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| Term | Definition | Key Concepts |
| Health Utility | A number between zero and one, with zero representing death and one representing perfect health. This can be measured in a number of ways, and is most frequently measured using patient preference based classification systems such as the EQ-5D. | Health utility measurement is used to compare the impact of disease states or interventions on perceived health. It can be used to compare similar or disparate health states as it is purely a subjective measure. Patients with identical objective health measures may perceive their health differently. |
| QALY | Quality adjusted life year- this is an effectiveness measure that incorporates health utility and time. The health utility value of any particular health state is multiplied by the time spent in that state in order to determine the QALY. | Changes in QALY are used to perform economic analysis of health interventions. The determination of a QALY value for an intervention is dependent both upon the magnitude of effect on health status, but on the duration of that effect. |
| ICER | Incremental cost effectiveness Ratio- this is a measure of the change in cost per change in effectiveness (as measured using QALY) | The ICER provides a method for comparing cost effectiveness between interventions that have different costs and health effects. The ICER is a potentially useful tool for payment and policy decisions at a societal level. |
| Cost to charge ratio | A calculated value describing the relationship between hospital charges and actual costs used to estimate costs of medical care when true cost data is not available. | True medical costs are often very difficult to determine due to confidential business agreements between hospitals and suppliers and difficulty assigning costs to individual patients. Charges are more easily assignable and information regarding charges is more readily available. Charges are usually in excess of costs, and if the overall ratio between charges and costs is known, this ratio can be used to roughly estimate costs for a given intervention. |
| Fee for Service | A traditional model of physician compensation. Physicians are paid based upon work performed. | Fee for service compensation provides an incentive to perform more service. In order to contain health care costs, policy makers are changing reimbursement schemes in an attempt to reward quality and efficiency as opposed to volume. |
| Center for Medicare and Medicaid Innovation (CMMI) | Created by the Affordable Care Act, this federal center is charged with testing new payment and care delivery models that improve coordination, quality, and efficiency. | A range of models are being tested through the CMMI. These include bundled payments for episodes of care to promote more effective care management, and Accountable Care Organizations (ACOs), or networks of providers that contract to reduce spending and meet quality targets in exchange for a share of Medicare savings that exceed certain quality and spending benchmarks |
| PQRS | Physician Quality Reporting System | Medicare Part B pay-for-reporting program that continues to rely heavily on claims-based process of care measures that are not necessarily linked to better clinical outcomes. This traditionally voluntary program essentially becomes mandatory in 2015 as it transitions from Medicare bonuses to penalties. |
| VBM | Physician Value-Based Payment Modifier | Adjustments to Medicare Part B payments based on a composite of quality, patient experience, AND cost measure performance. The modifier was first applied to large group practices in 2015 and must apply to all physicians by 2017. |