Payment Glossary of Terms

Excerpted from the Value-based Payment Toolkit, Center to Advance Palliative Care

Accountable Care Organization (ACO) – a group of providers organized to take responsibility for the overall quality of care and the total cost of all the health care services needed by a group of patients over a period of time. An Accountable Care Organization is not a *payment model*; it is an *organizational structure* designed to accept accountability for care delivery quality and costs.

Actuary (and Actuarial Models) – a business discipline that deals with the measurement and management of risk and uncertainty. Using financial models based on historical utilization and claims-based diagnoses, an actuary can predict ranges of expected cost for different populations. These models can also be adapted to incorporate assumptions that change the projected utilization from the historical utilization.

Note that actuarial models use Population Management assumptions to modify cost predictions. The model lowers the expected cost when mechanisms are in place to better manage a population. The Milliman Medical Index (MMI) is one actuarial tool that factors in a continuum calculation from loosely-managed to well-managed health care.

Admits per Thousand (APK) – the number of hospital admissions per thousand patients per year. This is a common measure that payer-provider partnerships use to track the intersection of cost and quality. In palliative care, this is often a better measure than readmission rate.

To calculate APK, take the number of hospital admissions a practice's patients have in a year, divided by [the total number of patients seen by the practice in a year divided by 1,000]: admissions/(patients/1,000). In a practice that sees 500 patients annually and experiences 100 admissions, the APK is 200. The APK is a measure of provider effectiveness in avoiding hospitalizations. The overall United States APK is 104, and in 2013 the Medicare 65+ population's APK was 271.

Advanced Alternative Payment Models (AAPM) – a designation for certain alternative payment models (APMs) under the Medicare Access and CHIP Reauthorization Act (MACRA) which enables participating providers to bypass much of the Medicare quality reporting burden and receive an automatic 5 percent bonus payment. Advanced APMs must accept more than nominal downside financial risk, evaluate their participating providers on evidence-based quality metrics and require their providers to use certified electronic health records.

Adverse Selection – situation in which high-risk persons actively seek out more generous products or plans to meet their needs, resulting in a disproportionate share of costly beneficiaries in certain plans. This could lead to unduly high utilization patterns that put plan sustainability at risk.

Affordable Care Act (ACA) – a federal law passed in 2010 which, among other things, required additional consumer protections for health insurance; created state marketplaces (exchanges) to purchase individual insurance; and established the Center for Medicare and Medicaid Innovation (CMMI) to conduct demonstrations and implement innovative models of care that advance quality and cost-effectiveness.

All-Payer Claims Database (APCD) – state-managed databases which collect claims data from Medicare, Medicaid and in many instances, commercial payers. States use APCDs to analyze and understand health care costs across the entire state population. A consolidated set of utilization and cost data enables a full picture of how health care is being delivered, and provides insights into opportunities to improve value.

Alternative Payment Model (APM) – the method of paying for services in which providers choose to receive rewards and penalties for quality and cost outcomes. It differs from the standard fee-for-service schedules for each defined encounter or procedure in one of two ways: a) the provider's ultimate earnings are enhanced or reduced by their quality and/or cost outcomes; or b) the provider's ultimate earnings are dependent upon the difference between actual costs and target costs.

According to the Medicare and CHIP Reauthorization Act of 2015 (MACRA) statute, APMs are defined as: CMMI models, the Medicare Shared Savings Program, programs under the Health Care Quality Demonstration program and payment demonstrations required by federal law.

Attribution – a process for determining which provider(s) will be held responsible for one or more specific aspects of the cost or quality of a patient's care, in the absence of an explicit signal from the patient or a particular provider. A common way to attribute patients uses prior claims history to identify a primary care or treating provider relationship.

There are several ways to attribute patients to the responsible provider(s), which vary according to whether the process is prospective or retrospective, as well as the number of levels in the algorithm. Attribution is used in Medicare ACOs to determine which single provider is responsible for the total cost and quality of care. Attribution will also be used to evaluate certain providers' costs based on episodes of care as part of the Resource Use measurement under MACRA.

