Value-Based Care Dictionary - *Contracting*

CHESS HEALTH SOLUTIONS

Acronym	Term	Definition
	Contracting	
ACO	Accountable Care Organization	A group of health care providers incentivized to improve patient care.
	Capitation	A fixed amount of money per patient paid in advance for the delivery of health care services.
CIN	Clinically Integrated Network	Legal entity that provides anti-trust framework to coordinate care, exchange data, improve documentation, and hold physicians accountable for providing quality care.
CAHPS	Consumer Assessment of Healthcare Providers and Systems	Annual survey that asks patients to evaluate their healthcare experience.
CMS	Centers for Medicare and Medicaid Services	A Federal agency that administers the Medicare program and works with state governments to administer Medicaid.
CDI	Clinical Documentation Integrity	The process of reviewing medical record documentation for completeness and accuracy.
	Cut Points	Targets set by payer.
DUA	Data Use Agreement	Contract used for the transfer of data.
	Deficit	Occurs when medical expenses are more than target.
	Denominator	Number of patients who quality for a quality measure.
DOFR	Division of Financial Responsibility	Codifies which party is financially responsible for providing covered services.
	Exclusions	Patients excluded from quality measures after appropriate documentation provided.
FFS	Fee-for-Service	Traditional healthcare reimbursement model focused on the number of services provided by a health provider.
HMO	Health Maintenance Organization	Type of Medicare Advantage plan that pays for care from providers in network and require the patient to select a primary care physician.
HOS	Health Outcomes Survey	Survey for Medicare Advantage that gathers health status data.
HEDIS	Healthcare Effectiveness Data and Information Set	Tool used to measure performance on important dimensions of patient care and services.
HCC	Hierarchical Condition Category	Refers to a risk adjustment coding model used to estimate a patient's future health care costs.
IBNR	Incurred But Not Reported	Financial accounting of health care services performed/provided but have not yet been invoiced.
	Managed Care	Types of health insurance focused on providing quality care and reducing costs.
MSO	Managed Services Organization	A business that supports the administrative and management functions of a risk-bearing entity.
MY	Measurement Year	12-month timeframe when services are rendered. Also known as Performance Year (PY).
	Medical Expense	Paid claims plus any chargebacks.
	Medical Record Data	Information directly from a patient's medical record to validate services rendered, not otherwise captured via medical or pharmacy claims, encounters, or supplemental data.
	Medicare Part A, B, C, D	Medicare Part A – covers inpatient care, SNF, home health, hospice Medicare Part B – provider services, durable medical equipment, preventative services, some home health Medicare Part C – Medicare Advantage or Medicare replacement Medicare Part D – prescription drug coverage
NCQA	National Committee for Quality Assurance	A non-profit organization dedicated to improving health care quality and evaluating managed health care.
NDA	Nondisclosure Agreement	Legally binding contract that establishes a confidential relationship.
	Numerator	Number of members who are compliant with a quality measure.
P4P	Pay-for-Performance	Payment model that ties financial incentives to provider performance.
PMPM	Per Member Per Month	Money paid or received monthly for each attributed member.
PMPY	Per Member Per Year	Money paid or received annually for each attributed member.

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PoP	Percent of Premium	The proportion of direct medical expenses incurred for care to total premiums paid to the plan. Also known as Medical Loss Ratio (MLR).
	Pooling	Combining financial and/or quality performance of multiple organizations within one agreement to improve collective performance and provide more agreement options
PPO	Preferred Provider Organization	Type of Medicare Advantage plan where patients have the option to see specialists and any provider in or out of network.
PDC	Proportion of Days Covered	According to Pharmacy Quality Alliance (PQA), the percent of days in the measurement period covered by prescription claims for the applicable medication(s).
	Reporting Year	Timeframe when final data is reported for the measurement year, usually the year following the performance year.
	Risk	Payment model that requires the provider to refund the payer for any losses incurred if financial benchmarks/medical loss ratio are exceeded.
RAF	Risk Adjustment Factor	A numerical score that considers disease acuity and demographics to calculate payment for healthcare services.
	Risk-Bearing Entity	An organization that assumes financial responsibility for cost of care.
	Shared Savings	Payment model that compares total spending to a target.
	Stop Loss	A product that provides protection against catastrophic or unpredictable losses.
	Surplus	Occurs when medical expenses are less than target.
	Value-Based Care	Healthcare delivery system that incentivizes providers to focus on the quality of care opposed to the quantity.