Terms & Definitions

ACI (Advancing Care Information) - This is what was formerly known as Meaningful Use and covers the technological aspects of MIPS.

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. The goal is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. Some ACOs participating in CMS programs will qualify as APMs or Advanced APMs if they meet the criteria. Most will not, at least not initially.

APM (Alternative Payment Models) - New approaches to paying for medical care of Medicare patients that incentives quality and value. ACP hopes that the final rule will provide more clarity of the definitions and flexibility in types of APMs.

- **Advanced APM** – Not all APMs will qualify as "advanced." In order to be considered an "Advanced APM" the following criteria must be met: it must meet the legislative definition of an APM, at least 50% of participants must use a certified EHR, payment must be based on quality measures comparable to those used in MIPS (of which one must be an outcome measure), and it must bear more than nominal financial risk (or is a CMMI Medical Home Model expanded by the Secretary of DHHS).
- **MIPS APM** – A sub-set of APMs whose APM clinicians otherwise would be subject to the full range of MIPS requirements in addition to their APM obligations. In other words, they are APMs that meet the following criteria: (1) the APM entity participates in under an agreement with CMS; (2) the APM Entity includes one or more MIPS eligible clinicians on a participation list; and (3) the APM bases payment incentives on performance (either at the APM entity or eligible clinician level) on cost/utilization and quality measures. Because the criteria for the identification of MIPS APMs are independent of the criteria for Advanced APM determinations, a MIPS APM may or may not also be an Advanced APM. Thus, it is possible that an APM meets all three proposed criteria to be a MIPS APM, but does not meet the Advanced APM criteria. Conversely, it would be possible, that an Advanced APM does not meet the criteria because it does not include MIPS eligible clinicians as participants.

CAHPS (Consumer Assessment of Healthcare Providers and Systems) - A survey that measures patient experience. Voluntary participating in CAHPS for MIPS surveys would count as a cross-cutting or patient experience measure for Quality scoring purposes.

CEHRT (Certified EHR Technology) - Certification of EHR products is done by the Office of the National Coordinator of Health Information Technology (ONC).

CHIP (Children's Health Insurance Program) - This program provides health coverage to eligible children, both through Medicaid and separate CHIP programs. CHIP is administered by states, according to federal requirements and is funded jointly by states and the federal government.

CMMI (Center for Medicare and Medicaid Innovation) - This is the department within CMS that oversees programs such as MSSP, TCPI, ACOs, and other demonstration projects.

CPCI (Comprehensive Primary Care Initiative or CPC Classic) - This is a four-year multi-payer initiative designed to strengthen primary care. It launched in October 2012 and expires in October 2016. It will be replaced by CPC+ beginning in January 2017. CPC Classic is a collaboration between CMS and commercial and State health insurance plans in 7 markets to offer population-based care management fees and shared savings opportunities to participating primary care practices to support the provision of a core set of five "Comprehensive" primary care functions. These five functions are: (1) Risk-stratified Care Management; (2) Access and Continuity; (3) Planned Care for Chronic Conditions and Preventive Care; (4) Patient and Caregiver Engagement; (5) Coordination of Care across the Medical Neighborhood.

CPC+ (Comprehensive Primary Care Plus) - CPC+ is a five-year model that will begin in January 2017 and replaces CPC Classic. CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation. CPC+ will include two primary care practice tracks with incrementally advanced care delivery requirements and payment.

CPIA (Clinical Practice Improvement Activities) - One component of the total MIPS Composite Score. There are over 90 proposed activities from which practices can choose to implement. Some of the categories include expanded practice access, population management, care coordination, beneficiary

Terms & Definitions

engagement, patient safety and practice assessment, emergency preparedness, and behavioral health integration.

CPS (Composite Performance Score) - The sum of the 4 MIPS categories Quality + Resource Use + Advanced Care Information + CPIA. It was previously referred to as the MIPS Composite Score.

CQM (Clinical Quality Measure) - CQMs measure and track quality of services provided by ECs. They measure aspects of patient care, including health outcomes, clinical processes, patient safety, efficient use of resources, care coordination, patient engagement, population health, and adherence to clinical guidelines.

EC (Eligible Clinician, formerly EP or eligible professional) - A term used to indicate which professionals are qualified to participate. "Eligible" is defined by each program.

FFS (Fee for Service) - Most Medicare payments are based on services provided. Traditional Medicare (Part B) is based on FFS payments.