While attribution can be a complicated process, its intent is simple: to ensure that a provider is held responsible only for the outcomes and cost of the appropriate patients.

Benchmark – a measure of spending or quality that a provider must achieve in order to qualify for a payment bonus or penalty. Benchmarks often work as targets for performance. In addition, the payment adjustment may be proportional to the amount of difference between the provider's performance level and the benchmark level.

Benchmarks are often set to the average of that measure in a geographic area or specific population, or the measure from a prior time period. Some examples of common benchmarks in use include: hospital utilization rates; total 90-day costs; vaccination rates; and minimum satisfaction scores.

Benefit Design – a set of rules in a health insurance plan that describes which types of health care services will be covered by the plan, the providers from which a member of the plan can receive a covered service, the cost-sharing amounts that a member of the plan will be responsible to pay when receiving a service and any other requirements or restrictions on how or when the plan member can receive covered health care services. Benefit design is used to both control the predictability of costs and to encourage or discourage certain behaviors by members.

Bundled Payment (aka Bundling) – a general term for combining a range of services into a single payment. A common use of the term is meant to combine payment across providers for a single episode of treatment (such as a joint replacement procedure), including the services for addressing complications, and often, post-treatment aftercare.

Bundled Payment for Care Improvement (BPCI) – a term specific to CMS's demonstration program investigating Medicare bundled payment. A retrospective reconciliation is made between actual Medicare claims to a pre-determined target price covering a period of time of either 30, 60 or 90 days. BPCI has four Models. Model 2, bundling the initial hospital admission with post-acute care, is the most common.

Capitation (Global; Partial; Condition-Specific) – a payment model in which a health care provider is paid based on the number of individuals cared for, rather than on the number of services provided to those individuals. In Global Capitation, the provider is expected to cover the costs of all needed health care services, while a Partial Capitation payment covers a specific menu of services or the services delivered by a

subset of providers. Condition-Specific Capitation is a global capitation, but only for care directly related to a particular diagnosis. Payment is typically per member per month or per member per year (see below).

Care Management (sometimes called Case Management or Care Coordination) – terms applied generally to payer and provider staff who help members get the right care at the right time in the right setting. The goal of Care Management is to reduce gaps in services or missed information through poor handoffs among multiple providers, while simultaneously preventing illness exacerbations and service overutilization.

Carve-Outs – a set of services that is paid for in a way that differs from the way payment is made for other services. For example, a provider may be paid through Global Capitation, but specified services (such as Transplant) are excluded or carved-out from the arrangement.

Case Rate – a term describing a single payment for all or most of the services a provider delivers for a particular patient case. The definition of case is left to the payer and provider to negotiate, and depending on the definition, it can overlap with Partial Capitation.

Center for Medicare and Medicaid Innovation (CMMI) – an office within the Centers for Medicaid and Medicare Services (CMS) that is responsible for constructing and testing new care delivery and payment models. Models under the CMMI authority are considered Alternative Payment Models in the MACRA law.

Comprehensive Care for Joint Replacement (CCJR) – the first bundled payment program under Medicare that is mandatory (in 20 markets, to start). It covers a period of 90 days starting at a hospital admission for a joint replacement surgery.

Comprehensive Primary Care (CPC and now CPC-Plus) – a CMMI program that brings all payers together to support primary care providers in population management, especially in: risk-stratified care management; planned care for chronic conditions and preventive care; shared patient-provider decision making; 24/7 access; and coordination of care across the medical neighborhood. In CPC, providers are paid fee-for-service (FFS), but receive an additional per member per month (PMPM) payment for care management as well as shared savings if costs are lower than budgeted. CPC-Plus introduces additional tracks that enable risk-sharing and prospective payment. Importantly, CPC-Plus is considered an Advanced Alternative Payment Model (AAPM) under the MACRA payment rules.

