Overview of MIPS for Small, Rural, and Underserved Practices

Listening Session for Virtual Groups

Session #173, February 22, 2017

Jean Moody-Williams, Deputy Director of the Center for Clinical Standards and Quality, The Centers for Medicare & Medicaid Services
Conflict of Interest

Jean Moody-Williams, RN, MPP

Has no real or apparent conflicts of interest to report.
Learning Objectives

• Discuss how small, rural, and underserved practices can participate in the Merit-based Incentive Payment System (MIPS) and Alternative Payment paths of the Quality Payment Program
• Restate who is eligible to participate in the program
• Describe the data submission methods
• Recognize the requirements for 2017 and explore virtual groups
<table>
<thead>
<tr>
<th>Practice size category</th>
<th>Number of MIPS eligible TIN/NPIs</th>
<th>Percent of all MIPS eligible TIN/NPIs</th>
<th>TIN/NPIs excluded by reason</th>
<th>Total Exclusions</th>
<th>Total Inclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Newly Enrolled**</td>
<td>Qualifying APM Participants (QPs)**</td>
<td>Low-volume****</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Number</td>
<td>Number</td>
<td>Number</td>
</tr>
<tr>
<td>OVERALL NUMBER OF MIPS ELIGIBLE CLINICIAN TYPES</td>
<td>1,062,550-1,121,892</td>
<td></td>
<td>1,180,032</td>
<td>1,180,032</td>
<td>1,180,032</td>
</tr>
<tr>
<td>ALL PRACTICE SIZES (SCORING MODEL)</td>
<td></td>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>1-9 clinicians</td>
<td>331,546</td>
<td>28.1%</td>
<td>17,930</td>
<td>5.4%</td>
<td>2,336</td>
</tr>
<tr>
<td>10-24 clinicians</td>
<td>134,653</td>
<td>11.4%</td>
<td>9,683</td>
<td>7.2%</td>
<td>889</td>
</tr>
<tr>
<td>25-99 clinicians</td>
<td>253,921</td>
<td>21.5%</td>
<td>18,456</td>
<td>7.3%</td>
<td>1,637</td>
</tr>
<tr>
<td>100 or more clinicians</td>
<td>459,912</td>
<td>39.0%</td>
<td>39,415</td>
<td>8.6%</td>
<td>7,902</td>
</tr>
</tbody>
</table>
TABLE 62: MIPS ESTIMATED PAYMENT YEAR 2019 IMPACT ON TOTAL ALLOWED CHARGES BY PRACTICE SIZE, STANDARD PARTICIPATION ASSUMPTIONS

<table>
<thead>
<tr>
<th>ALL MIPS ELIGIBLE CLINICIANS SUBJECT TO DATA SUBMISSION REQUIREMENTS</th>
<th>592,119-642,119</th>
<th>$76,598-$81,380</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Practice Sizes (Scoring Model)</td>
<td>676,722</td>
<td>$78,454</td>
</tr>
<tr>
<td>1-9 clinicians</td>
<td>147,739</td>
<td>$30,426</td>
</tr>
<tr>
<td>10-24 clinicians</td>
<td>63,829</td>
<td>$10,870</td>
</tr>
<tr>
<td>25-99 clinicians</td>
<td>132,406</td>
<td>$13,942</td>
</tr>
<tr>
<td>100 or more clinicians</td>
<td>332,748</td>
<td>$23,216</td>
</tr>
</tbody>
</table>

94.7% 94.7% 5.3% $199 $500 $699 -$199 $500 0.6%
90.0% 10.0% $72 $173 $244 -$99 $145 0.5%
90.0% 10.0% $24 $55 $80 -$37 $42 0.4%
92.6% 7.4% $31 $70 $101 -$47 $54 0.4%
98.5% 1.5% $72 $202 $274 -$16 $258 1.1%
QPP Strategic Goals

1. **Improve Beneficiary Outcomes** and engage patients through patient-centered Advanced APM and Merit-based Incentive Payment System (MIPS) policies.

2. **Enhance clinician experience** through flexible and transparent program design and interactions with easy-to-use program tool.

3. **Increase the availability and adoption of Advanced Alternative Payment Models**.

4. **Promote program understanding and maximize participation** through customized communication, education, outreach, and support that meet the needs of the diversity of clinician practices and patients, especially the unique needs of small practices.

