Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-3321-NC2

MACRA Technical Assistance RFI Response – NOSORH

**Preface:**

Section 1848(q)(11) of the Act provides for technical assistance to small practices and practices in HPSAs. In general, under section 1848(q)(11) of the Act, the Secretary is required to enter into contracts or agreements with entities such as quality improvement organizations, regional extension centers and regional health collaboratives beginning in Fiscal Year 2016 to offer guidance and assistance to MIPS EPs in practices of 15 or fewer professionals. Priority is to be given to small practices located in rural areas; HPSAs and medically underserved areas and practices with low composite scores. The technical assistance is to focus on the performance categories under MIPS, or how to transition to implementation of and participation in an APM.

* **What should CMS consider when organizing a program of technical assistance to support clinical practices as they prepare for effective participation in the MIPS and APMs?**

CMS should consider who may best provide technical assistance to the targeted clinical practices. In order to effectively organize a technical assistance program, CMS should evaluate which entities have both experience providing technical assistance, and established relationships with the targeted clinical practices. CMS may also want to identify entities that already have the infrastructure in place to best reach small clinical practices in the priority areas. CMS should also consider Congressional input regarding who may be well suited to provide the technical assistance. We would note that the Senate Labor and Health and Human Services Report states that:

Technical Assistance for Priority Areas –The Committee notes that the Medicare Access and CHIP Reauthorization Act of 2015 authorizes the Secretary to provide technical assistance on the Merit-based Incentive Payment System to eligible professionals with a priority given to practices located in rural, medically underserved, or health professional shortage areas. Due to their extensive experience working with providers in rural and underserved areas, the Committee highlights the significance of the **State Offices of Rural Health** (State Offices) and their ability to provide this type of guidance.

* **What existing educational and assistance efforts might be examples of “best in class” performance in spreading the tools and resources needed for small practices and practices in HPSAs? What evidence and evaluation results support these efforts?**

State Offices offer a suite of educational and assistance efforts for small practices in rural HPSAs. State Offices are flexible and no two states are the same. However we would like to offer the following examples of “best in class” performance for TA in rural HPSAs/MUAs:

-The South Carolina Office of Rural Health provides direct and ongoing technical assistance to over 105 RHCs and rural practices on meaningful use. Individual consultation and support is provided to rural practices and more than 230 Eligible Providers working in South Carolina rural practices have received Meaningful Use payments as a result.

-The Ohio Office of Rural Health provided technical assistance to FQHCs, black lung clinics, and small practices through informational webinars and phone/email consultation on ICD-10 training. This assistance has resulted in a largely successful transition to ICD-10 for small rural providers. Furthermore the Ohio Office of Rural Health has assisted 36 small practices in attaining Rural Health Clinic status, demonstrating the effectiveness of State Offices to transition small practices into new payment models.

-The Pennsylvania Office of Rural Health collaborated with the federally-funded Regional Extension Center to ensure that Meaningful Use Stage 1 adoption implementation was able to reach rural primary care sites. This collaboration allowed the Meaningful Use assistance to reach approximately 1,200, predominately rural, primary care sites.

These examples provide a small glimpse into the long menu of technical assistance that State Offices provide to small practices. NOSORH would encourage CMS to build this question into the bidding process and have each applicant describe their current technical assistance efforts and results.

* **What are the most significant clinician challenges and lessons learned related to spreading quality measurement, leveraging CEHRT to make practice improvements, value based payment and APMs in small practices and practices in health shortage areas, and what solutions have been successful in addressing these issues?**

The most significant challenge to providing any kind of technical assistance to small practices in rural HPSAs is cooperation and buy-in from the small practices themselves. If the individual or entity providing the assistance to the small practices is an outsider, practices may look at the new programs such as Meaningful Use as another “government mandate” which hurts the effectiveness of the policy. However, if the technical assistance is provided by someone who has already established a working relationship with the small practice (such as a State Office), someone the small practice knows will be available to long-term assistance, then the small practice is much more likely to embrace the support and technical assistance offered.

Furthermore, rural providers are often the only provider in their area, making it difficult to dedicate time to new training or technical assistance efforts. As a result, State Offices have learned to provide time sensitive assistance so that providers are better able to balance their responsibilities.

While it may be a bit premature to assess the challenges and lessons learned for adopting APMs in small practices, given the fact that APMs have not yet been fully developed or defined, State Offices have extensive experience helping small rural practices adopt new payment models. For example, the Louisiana Office of Rural Health has assisted 82 Rural Health Clinics in obtaining Rural Health Clinic status in Louisiana, which as you know entails an entirely different payment model than traditional fee-for-service. They learned that in order to provide the time effective constant support needed for adopting new payment models, that phone and email contact with the practice/provider is most effective. However, the Louisiana State Office of Rural Health found that if you visit the practice at least once in person, it establishes a better working relationship for the non-face-to-face contact. This is the kind of experience and lesson learned that State Offices can leverage to better transition small practices into Alternate Payment Models.

* **What kind of support should CMS offer in helping providers understand the requirements of MIPS?**

CMS should establish the exact methodology for MIPS in early 2016. Until the exact methodology is established it will be challenging to provide detailed assistance. CMS should also offer free webinars and/or calls on a regular basis to explain the details of MIPS when it is finalized. Guidelines specific to certain audiences, such as Critical Access Hospitals using Method II will also be helpful. CMS might also consider allowing providers the opportunity to test data submission on MIPS so that issues can be resolved before the program is fully implemented.

* **Should such assistance require multi-year provider technical assistance commitment, or should it be provided on a one-time basis?**

CMS should structure the assistance on a multi-year basis. Multi-year contracts will provide stability to the small practices and the demands of MIPS and APMs are such that assistance beyond the initial transition year is necessary. As previously mentioned, small practices are less likely to buy-in to a new program if they don’t know where the support is coming from long-term. However, it is important to allow entry points each year for additional entities to provide technical assistance. This structure will give CMS the needed flexibility and leverage to ensure that the technical assistance commitments are being fulfilled.

* **Should there be conditions of participation and/or exclusions in the providers eligible to receive such assistance, such as providers participating in delivery system reform initiatives such as the Transforming Clinical Practice Initiative (TCPI;**[***http://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/***](http://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/)**), or having a certain level of need identified?**

We do not believe that additional conditions of participation beyond the statutory language is necessary. Further restricting the types of practices that may be eligible to receive assistance would unnecessarily limit the reach of this technical assistance.

Sincerely,



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Executive Director

National Organization of State Offices of Rural Health