

Advancing health equity:

The power of member-reported data



Executive summary

As healthcare shifts toward a more quality- and outcomes-focused framework, health equity has taken center stage. Federal agencies have invested at least \$173 billion¹ to advance health equity over the past two decades alone, cementing it as a policy priority. In fact, the Centers for Medicare & Medicaid Services (CMS)—the nation's largest health insurance provider, overseeing state marketplaces and federal programs that support more than 170 million Americans—**has made health equity the first pillar of its strategic plan.**²

The push for more equitable care has big implications for payers. In April, the CMS finalized³ its Health Equity Index (HEI) reward—an incentive for Medicare Advantage (MA) and Medicare Part D plans to improve care for enrollees with social risk factors. The HEI replaces the existing reward factor for earning Quality Bonus Payments, beginning with the 2027 Medicare Star Ratings.⁴ That means health plans need to either demonstrate their ability to close health-equity gaps or potentially risk losing millions of dollars⁵ in bonus payments.

So, how can health plans best address health equity to improve access to care and support their member populations' unique needs? **It all starts with leveraging member-reported data.**

"Data is so critical to your success in improving health and health-equity outcomes ... It's really one of the most important tools that you have in your toolkit to address disparities," says Cindy Ward, a Managing Director at FTI Consulting with more than 20 years of experience providing strategic consulting and thought leadership on public health programs. "Developing a great data management strategy is going to be a critical component to making your health plan best in class."

Still, member-reported data has its limitations. Health plans collect it from countless sources, but many data sets are imputed,⁶ that is, not directly reported by members. Indeed, enrollees' race and ethnicity data are often missing or inaccurate, forcing health plans to rely on probabilistic sampling to make assumptions about their member populations. When that happens, key demographic groups may be disproportionately underrepresented, making it harder for health plans to effectively identify and address racial, ethnic and social inequities.

Here's the good news: Despite these challenges, there are proven, effective ways for health plans to obtain direct-source, member-reported data—and use it to inform their outreach and program-enrollment strategies. In doing so, they can more effectively address health equity, maintain or improve their Star Ratings and safeguard the federal bonus payments that fuel their ability to provide individualized member support.

Read on to learn how health plans can **obtain high-quality data directly from their members** and use it to drive more equitable care.



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1 View providers as partners

Providers are focusing more than ever on health equity,⁷ and aligning with their efforts is vital for efficiently obtaining member-reported data. Members trust their providers, and that trust can serve as a gateway to helping them achieve more equitable outcomes. But if health plans only have a transactional relationship with providers, rather than a partner-oriented collaboration, it may impede their ability to collect accurate, high-quality data at scale.

“Health plans can’t do anything in a silo,” Ward says. “The only way we’re going to truly address health disparities is by fostering a partnership between providers, health plans, healthcare organizations and community organizations.”

No doubt, health plans’ equity-improvement strategies will benefit from partnering with providers. Providers have the most face time with members, and they should feel empowered to explain to them why self-reporting their race, ethnicity and language (REL), sexual orientation and gender identity (SOGI) and social determinants of health (SDOH) is so important. That’s why it’s crucial for health plans to **acknowledge the implicit trust** that providers share with their patients—and **be mindful of the various touchpoints** that members have with their care team.

“Trust is really important when it comes to anything that you do with beneficiaries,” Ward says. “So, it’s important to collect this information from a place that is trusted for them, their provider, their community health worker, their *promotora de salud*—those are the opportunities that you have to get more accurate information, and to get members who are more readily providing that information.”

“If I’m a health plan today, I should be looking at where those touchpoints are for my beneficiaries—and know who my trusted partners are going to be moving forward,” Ward says.



2 Collect member-reported data at the point of care

The Affordable Care Act made data collection a key policy priority⁸ for reducing health disparities, requiring federally funded health programs to collect data on race, ethnicity, sex, primary language and disability status. Yet the vast majority of Medicare and Medicaid plans have incomplete data⁹ on their members' REL—and commercial plans have even less.

Still, advances in health information technology (IT) have significantly improved¹⁰ the ability to measure disparities at the provider level. And as MA plans increasingly move toward an omnichannel member experience,¹¹ technology is emerging as a powerful data-collection tool.

By partnering with providers and vendors to **digitally survey members at the point of care**, health plans can leverage IT to capture REL data¹² that can be included in a member's personal health record and utilized in their provider's EHR or other data system. With point-of-care surveys, health plans can prompt members to self-report key demographic information when their healthcare is top of mind, rather than make inferences from imputed data sets—and use that information to **better target their health-equity investments** and evaluate outcomes.

