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August 14, 2018

The Asian & Pacific Islander American Health Forum (APIAHF) appreciates the opportunity to comment on Health Care Innovation Caucus Request for Information (RFI). As an organization that values and strives for high-quality affordable care for all, APIAHF welcomes the creation of this bi-partisan caucus and its drive to examine policy solutions that improve health care and lower the cost of care for all consumers.

APIAHF is the nation's leading health policy group working to advance the health and well-being of over 20 million Asian Americans, Native Hawaiians and Pacific Islanders (AA and NHPI) across the U.S. and territories. 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 Health Care Innovation Caucus offers 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, particularly in the context of Medicaid and Medicare. 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. APIAHF is one of the few racial and ethnic focused health organizations working in health care and system transformation efforts. It is critical that such efforts address existing disparities that cost the nation over [\\$230 billion](#).¹

Thomas A. LaVeist, Darrell Gaskin, Patrick Richard, Estimating the Economic Burden of Racial Health Inequalities in the United States.
Int J Health Serv. 2011; 41(2): 231-238, April 2011.

Value-Based Provider Payment Reform

What barriers limit the full potential of innovation in Medicare and Medicaid?

The Centers for Medicare and Medicaid Services (CMS) should implement the recommendations of the Assistant Secretary for Planning and Evaluation (ASPE),² National Academy of Sciences, Engineering, and Medicine (NASEM),³ and National Quality Forum (NQF)⁴ to make value-based payment adjustments based on patient social risk factors in Medicare, as well as in Medicaid and other CMS innovation programs. ASPE, NASEM, and NQF have identified the types of patient social and behavioral risk factors that would be most relevant for payment risk adjustment. Without such payment risk adjustments, safety net providers and essential community providers who serve medically underserved patients will continue to be unfairly penalized, or lack sufficient financial incentives, to participate in value-based payment activities.

We also support the funding of additional State Innovation Models by CMS, with the condition that any future models be multi-payer models (some combination of Medicare, Medicaid, state government payers, and private payers in the state's health care market). States are able to design and test innovations that are tailored for their respective health care markets and delivery systems, and CMS should be proactively leveraging federal programs to drive such state-level innovation towards value.

In addition, we note that the capacity of providers who are small, rural, safety net or essential community providers to participate in value based payment programs is limited by technical and financial constraints. It is critical that these providers be able to fully participate in system reform efforts by ensuring that they have the necessary technical assistance and financial supports.

How can we develop better outcomes measures that accurately reflect quality, safety, and value without burdening innovation?

Last year, NQF published its *Roadmap for Promoting Health Equity and Eliminating Disparities*, identifying quality measures that would advance both quality improvement and health equity.³ The use of equity measures would continue to advance value-based delivery system and payment reforms that also address the continuing disparities in health care quality experienced by racial and ethnic, and other medically underserved populations.

NASEM has published a commissioned paper (authored by the National Committee for Quality Assurance) that proposed integrated measurement of health literacy, language access, and cultural competence.⁵ The use of such

² U.S. Department of Health and Human Services Office of Assistant Secretary of Planning and Evaluation, Report to Congress on Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs, 2016, at: <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicare-value-based-purchasing-programs>

³ National Academies of Sciences, Engineering, and Medicine, Accounting for Social Risk Factors in Medicare Payment Programs, 2016, at: <http://www.nationalacademies.org/hmd/Activities/Quality/Accounting-SES-in-Medicare-Payment-Programs.aspx>

⁴ National Quality Forum, Roadmap for Promoting Health Equity and Eliminating Disparities, 2017, at: https://www.qualityforum.org/NQFs_Roadmap_to_Health_Equity.aspx

⁵ National Academies of Sciences, Engineering, and Medicine, Measuring Improvement in the Patient Experience of Health Care: Aligning and Leveraging Measures of Health Literacy, Language Access, and Cultural Competence, 2017, at: <http://nationalacademies.org/hmd/~media/Files/Activity%20Files/PublicHealth/HealthLiteracy/Commissioned%20Papers%20-Updated%202017/Briefer%20French%20et%20al%202017%20Measuring%20improvement%20in%20the%20patientconsumer%20experience%20of%20health%20care.pdf>

integrated measures would improve both patient-centeredness and equity, two domains of health care quality that are often overlooked, under-measured, and vital to achieving health care value, i.e., improved quality and reduced costs.

There are many ongoing discussions about balancing the need for less (and more widely used, or “core”) quality measures, with the ongoing need for additional measure development to measure what matters in quality improvement, and in value-based delivery system and payment reforms. We strongly support the continued development and adoption of additional patient experience measures and patient-reported outcomes (PROs) measures⁶ as part of value-based reforms.

