COLLEGE of AMERICAN PATHOLOGISTS

Value-Based Care Glossary

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Accountable Care Organization (ACO): Health care organization that is accountable for the quality of care provided for individual patients and the risk-adjusted cost of providing care for a population of individuals. The organization's incentive payments for providing care are typically based on the organization and/or its providers meeting defined quality of care and cost metrics. ACOs may be made up of a variety of combinations of health care providers including hospitals. Several different models of ACOs exist, including some sponsored and sanctioned by the Centers for Medicare and Medicaid Services (CMS) and others based on contracts with commercial health plans or other government payers.

Advancing Care Information (ACI): A performance category within the Merit-Based Incentive Payment System (MIPS) established under the Medicare Access and CHIP Reauthorization Act (MACRA) that rewards eligible clinicians and groups points based on the meaningful use (MU) of certified electronic health records technology. The CMS renamed MU as ACI in 2016 under MACRA. Under current MACRA requirements, non-patient-facing clinicians do not need to report on this category.

Alternative Payment Models (APM): A model of payment other than simple fee for service; typically such models deploy payment approaches and offer added incentive payments based on the quality, efficiency, and cost of care provided. These models can apply to a specific clinical condition, care episode, or a population. Examples include, but are not limited to ACOs, patient-centered medical homes, and bundled payment arrangements.

Bundled Payment: Originally, a single combined payment for both professional and facility services. A payment more generally is described as "bundled" when it covers multiple healthcare services, particularly when those services had previously been paid for separately. Bundling is a very generic term and it can apply to many different combinations of services. Episode-based payment, case rate, global payment, or package pricing, also refer to bundled payments. Underlying the concept is the reimbursement of health care providers (such as hospitals and physicians) on the basis of expected costs for clinically-defined episodes of care. A bundled payment can involve just one provider or many providers and it can involve two services or dozens of services. A bundled payment that is a "global payment" includes all services from all providers in a single bundle.

Capitation: The per capita (per patient or beneficiary) payment arrangement for providing a specific menu of health services to a defined population over a set period of time. The provider usually receives, in advance, a negotiated monthly payment from the payer. This payment is the same regardless of the amount of service rendered by the provider.[i]

Center for Medicare and Medicaid Innovation (CMMI): The center within the Centers for Medicare and Medicaid Services (CMS) created by the Affordable Care Act to develop new payment and service delivery models. Congress created the center (also known as the Innovation Center) for the purpose of testing "innovative payment and service delivery models to reduce expenditures. . . while preserving or enhancing the quality of care" for Medicare, Medicaid or Children's Health Insurance Program (CHIP) beneficiaries. The Innovation Center's models are organized into the following seven categories: accountable care organizations, episode-based payment initiatives, primary care transformation, initiatives focused on the Medicaid and CHIP population, initiatives focused on the Medicare-Medicaid enrollees, initiatives to accelerate the development and testing of new payment and service delivery models, and initiatives to speed the adoption of best practices. The Innovation Center is also playing a significant role in implementation of the Quality Payment Program created under the Medicare Access and CHIP Reauthorization Act, particularly in the advanced alternative payment model arena.[ii]

Centers for Medicare and Medicaid Services (CMS): The agency of the U.S. Department of Health and Human Services, which administers programs including Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and the Health Insurance Marketplace.[iii]

Clinical Informatics: The application of information management in healthcare to promote safe, efficient, effective, personalized, and responsive care. The data and clinical decision support involved in this field are developed for and used by clinicians, patients, and caregivers for the benefit of individuals, institutions, populations and communities. The field includes methods to collect, store and analyze health care data, the study of information needs and cognitive processes and optimal ways to meet those needs, methods to support clinical decisions including active decision support, optimizing the flow of information and coordinating it with care providers' and patients' workflows to maximize patient safety and quality, methods and policies for information infrastructure, including privacy and security.[iv]

Clinical Integration: The coordination of care across a continuum of services, potentially including preventive, outpatient, inpatient acute hospital care, post-acute including skilled nursing, rehabilitation, home health services, and palliative care to improve the value of the care provided. The term describes the integration of clinical information and healthcare delivery services from distinct entities with a focus on quality, value, and population health management.[v]

Clinical Laboratory Utilization Committee: An interdisciplinary team of pathologists and clinicians who communicate at the institution or health system level to determine appropriate laboratory ordering practices, guidelines and interventions for efficient and effective outcomes. To access examples of clinical laboratory utilization committees, click here.

