



Hello, everyone, and thank you for joining today's session on data.

Today's webinar will be entitled The Path Forward - Improving Data to Advance Health Equity Solutions. My name is Brian Young with the Centers for Medicare/Medicaid Services Office of Minority Health, and I will be moderating today's session.

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Before we start, we want to note that closed captioning and ASL interpretation are both available for this webinar. To access this feature, go to the menu at the bottom of the screen and click on captions, which will display another menu where you select show captions. Select and show captions will allow closed captioning to appear at the bottom of the screen. To access ASL interpretation, go to the menu at the bottom of the screen and click the interpretation icon. Under watch, choose American Sign Language, and a video window of the interpreter that you've chosen will appear on the screen.

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On this slide are the speakers that will be participating in today's session. Today, we have Ashley Peddicord-Austin, Meagan Khau, and Nancy Chiles Shaffer.

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We will begin this session with an overview of the Office, including a description of some of the available data tools and resources. Following this overview of the Office, we will move onto the presentation of OMH's recently released white paper, The Path Forward - Improving Data to Advance Health Equity Solutions.

Next slide, please.

I will now turn it over to Ashley Peddicord-Austin to begin an overview of the CMS Office of Minority Health and some of our available data resources.

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Thank you, Brian. And thanks everyone for joining us today. So, CMS is the largest provider of health insurance in the United States responsible for ensuring more than 150 million individuals supported by the programs are able to get the care and health coverage they deserve.

Our Office, the CMS Office of Minority Health, is one of 80 minority health offices within the larger Department of Health and Human Services. Each office is aligned with their respective agency mission. So, our office serves as a principal advisor to the entire CMS agency on the needs of minority and underserved populations. And that includes people of racial and ethnic communities, people of limited English proficiency, LGBTQI+ persons, persons with disabilities, people who live in rural areas, and those otherwise adversely affected by persistent poverty or inequity.

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Our mission is to lead the advancement and integration of health equity, and the development, evaluation, and implementation of CMS's policies, programs, and partnerships. Our vision is to see all those served by CMS achieve their highest level of health and wellbeing and that we've eliminated disparities in healthcare equality and access.



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Here you'll see some examples of the different types of health care disparities data resources available on our website. CMS offers a variety of resources to help increase awareness about healthcare disparities. Among the healthcare disparities data resources available to help your organization, to advance your work toward health equity, are data highlights, data snapshots, and issue briefs.

Data highlights present national and regional data on healthcare service utilization, spending, and quality indicators for the Medicare population. The information products include an overview of specific public health issues, provide a brief quantitative and/or qualitative analysis of the data, and explain how the finance support or relate to a CMS or HSS policy or initiative. I did mention, most of them are Medicare, but we have some on the Marketplace as well. Some of the recent highlights include Utilization of Z-Codes for Social Determinants of Health, which can be seen on the left-hand side of the screen, or Access to Medication for Opioid Use Disorder Among Medicare Fee-for-service Beneficiaries influence of the CARES Act implementation.

Today's snapshots are short fact sheets that focus on various health disparities in the Medicare population, including data from CMS's Mapping Medicare Disparities Tool, which we'll talk about in a second. And among our most recent data snapshots is the Hypertension Disparities in Medicare Fee-for-service Beneficiaries, which outlines prevalence of hypertension among Medicare FFS, or fee for service, enrollees varied by race, ethnicity, and geographic areas.

And then finally, issue briefs summarize particular issues and policies that impact the quality of and access to healthcare for minority and disadvantaged populations. These briefs evaluate CMS programs, including Medicare/Medicaid, to include recommendations and selections relating to the issue at hand. Among recent issue briefs is the white paper that would be the center of today's discussion.