Concierge Medicine – a model of care delivery by a physician practice that provides more time with patients and more rapid response to requests for assistance than is possible under typical fee-for-service (FFS). Characteristics often include longer office visits, unlimited phone calls and 24-hour access to a physician. There is typically an annual fee for concierge care in addition to fees for individual services.

Consumer Assessment of Health Performance and Satisfaction (CAHPS) – A validated survey that asks consumers to rate their experiences receiving care in a variety of health care settings; there is also a specific CAHPS for consumers to rate their health plan. The survey is managed by the Agency for Healthcare Research and Quality (AHRQ), which also manages a database of results that allows for the creation of benchmarks and analysis.

Because patient satisfaction is such a key measure of quality of care, the CAHPS survey has been continually adapted and is now utilized (mostly by CMS) in many settings, including hospital, home health, nursing home, hospice, clinical group and dialysis.

Credentialing – the process of verifying the qualifications of providers by reviewing educational, licensing and malpractice history. Payers often add additional qualification requirements when they establish Narrow Networks or Centers of Excellence; palliative care certification can be an advantage for inclusion in these narrow networks.

Delivery System Reform Incentive Program (DSRIP) – a Medicaid option in which selected states receive additional federal monies for their Medicaid program to support targeted and measurable efforts to

transform their Medicaid delivery system. In most of the participating states, the DSRIP funds are intended to help hospitals and other providers transition their processes to manage Medicaid populations proactively rather than reactively.

Direct Contracting – an arrangement between a purchaser (often an employer) and a provider to deliver health care services for its members for a negotiated payment amount. It is a direct contract between the purchaser and provider only, without a health plan serving as an intermediary.

Disease Management –a type of care management service that is focused on a particular diagnosis; the main goal is to ensure that the patient/member receives evidence-based care for that disease. Disease management becomes difficult and relatively ineffective when patients/members have multiple diseases and/or social issues that impact their health and health care utilization.

Downside Risk – See Upside and Downside Risk.

Dual-Eligible (aka Dual) – an individual who is eligible for both Medicare and Medicaid. While both Medicare and Medicaid are federal health insurance programs, overall, Medicare eligibility is based on age and Medicaid is based on income (means-tested). Thus, low-income older adults and low-income adults with disabilities are dually eligible for both types of insurance. Dual-eligibles have disproportionately higher levels of morbidity and disability than their Medicare-only counterparts.

Episode (of Care) – either: a) the care delivered during a fixed period of time (as in a bundled payment period that lasts 30, 60 or 90 days); or b) the complete set of services related to a condition or procedure (such as a chemotherapy episode that covers the entire round of chemotherapy along with all other health care services given during that same time period).

Fee-for-Service (FFS) – a payment system in which a provider bills and is paid for each individual encounter, service or procedure that is performed. For example, if a patient comes to an office with a potential bacterial infection and an advance care plan conversation is held, the provider bills and receives reimbursement for: the office visit, the venipuncture, the laboratory testing and an advance care plan discussion.

Gain-sharing – a payment made by a risk-holding provider to another provider if the risk-holding provider experiences savings or higher profits due to actions taken by the second provider.

Global Payment (aka Global Capitation) – See Capitation.

Health Effectiveness Data and Information Set (HEDIS) – a recognized set of quality measures that is used to create public information about a health plan. HEDIS is used by more than 90 percent of American health plans and is managed by the National Committee for Quality Assurance (NCQA). For Medicare Advantage plans, their scores on the HEDIS measures impact the payment that they receive to cover the costs of their enrollees. Palliative care providers can have an impact on a plan's HEDIS scores.

Health Risk Assessment (HRA) - questionnaires conducted by health plans with their members as a way to identify people at risk of becoming ill and costly. HRAs ask members to assess their health status across a variety of dimensions, such as functional impairment, family history, lifestyle, nutrition, behavior and social support, with the goal of generating a more complete picture of the enrollee. HRAs are able to identify health behaviors and risk factors that would not be picked up in claims data. Note that HRAs are required by CMS for all Medicare Advantage programs.

