

January 14, 2019

**2019 BOARD OF DIRECTORS**

**Executive Committee**

Walter Tsou, MD, MPH  
**Chairperson**

Diane Paloma, MBA, PhD  
**Vice Chair/Secretary**

Elizabeth M.S. Krause, ScM  
**Treasurer**

Gail Mukaihata Hannemann  
**Immediate Past Chair**

Gayle Tang, MSN, RN  
**At-large**

Dianne Yamashiro-Omi  
**At-large**

Kathy Ko Chin  
**President & CEO**

Debbie I. Chang, MPH

Marc E. Chow, M.S.

Jacob Fitisemanu Jr., MPH

Kealoha Fox, PhD, MA

Sohini Gupta, Esq.

Mark L. Keam, JD

Misun C. Kim

Oliver Kim, LL.M, JD

Jennifer Requiro Neal Shah

Payal Shah, Esq.

Chuen L. Yee, MD

**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

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2408-P  
P.O. Box 8016  
Baltimore, MD 21244-8010

***Re: Comments in Response to Medicaid Program: Medicaid and Children's Health Insurance Program (CHIP) Managed Care CMS-2408-P***

Dear Secretary Azar and Administrator Verma:

The Asian & Pacific Islander American Health Forum (APIAHF) appreciates the opportunity to comment on the Medicaid and CHIP managed care proposed rule. 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. With more than 150 community-based organizational partners in over 28 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.

For over 6 years, APIAHF has partnered with organizations helping consumers enroll in health coverage, including Affordable Care Act (ACA) Marketplace plans, Medicaid and the Children's Health Insurance Program (CHIP). As part of these efforts, we co-founded *Action for Health Justice* with the Association of Asian Pacific Community Health Centers (AAPCHO), Asian Americans Advancing Justice and Asians Americans Advancing Justice – Los Angeles. As part of *Action for Health Justice*, we worked with 72 community based organizations and health centers and countless local assistants to inform efforts by the U.S. Department of Health and Human Services to reduce barriers for AA and NHPI individuals navigating an often deeply complex enrollment process. The complexities that exist as part of enrolling in private or public health insurance are multiple for immigrant and limited English proficient (LEP) populations. Through this experience, and others first hand, we know both the importance of health insurance for LEP persons, immigrants and their families, as well as the existing institutional problems that they already face in getting and stayed enrolled in the programs they are legally eligible for.

Overall APIAHF expresses concerns that a number of the Department's provisions are aimed at reducing or eliminating critical patient and beneficiary safeguards. Such safeguards are essential to the Medicaid and CHIP programs, which by their program design and purpose, serve vulnerable populations who are low-income, may be unfamiliar with the health care system, have low literacy and/or low health literacy and experience a range of factors, including difficulty

speaking or reading English, accessing transportation, etc. to maintaining good health and understanding their rights.

Medicaid provides a lifetime to more than 75 million low-income persons, including the 17.3% of AAs and 27.5% of NHPIs who rely on coverage in Medicaid and CHIP.<sup>1</sup> 28% of AA children and half of NHPI children are covered by the same programs.<sup>2</sup>

As CMS notes, by 2017, over 68 percent of all Medicaid beneficiaries were enrolled in compressive plans offered by Medicaid managed care organizations (MCOs). Given the breadth and scope of managed care in the Medicaid program, it is the primary way maternity and pediatric care is delivered to low-income populations.

As such, it is critical that CMS consider both the beneficiary pool and type of health care they need as well as how numerous factors outside of health care itself affect their participation and needs in the program when proposing policy changes.

## **I. Information Requirements to Plan Enrollees (§438.10)**

### *483.10(d)(2)*

Over twenty-five million Americans are limited English proficient (LEP), meaning they speak little or no English.<sup>3</sup> Sixty six percent of AAs speak a language other than English at home and twenty nine percent are LEP, meaning that English is not their primary language and they have a limited ability to read, write, speak or understand English.<sup>4</sup> Twenty-eight percent of NHPIs speak a language other than English at home. Sixty-three percent of Burmese, 45 percent of Nepalese and forty-four percent of Bangladeshis are LEP, as are 16 percent of Micronesians. AAs and NHPIs make up twenty-two percent of the LEP speakers in the country. Having meaningful access to language services is critical to ensuring these populations understand their health care rights and are able to access and utilize health care services.

