What's It All Mean?

A Glossary of Terms For Payment & Delivery System Reform

bundled payments
community care organization
shared savings
triple aim
value-based purchasing
gainsharing
hospital-physician alignment
payment reform
meaningful use
evidence-based medicine
population health
health information exchange
clinical integration
affordable care act
glossary
delivery system reform
care plan
bundled payments
clinically integrated network
patient-centered medical home
care management
patient engagement
protocols
healthcare reform
wellness programs
medical neighborhood
case management
care coordination
pay-for-performance

Overview

It would seem that an industry replete with scientific jargon, complicated business terminology, and a dizzying array of acronyms would have an easy time expanding its vocabulary to include healthcare reform-related concepts. However, the healthcare industry has been slow to reach consensus on the meaning of key terms. As a result, crucial conversations regarding the direction of and response to reform often become muddled and confused.

To bring some clarity to these conversations, PYA has developed the following glossary of terms. To develop the following definitions, we researched hundreds of sources and interviewed dozens of industry leaders. No definition can be attributed to a single, third-party source.

While we may not have produced the definitive treatise on payment and delivery system reform, this glossary at least provides a common starting point for discussions and decision-making regarding reform. Because many terms are interrelated (one has to understand one concept to appreciate another), we have not arranged the glossary in alphabetical order. Instead, the terms are grouped by subject matter:

1 | Big Concepts
2 | Clinical Practice
3 | Provider Organizations and Arrangements
4 | Payment Models (and Related Concepts)
5 | Technology

> " One has to understand one concept to appreciate another. "

Section 1 Big Concepts

Affordable Care Act

The ACA, enacted in 2010, is the driving force behind both health insurance reform and healthcare payment and delivery system reform. In the "front half" of the ACA, the federal government acts as a market regulator, imposing new requirements and establishing new programs with the goal of providing access to affordable and adequate health insurance for all citizens. The "front half" often is referred to as "Obamacare."

The "back half" of the ACA, which receives little public attention, has a more direct impact on healthcare providers. In the "back half," the government drives healthcare payment and delivery system reform by acting as a market participant, pursuing several initiatives to improve quality and reduce costs in the Medicare and Medicaid programs. These initiatives, along with similar efforts by commercial payers to reform payment from fee-for-service reimbursement to value-based purchasing (both defined herein), are the impetus behind emerging healthcare delivery system reforms.

This glossary does not include terms specifically relevant to the "front half," *e.g.*, health insurance marketplaces, medical loss ratio. For definitions of these terms, we recommend a glossary made available by the Kaiser Family Foundation.

Healthcare Reform

A constant source of confusion is the use of this term to refer to both health insurance reform and healthcare payment and delivery system reform. To remedy this, we recommend avoiding this term; instead, refer to "health insurance reform" and "payment and delivery system reform."

Triple Aim

This term, coined by the Institute for Healthcare Improvement, refers to the goals of payment and delivery system reform:

1 | Improved patient experience (including improved quality and safety and patient satisfaction).
2 | Improved health outcomes in a specific population.
3 | Improved efficiency (and resulting reductions in per capita healthcare costs). The Triple Aim represents value in healthcare.

Population Health

This academic discipline, developed in Canada, studies why people who live in different locations experience different degrees of health and wellness. Research in this field focuses on social determinants of health: education, wealth, geographic location, and class. Many who study population health believe your zip code is more important than your genetic code in predicting health outcomes.

Population Health Management

PHM involves a team of healthcare and community service providers that works in concert to proactively identify and address the healthcare needs of a specific population. It is best understood in juxtaposition to the current reactive healthcare system, in which individual providers reactively diagnose and treat patients presenting with injury or illness. Generally speaking, PHM is a four-step process:

1 | Identify those high-risk and rising-risk individuals in the defined population (*i.e.*, risk stratify the population).
2 | Define and implement clinical practice guidelines and care management programs among the provider team.
3 | Engage identified individuals using these guidelines and services.
4 | Ensure healthy individuals receive regular preventive services and wellness resources.

Widespread and sustained implementation of PHM will require new healthcare payment models. The current fee-for-service reimbursement model offers little incentive for providers to pursue PHM. Each PHM step requires resources, but none generates significant revenue. The emerging value-based payment models are discussed in Section 4 herein.