"You can now ask those questions to specific targeted membership that you don't have that data on today," says Krunal Patel, a Director at FTI Consulting with nearly a decade of project-management experience related to HEDIS, CAHPS, HOS and the Star Ratings system. "[That data] can be then incorporated into various programs, including member profiles, clinical platforms, stratification algorithms and reporting platforms."



3 Consolidate data sets

Inconsistent data-collection methods¹³ are one of the most pervasive challenges health plans face in gathering member data. They often lead to fragmented reporting, duplicative efforts, inefficient resource utilization and undue burdens on the members whose data is collected. That's a major reason why health plans rely on supplemental data sources—census data, provider-reported ICD-10 Z codes, health information exchanges and EHRs—to capture important member information.

“These additional sources can help in identifying and addressing health disparities within the membership of a population,” Patel says. “But without consistent and comprehensive categories, it becomes challenging to analyze and compare data across different populations.”

Indeed, the CMS has said that data standardization is critical¹⁴ to improving health outcomes, emphasizing its goal to ensure that “provider and patient self-reported data collection is standardized and accessible across settings, regions, and communities.” Lack of standardization hampers efforts to advance health equity¹⁵ because of the variability among data sets and modeling—but it doesn't have to remain that way.



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Provider organizations are working to standardize REL and other data to make it more inclusive of the populations they serve—and leveraging Fast Healthcare Interoperability Resources (FHIR®) and United States Core Data for Interoperability (USCDI) specifications to meet reporting requirements for various state and health-equity initiatives. Those efforts align with CMS recommendations to leverage inclusive data sets that are representative of populations, rather than data sets imputed from non-member-reported information.

By **consolidating multiple data sources** into one place using the latest standardization guidance, health plans can improve data integrity and gain greater visibility into information gaps, which can better inform their health-equity efforts at the population level. In fact, many of the nation's largest health insurers are already advocating universal data-collection standards for REL, SOGI and SDOH data¹⁶—as well as for imputed data—to **more efficiently address disparities** and **advance health equity**.

“Health plans need reliable member-reported and supplemental data to be best in class at achieving health equity,” Ward says. “With good data, you’ll be able to identify disparities and outcomes and target interventions for equitable care. You’ll be able to track and trend performance and evaluate the effectiveness of your interventions. You’ll also be able to direct resources to the interventions and services that best reduce those disparities—and enhance the overall quality of care for your beneficiaries.”

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4 Double down on member engagement

It's well established that member-reported data is often incomplete. Members don't always feel comfortable sharing their SDOH information¹⁷, particularly when they don't know how it will be used. And if members aren't comfortable answering sensitive social-risk questions, they may disengage with their health plan entirely, which can hinder efforts to advance health equity—and make it harder for members to learn about the resources available to them.

“As health plans and providers, we don't want members having a different outcome with the same service,” Ward says. “But there's a fear factor that sometimes permeates these questions around race and ethnicity that we have to recognize.”

Fortunately, some of the largest payers recognize that **being transparent with members engenders trust**, which can help them feel more comfortable¹⁸ sharing REL, SOGI and other data. The benefits of doing so are twofold: Health plans can collect the direct-source data they need, and members can better engage with resources designed to help them achieve equitable health outcomes. Indeed, effectively engaging and educating members directly correlates with higher care-plan compliance and health literacy¹⁹—and in turn, improved health equity.

Engaging with community organizations is a good place to start, Krunal says. Partnering with community-based organizations helps health plans identify members' specific social risk factors—and better informs the types of engagement that might help members address them.

In addition, health plans can shore up their member-engagement strategies by:



Making resources readily available by disseminating plan information through a variety of channels, including emails, phone calls, text messages and mailers



Providing plain-language information that avoids jargon or technical terms and helps members easily understand the resources available to them



Training support staff to provide personalized guidance, particularly when explaining complex topics like plan benefits and services



About Phreesia

Phreesia is a trusted leader in patient activation, giving providers, health plans, life sciences companies and other organizations the tools to help patients take a more active role in their care. Founded in 2005, Phreesia enabled more than 120 million patient visits in 2022 – more than 1 in 10 visits across the U.S. – scale that we believe allows us to make meaningful impact. Offering patient-driven digital solutions for intake, outreach, education and more, Phreesia enhances the patient experience, drives efficiency and improves healthcare outcomes.

To learn how Phreesia can help you collect member data and engage your members at scale, **visit phreesia.com**.

End notes

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