APIAHF opposes the proposed change to reduce the scope of required taglines from the current standard of “all written materials for potential enrollees and enrollees” to those that “are critical to obtaining services.”

---

<sup>1</sup> Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2017. Available at: [https://ftp.cdc.gov/pub/Health\\_Statistics/NCHS/NHIS/SHS/2017\\_SHS\\_Table\\_P-11.pdf](https://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2017_SHS_Table_P-11.pdf)

<sup>2</sup> Samantha Artiga, et al., *Key Facts on Health and Health Care by Race and Ethnicity*, Kaiser Family Foundation, June 7, 2016, available at: <http://www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-section-4-health-coverage/>.

<sup>3</sup> APIAHF Analysis of 2017 American Community Survey Data

<sup>4</sup> APIAHF Analysis of 2017 American Community Survey Data

CMS notes that its proposal to require taglines only on documents that “are critical to obtaining services” aligns with the same documents that must be translated into prevalent non-English languages. This rationale, however, fails to account for the different rationales for the beneficiary protections of taglines and translated written materials. At their core, taglines are designed to explain rights and availability of services to the widest possible audience of readers, including to those persons who may speak or read a language that is not “prevalent” and thus a language in which there will not be written translated materials. By limiting the provision of taglines and conforming the thresholds to those covered by prevalent non-English languages, the proposal will reduce beneficiary knowledge of their rights by reducing the types of documents where taglines will be included.

More concerning, the “critical to obtaining health services” standard is not defined and unclear who it will be defined by, creating ambiguity both for covered entities as well as for beneficiaries. For example, would the standard apply to services that an MCO, PIHP, PAHP, or PCCM are not currently providing, but which are guaranteed to be available to Medicaid beneficiaries in which the beneficiary would want to know this information and choose another plan? What documents are and are not included in “critical to obtaining health services?” We further raise serious concerns about the burden that such ambiguity creates in light of potentially conflicting with existing language access standards under Section 1557 of the Affordable Care Act, which requires that all covered entities provide taglines on all “significant documents.” If this proposal were to be finalized, covered entities receiving federal funds, which include MCO, PIHP, PAHP, or PCCM, would be placed in the difficult situation of not knowing if they are in compliance with respect to which documents are considered “critical” under the managed care regulation, but not “significant” under 1557 or “significant” but not “critical.” We support the comments of the National Health Law Program pointing to the extensive administrative record that went into proposing and ultimately finalizing Section 1557 and the harm this proposal would do by creating a regulation potentially in conflict with it.

In addition, we remind CMS that taglines are designed to offer this notice of rights that is particularly important in the absence of written translated materials. Further, taglines offer covered entities the ability to learn about the linguistic needs and provide tailored linguistic resources.

Similarly, while we appreciate CMS reminding states that they can always require additional and stronger language access protections, APIAHF raises concerns when federal protections are proposing to be narrowed and reduced.

Current regulations require taglines in large print no smaller than 18 point font (42 C.F.R. § 438.109(d)(2)). In 2016, HHS explained that it based this standard on guidance from the American Printing House (APH) for the Blind (81 Fed. Reg. 27724). The APH established standards for print documents, including the minimum of 18 point font for large print, to allow “optimal usability for persons

with low vision.”<sup>5</sup> The APH developed its standards for large print and other features for print document readability based on “research that originated from the study of the impact of print characteristics on readers.”<sup>6</sup>

However, HHS now proposes to replace this evidence-based standard with a vaguer requirement that taglines be “conspicuously visible.” We oppose this change.