Clinical Integration

Much ink has been spilled trying to explain the concept of clinical integration and its role in PHM, and there seems to be more confusion than clarity on the subject. At the basic level, clinical integration means the working relationship among providers working together in PHM. There are two key components:

1 | The development, adoption, implementation, and enforcement of clinical protocols and guidelines among participating providers.
2 | The coordinated deployment of care management services.

Dr. Atul Gawande captured the essence of clinical integration in his 2011 commencement address at Harvard Medical School, when he urged graduates to function as part of a pit crew, rather than behaving like cowboys.

Hospital–Physician Alignment

One strategy often pursued as a path to clinical integration is hospital-physician alignment. Some equate alignment with hospital employment of physicians, but employment alone is not sufficient (or even necessary) to achieve the alignment of interests necessary for clinical integration.

Hospital-physician alignment is an ongoing journey, not a final destination. Alignment is driven by identifying common interests and creating incentives to pursue those interests. It involves medical staff members assuming leadership roles in the hospital's quality and safety programs with the full support of the hospital's governing board and management team.

Successful alignment strategies enlist and reward physician involvement in initiatives to improve hospital efficiency and support physician recruitment and retention efforts. Alignment strategies may also include hospital and physician participation in one or more of the provider organizations or arrangements discussed in Section 3 herein.

Clinically Integrated Network

A CIN is the lean infrastructure established to support clinical integration among participating providers. Although the form and structure of CINs may vary widely, key elements include:

1 | A governance structure that creates a trust environment among participating providers.
2 | Supportive technology.
3 | Dedicated support staff.

A CIN may be a closed economic system (*e.g.*, a hospital system and its employed physicians) or it may be comprised of independent providers. In the case of the latter, individual providers sign a participation agreement with the CIN, committing to adhere to processes and procedures adopted by the CIN governing body. A more thorough discussion of the different organizational forms in which a CIN may function may be found in Section 3 herein.

Generally speaking, federal antitrust laws prohibit competitors from jointly negotiating price. Thus, independent providers cannot negotiate with payers as a network. However, regulators have recognized an exception for clinically integrated networks, acknowledging that CINs have a pro-competitive effect by improving quality and reducing costs. Recently, however, some commercial payers have indicated an unwillingness to negotiate with such CINs, stating they will only contract with single economic entities.

Care Coordination

With so many terms involving the words “clinical” and “care,” it becomes easy to confuse concepts. Care coordination refers to those clinical guidelines (and clinical practice consistent with those guidelines) that address how individuals with certain diagnoses should move through the continuum of care, with a particular focus on communication among providers regarding the patient’s condition and treatment.

Care Management

While care coordination deals with how providers relate to each other, care management focuses on bringing needed resources to the patient. A specially trained care manager (sometimes referred to as a health coach or care navigator) works one-on-one with a patient to implement a care plan developed and updated by the patient’s physician. A care manager will identify and secure needed resources (*e.g.*, transportation, nutrition services) and monitor and report on a patient’s compliance (*e.g.*, medication reconciliation, reporting vital signs). The effectiveness of care management can be enhanced through the use of supportive technology.

Despite its obvious benefits, payers historically have not reimbursed providers for care management services. However, many payers – including Medicare – now are planning to pay for two specific types of care management: transitional (post-discharge) care management and chronic care management (CCM). PYA has prepared white papers explaining the requirements for providing and billing Medicare for these services.

Case Management

While care management focuses on a patient’s ongoing plan of care, case management generally relates to a single acute episode. Typically, a hospital case manager will handle utilization review (and related communications with payers) and arrange for post-discharge services (*e.g.*, skilled nursing, home health).

Section 2 Clinical Practice

protocols
medical neighborhood
patient engagement
clinical practice
evidence-based medicine
patient-centered medical home
care plan

Clinical Practice Guidelines (a.k.a. Protocols)

Clinical practice guidelines are regularly updated reference tools that synthesize the best available external clinical evidence relating to a specific clinical diagnosis. Guidelines do not dictate a one-size-fits-all approach to patient care; instead, they provide objective information to assist a provider in designing a unique care plan reflecting the patient's specific needs and preferences.

