Current State of Medicare

Robert Roth & John Hellow
Hooper, Lundy & Bookman, PC
FY 2018 Proposed and FY 2017 Final IPPS Rules

C. Highlights covered today:
   1. Inpatient payment update
   2. ATRA Adjustment/MACRA Restoration
   3. Two Midnight Payment Adjustment
   4. Outlier Threshold
   5. Disproportionate Share Hospital (DSH) and UC-DSH
   6. Payment Consequences of Quality Metrics
   7. 21st Century Cures Act — Changes on Readmissions
## Basic IPPS Rates for FFYs 2017 and 2018

<table>
<thead>
<tr>
<th></th>
<th>FY 2017 Final IPPS Rule</th>
<th>FY 2018 Proposed IPPS Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Market Basket</strong></td>
<td>2.7%</td>
<td>2.9%</td>
</tr>
<tr>
<td><strong>ACA Reductions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Market Basket</td>
<td>-0.75%</td>
<td>-0.75%</td>
</tr>
<tr>
<td>Productivity</td>
<td>-0.3%</td>
<td>-0.4%</td>
</tr>
<tr>
<td><strong>Subtotal = Applicable Percentage Increase</strong></td>
<td>1.65%</td>
<td>1.75%</td>
</tr>
<tr>
<td><strong>ATRA Reduction (additive) or Cures Act Restoration</strong></td>
<td>-1.5%</td>
<td>0.4588%</td>
</tr>
<tr>
<td><strong>TWO-MIDNIGHT ADJUSTMENT</strong></td>
<td>0.8% (only 0.2% permanent)</td>
<td>-0.6%</td>
</tr>
<tr>
<td><strong>Total General Adjustment before Sequester</strong></td>
<td>0.95%</td>
<td>1.6088%</td>
</tr>
</tbody>
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*Note: This update does not include hospital-specific payment changes due to readmissions, value-based purchasing, hospital acquired conditions, meaningful use, etc.*
Market Basket Updates

1. Latest market basket updates can be found on CMS website
2. CMS rebases the market basket and labor share every 4 years and proposes to rebase in 2018:
   a. Labor share 68.3% (down from 69.6%) for hospitals with a wage index value greater than 1.0000; and
   b. Labor share 62% for hospitals with a wage index value less than or equal to 1.0000
3. FY 2017 final rule used a market basket update of 2.7%
4. FY 2018 proposed market basket update is 2.9%
5. Quality reporting and meaningful use reductions to market basket rate will be discussed later
ACA Productivity Cuts

1. Applies beginning in FY 2012
2. 10-year moving average of changes in annual non-farm productivity, as determined by the Secretary
3. Can result in a market basket increase of less than zero
4. Payments in a current year may be less than the prior year
5. Applies to other provider types

<table>
<thead>
<tr>
<th>Fiscal Year</th>
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<tbody>
<tr>
<td>2012</td>
<td>- 1.0%</td>
</tr>
<tr>
<td>2013</td>
<td>- 0.7%</td>
</tr>
<tr>
<td>2014</td>
<td>- 0.5%</td>
</tr>
<tr>
<td>2015</td>
<td>- 0.5%</td>
</tr>
<tr>
<td>2016</td>
<td>- 0.5%</td>
</tr>
<tr>
<td>2017</td>
<td>-0.3%</td>
</tr>
<tr>
<td>2018 est.</td>
<td>-0.4%</td>
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Additional ACA-Mandated Reduction

- Market basket adjustment for FYs 2012 – 2019

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<th>Fiscal Year</th>
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<tr>
<td>2012</td>
<td>.1%</td>
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<td>2013</td>
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<td>2014</td>
<td>.3%</td>
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<td>2015</td>
<td>.2%</td>
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<td>2016</td>
<td>.2%</td>
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<tr>
<td>2017</td>
<td>.75%</td>
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<tr>
<td>2018</td>
<td>.75%</td>
</tr>
<tr>
<td>2019</td>
<td>.75%</td>
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- Similar, if not identical, market basket adjustments apply for long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals, and outpatient hospital services
A. ATRA imposed an aggregate estimated $11 billion recoupment of asserted coding overpayments in FYs 2010-2012

1. Recoupment to take place over 4 years (FYs 2014 – 2017)
2. Secretary has discretion on timing and level of the recoupment
3. Adjustments are to be based on estimated discharges
4. CMS used a level 0.8% reduction per year, for FYs 2014 – 2016
5. CMS finalized a -1.5% adjustment to complete the recoupment in FY 2017
ATRA Recoupment and MACRA Restoration (cont.)