HHS provides no information or description of what constitutes a “conspicuously visible” tagline; nor does HHS provide any evidentiary basis for how persons with low vision would be able to access health information under this new standard. The potential harm to persons with low vision under an ambiguously defined “conspicuously visible” standard far outweighs any possible benefit for insurers in reducing paperwork. As such, we echo the comments of the National Health Law Program and recommend that HHS withdraw this ill-advised proposal.

*438.10(f)(1)*

APIAHF opposes changing the requirement that managed care plans issue notice of termination of providers to affected beneficiaries from 15 days of notice to 30 days before effective date of termination or 15 days after notice of termination to the provider, whichever is later. The delay in notifying beneficiaries raises serious concerns that beneficiaries may not realize a provider is no longer in their network until they seek care, creating unnecessary burdens.

*438.10(h)(1)(vii)*

Since 2012, CMS has supported the Culturally and Linguistically Appropriate Services (CLAS) standards as a way to improve the quality of care to all persons and promote health equity. CMS has incorporated CLAS standards and their underlying goals, including the attainment of health equity, into several CMS programs, including the Quality Payment Program, among others.

As such, APIAHF opposes eliminating the requirement that provider directories indicate whether the provider has completed cultural competency training. Under the proposal, a provider directory would only be required to include the “physician's or provider's cultural and linguistic capabilities, including the languages spoken by the physician or provider or by the skilled medical interpreter providing interpretation services at the physician's or provider's office.” Note however, that mere attestation of the provider or their staff of language ability does not necessarily mean that the same individual has the skills and training required to effectively provide language assistance. That is, not all bilingual persons are able to serve as qualified interpreters or translators. As such, the existing requirement that notes whether or not the provider has completed

---

<sup>5</sup> J. Elaine Kitchel, Low Vision Project Leader, APH Guidelines for Print Document Design, American Printing House for the Blind, <https://www.aph.org/research/design-guidelines/> (accessed Dec. 23, 2018).

<sup>6</sup> *Id.*

cultural competence training should be maintained as an indication of at least their ability.

*438.10(h)(3)*

Again APIAHF expresses concern that, particularly when coupled with the other proposed changes to beneficiary access, CMS is reducing beneficiary protections on the basis of unexplained assumptions. While the majority of managed care beneficiaries may have access to a smart phone, they may not have the data/broadband coverage or understanding knowledge necessary to navigate the sometimes lengthy process of sorting through provider directories. HHS should maintain the existing standard with respect to provider directories.

**II. Network Adequacy (§438.68)**

Strong network adequacy requirements are crucial to ensuring that Medicaid managed care enrollees can access covered services. Prescriptive national standards, like those used in Medicare Advantage, are appropriate in the Medicaid context, given the low-income and high need population served by the program. HHS should adopt specific minimum standards in the areas of geographic access, provider-patient ratios, and timely access to care. Setting a national minimum standard for network adequacy in Medicaid Managed Care will provide consistency and continuity for enrollees, and will ensure that enrollees in all states are held to the same basic standards of access. Time and distance standards, which the rule currently requires states to adopt for many services, including LTSS where the enrollee travels to a provider, are a critical component of network adequacy since they ensure that enrollees can access network providers within an appropriate distance. It does an enrollee no good to be given a next day appointment, if the location of that appointment is so far away that the enrollee cannot travel there.<sup>7</sup>

The current rule provides significant flexibility, as it permits each state to set its own time and distance standards without any outside limits set by HHS, and its implementation has varied widely among states. The proposed changes to this section of the rule take a further step in the wrong direction. Rather than moving states toward a national network adequacy standard, the proposed rule gives states even more discretion to adopt different standards, as long as those standards are quantitative. If adopted, the proposed changes to this section will lead to more divergent standards, which will mean that Medicaid beneficiaries are more likely to go without care they need, and oversight by HHS will become even more challenging.<sup>8</sup>

---

<sup>7</sup> HHS notes that time and distance standards may not be properly account for access to telehealth. Preamble at 57278. This does not mean, however, that time and distance standards should be discarded altogether. Rather, HHS could provide guidance to states on how to account for telehealth when devising time and distance standards, such as counting the time and distance to a spoke site.

