Qualis Health Toolkit:
How to Succeed with MIPS
Under the Quality Payment Program
Introduction

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a milestone in efforts to improve and reform health care with increased focus on the quality and value of care delivered. MACRA repealed the Medicare Sustainable Growth Rate (SGR) methodology for updates to the Medicare Physician Fee Schedule (PFS) and replaced the SGR with a new approach to payment called the Quality Payment Program (QPP).

The QPP rewards high quality patient care through two interrelated pathways: Advanced Alternative Payment Models (APM) and the Merit-based Incentive Payment System (MIPS). The QPP establishes incentives for participation in Advanced APMs, supporting the goal of transitioning from fee-for-service (FFS) payment to payment for quality and value, including approaches that focus on better care, smarter spending and healthier people.

To be an Advanced APM, an APM must meet the following three criteria:

1. Require participants to use certified EHR technology;
2. Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment System (MIPS); and
3. Bear a certain amount of greater than nominal financial risk (as outlined below) OR qualify as a Medical Home Model
   - Meet revenue-based standard (average of at least 8% of revenues at-risk for participating APMs) or
   - Meet benchmark-based standard (maximum possible loss must be at least 3% of spending target)

The APM entity must also meet requirements for the minimum percentage of payments OR patients tied to an Advanced APM. CMS will choose to use whichever threshold is more favorable for the APM entity in determining eligibility for the APM track. Over time, the payment and patient count percentages will gradually increase.

MIPS is a new program that will make payment adjustments based on quality, cost and other measures for certain Medicare-participating eligible clinicians. MIPS consolidates components of three existing programs; Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals (EPs), and will continue the focus on quality, cost, and use of certified EHR technology (CEHRT) in a cohesive program that avoids redundancies.

With the arrival of CMS' Quality Payment Program it is critical to understand how this transition will impact your practice. Qualis Health developed this toolkit to help you successfully prepare for and understand the transition to value-based payment. The toolkit provides you with strategies, tools and resources. Additionally, Qualis Health’s QPP online resource center is home to many helpful tools including an online readiness assessment and a MIPS calculator. We also offer regular webinars on timely and pertinent QPP topics.

- Section 1 – Understand the Quality Payment Program and its Requirements
- Section 2 – Analyze Current State
- Section 3 – Develop Data and Reporting Plan
- Section 4 – Implement Improvement Strategies

Qualis Health is the Quality Innovation Network QIO (QIN - QIO) for Idaho and Washington. We engage providers at all levels of performance in rapid-cycle projects for collaborative learning and action that accelerate healthcare quality improvement. We bring the voices of beneficiaries and families into healthcare quality improvement initiatives so providers can understand and improve the experience of care.

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Section 1: Understand the Program Requirements

Section one serves as an introduction to the Quality Payment Program. It includes key strategies, resources and tools. Our goal is to put you on the road to success with the Quality Payment Program.

Learning Objectives

At the end of section one, we hope you will:

- Develop a familiarity with key terms and acronyms
- Utilize key resources to gain program knowledge
- Be aware of the 2017 MIPS timeline and important dates
- Determine which pace works for your practice

Key Resources

We assembled a list of key resources and links for you to review that will help you understand the Quality Payment Program. We will link to the Qualis Health MIPS Minute video series throughout this toolkit. We recommend reviewing the series and referring to key episodes as needed. The series is designed to help you get clarity around individual topics such as eligibility or the timeline, without having to spend too much time digging for information. Each episode is brief and focuses on an important aspect of the Quality Payment Program in a short, easy to digest format.

- Review Qualis Health’s MIPS Minute Series Episode: MACRA The Medicare Access & CHIP Reauthorization Act
- Get more in-depth information on the Quality Payment Program by reviewing the CMS Quality Payment Program website.
- Subscribe to email updates
- Attend CMS webinars
- Read the CMS QPP Executive Summary
- Read the CMS Final Rule at the Federal Register
- Listen to the AMA ReachMD Podcast Implementing MACRA: The AMA’s Keys to Advancing Opportunities, Avoiding Pitfalls

Need help? The Quality Payment Program Service Center is available to help.

- 1-866-288-8292; TTY: 1-877-715-6222
- Available M-F 8:00am to 8:00pm ET
- QPP@CMS.hhs.gov
Review the 2017 MIPS Timeline and Learn about Important Dates

Understanding the MIPS timeline is an important step in your success with the Quality Payment Program. We’ve outlined a few critical dates below.

