

GLOSSARY OF KEY TERMS

The Medicare Access and CHIP Reauthorization Act is a sweeping piece of legislation that adds significant new complexity to the already complex federal health reimbursement system. Understanding and participating in this new program requires a knowledge base in federal healthcare programs and terminology.

This glossary is meant to help you learn about MACRA, the individual programs that it is comprised of, and some other common terminology that relates to federal health reporting programs. It goes from the macro (e.g., what is the U.S. Department of Health and Human Services?) to the micro (e.g., what is a quality measure?), and it is meant to be a *living document* that expands and changes as MACRA continues to evolve.

All terms covered in the glossary are listed immediately below, along with the page where they can be found. If you have additional terms you think should be incorporated, please email advocacy@plasticsurgery.org.

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Advancing Care Information (ACI) Performance Category



One of the four Performance Categories under the Merit-Based Incentive Payment System (MIPS), ACI is essentially a reframing of the federal Electronic Health Record (EHR) Incentive Program, also known as “Meaningful Use”. The [ACI Performance Category](#) measures and scores physicians based on the extent to which they use Certified EHR technology, commonly referred to as “CEHRT”. CEHRT is a formal designation given to a product that satisfies the standards and specifications required for successful use under MIPS. If your EHR is not CEHRT, you will not be able to obtain a score under the ACI Performance Category.

ACI Base Score/Performance Score



Your score in the Merit-Based Incentive Payment System (MIPS) ACI Performance Category has two components – a base score of 50% and an additional performance score. Physicians can achieve the ACI base score by reporting on all five required measures (e-Prescribing, Provide Patient Access, Security Risk Analysis, Send a Summary of Care Record, and Summary of Care Measure). Physicians can earn up to 100% in the ACI Performance Category by reporting on additional measures, each of which are worth up to 10% in additional scoring.

Alternative Payment Model (APM)



A method of reimbursement that seeks to reward care quality, outcomes and efficient resource use, rather than the volume of care delivered. Episodic bundling of payments, per patient payment capitation, and shared savings/shared loss are the most common underlying APM payment structures.

APMs can be implemented by public or private payers, and they can also be developed by and integrated throughout large health systems. Accountable Care Organizations, the Medicare Shared Savings Program, Patient Centered Medical Homes, and integrated health systems are examples of APMs.

There are two types of [APMs under MACRA](#): (1) Advanced APMs, which exempt participating providers from MIPS reporting and offer a 5% payment bonus, and (2) MIPS APMs, which still require providers to participate in MIPS, but may result in a positive adjustment to certain components of your MIPS Performance Score.

Advanced Alternative Payment Model (A-APM)



One of two [APM designations under MACRA](#), A-APMs are those APMs that (1) require participants to use CEHRT; (2) when adjusting physician payments, utilize quality measures comparable to those used in MIPS; and (3) either require participating entities to bear risk for more than a nominal financial loss or is a Patient-Centered Medical Home.

In 2017, clinicians who participate in an A-APM that receives 25% of its payments from Medicare or sees Medicare patient volume in excess of 20% of its total volume will be deemed Qualified Participants (QPs) and will be exempt from MIPS reporting and eligible for a 5% payment bonus.

Certified Electronic Health Record Technology (CEHRT)



An EHR system that has received formal certification for use in the Merit-Based Incentive Payment System (MIPS) Advancing Care Information (ACI) Performance Category. Certifications are given based on standards, specifications and criteria for structured data determined by the Office of the National Coordinator for Health Information Technology (ONC). This certification is meant to ensure that EHR system has the technological capability, functionality and security to [successfully participate](#) in CMS programs.

Centers for Medicare and Medicaid Services (CMS)



Part of the federal Department of Health and Human Services (HHS), CMS is responsible for administering Medicare, Medicaid, CHIP and the federal health insurance exchange. CMS is responsible for writing regulations that operationalize (also known as “implementation”) much of federal health care law, including MACRA. ASPS communicates directly with CMS to try to improve federal health policy.

Children’s Health Insurance Plan (CHIP)



A health program that provides coverage to eligible low-income children, CHIP is administered by the states and is jointly funded by the federal and individual state governments. While MACRA included a reauthorization of the program, you will not be impacted by this part of the law unless you participate in your state’s CHIP program.

Clinical Practice Improvement Activities (CPIA) Performance Category



Unlike the other three MIPS performance categories, the CPIA Performance Category has no predecessor program. CPIAs were introduced under MACRA to incent providers to incorporate

processes, participate in programs, and modify care delivery in a dedicated fashion with the aim of improving practice and, ultimately, improving outcomes. There are 93 CPIAs you can conduct in 2017 to receive credit in this category.