<sup>8</sup> Suzanne Murrin, Dept. of Health & Human Servs., Office of Inspector General, *State Standards for Access to Care in Medicaid Managed Care* 8-9 (2014) (“CMS and States need to do more to

### III. Managed Care Quality Rating Systems (§438.34)

#### 438.340(b)(6)

States must provide demographic information (race, ethnicity, sex, primary language, age and disability status) for each Medicaid enrollee to the managed care plan at the time of enrollment. This is the minimum standard and we appreciate the reminder by CMS that states are encouraged to send updated demographic information.

Given a state's quality plan is designed to reduce health disparities on the basis of race, ethnicity, primary language, sex, age and disability status, the level of granularity of the data is critical to accurately identifying, reporting and understanding disparities and whether such a plan is effective at reducing them. For example, the CMS Equity Plan for Improving Quality in Medicare states that the "comprehensive patient data, including race, ethnicity, language... are required to plan for quality improvements, and to address changes among the target populations over time."<sup>9</sup> The CMS National Quality Strategy, for goals 1 and 6, includes the collection of quality race and ethnicity data in its foundational principles.<sup>10</sup>

While we understand that state data collection systems vary, there are serious gaps remaining with respect to the level of detail for race and ethnicity that particularly impact diverse populations such as Asian Americans, Native Hawaiians and Pacific Islanders. CMS should encourage and incentivize the ability of states to collect more detailed race and ethnicity data that aligns with the National Academies for Science, Medicine and Engineering (formerly Institute of Medicine) recommendations. This would follow the lead emerging at the state level, such as in Oregon, which requires data collection and eligibility intake forms to include 9 Asian and 3 Native Hawaiian and Pacific Islander groups. In determining which programs to support more detailed data collection first, Oregon is updating its Medicaid systems first, before moving on to other enrollment systems, as they found Medicaid enrollees are mostly also enrolled in other programs. They are also focused on future cost savings by combining

---

ensure that all States have adequate access standards and strategies for assessing compliance.”), <http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf>; see also, e.g., Abbi Coursolle, Nat'l Health Law Prog., *Medicaid Managed Care Model Provisions: Network Adequacy* (2014), <http://www.healthlaw.org/issues/medicaid/managed-care/medicaid-managed-Care-model-provisions-issue-3> (describing various state standards for travel time and distance, ranging from 5 miles in two states, to 100 miles in two other states).

<sup>9</sup> Centers for Medicare & Medicaid Services Office of Minority Health. *The CMS Equity Plan for Improving Quality in Medicare*. (2015), [https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH\\_Dwnld-CMS\\_EquityPlanforMedicare\\_090615.pdf](https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf)

<sup>10</sup> Centers for Medicare and Medicaid Services. *CMS Quality Strategy*. (2016), <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy.pdf>

eligibility systems into a unified data collection platform, avoiding the costs of keeping multiple systems updated.

Further, CMS should note to states that data stratification and reporting is one way of working to achieve health equity and improve the quality of Medicaid and CHIP enrollees, such as what Oregon is doing.

Further, while we appreciate the desire to strive toward alignment between quality rating systems in Medicaid, Qualified Health Plans in the Marketplace, CHIP and Medicare, there are serious challenges to what CMS is proposing. For example, Medicaid and CHIP plans cover services, and have different legal requirements governing access to those services, then those covered by Medicare or QHP plans, including LTSS and family planning. In addition, CMS proposes to water down the requirement that a state-based alternative to a quality rating system be “substantially comparable” to the federally developed Medicaid quality rating system by adding the clause “to the extent feasible.” The term “substantially comparable” already provides enough flexibility for states to account for differences due to covered populations, benefits, and other factors cited by CMS.

Thank you again for the opportunity to comment. Should you have any questions, please contact Amina Ferati, APIAHF Senior Director of Government Relations and Policy at [afferati@apiahf.org](mailto:afferati@apiahf.org).

Sincerely,



Kathy Ko Chin  
President & CEO