NEW YORK STATE OF OPPORTUNITY. Department of Health

As of 10/10/2017

Value Based Payment (VBP) Acronym List and Key Terms

The following list represents key terms that are important to the NYS VBP Program and are commonly referred to in the NYS VBP Roadmap. This document is intended to support MCOs, providers, community based organizations (CBO) and stakeholders in their transition to VBP.

Acronym	Term	Description
ACA	Affordable Care Act	The Patient Protection and Affordable Care Act, passed in 2010, paved the way for much of the Value Based Care we see today.
ACO	Accountable Care Organization	An organization of clinically integrated health providers that work together to provide, manage, and coordinate health care (including primary care) for a defined population; with a mechanism for shared governance; the ability to negotiate, receive, and distribute payments; and accountability for the quality, cost, and delivery of health care to the ACO's patients.
AHRQ	Agency for Healthcare Research and Quality	The lead Federal agency charged with improving the safety and quality of America's health care system.
CAGs	Clinical Advisory Groups	Created to review the care bundle design and subpopulation definitions most relevant to NYS Medicaid. The CAGs made recommendations to the State on quality measures, data and support required for providers to be successful, and addressed other implementation details related to specific VBP arrangements. CAGs discussed key aspects of the following: Maternity, Chronic Heart/Diabetes, Behavioral Health, HIV/AIDS, Managed Long Term Care, Intellectually/Developmentally Disabled, and Children's Health.
CAHPS	Consumer Assessment of Healthcare Providers and Systems	Surveys consumers and patients to report on and evaluate their experiences with health care. A survey maintained by AHRQ, as seen above.
CBO	Community Based Organization	CBOs are non-profit groups that work to improve the well-being of their local residents. Specifically, these organizations provide a wide variety of social and support services to individuals, families, and populations that range across housing, job placement, transportation, legal services and mental health services.

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CMS	Centers for Medicare and Medicaid Services	The federal agency responsible for administering Medicare and overseeing state administration of Medicaid. CMS signed the 1115a waiver, which allowed for the funding for the DSRIP program.
CQI	Continuous Quality Improvement	Management of population/members through provider alerts, decision tools/dashboards, registries, enhanced access to data.
DFS	Department of Financial Services	A department which incorporated both the NYS Banking Department and the NYS Insurance Department. DFS regulates financial services in the state.
DSRIP	Delivery System Reform Incentive Payment Program	A program designed to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospitable use by 25% over 5 years. The program is $8 Billion+ in funding, and includes a VBP requirement.
EHR	Electronic Health Records	Electronic database that stores confidential patient information
FFS	Fee-for-service	A payment model where services are unbundled and paid for separately. In health care, it gives incentive for physicians to provide more treatments because payment is dependent on quality.
FQHC	Federally Qualified Health Centers	They are federally funded health centers or clinics that focus on serving underserved areas and populations.
HARP	Health and Recovery Plan	Managed Care product that manages physical health, mental health, and substance use services in an integrated way for adults with significant behavioral health needs.
HEDIS	Healthcare Effectiveness Data and Information System	The Healthcare Effectiveness Data and Information System, is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. NCQA collects HEDIS data on behalf of CMS. There are multiple measures that change annually. Data Collection, comes directly from health plans and PPOs through the Healthcare Organization Questionnaire and collects HEDIS nonsurvey data through the Interactive Data Submission System (IDSS)
HH	Health Home	Enhanced care management services. New York State quality measures are compiled using the Health Home Care Management Assessment Reporting Tool (HH-CMART) which is a tool for the collection of standardized

