RHC Guide to the MACRA Final Rule

We understand that there are a lot of questions and interest around MACRA (Medicare Access and CHIP Reauthorization Act) especially around the specifics of how it does and does not affect RHCs. We have put together the following Q&A to address many of the relevant aspects of the final rule for RHCs.

It is important that we make a distinction at the outset between RHC claims – those submitted for RHC services using a UB-04 claim form and traditional Medicare Part B claims submitted by Physicians, PAs and NPs using an individual or group NPI using a 1500 claim form.

Q: Will my RHC All-Inclusive Rate be affected by the new Medicare Incentive Payment system (MIPS)?

A: No. The final rule states that because RHC services furnished by eligible clinicians (Physician, PAs and NPs) are not reimbursed under the Medicare PFS (Physician Fee Schedule), RHC services are not covered by the MIPS program. Reimbursement for RHC UB-04 claims will be unaffected by this new program. The RHC Cap will continue to adjust each year to reflect medical inflation and productivity improvements.

However, non-RHC claims submitted by RHC Physicians, PAs and NPs to Medicare Part B (i.e. items billed on a 1500-form) may be affected (see below).

Q: Will non-RHC services (billed on a 1500) using the individual/group NPI be affected by MACRA?

A: Potentially. We believe MOST RHC physicians, PAs and NPs will fall under a low-volume exemption threshold (see below), which will exempt these clinicians and their 1500 claims from MIPS reporting and payment adjustments.

Q: What is the low-volume threshold?

A: CMS has determined that Physicians, PAs and NPs who do not submit sufficient Medicare Physician Fee Schedule (1500) claims will be exempt from the MIPS program. These are classified as "low-volume" providers. A low-volume provider is defined as a Physician, PA or NP who, during the low-volume threshold period,

1. has billed Medicare Part B allowed charges of $30,000 or less during the billing cycle; **OR**
2. provided care to 100 or fewer Medicare Part B-enrolled beneficiaries during the billing cycle.

RHC claims are NOT counted when determining whether or not a clinician meets the threshold.

Q. What billing cycle will CMS use to do the claim or patient count?

CMS will review Physician, PA and NP Medicare Physician Fee Schedule billing for the 24 months preceding the reporting year broken into two, separate 12 month calculations or "billing years". These will not be calendar years but rather so-called "billing year". For 2017 (2019 payment adjustment year), the "billing year" reviewed by Medicare will be claims submitted between September 1, 2015 through August 31, 2016. CMS will conduct a second "billing year" calculation based on claims submitted between September 1, 2016 through August 31, 2017 to determine additional eligible clinicians and groups.

If the individual Physician, PA or NP claim submissions are $30,000 or less during EITHER of these billing years, the clinician will be considered exempt from MIPS for the associated Payment Adjustment Year. Each year after 2017, CMS will conduct a similar review with the older year dropping from the calculation and the most recent September – August "billing year" being added to the calculation. Again, as long as the Physician, PA or NP meet the low volume criteria during either of the two years, the clinician would be deemed MIPS exempt.

CMS will also use this same 24 month review method to do the patient count.

Q: How will Medicare know if an individual clinician provides care to 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. This is a count of patients, not claims. For example, if an eligible clinician provides multiple services to one RHC beneficiary over the course of the "billing year", this only counts as one Medicare enrolled beneficiary for purposes of the low-volume threshold.

Q: Will Clinicians have to apply for the low-volume exemption?

A: No. CMS says it set up the low-volume threshold determination period in such a way that will allow CMS to notify Physicians, PAs and NPs who qualify for the exemption during the month of December preceding the quality reporting year. CMS has not specified how notification will occur. We expect that CMS will issue guidance on this within the next few weeks.

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 five RHC eligible clinicians 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 group quality score) or to report as individual eligible clinicians and take the low-volume exemption.

In this example, if they report as a group with total Medicare allowable charges of $50,000, then their Part B claims are going to be required to report MIPS quality data to CMS and have their Part B (1500) claims subject to MIPS adjustments (positive or negative). However, if the clinicians report individually, $10,000 per, then all five would be exempt from quality reporting and exempt from MIPS adjustments (positive or negative) on their Medicare Part B claims.

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

A: No. Once it has been determined that for the reporting year a clinician or group is deemed "low-volume", the clinician or group is ineligible to participate in MIPS for that reporting year.

Q: Can Rural Health Clinics voluntarily report MIPS data?

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

At some point Congress may propose to extend the MIPS program to RHCs and it would be helpful to know how RHCs would fair under the MIPS data reporting requirements.