As a starting point, we recommend that CMS work with the Agency for Healthcare Research and Quality (AHRQ) to further develop the Consumer Assessment of Health Providers and Systems (CAHPS) surveys. Specifically, the CAHPS Clinician and Group Survey should incorporate the Patient-Centered Medical Home, Health Literacy, and Cultural Competence Supplemental Item Sets in order to measure patient experience of care more comprehensively.⁷ While CMS has made the Patient Quality Reporting System CAHPS survey available in Spanish, Cantonese, Mandarin, Korean, Vietnamese, and Russian⁸ and the Medicare Accountable Care Organization CAHPS survey available in Spanish, Cantonese, Mandarin, Korean, Vietnamese, Russian, and Portuguese,⁹ we strongly encourage CMS and AHRQ to work together to develop validated translations of *all* CAHPS surveys in at least the top fifteen primary languages spoken by Medicare and Medicaid beneficiaries.

We also support the development of alternate methodologies for measuring individual, family, and caregiver experiences besides mailed paper surveys, including obtaining qualitative feedback (such as focus groups) and the development of online/smartphone-based surveys. These methodologies are commonly used in other industries to receive consumer feedback, without reliance on costly administration of surveys. Such efforts would provide CMS, payers, and providers with important, real-time feedback from the American public about the quality of health care received.

Are there any examples of cross-payer collaborations, such as employer-Medicare or employer-Medicaid, that have achieved promising results?

The Partnership for Improving Lifestyle Intervention (PILI) ‘Ohana program is a diabetes prevention program that has been culturally adapted for Native Hawaiian and Pacific Islander populations. The program’s participants have consistently achieved and maintained weight loss outcomes, and the program now is being implemented at worksites in Hawaii.¹⁰ This is an example of a culturally tailored intervention that could be supported through payer-employer collaborations. We encourage the identification and support of other culturally and linguistically appropriate prevention and intervention programs by payer collaborations to advance value.

⁶ National Quality Forum, Patient-Reported Outcomes, 2012, at: https://www.qualityforum.org/Projects/n-r/Patient-Reported_Outcomes/Patient-Reported_Outcomes.aspx

⁷ <https://www.cahps.ahrq.gov/surveys-guidance/item-sets/index.html> We note that both the Cultural Competency and Health Literacy Supplemental Item Sets have been endorsed by the National Quality Forum, but have not been widely used.

⁸ <http://www.pqrscahps.org/en/survey-instruments/>

⁹ <http://acocahps.cms.gov/en/faqs/faqs-for-vendors/>

¹⁰ Townsend CK, Miyamoto RE, Antonio M, Zhang G, Paloma D, Basques D, Braun KL, Kaholokula JK. The PILI@Work Program: A translation of the Diabetes Prevention Program to Native Hawaiian-serving worksites in Hawaii. *Transl Behav Med.* 2016;6(2):190-201; Ing CT, Miyamoto RES, Fang R, Antonio M, Paloma D, Braun KL, Kaholokula JK. Comparing weight loss-maintenance outcomes of a worksite-based lifestyle program delivered via DVD and face-to-face: a randomized trial. *Health Educ Behav.* 2018;45(4):569-580

How can Congress help the Center for Medicare and Medicaid Innovation achieve its purpose of developing and testing innovative payment and delivery models?

CMS' Center for Medicare and Medicaid Innovation (CMMI) has a significant role in supporting innovation in value-based delivery system and payment reforms, and in leveraging the purchasing power of the Medicare and Medicaid programs to align with innovation by private payers. This is particularly critical given the outsize role that CMS is able to play as the nation's largest payer. One of the promising practices initiated by Congress through the Medicare Access and CHIP Reauthorization Act (MACRA) was the establishment of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to develop and recommend alternative payment models (APMs) for CMS adoption. We concur with the recommendation that the mandate of the PTAC be broadened to function as a standing federal advisory committee to CMS, and be allowed to initiate its own recommendations about APMs to CMS. In addition, Congress (or HHS, without any additional statutory mandates), should create additional PTACs to develop and recommend additional alternative payment models for CMS adoption, including those that specifically would address health care disparities, and advance health equity, and those tailored for safety net providers and essential community providers.¹¹

We also strongly support the requirement of Patient Advisory Councils in all CMMI programs, and the establishment of an ombudsperson within CMMI that would be able to directly address Medicare and Medicaid beneficiary concerns about CMMI programs and their impact on health care access and quality.

Lastly, we reiterate existing law and policy that CMMI's work must operate consistent with 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, but are not limited to, 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 and CMS to ensure that HHS' programs and activities, such as those operated by CMMI, and those it supports with federal funds, are responsive to consumer demands.

What should the landscape look like in 2025 and what role does government play in achieving it?

