



June 27, 2016

Mr. Andy Slavitt  
Acting Administrator Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
200 Independence Avenue, S.W. Washington D.C., 20201

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*National Advocates for  
Asian American,  
Native Hawaiian &  
Pacific Islander Health*

**RE: CMS-5517-P Medicare Program; 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**

Dear Mr. Slavitt:

The Asian & Pacific Islander American Health Forum (APIAHF) appreciates the opportunity to provide comments to the rule implementing the Medicare Access and Children’s Health Insurance Program Reauthorization Act (MACRA). APIAHF is the nation’s leading health policy group working to advance the health and well-being of over 18 million AAs and NHPs across the U.S. and territories. As such, APIAHF works to improve access to and the quality of care for communities who are predominately immigrant, many of whom are limited English proficient, and may be new to the U.S. health care system or unfamiliar with private or public coverage.

The CMS Quality Payment Program, comprising the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APM) offer an opportunity to accomplish the Triple Aim of better care, better health and lower costs for AAs and NHPs and other diverse and minority consumers who have traditionally not been adequately served by the U.S. health care system. In order to do so, however, the needs and experiences of diverse consumers must be taken into account to ensure that patient care experiences are as inclusive as possible. As such, APIAHF’s comments principally concern recommendations to ensure that patients are informed and engaged, care is coordinated and providers, patients and caregivers have access to information necessary to inform their care and monitor and improve health care quality. APIAHF believes that the push to improve the health care quality must correspondingly include a drive to improve health equity and decrease disparities.

Each year, approximately 83,000 racial and ethnic minorities die as a result of health disparities. APIAHF is pleased to see a welcomed emphasis on improving health equity across the CMS Quality Payment Program. This emphasis is consistent with CMS’ first Health Equity Plan to Improve Quality in Medicare, Healthy People 2020 and numerous other federal initiatives that have long recognized the need to reduce burdensome and expensive health disparities. Health disparities are caused by a multitude of factors and impacted by race, ethnicity, sex, immigration, primary language, among others. As such, clinicians who provide care to underserved and minority populations need additional support to deliver quality care and to address the social determinants of health that impact health outcomes. This is critical to ensuring that the Quality Payment Program does not disadvantage clinicians in underserved communities.

APIAHF's comments principally concern the Merit-based Incentive Payment System (MIPS) program given that an estimated 95% of clinicians will be part of the program.

### **Data Collection**

Data about patient experiences and outcomes is critical to identifying disparities in care that may arise on the basis of race, ethnicity, primary language, sexual orientation, gender identity, disability status and social, psychological and behavioral health status. The Quality Payment Program should require that data be collected at the granular level, consistent with U.S. Department of Health and Human Services, Section 4302 data collection standards and at minimum, OMB standards. Under the proposed rule, participants of MIPS and APMs must use the October, 2015 Office of the National Coordinator (ONC) CEHRT standards. The ONC criteria incorporates the standards for granular data collection recommended by the Institute of Medicine (IOM) and uses the CDC race and ethnicity code set, the International Organization for Standardization (ISO) codes for spoken and written languages, requires that EHRs be able to document sexual orientation and gender identity and social determinants of health (education, financial resource strain, depression, stress, social connection and isolation, alcohol use, exposure to violence and physical activity). This information is foundational to the Quality Payment Program and can assist consumers to more effectively use quality measure data and can assist providers in the dual goals of accountability and improvement.

Capturing and reporting data stratified by primary language is critical given that an estimated 25 million Americans are limited English proficient (LEP) and speak either no English or speak English less than very well.

### **Health IT and EHRs**

Data and information that providers should make available to consumers must be in a meaningfully accessible manner. This includes being able to view, download and edit information. In addition, the patient should be able to easily access information, including being able to review information in languages other than English and in their preferred language. Information should be provided at an appropriate reading level, no higher than 5th grade reading and comprehension, to ensure the information is accessible to most patients.

