



## HEALTH SYSTEM TRANSFORMATION GLOSSARY

*This glossary is a resource to help advocates who are already very knowledgeable about the US health care system to understand common acronyms and other terminology related to health system transformation. The glossary is separated into two sections – Organizations and Terms. Entries are in alphabetical order with a brief definition. In most cases, one or two links are provided for those seeking additional information. This is intended to be a living document, so we welcome suggested additional entries, information about outdated entries, and suggestions about alternative links. Please forward any suggestions to Andi Mullin at Community Catalyst, [amullin@communitycatalyst.org](mailto:amullin@communitycatalyst.org).*

### **ORGANIZATIONS**

This section highlights specific organizations as well as state and federal agencies related to health system transformation.

#### [CMMI - Center for Medicare and Medicaid Innovation](#)

Located within CMS and often called simply “the Innovation Center,” CMMI supports the development and testing of innovative health care payment and service delivery models.

#### [CMS - Centers for Medicare and Medicaid Services](#)

The federal agency responsible for operating the Medicare and Medicaid programs.

#### [CU - Consumer’s Union](#)

The policy and action division of *Consumer Reports*.

#### [HPC - Health Policy Commission \(Massachusetts\)](#)

An independent Massachusetts state agency that develops policy to reduce health care cost growth and improve the quality of patient care in Massachusetts. The HPC also monitors the Commonwealth’s health care market, providing data on the impact of health care mergers, guidance for reform of the delivery and payment systems, and investments in community hospitals.

#### [IHI - Institute for Healthcare Improvement](#)

An independent not-for-profit organization based in Cambridge, MA focused on health and health care improvement worldwide.

### [LAN - Learning and Action Network](#)

The US Department of Health and Human Services launched the LAN to advance the work being done across sectors to increase the adoption of value-based payments and alternative payment models.

### [MMCO - Medicare-Medicaid Coordination Office](#)

The MMCO serves people who are enrolled in both Medicare and Medicaid, also known as dual eligibles or duals. MMCO works across Federal agencies to align and coordinate benefits between the two programs and partners with states to develop new care models and improve the way dual eligibles receive health care.

### [NCQA – National Committee for Quality Assurance](#)

Founded in 1990, NCQA is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. NCQA works to build consensus around quality issues by working with large employers, policymakers, doctors, patients and health plans to develop quality standards and performance measures for a range of health care entities.

### [NQF – National Quality Forum](#)

A not-for-profit, nonpartisan, membership-based organization that works to improve the quality of health care. NQF endorses consensus standards for performance measurement to make patient care safer.

### [PCORI – Patient Centered Outcomes Research Institute](#)

A non-profit, nongovernmental organization in Washington, DC that was established by the Affordable Care Act. PCORI helps people make informed health care decisions and improves health care delivery and outcomes by producing and promoting research guided by patients, caregivers, and the broader health care community.

## **TERMS**

This section highlights terms commonly associated with health system transformation.

### [ACO – Accountable Care Organization](#)

The definition continues to evolve, but generally an ACO is a network of primary care doctors, specialists, at least one hospital, and other kinds of providers that contract with payers to provide coordinated care. ACOs take on some degree of risk, with some getting bonuses for meeting quality standards and reducing costs, and others taking on full capitated risk.

### [APCD - All Payer Claims Database](#)

Large-scale databases that systematically collect medical, pharmacy and other health claims, eligibility and provider files from private and public payers. APCD data about health care use and cost can contribute to effective policy decisions.

### [APM – Alternative Payment Models](#)

Methods of paying for health care services that reward quality and value rather than volume. APMs are alternatives to the traditional Fee-For-Service payment model.

### [AQC - Alternative Quality Contract \(Massachusetts\)](#)

An Alternative Payment Model adopted by Blue Cross/Blue Shield of Massachusetts (BCBSMA) in 2008. It now includes 85% of the physicians in the BCBSMA network.

### [BIP - Balancing Incentive Program](#)

Established by the Affordable Care Act, this Medicaid Program is designed to increase access to home and community-based services (HCBS) as an alternative to institutional care.

