RACE AND ETHNICITY STRATIFICATION RESOURCE GUIDE

MEASUREMENT YEAR 2026

NCQA
Measuring quality.
Improving health care.

Certain content contained in this publication has been reproduced from HEDIS® Volume 2: Technical Specifications for Health Plans *by the National Committee for Quality Assurance (NCQA). HEDIS® is a registered trademark of NCQA. HEDIS measures and specifications are not clinical guidelines, and do not establish a standard of medical care. NCQA makes no representations, warranties or endorsement about the quality of any physician or organization that uses or reports performance measures, and NCQA has no liability to anyone who relies on such measures or specifications. Limited proprietary coding is contained in the measure specifications for convenience.*

Users of proprietary code sets should obtain all necessary licenses from their owners. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications.

No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording or any information storage and retrieval system, or used in a commercial manner without the written permission of NCQA.

© 2025 by the National Committee for Quality Assurance
1100 13th Street NW, Third Floor
Washington, DC 20005
All rights reserved. Printed in the U.S.A.

NCQA Customer Support: 888-275-7585
NCQA Fax: 202-955-3599
NCQA Website: www.ncqa.org

Contents

About This Guide

The purpose of this guide is to support stakeholders in using the HEDIS race and ethnicity stratification (RES). NCQA hopes its technical guidance will help readers better understand our data element requirements, and support improvement to collection and reporting of race and ethnicity data for HEDIS.

The RES has been included in HEDIS since MY 2022. During this time, NCQA has obtained feedback from health plans, auditors and other key stakeholders to understand common questions about implementing the RES. This guide features relevant examples and answers these questions:

1. Will organizations be evaluated to confirm that a certain percentage of directly collected data is complete? If so, how?
2. How will mapping of race and ethnicity information to the OMB categories be evaluated?
3. How are the types of data sources determined (imputed vs. direct)? Will imputed methods need to be approved?
4. How does NCQA address small sample sizes in the race and ethnicity strata for hybrid measures?
5. How should organizations prioritize reporting race and ethnicity when values from different sources do not agree?
6. How can auditors support their clients in improving collection of race and ethnicity data? What resources can be shared?

Note: *This guide does not replace or modify any content of* HEDIS Volume 2: Technical Specifications for Health Plans or Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.

About NCQA

NCQA is a leading nonprofit organization dedicated to improving health care quality through measurement, transparency and accountability. Since its founding in 1990, NCQA has been central in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda.

Acknowledgments

NCQA's initial research to develop the *Race and Ethnicity Stratification Resource Guide* involved interviews with licensed organizations and analysis of feedback from key stakeholders, including health plan representatives. These interviews and feedback were invaluable to our work, and provided insights into the types of challenges plans and auditors may face when reporting measures by race and ethnicity, and when implementing the stratification. NCQA appreciates the continued feedback and engagement of stakeholders.

NCQA Staff

Many NCQA staff contributed to this guide’s development:

Keirsha Thompson, MSW, Assistant Director, Health Equity Sciences

Christina Dai, MPH, Health Care Analyst, Chronic Conditions

Rachel Harrington, PhD, Senior Product Strategist, Product Management

Jamar Dues, Manager, Measure and Data Operations

Taylor Musser, MPH, Director, Measure and Data Operations

Ashley Buchanan, Senior Project Specialist, Measure and Data Operations

Wendy Talbot, MPH, Vice President, Measure and Data Operations

Judy Lacourciere, Editor, Writing, Editorial and Publications

Licensed Organizations

NCQA thanks the HEDIS Compliance Audit™ Licensed Organizations for providing initial input on this work.

Introduction

Health Disparities

Disparities in morbidity and mortality by race and ethnicity are well documented.[1,2] A 2019 review of health status across racial groups found that while policy and program efforts such as the Affordable Care Act have begun to narrow disparities, notable differences in health outcomes persist. Organizations such as the Centers for Disease Control and Prevention (CDC) and the World Health Organization, and policy initiatives like Healthy People 2030, indicate the need to pursue health equity in the face of widening disparities.[3,4,5] For example, infant mortality rates for the Black and Native American populations are approximately twice as high as for the White population.[6] The incidence of colorectal cancer in the non-Hispanic Black population is 20% higher than that of the non-Hispanic White population, and the mortality rate is 40% higher. Differences in screening rates are estimated to account for almost half of this disparity.[7]

Racial and ethnic health disparities call attention to a need for targeted interventions to improve health outcomes. Although socially constructed categories of race and ethnicity do not cause health disparities, they often link directly to other dimensions that impact health, including systemic racism, geographic location, socioeconomic status and access to care.[8]

Motivation to Address Health Disparities

NCQA believes high-quality care must be equitable care. Advancing equity is fundamental to NCQA's mission of improving the quality of health care, identifying inequities in care and promoting health equity through performance measurement. As a central part of this effort, NCQA seeks to leverage HEDIS measures to highlight disparities in care, and to hold organizations accountable for implementing interventions to reduce them.

Organizations reporting HEDIS play a key role in this effort by supporting thorough and accurate implementation of the measure specifications. Helping to ensure that the RES is implemented as intended will advance efforts to improve race and ethnicity documentation, call attention to disparities in care and promote efforts to reduce disparities.

HEDIS Resources

Have you had an opportunity to review NCQA's Data, Measurement and Equity website? It contains background and narrative for the RES as well as resources related to other ongoing equity efforts at NCQA.

This site contains a section describing the intent and expected use of race and ethnicity data in HEDIS.

Using This Guide

This guide is designed to accompany the *Race and Ethnicity Stratification* general guideline. Each section corresponds to a section of the guideline, and contains technical guidance on implementing the stratification, as well as resources, conversation aids and tools to support auditors.

Section 1: Stratified Measures. Current measures stratified by race and ethnicity.

Section 2: Reporting Categories. How to report race and ethnicity categories; appropriate mapping approaches; instructions for reporting missing data and unknown values.

Section 3: Data Sources. How to distinguish direct and imputed data sources and resolve disagreements in values across multiple sources.

Section 4: Sampling and Reporting. Applying sampling guidelines for hybrid measures and minimum denominator size.

Section 5: Expectations for Use of Data. NCQA's expectations for use of race and ethnicity data.

Section 6: Future Directions. Preparing for the expansion and evolution of RES.

This guide is evaluated periodically to identify where updates are needed in response to changes to the RES, and/or to clarify expectations based on ongoing stakeholder feedback.

Note: *Guidance and tools in this guide are intended to be supplemental resources. HEDIS* Volume 2: Technical Specifications for Health Plans *includes the full RES general guideline specifications with RES reporting requirements.* Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures *includes the validation methodology used by Certified HEDIS Compliance Auditors*.

Summary of Changes

NCQA released the first version of this guide in 2022. Based on our work since then, and the evolution of the race and ethnicity data environment, we made some key changes:

- Clarified that only unknown race or ethnicity values may be attributed to an "Unknown" data source type (as opposed to values of "Asian," "Hispanic/Latino," "Asked But No Answer" and so on). "Unknown" values were previously attributed to an indirect data source type. Use of this new data source category (i.e., "Unknown) is limited to "Unknown" values only. This change aligns with the HEDIS MY 2023 *Technical Update,* which introduced the "Unknown" data source option. Please note that any guidance mentioned in this guide regarding data sourcing applies only to the *Race and Ethnicity Description of Membership* (RDM) measure (not to stratified measures).
- Clarified how value sets explicitly build into Centers for Disease Control and Prevention (CDC) Race/Ethnicity categories.
- Added a note acknowledging that CMS's Medicare enrollment data are supplemented by imputed methods, including resources for direct and imputed data collection and a discussion of the evolution of the RES.