We are pleased to see a strong emphasis on use of health IT and EHRs in the Quality Payment Program. We reiterate, as numerous other commenters have done as well, that incentives must ensure that patients can actually use the information that is provided, and not just access it in a "check-the-box" manner. Merely providing access to information does not guarantee that patients can engage in their care.

### **Merit-Based Incentive Payment System (MIPS)**

We believe the overall framework is a positive step toward paying for value and welcome the strong emphasis on care coordination and the foundational role that EHR technology plays in supporting health care delivery and tracking.

*Advancing Care Information (ACI)*

It is critical that the Advancing Care Information measure builds on Meaningful Use and is appropriately flexible and stringent to ensure that EHRs are meaningfully adopted, used and result in real access to information and use by patients. We strongly agree that implementation of the Advancing Care Information performance category is an important opportunity to increase clinician and patient engagement and improve the use of health IT to achieve better patient outcomes. We are concerned, however, that the standards employed in the proposed rule do not go far enough to fully utilize health IT. For example, as recommended by the Consumer Partnership for e-Health (CPEH), APIAHF strongly recommends that the proposed “one-person” standard be replaced with a five percent threshold, starting in 2019. Relying on a “one-person” standard is inadequate and fails to leverage the full potential of health IT and the foundational role it plays in patient experience, care coordination and improving quality. We share CPEH’s concerns that the “one-person” standard seriously undermines the ability of patients to meaningfully engage in their care and to promote robust adoption and use of health IT.

APIAHF supports alignment of the performance period for the advancing care information performance category to the proposed MIPS performance period of one full calendar year. This reflects how patients and consumers engage with the health system and will promote uniformity and ease of reporting.

In the performance score category, APIAHF strongly supports the increased focus on consumer engagement and care coordination beyond just the consumer/patient, but to include caregivers and gathering both clinical and non-clinical data. As detailed in the Clinical Practice Improvement Activities and our comments above regarding data collection, it is critical that EHRs include patient self-reported data across demographic points, including race, ethnicity, preferred language, sexual orientation, gender identity, social, psychological and behavioral data. CEHRT are already able to capture this data and disability questions and, as used in the American Community Survey, should be added as a requirement for CEHRT. Without required and stratified data, there is no way to measure if the Quality Improvement Program is having an impact across demographic measures.

Lastly, given that CEHRT will be required under MIPS and APM, providers who are smaller, work in rural settings, provide care to the underserved, and/or to persons whom are limited English proficient or without broadband access will need additional assistance to participate. CMS should provide the necessary financial and technical resources to ensure these clinicians can come into compliance and most effectively use CEHRT in their practices.

#### *Clinical Practice Improvement Activities (CPIA)*

APIAHF welcomes the emphasis and strategic goals of using a patient-centered approach to program development that leads to better, smarter and healthier care. We note that in moving toward such care, there must not only be an improvement in health care quality, but a similar drive to reduce and eliminate health care disparities. Doing so requires not just encouragement, but incentivization of care that improves quality in a truly patient-centered manner. APIAHF recommends that CMS add more specificity to the requirements when reporting CPIA categories to distinguish between merely identifying a CPIA measure and providing data to demonstrate if the

CPIA measure had an impact. Further, there is an overall need for greater specificity in reporting measures that can be disaggregated to account for differences and identify differences among patient populations. APIAHF recommends that in the future, the CPIA category be weighted higher than the proposed 15%.

Care coordination: Communication of information must be in a manner accessible to the patient, in language the patient can understand and at an appropriate 5<sup>th</sup> grade reading level or lower. We also encourage providers to consider providing information in ways beyond merely text to display information graphically to help patients better interpret their data and information. For example, raw lab values of someone's HgA1c may not be very helpful provided alone. However, when graphically displayed and logged over time, the patient and clinician can track the patient's health and better understand the importance of this measurement.