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		care management data for members assigned to health homes. The data is then used for the Department of Health, who will evaluate the findings.
HIT	Health Information Technology	The exchange of health information electronically, with the goal to improve quality of care by reducing costs, errors, and inefficiency.
IBNR	Incurred but not reported	Amount owed by an insurer to all valid claimants who have had covered expense but have not yet reported it.
IPA	Independent Practice Association	A corporation (nonprofit or for-profit) and/or LLC that contracts directly with providers of medical or medically related services, or another IPA in order to contract with one or more MCOs.
IPC	Integrated Primary Care	VBP arrangement that includes: behavioral health, primary care, effective management for chronic disease, etc. It is designed to incentivize primary care providers (PCPs) to collaborate with behavioral health and other specialty medical and community-based providers to improve the quality of preventative care.
MAPP	Medicaid Analytics Performance Portal	A performance management system that provides tools and program performance management technologies to Performing Provider Systems in their effort to develop and implement transformative projects through the DSRIP program. It also supports care management efforts for the State's Health Home program.
MCO	Managed Care Organization	Managed Care is a health care delivery system organized to managed cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies. VBP contracts will be created between MCOs and VBP contractor. MCO manages several contracts that tie together the financial and quality performance of multiple providers.
MLTC	Managed Long-Term Care	A system that streamlines the delivery of long-term services to people who are chronically ill or disabled and who wish to stay in their homes and communities. These services, such as home care or adult day care, are provided through managed long-term care plans that are approved by the New York State Department of Health. The entire array of services to which an enrolled member is entitled can be received through the MLTC plan the member has chosen.

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MRT	Medicaid Redesign Team	Established as a means of finding new ways to lower Medicaid spending in New York State. It is comprised of stakeholders and health care experts from throughout NYS.
NCQA	National Committee for Quality Assurance	A private, not-for-profit organization dedicated to improving health care quality. Maintains the HEDIS Score and researches quality measures, as well as providing accreditation and certification around quality.
NPI	National Provider Identifier	NPI is a unique identification number for covered health care providers. NYS Medicaid will transition to the use of NPI for all providers. NPI will assist NYS ability to recognize and properly reimburse claims.
NSTV	Nulliparous Singleton Term Vertex	A measure which identifies the proportion of live babies born at or beyond 37.0 weeks gestation to women in their first pregnancy, that are singleton (no twins or beyond) and in the vertex presentation
OASAS	Office of Alcohol and Substance Abuse Services	An office within the NYS Department of health that focuses on preventing and treating alcohol and substance abuse.
OHIP	Office of Health Insurance Programs	An office within the NYS Department of Health that is responsible for Medicaid Administration and reimbursement.
OQPS	Office of Patient Quality and Safety	An office within the NYS Department of Health, dealing with Patient Quality and Safety across the state
PAC	Potentially Avoidable Complications	A number of complications or events that may occur during or within 30 days of a stay in a hospital. These complications are considered avoidable with proper medical care.
PFR VBP Measures	Pay for Reporting	A more extensive set of measures that is predominantly process based and required for monitoring and process improvement (e.g. in diabetes care, reporting % of patients with blood pressure in control).
P4P	Pay for Performance	The payment model in which providers are reimbursed based upon the quality of care provided
PDI	Pediatric Quality Indicator	A set of population-based measures that can be used to present information on the quality of pediatric healthcare. These are conditions where 1) the need for hospitalization is potentially preventable with appropriate outpatient care, or 2) conditions that could be less severe if treated early and appropriately in a high