5. **Improve data, information sharing capabilities** to provide accurate, timely, and actionable feedback to clinicians and other stakeholders.

6. **Deliver IT systems capabilities that meet the needs of users** and are seamless, efficient and valuable on the front and back-end.

7. **Ensure operational excellence in program implementation** and ongoing development.
Easier Access for Small Practices

Small practices will be able to successfully participate in the Quality Payment Program

Why?

• Reducing the time and cost to participate
• Providing an on-ramp to participating through Pick Your Pace
• Increasing the opportunities to participate in Advanced APMs
• Including a practice-based option for participation in Advanced APMs as an alternative to total cost-based
• Conducting technical support and outreach to small practices through the forthcoming QPP Small, Rural and Underserved Support (QPP-SURS) as well as through the Transforming Clinical Practice Initiative.
Discussion Structure

Clinicians have two tracks from which to choose:

**MIPS**

The Merit-based Incentive Payment System (MIPS)

*If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.*

**Advanced APMs**

Advanced Alternative Payment Models (APMs)

*If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.*
When Does the Merit-based Incentive Payment System Officially Begin?

### Performance Year
- **2017 Performance Year**
  - Performance period opens January 1, 2017.
  - Clinicians care for patients and record data during the year.

### Deadlines
- **March 31, 2018 Data Submission**
  - Deadline for submitting data is March 31, 2018.
  - Clinicians are encouraged to submit data early.

### Feedback
- **Feedback**
  - CMS provides performance feedback after the data is submitted.
  - Clinicians will receive feedback before the start of the payment year.

### Payment Adjustment
- **January 1, 2019 Payment Adjustment**
  - MIPS payment adjustments are prospectively applied to each claim begin January 1, 2019.
Eligible Clinicians:

Clinicians billing more than $30,000 a year in Medicare Part B allowed charges **AND** providing care for more than 100 Medicare patients a year.

These clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetists
Who is Exempt from MIPS?

Clinicians who are:

- Newly-enrolled in Medicare
  - Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

- Below the low-volume threshold
  - Medicare Part B allowed charges less than or equal to $30,000 a year
  - OR
  - See 100 or fewer Medicare Part B patients a year

- Significantly participating in Advanced APMs
  - Receive 25% of their Medicare payments
  - OR
  - See 20% of their Medicare patients through an Advanced APM
If You Are Exempt

• You may choose to voluntarily submit quality data to CMS to prepare for future participation, but you will not qualify for a payment adjustment based on your 2017 performance.

• This will help you hit the ground running when you are eligible for payment adjustments in future years.
Eligibility for Clinicians in Specific Facilities

- Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC)
  - Eligible clinicians billing under the RHC or FQHC payment methodologies are not subject to the MIPS payment adjustment.

  *However...*

  - Eligible clinicians in a RHC or FQHC billing under the Physician Fee Schedule (PFS) are required to participate in MIPS and are subject to a payment adjustment.
Eligibility for Clinicians in Specific Facilities

- Critical Access Hospitals (CAH)

1. For eligible clinicians practicing in Method I:
   - MIPS payment adjustment would apply to payments made for items and services that are Medicare Part B charges billed by the MIPS eligible clinicians.
   - Payment adjustment would not apply to the facility payment to the CAH itself.

2. For eligible clinicians practicing in Method II (who assigned their billing rights to the CAH):
   - MIPS payment adjustment would apply to the Method II CAH payments

3. For eligible clinicians practicing in Method II (who have not assigned their billing rights to the CAH):
   - MIPS payment adjustment would apply similar to Method I CAHs.
Eligibility for Non-Patient Facing Clinicians

- Non-patient facing clinicians are eligible to participate in MIPS as long as they exceed the low-volume threshold, are not newly enrolled, and are not a Qualifying APM Participant (QP) or Partial QP that elects not to report data to MIPS

- The non-patient facing MIPS-eligible clinician threshold for individual MIPS-eligible clinicians is $\leq 100$ patient facing encounters in a designated period

- A group is non-patient facing if $> 75\%$ of NPIs billing under the group’s TIN during a performance period are labeled as non-patient facing

- There are more flexible reporting requirements for non-patient facing clinicians
MIPS for First-Time Reporters

You Have Asked: “What if I do not have any previous reporting experience?”