### [Bundled Payments](#)

A single payment to providers or health care facilities for all services to treat a given condition or provide a given course of treatment. Bundled payment asks providers to assume financial risk for the cost of services, as well as costs associated with preventable complications. This is sometimes called episode of care (EOC) payment, episode-based payment, or episodic bundling.

### [BPCI - Bundled Payments for Care Improvement](#)

A CMS alternative payment initiative that is comprised of four broadly defined models of care which link payments for multiple services beneficiaries receive during an episode of care.

### [Capitation - Full and Partial](#)

Under full, or global, capitation whole networks of hospitals and physicians band together to receive single fixed monthly payments for enrolled health plan members. Payment is made on a per member basis. Under partial, or blended, capitation a single payment is made for a defined set of services, while other services involved in a patient's care are paid for on a traditional fee-for-service basis.

### [Care Coordination](#)

A mechanism through which teams of health care professionals work together to ensure that their patients' health needs are being met and that the right care is being delivered in the right place, at the right time, and by the right person.

### [Case Management](#)

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy of options and services to meet an individual's and family's comprehensive health needs.

### [CON – Certificate of Need](#)

Programs aimed at restraining health care facility costs and allowing coordinated planning of new services and construction by limiting facilities to building only enough capacity to meet actual needs.

### [CCM – Chronic Care Management](#)

Non-face-to-face care management/coordination of services for patients having multiple chronic conditions.

### [CHW - Community Health Worker](#)

A frontline public health worker who is a trusted member of and/or has a close understanding of the community served, and who serves as a liaison between health services and the community to facilitate access, improve quality and enhance cultural competence in care delivery.

### [CDHP – Consumer-Driven Health Plan](#)

A type of health insurance plan that typically has a higher deductible and lower monthly premiums than more traditional health plans (see also HDHP).

### [CCO - Coordinated Care Organizations \(Oregon\)](#)

The term that the state of Oregon uses for their 16 Medicaid ACOs, this is a network of all types of health care providers who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Medicaid program.

### [CPT – Current Procedure Terminology](#)

A listing of standardized descriptions and five-character, alphanumeric codes that medical coders and billers use to report healthcare services and procedures to payers for reimbursement.

### [DSRIP – Delivery System Reform Incentive Payment](#)

Initiatives that are part of broader Section 1115 CMS waiver programs and provide states with significant funding for providers who change how they care for Medicaid beneficiaries. Typically, states undertake initiatives expected to save Medicaid funds and then use the available savings for new investments in delivery system reform. To obtain DSRIP funds, providers must meet certain performance metrics.

### [DRG – Diagnosis-Related Group](#)

A framework that enables hospitals to monitor the utilization of resources and quality of service by relating diagnoses to the costs involved in their care. First developed in the 1980s, DRGs have enabled a prospective payment model in which hospitals receive a set payment based on the patient's diagnosis.

### [Dual Eligibles or Duals](#)

Individuals who are dually eligible for both Medicare and Medicaid.

### [EHR – Electronic Health Records](#)

A digital collection of patient health information compiled at one or more meetings in any care delivery setting, designed to replace paper health records.

### [FFS - Fee-For-Service](#)

The traditional health care payment system in which providers are paid for each individual service, such as an office visit, lab test, or procedure. Providers bear no risk in this payment system.

### [Global Budgeting](#)

A health care payment system in which providers are given a specific budget to care for a population of patients.

### [HCVH - Health Care Value Hub](#)

A web-based networking and resource center managed by Consumer's Union for advocates working for better value in health care. The Hub supports and connects consumer advocates and arms them with fact-based information to help them advocate for change.

### [HH - Health Home \(Medicaid\)](#)

Established by the ACA, this model is targeted to individuals with multiple chronic conditions, including serious mental illness. HHs are designed to be person-centered systems of care that

facilitate access to and coordination of a full array of primary and acute health services while meeting quality standards established by CMS.

#### [HIT – Health Information Technology](#)

Also called Health IT, this refers to the exchange of health information in an electronic environment.

