitals, such as non-payment for preventable hospital-acquired conditions or readmissions (Delbanco, 2014).

DRG (Diagnosis Related Group) - A classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual (U.S. Centers for Medicare & Medicaid Services/Glossary, 2006).

Episode of Care (episode) - The set of services provided to treat a clinical condition or procedure (U.S. Centers for Medicare & Medicaid Services, 2016).

Episode-Based Payment Initiatives - Under these models, health care providers are held accountable for the cost and quality of care beneficiaries receive during an episode of care, which usually begins with a triggering health care event (such as a hospitalization or chemotherapy administration) and extends for a limited period of time thereafter (U.S. Centers for Medicare & Medicaid Services/CMMI, 2019).

Fee-For-Service (FFS) - A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits (U.S. Centers for Medicare & Medicaid Services/HealthCare.gov, 2019).

Full Risk (also known as two-sided risk) - In two-sided risk models, providers still share in the savings but are also responsible for some of the loss if spending is above the benchmark (Chernew & Frakt, 2018). Participating in these models can generally earn larger shared savings payments if they are

successful, but they also face "downside" risk because they are responsible for repaying a portion of any losses to the government (Mechanic, Perloff, Litton, Edwards, & Muhlestein, 2019).

Global Payment - A fixed prepayment made to a group of providers or a health care system (as opposed to a health care plan), covering most or all of a patient's care during a specified time period. Global payments are usually paid monthly per patient over a year, unlike fee-for service, which pays separately for each service (National Conference of State Legislatures , 2010).

Healthcare Disparities - Differences and/or gaps in the quality of health and healthcare across racial, ethnic, and/or socio-economic groups. It can also be understood as population-specific differences in the presence of disease, health outcomes, or access to healthcare (Riley, 2012).

High Value Care - The best care for the patient, with the optimal result for the circumstances, delivered at the right price (Smith, Saunders, & Stuckhardt, 2013).

HMO (Health Maintenance Organization) - A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You usually must get your care from the providers in the plan and coverage typically includes a broader range of preventive care (U.S. Centers for Medicare & Medicaid Services/Glossary, 2006).

Medicaid - A joint federal and state program that helps with medical costs for some people with low incomes, disabilities, and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid (U.S. Centers for Medicare & Medicaid Services/Glossary, 2006).

Medicare - The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD) (U.S. Centers for Medicare & Medicaid Services/Glossary, 2006).

Modifiable Risk Factors - Risk factors are conditions that increase your risk of developing a disease. Modifiable risk factors mean you can take measures to change them (UCSF Health, 2019).

Network - A group of doctors, hospitals, pharmacies, and/or other health care experts hired by a health plan to take care of its members (U.S. Centers for Medicare & Medicaid Services/Glossary, 2006).

OCM (Oncology Care Model) - A payment and delivery model designed to improve the effectiveness and efficiency of specialty care in oncology. Physician practices have entered into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients (U.S. Centers for Medicare & Medicaid Services, 2019).

Outcome Measures - Outcome measures reflect the impact of the health care service or intervention on the health status of patients. One example of a health-related outcome measure: the percentage of patients who died as a result of surgery (surgical mortality rates) (Agency for Healthcare Research and Quality, 2011).

P4P (Pay-for-Performance) - An umbrella term for early initiatives aimed at improving the quality, efficiency, and overall value of health care by addressing how providers are paid for healthcare. These early efforts paved the way for value-based payment reform by focusing on patient outcomes and provider performance (CMS/ORDI/MDPG, 2005)

PCF (Primary Care First) - Primary Care First is a set of voluntary five-year payment options that reward value and quality by offering an innovative payment structure to support delivery of advanced primary care. In response to input from primary care clinician stakeholders, Primary Care First is based on the underlying principles of the existing CPC+ model design: prioritizing the doctor-patient relationship; enhancing care for patients with complex chronic needs and high need, seriously ill patients, reducing administrative burden, and focusing financial rewards on improved health outcomes. (U.S. Centers for Medicare & Medicaid Services, 2019).

PCMH (Patient Centered Medical Home) - An approach to providing comprehensive primary care for children, youth and adults by transforming how care is organized and delivered. The PCMH re-designs primary care to provide comprehensive, person-centered care coordinated among patients, patient's families, specialty care, hospitals, home health, and/or community-based supports and services (American Academy of Family Physicians, 2007), (Agency for Healthcare Research and Quality, 2019).

PPO (Preferred Provider Organization) - A managed care plan in which patients can use doctors, hospitals, and providers that belong to the network, but can use doctors, hospitals, and providers outside of the network for an additional cost (U.S. Centers for Medicare & Medicaid Services/Glossary, 2006).

P-VBPM (Physician Value-Based Payment Modifier) - Provides for differential payment under the Medicare Physician Fee Schedule (PFS) based on the quality of care furnished compared to the cost of care during a performance period. The Value Modifier is an adjustment made to Medicare payments for items and services under the Medicare PFS (U.S. Centers for Medicare & Medicaid Services/Glossary, 2006).

PQRS (**Physician Quality Reporting System)** – PQRS, formerly known as the Physician Quality Reporting Initiative, is a healthcare quality improvement incentive program initiated by CMS. PQRS measures were developed across a wide range of quality and health outcomes and providers are required to submit data on these measures annually. According to the Affordable Care Act (2010), providers who fail to submit PQRS data will receive financial penalties (U.S. Centers for Medicare & Medicaid Services, 2008).

Reimbursement – An umbrella term for the policies and practices that define the terms of coverage and payment for health care and technology (Bruen, et al., 2016). Reimbursement mechanisms for healthcare have included salary, Fee-for-service (FFS), capitation, Pay-for-performance (P4P), and diagnosis-based payment (DRGs, diagnosis-related groups) (Britton, 2015).

Risk-Based Contracting - Risk-based contracts come in a variety of shapes and sizes. The highest form is full capitation in which hospitals or physician groups receive a monthly payment to provide all care for a patient (Barkholz, 2016).

Risk Based Payment Model - There are a variety of risk-based payment models being developed. Risk-based models are predicated on an estimate of what the expected costs to treat a particular condition or patient population should be (American Academy of Pediatrics, 2019).

RVU (Relative Value Unit) - A national standard used for measuring productivity, budgeting, allocating expenses, and cost benchmarking. RVUs do not represent monetary values. Instead, they represent the relative amount of physician work, resources, and expertise needed to provide services to patients. The actual dollar amount of a payment for the physician's services results only when a conversion factor (CF), dollar per RVU, is applied to the Total- RVU (Quan, 2007).

SDoH (Social Determinants of Health) - Conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. These include conditions impacted by the distribution of wealth and resources (Centers for Disease Control and Prevention, 2018).

TD-ABC (Time Driven Activity-Based Costing) - A methodology that calculates the costs of healthcare resources consumed as a patient moves along a care process (Martin, et al., 2018).

Upside Risk (also known as one-sided risk) – Upside risk includes value-based payment models where the provider only shares in savings and not the risk of loss. For example, if the actual total cost of care of patients assigned to a physician's practice are lower than projected budgeted costs, the practice receives a bonus payment (shared savings). If, however, the total cost of care of patients assigned to a physician's practice are higher than projected budgeted costs, the practice would not be penalized financially in an upside-only risk payment model (American Academy of Pediatrics, 2019).

Value-Based Healthcare (VBH) - A healthcare delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes. (NEJM Catalyst, 2017) Value-based programs reward health care providers with incentive payments for the quality of care they give to people with Medicare (U.S. Centers for Medicare & Medicaid Services, 2019).

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