Alternative Payment Model Term Glossary

The definitions in this glossary reflect AAPMR's current understanding of these terms as they are used in the context of health system transformation and delivery system reform, which focuses on transitioning the health system away from incentives to maximize the volume of care delivered and instead emphasize high-value, efficient, and accountable care delivery. Some of these terms may be defined differently in different contexts.

Accountable Care Organization (ACO): An ACO is a network of doctors, hospitals, and other providers that share financial and medical responsibility for providing coordinated care to patients to optimize care, prevent duplication and errors, and limit unnecessary spending. ACOs seek to make providers jointly accountable for the health of their patients, generally giving them financial incentives tied to quality metrics and overall costs for care.

Advanced Alternative Payment Model (APM): A specific class of alternative payment models defined by the Centers for Medicare and Medicaid Services (CMS) for the purposes of adjusting payment under the Quality Payment Program. To qualify as an Advanced APM, APMs must meet specified criteria related to the use of certified electronic health record technology, payment based on quality measures comparable to those used in MIPS (see separate definition), and financial risk. As an alternative to the financial risk requirement, some APMs may qualify as Advanced APMs if they are medical home models that meet certain criteria specified by CMS. Significant participation in Advanced APMs can allow participants of Advanced APMs to qualify for a 5% incentive payment from 2019 through 2024, or higher annual payment updates than they would otherwise receive starting in 2026.
See also: Alternative Payment Model

Alternative Payment Model (APM): A general term used to describe payment arrangements that are not purely fee-for-service. These tend to be value-based payment approaches that apply financial incentives intended to foster the provision of high-quality and cost-efficient care. APMs can apply, for example, to a specific clinical condition, a care episode, or a patient population.

Bundled Payment Model: A type of APM that involves linking payment for a bundle of related services for an episode of care. Bundled payment models generally establish specified payment amounts (e.g., "target prices) based on the expected costs of those items and services furnished to a patient during the episode that are included in the bundle. Providers participating in bundled payment models are typically incentivized to manage costs while achieving positive outcomes for patients, for example by standardizing care, optimizing costs for services provided under the bundle, minimizing complications, and maximizing outcomes to optimize financial benefit. Generally, when costs for the bundled services fall below contracted or target amounts for the bundle, model participants may retain some or all the savings; alternatively, if costs fall above that amount, model participants may be responsible for excess costs. Financial benefits and costs are governed by the terms of the specific model in which a provider participates. Episodes of care typically have a specified starting point, such as the day of a scheduled operative procedure or the onset of symptoms, and a time-related endpoint, such as 90 or 180 days from the starting date. The Medicare Bundled Payments for Care Improvement Advanced (BPCI-A) Model is a

bundled payment model operated by the CMS Innovation Center and qualifies as an Advanced APM under the Quality Payment Program.

Capitation: Capitation is a type of payment arrangement under which providers or other entities are given a fixed amount of money per patient per unit of time for the delivery of health care services. The per-patient payment is based on the range of services that are provided and the period during which the services are provided. Under full-capitation arrangements, there is generally no separate fee-for-service payment for specific services that are already covered by the capitated amount.

Center for Medicare and Medicaid Innovation (CMMI, or CMS Innovation Center): Established under the Affordable Care Act, this Center within the Centers for Medicare and Medicaid Services (CMS) oversees the development and testing of innovative health care payment and service delivery models for Medicare, Medicaid, and CHIP.

The Centers for Medicare and Medicaid Services: Part of the U.S. Department of Health and Human Services, a federal agency that administers the Medicare, Medicaid, and CHIP programs, and that implements and oversees the private health insurance reforms included in the Affordable Care Act.

Downside Risk: This refers to payment arrangements under which providers or other entities assume the risk of a financial penalty (typically a portion of excess costs) if the cost of care under a given contract exceeds an agreed upon target. Downside risk can be included in contracts that provide incentives for meeting cost and outcome targets. Some consider the assumption of downside risk to reflect a greater commitment to achieving cost and outcome metrics.