B. MACRA Restoration

1. To generate savings to pay for the physician SGR fix, Congress prohibited CMS from restoring the aggregate ATRA adjustment to the IPPS rate in FY 2018.

2. Congress, anticipating a 3.2% ATRA adjustment in FY 2017 (4 X 0.8%), allows CMS to ramp up the IPPS rate by 0.5% per year between FYs 2018 and 2023 to restore part of the adjustment.

3. Unfortunately, CMS imposed an aggregate -3.9% ATRA adjustment, potentially leaving -0.9% permanent.

C. Cures Act Modification — limits increase in FY 2018 to 0.4588%
Two Midnight Policy and Payment Reduction

A. Original 2-midnight policy FYs 2014 and 2015
   1. CMS will generally consider hospital admissions spanning two midnights as appropriate for inpatient Part A payment
   2. In contrast, hospital stays of less than 2 midnights will generally be considered outpatient cases, regardless of clinical severity
   3. CMS imposed a -0.2% payment reduction under the assumption the policy would increase claims inpatient stays

B. Modifications to the two-midnight policy CY 2016
   1. CY 2016 outpatient PPS final rule
   2. Stays less than 2 midnights may be appropriate for inpatient admission based on “the clinical judgement of the admitting physician and medical record support for that determination”
C. Litigation Update

1. District Court orders CMS to publish explanation of assumption that inpatient stays would increase under policy and to consider comments in response thereto.

2. As part of FY 2017 IPPS final rule CMS provides a permanent 0.2% adjustment and restores prior period adjustments by providing additional increase of 0.6% only in FY 2017, for an aggregate increase of 0.8% in FY 2017.
## Hospital-Dependent Adjustments for FY 2018

### Proposed FY 2018 Summary by HPA

<table>
<thead>
<tr>
<th>Proposed FY 2018 Summary by HPA</th>
<th>Hospital Submitted Quality Data and is a Meaningful EHR User</th>
<th>Hospital Submitted Quality Data and is NOT a Meaningful EHR User</th>
<th>Hospital did NOT Submit Quality Data and is a Meaningful EHR User</th>
<th>Hospital did NOT Submit Quality Data and is NOT a Meaningful EHR User</th>
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<tr>
<td>Market Basket Increase</td>
<td>2.9</td>
<td>2.9</td>
<td>2.9</td>
<td>2.9</td>
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<tr>
<td>Adjustment for Failure to Submit Quality Data</td>
<td>0.0</td>
<td>0.0</td>
<td>-0.725</td>
<td>-0.725</td>
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<td>Adjustment for Failure to be a Meaningful EHR User</td>
<td>0.0</td>
<td>-2.175</td>
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<td>MFP Adjustment</td>
<td>-0.4</td>
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<td>-0.4</td>
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<td>Statutory Adjustment SSA section 1886(b)(3)(B)(xii)</td>
<td>-0.75</td>
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<tr>
<td>Applicable % Increase Applied to Standardized Amounts</td>
<td>1.75</td>
<td>-0.425</td>
<td>1.025</td>
<td>-1.15</td>
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Outlier Payment Adjustment

A. FY 2017

1. CMS proposed a $23,681 fixed loss threshold for FY 2017, and finalized a $23,573 threshold
2. CMS now estimates FY 2016 outlier payments at 5.37% of MS-DRG payments.

B. Proposed FY 2018

1. CMS proposed a $26,713 fixed loss threshold, a surprisingly large increase from FY 2017; we think this is driven in part by an increasing number of cases with charges over $1.5 million
2. While CMS does not provide a specific estimate of its estimate outlier payments as a percentage of total DRG payment for FY 2017, a percentage of 4.9% can be inferred from an unexplained difference between the FY 2017 and 2018 modeled payments
ACA changed Medicare DSH payments starting in FY 2014

- New statute codified at 42 U.S.C. § 1395ww(r)
- CMS adds new 42 C.F.R. § 412.106(f)-(h) effective with discharges on and after 10/1/13

- Total Uncompensated Care fund pool reduced as uninsured rate declines; hospital share of fund pool based on the relative uncompensated care each DSH Hospital provides relative to all DSH hospitals, but CMS uses a proxy for uncompensated care costs
UC – DSH Basics

- Affected Hospitals –
  - 2440 hospitals, including Puerto Rico
  - Excludes Maryland and CAHs
  - Sole Community Hospitals – consider all DSH when assessing eligibility for a hospital specific rate

