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Headquarters:

One Kaiser Plaza
Suite 850
Oakland, CA 94612
Main 415-954-9988
Fax 510-419-0263
www.apiahf.org

Washington D.C. Office:

1629 K Street N.W.
Suite 400
Washington, D.C. 20006
Main 202-466-7772
Fax 202-466-6444

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

October 26, 2017

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Strategic Planning Team
Attn: Strategic Plan Comments
200 Independence Avenue, SW
Room 415F
Washington, DC 20201
Via email: HHSPlan@HHS.GOV

Re: Draft HHS Strategic Plan FY 2018-2022

To whom it may concern:

The Asian & Pacific Islander American Health Forum (APIAHF) thanks you for the opportunity to submit comments on the U.S. Department of Health and Human Services Draft Strategic Plan for FY 2018-2022 (Draft Strategic Plan).

APIAHF is the oldest and largest health policy and public health organization working with Asian American (AA), Native Hawaiian and Pacific Islander (NHPI) communities across the nation and its Pacific jurisdictions. APIAHF influences policy, mobilizes communities and strengthens programs and organizations to improve the health of AAs and NHPIs. With more than 30 community-based organizational partners in over 20 states and territories, APIAHF provides a voice in the nation's capital for underserved AA and NHPI communities and works toward health equity and health justice for all.

Absence of the Affordable Care Act

We begin our comments by noting the importance of the Affordable Care Act (ACA) for AA and NHPI communities and particularly the importance of its consumer protections for these communities. From our work with AA and NHPI communities, we understand the role the ACA has played in improving access to health insurance for communities of color across the nation. Since 2010, the uninsured rate has fallen from 15.1 percent to 6.5 percent in 2016 for AAs and from 14.5 percent to 7.7 percent for NHPIs, higher than any other racial group. In addition, the uninsured rate fell from 17.8% to 9.4% for African Americans, 30.9% to 18% for Latinos, and 24.2% to 14.4% for American Indians and Alaska Natives.¹ It is our strong belief that all consumers will be best served by maintaining and continuing to implement the ACA, including strong enforcement of consumer protections in regulation and in statute and that HHS and the Centers for Medicare & Medicaid Services (CMS) can best act to ensure stability in the marketplace by maintaining these standards that have led to such record low uninsured rates and substantially reduced disparities in coverage—one of the aims of the Strategic Plan. As such, we are deeply troubled by the complete absence of the ACA in the Draft Strategic Plan and recommend the plan be revised to incorporate the ACA across numerous objectives and strategies, as detailed below.

¹ American Community Survey Table S0201, 2010 and 2016 1 year estimates.

Further, the Strategic Plan must specifically mention and address HHS' legal responsibility to uphold the laws of the United States, including the ACA and Medicaid. Without robust implementation of the ACA and adherence to Medicaid's governing statute and regulations, many of the goals and strategies outlined in this plan will be unobtainable. Further, we appreciate the recognition that consumers and enrollees should have choice but that choice must come with sufficient knowledge and information to make informed choices. The recent actions by the Administration to cut funding for navigators and open enrollment outreach are contrary to the stated ability to provide consumers with choices that they actually can understand. Navigators in particular play a critical role in informing consumers about their eligibility for health insurance, helping them enroll, explaining how to use health insurance, and connecting them with health care.

We thus suggest adding a new "strategy" bullet that would read as follows:

Implement and enforce the ACA

- Ensure sufficient resources to maintain and improve healthcare.gov and its Call Center.
- Provide sufficient financial support to FFM navigators to ensure they can operate in all counties in all FFM states and throughout the entire calendar year.
- Conduct outreach activities commensurate with the need to educate and inform individuals about the marketplaces, public health insurance programs (including Medicaid, CHIP and Medicare), their health insurance options, and how to enroll.
- Ensure compliance with all statutory and regulatory requirements regarding the Affordable Care Act and Medicaid.

Insufficient References to Disparities Experienced by Racial and Ethnic Minorities

While we welcome the numerous references to addressing health and health care disparities, including those experienced by limited English proficient persons, we strongly object to the lack of reference to the distinct disparities that racial and ethnic minorities, in particular, experience. Each year, approximately 83,000 African Americans alone die as a result of health disparities.² Health disparities are caused by a multitude of factors and impacted by race, ethnicity, sex, immigration and primary language, among others. This is one reason the HHS Office of Minority Health (OMH), Centers for Medicare & Medicaid Services Office of Minority Health and numerous other OMH divisions within HHS serve critical roles in supporting HHS' Strategic Plan and why a Plan that is designed to advance the needs of the American public must reflect the demographics of the American public.

For example, children of color experience a number of distinct disparities that impact them across the lifespan. AA and NHPI children suffer from high rates of diabetes compared to other groups. The rate of new diagnoses of Type 2 Diabetes in AA and PI children rose 8.5% annually between 2002-2012, compared to 4.8% amongst all youth.³ Similarly, African American children are four times more likely to die from asthma than white children, even though this condition is easily treated with regular care.⁴

² Satcher et al, *What If We Were Equal? A Comparison Of The Black-White Mortality Gap In 1960 And 2000*, Health Affairs March 2005 vol. 24 no. 2 459-464, <http://content.healthaffairs.org/content/24/2/459.long>

³ Lenna L. Liu, MD, MPH, et al., *Type 1 and Type 2 Diabetes in Asian and Pacific Islander U.S. Youth*, Diabetes Care, Vol. 32 (Suppl 2), March 2009, available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2647693/>

⁴ *Children's Environmental Health Disparities: Black and African American Children with Asthma*, Environmental Protection Agency, 2014, available at: https://www.epa.gov/sites/production/files/2014-05/documents/hd_aa_asthma.pdf.

