November 20, 2017

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Centers for Medicare & Medicaid Services Innovation Center
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Innovation Center New Direction RFI

Dear Administrator Verma,

AAPCHO is a national not-for-profit association of 33 community-based health care organizations, mostly federally qualified health centers, dedicated to promoting advocacy, collaboration, and leadership that improves access to and the health status 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.

AAPCHO strongly supports patient-centered care and ensuring that patients have the tools and information they need to make decisions that work best for them—while improving health care outcomes. Our member centers have significant expertise in delivering high quality, efficient care and working with patients to improve their health while empowering their decision-making.

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.

To that end, AAPCHO supports patient-centered care that empowers beneficiaries and looks forward to working with the Innovation Center to build on the success of the triple aim for the Innovation Center's new direction. Care that is truly patient centered requires more than patients taking ownership over their health and having flexibility, it requires that health entities help patients to be active participants in the process and overarching system (including the Innovation Center's direction), that patients have ready access to relevant information in-language and at an appropriate health literacy reading level, and that such access to information be timely and displayed in a manner that is useful and accessible to patients. Additionally, the patient experience must be respected, and be culturally and linguistically accessible.

AAPCHO agrees that beneficiaries should be empowered as consumers to drive change in the health system through their choices. Important opportunities exist to support consumers with limited English proficiency (LEP) by providing the tools they need to make informed choices and by ensuring access to providers who can deliver linguistically and culturally appropriate care.

CMS and the Innovation Center have a long history of federal initiatives to draw upon to support this guiding principle and ensure its clear and explicit application throughout the Innovation Center's work. This includes the CMS Health Equity Plan and the Culturally and Linguistically Accessible Standards (CLAS) in healthcare, under the U.S. Department of Health and Human Services' Office of Minority Health (OMH). AAPCHO member centers strongly believe in working towards addressing the CLAS standards, as much of their daily clinical practices in integrative care models address CLAS. As such, we strongly recommend that the Innovation Center consult with HHS OMH to ensure alignment with existing equity measures. Further, the Innovation Center should consult external efforts, such as the National Academy of Medicine report "Harnessing Evidence and Experience to Change Culture: A Guiding Framework for Patient and Family-Engaged Care."

We also strongly encourage the Innovation Center to explicitly address achieving health equity as a core tenant of its new direction by adding "Achieving Health Equity" as an overarching guiding principle. The Innovation Center's push to improve the health care system and quality must correspondingly include a drive to improve health equity and eliminate disparities. In particular, we urge CMS and the Innovation Center to consult the released draft National Quality Forum report "A Roadmap to Reduce Healthcare Disparities Through Measurement"and the "Principles for Patient- and Family-Centered Engagement from the Consumer and Patient Advisory Group of the Learning Action Network," as ways to operationalize the goal of health equity though explicit methods and leveraging existing measures.

Further, we recommend that any changes to the Innovation Center's new direction be consistent with and build upon existing federal initiatives, including 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 issues, leading to disparities. Health disparities are caused by a multitude of factors and are impacted by race, ethnicity, sex, immigration and primary language, among others.

To support patient-centered care, and to achieve health equity, AAPCHO strongly encourages that all new models adhere to the following principles:

Ensure all patients receive linguistically and culturally appropriate care

Health centers serve disproportionately more LEP patients than the average health facility, and know that effective care means reducing language barriers. According to a report from the National Association of Community Health Centers, 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. 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." AAPCHO therefore encourages the Innovation Center to specifically address the needs of these underserved communities, and to incentivize providers to reduce language barriers.

AAPCHO recommends that the Innovation Center test a payment model that supports the consumer-directed care needs of LEP populations so that they can receive holistic linguistically and culturally appropriate care. CMS seeks creative ideas on how to operationalize these models—and AAPCHO recommends that this be done by ensuring that LEP individuals have full opportunity to participate in these models.