Section 1: Stratified Measures

As of HEDIS MY 2026, NCQA has implemented the RES in 22 measures:

- Childhood Immunization Status.
- Immunizations for Adolescents.
- Adult Immunization Status.
- Prenatal Immunization Status.
- Breast Cancer Screening.
- Cervical Cancer Screening.
- Colorectal Cancer Screening.
- Controlling High Blood Pressure.
- Blood Pressure Control for Patients With Hypertension.
- Glycemic Status Assessment for Patients With Diabetes.
- Eye Exam for Patients With Diabetes.
- Kidney Health Evaluation for Patients With Diabetes.
- Follow-Up After Emergency Department Visit for Substance Use.
- Pharmacotherapy for Opioid Use Disorder.
- Initiation and Engagement of Substance Use Disorder Treatment.
- Follow-Up After Hospitalization for Mental Illness.
- Follow-Up After Emergency Department Visit for Mental Illness.
- Prenatal Depression Screening and Follow-Up.
- Postpartum Depression Screening and Follow-Up.
- Prenatal and Postpartum Care.
- Well-Child Visits in the First 30 Months of Life.
- Child and Adolescent Well-Care Visits.

Measures were selected for stratification based on prioritization of disparities-sensitive clinical topics and on extensive stakeholder, expert panel and public comment feedback.

Each measure specification includes a section instructing plans to report measures according to specified race and ethnicity categories. Measure specifications also include tables for reporting data elements by race and ethnicity, as pictured in the example below.

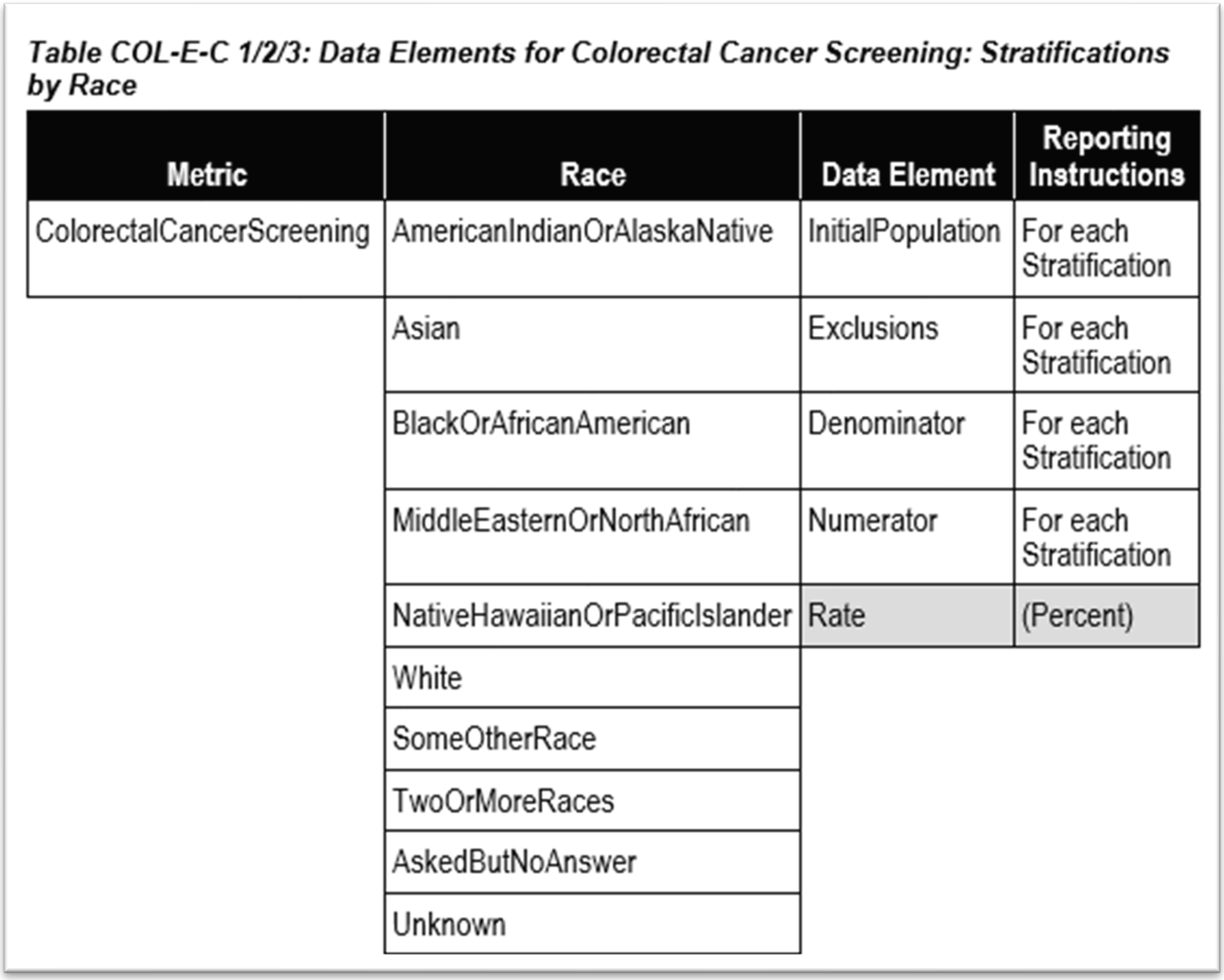


Table COL-E-C 1/2/3: Data Elements for Colorectal Cancer Screening: Stratifications by Race

Metric	Race	Data Element	Reporting Instructions
ColorectalCancerScreening	AmericanIndianOrAlaskaNative	InitialPopulation	For each Stratification
	Asian	Exclusions	For each Stratification
	BlackOrAfricanAmerican	Denominator	For each Stratification
	MiddleEasternOrNorthAfrican	Numerator	For each Stratification
	NativeHawaiianOrPacificIslander	Rate	(Percent)
	White		
	SomeOtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

TECHNICAL GUIDANCE

- All rates in the reporting table for Stratifications by Race and Stratifications by Ethnicity will be validated to help ensure they are reported by the data elements specified (race and ethnicity categories).
    - *Example:* In the table above, plans report the initial population, denominator and numerator for each race and ethnicity category for COL-E. Plans report the number of members in the initial population who are categorized as “American Indian or Alaska Native,” “Asian” and so on for each stratification category, for both race and ethnicity.
- Data populated for every stratification category will be validated. No stratification category should be blank.
    - *Example:* If there are no members for whom a race was determined, “0” is reported for that race category for the initial population, denominator and numerator.

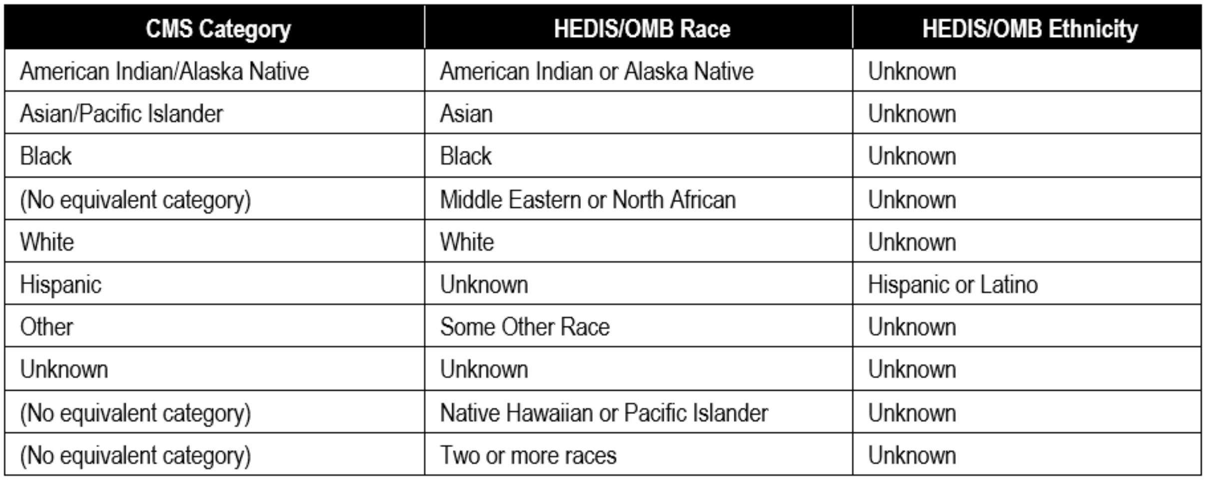
Section 2: Reporting Categories

NCQA requires organizations to report race and ethnicity data according to the Office of Management and Budget (OMB) 1997 and 2024 Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.[9,10] The federal government uses these standards for record keeping, and collecting and presenting data on race and ethnicity; they form the basis for race and ethnicity data collection for many health care organizations.