CMS has provided options that may reduce participation burden to first time reporters by:

- Adjusting the low-volume threshold to exclude more individual clinicians and groups
- Allowing clinicians to pick their pace of participation for Transition Year 2017 by lowering the performance threshold to avoid a negative adjustment
Merit-based Incentive Payment System

Performance Categories

- Quality
- Cost
- Improvement Activities
- Advancing Care Information

- Comprised of four performance categories
- Provides clinicians with flexibility to choose the activities and measures that are most meaningful to their practice

Consideration: may report as an individual or group
MIPS: Choosing to Test for 2017

- Submit minimum amount of 2017 data to Medicare
- Avoid a downward adjustment
- Gain familiarity with the program

Minimum Amount of Data

1 Quality Measure

OR

1 Improvement Activity

OR

4 or 5* Required Advancing Care Information Measures
MIPS: Partial Participation for 2017

- Submit 90 days of 2017 data to Medicare
- May earn a positive payment adjustment

“So what?” - If you’re not ready on January 1, you can start anytime between January 1 and October 2

JAN 1

Need to send performance data by March 31, 2018

Oct 2
MIPS: Full Participation for 2017

- Submit a full year of 2017 data to Medicare
- May earn a positive payment adjustment
- Best way to earn largest payment adjustment is to submit data on all MIPS performance categories

Key Takeaway:
Positive adjustments are based on the performance data on the performance information submitted, not the amount of information or length of time submitted.
Bonus Payments and Reporting Periods

MIPS payment adjustment is based on data submitted. Clinicians should pick what's best for their practice.

Submit a Full Year

Full year participation

- Is the best way to get the max adjustment
- Gives you the most measures to choose from
- Prepares you the most for the future of the program

Submit a Partial Year

Partial participation (report for 90 days)

- You can still earn the max adjustment
## Submission Methods

### Individual
- Qualified Clinical Data Registry (QCDR)
- Qualified Registry
- EHR
- Claims

### Group
- QCDR
- Qualified Registry
- EHR
- Administrative Claims
- CMS Web Interface
- CAHPS for MIPS Survey

### Quality
- QCDR
- Qualified Registry
- EHR
- Attestation

### Improvement Activities

### Advancing Care Information
- QCDR
- Qualified Registry
- EHR
- Attestation

*Must be reported via a CMS approved survey vendor together with another submission method for all other Quality measures.*
MIPS Performance Category: Quality

- 60% of Final Score in 2017
- 270+ measures available
  - You select 6 individual measures
    - 1 must be an Outcome measure
      - OR
    - High-priority measure
      - Defined as outcome measures, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination.
  - You may also select specialty-specific set of measures

- Keep in mind:
  - Replaces PQRS and Quality portion of the Value Modifier
  - Provides for an easier transition for those who have reporting experience due to familiarity
Quality: Requirements for the Transition Year

- **Test means:**
  - Submitting 1 Quality measure

- **Partial and Full means:**
  - Submitting at least 6 quality measures, including 1 Outcome or 1 High-Priority measure
    - 90 days for Partial Year
    - 1 year for Full Year

*For a full list of measures, please visit QPP.CMS.GOV*
MIPS Performance Category: Cost

- No reporting requirement; 0% of Final Score in 2017
- Clinicians assessed on Medicare claims data
- CMS will still provide feedback on how you performed in this category in 2017, but it will not affect your 2019 payments.

*Keep in mind:*

Uses measures previously used in the Physician Value-Based Modifier program or reported in the Quality and Resource Use Report (QRUR)

Only the scoring is different
MIPS Performance Category: Improvement Activities

- **15%** of Final Score in 2017
- Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access
- **Clinicians choose** from 90+ activities under 9 subcategories:
  
  1. Expanded Practice Access
  2. Population Management
  3. Care Coordination
  4. Beneficiary Engagement
  5. Patient Safety and Practice Assessment
  6. Participation in an APM
  7. Achieving Health Equity
  8. Integrating Behavioral and Mental Health
  9. Emergency Preparedness and Response
MIPS Performance Category: Improvement Activities

- **Special consideration for:**

  - **Groups with 15 or fewer participants, non-patient facing clinicians, or if you are in a rural or health professional shortage area:** Attest that you completed up to 2 activities for a minimum of 90 days.

  - **Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model:** You will automatically earn full credit.