We can go to the next slide. So, on this slide, we have another one of our resources, the Mapping Medicare Disparities Tool, or MMD Tool. This is a really cool tool, and it's very popular. So, if you don't know it, hopefully this review will help. This tool is interactive, it's a map designed to identify areas of disparities between subgroups of Medicare fee for service enrollees. So, that includes racial and ethnic groups, and health outcomes, utilization, and spending. So, we note this tool as an excellent starting point for understanding and investigating the geographic and racial and ethnic differences in health outcomes with information that can be used to inform policies or targeted interventions.

The MMD Tool provides two views: Population and Hospital. The Population View provides a script of statistics on chronic disease prevalence, Medicare spending, hospital and emergency department utilization, preventive services, and preventable hospitalizations averaging patient days per admission. Patient safety indicator admissions, average Medicare reimbursement, and patient admission type, and patient admission/discharge destination, you get the idea. And it's defined by state, territory, or county of residence, urban or rural location, sex, age, dual eligibility for Medicare and Medicaid, and race and ethnicity. On the left side, you'll see an image of MMD Tool's Population View. And the options that are available when you're using that particular view.

Then the Hospital View uses hospital compare data to allow users to identify disparities and selected health outcome equality measurements between hospitals at the state or county level. On the right side of the slide, you'll see an image of the MMD's Hospital View and unique options that are available when using that view.

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So, the final set of resources we wanted to make sure to highlight for you are stratified reporting. We understand the necessity to measure and publicly report the nature and extent of healthcare disparities data to comprehensively address and eliminate health disparities. Our stratified reports provide useful information for targeting quality improvement activities and resources, monitoring health and drug plan performance, and advancing the development of culturally and linguistically appropriate quality improvement interventions and strategies. There are a few variations of the stratified reporting, but listed on this slide are two popular ones that are going to be updated this spring.

So, first, Part C and D Performance Data Stratified by Race, Ethnicity, and Gender describes the quality of healthcare received by people who are enrolled in Medicaid Advantage plans nationwide, highlighting racial and ethnic differences in healthcare experiences and comparing the quality of care for men and women. Our webpage includes reports from 2015 through 2022, which is based on data from one year before. So, 2014 to 2021. And that should be updated this April. So, look out for it.

On the left side of the slide, you'll see an examples of one of the charts included in this report, which examines all patient experience measures. You'll note that this chart compares the measures according to patient race and ethnicity.

Part C and D Performance Data Stratified by Geography highlights rural and urban differences in healthcare experiences and clinical care. How rural and urban differences vary by race and ethnicity, and how racial and ethnic differences vary between rural and urban areas. Our webpage includes reports from 2018 through 2020, so that's data from 2017 through 2019. And a report was released in 2022. Those usually come out in November around National Rural Health Day. So, there's some time before that one. But we should have reports coming out this spring, so do keep an eye out.

On the right side of the slide, you'll see from that rural geography report an example of one of the charts. And that includes all patient experience measures. And you'll note here that in addition to comparing the measures according to geographic locations of the patients, this report also compares measures based on whether the patient is enrolled in Medicare Advantage or Fee-for-service.

Alright, we can go to the next slide.

Thank you. So, before we move on to the focus of this particular webinar, we do want to take a moment to highlight an initiative from our colleagues at the Office of the Chief Statistician of the U.S., which recently moved forward in a process to revise the OMB statistical standards for collecting and reporting race and ethnicity data across federal agencies. So, this is pretty important.

They're publishing an initial set of recommended revisions that are proposed by an inter-agency technical working group. That working group, which consists of federal government career staff from more than 20 agencies, was tasked with proposing recommendations for improving the quality and usefulness of federal race and ethnicity data. So please, we hope this is of interest to many of you on the call.

And if so, you have until April 12th to visit [regulations.gov](https://www.regulations.gov) and provide thoughts and reactions, including how you believe it may impact different communities. You can submit comments by searching for OMB 2023-001 on [regulations.gov](https://www.regulations.gov).

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So, with that, I will turn it over to Meagan Khau to discuss the white paper. Meagan?