- Total Uncompensated Care payments subject to 3 factors:
  - 1 – Estimate 75% of traditional DSH payments and reduce traditional DSH payments to hospitals by that amount
  - 2 – Establish Uncompensated Care DSH Fund by taking 75% of estimated traditional DSH payments reduced by improvement in insured rates + an additional statutory factor (0.2 percentage points for FYs 2016 and 2017)
  - 3 – Distribute Uncompensated Care DSH Fund based on the ratio of each hospital’s 3 year average of Medicaid and SSI days to all DSH hospitals’ Medicaid and SSI days using at least through FY 2017, CMS is proposing a transition to uncompensated care costs from W/S S-10 beginning in FY 2018
Factor 1

A. Initial size of the 75-percent aggregate uncompensated care payments

B. Difference between CMS estimates of
   1. The amount of DSH payments that would be made to all hospitals in the absence of
      the ACA payment provision; and
   2. The amount of the empirically justified Medicare DSH payments actually made in
      that year

C. 75 percent of DSH payments that would be made to all hospitals in the absence
    of the ACA payment provision

D. Set **prospectively**

E. Historical Factor One:
   - FY 2017: $10.797 billion
   - FY 2016: $10.058 billion
   - FY 2015: $10.037 billion
   - FY 2014: $9.579 billion

F. Proposed FY 2018: $12.002 billion
Factor 2 Calculation for Final FY 2017

A. Change in the percentage of uninsured from 2013 baseline of 18%

B. Congressional Budget Office (CBO) data
   1. Estimate of individuals under the age of 65 with insurance in CY 2016 is 89% (un-insurance rate of 11%)
   2. Estimate of individuals under the age of 65 with insurance in CY 2017 is 90% (un-insurance rate of 10%)
   3. These figures are then weighted to determine the un-insurance rate for FY 2017
   4. Percent change from 2013 un-insurance rate minus an additional statutory factor (0.2 percentage points or .002)
   5. Proposed FY 2017 Factor 2 is equal to 0.5536

C. As a result, CMS retains 55.36% — or $5.977 billion — of the original aggregate uncompensated care payments (75%) in FY 2017

D. This amounts to a reduction of approximately $400 million in Medicare DSH payments in FY 2017 compared to FY 2016
Factor 2 Calculation for FY 2018

A. Prior to FY 2018, the statute focused on the change in the uninsured population under 65; beginning in FY 2018 the measure must focus on the change in the total uninsured population between the base year of FY 2013 and each year beginning on and after FY 2018

B. The statute allows CMS more data source flexibility in assessing that change in the uninsured population. CMS determined that uninsured estimates produced by CMS’ OACT as part of the development of the National Health Expenditure Accounts (NHEA) best meet that goal

C. CMS calculated Factor 2 for the FY 2018 proposed rule to be 58.01%

D. The proposed uncompensated care amount for FY 2018 to be $12.002 billion “times” 0.5801 = $6.962 billion

E. This is about $1 billion more than FY 2017 available to distribute to hospitals using Factor 3
Factor 3 Calculation for FYs 2016 and 2017

A. Premised on Hospitals’ uncompensated care costs
B. Allocates Factor 2 pool based on relative uncompensated care costs
C. Proportion of each hospital’s measure to aggregate hospitals’ total measure for all DSH eligible hospitals:

1. CMS continues to use inpatient days of Medicaid beneficiaries plus inpatient days of Medicare supplemental security income (Medicare SSI) beneficiaries as a proxy for measuring the amount of uncompensated care each hospital provides,

2. For FY 2016 CMS used March 2015 update of the 2011/2012 Medicare cost reports for the Medicaid days and the FY 2013 SSI ratios for the Medicare SSI days,

3. For FY 2017 CMS used a 3-year average for Medicaid and Medicare with SSI days (Puerto Rico hospitals would receive a proxy for this factor) from March 2016 update for FYs 2011-13 (but is not annualizing partial periods) and the FY 2014 SSI ratios for the Medicare SSI days,

4. CMS published on its website, a table listing Factor 3 for all IPPS hospitals it estimates would receive uncompensated care payments
DSH: 3-Year Averaging of Factor 3 vs. FY 2016 Single Year
A. As part of the FY 2018 IPPS proposed rule, CMS proposes to begin using W/S S-10 data in FY 2018, as a transition to full use of such data by FY 2020

