national partnership for women & families

Key Terms & Resource Directory for Equity-Centered Payment Reform

NOVEMBER 2023

Accountable care: A term adopted by the Center for Medicare and Medicaid Innovation, described as when a person-centered care team takes responsibility for improving quality of care, care coordination, and health outcomes for a defined group of individuals, to reduce care fragmentation and avoid unnecessary costs for individuals and the health system.

> Medicare, state Medicaid programs, and commercial insurers have instituted accountable care models. The Centers for Medicare and Medicaid Services (CMS) is aiming for nearly all Medicare fee-for-service beneficiaries and Medicaid beneficiaries to be in a care relationship with accountability for quality and total cost of care by 2030.

- Learn more: CMS Innovation Center Key Concepts

Accountable Care Organizations (ACOs): A group of doctors, hospitals, and other health care professionals that shares responsibility to provide high-quality, coordinated care to patients, improve health outcomes, and manage costs.

- Learn more: Designing Accountable Care: Lessons from CMS Accountable Care Organizations

Advanced Primary Care: An approach to providing primary care services that involve an interdisciplinary team of health care professionals working together to provide comprehensive, whole person (see definition below), and longitudinal care to individuals and families.

- Learn more: Attributes of Advanced Primary Care

Alternative Payment Model (APM): A payment model that deviates from traditional fee-for-service, designed to incentivize lower-cost, high-value patient care, and can be applicable to a specific condition, care episode, or population.

- Learn more: Advancing Health Equity through APMs

Area Deprivation Index (ADI): A measure created by the Health Resources & Services Administration (HRSA) and the University of Wisconsin-Madison that allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest by using factors such as income, education, employment, and housing quality.

- Learn more: ACO Benchmarks Based on Area Deprivation Index Mask Inequities

Benchmarking: The basis for measuring progress on quality of care, and comparing data on providers, both internally and externally, to identify best practices and create accountability for performance.

CMS is addressing historical underinvestment in systemically underserved communities through payment adjustments, such as the Health Equity Benchmark Adjustment (HEBA) in the ACO REACH Model, to expand access and improve care. HEBA takes public information about communities and aggregates the data to make adjustments to the benchmark based on the population served.

- Learn more: Embedding Equity in Financial Benchmarks: Changes to the Health Equity Benchmark Adjustment and Building Better Benchmarks: Principles for Implementing Sustainable Benchmarking in Value-Based Care

Bundled (or Episode) Payment: A payment model in which health care providers or facilities are paid a single payment for all the services performed to treat an individual's specific condition within a defined period of time, such as a hip or knee replacement, cardiac surgery, or maternity care, rather than being paid for each individual treatment, test, or procedure. As a result, providers are rewarded for coordinating care, preventing complications and errors, and reducing unnecessary or duplicative tests and treatments.

- Learn more: Changes in Racial Equity Associated with Participation in the Bundled Payments for Care Improvement Advanced Program

Data Stratification: Sorting and analyzing data (e.g., quality measures, experience data, outcomes data) by patient subgroups (e.g., race, ethnicity, language, disability status, SOGI) to identify gaps in quality, patient experience, or access between patient groups.

- Learn more: Stratified Measures: How HEDIS Can Enhance Health Equity

Downside risk (or two-sided risk): A payment arrangement where providers share in savings and risks. In this arrangement, if the actual care costs exceed financial benchmarks, providers are responsible for refunding the payer. However, greater financial rewards are available to providers who perform well under this arrangement.

- Learn more: It's Not Just Risk: Why the Shift to Value-Based Payment Is Also About Provider Flexibility

Fee-for-Service (FFS): The predominant payment model in the United States, whereby providers receive payment for each health care service provided, rather than the quality or outcomes achieved.

- Learn more: Promoting Health Equity by Changing How We Pay for Care

Health Related Social Needs (HRSNs): Individual-level adverse social conditions that negatively impact a person's health or health care. Examples include food insecurity, housing instability, and lack of access to transportation.

> CMS has most often referred to individual-level, non-clinical needs that are identified through screening as HRSNs. In 2024, hospitals will be required to screen patients for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. This SDOH measure has also been applied in CMMI models.

- Learn more: The Accountable Health Communities Health-Related Social Needs Screening Tool

Hybrid Payment: A form of payment that enables health care providers to get traditional, fee-for-service payments alongside performance-based payments for services, such as care coordination, behavioral health integration, home visiting, and telehealth services.

- Learn more: An Option for Medicare ACOs to Further Transform Care

Interdisciplinary (or multidisciplinary) care teams: Teams composed of both clinical and nonclinical professionals from various disciplines, such as community health workers, mental health providers, peer support counselors, and social workers, working together to coordinate whole-person care seamlessly across services.

- Learn more: Enhance Team-Based Primary Care Approaches: Advancing Primary Care Innovation in Medicaid Managed Care

Medicare Shared Savings Program (MSSP): The Shared Savings Program offers providers and suppliers (e.g., physicians, hospitals, and others involved in patient care) an opportunity to create an ACO, where they will be held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service beneficiary population.

