

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

August 25, 2015

By electronic submission at regulations.gov

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue SW.
Washington, DC 20201.

Re: CMS-1631-P

Dear Mr. Slavitt:

On behalf of Justice in Aging, I am writing to strongly support the reporting and stratification requirements for the physician quality measures by race, ethnicity, sex, primary language, and disability status in the Physician Quality Reporting System (PQRS). Those requirements are found at 80 FR 41816-41817 (Physician quality reporting system) and at 80 FR 41815 (Physician Compare web site). Our comments are limited to those two provisions.

Justice in Aging is a national advocacy organization that uses the power of law to fight senior poverty. Advocacy on behalf of Medicare and Medicaid beneficiaries who are minority or who have limited proficiency in English has been an important component of our health care work. These individuals are disproportionately low income and disproportionately experience poorer health compared to other beneficiaries.

Stratification of such physician quality measures will be an important step in addressing these disparities. It will increase transparency and accountability to identify and reduce known and persistent health care disparities. Achieving health equity, eliminating disparities, and improving the health of all groups are among the overarching goals of Healthy People 2020. Achieving health equity also is one of the six elements of the Institute of Medicine's framework for health care quality. We urge the Centers for Medicare and Medicaid Services (CMS) to require such reporting and stratification as soon as possible, and no later than the Physician Fee Schedule requirements for Calendar Year 2017. Since these data already are available in patient records, there is no need to phase in the implementation of any reporting or stratification requirements.

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Given the continued implementation of the Health Information Technology for Economic and Clinical Health (HITECH) Act incentive program for the meaningful use of certified electronic health records (EHRs) by Medicare eligible providers, more and more Medicare physicians will be using their EHRs to electronically report their quality measures to the PQRS. Since patient demographic data (race, ethnicity, sex, primary language) already are required to be collected under the meaningful use requirements (for at least 80% of unique patients under Stage 2), there is no additional burden in electronically reporting these additional data already contained in the EHR.

When additional patient demographic data such as sexual orientation, gender identity, and social, psychological and behavioral data are documented in electronic health records as part of Office of the National Coordinator for Health IT EHR certification and CMS meaningful use requirements, physician quality measures also should be reported and stratified by these additional patient demographic data.

Many Medicare physicians in group practices use the Group Practice Reporting Option (GRPO) web interface or their reports to a Qualified Clinical Data Registry (QCDR) to report their physician quality measures to the PQRS. Given the greater operational capabilities of such physician group practices, electronically extracting and reporting patient demographic data also would not be an administrative burden for these physicians and group practices.

In addition, the patient experience data collected and reported by Consumer Assessment of Health Providers and Systems (CAHPS) vendors used by Medicare physicians already include patient demographic data. Again, there would be no administrative burden for these CAHPS vendors to also report the patient demographic data to the PRQS.

Once physician quality measures are reported to PRQS with stratifications by race, ethnicity, sex, primary language, disability status, and other patient demographic data, these data should then be made publicly available on the Physician Compare web site. Physicians would be able to review these data prior to release on Physician Compare, similar to any other data reported on Physician Compare.

Since Physician Compare already has requirements in place for minimum sample sizes (20 patients in any reportable category), there can be no argument that there would be unreliable data when physician quality measures are stratified by race, ethnicity, or other patient demographic variables. For example, if a physician did not have at least 20 African American patients with diabetes in his or her panel of patients, then diabetes-related quality performance measures would not be reportable separately for that physician's African American patients.

Finally, Justice in Aging strongly supports CMS' reminder in the proposed rule that Medicare practitioners providing telehealth services are subject to non-discrimination laws, including requirements for effective communication for persons with disabilities under the Rehabilitation Act and requirements for language access for persons with limited English proficiency under Title VI of the Civil Rights Act of 1964 (80 FR 41781). Meanwhile, we urge CMS to work with the Office of Civil Rights to issue implementing regulations for section 1557 of the Affordable Care Act to ensure consistent application of non-discrimination laws across all federally funded health care programs.

Thank you for the opportunity to comment on these important issues.

Sincerely,

A handwritten signature in black ink, appearing to read "K. Prindiville". The signature is written in a cursive, flowing style.

Kevin Prindiville
Executive Director