Clinical practice guidelines can be formatted in several different ways (*e.g.*, care pathway, care plans, protocols, standardized order sets) to better facilitate their usage in everyday practice.

While there are several sources for examples of clinical practice guidelines, the best tools are those that are developed, debated, approved, reviewed, and updated by a local community of providers (*e.g.*, a CIN, hospital medical staff). Ideally, compliance with the guidelines should be evaluated using specific performance measures to promote a culture of accountability.

Evidence-Based Medicine

Practitioners of EBM integrate their individual clinical experience with the best available clinical research to diagnose and develop a plan of care for a specific patient. Research shows physicians who have access to information regarding the uses and limitations of different tests and treatments order fewer unnecessary services and provide better patient care. These physicians also reduce their risk of malpractice claims against them.

Widespread adoption of EBM is limited by two factors. First, there is a dearth of reliable research on the most effective treatment for many conditions. Using data analytics (discussed in Section 5 herein), however, researchers now can identify correlations (or lack thereof) between treatments and outcomes not previously recognized.

Second, few providers have the time or resources to stay up-to-date on the latest research. By participating in a CIN, however, a provider can leverage the learning of his or her colleagues. For example, many CINs are deploying electronic decision-support tools consistent with their approved clinical protocols.

Patient-Centered Medical Home

One should not confuse the concept of PCMH with formal recognition as a PCMH. As a concept, PCMH is a way of organizing and operating a primary care practice to (1) provide an accessible "one-stop shop" for patients' primary care needs (including preventive, mental health, and urgent care), and (2) serve as an "on-ramp" to access other healthcare services.

The National Committee for Quality Assurance (NCQA), along with similar organizations, have developed specific standards a practice must meet to receive formal recognition as a PCMH. These standards can serve as a roadmap for transforming a practice into one that is patient-centered. Some commercial payers require NCQA recognition as a PCMH as a condition for participation in certain payment programs.

Medical Neighborhood

The medical neighborhood refers to the collection of healthcare and social service providers to which patients are referred by PCMH practices. Those providers in the neighborhood commit to cooperating with the PCMH practice to coordinate patient care. This may include, for example, arrangements for data sharing and adherence to specific clinical practice guidelines. One can think of a medical neighborhood as a microcosm of a CIN. A medical neighborhood focuses on meeting the needs of the individual patient, but also incorporates aspects of population health and overall community health needs.

Care Plan

A patient care plan is a document developed and regularly updated by a primary care provider based on a systematic assessment of the patient's medical, functional, and psychosocial needs. The care plan centralizes the strategy for managing the patient's conditions over time. It should be readily available to the patient and all caregivers.

Typically, a care plan includes a problem list; expected outcome and prognosis; measurable treatment goals; symptom management and planned interventions; community/social services to be accessed; a plan for care coordination with other providers; medication management (including a current and complete list of current meds and allergies, reconciliation with review of adherence and potential interactions, and oversight of patient self-management); a responsible individual for each intervention; and requirements for periodic review/revision.

Clinical Documentation Improvement

Under value-based payment models, provider payments are based in part on patient acuity. A payer assigns an acuity level based on the information regarding the patient furnished by the provider. If a provider does not capture all of a patient's diagnoses and appropriately document the severity of illness, that provider will not receive payment adequate to cover the cost of caring for the patient.

In light of this, many providers now are pursuing clinical documention improvement (CDI) programs, aimed at systematic improvements in documentation and coding. These programs typically involve a clinician reviewing a patient's documentation, identifying potential gaps, and requesting clarifications from the physician.

Patient Engagement

Most likely, the key to providers' success under new payment and delivery models will be patient engagement and activation – moving the patient to accept personal responsibility for his or her own health. Patient engagement is based on an effective collaboration between the patients and healthcare providers that empowers the patient through useful information and workable strategies.

Key to patient engagement is shared decision-making, whereby a patient and provider(s) together consider the patient's condition, treatment options, medical evidence behind the treatment options, benefits and risks of treatment, and patient's preferences, then determine and execute a care plan. As an example, the rise of mHealth (discussed in Section 5) expands patient access to health information and opportunities for interaction with care providers.

