Medicare ACO Beneficiary Board Representative Orientation

Glossary of Key Terms and Acronyms

Acronym	Term	Definition
	340B	A federal drug pricing program that permits qualifying organizations, such as federally qualified health centers and hospitals that treat low-income and uninsured patients, to buy outpatient prescription drugs at a 25% to 50% discount.
	Accountable care	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.
ACO	Accountable care organization	Groups of doctors, hospitals, and other health care professionals that work together to give patients high-quality, coordinated service and health care, improve health outcomes, and manage costs. ACOs may be in a specific geographic area and/or focused on patients who have a specific condition, like chronic kidney disease
ACO REACH	Accountable Care Organization Realizing Equity, Access, and Community Health Model	An ACO model being tested by the CMS innovation center, which provides novel tools and resources for health care providers in REACH ACOs to improve the quality of care and address health disparities for people with Traditional Medicare. There are three types of REACH ACOs: "Standard," "New Entrant," and "High Needs Population."
AAPM	Advanced APM	Category of APMs that require (1) use of CEHRT (2) payment based on quality measures and (3) bearing financial risk. Advanced APMs are one track of the QPP that offer incentives for meeting participation thresholds based on a health care provider's levels of payments or patients through Advanced APMs. If providers meet these thresholds, they become a Qualifying APM Participant (QP).
ACA	Affordable Care Act	A law enacted to ensure that all Americans have access to affordable health insurance. It does this by offering consumers discounts (known as tax credits) on government-sponsored health insurance plans, and by expanding the Medicaid assistance program to include more people who don’t have it in their budgets to pay for health care.
APM	Alternative payment model	A payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.
AWV	Annual Wellness Visit	For Medicare beneficiaries, a yearly appointment with a primary care provider to create or update a personalized prevention plan. This is not the same as an annual physical exam.
	Attribution	The process used to assign patients to the physicians or other health care professionals (e.g., an ACO) who are responsible for managing their health care; or a method of identifying a patient-provider health care relationship.
BHI	Behavioral health integration	A team-based approach to delivering patient-centered care that addresses mental health and substance use conditions, health behaviors, life stressors, and stress-related physical symptoms, usually in a primary care setting.
	Benchmark	An established price for health care services; also known as a “target price," used as a point of reference for evaluating savings and losses generated in accountable care models.
	Beneficiary	General term used for one who receives a benefit. Used to describe those people receiving Medicare benefits, or, when accompanied by "Dual(ly) Eligible," those receiving both Medicare and Medicaid benefits.

	Capitation/pre-payment	A way of paying health care providers or organizations in which they receive a predictable, upfront, set amount of money to cover the predicted cost of all or some of the health care services for a specific patient over a certain period.
	Care coordination	The organization and navigation of an individual's care across multiple health care providers and settings.
CMMI	Center for Medicare and Medicaid Innovation	The innovation arm of CMS, which develops and tests new healthcare payment and service delivery models to improve patient care, lower costs, and better align payment systems to promote patient-centeredness.
CMS	Centers for Medicare and Medicaid Services	Part of the Department of Health and Human Services (HHS), CMS oversees Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.
CEHRT	Certified EHR technology	EHR technology that meets certain standards and criteria for structured data, established by CMS and the Office of the National Coordinator for HIT. EHRs must meet CEHRT criteria to qualify for use in Medicare's quality programs.
CCM	Chronic care management	Care coordination services done outside of the regular office visit for patients with two or more chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
CCLF	Claim and Claim Line Feed	A set of Medicare claims files incorporating all Medicare Part A and B claims from Inpatient Facility, Outpatient Facility, Skilled Nursing Facility, Home Health Agency, Hospice, Professional, Durable Medical Equipment, and Prescription Drug services.
CIN	Clinically integrated network	A unique legal structure that allows a group of health care providers, which may include hospitals, group practices, and independent physicians, to collaborate on goals through an integrated information-sharing system.
	Cost sharing/ co-pay/ coinsurance	The amount beneficiaries pay out-of-pocket for services. Cost sharing is a general term for the portion that is beneficiaries' responsibility, including deductibles, co-pays, and coinsurance; co-pays typically refer to a set dollar amount owed (e.g., $10) per service and coinsurance typically refers to a percentage (e.g., 20%) of the Medicare approved amount.
	Deductible	The amount beneficiaries pay for health care, services, or prescriptions before Medicare pays. For example, in traditional Medicare, beneficiaries pay an annual Part B deductible.
	Downside risk/ two-sided risk	Refers to a risk model with uncertainty regarding potential financial gains or losses; a risk arrangement that includes both upside and downside risk may be referred to as a "two-sided risk arrangement."
	Dual eligible	A beneficiary eligible for both Medicare and Medicaid.
DME	Durable medical equipment	Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.
EHR/ EMR	Electronic health record/ electronic medical record	An electronic version of a patient's medical history that is maintained by the provider over time and may include all of the key administrative clinical data relevant to that person's care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and reports.
ESRD	End-stage renal disease	Kidney failure that requires a regular course of dialysis or a kidney transplant. People with ESRD are eligible to receive Medicare benefits prior to age 65.
E&M	Evaluation and Management	Refers to cognitive (as opposed to procedural) services in which a physician or other qualified healthcare professional diagnoses and treats illness or injury.

