CareQuest Institute for Oral Health®

Value-Based Care Readiness Assessment Glossary of Terms

- **Accountable Care Organization (ACO**) – Care entities designed to improve care coordination and delivery, measured by people's health outcomes.

- **Alternative Payment Models (APMs)** – Forms of reimbursement that are not based on the traditional fee-for-service (FFS) model and are, instead, expected to demonstrate better outcomes for patients at a lower cost. An Alternative Payment Model (APM) is 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.
- **Capitation** – A flat rate payment system in which providers or a group of providers are given a set amount of money for each enrolled person assigned to them, per period, whether that person seeks care. This amount is based on the number of patients within the practice and many other factors related to the cost of care to patients. The intent of a capitated payment is to relieve providers of their need to bill for every patient service to earn income at each visit, thus allowing them to focus more on patient health outcomes.

- **Caries Risk Assessment** – Categorizes a patient's overall risk of developing caries, based on history and clinical examination.

- **Coordinated Care Organization (CCO**) – A network of all types of health care providers who work together in their local communities to serve people who receive health care coverage under certain health plans.

- **CDT Code –** A code set with descriptive terms developed and updated by the American Dental Association (ADA) for reporting dental services and procedures to dental benefits plans.

- **CPT Code –** A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.

- **Dentistry** – A broad profession that focuses on the treatment of diseases and other conditions that affect the teeth, gums, and supporting structures.

- **Dental Care** – Often refers to the surgical interventions and maintenance of the mouth.

- **Dental Care Organization** – An organization that contracts with a managed care organization to provide service to the catchment area for which they are responsible.

These types of organizations, i.e., Advantage Dental by DentaQuest can and should strive to operate at lowest cost, best care, and provide adequate access to the members of the managed care organization or insurance company.

- **Dental Service Organizations (DSOs**) – Independent businesses that handle administration and operation for their own group of dental practices. This ownership structure is an alternative to private-owned dental practices, in which the provider/single owner is responsible for administration and operations for their own practice.

- **Downside Risk** – The provider or practice shares in the savings if the actual total costs of care of assigned patients are lower than projected budgeted costs, and if the actual total costs of care exceed the budget costs, the practice is responsible for the difference.

- **Fee-For-Service (FFS)** – Payment model in which a provider is paid for each individual service rendered to a patient. Most commercial/private insurance companies reimburse providers this way, as do many Medicaid Managed Care companies.

- **Global Payment –** A fixed prepayment made to a group of providers or a health care system as opposed to a health care plan to cover most or all a patient's care during a specified time period. Full capitation with quality indicators is sometimes also referred to as global payment.

- **Health Care Payment Learning and Action Network (HCPLAN)** – Launched by the Department of Health and Human Services in 2015, HCPLAN is a collaborative network of private stakeholders across sectors whose mission is to accelerate the health care system's transition to alternative payment models (APMs) by combining the innovation, power, and reach of the public and private sectors.

- **ICD-10 Code –** International Classification of Diseases, 10th edition, Clinical Modifications: A standard diagnostic code set and classification system used to track health care statistics/disease burden, managing health and treating conditions, quality outcomes, mortality statistics and for billing/payment purposes.

- **Interprofessional Practice (IPP)** – Frequently refers to the collaboration and integration of care among medical and dental professionals, however this term is inclusive of other professions beyond those two such as mental health. When referring specifically to medical and dental, use "medical-dental integration."

- **Low Valued Health Care –** Unnecessary health care services (medical tests and procedures) that have proven to add little to no value in clinical circumstances, which can lead to potential risks for patients and higher total cost of care.

- **Medicaid Managed Care** – A health care delivery system organized to manage cost, utilization, and quality. Medicaid health benefits and additional services are delivered

through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

- **Minimally Invasive Dentistry** – Respecting the health, function, and aesthetics of all oral tissues by preventing disease from occurring or by intercepting its progress with minimal tissue loss.

- **Oral Health –** As a fundamental component of health, physical and mental well-being, oral health is multi-faceted and includes the ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and without pain, discomfort and disease of the craniofacial complex.

