COMMUNITY CATALYST

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VIA ELECTRONIC MAIL
Dr. Cara James, Director
Office of Minority Health
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop: S2-12-17
Baltimore, MD 21244

Dear Dr. James:

We are writing to you in response to your office's recent announcement on the Plan to Address Health Equity in Medicare.[1]

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone – especially vulnerable members of society.

We appreciate the steps that the Centers for Medicare and Medicaid Services Office of Minority Health (CMS OMH) is taking to tackle health disparities within the Medicare population. These are significant steps in the right direction, and we applaud OMH for putting forward a bold new agenda. We are particularly pleased to see:

- The inclusion of a robust evaluation to document progress towards increasing equity in Medicare quality. We urge OMH to include a beneficiary-reported assessment that is stratified by race, ethnicity, language, gender and sexual preference and is representative of the diverse population Medicare serves.
- Community based organizations (CBOs), advocates and organizations representing priority populations are included in the list of stakeholders who participated in stakeholder engagement activities to inform OMH's plan. We urge

[1] Centers for Medicare & Medicaid Services Office of Minority Health "The CMS Equity Plan for Improving Quality in Medicare September 2015" Retrieved: https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf

OMH to continue to prioritize these groups and engage them in a meaningful way both during implementation, as well as in the evaluation process.

- The framework that OMH has developed to guide its thinking in addressing disparities is promising. We strongly urge that beneficiary and provider engagement and education be a key component in each domain identified to ensure better health outcomes are being achieved.[2]

We are excited to see the priority areas that OMH has presented and note below suggestions for improvement.

Priority 1: Expand the Collection, Reporting and Analysis of Standardized Data

We applaud OMH's commitment to improving the collection, reporting and analysis of comprehensive patient data. To further strengthen this priority, we urge OMH to:

- Prioritize consumers in their efforts to increase understanding and awareness in this area. Consumers should understand the reasons for and importance of collecting demographic data.

- Train providers to collect and report comprehensive patient data. Providers and provider organizations also need to understand how to use these data in a meaningful way (e.g. in care planning/coordination). OMH has an opportunity to build this understanding through long-term support and system-level infrastructure, substantial incentives and alternative payment arrangements, and new processes for monitoring and addressing health disparities.

- Identify opportunities to target data collection, reporting and analysis at the community and population levels in order to gain a better understanding of beneficiaries' social circumstances, which could potentially have an effect on their health and well-being, and opportunities to address health disparities through upstream interventions. We encourage OMH to use the new consensus metrics developed by the National Quality Forum (NQF) to assess cultural competency and language services.[3] Implementing these measures is critical in addressing provider biases, poor patient-provider communication, and poor health literacy.

Priority 2: Evaluate Disparities Impacts and Integrate Equity Solutions Across CMS Programs

We are pleased to see that evaluation is a priority in this plan. We urge OMH to use concrete means to evaluate the impacts of disparities and to integrate equity solutions across CMS programs. Specifically:

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[2] A key lesson learned to date through the Financial Alignment Demonstration (FAD) is the importance of outreach to – and education of – both consumers and providers. Lack of this education has created a number of early implementation challenges for those states pursuing an FAD. See: MACPAC Report on "Experiences with Financial Alignment Initiative Demonstration Projects in Three States". Retrieved: https://www.macpac.gov/wp-content/uploads/2015/05/Experiences-with-Financial-Alignment-Initiative-demonstrations-in-three-states.pdf

[3] National Quality Forum (August 2012). Healthcare Disparities and Cultural Competency Consensus Standards. http://www.qualityforum.org/projects/Healthcare_Disparities_and_Cultural_Competency.aspx

- Continue to prioritize community-based organizations and consumer advocacy organizations and meaningful input from beneficiaries who are directly affected by these programs. This can be done through a number of means: surveys, focus groups, town hall style meetings.

