RHC Guide to the MACRA Final Rule

In case you missed it!

Q. Is it still true that Rural Health Clinics are not required to take part in the Medicare Quality Payment Program?

A. Rural Health Clinic payments are not affected by the new Medicare Quality Payment Program (MQPP) This program is - at this time - exclusive to the traditional fee-for-service (claims using the 1500 claim form) part of Medicare. RHCs are authorized to voluntarily report on the new MQPP but such reporting will have no impact on RHC payments. CMS has not issued any guidance on how an RHC - wishing to voluntarily report - will do that.

Q: Will my RHC All-Inclusive Rate be affected by MACRA?

A: No. The final rule states that "because professional services furnished by eligible clinicians at RHCs and FQHCs are not reimbursed under the Medicare PFS (Physician Fee Schedule), professional services furnished in these settings do not constitute "covered professional services." Any reimbursement for RHC UB-04 claims will be unaffected by this final rule.

However, non-RHC claims, or in other words, items billed on a 1500-form may be affected (see below).

Q: Will non-RHC services (billed on a 1500 to a part-B MAC) be affected by MACRA?

A: Potentially. Many RHCs will fall under a low-volume threshold (see below), which will exempt these claims from MACRA. Those clinicians that are a part of a group that is choosing to participate in MIPS as a group will see their non-RHC services affected by their groups CPS score.

Q: What is the low-volume threshold?

A: CMS has finalized the low-volume threshold as eligible clinicians or groups who, "during the low-volume threshold period, has billed Medicare Part B allowed charges less than or equal to $30,000 or provides care for 100 or fewer Part B-enrolled Medicare beneficiaries."

Q: How will Medicare know who provides care for fewer than 100 Part B-enrolled Medicare beneficiaries?

A: CMs will use social security numbers reported on 1500 claims to determine this part of the exclusion. For example, if an eligible clinician provides more than one non-RHC service billed on multiple claims to the same patient, it would still only count as 1 Part B-enrolled Medicare beneficiary for purposes of the low-volume threshold.

Q: What is the low-volume threshold determination period for the first year of MIPS?

A: For purposes of the 2019 MIPS payment adjustment, CMS will identify those individual eligible clinicians and groups that fall under the low-volume threshold based on 12 months of data from September 1, 2015 through August 31, 2016. CMS will conduct a second calculation based on claims from September 1, 2016 through August 31, 2017 to determine additional eligible clinicians and groups how may qualify for low-volume status.

If an individual eligible clinician or group is identified as not exceeding the low-volume threshold in either determination period, they will not be able to participate in MIPS.

Continued on the next page…

Q: How will RHC eligible clinicians know if they qualify for the law-volume exclusion?

A: CMS says that setting up the low-volume threshold determination period in such a way will allow them to inform eligible clinicians and groups of their low-volume status during the month of December after the low-volume determination period. CMS did not specify how this notification would occur.

Q: How is CMS identifying individuals versus groups for the purposes of the low-volume exclusion?

A: For individuals, the low volume threshold exclusion is determined by the Tax ID Number (TIN)/National Provider Identifier (NPI) combination. For groups, low volume exclusions are determined by simply the TIN. Individual eligible clinicians that are part of a group that chooses to report as a group, will be required to participate in MIPS if the entire group qualifies.

For example, if 5 RHC eligible clinician are a part of the same group (TIN) and each eligible clinician bills $10,000 of allowable Medicare Part B charges. Then that group has the option to report as a group and be subject to MIPS as a group (meaning they all get one CPS score) or to report as individual eligible clinicians and take the low-volume exclusion.

Q: If an eligible clinician qualifies for the low-volume exclusion, can they chose to opt-in to MIPS anyways and receive an adjustment?

A: No. eligible clinicians or groups that qualify for the low-volume exclusion cannot participate in MIPS.

Q: Can Rural Health Clinics voluntarily report MIPS data?

A: Yes RHCs may voluntarily report MIPS data and receive a MIPS CPS scores on their UB-04 claims. However, any MIPS data reported on RHC services would not be used for the purposes of the MIPS payment adjustment on non-RHC claims.

Q: I am an RHC participating in an Advanced APM entity what do I need to know?

A: Professional services furnished at RHCs and FQHCs that participate in ACOs, and are reimbursed under the RHC AIR or FQHC PPS (respectively), may be counted towards the QP determination calculations under the patient count method but not under the payment amount method.

CMS will include payments for Method II CAH professional services furnished by eligible clinicians in an Advanced APM Entity in the numerator of the Threshold Score for the payment amount method. We will also count a beneficiary in the numerator of the Threshold Score for the patient count method if the beneficiary receives Method II CAH professional services furnished by eligible clinicians in an Advanced APM Entity and professional services furnished by eligible clinicians in an Advanced APM Entity at RHCs and FQHCs.

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