Value-Based Care Dictionary

Acronym	Term	Definition
General		
ACA	Affordable Care Act	Comprehensive health care reform law enacted in March 2010, addressing health insurance coverage, health care costs, and preventive care.
ACO	Accountable Care Organization	Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients.
APM	Alternative Payment Model	Payment approach that gives added incentive payments to provide high-quality and cost-efficient care.
Attribution		Assignment of the results of a measure to an individual, group, or organization responsible for the decisions, costs, and outcomes.
CIN	Clinically Integrated Network	Selective partnership of physicians collaborating with hospitals to deliver evidence-based care, improve quality, efficiency, and coordination of care, and demonstrate value to the market.
DHHS	Department of Health & Human Services	Department created to protect the health of Americans and provide essential human services.
FFS	Fee for Service	Payment model where services are unbundled and paid for individually.
FQHC	Federally Qualified Health Center	Federally funded health centers that focus on serving underserved populations or areas.
HIPAA	Health Insurance Portability and Accountability Act of 1996	Federal law that ensures protection of sensitive patient health information.
HMO	Health Maintenance Organization	One of four types of Medicare Advantage plans. An HMO generally requires beneficiary to use in-network providers.
MAO	Medicare Advantage Organization	Public or private entity organized and licensed by CMS as a risk-bearing entity.
P4P	Pay for Performance	The payment model in which providers are reimbursed based upon the quality of care provided.
PBPM/PMPM	Per Beneficiary/Member Per Month	Unit of measurement, usually in dollars, to indicate amount per patient.
PCP	Primary Care Provider	Health care practitioner who coordinates, or helps, a patient access a range of health care services.
PFFS	Private Fee-for-Service	Medicare Advantage plan offered by a private insurance company.
PFS	Physician Fee Schedule	CMS rule that updates payment policies, payment rates, and other provisions for services.
PHI	Protected Health Information	Relates to the past, present, or future condition of an individual. Includes demographic data, medical histories, test results, and other information used to identify a patient.
PPO	Preferred Provider Organization	One of four types of Medicare Advantage plan. PPOs allow a person the flexibility of choosing either in- or out-of-network providers.
SS	Shared Savings	Payment strategy that offers incentives for providers to reduce health care spending for a defined patient population by offering them a percentage of any net savings realized.
TIN	Tax Identification Number	Number assigned by IRS for tax purposes.
Quality		
CAHPS	Consumer Assessment of Healthcare Providers and Systems	Survey tool used to ask patients about their health care experiences.
CQM	Clinical Quality Measure	Tools that help measure and track the quality of health care services.
eCQM	Electronic Clinical Quality Measures	Use data electronically extracted from EHRs to measure the quality of health care provided.
HEDIS	Healthcare Effectiveness Data and Information Set	Tool used to measure performance on important dimensions of care and service.
MIPS	Merit-Based Incentive Payment System	Program that determines Medicare fee for service payment adjustments.
NCQA	National Committee for Quality Assurance	Non-profit dedicated to improving health care quality. Maintains HEDIS score and researches quality measures.