- Use alternative payment arrangements with providers serving Medicare beneficiaries that emphasize disparities reductions in the overall quality improvement goals and the adoption of tools that support disparities measurement and interventions, such as patient activation tools. Several studies have found that patient activation is currently an area where there is a significant race-based disparity, but also an area where improvement is possible. For instance, White patients are statistically more likely to be more empowered than African American or Hispanic patients, particularly when there is a language barrier involved.[4] Other studies have concluded that White Americans are more likely to consider their relationship with their doctor as equitable (in relation to the power dynamic) than Hispanic or Black Americans. This likely leads them to ask more questions, be more engaged and assertive, and be more comfortable taking an active role in their care.[5]

- Finally, we urge any evaluation to be conducted in a transparent process with data available for public viewing and commenting. A key lesson learned through the Financial Alignment Initiative (FAI) is that while it includes an evaluation, there has been virtually no public reporting of data on the initiative's progress. Lack of data makes it difficult for beneficiaries and advocates to assess the benefits of the demonstration or identify areas that need improvement.

Priority 3: Develop and Disseminate Promising Approaches to Reduce Health Disparities

We applaud OMH's efforts to help improve discharge care coordination for diverse populations to prevent avoidable Medicare expenditures. We recommend the following approaches to strengthen this priority:

- In developing this approach for cutting costs and improving care coordination for vulnerable Medicare populations, we urge OMH to strongly consider exploring existing state-based models,[6] such as risk-adjustment, that aim to reduce preventable hospital readmissions and account for factors related to patients' unique health, social risks, and socioeconomic status.

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[4] Peter J. Cunningham, Judith Hibbard and Claire B. Gibbons "Low 'Patient Activation' Rates Among Hispanic Immigrants May Equal Expanded Coverage In Reducing Access Disparities" *Health Affairs*, 30, no.10 (2011):1888-1894; Available: http://content.healthaffairs.org/content/30/10/1888.full

[5] Alexander, J. A., Hearld, L. R., Mittler, J. N., & Harvey, J. (2012). Patient–Physician Role Relationships and Patient Activation among Individuals with Chronic Illness. Health Services Research, 47(3 Pt 1), 1201–1223. http://doi.org/10.1111/j.1475-6773.2011.01354.x. Available: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3423181/

[6] Community Catalyst's Medicaid Report Card: http://www.communitycatalyst.org/resources/tools/medicaid-report-card/payment-incentives/payment-incentives-reducing-hospital-readmissions

- As OMH considers different models to reduce health disparities, we want to stress the concerns around value based payment models that have the unintended consequences of shifting resources away from providers that disproportionately care for low income communities and communities of color which could have the effect of making disparities worse. We urge OMH to keep this in mind when implementing different approaches to reduce health disparities and ensure that providers serving this population are reimbursed appropriately.

- We also applaud OMH's efforts to improve the delivery of culturally and linguistically appropriate care in nursing homes, and its recognition of the need to eliminate the discrimination that LGBT elders from vulnerable populations face in nursing home facilities. We recommend that CMS explore existing models of care that capture both the experiences and needs of consumers placed in nursing homes to ensure their needs are met and that care is delivered in a culturally and linguistically appropriate way. For example, ensuring that those interacting with beneficiaries speak the preferred language, understand cultural norms and respect dietary requirements and restrictions.[7] [8]

- Finally, we urge OMH to use alternative payment arrangements to incentivize strategies that address the non-medical factors and social determinants that contribute to health and wellbeing (e.g., housing, public safety, access to education and job opportunities, language services, availability of places to exercise, healthy food choices, and other environmental factors). For example, ensuring information sharing and connections between providers and community-based resources, agencies, and organizations is vital in order to connect patients to appropriate community supports and services that can lead to better health outcomes.

Priority 4: Increase the Ability of the Health Care Workforce to Meet the Needs of Vulnerable Populations

We applaud OMH's efforts to prioritize workforce development. We support the important role CHWs play in connecting with low-income, communities of color on a more personal level to facilitate coordinated health care services. In addition:

- OMH should consider including mechanisms for incorporating **–** *and reimbursing* **–** CHWs.[9] There is ample evidence that CHWs are effective in (1) assisting people to access and navigate the health care system and better manage their health conditions, (2) coordinating services for people with multiple chronic conditions,

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[7] Community Catalyst "Miles to Go: Progress on Addressing Racial and Ethnic Health Disparities in the Dual Eligible Demonstration Projects" Retrieved: http://www.communitycatalyst.org/resources/publications/document/Miles-to-Go-Health-Disparities-in-the-Dual-Eligible-DemonstrationsFINAL.pdf

