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WHITE PAPER

Health Disparities Landscape ASSESSMENT

AMCP Health Disparities Advisory Group | Academy of Managed Care Pharmacy | December 2023

Introduction

Health disparities are defined by the Centers for Disease Control and Prevention (CDC) as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations."[i] Health equity is defined as the state in which all have a fair and just opportunity to attain their highest level of health. In the U.S. health care system, health disparities are long-standing and documented. Over the last few years, there has been an increased focus on the main contributors to disparities, including socioeconomic status, gender identification, sexual orientation, and geography. Health disparities can result in avoidable readmissions, reduced quality of care, higher health care costs, and lower patient satisfaction rates. Managed care pharmacy, the practice of developing and applying evidence-based medication-use strategies that enhance member and population health outcomes while optimizing health care resources, is vital in closing these gaps.[ii]

As part of AMCP's strategic priority on addressing health disparities and commitment to transition from awareness to action, AMCP is committed to leveraging managed care pharmacy to address disparities in benefit design, medication use, and outcomes in underserved populations. This health disparities advisory group at AMCP was built upon the recommendations from AMCP's 2021 Partnership Forum. The advisory group has guided AMCP efforts to create awareness of the role of managed care professionals in this area, identify partners, and develop tools and resources to aid managed care pharmacy transition from awareness to action. A landscape assessment was conducted in 2022 to understand the role of managed care pharmacy in identifying and addressing health care disparities. A landscape assessment analyzes a community's strengths, resources, and needs. It provides a framework for designing a service and ensuring it is embedded directly in the community's needs. More than 400 publicly available articles were identified on initiatives that managed care organizations (MCOs) designed to address health disparities in these specific areas: data, formulary management, benefit design, strategic partnerships, and patient access. Each category represents opportunities to dismantle inherent health disparities, including social determinants of health, ethnicity, race, language, disabilities, gender identification, sexual orientation, and geography.

Case studies were identified and summarized to highlight the top findings for each specific area. Data were defined as information on health outcomes among traditionally underserved populations necessary to determine where MCO initiatives should be focused. The definitions for these case studies are in Table 1 on the right. There were limited publicly available articles on the changes to incorporate health disparities into the formulary development and management process.

Table 1: Case Study Definitions

FORMULARY MANAGEMENT	A patient care process that allows health care professionals to work together to promote cost-effective medication therapy and positive therapeutic outcomes.
BENEFIT DESIGN	It is defined as calling upon data to fill in pre-existing gaps and approaching managed care programs by leveraging quality data to ensure the proper care is being provided.
STRATEGIC PARTNERSHIPS CATEGORY	MCOs work with community partners to develop initiatives that close the gap in care.
PATIENT ACCESS	The ability to take advantage of their health care using the available resources.

Methodology

A landscape assessment was conducted from March to May 2022 to identify health disparities and managed care pharmacy initiatives in the United States. This literature review focused on identifying publicly available resources of managed care pharmacy organizations' work within the health disparities space. Specifically, the search was focused on efforts conducted in the managed care pharmacy space (e.g., health plans, pharmacy benefit managers (PBMs), integrated delivery networks (IDNs), and other organizations) to improve health equity. During the search, there was an additional concentration on data collection, benefit design, patient access, and strategic partnerships.

The search criteria for the literature review were broad enough to capture current activities that pharmacy benefit managers, health plans, and other interested stakeholders were engaged in to address health equity and disparity concerns. The AMCP Health Advisory Disease Group provided feedback on the search criteria. *The search terms used in the landscape assessment are in the appendix under Table 2.*

Criteria were developed that identified health equity, disparities, and Social Determinants of Health (SDOH) as search terms for the literature review. We limited our search to health disparity initiatives from 2018 through 2022 that were underway or completed. The AMCP Health Disparities Advisory Group reviewed and approved the search criteria before beginning the literature review. Our search included gray and white literature, limited to U.S.-based, English-only manuscripts or documents and publicly sourced papers published in the past five years. Gray literature is information produced outside traditional publishing and distribution channels and can include reports, policy literature, working papers, newsletters, government documents, speeches, white papers, and urban plans. A white paper is a deeply researched report on a specific topic presenting a solution to an industry's problem. *The complete list of inclusions and exclusion criteria for this paper can be found in the appendix under Table 3.*

In total, 440 articles were identified with the search. These articles were organized into data collection, benefit design, patient access, and strategic partnerships. Formulary management was not a part of the categories. Further case studies on formulary management will be needed to assess formulary management accurately. The articles were further classified into two tiers. The first tier included programs that were directly related to health equity and managed care pharmacy; the second tier had descriptions of initiatives that focused on one or more elements of health disparities but were less closely related to the intent of this project. Managed care programs that directed attention toward health equity were prioritized first because health equity correlated with addressing health disparities, which is the strategic goal of AMCP and the health disparities advisory group. Once the Landscape Assessment was completed, articles from each category would be developed into case studies.