Thank you, Ashley. And welcome, everyone. And thank you again for being here today. I would like to spend a few minutes providing some additional background on the CMS Office of Minority Health, which



we will call CMS OMH for short, and what we have done as an agency to integrate health equity into all that we do at CMS. CMS OMH serves as the principal advisory and coordinator to the agency for specific needs and special needs for minority and disadvantaged populations. CMS OMH provides leadership, vision and direction to address CMS minority health and health disparities goal. Some of the ways we do that include leading the development of an Agency-wide data collection infrastructure for minority health activities, supporting the development of CMS goals, policies, strategies, and legislative proposals, consulting with federal agencies and external organizations to address health equity, and coordinating the implementation of health equity related executive orders.

Health equity is a priority across the federal government. And CMS has made great progress to help integrate equity into its various activities, especially over the past year. We developed the Framework for Health Equity 2022 to 2032, which contains cross agency priorities to push health equity forward now and for the decade to come.

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The CMS Framework for Health Equity 2022-2032 updates what some of you may know as the CMS Equity Plan for Improving Quality in Medicare. With an enhanced and more comprehensive 10-year approach to further embed health equity across all CMS programs, including Medicare, Medicaid, CHIP, and the Health Insurance Marketplaces.

While the initial Health Equity Plan identified high impact priorities based on stockholder engagement and review of the evidence based on discussions across HHS, CMS, and our federal partners, the Framework refines CMS equity, health equity priorities, and broadens the agency's focus beyond Medicare. The Framework is informed by stockholder input, evidence review, and knowledge and understanding gained through the Agency's work.

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There are five priorities included in the Framework, encompassing both system and community level approaches to achieve equity across CMS programs. Each of the priorities are complementary and they integrate adoption and implementation is central to the elimination of barriers to health equity for all Americans.

The five priority areas are listed here. First, expanding the collection, reporting, and analysis of standardized data. Second, assessing causes of disparities within CMS programs and addressing inequities in policies and operations to close gaps. Third, voting capacity of healthcare organization in the workforce to reduce health and healthcare disparities. Fourth, advancing language access, health literacy, and the provisions of culturally tailored services. And lastly, increasing all forms of accessibility to healthcare services and coverage.

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We also wanted to take a moment to restate the importance of data to CMS as CMS looks to advance health equity initiatives. In its role as the largest payer of healthcare in the United States, CMS can set the bar for meaningful health data equity correction and use across the healthcare system. Health equity data elements are essential to understanding and addressing health disparities for enrollees across CMS programs. With accurate and complete data, CMS is able to create evidence-based policy and regulations and assess how well these policies and regulations align with the needs of the communities and individuals that CMS serves.



Historically, some data elements were collected in forms that were not aligned to our data standards. The collection of data elements not aligned to data standards can result in inconsistent analysis when using and combining health equity data from multiple sources. Additionally, the lack of consistent data collection at the disaggregate level, broken down to the detailed subcategories presents barriers to understand the needs of specific subgroups and create challenges when comparing data across programs and populations.

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CMS's approach to monitoring progress towards achieving health data strategy is to first align our goals to the overall CMS Framework for Health Equity. Which is why we recently released a white paper titled The Path Forward - Improving Data to Improve Health Equity Solutions.

The white paper supports the CMS Framework for Health Equity priorities by outlining how CMS intends to expand the collection, reporting, and analysis of standardized data and use of health equity data to achieve its equity goals aligned with our previously mentioned priority 1 and 2.

This paper describes the current state of health equity data collection and consolidation across CMS programs, details progress to date in improving CMS data's completeness, quality, and alignment to standards, and defense CMS's future actions to continue improving health equity data collection and reporting to achieve its future visions of health equity data at CMS.

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The paper aims to achieve broad awareness of CMS visions for health equity data. It pulls from a wide range of sources, including CMS and the administration strategies, proposed program rules and guidance, feedback from stakeholders across CMS and the department, and internal information gathered from CMS.

CMS intends for this report to be a resource that summarizes the current state and future goals for health equity data. It will also provide the public and industry with knowledge of CMS's current state of health equity data while highlighting CMS's commitment to driving health equity through improved data.