Both the Institute for Healthcare Improvement (IHI) and Families USA have recently highlighted the importance of addressing issues of health care disparities as an essential part of any strategies to achieve value-based delivery systems and payment reforms. IHI has called equity the forgotten aim of health care quality improvement.¹² Families USA has issued comprehensive recommendations for integrating equity into value-based payment reform through the Health Equity Taskforce for Delivery and Payment Transformation.¹³ At a larger level, we encourage the Caucus to examine the Health Equity and Accountability Act (H.R. 5942) for an overarching examination of the role that Congress can play in advancing health equity, including in quality efforts and addressing social determinants of health.

In particular, we note that there must be a role for community based organizations (CBOs) and other trusted community partners to play in supporting a person's "whole health" and advancing the goals of health care quality improvement. CBOs are aptly positioned to be able to provide collaboration and linkage with health providers in non-health and 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

¹¹ See, section 443, H.R. 5942, Health Equity and Accountability Act

¹² Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations, Institute for Healthcare Improvement, 2016, at:

<http://www.ihl.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx>

¹³ Families USA, A Framework for Advancing Health Equity and Value, 2018, at:

https://familiesusa.org/sites/default/files/product_documents/HEV_Policy-Options_Report.pdf

other benefits claims and language access services. In addition, CBOs, for example, help patients understand what services are covered by their plans, provide assistance with scheduling appointments and help them obtain 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 literacy and health literacy and English proficiency.

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.¹⁴ 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. Overall, CMS and CMMI should continue to support the expansion of non-clinical services that can be provided, linked to and sustainably financed via reimbursement models to support whole population health.

Technology and Health IT

What impact does health IT and data interoperability have on successfully running value-based payment models and contracting? What are some ways to improve interoperability and the sharing of data?

While there has been significant discussion about advancing interoperability and health information exchange as essential to increased utilization of electronic health record data to report, monitor, and improve health care quality (and reduce costs from waste, duplication, and poor quality), the issue of standardization of patient demographic data continues to be overlooked. The ongoing challenges of patient matching will continue to be a barrier to effective and efficient interoperability.¹⁵ While the CMS proposed rule for the 2019 Quality Payment Program¹⁶ continues to support the ongoing implementation of the Office of National Coordinator for Health IT’s 2015 standards for certification of health IT (that include standards for collecting comprehensive patient demographic data),¹⁷ there is more that both HHS and Congress could do through statutory, regulatory, and

¹⁴ Asian & Pacific Islander American Health Forum, Connecting Limited-English Proficient Individuals to Health Care Services: The Important Role Of Community-based Organizations, June 2017, at:

http://www.apiahf.org/sites/default/files/2017.06.13_Connecting%20Limited-English%20Proficient%20Individuals%20to%20Health%20Care%20Services_Brief_0.pdf

¹⁵ Pew Charitable Trusts, Letter to CMS, June 25, 2018, at: http://www.pewtrusts.org/-/media/assets/2018/06/hit_pew_calls_on_federal_agency_to_promote_health_data_interoperability_track_medical_devices.pdf

¹⁶ U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program, Proposed Rule, 83 Fed. Reg. 35704-36368 (July 27, 2018), at:

<https://www.federalregister.gov/documents/2018/07/27/2018-14985/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions>

¹⁷ U.S. Department of Health and Human Services Office of National Coordinator for Health Information Technology, 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications, Final Rule, 80 Fed. Reg. 62602-62759 (October 16, 2015), at: <https://www.gpo.gov/fdsys/pkg/FR-2015-10-16/pdf/2015-25597.pdf>

financial requirements to leverage and accelerate the development and adoption of such health IT with such patient demographic data, and to ensure that standardized patient demographic data are included in health information exchange protocols and standards.

We also support consumer-directed health information exchange (that includes authorized family members and caregivers) as the primary driver towards interoperability. Centering consumers with responsibility and control over their own health information is the only long-term and effective solution to sharing that information across our fragmented health care delivery systems. Technological tools such as application programming interfaces (APIs) that allow consumers, providers, and payers to access and utilize health information and data in through secure platforms can help support such a consumer-directed approach.

Cross-collaborative Efforts

We strongly encourage the Caucus to consult the work of cross-collaborative efforts that already exist including the Health Care Payment Learning and Action Network (LAN) as the network has conducted foundational research and developed materials that ensure that the movement toward alternative payment models is one that values patient-centered care and drives alignment of public and private sectors. In particular, we recommend reviewing the [Alternative Payment Model Framework Refresh papers](#) that outline the latest developments in the sector and the [Patient Principles](#), which reflect high-level recommendations to ensure that value based programs address the needs of patients, their families and their caregivers.

Thank you for the opportunity to comment on the RFI. If you have questions, please contact Amina Ferati, Senior Director of Government Relations & Policy, afferati@apiahf.org.

Sincerely,



Kathy Ko Chin
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