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

September 10, 2018

Ms. Seema Verma, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-1693-P 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

Dear Administrator Verma:

The Asian & Pacific Islander American Health Forum (APIAHF) appreciates the opportunity to comment on the proposed rule for the Medicare Quality Payment Program.

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 work of CMS 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

APIAHF is pleased to see a continued 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 and primary language, among others. As such, clinicians who provide care to

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.

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.

Consumer Assessment of Health Providers and Systems (CAHPS) and Measures of Patient Experience of Care

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.² This would support CMS' stated goal of achieving health equity in the Medicare program. While CMS has made the Patient Quality Reporting System CAHPS survey available in Spanish, Cantonese, Mandarin, Korean, Vietnamese, and Russian³ and the Medicare Accountable Care Organization CAHPS survey available in Spanish, Cantonese, Mandarin, Korean, Vietnamese, Russian, and Portuguese,⁴ 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.

Improving Patient Outcomes and Reducing Burden Through Meaningful Measures

We appreciate CMS' desire to alleviate burdens on providers while improving patient outcomes. As CMS continues the work of the Meaningful Measures Initiative, we strongly encourage CMS to balance both the need for less (and more widely used "core") quality measures with the ongoing need for additional measure development to measure what matters in quality improvement, and in value-based delivery systems and payment reforms. We strongly support the continued development and adoption of additional patient experience measures and patient-reported outcomes (PROs) measures⁵ as part of value-based reforms. PROs are consistent with the goals of the Meaningful Measures Framework that they be patient centered and address measure needs for population based payment. In addition, we appreciate that in including Meaningful Measures, CMS has a goal of eliminating disparities.

Last year, the National Quality Forum 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.

² Agency for Healthcare Research and Quality, available at: <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.

³ Patient Quality Reporting System, available at: <http://www.pqrscahps.org/en/survey-instruments/>.

⁴ Medicare Accountable Care Organization Survey, available at: <http://acocahps.cms.gov/en/faqs/faqs-for-vendors/>.

⁵ National Quality Forum, Patient-Reported Outcomes, 2012, available at: https://www.qualityforum.org/Projects/n-r/Patient-Reported_Outcomes/Patient-Reported_Outcomes.aspx

The National Academies for Science, Engineering and Medicine (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.⁶ The use of such 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.

As such, we strongly support the comments of the National Council of Asian Pacific Islander Physicians (NCAPIP) and urge CMS to include specific Improvement Activities related to health equity in MIPS, drawing from the National Committee for Quality Assurance, Patient Centered Medical Home recognition and the standards for the Distinction in Multicultural Health Care.

In addition, we echo the comments of NCAPIP that CMS adopt a broad definition of health equity that is sufficiently inclusive and in line with the CMS Health Equity Plan, including racial and ethnic minorities, sexual and gender minorities, persons with disabilities and persons living in rural areas. The proposed rule's definition is in line with these standards, but should also include persons with limited English proficiency, given that 25 million Americans are limited English proficient and language barriers have a well-documented impact on health and access to care. Finally, we recommend, consistent with NCAPIP comments, that CMS explicitly add persons with lower levels of health literacy, persons living in Medically Underserved Areas, and persons with other relevant social and behavioral characteristics identified by the Institute of Medicine to the definition of health equity.

Promoting Interoperability Performance Category

We welcome CMS' emphasis on breaking down barriers that prevent patients from having electronic access and control over their own health records. In particular, we 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).⁷

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.⁸ As such, we urge CMS to continue to examine additional regulatory and financial ways it can support 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

⁶ 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, available 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](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).

⁷ 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), available at: <https://www.gpo.gov/fdsys/pkg/FR-2015-10-16/pdf/2015-25597.pdf>.

⁸ Pew Charitable Trusts, Letter to CMS, June 25, 2018, available at: http://www.pewtrusts.org/-/media/assets/2018/06/hit_pew_calls_on_federal_agency_to_promote_health_data_interoperability_track_medical_devices.pdf.

