MACRA Glossary

Accountable Care Organization (ACO)
Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated, high quality care to their patients. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

Advanced Alternative Payment Model (AAPM)
Advanced alternative payment models (AAPMs) must meet specific criteria outlined by MACRA legislation. AAPMs require participants to bear a certain amount of financial risk, base payments on qualify measures and require participants to use certified EHR technology. Based on the proposed rule, AAPMs will include MSSP Tracks 2 and 3, Next Generation ACOs, Comprehensive End Stage Renal Disease (ESRD) Care Model, Comprehensive Primary Care (CPC) Model and Oncology Care Model Two-Sided Risk Arrangement.

Alternative Payment Model (APM)
An Alternative Payment Model (APM) is one of two new payment tracks established by MACRA. It involves a new approach that incentivizes quality and value. APMs include: the Centers for Medicare & Medicaid Services’ (CMS) Innovation Center Model, Medicare Shared Savings Program (MSSP), demonstration under the Health Care Quality Demonstration Program, or a demonstration required by federal law. Qualifying APM participants will not be subject to Merit-Based Incentive Payment System (MIPS) adjustments; however, many components of MIPS, including electronic health records (EHRs), are also requirements of APMs. APMs involve increased transparency of physician-focused payment models and qualifying APMs will require that the provider organization take on some financial risk.

Children’s Health Insurance Program (CHIP)
The Children’s Health Insurance Program (CHIP) provides free or low-cost health coverage to eligible children, through both Medicaid and separate CHIP programs. CHIP is administered by states and is funded jointly by states and the federal government.

Certified Electronic Health Record (CEHRT) or Electronic Health Record (EHR)
Previously known as EMR. Meaningful use of certified EHR technology is one of four performance categories under the Merit-Based Incentive Payment System (MIPS). To get an incentive payment, you must use an EHR that is certified specifically for the EHR Incentive Programs. Certified EHR technology gives assurance to purchasers and other users that an EHR system or module offers the necessary technological capability, functionality, and security to help them meet the meaningful use criteria. Certification also helps providers and patients be confident that the electronic health IT products and systems they use are secure, can maintain data confidentially, and can work with other systems to share information.

Clinical Practice Improvement Activities (CPIA) or Clinical Practice Improvement (CPI)
Clinical practice improvement activities (CPIA) are four performance categories under the Merit-Based Incentive Payment System (MIPS). They include expanded practice access (such as same day appointments for urgent needs and after-hours access to clinician advice); population management (such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry); care coordination (such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth); beneficiary engagement (such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and
using shared decision-making mechanisms); patient safety and practice assessment (such as thorough use of clinical or surgical checklists and practice assessments related to maintaining certification); and participation in an Alternative Payment Model (APM).

**Clinically Integrated Network (CIN)**
A network of affiliated providers who are independent physicians that agree to certain quality standards. The CIN may have payer contracts.

**Comprehensive Primary Care (CPC)**
The Comprehensive Primary Care (CPC) initiative is a four-year multi-payer initiative designed to strengthen primary care. The Centers for Medicare & Medicaid Services (CMS) has collaborated with commercial and state health insurance plans in seven U.S. regions 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; and (5) coordination of care across the medical neighborhood. The initiative is testing whether provisions of these functions at each practice site — supported by multi-payer payment reform, the continuous use of data to guide improvement, and meaningful use (MU) of health information technology — can achieve improved care, better health for populations, lower costs, and can inform future Medicare and Medicaid policy.

**Comprehensive Primary Care Plus (CPC+)**
The Comprehensive Primary Care Plus (CPC+) is a five-year advanced primary care medical home model that aims to strengthen primary care through regionally-based multipayer reform and care delivery transformation. CPC+ begins in 2017, and will include two primary care practice tracks with incrementally advanced care delivery requirements and payment options. CPC+ will provide practices with a learning system, as well as actionable patient-level cost and utilization data feedback to guide decision making.

**Eligible Professional (EP)**
An eligible professional (EP) is an individual physician or health care provider who is eligible to participate in, or subject to, mandatory participation in a Medicare or Medicaid program. For the purposes of the Merit-Based Incentive Payment System (MIPS), an EP for years one to two of the program includes physicians, physician assistant, nurse practitioner, clinical nurse specialist, and certified registered nurse anesthetists.

**Fee for service (FFS)**
A service delivery system where healthcare providers are paid for each service separately (e.g., office visit, test, or procedure). Medicaid develops fee-for-service payment rates state by state, based on the costs of providing the service, a review of what commercial payers pay in the private market, or a percentage of what Medicare pays for equivalent services.