After [conducting CPIAs](#) for at least 90 days in 2017, participation in this category is reported through a simple attestation to CMS. To receive full credit, providers in small group practices (15 or fewer MIPS eligible clinicians) must conduct CPIAs worth 20 points. Providers in larger groups must conduct CPIAs worth 40 points.

CPIAs are classified as highly-weighted (worth 20 points) or medium-weighted (worth 10 points), and the aggregate value of the CPIAs you conduct and attest to must meet these thresholds to max out your score in the CPIA Performance Category.

Data Submission Mechanism

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A means of transmitting to CMS data and attestations on your activities within the four MIPS performance categories. There are a variety of data submission mechanism options, including attestation, claims, the CMS Web Interface (for groups of 25 or more), electronic health record (EHR), [Qualified Clinical Data Registry \(QCDR\)](#) and Qualified Registry.

Not all MIPS performance categories support all data submission mechanisms. Within performance categories that *do* support all mechanisms, not all of the individual reportable measures or activities within those categories allow for reporting from all mechanisms.

Electronic Health Record (EHR)

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A shareable, digital system that captures both a version of a patient's paper chart and a broader set of environmental and behavioral health determinants, with the aim of providing a wide view of patient health. EHRs should, in theory, travel with a patient across care sites and settings, be accessible to and updated by all clinicians involved in a patient's care, and serve as the pivotal tool in fostering care coordination.

Electronic Health Record (EHR) Incentive Program

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Also known as "Meaningful Use", this program launched in 2011 and provided bonuses to physicians, practices, and systems that adopted new or improved Certified EHR Technology (CEHRT) and, after adoption, used CEHRT in a meaningful way. The threshold for "meaningful use" has risen over time, and the latest iteration of the program requires the use of interoperable technologies to engage in health

information exchange, improve quality measurement and reporting, and increasing clinical effectiveness.

In the MACRA Quality Payment Program, the federal EHR Incentive Program will be modified slightly and incorporated into the Merit-based Incentive Payment System (MIPS) as the [Advancing Care Information Performance Category](#).

Exemption from MIPS, Low Volume Threshold

MIPS-eligible clinicians who do not exceed \$90,000 in Part B allowed charges or who see 200 or fewer Medicare patients do not have to participate in MIPS. These amounts are calculated at the NPI/TIN number level for individuals, the TIN level for groups, and the APM entity level for APMs.

CMS will base this exemption on your Medicare Part B claims for a time period prior to a reporting year. CMS will provide an NPI level lookup feature that will allow you to determine if you qualify for the low volume threshold exemption.

Exemption from MIPS, Other

Physicians who are in the first year of Medicare participation and/or physicians who meet the requirements of a Qualified Participant in and A-APM do not have to participate in MIPS.

Meaningful Use

Formally called the federal EHR Incentive Program, but also known colloquially as “Meaningful Use”, this program launched in 2011 and provided bonuses to physicians, practices, and systems that adopted new or improved Certified EHR Technology (CEHRT) and, after adoption, used CEHRT in a meaningful way. The threshold for “meaningful use” has risen over time, and the latest iteration of the program requires the use of interoperable technologies to engage in health information exchange, improve quality measurement and reporting, and enhance clinical effectiveness.

In the MACRA Quality Payment Program, Meaningful Use will be modified slightly and incorporated into the Merit-based Incentive Payment System (MIPS) as the [Advancing Care Information Performance Category](#).

Medicare Access and CHIP Reauthorization Act (MACRA)

Enacted into law in April 2015, this sweeping piece of legislation repealed the sustainable growth rate (SGR) for updating Medicare Part B reimbursements and replaced it with a new Quality Payment

Program (QPP). When practitioners talk about participating in “MACRA”, what they are really referring to is the QPP (a federal payment program) that MACRA (a piece of legislation) created. The QPP has two participation tracks – Advanced Alternative Payment Models (A-APMs) and the Merit-based Incentive Payment System (MIPS).

Merit-based Incentive Payment System (MIPS)

One half of the new Medicare Quality Payment Program (QPP) created by MACRA. MIPS participants will report on their actions across four performance categories – [Advancing Care Information](#), [Clinical Practice Improvement Activities](#), [Quality](#), and [Resource Use](#). Each of these categories is weighted differently, and a physician’s weighted scores from each category are aggregated to form a MIPS performance score. Your Medicare reimbursements will be increased, decreased or kept neutral based on how your performance score stacks up relative to the scores of all MIPS participants.

Office of the National Coordinator for Health Information Technology (ONC)

Part of HHS, this federal agency is charged with leading national efforts to improve the implementation and meaningful utilization of health information technology. ONC is responsible for, among other things, administering the Health IT Certification Program, under which EHRs are certified for use in federal payment programs, such as the MACRA Quality Payment Program (QPP).