(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.

In addition, limited English proficient (LEP) 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, including the draft report: “A Roadmap to Reduce Healthcare Disparities Through Performance Measurement.”⁹

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 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 ethnical 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.”¹⁰

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.¹¹

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.¹² As a result, language barriers can also increase the cost of care by creating what has been called a “language-barrier premium.”¹³ Such barriers are a primary reason why LEP

⁹ National Quality Forum, A Roadmap to Reduce Health and Healthcare Disparities through Measurement Draft Report, (July 21, 2017), available at http://www.qualityforum.org/Disparities_Project.aspx.

¹⁰ Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* (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). Available at 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), available at: http://www.calendow.org/uploadedFiles/language_barriers_health_care.pdf.

¹¹ 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/excesum.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).

¹² Kelvin Quan & Jessica Lynch, *The High Costs of Language Barriers in Medical Malpractice* (2010), available at: http://www.healthlaw.org/images/stories/High_Costs_of_Language_Barriers_in_Malpractice.pdf.

¹³ 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)

populations disproportionately underutilize less expensive and quality-enhancing preventive care.¹⁴ 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.¹⁵ 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.

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, ethnicity, preferred language, disability status, sexual orientation, and gender identity, psychological and behavioral status. Clinicians can use existing demographic data collection fields in CEHRT 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.

MIPS Determination Period

We support the ability of permitting clinicians and groups to opt-in to MIPS if they meet or exceed low-volume threshold criteria. This ensures that more clinicians are eligible and able to participate in the program.

MIPS Performance Period

As we commented in the Quality Payment Program Year 2 Proposed Rule, we strongly encourage CMS to have a unified 12-month reporting period across all MIPS categories, rather than the 90-day periods for Improvement Activities and Promoting Interoperability. Adopting a 12-month reporting period for all would promote consistency for clinicians and more accurate reporting and result in better and more comparable data.

Support for Safety-Net Providers

CMS should implement the recommendations of the Assistant Secretary for Planning and Evaluation (ASPE),¹⁶ National Academy of Sciences, Engineering, and Medicine (NASEM),¹⁷ and National Quality Forum (NQF)¹⁸ 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

(finding patients with a language barrier had higher charges and longer stays).

¹⁴ 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).

¹⁵ See, e.g., Barry Newman, *Doctors' Orders Can Get Lost in Translation for Immigrants*, WALL STREET J., Jan. 9, 2003.

¹⁶ 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, available at: <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs>.

¹⁷ National Academies of Sciences, Engineering, and Medicine, *Accounting for Social Risk Factors in Medicare Payment Programs*, 2016, available at: <http://www.nationalacademies.org/hmd/Activities/Quality/Accounting-SES-in-Medicare-Payment-Programs.aspx>.

¹⁸ National Quality Forum, *Roadmap for Promoting Health Equity and Eliminating Disparities*, 2017, available at: https://www.qualityforum.org/NQFs_Roadmap_to_Health_Equity.aspx.

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.

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.

Additional Comments

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.¹⁹ Families USA has issued comprehensive recommendations for integrating equity into value-based payment reform through the Health Equity Taskforce for Delivery and Payment Transformation.²⁰

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 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.²¹ 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

¹⁹ Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations, Institute for Healthcare Improvement, 2016, available at: <http://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx>.

²⁰ Families USA, A Framework for Advancing Health Equity and Value, 2018, available at: https://familiesusa.org/sites/default/files/product_documents/HEV_Policy-Options_Report.pdf.

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

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

Thank you for the opportunity to comment on the proposed rule. If you have questions, please contact Amina Ferati, Senior Director of Government Relations & Policy, [aferati@apiahf.org](mailto: aferati@apiahf.org).

Sincerely,

A handwritten signature in black ink, appearing to read 'Kathy Ko Chin', followed by a horizontal line extending to the right.

Kathy Ko Chin
President & CEO
Asian & Pacific Islander American Health Forum