Quality Payment
PROGRAM

MERIT-BASED INCENTIVE PAYMENT SYSTEM

Participating in the **Quality** Performance Category in 2018 (Year 2)

Table of Contents

How To Use This Guide

Table of Contents

The table of contents is **interactive**. Click on a chapter to read that section, and then click on the chapter title to return to the table of contents.

Hyperlinks

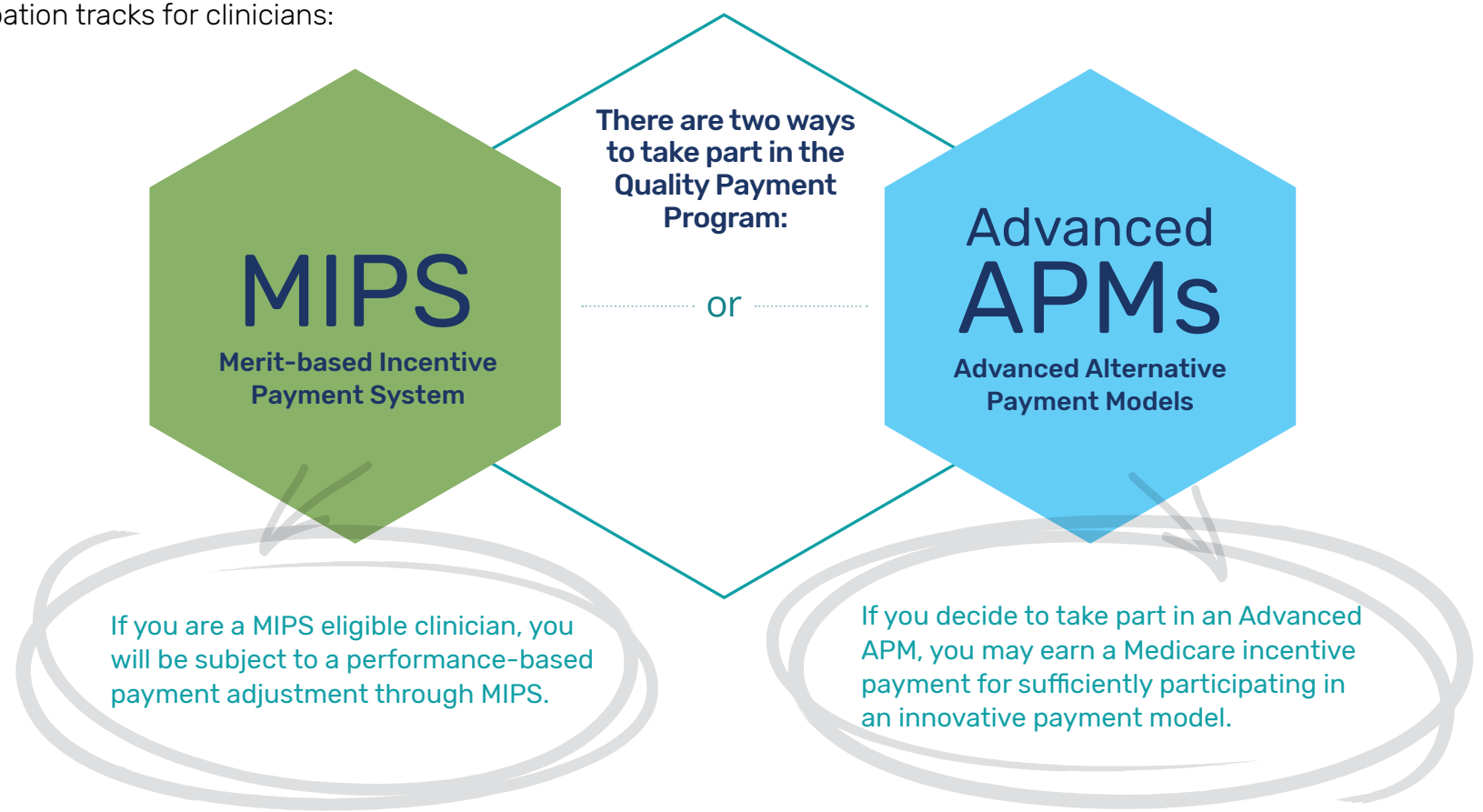
Hyperlinks to the Quality Payment Program website are included throughout this guide to direct you to more information and resources.

