PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE

Accountable Care Organization Workgroup Glossary

Accountable care organization (ACO)—a group of coordinated health care providers that care for all or some of the health care needs of a defined population. This business model generally focuses on moving away from fee-for-service by creating payment and delivery reforms that tie provider reimbursements to quality metrics, reductions in the total cost of care, and patient satisfaction. [1]

Actuary—a business professional who uses mathematical and statistical methods to study the potential outcomes of uncertain events. These methods are often applied to determining insurance risks and premiums, but can also be leveraged to help providers understand the risk inherent in taking on new payment methodologies. [1]

Affordable Care Act (ACA) (Public Law 111-148) – The ACA was implemented on March 23, 2010 and is intended to increase access to health care for more Americans, and includes many changes that impact the commercial health insurance market, Medicare and Medicaid. ACA is also referred to as the "health reform act" or "Patient Protection and Affordable Care Act" (PPACA).[2]

Attribution—a method of identifying and assigning a provider or provider organization that will be responsible for managing the care of a specific member or population. [1]

Bundled payments—a payment methodology where a provider agrees to manage a defined group of services for a specified price. Already common within hospital payment as a DRG, current bundle payment initiatives are looking to expand services to additional hospital services and post-acute for an episode of care as a means of driving improved clinical integration and transitions management. [1]

Capitation (cap)—a payment approach that defines a specific payment for a specific population for a specific period of time. This payment method is often used in terms of managing the average total cost of care for a defined population for a month, which is commonly referred to as a per member per month (PMPM). This payment model is designed to encourage organizations to manage the cost of patient care by following best practices, eliminating duplication of services, and boosting efficiency. [1]

Centers for Medicare & Medicaid Services (CMS)—a component of the Department of Health and Human Services (HHS), CMS oversees and administers Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and the Clinical Laboratory Improvement Amendments (CLIA). [1]

Centers for Medicare & Medicaid Innovation (CMMI)—Also known as the CMS Innovation Center, CMMI is a division within CMS that was established by the Patient Protection and Affordable Care Act (PPACA) and is tasked with developing and testing innovative care and payment models, such as the Pioneer ACO and Bundled Payment programs. [1]

Chronic care management—the coordination of both health care and supportive services to improve the health status of patients with chronic conditions, such as diabetes and asthma. These programs focus on evidence-based interventions and rely on patient education to improve patients' self-management skills. The goals of these programs are to improve the quality of health care provided to these patients and to reduce costs. [1]

Coinsurance: Coinsurance is a type of charge for covered health care expenses that a member must pay out of pocket according to his or her health plan. Coinsurance is charged as a predetermined percentage of the cost of covered services and is usually applicable after a deductible is met in a deductible plan, such as deductible HMO, preferred provider organization (PPO), point-of-service (POS), and indemnity plans. [3]

Comparative Effectiveness Research – Research that is federally sponsored to compare existing health care interventions to determine which works best for certain patients and which pose the greatest benefits and harms. The research also aims to improve the quality of care and to control costs. [2]

Continuum of care—a range of clinical services provided to an individual or group, which may reflect treatment rendered during a single inpatient hospitalization, or care for multiple conditions over a lifetime. The continuum provides a basis for analyzing long-term quality, cost, and utilization across all facilities from primary care and ER to post-acute and home health, ideally with shared medical records. [1]

Coordinated care—a care model approach that emphasizes a patient-centered, team-based strategy for delivering coordinated health care services. [1]

Copayment: A copayment is the fixed dollar amount that a member must pay out of pocket for services covered by his or her health plan. [3]

Deductible: A deductible is a predetermined amount that a member must pay out of pocket for services before his or her health plan begins to cover the charges of services. Not all services may be subject to a deductible. This type of cost-sharing mechanism is often found in deductible HMO, preferred provider organization (PPO), point-of-service (POS), and indemnity plans. [3]

Dual Eligibles – An individual who is eligible for Medicare and for some Medicaid benefits.[2]

Electronic health record / electronic medical record (EHR / EMR)—an electronic record of patient health information that may be stored on a computer or in the cloud, and can be retrieved by anyone who has access to the system. They are a critical component in building the integration needed to operate an ACO. [1]

Evidence-based medicine (EBM)—aims to apply the best available evidence gained from the scientific method to clinical decision making. It seeks to assess the strength of evidence of the risks and benefits of treatments (including lack of treatment) and diagnostic tests. EBM is identified through published best practices, clinical standards, and claims data to help clinicians learn whether or not any treatment will do more good than harm. When a community is connected within an ACO, this can be a powerful tool. [1]

Fee-for-service (FFS) reimbursement—currently the most prevalent health care payment system, it provides physicians and other health care providers with a payment on a per-unit or per-service basis. FFS tends to incent the treatment of conditions rather than the whole spectrum of a person's health and wellness. [1]

Health maintenance organization (HMO)—an entity that provides, offers or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium. There are four basic models of HMOs: group model, individual practice association, network model, and staff model. [1]

Health information exchange (HIE)—the mobilization of health care information electronically across organizations within a region, community, or hospital system. HIE provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged. An HIE is a foundational piece of the ACO because it provides a way for EMRs to exchange information across different types of medical records. [1]

In network: In network means a group of doctors, hospitals, pharmacies, and other providers that has contracted with a health plan to provide services to our members at negotiated rates. [3]