TECHNICAL GUIDANCE

- Validation will be performed to help ensure that plans reported in only one race category and in only one ethnicity category.
- Race and ethnicity must be reported separately; each member should be reported with a valid race value *and* a valid ethnicity value ("Unknown" included).
- If plans collect race and ethnicity together (e.g., "Hispanic" is an option for race), auditors evaluate how plans are disaggregating race and ethnicity for each member, and the approach to reporting race and ethnicity separately:
  - If plans collect race and ethnicity using CMS's combined categories (Table RES-A-1/2/3) or the combined categories in Table RES-B-1/2/3, the disaggregation of race and ethnicity can follow the specified mapping tables below.
  - Plans that collect race and ethnicity using CMS's combined categories should know that both race and ethnicity will be unavailable when disaggregated to HEDIS OMB categories. If a plan collects race and ethnicity using combined race/ethnicity categories not reflected in the mapping tables, auditors confirm that the plan has a process for consistently mapping categories in use to disaggregated HEDIS/OMB categories. The process should help ensure that categories in use are consistently and systematically mapped to the specified HEDIS/OMB categories.

Table RES-A-1/2/3: CMS Categories Crosswalked to HEDIS/OMB Race and Ethnicity



CMS Category	HEDIS/OMB Race	HEDIS/OMB Ethnicity
American Indian/Alaska Native	American Indian or Alaska Native	Unknown
Asian/Pacific Islander	Asian	Unknown
Black	Black	Unknown
(No equivalent category)	Middle Eastern or North African	Unknown
White	White	Unknown
Hispanic	Unknown	Hispanic or Latino
Other	Some Other Race	Unknown
Unknown	Unknown	Unknown
(No equivalent category)	Native Hawaiian or Pacific Islander	Unknown
(No equivalent category)	Two or more races	Unknown

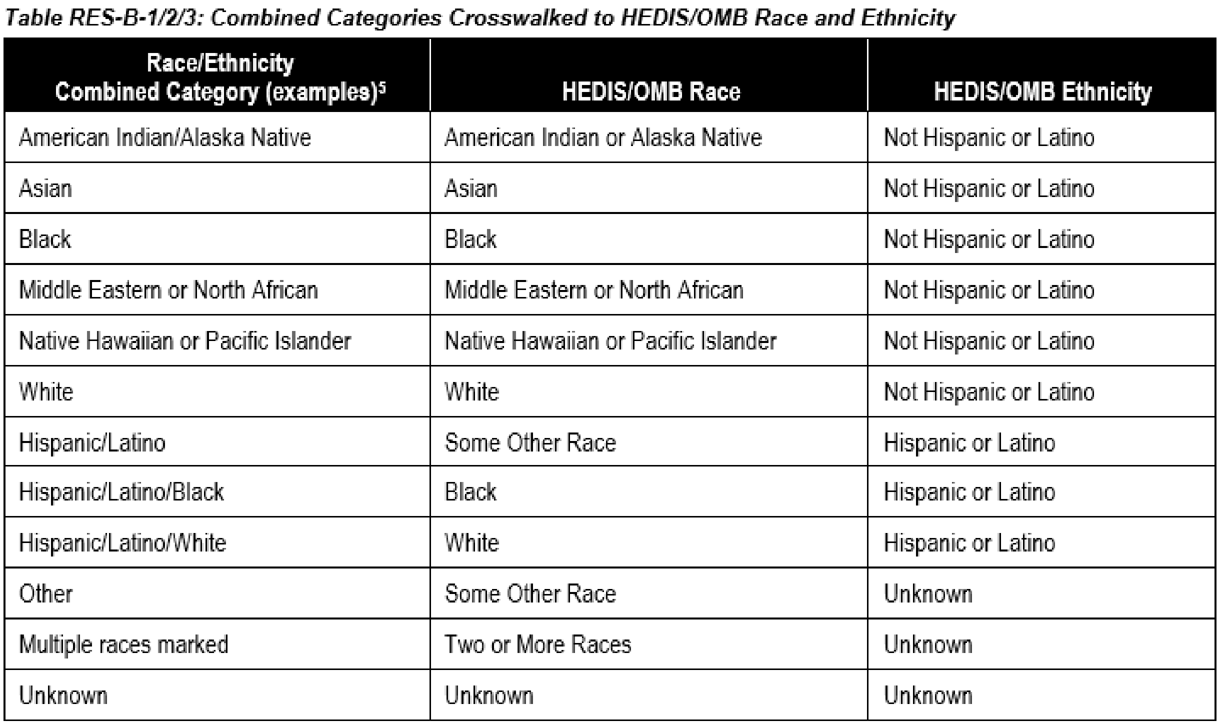


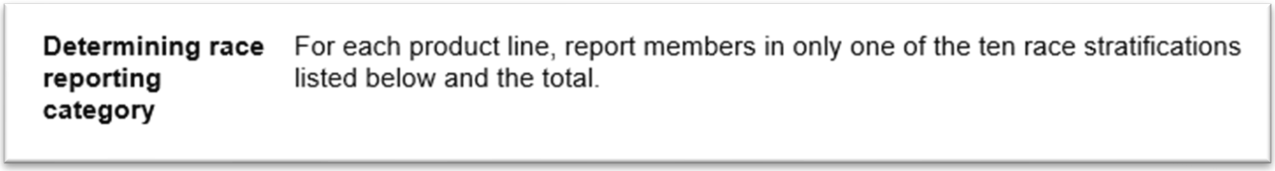
Table RES-B-1/2/3: Combined Categories Crosswalked to HEDIS/OMB Race and Ethnicity

Race/Ethnicity Combined Category (examples)[5]	HEDIS/OMB Race	HEDIS/OMB Ethnicity
American Indian/Alaska Native	American Indian or Alaska Native	Not Hispanic or Latino
Asian	Asian	Not Hispanic or Latino
Black	Black	Not Hispanic or Latino
Middle Eastern or North African	Middle Eastern or North African	Not Hispanic or Latino
Native Hawaiian or Pacific Islander	Native Hawaiian or Pacific Islander	Not Hispanic or Latino
White	White	Not Hispanic or Latino
Hispanic/Latino	Some Other Race	Hispanic or Latino
Hispanic/Latino/Black	Black	Hispanic or Latino
Hispanic/Latino/White	White	Hispanic or Latino
Other	Some Other Race	Unknown
Multiple races marked	Two or More Races	Unknown
Unknown	Unknown	Unknown

Determining Race and Ethnicity Reporting Categories

OMB standards include two categories for ethnicity (“Hispanic or Latino,” “Not Hispanic or Latino”) and six categories for race (“American Indian or Alaska Native,” “Asian,” “Black or African American,” “Middle Eastern or North African,” “Native Hawaiian or Pacific Islander,” “White”).

