Putting the Pieces Together
Practical Solutions for the GI Practice

MACRA Acronyms

Current Medicare Quality Programs

MACRA (Medicare Access and Chip Reauthorization Act) Underlying legislation repealing the Medicare Sustainable Growth Rate formula, and replacing with the Quality Payment Program. Shifts payment equation from number of services provided to a system that rewards clinicians for their work on improving overall quality of care.

QPP (Quality Payment Program) The new payment program under MACRA encompassing two payment pathways (i.e. MIPS as well as Alternative Payment Models).

MIPS (Merit-Based Incentive Payment System) One of two pathways. Streamlines prior Physician Quality Reporting (PQRS), Meaningful Use and Value-Based Payment reporting programs into one program. Also adds fourth component to promote ongoing improvement and innovation in clinical activity. For 2017, most gastroenterologists will participate in the program through the MIPS pathway.

APMs (Alternative Payment Models) One of two pathways. Provides added incentives to clinicians to provide high-quality and cost-efficient care. For 2017, most gastroenterologists will not participate as there are no currently approved GI APM's.

IA (Improvement Activities) New MIPS performance category designed to focus on activities identified as improving clinical practice or care delivery that, when effectively executed, are likely to result in improved outcomes.

Prior Medicare Quality Programs

PQRS (Physician Quality Reporting System) A quality reporting program encourages individual eligible professionals (EPs) and group practices to report information on the quality of care to Medicare· *Now the MIPS Quality performance category.*

MU (Meaningful Use) Established to encourage eligible professionals and eligible hospitals to adopt, implement, upgrade and demonstrate meaningful use of certified EHR technology. *Now the MIPS Advancing Care Information performance category.*

VBPM (Value-Based Payment Modifier) Provided payment to a physician or group of physicians under the Medicare Physician Fee Schedule (MPFS) based upon the quality of care furnished compared to the cost of care during a performance period. *Now the MIPS Cost performance category.*

Additional Terminology

ACO (Accountable Care Organization) A group of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.

CEHRT (Certified Electronic Health Record Technology) Set of standards and other criteria for structured data that EHRs must meet in order to qualify for use in the Medicare and Medicaid EHR Incentive Programs.

CHIP (Children's Health Insurance Program) Provides health coverage to eligible children, through both Medicaid and separate CHIP programs. Administered by states and jointly funded by states and the federal government.

CMS (Centers for Medicare and Medicaid Services) Agency within the Department of Health and Human Services (HHS). Administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and the Health Insurance Marketplace.

CMMI (Centers for Medicare and Medicaid Innovations) Supports the development and testing of innovative health care payment and service delivery models.

EC (Eligible Clinician) Physician's or healthcare providers eligible to participate in Medicare programs. *For the purpose of MIPS, eligible clinicians are defined as Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists.*

EHR (Electronic Health Records) Electronic version of a patient's medical history automatic access to information, including all administrative clinical data relevant to that persons care under a particular provider (i.e. demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports). Has the ability to support other care-related activities directly or indirectly through various interfaces, including evidence-based decision support, quality management, and outcomes reporting.

HHS (U.S. Department of Health and Human Services) Oversees CMS, and is principal U.S. agency charged with protecting the health of all Americans and providing essential human services.

QCDR (Qualified Clinical Data Registry) CMS-approved entity that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients.

QRUR (Quality Resource and Use Report) CMS report providing information on physician performance to physicians participating in Medicare in order to better understand the quality and efficiency of care provided to beneficiaries.

PFPM (Physician Focused Payment Model) Development of APM's where Medicare is a payer. All proposed models will be reviewed by the Physician Focused Payment Model Technical Advisory Committee (PTAC).

PFS (Physician Fee Schedule) List of Medicare covered services, calculation of payment rates and misvalued codes. Updated on an annual basis.

SGR (Medicare Sustainable Growth Rate Formula) Repealed formula on which fee-for-service Medicare Part B payments are based on through 2017. Replaced with the QPP.