2017 MIPS Timeline:
- Performance period – 1/1/2017 to 12/31/2017
- Submit data by March 31, 2018
- Access feedback reports in 2018
- Payment adjustments begin January 1, 2019

Pick Your Pace

Flexible participation options are available in 2017 MIPS eligible clinicians (EC) can pick a pace of participation that best suits their practice.

- Those that choose to not participate will receive an automatic 4% penalty.
- Those that submit “one thing,” such as a quality measure, improvement activity or the measures and objectives for Advancing Care Information that are required for the base score, will not receive a payment penalty in 2019.
- Those that choose to partially participate will not only avoid a penalty, but may be eligible for an incentive in 2019.
- Those that choose to participate in the full program will avoid penalties and be eligible for an incentive.
- Those that choose to submit 90 days of 2017 data could earn a neutral or positive adjustment, and may even earn the max adjustment.

Resources

Listen to Qualis Health’s MIPS Minute Series Episode 2: Pick your Pace
Section 2: Analyze Current State

One key component of the Quality Payment Program is gaining MIPS points. They are earned by meeting certain program requirements and exceeding benchmarks. Section two provides guidance on how to prepare for reporting.

A key strategy for MIPS success is to understand how it applies to your practice, and which clinicians are eligible for the program. Before diving into developing a strategic reporting plan, take some time to use your past experience to drive future success. Utilizing past reports such as previous Quality Resource Use Report and PQRS Feedback reports, is a great way to maximize your MIPS score.

Learning Objectives

At the end of section two, we hope you will:

- Leverage past reports, such as the 2016 Quality Resource Use Report (QRUR) and the PQRS Feedback Report to identify strengths and areas for improvement.
- Identify eligible clinicians

Leverage past reports

Utilizing past reports such as the 2016 Quality Resource Use Report (QRUR) and the PQRS Feedback Report to identify strengths and areas for improvement, is a great way to improve your MIPS score. Leveraging existing data from your QRUR to position you for MIPS can benefit you.

Past PQRS Feedback Reports show reporting details by eligible practitioner, including:

- Method(s) of reporting
- Total # of measures satisfactorily reported
- Indicator for whether a practitioner or a group is receiving a PQRS payment adjustment, as well as the rationale for that.
- Total Estimated Allowed Medicare Part B FFS Charges during the reporting period.
- PQRS Total Earned Incentive Amount for each Eligible Provider
- With 60% of the final MIPS score coming from Quality data, you can find out which measures are already positioned for high performance, and which measures you may want to improve throughout the year.

MIPS TIP

The Quality Payment Program is flexible instead of one-size fits all. Clinicians can choose to participate in a way that is best for them, their practice and their patients.
Identify Eligible Clinicians

2017 MIPS eligible clinicians include the following categories of clinicians who bill more than $30,000 in Medicare Part B allowed charges, AND provide care to more than 100 Medicare patients per year:

- Physicians: Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Oral Surgery, Doctor of Dental Medicine and Doctor of Chiropractic
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists

Exclusions

Exclusions to be aware of in determining if you are a MIPS eligible clinician in 2017 are:

- Clinicians who bill less than or equal to $30,000 in Medicare Part B allowed charges, OR if you provide care for 100 or fewer Medicare patients
- If 2017 is your first year participating in Medicare
- If you have significant participation in an Advanced Alternative Payment Model (APM) and are either a Qualifying APM Participant (QP) or Partial QP

Resources

To gain a thorough understanding of eligibility, listen to the Qualis Health:

- MIPS Minute video: What You Need to Know About MIPS Eligibility
- The Qualis Health MIPS Tracking Tool is used to identify and track your eligible clinicians. You can calculate the potential financial impact on 2019 Medicare Part B allowed charges.
- To assess your readiness to participate, take the Qualis Health On-line Readiness Assessment.
Section 3: Develop Data and Reporting Plan

Establishing and formalizing a reporting plan early on is a key strategy that ensures program success. There are many important decisions to consider during this process. Section three is designed to provide you with critical information to help make informed decisions to create a strategic plan.

