VBP Terms and Definitions

Value-based Payment (VBP) is a reimbursement model that incentivizes higher quality and lower cost of care. Below is a list of the terms commonly encountered when working in VBP.

This list provides a foundational definition of terms. It serves as an initial framework for understanding; however, additional research is recommended to gain a complete grasp of these concepts and their practical implications.

Accountable Care Organization (ACO): A group of healthcare providers and organizations, who come together voluntarily to coordinate care for a defined group of patients within a legal framework which allows participating providers to agree on standardization of care and coordination to improve efficiency and patient outcomes for a defined group of patients and contract together for value-based payments. This may also be referred to **a clinically integrated network (CIN)** or **independent practice association (IPA).**

Alternative Payment Methodology (APM): A payment methodology in which at least a portion of payments vary based on the quality or efficiency of health care delivery.

Assigned Members: Health plan members who have designated provider as their primary care physician (PCP) or assigned through attribution.

Attribution: Methodology of assigning plan members to a primary care provider when members do not choose a primary care provider for the purposed of accountability of outcomes.

Baseline Spend: The historical or predicted expense for a group of members assigned to a health care provider that is used as a comparison to determine if savings were created or additional expenses occurred.

Base Year: A 12-month period prior to the Measurement Year used to create a benchmark for performance.

Benchmarking: The baseline spend against which the future spend will be measured. Benchmarking may also be used to set performance targets for quality metrics that have financial implications, using either external providers or historical performance to establish the benchmark.

Benchmark Spend: The threshold cost of the assigned membership below which a provider becomes potentially eligible for shared savings or above which a provider may be responsible for a portion of excessive costs.

Bonus: A payment made to a physician or Physician Group beyond any salary, fee-for-service payments, capitation, or returned withhold.

Capitation: A set dollar payment per patient per unit of time (usually per month) paid to a physician or physician group to cover a specified set of services and administrative costs without regard to the actual number of services provided.

Care Coordination Fee: A fee (typically PMPM) that is paid by the payer to the health care provider, intended to fund population health infrastructure that works with the member to close gaps in care, coordinates services, and facilitates communication with other providers across the full continuum of care.

Carveout: Services and their related costs that are covered by the health plan but are not the financial responsibility of the provider under the Alternative Payment Methodology (APM).

Claims Run Out: A defined timeframe during which claims are paid for a specific incurred period after the completion of that incurred period.

Completion Factor: The percentage of claims that are adjudicated and paid by the health plan in each month following the delivery of the health care service. These factors are used to calculate the IBNR (incurred but not received) of spend in a given period.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): Surveys completed by consumers that rate healthcare experiences.

Default Member Assignment: A process by which a health plan assigns accountability for member outcomes to a provider when that member does not actively choose to be assigned to a provider.

Deficit Cap: The maximum amount of financial loss PMPM that a plan will hold a provider financially accountable for in a shared risk arrangement.

Division of Financial Responsibility: A specific delineation of the financial accountability for services into the risk pool or pools.

Enrollment Category: The different premium groups (TANF, CHIP, SSI) used to divide Medicaid enrollees into homogenous groups based on their eligibility criteria. Managed Medicaid plans are paid different risk adjusted capitations for enrollees in each Enrollment Category.

Fee-for Service: A system of health insurance payment in which a health care provider is paid a fee for each particular service rendered.

First Dollar Losses: The initial amount of financial risk or cost that an entity incurs when covering a claim or providing services before any cost-sharing or deductible provisions kick in.

First Dollar Savings: Once the minimal savings rate is exceeded, then a provider is financially entitled for its portion of all health care savings, not just those that exceed the minimal savings rate.

Global Risk: An APM in which a provider assumes complete (i.e. 100% upside and downside) financial accountability for total cost of care of assigned members.

Health Benefit Ratio (HBR): The amount of health care expenses as a percentage of a benchmark that occurs before a provider is financially responsible to pay a portion of those expenses in a shared risk APM.

Health Benefit Ratio (HBR) Target: The target below which shared savings are generated or above which shared losses occur.

Healthcare Effectiveness Data and Information Set (HEDIS): A set of core performance metrics used by more than 90% of America's health plans to measure performance on important dimensions of care and service sponsored by the National Committee for Quality Assurance.

Incurred but Not Reported (IBNR): The value of services for assigned members that have been delivered by all Providers during a defined period for which claims have not yet been received and/or adjudicated by the Payer.

Independent Provider Association (IPA): A group of healthcare providers and organizations, who come together voluntarily within a legal framework which allows participating providers to agree on standardization of care and coordination to improve efficiency and patient outcomes for a defined group of patients and contract together for value-based payments. This may also be referred to a clinically integrated network (CIN) or accountable care organization (ACO).