1. For FY 2018, CMS would calculate Factor 3 based on an average of Factor 3 calculated using low-income insured days (proxy data) determined using Medicaid days from FY 2012 and FY 2013 cost reports and FY 2014 and FY 2015 SSI ratios, and Factor 3 calculated using uncompensated care data based on FY 2014 Worksheet S-10, as amended

2. For FY 2019, CMS would calculate Factor 3 based on an average of Factor 3 calculated using low-income insured days (proxy data) determined using Medicaid days from the FY 2013 cost report and the FY 2015 SSI ratios, and Factor 3 calculated using uncompensated care data based Worksheet S-10 from the FYs 2014 and 2015 cost reports
3. For FY 2020, CMS would calculate Factor 3 using uncompensated care data based on Worksheet S-10 data from FYs 2014, 2015 and 2016 cost reports.

4. Indian Health Service and Puerto Rico hospitals’ Factor 3 calculation would not use S-10 data.

5. No charge structure hospitals would have CCRs established at statewide averages for S-10 data.

6. S-10 data is still unaudited and CMS proposed only one concrete edit of the data, a double trim of hospital CCRs that exceed by 3 standard deviations above the mean CCR, and the assignment of a statewide average CCR to such hospitals.

7. CMS is proposing to annualize short and long period cost report data.
A. Timing of reporting charity care and non-Medicare bad debt:

1. CMS revises Worksheet S-10 cost report instructions for Line 20 concerning the timing of reporting charity care, such that charity care will be reported based on date of write-off, and not based on date of service (See CMS Pub. 15-2, Chapter 40, Section 4012),

2. This is consistent with charity write-offs that hospitals report in accordance with GAAP,

3. Hospitals currently report non-Medicare bad debt without regard when the services were provided, and

4. CMS advised contractors to allow W/S S-10 amendments to the FY 2014 reported data to accommodate this change and other corrections hospitals may offer, so long as received by Sept. 20, 2016; a similar offer has been made for FY 2015 reported data.
Example: California DSH Breakout

Estimated Impacts of CMS' Proposals Related to Distribution of the DSH Uncompensated Care Pool

<table>
<thead>
<tr>
<th></th>
<th>Est. UCC Revenue</th>
<th>Est. Total Revenue</th>
<th>Impact ($)</th>
<th>Impact (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFY 2017 Calculation Maintained at Single Year of Data (Current)</td>
<td>$767,106,300</td>
<td>$10,887,038,200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FFY 2017 Calculation Based on Proposed Three Year Data Average</td>
<td>$756,857,200</td>
<td>$10,876,832,300</td>
<td>($10,205,900)</td>
<td>-0.09%</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>CCR Methodology</th>
<th>Transition Year</th>
<th>Factor 3 Data Mix</th>
<th>Est. UCC Revenue</th>
<th>Est. Total Revenue</th>
<th>Impact ($) vs Current Proxy Distribution</th>
<th>Impact (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFY 2014 S-10 Using Current CCR Calculation</td>
<td>1st</td>
<td>2 Proxy, 1 S-10</td>
<td>$617,744,600</td>
<td>$10,738,030,000</td>
<td>($149,008,200)</td>
<td>-1.37%</td>
</tr>
<tr>
<td></td>
<td>2nd</td>
<td>1 Proxy, 2 S-10</td>
<td>$481,605,900</td>
<td>$10,602,186,500</td>
<td>($284,851,700)</td>
<td>-2.62%</td>
</tr>
<tr>
<td></td>
<td>3rd</td>
<td>3 S-10</td>
<td>$338,855,700</td>
<td>$10,459,760,400</td>
<td>($427,277,800)</td>
<td>-3.92%</td>
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<tr>
<td>FFY 2014 S-10 After Applying Proposed Double-Trim Methodology to Hospital CCR</td>
<td>1st</td>
<td>2 Proxy, 1 S-10</td>
<td>$598,473,100</td>
<td>$10,718,741,300</td>
<td>($168,296,900)</td>
<td>-1.55%</td>
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<tr>
<td></td>
<td>2nd</td>
<td>1 Proxy, 2 S-10</td>
<td>$443,062,800</td>
<td>$10,563,609,200</td>
<td>($323,429,000)</td>
<td>-2.97%</td>
</tr>
<tr>
<td></td>
<td>3rd</td>
<td>3 S-10</td>
<td>$281,041,000</td>
<td>$10,401,892,400</td>
<td>($485,145,800)</td>
<td>-4.46%</td>
</tr>
</tbody>
</table>
Problems with the Reliable Use of Worksheet S-10

