While the Merit-based Incentive Payment System (MIPS) creates questions and headaches for practitioners, its evolution continues. Virtual Group (VG) reporting is a new option for solo/small practices to use, and the Centers for Medicare & Medicaid Services continues to make changes as the feedback, concerns, and recommendations pour in from various audiences.

In response to physician demands, CMS created VG MIPS reporting for calendar year 2018 with the goal of “simplifying” MIPS for small and solo practices. Using the existing MIPS data submission mechanisms, VG participants join together as a collective entity to report on MIPS requirements.

Although the 2018 program year enrollment window already is closed, it will reopen for 2019 later this year. Now is the time for post-acute and long-term care clinicians who are MIPS eligible to make informed decisions and assess the program’s potential merits for their practices.

Mechanics of the VG
A VG represents a combination of two or more taxpayer identification numbers (TIN) made up of MIPS-eligible solo practitioners who bill under a TIN, with no other national provider identifiers (NPIs) billing under that TIN; and/or a group practice with 10 or fewer eligible clinicians — at least one of whom must be MIPS eligible — who join with at least one other practitioner or group for a 1-year performance period. Eligible clinicians include physicians, physician assistants, clinical nurse specialists, nurse practitioners, and nurse anesthetists. The eligible clinicians within a group must aggregate their performance data across the TIN, and they receive the collective score of the group.

To be eligible to form or join a VG, a solo practitioner must:
- Be a practice of one eligible clinician who is also MIPS eligible.
- Not be newly Medicare-enrolled MIPS-eligible clinicians (i.e., in the first year of Medicare Part B participation).
- Not be a Qualifying Alternative Payment Model Participant (QP) or a partial QP not choosing to participate in MIPS.
- Not be excluded from MIPS based on the low-volume threshold exclusion at the individual level.
- Have at least one other solo practitioner or group of 10 or fewer eligible clinicians (including at least one MIPS-eligible clinician) as part of the VG.
- Have a TIN size that is not more than 10 eligible clinicians.
- Not be excluded from MIPS based on the low-volume threshold exclusion at the group level.
- Have at least one solo practitioner or group of 10 or fewer eligible clinicians (including at least one MIPS-eligible clinician) as part of the VG.

A formal written agreement among individual clinicians and groups electing to form a VG is required. This must identify all the clinicians who bill under the TIN of a group that is in the VG, and it will apply for at least one performance period. The VG must select a group representative — an individual who makes the election on behalf of the VG members regarding the group’s formation for the applicable performance period by the application deadline. A solo practitioner or group can only participate in one VG during any given performance period.

VGs participate in MIPS across all four performance categories — resource use/cost, quality, advancing care information, and clinical practice improvement. They are subject to the same measure and performance category requirements as other groups reporting under MIPS.

The MIPS score for a VG is calculated by combining the scores of all the performance categories using the score calculation rules applicable for MIPS groups. Each eligible clinician in the VG receives the same MIPS score, which reflects the combined performance of the VG.

To VG or Not to VG
There are advantages and challenges to participating in a VG. On the plus side, it rewards good partnerships by enabling practitioners to share the work across different groups and individuals. Because one administrator can be chosen to support the reporting for multiple practices, it can prevent duplicated efforts.

VGs also are a way to test collaborations. Initiatives such as accountable care organizations and bundled payment arrangements encourage breaking down silos and forming partnerships and professional relationships. Working as part of a VG lets individuals and small practices identify opportunities for possible mergers and partnerships. Successful collaborations could be the basis for developing a network model, a template for working together to identify opportunities and means for improving quality. Participation in a VG also may boost a clinician’s reputation, showing potential partners and others that he or she is serious about improving quality and documenting those efforts in a meaningful way. Finally, and perhaps most significantly, VGs may lead to better MIPS scores — which was CMS’s intent in establishing this initiative.