Target Audience

The information in this white paper can be used as a guiding tool for managed care pharmacy professionals and patients. The usage of this white paper can help inform patients in need or professionals looking to serve underserved populations. The targeted audience can use this information to help spark change or innovation in the communities they reside or operate in.

Collecting Data

Data is a crucial element in closing the gaps in health disparities. Data on health outcomes among traditionally underserved populations based on race, ethnicity, language, disabilities, geography, and social factors are necessary to identify where MCO initiatives should be focused. Health plans are investing in tools to improve data collection, analytics, and outcome-reporting tools to improve patient access and care for not just some but all health plan members. Below are examples of plans using improved data metrics to close the gap in care.

A. National Committee on Quality Assurance (NCQA) Health Equity Accreditation Program

In 2022, NCQA launched the Health Equity Accreditation Program, which focused on an organization's foundational health equity work. This program outlines a framework to assist health plans, health systems, and other health care organizations in the following:[iii]

- Standardizing processes, improving quality, and monitoring improvement to assess where disparities may exist.
- Working to eliminate gaps after identification.
- Guiding to deliver culturally and linguistically appropriate services.
- Becoming recognized for equity work.

In addition, NCQA developed the Health Equity Accreditation Plus Program. The program focuses on data collection on community social risk factors and patients' social needs. This will help offer resources to the organizations (e.g., health plans and PMBs) so they can have the most impact and to further review, enhance, and streamline their health equity work.iv Within the Health Equity Accreditation Plus Program pilot, nine organizations participated in meeting the Health Equity Accreditation requirements by:

- Sharing data with cross-sector partners to support interoperability while maintaining member privacy.
- Developing cross-sector partnerships to assist targeted patient populations.
- Referring members to cross-sector partners when appropriate and tracking outcomes.

By guiding, collecting, and stratifying the data based on community social risk factors and patients' social needs, NCQA strengthens the ability of MCOs to understand trends in patient needs based on their member, social, and cultural needs.

B. UnitedHealthcare Data Analytics Capability

In 2021, UnitedHealthcare launched a multi-faceted program to prioritize Social Determinants of Health (SDOH).[v] This multi-faceted approach focuses on the following to identify SDOH needs for their members:

- **Data analytics:** In collaboration with the American Medical Association (AMA), 23 new ICD-10 codes were developed to diagnose SDOHs accurately. When patients' SDOH need is flagged with an ICD-10 code, predictive analytics can identify members who will most likely need support at an individual or community level. These data generate a health-risk score to determine the recommendations for escalated services mounting and put them into a per, value-ranked dashboard.
- **Active listening:** UnitedHealthcare has begun to train their call center advocates to engage in "active listening" by looking out for "trigger words," such as callers implying they are hungry or are struggling to make ends meet. This information is then used to determine if members need additional assistance.

B. UnitedHealthcare Data Analytics Capability *continued*

- **Social needs questionnaire:** In tandem with internal active listening training, UnitedHealthcare advocates are provided with a list of culturally appropriate questions to ask members to identify their SDOH status. The culturally relevant question encompasses a patient's entire SDOH, including age, gender, geography, neighborhood, income, job opportunities, and education. This information is then fed into a predictive analytics model to develop action steps for the advocate to share with the members.

Additionally, UnitedHealthcare created a database to connect members with social services at the local level. For example, suppose members have been identified with a social need for food insecurity or financial stress. In that case, the database can refer those health plan members to low-cost or no-cost community-based resources.

By gathering and analyzing plan members' social needs data, UnitedHealthcare uses predictive analytics and local resources to provide actionable recommendations for its members.

C. Blue Shield of California the80 Mapping Tool

Blue Shield of California is using a mapping tool, the80, to identify and address the social needs of their members.[vi] The device can generate a report specific to a member's community based on zip codes and local data about the prevalence of chronic illnesses to assist health plans in gathering robust health inequity data through Community Health Advocates (CHA). CHAs are social workers who are designated to a specific zip code to represent the population they serve. This creates a more personalized approach for underserved communities by having CHAs representing the zip code they serve. Designated to a specific zip code to represent their population, the80 generates a report with targeted questions for the plan members based on zip codes. Then, CHAs identify the most relevant need and work with plan members to ensure they receive assistance. Through this program, the health plan does the following:

- Gaining insights into the community factors that may affect members' health at the zip code level data on specific social determinants.
- Engaging health care providers by providing additional information outside medical records to understand health disparities and inequities of the member.
- Building trust with the members by using CHAs to gain better insight into members' social challenges and capture additional data.