Hierarchical Condition Categories (HCCs) – a scoring algorithm used by CMS to risk-adjust payments to Medicare Advantage plans. The HCC system assigns weights to specific diagnoses reported on claims forms for an individual patient during the *preceding* year. These weights are aggregated in order to calculate a single numeric Risk Score for that patient. Only diagnoses that have been shown to drive future spend

(spending?) have an HCC score; for example, congestive heart failure has a weight, but hypertension does not. Palliative care providers can have an impact on the HCC risk score.

Independence at Home (IAH) – a CMMI Demonstration to test the cost-effectiveness of delivering comprehensive primary care services at home for Medicare beneficiaries with multiple chronic conditions and past hospitalization. IAH practices that achieve the quality measures and cost targets receive incentive payments. After the first year, most IAH practices had achieved nearly all of the quality measures and the vast majority also achieved significant cost savings.

Independent Practice Association (IPA) – an organization consisting of two or more independent physician practices that have the ability to jointly contract for payment.

Index Score – refers to either the target or the expected average of an indicator, such as total spending, from which Risk Adjustment or other adjustments are made. An index of 1.0 is the expected mean and median for the total population, so that an index score of, say 1.3, means your population's complexity or risk is above the average, and scores less than 1 mean below average.

Medicaid – a federal-state partnership health insurance program that is means-tested, or limited to people with incomes below a certain amount. The services covered, the amount paid and many other details of how Medicaid operates are determined by the individual state, although all programs must comply with certain federal requirements (e.g., mandatory benefits, anti-discrimination). For eligible beneficiaries, Medicaid covers long-term care services, including nursing homes and home-based personal care services.

Medical Home (aka Patient-Centered Medical Home or PCMH) – a way of practicing such that the entire patient population served in a primary care practice is proactively managed with attention to both quality and cost. Key features include a designated provider for each patient, expanded access and systems and processes to coordinate care and follow-up on referrals and key events. To be recognized as a PCMH, a practice must receive accreditation as such.

Medical Loss Ratio (MLR) – the ratio of health plan spending on medical care (in the numerator) to total health plan premium income (in the denominator). Under the Affordable Care Act, health plans must achieve an MLR of at least 80 – 85 percent (depending on the population), or the plan is required to provide a rebate of the difference to its members.

Medicare Access and CHIP Re-Authorization Act (MACRA) – a federal law passed in 2015 that repealed the Sustainable Growth Rate (SGR) and created incentives to advance value-based payment. Among other things, the law established a new Quality Payment Program (QPP) which governs how eligible clinicians in Medicare will be evaluated for bonus payments and penalties. The QPP has two tracks: MIPS and APMs. Please see those definitions for more information.

Medicare Advantage (MA) – aka Medicare Part C, a private health insurance plan that enrolls Medicare beneficiaries and covers their health professional and facility costs in exchange for a premium paid by the federal government. Medicare beneficiaries who enroll in a Medicare Advantage plan agree to have their health care payments determined by this private plan, and so waive their rights to participate in traditional Medicare. Note that the Medicare Hospice benefit is not currently included in Medicare Advantage (hospice carve-out). Beneficiaries can enroll and dis-enroll in Medicare Advantage plans only during the open enrollment period which lasts from October 15 to December 7 each year.

To help protect Medicare beneficiaries that are enrolled in these private health plans, CMS collects a variety of quality measures (including using HEDIS and CAHPS) to evaluate plans, and this evaluation – ranked from 1 to 5 stars – is publicly available.

Medicare Parts A, B, C and D – a federal health insurance program that covers people over the age of 65, as well as individuals with disabilities and end-stage renal disease, regardless of their income. Benefits are

divided into categories based on what is paid for. Part A usually pays for facility services (hospitals, hospices, some certified home health agency care and skilled nursing facilities); Part B pays for professional services (MDs, APRNs and some mental health professionals); Part C pays for the premiums to Medicare Advantage plans; and Part D pays for medications.

Member-Months – refers to months that a patient/member is included in payment calculations (rather than counting the number of patients). For example, if a patient dies in the 9th month of a contract, s/he only contributes 9 member-months.