1. Many errors obvious in filed S-10 data that strongly suggests data is unreliable as a basis to determine relative share of uncompensated care costs
   - Many hospitals did not report S-10 data at all, about 5%
   - 14% had no total bad debt data, but 90% of that group reported Medicare bad debt data
   - Some had a CCR of 1, many had CCRs above .6, a few had more gross charges on S-10 than on C
   - Some reported unreimbursed costs of Medicaid as uncompensated care
2. Definitional problems
   - Uninsured vs. charity — non-means tested uninsured discounts, or discounted care that is not charity care likely not included in charity
   - Charity must be determined during the cost reporting period
   - Medicaid and indigent programs’ non-covered charges must be addressed in charity policy or excluded

3. Converting charges to costs
   - Problem particularly acute with bad debt
   - Hospitals may be grossing up charges to address copayment shortfalls — should a hospital be allowed to claim a cost for a copayment that exceeds the actual copayment obligation? If the answer is yes, how do you standardize how that cost will be measured?
What is the “base operating DRG amount” subject to reduction?

- No changes to the penalty formula
- Excludes Indirect Medical Education (IME), DSH, outliers, low-volume adjustment, and additional payments made due to status as an Sole Community Hospital (SCH), but
- Includes new technology payments, and will be,
- Adjusted to account for transfer cases, and then equals,
- \[((\text{Labor Share} \times \text{Wage Index}) + (\text{Non Labor Share} \times \text{COLA}) \times \text{DRG Weight}) + \text{New Technology Add On Payment}) \times (\text{Adjustment Factor}-1)\)
Hospital Value-Based Purchasing Program

- ACA-mandated; applies to discharges on and after 10/1/2012
- Funded through base operating DRG reductions: 1% in FY 2013, 1.25% in FY 2014, 1.5% in FY 2015, 1.75% in FY 2016 and 2% for FY 2017 and thereafter
- Budget neutral — all funds withheld are redistributed as incentive payments to applicable hospitals
- The available pool for FY 2016 was estimated to be $1.5 billion and increases to $1.7 billion for FY 2017, and $1.9 billion for FY 2018
Hospital Value-Based Purchasing Program (cont.)

- Other details
  - CMS increases from 2 to 3 the number of surveys for which a hospital must be cited for immediate jeopardy before its exclusion from the VBP Program; a hospital must be cited on Form CMS-2567, Statement of Deficiencies and Plan of Correction, for immediate jeopardy on at least three surveys during the performance period in order to meet the standard for exclusion from the VBP Program.
  - CMS proposes to remove PSI 90 composite patient safety measure in 2019 but reformulate and reinstate it in 2023.
  - Beginning with FY 2022 payment, CMS proposes to add a hospital-level, risk standardized 30-day pneumonia episode of care payment measure to the VBP Program.
Hospital Readmissions Reduction Program (HRRP)

A. ACA-mandated and assesses penalties on hospitals for having “excess” readmission rates when compared to expected rates for 6 measures that are unchanged for FY 2018

B. The applicable period for purposes of the FY 2018 comparison is July 1, 2013 – June 30, 2016

C. Maximum penalty topped out at 3.0% of Medicare base operating payments in FY 2015, and remains at 3.0% in FY 2016 and thereafter

E. 21st Century Cures Act mandates changes to the HRRP program beginning in FY 2019:

1. Requires hospital be assigned to peer groups (5 proposed) stratified on the proportion of full Medicare to Dual Eligible patients at the hospital, and includes MA patients in the comparison,

2. Must be budget neutral,

3. No additional reporting requirements for hospitals,

4. Proposes payment formula change and will consider options, but favors a comparison of the excess readmission ratio (ERR) to the median ERR for the peer group
Hospital Readmissions Reduction Program (cont.)

Economic Report of the President 2014

Medicare 30-Day, All-Condition Hospital Readmission Rate
Percent, 12-month moving average

2007-2011 Average
Dec-15

A. Hospital-Acquired Condition Reduction Program (HACRP) is an ACA-mandated program that imposes a 1% reduction to all Medicare inpatient payments for hospitals in the top (worst performing) quartile of risk-adjusted national HAC rates

B. Therefore, for discharges on and after Oct. 1, 2014, hospitals in top quartile of risk adjusted HAC measures receive only 99% of total PPS payments

C. Adjustment is applied after VBP and HRRP adjustments

D. In FY 2018 proposed rule CMS is proposing policy changes that would impact FY 2020 including new measures and a new 2-year measurement window
Impact of Medicare Access and CHIP Reauthorization Act on Inpatient PPS

Extends enhanced low volume hospital payments and the Medicare-dependent Hospital programs until October 1, 2017, but sunsets after that absent additional Congressional action.
Overview of the MACRA Final Rule

General (Key Provisions)

MACRA institutes a new payment structure that will place most physicians accepting Medicare beneficiaries at risk for their value-based performance.