Learning Objectives

At the end of section three, we hope you will:

- Decide whether to report as an individual or a group
- Select a reporting mechanism
- Understand and estimate your MIPS final score
- Develop a strategic reporting plan for each category of MIPS
- Track your progress throughout the year

Determine whether to report as an individual or group

MIPS eligible clinicians can either participate in MIPS as an individual (by NPI) or with a group by Tax Identification Number (TIN). Determining how your organization will report is a critical step in developing a reporting plan.

Reporting MIPS as an individual:

- An individual is defined as a single National Provider Identifier (NPI)
- If you submit MIPS data as an individual, your payment adjustment will be based on your performance
- You will send your individual data (NPI level) for each of the MIPS categories

If you report MIPS as a group:

- A group is defined as a set of clinicians (identified by the NPIs) who share a common Tax Identification Number (TIN), regardless of locations, group size or specialties
- If you submit your MIPS data as a group, the group will get one payment adjustment based on the group’s performance
- The group, as a whole, will send in aggregated group level data for each of the MIPS categories

Resources

- The AMA ReachMD Podcast Preparing for Quality Reporting: Keys to Keeping Your Practice on Track for reporting options under the Merit-Based Incentive Payment System (MIPS), specifically related to the quality performance category.
- Qualis Health MIPS Tracking Tool
- Use the Qualis Health MIPS calculator to build your plan and predict your Final Score
### Section 3: Develop Data and Reporting Plan

#### Select a reporting mechanism for MIPS data submission

The chart below can assist you in determining which reporting mechanism will work best for you.

<table>
<thead>
<tr>
<th>Category</th>
<th>Individual</th>
<th>Group</th>
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</thead>
<tbody>
<tr>
<td>Quality</td>
<td></td>
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<tr>
<td>Quality – Qualified Clinical Data Registry (QCDR)</td>
<td>Qualified Clinical Data Registry (QCDR)</td>
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<td>Quality – Qualified Registry</td>
<td>Qualified Registry</td>
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<td>Quality – EHR</td>
<td>EHR</td>
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<tr>
<td>Quality – Claims - Medicare Part B</td>
<td>CMS Web Interface (groups of 25 or more)</td>
<td>CMS Survey vendor for CAHPS for MIPS</td>
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<td>Quality – Attestation</td>
<td>Qualified Clinical Data Registry (QCDR)</td>
<td>Qualified Clinical Data Registry (QCDR)</td>
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<td>Quality – Qualified Registry</td>
<td>Qualified Registry</td>
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<tr>
<td>Quality – EHR</td>
<td>EHR</td>
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<tr>
<td>Cost</td>
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<tr>
<td>Cost – Administrative claims (no submission required)</td>
<td>Administrative claims (no submission required)</td>
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<td>Advancing Care Information</td>
<td>Attestation</td>
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<td>Advancing Care Information – Qualified Clinical Data Registry (QCDR)</td>
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<td>Advancing Care Information – CMS Web Interface (groups of 25 or more)</td>
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<td>Improvement Activities</td>
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<td>Improvement Activities – Qualified Clinical Data Registry (QCDR)</td>
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<td>CMS Web Interface (groups of 25 or more)</td>
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</tbody>
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#### Understand and estimate your MIPS final score

The MIPS final score factors performance in 4 weighted categories on a 0-100 point scale. In 2017 the performance weights for each category are:

- Quality – 60%
- Advancing Care Information – 25%
- Improvement Activities – 15%
- Cost – 0% (will be evaluated based on claims but not scored in 2017)

#### MIPS Tip

There is no longer a registration deadline, unless a group plans to use the CMS Web Interface for reporting, or is submitting the CAHPS for MIPS Survey for Quality Measures or Improvement Activities.

#### Resources

- [Qualis Health’s MIPS Minute Series Episode 6: The MIPS Scoring System](#)
- The [Qualis Health MIPS calculator](#) is a good strategic planning tool
Develop a strategic reporting plan for each category of MIPS

The Qualis Health MIPS Tracking Tool will help you to track progress throughout the year.

**MIPS TIP**

Each quality measure accurately submitted is worth at least 3 points. A maximum of 10 points are scored based on how performance compares to the measure benchmark.

