



VIA ELECTRONIC FILING TO: <http://www.regulations.gov>

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: [CMS-1750-P] Medicare Program; FY 2022 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2021 (FY 2022); Request for Information – Closing the Health Equity Gap in CMS Quality Programs

Dear Administrator Brooks-LaSure:

The Pharmaceutical Research and Manufacturers of America (PhRMA) appreciate the opportunity to comment on proposed Medicare FY 2022 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2021. Our comments are specifically in response to the Request for Information on Closing the Health Equity Gap in CMS Quality Programs. PhRMA is a voluntary association of research-based pharmaceutical and biotechnology companies devoted to inventing medicines to allow patients to lead longer, healthier, more productive lives.

Consistent with our mission, PhRMA believes that diversity, equity and inclusion are essential to the discovery of new medicines and people of all ethnic and racial backgrounds should have equitable access to treatment.ⁱ We support policies that will enable a more just, equitable health care system, including improving clinical trial diversity and building a diverse workforce, investing in data infrastructure to assess disparities, and promoting best practices to improve equity in health care screening, diagnosis, and treatment.

As it relates to the intersection of inequities and medicines, numerous studies have demonstrated that Black and Brown populations have lower medication utilization and/or adherence than their white counterparts.^{ii,iii,iv} Evidence has shown that the downstream consequences of medication nonadherence include increased health care costs,^v poor health outcomes,^{vi,vii} and increased risk of mortality.^{viii,ix,x} Closing the gap on racial and ethnic inequities in access to medications is a critical step towards improving the health and well-being of diverse populations. Racial/ethnic

inequities in the use of medicines for the treatment of mental health illnesses are particularly alarming given the long-standing inequities associated with mental health care in the United States.^{xi,xii} Among adults with any mental illness, the utilization of mental health-related medicines among Asian Americans is approximately one-quarter the use of white adults while the utilization of mental health-related medicines among Black and Hispanic adults is approximately half the use of white adults.^{xiii} Therefore, advancing equitable access in the treatment of mental health through medicines and services is an urgent issue.

PhRMA commends the Centers for Medicare & Medicaid Services' (CMS) effort to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable, the effort to evaluate appropriate initiatives to reduce health disparities, and the broader effort to close the health equity gap in CMS's programs and policies. The COVID-19 pandemic continues to have a disproportionate impact on Black and Brown communities, which is attributed to factors such as systemic racism, inequitable access to health care, disproportionate share of essential workers, racial wealth-gap, and increased rates of living in crowded housing.^{xiv} The pandemic has shown us that the time to fix inequities in our health care system is now, and we look forward to supporting CMS in these efforts. Our detailed comments follow below:

(1) Stratification of Quality Measure Results

PhRMA supports stratifying quality measure results by factors such as race, ethnicity, and dual eligibility.

When considering how to stratify quality measure results, there are many current efforts that CMS might look to as examples. The National Committee for Quality Assurance (NCQA), recently launched a comprehensive effort to revamp and improve the use and collection of race and ethnicity data, with a goal of having all health plans surveyed through HEDIS report measure performance by race and ethnicity using directly collected member data to stratify results for multiple measures by model year 2024.^{xv} Similarly, the National Minority Quality Forum's (NMQF) Heart Failure Quality Improvement Initiative is closing gaps in care for underserved populations by creating quality and performance measures that recognize diversity and heterogeneity.^{xvi} We encourage CMS to continue working with these groups and other measure developers and clinical experts, such as the National Quality Forum and the Pharmacy Quality Alliance, who also have initiatives underway to examine adjustment and stratification of quality measure results.

PhRMA commends CMS for supporting the development of two methods of indirect estimation of race and ethnicity among Medicare beneficiaries.^{xvii,xviii} These developments have led to

improvements in the sensitivity of identifying the race/ethnicity among populations of Asian/Pacific Islander and Hispanic backgrounds. However, as acknowledged by CMS, these imputation methods are not void of potentially introducing bias in the identification of a population’s race/ethnicity, which may affect the results of stratified quality measures.^{xix} As such, PhRMA recommends that CMS continue to work with experts to develop, test, and pilot methods to impute the race/ethnicity of populations until “gold-standard” self-reported race/ethnicity data are more readily available.