Ultimately, the80 provides the context necessary to understand the greatest needs in a community, allowing plans to advocate and leverage critical data to address the inequities that their members face regionally.

D. Humana's Initiatives to Address Social Determinants of Health (SDOH)

Humana uses innovative methods to collect and use predictive modeling on SDOH data. One way they collect data is by using the Comprehensive Social Needs Survey Channel Test.[vii] This test screened over 100,000 Humana members for social needs using tools like the "Accountable Health Communities Health-Related Social Needs Screening Tool, Protocol for Responding to and Assessing Patients' Assets, Risks, Experiences, and Senior-Specific Social Needs Screener." An example of the questionnaire can be found in Figure 1. By having members complete these screenings, Humana's SDOH data ecosystem is more robust as it includes comprehensive information on the following social needs domains: financial strain, housing insecurity and quality, and access to transportation. These insights can further inform how specific social needs impact health care costs, potentially alter benefit offerings, and develop initiatives that address health barriers.

B. Humana's Initiatives to Address Social Determinants of Health (SDOH) *continued*

Humana is developing a social risk index for predictive modeling. This tool will leverage a combination of neighborhood and patient-level social risk data to create an index that will identify members at high social risks, prioritize screenings and interventions for those individuals, and align incentives for socially fragile populations. Humana started using value-based payment arrangements to encourage providers' screening engagement and document plan members' social needs.

To continuously improve SDOH data collection and quality, Humana intends to focus on the following priorities:

- Leveraging learning from the Comprehensive Social Needs Survey Channel Test.
- Installing a structured methodology across all lines of businesses, regions, and programs to better assess and document members' social needs.
- Streamlining identified member social needs or risks with the care team to avoid the need for screening for SDOH multiple times and informing them about potential barriers to health.

By emphasizing these initiatives and priorities, Humana intends to collect operational, quality SDOH data to inform actionable strategies and programs that make a difference in its member communities.

Figure 1: Humana Health-related Social Needs Assessment Questionnaire

1. How hard is it to pay for food, housing, medical care, and heating? Would you say it is:	a) Very Hard b) Somewhat Hard	c) Not Hard at All
2. Within the past 12 months, you were worried that your food would run out before you got money to buy more.	a) Often True b) Sometimes True	c) Never True
3. Within the past 12 months, the food you bought didn't last, and you didn't have money to get more.	a) Often True b) Sometimes True	c) Never True
4. Within the past 12 months, has a lack of reliable transportation kept you from medical appointments, meetings, work, or getting things needed for daily living?	a) Yes b) No	
5. How often do you feel lonely or isolated from those around you?	a) Always b) Often	c) Sometimes d) Rarely e) Never
6. What is your living situation today?	a) I have a steady place to live. b) I have a place today, but I am worried about losing it in the future. c) I do not live in a steady place.	
7. Think about the place where you live. Do you need help with any of the following? Choose all that apply.	a) Pests b) Mold c) Lead paint or pipes d) Lack of heat e) The oven or stove is not working	f) Smoke detectors are missing/not working g) Water leaks h) None of the above i) All of the above

Strategic Partnerships

Strategic partnerships are essential when MCOs are working to close the gaps in health care disparities. To appropriately address these disparities, MCOs need to work with partners in the community using initiatives that range from developing grants to local and nationwide community programs to internal organizational structure opportunities. Below are examples of plans working with strategic partners to close the gap in care.

A. LA Care Health Plan's Health Equity Action Plan

LA Care Health Plan has a multidimensional approach to advancing health equity, outlined in the LA Care Health Equity Action Plan.[viii] This effort involves internal and external work to further health equity across four areas: organizational structure, members, providers, and community partnerships. Their community partnership initiative engages in several approaches for their members, including:

- **Collaboration with community partners:** In partnership with the LA County Department of Public Health and the California Endowment, a summit was held to discuss current community-level interventions and expand the programs into the future.[ix]
- **Consumer Advisory Council:** To bring the voice of the members to the leadership and decision-making level of the health plan, a group of stakeholders meets with the community regarding their needs. This council comprises LA Care members, doctors, nurses, community-based organizations, and other health care providers.[x]
- **Sponsorship of local programs:** LA Care Health Plan sponsors community organizations that address equity and social determinants of health. In 2020, they partnered with local drive-through food pantries to provide food packages for the community.[xi]
- **Grants:** Provide grants to organizations that serve marginalized communities, such as Northeast Valley Health Corporation's recent opening of an Adult Wellness Center on the clinic's San Fernando Health Center campus.[xii]

With this action plan, LA Care Health Plan is working with many community partners to decrease the gaps in care their members receive, including collaborating with community organizations and listening to their member's needs.