Section 3 Provider Organizations & Arrangements

gainsharing
physician-hospital organization
accountable care organization
integrated delivery network
provider organizations & arrangements
clinical co-management
joint operating agreement
independent practice association
community care organization

Form follows function. *New types of organizations and business arrangements are emerging to facilitate population health management and clinical integration activities. In addition, some more familiar structures are being re-tooled to serve this same purpose.*

Accountable Care Organization

While the concept is still evolving, an ACO is comprised of healthcare providers that voluntarily come together to assume responsibility for the care of an attributed patient population (usually those individuals who receive the plurality of their primary care services from a provider in the ACO). Working together, ACO providers identify and adopt strategies to improve quality and reduce per capita costs for that population. Accountability comes in the form of financial rewards (and potentially penalties) tied to performance on specified metrics.

An ACO that elects to participate in the Medicare Shared Savings Program (discussed in greater detail in Section 4 herein) must meet certain regulatory requirements, such as the composition of its governing body and the operation of its quality assurance program. Otherwise, there are no regulatory requirements defining what organizations constitute or do not constitute ACOs.

Community Care Organization

The term CCO is used to describe an ACO that focuses on the needs of an at-risk population in a community, with special emphasis on addressing the social determinants of health such as poverty, unemployment, homelessness, poor housing, neighborhood violence, and other factors. CCO providers include community services agencies, such as federally qualified health centers and rural health clinics; community mental health and substance abuse treatment providers; recovery, peer, and wellness organizations; public health departments; hospitals; social service agencies; child welfare providers and family resource centers; housing and homeless services providers; oral health providers; pre-schools and schools; and job training and employment support organizations.

Integrated Delivery Network (or System)

Members of an IDN (or IDS) are economically integrated, often operating under a single tax identification number. Generally, an IDN involves providers within a community across the continuum of care (*e.g.*, a hospital, outpatient facilities, employed physicians, and long-term care providers).

Economic integration does not necessarily result in clinical integration; not every IDN is a CIN. In theory, an IDN should be better positioned to establish and enforce clinical guidelines and align provider incentives as would a CIN. However, merely employing a physician or buying his or her practice does not guarantee that the physician will adhere to or actively participate in the provider's quality and efficiency initiatives. The purse strings are not always sufficient to tie together a CIN.

Physician-Hospital Organization

PHOs are legal (or perhaps informal) organizations that bond hospitals and their attending medical staff. PHOs frequently are developed for the purpose of contracting with managed care plans. A PHO may be open to any member of the staff who applies, or it may be closed to staff members who fail to meet specific criteria (or who are part of an already overrepresented specialty).

While many PHOs were formed and flourished in the 1980s and 1990s, a good number of these organizations had languished by the turn of the century. Now, formerly dormant PHOs are re-emerging as CINs (or as a foundation for CIN development opportunities).

Independent Practice Association

Like PHOs, IPAs flourished in the latter part of the 20th century as a vehicle for independent physicians to contract with managed care plans. These activities, however, were constrained by the antitrust laws. Many IPAs have taken on different roles, including group purchasing and management services providers. And, like PHOs, many IPAs now are reinventing themselves as CINs.

Joint Operating Agreement/Virtual Merger

Much has been written analyzing and commenting on consolidation in the healthcare industry over the last five years. A related trend – provider affiliations – is gaining steam. Rather than merging all operations and having at least one party give up control, many providers now are looking for ways to work together on specific projects while otherwise remaining independent.

The parties may define their working relationship in a joint operating agreement, with that written contract defining respective rights and responsibilities. Alternatively, the parties may choose a virtual merger strategy, forming a new entity through which they will pursue joint projects. The new entity's bylaws (or operating agreement, in the case of an LLC) then define how the parties will make decisions in working together.