NOTE: *This guide was prepared as a general summary for informational purposes only, not intended to grant rights, impose obligations, or take the place of the written law. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.*

INTRODUCTION TO THE QUALITY PAYMENT PROGRAM

Introduction to the Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. By law, MACRA requires CMS to implement an incentive program, referred to as the Quality Payment Program, which provides two participation tracks for clinicians:



Who is a MIPS Eligible Clinician?

For the 2018 performance period, you are a MIPS eligible clinician if you are one of the following clinician types:

Physician (which includes doctor of medicine, doctor of osteopathy, doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, doctor of optometry, and chiropractors[1])

or **Physician Assistant (PA)**

or **Nurse Practitioner (NP)**

or **Clinical Nurse Specialist (CNS)**

or **Certified Registered Nurse Anesthetist (CRNA)**

- You can also participate as a group if the practice includes at least one MIPS eligible clinician (as indicated by clinician type) and exceeds the low-volume threshold at the group level.

[1] *With respect to certain specified treatment, a doctor of chiropractic must be legally authorized to practice by a State in which he/she performs this function.*

Who is Excluded from MIPS?

If you are a MIPS eligible clinician (as indicated by the clinician types on the previous page), you can still be excluded from participating in MIPS for the 2018 performance year if you:

Enrolled in Medicare for the first time in 2018 **or** Participate in an Advanced APM and are determined to be a Qualifying APM Participant (QP) **or** Participate in an Advanced APM and are determined to be a Partial QP and do not elect to participate in MIPS **or** Do not exceed the low-volume threshold. (More information about this exclusion is provided in the next section.)

- If you're not a MIPS eligible clinician or are otherwise excluded from MIPS in 2018, you do not have to participate in MIPS for the 2018 performance year and you will not receive a MIPS payment adjustment in 2020.

Voluntary Participation in MIPS

If you're not eligible to participate in MIPS, you can participate voluntarily. Voluntary participation allows you to prepare for and become familiar with the program without receiving a payment adjustment (positive or negative). This may be helpful if you become eligible for MIPS in future years.

Low-Volume Threshold Exclusion for 2018

There are two low-volume threshold determination periods for the 2018 performance year, during which CMS reviews both historical and performance period claims data.

Historical claims data:
September 1, 2016 – August 31, 2017

and

Performance period claims data:
September 1, 2017 – August 31, 2018

- The low-volume threshold is calculated at both the practice (Taxpayer Identification Number (TIN)) level and clinician (TIN-NPI) level. MIPS eligible clinicians who have reassigned billing rights to multiple practices will be evaluated for the low-volume threshold at each practice (under each TIN-NPI combination), which means you may be required to participate in MIPS at one practice but are excluded at another.

For the 2018 performance period, CMS updated the low-volume threshold; clinicians, groups and MIPS APM entities are excluded from MIPS if, during **either** determination period they:

Billed Medicare for **less than or equal to $90,000** in Medicare Part B allowed charges for covered professional services payable under the Medicare Physician Fee Schedule (PFS).

or

Provided care for **200 or fewer** Part B-enrolled Medicare FFS beneficiaries.

The low-volume threshold exclusion is applied at the level in which you will participate in MIPS.

- **If you participate as an individual (each MIPS eligible clinician submits their own individual data collected at the practice),** the low-volume threshold is applied at the individual level.
  - MIPS eligible clinicians who do not exceed the low-volume threshold as individuals are not required to submit individual data collected at this practice and will not receive a payment adjustment at this practice.
- **If you participate as a group (the practice submits aggregated data collected on behalf of all the MIPS eligible clinicians in the practice)**, the low-volume threshold is applied at the group level.
  - MIPS eligible clinicians who do not exceed the low-volume threshold as individuals will receive a payment adjustment at this practice based on the group's submission provided the group exceeds the low-volume threshold.
- **If you participate as a virtual group (the virtual group submits aggregated data collected on behalf of all the MIPS eligible clinicians in the virtual group)**, the low-volume threshold is applied at the virtual group level.
  - MIPS eligible clinicians who do not exceed the low-volume threshold as individuals will receive a payment adjustment at this practice based on the virtual group's submission. (The approval process requires that all virtual groups exceed the low-volume threshold.)
- **If you participate in a MIPS APM**, the low-volume threshold is calculated for the MIPS APM Entity, and is not applied at the individual or group level. MIPS eligible clinicians participating in a MIPS APM should work with their MIPS APM Entity to understand their data submission requirements.