FFS	Fee-for-service	A method of healthcare payment in which a doctor or other health care provider is paid a fee for each service rendered, rewarding medical providers for the volume and quantity of services provided, regardless of the outcome.
	Health disparities	Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health, health quality, or health outcomes experienced by disadvantaged populations.
	Health equity	The attainment of the highest level of health achievable for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.
HIT	Health information technology	Electronic hardware, software, and systems that are used for the collection, sharing, use, extraction, and analysis of information in health care.
HIPAA	Health Insurance Portability and Accountability Act	A federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.
HRSN	Health related social needs	Social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They put individuals at risk for worse health outcomes and increased health care use. HRSN refers to individual-level factors such as financial instability, lack of access to healthy food, lack of access to affordable and stable housing and utilities, lack of access to health care, and lack of access to transportation.
HHA	Home Health Agency	A public or private organization that delivers skilled nursing and other therapeutic services to a patient at home.
HHS	U.S. Department of Health and Human Services	The U.S. federal government department that provides health and human services and promotes research in social services, medicine, and public health.
IPA	Independent physician association	A business entity that allows groups of small physician practices to act as a unified whole when making large purchases, advocating for policy changes, or negotiating certain types of reimbursements.
IP	Inpatient	A patient who stays in a hospital while under treatment.
	Integrated care	An approach to coordinate health care services to better address an individual's' physical, mental, behavioral and social needs.
KPI	Key Performance Indicator	A quantifiable measure used to evaluate success over time for a specific objective or initiative.
LOS	Length of stay	Time between a patient's hospital admittance and discharge.
MCO	Managed care organization	Entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers. An MCO generally can be made up of Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and/or Point-of-Service plans.
MAC	Medicare Administrative Contractor	A private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B medical claims or DME claims for Medicare FFS beneficiaries. MACs serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program.
MACRA	Medicare Access and CHIP Reauthorization Act	Bipartisan legislation signed into law in 2015 which significantly changed the way the federal government pays for health care and created the Quality Payment Program.

MA	Medicare Advantage	A type of health plan offered by private companies that contract to provide Medicare Parts A and B benefits within the plan's network and service area. Established under Medicare Part C, MA plans may also include prescription drug coverage, hearing, dental, and vision care.
MBI	Medicare Beneficiary Identifier	A unique, confidential identifier assigned to every person with Medicare.
	Medicare Part A	The component of Medicare that covers inpatient hospital care, skilled nursing (not custodial or long-term care), hospice services, and home health care.
	Medicare Part B	The component of Medicare that covers medically necessary doctor's services, outpatient care (laboratory, x-ray, etc.), durable medical equipment, ambulance, and many other services, including some preventive services.
	Medicare Part C	The component of the Medicare Act that establishes private "Medicare Advantage" plans to finance services enumerated in Medicare Part A and Part B, and sometimes additional benefits.
	Medicare Part D	The component of Medicare that covers outpatient prescription drugs via private plans.
MSP	Medicare Savings Program	Programs that assist lower income people pay for Medicare Part A, B and D premiums, deductibles, and copayments. There are three MSP programs, and eligibility is determined at the state level. Beneficiaries who are enrolled in MSP programs automatically qualify for the Medicare Part D low-income (LIS) subsidy.
MSSP	Medicare Shared Savings Program	An APM for moving Medicare's payment system away from volume and toward value and outcomes that promotes accountability for a patient population, coordinates items and services for Medicare FFS beneficiaries and encourages investment in high quality and efficient services. MSSP is the largest and only permanent ACO program in Medicare.
	Medicare Star Ratings	CMS publishes the Medicare Advantage (Medicare Part C) and Medicare Part D Star Ratings each year to measure the quality of health and drug services received by consumers enrolled in MA and Prescription Drug Plans. The Star Ratings system helps Medicare consumers compare the quality of Medicare health and drug plans being offered.
MIPS	Merit-based Incentive Payment System	One of two payment tracks of the QPP created under MACRA, which moves Medicare Part B providers to a performance-based payment system.
NAACOS	National Association of ACOs	Advocacy and education group supporting ACOs and other value-based care providers.
NPI	National Provider Identifier	A unique identification number for covered health care providers. Providers and plans must use NPIs in the administrative and financial transactions adopted under HIPAA.
LIS	Part D low income subsidy	Also known as "Extra Help." LIS is administered by the Social Security Administration and helps pay for Part D premiums and drug costs, for eligible individuals.
PCMH	Patient-centered medical home	Also referred to as primary care medical home, advanced primary care, or healthcare home, PCMH is a model for transforming the organization and delivery of primary care in a way that is comprehensive, patient-centered, coordinated, accessible, and enhances quality and safety using evidence-based medicine and shared decision making.
PMPM/ PBPM	Per-member per month/ per-beneficiary per month	PMPM billing is based on a fixed amount that is charged per member per month, regardless of the number of services provided. Or, a method of calculating health care costs based on the average monthly cost for each member/ beneficiary.

