

MACRA and the Quality Payment Program – Glossary of Terms

ACA – The Affordable Care Act. Colloquially known as “Obamacare”, the Patient Protection and Affordable Care Act of 2010. In addition to redesigning the health insurance landscape, the ACA authorized implementation of several of the Center for Medicare and Medicaid Services (CMS’) current quality programs and initiatives, such as the value modifier (VM) and electronic health record (EHR) Incentive Program.

ACI – Advancing Care Information. One of the four performance categories under the Merit-based Incentive Payment System (MIPS). The ACI performance category replaces the Medicare EHR Incentive Program.

ACO – Accountable Care Organization. ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.

APM – Alternative Payment Model. Payment models that apply new methods of reimbursement from the traditional fee-for-service payment approach. In the Quality Payment Program, APMs are classified into advanced APMs, MIPS APMs, and other APMs.

Advanced APM – Advanced Alternative Payment Model. To be an Advanced APM, an APM must meet the following three criteria: 1. Require participants to use certified EHR technology; 2. Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment System (MIPS); and 3. Either: (1) be a Medical Home Model expanded under CMS Innovation Center authority; or (2) require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses. Qualifying participants (QPs) in an advanced APM are excluded from participating in the MIPS.

MIPS APMs – Merit-based Incentive Payment System Alternative Payment Models. Models that are either advanced APMs or APMs do not meet the criteria as an advanced APM but nonetheless are payment models recognized by CMS in the QPP. While participants in MIPS APMs are not excluded from the MIPS, participants in MIPS APMs receive several advantages in MIPS scoring as CMS recognizes that participating in an APM requires significant effort from practices and eligible clinicians. For example, for the improvement activities category, APM participants will automatically receive at least one-half of the highest possible score for the category.

CEHRT – Certified EHR technology. A term used to identify EHR products that are officially certified by the Office of the National Coordinator (ONC). A MIPS eligible clinician or group may earn bonus points by submitting certain data via CEHRT in the quality and advancing care information performance categories.

CQM – Clinical Quality Measure. Tools that help measure and track the quality of health care services provided by eligible professionals, eligible hospitals and critical access hospitals

Cost – One of the four performance categories under the MIPS. For 2017, the cost performance category will comprise of 0% of a MIPS eligible clinician or group’s final score. The cost performance category replaces the Value-based Payment Modifier (VM). For 2017, cost measures in the cost performance category stem from measures in the VM.

Improvement Activities – Quality – One of the four performance categories under the MIPS. For 2017, the improvement activities performance category will comprise of 15% of a MIPS eligible clinician or group’s final score. Unlike the other three performance categories in the MIPS, the improvement activities category is a new category that is not preceded by a previous CMS quality program.

Final Score – The sum measure of performance under the MIPS. The final score is the sum of the scores a MIPS eligible clinician or group achieves within each of the four performance categories – quality, advancing care information, improvement activities, and cost. The formula for the MIPS final score is: final score = [(quality performance category score x quality performance category weight) + (resource use performance category score x resource use performance category weight) + (CPIA performance category score x CPIA performance category weight) + (advancing care information performance category score x advancing care information performance category weight)] x 100.

EHR – Electronic Health Record.

FFS – Fee-For-Service. The traditional reimbursement method established by Medicare. The QPP seeks to move away from traditional FFS by emphasizing quality of care over quantity of services provided.

Group Practice – A group that consists of a single TIN with two or more eligible clinicians (including at least one MIPS eligible clinician), as identified by their individual NPI, who have reassigned their billing rights to the Tax Identification Number (TIN). A group electing to submit data at the group level would have its performance assessed and scored across the TIN, which could include items and services furnished by individual NPIs within the TIN who are not required to participate in MIPS.

High Priority Measures – For the quality performance category of the MIPS, CMS defines high priority measures as outcome, patient experience, patient safety, care coordination, cost, and appropriate use. These measures are designated and identified in rulemaking, based on their National Quality Forum (NQF) designation or if the measures are not NQF-endorsed, based on their NQS domain designation or measure description as defined by the measure owners, stewards and clinical experts. A MIPS eligible clinician or group can earn bonus points in the quality performance category for submitting data on high priority measures.

Low-Volume Threshold Exclusion –Clinicians who are below the low-volume threshold are not eligible for MIPS. For 2017, the low-volume threshold has been set at less than or equal to \$30,000 in Medicare Part B allowed charges OR less than or equal to 100 Medicare patients

MACRA – Medicare Access and CHIP Reauthorization Act of 2015. The bi-partisan legislation that replaced the SGR with the QPP. In addition to authorizing the establishment of the QPP, the MACRA also sunset certain CMS quality programs, such as the PQRS, VM, and Medicare EHR Incentive Program.

Medicare EHR Incentive Program – Also known as “Meaningful Use.” A program established under the ACA that provides incentive payments to eligible professionals (EPs) and eligible hospitals (EHs) as they demonstrate adoption, implementation, upgrading, or meaningful use of certified EHR technology.