Merit-based Incentive Payment System (MIPS) – a new payment track created under MACRA that uses a fee-for-service (FFS) architecture, but introduces positive or negative payment adjustments to providers based on eligible clinician performance in four categories: a) Quality as determined by performance on quality measures; b) Resource Use as determined by total per capita costs, Medicare spending per beneficiary and relevant episode groups (CMS calculates using claims data and attribution algorithms); c) Advancing Care Information as determined by use of Certified Electronic Health Record Technology (CEHRT); and d) Clinical Practice Improvement Activities (CPIA) as determined by completion of specific activities intended to improve. Each category is weighted differently, and these weights will change over time. CMS takes the scores from the four categories to calculate a composite performance score (CPS), which is then compared to a national benchmark to derive the ultimate payment adjustment.

Network (and Narrow Network) – consists of two or more providers who will deliver services to the population in return for agreed-upon payment. Payment may only flow if the provider is credentialed to be in-network. Narrow Networks are the same, but include only those providers who have met *additional* criteria for quality and cost.

Obamacare – a slang term for the federal Affordable Care Act. See Affordable Care Act.

Oncology Care Model (OCM) – a CMMI demonstration in which participating physician practices administering chemotherapy receive: a) a performance-based payment for OCM episodes (each episode lasting up to six months); and b) a $160 per-beneficiary-per-month (PBPM) payment to assist with care coordination. Currently, the model includes only upside risk; however, in 2018 OCM participants will have the option of accepting downside risk.

Patient-Centered Medical Home – See Medical Home.

Pay for Performance (P4P or Pay for Achievement) – a payment model where the amount paid to providers for services rendered is adjusted based on one or more measurable aspects of their performance.

Per Member Per Month (PMPM or PBPM (Per Beneficiary Per Month) for Medicare and Medicaid populations) – a fixed amount per patient that is paid to a provider each month for a defined set of services. PMPM is the typical payment under capitation, tying payment to accountability for a population's outcomes rather than to a quantity of services.

Per Member Per Year (PMPY or PBPY (Per Beneficiary Per Year) for Medicare and Medicaid populations) – same as PMPM above, but the time frame is yearly.

Population Management – an approach to care delivery that is designed to help individuals for whom a provider has contractual obligation to achieve maximum health outcomes. For example, population management activities include conducting proactive efforts to encourage prevention, prospectively identifying and supporting high-risk members and managing chronic conditions closely.

Potentially Preventable Event (or Admission or Re-Admission) – a patient event or admission that could potentially have been avoided if care had been delivered differently; for instance, an amputation due to uncontrolled diabetes. Quality measurement systems are designed to capture these events. Ambulatory

sensitive admissions, which include hospital stays for conditions such as dehydration, are a subset of potentially preventable events, and are still used as quality measures to assess a provider's performance.

Premium – the total monthly payment that a health plan receives from the buyer of the insurance. It is the price paid for the coverage of the risk, and it is paid on a per-person basis. For example, an individual buying insurance coverage for himself and his spouse might pay two premiums of $600 per month each. Often, there is a different premium for single and family coverage. Premiums are calculated by actuaries so that expected health care costs plus administrative expenses are less than the premium. See the definition of MLR.

Primary Care – A type of health care service that includes preventive care, as well as diagnosis and treatment of acute and chronic illnesses, by a personal provider. While not required, the provider often collaborates with a team that helps support patients' referrals to consultants, specialists and sometimes supportive services. Often, providers that work in internal medicine, family medicine, pediatrics, geriatrics and obstetrics and gynecology are considered primary care providers.

Prospective Payment – a fixed price determined ahead of time for a service or group of services, which is not adjusted based on actual experience. Hospitals have increasingly been paid with prospective payment, receiving a single pre-determined payment (diagnosis-related group or DRG) for each inpatient stay based on the patient diagnostic and procedural classification during his/her stay. Another example of prospective payment is in ambulatory surgery, where a single price is paid for, say, an appendectomy regardless of how long the procedure takes or the number of support staff involved.

