



June 17, 2016

Andy Slavitt  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington D.C., 20201

RE: CMS-5517-P; Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Administrator Slavitt,

The Health IT Policy subproject of the Transdisciplinary Collaborative Center (TCC) for Health Disparities Research at Morehouse School of Medicine (MSM) greatly appreciates the opportunity to provide comments in response to the MIPS and APM Incentive under the Physician Fee Schedule proposed rule (hereinafter referred to as “proposed rule”). The TCC is funded by the National Institute on Minority Health and Health Disparities (NIMHD) to study the impact of policy on the elimination of health disparities. The TCC’s Health IT Policy subproject specifically focuses on leveraging health IT policy to advance health equity. We have a national reach but place particular emphasis on reducing disparities for people living in Department of Health & Human Services (DHHS) Region IV states (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee). The TCC Health IT Policy subproject conducts original research, engages directly with the community and is informed by an advisory board of national experts in health IT and health equity. For more information on our research, outreach and advisory board, we welcome you to visit our website:

<http://healthpolicymatters.org/>.

As an institution, MSM has been recognized nationally for its social mission and has demonstrated its commitment to the advancement of health equity through its mission to improve the health of all individuals and communities, increase diversity in the medical professional workforce, and address primary healthcare needs for people of color and underserved communities. MSM is home to the National Center for Primary Care, which administers the only regional extension center in Georgia, the GA-HITEC. The GA-HITEC has assisted over 4,000 providers in Georgia adopt and implement electronic health records and launched the only mission-based health information exchange in Georgia, Georgia HealthConnect.

We are thrilled to see that many provisions within the proposed rule have the potential to significantly improve health disparities. As you are aware, racial and ethnic health disparities have persisted over many decades despite national efforts to eliminate them.<sup>1</sup> On a positive note, the science of eliminating health disparities is evolving rapidly, as shown by the July 2015 supplement issue of the *American Journal of Public Health*.<sup>2</sup> As national healthcare priorities continue to focus on quality and move towards precision

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<sup>1</sup> U.S. Department of Health and Human Services, *Report of the Secretary’s Task Force on Black and Minority Health*, vol. 1. Washington: U.S. Government Printing Office, August 1985.

<sup>2</sup> AJPB Highlights the Science of Health Disparities. Press Release April 23, 2015. Available at <https://www.apha.org/news-and-media/news-releases/ajph-news-releases/ajph-highlights-the-science-of-health-disparities>.



medicine, inequalities in healthcare access and delivery of services only hinder these efforts. These inequalities result in significant annual costs: \$35 billion in excess health care expenditures, \$10 billion in illness-related lost productivity, and nearly \$200 billion in premature deaths.<sup>3</sup> It is in the interests of all stakeholders, including federal and state governments, technology vendors, consumers, health systems and individual healthcare providers to target disparities and implement effective interventions to eliminate them. Fortunately, effective interventions have been developed and we know that disparities are not inevitable, as demonstrated by the elimination of racial and ethnic disparities in some child vaccine rates.<sup>4</sup>

As a school of medicine educating and training future physicians, public health professionals, policy leaders and researchers, we would like to take this opportunity to share some of our own research findings and those in the peer-reviewed health literature related to health disparities and the provisions in this proposed rule. In addition, we hosted a webinar on June 2, 2016, titled “Paying for Quality: What is the Impact on Health Equity?” We used this platform to inform our audience of the implications of the Quality Payment Program on health equity and to receive their feedback on the proposed rule. More than 250 people from 37 states registered for the webinar and 133 individuals attended. Of the total registrants, 98% responded affirmatively to the question “Is it important to ensure that the MIPS and APM programs advance health equity for underserved populations?” During this webinar we polled the audience on several issues. We have included the audience responses to these poll questions in the relevant sections of this public comment.

