National Indian
Health Board

Transmitted via: www.regulations.gov

March 29, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: Comment on CMS-5061-P, Medicare Program: Expanding Uses of Medicare Data by Qualified Entities

Dear Centers for Medicare and Medicaid Services:

On behalf of the National Indian Health Board (NIHB), I write to submit comments on the Medicare Program: Expanding Uses of Medicare Data by Qualified Entities.

Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/AN). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

<u>Background</u>

Section 10332 of the Patient Protection and Affordable Care Act (ACA) established the Qualified Entity Program, requiring the program to make available standardized extracts of Medicare claims data under parts A, B, and D to "qualified entities" for the evaluation of the performance of providers and suppliers. Qualified entities can use the information for the purpose of evaluating the performance of providers and suppliers in the geographic area(s) selected. A list of the 13 existing qualified entities is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/QEMedicareData/index.html?redirect=/QEMedicareData.

Proposed Rule

The Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) permits qualified entities to use the combined data and information derived from the evaluations and conduct non-public analyses to authorized users for non-public use in accordance with program requirements and other applicable laws. To implement these provisions, MACRA defines an authorized user as a provider, supplier, medical society, and hospital association. The proposed rule goes into more detail, proposing that: a provider, a supplier, an employer, a health insurance issuer, a medical society, a hospital association, a health care professional association, or a state agency as authorized users. We note specifically that the proposed rule does not include the Indian Health Service (IHS) or Indian health programs operated under the Indian Self-Determination and Education Assistance Act (P.L. 93-63, ISDEAA) specifically in the definition of authorized users.

We recommend that CMS include the IHS and Indian health programs as a separate distinct category and to include Tribal Epidemiology Centers and Tribal Advisory Committees, like the Tribal Technical Advisory Group (TTAG) to CMS. While IHS and Tribal health programs are not specifically referenced in the definition of authorized user at section 105(a)(9) of MACRA, we believe that including IHS and Tribal health programs would be a substantial benefit. IHS and Tribal health programs are important partners with CMS in the delivery of Medicare, Medicaid, and CHIP services. Access to data and its associated analyses would help IHS and Tribal health programs to improve the quality of health care services and reduce costs.

Tribal Epidemiology Centers

The Indian Health Care Improvement Act (IHCIA) authorizes the Secretary at 25 USC § 1621 "develop sets...of data for uniformly defining health status for the purpose of the objectives specified at section 25 USC §1602. The Act also designates Tribal Epidemiology Centers (TECs) to have access to public health entity status under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and such data sets are to be used by TECs, as a contractor grantee, when performing the functions of the Secretary. Because of this unique designation, we further recommend that CMS include TECs under the IHCIA as authorized users eligible to receive data and analysis under the final rule.

TECs serve American Indian/Alaska Native (AI/AN) Tribal and urban communities through management of public health information systems, assisting, coordinating and facilitating the public health response to disease outbreaks and clusters, surveillance, the management of disease prevention and control programs, and coordination of these activities with the local, state, and other federal public health authorities. The TECs are Indian Health Service (IHS), division funded organizations, and there are currently twelve (12) TECs in the United States. It is important to note that the TECs are not Tribal specific and they are not IHS region/area specific.

Tribal Epidemiology Centers provide various types of support and services due to the variation of the TECs organization structure, divisions, Tribal populations, and their mission and goals. The following are some examples of the support and services offered by each TEC:

- Providing timely and accurate access to meaningful health data.
- Updated community health data profiles that are specific to the Tribes.
- Training in epidemiology to Tribal members to improve health programs through enhancing capacity to collect and analyze data.
- Assisting Tribes in data management and reporting requirements.
- Surveillance: Assisting, coordinating and facilitating public health response to disease outbreaks and clusters in Tribal areas, dissemination of surveillance data, and investigation of disease outbreaks and clusters.
- Support and/or coordination of Tribal health surveillance systems.
- Participation and support for systems that share, improve, and disseminate aggregate health data of AI/AN populations for the purpose of advocacy and to further the understanding of health disparities.
- Maintain and/or enhance the Tribal system for developing/implementing health promotion/disease prevention (HP/DP) programs or studies in cooperation with other public health entities that are working to improve AI/AN health.
- Providing technical assistance in planning and evaluating current Tribal health programs and systems.

It is imperative that TECs have access to the data gathered by qualified entities as they are able to ensure that the data is used to support quality improvement assessment activities. By being able to measure the Medicare claims data, TECs can increase data access to evaluate Tribal health programs and increase access to care

Tribal Advisory Committees

Tribal Advisory Committees like TTAG are crucial to ensuring that the Trust responsibility to provide healthcare to American Indians and Alaska Natives is fulfilled. This is recognized in CMS' own Tribal Consultation Policy. CMS must seek early and frequent input from Tribes as it develops policies that will have a significant impact on Indian Country. Tribal consultation will assist CMS in its mission to improve healthcare outcomes, beneficiary experience of care, and population health while also reducing healthcare costs.

Tribal Advisory Committees like the TTAG should be considered authorized users for the benefit of acquiring timely information and data. There is a significant need to eliminate racial and ethnic health disparities that surround the Indian healthcare system. The uniqueness of the Indian healthcare system in relation to traditional healthcare sites must be taken into account for consideration of the gap analyses to enhance the number and utility of relevant reportable data collected by qualified entities. Being included as authorized users and gaining access to the data

collected by qualified entities would be a substantial benefit for Indian Country and would be consistent with the United States' Trust responsibility with Tribes.

Expanding data available to Qualified Entities

In the proposed rule, CMS states that given the difficulties of obtaining Medicaid Management Information System (MMIS) data, the timeliness issues with Medicaid data, and the variation of time period reflected in the data, qualified entities are better off seeking Medicaid and/or CHIP data through the State Medicaid Agencies. We disagree and strongly encourage CMS not to limit the data available to only State Medicaid Agencies.

The Trust responsibility that the United States has with Tribes is between the federal government and Tribes, not the state. As a result, states do not have the same obligations to Tribes that the United States government does. CMS, an agency within the federal government, with its own Tribal Consultation Policy, has a special responsibility to work with Tribes and ensure that they have access to this data, not the states. While we understand that State Medicaid Agencies will generally have more specific data available, we highly encourage CMS to remain involved and direct State Medicaid Agencies to work with Tribes and provide them with the data that they request.

Thank you for the opportunity to comment on the Expanding Uses of Medicare Data by Qualified Entities. Please contact Devin Delrow, NIHB's Director of Federal Relations at ddelrow@nihb.org if you have any questions on the issues addressed in these comments.

Sincerely,

Lester Secatero
Chairman, National Indian Health Board

cc: Kitty Marx, Director, CMS Division of Tribal Affairs