NCQA also includes values for “Two or More Races,” “Asked But No Answer” (declined response) and “Unknown” (not asked, missing data).



Determining race reporting category	For each product line, report members in only one of the ten race stratifications listed below and the total.

TECHNICAL GUIDANCE

- Validation helps ensure that plans accurately reported members according to OMB categories specified in the measure.
    - *Example:* If a member is categorized as “Black or African American” for reporting a stratified measure rate, the auditor may validate that the member’s race is documented as “Black or African American” in the source data.
- A member whose race value is listed as something other than an OMB category (or a value that does not map to a race category) should be reported in the “Some Other Race” category.

- A member who does not have a race or ethnicity value listed should be reported in the "Unknown" category for race and ethnicity.
    - Plans that collect race and ethnicity using CMS's combined categories should be aware that both race and ethnicity will be unavailable when disaggregated to HEDIS OMB categories. For example, for members whose CMS category was documented as "Hispanic," plans will have an available ethnicity value of "Hispanic" and no available race value when disaggregating.

Mapping Race and Ethnicity Categories

NCQA requires organizations to report race and ethnicity using OMB categories, even if more detailed categories are used in data collection. NCQA acknowledges that more detailed categories of race and ethnicity are helpful for understanding the unique experiences and needs of different populations, and encourages plans to collect at the most granular level possible. If organizations use more detailed subcategories of race and ethnicity, they must aggregate those subcategories into the OMB categories to report NCQA measures.

This approach is consistent with that outlined by the Office of National Coordinator for Health IT (ONC) 2015 Health IT certification criteria.[11] For information on standardized race and ethnicity data categories and guidance for aggregating at the OMB category level, refer to the CDC Race and Ethnicity Code Set Version 1.3 (CDCREC).[12]

TECHNICAL GUIDANCE

- Auditors assess a plan's process for consistently mapping race and ethnicity data collected in more specific categories to the HEDIS/OMB categories specified in the RES general guideline.
- NCQA recommends that if plans collect race and ethnicity using the CDC's detailed race and ethnicity categories, they use the crosswalk specified in tables RES-C-1/2/3 and RES-D-1/2/3 of the RES general guideline, but this is not required.
    - NCQA value sets already assign more granular CDC Race and Ethnicity values to the correct HEDIS/OMB reporting category. Plans that collect or manage data using these granular codes do not need to develop additional mapping.

      Example: If a member is assigned "Bolivian," the value will be accounted for in the Hispanic or Latino Detailed Ethnicity Value Set and does not need to be separately mapped, and Direct Reference Code 2135-2 does not need to be separately coded.

Table RES-C-1/2/3: HEDIS/OMB Race Crosswalked for Use With HEDIS Reporting Categories

HEDIS/OMB Race	CDCREC OMB Category: Direct Reference Code*	CDCREC Detailed Category: Value Set
American Indian or Alaska Native	1002-5	American Indian or Alaska Native Detailed Race Value Set
Asian	2028-9	Asian Detailed Race Value Set
Black	2054-5	Black or African American Detailed Race Value Set
Middle Eastern or North African	NA	Middle Eastern or North African Detailed Race Value Set
Native Hawaiian or Pacific Islander	2076-8	Native Hawaiian or Pacific Islander Detailed Race Value Set
White	2106-3	White Detailed Race Value Set
Some Other Race	2131-1	NA
Two or More Races	NA***	NA
Asked But No Answer	ASKU**	NA
Unknown	UNK**	NA

*Codes to identify race and ethnicity are from the CDC Race and Ethnicity code system developed by the U.S. Centers for Disease Control and Prevention (CDC). They resemble LOINC codes, but are not.

**HL7 v3 Code System NullFlavor.

***This value is defined by the measure calculation logic as the presence of two or more distinct CDCREC category codes and does not map to a specific direct reference code or value set.

Table RES-D-1/2/3: HEDIS/OMB Ethnicity Crosswalked for Use With HEDIS Reporting Categories

HEDIS/OMB Race	CDCREC OMB Category: Direct Reference Code*	CDCREC Detailed Category: Value Set
Hispanic or Latino	2135-2	Hispanic or Latino Detailed Ethnicity
Not Hispanic or Latino	2186-5	NA
Asked But No Answer	ASKU**	NA
Unknown	UNK**	NA

*Codes to identify race and ethnicity are from the CDC Race and Ethnicity code system developed by the U.S. Centers for Disease Control and Prevention (CDC). They resemble, but are not, LOINC codes.

**The NullFlavor concepts “Asked But No Answer” and “Unknown” are not included in the terminology binding for the US Core Ethnicity FHIR extension on which this digital logic is structured. NCQA allows these concepts to express ethnicity data to align with bound values for the US Core Race extension.

Missing Data

- *Asked But No Answer:* People who the organization asked to identify race but who declined to provide a response.
- *Unknown:* People for whom the organization did not obtain race information and for whom the organization did not receive a declined response (“Asked But No Answer”).
- *Total:* Total of all categories above.

Note: *The “Asked But No Answer” category is only reported using direct data.*

TECHNICAL GUIDANCE

Please note that any guidance mentioned below regarding data sourcing applies only to the RDM measure (not to stratified measures).

- Validation will help ensure that data have been accurately categorized as “Asked But No Answer” vs. “Unknown.”
- Auditors confirm that data characterized as “Asked But No Answer” are reported as direct, and that data characterized as “Unknown” are reported as unknown data source. For details on classifying data sources, refer to *Determining Data Source* in this guide.
- If a member who has been asked for race or ethnicity provides a response of “Decline,” “I choose not to answer,” “Prefer not to say” or “Skip” (or equivalent response), the response may be appropriately classified as “Asked But No Answer.” This must be categorized as “Direct” data because the member self-reported the data.
  - *Example:* A member survey asks the member for their race. Response options include all OMB categories, plus “I decline to answer.” The member selects that response option. The member is categorized as “Asked But No Answer,” and the data source as “Direct.”
- If a member has been asked for race or ethnicity, but no response is documented, the member is categorized as “Unknown” because it is unclear whether the member intentionally declined to respond or simply did not see the question (e.g., survey fatigue could result in a member failing to complete all questions on a survey). The data source is categorized as “Unknown.”
  - *Example:* A member survey asks members for their race. Response options include all OMB categories, plus “I decline to answer.” A member does not respond to the question. This member is categorized as “Unknown,” and the data source as “Unknown.”
- Members for whom there is no documented race or ethnicity value, and for whom it is unclear if they were asked, are categorized as “Unknown.”
- Any use of “Unknown” race or ethnicity values resulting from disaggregation of CMS’s combined race and ethnicity categories should be categorized as “Unknown,” even though the same data source may be identified as direct for the known race or ethnicity value.
  - *Example:* If a direct data source identifies a member as “Black” according to the CMS combined categories, this is disaggregated to the HEDIS OMB categories of “Black or African American” for race and “Unknown” for ethnicity, according to the mapping tables provided. Because the race is from the direct data source, it can be characterized as “Direct” data, but because the ethnicity is unknown and a member self-report value for ethnicity cannot be confirmed, it must be categorized as “Unknown” if the plan elects to use the “Unknown” value.