This public comment focuses on the impact of the proposed rule on health equity. It begins with general feedback concerning the timeframe, the impact on small, rural and HPSA practices, the importance of data collection and reporting, and risk adjustment. Then the comment is separated by three of the four components of the composite performance score (CPS) to provide specific feedback and suggestions. We will discuss the significance of specific provisions within each CPS category, as supported by the scientific literature and our own research. Because it is estimated that 95% of clinicians will be part of the Merit-based Incentive Payment System (MIPS) program, we focus most of our attention on this program.

## **General Comments**

### *Timeframe*

The proposed rule outlines an implementation timeframe for MACRA that is too aggressive. The complexity and length of the proposed rule are not conducive to initiating the performance period on January 1, 2017. The final rule is not expected to be published until the fall, leaving clinicians a few short months to prepare for the new reporting structure. Small, rural, and HPSA practices will face additional challenges due to fewer legal and policy resources available to assist with compliance. Clinicians that were ineligible for Meaningful Use also face unique challenges due to inexperience with the Advancing Care Information category. The disproportionate impact of these regulatory changes on all of these practices and clinicians may result in lower composite performance scores and therefore lower reimbursement rates. These same practices and clinicians are likely to be serving high disparity populations and therefore penalties and reduced reimbursement rates may negatively affect the most vulnerable patient populations and those providers willing to serve them. This risk should be considered in the timeline and throughout the proposed rule because it has the potential to exacerbate existing

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<sup>3</sup> Ayanian, JZ. The Costs of Racial Disparities in Health Care. Harvard Business Review. October 1, 2015. Available at <https://hbr.org/2015/10/the-costs-of-racial-disparities-in-health-care>.

<sup>4</sup> Hutchins SS, Jiles R, Bernier R. Elimination of measles and of disparities in measles childhood vaccine coverage among racial and ethnic minority populations in the United States. J Infect Dis. 2004 May 1;189 Suppl 1:S146-52. PubMed PMID: 15106103.



disparities. These clinicians and practices that voluntarily serve the most vulnerable should be rewarded for serving these populations, not penalized, especially if we hope to encourage recent graduates and residents to develop sustainable practices serving these populations.

### *Importance of Data Reporting*

Data collection, reporting and analysis are critical themes throughout the proposed rule and the Quality Payment Program. Data collection, specifically demographic data collection of disparity characteristics such as race, ethnicity, preferred language, disability status, sexual orientation, gender identity, socioeconomic status and social, psychological and behavioral health factors, is the foundation for identifying and addressing health disparities.<sup>5</sup> It is therefore critical that the Quality Payment Program leverage this opportunity to collect meaningful patient data, especially with regard to disparity variables such as race, ethnicity, preferred language, sexual orientation, gender identity, disability status and social, psychological and behavioral health status. Although robust demographic data collection is often cited as a critical component for reducing health disparities,<sup>6,7,8</sup> opportunities to maximize data collection through policy have been missed.<sup>9,10</sup> This public comment highlights several specific issues related to data collection, such as stratifying clinical quality measures by disparity variables, and we believe this issue is critical to every aspect of the proposed rule, laying the foundation for advanced use of demographic data to target existing health disparities for elimination. Incorporating standardized data stratification across most of these disparity variables is supported by Certified EHR Technology (CEHRT) currently or in 2017 when the 2015 criteria become effective, facilitating stratification, reducing burden on clinicians and enhancing transparency.<sup>11</sup>

### *Small, Rural, HPSA Providers*

We join the significant number of health policy experts and organizations that have expressed concern that the proposed framework will create financial difficulties for those trying to maintain smaller practices, a view supported by CMS' own estimates that "about 87% of doctors in solo practice could see reduced Medicare payments because they will fare poorly in metrics judging their performance next year, with about only 13% in line for higher pay. The numbers nearly flip for sites employing 100 or more doctors and other providers covered by the Medicare metrics, with 81 percent likely to get a "positive

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<sup>5</sup> Institute of Medicine. *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. Washington, DC: National Academy Press; 2009.