Of course, the VG concept isn’t perfect, and clinicians must consider it carefully before making any decisions. First, once you commit to participating in a VG, you must stick to that decision; you can’t switch to individual reporting even if you decide later that it is a better end-of-year strategy. Second, if the other VG members aren’t as diligent or hardworking as you, they could potentially create more headaches and problems than they solve — you need to know who you’re getting involved with before you make any commitments to work with them (a good rule of thumb in any walk of life). Third, coordinating work will create an added cost, so you need to determine with your team what the cost might realistically be, how you will cover it, and what everyone’s role will be in that effort.

VGs are flexible; they have no restrictions based on location, specialty, or other factors, and they can determine their own composition — there are no limits on the number of solo practitioners and groups who can participate in one VG. However, if you end up in a large VG, getting “too big for your britches” is a risk. Small or solo practices may become large MIPS groups through their VG, and that will make it harder to earn points.

Remember that a VG is considered to have small practice status if it comprises 15 or fewer clinicians. Small practice status is determined based on the collective VG entity, not on the small practice status of each TIN within that VG. Thus, if a VG comprises 16 or more clinicians, it is does not collectively have small practice status.
Here are a few examples to illustrate why small is beautiful:

- Small groups receive 5 bonus points if they report any MIPS data.
- Small groups receive a minimum of 3 points for each quality measure submitted at least one time. So submitting six different quality measure codes — even for a single patient — earns 18 quality points. (Large groups only receive the 3-point score if they report on over 60% of their eligible patients; otherwise, they earn just 1 point.)
- For small groups, CMS will not measure rehospitalization rates, which are scored as a seventh quality measure. (Note that, to date, PA/LTC medical groups have not performed well on this measure under value-based purchasing.)
- Quality is weighted at 50% of the total MIPS score. Each quality measure reported by a small group can score from 3 to 10 points. You must report on six measures — yielding a maximum possible quality point score of 60 points. If you do the minimum requirements, you earn 18 of those 60 possible quality points: (18 ÷ 60) x 50 = 15 MIPS points.
- Small groups only need to report on half the number of improvement activities that the large groups report.

**Special Considerations**

VGs have special considerations that you should understand. For instance, do you work in a rural location? A VG will be designated as a rural area or Health Professional Shortage Area (HPSA) practice if more than 75% of NPIs billing under the VG’s TINs are designated in a rural zip code.

Before you commit to a VG, there are several additional issues to consider. For instance, registry reporting is the only way to participate, and this type of reporting is only practical if all the clinicians involved are using the same electronic health record (EHR). Alternatively, individual VG members could contract in advance with a registry vendor to support VG reporting from their variety of EHRs.

The quality measures used and reported also must align across groups; misalignment leads to bad outcomes. Let’s say that the VG wants to achieve higher quality performance scores. Although it is easy to earn 3 points by reporting on a single patient, to earn 4+ points you must report on over 60% of all patients eligible for the measure. That means every group member’s patient count is included in the 60% calculation; if several group members fail to report on a particular measure, patient reporting for the VG could drop below the threshold.

Involvement with a VG needs to be a team effort from the start — you don’t want to make a decision then blindside your staff with it. Nor are VG arrangements suitable for everyone: some practitioners have indicated that they find grasping all the complexities of the MIPS reporting system hard enough without adding a new layer of risk or dealing with the issues a weak VG member might add to the equation. Validating that all VG members have aligned MIPS quality measures enabled, identifying any potential interoperability glitches, ensuring smooth communications, and monitoring CMS guidance on the VG program and data submission are all necessary steps. Your EHR vendor, practice manager, and other care partners may have guidance to offer you as you weigh the pros and cons and consider your own practice’s weaknesses and strengths before you make a VG commitment.

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**FOR MORE INFORMATION**

On the CMS site, the Virtual Groups Toolkit at www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html is available under the MIPS Group Participation section. It includes:

- Virtual Groups Agreement Checklist
- Virtual Groups Agreement Template
- Virtual Groups Election Process Fact Sheet
- Virtual Group Participation Overview Fact Sheet

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