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Some of the key takeaways from this report include that CMS recognizes that social demographic and social determinants health of data can help drive quality improvement, as well as strengthen the ability to evaluate programs and policies to assess the influence on health outcomes.

All the significant progress has been made, there are still gaps in the data remaining across CMS programs, along with challenges and barriers to overcome in order to improve the collection of this health equity data.

CMS is committed to improving the quality, accuracy, and completeness of data that enables improvements in health equity and efforts to address these data issues are already underway as priorities for CMS future vision for the health equity data.

Next, please.

And now, I will turn it over to my colleague, Nancy Chiles Shaffer, to provide further details from the white paper. Nancy?



Thank you, Meagan. The white paper's description of the current state of health equity data across CMS programs includes the identification of key issues and challenges in healthcare disparities.

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CMS collects enrollee sociodemographic data across the Medicare, Medicaid and CHIP, and Marketplace programs. But we acknowledge that there are issues with the completeness, quality, and accuracy of the data that are collected.

This table shown on the screen provides an overview of the current state of sociodemographic data collection across the different CMS programs. Black dots indicate that the data type has been collected, aligned to 2011 HHS Data Standards. For those of you who are not familiar with the 2011 HHS Data Standards, these are recommended data standards for race, ethnicity, sex, primary language, and disability status, developed to support the implementation of Section 4302 of the Affordable Care Act.

Empty dots indicate that the data element has been collected with standards and/or completeness issues. When it's a demand, this indicates the data has been calculated with no major issues but no adopted standard. And the dashes indicate the data element is not currently collected.

As you can see from the table, the collection of sex information is the most complete. With vast variations in the other categories by program. However, information on sexual orientation and gender identity is not currently collected.

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On this slide, we've outlined some of the existing challenges that we've experienced with data collection as well as gaining meaningful insights from the data that is gathered. We see that CMS has limited authority to collect all elements directly. Additionally, social determinant of health and self-reported data are collected in limited settings, contributing to incomplete sociodemographic data. Health equity data is often collected in inconsistent forms, not aligned to standards, or standards do not currently exist. Incomplete data reported to CMS on key health equity elements prevents fully data driven decisions. The utilization of some standardized data collection methods, such as Z-Codes, remains low. Lack of disaggregated data can cloud meaningful insights, especially on specifics for traditionally underrepresented populations. And finally, there may be bias in health equity data collection methods, which can challenge CMS's ability to interpret the data.

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Given the existing gaps identified, CMS is making significant progress to address these limitations and to improve availability and quality of health equity data.

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The white paper further details how various stakeholders and advisory groups are currently being encouraged to drive health equity action.

For example, the Health Equity Advisory Team, HEAT, was launched through the Innovation Center's Healthcare Payment Learning and Action Network to help identify and prioritize opportunities to advance health equity through alternative payment models nationwide. CMS has also published federal policy guidance for state and local health officials to address social determinants of health under their programs and support officials in designing policies and interventions that can address disparities. Furthermore,



CMS has provided guidance allowing for the tailoring of programs and policies in post-acute care settings based on needs and disparities as appropriate.

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Recognizing our challenges and their impacts on our data collection and analysis abilities, we include what we are doing to address these barriers. We have finalized regulations to collecting new health equity elements across CMS programs to fill existing gaps. For example, CMS is implementing SDOH data collection in post-acute care settings and via quality payment program participants. Additionally, we developed a Medicare race and ethnicity implementation algorithm to have better race and ethnicity data for analysis and are currently assessing its progress. CMS is also equipping the industry with new tools and capabilities aligned to help equity goals, which includes an inventory of resources for standardized demographic and language data collection that aims to provide stakeholders with guidelines for collecting these data in a more uniform way. Additionally, CMS is providing stratified reporting that the public can use to drive action, including the annual publication of the Rural/Urban Disparities in Healthcare and Medicare report, Disparities in Healthcare in Medicare Advantage with Dual Eligibility or Eligibility for Low-income Subsidy, and the Part C and D Performance Data Stratified by Race, Ethnicity, and Gender.