TIP: Beginning with the 2018 performance year, the low-volume threshold calculations will be based on PFS allowed charges and the number of patients receiving covered PFS services.

For more information on the low-volume threshold and the two determination periods, please refer to the 2018 MIPS Participation and Overview Fact Sheet.

What are my Participation Options?

In 2018, if you're eligible for MIPS, you can participate in the following ways:

- **As an Individual Clinician**
- **As a Group**
- **As a Virtual Group** (new for 2018)
- **As a MIPS APM Entity***

**If you're in a specific type of APM called a MIPS APM, you will participate in MIPS through that APM and be scored using what is called the "APM scoring standard." Clinicians in a MIPS APM are awarded credit for activities performed within the APM; all clinicians in the same MIPS APM Entity receive the same score, based on the data submitted by or on behalf of the Entity.*

Can I Participate as an Individual and a Group?

Yes: MIPS eligible clinicians can submit data as an individual and as part of a group under the same TIN. In this instance, the clinician will be evaluated across all four MIPS performance categories on their individual performance and on the group's performance, with a final score calculated for each evaluation. The clinician will receive a payment adjustment based on the higher of the two scores.

To learn more about how to participate in MIPS:

- Visit the About MIPS Participation and Individual or Group Participation web pages on the Quality Payment Program website
- View the MIPS Participation and Overview Fact Sheet
- Check your participation status using the QPP Participation Status Tool

There are **four** performance categories under MIPS that affect future Medicare payments. Each performance category has a specific weight, and your performance in these categories contributes to your MIPS final score.

This guide focuses on the **Quality** performance category in 2018 (or "Year 2") of the Quality Payment Program.

MIPS performance category weights in 2018:

Quality

50% of MIPS Final Score in 2018

Cost

10% of MIPS Final Score

Improvement Activities

15% of MIPS Final Score

Promoting Interoperability

(formerly Advancing Care Information)

25% of MIPS Final Score

Please note that for MIPS APM participants, scored under the APM scoring standard, the performance categories have the following weights:

50%	Quality	**0%**	Cost	**20%**	Improvement Activities	**30%**	Promoting Interoperability *(formerly Advancing Care Information)*

QUALITY BASICS

Why focus on Quality?

Quality measures are tools that help us to:

- Measure health care processes, outcomes, and patient experiences of their care
- Link outcomes that relate to one or more of these quality goals for health care that's:
  - effective
  - safe
  - efficient
  - patient-centered
  - equitable
  - timely

For the 2018 performance year, the Quality performance category:

- 50% Is worth 50 percent of your MIPS final score
- Has a 12-month reporting period (January 1 – December 31, 2018)

QUALITY MEASURES

For the 2018 performance year, you can choose measures most meaningful to your practice from **more than 270 MIPS quality measures**. You may also choose MIPS measures from a defined specialty measure set developed by boards or specialty societies. If you're working with a Qualified Clinical Data Registry (QCDR) to submit your Quality data, you may have additional QCDR measures (outside of the MIPS quality measure set) to choose from.

Below is an overview of the six types of quality measures you can report for the Quality performance category:

Quality Measures by Measure Type

Process Measures

Process measures show what doctors and other clinicians do to maintain or improve the health of healthy people or those diagnosed with a given condition or disease.

These measures usually show generally accepted recommendations for clinical practice.

For example:

- The percentage of people getting preventive services (such as mammograms or immunizations)

Process measures can tell consumers about the medical care they should get for a given condition or disease.