- **Pay-for-Performance (P4P)** – A reimbursement model that offers financial incentives for meeting certain performance measures. The measures usually include reducing costs and meeting health measures or patient outcome goals. The intention of the model is to incentivize quality and the value resulting from care rather than the volume of care. Incentives are typically paid on top of a base payment such as fee-for-service or population-based payment models. In some cases, if providers do not meet quality of care targets, their base payment is adjusted downward the subsequent year. Note: this term is sometimes used interchangeably with “value-based purchasing."

- **Person-Centered Care (PCC)** – An approach to health built on life-long relationships among people, providers, communities, and other invested in a person’s whole life and circumstances for overall well-being.

- **Patient-Centered Care** – A care model focused on improving experiences within the clinical setting until people are healthy, from managing specific diseases to empowering patients to best navigate the health care system.

- **Performance Measurement** – Performance measurement encompasses the development and implementation of metrics that assess the clinical quality, health outcomes, patient care experience, and cost of care provided to patients. Performance measurement can be used both for accountability and improvement purposes. Performance measurement makes it possible to monitor and quantify how well population-based payment models achieve and reward the Triple Aim of better care, better health, and lower costs.

- **Population** – A group of people who are cared for by a particular provider, live in a particular community, or share a similar characteristic (e.g., condition, age, gender, race, or ethnicity).
- **Population-Based Payment (PBP)** – Population-based payment models offer providers the incentives and flexibility to strategically invest delivery system resources, treat patients holistically, and coordinate care.

- **Population-Based Payment Model** – A payment model in which a provider organization is given a population-based global budget or payment and accepts accountability for managing the total cost of care, quality, and outcomes for a defined patient population across the full continuum of care. PBP models discussed in this paper correspond to payment models in Categories 3 and 4 of the LAN's APM Framework.

- **Population Health** – An interdisciplinary, customizable approach that allows health departments to connect practice to policy for change to happen locally. This approach utilizes non-traditional partnerships among different sectors of the community – public health, industry, academia, health care, local government entities, etc. – to achieve positive health outcomes. Population health "brings significant health concerns into focus and addresses ways that resources can be allocated to overcome the problems that drive poor health conditions in the population.
- **Quadruple Aim –** The quadruple aim adds provider experience or satisfaction as a fourth objective to the Institute for Healthcare Improvement's (IHI) framework for optimizing health system performance known as the triple aim (see definition below).
- **Risk-based Reimbursement** – Payments are predicated on an estimate of what the expected costs to treat a particular condition or patient population should be. This includes capitation, bundled payments, and shared savings arrangements.
- **Shared Savings** – Provides an incentive for providers or provider entities to reduce unnecessary health care spending for a defined population of patients, or for an episode of care, by offering providers a percentage of any realized net savings (e.g. upside risk only). "Savings" can be measured as the difference between expected and actual cost in a given measurement year, for example. Shared-savings programs can be based on a FFS payment system. Shared Savings can be applied to some or all of the services that are expected to be used by a patient population and may vary based on provider performance.

- **Social Determinants of Health (SDOH)** – The circumstances in which people are born, grow, live, work, and age that can influence health, as well as the systems put in place to deal with illness.

- **Triple Aim** – A framework for optimizing health system performance proposed by the Institute for Healthcare Improvement (IHI) which aims to simultaneously accomplishing three critical objectives: to improve health outcomes for individuals and populations, to provide better quality and experience of care, and to manage per capita costs and annual rate of increase for the cost of care.

- **Value-Based Care (VBC) –** A model designed to align patient or provider behaviors to achieve better outcomes at lower costs.

- **Value-Based Equation –** Value = Quality/Cost

- **Value-Based Payment (VBP)** – A generic term used to describe a payment model where the amount of payment for a service depends in some way on the quality or cost of the service that is delivered. There is no accepted minimum standard as to how much the payment must vary or what type of value measure must be used, so some payment models have been described as "value-based" even though there is very little difference in the amount of payments based on differences in quality or cost.

- **Value-Based Purchasing** – This is another way to say value-based care. Value-based purchasing looks at the form of reimbursement from the insurer's perspective. Payments for care delivery are tied to the costs and quality of care provided and rewards providers for both efficiency and effectiveness.

**Definitions have been adapted from several sources, including the Centers for Medicaid and Medicaid Services, American Academy of Pediatrics, Centers for Disease Control, Center for Healthcare Quality & Payment Reform, Health Affairs, Health Care Payment and Learning Action Network, Health Services Research, the Institute for Healthcare Improvement, and other organizations.*