	Population health	The focus on health outcomes of a group, rather than at the individual-level. When conceptualized there are typically three components: health outcomes, patterns of health determinants, and interventions and policies.
PAC	Post-acute care	Includes rehabilitation or palliative services that beneficiaries receive after, or in some cases instead of, a stay in an acute care hospital.
PCP	Primary care physician/provider	Health care providers who serve as an "entry point" to health care and treat a range of health-related issues. PCPs often maintain long-term relationships with patients, manage chronic conditions, and coordinate care with specialists.
PACE	Programs of All-inclusive Care for the Elderly	Medicare approved programs that offer medical, social, long-term care and prescription drug coverage for the frail elderly and disabled.
PHI	Protected health information	Any information in the medical record or designated record set that can be used to identify an individual and that was created, used, or disclosed in the course of providing a health care service such as diagnosis or treatment.
	Quadruple aim	An initiative focused on enhancing the patient experience, improving population health, reducing costs, and improving the work life of health care providers.
	Quality measures	Tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include effective, safe, efficient, patient-centered, equitable, and timely care.
QPP	Quality Payment Program	Program with two payment tracks (MIPS and Advanced APMs) established under MACRA to reward Medicare clinicians who provide high-quality patient-centered care. QPP aims to improve the quality and safety of care for all individuals and to reduce the administrative burden on clinicians, allowing more time to focus on person-centered care and improving health outcomes.
SS	Shared savings	A reimbursement methodology that evaluates providers on quality and cost of care. Shared savings contracts often include quality targets that must be achieved to be eligible for shared savings. When the actual total cost of care is lower than the projected budgeted cost of care, shared savings are achieved.
SNF	Skilled nursing facility	A licensed facility that has the staff and equipment necessary to provide skilled nursing and rehabilitation. To be covered by Medicare the facility must also be certified by Medicare.
SDOH	Social drivers of health	The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH refers to community-level factors. They are sometimes called “social determinants of health.”
TIN	Tax ID Number	The federal taxpayer identification number (TIN) that identifies the hospital/provider/physician/practice/supplier to whom payment is made for a service. CMS uses TINs to identify ownership and uses a combination of TIN and NPI to distinguish unique MIPS eligible clinicians.
	Telehealth/telemedicine	The use of electronic information and telecommunication technologies (such as audio or video) to support long-distance clinical health care, patient and professional health-related education, health administration, and public health. There are federal and state regulations and policies that address how providers conduct telehealth services.
	Traditional Medicare	The Medicare system as originally designed: a national public program, including coverage under Parts A and B. (Sometimes referred to as the “fee-for-service” program and as “original” Medicare.

TCM	Transitional care management	Services to address the hand-off period between the inpatient and community setting. After a hospitalization or other inpatient facility stay (e.g., in a skilled nursing facility), patients may be dealing with a medical crisis, new diagnosis, or change in medication therapy.
	Upside risk/one-sided risk	Refers to a risk model with uncertainty regarding potential financial gains; a risk arrangement that only includes upside risk may be referred to as a "one-sided risk arrangement."
VBC	Value-based care	Also called value-based health care, value-based care is the concept that health care providers should be paid for keeping people healthy rather than the volume of services delivered. The goal is to help patients maintain their highest possible level of wellness, rather than waiting until patients get sick to provide care, which is often more complex and expensive.
VBP	Value-based payment	Value-based payment or value-based reimbursement models pay health care providers based on the achievement of quality goals and, in some cases, cost savings rather than volume of services delivered. Payment that incentivizes the delivery of value-based care.