Adjust for social determinants of health

New payment models should ensure adequate payment for complex patients and those patients who experience a range of social determinants of health: the social, environmental, and economic factors that influence an individual's health (SDOH). For AAPCHO members, it important to take into consideration demographic factors (e.g., primary language written/spoken literacy level, poverty, etc.) in order to appropriately adjust for unique populations. In partnership with the National Association of Community Health Centers, the Oregon Primary Care Association, and the Institute for Alternative Futures, AAPCHO works on the Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) project to measure and capture health centers' patient social determinant of health risks. PRAPARE has moved past the pilot stage, and these measures are being implemented in health centers across the country.

Models should also consider the holistic view of health, which promotes integrated care through a team-based structure, and includes the social determinants of health. We encourage the Innovation Center to look at the National Academies of Science, Engineering, and Medicine report on the "Recommended Social and Behavioral Domains and Measures for Electronic Health Records." Payment systems and quality metrics must be appropriately adjusted to for these social determinants.

Build on successful care coordination models

Care transformation should work to improve the integration and coordination of core health and behavioral health services. This delivery system transformation may include key care coordination innovations such as the Patient Centered Medical Home (PCMH), the Patient Centered Health Home (PCHH), or the Chronic Care Model (CCM), models that have been effective in addressing the needs of patients with complex linguistic and cultural needs. The Innovation Center should test expansions of these models, including for patients with specific linguistic or cultural needs.

Ensure that health centers and other providers for vulnerable populations are able to participate in new models.

Health centers have a long history of providing comprehensive and coordinated care to their patients. AAPCHO's member centers have a long-track record of improving patient outcomes, providing enabling services and in patient engagement. The Innovation Center must ensure that health centers and other community providers are able to fully participate in new models—including the unique way that health centers provide services.

Include expanded opportunities for health center participation in advanced APMs

Health centers are interested in participating in advanced Alternative Payment Models (APMs) but have been limited by some of the requirements included for providers. AAPCHO encourages the Innovation Center to expand opportunities for health centers to participate in future models, and work with Primary Care Associations to do so.

Health centers have a unique payment methodology in Medicare and report to CMS as an entity, not as individual providers as the "typical" fee-for-service (FFS) provider does. Because of this, we strongly support policies that allow the FQHC to participate 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 by Medicare and would require the health center to revamp their entire system. In addition, AAPCHO encourages new models to ensure that:

- Quality metrics are obtainable, translatable, and comparable across providers, including health centers;
- Reimbursement for that quality takes into consideration the other factors impacting healthcare, such as limited English proficiency, access to housing, and socioeconomic status;
- Specific detail is provided to FQHCs on how to participate, including how to report data; and
- Quality measures are designed to reduce health disparities, address Social Determinants of Health (SDOH), and improve care coordination for vulnerable populations.

As discussed above, there is an expectation that quality measures and payment structures will be adjusted to reflect SDOH. Without such a 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 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 incentives for providers able to provide effective care to patients with diverse SDOH needs.

The RFI specifically seeks guidance on ways to capture appropriate data to drive the design of payment models. AAPCHO supports efforts to ensure that the data collected and reported will be adjusted to reflect patients' SDOH. Our Medicare patients come from diverse backgrounds and often need linguistically or culturally appropriate services that 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.

Encourage comprehensive care for Medicare beneficiaries through health centers

The Innovation Center seeks comment on what options might exist beyond fee-for-service (FFS) and MA for Medicare beneficiaries. AAPCHO recommends that the Innovation Center test the

comprehensive model of care utilized by health centers to appropriately treat Medicare patients and to ensure that their care is delivered in an effective, efficient, and culturally appropriate way.

Medicare beneficiaries, including those dually eligible for Medicare and Medicaid, represent on average 9.1% of AAPCHO health center patients, a small but growing patient population. Our members also have a higher rate of beneficiaries with LEP than other health centers (50% vs. 23%) and a high rate of beneficiaries at or below 200% of federal poverty level (FPL) (88%), and thus provide more enabling services (9,159 vs 4,875 encounters) given the needs of our patients (HRSA Uniform Data System, 2014).