B. UnitedHealthcare and Optum Anticipate Social Interventions

In conjunction with Optum, UnitedHealthcare is expanding its use of predictive analytics to include SDOH. This tool will help predict the members' need for social intervention in commercial plans by assessing more than 300 markets nationwide and analyzing over 100 metrics.[xiii] When combined with the employer's aggregate claims data, this tool can help members by identifying the following:

- Access to nutritious food through local food banks or comparable organizations.
- Financial subsidies offered by telecommunications companies to provide internet or smartphone access.
- Local support groups for continuing education and mentoring.
- Assistance programs for rent, mortgage, childcare, and utility bills.

By working with predictive analytics and local organizations, UnitedHealthcare and Optum are developing partnerships with the local community to ensure their members can access resources.

C. Community Health Plan of Washington Partners with Unite Us

In 2020, the Community Health Plan of Washington (CHPW) partnered with Unite Us, a technology company focused on improving health outcomes, to develop an accessible platform for CHPW members.[xiv] Through this dashboard, members can find local health, human, and social service organizations to address and improve their health needs and outcomes. Members can schedule checkups with their primary care providers, find safe housing options, and connect with agencies that provide free or low-cost meal delivery services through this platform. Examples of social service organizations that aim to uplift underserved communities by using this platform include North Urban Human Services Alliance, Global to Local, Center for Multicultural Health, and Evergreen Healthcare.

Through this program, plan members have a single platform for their benefits and help CHPW with collaboration, care coordination, and the ability to track member outcomes as they attain proper care for their health and social needs. This partnership was initially launched in select Washington state counties, with plans to expand to the entire state of Washington.

With this partnership between a health plan and a technology company, CHPW is building a health infrastructure that allows members' health and social needs to be met through care coordination.

D. Harvard Pilgrim Health Care and Tufts Health Plan's Point32Health Foundation

Point32Health Foundation is working to support local community organizations as members look at food and behavioral health access.[xv] They are leveraging their efforts to fund equity-focused solutions in Massachusetts, Rhode Island, Connecticut, Maine, and New Hampshire with several grantmaking initiatives to advance health equity further.

One example of a grant provided by Point32Health Foundation is assisting LGBTQ+ elders. Ethos, an Aging Services Access Point that offers information and resources in the community, leads the AgeWell Equality initiative. The initiative focuses on teaching other aging service organizations how to serve and improve the needs of the LGBTQ+ elderly. It Ethos is also developing a new model to engage older LGBTQ+ members to improve overall health, function, and quality of life, including training providers of LGBTQ+ competency and expanding services.[xvi]

The Point32Health Foundation prioritizes health equity through its Health Program, which leverages over 70 initiatives to address disparities affecting its members and communities. This includes attaining deeper insights into member needs by expanding data collection on SDOH.[xvii]

Point32Health Foundation is actively supporting the local community through grant funding of programs, including expanding care for the LGBTQ+ elderly and insights into SDOH.

111. Landscape Assessment Benefit Design Case Studies

Benefit design is essential for MCOs looking to address their members' SDOH. Designing a benefit can be difficult for MCOs because specific member populations may need intervention and support systems, which may vary across US regions. Companies are using data collection and metrics to decide where they should intervene. Details on company-specific interventions and examples of benefit designs are listed below.

CASE STUDY A. NATIONAL INSTITUTE FOR HEALTH CARE MANAGEMENT (NIHCM) TARGETS MANAGED CARE PROGRAMS TO IMPROVE HEALTH EQUITY

The NIHCM conducted a study to understand using a unique dataset from an extensive health system. This dataset includes the claims data needed to generate patient risk scores based on past spending and clinical data from medical records to characterize health status."[xviii] The study collected risk scores from 6,079 Black and 43,539 white patients, comparing the number of chronic conditions and values for a range of biomarkers at each predicted risk level by race.