Indexed Premium: Plan premium divided by the average risk score for all assigned members in each enrollment category.

Institutional Fund (sometimes referred to as the Part A Fund): A portion of the premium set aside to pay for all services provided to Members in an institutional setting defined in the contract. Those settings commonly include inpatient services, home health care services, skilled nursing facility, and inpatient rehabilitation. They may include outpatient surgical facility costs as well.

Intermediate Entities: Entities that contract with the health plan and in turn contract with physicians or physician groups. Intermediate entities can include, for example, an ACO, Integrated Delivery System, IPA, Managed Services Organization or Physician Hospital Organization.

Learning & Action Network (LAN) Framework: The APM Framework that establishes a common vocabulary categorizing payment models and helps stakeholders track progress on payment reform.

Measurement Year: The 12-month period during which Provider's quality and cost performance will be evaluated to determine whether Shared Savings or Shared Losses have been generated and whether quality performance targets have been met.

Medical Expense Ratio (MER): The actual expense for the contract year for covered services divided by the actual revenue for assigned members for the contract year. It is also referred to as Health Benefit Ratio (HBR) or Medical Loss Ratio (MLR).

Medical Loss Ratio (MLR): The actual expense for the contract year for covered services divided by the actual revenue for assigned members for the contract year. It is also referred to as Medical Expense Ratio (MER) or Health Benefit Ratio (HBR).

Member Months: The sum of assigned members for each month in the period being examined for each enrollment category.

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Minimal Savings Rate (MSR): The amount of health care savings as a percentage of a benchmark that must occur before a provider qualifies for shared savings.

Minimum attributed membership: The minimum number of assigned members that a provider must have for whom a specific APM to participate in that APM.

Non-Solicitation Clause: A clause in the contract stipulating that the provider shall not in any manner, directly or indirectly, cause a member to disenroll from the health plan.

Outcome Measure: The result of a treatment or intervention, whether desirable or adverse, used to objectively determine the impact or effectiveness on a desired population.

Outpatient Referral Fund (sometimes referred to along with the Primary Care Fund as the Part B Fund): A portion of the premium set aside to pay for all professional and other services provided to members in an ambulatory setting as defined in the contract. Those settings commonly include, but may not be limited to, hospital-based physician fees, specialists fees, hospital outpatient services, outpatient surgery procedures, podiatry, outpatient rehabilitation, physical therapy, occupational therapy, speech therapy, vision, supply costs of covered immunizations, therapeutic radiology, renal dialysis, outpatient laboratory, outpatient radiology and durable medical equipment.

Pay-for-Quality (P4Q): A payment arrangement that offers financial incentives in the form of bonuses to healthcare providers for meeting pre-established performance measure targets or benchmarks for measures of quality and/or efficiency. It is also known as pay-for-performance (P4P).

Per-member-per-month (PMPM): A monthly payment derived by taking the premium, a portion of the premium, or costs and dividing by member months.

Percentage of Premium: The portion of the premium set aside to pay for certain services provided to Members.

Physician Incentive Plan: Any compensation arrangement between an eligible organization and physician or physician group that may directly or indirectly have the effect of improving performance on quality metrics and/or reducing or limiting services provided with respect to individuals enrolled with the organization.

Potentially Preventable Admission (PPA): A measure for avoidable hospital use and are often referred to as avoidable hospitalizations. PPAs help to pinpoint hospital admissions that could have been prevented with consistent, coordinated care and patient adherence to treatment and/or self-care protocols. Associated costs for PPAs are also considered to be preventable.

Potentially Preventable Readmissions (PPR): A measure for avoidable hospital use. PPRs are readmissions that are clinically related to the initial admission. Clinically related readmissions are those in which the underlying reason for readmission can be plausibly related to the care rendered during or immediately following a prior hospital admission.

Potentially Preventable Emergency Room Visits (PPV): A measure for emergency room visits for a health condition that could have been treated in a non-emergency setting or prevented by keeping the patient healthier earlier on.

Predictive Modeling: The development of models to forecast future risks, events, trends, or patterns based on historical data.

Premium Withhold: The portion of the premium that is held back by the employer or governmental agency and paid to the health plan only after it meets defined performance expectations.

Primary Care Provider (PCP): The provider responsible for coordinating, providing, monitoring, and supervising the delivery of all health care services for any plan members assigned to them.

Primary Care Services Fund: A portion of the premium set aside to pay for all services provided to Members by the Primary Care Physician in office setting(s). In some contracts, it may also include payment of PCP services in any inpatient or other outpatient facility settings.