Racial and ethnic minorities, including AAs and NHPIs, disproportionately experience a number of chronic conditions due to factors including poverty, inability to afford quality coverage, and challenges accessing culturally competent care, among others. The AA and NHPI community speaks over 100 different languages and traces their heritage to more than 50 different countries. As of 2016, 11% of AAs and 23% of NHPI families live below the poverty line.⁵ Language barriers, lack of cultural competency, poverty, and immigration status all affect the ability of AAs and NHPIs to access coverage and care.

Moreover, AAs and NHPIs have a higher likelihood of suffering from a number of chronic conditions requiring routine access to care and underscoring the importance of early prevention. NHPIs have the highest age-adjusted percentage of people with diabetes (20.6%), more than 3 times that of whites (6.8%).⁶ AAs and NHPIs are the only racial group for whom cancer is the leading cause of death.⁷ Certain AA and NHPI subpopulations suffer from even greater health disparities. Fourteen percent of Indian Americans have diabetes, a rate higher than that of nearly all other racial groups.⁸ Vietnamese women have cervical cancer rates five times higher than white women.⁹ NHPIs are 30% more likely to be diagnosed with cancer than whites.¹⁰

It is for these reasons that we recommend that the Draft Strategic Plan be revised to explicitly reference disparities amongst racial and ethnic minorities. Including more explicit references to racial and ethnic minorities is consistent with numerous federal efforts including the [HHS Action Plan to Reduce Racial and Ethnic Disparities](#), the first [CMS Equity Plan for Improving Quality in Medicare](#), the [2016 National Health Care Quality and Disparities Report from the Agency for Healthcare Research and Quality](#), and numerous other federal initiatives. Failure to include more explicit references to the disparities that racial and ethnic minorities, in particular, experience is a marked departure from the 2014-2018 HHS Strategic Plan. HHS should build on previous efforts and use them as a foundation for further disparities elimination.

Importance of the Offices of Minority Health

The HHS Office of Minority Health (HHS OMH), the National Institute on Minority Health and Health Disparities within the National Institutes of Health and Offices of Minority Health within the Centers for Medicare & Medicaid Services, CMS, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, Food and Drug Administration, Health Resources and Services Administration, and the Substance Abuse and Mental Health Services Administration serve joint and distinct roles in addressing the burdensome impact of racial and ethnic health disparities in this country. The HHS OMH dates back to Secretary Heckler's report on the status of black and minority health, which was the first

⁵ Samantha Artiga, et al., *Key Facts on Health and Health Care by Race and Ethnicity, Section 1: Demographics*, Kaiser Family Foundation, June 7, 2016, available at: <http://kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-section-1-demographics/>.

⁶ Asian & Pacific Islander American Health Forum, *Native Hawaiian and Pacific Islander Health Disparities*, 2010, available at: www.apiahf.org/sites/default/files/NHPI_Report08a_2010.pdf

⁷ Heron, Melonie, *Deaths: Leading Causes for 2014. National Vital Statistics Reports* Volume 65, Number 5. United States Centers for Disease Control, 2016.

⁸ Spanakis, Elias and Sherita Hill Golden, *Race/Ethnic Difference in Diabetes and Diabetic Complications*. *Curr Diab Rep.* 13(6), 2013, available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3830901/>

⁹ Miller BA et al., *Racial/Ethnic Patterns of Cancer in the United States, 1988-1992, 1996*, available at: <https://seer.cancer.gov/archive/publications/ethnicity/>

¹⁰ *Cancer and Native Hawaiians/Pacific Islanders*, U.S. Department of Health & Human Services: Office of Minority Health, Last updated March 29, 2016, available at: <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=76>.

federal report to document the existence of such disparities. Since that time, HHS OMH has spanned both Republican and Democratic administrations, fulfilling the mission of HHS by examine the data available on disparities, supporting grant programs to address and eliminate disparities and coordinating functions within HHS. Similarly, individual offices of Minority Health across other HHS divisions operate to meet the needs of their respective agencies and have supported coordination on disparities elimination plans, programming, research and expanding participation in clinical research, and quality improvement activities. Together and separately, these offices meet critical functions within HHS and their respective divisions and should play a central role in HHS' Strategic Plan.

Exclusion of LGBT Communities

We join advocates to express grave concern about the exclusion of LGBT communities from the Strategic Plan, which is harmful and undermines HHS' mission. LGBT people are disproportionately impacted by health care inequities such as facing significant barriers to accessing care and feeling discriminated against or stigmatized by health care providers. Due to these and other factors, LGBT people face higher rates of HIV/AIDS, depression, PTSD and other mental health disabilities, an increased risk of some cancers, and are twice as likely as their heterosexual peers to have a substance use disorder.ⁱ We strongly recommend that the Draft Strategic Plan be revised to include interventions aimed at addressing the health and well-being of LGBT people.

The medical community and scientific research has repeatedly demonstrated that the poor health outcomes that LGBT people experience are associated with high rates of poverty, discrimination in the workplace, schools, and other areas, and barriers to nondiscriminatory health care that meets their needs. The Office of Disease Prevention and Health Promotion recognized these disparities in the LGBT community and made it a goal of the Health People 2020 report to improve the health, safety, and well-being of LGBT people. LGBT people were included in a number of other health objectives in the report, including mental health and mental illness, tobacco use, usual source of care, and health insurance coverage. In addition, the National Institute of Health (NIH) has formally designated sexual and gender minorities as a health disparity population in 2011 for NIH research.ⁱⁱ

As a population that experiences the significant disparities related to health care access, essential services, and economic security described above, LGBT individuals should be specifically mentioned in relevant portions of the Strategic Plan. In previous strategic plans, HHS included explicit references to the LGBT population when discussing goals related to providing access to quality, competent care, improving data collection, supporting the healthy development of youth, and expanding access to culturally competent services, among other goals.