Beneficiary Engagement: The measure should include information about linguistically and culturally accessible providers as part of shared decision-making mechanisms and beneficiary self-management.

Social and Community Involvement: The social and community involvement measure is a strong place where CMS can note the value of referrals and partnerships with trusted community and social service providers who can help facilitate coordination with appropriate funding mechanisms, such as by working with community health workers. In addition, this CPIA measure can include providers who contract with community based organizations or others to provide language access services as a means of providing patient-centered care.

Achieving Health Equity: The final rule should include the Achieving Health Equity CPIC category and should be integrated across the four MIPS measures. In addition, limited English proficient persons should be identified as a specific underserved group and CMS should give a high weight to providing language services for non-English speakers. Most clinicians are already required to provide language access under Title VI of the Civil Rights Act of 1964 as recipients of federal financial assistance, Section 1557 of the Affordable Care Act and other federal Medicare regulations, though meaningful access remains elusive for many LEP persons. Clinicians can demonstrate performance in this category by developing language access plans, providing oral interpretation services, and providing translated critical documents for the population served and eligible to be served. Overall, CMS should consult measures adopted by the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF) for existing examples on how to demonstrate performance in this category.

English proficiency stands as a major roadblock to quality coverage and accessing health care. Discrimination on the basis of national origin, which encompasses discrimination on the basis of limited English proficiency (LEP), creates unequal access to health care. Numerous studies have documented the consequences of language barriers in health care. The nonpartisan IOM found that language barriers “may affect the delivery of adequate care through poor exchange of information, loss of cultural information, misunderstanding of physician instruction, poor shared decision-making or ethical compromises (e.g., difficulty obtaining informed

consent). Linguistic difficulties may also result in decreased adherence with medication regimes, poor appointment attendance, and decreased satisfaction with services.<sup>1</sup>

Health care providers recognize the need to provide language assistance services for LEP patients. One study surveyed four major metropolitan areas where physicians identified language difficulties as a major barrier to immigrants' access to health care and a serious threat to medical care quality. These providers also expressed concern that they could not get information to make good diagnoses and that patients might not understand prescribed treatment.<sup>2</sup>

Patient experiences that have resulted in malpractice claims are documented in *The High Costs of Language Barriers in Medical Malpractice*, a joint publication by the National Health Law Program and University of California, Berkeley, School of Public Health.<sup>3</sup> As a result, language barriers can also increase the cost of care by creating what has been called a "language-barrier premium."<sup>4</sup> Such barriers are a primary reason why LEP populations disproportionately underutilize less expensive and quality-enhancing preventive care.<sup>5</sup> In addition, an inability to comprehend the patient, mixed with a fear of liability, can lead some providers to avoid LEP patients altogether or, in the alternative, to order expensive, otherwise avoidable tests.<sup>6</sup> As such, we strongly recommend that CMS provide additional resources to clinicians to ensure they are able to meet their federal requirements to provide language access and more effectively do so.

As outlined earlier in our comments, we strongly recommend that CMS include an explicit reference that data stratification and reporting is one way of working to achieve health equity. CMS should require that in reporting this measure, clinicians should stratify clinical quality measures by disparity variables, including race,

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<sup>1</sup> Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* 17 (2002) (citations omitted); see also Jane Perkins, Mara Youdelman & Doreena Wong, National Health Law Program, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities* (2003). [http://www.healthlaw.org/index.php?option=com\\_content&view=article&id=326:ensuring-linguistic-access-in-health-care-settings-legal-rights-and-responsibilities&catid=45](http://www.healthlaw.org/index.php?option=com_content&view=article&id=326:ensuring-linguistic-access-in-health-care-settings-legal-rights-and-responsibilities&catid=45); E. Jacobs, et al., *Language Barriers in Health Care Settings: An Annotated Bibliography of the Research Literature*, The California Endowment (2003), [http://www.calendow.org/uploadedFiles/language\\_barriers\\_health\\_care.pdf](http://www.calendow.org/uploadedFiles/language_barriers_health_care.pdf).

