

## **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 physician and hospital providers 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. Stage 1 sets the baseline for electronic data capture and information sharing. 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.

Stage 2 (beginning 2013) and Stage 3 (beginning 2015) will expand on Stage 1 criteria and be developed through future rule making.

#### Data Collection

All providers and hospitals seeking meaningful use incentive payments must record more than 50% of patients’ 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](#).

#### 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. All items on the menu set will likely be required in Stage 2 (2013).

#### 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

<b>January 2011</b> Program registration begins	<b>May 2011</b> Incentive payments begin	<b>2013</b> Stage 2 begins	<b>2015</b> Stage 3 begins	<b>2015</b> Penalties for Medicare providers who are not meaningful users begin	<b>2016</b> Last year to receive Medicare incentive payment	<b>2021</b> 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 Office of Management and Budget standard found [HERE](#).

### What Action is Required?

Developers of EHR technology (including hospitals and practices that have developed their own EHR systems) that wish to have their product tested and certified should contact an ONC-Authorized Testing and Certification Body. A list of authorized organization can be found [HERE](#).

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

### Data Collection

Requires any federally supported health care or public health program to collect self-reported data on patient race, ethnicity, sex, primary language and disability status in accordance with Office of Management and Budget 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.