Outcome Measures

Outcome measures show how a health care service or intervention affects patients' health status.

For example:

- The percentage of patients who died because of surgery (surgical mortality rates)
- The rate of surgical complications or hospital-acquired infections

Outcome measures may seem to be the "gold standard" in measuring quality, but outcomes happen for many reasons, some of which clinicians don't have control over.

Structure Measures

Structural measures give consumers a sense of a health care provider's capacity, systems, and processes to provide high-quality care.

For example:

- Utilizing electronic support systems such as a continuity of care recall system or a reminder system for mammogram screenings
- Checking for the availability of diagnostics for patient follow up and comparisons

NOTE: Outcome measures also include patient-reported outcome measures (PROMs) which are tools that utilize information provided by patients on their symptoms, experiences of care, quality of life, and other aspects of health and health care that can be used to assess provider performance. PROMs should require positive outcomes such as:

- Improved pain scores
- Improved functional status
- Improved patient satisfaction

Quality Measures by Measure Type, *continued*		
Patient Engagement and Patient Experience measures	**Intermediate Outcome measures**	**Efficiency measures**
Patient engagement and patient experience measures use direct feedback from patients and their caregivers about the experience of receiving care. The information is usually collected through surveys. For example: • Administering the CAHPS for MIPS Clinician/Group Survey	Intermediate outcome measures assess a factor or short-term result that contributes to an ultimate outcome, such as having an appropriate cholesterol level. Over time, low cholesterol helps protect against heart disease. Under MIPS, intermediate outcome measures meet the outcome measure criteria. For example: • Reducing blood pressure in the short-term decreases the risk of longer term outcomes such as cardiac infarction or stroke	Efficiency measures can be used to assess the variability of the cost of healthcare and to direct efforts to make healthcare more affordable. For example: • Ordering cardiac imaging when it does not meet the appropriate use criteria • Overusing neuroimaging in a target patient population (such as patients with headaches and a normal neurological exam)

High priority measures

MIPS scoring policies emphasize and focus on high priority measures that impact beneficiaries. High priority measures are measures that fall within these measure categories:

- Outcome
- Appropriate use
- Patient experience
- Patient safety
- Efficiency measures
- Care coordination

All 6 quality measure types (efficiency, intermediate outcome, outcome, patient engagement experience, process and structure) include high priority measures.

To review the 2018 Quality measures, including the specialty sets, visit the Explore Measures section of the Quality Payment Program website or review the QCDR measure specifications. Once you've found the Quality measures that work for you, you'll need to look at the appropriate measure specifications.

TIP

If you're in a MIPS APM, you'll have a set of required quality measures that the APM Entity will submit for you. For more information, refer to the 2018 Quality Performance Category Web Interface Reporting under the APM Scoring Standard fact sheet or the 2018 Other MIPS APM Quality Performance Category fact sheet.

REPORTING REQUIREMENTS

Participation Requirements

To participate fully in the Quality performance category, you need to submit collected data for **at least 6 Quality measures** (for the 12-month reporting period), **including at least 1 outcome measure**. If no outcome measures are applicable, you may report another high-priority measure.

Submit at least 6 Quality Measures

The CAHPS for MIPS Survey measure can count for 1 of the 6 measures (patient experience measure or 1 high priority measure).

or

Submit a Specialty Measure Set

You may also select a specialty-specific set of measures (e.g., cardiology, dentistry, emergency medicine, general surgery). Submitting a complete specialty set counts as full participation, even when the specialty set contains fewer than 6 measures.

EXCEPTION: If you're registered for and choose to submit data using the CMS Web Interface, you must **report all 15 required Web Interface measures for the full year** (January 1 – December 31, 2018).

TIP: To review the 2018 Quality measures, including the specialty sets, and identify outcome and other high priority measures, visit the "Explore Measures" section of the Quality Payment Program website.

