Rural Health Clinics & Medicare Incentive-Based Payments (MIPS)

What is next?

Medicare Incentive Payments have always been a confusing issue for Rural Health Clinics. Since the Physician Quality Reporting System, Meaningful Use, and Shared Savings programs were introduced, RHC veterans and newbies alike have been trying to figure out how and if they apply to us. We now have the Medicare Incentive-based Payment System to decipher.

In my last visit here with you all, we discussed our new acronyms MACRA and MIPS. As a refresher: The Medicare Access and CHIPS Reauthorization Act (MACRA) is the legislation passed by Congress in April 2015. MACRA created the Medicare Incentive-based Payment System. The question for today is, what do we do now?

To be clear: Medicare RHC payments are NOT affected by Medicare incentives/penalties. ALL current Medicare Incentive programs' payment adjustments are based on Medicare fee schedule payments for claims submitted on a 1500. Medicare negative adjustments are NOT applied to any payments for RHC claims submitted on a CMS-UB04. No RHC reimbursement is affected by Medicare Incentive penalties.

To be additionally clear: MACRA/MIPS payment adjustments ONLY apply to Medicare. Neither state Medicaid agencies nor commercial payers are applying comparable incentive adjustments to claims. This ONLY affects Medicare, non-RHC payments.

How will this affect us as RHCs? What should we do to prepare? First, you need to answer some basic questions about your own operation. How much does your Medicare non-RHC, CMS-1500 revenue stream represent to your practice? These would be for non-RHC services such as: lab testing, diagnostic testing technical components, in-patient hospital, outpatient hospital, and ER services.

According to Medicare: "You're a part of the Quality Payment Program in 2017 if you are in an Advanced APM or if you bill Medicare more than $30,000 a year and provide care for more than 100 Medicare patients a year. You must both meet the minimum billing and the number of patients to be in the program. If you are below either, you are not in the program." (Medicare Quality Payment Programs – qpp.cms.gov)

Many of our smaller RHCs will not meet this threshold. If your RHC no longer has a physician seeing hospital patients, or if you provide very limited lab and diagnostic testing services, your practice is assuredly below this threshold.

2017 Data = 2019 Payment Adjustments

MIPS payment adjustments will work in much the same manner as did PQRS payment adjustments. If you recall, 2016 PQRS payment adjustments were based on 2014 data. 2019 MIPS payment adjustments will be based on data submitted in 2017. 2017 is considered our base year. "The size of your payment will depend both on how much data you submit ***and your performance results***." (Medicare Quality Payment Programs – qpp.cms.gov)

The payment adjustments applied in 2019 will vary based on the amount of data submitted and the time frame over which that data was collected. Providers who choose not to participate, but have $30,000 or more in Medicare fee-for-service billing, will have a negative four percent (-4%) payment adjustment applied to 2019 payments. Providers who provide a minimum amount of data will have no, or neutral, payment adjustments. Providers who submit 90 days of data will have a positive payment adjustment. Providers who submit a full year of data will have a positive payment adjustment.

Additionally, providers who submit a full year of data AND participate in an Advanced ACO can earn an additional positive five percent (+5%). MIPS replaces the quality categories to which we have all become accustomed as well. (See Figure 1)

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Figure 1 – (From CMS Quality Payment Program)

 Quality	 Improvement Activities	 Advancing Care Information	 Cost
Replaces PQRS.	New Category.	Replaces the Medicare EHR Incentive Program also known as Meaningful Use.	Replaces the Value-Based Modifier.

The cost category will be calculated in 2017, but will not be used to determine your payment adjustment. In 2018, we will start using the cost category to determine your payment adjustment.

Quality Measures = 60%
Improvement Activities = 15%
Advancing Care Information = 25%

Required Measures

Category	Individual	Group	Note
Quality	**Most participants:** Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days.	Groups using the web interface: Report 15 quality measures for a full year.	APMs: Report quality measures through your APM. You do not need to do anything additional for MIPS quality.
Care Improvement	Attest that you completed up to 4 improvement activities for a minimum of 90 days.	Attest that you completed up to 2 activities for a minimum of 90 days (Groups <15; HPSA; Rural)	**Participants in certified patient-centered medical home**s: You will automatically earn full credit.
Advancing Care Information	90 days	90 Days	•Risk Analysis •e-Prescribing •Patient Portal •Tx Summary of Care •Request/Accept Summary of Care

What does this all mean for my RHC? We are advising our clients to be blind to the fact that RHC payments are exempt from MIPS. It is important for us to change the culture in our RHCs and embrace quality. We need to escape the mentality that "we are different than everybody else".

In my view, the point behind the recent RHC billing changes is to collect data for future implementation of quality payments in an RHC. (Just for the record, there has been no formal discussion of this – this is MY opinion). We are already starting to see some states (Nebraska!) requiring Patient-Centered Medical Home status for Medicaid HMO participation. That trend will accelerate.

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RHCs and MIPS continued…

Those of you that are beyond the $30,000 Medicare Payment threshold for participation will have no choice but to implement MIPS. Even the largest healthcare organizations are operating on razor-thin, single-digit profit margins. None of us are in a position to tolerate any negative adjustments.

The threshold for avoiding negative adjustments is not high. Clinicians can choose to report one measure in the quality performance category; one activity in the improvement activities performance category; or report the required measures of the advancing care information performance category and avoid a negative MIPS payment adjustment. Alternatively, if MIPS eligible clinicians choose to not report even one measure or activity, they will receive the full negative 4 percent adjustment.

Medicare has an excellent quality payment website (qpp.cms.gov). I encourage you all to study the measures in each of these categories. Choose the number of quality measures that at get you out of negative payment adjustments. Do not implement those measures you feel are easy. Choose measures with which your practice can perform better than your peers. It IS a competition. Your scores matter.

2017 is your base year of performance data. For better or worse, now is the time to be implementing your plan to avoid negative payment adjustments in 2019! March 31, 2018 is the deadline for submitting data. January 1, 2017 through December 31, 2017 is the first year for performance data. Good luck! I hope to see you all in San Antonio!

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