This study found that:

- Black patients have a noticeably higher burden of illness than white patients at every level of algorithm-predicted risk.
- Compared to white patients with the same future risk predicted, Black patients have more severe hypertension, diabetes, and renal failure, along with more dangerous bouts of anemia and cholesterol
- Achieving equity in how many chronic illnesses are represented across patients enrolled in the program would increase the enrollment of Black patients from 18 to 47 percent.
- Revising the model to include the prediction of the number of chronic illnesses a patient may experience in the next year reduced the presence of racial bias by 84 percent.[xix]

NIHCM found that the racial disparities in the U.S. health care system have caused Black patients to have lower spending than white patients for any given marker of health. Because of this, a spending-driven predictive algorithm points out that fewer Black patients are likely to have future spending needs. However, compared to white patients, their health status is significantly worse with the same prior spending level. This bias makes identifying Black patients with high clinical needs less likely to be recognized for program enrollment or allowed to benefit from intensive care management. NIHCM calls for improvements in the algorithm so that significant reductions in the extent of racial bias are possible by incorporating health status and spending.

CASE STUDY B. MOLINA HEALTHCARE'S PERSONALIZED SDOH STRATEGY TO IMPROVE HEALTH OUTCOMES

Molina Healthcare is a managed care company headquartered in Long Beach, CA. It has begun utilizing data and community connections to identify and support members affected by barriers to obtaining health care, such as lack of food, housing, and transportation (which are Social Determinants of Health); for example, in partnership with Icario, a health action company that leverages innovative technology, data science, and behavioral insights to improve health outcomes. Using member-driven data and heat maps with a high concentration of Molina members allows the identification of the most vulnerable groups. A team of individuals specific to SDOH, Molina calls Community Connectors, directly with its case management team to ensure all members receive the appropriate care. In proving the business case for SDOH in health plan organizations, indicators of short-term and long-term success have been highlighted to show the impact:

Short-term success:

- Decreased the use of emergency rooms.
- Saw slightly increased medical costs as members began seeking appropriate care for chronic illness from their primary care physicians (PCPs).

Long-term success:

- Lessened the churn rate due to more personalized communication and strategic outreach. The churn rate is when customers stop doing business with an entity, so a decreased churn rate is a reasonable implication.
- Achieved community impact, leading to the closure of some gaps in care.
- Attained better member ratings and experience.

Molina has gathered examples of success from the data, community, and personalized communications-based approach. One of these success stories includes the Molina Accord, which identified a high concentration of its membership in a school district that needed water bottles to compensate for shutting down water fountains following high COVID-19 transmission. Ten thousand water bottles were sent to the school district. At the same time, the Molina Accord could also provide essentials like lunches, school supplies, undergarments, checkups, immunizations, and dental exams to students in need.[xx] With an approach that blends data, community connection, and personalized communication based on member preferences, health plans benefit from improving quality measures like overall Star Ratings. They also make their communities healthier and more stable.

CASE STUDY C. CVS HEALTH ADDRESSES OUT-OF-POCKET COSTS FOR TYPE II DIABETICS

CVS Health is working to eliminate member costs as a barrier to medication adherence by launching RxZERO. This enables employers and health plan sponsors to use formulary and plan designs to offer all diabetes medications at no out-of-pocket cost for members without raising prices for plan sponsors.[xxi] CVS Caremark reported that members using branded diabetes medications spend $467.24 out-of-pocket per year, with nearly 12 percent spending over $1,000 annually.[xxii]

The new RxZERO plan design enables plan sponsors to eliminate member out-of-pocket costs for the entire diabetes therapeutic area, including oral medications for Type 2 diabetes, and to adhere to the American Diabetes Association standards fully.

CVS Health believes that eliminating out-of-pocket costs for diabetes drugs could be essential to all health plan sponsors to help address the growing diabetes epidemic without increasing other expenses, such as deductibles and premiums. CVS Caremark research demonstrates that by leveraging formulary and plan design approaches, plan sponsors can eliminate member out-of-pocket costs for all categories of diabetes medications without raising prices for the plan sponsor or increasing premiums or deductibles. The analysis demonstrates that the approach leads to savings for plan sponsors through improved adherence and a reduction in overall medical costs.

Clients can save $170 per member per year by adopting CVS's most cost-conscious, generics-focused Value Formulary. Plan sponsors can also save money in overall medical costs because higher adherence, meaning because of lower out-of-pocket costs, improves member health. CVS Pharmacy Care Economic Model reveals that for each diabetic member who goes from non-adherent to adherent, client health care costs drop by $2,202 per year. Applying these values to the entire member population, we estimate the value of the plan in improved adherence and lower medical costs is $156 per member per year.

