



August 21, 2017

CMS Administrator Seema Verma
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-5522-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically via www.regulations.gov.

RE: MS-5522-P: Medicare Program; CY18 Updates to the Quality Payment Program

Dear Administrator Verma,

AAPCHO is a national not-for-profit association of 35 community-based health care organizations, mostly federally qualified health centers, dedicated to promoting advocacy, collaboration, and leadership that improves the health status and access of medically underserved Asian Americans, Native Hawaiians, and Pacific Islanders (AA&NHPIs) in the U.S., its territories, and its freely associated states. As health care providers, AAPCHO members focus on providing services that are uniquely appropriate to their patient populations, including: culturally and linguistically appropriate health care services, comprehensive primary medical care, and wrap-around enabling services (ES) for the medically underserved throughout the country. For the approximately 500,000 patients our centers serve annually, AAPCHO advocates that the health care system provide access to comprehensive and linguistically and culturally competent care by our member community health center providers and for our patients.

Medicare beneficiaries, including those dually eligible for Medicare and Medicaid, represent on average, 9.1% of AAPCHO's health center patients rely on Medicare, a small but growing patient population. Our members also have a higher rate of beneficiaries with Limited English Proficiency (LEP) (50% vs. 23%) and a higher rate of beneficiaries at or below 200% of FPL (88%) than other health centers, and thus we provide more enabling services (9,159 vs 4,875 encounters) given the needs of our patients (HRSA Uniform Data System, 2014). The comprehensive model of care utilized by health centers allows AAPCHO members to appropriately treat Medicare patients and to ensure that their care is delivered in an effective, efficient and culturally appropriate way. AAPCHO members are on the cutting edge of system delivery and have developed systems of care that reward quality—not just quantity.

As the healthcare delivery system adapts to serve increasing numbers of Medicare patients, AAPCHO continues to urge the Administration to support quality metrics that are obtainable, translatable, and comparable across providers care AND that reimbursement for that quality take into consideration other factors impacting healthcare, such as Limited English Proficiency (LEP), access to housing and socioeconomic status.

In addition, AAPCHO supports efforts to ensure that the data collected and reported will be adjusted to reflect patients' Social Determinants of Health (SDOH). Our Medicare patients come from diverse



backgrounds and often need linguistically or culturally appropriate services which AAPCHO members provide. But these services do come at a cost greater than serving beneficiaries who do not need wrap-around services. AAPCHO wishes to emphasize the crucial importance of appropriate risk adjustment to reflect the SDOH affecting providers' patient populations. As decades of research have demonstrated, LEP patients have greater needs and often less access to community resources. This can cause providers who care for them to score lower on measures of quality and resource use because of their limited capacity to serve larger and more complex patient panels.

Our specific comments on the rule follow.

Improvement Activities

AAPCHO shares MIPS' goals of improving care coordination, beneficiary engagement, population management and health equity. To that end, AAPCHO strongly supports including Improvement Activities that are designed to reduce health disparities, address social determinants of health, and improve care coordination for vulnerable populations.

In particular, we support the activities listed in Table F: *Proposed New Improvement Activities for the Quality Payment Program Year 2 and Future Years*. We appreciate that CMS has included specific measures designated to the subcategory of achieving health equity and those that support patient engagement.

We are especially pleased to see the Improvement Activity: *Provide Clinical-Community Linkages*. AAPCHO has long advocated for wrap-around, or enabling services, which help patients to coordinate their care through community linkages. We specifically suggest that the term "community health worker" be clarified to include, but not limited to: case managers, patient/community education specialist, outreach workers, transportation staff, eligibility assistance workers, and interpretation staff. We also request that the definition of eligible activities expand to include "actions that reduce barriers to care", as connecting to services is very important, but some efforts, such as working with a patient on reducing homelessness or how they can find English classes, are very important activities to reduce barriers to care faced by the populations we serve. Additionally, the definition should be expanded to explicitly include interpretation and transportation.

We appreciate the focus on serving underserved communities, particularly in the Improvement Activities: *Provide Education Opportunities for New Clinicians* and *Participation in Population Health Research*. Both of these address ongoing challenges faced by our health centers. Incidence and interventions differ by ethnic groups within the large number of AANHPIs and other patients that we serve, and we strongly support good data collection and on-going evaluation of effective strategies. For both of these activities, "underserved" should be expanded to include Limited English Proficient individuals, who are often without providers or resources that are in-language. This would be similar to the Medically Underserved Area designation, used to define health center services area.

AAPCHO supports the comments submitted by the Asian Pacific Islander American Health Forum (APIAHF) that 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. We support APIAHF's recommendation that 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."

Health centers serve disproportionately more LEP patients, and know that effective care means reducing language barriers. According to a report from NACHC, in 2006 almost 1 in 3 patients served by health centers was LEP and in 2001, 95% of patients surveyed reported that their clinicians spoke their language. Addressing language needs in the health care setting has been linked to more appropriate medical and preventive care visits and follow-up. Addressing language needs in the emergency department setting has been shown to offer cost-savings as well. https://mail.google.com/mail/u/0/-m_-7292109632377251120_edn4 Additionally, a study specifically on the experience of nearly 3,000 LEP Chinese- and Vietnamese-Americans in health centers concluded that, "language barriers are associated with less health education, worse interpersonal care, and lower patient satisfaction. Having access to a clinic interpreter can facilitate the transmission of health education." We therefore encourage CMS to specifically address the needs of these underserved communities in this proposed rule, and to incentivize providers to reduce language barriers.