Gainsharing

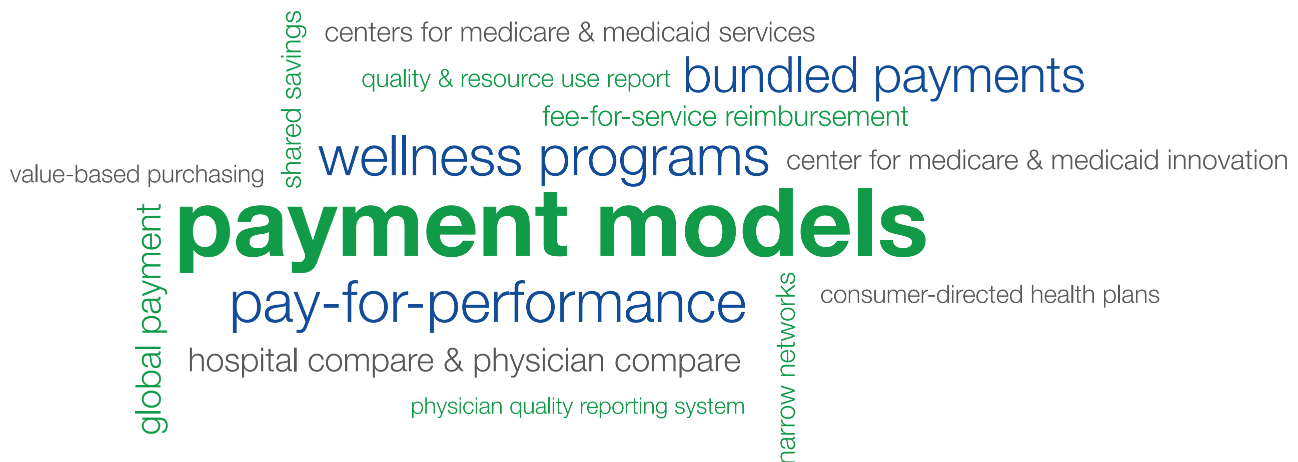
A gainsharing arrangement is a contract between a hospital and a physician organization for the purpose of improving hospital quality and efficiency. Specifically, the hospital agrees to pay the physician organization a portion of the savings the hospital realizes or the additional payments it receives by achieving specified goals.

The federal fraud and abuse laws prohibit a hospital from offering anything of value to a physician in exchange for reducing or limiting services, even if those services are determined to be medically unnecessary. Thus, gainsharing arrangements now must be carefully structured to avoid civil monetary penalties.

Clinical Co-Management

A clinical co-management arrangement is another form of contract between a hospital and a physician organization for the same purpose as gainsharing. Specifically, the physician organization agrees to provide identified management services for a certain department of the hospital to improve its quality, efficiency, and/or patient satisfaction. The hospital pays the physician organization a predetermined fee, as opposed to a share of savings or additional payments.

Section 4 Payment Models & Related Concepts



Fee-For-Service Reimbursement

Under FFS reimbursement--currently the dominant payment model--a provider receives payment based on the type and number of services furnished to a patient. FFS reimbursement tends to incentivize the rendition of services regardless of their effectiveness. It also reinforces provider "silos," running at cross-purposes with clinical integration. FFS reimbursement perpetuates a healthcare system that reacts to illness or injury, with little focus on maintaining a patient's health.

Consistent with the old adage "you get what you pay for," FFS reimbursement buys a lot of services, but not necessarily a lot of health. By way of illustration, a hospital administrator once facetiously lamented his organization could not afford to sponsor a flu clinic - not because of staffing or the cost of the vaccine, but because the hospital needed insured patients sick with the flu to generate revenue needed to maintain operations.

Centers for Medicare & Medicaid Services

CMS is the agency within the Department of Health and Human Services responsible for the operation of Medicare, Medicaid, and the Children's Health Insurance Program. Given that about one in three Americans is covered by these programs, CMS policy heavily impacts providers and strongly influences commercial payers.

Center for Medicare and Medicaid Innovation

CMMI was created (and given a 10-year, $10 billion budget) under the ACA to design and test new payment models. As part of its innovation mandate, CMMI also may waive statutory requirements (including the fraud and abuse laws) and regulatory restrictions that constrain payment reforms. While commercial payers also are pursuing innovative payment models that incentivize PHM and clinical integration, CMMI's funding and its broad statutory authority place the agency at the forefront of new model development.

Pay-for-Performance

Often referred to as a bridge between fee-for-service reimbursement and new value-based payment models, P4P programs provide enhanced fee schedule payments to providers that meet or beat specified performance measures or, in some cases, lower payments to providers that perform poorly on such measures. P4P measures may include patient experience, quality, safety, and costs-of-care measures.

