Quality Payment Program (QPP): Acronym List

ACO	Accountable Care Organization	Groups of doctors, hospitals, and other health care providers, who come together to give coordinated high quality of care to Medicare patients
APM	Advanced Alternative Payment Model	One of two payment paths to determine Medicare Part B payment adjustments. The APM path is for providers who are part of groups who take on risk and other requirements while delivering all around high quality care.
APRN	Advanced Practice Registered Nurse	Registered nurses that are currently not held required to participating in QPP
BPCI	Bundled Payments for Care Improvement	Payment delivery option which links multiple services which beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. This model may lead to higher quality and more coordinated care at a lower cost to Medicare.
CAHPS	Consumer Assessment of Healthcare Providers and Systems	Survey program that ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess. “CAHPS” is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)
CDS	Clinical Decision Support	A health information technology system that is designed to provide physicians and other health professionals with clinical decision-making tasks
CEHRT	Certified EHR technology	A structured electronic health record (EHR) data format which allows providers efficient access to capture and share patient data efficiently. Structured data allows patient information to be easily retrieved and transferred, and allows the provider to use the EHR in ways that can aid patient care.
CFR	Code of Federal Regulations	The codification of the general and permanent rules and regulations published in the *Federal Register* by the executive departments and agencies of the federal government of the United States
CHIP	Children’s Health Insurance Program	Federal subsidy program which provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid. Each states offers CHIP coverage, and works closely with its state Medicaid program.
CMMI	Center for Medicare & Medicaid Innovation (CMS Innovation Center)	The innovation center was created for the purpose of testing “innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care” for those individuals who receive Medicare, Medicaid, or CHIP benefits.
CMS	Centers for Medicare & Medicaid Services	The Centers for Medicare and Medicaid Services is part of the U.S Department of Health and Human Services. CMS covers 100 million people through Medicare, Medicaid, CHIP and the Health Insurance Marketplace.

COI	Collection of Information	The process of gathering and measuring information on targeted variables in an established systematic fashion, which then enables one to answer relevant questions and evaluate outcomes.
CPIA	Clinical Practice Improvement Activity	See “Improvement Activity”
CPS	Composite Performance Score	Overall score for all of the QPP categories combined.
CPT	Current Procedural Terminology	A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.
CQM	Clinical Quality Measure	Tools that help measure and track the quality of health care services provided by eligible professionals, eligible hospitals and critical access hospitals within our health system.
eCQM	electronic Clinician Quality Measure	The online version of Clinical Quality Measures, where individuals utilize the online measure submission form.
EHR	Electronic Health Record	An electronic version of a patient’s medical history, that is maintained by the provider over time. Also known as an electronic medical record (EMR).
EC	Eligible Clinicians	Healthcare professionals subject to the Quality Payment program (QPP). For the first two year the groups of eligible professionals are: Physicians, Physician assistants, certified registered nurse anesthetists, nurse practitioners, clinical nurse specialists. After 2020 the list of eligible professionals may change.
EP	Eligible Professional	See “Eligible Clinicians”
FFS	Fee-for-Service	A payment model where services are unbundled and paid for separately. In health care, it gives an incentive for physicians to provide more treatments because payments is dependent on the quantity of care, rather than the quality of care
FR	*Federal Register*	the official journal of the federal government of the United states that contains government agency rules, proposed rules and public notices.
FQHC	Federally Qualified Health Center	a reimbursement designation from the Bureau of Primary Health Care and the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. This designation is significant for several health programs funded under the Health Center Consolidation Act, such as community health centers.
GAO	Government Accountability Office	An independent, nonpartisan agency that works for Congress. The GAO investigates how the federal government spends taxpayer dollars.
HIE	Health Information Exchange	The mobilization of health care information electronically across organizations within a region, community or hospital system. In practice the term HIE may also refer to the organization that facilitates the exchange.
HIPAA	Health Insurance Portability and Accountability Act of 1996	Federal regulation which ensures equal access to certain health and human services and protects the privacy and security of health information.
HITECH	Health Information Technology for Economic and Clinical Health	Federal regulation enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology.