CASE STUDY D. HIGHMARK BLUE CROSS BLUE SHIELD (HIGHMARK BCBS) ON DATA-DRIVEN PREDICTIONS AND HUMAN EMPATHY

Highmark BCBS has begun using machine learning and predictive analytics to identify patients who may need help after being discharged from the hospital or who have severe or complex illnesses. This computer system learns to spot patterns and make predictions about patients after computing millions of data points, including data from providers, medical claims, and demographic data.[xxiii]

After the system recognizes patterns and identifies high-risk patients, the next step is supporting patients leaving the hospital. Highmark's Transitions of Care team members can help ensure prescriptions are filled and delivered, and follow-up appointments are booked. They can also arrange for meal services and help address financial concerns. The system also learns to spot any signs that patients may need support to stay out of the hospital, for example, those who have stopped refilling their prescriptions or are seeing doctors more frequently. In such instances, a case manager could then contact the plan members. The system is also set up to root out biases and test for accuracy in categories most susceptible to biases. Finally, Highmark is using Google's artificial intelligence tools to develop convenient strategies for reaching out to people who may need help but haven't pursued it.

IV. Landscape Assessment Patient Access Case Studies

Patient access to quality health care is one of the highest priorities related to SDOH for MCOs. As mentioned previously, MCOs may differ in benefit designs, but almost all MCOs acknowledge the need for better member access to health care-related services. Below are some unique approaches to providing members with better access and details on the programs currently in practice.

CASE STUDY A. North Carolina Develops the Healthy Opportunities Pilot Program

To address social needs that affect North Carolinians' health, the state of North Carolina has developed the Healthy Opportunities Pilot Program, which utilizes opportunities offered by the Centers for Medicare and Medicaid Services (CMS).[xxiv] The Healthy Opportunities Pilot Program focuses on four categories: food, housing, transportation, and interpersonal violence/toxic stress. CMS will invest in two to four state regions, budgeting $650 million over five years. Residents who qualify for this program must have the following:

At least one health risk factor, such as:

- Adults with two or more chronic conditions or repeated emergency department/hospital use.
- Pregnant women who are at high risk.
- High-risk infants and children with one or more chronic health conditions.

At least one social risk factor, such as:

- Homelessness and housing insecurity.
- Food insecurity.
- Transportation insecurity.
- Risk of witnessing or experiencing interpersonal violence.

Services created by the pilot to address the social risk factors include the following: tenancy support; housing quality and safety; legal referrals; financial assistance in security deposits and first month's rent; short-term, post-hospitalization housing assistance; food support; meal delivery; health-related and interpersonal violence-related transportation, and parent-child supports.

The pilot program funds are intended to be leveraged to build capacity, establish network leads, and deliver social services by supporting human service organizations. Setting network leads and providing social services by supporting human service organizations effectively creates collaborations and partnerships with health care payers and social service providers using entities with roots deep in their community.

CASE STUDY B. Elevance Health on Advancing Health Equity using Pharmaoequity

Elevance Health is using pharmacoequity in its strategies to advance health equity. Pharmacoequity is a term created by Dr. Utibe Essien, an assistant professor of medicine at the University of Pittsburgh School of Medicine. In concept, it is the notion that every person has access to the most appropriate, evidence-based medication regardless of race, class, or availability of resources. [xxv]

There are other barriers to pharmacoequity, such as affordability and access. A survey found that those taking four or more prescription medicines were more likely to have difficulty affording them (32 percent) than those taking three or fewer prescription medicines (20 percent). Additionally, people are less likely to take their medicine if it is harder to get. A study of 3.1 million people aged 50 and older found a decline in medicine adherence in the first three months after their pharmacy closed. This difference continued over 12 months and was greater among those who lived in neighborhoods with fewer pharmacies.

Additionally, people are less likely to take their medicine if it is more challenging because of a lack of access to a pharmacy. A study done by Dr. Dima Qato of the University of Illinois, Chicago, noted that of 3.1 million people aged 50 and over, a decline in medication adherence occurred in the first three months after their pharmacy closed, a difference that continued over 12 months and was greater among those who lived in neighborhoods with fewer pharmacies."[xxvi]

Using this idea of pharmacoequity, Elevance Health's IngenioRx pharmacist-led case management program (started in January 2021) is intended to help members who do not adhere to their medication instructions as prescribed by having the pharmacist team contact members to gauge whether the member may be experiencing barriers to accessing care. Elevance Health is attempting to use personalization and pharmacoequity strategies to provide a more proactive intervention in the lives of its members.

The program also addresses access and other health-related social needs. One of the members was using a shipping service to receive medications, which helped improve adherence. The pharmacist case manager arranged for mail-order pharmacy services and learned from speaking with the members about how they were looking for a lower-cost apartment and recreation opportunities, including transportation. The pharmacist case manager was able to help connect the members with resources for housing, recreational opportunities, and transportation, which also played an essential factor in improved outcomes.

