National Indian Health Board

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

August 21, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Program: CY 2018 Updates to the Quality Payment Program Proposed Rule (CMS-5522-P) Comments

Dear Administrator Verma:

On behalf of the National Indian Health Board (NIHB), I write to submit comments on the proposed rule with comment period, published in the Federal Register on June 30, 2017, CMS-5522-P entitled "CY 2018 Updates to the Quality Payment Program" (hereinafter Proposed Rule). The QPP implements the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and brings significant changes to how clinicians are paid within Medicare.

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 on the proposed rule governing the second year of the Quality Payment Program (QPP). NIHB values CMS's commitments in the proposed rule to conduct Tribal consultation when developing further regulatory and sub-regulatory guidance. As you know, Tribes and Tribal organizations are not merely stakeholders who may participate in the public comment processes. Rather, Tribes maintain government-to-government relations with the United States, and in fulfillment of the federal government's trust responsibility, all federal agencies have a duty to meaningfully consult with Tribes. **We would like to request Tribal consultation on the development of the proposed Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (APM) policies because**

it is of the utmost importance that the Indian Health Service (IHS) and Medicare and Medicaid within CMS conduct consultation for coordination so that the federal agencies are coordinated in implementing performance measures that are aligned. Congress has recognized that "[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the federal government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people." **NIHB encourages CMS to work with IHS to ensure there is some alignment with the MIPS and Advanced APMs measure requirements with the established Government Performance Results Act (GPRA) measures of which IHS is mandated to report on. We have several specific comments below. Overall, however, we recommend that CMS strive to make the QPP streamlined and reduce the participation burden on clinicians, particularly for providers serving patients in underserved areas such as Indian Country.** We look forward to working with CMS as it continues to implement MACRA.

MIPS Exclusions

NIHB applauds the proposed flexibilities in the QPP Year 2 to make it easier for clinicians to participate and gradually prepare clinicians for full implementation similar to the 2017 "pick your pace". Currently, eligible clinicians are excluded from MIPS if they bill less than or equal to $30,000 in Medicare Part B charges or provide services to 100 or fewer Medicare Part B patients. CMS has proposed to increase the low-volume threshold to exclude clinicians who bill less than or equal to $90,000 in Medicare Part B charges or provide services to 200 or fewer Medicare Part B beneficiaries. CMS estimates that this would exclude an additional 585,560 clinicians. **NIHB appreciates and supports the increased low-volume threshold, which will exempt more small practices and eligible clinicians in rural and Health Professional Shortage Areas (HPSAs) from MIPS participation.**

In order for clinicians who meet the low-volume threshold to participate in MIPS to be eligible for positive payment adjustments, CMS is proposing an opt-in process to MIPS beginning in 2019. **NIHB is supportive of a streamlined opt-in process beginning in 2019, allowing clinicians who meet the low-volume threshold to receive positive payment adjustments -- as long as there are no negative consequences to clinicians.**

MIPS Performance Threshold and Reporting Mechanisms

During the 2017 QPP transition year the performance threshold was set at 3 points, so an eligible clinician only needs to report one quality measure, one improvement activity, or 5 advancing care information measures. CMS is proposing the performance threshold to be set at 15 points for the 2018 QPP reporting year. Therefore, eligible clinicians will no longer be able to report on only one measure to avoid a negative payment. However, there remains flexibility in how the clinicians meet the 15 point performance threshold. **NIHB support the performance threshold of 15 points for 2018.**

CMS is proposing an additional performance threshold for exception performers. We understand the justification behind the additional performance threshold, but the health system as a whole could benefit more from using some of the funding allotted for exceptional performers to

strengthen the low performers. **NIHB encourages CMS to find ways to assist the lower performers, perhaps through making funds available through small awards or grants to lower performers who apply for them and have a specific area they believe could help them provide better quality care which could be demonstrated through better MIPS scores.**

For the 2018 reporting period, CMS proposes to allow multiple reporting mechanisms to submit measures and activities within the same performance category. **NIHB favors this proposal because it may help ease the reporting burden for some Tribal clinicians.**

MIPS Performance Category Scoring

CMS is proposing to keep the performance category weights the same for the 2018 reporting period as the 2017 transition year reporting period. For the 2017 reporting period, the quality performance category is 60%, advancing care information category is 25%, improvement activities are 15%, and the cost category is weighted at 0%. **NIHB supports the proposal to keep the cost category at 0%. We continue to urge CMS to ensure that the measures and activities are appropriate for eligible Tribal clinicians who provide services to rural and under-served Medicare beneficiaries.**

CMS is seeking comments on a proposal to score topped out measures differently by applying a 6-point cap in the quality performance category, provided it is the second consecutive year the measure is identified as topped out. **NIHB requests that providers caring for American Indian and Alaska Native (AI/AN) patients in Indian Country be excluded from the scoring cap.** If providers are doing well on any performance measure, we feel they should be awarded the maximum points.