  - **Participants in certain APMs, such as Shared Savings Program Track 1 or the Oncology Care Model:** You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.
Improvement Activity: Requirements for the Transition Year

Test means:

- Attesting to 1 Improvement Activity
  - Activity can be high or medium weight
  - In most cases, to attest you need to indicate that you have done the activity for 90 days.

Partial and Full means:

- Attesting to 1 of the following combinations:
  - 2 high-weighted activities
  - 1 high-weighted activity and 2 medium-weighted activities
  - At least 4 medium-weighted activities

- Clinicians with special considerations:
  - 1 high-weighted activity
  - 2 medium-weighted activities

For a full list of activities, please visit QPP.CMS.GOV
MIPS Performance Category: Advancing Care Information

- 25% of Final Score in 2017
- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Ends and replaces the Medicare EHR Incentive Program (also known as Medicare Meaningful Use)
- Greater flexibility in choosing measures
- In 2017, there are 2 measure sets for reporting to choose from based on EHR edition:
  - Advancing Care Information Objectives and Measures
  - 2017 Advancing Care Information Transition Objectives and Measures
MIPS Performance Category: Advancing Care Information

- Clinicians must use certified EHR technology to report

<table>
<thead>
<tr>
<th>For those using EHR Certified to the 2015 Edition:</th>
<th>For those using 2014 Certified EHR Technology:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Option 1</strong></td>
<td><strong>Option 1</strong></td>
</tr>
<tr>
<td>Advancing Care Information Objectives and Measures</td>
<td>2017 Advancing Care Information Transition Objectives and Measures</td>
</tr>
</tbody>
</table>
Advancing Care Information: Requirements for the Transition Year

Test means:
- Submitting 4 or 5 base score measures
  - Depends on use of 2014 or 2015 Edition
- Reporting all required measures in the base score to earn any credit in the Advancing Care Information performance category

Partial and Full means:
- Submitting more than the base score in the Transition Year

For a full list of measures, please visit QPP.CMS.GOV
Advancing Care Information: Flexibility

1. CMS will automatically reweight the Advancing Care Information performance category to zero for Hospital-based MIPS clinicians, clinicians who lack of Face-to-Face Patient Interaction, NP, PA, CRNAs and CNS
   • Reporting is optional although if clinicians choose to report, they will be scored.

2. A clinician can apply to have their performance category score weighted to zero and the 25% will be assigned to the Quality category for the following reasons:
   1. Insufficient internet connectivity
   2. Extreme and uncontrollable circumstances
   3. Lack of control over the availability of CEHRT
Calculating the Final Score Under MIPS

Final Score =

Clinician Quality performance category score × actual Quality performance category weight

Clinician Cost performance category score × actual Cost performance category weight

Clinician Improvement Activities performance category score × actual Improvement Activities performance category weight

Clinician Advancing Care Information performance category score × actual Advancing Care Information performance category weight

60 + 0 + 15 + 25 × 100
## Transition Year 2017

<table>
<thead>
<tr>
<th>Final Score</th>
<th>Payment Adjustment</th>
</tr>
</thead>
</table>
| ≥70 points  | • Positive adjustment  
             • Eligible for exceptional performance bonus—minimum of additional 0.5% |
| 4–69 points | • Positive adjustment  
             • Not eligible for exceptional performance bonus |
| 3 points    | • Neutral payment adjustment |
| 0 points    | • Negative payment adjustment of -4%  
             • 0 points = does not participate |
Small and Rural Providers Participating in MIPS: A Checklist

- Determine your eligibility and understand the requirements.
- Choose whether you want to submit data as an individual or as a part of a group.
- Choose your submission method and verify its capabilities.
- Verify your EHR vendor or registry’s capabilities before your chosen reporting period.
- Prepare to participate by reviewing practice readiness, ability to report, and the Pick Your Pace options.
- Choose your measures. Visit qpp.cms.gov for valuable resources on measure selection and remember to review your current billing codes and Quality Resource Use Report to help identify measures that best suit your practice.
- Verify the information you need to report successfully.
- Care for your patients and record the data.
- Submit your data by March 2018.
Alternative Payment Models

• An Alternative Payment Model (APM) is a payment approach, developed in partnership with the clinician community, that provides added incentives to clinicians to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

• APMs may offer significant opportunities to eligible clinicians who are not immediately able or prepared to take on the additional risk and requirements of Advanced APMs.
Advanced APMs Must Meet Certain Criteria

To be an Advanced APM, the following three requirements must be met.

