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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

August 30, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-4203-NC Medicare Program; Request for Information on Medicare

Dear Administrator Brooks-LaSure,

The Asian & Pacific Islander American Health Forum (APIAHF) sincerely appreciates the opportunity to submit comments in response to the Centers for Medicare and Medicaid Services (CMS) Request for Information (RFI) on the Medicare Advantage Program.

With longstanding relationships with over 150 community-based organizational partners in over 40 states and the territories, APIAHF is the nation's oldest and leading health advocacy organization dedicated to improving the health and well-being of over 25 million Asian Americans (AA), Native Hawaiians (NH), and Pacific Islanders (PI). For over 35 years, APIAHF has worked to improve access to and the quality of care for AA and NH/PI communities, many of whom are predominantly immigrant and limited English proficient (LEP), and may be new or unfamiliar with the U.S. healthcare system. We draw upon our extensive experience and relationships with community-based organizations to understand the needs and barriers faced by AA and NH/PI communities.

APIAHF commends the Biden Administration for its commitment to health equity, which CMS defines as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes." In that spirit, we urge CMS to protect Medicare Advantage (MA), which is vital in addressing health disparities and expanding access to quality medical coverage and social benefits like transportation to provider visits and nutrition services to seniors across all populations.

The MA program helps seniors have access to robust, affordable services not currently available in traditional Medicare. Seniors enrolled in MA save up to

\$2,000 a year compared to those in traditional Medicare Fee-for-Service (FFS).¹ They also experience a 43 percent lower rate of avoidable hospitalizations than Medicare FFS enrollees.²

AA & NH/PI enrollees

AAs are the fastest growing demographic group, while NH/PIs are the third fastest growing population in the U.S. In 2050, nearly 7 percent of the U.S. population aged 65 and over is projected to be AA, while 0.3 percent is projected to be NH/PI. AA and NH/PI communities are also incredibly diverse, representing more than 50 different ethnicities and 100 language groups. More than 60 percent of AA and NH/PI are foreign born, and many live in mixed immigration status households. Nearly one-third of AAs and one in ten PIs are limited English proficient (LEP).

In 2019, AA and NH/PI individuals comprised approximately 4 percent of all Medicare enrollees, or over 2.3 million and growing; they represent the fourth largest demographic group enrolled in Medicare. Of these, more than 400,000 Chinese, Korean and Vietnamese enrollees indicated that they do not speak English at home.³ More than 40 percent of Medicare enrollees are enrolled in a MA plan. In 2021, AA and NH/PI enrollees represented nearly 5 percent of all MA enrollees. However, despite their growing numbers, AA and NH/PI enrollees in MA reported worse health care experiences than White MA beneficiaries did on 6 out of the 7 patient experience measures.⁴

A. Advancing Health Equity

Language Access for Limited English Proficient (LEP) Enrollees

What steps should CMS take to better ensure that all MA enrollees receive the care they need for enrollees with limited English proficiency or other communication needs?

Language barriers are widely known to reduce rates in enrollment and lower the quality and effectiveness of prevention, treatment, and patient education programs.⁵ For MA enrollees who are LEP, language services are essential for navigating enrollment and

¹ Better Medicare Alliance, *Medicare Advantage Outperforms FFS Medicare on Cost Protections for Low-Income and Diverse Populations*, April 2022. Available at: <https://bettermedicarealliance.org/wp-content/uploads/2022/04/BMA-Medicare-Advantage-Cost-Protections-Data-Brief-FINv2.pdf>

² Center for Innovation in Medicare Advantage, *Positive Outcomes for High-Need, High-Cost Beneficiaries in Medicare Advantage Compared to Traditional FFS Medicare*, December 2020. Available at: <https://bettermedicarealliance.org/wp-content/uploads/2020/12/BMA-High-Need-Report.pdf>