Episode of Care: An episode of care describes a set of services provided to treat a certain condition or conduct a specific procedure during a fixed period. Depending on the definition of the episode, it may begin with a diagnosis or a procedure and may continue through acute and post-acute care related to the condition or procedure.

Fee-for-Service: Fee-for-service is a payment system under which the provider is generally paid a fee for each unit of service rendered.

Medical Home: The medical home is an approach to providing comprehensive primary care that emphasizes team-based care, enhanced patient access, and care coordination between patients, families, medical staff, and clinicians. Medical homes may also emphasize “neighbors” including specialists and other providers who are accessible to the patient through the care coordinated by the medical home team.

Medicare Access and CHIP Reauthorization (MACRA) Act of 2015: This act implemented widespread reforms for payment for physicians and other health professionals under the Medicare program. The Act was responsible for creating the Merit-based Incentive Payment System (MIPS) and for providing incentives for significant participation in Advanced APMs. It also created the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

Medicare Payment Advisory Commission (MedPAC): The MedPAC is a nonpartisan legislative branch agency that provides Congress with analysis and policy advice on issues which affect the Medicare program.

Medicare Shared Savings Program: The Medicare Shared Savings Program is a program established by the Patient Protection and Affordable Care Act that offers Medicare providers and suppliers an opportunity to create an Accountable Care Organization (ACO). The ACO, in turn, agrees to be responsible for the quality, cost and patient care experience for an assigned Medicare fee-for-service population, and may benefit from sharing in any cost savings relative to a benchmark if quality standards are also achieved. The Medicare Shared Savings Program includes different participation options with varying levels of downside risk, through which participating ACOs are expected to advance to take on successively higher levels of risk. This program seeks to promote accountability, better coordinate care, and encourage investment in infrastructure and redesigned care processes.

Merit-based Incentive Payment System (MIPS): MIPS is a value-based program established by MACRA that applies to payments under the Medicare Physician Fee Schedule and that comprises one of the tracks under the Quality Payment Program. Under MIPS, clinicians are assessed in four performance categories: Quality, Improvement Activities, Promoting Interoperability, and Cost. Based on performance across all applicable categories, MIPS eligible clinicians may qualify for an upward, neutral, or downward payment adjustment on their payments for covered professional services under Medicare Part B.

MIPS Value Pathways (MVP) - The MVP framework was first introduced in the Calendar Year 2020 Medicare Physician Fee Schedule as an alternate reporting pathway under MIPS. According to CMS, the MVP framework aims to align and connect measures and activities across the four MIPS performance categories for different specialties or conditions, such that measures, and activities are more meaningful to a clinician's practice, specialty, or public health priority.

Physician-Focused Payment Model Technical Advisory Committee (PTAC): This Committee was established under MACRA to encourage stakeholder engagement in the development of physician-focused payment models. The Committee is responsible for reviewing models developed and submitted by stakeholders and to prepare and submit comments and recommendations on such models to the Secretary of Health and Human Services.

Quality Payment Program (QPP): The QPP is the program established by CMS to implement the Medicare Physician Fee Schedule payment reforms enacted by MACRA. It includes two tracks: (1) MIPS and (2) the Advanced APM track. Both tracks offer incentives for physicians and other clinicians based on performance.

Two-sided risk: This refers to payment arrangements that include both upside (or one-sided) risk and downside financial risk

Upside Risk (or One-sided Risk): This refers to payment arrangements under which providers or other entities may achieve additional financial payments (typically a portion of savings) beyond what was already provided for care delivery if they achieve savings relative to a defined target. Under upside-only risk arrangements, providers are not required to assume any risk of financial penalty if the cost of care exceeds an agreed upon target.

Value-Based Healthcare (VBH): An approach to healthcare payment and delivery that seeks to hold participants, including hospitals and physicians, are accountable for the cost and quality of health care that is furnished. For example, participants may receive incentive payments for high-quality, high-value care or penalties for low-quality, low-value care.