MACRA (Medicare Access and CHIP Reauthorization Act of 2015) - This is the law that sunsets the volume-based SGR and replaces the payment system with one that is value-based. The goal is to create a sustainable payment system for physicians. The new payment system begins in 2019 and will be phased in over several years.

MIPS (Merit-based Incentive Payment System) - MIPS is the 1st option. This path will pay based on quality, technology, resource use (cost), and practice improvement. PQRS, MU, and VBM will cease to exist individually, but will be consolidated into MIPS beginning in 2019.

- **MIPS Composite Score –** The MIPS score (in Year 1) will be based on performance in 4 categories: Quality (50%), Advancing Care Information (25%), Clinical Practice Improvement Activities (15%), and Resource Use or Cost (10%). This is now referred to as the Composite Performance Score.

MSSP (Medicare Shared Savings Program) - MSSP was established by the ACA to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. MSSP aims to improve beneficiary outcomes and increase value of care by providing better care for individuals, better health for populations, and lowering growth in expenditures. The Shared Savings Program will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first.

MU (Meaningful Use) - The Affordable Care Act created incentives for physicians to adopt EHR and use them "meaningfully" in practice. The EHR Incentive Program was set up in 3 stages, but the program will be rolled into MACRA as part of MIPS. The new term for MU is "Advancing Care Information."

OCM (Oncology Care Model) - There are two types of Oncology Care Models: 1-sided risk and 2-sided risk arrangements. Those that are 2-sided risk arrangements will qualify as Advanced APMs.

PCMH (Patient-Centered Medical Home) - The PCMH is a model of care delivery whereby the physician practice coordinates all the care of the patient, even those with chronic conditions. Nationally recognized patient-centered medical homes are accredited by (1) the Accreditation Association for Ambulatory Health Care, (2) the National Committee for Quality Assurance (NCQA) PCMH Recognition, (3) the Joint Commission Designation, or (4) the Utilization Review Accreditation Commission (URAC).

PFPM (Physician Focused Payment Models) - These are Alternative Payment Models wherein Medicare is a payer, which includes physician group practices or individual physicians as APM Entities and targets the quality and costs of physician services.

- **PTAC (Physician-focused Payment Model Technical Advisory Committee)** - The body that will review and provide comments and recommendations on PFPMs submitted by stakeholders. The Secretary must establish, through notice and comment rulemaking, criteria for PFPMs, including models for specialist physicians that could be used by the PTAC for making its comments and recommendations.

PQRS (Physician Quality Reporting System) - PQRS is a quality reporting program that encourages individual eligible professionals (EPs) and group practices to report information on the quality of care to Medicare. PQRS will be consolidated into the new MIPS program.

Terms & Definitions

QCDR (Qualified Clinical Data Registries) - A QCDR is a CMS-approved entity that collects and submits PQRS quality measures data on behalf of eligible professionals (EPs). To be considered a QCDR for purposes of PQRS, an entity must self-nominate and successfully complete the qualification process.

QP (Qualified Professional) - This represents the subset of professionals who participate in Advanced APMs.

QPP (Quality Payment Program) - This is the name of the new payment program to implement MACRA in the proposed rule released on April 27, 2016.

QRUR (Quality and Resource Use Report) - Under the Value-Based Payment (see VBP below) program, QRURs provide information about the resources used and the quality of care furnished to a group's or solo practitioner's Medicare FFS beneficiaries. The 2015 QRURs will be generated for all groups and solo practitioners nationwide, as identified by their Medicare-enrolled TIN, regardless of whether the 2017 Value Modifier will apply to them. They can use their QRURs to see how their TIN compares with other TINs caring for Medicare beneficiaries.

SGR (Sustainable Growth Rate) - This is the formula on which fee-for-service Medicare Part B payments are based through 2017. This payment system is effectively replaced by MACRA (MIPS and APM).

TCPi (Transforming Clinical Practice Initiative) - This is an initiative within CMMI that is designed to help practices implement changes and improvements so that they can participate in APMs. The initiative is designed to support practices over the next four years in sharing, adapting and further developing their comprehensive quality improvement strategies.

TIN (Tax Identification Number) - This the number that identifies the billing entity. The TIN will be used to connect each EC to the entity under which they bill for purposes of calculating MIPS scores or APM participation.

VBP/VBMP/VM (Value-based payment modifier) - This program provides differential payment to a physician or group under the Medicare Physician Fee Schedule (PFS) based upon the quality of care furnished compared to the cost of care during a performance period. VM will also be consolidated into MIPS.