

National Indian Health Board



Submitted via: <http://www.regulations.gov>

December 19, 2016

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5517-FC
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program: Merit-Based Incentive Payment System and Alternative Payment Model Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (CMS-5517-FC) Comment

Dear Acting Administrator Slavitt:

On behalf of the National Indian Health Board (NIHB), I write to submit comments on the final rule with comment period, published in the Federal Register on November 4, 2016, CMS-5517-FC entitled “Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models” (hereinafter Final Rule). The Final Rule implements the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

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/ANs). 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.

We appreciate the opportunity to submit these comments. NIHB values CMS’s commitments in the Final Rule to conduct Tribal consultation when developing further regulatory and sub-regulatory guidance, however Tribes were not adequately consulted in the development of the Proposed Rule. Tribes and Tribal organizations are not merely stakeholders who may participate in the public comment processes because of the fulfillment of the federal government’s trust responsibility to engage in meaningful consultation with Tribes. Rather, Tribes maintain government-to-government relations with the United States, and all federal

agencies have a duty to meaningfully consult with Tribes. We look forward to working with CMS as it continues to implement MACRA.

To comply with MACRA, the Final Rule establishes a new CMS Quality Payment Program for Medicare Part B payments made to qualifying “eligible clinicians” under the Physician Fee Schedule (PFS). Under this new program, there are two paths that are designed to incentivize quality care: (1) the Merit-based Incentive Payment System (MIPS); and (2) incentive payments for participation in Advanced Alternative Payment Models (APMs). Providers at the Indian Health Service (IHS) and Tribal facilities will be subject to MIPS if they do not fall in one of the following exclusion categories: (1) if it is the first year of Medicare Part B participation for the clinician; (2) if Medicare billing charges are less than or equal to \$30,000 or the clinician provides care for 100 or fewer Medicare patients in one year; (3) if participating in Advanced Alternative Payment Models (APMs); and (4) to the extent that they do not bill under the Medicare Part B PFS.

We particularly welcome the Final Rule’s reduced reporting requirements, more generous low-volume threshold, and 2017 transition year. It is our understanding that CMS intends to make MIPS compliance more rigorous in future years. However, we hope that CMS will continue to provide flexibility and technical assistance for Tribal health programs that may have difficulty meeting MIPS requirements. We respectfully request CMS to continue the transition period past the first year for the Final Rule. The Indian health system is only funded at approximately 50% of need. CMS is, like all federal agencies, responsible for carrying out the United States’ trust responsibility to Tribes. It would be fundamentally inconsistent with this trust responsibility to further reduce funding to already underfunded Tribal health programs because they do not have the resources to comply with MIPS. Tribes have previously requested an exemption from MIPS. In the absence of a blanket exemption, we request that CMS work with Tribes to ensure that not a single Tribal health program is penalized due to the failure of the federal government to fulfill its responsibility to provide health care to American Indians and Alaska Natives (AI/ANs).

Technical Assistance for the Indian Health System

Many eligible clinicians in rural and underserved areas do not comprehend what will be required of them beginning in 2017. The Final Rule confirms that, as required by MACRA, \$100 million in technical assistance will be available to MIPS eligible clinicians in small practices, rural areas, and practices located in geographic health professional shortage areas (HPSAs). The \$100 million technical assistance funds are only available to eligible clinicians in practices with 15 or fewer clinicians. We understand that the contracts for technical assistance for practices of 15 or fewer will be awarded on a state-by-state basis, and NIHB requests that one contract be awarded to an entity specifically designated to, and experienced in, assisting I/T/Us. Alternatively, we request that the quality improvement organizations, regional health collaboratives, and other contractors all be familiar with the Indian health system and Tribal health programs.

The Indian Health Service, Tribal, and urban Indian health providers (I/T/Us) appreciate and share the goals of advancing quality care, but the final rule must take into account the

infrastructure and needs of I/T/Us. Historically, small and solo health care practices have been less likely to engage in the quality reporting programs. Therefore, NIHB requests Indian health system specific outreach and education efforts to increase awareness of what is required of eligible clinicians and how eligible clinicians participate in MIPS and Advanced APMs.