## Categories

### Quality

- 60% of the MIPS final score
- Under MIPS, most clinicians will report 6 quality measures, including an outcome measure.
- Up to 3 bonus points are available for submitting an additional high-priority measure (2 points for each additional outcome and patient experience measure and 1 bonus point for each additional high-priority measure)
- Groups who choose to use the web interface will report 15 quality measures for a full year.
- Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Track 1 will report quality measures through their APM and will not need to do anything additional for MIPS Quality.
- Individual MIPS eligible clinicians or groups submitting data on quality measures must report on at least 50% of the MIPS eligible clinician or group’s patients (all-payer) that meet the measure’s denominator criteria.
- The quality measure calculated for 2017 MIPS performance that does not require data submission is All-Cause Hospital Readmission rates for attributed beneficiaries.
- There are separate benchmarks for different reporting mechanisms. For example, there are different benchmarks for EHR, QCDR, registries, claims, CMS web interface, etc.
- Clinicians reporting with electronic clinical quality measures (eCQMs): Review the eCQM Implementation Checklist and download the technical specifications for eCQMs on the eCQI Resource Center.
Section 3: Develop Data and Reporting Plan

Special considerations about Quality Measures:

**Class 1: Measures**
- Measure scored based on performance
- Receive 3 to 10 points based on performance compared to the benchmark
- Measures that were submitted or calculated that met the following criteria:
  - 1) the measure has a benchmark
  - 2) Has at least 20 cases
  - 3) Meets the data completeness standard (generally 50%)

**Class 2: Measures**
- Measure cannot be scored based on performance and is instead assigned a 3-point score
- Measures that were submitted, but fail to meet one of the class 1 criteria. Measures either:
  - 1) Do not have a benchmark
  - 2) Do not have at least 20 cases
  - 3) Measure does not meet data completeness criteria
- Not applicable to administrative claims-based measures and CMS Web Interface measures

**Resources**
- Review Qualis Health’s MIPS Minute Series Episode: [What You Need to Know About the Quality Performance Category](#)
- Pick measures from the QPP website
- [Quality Measures Specification](#)
- [Link to 2017 benchmarks](#)

**Cost**
The Cost category will not be factored into the 2017 MIPS final score but is an important part of MIPS and will be evaluated in future years. A two-step attribution process is used to look at medical cost measures for practices “attributed beneficiaries.” There is no reporting required for this category. CMS will use data from Medicare claims to examine comparative cost and quality measures for attributed patients.

- Medicare Spending Per Beneficiary (MSPB)
- Total Per-Capita Cost for All Attributed Beneficiaries
- Medicare spending for 10 Episode Groups (i.e. Aortic/Mitral Valve Surgery, Colonoscopy, Mastectomy for Breast Cancer)

**Resources**
- Review CMS fact sheet on the [two-step attribution process](#) for claims-based quality outcome measures and per capita cost measures
- Review Qualis Health’s MIPS Minute Series Episode: [What You Need to Know About the MIPS Cost Performance Category](#)
Section 3: Develop Data and Reporting Plan

Advancing Care Information

2017 Advancing Care Information is 25% of the MIPS Score. MIPS eligible clinicians have the ability to earn up to 155 percentage points for the Advancing Care Information performance category, which will be capped at 100%.

- Base Score – 50%
- Performance Score – Up to 90%
- Bonus Score – Up to 15%

There are two measure set options, based on your certified EHR technology edition:

- Advancing Care Information Objectives and Measures
  - If you have technology certified to the 2015 Edition
  - If you have a combination of technologies from 2014 and 2015 Editions that support these measures.

- 2017 Advancing Care Information Transition Objectives and Measures
  - If you have technology certified to the 2015 Edition
  - If you have technology certified to the 2014 Edition
  - If you have a combination of technologies from 2014 and 2015 Editions.

When is the Advancing Care Information Score Reweighted?

MIPS eligible clinicians must use certified electronic health record technology (CEHRT) to report to the Advancing Care Information performance category. If they do not have a certified EHR, they must meet certain criteria in order to qualify for a reweighting of the performance category to 0% so that it is not included in the total score. Simply lacking CEHRT is not sufficient to qualify to have the Advancing Care Information performance category weight to be set at 0% of the MIPS final score.

A MIPS eligible clinician’s performance score may be reweighted for the following reasons:

- Insufficient Internet Connectivity
- Extreme and Uncontrollable Circumstances
- Lack of Control over the Availability of CEHRT

These MIPS eligible clinicians must submit an application for CMS to reweight the Advancing Care Information performance category to 0%. The application can be found on the qpp.cms.gov website.