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The paper also provides additional examples of current tools and resources that CMS has developed in alignment with health equity goals. You'll remember some of these tools and resources from the earlier portion of the session: The Mapping Medicare Disparities Tool, again, is an interactive, highly visual way for individuals to view disparities between subgroups of Medicare fee for service enrollees, and subsequent outcomes, utilization, and spending results. Another resource that was previously discussed, the CMS Health Equity Technical Assistance Program, provides personalized coaching, resources, and data tools to help organizations more effectively embed health equity into their strategic plans. The CMS Disparity Impact Statement provides a worksheet tool for all healthcare stakeholders to achieve health equity, especially for populations who have historically been underserved. To address the gaps in standardized collection of Z-Codes, CMS has also developed an info graphic for healthcare administrators and other team members to understand the best practices and importance of both gathering and tracking SDOH data.

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This timeline represents actions that CMS has taken over the past few years towards improving health equity data. Since the release of the Mapping Medicare Disparities Tool in 2016, efforts towards improved data collection and analysis procedures have steadily been expanding. As of 2020, standards for SDOH data and commitments towards equity have been driving forces for CMS action.

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I will now turn it back to Meagan Khau to conclude our white paper presentation.

Thank you, Nancy. The white paper also discusses future actions to continue this progress in leveraging health equity data to reduce disparities and inequities in the CMS programs.

Building on the current progress today, the white paper further details the steps that CMS is planning to implement in the future. Four objectives have been identified to help the agency as it works to improve the health equity data landscape. The first being improving completeness of health equity data and alignment to standards, expand disaggregated standardized data collection, and stratify reporting for



social demographic data elements, gradually implement health equity scores, and assess minimal potential bias in data algorithm.

Under these objectives are the individual asks designed to meet the goals. And some of the tasks are working together.

The Agency works to fill the gap in existing data through new data collection methods, collaborating with partners, and allowing broader access to statistical methods and collect new data elements to strengthening health equity data. I apologize, so are we on the right slide? I'm sorry. There we go. I apologize for that. So, as we talk about filling data gaps, CMS is also planning to align data standards across existing and emerging new data collection practices, including collecting and reporting on disaggregating data to gain insight on specific subpopulations, when appropriate, and in ways that protect data privacy and confidentiality, which is very important to CMS.

There is also continued work on the development of equity scores, including refining the Health Equity Summary Score, as some of you may know, to use as quality improvement tool, and considering new applications for equity scores, such as the health equity index. Releasing resources and training for health care professionals to help understand equity data and acting on feedback received from the public are both actions that CMS will take to improve public and stakeholder engagement with equity data improvement efforts.

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Most importantly, in order for progress to continue and future action to be successful, collaborations and ongoing measurement are critical for CMS health equity data strategy success. Continued collaborations with other federal agency and industry partners will be key in order to receive data, establish standards, and improve program changes to support equity data improvement. Feedback from organizations and individuals is vitally important as CMS assesses the feasibility of process changes, determines the metrics useful in its programs, and forecasts the impact of proposed improvements.

Continuous monitoring of the progress of CMS data collection, standardizations, and use across CMS programs will help increase the understanding and awareness of health disparities and their causes. It will also allow for creating, testing, and implementing solutions and lead to sustainable actions that advance equity in CMS programs.

This white paper for the first time outlines a plan to tackle data efforts to achieve health equity by underlining the importance of health equity data collection and chart the next steps for CMS to improve data collection efforts and, in turn, advance health equity.

We would like to thank you all for joining us today to learn more about CMS's continued work in improving health equity data collection, and I will now turn it back over to Brian.

Thank you, Meagan, Nancy, Ashley, and the entire DPAG team for this presentation.

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So, before we leave today, we wanted to have the panelists answer a few questions regarding the white paper and CMS data collection. So let me pull up the questions. Okay.