The proposed rule includes improvement scoring based on the rate of improvement for quality and cost measures. **NIHB favors the proposed methodology to award improvement points based on the rate of improvement instead of improvement at the band level in the quality and cost measures.** We believe it is more fair and easier to understand the rate of improvement instead of the improvement at the band level. **Due to the need to have data from two consecutive performance periods for specific providers, we are concerned that improvement scores may reward stable and high performing practices and providers while struggling practices with high turnover rates may fall further behind. NIHB suggests that accepting IHS as a qualified clinical data registry (QCDR) or Registry and allowing Tribal, Urban, and federal sites submit GPRA measures in lieu of the outlined quality measures for the quality performance category may be one way to recognize that the AI/AN population is unique and account for some of the differences in geography, social risk factors, complexity and historical trauma.** The GPRA measures have many years of benchmarks and compare the AI/AN population to itself instead of to the population at large.

The proposed rule highlights CMS efforts in the scoring methodology related to social risk factors such as income, education, race and ethnicity, employment, disability, community resources, and social support. **NIHB supports rewarding improvement for clinicians caring for patients with social risk factors. We encourage CMS to consider giving MIPS eligible clinicians caring for AI/AN patients in Indian Country a bonus score similar to other bonuses**

discussed in the proposed rule because a high percentage of our patient population have social risk factors and are complex patients. For example, the health of AI/AN patients is affected by additional social risk factors like adverse childhood events (ACE), trauma informed care, and historical trauma. **We recommend that CMS include these types of social risk factors and provide a bonus score.**

CMS is proposing to incorporate a new scoring option to use facility-based scoring for facility-based clinicians. MIPS eligible clinicians have the option to choose to use their facility performance rate in the Hospital Value-Based Purchasing (VBP) Program for the MIPS quality and cost performance categories. **NIHB supports the facility-based scoring option for MIPS eligible clinicians because it will assist in reducing the MIPS reporting burden on Tribal clinicians based in hospitals.**

Small Practice and Complex Patient Bonuses

NIHB is pleased with the additional support for small practices during the 2018 reporting period. CMS is proposing to reduce the MIPS burden on small and rural clinicians by creating a small practice bonus and a complex patient bonus. The proposed small practice bonus would be 5 additional points to the final score for eligible clinicians in small practices with 15 or fewer clinicians that report on at least one performance category. In addition, CMS is proposing to award small practices 3 points for measures in the quality performance category that do not meet data completeness requirements. **NIHB supports the 3 additional points in the quality performance category that do not meet data completeness requirements.** CMS has proposed to add 3 points to a MIPS score by adding the Hierarchical Conditions Category (HCC) risk score to the final score. **NIHB strongly supports the additional 5 point small practice bonus and the 3 point complex patient bonus.** We also take the opportunity to suggest that Adverse Childhood Events (ACE) scores may be a way to help stratify patient complexity. **NIHB requests that all eligible clinicians caring for AI/AN patients in Indian Country should receive this complex patient bonus. Additionally, we recommend that the definition of small practice include full time equivalents (FTEs) because of the number of different staffing arrangements that occur in rural and HPSAs.**

Providers in Indian Country tend to serve patients with greater chronic disease burden and a greater rate of acute illness. Due to the shortage of health care providers in Indian Country, these providers are focused on providing direct quality care to their Tribal community without additional time or resources. **NIHB recommends that CMS create a bonus for eligible clinicians who provide Medicare Part B services to AI/AN patients in Indian Country. We recommend that the proposed bonus for eligible clinicians should extend for the life of the program.** Eligible clinicians in Indian Country provide high quality care to a vulnerable patient population with fewer resources to invest in their care infrastructure. Penalization for not meeting quality in Indian hospitals and penalizing for not meeting reporting burdens is unacceptable. NIHB would like to reiterate our request to have Tribal clinicians exempt from participation in MIPS and Advanced APMs. It is unacceptable for an agency of the federal government to penalize an IHS, Tribal, or Urban (I/T/U) health program for its inability to meet efficiency and quality of care benchmarks by withholding resources that could be used to help reach those benchmarks. Rather, the trust

responsibility requires that the federal government assist IHS, Tribal, and Urban Indian health programs in meeting the highest standards for efficiency and quality of patient care.