Value-Based Purchasing

VBP is a catch-all phrase for the yet-to-be-fully-defined payment models intended to replace fee-for-service reimbursement and incentivize providers to pursue the Triple Aim. In 2013, CMS launched its VBP program for hospitals, adjusting payments based on hospital readmission rates, patient satisfaction scores, performance on specific quality measures, and efficiency in providing services (*i.e.*, lower per capita costs of care). In 2015, CMS will launch its VBP program for physicians, also adjusting payments based on similar criteria. By 2017, nearly 10% of Medicare physician payments will be at risk under the VBP program and related quality improvement initiatives.

Physician Quality Reporting System

Beginning back in 2007 and continuing through 2014, CMS made bonus payments to physicians for reporting their performance on specified quality measures. Starting in 2015, physicians will be penalized if they fail to report. A physician is not limited to a single set of quality measures; he or she may choose from 200+ measures, selecting those that best reflect his or her practice.

Quality and Resource Use Report

The QRUR is a report produced by CMS on an annual basis for each physician practice group (including solo practitioners) that bills Medicare. Using the information reported by the group through PQRS and claims data, CMS produces a quality composite score and a cost composite score that compares the group to its peers. These composite scores determine the group's value modifier, or VM, which in turn determines how the group performs on Medicare's physician VBP program. All of this will directly impact the group's reimbursement and revenue as well as its reputation.

Hospital Compare and Physician Compare

Using these two CMS-maintained websites, consumers can access information regarding a provider's scores on various VBP measures. CMS intends to significantly expand the information available on the sites over the next two years.

Narrow Networks

Some commercial insurance plans (including Medicare Advantage plans) limit a beneficiary's choice of providers to a narrow network, usually by increasing the out-of-pocket cost for services provided outside the network. Network members may be selected based on several factors, including willingness to accept discounted rates or scores on quality measures. In some instances, the payer will pay a care management fee to the network for each individual assigned to or electing the narrow network.

Shared Savings

Under a shared savings arrangement (like the MSSP), a payer attributes covered lives to an organization, usually based on who furnishes primary care services. Using claims data, a total cost-of-care benchmark is established for that attributed population. If the actual total costs of care are less than the benchmark amount and the providers in the organization meet certain quality performance standards, the organization will receive a predetermined portion of those savings for distribution among the participating providers.

In a two-sided shared savings arrangement, the organization is liable to the payer if the actual total cost of care exceeds the benchmark. Presently, there are very few of these arrangements in place; most are one-sided (upside only). As the push for providers to assume more risk continues, more ACOs will enter into two-sided arrangements.

Bundled Payments

Under a prospective bundled payment arrangement, a payer pays a single entity a predetermined amount for all goods and services associated with a specific episode of care (*e.g.*, from the decision to perform surgery through 90 days post-op). The single entity then distributes the payment among the providers involved in that episode of care, as opposed to those providers individually billing the payer.

Under a retrospective bundled payment arrangement, the single entity (representing the providers) and the payer negotiate a bundled rate in advance. The participating providers then bill and collect as they always have. If the total amount paid by the payer to the various providers for the episode of care is less than the bundled rate, the payer pays the difference to the single entity for distribution to the providers. If the total amount paid is more, the single entity (and its providers) is liable to the payer for the difference.

Global Payment/Capitation

Under the global payment (or capitation) payment method, providers receive a set payment for each person or "covered life" instead of receiving payment based on the number of services provided or the costs of the services rendered. These payments are adjusted based on risk, *i.e.*, patients' diagnoses and demographic characteristics (*e.g.*, age, gender).

Global payment shifts the risk from the payer to the providers. Thus, these arrangements incentivize providers to do what is needed to keep patients healthy – sponsor a flu clinic, for example – as opposed to providing more healthcare services. Public reporting on performance measures deters providers from withholding medically necessary care under global payment arrangements – the big complaint against capitation in the 1990s.

Wellness Programs

These employer- or community-based programs provide incentives for individuals to obtain preventive care and engage in healthier lifestyles. Such incentives may include, for example, free or low-cost services, educational opportunities, or a reduction in cost-sharing for successful participation in the program.

Consumer-Directed Health Plans

Consumer-directed health plans seek to increase consumer awareness about healthcare costs and provide incentives for consumers to consider costs when making healthcare decisions. These health plans usually have a high deductible accompanied by a consumer-controlled savings account for healthcare services. There are two types of savings accounts: Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs).