CASE STUDY C. SCAN Health Plan to Address SDOH to Allow Medicare Advantage Beneficiaries to Live Independently

SCAN Health Plan addresses beneficiaries' SDOH and functional status barriers to care, including access to food and social programs and adequate care in the home. SCAN Health Plan's Member2Member program, staffed by Peer Advocates, is an example of SCAN using data to address patients with SDOH needs. Specifically, Member2Member is helping seniors access the services and resources they need to remain independent, such as:

- Addressing nutrition, SCAN provides nutrition support services to beneficiaries who cannot prepare food for themselves. This benefit includes home-delivered meals and nutritional supplements for their Fully Integrated Dual-Eligible Special Needs Plan (FIDE SNP) members. SCAN also provides post-hospitalization meals to members as they transition out of the hospital.
- Addressing social isolation, SCAN provides home and community-based services for adult beneficiaries to help care for themselves through nursing services, physical, occupational, and speech therapies, and counseling on nutrition. SCAN has found that hearing loss can lead to more severe health conditions, such as depression, cognitive decline, and an increased risk of falls. To address this, SCAN is offering hearing benefits to its members, such as routine hearing exams and coverage for hearing aids.[xxvii]

In addition to the Member2Member program, SCAN has implemented the Connected Provider to Home (CP2H) program for its members with the highest clinical needs. This program connects a community health worker with a social worker who coordinates with the member's PCP to create a care team that visits the patient at home, accompanies them to doctor's appointments, and conveys any challenges the member may have with treatment adherence to the care team. That team can then personalize and modify care treatments to best fit the member. SCAN reported that "…the overall results of the CP2H program are extremely positive. For patients participating in CP2H, there was a 39 percent reduction in emergency room visits, 27 percent fewer hospitalizations, and improved A1c levels for those with diabetes."[xxviii] The CP2H program works in tandem with non-skilled in-home care provided by SCAN, such as bathing, dressing, and cooking, as well as SCAN's program to help members access mental health care.

CASE STUDY D. CVS Health Zones

CVS Health has created CVS Health Zones to identify concentrated community investments that complement the scope and scale of CVS Health's footprint and assets. These concentrated community investments by CVS reaffirmed its commitment to addressing housing insecurities and increasing access to health care services in underserved communities by investing $185 million in affordable housing in 2021. These investments are part of the company's nationwide efforts to advance health equity. They will support developing and rehabilitating more than 6,570 affordable housing units in 64 cities across 28 states and Washington, DC. To address SDOH, the CVS Health Zone strategy and program offerings will combine community partnerships and commercial business assets to support the needs of underserved communities.[xxix]

The CVS Health Zone focus areas that will be addressed include:

- Housing
- Education
- Access to Food
- Labor and Workforce
- Transportation
- Health care

The CVS Health Zones will be launched in five markets, including Atlanta, Ga.; Columbus, Ohio; Fresno, Calif.; Hartford, Conn.; and Phoenix, Ariz... CVS Health Zone partners include Feeding America and Uber Health, whose partnership with CVS Health has emphasized support in underserved communities through food drives and mobile health screenings.

CASE STUDY E. Geisinger Community Programs

The Geisinger Health System is in a rural part of northeastern Pennsylvania. Every three years, they conduct community health needs assessments (CHNAs). These assessments have pinpointed the community's greatest need: access to care. With this information, they responded to community needs by implementing multiple community programs, including:

- Injury prevention programs include Dying to Be the Life of the Party, Driver Safety, CarFit, ATV Safety, Safe Kids, Gunlock Safety, Distracted Drivers, A Matter of Balance, and Stop the Bleed.
- Health and wellness programs, such as no-cost flu shot events, care gap screening, diabetes prevention programs, kick the tobacco habit, live your best life, live your best life with diabetes.
- Neighborly: a program designed to help patients find housing assistance, food banks, financial help, and other assistance in their local area.

As recently as April 2023, Geisinger teamed up with Kaiser Permanente to create Risant Health, a non-profit organization that will bring additional resources to the rural northeast Pennsylvania area. These resources are predicted to help Geisinger focus on value-based care while improving accessibility in the community.

CASE STUDY F. Centene Provider Accessibility Initiative

To reduce barriers related to health care, Centene launched its Provider Accessibility Initiative (PAI). This initiative aimed to identify and improve access for patients with disabilities. This program includes on-site accessibility reviews, which provider offices use to improve their facilities. Between 2017 and 2019, over 2,600 on-site accessibility reviews were conducted. Once studies are performed, and barriers have been identified, providers can apply for funding from the PAI's Barrier Removal Fund (BRF). In the first two years, 140 provider offices received grants to provide patients better access to quality care. The grants given by the BRF were used for things like wheelchair accessibility ramps, mobility handrails, braille signage, and assistive listening devices.

