Glossary of Terms - Healthcare Reform

Accountable Care Organizations (ACOs): Groups of providers who agree to meet specific quality measures and deliver care based on a projected spending rate and who keep part of any savings generated (may or may not owe Medicare money if spending exceeds projected rate).

Affordable Care Act (ACA): The goal of the ACA is to improve access, quality and efficiency while reducing and controlling spending. Paid for by a combination of newly insured, new taxes and fees, Medicare payment cuts, and changes in payment for services to recognize quality and efficiency.

Bundled Payments for Care Improvement (BPCI): Medicare program where a single payment (or bundled payment) is issued and shared by physicians, hospitals and/or post-acute providers involved in delivering an episode of care during a specific time period (depending on the model selected).

E-Prescribing (eRx): A provider's ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point-of-care. An important element in improving the quality of patient care by reducing errors and one of the key action items to expedite the adoption of electronic medical records and build a national electronic health information infrastructure in the United States.

Health Insurance Exchanges (HIEs): Competitive, federal- and state-based online marketplaces for individuals and small employers to compare and purchase health coverage. An important component of the ACA's coverage expansion initiative.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): A national, standardized, publicly reported survey of patients' perspectives of hospital care. Used as part of the Patient Experience of Care domain for the Hospital Value-Based Purchasing program.

Physician Quality Reporting System (PQRS): A reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).

Surgical Care Improvement Project (SCIP): A national quality partnership of organizations interested in improving surgical care by significantly reducing surgical complications. Develops measures used to improve quality of care. Data used as part of the Clinical Process of Care domain for Medicare's Hospital Value-Based Purchasing program.

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Medicare Quality Programs - Hospital Summary FY2016

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Program Name	Program Description	Effective Date FY=Fiscal Year (Oct. 1 - Sept. 30)	Incentive - or - Penalty	Incentive/Penalty Defined
Inpatient Quality Reporting Program (IQR)	**GOAL: Provide hospitals a financial incentive to report the quality of their services and provide CMS with data to help consumers make more informed decisions about their health care** - Requires hospitals to report data on measures selected by the Secretary of Health and Human Services (HHS) for the Hospital IQR Program - For the FY 2016 payment determination, the IQR Program allows hospitals to choose from four measure sets (STK, ED, VTE and PC) to be submitted as electronically specified clinical quality measures (eCQMs). - Some of the hospital quality of care information gathered through the program is available to consumers on the Hospital Compare website at: *www.hospitalcompare.hhs.gov*	**FY2009**	**PENALTY**	Hospitals that do not successfully participate in the IQR program will lose one quarter of their annual percentage increase to their FY2016 Medicare INPATIENT payments, which would mean a loss of 0.6% of their FY2016 market basket update.
Electronic Health Record (EHR) *(aka "Meaningful Use")*	**GOAL: Encourage use of certified EHR technology in ways that can positively impact patient care** - Eligible Hospitals (EHs) can qualify for incentive payments under the Medicare EHR Incentive Program if they successfully demonstrate "meaningful use" - Hospitals can begin receiving EHR incentive payments in any federal fiscal year (FY) from FY2011 to FY2015, but payments will decrease for hospitals that start receiving payments in 2014 and later - Incentive payments to EHs are based on a number of factors, beginning with a $2M base payment - EHs that do not successfully demonstrate meaningful use of certified EHR technology will be subject to Medicare payment adjustments (aka, penalties)	**FY2009**	**INCENTIVE** (thru FY2016)	Potential incentive amounts vary based on initial year of participation.
			PENALTY	Eligible hospitals that do no demonstrate meaningful use will lose one quarter of their annual percentage increase to their FY2016 Medicare INPATIENT payments, which would mean a loss of 0.6% of their FY2016 market basket update.
Hospital- - Acquired Condition Reduction Program (HAC)	**GOAL: Reduce reasonably preventable hospital-acquired conditions and infections (e.g. certain health care-associated infections, foreign objects left after surgery and other patient safety issues)** - Currently 11 events or conditions identified (e.g. falls, pressure ulcers, surgical site infections, etc.) - Hospitals with a Total HAC score in the lowest performing quartile (25%) will be penalized beginning in FY2015 - Uses hospital Inpatient Quality Reporting (IQR) data with a 2-year lag period from two distinct domains. *- Domain 1 = AHRQ patient safety measures reported July 1, 2011 thru June 30, 2013 (35%)* *- Domain 2 = CDC/NHSN surveillance measures reported July 1, 2012 thru Dec. 31, 2013 (65%)*	**FY2015**	**PENALTY** (eff. FY2015)	Potential reduction of 1.0% to a hospital's total Medicare INPATIENT DRG payments, beginning FY2015 for all inpatient discharges (not restricted to those being measured). Since FY2008: No reimbursement for additional cost of care under the HAC Present on Admission (POA) program.
Readmission Reduction Program (RRP)	**GOAL: Reduce excessive 30-day hospital INPATIENT readmissions** - Measured conditions for FY2016 include heart attack, heart failure, pneumonia, COPD, and hip/knee replacements - Expect focus to expand in future years to include CABG (FY2017) and potentially other additional conditions as determined by CMS - Uses hospital readmission data with a 3-year lag period (e.g. FY2016 uses hospital readmission data reported July 1, 2011 – June 30, 2014)	**FY2013**	**PENALTY**	Potential reduction of 3.0% to a hospital's base Medicare INPATIENT DRG payments in FY2016 and beyond for all inpatient discharges (not restricted to those being measured).
Value-Based Purchasing (VBP)	**GOAL: Measure, report and reward excellence in healthcare delivery** - For FY2016, hospitals will be evaluated in four main areas (domains) to create a Total Performance Score (TPS) (data reporting periods vary by domain): - Outcomes (40%) - Efficiency/cost Reduction (25%) - Patient Experience (25%) - Clinical Process of Care (10%) - Pay-for-performance program that withholds a portion of all Medicare INPATIENT DRG payments for all hospitals	**FY2013**	**INCENTIVE & PENALTY**	Withhold of 1.75% of a hospitals FY2016 base Medicare INPATIENT DRG payments. Withhold amounts are then redistributed to top hospital performers, based on Total Performance Score (TPS), via increases in the following year's INPATIENT DRG payments. (withhold increases 0.25% annually to a max of 2.0% in FY2017 and beyond)

For additional information, visit Medicare's **'Quality Initiatives'** section on the CMS website (www.cms.gov/Medicare/Medicare.html) or enter the specific program of interest in the search box.