Acronym	Stands for	Definition
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 while operating under alternative payment models.
APM	Alternative Payment Models	Alternative Payment Models (APM) are payment approaches that include both value and shared savings or risk-based payment models where practices are incentivized to provide high-quality and cost-efficient care.
CEHRT	Certified electronic health record technology	In 2011, the Centers for Medicare & Medicaid Services (CMS) established the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs to encourage Eligible Professionals (EPs), Eligible Hospitals, and Critical Access Hospitals (CAHs) to adopt, implement, upgrade (AIU), and demonstrate meaningful use of certified EHR technology (CEHRT).
CMMI	Centers for Medicare and Medicaid Innovation	The Centers for Medicare & Medicaid Innovation (the Innovation Center) under CMS supports the development and testing of innovative health care payment and service delivery models.
CMS	Centers for Medicare and Medicaid Services	The Centers for Medicare & Medicaid Services (CMS), previously known as the Health Care Financing Administration (HCFA), is a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
CQM	Clinical quality measure	Clinical Quality Measures are tracked metrics that help to demonstrate quality in healthcare delivery. Collecting, reporting and using data for is a key activity in quality improvement.
EHR	Electronic health record	An electronic health record (EHR), or electronic medical record (EMR), is the systematized collection of patient and population electronically-stored health information in a digital format.
EIDM	Enterprise Identity Management System	Provides a way for business partners to apply for, obtain approval of, and receive a single user ID for accessing multiple CMS applications.
IA	Improvement Activities	Under the Quality Payment Program, this is a new performance category for 2017 Medicare reimbursement. These activities reward activities that promote care coordination, beneficiary engagement, and patient safety.
LAN	Learning and Access Network	The Department of Health and Human Services launched (through CMS) the Health Care Payment Learning and Action Network (LAN) in March 2015 to align with public and private sector stakeholders in shifting away from a Fee-for-service to a value-based payment system that pays for high-quality care and improved health outcomes.

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MACRA	Medicare Access and CHIP Reauthorization Act	Medicare and Chip Re-authorization act of 2015 – Ended the sustainable growth rate formula and ushered in the transition to value or risk based payment models for Medicare reimbursement.
MIPS	Merit-based Incentive Payment System	This is one of the new alternative payment models under the Quality Payment Program. Three legacy programs; Patient Quality Reporting System (PQRS), Meaningful Use (MU), and the Value-Based Modifier (VBM) have been rolled into MIPS, as well as a fourth performance category Improvement Activities (IA). Performance across all four sections will determine Medicare payment adjustments.
MSSP	Medicare Shared Saving Program	The Shared Savings Program offers providers and suppliers (e.g., physicians, hospitals, and others involved in patient care) an opportunity to create a new type of health care entity, an ACO. An ACO agrees to be held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service (FFS) beneficiary population. The Shared Savings Program has different tracks that allow ACOs to select an arrangement that makes the most sense for their organization.
MU	Meaningful Use	A Medicare EHR incentive program that required eligible professionals to demonstrate the meaningful use of EHR's to improve the quality, safety, and efficiency of care delivery as well as reducing health disparities.
NPI	National Provider Identifier	A unique 10-digit number assigned to health care providers to identify themselves in a standard way throughout their industry.
PAT	Practice Assessment Tool	A device designed by the Centers for Medicare and Medicaid Services (CMS) for practices to systematically evaluate themselves on practice transformation as part of the TCPi. The score reflects the practice's current status among the programs five phases of transformation.
PECOS	Provider Enrollment, Chain, and Ownership System	PECOS supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information.
PCMH	Patient Centered Medical Home	A model of care delivery that focuses on the organization of care originating from a central primary care provider who operates within a connected care system. The medical home encompasses five functions and attributes: • Comprehensive Care • Patient-Centered • Coordinated Care • Accessible Services • Quality and Safety
PI (formerly ACI)	Promoting Interoperability Requirements (formerly Advancing Care Information)	This performance category promotes patient engagement and electronic exchange of information using certified electronic health record technology (CEHRT). CMS is re-naming the Advancing Care Information (ACI) performance category to promoting interoperability (PI) to focus on interoperability, improving flexibility, relieving burden.