As CMS works towards the availability of sufficient self-reported race/ethnicity data, PhRMA suggests that CMS consider testing, piloting, and facilitating activities to generate accurate granular-level data on ethnically diverse populations, such as Native Americans and Asian Americans and Pacific Islanders, who represent a broad range of cultures, backgrounds and lived experiences, such as American Indian or Alaska Native, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, other Asian, Native Hawaiian, Guamanian or Chamorro, Samoan, and other Pacific Islander populations.^{xx,xxi}

(2) Improving Demographic Data Collection

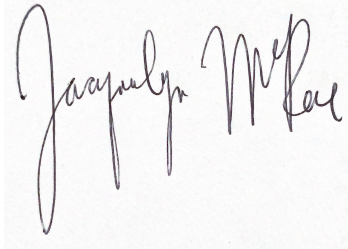
PhRMA supports CMS’s efforts to expand the collection of demographic data to a minimal set of social, psychological, and behavioral data for the purpose of improving efforts/activities related to quality. PhRMA recommends that CMS continue to work alongside experts and activities aimed at improving the collection of structured, granular demographic data for health care measurement and improvement.

Federal health care programs are uniquely positioned to contribute to the efforts improving the quality and accessibility of demographic data, and PhRMA supports CMS’s efforts to do so here.

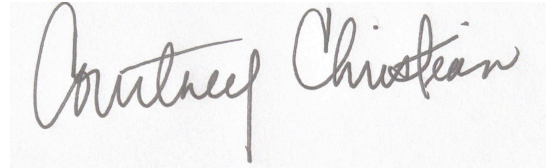
(3) Summary

Stratifying quality measures by demographic characteristics and improving demographic data collection can create incentives to target improvements in health outcomes and, if designed and implemented appropriately, can encourage investment in disadvantaged and underrepresented patients. PhRMA supports efforts to make quality measures and data more actionable towards equity for patients, health care providers, and health systems.

Thank you for the opportunity to comment on this important matter. Please contact Jacquelyn McRae at jmcr@phrma.org, if you have any questions related to this letter.



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- ⁱ PhRMA, “Building a Better Health Care System: PhRMA’s Patient-Centered Agenda” (available at: <https://phrma.org/report/Building-a-Better-Health-Care-System-PhRMAs-Patient-Centered-Agenda>).
- ⁱⁱ Mehta KM, Yin M, Resendez C, Yaffe K. Ethnic differences in acetylcholinesterase inhibitor use for Alzheimer disease. *Neurology*. 2005 Jul 12;65(1):159-62. doi: 10.1212/01.wnl.0000167545.38161.48. PMID: 16009909; PMCID: PMC2830864.
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- ^x Khunti K, Seidu S, Kunutsor S, Davies M. Association Between Adherence to Pharmacotherapy and Outcomes in Type 2 Diabetes: A Meta-analysis. *Diabetes Care*. 2017 Nov;40(11):1588-1596. doi: 10.2337/dc16-1925. Epub 2017 Aug 11. PMID: 28801474.
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^{xv} The Future of HEDIS: Digital Measures and Health Equity. NCQA. Feb 24, 2021. https://www.ncqa.org/wp-content/uploads/2021/02/Future-of-HEDIS_Digital-Measures-and-Equity_20210224.pdf

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^{xviii} Haas, A., Elliott, M. et al (2018). Imputation of race/ethnicity to enable measurement of HEDIS performance by race/ethnicity. *Health Services Research*, 54:13-23.

^{xix} See citation xiii.

^{xx} The Initiative on Asian Americans and Pacific Islanders. The White House. Available at:

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