#### [HDHP – High Deductible Health Plan](#)

A health insurance plan with lower premiums and higher deductibles than more traditional health plans. Often combined with an [HSA \(Health Savings Account\)](#).

#### [HCBS - Home and Community Based Services](#)

Usually used in reference to Medicaid, home and community based services provide supports to help older adults and persons with disabilities integrate into and remain in their communities, preventing unnecessary institutionalization.

#### [MLTSS - Managed Long Term Services and Supports](#)

Risk-based arrangements for the delivery of Medicaid long-term services and supports, which often include both institutional and home and community-based services.

#### [MLR – Medical Loss Ratio](#)

Limits the portion of premium dollars that health insurers may spend on administration, marketing, and profits. Health insurers must publicly report the portion of premium dollars spent on health care, quality improvement and other activities, and insurers failing to meet the applicable MLR standard must pay rebates to consumers.

#### [MA – Medicare Advantage](#)

A managed care health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits. For MA enrollees, Medicare services are covered through the plan and aren't paid for under original Medicare.

#### [MSSP - Medicare Shared Savings Program](#)

Established by the Affordable Care Act, the MSSP was created to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization.

#### [NSQIP - National Surgical Quality Improvement Program](#)

The American College of Surgeons' risk-adjusted, outcomes-based program to measure and improve the quality of surgical care in the primary health care sector.

#### [NP – Nurse Practitioner](#)

Registered nurses who are prepared through advanced education and clinical training to provide preventive and acute health care services. NPs are primary care providers with prescription-writing privileges – to varying degrees – in all 50 states.

#### [Patient Activation/Patient Confidence/Patient Engagement](#)

Often used interchangeably, these terms are presented by some consumer advocates as alternatives to measuring patient satisfaction. These metrics measure a patient's understanding of her/his health problems and their confidence in managing those problems.

### [PCMH - Patient Centered Medical Home](#)

Sometimes also referred to as a PCHH (Patient Centered Health Home), a PCMH is a way of organizing primary care, often in one location, to emphasize care coordination and communication with the patient. The PCMH provides the large majority of an individual's care, including prevention, acute care and chronic condition care through a coordinated team of providers.

### [PROM - Patient Reported Outcomes Measures](#)

PROMs attempt to capture whether the health care services provided actually improved patients' health and sense of well-being. Examples include asking patients to assess their general health, ability to complete various activities, mood, level of fatigue and/or pain.

### [Patient Satisfaction](#)

A measure, usually determined by post-care surveys, that quantifies how satisfied patients are with their care. Patient satisfaction is a frequently used component in Pay for Performance programs. Many consumer advocates fear that this measure can be easily manipulated by providers and is not a good proxy for good health outcomes.

### [P4P – Pay for Performance](#)

A payment model that rewards providers financially for achieving or exceeding specific quality or other goals. Typically, a P4P payment system would link a portion of a clinician's or hospital's payment to certain performance metrics.

### [PMPM - Per Member Per Month](#)

A common method of capitation payment in which providers are paid a flat fee monthly for each patient.

### [PA – Physician's Assistant](#)

A primary care health clinician, similar to a Nurse Practitioner, who works with physicians and has prescription-writing privileges – to varying degrees – in all 50 states.

### [Pioneer ACOs](#)

A CMS program designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. This model will allow these provider groups to move more rapidly from a shared savings payment model to a population-based payment model. It is designed to work in coordination with private payers by aligning provider incentives for all patients.

### [PAC - Potentially Avoidable Complications](#)

Deficiencies in care that cause harm to the patient and could have been prevented with more effective treatment. PACs typically include things like hospital acquired infections and avoidable hospital readmissions within 30 days of discharge, and they are particularly associated with chronic conditions like diabetes, congestive heart failure, etc.

### [PCCM - Primary Care Case Management](#)

A model of Medicaid managed care in which state Medicaid agencies contract with primary care providers to serve as a beneficiary's "medical home" for primary and preventive care. States pay these providers a small monthly case management fee in addition to regular fee-for-service payments. Providers do not assume any financial risk under this model.

