MACRA, MIPS, and RHCs
Payment for Quality

It is no news to any of us that the healthcare industry of the past several years has been filled with rapid change. These changes always represent a new menu of acronyms for us to learn, such as UPIN, BBA, NPI, and HIPAA. More recently, these have been PQRS, ICD-10, and QVLs among many others. The operative acronyms this year are MACRA, MIPS, and APMs.

Amidst all of the political noise which has been increasing in volume over the past 18 months, real change was affected by the President & Congress in passage of the Medicare Access & CHIP Reauthorization Act. According to the CMS website:

"The MACRA makes 3 important changes to how Medicare pays those who give care to Medicare beneficiaries. These changes create a Quality Payment Program (QPP):

- Ending Sustainable Growth Rate (SGR) formula for determining Medicare payments for health care providers' services.
- Making a new framework for rewarding health care providers for giving better care not just more care.
- Combining our existing quality reporting programs into one new system.

These proposed changes replace a patchwork system of Medicare reporting programs with a flexible system that allows you to choose from two paths that link quality to payments: the ***Merit-Based Incentive Payment System (MIPS)*** and ***Advanced Alternative Payment Models (APMs)***." (CMS MACRA Website)

The "Sustained Growth Rate" was the law requiring the Medicare Physician Fee Schedule to be reduced by a certain percentage each year. The purpose was to constrain the growth of costs to the program. This created the untenable requirement to have Congress intervene each year to protect draconian cuts to provider payments.

MACRA replaces this mechanism. The Medicare fee schedule will be updated annually by .5% each year through 2019. After 2019, negative and positive payment adjustments will be applied to providers based on compliance in four areas: Quality, Resource Use, Clinical Practice Improvement, and Meaningful Use.

Rural Health Clinics' Medicare payments (via UB04) are exempt from these payment adjustments – for now. All of these changes apply ONLY to providers paid on the Medicare Physician Fee Schedule. These changes do not currently affect RHC payments.

Non-RHC revenue is already subject to these penalties. Many of you have negative payment adjustments based on 2014/2015 PQRS reporting. CMS-1500 revenue streams remain exposed to these payment adjustments under MIPS. Payments for professional services rendered in the hospital, diagnostic testing, laboratory services, and any other non-Rural Health Clinic services billed fee-for-service on a CMS-1500 will continue to be affected by MIPS. That effect will grow under MIPS/APMs.

One of the main reasons that CMS converted Rural Health Clinics to line item billing is in preparation for quality reporting. All of us should be preparing to live in a quality-reporting world. It will come to our RHC revenue stream. When & how, we ask. The question is no longer "if". (The author reiterates that, to date, Part A RHC revenue is unaffected.)

The question becomes how do we RHCs prepare for this new world? How can we report quality data? The author's suggestion is to start familiarizing yourselves with quality measures. Perhaps low-volume reporting is an option for your clinic. Why not choose which measures are appropriate for your operation and start capturing the data to make sure your software is configured appropriately. Participation with alternate payment mechanisms such as PCMH and ACOs should be investigated. To paraphrase my friend and departed colleague Lt. Col Tom Warner, "Proper preparation prevents poor performance!" I suggest getting started now!

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