So, the first question is, will the CMS health equity assessments include changes to the race question that was covered in one of the first slides?





So, I'm not quite sure which slide the person is asking about. But in terms of any-- so in general, any changes to our race and ethnicity category, we try to be as up to date as possible. So, we are following the 2011 HHS Data Standards, as Nancy mentioned earlier. But also, as Ashley provided earlier, there is currently public comment open for the OMB revision to their race and ethnicity data categories. And as you know, OMB currently have, I believe, five or six race categories with two ethnicity categories.

And the 2011 HHS Data Standards, it's an expanded version of the OMB. The OMB is looking to revise their current version. So, as OMB provided updated guidance over the next couple of years, we will make sure that whatever standards were working to collect the data and reporting the data out, that we will try our best to align with the OMB category, or updated categories. Of course, it'll take a bit of time for us to implement and get up to date, but we always will try to align with the latest standards available.

Thank you, Meagan. The next question is will CMS add reimbursement to the Z-Codes? Most entities struggle with staff knowing to add it, but when organizations are losing money, they make it a best practice.

Yes, and this is a question we have received over time. And it's not an easy thing for us to do, right? In order for things to be reimbursed or services to be reimbursed it has to have statutory requirement and regulations and all of that. So, it's definitely a good question, and unfortunately, I don't have an answer at the moment for the individual who asked the questions. But we are definitely taking this into considerations as we continue to improve our program and how to better address Z-Codes as we monitor the reporting of Z-Codes from providers.

Thank you, Meagan. How do these align to USCDI?

I'm going to assume "these" refer to our 2011 HHS Data Standards. I don't know, Nancy, do you want to take this question?

Sure. So, the HHS 2011 Data Standards have alignment with the USCDI standards, so interoperability is of high priority and even at various levels where a data standard may not have the level of granularity that might be specified in other standards, there's always the ability to roll up so that all of these standards are in alignment. So, to briefly answer your question, yes, there is alignment with USCDI.

Thank you, Nancy. Let me see. So, are people providing these demographics data allowed to indicate they identify as more than one race or non-binary sex/gender?

So it depends on the form, the enrollment form, the survey, or whichever the reporting vehicle that they're reporting their information on. Some do include a written in line to allow the individual to report multiple races or a checkbox, or more than one race.

In terms of the gender sex question, some have, just simply, the traditional male or female. There are some updated that may include a gender "x" as in some of the licenses that the states have updated. But these are the different categories that we are working to improve our data collection as we are aware of the different categories that are available and the different standards that we should align our data collection with.

Thank you, Meagan. Next question. Can you provide an update on sexual orientation and gender identity SOGI collection standards?

So, CMS is definitely looking into how we can better-- or start with collecting the data. Any type of data collection from the federal government perspective needs to have statutory authority to collect the data. And then as we consider our authority, we have to then work through the Paper Reduction Act process to



collect the data. So, there's a process we have to go through, but we are looking into how we can start collecting the data, where we should start across the different programs that CMS oversees. It is something that we are currently working on.

Thank you, Meagan. Our next question. Would the updated OMB's recent ethnicity statistical standards, if approved, impact the HHS Data Collection Standards?

So, the HHS data standards, that was released by ASPI. And so, as part of Section 4302 of the Affordable Care Act, they followed that alignment and released the 2011 HHS Data Standards. So my assumption - again, my personal assumption - that if there are new guidance issued by OMB, that ASPI at the department level will then look at that new guidance when it is available to see how the 2011 HHS Data Standards can be updated to align with the new OMB standard.

Thank you, Meagan. Is the HEAT, H-E-A-T, Advisory Team made up of government officials only, or can private partners participate? Are there other public/private advisory committees stakeholders can join/participate in?

Nancy, do you happen to know?