Section 2 Resources

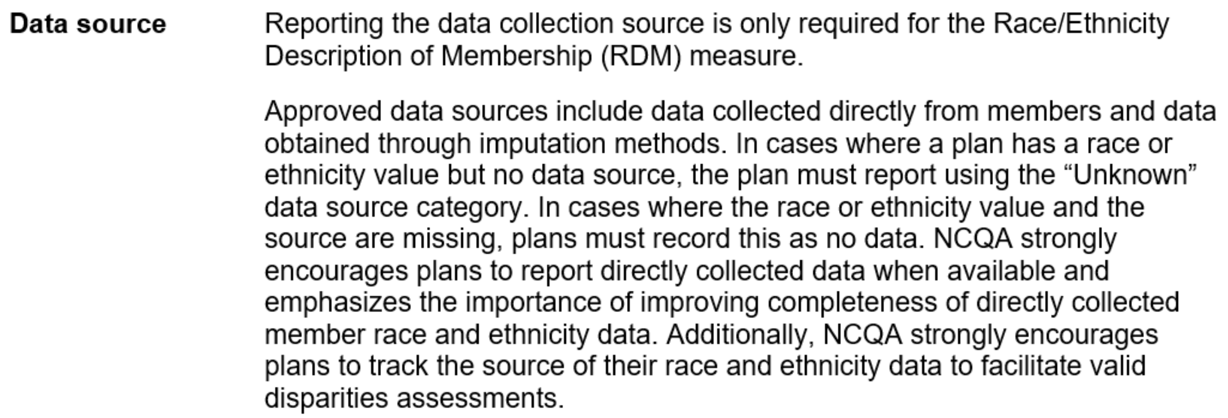
CDC/OMB Race/Ethnicity Mapping: For guidance on rolling up detailed CDC race and ethnicity categories to the OMB minimum categories specified in the stratification, refer to *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*, published by the Agency for Healthcare Research and Quality. For digital measures reported using Electronic Clinical Data Systems (ECDS), this source also references the FHIR®/ US Core race and ethnicity code sets on which ECDS measures rely.

Section 3: Data Sources

For the RDM measure, plans must report race and ethnicity *by data source* (direct, imputed, unknown). In rare instances where an organization did not collect race/ethnicity information and race/ethnicity source information, it must report race/ethnicity source as No Data.

NCQA allows identification of race and ethnicity using three methods:

1. Direct data collection of race and ethnicity from members.
2. Imputed methods to assign race and ethnicity.
3. Unknown data sources when members are assigned a race or ethnicity value of “Unknown,” as indicated in the *Data source* section of the stratification specification.



Data source	Reporting the data collection source is only required for the Race/Ethnicity Description of Membership (RDM) measure. Approved data sources include data collected directly from members and data obtained through imputation methods. In cases where a plan has a race or ethnicity value but no data source, the plan must report using the “Unknown” data source category. In cases where the race or ethnicity value and the source are missing, plans must record this as no data. NCQA strongly encourages plans to report directly collected data when available and emphasizes the importance of improving completeness of directly collected member race and ethnicity data. Additionally, NCQA strongly encourages plans to track the source of their race and ethnicity data to facilitate valid disparities assessments.

TECHNICAL GUIDANCE

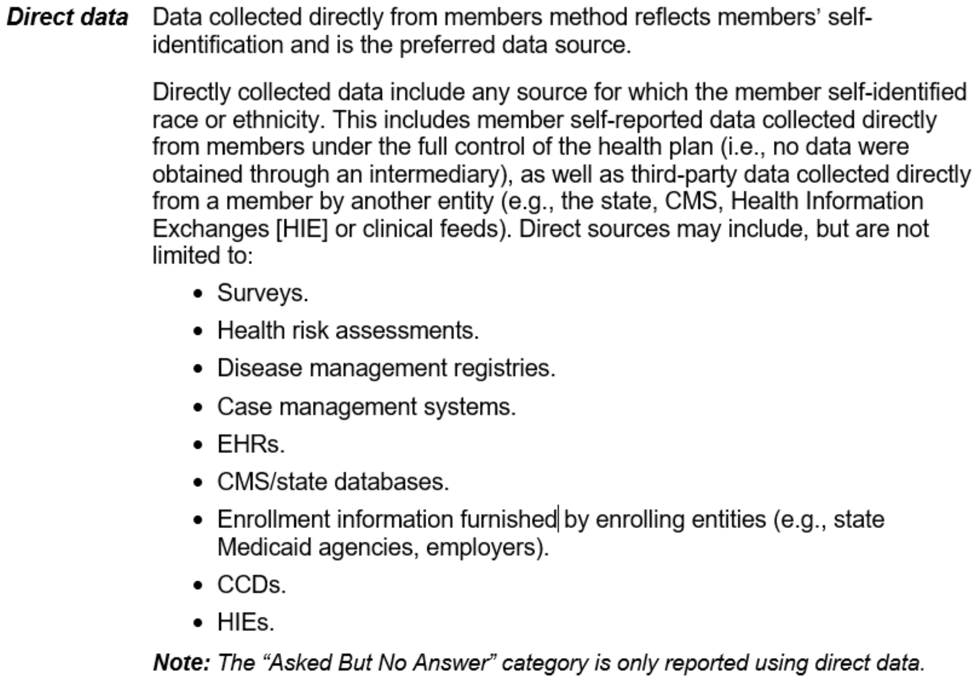
- For the RDM measure, NCQA’s Interactive Data Submission System (IDSS) validates that all stratified data elements have been reported by data source. IDSS checks that for each race and ethnicity stratification category, there is a rate reported for direct, imputed, unknown and no data.
- NCQA has not implemented a direct data completeness requirement. Auditors do not confirm that a certain proportion of data comes from direct data sources. (Refer to *Data Completeness Expectations* and *Section 6: Evolution of Race and Ethnicity Stratification* for more information.)

Determining Data Source

NCQA prefers data collected directly from the member, but allows use of imputed methods when directly collected data are unavailable. Plans must report data elements according to the data source from which race and ethnicity were determined, and auditors must validate that plans accurately determined the data source for each data element.

Direct Data

Self-identification of race and ethnicity is the gold standard, and is always preferred to imputation methods or unknown data. Direct methods of data collection include methods for which a member (or parent, guardian or caregiver on behalf of a member) self-reports race and ethnicity, such as through survey or enrollment data. Because direct collection of data is the most accurate method of identifying an individual's race and ethnicity, it can therefore support more accurate estimates of disparities.



Direct data Data collected directly from members method reflects members' self-identification and is the preferred data source.

Directly collected data include any source for which the member self-identified race or ethnicity. This includes member self-reported data collected directly from members under the full control of the health plan (i.e., no data were obtained through an intermediary), as well as third-party data collected directly from a member by another entity (e.g., the state, CMS, Health Information Exchanges [HIE] or clinical feeds). Direct sources may include, but are not limited to:

- Surveys.
- Health risk assessments.
- Disease management registries.
- Case management systems.
- EHRs.
- CMS/state databases.
- Enrollment information furnished by enrolling entities (e.g., state Medicaid agencies, employers).
- CCDs.
- HIEs.

Note: *The "Asked But No Answer" category is only reported using direct data.*

Direct data collection does not only refer to data collected directly from the member by the plan; it also refers to data collected from a source that can reasonably be assumed to be the member (e.g., state or CMS enrollment data, health information exchange, EHR data).