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		quality primary care setting. Implemented by NYS as part of QIP.
PMPM	Per Member Per Month	Refers to the dollar amount paid to MCOs each month by NYS. PMPM is under a capitation revenue stream or cost for each enrolled member each month.
PMPY	Per Member Per Year	Refers to the dollar amount paid to MCOs each year by NYS. PMPM is under a capitation revenue stream or cost for each enrolled member each month.
PPC	Prenatal and Postpartum Care	Monitoring health prior, during, and after birth of both the mother and child.
PPR	Potentially Preventable Readmissions	Part of the nationally recognized measures for avoidable hospital use. PPRs measure readmissions to a hospital following a prior discharge from a hospital and that is clinically-related to the prior hospital admission.
PPS	Performing Provider System	Entities that are responsible for performing a DSRIP project. DSRIP eligible providers, which include both major public general hospitals and safety net providers, collaborating together, with a designated lead provider for the group.
PQI	Prevention Quality Indicators	A set of measures developed by the federal AHRQ or used in assessing the quality of outpatient care for "ambulatory care sensitive conditions”. These are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. The NYS DOH calculates and provide PQI data to MMC plans on a yearly basis.
QARR	Quality Assurance Reporting Requirements	A set of indicators used by the New York State Department of Health to monitor health plan performance. Data collection method used dictates how the statewide averages are represented for each measure. QARR consists of measures from the NCQA’s HEDIAS, CMS QRS Technical Specifications and New York State specific measures. The major areas of performance included in the 2017 QARR are: 1) Effectiveness of Care 2) Access to/Availability of Care 3) Satisfaction with the Experience of Care 4) Use of Services 5) Health Plan Descriptive Information 6) NYS-specific measures

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VBP QIP	Quality Improvement Program	Distressed facilities that receive extra funds from NYS to ensure they remain open. They are required to enter into Level 1 VBP arrangements and develop sustainable plans to remain eligible for funding
QIP	Quality Incentive Program	A NYS incentive program that incentivizes health plans and their providers to improve the measurement and delivery of health care to Medicaid managed care enrollees. Currently, the QIP has a defined methodology to determine the percentage of the potential financial incentive that a plan receives, based on results from the four components of Quality of Care, Consumer Satisfaction, PQIs and Compliance. Compliance points are deducted for any Statements of Deficiency issued for failure to fulfill managed care requirements. Assessments of quality satisfaction and efficiency are derived from QARR measures, satisfaction data from CAHPS, and AHRQ's PQIs.
RHIO	Regional Health Information Organization	A multi-stakeholder organization created to facilitate a health information exchange among stakeholders of that region's healthcare system.
SDH	Social Determinant of Health	Conditions in which people are born, grow, live, work. Their circumstances are affected by the distribution of money, power, and resources. VBP contractors in Level 2 or Level 3 agreements will be required statewide to implement at least one SDH intervention. DOH has created a reporting template that will be used to measure progress.
TCGP	Total Care for General Population	A VBP arrangement by which party(ies) contracted with the MCO assumes responsibility for the total care of its attributed population
VBP	Value Based Payments	A methodology of arrangements which incentivize value and quality of care, in contrast to the current arrangement of incentivizing quantity of care

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VBP Levels and Arrangement Types Acronym Listing		
Acronym	Term	Description
VBP Level 0	Value Based Payments Level 0	The initial level of Value Based Payments. This level consists of FFS with bonus and/or withhold based on quality scores.
VBP Level 1	Value Based Payments Level 1	FFS with upside-only shared savings when outcome scores are sufficient.
VBP Level 2	Value Based Payments Level 2	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)
VBP Level 3	Value Based Payments Level 3	Only feasible after experience; requires a mature PPS. This level consists of Global capitation. (with an outcome-based component)

Source: VBP Roadmap

VBP Arrangements by Level				
Options	Level 0	Level 1	Level 2	Level 3
All care for total population	FFS with bonus and/or withhold based upon quality scores	FFS with upside-only shared savings when outcome scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Global capitation (with outcome-based component)
Integrated Primary Care	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS (plus PMPM subsidy) with upside only shared savings based on total cost of care (savings available when outcomes scores are sufficient)	FFS (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM Capitated Payment for Primary Care Services (with outcome-based component)
Acute and Chronic Bundles	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundle of care (savings available when outcome scores are sufficient)	FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced when outcome scores are high)	Prospective Bundled Payment (with outcome-based component)
Total Care for Subpopulation	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on subpopulation capitation (savings available when outcome scores are sufficient)	FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM Capitated Payment for total care for subpopulation (with outcome-based component)

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