Implications for Reproductive Health

We support HHS program and initiatives that serve and protect *all* individuals across the lifespan. Public health programs and policies must be based on research, evidence, and medical and health-related facts, and must be responsive to individual patient and consumer needs and wishes. However, we note that religion and conscience are not limited to those who support the idea of life beginning at conception. In fact, the vast majority of patients have religious and conscience needs and wishes that are not served using that limited framework. In order to fulfill the person-centered strategy laid out by HHS, consumers require medically accurate, evidence-based, unbiased comprehensive health care services so that they can use their own decision making capacity to choose health care services that comport with their individual morality and circumstances. This means that reproductive health care services, including

hormonal contraception, sterilization, and pregnancy termination, must be available to all who desire those services in accordance with their own individual beliefs.

We are concerned that HHS is inserting concepts such as “the unborn” and life “from conception” into its strategic plan. These concepts run contrary to medical and health-related evidence and standards of care, and instead reflect one particular religious point of view that has no role in advancing and protecting the public health of a diverse population. Elevating a fertilized egg to equal status with a person is contrary to U.S. law and establishes a policy framework that would undermine the ability of women and others to make the best decisions for themselves and their families, including decisions impacting their health and well-being, and their ability to participate in public life.¹¹ Such policies will impede the ability of HHS to cultivate and inform best practices for women’s health, and in turn, interfere with the ability of providers, particularly those who offer reproductive health services, to provide quality care to their patients.

Second, one of the basic functions of government is to ensure the health and well-being of its population. Privileging embryos and fetuses over people threatens the capability of HHS to fulfill this function, and would deprive women of health care benefits that medical and health care experts recognize as critical to ensuring women’s health and well-being.¹² Elevating the status of a fetus over the health needs of pregnant women would result in poorer maternal health and poorer birth outcomes.¹³ Moreover, adopting policies that give health rights to fetuses would also undermine a woman’s constitutional right to access abortion, and interferes with the patient-provider relationship by limiting the information, counseling, referral and provision of abortion services that a woman can receive, despite the fact that these are part of the standard of care for a range of common medical conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer. The language is overly broad, confusing, and subject to misuse and abuse by creating a federal health care framework that invites HHS to refuse to participate in the orderly delivery of evidence-based health care services.

In addition, we recommend considering the importance of reproductive and sexual health in relation to preventing interpersonal violence and promoting healthy relationships.

Maintain and Enforce Civil Rights Protections and Nondiscrimination

We are deeply concerned that the Strategic Plan fails to reference existing federal civil rights laws and obligations and Executive Orders that HHS, its divisions, and recipients of HHS federal funding are subject to. These civil rights protections include Executive Order 13166, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, the Age Discrimination Act, and Section 1557 of the Affordable Care Act. All of these laws must be fully implemented and enforced by HHS to ensure that HHS’ programs and activities, and those it supports with federal funds, are responsive to consumer demands. As such, we support the recommendation of the National Health Law Program and recommend that HHS add a new section that reads:

¹¹ Roe v. Wade, 410 U.S. 113, 153 (1973); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 856 (1992).

¹² AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, COMMITTEE OPINION: INCREASING ACCESS TO ABORTION (2014), <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co613.pdf?dmc=1&ts=20171019T1538434634>.

¹³ CENTER FOR REPRODUCTIVE RIGHTS AND IBIS REPRODUCTIVE HEALTH, EVALUATING PRIORITIES: MEASURING WOMEN’S AND CHILDREN’S HEALTH AND WELL-BEING AGAINST ABORTION RESTRICTIONS IN THE STATES (2017), <https://ibisreproductivehealth.org/sites/default/files/files/publications/Evaluating%20Priorities%20August%202017.pdf>.

- Vigorously enforce laws, regulations and other authorities, especially Title VI of the Civil Rights Act of 1964, Executive Order 13166, Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, the Age Discrimination Act, and Section 1557 of the Affordable Care Act

Goal 1: Strategic Goal 1: Reform, Strengthen, and Modernize the Nation’s Health Care

Objective 1.1: Promote affordable health care, while balancing spending on premiums, deductibles, and out-of-pocket costs.

Promote preventive care to reduce future medical costs

Overall we appreciate an emphasis on reducing costs for consumers, but note that in the drive to reduce costs, health care quality and health equity must be paramount goals. As addressed in our introductory comments to the Draft Strategic Plan, this is an area that would benefit from an explicit reference to the fact that racial and ethnic minorities are at high risk of developing chronic diseases. For example, stroke, heart disease and cancer are amongst the leading causes of death for all Americans and are more common in racial and ethnic minority groups. These conditions are often impacted by a number of underlying factors, including barriers affording and accessing routine preventive care, literacy around preventive care and linguistic challenges. As a result, expensive and burdensome chronic conditions continue to disproportionately impact minority populations, including the fact that African Americans are more than 40% more likely than non-Hispanic whites to have high blood pressure and less likely to have this under control.¹⁴ In addition, the rate of diagnosed diabetes is 18% higher among Asian Americans than among non-Hispanic whites.¹⁵

AAs, compared to other groups, have significantly lower utilization rates of preventive care and certain vaccines. For example, AAs are significantly less likely to have had a blood cholesterol test, colonoscopy or pneumococcal vaccine.¹⁶

As a result, having access to primary and secondary preventive health services, as addressed in the Draft Strategic Plan, is critical for reducing the burden of chronic conditions and access to immunizations and vaccines. Current HHS efforts through the implementation of the National Standards for Culturally and Linguistically Appropriate Services in health and health care and the CMS Coverage to Care initiative offer concrete steps to accomplish this objective.