AAPCHO supports innovative care delivery for Medicare beneficiaries with chronic conditions. We anticipate that AA&NHPI beneficiaries with specific chronic conditions would benefit from a tailored benefit package and incentives for care. However, these packages must be designed in a manner that is culturally and linguistically appropriate. Developing an alternative benefits package that includes specific benefit design or supplemental services offers an opportunity to add the enabling services to support AA&NHPI beneficiaries. We strongly encourage new models to include support services, including linguistically and culturally competent care and supported transportation. We also support supplemental benefits that would positively impact AAPCHO member patients including alternative therapies, counseling services, and enhanced disease management.

AAPCHO recommends that CMS test an enhanced package of services for patients getting care at FQHCs through Medicare. We have supported improving care management services through Medicare at FQHCs, as well as addressing the need for behavioral health services among chronically ill patients at health centers. For low-income AA&NHPI Medicare beneficiaries, this type of coordinated service provides full access to culturally competent care, eases the burden of transportation, and integrates treatment protocols.

Support health centers' mission in serving vulnerable AA&NHPI patients

Across all states, health centers play a critical role in supporting Medicaid beneficiaries. They offer a wide range of primary care services—and also integrate behavioral health, social services and coordinated medical care.

AAPCHO members also offer enabling services—non-clinical services provided to patients to support care delivery, enhance health literacy, and facilitate access to care. These enabling services are incorporated with medical care to reduce health disparities and improve outcomes, and are vital to reaching medically underserved and linguistically isolated AA&NHPI households. These services are also necessary for the management of a beneficiaries' health and are integral to the health center model of care.

AAPCHO members are able to provide Medicaid beneficiaries holistic and culturally appropriate care because the unique Medicaid payment rate takes in to account each center's unique bundle of services, including the range of enabling services provided.

AAPCHO members are on the cutting edge of system delivery and have developed systems of care that reward quality—not just quantity. In 2010, Hawaii's health centers developed a comprehensive and innovative program to provide comprehensive FQHC services in a way that

would correctly balance incentives towards improving value and addressing preventable costs in health care. The plan allows health centers to exclude from PPS wraparound payments, bonus payments for shared savings with Medicaid managed care plans, non-PPS services that plans and health homes consider integral to addressing health needs (yet not an allowable cost under PPS), and continuous quality improvement payments including those that can lead to improvements in health information technology and care coordination systems. The result has led to a profound change in how community health centers structure their clinics and systems.

In considering state and local innovations, the Innovation Center should look to health centers to play a critical role in supporting Medicaid beneficiaries and other low-income, vulnerable patients. Managed care and other commercial and merging models of care do not have experience in delivering care to this population or in addressing the key social determinants of health—health centers do. In fact, providing coordinated care for high cost patients, such as currently underserved AA&NHPI beneficiaries, will be difficult in new delivery systems without comprehensive and accessible primary care.

The unique health center payment rate must be maintained in order support the unique needs of our patients. Without these stable funds to pay for enabling services, appropriate access to care is hindered for our patients, and advances in health equity and in reducing health disparities will be diminished. We note that the on-the-ground and regulatory relationship between our member health centers and states is strong; together we are able to provide comprehensive, culturally, and linguistically appropriate care to AA&NHPI populations nationally.

In addition, the Innovation Center could test the role of appropriate payment for enabling services on health care outcomes for LEP populations. Enabling services provide real and life-saving value to our beneficiaries but are at risk when bundled reimbursement falls below the cost of medical care. Reimbursement formulas must ensure that adequate payment these services are included. The Innovation Center can play a critical role in testing appropriate payment rates.

In conclusion, AAPCHO looks forward to working with the Innovation Center to support comprehensive care for AA&NHPI patients at health centers. Thank you for the opportunity to submit comments.

If you have any questions or need more information, please contact Isha Weerasinghe, AAPCHO's Director of Policy and Advocacy, at isha@aapcho.org.

Sincerely,

Isha Weerasinghe
Director of Policy and Advocacy