<sup>6</sup> Agency for Healthcare Research and Quality. 2012 National Health Care Disparities Report. 2013;Pub No. 13-0003. Available at <http://www.ahrq.gov/research/findings/nhqrd/nhdr12/2012nhdr.pdf>.

<sup>7</sup> Joint Center for Political and Economic Studies. Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations. 2010. Available at <http://csmh.umaryland.edu/Toolbar/Toolbardocs/reformdiversepopulations.pdf>.

<sup>8</sup> Health Research & Educational Trust. (2013, August). Reducing health care disparities: Collection and use of race, ethnicity and language data. Chicago: Health Research & Educational Trust. Retrieved from [www.hpoe.org](http://www.hpoe.org).

<sup>9</sup> Douglas MD, Dawes DE, Holden KB, Mack D. Missed Policy Opportunities to Advance Health Equity by Recording Demographic Data in Electronic Health Records. *Am J Public Health*. 2015 Jul;105 Suppl 3:S380-8. doi: 10.2105/AJPH.2014.302384. Epub 2015 Apr 23. PubMed PMID: 25905840; PMCID: PMC4455508.

<sup>10</sup> Department of Health and Human Services. (2011). Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status. Available at <http://aspe.hhs.gov/datacncl/standards/aca/4302/index.pdf>.

<sup>11</sup> 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications. 80 Fed Reg 62602 (Oct. 16, 2015) (codified at 45 CFR Part 170).



adjustment” in reimbursement.”<sup>12</sup> Furthermore, the proposed rule mentions receiving feedback from “high performing” and “top performing” small, rural and HPSA providers, which is necessary, but insufficient to fully assess the impact of the proposed framework on small, rural and HPSA providers. Average and even low-performing providers should be consulted to better understand the sources of these average and low performance scores. Based on our work with many small, rural and HPSA providers, performance as defined by CMS may or may not be an indicator of quality care (or lack thereof), but is also potentially an indicator of serving the sickest, poorest, most complex patient populations. If this is the case, these practices need more resources, not fewer in order to improve the health of their patients and reduce disparities.

### *Risk Adjustment*

Risk adjustment is also a hot topic of debate among health policy experts and organizations. Similarly to the impact of the proposed rule on small, rural and HPSA providers, risk adjustment must be used to level the playing field for all participating providers. Otherwise, providers with the most resources will be more likely to outperform those with fewer resources, exacerbating existing disparities and potentially putting lower resourced providers out of practice. There are a number of considerations for improving risk adjustment and the evidence on best-practices continues to evolve. Four methods that we believe are more equitable and therefore should be considered are:

- Spatial stratification. This method controls for regional and geographic variation in outcomes and accounts for quality variability by region across the country.
- Size stratification. This method controls for practice and provider-level characteristics, comparing small practices to small practices, large systems to large systems and safety-net settings to other safety-net settings.
- Disparity stratification. This method controls for community-level and practice-level factors associated with disparities, comparing providers in communities with similar socioeconomic status, teaching status, tax exempt status, etc. Similar to the methodology used by Kahn et al., several characteristics should be identified and case-matched with clinicians with similar characteristics.<sup>13</sup>
- Redistribution of penalties (or portion thereof). Rather than outright penalties to the lowest performing providers, a portion of the reimbursement enhancements should be redistributed to low performers through grants and other funding opportunities. This strategy provides low performers with opportunities for quality improvement and additional resources.

### **Clinical Practice Improvement Activities**

The proposed Clinical Practice Improvement Activities (CPIA) component of the composite performance score (CPS) has the most robust implications for health equity, as reflected in the direct mention of “health equity” 14 times in the CPIA section of the proposed rule. As the literature on health disparities demonstrates, targeted approaches (as opposed to universal approaches) are imperative to advancing

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<sup>12</sup> Young, K. New Medicare Pay Rules Threaten Small Practices, Doctors Say. May 9, 2016. CQ Roll Call. Available at <http://www.commonwealthfund.org/publications/newsletters/washington-health-policy-in-review/2016/may/may-9-2016/new-medicare-pay-rules-threaten-small-practices>.