³ U.S. Department of Health and Human Services, *Fact Sheet: Celebrating Asian American, Native Hawaiian, and Pacific Islander Heritage Month*, 2022. Available at: <https://www.hhs.gov/about/news/2022/04/29/fact-sheet-celebrating-asian-american-native-hawaiian-and-pacific-islander-heritage-month-2022.html>

⁴ CMS in collaboration with the Rand Corporation, *Disparities in Health Care in Medicare Advantage by Race, Ethnicity, and Sex*, April 2022. Available at: <https://www.cms.gov/files/document/disparities-health-care-medicare-advantage-race-ethnicity-and-sex.pdf>

⁵ CMS, *Understanding Communication and Language Needs of Medicare Beneficiaries*, April 2017. Available at: <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf>

care. Title VI of the Civil Rights Act of 1964 protects persons from discrimination based on their race, color, or national origin in programs and activities that receive Federal financial assistance. Furthermore, the Health Care Rights Law (Section 1557 of the Affordable Care Act (ACA)), also prohibits discrimination in health care on the basis of race, color, national origin, sex, age, and disability. This means that healthcare providers and insurers must take reasonable steps to ensure meaningful access to programs by LEP individuals, including the Medicare program and Medicare Advantage Plans by providing interpreters and translated documents.

Recommendations:

- **At minimum, CMS should make key educational and enrollment materials on Medicare Advantage available in additional AA and NH/PI languages .** CMS currently provides information on Medicare, *Understanding Medicare Advantage Plans*, in a number of AA and NH/PI languages.⁶ While these languages may provide translated information to some of the largest AA and NH/PI subgroup populations, it falls short when it comes to providing access to information to many AA and NH/PI subgroup populations. The availability of more translated documents on MA plans will better ensure that AA and NH/PI enrollees and potential enrollees are able to navigate the enrollment process and choose a plan that is best suited to address their health care needs.
- **CMS should develop an enforcement mechanism to ensure that MA plans comply with the requirement to provide meaningful access to information about enrollment, coverage/benefits, providers and care in different languages.** A study conducted in 2010 by the Department of Health & Human Services, Office of Inspector General found that not all MA plans met the Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards and four factor assessment recommended by the Office for Civil Rights⁷ (OCR) guidance when determining which language access services to offer. For example, only 88 percent of MA plans conducted the recommended four-factor assessment when determining which language access services to offer and only 67 percent of plans offered services consistent with all four CLAS standards on language access services.⁷

At present, there is no enforcement mechanism to ensure that all MA plans provide language services in compliance with OCR guidance and CLAS standards. For example, the MA Star Ratings system- which measures the quality of health and drug services received by beneficiaries-includes only one measure that is related to language services: whether or not a foreign language interpreter and TTY is available. An important component of the Star Ratings system is to provide beneficiaries and their caregivers meaningful information about a MA plan's benefits, coverage, care and cost. In order to ensure that plans are held accountable for how they select the language services provided,

⁶ *Understanding Medicare Advantage Plans* is available in the following AA & NH/PI languages: Chinese, Cambodian, Hindi, Hmong, Japanese, Korean, Laotian, Samoan, Tagalog, Tongan, and Vietnamese. Available at: <https://www.medicare.gov/about-us/information-in-other-languages>

⁷ HHS Office of the Inspector General (OIG), *Guidance and Standards on Language Access Services: Medicare Plans*, July 2010. Available at: <https://oig.hhs.gov/oei/reports/oei-05-10-00051.pdf>

the Star Ratings should include whether or not language services comply with CLAS standards and OCR guidance. Furthermore, LEP beneficiaries should have a way to rate MA plans based on whether the language service provided met their needs.

Data Equity & Health Equity: Data Disaggregation

What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work?

