Value Based Payment (VBP) Terms and Definitions

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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: A group of healthcare providers and organizations, who come together voluntarily to coordinate care for a defined group of patients.

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: The method for defining the patients for whose care a provider or provider group is accountable

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: The 12-month period prior to the Measurement Year.

Benchmarking: The process of measuring performance against a target or threshold in comparison to other organizations.

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.

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

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.

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)

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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 that a provider is financially entitled for its portion of all health care savings, not just those that exceed the minimal savings rate.

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.

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.

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

Independent Provider Association (IPA): A type of organization formed by independent healthcare providers who come together to collectively negotiate contracts with payers (e.g., insurance companies, Medicare, Medicaid) and collaborate on various aspects of healthcare delivery.

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

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.

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.

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 premium, a portion of premium or costs and dividing by member months.

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

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

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.

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 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.

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.

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

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.

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 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.