The APM:

1. Requires participants to use certified EHR technology;

2. Provides payment for covered professional services based on quality measures comparable to those used in the MIPS quality performance category; and

3. Either: (1) is a Medical Home Model expanded under CMS Innovation Center authority OR (2) requires participants to bear a more than nominal amount of financial risk.
Small/Rural Practices and Advanced APMs

• Qualifying APM Participant (QP)
  – Earn a 5% incentive payment.
  – 25% of your payments OR 20% of your Medicare Part B patients must be through an Advanced APM.

• Services at FQHCs, RHCs, and CAHs, may be counted toward the Qualifying APM Participant determination
  – For FQHCs and RHCs:
    • QP status will be determined through the patient count method.
  – For CAHs:
    • QP Status will be determined through the payment amount and patient count methods.
Advanced APMs for 2017

- Comprehensive Care for Joint Replacement (CJR) Model – Track 1
- Comprehensive End-Stage Renal Disease Care Model (Two-Sided Risk Arrangements)
- Comprehensive Primary Care Plus (CPC+)
- Shared Savings Program – Track 2
- Shared Savings Program – Track 3
- Next Generation ACO Model
- Oncology Care Model (Two-Sided Risk Arrangement)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
Spotlight Advanced APMs considering Small, Underserved and Rural Clinicians

Next Generation ACO Model
Benefits for rural practices:
• Waivers to expand telehealth and post discharge home visits.
• Waive three-day SNF admission rule.

The application period for 2018 participation is ongoing and will run until May 4, 2017.

Comprehensive Primary Care Plus (CPC+)
Benefits for small and rural practices:
• Two tracks to accommodate diversity of practices.
• Opportunity for new practices to participate in 2018.
• 54 public and private payers in CPC+ regions.
• Performance-based incentive payments.
Spotlight Advanced APMs considering Small, Underserved and Rural Clinicians

Medicare ACO Track 1+ Model

Benefits for small and rural practices:

• Designed to help practices move to performance-based risk.
• Expands participation for small rural hospitals.
• ACOs with small rural hospitals may qualify for lower levels of downside risk.

The application period for this model aligns with the annual application cycle timing for the Shared Savings Program. Additional information is forthcoming.
Future Advanced APM Opportunities

- MACRA established the **Physician-Focused Payment Model Technical Advisory Committee (PTAC)** to review and assess Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee.

Technical Assistance for Clinicians

**PRIMARY CARE & SPECIALIST PHYSICIANS**
Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- *Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)* are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPIISC@TruvenHealth.com for extra assistance.

*Locate the PTN(s) and SAN(s) in your state*

**SMALL & SOLO PRACTICES**
Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in *solo or small practices (15 or fewer)*, particularly those in *rural and underserved areas*, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - Organizations selected to provide this technical assistance will be available in early 2017.

**LARGE PRACTICES**
Quality Innovation Networks-Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in *large practices (more than 15 clinicians)* in meeting Merit-Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

*Locate the QIN-QIO that serves your state*

**TECHNICAL SUPPORT**
All Eligible Clinicians Are Supported By:

- **Quality Payment Program Website:** qpp.cms.gov
  Serves as a starting point for information on the Quality Payment Program.

- **Quality Payment Program Service Center**
  Assists with all Quality Payment Program questions.
  1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

- **Center for Medicare & Medicaid Innovation (CMMI) Learning Systems**
  Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs.
Transforming Clinical Practice Initiative (TCPI) for rural and underserved locations

TCPI is designed to support more than **140,000 clinical practices** achieve large-scale transformation by sharing, adapting and further developing their comprehensive quality improvement strategies.

Funding for practice transformation networks (PTNs) is contingent upon **minimum 20%** of clinicians served are from rural or underserved locations.

Several PTNs have committed **greater than 50%** of clinicians who participate stem from rural areas, including:

- Rural health clinics
- Rural community health centers
- Health profession shortage areas
- Supporting medically underserved populations
Small, Underserved, and Rural Support

• Five-year technical assistance program authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

• Designed for practices with **15 or fewer eligible clinicians**.
  – Includes small practices in: rural locations, health professional shortage areas (HPSAs), and medically underserved areas (MUAs).

