

July 6, 2021

VIA ELECTRONIC SUBMISSION TO: <https://www.regulations.gov/>

Office of Management Budget
Executive Office of the President

Re: Response to Request for Information (RFI), Docket No. OMB-2021-0005
Methods and Leading Practices for Advancing Equity and Support for Underserved
Communities Through Government

Ladies and Gentlemen:

Thank you for the opportunity to provide information to the Office of Management and Budget (OMB) regarding inequities in government policies and programs. We¹ write to you to provide information on Area 1, Equity Assessments and Strategies. Specifically, we explain below how the lack of racial and ethnic data collection on federally approved healthcare billing forms makes it difficult for researchers to assess the causes of and possible solutions for well-known inequities in healthcare. Requiring this data to be collected on standard billing forms is therefore a public policy that would advance equity.

Our organizations advocate on behalf of underserved communities, the advancement of health research and the achievement of equity in health care and federal policy. We use data to better understand and address health disparities among immigrants, people of color, individuals with disabilities and other underserved communities. These experiences inform the recommendations made below.

Area 1: Standard, Federally-Approved, Healthcare Billing Forms Should Be Revised to Collect Race and Ethnicity Data.

As you know, longstanding health disparities in the United States are well documented.² Unfortunately, research into the causes for—and possible solutions to—these disparities and inequities is constrained by the lack of basic data collection on race and ethnicity on standard medical billing forms. We believe this can be remedied through a very simple rule change.

Medicare regulations require providers to submit bills using uniform forms approved by CMS. 42 CFR 424.5(a)(5). [These forms are subject to the Paperwork Reduction Act's requirements](#) and therefore must be approved by OMB. There are two such forms:

¹ This comment was prepared with the assistance of Samara Spence and Sean Lev of the Democracy Forward Foundation.

² Agency for Healthcare Research and Quality, [Compendium of Federal Datasets Addressing Health Disparities \(September 2019\)](#); Commonwealth Fund, [Inequities in Health and Health Care in Black and Latinx/Hispanic Communities: 23 Charts](#) (June 2021).

- The [837I \(Institutional\)](#) is the standard format used by institutional providers to transmit health care claims electronically.³ It is the electronic version of the UB-04, also known as the CMS-1450, which is the paper form used by the very small percentage of providers who are exempt from electronic filing requirements. The UB-04 CMS-1450 and its 837I electronic counterpart are the current iteration of a form that was developed by the National Uniform Billing Committee, a health and insurance industry body established by the American Hospital Association in 1975. The current version was [last revised in March 2007. The current OMB approval \(OMB 0938-0997\) of UB-04 CMS 1450 expires August 31, 2023.](#)
- The [CMS-1500](#) is the current version of a form used to document non-institutional health services. It was developed by the American Medical Association, the federal Centers for Medicare and Medicaid Services (CMS) and other payers. CMS 1500 was [last revised in February 2012. The current OMB approval \(OMB 0938-1197\) expires October 31, 2023.](#)

Approval by CMS and OMB of these privately developed forms for federal use has had the effect of establishing them as the universal standard used by private providers and payers throughout the country. The two forms document almost all clinical care provided in the United States. The administrative data compiled from these forms include patient demographics, diagnoses, and treatment, and they support much of the nation's medical and health policy research. Unfortunately, however, neither form collects data on patient race or ethnicity. This means that the data cannot support any examination of the relationships between race/ethnicity and morbidity, access to care, or patient treatment. Inclusion of such data would greatly expand the quantity and quality of clinical encounter data available to communities, researchers, and policymakers seeking to understand the nature and causes of health disparities and inform policy solutions that could redress such inequities.

Several states require hospitals to report race/ethnicity. Some researchers in those states try to make up for deficits in the data by matching encounter data from the UB-04 CMS 1450 and the CMS-1500 to electronic health records or insurance enrollment files that contain race and ethnicity information. These efforts are expensive and time-consuming, and resources containing race and ethnicity data are not always available. Even when they are, the need to pull the information from other sources creates increased cost, complexity, and delay for those seeking to better understand racial disparities and inequities, and those who are trying to develop effective clinical and policy responses.

³ The “institutional provider” category for these purposes includes hospitals, Skilled Nursing Facilities (SNFs), End Stage Renal Disease (ESRD) providers, Home Health Agencies (HHAs), Hospice Organizations, Outpatient Physical Therapy/Occupational Therapy/Speech Pathology Services, Comprehensive Outpatient Rehabilitation Facilities (CORFs), Community Mental Health Centers (CMHCs), Critical Access Hospitals (CAHs), Federally Qualified Health Centers (FQHCs), Histocompatibility Laboratories, Indian Health Service (IHS) Facilities, Organ Procurement Organizations, Religious Non-Medical Health Care Institutions (RNHCIs), and Rural Health Clinics (RHCs)

The inclusion of these data elements in the billing forms has the additional benefit of providing a cost-effective means to collect data in support of enforcement of Title VI of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act, which prohibit discrimination by health care providers that receive federal funds. When the Office for Civil Rights of the Department of Health and Human Services promulgated rules implementing Section 1557, several commenters recommended that OCR require covered entities to collect data on race, ethnicity, language, and other patient characteristics to support assessments of how providers can better serve the communities protected by Section 1557. When it adopted the final rule, OCR agreed that “data collection is an important tool that can help covered entities to better serve their communities, and encourages covered entities to regularly evaluate the impact of the services they provide on different populations.” However, OCR declined to require data collection as part of the assurances required under Section 1557. OCR noted its authority to require covered entities to collect data and to provide OCR access to information and stated that it “will exercise this authority as needed and appropriate under particular circumstances in the future.” [81 Federal Register 31376](#), 31392-3 (May 18 2016). If the uniform claim forms are revised to include race and ethnicity, it will save providers from having to create a separate process for collecting the data, or from compiling it from patient health records in response to OCR demands for the information.

The absence of race and ethnicity from encounter data is therefore a barrier to equity. CMS should therefore revise the UB-04 CMS 1450 and CMS-1500 forms, and OMB should approve the CMS revisions, to include those missing data elements. This is a policy strategy that would advance equity. This solution would involve negligible cost, since the two billing forms are already fully integrated into the health care system's administrative infrastructure.

Thank you for your consideration of our comment. We ask that you include the full text of each of the regulations cited in our comment in the formal administrative record of any rulemaking for purposes of the Administrative Procedures Act. Please contact us at ccapp@tnjustice.org if you have any questions or if we can be of further assistance.

Respectfully submitted,

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