Strengthen informed consumer decision-making and transparency about the cost of care

Comparison and decision-making tools, while important aspects of supporting patient engagement in their care, must be culturally and linguistically accessible. 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. Similar guidelines should apply to health literacy tools and partner efforts to promote understanding the health care system, plans and terminology.

¹⁴ *Racial and Ethnic Approaches to Community Health*, Centers for Disease Control and Prevention, Last accessed October 10, 2017, available at: <https://www.cdc.gov/chronicdisease/resources/publications/aag/reach.htm>.

¹⁵ *Racial and Ethnic Approaches to Community Health*, Centers for Disease Control and Prevention, Last accessed October 10, 2017, available at: <https://www.cdc.gov/chronicdisease/resources/publications/aag/reach.htm>.

¹⁶ <https://www.ncbi.nlm.nih.gov/pubmed/20828104>

Since 2012, APIAHF and partners have outreached to, educated and enrolled nearly 1 million AAs and NHPs in more than 56 languages through Action for Health Justice, a national collaborative of more than 70 AA and NHP national and local community-based organizations and health centers. As part of these efforts, APIAHF and Action for Health Justice member organizations developed [glossaries of the most common 100 insurance terms, available in 12 Asian and Pacific Islander languages](#) to promote better understanding of coverage and how to effectively use it amongst the newly insured. In addition to increasing education and awareness about the delineated coverage options, we recommend adding ACA marketplace coverage and availability of financial assistance and the Children's Health Insurance Program (CHIP).

We appreciate the work that CMS has undertaken to educate consumers about their options for buying healthcare. These actions have had the effect of empowering millions of patients around the country. Providing education and technical assistance to enrollment workers of all types, supporting and funding the navigator program, and developing web and print materials in multiple languages have all been critical steps to promoting consumer choice. HHS should continue these efforts and reverse planned cuts for the upcoming Open Enrollment period beginning November 1, 2017 as they undermine the aims of the Draft Strategic Plan.

We encourage CMS to continue to provide robust support for consumers who are limited English Proficient (LEP). Being LEP, consumers may miss information about enrolling in healthcare or additional steps needed to verify eligibility. Among those who speak languages other than English at home, AAs (31.4%) have an LEP rate almost four times higher than the rate for Non-Hispanic Whites (6.0%) and the total U.S. population (8.6%). We appreciate the improvements CMS has made to the language line, such as conducting greater oversight of the line's quality. We encourage CMS to build on these efforts and continue to work towards ensuring LEP consumers do not face barriers to education and enrollment. For example, we urge CMS to provide more in-language enrollment and notice resources.

HHS and CMS must also maintain existing civil rights protections under Section 1557 of the ACA. The existing statutory and regulatory language under 1557 provide important legal standards for consumers based on long-standing protections under Title VI of the Civil Rights Act of 1964. Section 1557's protections for language access in health care mean that LEP consumers do not have to worry about missing critical information because of their language skills. We would be deeply concerned about potential changes to 1557 under review by the U.S. Department of Justice and strongly oppose reopening the rule finalized in May 2016, which health industry and consumers have now spent over a year adopting. Instead, CMS should continue to enforce existing 1557 standards so that consumers are not burdened by discriminatory plan or provider actions.

Strengthen coverage options to reduce consumer costs

Providing robust funding for navigators is essential to ensuring that hard to reach populations are empowered to understand their health care options. APIAHF learned firsthand the importance of in-person assistance through our Action for Health Justice (AHJ) work described above, a national collaborative of more than 70 organizations that has worked to enroll more than 1 million consumers in 22 states and in 56 languages. After the first open enrollment period, AHJ issued a report citing the need for one-on-one assistance to overcome barriers faced by Asian American, Native Hawaiian and

Pacific Islander populations, like limited English proficiency.¹⁷ Navigators and other enrollment workers will be even more important in the coming open enrollment period, given the changes to the enrollment process and consumer eligibility finalized in the marketplace stabilization regulation on April 13, 2017. We urge CMS to continue to provide funding to navigators at at-least equivalent levels as previous years and continue to include organizations with expertise in reaching culturally and linguistically diverse populations as navigator grant recipients. Similarly, we strongly oppose CMS' planned cuts to overall outreach and enrollment for the 2017-2018 Open Enrollment Period and the 41 percent reduction in navigator funding. As detailed above, these cuts run directly counter to the access aims of the Draft Strategic Plan.

In addition to funding navigators, CMS should ensure enrollment workers, including but not restricted to navigators, are provided robust technical assistance and training. With changes coming to enrollment that may cause consumer confusion, such as requiring greater SEP documentation or allowing insurers to deny consumers who were unable to pay previous premiums, organizations that work with communities to provide enrollment assistance will play a critical role in reducing burdens on consumers. CMS should similarly invest in direct-to-consumer education efforts and maintain the marketing activities of previous enrollment campaigns.

As we expressed in our comments on the proposed marketplace stabilization rule, we are concerned that the action CMS took to allow greater *de minimis* variation in actuarial value (AV) will decrease consumer empowerment and education. The ACA's metal tiers allow marketplace customers to better understand the differences between plans, particularly in how their own cost sharing might vary for the different levels. Allowing greater AV variation blurs the lines between metal tiers and may lead to consumer confusion. We urge CMS to consider restricting the variation allowed.

