



Bracing for the impact of CMS' Health Equity Index

In the US, a person's home zip code is an effective predictor of life expectancy.¹ A difference of just a few miles between one code and another often translates into years added or shaved off a life. That reality is just one indicator of healthcare inequity throughout the country. Many organizations have compiled alarming statistics: The maternal mortality rate for Black women

is four times greater than that for non-Hispanic White women.² Hispanic women are 20 times more likely to die from cervical cancer than non-Hispanic white women.³ And the list of disparate health outcomes goes on, across a range of chronic conditions, from asthma to stroke.⁴

The Centers for Medicare & Medicaid Services (CMS) is zeroing in on health equity to reduce such healthcare disparities. Its focus on health equity issues will be reflected in how it designs regulations, measures quality and rewards payers. The agency has already announced how new equity measures will affect its Five-star Quality Rating System (Star ratings) and health plan bonuses.⁵ Payers offering government health plans must act now to align with CMS' health equity priorities. Health equity accreditation and

standards are emerging from other organizations too, including The Joint Commission and other arms of the Department of Health and Human Services.

In the following, we recap CMS' health equity priorities and other influential equity pathways and discuss the data infrastructure in which payers must invest to ensure their members and their plans thrive under the agency's new Health Equity Index.

CMS' Health Equity Index makes a big impact

CMS' defines health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes." The agency has published its framework for achieving equity through these five priorities:⁷

- **Priority 1:** Expand the collection, reporting and analysis of standardized data
- **Priority 2:** Assess causes of disparities within CMS' programs and address inequities in policies and operations to close gaps
- **Priority 3:** Build capacity of healthcare organizations and the workforce to reduce health and healthcare disparities
- **Priority 4:** Advance language access, health literacy and the provision of culturally tailored services
- **Priority 5:** Increase all forms of accessibility to healthcare services and coverage

The agency will include these priorities in all its programs "using policy levers and program authorities." Beginning in 2027, the Health Equity Index will factor into Star ratings.

To successfully address all the components and adjacent dependencies that affect health equity issues, payers need to build or modernize a wide range of capabilities that will improve access to care and reduce disparities through plan benefit design. Some of them include:

- Measuring equity in encounter and Information Set (HEDIS[®]) data
- Comprehensively capturing equity data to fuel revenue cycles
- Employing Medicare risk adjustment strategies
- Transitioning to value-based payments

To achieve these capabilities, payers will need to create new product strategies and invest in technology with clear health equity road maps. We look at these in more detail below.





CMS' Health Equity initiatives impacting payer & provider value stream

Designing benefits to tackle equity issues

CMS' is encouraging payers to address social risk factors that drive high healthcare costs and poor outcomes. Plan design and benefits that have direct impacts on health equity include co-pays, out of pocket expenses, contracts, provider networks, drug formularies, population health management, care management, transportation, food access, housing and more.⁸

Designing benefits directly relevant to the at-risk members in populations they serve will require payers to achieve new dimensions of data gathering and analysis. Then payers will need to use that data to fully understand their members' social risk factors and needs.

This will be challenging because often the data that signals adverse social determinants is highly sensitive for members, such as sexual orientation and gender identity (SOGI) and race and ethnicity. We studied aggregate data across multiple lines of business and found high rates of "unknown race" responses, suggesting to us that many members choose not to reveal their racial identity. Collecting such data requires education about how to approach members with SOGI and other sensitive questions.⁹

Many pathways to collect meaningful data to reduce healthcare disparities

Other industry organizations are creating their own paths toward achieving the better data collection necessary to identifying and mitigating healthcare disparities. Here's a quick round up of other emerging national standards and accreditations:¹⁰

- **The National Committee for Quality Assurance (NCQA)** offers two health equity accreditations. Its Health Equity Accreditation “focuses on the foundation of health equity work: building an internal culture that supports the organization’s external health equity work; collecting data that help the organization create and offer language services and provider networks mindful of individuals’ cultural and linguistic needs; identifying opportunities to reduce health inequities and improve care.”