<sup>2</sup> L. Ku & A. Freilich, Urban Institute, *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston* at ii-iii (2001), available at <http://aspe.hhs.gov/hsp/immigration/caring01/execsum.htm>; see also Jennifer Cho & Beatriz M.

Solis, L.A. Care Health Plan, *Healthy Families Culture & Linguistic Resources Survey: A Physician Perspective on their Diverse Member Population* (2001) (51% of doctors reported their patients do not adhere to treatments because of culture and language barriers).

<sup>3</sup> Kelvin Quan & Jessica Lynch, *The High Costs of Language Barriers in Medical Malpractice* (2010), [http://www.healthlaw.org/images/stories/High\\_Costs\\_of\\_Language\\_Barriers\\_in\\_Malpractice.pdf](http://www.healthlaw.org/images/stories/High_Costs_of_Language_Barriers_in_Malpractice.pdf).

<sup>4</sup> See, e.g., Judith Bernstein et al., *Trained Interpreters in the Emergency Department: Effects on Services, Subsequent Charges, and Follow-Up*, 4 J. IMMIG. HEALTH 171 (2002) (finding interpreters improved clinic follow-up and reduced post emergency room visits and charges); L.C. Hampers, *Language Barriers and Resources Utilization in a Pediatric Emergency Department*, 103 PEDIATRICS 1253 (1999) (finding patients with a language barrier had higher charges and longer stays).

<sup>5</sup> See, e.g., Michelle M. Doty, The Commonwealth Fund, *Hispanic Patients' Double Burden: Lack of Health Insurance and Limited English*, at vii-viii, 8, 11-14 & 21 (2003); D. Andrulis et al., The Access Project, *What a Difference an Interpreter Can Make* 1-2 (2002).

<sup>6</sup> See, e.g., Barry Newman, *Doctors' Orders Can Get Lost in Translation for Immigrants*, WALL STREET J., Jan. 9, 2003.

ethnicity, preferred language, disability status, and sexual orientation, and gender identity, psychological and behavioral status. Clinicians can use existing demographic data collection fields in EHRs to do this. Stratified data can help clinicians identify and distinguish efforts to improve quality from efforts to reduce disparities, which may not correlate without dedicated work.

In addition, CMS should note that clinicians can demonstrate this performance activity by using fully completed records that include effective collection of self-identified demographic data by race, ethnicity, preferred language, disability status, sexual orientation, gender identity, social, psychological and behavioral data. This activity is critical to disparity identification and is not being effectively performed to the extent it is needed to support health disparity analysis.

Promoting Health Equity and Continuity: The measure outlines several ways in which providers can improve health equity in ways that will directly benefit patients. In addition, as noted previously, we strongly encourage CMS to include the provision of language services and resources as part of this category, particularly when taking into account the cumulative toll that language barriers can take on persons who are low-income and otherwise underserved. This is also a place where CMS should directly reference the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care that are intended to advance health equity and improve quality.

#### *Quality*

Given the importance and documentation of health disparities, it is concerning that the quality category, comprising 50% of the composite score, does not mention health equity. The final rule should include health equity as a priority measure and should report data stratified by race, ethnicity and primary language, and other disparities variables as relevant.

#### **Alternative Payment Models (APM)**

Similar to our comments on MIPS, we note that drives to improve quality will not necessarily advance health equity and reduce disparities for underserved and minority populations. All APMs should stratify data by disparity variables and include targeted approaches to address health disparities.

We thank you for the opportunity to provide comments on the MACRA proposed rule. Please do not hesitate to contact Amina Abbas, Director of Government Relations ([aabbas@apiahf.org](mailto:aabbas@apiahf.org)) if you have any questions.

Sincerely,



Kathy Ko Chin  
President/Chief Executive Officer