[8] Community Catalyst "Putting Consumers First: Promising Practices for Medicaid Managed Long-Term Services and Supports: Executive Summary" Retrieved: http://www.communitycatalyst.org/doc-store/publications/putting_consumers_first_LTSSmanagedcare_execsummary.pdf

[9] http://content.healthaffairs.org/content/20/6/64.full.html

and (3) leading community-wide efforts to identify and address underlying causes of poor health.[10]

- We strongly encourage OMH to consider the role that multiple providers in the health care delivery system, including physicians and nurse practitioners, could play in ensuring comprehensive benefits are provided in a culturally competent manner.

- OMH should explore ways health professionals recognize, address and reduce implicit bias when delivering health care services to diverse communities. CMS can look at existing models[11],[12] instituted at medical schools that aim to help train health care professionals around reducing implicit bias[13] in the delivery of health care services.

- The use of alternative payment arrangements can also incentivize investment in a diverse and effective health care workforce that can meet the physical, behavioral, social, and economic needs of patients.

Priority 5: Improve Communication and Language Access for Individuals with Limited English Proficiency and Persons with Disabilities

We applaud CMS' recognition of the importance of communication and language access as part of health equity. We urge CMS to use multiple means to effectively implement this plan, such as:

- Surveys in multiple languages to Medicare beneficiaries about their care.
- Conduct focus groups in multiple languages to understand the communications and language access needs of Medicare beneficiaries.
- Require providers at all levels to be trained in working with diverse Medicare populations to ensure appropriate delivery of services.
- Collaborate with community based organizations, including the advocacy community, to understand needs of this population.

Priority 6: Increase Physical Accessibility of Health Care Facilities

We are encouraged to see that CMS plans to conduct research on the current landscape of the physical accessibility of facilities. We recommend the following to improve this priority area:

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[10] NYS Health Foundation (October 2014). A Critical Link for Improving Health Outcomes and Promoting Cost-effective Care in the Era of Health Reform. http://nyshealthfoundation.org/uploads/resources/community-health-workers-critical-link-october-2010.pdf

[11] Implicit Association Test is a computerized measurement tool designed to measure the strength of automatic associations people have in their minds. This tool has been used to measure implicit bias in physicians https://implicit.harvard.edu/implicit/iatdetails.html

[12] US National Library of Medicine National Institutes of Health (November 2013). Physician and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities http://www.ncbi.nlm.nih.gov/pubmed/23576243

[13] http://khn.org/news/can-health-care-be-cured-of-racial-bias/?utm_campaign=KHN%3A+Daily+Health+Policy+Report&utm_source=hs_email&utm_medium

- In addition to physical accessibility, ensure programmatic accessibility as well[14]; such as, appropriate scheduling, communication on medical information, and provider staff training and knowledge.[15]

- Conduct regular assessments of provider competency, physical barriers of provider practice locations, and equipment such as use of appropriate exam tables or diagnostic equipment; use that data to make improvements and make assessment results publically available.

- Conduct provider and staff training on the ADA and the independent living philosophies and practice.

- Conduct beneficiary focus groups to better understand what is working and where improvements need to be made.

We are excited about this new health equity plan in Medicare. It will be vitally important to work with state and local consumer advocates who can offer valuable feedback to federal policymakers about what is working and what needs to be improved, and we are eager to work with our advocacy partners and OMH on these efforts. We look forward to following up with you to discuss our letter in more detail.

As always, thank you for your time and attention to these issues.

Sincerely,

Rob Restuccia
Executive Director
Community Catalyst

Leena Sharma
Senior State Advocacy Manager
Community Catalyst

[14] Disability Competent Care Self-Assessment Tool: https://www.resourcesforintegratedcare.com/sites/default/files/Disability-Competent%20Care%20Self%20Assessment%20Tool_508%20Compliant.pdf

[15] Disability Rights and Education Defense Fund "Defining Programmatic Access to Healthcare for People with Disabilities" Retrieved: http://dredf.org/healthcare/Healthcarepgmaccess.pdf