• Goal is to provide on-the-ground support to eligible clinicians by:
  – Assisting in the selection and reporting of appropriate Merit-based Incentive Payment System (MIPS) Quality measures and Improvement Activities;
  – Optimizing their Health Information Technology (HIT);
  – Supporting change management and strategic planning; and
  – Evaluate their options for joining an Advanced Alternative Payment Model (APM).

• Support is available immediately and is **FREE** to clinicians in small practices.
Small, Underserved, and Rural Support

• Adds an additional layer to the multi-level outreach effort to help eligible clinicians understand, prepare for, and participate in the Quality Payment Program.

• Integrated Technical Assistance now includes:
  – Quality Innovation Networks – Quality Improvement Organizations (QIN-QIOs)
  – Small, Underserved, and Rural Support (SURS)
  – Transforming Clinical Practice Initiative (TCPI)
  – APM Learning Networks
  – Quality Payment Program: qpp.cms.gov; email: qpp@cms.hhs.gov; or dial 1-866-288-8292 (Monday-Friday 8AM-8PM ET). TTY users can call 1-877-715-6222.

• Shared goal of ensuring 100% of eligible clinicians have access to technical assistance.
National Coverage of Technical Assistance for Small, Underserved and Rural Clinicians

11 uniquely experienced organizations to provide national coverage to eligible clinicians in small practices.
Summary of Small, Rural and Health Professional Shortage Areas (HPSAs) Considerations

• Established low-volume threshold
  – Less than or equal to $30,000 in Medicare Part B allowed charges or less than or equal to 100 Medicare patients

• Reduced requirements for Improvement Activities performance category
  – One high-weighted activity or
  – Two medium-weighted activities

• Increased ability for clinicians practicing at Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) to qualify as a Qualifying APM Participant (QP).

• Enhanced Technical Assistance

• Advanced APM opportunities

• Exploring Virtual Groups
Virtual Groups

- Virtual Groups will be comprised of solo practitioners and small practices that join together to report on MIPS requirements as a collective entity.
- A Virtual Group is an participation option in MIPS that will be available starting in 2018.
- A Virtual Group is not a data submission mechanism.
Virtual Group Statutory Provisions

• Virtual Groups will be scored on combined performance (for quality and cost).

• Election:
  – Individual eligible clinicians and small group practices (10 or less eligible clinicians reassigning to the same TIN) may join Virtual Groups.
  – A Virtual Group may be based on “appropriate classifications” such as geography or specialty.
Virtual Group Statutory Provisions Cont.

• Requirements:
  – Eligible clinicians and groups must elect to participate prior to the performance year and may be not be changed during the performance period.
  – If a group practice elects to join a Virtual Group, all group practice members must be included in the Virtual Group. A group can only be in ONE virtual group.
  – A Virtual Group must be comprised of a combination of TINs.
  – CMS must provide for formal written agreements between clinicians entering into a Virtual Group.
  – Other requirements as the Secretary determines appropriate.
Rulemaking Process

• Currently, we are in the rulemaking process and not able to comment on or address questions relating to policies that are being developed.

• However, as we develop policies pertaining to virtual groups, your feedback and recommendations are critical to the rulemaking process.
Rulemaking Process Cont.

• We are in the process of reviewing comments that were submitted in response to Quality Payment Program final rule. We sought comment on the following:
  – Establishing minimum standards for members of virtual groups;
  – How virtual groups could use their data for analytics;
  – Requirements that could facilitate use of virtual groups to enhance health outcomes and goals such as coordination of care; and
  – Use of a group identifier for virtual groups.
• Today’s listening session provides another opportunity to receive input from you.
Feedback

• What types of factors would individual eligible clinicians and small practices take into consideration when forming/joining a Virtual Group?
• What potential barriers and challenges that individual eligible clinicians and small practices would need to address in order to form/join a Virtual Group?
• What timeframe would Virtual Groups need form and operationalize the Virtual Group, and be prepared for reporting?
• What options or elements could be considered or included in an election process that would enhance user experience
• What other issues or factors will CMS need to consider as Virtual Group policies are developed?
Questions

Jean Moody-Williams
Jean.MoodyWilliams@cms.hhs.gov
CMS Office Hours Schedule

• All Office Hours will be held in Booth #229
• Wednesday, February 22
  o Office Hours: Improvement Activities, 12:00-1:30 p.m.
  o Office Hours: MIPS, 1:30-2:30 p.m.
  o Office Hours: Quality and Cost, 2:30-4:00 p.m.