Yes. So, the HEAT is comprised of public and private members. So, the board is largely made up of private partners in addition with government officials. I am unaware of who all is able to participate in a leadership capacity or advisory capacity. But certainly if you look at the HEAT's website, you can find more information about the different meetings and webinars that they have and learn how you can become more involved. Offhand, I know that there are other public/private advisory committees that stakeholders can join, not aware of that offhand. But if you would like to follow up with the office, we can provide any additional information that we have.

Thank you, Nancy. Next question. Can you speak a bit more on these health equity scores? Will these be a composite measure like PSI90?

So, I actually have to look up PSI90. And I want to say at the high level, it's not quite the case. Because it seems to be focusing on patient safety. And Erin, if you don't mind, if you can send me an email, we have a presentation that we did for our Quality Conference from last year that goes into the detail of the Health Equity Summary Scores.

It's basically a methodology that looks across the different, for example, race and ethnicity category over time, as well as their performance and come up with a composite score to see how well a plan is addressing certain issues when it comes to certain race or ethnicity, for example. Or send an email to Health Equity TA, that email box, and we can send you that presentation. And we'll be more than happy to set up additional full meetings to talk more about it if you have an interest in the health equity summary score.

Thank you, Meagan. Next question. How does Title VI of the Civil Rights Act play a role in how CMS will implement strategies to advance health equity across racial populations?

It does play a big role in terms of how we address some of the issues that we're looking at, and we do talk to the Office of Civil Rights, the attorneys over there, as we- and we have our own counselors - as we address the different requests or update to changes, or as we go through rule making. But it does play a big part.

Thank you, Meagan. Another question. I don't know, let's see. So, are the social determinants of health questions also being mapped to LOINC codes?



So, I am not the lead who worked on this, but I want to say when we were putting out the proposed rule, there have been discussions, for example, cognitive testing in other questions that we review and how does that alone with the different questions that are out there that are currently being used? So, I'm not quite sure if it's being directly mapped, but there were some discussions about this in the NPRM.

Thank you, Meagan. While CMS stated they do not capture gender identity and sexual orientation, do they plan to in the future, and if so, does that mean that Medicare/Medicaid organizations must capture this data?

So that's a two-part question, right? So, are we planning to? Yes. As I previously mentioned, we are looking into that and figuring out the options for us to from an authority perspective to a collection option perspective. As to how the states, the providers, and others will have to follow? That will need further guidance as we continue to have this discussion. So unfortunately, I don't have a direct answer for you at the moment. So hopefully more to come in the future.

Thank you, Meagan. Next question. Is CMS going to align disability demographic data collection with the 2011 Standards as well?

As we're looking for aligning data standards across the different programs and looking at different data elements, we are trying to determine the different options and how that will actually work. Because aligning is one thing, but when it comes to data analysis, right? Can it still be applied? Which whatever the method is, but also how do we collect the data and the other thing to consider, the six questions, I believe it's six questions from the 2011 HHS Data Standards. Do those questions really get to the core of the information we need that can lead to better analysis to actually identify what are the issues and how to address disparities for our populations? So, another thing that we're currently looking into.

Thank you, Meagan. Next question. Will Z-Codes for social determinants of health be incorporated into risk adjustment models?

Unfortunately, we don't have folks who work on risk adjustment at this webinar, so I cannot directly answer that question at the moment.

This may not be something that we know, but let's see. Can you describe the proposed construction of the new CMS Hospital Disparity Index?

So, the only thing I can say at this moment is unfortunately we don't have the subject matter expert to speak about the Hospital Disparity Index. But one of the things that we try to mirror that off of the Health Equity Summary Score is all that I can say at the moment. But if you would like more information on that, again, send us an email and then we can connect you with the right individual. And then we can have further conversation about that.

Thank you, Meagan. Next question. CMS stakeholders have made known their interest in the agency further disaggregating data based on subpopulations. How is CMS working to help ensure that subpopulations are accounted for in data collection?

Nancy, do you want to take that?

