QPP Year 7: MACRA & The Quality Payment Program
Glossary of Terms

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 sunset in 2022. A 3.5% transition payment was provided in PY23 in preparation for the transition to the annual PFS adjustment model in PY2024.

Alternative Payment Model (APM) Performance Pathway (APP): A new reporting framework beginning with 2021 performance period for All MIPS APMs participants. Required for MSSP *(See page 2 of Glossary for MSSP)*.

Application Programming Interface (API): Messengers or translators that work behind the scenes to help software programs communicate with each other. API activation is required in the PI Objective "Provide Patient Access".

Ambulatory Surgical Center (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.

Attest: Manual entry of data during the submission period for the Promoting Interoperability and improvement activities performance categories. (E.g. Typing in numerators and denominator, or marking an action or activity as performed.)

Benchmark: A measure benchmark is a point of reference used for comparing your Quality or Cost performance to that of other clinicians on a given Quality or Cost measure. CMS calculates and publishes Quality benchmarks using historical data whenever possible. When there's not enough historical data, CMS calculates a benchmark using data submitted for the performance period. Each measure is awarded points based on where your performance falls in comparison to the benchmark.

Certified Electronic Health Record Technology (CEHRT): Certified Electronic Health Record Technology Electronic health record (EHR) technology that meets the criteria to be certified under the ONC Health IT Certification Program. CEHRT edition requirements can change each year in QPP.

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.

CMS Web Interface: A system provided by CMS to let groups, virtual groups and APM Entities of 25 or more eligible clinicians submit quality data at the beneficiary level for a specified set of measures. This submission reporting option will sunset at the end of performance year (PY) 2022 for MIPS. MIPS APM participants submitting via the APP will be able to utilize this method through PY 2024.

Collection Type: Refers to the way you collect data for a quality measure. An individual quality measure may be collected in multiple ways, each collection type has its own specification for reporting that measure. Collection types include, as applicable: electronic clinical quality measures (eCQMs) (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.

Cost Measure Code List: Resource with all Cost measure information, including: Attribution, Exclusions, Trigger Codes, and Risk Adjustment Codes.

Determination Period: A 24-month period in which CMS reviews past and current Medicare Part B Claims and PECOS data to evaluate clinicians and practices for MIPS eligibility. Each determination period consists of two 12-month segments.

Direct Submission: Data submitted to CMS through a computer-to-computer interaction, such as an Application Programming Interface (API). This doesn't include submissions by attestation or file upload.

Episode-based Measures: 23 measures (include Procedural, Acute-Inpatient, and Chronic Condition Episodes) that assess the cost of care clinically related to initial treatment of a patient and provided during an episode's time frame.

Facility-based Measurement/Scoring: Measurement that offers clinicians and groups the opportunity to receive scores in the MIPS Quality and Cost performance categories based on the corresponding score for the Hospital Value-Based Purchasing (VBP) Program earned by their assigned facility that performance year. This option is not available in 2022.

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.

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 Sept. 1 – Aug. 31.

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.
Hospital Value-Based Purchasing: A program that rewards acute care hospitals with incentive payments for the quality of care they give to people with Medicare. This program adjusts payments to hospitals under the Inpatient Prospective Payment System (IPPS) based on the quality of care they deliver.

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. Activities can be classified as either Medium-weighted (worth 10pts) or Highly-weighted Activities (worth 20pts). Specials status may be awarded at the individual or group level that provide reduced reporting requirements.

Low-Volume Threshold (LVT): The volume of covered professional services, Medicare patients and associated charges a clinician or group must exceed in order to be MIPS eligible.

Measure Information Form: Formerly known as Measure Specification Sheet as related to the Cost Performance Category.

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 tracks; choice of program track and performance determines reimbursement rates to be paid on Part B claims two years following the performance year. EX: Performance Year 2022 positive or negative adjustments will be reflected in Medicare Part B payments in CY 2024.

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. This APM has varying degrees of shared savings and shared risk based on cost savings and quality performance based on the. MSSP Levels A&B are primarily shared savings models with little to no downside risk. Levels C, D, E and the ENHANCED track have increasingly higher rates of shared risk. Track E and ENHANCED models are considered Advanced APMS.

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.

Medicare Spending Per Beneficiary Clinician (MSPBC): Assesses the cost of care for services related to qualifying inpatient hospital stay (immediately prior to, during, and after) for a Medicare patient.

MSPBC - Medicare Severity – Diagnosis Related Group (MSPBC – MS-DRG): System of classifying a Medicare patient's hospital stay into various groups in order to facilitate payment of services.

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

MIPS Alternative Payment Model (MIPS APM): Eligible Clinicians (ECs) participating in a CMS-deemed MIPS APM or ECs who participate in an Advanced APM but does not meet Qualified Participant (QP) thresholds. Subject to different performance category weights/Scoring Standards from the APM Track or the MIPS track.