<sup>13</sup> Kahn JM, Le TQ, Barnato AE, Hravnak M, Kuza CC, Pike F, Angus DC. ICU Telemedicine and Critical Care Mortality: A National Effectiveness Study. *Med Care*. 2016 Mar;54(3):319-25. doi: 10.1097/MLR.000000000000485. PubMed PMID: 26765148; PubMed Central PMCID: PMC4752864.



health equity.<sup>14</sup> Health disparities have persisted over many decades and generations. We are cautiously optimistic that the incentives (CPS percentage, individual activity weights, number of activities) as proposed in the CPIA framework are enough to move the needle.

*Proposed and future health equity subcategories*

During our June 2 webinar, 100% (n=55) of our audience responded that Achieving Health Equity and Integrated Behavioral Health Care should be included as CPIA subcategories. The Achieving Health Equity CPIA subcategory should be adopted into the final rule to incentivize clinicians to adopt targeted approaches to reduce disparities. We believe there are additional activities that should be included within this subcategory:

- Stratification of CQMs by a disparity variable such as race, ethnicity, preferred language, disability status, sexual orientation, gender identity, social, psychological and behavioral status – weight High.<sup>15</sup> This activity would provide critical data to distinguish between overall quality and health disparities. Clinicians could have flexibility in which CQM they chose to stratify and which disparity variable(s) to look at. This activity would support stratification within the quality performance category and is supported by the demographic data collection fields in certified EHR technology. For example, knowing that racial and ethnic minorities have higher diabetes prevalence and worse outcomes, a primary care practice might decide to report on the Hemoglobin A1c Poor Control CQM (CMS e-measure ID: 122 v4) and stratify patients by race and ethnicity to differentiate between overall quality outcomes and minority quality outcomes.
- Practice-wide dissemination of disparity reports for priority conditions on a quarterly basis – weight High. This activity would involve inclusion of all patients across a single practice or entire system and dissemination of the report to all clinicians on a quarterly basis. This activity also informs practices of performance with regard to reducing health disparities. Again, flexibility on which disparity variables to include allows clinicians to target disparities specific to their distinct patient populations. Priority conditions would also be defined by the practice based on current health disparity data within the selected patient population. Using the above diabetes example, the practice might decide to circulate the diabetes disparity report to all clinicians to provide transparency and facilitate continuous quality improvement for disparity populations. We expect that these measures would increase in stringency as the Quality Payment Program evolves.
- Effective collection of self-identified demographic data by race, ethnicity, preferred language, disability status, sexual orientation, gender identity, social, psychological and behavioral data – weight High. This activity is critical to disparity identification and is not being effectively performed to the extent it is needed to support health disparity analysis. For example, Craddock Lee et al. demonstrated that high quality race and ethnicity data is attainable, however in some health care settings, especially where data collection is not prioritized, quality is poor with many “unknown” or blank fields.<sup>16</sup> Performance on this activity would be demonstrated by percentage of complete records.

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<sup>14</sup> Centers for Disease Control and Prevention. CDC Health Disparities and Inequalities Report — United States, 2011. MMWR 2011;60(Suppl):1-116.

<sup>15</sup> Chin MH. Creating the Business Case for Achieving Health Equity. J Gen Intern Med. 2016 Feb 16. [Epub ahead of print] PubMed PMID: 26883523.

<sup>16</sup> Lee SJ, Grobe JE, Tiro JA. Assessing race and ethnicity data quality across cancer registries and EMRs in two hospitals. J Am Med Inform Assoc. 2016 May;23(3):627-34. doi: 10.1093/jamia/ocv156. Epub 2015 Dec 11. PubMed PMID: 26661718.