Health equity cannot be achieved without data equity, including data that is complete, accurate and disaggregated. The COVID-19 pandemic underscored the deficiency of the reporting of data for AA and NH/PI communities in the U.S.⁸ Detailed demographic data is often not collected, analyzed or reported for AA and NH/PI Medicare Advantage beneficiaries, obscuring the experiences of this growing demographic. Not only is demographic data on AA and NH/PI beneficiaries not regularly available, when the data is reported, it may be inaccurate. A 2022 report by HHS OIG found that Medicare’s enrollment data on race and ethnicity is less accurate for some groups, especially groups who identify as American Indian/Alaska Native, Asian/Pacific Islander, or Hispanic.⁹

Further, data for AA and NH/PI communities is often aggregated obscuring differences and disparities between subgroup populations. Without disaggregated data, the experiences of AA and NH/PI subgroup populations are rendered invisible and unknown to CMS, MA plans and providers, and beneficiaries and their caregivers. The lack of disaggregated data for AA and NH/PI subgroup populations has significant implications because the data often dictates the amount of resources directed to and made available for communities. Aggregated data often obscures the true stories and needs of AA and NH/PI communities and fuels misconceptions such as the model minority myth, where AA and NH/PI communities are seen as “healthy” by the general public.¹⁰

Recommendations:

- **CMS should require MA plans to collect, analyze, and report race and ethnicity data that is disaggregated into subgroup populations.** Section 4302 of the ACA contains provisions that direct the HHS Secretary to implement standards for the collection of data on five demographic categories: race, ethnicity, sex, primary language and disability status. At minimum, HHS’s race and ethnicity standards mirror federal Office of Management and Budget

⁸ Stella Yi et al, *The Mutually Reinforcing Cycle of Poor Data Quality and Racialized Stereotypes That Shapes Asian American Health*, February 2022. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01417>

⁹ HHS OIG, *Data Brief: Inaccuracies in Medicare’s Race and Ethnicity Data Hinder the Ability to Assess Health Disparities*, June 2022. Available at : <https://oig.hhs.gov/oei/reports/OEI-02-21-00100.pdf>

¹⁰ Stella Yi et al, *The Mutually Reinforcing Cycle of Poor Data Quality and Racialized Stereotypes That Shapes Asian American Health*, *Health Affairs*, February 2022. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01417>

(OMB) Standards, but encourage additional granularity where possible. Section 4302(b) requires continuing evaluation of this data collection to implement these standards. **Additionally, we urge CMS to encourage MA plans to update data systems so that they are able to collect, analyze, and report disaggregated race and ethnicity data.** The challenges of updating and changing data systems are widely known, yet without these changes, accurate and complete data cannot be acquired. For instance, the entire data infrastructure of plans and providers may need to change in order to allow for standardized data collection that allows for disaggregated race and ethnicity categories, including the addition of write-in options.

B. Expand Access: Coverage & Care

Behavioral Health

What steps should CMS take to ensure enrollees have access to the covered behavioral health services they need?

During the COVID-19 pandemic, we saw AA and NH/PI communities suffer heavily from mental health issues. In addition to the feelings of isolation encountered by many Americans during the pandemic, AA and NH/PI communities faced heightened threats to safety and well-being through the rise in the incidence of anti-Asian hate crimes.¹¹ In our national survey of AA and NH/PI community-based organizations, approximately 69 percent indicated that mental health programming is a top priority going forward.¹²

Despite the increase in behavioral health needs, AAs are least likely to seek mental health services of all racial and ethnic groups due to a variety of reasons, including cultural stigma.¹³ Moreover, AA & NH/PI seniors may face barriers in access to behavioral health services because of the overall shortage of in-network behavioral health providers in MA plans, including those who can provide culturally and linguistically competent care.¹⁴ According to the Kaiser Family Foundation, psychiatrists have the highest rate among physician specialties in opting out of Medicare at approximately 7 percent, compared to the average 1 percent opt-out rate across all specialties.¹⁵

¹¹ Oliver Kim, *Addressing the Mental Health Needs of the AAPI Community*, Health Affairs, September 2021. Available at: <https://www.healthaffairs.org/doi/10.1377/forefront.20210827.800655/full/>