MIPS Value Pathways (MVPs): MVPs framework aims to align and connect measures and activities across the performance categories of MIPS for different specialties or conditions – creates a foundation that leverages Promoting Interoperability measures and a set of administrative claims-based quality measures that focus on population health/public health priorities, and reduced reporting. Voluntary participation in MVPs begins with the 2023 performance year.

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.

Outcome Measure: A measure that assesses patient outcomes, whether desirable or adverse, as a result of your care.

Partial Qualifying APM Participant (Partial QP): Eligible Clinicians who are part of an Advanced APM do not meet the required patient/billing threshold to be determined a Qualified Participant (QP). Partial QPs may choose to participate in MIPS or elect to be exempt from MIPS. 2022 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. Participants may receive favorable Improvement Activity scoring if at least 50% of locations within the TIN achieve/maintain this designation for the performance year.

Payment Adjustment: CMS applies adjustments to your Medicare reimbursements on future covered professional services based on your participation and performance in MIPS. The payment adjustment is based on the MIPS eligible clinician's final score.

Performance Period: The time period for which CMS assesses a clinician, group, virtual group, or APM Entity's performance in MIPS. Each MIPS performance category has its own defined performance period.

Performance Year (PY): The period in which program participants must collect QPP data. They report the data they've collected in the first few months of the following year.

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 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.

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

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 thresholds for a year based on participation in an Advanced APM. 2023 Threshold requirements: % of Payments = 50% | % of Patients = 35%; 75% of practices in Advanced APM should be using CERHT.

Qualified Registry: CMS-approved entity that collects MIPS data from MIPS eligible clinicians and submits it to CMS on their behalf. Clinicians typically work directly with their chosen Qualified Registry to submit data on the selected measures or activities they have selected.

Qualified Clinical Data Registry (QCDR): A QCDR is a CMS-approved entity that demonstrates clinical expertise in medicine and quality measurement development that collects medical or clinical data on behalf of a MIPS eligible clinician for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients.

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 tracks; choice of program and performance will determine reimbursement rates on Medicare Part B claims.

Rural: An eligible clinician associated with a practice in a ZIP code designated as rural by the Federal Office of Rural Health Policy (FORHP) using the most recent FORHP Eligible ZIP code file available.

Small Practice: A solo practitioner or a practice (TIN), virtual group or APM Entity with 15 or fewer clinicians. Clinicians, practices, virtual groups and APM Entities with the small practice special status have modified scoring and reporting requirements.

Snapshot: A date on which CMS will capture Participation Lists and Affiliated Practitioner lists. These lists will be used to identify participants in MIPS APMs and to run QP determination calculations.

Security Official: A role for the Quality Payment Program system that allows the user to report data, view eligibility information for the organization, and approve other users to access the organization in the QPP system.

Specialty Measure Set: A group of Quality measures identified as applicable to a specific specialty.

Special Status: An automatically applied determination by CMS that qualifies clinicians, practices, or virtual groups for reduced reporting requirements in certain performance categories.

Staff User: A role for the Quality Payment Program system that allows the user to report data and view eligibility information for the organization.

Submission Type: The mechanism by which the submitter type submits data to CMS, including, as applicable: direct submission via API, log in and upload, log in and attest, Medicare Part B Claims, and the CMS Web Interface. Cost data is automatically collected and calculated by CMS from Part B and administrative claims data submitted for payment.

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.

Targeted Review: A process that allows clinicians, groups, virtual groups, and APM Entities to request that CMS review their final score and MIPS payment adjustment. CMS will update the final score and payment adjustment if it's determined that a MIPS scoring policy wasn't applied correctly. Individuals and APM Entities may also use the Targeted review process for limited reviews of participation lists used in QP determinations.

Third-Party Intermediary: An entity that has been approved to submit data on behalf of a MIPS eligible clinician, practice, or virtual group for one or more of the Quality, Improvement Activities, and Promoting Interoperability performance categories.

TIN/NPI Combination: When a clinician reassigns their Medicare billing rights to a TIN, their NPI becomes associated with that TIN. This association is referred to as a TIN/NPI combination.

Total Per Capital Cost (TPCC): Assesses the primary care clinician's overall care for a Medicare patient during the performance period.

TPCC – Candidate Event: Start of a primary care relationship between clinician & beneficiary; identified by the occurrence of two-Part B Physician/Supplier (Carrier) claims with particular CPT/HCPCS codes.

TPCC – Risk Window: Begins on the date of the candidate event and continues until one year after that date. A beneficiary's costs are attributable to a clinician during months where the risk window & measurement period overlap.

Virtual Group: A participation option available to solo practitioners and practices with 10 or fewer clinicians that allows them to join forces and submit aggregated data for all the clinicians in the TINs.

Voluntary Reporting: A reporting option available to a clinician, practice, or APM Entity that is not MIPS eligible but does bill Medicare Part B claims in segment 2 of the MIPS determination period. If you report voluntarily, you'll receive limited performance feedback and a final score but no payment adjustment.