The ABCs of ACOs: A Brief Glossary of Terms

Value-Based Care (VBC) can take many forms.

It is an umbrella term that encompasses many different ways to coordinate and pay for care, from performance-based contracts with physicians and hospitals to bundled payments for treating specific illnesses to primary care bonuses for closing specific gaps in care. The most important thing to know about Value-Based Care is that it puts the patient at the center of the health care experience by achieving a balance of quality, efficiency, and lower costs.

Following are some common terms used when speaking about VBC, because health does not need to be as complex as it sounds.

Accountable Care Organizations (ACO)

A group of physicians, hospitals, and other health care professionals working together to coordinate care for an overall patient population and share the financial accountability for the patients whose care they're collectively managing.

Actionable Data

Data that often comes from claims information and notifications about people's interactions with the health system that can be translated into usable actions; examples include patient profiles, identifying specific gaps in care, and real-time emergency room and inpatient admissions data.

Analytics Reporting

Examining raw data to extract insights that help care providers and health plans make better health care decisions about individuals and entire patient populations.

Bundled Payments / Episode Payments

A payment model whereby care providers are reimbursed up-front for an entire treatment program based on the expected cost of a standard treatment regimen for a specific condition as predetermined by a physician.

Capitation Arrangements

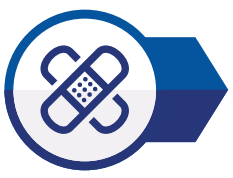
Payment systems based on fixed, monthly payments for each person assigned to the physician or practice rather than receiving payments for each service provided.

Centers of Excellence

Centers of Excellence provide best-in-class services with proven clinical quality and predictable consumer outcomes for specific treatments. The Center of Excellence designation is often condition-specific (e.g., orthopedic) and identifies physicians and facilities with specialized clinical expertise and care management to support patients.

Fee-For-Service (FFS)

A way of paying for health care where each individual service and procedure is paid for separately. (This model can give providers an incentive to perform more treatments since payment is contingent on quantity of care as opposed to quality.)



Gaps in Care

When a physician and/or the health plan identify when a person has missed an opportunity for getting needed care (e.g., an annual preventive screening or follow up visit after surgery).

Patient-Centered Medical Home (PCMH)

A health care setting in which a primary care physician gives patients support and guidance on recommended care and where to get it, essentially serving as their health care navigator or quarterback.

Performance-Based Contracts

A portion of the provider's potential rate increases in the future are tied to specific quality metrics and hitting those metrics.

Risk-Sharing

Provider organizations take accountability for the care of a specific patient population and a portion of their payment is based on achieving quality, cost, and patient experience targets. Performance-based contracts and capitation are forms of risk-sharing.

Value-Based Care (VBC)

A shift in the traditional Fee-For-Service health care system to a model that emphasizes the importance of keeping people healthy and rewards physicians for coordinating care, for providing the appropriate care for each patient's situation, and for actual health outcomes. Care providers' compensation in this model is based in part on keeping a population healthy, rather than the number of tests or services performed.