Rural HEALTH VALUE

Glossary of Value-Based Care Terms

The Rural Health Value team has compiled key terms with brief definitions to help readers understand the vocabulary and terminology used in value-based care and payment.

Healthcare Value Definitions and Key Terms

Value-Based Care (VBC): A healthcare delivery model that emphasizes quality and patient experience, improving efficiency, and coordination of care rather than the volume of services delivered.

Value-Based Payment (VBP): A reimbursement approach that ties compensation to performance on defined metrics such as cost, quality, and patient outcomes, replacing or supplementing traditional fee-for-service models.

Accountable Care Organization (ACO): A group of healthcare providers that voluntarily collaborate to deliver coordinated, high-quality care to a defined patient population, with shared accountability for improving outcomes and controlling costs.

Alternative Payment Models (APMs) Payment approaches in healthcare that shift the focus of reimbursement from traditional fee-for-service (which provides compensation based on the volume of services provided), to incentivize value-based care with incentives focused on improving quality while controlling or reducing costs.

APM Framework: Developed by the Health Care Payment Learning & Action Network (HCP-LAN), a public and private group of health care leaders focused on advancing payment reform that improves value. The Framework provides a classification system and common vocabulary for payment models based on risk level and value orientation.

Attribution: The process that payers use to assign patients to healthcare organizations and/or providers that are held accountable for their care through an alternative payment model or ACO.

Triple Aim: A framework, developed by the Institute for Healthcare Improvement, which seeks to simultaneously improve the patient's experience of care, enhance population health, and reduce per capita healthcare costs.

Whole-Person Care: An approach that integrates physical, behavioral, and social health needs into care delivery.

Payment & Incentive Structures

Bundled Payments: A single payment for all services related to a treatment episode, encouraging coordination and cost control.

Capitation: A fixed per-member-per-month payment (PMPM) to providers, regardless of services delivered.

Hospital Global Budget: Payment mechanism that includes a fixed payment that covers all inpatient and outpatient services based on the hospital's patient population's expected costs, regardless of the number of services provided. The Pennsylvania Rural Health Model (PARHM) utilized hospital global budgets.

Pay-for-Performance (P4P): Financial incentives tied to achieving specific quality or efficiency targets.

Shared Savings (in ACOs): A financial incentive in which an ACO receives a portion of the cost savings it generates by delivering high-quality care below spending benchmarks which are defined by the payer.

- **Upside Risk:** A financial arrangement in which providers earn shared savings if care is delivered below cost benchmarks while meeting quality targets, without being penalized for overspending. An agreement that only includes upside risk may also be called 'one-sided risk'.

- **Downside Risk:** A financial arrangement in which providers are held accountable for exceeding cost benchmarks and are required to repay a portion of the losses to the payer.

- **Two-Sided Risk:** A payment model in which an ACO can earn shared savings for reducing costs and meeting quality benchmarks but is also liable for repaying a portion of excess spending if benchmarks are exceeded. Agreements including two-sided risk typically include the potential for greater financial reward than agreements that only include upside risk.

Total cost of care (TCOC): All direct and indirect costs associated with an episode of care or for a period of health care coverage (e.g., a health plan benefit year). Typically measured at a population level (such as a state or geographic region) or for a group of attributed patients (such as in an ACO).

Care Delivery Innovations

Annual Wellness Visit (AWV): A yearly preventive service covered by Medicare that includes a health risk assessment and the development or update of a personalized prevention plan, without requiring a physical exam.

Care Coordination: The deliberate organization of patient care activities across multiple providers over time to ensure timely, efficient, and appropriate delivery of services aligned with a patient's needs and preferences.

Care Transitions: Coordinated support during shifts between care settings (e.g., hospital to home, or hospital to post-acute care facility).

Chronic Care Management (CCM): A set of coordinated, non-face-to-face services provided to patients with two or more chronic conditions to support ongoing care, improve health outcomes, and reduce avoidable healthcare utilization.

Patient-Centered Medical Home (PCMH): A primary care model that emphasizes comprehensive, coordinated, and accessible care delivered by a team, with a focus on long-term patient relationships and whole-person health management.

Person-Centered Care: Health care services delivered in a setting and manner that is responsive to individuals and their goals, values and preferences, in a system that supports good provider–patient communication and empowers individuals receiving care and providers to make effective care plans together.

Population or Community Health Improvement: A systematic effort to enhance the health outcomes of a defined group by addressing clinical care, health behaviors, and social and environmental factors that influence well-being.

Pre-Visit Planning: A proactive strategy to prepare for patient visits by reviewing history, labs, and care gaps.

Team-Based Care: Collaborative care involving physicians, nurses, social workers, and others that may include community health workers.

Data & Technology

Certified Electronic Health Record Technology (CEHRT): Standard that defines whether an electronic health record (EHR) system meets federal requirements for data exchange, privacy, and clinical functionality to ensure healthcare organizations can efficiently record and share patient data.

Clinical-Decision Support (CDS): Electronic or other tools that provide evidence-based guidance to clinicians and care teams at the point of care.

Interoperability: The ability of health information technology (IT) systems to exchange and use patient data across platforms.

Risk Stratification: Segmenting patient populations by health risk to tailor interventions.

Community & Social Context

Community-Based Organizations (CBOs): Non-clinical partners that address health-related social needs and support care coordination.

Community Health Needs Assessment (CHNA): A process used by hospitals and health systems to identify and address local health priorities. Non-profit hospitals are required to conduct a CHNA every three years as part of the tax-exemption requirements for the Internal Revenue Service (IRS).

Social Risk Adjustment: Modifying payment or performance metrics to account for socioeconomic factors affecting patient outcomes.

Upstream Drivers of Health: Non-medical factors that influence health outcomes, including the conditions in which people are born, live, learn, work, and age. May also be referred to as health-related social needs or social drivers of health.

Centers for Medicare & Medicaid Services (CMS) & Federal Programs

CMS Innovation Center (also known as CMMI or Center for Medicare & Medicaid Innovation): The CMS division responsible for testing and scaling innovative payment and service delivery models.

Medicare Shared Savings Program (SSP): A foundational ACO program that rewards providers for reducing costs while meeting quality benchmarks.

Quality Payment Program (QPP): A CMS funding system that rewards clinicians who provide high-quality and patient-centered care, QPP has two payment tracks:

- **Merit-Based Incentive Payment System (MIPS):** Adjusts provider payments based on performance in four categories: quality, cost, improvement activities, and promoting interoperability.

- **Advanced Alternative Payment Models (AAPMs):** A subset of Medicare APMs that include specific features set by CMS such as requiring use of CEHRT, financial risk, and quality performance payment. A clinician that achieves thresholds for payment or patient count threshold through the advanced APM is considered a Qualifying APM Participant (QP) and is eligible for an APM Incentive Payment and excluded from MIPS reporting requirements and payment adjustments.

See the Rural Health Value Catalog of Value-Based Initiatives for Rural Providers for one-page summaries of rural-relevant, value-based programs currently or recently implemented by the Department of Health and Human Services (HHS), primarily by CMS and CMMI.

(January 2026)

This resource was developed with funding from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $500,000 with 0% financed with non-governmental sources. The contents are those of the authors(s) do not necessarily represent the official views of, nor an endorsement by HRSA, HHS or the U.S. Government.