Sure. So, that directly aligns with our goals in assessing the best and recommended data standards to allow for collection at a more granular level. So, as standards are coming down the pipeline that allow for that specificity for greater assessment of subgroups, such as the proposed OMB updates, this will



prepare us to be better equipped with doing the subgroup analysis that you've highlighted are very important. So that is something that we are differently working towards.

Thank you, Nancy. Let's see. Would you provide more details on how CMS is looking to working with other government agencies to expand sociodemographic data collection? Additionally, how are non-government partners being leveraged?

So, we are working, at least within under the department, right? We do have what we call HHS Data Council where the different agencies come together and have discussions about the challenges with data collections, data linkages, and as of most recent, the OMB revision to the race and ethnicity data categories. We also host a series of what we call listening sessions to get feedback from our stakeholders in terms of the things that we are proposing to consider what are the challenges, most impactful, or the benefits for them. And of course, when we put out new regulation, as you all know, there is a proposed rulemaking process that allows the public to provide comments to whatever we want to make changes for our programs. And then we do receive a number of requests and meet internally with CMS across the different components, across different programs, in terms of what they want to share with us or what innovative or best practices that they have that may be helpful for us. Or what they think is currently not working and share those ideas with us. So, we are definitely leveraging internal CMS staff, department staff, other agencies outside the department, as well as non-federal government partners.

Thank you, Meagan. So, one last question. Of the health equity data issues that are currently impacting CMS programs, which do you feel pose the largest challenge to the agency's ability to advance health equity?

Nancy, you want to take that?

That's quite the question. I'm going to kick it back to you, Meagan, while I think of mine and then I'll piggyback with you.

Yeah, so there are a number of challenges, right? I guess the biggest is probably the process of getting there. For any new data collection, again, we have to determine the authority. And the authority, what does that authority allow us to collect from whom, on what? And what does that authority allow us to use the data for? And then how can we disseminate that information?

Of course, taking into consideration privacy and confidentiality to make sure that the information we receive from our enrollees are secured and not being used inappropriately. And then of course, the process as we establish authority, then how do we go about updating the multiple data collection vehicles that we have in making sure that they all going forward are collecting the same set of information? So, for example, we can have one form collecting race and ethnicity at X standard, while the other one is Y standard, and another one is Z standard. Because when we pool them together, we are not able to sort of follow our enrollee through the different programs, or even for analysis purposes. So, there are quite a number of challenges as we continue to explore our options.

And from a data collection as well as from a legal perspective. And how does that, when we do put out there the information, is that useful and helpful to our stakeholders? To our providers? Or even to our enrollees who want to see what information CMS is putting out? So, we all have to take all of that into consideration as we explore what we can do moving forward.

And I'll just add to that as well, providing appropriate resources for thoughtful usage of the data once it's collected. Particularly when we have the ability to do some of the subgroup analysis that we've talked about are really important to disaggregate, how to do so in the most meaningful way with this additional



wealth of information and granular level of information that we'll have. So, I think that will be a challenge over time, but a welcome challenge.

Thank you, Meagan and Nancy for answering all of these questions. Next slide, please.

So, this slide has an image of people looking at different types of media.

As we all work together to achieve health equity, our office is here to assist. The Health Equity Technical Assistance program is an ongoing program that CMS staff can utilize for assistance in including equity as part of your work. This program is offered to anyone, whether external to government, or CMS staff.

Anyone can contact our technical assistance team for assistance. All you have to do is send an email to [healthequityta@cms.hhs.gov](mailto:healthequityta@cms.hhs.gov) to get started.

Next slide, please.

We have listed on this slide our contact information. We have several mailboxes listed here, with the main one being [OMH@CMS.HHS.gov](mailto:OMH@CMS.HHS.gov). We encourage you to visit our website at [go.CMS.gov/OMH](http://go.CMS.gov/OMH) and sign up for our Listservs so you can stay up to date on all of our health equity related initiatives.

Next slide, please.

We would like to thank you all again for joining us this afternoon for this webinar. It is our hope that you all leave today's call with a better understanding of how CMS is utilizing data to help address health disparities. Have an awesome afternoon!