Clinical Practice Improvement Activities (CPIA) or Improvement Activities (IA): A performance category within the Merit-Based Incentive Payment System (MIPS) established under the Medicare Access and CHIP Reauthorization Act (MACRA) that awards points to eligible clinicians and groups based on their participation in a menu of activities CMS produces from which they can select. Unlike the other three MIPS performance categories, CPIA is a new element of Medicare quality reporting introduced under MACRA. While at launch of the program, CMS referred to the efforts as CPIA, it has now shortened the terminology to IA.

Data mining: The process of sifting through very large data sets to discover patterns and use those patterns to forecast or predict the likelihood of future events, or understand past or current conditions. In the health care context, its goal is to enable health systems to systematically use data and analytics to identify inefficiencies and best practices that improve care and reduce costs. Data mining uses artificial intelligence techniques and advanced statistical tools to reveal trends, patterns, and relationships, which might otherwise have remained undetected.[vi]

Diagnosis-related groups (DRGs): The statistical system of classifying an inpatient stay into groups for purposes of payments. The groupings determine how Medicare, some states and many health insurance companies categorize hospitalization to determine reimbursement for the inpatient care provided to patients. Medicare pays a fixed amount corresponding to the DRG group assigned to a given patient. Factors used to determine the DRG payment include the diagnosis involved as well as modifiers reflecting expected hospital resources necessary to treat the condition.

Electronic health record (EHR) system: A computer-based medical record system that provides for the capture of patient data (medical and treatment history, diagnoses, medications, immunization dates, allergies, radiology images, and laboratory and other test results) from multiple sources and is used as the primary source of information to support clinical decision making at the point of care.

Episode of Care: All the care and services provided to treat a specific diagnosis or condition within a defined time frame.

Expected Payment: The payment amount that a practice expects to receive from a payer based on negotiated terms. Practices use this information to compare actual payments against expected payments to determine instances of under or overpayments.

Fee for service: A payment method under which healthcare providers are paid separately for each individually designated service that is provided.

Fee schedule: Specific charges or allowances for procedures and services, generally a complete listing.

Global Fee: The fee that includes both the Professional Component (PC) and the Technical Component (TC).

Meaningful Use EHR Incentive Program (MU): The commonly used term for the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record (EHR) Incentive Program. It arose from the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub.L. 111–5) that was enacted on February 17, 2009 and established incentive payments to eligible professionals, eligible hospitals, critical access hospitals, and Medicare Advantage Organizations to promote the adoption and meaningful use of interoperable health information technology (HIT) and qualified electronic health records (EHRs). In 2016, CMS renamed this program "Advancing Care Information," as a component of the Merit-Based Incentive Payment System component of the Quality Payment Program (QPP) under the Medicare Reauthorization and CHIP Reauthorization Act (MACRA).[vii]

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): A law passed with bipartisan support in 2015 intended to fundamentally change the way clinical services rendered to Medicare beneficiaries are evaluated and paid. These changes together are now referred to as the Quality Payment Program (QPP) and are designed to move toward a goal of paying for value over volume. The changes under MACRA will go into effect over a timeline from 2017 through 2022 and beyond. The MACRA made three important changes to how Medicare pays for services rendered to beneficiaries: 1) ended the Sustainable Growth Rate (SGR) formula for determining Medicare payments for health care providers' services; 2) created a new framework for rewarding health care providers for meeting quality and cost-effectiveness metrics; and 3) combined the existing CMS quality and cost-effectiveness reporting incentive programs into one new system. Under MACRA, providers and provider organizations will be assigned to one of two payment pathways, the Merit-Based Incentive Payment System (MIPS, the default under the law) or Alternative Payment Models.

Merit-Based Incentive Payment System (MIPS): Part of the Centers for Medicare & Medicaid Services (CMS) Quality Payment Program (QPP) or pay-for-performance system created by Medicare Access and CHIP Reauthorization Act (MACRA). This system consolidates three existing CMS quality programs: Meaningful Use of electronic health records (EHR), the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier (VM) with a new program of Clinical Practice Improvement Activities into a single pay-for-performance program. The QPP changes Medicare's payment methodology by incorporating physician-submitted data, providing performance feedback, and determining MIPS scores to adjust payments. MIPS focuses on these four categories, assigning providers a composite score based on their performance, which will serve as a modifier for their Medicare Part B reimbursements. The categories are: 1) Quality (formerly PQRS), 2) Resource Use/Cost (formerly VM) 3) Clinical Practice Improvement Activities (CPIA; a new category), and 4) Advancing Care Information (Meaningful use of a certified EHR). MIPS will assess the total performance of each MIPS eligible clinician (EC) according to national performance standards annually beginning in 2017. Beginning in 2019,

physicians will receive either increases or decreases in their payments under the Medicare Physician Fee Schedule based on their performance. Two pathways exist under MACRA, MIPS and alternative payment models (APM). MIPS is the default pathway unless a provider meets an exemption for MIPS or qualifies for payment under an advanced APM.[viii]

Narrow Networks: A strategy employed by health insurance companies (payers) that limit the number and types of physicians that are included in their network. In return, those physicians "in the network" typically extend greater discounts to the payer and receive greater numbers of patients.