The second is Health Equity Accreditation Plus, which “focuses on collecting data on community social risk factors and patients’ social needs, to help the organization offer social resources that can have the most impact; establishing mutually beneficial partnerships that support community-based organizations; building meaningful opportunities for patient and consumer engagement; identifying opportunities to improve social need referral processes and the partnerships that make them possible.”

The NCQA is also stratifying more HEDIS measures by race and ethnicity with the goal of uncovering data about healthcare access disparities and/or best practices.¹¹ The organization has released new HEDIS measures for social needs screening and intervention for unmet member food, housing and transportation needs for measurement year 2023.¹² In addition, NCQA is working on measures to capture more gender-inclusive data about healthcare disparities.

- **The Joint Commission** recently announced its new Health Care Equity Certification Program, which will “distinguish those organizations making health care equity a strategic priority and are collaborating with patients, families, caregivers and external organizations to identify and address needs that help translate equitable health care into better health outcomes.”¹³ In addition, the Joint Commission has made improving health equity a National Patient Safety Goal.¹⁴

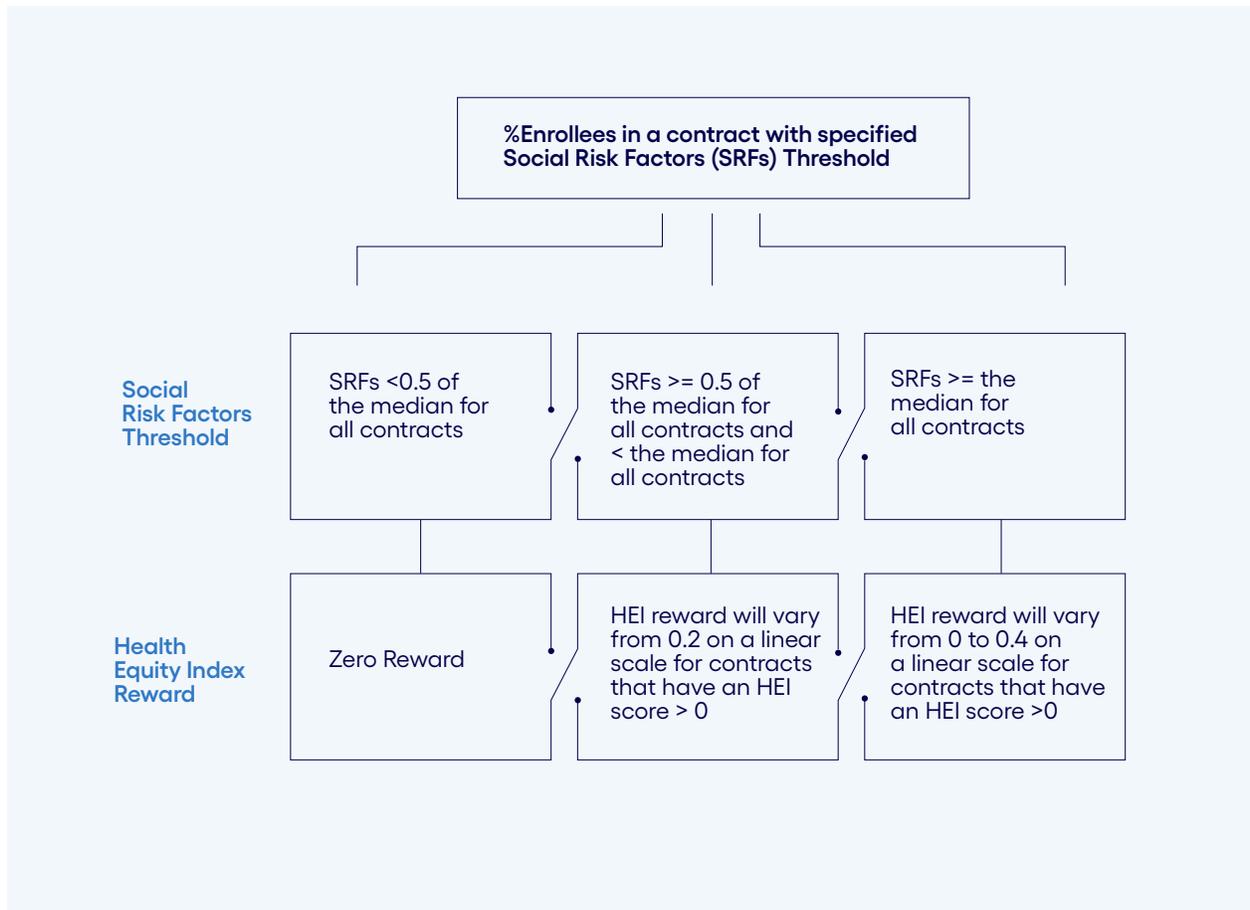
- **The Office of Minority Health at the Department of Health and Human Services** promotes national standards for culturally and linguistically appropriate services (CLAS).¹⁵ The principal standard is “provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.” There are 15 additional action steps toward advancing health equity via CLAS.
- **The utilization review accreditation commission (URAC)** recently introduced its Health Equity Accreditation. The organization says the accreditation’s focus areas are designed to promote integration of health equity principles; support industry initiatives to eliminate health disparities and ensure that high-risk racial and ethnic populations, as well as those with disabilities, receive optimal health care.¹⁶
- **HL7 Gravity Project** participants plan to use modern coding and exchange standards so healthcare organizations may document and share SDoH data to address whole person care. Initially the project is focused on Social Determinants of Health (SDoH) SDoH data in EHRs found in screening, diagnosis, planning and interventions. In its initial phase, the project is focusing on three social risk areas: food insecurity, access to transportation and housing instability and quality. It will develop recommendations for how best to document these issues in EHRs and how to capture and group those data elements for interoperable data exchange and aggregation via FHIR.¹⁷
- **The Da Vinci HL7 fire project** is a US accelerator project that brings together payers, providers and healthcare technology vendors and HL7 International. All these stakeholders have a common goal to improve healthcare, become interoperable and reduce waste in the system by moving to an outcomes-based model of care rather than a purely transactional fee-for service model. Commonly referred to as value-based care, this model reflects the importance of the overall value that is delivered by providing improved healthcare outcomes at the lowest cost.

