MACRA, MIPS, and RHCs

RHCs and Quality Payment Programs – Beyond 2017

Many of us are concerned about how and whether the new quality payment requirements affect RHCs. Medicare Access and CHIP Reauthorization Act was passed during the previous presidential administration. MACRA authorized new quality payment mechanisms to replace the Medicare Physician Fee Schedule. The Merit-based Incentive Payment System (MIPS) and Alternate Payment Mechanisms (APM) are the two main tracks that providers will be able to choose. All of you have spent significant time in webinars and teleconferences educating yourselves on these topics.

To reiterate: Medicare RHC payments are not subject to MACRA incentives or penalties. These incentives/penalties are applied to Medicare Physician Fee Schedule payments based on allowed charge amounts. Our RHC claims are NOT paid on the Medicare Physician Fee Schedule.

CMS has issued a proposed rule for MACRA in 2018. The comment period extends until August 21, 2017. Medicare incentive payments under MACRA/MIPS/APMs are all based on Medicare Physician Fee Schedule payments. In 2017, only providers submitting more than $30,000 annually in Medicare Physician Fee Schedule allowed charges or less than or equal to 100 Medicare beneficiaries are eligible for MIPS incentives/penalties. (not Total Charges – Allowed Medicare Charges!) The 2018 MACRA Proposed Rule increases this low volume threshold to:

> "…to less than or equal to $90,000 in Medicare Part B allowed charges or less than or equal to 200 Medicare Part B patients." (2018 MACRA Proposed Rule).

The increase in the low volume threshold effectively renders the whole MACRA/MIPS/APMs moot for RHC purposes…doesn't it? Yes, it does for Medicare right now. But what about the rest of our practice?

First, it seems a safe assumption that transitioning RHC billing to include qualifying visits, CG-modifiers, and reporting service detail is preparation for future RHC participation in Medicare quality payment programs.

Second, many commercial payers are starting to implement their own quality payment incentive programs. Pennsylvania has major commercial payers implementing quality payment programs. Finally, Medicaid plans are beginning this transition. Nebraska requires participation in Patient-Centered Medical Home ***as a prerequisite*** for participation in Medicaid managed care plans for RHCs.

Information is rapidly becoming an important currency for healthcare providers and organizations. Quality payments will soon extend beyond Medicare. To once more quote my friend and deceased colleague Lt. Col. Tom Warner (Ret.): "Proper preparation prevents poor performance". We should all be preparing our organizations culturally, technologically, and operationally to participate in quality payment programs beyond Medicare.

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