FEDERAL & NEW YORK STATE
HEALTHCARE REFORM GLOSSARY

Access: The ability to obtain needed medical care. Access to care is often affected by the availability of insurance, the cost of care, and the geographic location of providers.

Accountable Care Organization (ACO): An ACO is a local health care organization and a related set of providers (at a minimum, primary care physicians, specialists, and hospitals) that can be held accountable for the cost and quality of care delivered to a defined patient population. The goal of the ACO is to deliver coordinated and efficient care. ACOs that achieve quality and cost targets will receive some sort of financial bonus, and under some approaches, those that fail will be subject to a financial penalty.

Advanced Primary Care (APC): Leading model for efficient management and delivery of quality health care services that builds on the principles embodied by the NCQA-certified medical home. An APC practice utilizes a team approach, with the patient at the center. The care model emphasizes prevention, health information technology, care coordination and shared decision-making among patients and their providers. The APC model is designed to leverage the strengths of New York State's emerging NCQA-certified medical homes while laying out a graduated path for all practices to advance toward integrated care.

Affordable Care Act of 2010 (ACA): Also known as the Patient Protection and Affordable Care Act, ACA along with the changes included in the Health Care and Education Affordability Reconciliation Act of 2010, constitutes comprehensive federal health care reform that aims to substantially increase health insurance coverage of Americans, end some insurance company abuses, reduce health care costs, and improve care. The law includes far-reaching changes for health care providers, including significant reductions in reimbursement.

Agency for Healthcare Research and Quality (AHRQ): Federal agency charged with improving the quality, safety, efficiency, and effectiveness of and effectiveness of health care for all Americans.

Assertive Community Treatment (ACT): A multidisciplinary team treatment model provided by the mental health system that offers comprehensive, community-based psychiatric treatment, rehabilitation, and support to people with long-term psychiatric disabilities.

American Health Benefits Exchange (AHBE): The Affordable Care Act directs states to develop an AHBE for individuals who are unable to obtain employer-sponsored health insurance coverage, by January 1, 2014.

Ambulatory Care: Health care services that do not require the hospitalization of a patient. These services include outpatient care at a hospital and care provided at a physician's office, clinic, or other facility.

Avoidable Hospital Use: This term is used to designate all avoidable hospital service use including avoidable emergency department use, avoidable hospital admissions and avoidable hospital readmissions within 30 days. This can be achieved

through better aligned primary care and community based services, application of evidence based guidelines for primary and chronic disease care, and more efficient transitions of care through all care settings.

Capitation: A method of paying for health care services under which providers receive a set payment for each person instead of receiving payment based on the number of services provided or the costs of the services rendered. These payments can be adjusted based on the demographic characteristics, such as age and gender, or the expected costs of the members.

Case Management: The process of coordinating medical care provided to patients with specific diagnoses or those with high health care needs. These functions are performed by case managers who can be physicians, nurses, or social workers.

Case Mix Index: A number which represents an average of a facility's patient review instrument scores at a moment in time. A higher score generally means that residents require a great deal of care, and therefore, the facility receives higher reimbursement.

Centers for Medicare and Medicaid Services (CMS): Federal agency responsible for administering Medicare and overseeing the state administration of Medicaid.

Chronic Care Management: The coordination of both health care and supportive services to improve health status of patients with chronic conditions, such as diabetes and asthma. The goals of these programs are to improve the quality of health care provided to these patients and to reduce costs.

Clinical Quality Measure: CMS' Clinical Quality Measures help measure and track the quality of health care services provided by hospitals and providers. CQMs measures aspects of patient care including: health outcomes, clinical processes, patient safety, efficient use of health care resources, care coordination, patient engagement, population and public health, and clinical guidelines. Providers are required to report CQMs to CMS as part of quality improvement and reimbursement programs.

Community Health: Health and quality-of-life improvement initiatives that improve the health and well being of people in the local community and use resources effectively and efficiently to promote health and reduce the overall cost of health care.

Community Health Needs Assessment: Section 501(r) of the Affordable Care Act requires hospitals to conduct a Community Health Needs Assessment every three years and adopt an implementation strategy to meet the community health needs identified.