The Indian health care system already faces a critical resource gap and many of its facilities have longstanding provider vacancies. Recruiting and retention has always been a challenge for the Indian health care system, and has reached such a crisis in certain areas like the Great Plains that legislation has been proposed in both the Senate and the House that would give the IHS additional authorities to increase provider payments for recruitment and retention purposes. NIHB requests that CMS develop a roadmap with the inclusion of the various options to participate in MIPS and Advanced APMs along with what needs to be reported and when for eligible clinicians. Although we very much appreciate the resources currently provided on www.gpp.cms.gov, there is a need for a Tribal-specific roadmap to help Tribal health programs figure out if MIPS applies to them, if any exclusion apply to them, how to proceed with MIPS participation, and what the penalties are for choosing not to participate in MIPS.

Low-volume Threshold

NIHB appreciates the significant changes to the Final Rule as it applies to small and rural Medicare Part B providers. We value the low-volume threshold increase of Medicare Part B allowed charges from the \$10,000 that was previously proposed to \$30,000. We fully support that the Final Rule excludes providers who either bill less than \$30,000 in Medicare Part B services or care for 100 or fewer Medicare Part B enrollees. The Final Rule estimates that this low-volume threshold will exempt over 380,000 clinicians.

Reporting Measures/Systems

NIHB appreciates the reporting simplification and reductions of reporting measures. We particularly appreciate the reduced reporting requirements for the 2017 transition year, and we hope that CMS will continue to provide flexibility in future years for practices, such as Tribal health programs, that may have difficulty meeting future, heightened MIPS requirements.

We also support the ability for providers to report as a group because we believe that it will help ease the reporting burden. However, CMS must take into consideration the impact of high rates of staff turnover at IHS, Tribal, and urban Indian health programs. NIHB invites CMS to work with Tribes to develop a group reporting tip sheet specific to small and rural providers to outline the benefits and requirements of reporting as a group.

We understand that MIPS eligible clinicians and groups are responsible for the data that is submitted by third party intermediaries. We request, however, that CMS leave open opportunities for MIPS eligible clinicians and groups that discover an issue with their third party intermediary to switch reporting methods and/or third party intermediaries without restriction on the eligible clinicians.

I. Quality Measures

NIHB appreciates the reduced number of quality measures. For small practices, rural practices, and health professional shortage areas (HPSAs), this requirement was reduced from two high-weighted measures to one high-weighted measure or two medium-weighted measures. This lower threshold for small or rural practices and HPSAs is consistent with section 1848(a)(2)(B)(iii) of the Act. We understand that there will be more stringent requirements in future years. We request that CMS consult with Tribes in developing future requirements and consider both the unique responsibility of the United States to provide for Indian health care and the particular challenges that small, rural practices, and HPSAs are burdened with each day.

However, we further request the use of Government Performance and Results Act (GPRA) reporting measures because we must work together to minimize the administrative burden of reporting for eligible clinicians in Indian Country. The Indian Health Service Office of Planning and Evaluation already collects and reports clinical performance results annually to the Department of Health and Human Services and to Congress. Given the already strained resources of I/T/Us, CMS should do everything within its power to help reduce duplicative reporting burdens by accepting GPRA measures as quality measures. The Final Rule notes the concerns that Tribes raised regarding reporting duplicative quality measures, and the request that MIPS accept the GPRA measures that Tribal and urban Indian health organizations are already required to report.

NIHB requests that CMS form a workgroup with IHS to align the quality reporting measures accepted to report for full MIPS participation. We also ask CMS to create a workgroup with Tribal technical advisors to work with CMS with the acceptance of the IHS Resource and Patient Management System (RPMS) as a qualified registry and that you work with IHS to ensure that the RPMS is capable of meeting MIPS reporting requirements.