Note: *NCQA acknowledges that CMS's Medicare enrollment data are supplemented by imputed methods.*[13] *For consistency in how CMS enrollment data are classified in NCQA's RDM measure, such data are considered direct, according to the RES general guideline. NCQA is exploring how to classify CMS enrollment data, and will update the RES general guideline, and this guide, as needed.*

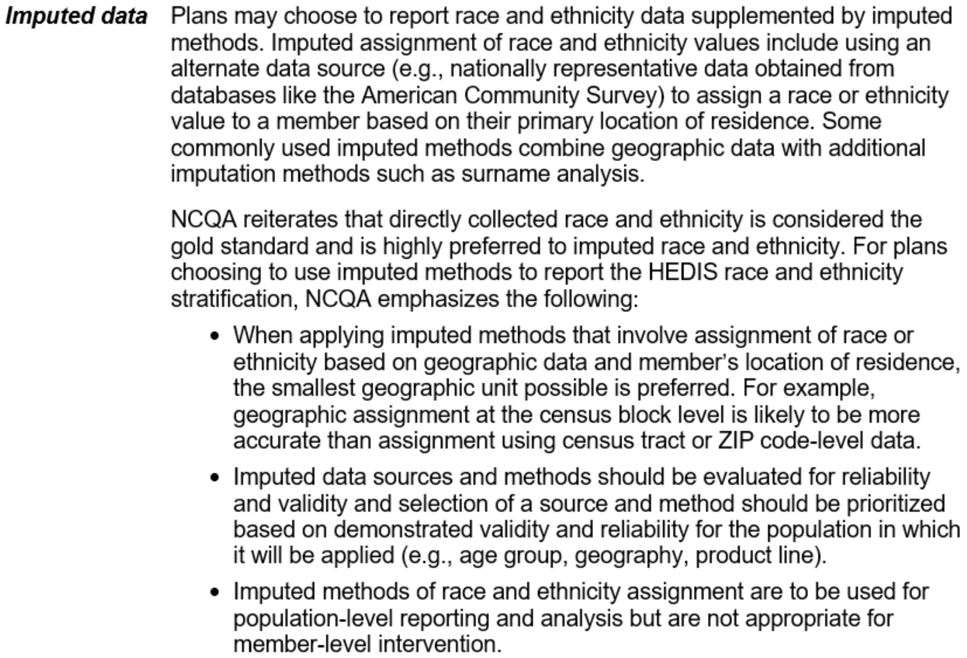
TECHNICAL GUIDANCE

- Auditors assess which race or ethnicity data are considered as coming from a direct source.
  - Data from a direct data source, as specified in the RES general guideline, may be determined to be direct.
  - Data from a source not specified in the RES general guideline (e.g., data purchased from a third-party vendor) may be determined to be direct if there is a reasonable expectation that race or ethnicity was based on member response.
  - Data from a source for which race or ethnicity was determined by observation, imputation or a method other than member response are not considered direct.
- The rationale for reclassifying data should be comprehensively documented and subject to auditor review (e.g., data previously characterized as direct have been changed to imputed).

Imputed Data

NCQA encourages plans to work toward achieving a high level of completeness of directly collected member data. If such data are not available, a common alternative is to identify demographic information using a community proxy, such as aggregated geographic-level data from national surveys or data sources like the U.S. Census Bureau. In this approach, community-level (e.g., census block or ZIP code) data may be used to attribute a characteristic to a member who resides in a particular location.[14,15]

In 2009, the Institute of Medicine recommended that organizations use imputed estimation to support analyses of race and ethnic disparities when race and ethnicity data are unavailable.[16] The National Quality Forum supports organizations using proxy data from geocoding, surname analysis and Bayesian estimation when conducting community-level interventions.[17]



Imputed data Plans may choose to report race and ethnicity data supplemented by imputed methods. Imputed assignment of race and ethnicity values include using an alternate data source (e.g., nationally representative data obtained from databases like the American Community Survey) to assign a race or ethnicity value to a member based on their primary location of residence. Some commonly used imputed methods combine geographic data with additional imputation methods such as surname analysis.

NCQA reiterates that directly collected race and ethnicity is considered the gold standard and is highly preferred to imputed race and ethnicity. For plans choosing to use imputed methods to report the HEDIS race and ethnicity stratification, NCQA emphasizes the following:

- When applying imputed methods that involve assignment of race or ethnicity based on geographic data and member's location of residence, the smallest geographic unit possible is preferred. For example, geographic assignment at the census block level is likely to be more accurate than assignment using census tract or ZIP code-level data.
- Imputed data sources and methods should be evaluated for reliability and validity and selection of a source and method should be prioritized based on demonstrated validity and reliability for the population in which it will be applied (e.g., age group, geography, product line).
- Imputed methods of race and ethnicity assignment are to be used for population-level reporting and analysis but are not appropriate for member-level intervention.

Although imputed methods of race and ethnicity assignment have value in population-level estimates of disparities, they are inappropriate for individual-level interventions. Community-level data are subject to the ecological fallacy that an individual in a neighborhood may not match the overall attributes of that neighborhood.[18] NCQA recognizes this limitation, and hopes that use of imputed methods will help health plans estimate disparities in care across member populations (when directly collected data are unavailable), but reiterates that these methods may not be used to assume a member's characteristics, and are therefore inappropriate to inform individual member care.

TECHNICAL GUIDANCE

- Evaluation during reporting will occur to help ensure data have been accurately characterized as imputed. For example:
  - If a plan reports that all stratified data elements came from imputed data sources, the auditor assesses which method(s) are used by the plan to determine race and ethnicity.

  - If a plan reports that geographic assignment was used, the auditor confirms that data were accurately characterized as imputed.
  - If a plan reports that member survey data were used, the auditor confirms that the plan inaccurately characterized data as imputed.
- There is no validation requirement on the validity, reliability or accuracy of the imputed methods used by plans to assign race and ethnicity. NCQA guidance on evaluating imputed methods for accuracy is meant to assist plans in data quality; auditors are not expected to confirm that accurate, valid, reliable methods were used.
- Auditors are not required to ensure that plans follow guidance on using imputed data only at the population level.

Unknown Data

When the race or ethnicity value (e.g., reporting category) is unknown, the data source is also considered unknown. The “Unknown” data source category is allowed only in this situation. While NCQA acknowledges that race and ethnicity data sources are not always known, even when values are known or present, plans must identify and assign a direct or imputed source for HEDIS reporting for known values. NCQA encourages plans to have processes for recording the provenance of race and ethnicity data.

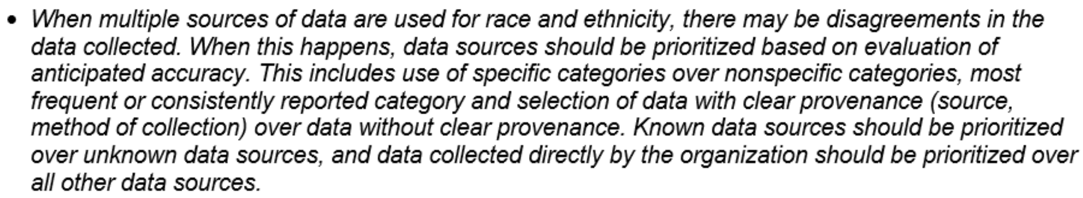
No Data

Reflects instances where the organization did not obtain race or ethnicity information and did not obtain source information.

TECHNICAL GUIDANCE

- Data categorized as “Unknown” will be evaluated to help ensure they are characterized correctly. For example:
  - If a plan reports that all stratified data elements came from unknown sources (applies to the RDM measure only), the auditor confirms that the method(s) used to determine race and ethnicity are unknown.
  - If a plan reports that geographic assignment was used, the auditor confirms that data were not inaccurately characterized as unknown.
  - If a plan reports that member survey data were used, the auditor confirms that data were not inaccurately characterized as unknown.