¹² APIAHF, *Asian American, Native Hawaiian, and Pacific Islander Networks for Community Health in the age of COVID-19: Results of a National Survey of Community-Based Organizations*, November 2021. Available at:

<https://www.apiahf.org/wp-content/uploads/2021/11/APIAHF-CBO-Report-November-2021-Final.pdf>

¹³ SAMHSA, *Racial/Ethnic Differences in Mental Health Service Use among Adults*, February 2015. Available at <https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4906.pdf>

¹⁴ Chris Larson, *Why Medicare Advantage Plans May Struggle Finding Enough Behavioral Health Providers*, February 2022. Available at:

<https://bhbusiness.com/2022/02/09/why-medicare-advantage-plans-may-struggle-finding-enough-behavioral-health-providers/>

¹⁵ Kaiser Family Foundation (KFF), *How Many Physicians Have Opted-Out of the Medicare program?* October 2020. Available at:

<https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/>

Recommendations

- **CMS should incentivize MA plans to foster a robust network of behavioral health providers, including telehealth.** The Biden Administration’s national strategy to address our national mental health crisis identified expanding access to tele- and virtual mental health care options as a key component of connecting Americans to behavioral health care.¹⁶ During the pandemic, the use of telehealth to address mental health increased dramatically, proving to be a safe and effective means of providing access to behavioral health. CMS should work with MA plans to identify and address the shortage of behavioral health providers through incentives for recruitment and retainment.
- **CMS should require MA plans to continue to conduct outreach and messaging to beneficiaries about covered behavioral health services, including information about providers who provide linguistically and culturally appropriate care as well as resources on community-based mental health.** APIAHF commends efforts by CMS to strengthen behavioral health care and to address our national mental health crisis by mobilizing the behavioral health workforce.¹⁷ For LEP and immigrant populations, access to behavioral health providers who are trained to provide culturally and linguistically appropriate care is critical especially given AA and NH/PI communities’ reluctance to seek treatment and medication for behavioral health issues. Studies have found that Asian American older adults face lower life satisfaction compared with all other races/ethnicities, with clinicians playing a key role in identifying those who have low social and emotional support.¹⁸
- **CMS should ensure that behavioral health services provided by MA plans are culturally and linguistically appropriate for AA & NH/PI communities.** CMS should encourage approaches that result in the recruitment of diverse providers who serve underserved communities, communities of color, and LEP communities. For example, MA plans could reimburse providers who provide culturally and linguistically appropriate care at a higher rate or require that providers and hospitals complete cultural competence training on an annual basis.

Conclusion

APIAHF appreciates the opportunity to comment on the benefits of the Medicare Advantage program. We thank CMS’s leadership on soliciting stakeholder feedback

¹⁶ White House, *Fact Sheet: President Biden to Announce Strategy to Address Our National Mental Health Crisis, As Part of Unity Agenda in his First State of the Union*, March 2022. Available at: <https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/>

¹⁷ Seshamani, Meena and Douglas Jacobos, *Strengthening Behavioral Health Care for People with Medicare*, July 2022. Available at: <https://www.cms.gov/blog/strengthening-behavioral-health-care-people-medicare>

¹⁸ Shimkhada Riti, Hin Wing Tse and Ninez A. Ponce, Life Satisfaction and Social and Emotional Support Among Asian American Older Adults, *Journal of the American Board of Family Medicine*, 35(1):203-5, January 2022. Available at: <https://www.jabfm.org/content/35/1/203.full>

and efforts to address health equity for Medicare Advantage beneficiaries. We hope that our comments and recommendations have provided insight to the experiences of AA and NH/PI communities. Should you have questions or would like to request additional information, please contact policy@APIAHE.org.

Sincerely,

A handwritten signature in blue ink, appearing to read 'JK Choi', with a stylized flourish at the end.

Juliet K. Choi
President & CEO