MIPS TIP

If you have previously submitted PQRS and participated in the EHR Incentive Program, we highly recommend full participation in the QPP. It’s good practice and could bring big rewards.
MIPS eligible clinicians that qualify for an automatic re-weighting of the Advancing Care Information category are:

- Hospital-based MIPS clinicians
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Clinicians who lack face-to-face interactions with patients

These MIPS eligible clinicians can still choose to report if they would like, and if data is submitted, CMS will score their performance and weight their Advancing Care Information performance accordingly.

For these two groups of MIPS eligible clinicians, CMS will reweight the category to 0% and assign the 25% to the Quality performance category to maintain the potential for participants to earn up to 100 points in the MIPS Final Score.

Resources

- Review Qualis Health’s MIPS Minute Series Episode: [What You Need to Know About Advancing Care Information](#)
- Check that your electronic health record is certified by the Office of the National Coordinator for Health Information Technology. If it is, it should be ready to capture information for the MIPS advancing care information category and certain measures for the quality category.
- [Read the OPP Advancing Care Information Performance Category Fact Sheet](#)
- Listen to the AMA ReachMD Podcast [How an EHR Can Help You Participate in MACRA](#) to hear Information for physicians about the importance of electronic health records (EHRs) to participation in MACRA (6:30)

**MIPS TIP**

Use the Qualis Health MIPS Tracking Tool to track your progress with Advancing Care Information throughout the year.
Section 3:
Develop Data and Reporting Plan

Improvement Activities

- 15% of the final score
- For full participation, most clinicians will attest to up to four activities to earn the highest possible score of 40 (medium-weighted activities score 10 points, high-weighted activities score 20 points).
- Groups with 15 or fewer ECs and groups in rural or health professional shortage areas will attest to up to 2 Improvement Activities (one high-weighted or 2 medium-weighted).
- Participants with a patient-centered medical home designation, comparable specialty practices or APMs designated as a Medical Home Model will receive full credit for this performance category.

Bonus points in the Advancing Care Information category can be achieved by attesting to certain Improvement Activities that are completed using CEHRT.

Reporting for the Improvement Activities Category

In order to plan strategically to report Improvement Activities, we recommend you:

- Understand how the Improvement Activities impact your MIPS final score
- Select from 90+ Improvement Activities
- Perform activities for at least 90 days

Resources

- Qualis Health’s MIPS Minute Series Episode: What You Need to Know About Improvement Activities
- The AMA ReachMD Podcast Why Participating in Clinical Practice Improvement Activities (CPIA) Matters for an overview of the Improvement Activities, or CPIA, category, including how the activities may be reported and scored by CMS (5:29)

Advanced Alternative Payment Model (APM)

An APM is a payment model that provides incentive payment to provide high-quality and cost-efficient care. In 2017, you are in an Advanced APM if you participate in one of these APMs:

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3
- Oncology Care Model (OCM) - Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)
Section 3: Develop Data and Reporting Plan

Resources

- Quality Payment Program Alternative Payment Models
- Qualis Health’s MIPS Minute Series Episode: What You Need to Know about Alternative Payment Models
- The Rise of Specialist-Driven Alternative Payment Models in American Medicine
  Some physicians across the country have taken it upon themselves to design APMs that work within their specialties. In this podcast, Lawrence Kosinski, MD, a gastroenterologist in Illinois, describes SonarMD, a web-based platform that pings patients to keep track of their symptoms outside the office visit to get ahead of issues before they become emergencies. (27:00)

**NOTE:** If you leave the Advanced APM during 2017, you should make sure you’ve seen enough patients or received enough payments through an Advanced APM to qualify for the 5% bonus. If you haven’t met these thresholds, you may need to submit MIPS data to avoid a downward payment adjustment.
Learning Objectives
At the end of section four, we hope you will:

- Identify opportunities for improvement and apply improvement methodology
- Identify tools to initiate or continue quality improvement for MIPS

Improvement Process
The Plan-Do-Study-Act (PDSA) cycle is a simple tool for quality improvement in the real work setting — by planning it, trying it, observing the results, and acting on what is learned. The model is not meant to replace change models that practices and organizations may already be using, but rather to accelerate improvement. This model has been used very successfully by hundreds of healthcare organizations to improve many different healthcare processes and outcomes.