Resolving Disagreements in Data From Different Sources



- *When multiple sources of data are used for race and ethnicity, there may be disagreements in the data collected. When this happens, data sources should be prioritized based on evaluation of anticipated accuracy. This includes use of specific categories over nonspecific categories, most frequent or consistently reported category and selection of data with clear provenance (source, method of collection) over data without clear provenance. Known data sources should be prioritized over unknown data sources, and data collected directly by the organization should be prioritized over all other data sources.*

TECHNICAL GUIDANCE

- Auditors are not required to ensure that plans adhere to the instructions above, but may refer plans to guidance on resolving data disagreements (e.g., multiple race or ethnicity values that do not agree).
  - *Example:* A member's race is listed as "White" in the enrollment database, and is listed as "Asian" in the EHR.
- NCQA advises plans to prioritize data that come from a specific source with clear provenance (i.e., from direct data over imputed or unknown data).
  - *Example of direct data:* A member's ethnicity is "Hispanic" in a case management system, based on member survey response, but is categorized as "Not Hispanic" through an imputation method combining ZIP code and surname analysis. Data that come directly from member response are prioritized, and the member's ethnicity is categorized as "Hispanic or Latino."
  - *Example of specificity:* A member is listed as "Native Hawaiian or Other Pacific Islander" in Source A and "Filipino" in Source B. Source B is considered more specific, and should be prioritized. Filipino maps to "Asian," according to the CDC/OMB category mappings, and thus the member's race is categorized as "Asian."
  - *Example of provenance:* A member is listed as "African American" in enrollment data and "White" in the EHR. The accuracy of the EHR data is unknown (e.g., unclear whether data came from direct member response or from imputed methods [observation, imputation]). Enrollment data should be prioritized, given the clearer provenance, and the member's race categorized as "Black or African American."
- When specificity and provenance are consistent across two sources that disagree, plans should use their best judgment about data accuracy, and should prioritize the data they perceive to be most accurate. Auditors are not expected to validate the plan's judgment.

Data Completeness Expectations

Data completeness refers to the percentage of members for whom there is a documented race and ethnicity value. *Direct data completeness* refers to the percentage of members whose documented race and ethnicity value comes from direct self-report.

NCQA acknowledges the challenges inherent to collecting race and ethnicity directly (e.g., member mistrust or unwillingness to self-identify, staff discomfort or lack of training, technical limitations of systems).[19] While NCQA expects organizations to invest in overcoming these barriers over time, current analyses indicate that many organizations do not yet have a high level of complete, directly collected race and ethnicity data.

A 2016 CMS analysis of Medicaid and Children's Health Insurance Program (CHIP) beneficiary enrollment data found that despite regulations requiring all states to report race and ethnicity data on all or almost all beneficiaries, only 21 states reported having such data for more than 90% of beneficiaries;[20] data were incomplete for the majority of states. The lack of completeness of direct race and ethnicity data causes concern about relying solely on direct methods to measure disparities in care.

TECHNICAL GUIDANCE

- Auditors do not validate data completeness.
- Plans may report direct, imputed, unknown data or no data; there is no required proportion for any of these source categories.

Section 3 Resources

Direct data collection

1. The American Hospital Association Institute for Disparities and Health Equity Health Disparities Toolkit provides guidance on collecting race and ethnicity data.
2. The Minnesota Community Measurement Handbook on the Collection of Race, Ethnicity, Preferred Language, and Country of Origin Data in Medical Groups contains practical guidance on collecting race and ethnicity. Refer to the *Implementation Considerations* section for critical success factors, best practices for asking about race and ethnicity and guidance for addressing common administrative barriers.
3. The Urban Institute Report on Collection of Race and Ethnicity Data for Use by Health Plans to Advance Health Equity provides guidance on opportunities for better race and ethnicity data collection, solutions to reduce existing barriers to data collection and jump-starting action.
4. The Agency for Healthcare Research and Quality Report on Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement identifies standardized categories for variables of race, ethnicity and language that can be used to facilitate sharing, compilation and comparison of quality data stratified by standard categories.
5. The National Academies of Sciences, Engineering, and Medicine Report on Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement.

Imputed data collection

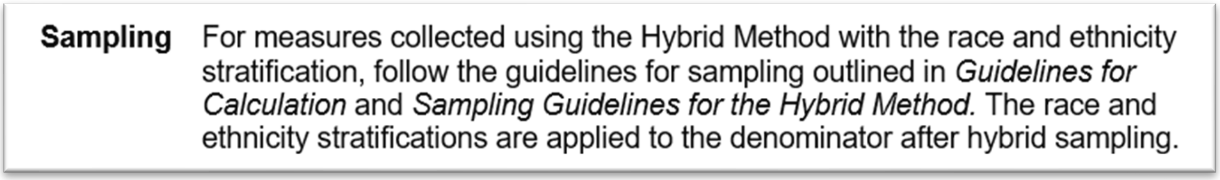
1. Fremont, A., J.S. Weissman, E. Hoch, and M.N. Elliott. 2016. *When Race/Ethnicity Data Are Lacking: Using Advanced Indirect Estimation Methods to Measure Disparities.* Santa Monica, CA: RAND Corporation. https://www.rand.org/pubs/research_reports/RR1162.html
2. Haas, A.C., M.N. Elliott, J. Dembosky, J.L. Adams, S. Wilson-Frederick, J. Mallett, S.J. Gaillot, S.C. Haffer, and A. Haviland. September 17, 2021. "Imputation of Race/Ethnicity to Enable Measurement of HEDIS Performance by Race/Ethnicity." *Health Services Research* 54, no. 1: 13–23. https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.13099
3. Liang, Z., C. Nau, F. Xie, R. Vogel, and W. Chen. December 2020. "The Application of Community-Based Information from the American Community Survey in a Large Integrated Health Care Organization." *The Permanente Journal* 25: 1–3. https://pmc.ncbi.nlm.nih.gov/articles/PMC8803254/
4. The Urban Institute's *Ethics and Empathy in Using Imputation to Disaggregate Data for Racial Equity: Recommendations and Standards Guide* provides guidance on imputation and its importance in race-conscious policy making.

Data management and provenance

1. NCQA's *Race and Ethnicity Stratification Data Learning Network Summary Report* contains best practices for tracking and mapping race and ethnicity data for quality improvement and reporting.

Section 4: Sampling and Reporting

Sampling Hybrid Measures



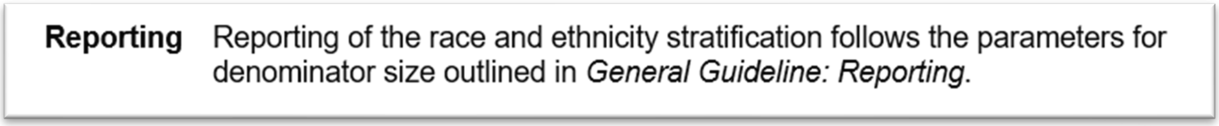
Sampling For measures collected using the Hybrid Method with the race and ethnicity stratification, follow the guidelines for sampling outlined in *Guidelines for Calculation* and *Sampling Guidelines for the Hybrid Method.* The race and ethnicity stratifications are applied to the denominator after hybrid sampling.

TECHNICAL GUIDANCE

- Auditors confirm that plans followed sampling guidelines for the Hybrid Method, as described above. Auditors should refer to HEDIS *Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures,* “Determination Standards” to validate that the appropriate systematic sampling methodology was used correctly.

Determining Minimum Denominator Size

The RES guideline instructs plans to follow HEDIS guidelines for denominator size.



Reporting Reporting of the race and ethnicity stratification follows the parameters for denominator size outlined in *General Guideline: Reporting*.

TECHNICAL GUIDANCE

- Auditors are expected to follow guidance in HEDIS Volume 5 for determining a rate designation.

Data Refresh

Plans are allowed to refresh their data when using the Hybrid Method. The systematic sample and initial population reported in the IDSS do not change when data are refreshed. As sources for race and ethnicity information are integrated during data refresh, there may be changes to member race or ethnicity categorizations because of differences between RES initial population and denominator data elements.

Section 4 Resources

HEDIS *Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures* contains instructions for validating sampling methodology and determining a designation for reported measure rates.