Submission Methods

There are 6 ways you can submit your Quality performance category data:

- Electronic Health Record (EHR)
- Qualified Clinical Data Registry (QCDR)
- Qualified Registry
- CMS Web Interface (registered groups or virtual groups of 25 or more clinicians)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey (registered groups or virtual groups of 2 or more clinicians)
- Claims (individual MIPS eligible clinicians only)

Note: Except for the CAHPS for MIPS survey, we will not combine measures submitted via multiple submission methods into a single Quality score. For example, if you submit 3 measures by claims and 3 measures via EHR, you will receive one score for the claims measures and a second score for the EHR measures—the higher of these 2 scores will be used for your Quality performance category score.

The table below provides additional details on each submission method.

Reporting Methods

Electronic Health Record (EHR)

MIPS eligible clinicians, groups, and virtual groups

- MIPS eligible clinicians submit data they've collected through their certified EHR technology (CEHRT)
  - Clinicians can submit themselves, or
  - Work with a health IT vendor
- Groups and virtual groups that collect data using multiple EHR systems will need to aggregate their data before it's submitted

Qualified Clinical Data Registry (QCDR)

MIPS eligible clinicians, groups, and virtual groups

- Collects medical and/or clinical data to track patients and disease
- For MIPS, you must participate with a QCDR that CMS approved

Qualified Registry

MIPS eligible clinicians, groups, and virtual groups

- Collects clinical data and submits it to CMS
- For MIPS, you must participate with a Qualified Registry that CMS approved

CMS Web Interface

Only for preregistered groups and virtual groups with 25+ eligible clinicians

- Secure Internet-based application
- A sample of beneficiaries are identified for reporting and CMS partially pre-populates with claims data from the group's Medicare Part A and B beneficiaries who've been assigned to the group
- The group adds the rest of the clinical data for the pre-populated Medicare patients
- Requires you to submit data for all measures in the application

CAHPS for MIPS Survey

Only for preregistered groups and virtual groups with 2 or more eligible clinicians

- Must meet minimum sample sizes to administer survey
- You can report patient experience data via the survey; you must choose another way to submit remaining quality measures

Claims

Only for individual MIPS eligible clinicians

- Clinicians pick measures and report through their routine billing processes
- You need to add certain billing codes to denominator eligible claims to show that the required quality action or exclusion happened
- Claims should be processed via Medicare Administrative Coordinators (MACs) no later than 60 days following the close of the performance period

Submission Methods

Administrative Claims

The Quality performance category has one measure that is evaluated by administrative claims: All-Cause Hospital Readmission measure.

The All-Cause Hospital Readmission measure:

Applies to groups and virtual groups with 16 or more clinicians

if they meet the case minimum of 200 patients for the measure

or

Won't be calculated if a group or virtual group falls below the case minimum;

clinicians will only be scored on the reported measures

Note: No data submission action is required for administrative claims evaluation; the All-Cause Hospital Readmission measure is not part of the APM Scoring Standard and won't be calculated for groups participating in a MIPS APM.

SCORING

Each quality measure is scored against a benchmark to determine how many points you'll receive for each measure.

Between 3 and 10 points

based on your performance if the quality measure can be reliably scored against a benchmark (Exception: several topped out measures are capped at 7 points)

or

3 points

if your quality measure doesn't have a benchmark or does not meet the case minimum (denominator of 20)

or

1 point

if your quality measure doesn't meet data completeness requirements (60% in 2018); Exception: if you're a small practice with 15 or fewer eligible clinicians, you would receive 3 points

Reliably scored means that:

- A national benchmark exists
- Sufficient case volume has been met (≥ 20 cases for most measures; ≥200 cases for readmissions)
- The data completeness requirement has been met (meaning at least 60% of possible data is submitted)

Topped out Quality measures

The following measures are considered "topped out" and have been capped at 7 points for 2018.

1. Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin. (Quality measure ID: 21)
2. Melanoma: Overutilization of Imaging Studies in Melanoma. (Quality measure ID: 224)
3. Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients). (Quality measure ID: 23)
4. Image Confirmation of Successful Excision of Image-Localized Breast Lesion. (Quality measure ID: 262)
5. Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description. (Quality measure ID: 359)[2]
6. Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy. (Quality measure ID: 52)

[2] Please note, for 2018, there was not enough data to create a **historical** benchmark for this measure. If a **performance period** benchmark can be created and the measure remains topped out, this measure will be capped at 7 points.