Network Provider: A healthcare provider who has a contractual relationship with a health insurance company and is considered a participating provider. Among other things, this contractual relationship may establish administrative requirements and procedures as well as allowable charges for specific services.

Out of network (OON): Healthcare services delivered by a provider who is not part of the health plan's network of providers that a patient is incentivized or required to use. Typically, patient financial responsibility is greater if care is received from an out-of-network provider.[ix]

Participating Provider: Generally, this term is synonymous with Network Provider. However, not all healthcare providers contract with health insurance companies at the same level or for all of a payers' products.

Patient-Centered Medical Home (PCMH): A team-based model of care intended to provide comprehensive and continuous medical care to patients with the goal of maximizing health outcomes and improving access to health care, patient satisfaction and health. The PCMH is responsible for providing or arranging care with other health care professionals for all of a patient's health care needs including preventive services and treatment of acute and chronic illness. Care coordination is an essential component of the PCMH. A team of health professionals under the PCMH model is expected to work collaboratively to achieve access, communication, integration and patient safety. PCMHs typically not only emphasize but also incentivize these features.

Pay for performance (PFP or P4P): An incentive system offered by some payers to healthcare providers based on their quality practices and/or outcomes or other factors. P4P programs come in a variety of forms based on the payer. Examples include Medicare's Quality Payment Program (QPP). Some other programs offer financial incentives to providers who can meet evidence-based standards of care for particular conditions, such as heart disease, asthma and breast cancer screening that may exist both in government and private health plans or programs.[x]

Payer mix: A quantitative method to calculate the percentage of billings that each payer represents of the practice's total billing generally expressed as (Total Billing Payer by payer) / (Total Practice Billing).

Physician Quality Reporting System (PQRS): A reporting program that encouraged individual eligible professionals (EPs) and group practices to report quality metrics to the CMS on their Medicare patients. 2016 was the last program year for PQRS. The program has been consolidated with other existing Medicare quality measurement programs and replaced with Medicare's Quality Payment Program (QPP) under the Medicare Access and CHIP Reauthorization Act's (MACRA) Merit-Based Incentive Payment System for 2017.[xi]

Physician Value-Based Payment Modifier (VBM): An adjustment that provides for differential payment to a physician or group of physician under the Medicare Physician Fee Schedule (PFS) based on measures of quality and cost of care furnished during a performance period. The VBM was established under the

Affordable Care Act as part of the Centers for Medicare and Medicaid Services' move toward rewarding value rather than volume in the Medicare program. Specifically, it is used to adjust Medicare payments for items and services under the Medicare PFS. The VBM is an adjustment made on a per claim basis to Medicare payments for items and services under the Medicare PFS. It is applied at the Taxpayer Identification Number (TIN) level to physicians (and beginning in 2018, to non-physician eligible professionals (EPs) billing under the TIN. The VBM is amongst the existing CMS quality measurement programs that will be consolidated for the 2017 performance period into the Quality Payment Program. The value modifier will become the Resource Use/Cost component under the Merit-Based Incentive Payment System.[xii]

Population health management: An approach to health care delivery that aims to improve the overall health outcomes of a defined population of individuals, based on the preservation of health, prevention of disease, and management of acute and chronic disease among members of the group. It typically relies on the aggregation of patient data across multiple health information resources, and analysis of data and actions through which care providers can improve both clinical and financial outcomes.[xiii]

Population health: The overall health outcomes of a defined group of individuals, based on the preservation of health, prevention of disease and management of acute and chronic disease among members of the group.

Population-based payment: A term used to describe the acceptance of responsibility for the health of a group of patients in exchange for a set amount of money. This form of payment may also include the ability to keep a portion of savings generated if quality of care targets are met. Depending on the structure of the payment, a provider may be responsibility for deficits or costs that exceeded a designated target.[xiv]

Predictive Analytics: The use of technology and statistical methods to search through large amounts of data in order to analyze and predict outcomes for individual patients. The information processed typically includes data from past treatment outcomes, individual symptoms, and peer-reviewed medical research and data sources. Health care predictions can range from responses to medications to hospital readmission rate. Examples include predicting infections, determining the likelihood of disease, helping a physicians with diagnosis and even predicting future health.[xv]

Quality Category: The performance category under the Merit-Based Incentive Payment System (MIPS) that was formerly known as the Physician Quality Reporting System or PQRS.