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PMPM/PMPY	Per Member Per Month/Year	Refers to the dollar amount paid each month for each individual enrolled in a managed care plan, often referred to as capitation.
PY	Performance Year	12-month period beginning during the agreement period, unless otherwise specified or noted in the contract.
RAR	Readmission Rate	Percentage of admitted patients who return to the hospital within 7 days of discharge.
WIQM	Web Interface Quality Measure	Clinical quality measures reported by an ACO to Medicare based on the patient population.
		Clinical
ASC	Ambulatory Surgical Center	Health care facility providing same-day surgical care.
ACSC	Ambulatory Care Sensitive Conditions	Conditions for which hospital admission could be prevented by timely and effective outpatient care.
APC	Advanced Practice Clinician	Includes advanced practice registered nurses and physician assistants.
APP	Advanced Practice Provider	Provider who is not a physician but performs medical activities typically performed by a physician. Most commonly a nurse practitioner or physician assistant.
AWV	Annual Wellness Visit	Medicare covers the AWV, a preventive wellness visit.
CCM	Chronic Care Management	Non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more) significant chronic conditions.
DTP	Drug Therapy Problems	Clinical problems related to the use of medications.
EHR	Electronic Health Record	Electronic database that stores confidential patient information.
EMR	Electronic Medical Record	Digital version of a patient's chart.
SNF	Skilled Nursing Facility	In-patient rehabilitation and medical treatment center staffed with trained medical professions.
TCM	Transitional Care Management	Services that address the hand-off period between inpatient and community settings.
TOC	Transitions of Care	Process of transferring a patient's care from one setting or level of care to another.
SDOH	Social Determinants of Health	Conditions in the places where people are born, live, learn, and work that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
HPI	History of Present Illness	Description of development of patient's present illness.
LTC	Long Term Care	Services to meet needs of people with chronic illness or disability who cannot care for themselves for long periods.
		Coding
CDI	Clinical Documentation Improvement	Process of improving health care records to ensure improved patient outcomes, data quality, and accurate reimbursement.
HCC	Hierarchical Condition Category	Medical codes linked to specific clinical diagnoses.
ICD-11	International Classification of Diseases	Medical classification list by the World Health Organization.
RADV Audits	Risk Adjustment Data Validation Audits	Process of verifying diagnosis codes submitted for payment with the support of medical record documentation.
RAF	Risk Adjustment Factor	Medical risk adjustment model used by CMS to represent a patient's health status.
		CMS
CMS	Centers for Medicare and Medicaid Services	Federal agency responsible for administering Medicare and overseeing state administration of Medicaid.
CMMI	Center for Medicare & Medicaid Innovation	The innovation center was created for the purpose of testing "innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care."
GPDC	Global and Professional Direct Contracting Model	Set of two voluntary risk-sharing options aimed at reducing expenditures and preserving quality of care for beneficiaries in Medicare FFS.

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MA	Medicare Advantage	Type of Medicare health plan offered by a private company that contracts with Medicare to provide Part A and B benefits.
MACRA	Medicare Access and CHIP Reauthorization Act of 2015	Changed how Medicare pays physicians who provide care to Medicare beneficiaries.
MBI	Medicare Beneficiary Identifier	Every person with traditional Medicare is assigned an MBI.
MBR/MLR/MER	Medical Benefit Ratio Medical Loss Ratio Medical Expense Ratio	Amount of premium revenue spent on medical care and services.
MIPPA	Medicare Improvements for Patients and Providers Act of 2008	Supports states through grants to provide outreach and assistance to eligible Medicare beneficiaries to apply for benefits programs that help lower cost of their premiums and deductibles.
MIPS	Merit-Based Incentive Payment System	One option of the MACRA Quality Payment Program. Comprised of quality, cost, improvement activities, and advanced care information.
MSPB	Medicare Spending per Beneficiary	Assesses Medicare Part A and Part B payments for services provided to a Medicare beneficiary during a spending-per-beneficiary episode. Evaluates hospitals' efficiency relative to the efficiency of the median hospital.
MSSP	Medicare Shared Savings Program	Voluntary program that encourages doctors, hospitals, and other health care providers to come together as an ACO to give coordinated, high quality care to their Medicare beneficiaries.
NGACO	NextGen or Next Generation	Initiative for ACOs that were experienced in coordinating care for Medicare populations. It allowed these provider groups to assume higher levels of financial risk and reward.
Data + Tech		
CDS	Clinical Decision Support	A health IT system that is designed to provide physicians with clinical decision-making tasks.
CEHRT	Certified Electronic Health Record Technology	EHR that's demonstrated the tech capability, functionality, and security requirements required by DHHS.
HIE	Health Information Exchange	Use of technology to manage current and historical information related to a person's care.
HIT	Health Information Technology	The exchange of health information electronically, with the goal of improving quality of care by reducing costs, errors, and inefficiency.