What are benchmarks?

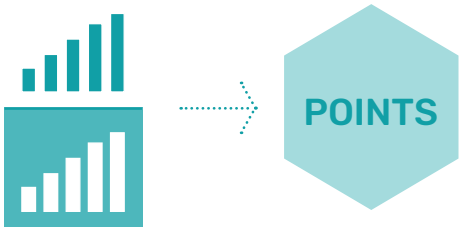
Benchmarks are a standard, or point of reference for comparison. In MIPS, we establish benchmarks as a means of scoring quality measures.

The 2018 Quality benchmarks, for qualified registries, QCDRs, claims, and EHR submission mechanisms, are based on data that was reported via the Physician Quality Reporting System (PQRS) in 2016, two years before the performance period.

Note: 2018 CAHPS for MIPS survey measure benchmarks haven't been established yet since we're using a revised survey but will be available for each summary survey measure (SSM). This means we'll calculate benchmarks based on 2018 performance data.

For the CMS Web Interface quality measures, benchmarks are the same as those used for the Medicare Shared Savings Program.

How are benchmarks converted to points?



- Each measure you submit is assessed against its submission mechanism specific benchmark to see how many points are earned based on your performance (as determined by the performance rate)
- Each quality measure is scored using a 10-point scoring system
  - Except for the topped-out MIPS quality measures finalized with a 7-point maximum
- Historical performance distribution for each measure is used to define deciles of performance that are used as the benchmark for the measure
- The decile benchmarks are used to assign a measure score between 3 and 10 points
- We compare your performance on a Quality measure to the benchmark performance levels in the national deciles
- The points you earn are based on the decile range that matches your performance level

There are a maximum number of points available for the Quality performance category based on the method you use to submit your quality measure data. The maximum number of points is 10 x the number of required measures, which may include the All-Cause Hospital Readmission measure.

Please note that registration was required (between April 1, 2018 and June 30, 2018) to submit your quality measure data through the CMS Web Interface or to administer the CAHPS for MIPS survey.

Maximum Number of Points by Submission Mechanism

CMS Web Interface

130 POINTS
complete reporting, scored on the readmission measure, AND administer CAHPS survey

120 POINTS
complete reporting, scored on the readmission measure OR administer CAHPS survey

110 POINTS
complete reporting, not scored on readmission measure, did not administer CAHPS survey

or

Other Submission Mechanisms (EHR, QCDR, Qualified Registry, Claims)

70 POINTS
scored on the readmission measure

60 POINTS
not scored on readmission measure

Reweighting the Quality performance category

If you don't submit data for the Quality performance category because there are no Quality measures available to you, you won't earn any points in this category, and the Improvement Activities and Promoting Interoperability performance categories would each be reweighted to 45%.

Quality

0% of MIPS Final Score in 2018

Cost

10% of MIPS Final Score

Improvement Activities

45% of MIPS Final Score

Promoting Interoperability
(formerly Advancing Care Information)

45% of MIPS Final Score

NOTE: We anticipate that reweighting of the Quality performance category would be a rare occurrence because there are Quality measures applicable and available for most clinicians. Please contact the Quality Payment Program if you believe there are no quality measures available to you.

Bonus Points

What is the end-to-end electronic reporting bonus?

1 bonus point per measure for reporting your quality data directly from your certified EHR technology (CEHRT) either directly to CMS, through a Qualified Registry or QCDR, or via the CMS Web Interface

What is the bonus for submitting additional measures beyond the required outcome/ high priority measure?

Each additional high priority measure submittted will earn:

- **2 bonus points** if it is an outcome or patient experience measure, or
- **1 bonus point** if it is another type of high priority measure

Note: Bonus points will be added to measure achievement points (those earned based on performance). Each bonus is capped at 10% of the maximum achievement points possible.

How do we evaluate eligibility for improvement scoring?