Payment Adjustment

Under the MACRA Quality Payment Program (QPP), your Medicare Part B reimbursements may be “adjusted” based on your participation and performance in one of the two QPP tracks. If you are a Qualified Participant in an Advanced Alternative Payment Model (A-APM), your Part B payments will be subjected to a 5% bonus. If you are a MIPS participant, your Part B payments will be subjected to as much as a 4% penalty or bonus in the first payment year. The upside/downside calculus increases every year under MIPS through the 2022 payment year, when it reaches +/- 9%.

Payment Year

Under the MACRA QPP, adjustments to your Medicare Part B reimbursements are determined by your performance two years prior. So, your first QPP payment adjustment will occur in 2019 based on your performance in 2017, your payments in 2020 will be impacted by your performance in 2018, and so on.

Performance Category, MIPS

The Merit-based Incentive Payment System (MIPS) measures performance across four domains: (1) the [Advancing Care Information \(ACI\) Performance Category](#); (2) the [Clinical Practice Improvement Activities](#)

[\(CPIA\) Performance Category](#); (3) the [Quality Performance Category](#); and (4) the [Resource Use Performance Category](#).

Your performance in each category is scored individually, and the scores for each category are weighted differently. (For 2017, the weights are: ACI - 25%; CPIAs - 15%; Quality - 60%; Resource Use - 0%). The individual performance category scores are aggregated to produce a MIPS Performance Score.

Performance Score, Category



The Merit-based Incentive Payment System (MIPS) measures performance across four domains: (1) the [Advancing Care Information \(ACI\) Performance Category](#); (2) the [Clinical Practice Improvement Activities \(CPIA\) Performance Category](#); (3) the [Quality Performance Category](#); and (4) the [Resource Use Performance Category](#).

Your performance in each category is scored individually based on whether and how well you conduct activities specified within each MIPS domain. The individual MIPS performance category scores are then aggregated to produce a MIPS final performance score.

Performance Score, Final



Your performance in each of the four MIPS performance categories is scored individually, and the scores for each category are weighted differently. (For 2017, the weights are: ACI - 25%; CPIAs - 15%; Quality - 60%; Resource Use - 0%). The individual performance category scores are aggregated to produce a MIPS final score.

Your MIPS final score is used to benchmark your performance relative to all other MIPS physicians. Your Part B payments will be increased, decreased or remain neutral based on how your score ranks relative to the full field of scores.

Performance Year



Under the MACRA QPP, adjustments to your Medicare Part B reimbursements are determined by your performance two years prior. So, your first QPP payment adjustment will occur in 2019 based on your performance in 2017, your payments in 2020 will be impacted by your performance in 2018, and so on.

Physician Quality Reporting System (PQRS)



Initiated by CMS in 2006, a quality reporting program under which physicians and practices collect patient care data and report on that data through quality measures. Beginning in 2016 – the final year of

PQRS reporting – physicians will have penalties assessed to their Medicare Part B reimbursements for not participating in the program.

In the MACRA Quality Payment Program, PQRS will be modified slightly and incorporated into the Merit-based Incentive Payment System (MIPS) as the Quality Performance Category.

Qualified Clinical Data Registry (QCDR)

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A CMS-approved entity that collects medical and/or clinical data for the purpose of quality measure reporting to federal pay-for-reporting programs. QCDRs were created specifically to support reporting to PQRS and, once it is in place, the MACRA Quality Payment Program. Additionally, CMS initiated the QCDR program in part as a response to the lack of highly-relevant, specialty-specific PQRS, and as a result QCDRs include non-PQRS measures that are more relevant to specialty practice. When reporting through a QCDR, physicians can report on these non-PQRS measures and still satisfy PQRS reporting requirements.

One factor to note is that QCDRs are approved annually. As a result, the specifications for MIPS QCDRs are forthcoming. That said, most observers believe that QCDRs under MIPS will offer the same functionality and benefits that they have offered under PQRS.

ASPS-QCDR

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The ASPS-QCDR is an ASPS-developed and CMS-approved entity that allows for the collection and submission of quality measures to the Physician Quality Reporting System (PQRS) for 2016. Because the ASPS-QCDR has been reviewed and approved by CMS, plastic surgeons who utilize it are able to report on PQRS measures most relevant to their practice *and* additional non-PQRS measures that have been developed by ASPS. These non-PQRS measures were developed to fill gaps in the existing PQRS measure set and offer a better look at care quality in key aspects of our specialty.

QCDRs must apply for CMS approval every year. The application process for MIPS QCDRs will occur in 2017, and ASPS will nominate the [ASPS-QCDR for use in the MIPS program](#). After approval, the ASPS-QCDR will be a pivotal resource for satisfying the reporting requirements of multiple MIPS performance categories.