Overall, we believe many of the measures discussed above to improve outreach and enrollment would bring greater stability to the risk pool. Younger and healthier populations require greater assistance and face larger barriers to enrollment.¹⁸ We encourage CMS to take actions that increase resources to these and other harder to reach populations, as well as reduce obstacles to their enrollment. For example, CMS can simplify enrollment during Special Enrollment Periods, as young adults are more likely to experience SEP qualifying events.¹⁹ Similarly, continuous coverage requirements or penalties are likely to discourage enrollment from those who are the healthiest and are most needed within insurance to spread risk. We encourage CMS to study the impact of these enrollment barriers.

We echo comments from the National Association of Insurance Commissioners (NAIC) Consumer Representatives that it is vital for the ACA's cost sharing reductions (CSRs) to be funded. Many insurance companies have cited the uncertainty around CSR funding as a source of premium hikes. By not providing this funding, the Administration could cause an at least 19% increase in premiums.²⁰ We

¹⁷ Improving the Road to ACA Coverage: Lessons Learned on Outreach, Education, and Enrollment for Asian American, Native Hawaiian, and Pacific Islander Communities, Asian and Pacific Islander American Health Forum. September 2014. <http://www.apiahf.org/resources/resources-database/improving-road-aca-coverage-lessons-learned-outreach-education-and-enro>

¹⁸ See for example, Andrews, Michelle, Young Adults Can Face Challenges To Health Enrollment, Kaiser Health News. July 5, 2016. <http://khn.org/news/young-adults-can-face-challenges-to-health-enrollment/>

¹⁹ Schutlz, Sarah, Restricting Special Enrollment Periods Could Hurt Young Adults – and the Health Insurance Marketplaces. Young Invincibles. October 16, 2016. <http://younginvincibles.org/reports-briefs/restricting-special-enrollment-periods-hurt-young-adults-health-insurance-marketplaces/>

²⁰ Kaiser Family Foundation, Estimates: Average ACA Marketplace Premiums for Silver Plans Would Need to Increase by 19% to Compensate for Lack of Funding for Cost-Sharing Subsidies (Apr. 2017); see also Linda J. Blumberg & Matthew Buettgens, The Implications of a Finding for the Plaintiffs in *House v. Burwell*, Urban Institute (Jan. 2016).

urge CMS to fully and permanently provide stability to the insurance markets by funding the CSRs and reverse the planned elimination for the 2018 plan year which runs counter to the coverage aims of the Draft Strategic Plan.

Promote higher value and lower cost healthcare options

While we welcome the numerous references to community health workers and community organizations throughout the Draft Strategic Plan, we note that having formal, sustainable funding mechanisms and avenues for partnership with public and private partners are critical to engaging such persons and entities in the health care delivery system. We encourage the inclusion of a path to such mechanisms in the final Plan.

As outlined in our “Connecting Limited English Proficient Individuals to Healthcare Systems Report,” there is a recognition amongst various sectors of the need to include community-based organizations (CBOs) within the healthcare system, yet operational challenges to doing so.²¹

Community based organizations and other trusted community partners play a vital role in supporting a person’s “whole health” as they relate to language access, faith, mental and social support, education, financial security, etc. As noted in our Report, it is critical that there be collaboration and linkage amongst health providers of different types and amongst those who are in non-health/non-clinical areas. Such non-health/non-clinical entities provide essential services that are often not reimbursed by many payers (public or private), including patient navigation at the onset of enrollment in coverage, selection of appropriate primary care provider, resolution of and filing of appeals and other benefits claims. In addition, CBOs, for example, help patients understand what services are covered by their plans, provide assistance with scheduling appointments and help them obtain and understand proper use of prescription drugs. These services are often provided with little to no reimbursement or resources to the CBO and are relied upon by racial and ethnic minorities and those with limited health literacy and English proficiency.

Although more LEP individuals have gained coverage, language continues to present a significant barrier when accessing health care services. Spoken language differences between patient and provider, the lack of appropriate interpretation services, and inadequate translated materials for patients all contribute to communication barriers that adversely affect health outcomes and contribute to the existence of health disparities. Patients who are LEP are less likely to seek care, even when insured, and experience lower quality of care and more adverse health outcomes, such as longer hospital stays and a greater chance of hospital readmission for certain chronic conditions, compared to those who speak English well. Many of those who need interpretation services are not aware of their rights to receive language assistance at a hospital or clinic.

CBOs serving AA and NHPI communities often focus on providing services to specific AA and NHPI ethnic subgroups that are most represented in the community. Others provide services for segments in a community, such as immigrants and refugees, that often have a large proportion of individuals who came to the U.S. from an Asian or Pacific Island nation. Many of these individuals are LEP, and therefore CBOs frequently have multilingual staff and volunteers who come from the community with

²¹ Asian & Pacific Islander American Health Forum, Connecting Limited-English Proficient Individuals to Health Care Services: The Important Role Of Community-based Organizations, (June 2017), http://www.apiahf.org/sites/default/files/2017.06.13_Connecting%20Limited-English%20Proficient%20Individuals%20to%20Health%20Care%20Services_Brief_0.pdf

the necessary cultural understanding to competently provide in-language assistance to the individuals they serve.

CBOs can function as a hub for LEP individuals who want to access care, but who need culturally and linguistically appropriate assistance to navigate the health care system. Although CBO staff may not be certified community health workers (CHWs), they still provide culturally competent in-language enrollment assistance and assistance in helping people access care and navigate the health care system. CBOs can serve as important members of a care coordination system designed to improve health care access and quality for LEP individuals and receive compensation for services provided by staff, just as CHWs are compensated for helping individuals navigate the health care system. This compensation could come in the form of contracts between CBOs and hospitals, insurers, and provider networks in which CBO staff provide interpretation and health system navigation for LEP individuals. Health plans could contract with CBOs to help their LEP members find providers, describe services covered under their plan, make appointments with providers, and provide interpretation assistance during clinic visits.