**KEY PROVISIONS**

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<tr>
<th>Two-Track System</th>
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<tr>
<td>» Merit-Based Incentive Payment System (MIPS)</td>
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<td>» Advanced Alternative Payment Models (A-APMs)</td>
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<tr>
<th>More Consistent Rate Increases</th>
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<tr>
<td>» Rate increases have been standardized at 0.5% through 2019</td>
<td></td>
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<tr>
<td>» Rates will remain constant from 2020 through 2025</td>
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<tr>
<td>» Beginning in 2026, rate increases will be dependent on an eligible clinician’s designated track (MIPS at 0.25% and APMs at 0.75%)</td>
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<tr>
<th>Integrated QPP</th>
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<tr>
<td>» The MIPS track combines the historic Physician Quality Reporting System (PQRS), meaningful use, and the VBPM program</td>
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<tr>
<td>» The A-APM track includes similar performance categories, and metrics already incorporate value-based payment programs</td>
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Overview of the Final Rule
MIPS (Eligible Clinicians)

Physicians

Physician Assistants

Nurse Practitioners

Clinical Nurse Specialists

Certified Registered Anesthetists

Group of Such Clinicians Who Bill Under Medicare Part B

Newly Medicare-enrolled MIPS-eligible clinicians, qualifying participants (QPs), certain partial QPs, and clinicians falling under the low-volume threshold will be excluded from MIPS.
Overview of the Final Rule
MIPS (Performance Categories)

The MIPS track will measure and incentivize performance across four key categories, utilizing a single composite score in a budget-neutral fashion.

### Quality (60% to 30%)
- There are more than 200 measures (with more than 80% being tailored to specialists) and 26 specialty specific measures sets to choose from
- A maximum score is given for the following:
  - Six measures (including one outcomes measure)
  - One specialty-specific measure set (including one outcomes measure)
  - All measures included in the interface for the first 248 consecutively ranked and assigned Medicare beneficiaries (via the Web Interface)

### Cost/Resource Use (0% to 30%)
- This is calculated based on Medicare claims experience (no submission)
- Metrics include the following:
  - Total per capita cost (minimum case volume of 20)
  - Medicare spending per beneficiary (MSPB) (minimum case volume of 35)
  - 10 measures related to specific episodes (minimum case volume of 20)

### Clinical Practice Improvement Activities (15%)
- Clinicians can select from more than 90 options
- The maximum score is 40 (two high-weighted or four medium-weighted measures). Small (≤15), rural, and HPSA practices and non-patient-facing MIPS-eligible clinicians' score effectively doubled
- Activities must occur for a minimum of 90 consecutive days
- Practices in a certified patient-centered medical home (PCMH) would receive full credit toward this category, and practices in a qualified APM would receive a minimum of half credit toward this category

### Advancing Care Information (25%)
- This consists of a base score and a performance score (and bonus potential for specific activities)
- Measures align with the Office of the National Coordinator for HIT's 2015 HIT Certification Criteria
- Criteria must be met for a minimum of 90 consecutive days
- Exclusions for hospital-based MIPS-eligible clinicians (75%) and MIPS-eligible clinicians who have less than $10,000 in Medicare-billed charges or less than 100 Medicare Part B–enrolled beneficiaries
Overview of the Final Rule
MIPS (Combined Performance Score)

A sliding scale will be used to establish the potential risk component of reimbursement adjustments under MIPS.

A sliding scale will be used to establish the potential risk component of reimbursement adjustments under MIPS.
# Overview of the Final Rule
## General (Payment Adjustments Summary)

**Source:** CMS, The Medicare Access and CHIP Reauthorization Act of 2015: Path to Value..

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**MIPS Payment Adjustment (+/-)**

- Quality: 4%, 5%, 7%, 9%
- Cost/Resource Utilization: 60%, 50%, 30%
- Clinical Practice Improvement Activities: 0%, 10%, 30%
- Advancing Care Information: 15%, 15%, 15%

**Certain APMs**

- Qualifying APM Participant Medicare Payment Threshold Excluded From MIPS
- 5% Incentive Payment Excluded From MIPS


* Qualifying APM conversion factor.
** Non-qualifying APM conversion factor.
Questions?
Thank you

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