The model has two parts:

- Three fundamental questions, which can be addressed in any order:
  1) What are we trying to accomplish?
  2) How will we know that a change is an improvement?
  3) What changes can we make that will result in an improvement?


- The Plan-Do-Study-Act (PDSA) cycle to test changes in real work settings.

Resources

- Qualis Health Quality Improvement website
- National priorities and programs that apply best practices such as the Million Hearts Campaign, Centers for Disease Control, etc.

For More Information
The Quality Payment Program Service Center is available to help.

- 1-866-288-8292
- TTY: 1-877-715-6222
- Available Monday – Friday, 8:00AM – 8:00PM Eastern Time
- Send your questions about the Quality Payment Program to QPP@cms.hhs.gov.

Qualis Health Quality Payment Program Resource Center

- QPP@qualishealth.org
- 1-877-560-2618
## Key Terms and Acronyms List

Understanding key terms is critical to gaining deeper knowledge of the Quality Payment Program. We assembled a list of important acronyms and terms for you to review.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ABC™</td>
<td>Achievable Benchmark of Care</td>
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<td>ACO</td>
<td>Accountable Care Organization</td>
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<tr>
<td>APM</td>
<td>Alternative Payment Model</td>
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<td>APRN</td>
<td>Advanced Practice Registered Nurse</td>
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<tr>
<td>CAHPS</td>
<td>Consumer Assessment of Healthcare Providers and Systems</td>
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<tr>
<td>CEHRT</td>
<td>Certified EHR technology</td>
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<tr>
<td>CMMI</td>
<td>Center for Medicare &amp; Medicaid Innovation (CMS Innovation Center)</td>
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<tr>
<td>CPIA</td>
<td>Clinical Practice Improvement Activity</td>
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<tr>
<td>CPOE</td>
<td>Computerized Provider Order Entry</td>
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<tr>
<td>CPS</td>
<td>Composite Performance Score (final score)</td>
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<tr>
<td>CQM</td>
<td>Clinical Quality Measure</td>
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<tr>
<td>eCQM</td>
<td>Electronic Clinical Quality Measure</td>
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<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
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<td>EC</td>
<td>Eligible Clinician</td>
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<tr>
<td>FFS</td>
<td>Fee-for-Service</td>
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<tr>
<td>FQHC</td>
<td>Federally Qualified Health Center</td>
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<td>HIE</td>
<td>Health Information Exchange</td>
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<td>HPSA</td>
<td>Health Professional Shortage Area</td>
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<td>MACRA</td>
<td>Medicare Access and CHIP Reauthorization Act of 2015</td>
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<tr>
<td>MIPS</td>
<td>Merit-based Incentive Payment System</td>
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<td>MSPB</td>
<td>Medicare Spending per Beneficiary</td>
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<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
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<td>PECOS</td>
<td>Medicare Provider Enrollment, Chain, and Ownership System</td>
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<td>PFFPs</td>
<td>Physician-Focused Payment Models</td>
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<td>PFS</td>
<td>Physician Fee Schedule</td>
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<td>PTAC</td>
<td>Physician-Focused Payment Model Technical Advisory Committee</td>
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<td>PQRS</td>
<td>Physician Quality Reporting System</td>
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<tr>
<td>QCDR</td>
<td>Qualified Clinical Data Registry</td>
</tr>
<tr>
<td>QPP</td>
<td>Quality Payment Program</td>
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<tr>
<td>QRDA</td>
<td>Quality Reporting Document Architecture</td>
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<td>QRUR</td>
<td>Quality and Cost Reports</td>
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<tr>
<td>RHC</td>
<td>Rural Health Clinic</td>
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<tr>
<td>SGR</td>
<td>Sustainable Growth Rate</td>
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<tr>
<td>TCPI</td>
<td>Transforming Clinical Practice Initiative</td>
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<tr>
<td>TIN</td>
<td>Tax Identification Number</td>
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<tr>
<td>RBRVS</td>
<td>Resource-Based Relative Value Scale</td>
</tr>
<tr>
<td>RFI</td>
<td>Request for Information</td>
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<tr>
<td>RIA</td>
<td>Regulatory Impact Analysis</td>
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<tr>
<td>RVU</td>
<td>Relative Value Unit</td>
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<tr>
<td>VM</td>
<td>Value-Based Payment Modifier</td>
</tr>
<tr>
<td>VPS</td>
<td>Volume Performance Standard</td>
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