Glossary of Terms

ASC-Based: An eligible clinician can be deemed with a Special Status/Consideration if they furnish 75% or more of their covered professional services in sites of service identified by POS codes 24.

Accountable Care Organization (ACO): Group of health care providers who provide coordinated care and chronic care management, and thereby improve the quality of care patients receive; payment is tied to achieving quality goals and outcomes that result in cost savings.

Alternative Payment Model (APM): CMS Innovation Model that pays providers for services based on quality, outcomes, and cost-containment; 5% annual bonus payment to physicians who are participating in APMs and exempts them from participating in MIPS.

Collection Type: Set of quality measures with comparable specifications and data completeness criteria including, as applicable: electronic clinical quality measures (CQMs) (formerly referred to as "Registry measures"); Qualified Clinical Data Registry (QCDR) measures; Medicare Part B claims measures; CMS Web Interface measures; the CAHPS for MIPS survey measure; and administrative claims measures.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): Survey tool for measuring patient satisfaction with service and care delivered by provider.

Chronic Care Management (CCM): Services furnished to Medicare beneficiaries having multiple (two or more) chronic conditions that are expected to last at least 12 months or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; providers manage illness through screenings, check-ups, monitoring and coordinating treatment, and patient education; goal is to improve quality of life while reducing health care costs by preventing or minimizing the effects of a disease.

Group Practice Reporting Option (GPRO): Web-based quality measure reporting option for group practices defined as a single TIN with 2 or more individual ECs who have reassigned their billing rights to the TIN. Group practices can register to participate in PQRS through the GPRO to be analyzed at the TIN level.

Group: A single TIN associated with two or more ECs (including at least one MIPS EC), as identified by an NPI, that have their Medicare billing rights reassigned to the TIN.

Health Information Service Provider (HISP): Service which enables providers to share patient health information across a secure network.

Hospital-Based MIPS Eligible Clinician: A MIPS EC who furnishes 75% or more of his/her covered professional services in sites of service identified by the Place of Service codes used in the HIPAA standard transaction as an inpatient hospital, on campus outpatient hospital or emergency room setting based on claims for a period prior to the performance period as specified by CMS.

Health Professional Shortage Area (HPSA): A geographic area, population, or facility with a shortage of primary care, dental, or mental health providers and services. An eligible clinician can be deemed with a Special Status/Consideration if they are associated with a practice in an area designated under the Public Health Service Act as a HPSA.

Hospital-based: An eligible clinician can be deemed with a Special Status/Consideration if they furnish 75% or more of their covered professional services identified by (POS) codes: 19, 21, 22, or 23, based on claims during September 1 – August 31.

Improvement Activities (IA): One of the four performance categories under MIPS. Six pillars are expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, and participation in an APM.

Medicare Access and CHIP Reauthorization Act (MACRA): Legislation that replaced SGR with alternative set of predictable, annual baseline payment increases; goal is for CMS to pay for quality and value, rather than volume (fee for service); providers will choose between MIPS and APM; choice of program and performance will determine reimbursement rates after 2019.

Medicare Spending Per Beneficiary (MSPB): Performance measure used to determine the Value-Based Incentive Payment Adjustment for a hospital and to determine the Value-Based Payment Modifier for a physician practice.

Merit-Based Incentive Payment System (MIPS): Medicare pay-for-performance system for physicians created by MACRA that consolidates several existing Medicare pay-for-performance programs – the EHR Incentive program, the Physician Quality Reporting System, and the Value-Based Modifier programs.

Medicare Shared Savings/ACO Program (MSSP): Payment program established by the Affordable Care Act that providers can voluntarily choose to participate in if they meet the qualifications for an ACO.

Non-Patient Facing: An individual MIPS EC that bills 100 or fewer patient facing encounters during determination period or a group with more than 75% of the NPIs billed under the group's TIN that meet the definition of a non-patient facing individual MIPS EC.

Partial Qualified Participant (Partial QP): Eligible Clinicians who are part of an Advanced APM and just barely miss the patient/billing threshold to be determined a Qualified Participant (QP). Partial QPs may choose to participate in MIPS or elect to be exempt from the MIPS program. 2019 Threshold requirements: % of Payments = 40% **|** % of Patients = 25%.

Patient Centered Medical Home (PCMH)/Patient Centered Specialty Practice (PCSP): Primary care practice/specialty practice that is structured and operated based on a set of established principles; care delivery model whereby patient treatment is coordinated through the primary care physician to ensure patients receive the necessary care when and where they need it, in a manner they can understand.

Physician Quality Reporting System (PQRS): Reporting program that encourages individual EPs and group practices to report information on the quality of their care to CMS; data publicly available on Physician Compare.

Promoting Interoperability Program (PI): Formerly known as the EHR Incentive Program (Meaningful Use).

Promoting Interoperability Performance Category (PI): One of four performance categories under MIPS, formerly known as the Advancing Care Information category. In this performance category, measures are selected that help advance the productive use of the healthcare information created. This is done by proactively sharing information with other clinicians or the patient in a comprehensive manner.

Quality Clinical Data Registry (QCDR): Reporting mechanism for PQRS; collects and submits PQRS quality measure data on behalf of provider.

Quality Payment Programs (QPP): Unified framework created by the MACRA legislation which pays for quality and value rather than volume (fee for service); providers will choose between MIPS and APM; choice of program and performance will determine reimbursement rates after 2019.

Qualified APM Participant (QP): Advanced APMs provide the pathway through which ECs, who would otherwise participate in MIPS, can become QPs, and therefore, earn incentive payments for their Advanced APM participation. A QP is an EC who is determined by CMS to have met or exceeded the relevant QP payment amount or QP patient count threshold for a year based on participation in an Advanced APM. 2019 Threshold requirements: % of Payments = 50% | % of Patients = 35%.

Rural: All counties that are not part of a Metropolitan Statistical Area (MSA). An eligible clinician can be deemed with a Special Status/Consideration if they are associated with a practice in a zip code designated as rural, using the most recent Health Resources and Services Administration (HRSA) Area Health Resource File data.

Small Practice: An eligible clinician can be deemed with a Special Status/Consideration if they are associated with a practice with 15 or fewer clinicians under the tax identification number (TIN).

Submitter Type: The MIPS eligible clinician, group, or third party intermediary acting on behalf of a MIPS eligible clinician or group, as applicable, that submits data on measures and activities.

Submission Type: The mechanism by which the submitter type submits data to CMS, including, as applicable: direct, log in and upload, log in and attest, Medicare Part B claims, and the CMS Web Interface. There is no submission type for cost data because the data is collected and calculated by CMS from administrative claims data submitted for payment.