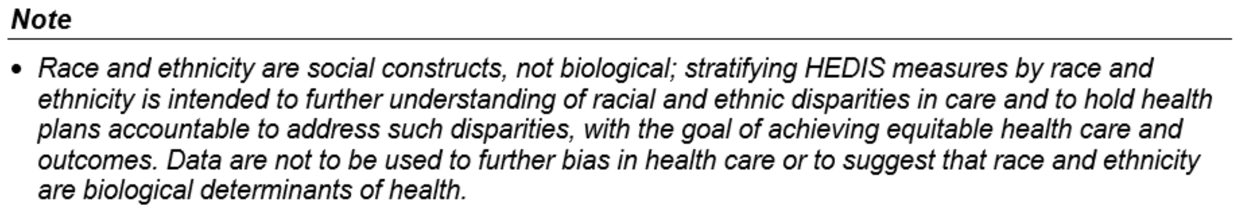
Purchase it at the NCQA Store.

Section 5: Expectations for Use of Data

NCQA acknowledges that race is a social construct, and a proxy for social, environmental and political forces that influence health, including structural and institutional discrimination and racism. Race does not cause health inequities; rather, the conditions and systems in which patients are born, grow, work, live and age directly affect gaps in care and outcomes. These systemic forces may manifest as inequities in care and health outcomes.

NCQA is committed to promoting appropriate use and interpretation of race and ethnicity data. These data may be used to inform efforts to identify and eliminate health disparities, but not to suggest that race is a biological determinant of health.

NCQA expects health plans to use race and ethnicity stratifications of HEDIS data to confront and correct disparities in care, not to further bias in health care, and includes the following note in the RES specification:



Note

- *Race and ethnicity are social constructs, not biological; stratifying HEDIS measures by race and ethnicity is intended to further understanding of racial and ethnic disparities in care and to hold health plans accountable to address such disparities, with the goal of achieving equitable health care and outcomes. Data are not to be used to further bias in health care or to suggest that race and ethnicity are biological determinants of health.*

TECHNICAL GUIDANCE

- Auditors do not validate that health plans follow the guidance in the note.

Section 5 Resources

In A New Effort To Address Racial And Ethnic Disparities In Care Through Quality Measurement, a *Health Affairs* blog post, NCQA describes the intent of RES in quality measurement, and the impetus for greater race and ethnicity data collection in health care.

Section 6: Evolution of Race and Ethnicity Stratification

NCQA intends to evolve and expand RES to maximize the ability of HEDIS to identify disparities in care.

Organizations should be prepared to support a broader set of stratified measures in the coming years. The MY 2026 stratified measure set includes 22 measures, and is anticipated to expand.

Regarding the RDM measure, NCQA may eventually implement a data completeness threshold and require plans to have a certain percentage of race and ethnicity data gathered from direct sources. If NCQA does pursue this requirement, organizations will be notified well in advance and will be provided with an opportunity for public comment.

For now, organizations can prepare for the evolution of RES by promoting improved collection of race and ethnicity data directly from members; improved data sharing to facilitate duplication of collection efforts; and disparity reduction efforts in high-priority, disparity-sensitive clinical areas.

Section 6 Resources

1. The American Hospital Association Institute for Disparities and Health Equity *Health Disparities Toolkit* contains guidance on collecting race and ethnicity data.
2. NCQA's *Race and Ethnicity Stratification Data Learning Network Summary Report* contains best practices for tracking and mapping race and ethnicity data for quality improvement and reporting.
3. In A New Effort To Address Racial And Ethnic Disparities In Care Through Quality Measurement, a *Health Affairs* blog post, NCQA describes the intent of RES in quality measurement, and the impetus for greater race and ethnicity data collection in health care.

References

[1] Baciu, A., Y. Negussie, A. Geller, J.N. Weinstein. 2017. *The State of Health Disparities in the United States*. National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK425844/

[2] Penman-Aguilar, A., M. Talih, D. Huang, R. Moonesinghe, K. Bouye, & G. Beckles. 2016. Measurement of Health Disparities, Health Inequities, and Social Determinants of Health to Support the Advancement of Health Equity. *Journal of Public Health Management and Practice*, *22*, S33–S42. https://doi.org/10.1097/PHH.0000000000000373

[3] Centers for Disease Control and Prevention. 2020. *Healthy People 2030*. https://health.gov/healthypeople

[4] Commission on the Social Determinants of Health. (2008). *Closing the Gap in a Generation: Health Equity through Action on Social Determinants of Health. Final Report of the Commission on Social Determinants of Health*. World Health Organization. https://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf

[5] Pendo, E., L.I. Iezzoni. 2020. *The Role of Law and Policy in Achieving Healthy People's Disability and Health Goals around Access to Health Care, Activities Promoting Health and Wellness, Independent Living and Participation, and Collecting Data in the United States*. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. https://www.healthypeople.gov/sites/default/files/LHP_Disability-Health-Policy_2020.03.12_508_0.pdf

[6] Artiga, S., K. Orgera. 2019. *Key Facts on Health and Health Care by Race and Ethnicity*. https://www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-health-status/

[7] American Cancer Society. 2020. *Colorectal Cancer Facts and Figures 2020-2022*. https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/colorectal-cancer-facts-and-figures/colorectal-cancer-facts-and-figures-2020-2022.pdf

[8] Cogburn, C.D. 2019. Culture, Race, and Health: Implications for Racial Inequities and Population Health. *The Milbank Quarterly 97*(3), 736–61. https://doi.org/10.1111/1468-0009.12411

[9] Office of Management and Budget. (1997). *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*. https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf

[10] OMB Statistical Policy Directive No. 15 on Race and Ethnicity Data Standards: Categories and Definitions: https://spd15revision.gov/content/spd15revision/en/2024-spd15/categories-definitions.html

[11] Office of the National Coordinator for Health IT. (2021). *Representing Patient Race and Ethnicity*. https://www.healthit.gov/isa/representing-patient-race-and-ethnicity

[12] Centers for Disease Control and Prevention. (2024). *Race and Ethnicity Code Set Version 1.3*. https://www.cdc.gov/phin/media/pdfs/2024/11/CDCREC-1.3-Background-Paper-20241021.pdf

[13] Office of Inspector General. 2022. *Inaccuracies in Medicare's Race and Ethnicity Data Hinder the Ability To Assess Health Disparities.* https://oig.hhs.gov/oei/reports/OEI-02-21-00100.pdf

[14] Centers for Medicare & Medicaid Services Office of Minority Health. 2020. *Racial, Ethnic and Gender Disparities in Health Care in Medicare Advantage.* https://www.cms.gov/files/document/2020-national-level-results-race-ethnicity-and-gender-pdf.pdf

[15] Elliott, M.N., A. Fremont, P.A. Morrison, P. Pantoja, & N. Lurie. 2008. A New Method for Estimating Race/Ethnicity and Associated Disparities Where Administrative Records Lack Self-Reported Race/Ethnicity. *Health Services Research*, *43*(5 Pt 1), 1722–1736. https://doi.org/10.1111/j.1475-6773.2008.00854.x

[16] Institute of Medicine. 2009. *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. http://www.ahrq.gov/research/findings/final-reports/iomracereport/index.html

[17] National Quality Forum (NQF). 2008. *National Voluntary Consensus Standards for Ambulator Care- Measuring Healthcare Disparities*. https://www.qualityforum.org/Publications/2008/03/National_Voluntary_Consensus_Standards_for_Ambulatory_Care%E2%80%94Measuring_Healthcare_Disparities.aspx

[18] Gottlieb, L. M., Francis, D. E., & Beck, A. F. (2018). Uses and Misuses of Patient- and Neighborhood-level Social Determinants of Health Data. *The Permanente Journal 22*. https://doi.org/10.7812/TPP/18-078

[19] Institute of Medicine. n.d. *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. http://www.ahrq.gov/research/findings/final-reports/iomracereport/index

[20] State Health Access Data Assistance Center. 2020. *Race/Ethnicity Data in CMS Medicaid (T-MSIS) Analytic Files*. SHADAC. https://www.shadac.org/news/raceethnicity-data-cms-medicaid-t-msis-analytic-files