Process Measure: Directly measurable and immediately available metrics which are intended to measure activities that promote outcomes or patient experience of care.

Provider Risk Score: The average risk score for a provider's assigned members for each enrollment category.

Quality: A paradigm of how well an entity keeps patients healthy or provides necessary care when needed.

Quality Improvement: The attainment, or process of attaining, enhanced performance or quality that is superior to any previous level of quality performance.

Quality Score: The number of points awarded to a provider based upon performance in process measures and outcome measures. The quality score may be used to determine the percentage of a provider's savings pool that the provider will receive as shared savings or be responsible for under shared risk.

Quality Threshold: The minimum performance score that a provider must meet to access to value-based incentive payments.

Reconciliation: The process by which a health plan calculates a provider's quality score and/or shared savings for a measurement period.

Reconciliation Period: The period following the measurement year in which the reconciliation occurs.

Reconciliation Report: The final report by a plan on cost and quality that will indicate the calculations for the reconciliation.

Referral Services: Any specialty, inpatient, outpatient, or laboratory services that a physician or physician group orders or arranges but does not furnish directly.

Reserve Fund: Funds set aside as the financial guarantee in case a deficit is created in the shared risk pool.

Risk Allocation: The split of financial accountability between the provider entity and the payer in the shared savings or risk pool.

Risk Adjustment: The use of severity of illness measures, such as patient demographic information, diagnosis codes, procedure codes, and pharmaceutical data used to estimate the risk (measurable or predictable chance of loss, injury, acute event, illness, or death) to which a patient is subject to before receiving a health care intervention.

Risk-Adjusted Premium: The provider risk score multiplied by the indexed plan premiums for each enrollment category.

Risk Corridor: The maximum amount paid in shared savings or shared losses.

Risk Stratification: A process used to identify and categorize individuals or groups within a population based on their level of health risk. The goal of risk stratification is to target resources, interventions, and care management strategies more effectively to those individuals

who are at higher risk of developing certain health conditions or experiencing adverse health outcomes.

Risk Threshold: The maximum risk, if the risk is based on referral services, to which a physician or physician group may be exposed under a physician incentive plan without being at substantial financial risk.

Shared Risk Payment: The portion of the shared risk pool that is paid by the provider to the plan when the amount of measurement year aggregate care costs exceeds the aggregate cost benchmark.

Shared Savings or Risk Pool: A portion of the premium set aside to pay for all services for which the provider has financial accountability as defined in the division of responsibility portion of the agreement.

Shared Savings Payment: The portion of the shared savings pool that is paid to the provider when the aggregate cost benchmark exceeds the amount of the measurement year aggregate care costs.

Stop loss: An upper limit on the amount a provider can lose in a shared risk arrangement.

Stop Loss Coverage: Reinsurance to provide protection to the provider against excessive medically necessary costs for assigned members. The amount of stop-loss coverage must be in compliance with 42 C.F.R. §422.208.

Stop Loss Premium: The expense of obtaining stop loss coverage either from the health plan or a third party.

Stop Loss Recovery: Expenses that are not charged against the primary care, referral, institutional or other fund pools for which the provider has financial accountability.

Stop Loss Threshold: The deductible/threshold amount in any calendar year after which stop loss coverage begins to assume all or most (commonly 90%) of subsequent costs attributable to that member.

Substantial Financial Risk: Risk for Referral Services that exceeds the Risk Threshold.

Surplus Cap: The maximum of amount of shared savings PMPM that a provider is eligible to receive under a shared savings program.

Total Cost of Care (TCOC): Total spending on services from which shared savings and shared risk rates are based.

Trend Factor: The measurement year aggregate risk adjusted premium divided by the base year aggregate risk adjusted premium.

Trended Base Year Claims-Based Costs: The base year claims-based costs (PMPM) multiplied by the trend factor.

Value: Value of care as a measure of specified preference-weighted assessment of a particular combination of quality and cost of care performance

Value-based Payment (VBP): A reimbursement model that incentivizes higher quality and lower cost of care.

Value-added Services: Services that a health plan offers its members beyond those required and paid for by the employer or governmental entity.

Value-based care (VBC): Restructuring health care systems with the goal of value for patients defined as health outcomes per unit of costs.

Value Proposition: A value proposition is a clear and compelling statement that outlines the unique benefits, advantages, and outcomes that a particular healthcare service offers to patients, providers, or other stakeholders. It articulates how the offering addresses specific needs, solves problems, or enhances the overall well-being of individuals or the healthcare system.

Withhold: A percentage of payments or set dollar amounts deducted from a physician's service fee, capitation, or salary payment, and that may or may not be returned to the physician, depending on specific predetermined factors.