and providing the care and support that our enrollees need to thrive."[45,46] The CMS Framework for Health Equity (2022-2032)[47] includes six priorities for operationalizing health equity across CMS programs: Priority 1 is to expand the collection, reporting, and analysis of standardized data. In support of this priority, CMS strives to improve our collection and use of comprehensive, interoperable, standardized individual-level demographic and social determinants of health data, including race, ethnicity, language, gender identity, sex, sexual orientation, and disability status. By increasing our understanding of the needs of those we serve, including social risk factors and changes in communities' needs over time, CMS can leverage quality improvement and other tools to ensure all individuals have access to equitable care and coverage.

Stratification of data is necessary to use the HCBS Quality Measure Set effectively to identify health disparities experienced by Medicaid beneficiaries receiving HCBS, and to identify effectively where targeted interventions are needed to reduce inequities. We strongly recommend and encourage states that implement the measure set to stratify a subset of measures within two years of implementing the HCBS Quality Measure Set, and to increase meaningfully the number of measures that they stratify over time. Further, we strongly recommend and encourage states to oversample sufficiently to be able to stratify their data on key demographic and other beneficiary characteristics, such as race and ethnicity, sex, age, rural/urban, disability, and language. CMS recognizes that oversampling may be associated with increased cost of implementation and recommends that states consider using part of the enhanced FFP noted above for system improvements that will enhance their ability to collect the demographic and other data necessary for stratification.

We encourage states to pay particular attention to measures that are "disparity-sensitive,"[48] based on the prevalence and magnitude of the disparity and the actionability of the measure, when using the measures to address disparities in health care access, quality, and outcomes for people receiving HCBS. We also encourage states to consider whether stratification can be accomplished based on valid statistical methods and without risking violation of beneficiary privacy, as states may not serve large enough HCBS populations to be able to stratify all measures and/or to stratify measures for all beneficiary characteristics of interest.[49] In addition, states should consider the specific variables that are available through the survey or other data source in determining which measures to stratify. We note that many key demographic characteristics are included as part of the United State Core Data for Interoperability (USCDI) standard adopted by the Office of National Coordinator for Health IT (ONC).[50] This standardized set of health data classes can not only support stratification activities but also support reporting and care delivery as measures elements may align with an existing or future

[45] Executive Order 13985: https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/
[46] Centers for Medicare and Medicaid Services, "Health Equity" https://www.cms.gov/pillar/health-equity
[47] Centers for Medicare and Medicaid Services, "CMS Framework for Health Equity (2022-2032)." https://www.cms.gov/files/document/cms-framework-health-equity.pdf
[48] See https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=72347 for more information.
[49] Privacy issues can occur, in particular, when stratifying data for smaller and less diverse populations, as it becomes possible to identify individual data when there are small numbers to report.
[50] *See* https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi.

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