Quality (and Quality Measures) – objective observation of processes or outcomes that are integral to ensuring value in health care. Payers are increasingly tracking quality based on providers' performance on specific indicators, often with a defined numerator and denominator. According to the National Academy of Medicine (formerly the Institute of Medicine), quality care is care that is safe, timely, efficient, effective, equitable and patient-centered. An example of a Quality Measure is the percentage of adults in the population over the age of 65 (and without a contraindication) who received a flu shot.

Reconciliation – implementation of a value-based payment model in which providers receive preliminary payments, typically through fee-for-service (FFS), and then the total of these payments is compared to the prospective or target payment amount for the episodes or populations. Any discrepancies in these amounts are adjusted through a positive or negative transfer of funds so that the provider ultimately receives only the prospective amount.

Reinsurance (aka Stop-Loss Insurance) – a policy designed to limit losses to a specific amount. Coverage can be written for catastrophic claims (specific stop-loss) or numerous claims (aggregate stop-loss). This type of coverage may be difficult or expensive for health care providers to obtain.

Retrospective Payment – a payment that is furnished to providers based on what services they have provided. A provider will treat a patient and submit an itemized bill to an insurance company detailing the services rendered. The insurance company, in turn, may approve or deny payment for the treatment or portions thereof, but health care providers get paid for their services after the service has occurred.

Risk Adjustment – calculations used in payment models to avoid holding providers accountable for factors they cannot control, such as socio-demographic characteristics or co-morbid conditions. Risk adjustment is also used to pay premiums, and is intended to encourage health plans to accept enrollments of older and sicker individuals.

Risk Corridor – means by which a provider's loss and gain are limited to specific amounts or percentages, as protection against undue financial swings. Providers' bonus payment will be limited if their actual savings are greater than the upside corridor and conversely, their losses will be limited if their actual losses are greater than the downside corridor.

Risk Score (aka Risk Adjustment Factor or RAF) – a factor in risk adjustment, where an individual patient/member/beneficiary is assessed and assigned a value that is incorporated into the risk adjustment calculation. The Medicare Advantage risk adjustment process uses each member's Risk Score to determine the premium payment, relying on the HCCs.

Shared Risk – See Upside and Downside Risk.

Shared Savings (and First Dollar Shared Savings) – a model in which providers are given a proportion of the savings if their actual costs are less than an established benchmark. In some instances, providers must meet an additional threshold above the benchmark before they share in savings; however, First Dollar Shared Savings are calculated by subtracting the actual spending from the benchmark. There is no downside risk in a shared savings program.

Stop-Loss Insurance – See Reinsurance.

Threshold, Achievement or Improvement – a level of performance which a provider must reach in order to receive a payment increase or avoid a penalty. A threshold may be set for cost, for quality or for both.

Two-Sided Risk – See Upside and Downside Risk.

Underwriting – the process by which a payer works to understand the expected costs of a population, and agrees to guarantee payment in return for a premium.

Upside and Downside Risk (aka Two-Sided Risk aka Shared Risk) – the risk for profit and loss. Accepting upside risk means that a provider is eligible for shared savings if actual costs are lower than the predicted/targeted costs (this is generally considered a positive event). Accepting downside risk means that a provider is responsible for and must repay losses if the actual costs exceed the predicted/targeted costs (this is generally considered a negative event). Accepting two-sided risk means that the provider is responsible for both the upside and the downside risk.

Utilization Management/Utilization Review – the evaluation of the medical necessity, appropriateness and efficiency of the use of health care services, procedures and facilities under the Benefit Design. Providers' experience with Utilization Review often occurs in the form of payment denials.

Value-based Payment – payment for health care services when cost and/or quality measures are factored into payment determinations for providers.

Withhold, Withhold Pool – a portion of the payments to providers that is held back, and paid to providers only at the end of the specified time period if performance targets and thresholds are met. Sometimes these amounts are pooled across providers and paid only if the provider group as a whole achieves predetermined targets.