Community Health Worker (CHW): Community health workers are lay members of communities who work with the local health care system and usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve. They have been identified by many titles such as community health advisors, lay health advocates, outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): Surveys that ask consumers and patients to report on and evaluate their experiences with health care. The surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of

providers and ease of access to health care services. The CAHPS program is funded and overseen by the U.S. Agency for Healthcare Research and Quality (AHRQ).

Continuous Quality Improvement (CQI): A management strategy that builds quality into every aspect of the organization, encouraging staff to become involved in problem-solving processes to improve operations.

Continuum of Care: A comprehensive set of services including preventive, acute, long-term, and rehabilitative services, or the set of providers offering those services.

Delivery System Reform Incentive Payment Program (DSRIP): As part of New York's Medicaid Redesign Team (MRT) Waiver Amendment, DSRIP's purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goals stabilizing the safety-net system and reducing avoidable hospital use by 25% over 5 years. DSRIP is the largest piece of the MRT Waiver Amendment with a total allocation of $6.9 billion.

DSRIP Achievement Value: Points received by a Performing Provider System for reaching a specified performance target/milestone during a specific reporting period. Achievement values are either expressed as 0=not meeting benchmark or 1=meeting benchmark. Achievement Values are used to determine incentive payments based on performance.

DSRIP Attribution: A formula used to determine how a population is assigned to an affiliated group of providers responsible for the care of the population. For DSRIP, attribution will be done utilizing a hierarchical geographic and service loyalty methodology, to ensure that a beneficiary is only assigned to one Performing Provider System.

DSRIP Baseline Data: A set of data collected at the beginning of a study or before intervention has occurred. For DSRIP, Performing Provider System improvement targets will be established annually using the *baseline data* for DY 1 and then annually thereafter for DY2-5. The state must use existing data accumulated prior to implementation to identify performance goals for performing providers.

DSRIP Clinical Improvement Milestones: Noted under Domain 3, these milestones focus on a specific disease or service category, e.g., diabetes, palliative care, that is identified as a significant cause of avoidable hospital use by Medicaid beneficiaries. Milestones can either relate to process measures or outcome measures and can be valued either on reporting or progress to goal, depending on the metric. Every Performing Provider System must include one strategy from behavioral health. Payment for performance on these outcome milestones will be based on an objective demonstration of improvement over baseline, using a valid, standardized method.

DSRIP Domain: Overarching areas in which DSRIP strategies are categorized. Performing Provider Systems must employ strategies from the domains two through four in support of meeting project plan goals and milestones. Domain one is encompasses project process measures and does not contain any strategies. The Domains are:

- Domain 1: Overall Project Progress
- Domain 2: System Transformation
- Domain 3: Clinical Improvement
- Domain 4: Population-wide Strategy Implementation

DSRIP High Performance Fund: A portion of the Public Hospital Transformation Fund and Safety Net Performance Provider System Transformation Fund will be set aside to reward Performing Provider Systems that exceed their metrics and achieve high performance by exceeding a preset higher benchmark for reducing avoidable hospitalizations or for meeting certain higher performance targets for their assigned behavioral health population.

DSRIP Index Score: An evaluation or score assigned to DSRIP projects, based on five elements (1. Potential for achieving system transformation, 2. Potential for reducing preventable event, 3. % of Medicaid beneficiaries affected by project, 4. Potential Cost Savings and 5. Robustness of Evidence Based suggestions). Project index scores are set by the state and are released prior to the application period.

DSRIP Lead Coalition Provider: Provider that is primarily responsible for ensuring that the coalition partnerships meet all requirements of performing provider systems (PPS), including reporting to the state and CMS.

DSRIP Learning Collaborative: Learning collaboratives are required forums for Performing Provider Systems to share best practices and get assistance with implementing their DSRIP projects.

DSRIP Maximum Application Valuation: Represents the highest possible financial value placed on a Performing Provider System's final DSRIP plan. The Maximum Application Valuation is the sum of the of all the maximum project valuation for each of the projects within a Performing Provider System DSRIP application.

DSRIP Maximum Project Valuation: Represents the highest possible financial value placed on an individual project within a Performing Provider System's final DSRIP plan.