Quality Payment Program (QPP): The program that changed Medicare Part B payments for more than 600,000 clinicians across the country under the Medicare Access and CHIP Reauthorization of 2015 (MACRA) which ended the Sustainable Growth Rate formula. If clinicians do not qualify for an exemption under MACRA, they choose how they will participate in the program based on their practice size, specialty, location, or patient population. The QPP offers two tracks from which physicians can participate, 1) the Merit-based Incentive Payment System (MIPS) or 2) qualifying Advanced Alternative Payment Model (AAPM) participation. MIPS is the default for clinicians participation unless they qualify for AAPM participation, through participation in an innovative payment model CMS has identified under MACRA. Those participating in an AAPM may earn an incentive payment. Those participating in MIPS will earn a performance-based payment adjustment, positive or negative.

Resource Use: One of the four performance categories under the Merit-Based Incentive Payment System (MIPS) that replaces what was the value-based modifier and is intended to measure the number and intensity of services, tests and treatments provided to beneficiaries. The result is expressed in dollars compared to expected expenditures for each measure adjusted for both geographic differences and

beneficiary risk factors. This category is the only one of the four performance categories under MIPS that does not require reporting by the clinician. All data will be generated from Medicare administrative claims. This category will not be scored for 2017.[xvi]

Risk adjustment: A statistical process that attempts to take into account the known and latent comorbid conditions of a patient cohort when comparing health care outcomes or health care costs.

Risk Scoring: A numeric value assigned to a particular patient in a risk adjustment system that indicates the relative level of spending that is expected for that patient and/or the relative level of quality or outcomes that can be expected in the delivery of care to that patient relative to other patients.[xvii]

Risk Stratification: A process of identifying, predicting, and separating patient populations into high-risk, low-risk, and likely to be at high risk (or rising-risk group) to assist in population health management activities.[xviii]

Shared Savings: A payment strategy that offers incentives for provider entities to reduce health care spending for a defined population by offering them a percentage of any net savings realized as a result of their efforts. Shared savings can be applied to some or all of the services that are expected to be used by a patient population. The concept attracted increased attention in 2011, in part fueled by provisions within the Affordable Care Act that created accountable care organizations (ACOs). Specifically, the creation of the Medicare Shared Savings Program for ACOs, beginning in 2012, calls for shared savings as a primary incentive methodology. Shared savings arrangements have also been deployed by commercial insurers and other payers.[xix]

Sustainable Growth Rate (SGR): A method used by the Centers for Medicare and Medicaid Services (CMS) to define the annual conversion factor update by Medicare for physician services. The bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended use of the SGR.

Value-Based Care: Generically, care that is based on the quality and appropriateness of the care provided. The “value equation” is often expressed as Value = Quality/Cost. This is the basis of much of health care reform over the past 15 years and is premised on the Institute for Healthcare Improvement’s Triple Aim and the move to more integrated team-based care provided through alternative payment models that reward “value” over simple volume. The Triple Aim is focused on simultaneous pursuit of improving the patient experience and the health of populations while reducing the per capita cost of health care. In the movement from volume to “value,” the Department of Health and Human Services devised a continuum marked by four categories, as follows:

- Category 1—fee-for-service with no link of payment to quality
- Category 2—fee-for-service with a link of payment to quality
- Category 3—alternative payment models built on fee-for-service architecture
- Category 4—population-based payment

Vulnerable patient populations: Populations characterized by demographics (social determinants) or chronic disease that put them at an elevated risk for poor health outcomes.[xx]

Acronyms and Abbreviations

ACI: Advancing Care Information

CMS: Centers for Medicare and Medicaid Services

CMMI: Centers for Medicare and Medicaid Innovation

CPIA: Clinical Practice Improvement Activities

ACO: Accountable Care Organization

MSSP: Medicare Shared Savings Program

PCMH: Patient Centered Medical Home

MU: Meaningful Use

P4P (PFP): Pay for Performance

MACRA: Medicare Access and CHIP Reauthorization Act of 2015

QPP: Quality Payment Program

APM: Alternative Payment Model

EHR: Electronic Health Record

MIPS: Merit-Based Incentive Payment System

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