Community Based Participatory Research (CBPR) has been a very effective tool for engaging health centers in research that they define and that they can use effectively. We strongly support the Improvement Activity: *MIPS Eligible Clinician Leadership in Clinical Trials or CBPR*. An example of impactful CBPR in our health centers is our HIT-B Project, which aimed to determine the effectiveness of an electronic health record (EHR) data-driven clinical intervention to improve HBV screening and vaccination rates at a community health center serving primarily Asian American patients. Using a community-engaged approach, AAPCHO conducted a study to compare the differences in screening and vaccination rates for over 6000 patient encounters before and after implementation of the EHR intervention, analyzed through multivariate logistic regression. Analyses indicated that patients who visited the clinic after implementing the EHR intervention were more likely to be screened and vaccinated for hepatitis B. The conclusion is that EHR interventions implemented using a community-engaged approach may improve delivery of appropriate care to patients at risk for health disparities in a community health setting. CBPR efforts like this are extremely useful in improving patient care and ensuring effective outcomes and we commend the MACRA draft regulations for encouraging such efforts.

For the Improvement Activity, "Glycemic Referring Services", we recommend a change in weight of this activity from Medium to High. There are over 1,200 CDC recognized organizations in 50 states, however priority populations including Medicare beneficiaries, men, African Americans, Asian Americans, Hispanics, American Indians, Alaska Natives, and Pacific Islanders have been under-enrolled into CDC diabetes prevention programs. Incentive to support and increase referral of these underserved populations to CDC programs known to significantly reduce the risk of developing type 2 diabetes, would help to address disparities for not only AANHPI, but other high risk groups. These Improvement Activities represent a step in the right direction. In moving forward towards health equity, CMS and stakeholders must address the specific disparities faced by LEP populations and



strengthen providers' ability to provide culturally appropriate care. We strongly recommend that CMS consider additional Improvement Activities for the future that would directly impact LEP populations or help providers provide linguistically and culturally appropriate care.

AAPCHO also voices its support for the changes to the Improvement Activities Bonus Score that will require MIPS eligible clinicians to be in active engagement with a public health department or clinical data registry to be eligible for the bonus score. Data collection is critically important for public health departments and we encourage CMS to maintain data collection and coordination. AAPCHO believes that accurate, well used and trackable data is essential to identifying and addressing health disparities and effective interventions.

Voluntary FQHC Reporting

As the healthcare delivery system adapts to serve increasing numbers of Medicare patients, AAPCHO urges the Administration to ensure that quality metrics are obtainable, translatable, and comparable across providers care AND that reimbursement for that quality strive to take into consideration the other factors impacting healthcare, such as Limited English Proficiency, access to housing and socioeconomic status. To accomplish this goal, AAPCHO supports CMS' proposal to permit FQHCs to voluntarily report MIPS data. This will allow FQHCs to be included in comparisons assuming they are based on consistent data and appropriately risk adjusted.

AAPCHO supports the comments made by the National Association of Community Health Centers (NACHC) in their comment letter on this NPRM. Like NACHC, we strongly encourage CMS to provide specific detail to FQHCs on how to voluntarily report under MIPS, should they choose to do so. In addition, as we have previously mentioned, health centers have a unique payment methodology in Medicare and report to CMS as an entity, not as individual providers as the "typical" PFS provider does. Because of this, we strongly encourage CMS to allow the FQHC to report as an entity, not as individual providers. Requiring a health center to report as individual provider is contrary to the way that FQHCs are paid via Medicare and would require the health center to revamp their entire system, which would likely discourage health centers from voluntarily reporting this valuable information.

In addition, AAPCHO's support for FQHCs voluntarily reporting on MIPS is conditioned on the expectation that the data collected will be adjusted to reflect SDOH. Without such risk adjustment, it is inevitable that the value and quality of care that FQHCs provide will be understated relative to other providers. If this occurs, the benefits of having a consistent system to measure performance and publicizing this data would be more than outweighed by the fact that the playing field would be uneven, with providers who serve the most challenging patients being at a clear disadvantage. It is essential that any system that seeks to measure and pay for quality and performance weigh that data on the challenges of providing care to complex patients and provide incentive for providers able to provide effective care to patients with diverse SDOH needs.

Complex Patient Bonus

We echo the comments submitted by the National Partnership for Women and Families in support of the Complex Patient Bonus. Payment policies should endeavor to offer providers and practices adequate resources to provide high-quality care for their patient population. We appreciate the approach to defining patient complexity to take into account a multitude of factors that have an impact on patient



health outcomes including the health status and medical conditions of patients, as well as social risk factors. As CMS' states, we believe this proposal will help address discrepancies in the resources needed to treat high-need patients, without masking provider performance. In addition, AAPCHO encourages CMS to put a significant focus on providers who serve culturally and linguistically complex patients.

Conclusion

In providing care to patients with high LEP and low socioeconomic status, AAPCHO's research team and clinics have a great deal of research on the value of addressing the SDOH and the impact of providing linguistically and culturally competent care. We would like to offer to be of assistance as to determine how best to adjust measures and payments to reflect SDOH. AAPCHO, in partnership with NACHC, is currently engaged in an extensive study to create, test, and promote a national standardized patient risk assessment protocol to assess and address patients' social determinants of health.