MIPS – Merit-based Incentive Payment System. One of the two tracks in the Quality Payment Program (QPP). Participation in the MIPS is not voluntary; anyone classified as an “eligible clinician” will receive a positive, negative, or neutral payment adjustment based on his/her participation in the MIPS. For 2017, most eligible clinicians will participate in the MIPS.

New Medicare-Enrolled Eligible Clinician – A professional who first becomes a Medicare-enrolled eligible clinician within the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) during the performance period and who has not previously submitted claims as a Medicare-enrolled eligible clinician either as an individual, an entity, or a part of a physician group or under a different billing number or tax identifier. New Medicare-enrolled eligible clinicians are excluded from participation in the MIPS.

NPI – National Provider Identifier. In the MIPS, the NPI is used to identify a MIPS eligible clinician. CMS will use a combination of billing Tax Identification Number (TIN)/NPI as the identifier to assess performance of an individual MIPS eligible clinician. While CMS will use multiple identifiers for participation and performance, it will use a single identifier, the TIN/NPI combination, for applying the payment adjustment, regardless of how the clinician is assessed. For more information on MIPS eligible clinician identifiers, please see “TIN.”

PCMH – Patient-Centered Medical Home. MIPS eligible clinicians practicing in a PCMH may earn special scoring considerations in the MIPS.

Performance Period – The period for which a MIPS payment adjustment is based. CMS will use performance in calendar year (CY) 2017 as the performance period for the 2019 payment adjustment which is for a minimum of a continuous 90-day period within CY 2017, up to and including the full CY 2017.

PFPMs – Physician-Focused Payment Models. An APM: (1) in which Medicare is a payer; (2) in which eligible clinicians that are eligible professionals (EPs) as defined in section 1848(k)(3)(B) of the Act are participants and play a core role in implementing the APM’s payment methodology, and (3) which targets the quality and costs of services that eligible clinicians participating in the Alternative Payment Model provider, order, or can significantly influence.

PQRS – Physician Quality Reporting System. A CMS quality program that was replaced by the quality performance category of the MIPS.

PTAC – Physician-Focused Payment Model Technical Advisory Committee. The body that reviews and provides recommendations on PFPMs that CMS could recognize as APMs in the QPP.

QCDR – Qualified Clinical Data Registry. QCDRs may submit data on measures, activities, or objectives for any of the following MIPS performance categories: quality; improvement activities; and/or advancing care information, if the MIPS eligible clinician or group is using certified EHR technology.

QP – Qualifying APM Participant. An eligible clinician determined by CMS to have met or exceeded the relevant QP payment amount or QP patient count threshold. QPs are excluded from participating in the MIPS.

QPP – Quality Payment Program. Authorized by MACRA, the Quality Payment Program gives new tools, models, and resources to help physicians provide patients with the best possible care. The Quality Payment Program has 2 tracks: (1) The Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (APMs).

Quality Performance Category – One of the four performance categories under the MIPS. For 2017, the quality performance category will comprise of at least 60% of a MIPS eligible clinician or group's final score. The quality performance category replaces the Physician Quality Reporting System (PQRS). For 2017, requirements and quality measures in the quality performance category stem from requirements and measures in the PQRS.

QRUR – Quality and Cost Reports. Feedback reports that contain detailed information on a MIPS eligible clinician or group's performance on quality and cost.

Specialty Measure Set/Specialty-Specific Measure Set – For the quality performance category, CMS designed specialty-specific measure sets to make it easier for MIPS eligible clinicians to select measures within the MIPS measure set. Note that some specialty-specific measure sets include measures grouped by subspecialty; in these cases, the measure set is defined at the subspecialty level. To meet full participation requirements in the MIPS, if a specialty-specific measure set contains more than six measures, MIPS eligible clinicians or groups may report six measures within a measure set. In instances where a specialty-specific measure set has less than six measures, MIPS eligible clinicians would report on all of the available measures in the set, including an outcome measure or, if an outcome measure is unavailable, another high priority measure within the set and a cross-cutting measure if they are a patient-facing MIPS eligible clinician. For example, the **electrophysiology cardiac specialist specialty-specific measure set** only has three measures within the set, all of which are outcome measures. For full participation, MIPS eligible clinicians and groups reporting on the electrophysiology cardiac specialist specialty-specific measure set would report on all three measures.

Submission Mechanisms – Approved methods by which individual clinicians and groups would submit data to CMS on measures and activities for the quality, CPIA and advancing care information performance categories in the MIPS. The submission mechanisms in the MIPS include: Administrative Claims; Attestation; Claims; CMS-approved survey vendor; CMS Web Interface; EHR – Electronic Health Record; and Qualified Clinical Data Registry.

TIN – Tax Identification Number.

VM – Value-Based Payment Modifier. A CMS quality program authorized under the ACA that was replaced by the cost performance category of the MIPS. Pursuant to MACRA, payment adjustments under the VM will end in 2018.