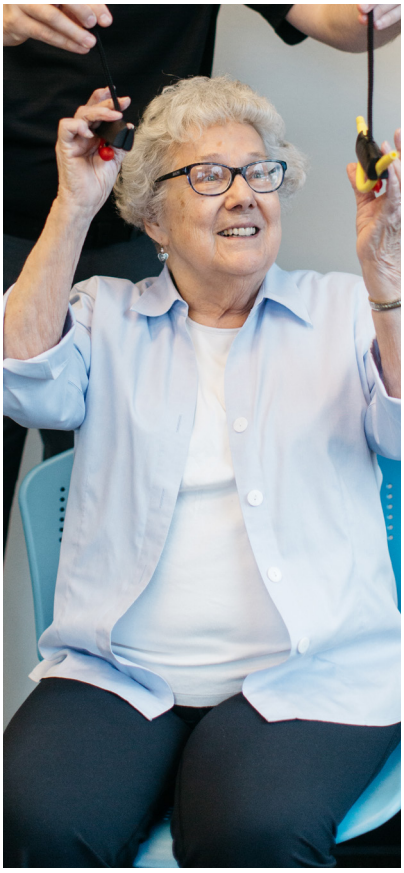
Merit Based Incentive Payment System (MIPS) Terminology

For Physical Therapists, Occupational Therapists and Speech Language Pathologists



Worried you are losing the battle against healthcare acronyms? Get caught up on MIPS with this glossary of terms for PTs, OTs and SLPs.

Advancing Care Information (ACI)

See “Promoting Interoperability Measures”.

Alternative Payment Models (APM)

New payment models that move away from traditional fee-for-service to more value-based payments.

Children’s Health Insurance Program (CHIP)

The Children’s Health Insurance Program provides health insurance to eligible children through both Medicaid and separate CHIP programs. It is administered by states but funded jointly by states and the federal government. It’s also the “C” in MACRA.

Composite Performance Score (CPS)

CPS is the combined score for each of the four performance categories for MIPS. They include: Quality Measures, Promoting Interoperability, Improvement Activities, and Cost. Each category has a different weight that changes from year to year. The score for the performance year affects the CMS payment adjustment (positively or negatively) for the payment year.

Cost Measures

One of the four reporting categories under MIPS, the cost measures aim to measure how a particular clinician or group impacts a patient’s cost, either directly or indirectly.

Eligible Clinician (EC)

EC indicates which professionals/clinicians are qualified to participate (formerly known as EP or eligible professional).

Improvement Activities

One of four performance categories under MIPS. It is a new category that rewards eligible clinicians for care focused on care coordination, beneficiary engagement, and patient safety.

Low Volume Threshold

Sets a threshold for MIPS participation. Eligible clinicians with low volumes of Medicare patients are exempt from participating in MIPS. The low volume threshold varies year to year.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a two-track quality payment program. Tracks include:

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- Advanced Alternative Payment Models (APMs) or
- The Merit-based Incentive Payment System (MIPS)

Merit-Based Incentive Payment System (MIPS)

The Merit Based Incentive Payment System (MIPS) was established under Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

It streamlines several quality reporting programs under Medicare Part B into one program. This includes PQRS, the value-based modifier program, and meaningful use of EHR technology.

Medicare Shared Savings Program (MSSP)

The Medicare Shared Savings Programs was created by Congress to facilitate coordination and cooperation among clinicians to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. Eligible clinicians may participate in the MSSP by creating or participating in an ACO.

Payment Year

The calendar that payment adjustments are administered based on performance for the MIPS Performance Year. The Payment Year is 2 years after the Performance Year. (See “Performance Year”)

Performance Year

The calendar year used to measure MIPS performance. The Performance Year is 2 years prior to the year that Medicare payments are adjusted. (See “Payment Year”)

Promoting Interoperability Measures

Promotes patient engagement and electronic exchange of information using certified electronic health record technology. Formerly called Advancing Care Information, and prior to that Meaningful Use.

Quality Measures

One of four performance measures under MIPS. It was formerly known as PQRS.

Qualified Clinical Data Registry (QCDR)

Under MIPS, there are several data submission methods, one of which is a Qualified Clinical Data Registry (QCDR). A CMS approved QCDR is an entity that collects clinical data from MIPS clinicians (both individual and groups) and submits it to CMS on their behalf.

Quality and Resource Use Report (QRUR)

The Quality and Resource Use Report (QRUR) shows how your payments under Medicare Part B fee-for-service (FFS) will be adjusted based on quality and cost.

Quality Payment Program (QPP)

The Quality Payment Program aims to improve health outcomes, promote smarter spending, minimize burden of participation, and provide fairness and transparency in operations. It ends the Sustainable Growth Rate formula and gives clinicians new tools, models, and resources to help them provide patients the best possible care.

How It Works

Quality
Replaces PQRS.

Improvement Activities
New Category.

Promoting Interoperability
Replaces Advancing Care Information.

Cost
Replaces the Value-Based Modifier.

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