which is exactly the reason why we call for a similar delay in the proposed start of the initial performance period later in this letter.

There are at least two negative consequences to the proposed delay in implementation of virtual groups. First, a delay violates the statute. Section 1848(q)(5)(I)(ii) of the Act states:

> *The Secretary shall, in accordance with the requirements under clause (iii), establish and have in place a process to allow an individual MIPS-eligible professional or a group practice consisting of not more than 10 MIPS-eligible professionals to elect, with respect to a performance period for a year to be a virtual group under this subparagraph with at least one other such individual MIPS-eligible professional or group practice.*

In other words, the law requires CMS to have in place a virtual group election process with respect to a performance period. However, CMS is implementing a performance period, 2017, without this statutorily required process.

The other negative consequence of CMS's inaction here is that solo and small group physicians who had been counting on the virtual group option to be successful under MIPS will not have the opportunity. The AAFP is committed to the implementation and eventual success of virtual groups. Our members are inquiring about it and viewed it as an option to band together to share resources while maintaining their independence as solo physicians and small groups. The AAFP is ready to help them.

Unfortunately, the lack of a virtual group option is harmful to such practices that were otherwise ready to engage MACRA in this way, and we are concerned that they will be among those hardest hit when CMS implements MIPS in 2017. Thus, we strongly urge CMS to allow for a safe harbor that would exempt solo and small group practices (i.e., five or fewer eligible clinicians) from MIPS until the virtual group option is in place. This would allow such practices to receive a minimum 0 percent update (e.g., they could receive bonuses if they are high performers) To finance this "hold harmless" provision, CMS should use a percentage of the $500 million otherwise allocated to high performers under MIPS. Furthermore, CMS should prioritize technical assistance funding for those affected by virtual group delay.

We also note that it is consistent with the way in which CMS has implemented the VM for solo physicians and small group practices by holding them harmless from negative adjustments during the first year in which the VM applied to them.

When CMS does, in fact, get around to implementing virtual groups in future rulemaking, then we would offer the same guidance we provided the agency almost six months ago in response to its request for information on MACRA. Specifically, for virtual groups, eligibility, participation, and performance should be assessed no differently than any other groups under MIPS. The AAFP believes voluntary virtual groups should be able to collaborate as a team in order to transform health care delivery. Virtual groups can demonstrate this by signing an agreement with a payer, outlining performance expectations, as well as risk and reward parameters. The program should be balanced such that quality and cost performance are rewarded.

Virtual groups should have a unique, newly created identifier to enable effective identification of the group. If a virtual group consists of a subset of EPs for one TIN, CMS needs to be able to identify the subset that is part of the virtual group separate from the entire TIN. However, at