

Medicare Reimbursement Reform Glossary

ACO – Accountable Care Organization

[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 Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. 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. (Source: CMS Website)

APMs – Alternative Payment Models

APMs are new ways to pay health care providers for the care they give patients.

[Accountable Care Organizations](#) (ACOs), Patient Centered Medical Homes, and [bundled payment models](#) are some examples of APMs. (Source: CMS website)

CEHRT – Certified Electronic Health Records Technology

In order to capture and share patient data efficiently, providers need an EHR that stores data in a structured format. Structured data allows patient information to be easily retrieved and transferred, and it allows the provider to use the EHR in ways that can aid patient care.

CMS and the Office of the National Coordinator for Health Information Technology (ONC) have established [standards and other criteria](#) for structured data that EHRs must use in order to qualify for this incentive program.

CHIP – Children’s Health Insurance Program

CHIP is a program unrelated to Medicare reimbursement, and was simply bundled with the larger MACRA and repeal of the SGR for political reasons. CHIP provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid. In some states, CHIP covers parents and pregnant women. Each state offers CHIP coverage, and works closely with its state Medicaid program. (Source: Healthcare.gov)

CMS – Centers for Medicare and Medicaid Services

[The Centers for Medicare & Medicaid Services](#), CMS, is part of the Department of Health and Human Services (HHS).

CMMI – Centers for Medicare and Medicaid Innovation

[The Center for Medicare & Medicaid Innovation](#) (the Innovation Center) is a sub-division within

CMS. CMMI, with the help of CMS as a whole, supports the development and testing of innovative health care payment and service delivery models.

EHR – Electronic Health Record

EHRs are, at their simplest, digital (computerized) versions of patients' paper charts. But EHRs, when fully up and running, are real-time, patient-centered records. They make information available instantly, "whenever and wherever it is needed". And they bring together in one place everything about a patient's health. One of the key features of an EHR is that it can be created, managed, and consulted by authorized providers and staff across more than one health care organization. A single EHR can bring together information from current and past doctors, emergency facilities, school and workplace clinics, pharmacies, laboratories, and medical imaging facilities. (Source HHS Website)

EP – Eligible Professional

Covered professionals for the services at issue. EPs are based on a specific definition in MACRA.

HCPLAN – Health Care Payment Learning and Action Network

The Health Care Payment Learning and Action Network ("Network a forum for public-private partnerships to help the U.S. health care payment system meet or exceed recently established Medicare goals for value-based payments and alternative payment models. The Network is a forum where payers, providers, employers, purchasers, states, consumer groups, individual consumers, and others can discuss, track, and share best practices on how to transition towards alternative payment models that emphasize value. The Network will be supported by an independent contractor that will act as a convener and facilitator. (source: CMS website)

HHS –US Department of Health and Human Services

HHS or DHHS administers many of the "social" programs at the Federal level dealing with the health and welfare of the citizens of the United States. (It is the "parent" agency of CMS.) (Source: CMS Website)

Information Blocking

Information blocking occurs when persons or entities knowingly and unreasonably interfere with the exchange or use of electronic health information. Information blocking not only interferes with effective health information exchange but also negatively impacts many important aspects of health and health care. When health information is unavailable, decisions can be impaired—and so too the safety, quality, and effectiveness of care provided to patients. Information blocking also impedes progress towards reforming health care delivery and payment because sharing information seamlessly across the care continuum is fundamental to moving to a person-centered, high-performing health care system. (Source: https://www.healthit.gov/sites/default/files/reports/info_blocking_040915.pdf)

Interoperability

Interoperability is generally accepted to mean the ability of two or more systems or components to exchange information and use the information that has been exchanged. That means that there are two steps to interoperability: 1) the ability to exchange information; and 2) the ability to use the information that has been exchanged. (Source CMS Website)

MACRA – Medicare Access and CHIP Reinvestment Act of 2015

The “Medicare Access and CHIP Reauthorization Act of 2015” (MACRA), repealed the sustainable growth rate and put into place a new payment system touted as promoting quality over volume. MACRA contains scheduled Physician Fee Schedule (PFS) updates, a new Merit-Based Incentive Payment System (MIPS), a new Technical Advisory Committee for assessing Physician Focused Payment Model (PFPM) proposals, and incentive payments for participation in Alternative Payment Models (APMs).