DSRIP Mid-point assessment: As part of the DSRIP review and ongoing funding, during DY3 of DSRIP, the state's independent assessor shall assess Performing Provider Systems performance to determine whether their DSRIP project plans merit continued funding and provide. Based on the findings, the independent assessor makes a recommendation to the state. The state then uses the assessor's recommendations to determine whether a project plan should be continued, discontinued or continued with alterations to the project plan.

DSRIP Milestone: DSRIP project actions or activity goals, achieved over time.

DSRIP Percentage Achievement Value (PAV): The ratio of the actual Achievement Value (AV) points earned by a Performing Provider System for meeting performance metrics during a reporting period to the total possible achievement value points that could have been earned by the Performing Provider System during the reporting period.

DSRIP Performing Provider Systems (PPS): 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.

DSRIP Population-wide Project Implementation Milestones: Also known as Domain 4, DSRIP performing provider systems responsible for reporting progress on measures from the New York State Prevention Agenda.

DSRIP Prevention Agenda: As part of DSRIP Domain 4, Population-wide Strategy Implementation Milestones, the Prevention Agenda refers to the "blueprint for state and local action to improve the health of New Yorkers in five priority areas and to reduce health disparities for racial, ethnic, disability, socioeconomic and other groups who experience them", as part of New York State's Health Improvement Plan.

DSRIP Project: Individual method created by a Performing Provider System to transform the delivery of care that support Medicaid beneficiaries and uninsured as well as address the broad needs for the population the performing provider system serves. DSRIP projects will be designed to meet and be responsive to community needs while meeting 3 key elements: appropriate infrastructure, integration across settings and assumes responsibility for a define population.

DSRIP Project Plan: Detailed plans that Performing Provider Systems submit to the state detailing DSRIP strategies they have selected to be directly responsive to the needs and characteristics of the their community in order to DSRIP's objectives.

DSRIP Project Progress Milestones: Also known as Domain 1, measures the investments in technology, tools, and human resources that strengthen the ability of the performing provider systems (PPS) to serve target populations and pursue DSRIP project goals. The Project Progress milestones include monitoring of the project spending and post-DSRIP sustainability. In addition, submission of quarterly reports on project progress specific to the PPS DSRIP project and it's Medicaid and low-income uninsured patient population.

DSRIP Project Toolkit: A state developed guide that will provide additional information on the core components of each DSRIP strategy, how they are distinct from one another, and the rationale for selecting each strategy (i.e. evidence base for the strategy and it's relation to community needs for the Medicaid and uninsured population). In addition, the strategy descriptions provided in the toolkit will be used as part of the DSRIP Plan Checklist and can serve as a supplement to assist providers in valuing projects.

DSRIP Project Valuation: Process by which the state assigns monetary value to Performing Provider Systems' final project plans.

DSRIP Quality Strategy: A requirement of the 1115 Waiver, delineates the goals of the NYS Medicaid managed care program and the actions taken by the New York State Department of Health to ensure the quality of care delivered to Medicaid managed care enrollees.

DSRIP Rapid Cycle Evaluation: As part of the DSRIP Project Plan submission requirements, the Performing Provider Systems must include in its' plan, an approach to rapid cycle evaluation, which informs the system in a timely fashion of its progress, how that information will be consumed by the system to drive transformation and who will be accountable for results, including the organizational structure and process to be overseen and managed.

DSRIP Statewide Accountability: New York State meeting overall state milestones as described in the STCs and Attachment I. Statewide achievement of performance goals and targets must be achieved and maintained for full access to the funding level as specified in the STCs.

DSRIP System Transformation Milestones: Also known as Domain 2, these are outcomes based on a community needs assessment, which reflect measures of inpatient/outpatient balance, increased primary care/community-based services utilization, rates of global capitation, partial capitation, and bundled payment of providers by Medicaid managed care plans and measures for patient engagement.

DSRIP Valuation Benchmark: An external benchmark expressed in a per capita value that is based on a similar delivery reforms and used in the project valuation process. The valuation benchmark is set based on the overall scope of applications received with a maximum statewide value on $15.