You'll be evaluated for improvement scoring in 2018 when you:

- Have a Quality performance category achievement score based on reported measures for the last performance period (2017 transition year) and the current performance period (2018)
- Participate fully in the Quality performance category for the current performance period (submit 6 measures/specialty measure set with at least 1 outcome/high priority measure **OR** submit as many measures as were available and applicable **OR** submit all measures in the CMS Web Interface; all measures must meet data completeness requirements)
- Submit data under the same identifier for the 2 performance periods, or if we can compare the data submitted for the 2 performance periods

For the 2018 performance period, you can earn **up to 10 percentage points** based on your rate of improvement in the Quality performance category from the year before.

Improvement scoring is calculated by comparing the Quality achievement percentage points (those earned by measures based on performance) from the previous period to the Quality achievement percentage points earned in the current period.

$$\text{Improvement Percent Score} = \left(\frac{\text{Increase Quality Performance Category Achievement Percent Score (From Prior Performance Period to Current Performance Period)}}{\text{Prior Performance Period Quality Performance Category Achievement Percent Score}} \right) \times 10\%$$

Below is the updated calculation for the Quality performance category, which now includes the improvement score.

$$\text{Quality Performance Category Percent Score (Not to exceed 100\%)} = \left(\frac{\text{Total Measure Achievement Points} + \text{Measure Bonus Points}}{\text{Total Available Measure Achievement Points}} \right) + \text{Improvement Percent Score}$$

Resources

You can find more resources at these links:

- 2018 MIPS Quality Performance Fact Sheet
- MIPS Participation and Overview Fact Sheet
- MIPS Bonus Overview Fact Sheet
- MIPS Group Participation User Guide
- Qualified Clinical Data Registry (QCDR) Measure Specifications
- CAHPS for MIPS Survey Fact Sheet
- Performance Year 2018 Quality Performance Category Scoring Web Interface Reporters under the APM Scoring Standard
- 2018 Other MIPS APM Quality Performance Category
- Quality Benchmarks


Quality Payment
PROGRAM

2018 Merit-based Incentive Payment System
Bonus Overview Fact Sheet

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. MACRA requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, which provides two participation tracks for clinicians:

MIPS
The Merit-based Incentive Payment System (MIPS)

OR

Under MIPS, there are four performance categories

- Quality
- Improvement Activities
- Promoting Interoperability (formerly Advancing C
- Cost

MIPS eligible clinicians, groups, Virtual Groups, and participating with MIPS eligible clinicians in a MIPS points) as part of their performance category scores Interoperability (formerly Advancing Care Informatio earn bonus points towards their final score if they m

- Quality Performance Category Bonuses
- Promoting Interoperability Performance Category
- Final Score Bonuses

Quality Payment
PROGRAM

2018 Merit-based Incentive Payment System
(MIPS) Participation & Overview

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. MACRA requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, which provides two participation tracks for clinicians:

MIPS
The Merit-based Incentive Payment System (MIPS)

OR

Advanced APMs
Advanced Alternative Payment Models (Advanced APMs)

This fact sheet is divided into three sections:

- Quality Payment Program Year 2: MIPS participation
- Quality Payment Program Year 2: MIPS policy highlights
- Quality Payment Program: Comparing final Year 1 & Year 2 policies

Quality Payment Program Year 2: MIPS participation

Who can participate in Year 2?

For the 2018 MIPS performance year (Year 2), the following clinician types are eligible for MIPS:

- Physicians, which includes doctors of medicine, doctors of osteopathy (including osteopathic practitioners), doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors;
- Physician assistants (PAs);
- Nurse practitioners (NPs);
- Clinical nurse specialists;
- Certified registered nurse anesthetists; and
- Any clinician group that includes one of the professionals listed above.

CMS

Glossary


APM
Alternative Payment Model
CAHPS
Consumer Assessment of Healthcare Providers and Systems
CEHRT
Certified Electronic Health Record Technology
CMS
Centers for Medicare & Medicaid Services
EHR
Electronic Health Record
MIPS
Merit-based Incentive Payment System
NPI
National Provider Identifier
QCDR
Qualified Clinical Data Registry
QPP
Quality Payment Program
TIN
Taxpayer Identification Number