Incentivize quality and value-based care

We welcome the emphasis on efforts to incentive quality and value-based care, which offer an opportunity to accomplish the Triple Aim of better care, better health and lower costs for AAs and NHPIs 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. We believe that the push to improve the health care system and quality must correspondingly include a drive to improve health equity and eliminate disparities. Such a drive must integrate and explicitly include achieving health equity as a goal. In particular, we urge HHS and CMS to consult the released draft National Quality Forum report “A Roadmap to Reduce Healthcare Disparities Through Measurement”²² and the Principles for Patient- and Family-Centered Engagement from the Consumer and Patient Advisory Group of the Learning Action Network, as ways to operationalize the goal of higher quality and value-based care and health equity through explicit methods and leveraging existing measures.²³

Collect, analyze, and apply data to improve access to affordable health care

We strongly agree with the emphasis on the overarching need to collect, analyze and apply data to both monitor health outcomes and access, identify disparities and improve access to affordable health care. The collection, analysis and reporting of detailed, granular data 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. Under the ACA, federal health surveys are required to comply with Section 4302 data collection standards and, at minimum, OMB standards. Other CMS programs, such as the Quality Payment Program under MACRA, required more detailed compliance, including the use of 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

²² National Quality Forum, *A Roadmap to Reduce Health and Healthcare Disparities through Measurement Draft Report*, (July 21, 2017), http://www.qualityforum.org/Disparities_Project.aspx

²³ Health Care Payment Learning & Action Network, *Principles for Patient- and Family-Centered Payment*, (April 26, 2016), <https://hcp-lan.org/2016/04/cpag-principles-approved/>

activity). This information is foundational to HHS' overall quality improvement efforts and those by CMS in 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.

We stress the importance of the collection and reporting of specifically disaggregated data, not just by the 1997 OMB standards, but as envisioned by the progress made through Section 4302. Different communities, particularly within AA and NHPI populations have widely varying needs, which are often obscured when data is only reported at aggregated levels. Data that breaks down race groups by subgroups, ideally at smaller levels of geography, provide much richer details on how to craft policy and program solutions that meet the needs of communities.

Capturing and reporting data stratified by primary language is critical given that an estimated 25 million Americans are LEP and speak either no English or speak English less than very well. Improved reporting of data on Americans who are LEP can help providers better understand and serve their communities, issuers target their marketing and customer materials and policy makers ensure resources are directed to ensuring health programs are accessible. Because providing information in-language can be resource intensive, quality data on primary language ensures resources are spent on the most productive means.

While we agree with the need for HHS to track trends in premiums, out-of-pocket payments and other matters relating to affordability of health plans, we note that recent efforts by HHS related to the upcoming marketplace Open Enrollment Period undermine such efforts as well as the strategy of ensuring that Americans understand their plan options and are able to effectively access their benefits. For example, HHS' planned 90 percent reduction in supporting efforts related to outreach and enrollment, significant cuts to the navigator program and scheduled outages of Healthcare.gov during critical business hours all threaten to drive down enrollment and prevent Americans from identifying and enrolling in plans and effectively using their coverage.

Objective 1.2: Expand safe, high-quality healthcare options, and encourage innovation and competition

Incentivize safe, high-quality care

With respect to the development of new payment and service delivery models, we reiterate our comments from Objective 1.1 related to the need to address health equity and elimination of health disparities for communities of color in quality improvement efforts.

We note that alternative payment models must not be implemented in such a way that they create incentives to stint on needed care or avoid costlier patients. We believe that HHS should focus on models that prioritize primary care (for example, that include strong PCMH requirements). Furthermore, we recommend that if HHS uses financial incentives, those incentives should be focused on improving outcomes and not reducing costs.

Leverage technology solutions to support safe, high-quality care

We agree with the need to support interoperable clinical information flows and reiterate our comments from objective 1.1 regarding the foundational role that accurate, detailed and disaggregated data plays in assisting providers.

Empower patients, families, and other caregivers to facilitate the delivery and increase the use of safe, high-quality, person-centered care

In promoting patient-centered care, we recommend that HHS consult with the [Consumer and Patient Advisory Group of the Learning Action Network patient principles](#) which describe several ways in which patients, their families and advocates should be involved in all steps of developing and implementing health systems and payment and care models.

With respect to outcome measures, we note that it is critical that electronic health records (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. The collection and reporting of such data enables policymakers to better understand the experiences that different demographic populations experience in clinical settings and how quality improvement programs can be best tailored to their needs.

Reduce disparities in quality and safety

With respect to the use of health information technology and EHRs, we reiterate our earlier comments and agree that safety-net providers and community-based organizations should not only inform decision-making, but must be active participants and have the resources to do so.

Workforce solutions that deliver culturally competent care must also be able to deliver linguistically accessible care in compliance with existing federal civil rights protections. Any flexibility should not result in reduced patient access or increased costs to patients. For example, interpretation services must be provided by certified interpreters to ensure quality delivery of care and patient engagement.

We agree that more information must be provided to patients in languages other than English to improve health care knowledge and that this information must be provided at appropriate literacy levels. It is also imperative that these materials be translated through quality translation services and that terms and language reflect the terms and language actually used in communities.

With respect to the funding of research into the social determinants of health, we agree conducting such research may improve access, quality and safety. Social determinants of health include poverty, geography, immigration status, education and social support networks. We believe funding will help study the impact of these factors on lives and also offset disparities.

Collect, analyze, and apply data to improve access to safe, high-quality health care

In general, we agree with the foundational need to improve the collection, analysis and reporting of data to ensure that care is high quality and the provisions of resources to entities to do so. As such, we reiterate our earlier comments about detailed and disaggregated data.