Qualified Registry

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A qualified registry is an entity that collects clinical data from a an eligible professional (for the purposes of a federal reporting program, like MIPS, or the predecessor programs it replaces) or group practice

and submits it to CMS on behalf of the participants. Qualified registries only allow for reporting on Medicare Part B beneficiaries and a limited quality measure set.

Qualifying APM Participant (QP)

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Just as not all Alternative Payment Models qualify as “Advanced” Alternative Payment Models under the MACRA Quality Payment Program, not all clinicians participating in an Advanced Alternative Payment Model (A-APM) will qualify for the 5% bonus given to A-APMs. Only Qualified Participants (QPs) will receive the bonus.

In 2017, a QP is a practitioner in an A-APM entity whose clinicians *collectively* receive 25% or more of their total payments from Medicare Part B payments, or who see a volume of Medicare beneficiaries in excess of 20% of their total patient volume. Once the A-APM entity exceeds one of these thresholds, all clinicians in the entity will be deemed QPs.

Quality Measure

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A tool used to quantify and assess key characteristics of healthcare delivery, such as effectiveness, safety, resource use, patient experiences and the care outcomes. Quality measures are used by private payers, health systems and, most commonly, as essential indicators in public pay-for-reporting programs.

The MACRA Quality Payment Program continues the federal government’s growing focus to measure the quality of care delivered to Medicare beneficiaries by basing the qualifications for an Advanced APM and basing a substantial portion of individual MIPS final performance scores on [physician reporting and performance on specific quality measures](#).

Quality Payment Program (QPP)

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A new scheme for Medicare Part B reimbursements created by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The QPP offers two participation tracks: Advanced Alternative Payment Models and the Merit-based Incentive Payment System (MIPS). The former rewards clinicians with a 5% payment bonus for participation in specific sub-sets of existing alternative payment models. The latter replaces the sustainable growth rate (SGR) for updating Medicare Part B fee-for-service reimbursement rates and replaces it with payment penalties/bonuses tied to your performance in quality, clinical practice improvement, resource use and health IT.

Quality Performance Category



One of the four Performance Categories under MIPS, Quality is essentially a reframing of the federal Physician Quality Reporting System (PQRS) that has been administered by CMS since 2006. This performance category requires physicians and practices to collect patient care data and report on that data through quality measures, and it is weighted to contribute 60% of your MIPS final performance score.

For the 2017 performance year, you can avoid a payment penalty as long as [some data is reported](#). However, going forward (or, if you're ambitious, to receive a bonus for your 2017 performance) you will be required to report at least 6 quality measures, including one outcome measure. If no outcome measure is available, you must report at least on high priority measure.

Quality and Resource Use Report (QRUR)



A tool designed to provide feedback on performance data relative to federal quality and cost metrics. CMS provides QRURs to physicians and practices that have billed for Medicare-covered services and have reported a quality or cost measure in conjunction with a Medicare fee-for-service case. QRURs are used by CMS in calculating the Value-Based Payment Modifier (VM) and consequently reflect data that will be used by CMS to score your performance under the MIPS Resource Use Performance Category, which replaces the VM.

Resource Use Performance Category



One of the four performance categories under MIPS, Resource Use is a continuation of the federal Value-Based Payment Modifier (VM) program that CMS uses to adjust individual physicians' Medicare Part B payment based on how they rank relative to their peers on cost and quality measures.

This [performance category will be measured](#) by CMS in 2017, but not scored, so it will not impact your 2017 MIPS final performance score. In future years, it will require physicians and practices to collect and report on patient care data through quality measures

Small Practice



For the purpose of MACRA, practices with 15 or fewer MIPS-eligible clinicians.

Transitional Year




In recognizing that many physicians will not yet understand, let alone have the capability to participate in, the Quality Payment Program on January 1, 2017, CMS introduced transitional participation options

that allowed clinicians to test the program in 2017 and easily avoid a payment penalty. In year two and subsequent years of MIPS, there will no longer be a transition period.

U.S. Department of Health and Human Services (HHS)

The cabinet-level federal department responsible for protecting the health of Americans and providing essential human services. HHS is the parent department for the Centers for Medicare and Medicaid Services (CMS), which administers most federal health programs, including MACRA's Quality Payment Program (QPP).

Value-Based Payment Modifier (VM)

An adjustment to Medicare Part B reimbursements determined by how physicians rate relative to their peers on federal reporting program cost and quality measures.  the VM, physicians are rated as Low Cost/High Quality, High Cost/High Quality, Low Cost/Low Quality, High Cost/Low Quality and their payments are increased or decreased accordingly.