HHS	Department of Health & Human Services	U.S. department with the mission to enhance and protect the health and will-being of all Americans by providing for effective health and human services and fostering advances in medicine, public health, and social services.
HRSA	Health Resources and Services Administration	The primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.
IA	Improvement Activity	One portion of the new Quality Payment Program (QPP). Participants complete activities from the 90+ proposed activities for a partial score, with additional scoring for more activities. Activities are categorized as "high" or "medium" weight, earning 20 or 10 points each, respectively. In order to receive full credit one must achieve 60 points. In 2016, weight for Improvement Activities in the QPP is 15%.
MACRA	Medicare Access and CHIP Reauthorization Act of 2015	Federal regulation which serves as the overhead for the Quality Payment Program which ends the Sustainable Growth Rate formula and gives clinicians new tools, models, and resources to help give their patients the best possible care.
MEI	Medicare Economic Index	A measure of practice cost inflation that was developed as a way to estimate annual changes in physicians' operating costs and earning levels.
MIPAA	Medicare Improvements for Patients and Providers Act of 2008	Legislation which allocated federal funding for State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), and Aging and Disability Resource Centers (ADRCs) to provide outreach to low income Medicare beneficiaries to increase enrollment in Medicare low income assistance programs
MIPS	Merit-based Incentive Payment System	One option of the MACRA Quality Payment Program. Comprised of four categories-Quality, Cost, Improvement Activities and Advancing Care Information
MLR	Minimum Loss Rate	The proportion of premium revenues spent on clinical services and quality improvement
MSPB	Medicare Spending per Beneficiary	This measure is used to assess the cost to Medicare of services performed by hospitals and other healthcare providers during a Medicare Spending per Beneficiary (MSPB) episode. The Medicare Spending per Beneficiary (MSPB) Measure evaluates hospitals' efficiency relative to the efficiency of the median hospital
NPI	National Provider Identifier	A unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). The NPI has replaced the unique physician identification number as the required identifier for Medicare services, and is used by other payers, including commercial healthcare insurers
OCM	Oncology Care Model	An innovative, multi-payer model focused on providing higher quality, more coordinated oncology care. Under OCM, physician group practices have entered into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients. Participants may use this model to participate in an APM under the QPP.
ONC	Office of the National Coordinator for Health Information Technology	A position within the US Department of Health & Human Services (HHS) which providers oversight and guidance regarding healthcare technology. The position was created by Executive Order in 2004 and written into legislation by the HITECH Act

PECOS	Medicare Provider Enrollment, Chain, and Ownership System	Online system which supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely and electronically submits and manage Medicare enrollment information.
PFS	Physician Fee Schedule	System used to reimburse physician services. This fee schedule replaced the old "customary, prevailing, and reasonable" (CPR) charge system.
PQRS	Physician Quality Reporting System	A federal quality reporting program which encourages individual eligible professionals (EPs) and group practices to report information on the quality of care to Medicare.
PTAC	Physician-Focused Payment Model Technical Advisory Committee	Committee that makes recommendations to the Secretary of the Department of Health and Human Services (HHS) on proposals for Physician Focused Payment Models. Committee consists of 11 members.
QCDR	Qualified Clinical Data Registry	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.
QPP	Quality Payment Program	A policy that reforms Medicare payments for more clinicians across the country with the purpose of providing new tools and resources to help give patients the best possible, high value care. The two tracks which clinicians can choose to participate from are Advanced Alternative Payment Models (APMs) or the Merit- based Incentive Payment System (MIPS). The four categories that clinicians must submit data on are: Quality, Improvement Activities, Advancing Care Information, and Cost.
QRUR	Quality and Cost Reports	CMS's Physician Feedback Program which provides physicians with comparative information about the quality and cost of the care delivered.
RBRVS	Resource-Based Relative Value Scale	Scale used to determine how much money medical providers should be paid based on three components: Physician Work, Practice Expense, and Professional Liability Insurance.
RVU	Relative Value Unit	Part of the Resource- Based Relative Value Scale, an RVU is a measure used in the United States Medicare reimbursement formula for physician services.
TCPI	Transforming Clinical Practice Initiative	Federal program initiated by CMS and designed to help further develop comprehensive quality improvement and strategies of over 140,000 clinician practices over the next four years.
TIN	Tax Identification Number	The number assigned by the internal Revenue Service (IRS) for tax purposes. Also known as the Employer Identification Number.
VM	Value-Based Payment Modifier	A differential payment to a physician or physician group under the Medicare Physician Fee Schedule, based upon the quality of care given compared to the cost of care during a performance period.