Objective 1.3: Improve Americans' access to health care and expand choices of care and service options

Improve consumer understanding of healthcare options and consumer-directed healthcare decisions

As detailed in our comments to Objective 1.1, community based organizations and other trusted community partners play a vital role in supporting a person's "whole health" as they relate to language

access, faith, mental and social support, education, financial security, etc. These organizations play a central role in the coordination and communication of information about healthcare options within communities. We strongly support an emphasis on improved consumer understanding of healthcare options through expanded partnerships, pilot programs and demonstrations that fund community based organizational partners as they strive to serve non-health/non-clinical areas.

When LEP consumers seek care, even when insured, they experience lower quality of care and more adverse health outcomes, such as longer hospital stays and a greater chance of hospital readmission for certain chronic conditions, compared to those who speak English well. Many of those who need interpretation services are not aware of their rights to receive language assistance at a hospital or clinic. It is important, as noted earlier in our comments, that patients receive not just information, but information in high quality translations at the appropriate literacy level.

Design healthcare options that are responsive to consumer demands, while removing barriers for faith-based and other community-based providers

The ACA for the first time established ten Essential Health Benefits (EHBs) that all qualified health plans must cover. Prior to the enactment of the ACA, consumers had little knowledge about what their insurance plans covered, both when purchasing their plans and when attempting to use health care. It was not uncommon for consumers to make assumptions that their insurance would cover critical services like cancer treatment, only to find out that it did not and be forced with unthinkable decisions. Therefore, while we do support consumer choice in health care, we wish to stress the importance of upholding the standards for plans under EHB and other protections in the ACA, ensuring that health insurance provides a minimum standard of coverage.

Reduce disparities in access to health care

We reiterate our comments from the introductory section that detail the significant gaps in this section for failing to explicitly include disparities experienced by racial and ethnic minorities. New patient centered models of care will not succeed if they fail to take into consideration the specific needs of the populations they aim to improve the health of. It is important for all actors in both the design and implementation of models like patient-centered medical homes, to consider how the language, place of origin, cultural practices, health status, likelihood for certain conditions, trust of the health system and other factors relating to race and ethnicity of the patients participating in these systems impact their use of them.

While we support research on new ways to expand access to affordable coverage, we wish to reemphasize the central role the ACA has played in reducing disparities in health insurance coverage rates between race and ethnic groups. While gaps remain and we support efforts to further enhance coverage, which we believe is achievable by ensuring resources are directed to the most vulnerable, the best mechanism for the Secretary to increase access to coverage is to promote and work within the framework of the ACA, such as exploring ways to expand coverage of oral health and vision in plans.

Similarly, while we support efforts to identify populations at risk for limited health access, these populations have been largely identified. In addition to AA and NHPI groups, particularly among those with high uninsured rates (such as Pakistani, Nepalese, Korean and Micronesian), LGBT populations, people with disabilities and low-income individuals are all at risk. As we have stated, CBOs play a critical role in connecting these groups to care. For example, an important program for many in prevention and screening has been the Racial and Ethnic Approaches to Community Health (REACH)

program, which funds CBOs to conduct population-based healthy eating and active living campaigns. Organizations using REACH funds have created coalitions with faith groups to improve access to recreational areas, brought farmers markets to low-income housing and conducted education campaigns about eating healthy.

Objective 1.4: Strengthen and expand the healthcare workforce to meet America's diverse needs

While we support the goals of expanding the healthcare workforce, we again point out the lack of inclusion of the workforce issues impacting communities of color.

Reduce provider shortages in underserved and rural communities

We wish to note the important role Federally Qualified Health Centers play in increasing access to providers in underserved areas and, particularly, the role of the National Health Service Corps of increasing pipeline of the healthcare workforce into those communities. We also wish to note that for some communities, underserved means a lack of providers who are culturally competent with quality translation services, clinical practices that align with the cultural practices of communities and diverse backgrounds. We encourage efforts to increase providers not just in number but also in the quality of services they provide to diverse communities.

Support professional development of the healthcare workforce

We support increased training of health care providers in patient engagement as well as in partnering with community health workers and partners, which we have noted lack stable funding mechanisms. We also support training providers in cultural competencies, such as knowledge of the [Culturally and Linguistically Accessible Services \(CLAS\) Standards](#). We note the existence of the Merit-Based Incentive Payment System: Clinical Practice Improvement Activities Performance Categories, particularly the category to take steps to close disparities among communities, which provides a strong opportunity for provider engagement in those communities and learning of community practices.

Collect, analyze, and apply data to better understand opportunities to strengthen the healthcare workforce

We reiterate our previous comments about the importance of collecting disaggregated data on racial and ethnic minorities for improving healthcare. Data on the diversity of our workforce and the populations they work with are critical to understanding whether and how community needs are being met. Gaps in both the makeup of and the geographical distribution of a diverse workforce indicate to policymakers the steps that must be taken to address disparities.

We encourage the expansion of mid-level practitioners and note that Community Health Workers also play an important role in many models in which the concept of care is not restricted to a physician's office. We face serious physician shortages in many communities and expansion of nurse practitioners and dental therapists help to alleviate pressure on the existing work force as well as provide opportunities to communities that have faced financial and other barriers to physician training.

Goal 2: Protect the Health of Americans Where They Live, Learn, Work, and Play

Objective 2.1: Empower people to make informed choices for healthier living

In supporting culturally and linguistically competent health care services and providers, we recommend referring to the CLAS in health care, which provide 15 action steps to advance health equity in a tangible manner. In particular, compliance with the CLAS standards, existing federal civil rights protections and guidance, such as developing language access plans, can all support empowering people to make informed choices for healthier living.

