Q&A in Response to the Summer 2022 Public Comments on the Quality Measure Alignment Taskforce's Draft Health Equity Data Standards

Q: Why don't these data standards align with those in consideration for the MassHealth hospital incentive program?

A: Since the Taskforce draft health equity data standards were posted for public comment, the Taskforce and MassHealth have aligned their data standards to avoid complicating provider and payer data workflows.

Q: Will these data standards be required for adoption by all providers in value-based payer arrangements, including MassHealth ACOs?

A: These are minimum standards that will be recommended for voluntary adoption and use by commercial payers, MassHealth and provider organizations statewide.

Additionally, the Taskforce has separately recommended methods for payers and ACOs to introduce accountability for adoption and implementation of these data standards into contracts.

Q: Can implementation of the data standards be staggered given the operational demands associated with standards implementation?

A: Implementation of race, ethnicity (including granular ethnicity), and language data standards is recommended by January 1, 2024 and then disability, sexual orientation, gender identity, and sex data standards by January 1, 2025.

Q: Can there be flexibility in how questions are asked to collect these data in order to allow for the utilization of existing workflows?

A: Organizations should aim to align with the recommended data standards, including question language.

Q: Can the Taskforce specify a recommended frequency of data collection and/or validation for each data standard?

A: The Taskforce recommends that these data be collected (or validated) at least annually, with the potential for greater frequency for particular data standards at the discretion of the payer or provider organization.

Q: Are other data allowed to fulfill collection against these standards (e.g., EOHHS-collected at enrollment, provider EMR data, or plan claims data on diagnoses/conditions)?

A: The Taskforce recommends that previously collected data, which may have used different question and data standards, should initially be used to populate fields against these standards, but in the future, data should be self-reported using the prescribed standards. Additional data sources should be used only when the provider or plan has been unable to directly collect patient/member self-reported data. These additional data sources may include the Massachusetts Immunizations Information System. However, longer-term use of these other sources should be limited to those that can be confirmed to have been collected through patient/member self-report.

Additionally, please see the Taskforce's final accountability recommendations for more information on recommended sources when health equity data are being used for accountability purposes.

Q: How should conflicting patient-reported answers from different sources be handled since data sharing between payers and providers is recommended?

A: Organizations should create their own data hierarchies to determine which data take precedence based on factors such as source, recency, and method of obtainment, among others.

Q: Will the state apply the label of 'other' to any categorization not exactly aligned with the state's ethnicity classification? If so, that will limit disaggregated information.

A: These data standards are recommended minimum standards and do not represent standards that any values must 'roll up' to at the state level. Collection of ethnicity values beyond those in the minimum recommended standards to meet an individual organization's needs is welcomed and encouraged.

Q: May individual payers and providers individually supplement the required granular ethnicity by adding additional granular ethnicities that align with extant data standards (e.g., HL7) or currently customized ethnicity categories?

A: Yes. The Massachusetts Superset is a minimum standard for granular ethnicity data collection. Organizations are welcome and encouraged to collect additional granular ethnicities as relevant for the populations they serve.

Q How do the draft data standards affect our ability to collect a longer list of language response options or to ask additional language questions [e.g., English proficiency, literacy, etc.]?

A: These are minimum language data standards. Organizations are welcome and encouraged to ask additional questions and/or collect additional response option values as relevant for the populations they serve.

Q: How should disability patient information best be provided based on patient query and/or clinical assessment, and how should that be differentiated from disability status for benefits applications?

A: The disability data standards are to be used for demographic purposes and should not be confounded with clinical assessment, diagnoses, or disability status for benefits applications.