Section 5 Technology

"Big Data"

When electronic data sets become so large and complex that it is no longer feasible to process the information using traditional data-processing applications, they cross over into the realm of Big Data. One classic example of Big Data is CMS' warehouse of claims data.

Predictive Data Analytics

PDA describes the discovery and communication of actionable correlations found by data-mining claims and clinical data. It relies on the simultaneous application of statistics, computer programming, and operations research to quantify performance. In healthcare, PDA holds the promise of supporting clinical protocol development, disease surveillance, and population health management.

Clinical Data Repository

A CDR is an aggregation of granular patient-centric health data usually collected from multiple-source IT systems and intended to support multiple uses. Because a CDR is intended to support multiple uses, we do not categorize the database within any single application as a CDR. When a CDR holds data specifically organized for analytics, it meets the definition of a clinical data warehouse.

All-Payers Claims Databases

APCDs are large-scale databases maintained by state governments (usually pursuant to legislative mandate) that systematically collect healthcare claims data from a variety of payer sources (*e.g.*, Medicaid, state employees, commercial insurers). Like Medicare data, APCDs offer a rich opportunity for PDA because information regarding an individual can be tracked across multiple payers.

mHealth (or eHealth)

This is an abbreviation for mobile (or electronic) health, a term used for the practice of medicine and public health supported by mobile devices. The term is most commonly applied in reference to using mobile communication devices, such as mobile phones, tablet computers, and personal data assistants for health services and information.

Telehealth (or Telemedicine)

Telehealth refers to the use of technology by a healthcare provider to deliver healthcare services without having to be physically present with the patient. Payment for telehealth services generally is limited to certain originating sites, restricting the use of telehealth under fee-for-service reimbursement. The use and demand for telehealth services likely will expand significantly under new payment models in which providers bear risk.

Health Information Exchange

HIE is the electronic movement of health-related information among organizations according to nationally recognized standards. The goal of health information exchange is to facilitate access to and retrieval of clinical data to provide safe, timely, efficient, effective, equitable, patient-centered care. The challenge in meeting this goal is achieving interoperability, *i.e.*, the ability to compile and manipulate data from different information systems. Presently, many technical challenges remain on this front.

Health Information Organizations

HIOs provide the capability to electronically move clinical information between disparate healthcare information systems while maintaining the meaning of the information being exchanged. HIOs also provide the infrastructure for secondary use of clinical data for purposes such as public health, clinical, biomedical, and consumer health informatics research as well as institution and provider quality assessment and improvement.

Meaningful Use

MU is shorthand for meaningful use of a certified electronic health record (EHR) for the purpose of:

1 | Improving healthcare quality, safety, and efficiency.
2 | Engaging patients and family members.
3 | Improving care coordination.
4 | Maintaining the privacy and security of health information.

A certified EHR is one that has demonstrated specific capabilities as defined by federal regulations.

Since 2011, hospitals and physician groups that can demonstrate a specific level of MU have been eligible for Medicare and Medicaid bonus payments. Starting in 2015, those providers that do not achieve such a level of MU will be subject to penalties.

Conclusion

While this glossary may not include every term you may have encountered with regard to payment and delivery system reform, we believe it provides a firm foundation for meaningful discussions on the subject. Hopefully, with a common language at our disposal, we can begin to have important conversations regarding the way forward in the face of these reforms.

We will continue to update this glossary on a regular basis, in an effort to bring greater clarity to these conversations. If you believe we have failed to include an important term, or want to offer a revision or refinement to any of the definitions herein, please contact one of the PYA professionals listed below or reach out to us on Twitter at: @PYAHealthcare. We look forward to your feedback!

PYA's Opportunity Forecasting & Positioning Team can assist your organization in analyzing the impact of new payment policies and preparing comments for submission to CMS on future proposals. Additionally, our consultants can support your organization in developing CCM services, maximizing performance under the value modifier, complying with PQRS and Open Payment Act requirements, and establishing and expanding a successful telehealth program.

Marty Brown
mbrown@pyapc.com

David McMillan
dmcmillan@pyapc.com

Martie Ross
mross@pyapc.com

All can be reached at (800) 270-9629