Diagnosis Related Groups (DRGs): A method for classifying patients in categories according to patient diagnosis and treatment resource requirements. It is the basis for CMS' hospital Prospective Payment System for Medicare and for state Medicaid inpatient reimbursement.

Disproportionate Share Hospital: A hospital that serves a relatively large volume of low-income patients. These hospitals receive an additional payment amount under the Medicare Prospective Payment System.

Dual Eligibles: A term used to describe an individual who is eligible for Medicare and for some level of Medicaid benefits. Most dual eligibles qualify for full Medicaid benefits including nursing home services, and Medicaid pays their Medicare premiums and cost sharing. For other duals Medicaid provides the "Medicare Savings Programs" through which the enrollees receive assistance with Medicare premiums, deductibles, and other cost sharing requirements.

Electronic Medical Record: A computer-based patient medical record, an EMR facilitates access to patient data by clinical staff at any given location, claims processing by insurance companies, automated checks for drug and allergy interactions, clinical notes, prescriptions, and scheduling.

Fee-For-Service: The traditional payment system in which the health care provider bills the patient or insurer for each visit and service provided.

Federally Qualified Health Center (FQHC): FQHCs are community-based and patient-directed organizations that provide comprehensive primary care and preventive care, to populations with limited access to health care, regardless of ability to pay. These include low income populations, the uninsured, those with limited English proficiency, migrant and seasonal farm workers, individuals and families experiencing homelessness, and those living in public housing.

Five Star System/Nursing Home Compare: A web-based resource offered through CMS to help consumers, their families, and caregivers compare nursing homes more easily using a Five-Star Quality Rating System (similar to hotel or restaurant reviews). The rating system is based on three sources of data: Health Inspections, Staffing, and Quality Measures.

Hospital Acquired Condition (HAC): Conditions that are acquired during hospitalization that may have been prevented (such as infections, deep vein thrombosis, or falls with injury).

Healthcare Reform: A general term used to describe health care policy changes or creation. The most recent federal policy promoting health care reform is the Patient Protection and Affordable Care Act, signed into law by President Barack Obama on March 23, 2010.

Health Information Exchange (HIE): HIE provides the capability to electronically move clinical information among disparate health care information systems to facilitate access to and retrieval of clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care.

Health Information Technology: Computer-based tools developed specifically for health care delivery. These tools can provide physicians and other clinicians up-to-date information about their patients, access to cutting-edge medical knowledge and best practices through decision-support systems, and other benefits. According to the Bureau of Labor Statistics, demand for health information professionals will increase by 20 percent through 2018.

Health Plan Employer Data and Information Set (HEDIS®): Part of the process used by the National Committee for Quality Assurance in accrediting managed care organizations. This tool is used by more than 90% of America's health plans to measure performance on important dimensions of care and service.

Health Resources and Services Administration (HRSA): An agency of the U.S. Department of Health and Human Services, HRSA is the primary Federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.

Home Health Agency: An agency that provides health care, social work, and rehabilitation services in the home. To be certified under Medicare, an agency must provide skilled nursing services and at least one additional therapeutic service in the home.

Hospice Care: Health care that addresses the physical, emotional, social, financial, and legal needs of terminally ill patients and their families.

Hospital Inpatient Quality Reporting Program: Formerly known as the Reporting Hospital Quality Data for Annual Payment Update, this initiative requires hospitals to submit data for specific quality measures for health conditions common among people with Medicare, and which typically result in hospitalization. Hospitals that do not participate in HIQRP receive a reduction in their Medicare annual inpatient payment update.

Inpatient: A patient who has been admitted at least overnight to a hospital or other health facility and occupies a hospital bed, crib, or bassinet while under observation, care, and diagnosis. Also refers to the services provided to these individuals.

Inpatient Rehabilitation Facility: A facility that specializes in caring for people recovering from injuries or illnesses that severely impair their physical functioning or understanding. These include strokes, spinal cord injuries, traumatic brain injuries, chronic pulmonary problems, or neurological disorders.

Integrated Delivery System (IDS): An organized, coordinated, and collaborative network of various healthcare providers that care connected with the aim to offer a coordinated, continuum of services to a particular patient population or community. A goal of an efficient Integrated Delivery System is to be accountable, both clinically and fiscally, for the clinical outcomes and health status of the population or community served, and has systems in place to manage and improve them.