II. Improvement Activities

NIHB supports the inclusion of a broad range of improvement activities and flexibility in allowing eligible practitioners to select improvement activities across subcategories. We are also appreciative of the changed weighting of participation in IHS as a high-weighted improvement activity compared to the proposed medium-weighted improvement activity classification. This is consistent with section 1848(q)(2)(B)(iii) of the Act. CMS should, however, consult with Tribes to determine exactly what qualifies as participation in IHS improvement activities, adopting the broadest interpretation possible in order to support Tribal quality improvement while reducing the burden on already underfunded Tribal health programs. We also request that CMS consult with I/T/Us regarding development of additional improvement activities in order to support activities that providers are already engaged in. This will help support quality of care improvements rather than adding process-oriented burdens.

In response to the CMS request for comments on activities that will advance the usage of health information technology, we would like to highlight that it is difficult for many Indian health care facilities to implement health information technology. Activities surrounding the

advancement of health information technology usage must be based upon additional training and technical assistance provided for rural, small practices, and health professional shortage areas (HPSAs). CMS must account for the lack of technological infrastructure throughout Indian Country when addressing or incentivizing the use of health information technology.

III. Advancing Care Information

The Final Rule highlights that CMS understands some providers may not have prior experience with certified electronic health record technology (CEHRT), therefore they have proposed a scoring methodology that provides flexibility. The electronic health record (EHR) requirements add an additional burden to providers, which leads to provider burnout. Much of the EHR/CEHRT in Indian Country is dependent on IHS, therefore upgrades to the EHR are dependent upon funding to IHS. CMS has also reweighted the advancing care information performance category to zero for certain hospital-based and other providers where the measures may not be available or applicable. NIHB supports the greater flexibility of the Advancing Care Information approach in comparison to the Electronic Health Record (EHR) Stage 1 and 2 requirements. We also request that CMS consult with Tribes and Tribal organizations for future consideration of new EHR measures.

We appreciate the hardship exemption that CMS has continued under the new quality payment program. NIHB would like to request that CMS issue a blanket hardship exemption for Indian health providers, rather than making Indian health providers separately demonstrate that they qualify for a hardship exemption.

IV. Cost Performance

We support CMS's decision not to consider cost in the 2017 transition year. We request that CMS consult with Tribes regarding future regulations and sub-regulatory guidance applying to cost performance in order to ensure the unique structure, function, and challenges of the Indian health care system are accounted for when considering cost.

IHS/Tribal Health Programs as Alternative Payment Models

The MACRA and the Final Rule reward participation in APMs. We would like for CMS to explore Other Payer Advanced APMs that are population/provider based, or consider other options for categorizing I/T/Us as APMs. NIHB requests clarification on the nominal financial risk requirement applicable to clinicians in the Indian health system. We are still uncertain as to how eligible clinicians will be identified as eligible to participate in an Advanced APM. We believe that there will be administrative management burden on Tribal entities who choose to participate in Advanced APMs. We are concerned that smaller organizations will be excluded from participation, so we request that CMS provide technical assistance to eligible clinicians in small, rural, and HPSAs in developing a population-based model that would qualify as an Advanced APM. I/T/Us should be included in the qualified participant determination calculation along with Rural Health Clinics and Federally Qualified Health Centers.

Conclusion

NIHB hopes that CMS, in the spirit of its partnership and shared interest in improving American Indian and Alaska Native (AI/AN) access to its resources and services, will work with the Indian Health Service, Tribes, and Urban Indian health care providers to prevent harm to the Indian health care delivery system. Until further Tribal consultation can be conducted and all of our concerns/questions are addressed, we respectfully request CMS to continue the transition period past the first year for the Final Rule. We also request that CMS continue to consult with IHS, Tribes, and urban Indian health care programs. We thank you for this opportunity to provide our comments and recommendations and look forward to further engagement with CMS on the implementation of the Final Rule. Please contact NIHB's Director of Federal Relations, Devin Delrow at ddelrow@nihb.org or at (202) 507-4072 if there are any additional questions or comments on the issues addressed in these comments.

Sincerely,



Lester Secatero
Chairman, National Indian Health Board

Cc: Kitty Marx, Director, CMS Division of Tribal Affairs
Mary Smith, Principal Deputy Director, Indian Health Service