Legislative and Regulatory Levers to Collect Patient Race, Ethnicity, and Language (R/E/L) Data

The American Recovery and Reinvestment Act of 2009 (ARRA)

Meaningful Use

ARRA established incentive payments for physicians and hospitals who are successful in becoming “meaningful users” of certified electronic health records (EHR). The criteria for meaningful use will follow a staged implementation over five years. To qualify for incentives in Stage 1, providers must achieve all objectives listed as the “core set”, as well as a limited number of “menu set” objectives. Collecting patient R/E/L information is one of 15 required “core set” objectives; use of that data is one of several optional menu objectives.

Data Collection

All providers and hospitals seeking meaningful use incentive payments must record patient demographics as structured data (i.e., specific data categories, not free text), including preferred language, gender, race and ethnicity, date of birth. Race and ethnicity are to be recorded in accordance with the Office of Management and Budget standard, at a minimum, found HERE. Proposed criteria for Stage 3 (beginning 2015) will require inclusion of IOM categories, found HERE.

Use of Data

Providers and hospitals may choose to use R/E/L data to generate lists of patients by specific conditions (i.e. to stratify patient lists by R/E/L) as one of five menu set objectives. Proposed criteria for Stage 2 (beginning 2013) will include a core requirement that providers and hospitals to use collected R/E/L data to produce stratified quality reports.

Evaluation

In Stage 1, providers and hospitals must demonstrate they have met the R/E/L data collection requirement through attestation (i.e., to declare to CMS that the requirement has been satisfied). Electronic reporting of data may be required in later stages.

Incentives and Penalties

Meaningful use incentives can total up to $44,000 for Medicare providers over the course of 4 years, or $63,750 for high volume Medicaid providers. Hospitals will receive incentive payments of $2million base + a per-discharge amount based on Medicare/ Medicaid share per year for up to 4 years.

After 2015, Medicare providers who are not meaningful users of EHRs will be subject to a payment adjustment of up to 3% of the Medicare physician fee schedule amount for covered professional services. Medicare hospitals who are not meaningful users of EHRs will be subject to a payment reduction of up to 3/4 of their market basket update. There is no penalty under Medicaid.

Timeline

January 2011	May 2011	2013	2015	2015	2016	2021
Program registration begins	Incentive payments begin	Stage 2 begins	Stage 3 begins	Penalties for Medicare providers who are not meaningful users begin	Last year to receive Medicare incentive payment	Last year to receive Medicaid incentive payment

Standards and Certification Criteria for Electronic Health Records

ARRA also established an EHR certification process to ensure that EHR functionality can support, at a minimum, Stage 1 meaningful use objectives as described above (e.g., have the appropriate fields to capture R/E/L and the capability to stratify patient lists). Hospitals and providers must use certified EHR systems to be deemed eligible to receive incentive payments under meaningful use.

Data Capture

In order to be certified, EHRs must have the capacity to allow a user to electronically record, modify, and retrieve patient demographic data including preferred language, gender, race, ethnicity, and date of birth. Race and ethnicity data must be able to be recorded in accordance with OMB standards found HERE.

The Patient Protection and Affordable Care Act of 2010 (ACA)

Data Collection

Requires federally supported health care programs to collect self-reported data on patient race, ethnicity, sex, primary language and disability status in accordance with OMB standards at a minimum, by 2012.

Use of Data

The Secretary of Health and Human Services will be responsible for analyzing data and monitoring trends in health disparities at the Federal and State levels, and for disseminating findings.

The Joint Commission

Data Collection

In December 2009, the Joint Commission approved revised standards for hospital accreditation that will expand requirements related to the collection of patient language data.

Currently, standards require that written information is appropriate to the language of the patient, and that the organization provides interpretation services as necessary. Beginning in 2012, hospitals will also be required to include information on language and communication needs, including a patient's preferred language for discussing health care and written communication needs, in patient’s medical record.

The revised standards will also require collection of patient-level demographic data on race and ethnicity (among other data elements) no sooner than January 2012.

NCQA Patient-Centered Medical Home Standards

Data Collection

The 2011 NCQA’s Standards and Guidelines for Patient-centered Medical Home includes several elements in which care providers can earn points toward the recognition process by collecting and analyzing REL data. While none of these elements are Must-Pass elements, care providers can earn up to 10 accumulative points if they satisfy these elements:

- PCMH 1, Element F **2 points**, asks providers to assess patient race, ethnicity and language needs, and to provide interpretation or bilingual services.
- PCMH 2, Element A **3 points, r**equires providers to collect, among other data elements, patient race, ethnicity and preferred language, as structured data for more than 50% of patients.
- PCMH 6, Element A **4 points**, includes a requirement that providers stratify performance data by race and ethnicity for vulnerable populations.
- PCMH 6, Element C **4 points,** requires providers to address any identified disparities in care or services for vulnerable populations. While R/E/L data collection is not mentioned directly, it is necessary for the carrying out of this Element.