Such a move significantly increases the need for high quality and timely exchange of data between participants that do not typically share data easily. Selecting FHIR as the standard demonstrates the belief in those communities that FHIR has the maturity, acceptance and staying power that is needed to support this exchange.

Payers must be prepared to adopt these accreditation standards and best practices for gathering meaningful data. For example, NCQA' experts say that if plans want to assign race or ethnicity to a member based on geographic data, they should do so using the smallest possible geographic unit, such as census block level vs. zip code.¹⁸ Even then, payers must also evaluate the data source for validity and reliability.

Managing equity measure effects on revenue realization

In April 2023, CMS' announced a health equity index (HEI) reward that will begin with the 2027 Star Ratings "to further encourage MA and Part D plans to improve care for enrollees with certain social risk factors."¹⁹



Plan contracts that cover a high number of members with social risk factors and deliver strong quality performances—likely with benefits tailored to these members’ needs—will be in the best position to do well under the HEI reward structure. Payers must learn more about the interplay between member enrollment, benefit design, HEDIS quality measurement and CMS’ Star ratings.

The CMS’ Health Equity initiatives also will affect Medicare Advantage risk adjustment strategies and value-based care. Providers coding claims will need to map information gathered from patients and social agencies to use correct Z codes to help identify members’ adverse social determinants and ensure

they receive appropriate services.²⁰ Z code categories include problems relating to education and literacy, occupational hazards, housing and transportation issues, and many more.²¹ The codes support the HEDIS quality measurement, risk adjustment and benefit design strategies. Payers likely will need to collaborate with providers to capture more comprehensive SDOH data.