- Establish health equity council – weight Medium. This activity provides a mechanism for practices to understand and address health disparities within their organization. This is an opportunity to leverage the HHS Office of Minority Health resources to establish evidence-based approaches and measures to effectively utilize these entities to advance health equity.
- Provision of language services for non-English speaking patients in their preferred language – weight High. This activity is something that health care providers should already be doing, but we know also presents a challenge for many practices. Better resources must be developed to assist practices meet the language needs of their patients.

Integrated Behavioral Health Care should also be included as a CPIA subcategory due to significant mental and behavioral health disparities in underserved populations. This subcategory will help to incentivize primary care clinicians to incorporate mental health screenings into their workflows, provide basic, culturally competent mental health services and enhance referral networks to address patient needs.

Even those subcategories that do not directly mention health equity have significant potential to reduce disparities. For example, expanding practice access through evening and weekend hours will benefit patients with strict work schedules and those receiving hourly wages who are unable to freely take time off of work to visit the doctor. Several of the population management activities will also reduce health disparities, including the broad “take steps to improve healthcare disparities...” activity and the specific “participation in Indian Health Service....” More targeted activities would be more likely to reduce specific disparities. For example, as previously mentioned, stratification by disparity variables such as race, ethnicity, preferred language, disability status, sexual orientation, gender identity, and/or social, psychological and behavioral health data is the first step to identifying disparities and is necessary to implement targeted interventions to address disparities.

In addition, the proposed rule mentions future rulemakings that may include Promoting Health Equity and Social/Community Involvement as CPIA subcategories. The Promoting Health Equity activities are very important for advancing health equity, especially “(d) maintaining adequate equipment and other accommodations (for example, wheelchair access, accessible exam tables, lifts, scales, etc.) to provide comprehensive care for patients with disabilities.” Significant disability-related disparities have been identified, however not enough is being done to eliminate these disparities in healthcare. Disability or functional status is not collected as demographic data in EHRs and therefore clinicians are unable to use structured data to identify disparities within this population. The Americans with Disabilities Act and the non-discrimination provisions of the Affordable Care Act require the maintenance of accessible equipment in healthcare settings, but we know that many health care practices do not comply. Social determinants of health significantly contribute to poor health outcomes and are often viewed by clinicians as outside the scope of their practice. However, clinicians are in a position to link patients with social services that address the social determinants, and therefore should be recognized as and incentivized to incorporate these factors into clinical practice. For these reasons we believe both Promoting Health Equity and Social/Community Involvement should be included as CPIA subcategories in the final rule, rather than wait for future rulemakings.

#### *Patient-Centered Medical Homes (PCMH)*

We support the PCMH model as an incentive for providers to become accredited PCMH, these entities should receive full credit for CPIA. However, PCMH accreditation alone does not necessarily advance

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health equity.<sup>17</sup> It is important that PCMH stratify data by disparity variables and implement targeted interventions to address health disparities.

#### *Evaluation & future considerations*

It is unknown how effective the CPIA incentives will be for directing clinician behavior. The proposed CPIA category provides flexibility for clinicians to select measures that are relevant to their clinical practices and that are currently prioritized by themselves and their organizations. Conversely, this flexibility also provides a mechanism for providers to avoid reporting on activities that they do not prioritize and/or do not excel at. For this reason, it is critical that each subcategory and activity is evaluated on both effectiveness and utilization. The number of clinicians electing to report on Achieving Health Equity or other equity-related subcategories should be tracked and compared to the non-equity related subcategories. Activities within the subcategory should also be evaluated. Even for the activities that are reported, thresholds of patients being provided these services should be tracked to ensure robust execution of the activities as opposed to minimal/nominal numbers simply to report affirmatively. Robust evaluation may also show whether the CPIA percentage (15%) of the CPS is appropriate to incentivize these activities or if a higher weighted percentage is needed. Only critical evaluation of this category with a specific focus on health equity will tell us whether this is the case or whether stronger incentives are needed. Outstanding questions that should be evaluated include:

- Whether in future rulemakings, the CPIA category should be worth more than 15% of the total CPS;
- Whether individual activity weights should be increased to further incentivize clinicians to report on them;
- How many clinicians and what characteristics are associated with those clinicians that elected to report on health equity CPIA;
- How performance on health equity CPIA correlates with quality performance;
- Whether CPIA activities actually result in better outcomes;
- What additional activities should be included as CPIA.