During 2017–2019, 123,000 Centene health plan members received improved disability access at their provider's office. Because of the program's initial success, PAI was continued and is still being utilized today.

Conclusion

There is an increased focus on health disparities, including socioeconomic status, ethnicity, race, sexual orientation and gender, disabilities, geography, and social needs. This white paper will guide patients, providers, and AMCP members on addressing health disparities through case studies on how managed care pharmacy is proactively closing the gap in health inequities. MCOs are engaged on the topic of health disparities. These evolving case studies allow for greater access to care and more robust standards of care while also addressing critical social determinants of health.

Health disparities in the United States have been the focus of remediation efforts for decades. COVID-19 created a shared urgency and a common language for all health care professionals to understand their extent and impact on the national stage. Health inequities are the cumulative result of a neglected system; the lived experiences of diverse individuals and the challenging environments that impact all dimensions of people's lives should be considered in future health care in the US.

Health equity is an aspirational goal whereby all people experience similar health outcomes regardless of race, ethnicity, socioeconomic status, education, neighborhood, or other potentially disadvantaging social and structural determinants of health. Health equity can be achieved by first addressing health disparities.

Health equity has become an organizational priority for many sectors across the managed care pharmacy spectrum. Understanding how other organizations approach health equity within and across managed care can provide essential learnings for peers seeking to drive impact on outcomes and delivery. Health equity initiatives necessitate collaborative, coordinated action underpinned by strategic intent and measurable results.

Appendix

Table 2: Specific Search Terms

"Pharmacy benefits manager" "equity"	"Pharmacy benefits manager" & "disparity*"	"Pharmacy benefits manager" & ("SDOH" OR "social determinants of health")
"Managed care" & "equity"	"Managed care" & "disparity*"	"Managed care" & ("SDOH" OR "social determinants of health")
"Managed care pharmacy" & "equity."	managed care pharmacy" & "disparity*"	"Managed care pharmacy" & ("SDOH" OR "social determinants of health")
"pharmacy" & "benefits design" & equity	"pharmacy" & "benefits design" & "disparity*"	"Pharmacy" & "benefits design" & ("SDOH" OR "social determinants of health")
"health plan" & Equity	"Health plan" & "disparity*"	"Health plan" & ("SDOH" OR "social determinants of health")
"Insurance" & "equity"	"Insurance" & "disparity*"	"Insurance" & ("SDOH" OR "social determinants of health")
"Formulary Management" & Equity	"Formulary management" & "disparity*"	"Formulary management" & ("SDOH" OR "social determinants of health")
" Pharmacy benefits management" & "equity "	" Pharmacy benefits management" &"disparity*"	" Pharmacy benefits management" & ("SDOH" OR "social determinants of health")
"Benefit design" & "equity"	"Benefit design" & "disparity*"	"Benefit design" & ("SDOH" OR "social determinants of health")
"Medicaid managed care" & "equity."	"Medicaid managed care" & "disparity*."	"Medicaid managed care" & & ("SDOH" OR "social determinants of health")
NCQA & "equity."	NCQA & "disparity*"	NCQA & ("SDOH" OR "social determinants of health")
BCBSA & "equity."	BCBSA & "disparity*"	BCBSA & ("SDOH" OR "social determinants of health")
ACHP & "equity."	ACHP & "disparity*"	ACHP & ("SDOH" OR "social determinants of health")
Health Affairs & Equity	Health Affairs & "disparity*"	Health Affairs & ("SDOH" OR "social determinants of health")
URAC & "equity."	URAC & "disparity*"	URAC & ("SDOH" OR "social determinants of health")
PCMA & "equity."	PCMA & "disparity*"	PCMA & ("SDOH" OR "social determinants of health")

Please note that PubMed and Google search engines used these search terms to complete the landscape assessment.
*Important Acronyms – see next page

Appendix *continued*

***Important Acronyms:**

NCQA: National Committee for Quality Assurance

BCBSA: Blue Cross Blue Shield Association

ACHP: Alliance of Community Health Plans

URAC: Utilization Review Accreditation Commission

PMCA: Pharmaceutical Care Management Association

Table 3: Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Publicly available white and grey literature (e.g., white papers, fact sheets, articles, press releases, peer-reviewed journals, etc.)	Closed access or non-published literature
U.S.-based English work	Work outside of the US initiatives or publications outside of English.
Initiatives from 2018– 2022	Initiatives that were not managed care pharmacy-related

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ACKNOWLEDGEMENTS

Developed in partnership with the AMCP Health Disparities Advisory Group, Atlas Clarity, and AMCP staff.

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