In value-based arrangements, shared payer-provider risk will become the norm so upside-only contracts will fade away. Health plans will need to acquire clinical data and identify gaps in care, including unaddressed social factors, to ensure better outcomes.

The critical move: Investing in data management, governance and analytics

Data and interoperability are clearly central to all health equity efforts—and are major challenges payers and their provider networks need to address.

The data that reveals members’ potential social risk factors, from SOGI to income levels, is highly sensitive and difficult to collect. Patients and members are wary of revealing such personal information when the benefits of doing so are not clear to them. Payers and providers need to learn appropriate ways of asking for such information. That’s just the start: once the data is collected, it must be standardized/normalized so it can be shared—and yet also be secure and compliant with privacy and security regulations. In the aggregate, data must be analyzed to reveal patterns and identify equity issues affecting specific populations.

Doing this effectively requires payers to build comprehensive data management strategies and capabilities. Migrating core systems to the cloud and interoperability compliance solutions are just starting points. Managing and making sense of huge new data volumes coming from disparate sources demands strong data orchestration capabilities. Orchestration is the ability to accept data in different formats, normalize it and make it available to other systems and applications. Payers will need to accept data from disparate sources, including administrative, clinical and social agency systems.

Increasingly data will be collected and shared digitally. For example, the new HEDIS social needs screening measures may only be reported via electronic clinical data systems (ECDS). While such screenings may be done by entities other than a health plan, the plan will need the ability to tap those data sources. That will be key not only to analysis and reporting but also to giving care managers and providers real-time actionable insights about addressing gaps in patients’ social determinants as well as clinical care.

Data governance—standards and policies about how data gets used and by whom—is intertwined with orchestration. Clear governance over SDOH data will be essential to meeting compliance requirements as well as clinical and business objectives. Governance can be built into modern orchestration platforms when payers develop their policies and procedures and/or determine which health equity accreditations to pursue.

To support data governance, orchestration and analytics, plans should choose platforms that support healthcare data exchange standards. Open, modern technology platforms will enable payers to select from best-in-class AI tools, including machine learning and clinical natural language processing. Plans can also adopt the HIMSS Digital Health Analytics framework.²² The more data collected and analyzed, the sooner plans can become learning health systems implementing evidence-based practices related to social factors.²³

A holistic approach to health equity

These five areas—benefit design, quality measurement, revenue cycle management, value-based care and data management technology—are intertwined. Designing the right benefits that reduce disparate health access and outcomes will depend on the data payers collect that enable them to know their members. Quality improvement will depend on whether payers offer the right benefits and best practices that address local issues. Outcomes and quality will influence Star ratings, plan enrollment and reimbursement. And underlying data strategies and supporting technology will determine how well payers are able to gather data, create meaning from it and act on it to better serve their members.

Clearly, addressing health equity must be treated as a single flowing process. Payers and payviders need to vet core administrative and quality platforms accordingly.

Addressing health equity issues is likely to reveal less obvious industry bias and practices that affect a wide range of health consumers. Payers that initially embrace efforts to eliminate health inequity for compliance reasons will soon find they are well positioned to attract members across all lines of business because of their ability to deliver whole person quality care regardless of age, SOGI, race and ethnicity.

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Chenny's notable track record includes providing consulting services to over 30 health plans—supporting 30 million member lives across the nation—consistently raising Quality and Star ratings in Medicaid, Medicare, Federal Employees Health Benefits Programs (FEHB) and Commercial health plan sectors. His outstanding leadership and innovative contributions have earned him prestigious awards, including the 2023 Top 20 Global Product Manager Award by Products That Count, as well as the 2021 and 2019 Product of the Year awards by Cognizant TriZetto.

Endnotes

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