Intensive Case Management: A case management model provided by the mental health system that includes crisis management, screening, assessment, care planning, service arrangement, monitoring, evaluation, and advocacy.

Interim Access Assurance Fund (IAAF): Temporary, time limited, funding available from an IAAF to protect against degradation of current access to key health care services and avoid gaps in the health delivery system. New York is authorized to make payments for the financial support of selected Medicaid providers.

Island Peer Review Organization (IPRO): A federally designated QIO organization that works specifically with long-term care organizations in NY State. QIOs often collect data and make specific recommendations around care delivery and work on any quality improvement initiatives set forth by CMS.

Long Term Care Hospital (LTCH): LTCHs furnish extended medical and rehabilitative care to individuals who are clinically complex and have multiple acute or chronic conditions. An LTCH must be certified as an acute care hospital that meets criteria to participate in the Medicare program and has an average inpatient length of stay greater than 25 days.

Managed Care Organization (MCO): Any organization or health care plan that attempts to control costs by closely monitoring patient treatment, limiting referrals to outside providers, and requiring preauthorization for hospital care and surgical procedures. Managed care arrangements typically rely on primary care physicians to act as “gatekeepers” and manage the care their patients receive.

Meaningful Use: The American Recovery and Reinvestment Act of 2009 authorizes the Centers for Medicare & Medicaid Services (CMS) to provide incentive payments to eligible professionals (EPs) and hospitals who adopt, implement, upgrade, or demonstrate meaningful use of certified electronic health record (EHR) technology. Meaningful Use is defined by the use of certified EHR technology in a meaningful manner (for example electronic prescribing); ensuring that the certified EHR technology is connected in a manner that provides for the electronic exchange of health

information to improve the quality of care; and that in using certified EHR technology the provider must submit to the Secretary of Health & Human Services (HHS) information on quality of care and other measures.

Medicaid: A joint federal and state health care assistance program for low-income persons of any age and some people with long-term disabilities. In New York State, county governments share in funding Medicaid.

Medicaid Redesign Team (MRT): The New York Medicaid Redesign Team (MRT) was created by New York Governor Andrew Cuomo in 2011 to find ways to reduce costs and increase quality and efficiency in the Medicaid program.

Medicaid Redesign Team Waiver Amendment: An amendment allowing New York to reinvest $8 billion in Medicaid Redesign Team generated federal savings back into NY's health care delivery system over five years. The Waiver amendment contains three parts: Managed Care, State Plan Amendment and DSRIP. The amendment is essential to implement the MRT action plan as well as prepare for ACA implementation.

Medical Home: A model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team, which also may include roles for nurse practitioners or physician assistants, is responsible for providing all the patient's health care and, when needed, arranges for appropriate care with other qualified physicians.

Medicare: A federally-sponsored health insurance program for those aged 65 and over, as well as certain other eligible individuals. It has four parts: Part A covers inpatient costs; Part B covers outpatient costs; Part C is the Medicare+Choice program; and Part D covers prescription drugs.

Minimum Data Set (MDS): The MDS is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems.

National Committee for Quality Assurance (NCQA): A private, not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda. NCQA has helped to build consensus around important health care quality issues by working with large employers, policymakers, doctors, patients and health plans to decide what's important, how to measure it, and how to promote improvement.

Nursing Home Quality Initiative (NHQI): A CMS initiative that provides nursing homes with information, education, and technical assistance for quality improvement and that publicly reports quality measures in several nursing home care delivery areas.

Palliative Care: Palliative care is medical care focused on the relief of suffering and specialized support for the best possible quality of life for patients with serious illness and their families. It is provided simultaneously with all other appropriate medical treatment, including life-prolonging or curative care. A key benefit of palliative care is that it customizes treatment to meet the needs of each individual patient and may be provided at any time during a patient's illness, from the time of diagnosis and throughout the course of illness.

Patient Centered Care (PCC): Providing care that is respectful of and responsive to individual patient preferences, needs, and values.