Certified Electronic Health Record Technology (CEHRT)

CMS has emphasized the use of certified electronic health record technology (CEHRT) to support interoperability and advanced quality objectives in a single, cohesive program that avoids redundancies. Much of the EHR/CEHRT in Indian Country is dependent on the IHS, therefore upgrades to the EHR are dependent upon funding to IHS. NIHB suggests that some providers may want to use their CEHRT to submit data directly to CMS, but the CEHRT may not be able to do this or may not have all of the possible measures available for this submission method. NIHB encourages exploring ways to incentivize vendors to make this submission method available and as easy to use as possible in order to encourage providers to use this method. CMS has proposed to continue to allow the use of the 2014 Edition of the CEHRT. **NIHB is appreciative and supportive of the inclusion of the 2014 Edition of CEHRT, which is the most up-to-date version that IHS utilizes.**

For CY 2018, CMS is proposing a one-time bonus of 10 points to support and recognize MIPS eligible clinicians and groups that invest in implementing the 2015 CEHRT in their practice. Therefore, MIPS eligible clinicians would be able to earn a bonus score of up to 25 points in CY 2018 under the advancing care information performance category. NIHB would like to highlight that there are a lack of products certified to the 2015 Edition of CEHRT. Additionally, switching from the 2014 Edition to the 2015 Edition will require a large amount of cost, time and planning that smaller and rural practices do not have. NIHB supports the 10 point bonus for MIPS eligible clinicians and groups implementing the 2015 CEHRT

Advancing Care Information (ACI) Performance Category

The Advancing Care Information (ACI) performance category is an incentive restructuring category of the Medicare Electronic Health Record (EHR) incentive program. Section 4002 of the 21st Century Cures Act authorizes several exemptions to the ACI performance category, including hardship exemptions for clinicians who use health information software that is not certified. [1] The CMS proposed rule includes hardship exemptions for small practices; clinicians using decertified EHR technology; nurse practitioners, physicians assistants, clinical nurse specialists, and certified registered nurse anesthetists; as well as clinicians based in ambulatory surgical centers. **NIHB is supportive of the CMS proposal to not include a 5 year cap on clinicians' ability to claim the hardship exemption that was included under the Medicare EHR Incentive Program.** However, we are still concerned that this bonus will not be sufficient to overcome the disparities that Tribal clinicians in Indian Country face compared to clinicians in larger urban facilities. **We suggest that CMS include a hardship exemption for clinicians who provide services in Tribal health care facilities. We are concerned that clinicians may be deterred from providing services at Tribal health care facilities because they could receive a negative payment adjustment that will follow them to other facilities**.

[1] Sec.4002(b) Transparent Reporting on Usability, Security, and Functionality of the 21st Century Cures Act (P.L. 114-255)

Virtual Groups

CMS's proposed rule offers virtual group participation as a way for clinicians to participate in MIPS during QPP Year 2. Eligible clinicians could participate in MIPS as individuals, a group, or a virtual group starting in 2018. Virtual groups would be comprised of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" with at least 1 other solo practitioner or group to participate in MIPS for a year performance period. CMS provides that each virtual group participant would be required to fulfill a written agreement to ensure that the MIPS requirements are met. **NIHB supports the virtual group option, but we believe there should be no maximum limit on the size of the group, for clinicians who may otherwise be excluded from participating in MIPS. NIHB also recommends that CMS provide additional assistance to clinicians in rural and under-served areas, such as Indian Country, who are interested in virtual group participation, and to ensure that it is a simple and streamlined process to form a virtual group.** The requirements for virtual groups should be flexible and have as few obstacles as possible, because the clinicians are in the best position to determine how the virtual groups should be structured based on needs and resources.

Advanced Alternative Payment Models (APMs) Proposals

CMS has highlighted the advanced alternative payment model (APM) track as a vital part of bending the Medicare cost curve by encouraging the delivery of high quality, low-cost care. CMS has recognized that it must provide ongoing education, support, and technical assistance so that eligible clinicians can understand program requirements, use available tools to enhance their practices, and improve quality and progress toward participation in APMs if that is the best choice for their practice. The proposed rule makes several changes to participation in the Advanced APM track. During the 2017 reporting year, there are no Advanced APMs that Tribal heath care providers could consider and participate successfully in. However, in 2021 the Medicare Access and CHIP Reauthorization Act (MACRA) will include provisions for non-Medicare beneficiaries to count toward qualifying APM clinician participation. CMS has proposed an "All-Payer Combination Option" which will include Advanced APMs with non-Medicare beneficiaries. However, the "All-Payer Combination Option" Advanced APMs would still need to bear more than nominal risk for monetary losses. **NIHB remains concerned with the lack of opportunities for rural and HPSA clinicians to participate in Advanced APMs due to the proposed risk requirements at a time when CMS is attempting to increase participation in APMs.**

CMS's proposed rule maintains that participating APM entities bear more nominal risk for monetary losses standard of 8% risk for Advanced APMs. **NIHB recommends that the nominal risk standard should be lower for the 2019 and 2020 reporting years, in order to increase participation in the Advanced APM track for various eligible clinicians who provide quality services to under-served and HPSAs.**

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. NIHB respectfully requests CMS to 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 QPP. 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,

Vinton Hawley
Chairman, National Indian Health Board

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