**Medicare Access and CHIP Reauthorization Act (MACRA)**
The Medicare Access and CHIP Reauthorization Act (MACRA) is landmark legislation that makes three important changes to how Medicare pays physicians who provide care to Medicare beneficiaries. These changes include: repealing the sustainable growth rate (SGR) formula for determining Medicare payments for health care providers’ services; creating a new framework for rewarding health care providers for giving better care, and combining existing quality reporting programs into one new system. The goal is for CMS to pay for value, rather than fee for service. Through 2019, there will be an annual baseline payment increase of 0.5%. From that point on, annual automatic increases come to an end and physicians will have to choose between the Merit-Based Incentive Payment System (MIPS) and alternative payment models (APMs). Their choice and performance in each system will determine reimbursement rates after 2019.

**Medicare Physician Fee Schedule (PFS)**

A comprehensive list of fee maximums used by Medicare to reimburse a physician and/or other providers in a fee-for-service system.

**Medicare Shared Savings Program (MSSP)**

Established by the Affordable Care Act as a new approach to the delivery of health care. Eligible providers, hospitals and suppliers may participate in the Medicare Shared Savings Program by creating or participating in an Accountable Care Organization (ACO) and are rewarded for meeting cost and performance standards.

**Merit-Based Incentive Payment System (MIPS)**

The Merit-Based Incentive Payment System (MIPS) is one of two new payment tracks established by MACRA that combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-Based Payment Modifier), and the Medicare Electronic Health Record (EHR) Incentive Program. MIPS consolidates these Medicare initiatives into one single program based on: quality, resource use, clinical practice improvement activities, and meaningful use of certified EHR technology. New program, invented by MACRA, that combines elements of the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VBM), and Meaningful Use. Eligible professionals will be assessed for reimbursement based on four weighted performance categories: 1) quality, 2) resource use, 3) clinical practice improvement activities, and 4) advancing care information (MU). Physicians will be assessed as a group based on every doctor who is part of their tax identification number (TIN).

**National Practitioner Identifiers (NPIs)**

Unique identification number for covered healthcare providers. For those choosing the alternative payment model (APM) option under MACRA, the method of attribution will be by the physician’s NPI.

**Patient-Centered Medical Home (PCMH)**

A patient-centered medical home (PCMH) is a model or philosophy of primary care that is patient centered, comprehensive, team based, coordinated, accessible, and focused on quality and safety. It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system. The terms "medical home" and "certified medical home" included in MACRA are still yet to be defined. This care delivery model aims to transform how comprehensive primary care is provided by coordinating patient treatment through the primary care physician to ensure patients receive the necessary care when and where they need it, in a manner they can understand. The objective is to have a centralized setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family. Ideally, care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the appropriate care.

**Pay for performance**

An approach where a health insurer or other payer compensates physicians according to an evaluation of physician performance, typically manifest as a potential bonus on top of the physician’s fee-for-service compensation. The payer bases its evaluation on the data it has on that physician or physician group, most commonly administrative or claims data measuring quality and/or cost of care.

**Physician Quality and Reporting System (PQRS)**

The Physician Quality and 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.

**Qualifying Alternative Payment Model Participant (QP)**

Qualifying participants (QPs) are physicians and practitioners who have a certain percent of their patients or payments through an
advanced alternative payment model (AAPM). CMS calculates a "threshold score" for each AAPM entity and it is compared to the corresponding QP threshold. QP determinations are made at the Advanced APM entity level and all participating eligible clinicians are assessed together. The period of assessment for each payment year is the full calendar year that is two years prior to the payment year. (e.g. 2017 performance for 2019 payment). QPs are excluded from MIPS, receive 5% lump sum bonus payments for years 2019-2024 and receive a higher fee schedule update for 2026 and beyond.

**Sustainable Growth Rate (SGR)**
The sustainable growth rate (SGR) was the target set by the Centers for Medicare & Medicaid Services (CMS) to control the growth in aggregate Medicare expenditures for physicians' services. It was repealed as part of MACRA and is no longer used in the Medicare program.

**Tax Identification Numbers (TINs)**
Number assigned by the Internal Revenue Service (IRS) for tax purposes. Under Merit-Based Incentive Payment System (MIPS), rheumatologists will be judged as a group based on every doctor who is part of a single TIN. If a patient with a complex condition sees many different doctors, cost and quality measurements will be aggregated for all doctors in the TIN.

**Value-Based Payment Modifier (VBPM) or Value-based modifier (VBM)**
A budget-neutral Value-Based Payment Modifier (VBPM) provides for differential payment under the Medicare Physician Fee Schedule (PFS) to a physician or group of physicians based upon the quality of care compared to the cost of care furnished to Medicare Fee-for-Service (FFS) beneficiaries during a performance period. The VBPM is separate from the payment adjustment and incentives under the Physician Quality Reporting System (PQRS). An adjustment made on a per claim basis to Medicare payments for items and services under the Medicare Physician Fee Schedule (PFS). The Value Modifier Program determines the amount of Medicare payments to physicians based on their performance on specified quality and cost measures. The program rewards quality performance and lower costs.