With respect to partnering with organizations that support healthy living, we reference the existing Centers for Disease Control and Prevention's Racial and Ethnic Approaches to Community Health (REACH) program, which has for decades demonstrated return on investment in partnering with community based organizations.

Promote better nutrition and physical activity

We support efforts to help consumers better understand how diet, exercise and other lifestyle choices impact their health. Healthy eating and active living programs play a core role in addressing health disparities and the social determinants of health. It is important that HHS acknowledge the role of disparities and the role of community groups in addressing them in promoting better nutrition and physical activity.

For many AA and NHPI communities, particularly amongst immigrant and first generation populations, a successful strategy often involves adapting and educating around cultural recipes for ingredients more commonly found in the grocery store as well as engaging communities and farms in growing ingredients that populations are more used to. It also looks like ensuring that physical activity programs are in locations where communities feel comfortable. Successful strategies often involve adapting cultural dance for workouts or creating spaces where women and girls can exercise. We previously mentioned the REACH program, which has encouraged innovation in these practices.

Promote healthcare access and reduce healthcare disparities

HHS OMH serves a critical function in promoting healthcare access and reducing healthcare disparities. In addition to supporting and working to disseminate disparities related data analysis and reporting, OMH is one of the few offices that fund work in the U.S. territories aimed at stemming the tide of HIV/AIDS. We view OMH as the right home for partnerships across private and public entities focused on improving healthcare decision making among racial and ethnic minority communities.

Objective 2.2: Prevent, treat, and control communicable diseases and chronic conditions

Support early detection and treatment of communicable and chronic diseases

AAs and NHPIs constitute 50 percent of all cases of chronic liver infection. Half of the 1.2 million Americans living with Hepatitis B Virus (HBV) are AA, despite making up less than 5 percent of the population. HBV and HIV present similar risk profiles and challenges to addressing education, outreach and connection to care. Similar to HIV, HBV is a condition that is highly stigmatized, both because of its presumed relationship to promiscuity as well as association with immigrant populations. This is an important concern for AAs, of whom 60 percent are foreign born. While the conditions share similar risk profiles, they also present different challenges in patient and community education and testing as HIV can be done via a rapid test, while HBV requires additional follow-up and assessments. Thus, it may not always be practicable to screen for HBV when conducting HIV or other Sexually Transmitted Disease tests. Moreover, the risk of infection through personal and nonsexual contact differs greatly from HIV,

presenting additional challenges in education and outreach for AA and NHPI audiences. Given these considerations and underlying data, we recommend the Strategic Plan be revised to explicitly reference the disproportionate burden these conditions have amongst AA and NHPI communities.

Strategic Goal 4: Foster Sound, Sustained Advances in the Sciences

Strengthen surveillance and epidemiology to protect health security and improve health outcomes

Despite numerous national, state, and local efforts to improve HIV/AIDS surveillance and epidemiology, there continues to be significant gaps in the collection, reporting, and dissemination of HIV/AIDS data related to AA and NHPI populations. Several states continue to aggregate or “lump” AA and NHPI data into an “other” category. Few states provide disaggregated AA and NHPI data in their surveillance reports and epidemiologic profiles. Despite these gaps, there have been some health departments who have sought to address their own internal as well as their constituents’ data needs related to AA and NHPI populations.

In 2011, the Asian & Pacific Islander American Health Forum (APIAHF) began a [qualitative review](#) of HIV/AIDS surveillance reports, epidemiologic profiles (epi-profiles), and other surveillance-related documents across 50 state health departments and several cities funded directly by the CDC. Through this review, several jurisdictions were identified for further review to detail and document “promising” practices related to HIV/AIDS data collection, reporting, and dissemination for AA and NHPI populations.

This [report](#) includes in-depth case studies of three jurisdictions: New York, Hawaii, and San Francisco. All three represent jurisdictions with significant AA and NHPI populations and significant rates of HIV/AIDS in AA and NHPI populations. Each jurisdiction historically and/or currently demonstrates a level of responsiveness to increased needs for AA and NHPI HIV/AIDS data to inform planning and prevention service efforts. This report also includes “bright ideas” or mini-case studies of practices implemented by jurisdictions across the U.S. These mini-case studies include states where there are emerging AA and NHPI communities and/or trends of increasing impact of HIV/AIDS on AA and NHPI communities. Similar to the in-depth case studies, these “bright ideas” were developed based on review of available documents as well as key informant interviews with health department staff.

In summary, the report provides detailed background for HHS on the continuing data needs of smaller, diverse populations like AAs and NHPIs.

Conclusion

Thank you for the opportunity to comment on the Draft HHS Strategic Plan. Please contact Amina Ferati, Senior Director of Government Relations & Policy ([aferati@apiahf.org](mailto: aferati@apiahf.org)) if you have any questions.

Sincerely,



Kathy Ko Chin

President & CEO
Asian & Pacific Islander American Health Forum

ⁱ Kellan Baker, “Open Doors for All” (Washington: Center for American Progress, 2015), available at <https://www.americanprogress.org/issues/lgbt/reports/2015/04/30/112169/open-doors-for-all/>.

ⁱⁱ Office of Disease Prevention and Health Promotion, “Lesbian, Gay, Bisexual, and Transgender Health: Overview,” Healthypeople.gov, available at <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health>; Eliseo J. Pérez-Stable, “Director’s Message: Sexual and Gender Minorities Formally Designated as a Health Disparity Population for Research Purposes,” *National Institute on Minority Health and Health Disparities*, October 6, 2016, available at <https://www.nimhd.nih.gov/about/directors-corner/message.html>; Office of Disease Prevention and Health Promotion, “Lesbian, Gay, Bisexual, and Transgender Health: Objectives,” Healthypeople.gov, available at <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health/objectives>