We hope that future rulemakings are used to maximize quality payment incentives to achieve health equity.

### **Quality**

#### *Clinical Quality Measures*

The Agency for Healthcare Research and Quality's (AHRQ) annual healthcare disparities report has repeatedly shown that improvements in overall quality do not directly result in reductions in disparities.<sup>18</sup>

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<sup>17</sup> Wong W, Anderson KM, DankwaMullan I, Simon MA, Vega WA. The Patient-Centered Medical Home: A Path Toward Health Equity? Available at: <https://www.pcpc.org/sites/default/files/resources/PatientCenteredMedicalHome.pdf>.

<sup>18</sup> Agency for Healthcare Research and Quality. 2011 National Health Care Disparities Report. 2012;Pub. No. 12-0006. Available at <http://www.ahrq.gov/research/findings/nhqrdr/nhdr11/nhdr11.pdf>.



<sup>19,20</sup> It is concerning that the proposed quality performance category fails to explicitly mention health equity as a priority. It is equally concerning that the Quality performance category, which makes up 50% of the clinician's composite performance score fails to incorporate equity. There are a number of approaches that could be added to the Quality performance category to advance health equity:

- CQMs should be stratified by race & ethnicity (or other disparity variable), especially CQMs related to known health disparities;
- Stand-alone health equity CQMs should be developed and incentivized with bonus points as a high priority measure.

When polled, 76% of our webinar audience (n=68) stated that both stratification and stand-alone CQMs should be included in the final rule. We understand that the process for developing CQMs is lengthy and rigorous. We are eager to work with the CMS to develop these CQMs.

#### *Health Equity as a priority measure*

Health equity should be added as a high priority measure for which clinicians can receive a bonus point for demonstrating. The added incentive for receiving bonus points will encourage clinicians to work towards the high priority measures.

#### *Patient Experience*

Patient experience should be kept as a priority measure for a bonus point in the final rule.

### **Advancing Care Information**

#### *Timeline*

The proposed framework is a step in the right direction regarding flexibility and focus on the most critical measures. In fact, 84% of our webinar audience (n=25) replied "yes" to the question of whether the proposed framework is an improvement over Meaningful Use. However, more flexibility is needed, especially for small and rural practices and those serving underserved communities. Our research has found primary care EHR adoption disparities within small and rural practices and providers serving high Medicaid populations.<sup>21</sup> As the requirements for EHR use evolve to more advanced requirements, those clinicians that are currently behind will only continue to face challenges and potentially fall further behind. Due to the TCC and MSM's missions, the impact this has on these providers and also the patients they serve is highly concerning. Whereas Meaningful Use was voluntary, despite being heavily incentivized, participation in the Quality Payment Program is a requirement in order to receive reimbursement for serving Medicare patients. This is a major shift in incentives and means that those clinicians who lag in EHR adoption will need to catch up quickly. As mentioned earlier with regard to the timeline, the proposed timeline for the first reporting period to begin January 1, 2017 is unreasonable for clinicians to prepare for such major changes. Given that the final rule is expected to be published in the fall of 2016, it will take months to examine and fully understand the requirements and additional months

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<sup>19</sup> Agency for Healthcare Research and Quality. 2012 National Health Care Disparities Report. 2013;Pub No. 13-0003. Available at <http://www.ahrq.gov/research/findings/nhqrdr/nhdr12/2012nhdr.pdf>.

<sup>20</sup> Agency for Healthcare Research and Quality. 2013 National Health Care Disparities Report. 2014;Pub. No. 14-0006. Available at <http://www.ahrq.gov/research/findings/nhqrdr/nhdr13/2013nhdr.pdf>.