### [PACE – Program of All-Inclusive Care for the Elderly](#)

A Medicare and Medicaid program available in select locations that helps enrollees meet their health care needs in the community instead of going to a nursing home or other care facility.

### [Price Transparency](#)

The practice of making the price of health care – office visits, procedures, lab work, medications, etc. – transparent to consumers. Some believe that price transparency will motivate consumers to make more cost-effective health care choices.

### [Quality Measures](#)

The process of using data to evaluate the performance of health plans and health care providers against recognized quality standards.

### [Reference Pricing](#)

A strategy used by payers to set a cap – or “reference price” – to limit what they will pay for a certain procedure. If combined with quality thresholds, this strategy can guide consumers toward more reasonably priced providers.

### [RCCO - Regional Care Collaborative Organization \(Colorado\)](#)

The name that the state of Colorado uses for its Medicaid ACOs, RCCOs provide coordinated care for Colorado Medicaid beneficiaries by connecting them with Medicaid providers and other community and social services.

### [RCO - Regional Care Organization \(Alabama\)](#)

Community-led regional organizations created to coordinate care for Medicaid patients in the state of Alabama. RCOs will ultimately be risk-bearing organizations. There are currently eleven provisionally certified RCOs in Alabama.

### [ROI - Return on Investment](#)

A common business concept that, when applied to health care, specifically refers to the net financial benefits of initiatives designed to improve care quality and reduce costs.

### [RBPO – Risk Bearing Provider Organization](#)

Any provider, such as an ACO, that is using a payment model that requires the provider to bear some degree of the risk traditionally borne by payers.

### [SPMI – Severe and Persistent Mental Illness](#)

Mental illnesses with complex symptoms that require ongoing treatment and management, most often varying types and dosages of medication and therapy.

### [SDM - Shared Decision Making](#)

A collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient’s values and preferences.

### [Shared Savings](#)

A payment strategy that offers incentives for providers to reduce health care spending for a defined patient population over a discrete time period (usually one year) while still meeting specific quality benchmarks. Upside-only shared savings programs offer providers a percentage of net savings realized as a result of their efforts. Upside/downside programs – sometimes

called [Shared Risk](#) - not only offer a percentage of savings but also penalize providers financially if they do not meet savings and quality goals. Usually, risk-sharing is added to shared-savings arrangements after some experience has been accumulated.

#### [SHCIP – State Health Care Innovation Plan](#)

Plans developed by states seeking State Innovation Model grants from CMS.

#### [SIM - State Innovation Models](#)

A CMS initiative that provides financial and technical assistance to help states plan, design and test new service delivery and payment models to advance broad health system reform.

#### [SUD - Substance Use Disorders](#)

A disorder that occurs when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school or home.

#### [TCOC - Total Cost of Care](#)

A National Quality Forum (NQF)-endorsed methodology which includes all costs associated with treating commercially insured patients.

#### [TME – Total Medical Expenses](#)

Measures the medical expenditures for health care services delivered to patients covered by commercial or public health insurance. Often expressed on a per member, per month basis.

#### [Triple Aim](#)

Developed by the Institute for Healthcare Improvement (IHI) and now commonly used in discussions of health system transformation, the Triple Aim is a framework that describes an approach to optimizing health system performance by simultaneously pursuing three dimensions:

- Improving the patient experience of care
- Improving the health of populations
- Reducing the per capita cost of health care

#### [UM - Utilization Management or Utilization Review](#)

The evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures and facilities under the provisions of a health benefits plan.

#### [VBP – Value Based Purchasing \(or Payment\)](#)

A Medicare Program, established by the Affordable Care Act, that implements a pay-for-performance (P4P) approach to inpatient hospital stays.

***Have a suggestion for the glossary? Please email Andi Mullin at [amullin@communitycatalyst.org](mailto:amullin@communitycatalyst.org)***

- The Center for Healthcare Quality and Payment Reform has a [glossary](#) which is more detailed and technically oriented.
- Consumers Union has a [glossary](#) that is a bit more consumer-facing.
- The Kaiser Family Foundation has a [glossary specific to Medicaid](#).