MSSP is the largest and only *permanent* ACO program, serving nearly 11 million traditional Medicare beneficiaries, making the program well-positioned to drive primary care innovation and health equity.

▶ Learn more: An Option for Medicare ACOs to Further Transform Care

Multi-Payer Alignment: Agreement among public and private payers on foundational performance measurement and reporting, health equity, key payment model components, timely and consistent data sharing, and technical assistance priorities to accelerate value-based care that reduces burden and improves quality of care.

▶ Learn more: Multi-Payer Alignment Blueprint

Patient Attribution: The process that public and private payers use to assign patients to the physicians who are held accountable for their care. This forms the basis for measuring performance of physicians or provider groups in a population-based payment model.

▶ Learn more: Patient Attribution Fact Sheet

Patient and Family Engagement (PFE): An approach to health care that involves patients and families as members of the care team. PFE promotes two-way communication and information sharing, as well as shared decision-making and care planning – all oriented around people's priorities, needs, and goals in order to achieve better health.

▶ Learn more: Patient & Family Engagement: Improving Health and Advancing Equity

Patient-Reported Experience Measures (PREMs): The tools used to measure and collect data on patients' and families' experience receiving care, most commonly in the form of questionnaires. PREMS are a critical component for measuring person-centeredness and whether a person is being treated with dignity and respect and involved in decisions about their health.

In 2019, the Larry A. Green Center introduced the Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM) endorsed by both CMS and the National Quality Forum (NQF). The measure is an 11-item survey that assesses aspects of primary care focusing on a patient's relationship with their clinician or practice. CMS is using this new measure in the MIPS program and in the Making Care Primary model to assess patient experience.

Patient-Reported Outcome Measures (PROMs): The tools used to measure and collect data on patient-reported outcomes such as quality of life, symptoms and symptom burden of a chronic illness, and functional status (i.e., how well a patient functions in daily life).

- Learn more: Patient-Reported Outcome Measures

Person-Centered Care: Care where providers treat patients as people, rather than see them as subjects or diagnoses, and provide care that is respectful, while focusing on ensuring that people's preferences, needs and values guide decision-making.

- Learn more: Person-Centered Care as a Cornerstone of Value-Based Payment: Five Guiding Principles

Prospective Population-Based Payment: An alternative payment model that pays health care organizations a predetermined fixed payment for covering all future health care services of a broad population. Providers assume accountability for quality and take on risk for costs of care that exceed the budgeted amount.

- Learn more: Leveraging Primary Care Population-Based Payments in Medicaid to Advance Health Equity

Quality (or performance) measures: Measures used to assess and compare the quality of health care organizations, including structure, process, or outcome measures. Health care quality is often defined by safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.

There's a growing understanding that high-quality care should not only be what clinicians and health organizations determine is effective, but must also address what matters most to patients. For example, CMMI has committed that by 2030 at least 75 percent of all models will be using at least two patient-reported measures.

- Learn more: Measuring What Matters to Patients: Innovations in Integrating the Patient Experience into Development of Meaningful Performance Measures (download)

Social Risk Adjustment: Method of adjusting payments to account for patients' social risk factors, such as race, ethnicity, low-income subsidy, dual eligibility, neighborhood disadvantage and poverty status, and disability.

Traditional risk adjustment methods based on clinical factors are not robust, complete, or comprehensive enough, and have penalized providers caring for underserved populations and people with complex needs by underestimating their expected cost of care.

- Learn more: Advancing Health Equity through APMs Guidance on Social Risk Adjustment

Upside (or One-Sided) Risk: Payment arrangement where providers are rewarded for spending below a given threshold but not penalized or required to assume costs if they exceed the limit.

- Learn more: The Future of Value-Based Payment: A Road Map to 2030

Value-Based Care: A form of reimbursement that ties payments for care delivery to the quality and cost of care provided.

In the movement toward value-based care, CMS assigns payments from payers to health care providers to four categories, such that movement from Category 1 to Category 4 involves increasing provider accountability for both quality and total cost of care, with a greater focus on population health management. The categories are as follows:

- **Category 1:** fee-for-service with no link of payment to quality
- **Category 2:** fee-for-service with a link of payment to quality
- **Category 3:** alternative payment models built on fee-for-service architecture
- **Category 4:** population-based payment

▶ Learn more: Making the Promise of Value-Based Care Meaningful to Consumers and Talking about Health Care Payment Models that Prioritize Quality over Quantity (aka Value-Based Care)

Whole-Person Care: a holistic approach to care that integrates physical, emotional, socioeconomic, and environmental health.

▶ Learn more: Whole Person Health: A Path to Health Equity

About the National Partnership

The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to achieving equity for all women. We work to create the conditions that will improve the lives of women and their families by focusing on achieving workplace and economic equity, and advancing health justice by ensuring access to high-quality, affordable, and equitable care, especially for reproductive and maternal health. We are committed to combatting white supremacy and promoting racial equity. We understand that this requires us to abandon race-neutral approaches and center the intersectional experiences of women of color to achieve our mission.

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