



January 8, 2016

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Re: Input on How to Improve Medicaid Reporting Requirements

Dear Chairman Hatch and Ranking Member Wyden:

The Association of Asian Pacific Community Health Organizations (AAPCHO) is a national not-for-profit association of 35 community-based health care organizations, 29 of which are Federally Qualified Health Centers (FQHCs), located across the United States. AAPCHO members are located in communities with high concentrations of medically underserved Asian Americans, Native Hawaiians, and other Pacific Islanders, and are at the forefront in providing responsive, financially affordable, and culturally and linguistically appropriate primary health care services.

Compared to the average health center, AAPCHO member centers serve a higher percentage of Medicaid patients (44% vs. 41%). As such, AAPCHO members have a great interest in the Medicaid program, and in the reporting measures that surround the program.

In response to the questions posed by Chairman Hatch and Ranking Member Wyden:

1) What data sources are lacking or should be employed more effectively, updated, or better coordinated to facilitate state operations, administrative functions, and inform state and federal decision-making? Are there specific reporting requirements in the Medicaid program that are duplicative, overlapping, or outdated that could be streamlined? If so, please be specific about which reporting requirements are duplicative, overlapping, or outdated, or could otherwise be streamlined.

As Medicaid collects procedure and diagnostic codes from providers, we recommend that Medicaid also collect quality outcome measures, with the objective of rewarding providers who produce better quality outcomes. This could be operationalized by requiring all contracted insurance plans to create a quality-based payment system at a minimum---having data gathering of provider outcomes done by the insurance companies, and data consolidation done by State Medicaid programs.

In a response to an RFI recently sent by CMS, we encouraged CMS to collect additional data on how different populations access Medicaid in each delivery system. As there may be differences in access to service for different populations; this must be captured in data requests. What is more, data sets should include disaggregated race and ethnicity data. AAPCHO recommends that the data mirror the 2010 Census categories for race and ethnicity.

Specifically, AAPCHO recommends that data be collected on access to Medicaid by beneficiaries who are limited English proficient (LEP). We recommended that CMS collect data by region or, in the case of beneficiaries enrolled in managed care, by the plan's service area—and not based on the state or county. AAPCHO recommends that “prevalent” be defined as 1,000 or 5% of potential enrollees or enrollees in the plan's service area.

States must collect primary language data within plan networks, including how many in-network providers they have who can provide services in prevalent non-English languages—and if that network is sufficient for the anticipated number of enrollees in the service area. If a region has a high concentration of LEP enrollees—but has only one provider who can provide in-language services, whether in one language or many—CMS should use these data to encourage the plan to improve the provider network to reflect the languages spoken within a region.

AAPCHO also strongly recommended that CMS collect beneficiary-reported access data with a specific focus on LEP populations. A meaningful sample of LEP beneficiaries in each state (and by each prevalent language) must be surveyed and asked the same panel of questions as English-only beneficiaries.

2) As payment methodologies continue to move towards incorporating pay for performance methodologies, the development and use of standard quality indicators will become more prevalent—such as with the Adult and Pediatric Quality Measures Programs. What quality indicators should be required reporting in Medicaid and what steps should be taken to move in this direction?

Out of the quality indicators that AAPCHO members use, the Healthcare Effectiveness Data and Information Set (HEDIS) was recommended as being the easiest to utilize.

6) Are there any other programs or requirements that you think should be considered as part of our review of reporting requirements at the state and Federal level?

AAPCHO believes that additional measures must be integrated into Medicaid data collection in order to measure LEP patients' access to care. Patients who cannot speak English, for example, will be unable to ask their providers pertinent questions about their care, and may not understand how to prevent a medical issue from getting worse because they are unable to talk to their doctor.

One of AAPCHO's members, International Community Health Services (ICHS), based in Seattle, has been utilizing a Common Measure Set in Washington State, including an initial



52 measures, introduced in December 2014. Results have been publicly reported for both Medicaid and private insurance plan populations, and can be found here:

http://www.hca.wa.gov/hw/Documents/community_checkup_report2015.pdf. ICHS has found the Common Measure Set to be helpful within Washington, and would recommend this model to be expanded nationally.

Thank you for the opportunity to provide input on this important initiative to streamline Medicaid reporting requirements. If you have any questions, please feel free to contact me (isha@aapcho.org).

Thank you,

A handwritten signature in black ink, appearing to read "Isha Weerasinghe", is placed over a light yellow rectangular background.

Isha Weerasinghe
AAPCHO
Director of Policy and Advocacy