Interoperability—The ability of disparate technologies and services to communicate and work with each other. For example, a health information exchange enables interoperability of different EHRs so that data may be shared despite providers having different EHRs. [1]

Management service organization (MSO)—a legal entity that provides practice management, administrative, and support services to individual physicians or group practices. MSOs may be used to drive collaboration between groups with different tax IDs. [1]

Medicaid (Title XIX of the Social Security Act) – A federal and state funded program that provides medical assistance for certain individuals and families with low income and resources. The ACA expands Medicaid eligibility to nonMedicare eligible individuals with incomes up to 133% of the FPL, establishing uniform eligibility for adults and children across all states by 2014. [2]

Medicare (Title XVIII of the Social Security Act) – A federal program that provides health care coverage to people age 65 and older, and to those who are under 65 and are permanently disabled or who have a congenital disability; or to those who meet other special criteria such as end-stage renal disease. Eligible individuals can receive coverage for hospital services (Medicare Part A), physician-based medical services (Medicare Part B), coverage through a private insurance plan (Medicare Part C – Medicare Advantage) and prescription drugs (Medicare Part D). Together, Medicare Part A and B are known as Original Medicare. Medicare Part D Donut Hole – A gap in prescription drug coverage under Medicare Part D, where beneficiaries pay 100% of their prescription drug costs after their total drug costs exceed an initial coverage limit and until they qualify for a second tier of coverage. [2]

Medicare shared savings program (MSSP)—CMS' shared savings program designed to facilitate coordination and cooperation among providers to improve the quality of care and reduce unnecessary costs for Medicare FFS beneficiaries. Eligible providers, hospitals, and suppliers may participate in the MSSP by creating or participating in an ACO. Physicians that volunteer to participate may take on payment risk for hitting quality and cost targets depending on the model they choose. In this program, providers take on less risk than they would in a pioneer ACO (see below). [1]

Out-of-network: Out-of-network means a group of doctors, hospitals, pharmacies, and other providers that has not contracted with a health plan to provide services to our members at negotiated rates. Members typically pay more out of pocket when seeking services from an out-of-network provider. Depending on a member's plan benefits, the plan may or may not pay for a portion of the charges from out-of-network providers. [3]

Out-of-pocket maximum: An out-of-pocket maximum is the limit to the total amount of deductibles, copayments, and coinsurance an individual or family must pay in a calendar, contract, or plan year for covered health care services. [3]

Patient-centered medical home (PCMH)—an approach to providing comprehensive primary care for patients by facilitating partnerships between patients and their primary care provider (PCPs). It is designed to encourage the PCP to coordinate, but not necessarily directly provide, all aspects of a patient's care, including emergency room and post-discharge care. [1]

Per member per month (PMPM)—the average cost for a defined membership for a defined set of service over the course of a month. A full risk-bearing organization may be paid by insurers on a PMPM basis. [1]

Pioneer ACO—a CMMI initiative designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. This model is designed to allow these providers to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the MSSP. There are currently 32 systems that have been chosen to participate as Pioneer ACOs across the nation, and these systems will have a portion of their compensation tied to quality measures and their ability to manage PMPM. [1]

Population health—the health of a defined population which includes not only the amount of services they receive, but the general well-being of that group. [1]

Preventative care—health care that emphasizes the early detection and treatment of diseases. The focus on prevention is intended to keep people healthier for longer, thus reducing health care costs over the long term. [1]

Primary care physician (PCP)—a physician, the majority of whose practice is devoted to internal medicine, family/general practice and pediatrics. An obstetrician/gynecologist sometimes is considered a primary care physician, depending on coverage. In an ACO model, PCPs are expected to play an expanded role in coordinating a patient's care because PMPM payments are driven by attribution to a PCP. [1]

Referral—the recommendation by a physician and/or health plan for a patient to receive care from a another physician or organization. [1]

Risk—the amount of accountability that an institution takes on for managing the cost of a given population. [1]

Risk Adjustment – The process of increasing or reducing payments to health plans to reflect higher or lower than expected spending. Risk adjusting is designed to compensate health plans that enroll a sicker population as a way to discourage plans from selecting only healthier individuals. [2]

Risk analysis—the process of evaluating expected medical care costs for a prospective group against what revenue or premium an organization would bring in on their account. [1]

Risk sharing—a reimbursement method where a provider shares in the financial risk of managing the patient's care. An example of risk sharing is capitation. In an ACO, the provider takes greater accountability for managing the amount of expenses for a given population. [1]

Service area: A service area is a designated geographic area covered by a member's health plan. [3]

Sustainable health community—a community that features interoperable technology that offers near real-time information at the point of care, streamlines administration, and manages compliance risks and costs; alignment in accountability for patient-centered care delivery and continuity of care; implementation of performance-based and evidence-based payment models; and personal responsibility for lifestyle choices and health management.[1]

Triple aim or three-part aim—CMS and The Institute for Healthcare Improvement (IHI) devised goals for improving the health care system by delivering care more efficiently. The three critical objectives include: improve the health of the population; enhance the patient experience of care (including quality, access, and reliability); and reduce, or at least control, the per capita cost of care. [1]

Utilization—the extent the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per 100 or 1,000 people eligible for the service. The goal of an ACO is to focus on appropriate utilization while reducing unnecessary utilization. [1]

References:

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