Acronym	Stands for	Definition
PQRS	Physician Quality Reporting System	A quality reporting program that encouraged eligible professionals to report information on the quality of care to Medicare. PQRS gave participating providers the opportunity to assess the quality of care they provide to their patients. 2016 was the last program year for PQRS as it has been absorbed into the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program.
PTAN	Provider Transaction Access Number	A PTAN is a Medicare-only number issued to providers by Medicare Administrative Contractors (MACs) upon enrollment to Medicare. MACs issue an approval/notification letter, including PTAN information, when an enrollment is approved.
PTN	Practice Transformation Network	The Practice Transformation Networks are peer-based learning networks designed to coach, mentor and assist clinicians in developing core competencies specific to practice transformation. This approach allows clinician practices to become actively engaged in the transformation and ensures collaboration among a broad community of practices that creates, promotes, and sustains learning and improvement across the health care system.
QCDR	Qualified clinical data registries	A qualified clinical data registry (QCDR) is a reporting mechanism available for eligible professionals (EPs). A QCDR will complete the collection and submission of quality measure data on behalf of EPs. A QCDR is a CMS-approved entity (such as a registry, certification board, collaborative, etc.) 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.
QIA	Quality Improvement Advisor	Quality improvement advisors train, educate, and coach practices in the transformation phases.
QIO	Quality Improvement Organization	QIO is one of the largest federal programs with a goal to improve health quality at the community level, through greater connectivity and care coordination across all health care settings to improve health care delivery for Medicare beneficiaries. The QIO program operates through a national network of QIOs, which are independent, mostly non-profit, private organizations staffed by health care professionals and quality improvement experts working to improve the quality and efficiency of health care across all care settings. There are two kinds of QIOs: Quality Innovation Network-QIOs (QIN-QIOs) and Beneficiary and Family Centered Care-QIOs (BFCC-QIOs). Fourteen QIN-QIOs and two BFCC-QIOs serve the entire United States and its territories.
QPP	Quality Payment Program	The Centers for Medicare and Medicaid Services (CMS) has developed the Quality Payment Program (QPP) to eventually replace Fee-for-service reimbursement for clinicians who bill Medicare Part B. QPP has two tracks: • The Merit-based Incentive Payment System (MIPS) • Advanced Alternative Payment Models (APMs)
QRUR	Quality and Resource Use Report	A report made available nationwide by CMS to show how eligible practitioners performed on tracked quality and cost measures. This data was used to calculate the Value-Based-Modifier (VBM) that determined payment adjustments.

Acronym	Stands for	Definition
SAN	Support and Alignment Network	A system for workforce development utilizing national and regional professional associations and public-private partnerships that are currently working in practice transformation efforts.
SGR	Sustainable Growth Rate	A system for establishing goals for the rate of growth in expenditures for physicians' services. Ended with the passing of MACRA in 2015.
SNE-PTN	Southern New England Transformation Network (UMass in partnership with UCONN Health)	The Southern New England Practice Transformation Network (SNE-PTN) is one of the 29 original networks in TCPi and is a collaboration between UMass Medical School (UMass) and UConn Health.
TCPI	Transforming Clinical Practice Initiative	An initiative funded by the Centers for Medicare and Medicaid Services (CMS), whose aim is to assist 140,000 clinicians to improve the way they deliver care by providing technical assistance support for quality and process improvement. With $685M in awards to 29 original practice transformation networks and 10 support and alignment networks, it is one of the largest federal investments designed to support clinicians in all 50 states through peer-based learning networks.
TIN	Tax Identification Number	An identification number issued by the Social Security Administration (SSA) or the Internal Revenue Service (IRS) to eligible practitioners for the purpose of submitting claims and revenue data.
VBM	Value-based Payment Modifier Program	Provided the means for determining 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.