MedPAC – Medicare Payment Advisory Council

A commission established by Congress in the Balanced Budget Act of 1997 to provide the Congress with advice and recommendations on policies affecting the Medicare program. (Source: CMS Website)

MIPS – Merit-Based Incentive Payment System

A system under MACRA by which eligible professionals receive a score and payment adjustments based on a Composite Performance Score that incorporates EP performance on quality, resource use, clinical practice improvement activities, and meaningful use of certified electronic health records.

MU – Meaningful Use

Meaningful use, of certified EHR technology.

PCMH - Patient Centered Medical Home

[The Patient Centered Medical Home](#) model is a way to organized and deliver care.

PFPM – Physician Focused Payment Model

A PFPM is a physician-focused payment model. MACRA establishes a process for stakeholders to propose PFPMs to a Technical Advisory Committee that will review, comment on, and provide recommendations to the Secretary on proposed models. The Secretary will review the Committee’s comments and recommendations on proposed PFPMs and post “a detailed response” to such comments and recommendations on the CMS website. (CMS website).

PFS – Physician Fee Schedule

A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.

PQRS – Physician Quality Reporting System

[The Physician Quality Reporting System](#), formerly known as the Physician Quality Reporting Initiative (PQRI), is a health care quality improvement incentive program initiated by the Centers for Medicare and Medicaid Services (CMS) in the United States in 2006.

QCDR – Qualified Clinical Data Registry

[The qualified clinical data registry](#) (QCDR) reporting mechanism was introduced for the

Physician Quality Reporting System (PQRS) beginning in 2014. A QCDR will complete the collection and submission of PQRS quality measures data on behalf of individual eligible professionals (EPs). For 2015, a QCDR is a 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. Individual EPs who satisfactorily participate in 2015 PQRS through a QCDR may avoid the 2017 negative payment adjustment (-2.0%). To be considered a QCDR for purposes of PQRS, an entity must self-nominate and successfully complete a qualification process. (Source: CMS Website).

RU- Resource Use

Resource use is one category that will impact an eligible professionals composite score under the MIPS Program. Researchers and others have often compared the costs of care for specific populations based on per capita costs. Some researchers have used per capita Medicare costs for certain conditions to assess geographic variation in Medicare spending. CMS has used per capita cost for patients of several group practices to calculate savings associated with improved care management in the physician group practice (PGP) demonstration. Another measure of resource use is related to specific services. For example, it is widely agreed that some costly re-admissions could be prevented with better care management and, thus, represent inefficient care delivery.

While per capita and service-specific measurements are useful, CMS efforts have focused primarily on metrics associated with episodes of care, that is, a series of separate but clinically related services delivered over a defined time period. Episodes are often difficult to define because of differing opinions regarding which services should be grouped together. They provide several advantages over per capita or service-specific metrics, however, because they are more likely to:

- Compare more similar patients than per capita calculations, as they are defined by similar procedures or conditions.
- Capture the multiple ways in which services can be combined and substituted to produce the best outcome at the lowest cost,
- Reflect patients' view of care as they move between and across settings and managers of their care, rather than simply measuring resources used for just a part of their care in one setting, and
- Encourage improved coordination across settings included in the episode.

Resources used in episodes of care are defined as the program costs (including both the Medicare program and the beneficiary payment) as opposed to the costs that providers incur to deliver the services.

SGR – Sustainable Growth Rate

The Medicare Sustainable Growth Rate was a flawed method used by the Centers for Medicare and Medicaid Services (CMS) in the United States to control spending by Medicare on physician services. It was repealed by MACRA.

TAC – Technical Advisory Committee

The TAC was formed by MACRA to advise CMS on physician-focused payment models. The TAC consists of 11 members, 5 of whom must be physicians, and are appointed by CMS. MACRA establishes a process for stakeholders to propose PFPs to a Technical Advisory

Committee that will review, comment on, and provide recommendations to the Secretary on proposed models. The Secretary will review the Committee's comments and recommendations on proposed PFPs and post "a detailed response" to such comments and recommendations on the CMS

VBM – Value Based Modifier

[The Value Based Modifier](#) provides for differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule (PFS) *based* upon the quality of care furnished compared to the cost of care during a performance period.