<sup>21</sup> Mack, D., Zhang, S., Douglas, M., Sow, S., Strothers, H., Rust, G. (2016). Disparities In primary care EHR adoption rates. J Health Care Poor Underserved.





to implement, test and prepare for the reporting. Delaying this timeline to 2018 or later is more realistic for providers to meet.

#### *Performance score categories & holistic approach*

Focusing the performance score on Patient Electronic Access, Coordination of Care through Patient Engagement and Health Information Exchange will drive adoption and utilization of these activities and we strongly support this goal. The proposed framework continues to focus too much on process and not enough on outcomes. We are encouraged to see that the goal for future rulemakings is to continue moving in this direction. A “holistic approach” sounds like an excellent goal for shifting from process to outcomes and of course, the devil is in the details. This approach presents a tremendous opportunity to ensure that outcomes are equitable and health disparities are being eliminated. As mentioned throughout this proposed rule, stratification of CQMs and the proposed Advancing Care Information measures by disparity variables is critical and necessary to the advancement of health equity. In order to do this, the technology must be developed in a way to make reporting and stratification easy and streamlined. The Meaningful Use program laid the foundation for this through recording of patient demographic data, including race, ethnicity, preferred language, sexual orientation, gender identity, social, psychological and behavioral data. Impact of disabilities on activities of daily living, as captured by the six functional questions of the American Community Survey is still needed as a requirement for certified EHR technology (CEHRT). Effective collection of this data via patient self-report must be required and providers who are doing a good job of collecting this data from all patients should be rewarded. As use of health IT evolves, so must use of this data to identify and address health disparities through stratification, mandatory reporting and targeted interventions.

#### *Impact on Small, Rural, HPSA Providers*

The potential disparate impact of this proposed rule on small, rural and HPSA providers is highly concerning. Additional financial resources and technical support is needed for small and rural practices and those serving underserved communities in order to meet the base score objectives and especially to meet the performance score objectives, as these are more advanced measures. Hardship exemptions are critical for some providers serving rural and underserved communities. We support the inclusion of these exemptions. However, it is problematic that utilization of an exemption re-weights the Advancing Care Information category to zero. This puts too much weight on the other categories and basically penalizes these clinicians for situations outside their control.

#### *Telemedicine*

We are very pleased with the inclusion of telemedicine in various provisions throughout the proposed rule, demonstrating recognition that this technology should be incentivized. Telemedicine has the potential to provide access to health care services that may otherwise be unavailable to many patients. However, it is underutilized in Medicare and Medicaid programs. In 2012, Medicare expenditures for telemedicine were \$5 million and in 2008-2009, 0.1% of total Medicaid enrollees received services via telemedicine.<sup>22,23</sup> In both Medicare and Medicaid programs, telemedicine claims were predominantly for behavioral health services (70% and 90%, respectively). These statistics further illustrate how telemedicine is being used to advance health equity for individuals with behavioral health conditions.

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<sup>22</sup> Neufeld JD, Doarn CR. Telemedicine Spending by Medicare: A Snapshot from 2012. *Telemed J E Health*. 2015 Aug;21(8):686-93. Epub 2015 Apr 3. PubMed PMID: 25839672.

<sup>23</sup> Douglas MD, Xu J, Heggis A, Wrenn G, Mack D, Rust G. Assessing Telemedicine Utilization Using Medicaid Claims Data. *Psychiatric Services*. Under Review, submitted Nov. 30, 2015.



## **Conclusion**

Overall, the Quality Payment Program has the potential to advance health equity. It is critical that the health equity provisions in the proposed rule are maintained in the final rule and enhanced as recommended in this public comment. Health disparities have persisted for far too long and it is time to aggressively implement policies that will improve outcomes for all and eliminate disparities.

Thank you for taking the time to review these comments. The TCC's Health IT Policy project and the National Center for Primary Care at MSM are ready and equipped to be of assistance in any capacity to advance health equity. We look forward to assisting you as needed to further the national objective of eliminating health disparities.

Kindest regards,

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