Patient Centered Medical Home (PCMH): Also known as a medical home, PCMH is an approach to providing comprehensive primary care that facilitates partnerships between individual patients, and their personal providers, and

when appropriate, the patient's family. The provision of medical homes may allow better access to health care, increase satisfaction with care, and improve health.

Patient Review Instrument: A form that briefly summarizes a resident's medical, psycho-social and physical needs. This form is required for all newly-admitted residents and is updated on a regular basis. Data from this form is used to determine a resident's resource utilization group category and is directly connected to a facility's reimbursement rate.

Pay for Performance: A financial incentive program that pays health care providers based on performance in quality and efficiency measures.

Payer: A public or private organization that pays for or underwrites health care coverage expenses.

Performance Improvement (PI): In health care, PI refers to the use of concurrent systems to improve quality. PI programs usually use tools such as task forces, statistical studies, cross-functional teams, process charts, etc.

Plan-Do-Study-Act (PDSA): A quality improvement methodology based on breaking down change into manageable chunks by testing change on a micro level and analyzing the results to validate improvement before implementing across the organization.

Population Health: Population health is the health status within a population and the factors, policies, and interventions that influence this status. Population health management is an approach to managing health care through education, behavioral interventions, care coordination, and the evidence-based use of health care resources. It places greater emphasis on preventive care and maintaining good health, rather than treating illness, and can be targeted at specific diseases or at improving the overall health of a community.

Potentially Preventable Emergency Room Visits (PPVs): Part of the nationally recognized measures for avoidable hospital use. The measures identify emergency room visits that could have been avoided with adequate ambulatory care.

Pre-Existing Condition Exclusions: A pre-existing condition is a health problem that existed before you apply for a health insurance policy or enroll in a new health plan. One of the hallmarks of the Patient Protection and Affordable Care Act signed into law in March 2010 is the elimination of pre-existing condition requirements imposed by health plans.

Preventative Care: Health care that emphasizes the early detection and treatment of diseases. The focus on prevention is intended to keep people healthier for longer, thus reducing health care costs over the long term.

Primary Care Physician (PCP): A doctor who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions.

Quality Indicator Survey: The Quality Indicator Survey (QIS) is a computer-assisted long-term care survey process that was developed under Centers for Medicare & Medicaid Services (CMS). The primary goal is to improve consistency and accuracy of quality of care and quality of life problem identification by using structured investigation.

Quality of Life: A complex concept reflecting the characteristics of an individual's relationship to his social and physical environment.

Readmissions: CMS and New York State are targeting readmissions to the hospital within 30 days of discharge as a probable marker for quality of care. CMS defines a readmission as a hospital admission within 30 days of initial hospital discharge. Hospitals with higher than average readmission rates are penalized financially.

Safety Net Provider: Entities that provider care to underserved and vulnerable populations. The term "safety net" is used because for many low-income and vulnerable populations, safety net providers are the “invisible net of protection” for individuals whose lack of health coverage or other social and economic vulnerabilities limits their ability to access mainstream medical care.

Sub-Acute Care: Sub-acute care falls between acute hospital care and traditional nursing home care. Compared to acute care, sub-acute care is less diagnostically oriented, yet is more intensive and of shorter duration than skilled nursing facility care.

Telemedicine: The practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and health education, using interactive audio, video, or data communications.

Two-Midnight Rule: Under CMS’ “two-midnight” rule, hospital inpatient admissions spanning two midnights in the hospital would generally qualify as appropriate for payment under Medicare Part A. Providers believe this policy undermines medical judgment by placing a restrictive timeframe on when a beneficiary should be admitted as an inpatient.

Value-Based Purchasing (VBP): Also referred to as pay-for-performance, this modification to the current Medicare payment system will link provider reimbursement rates to reporting and performance on select measures, including the quality, safety, and cost of care.

Vital Access Provider (VAP) Program: Funding available to qualified healthcare providers for supplemental financial assistance to improve community care in support of ensuring financial stability and advance ongoing operational change to improve community care.

Wellness Program: Employer-sponsored program created to promote health and prevent chronic disease. Goals of wellness programs include: reducing health care costs, sustaining and improving employee health and productivity, and reducing absenteeism due to illness.