Health equity by design

A comprehensive, scalable solution to equity for payers

Health equity is becoming an increasingly important issue for health care payers. The Center for Medicare and Medicaid Services (CMS) has signaled to both payers and providers that health equity will be measured and rewarded. Payers have responded by focusing on whole-person data and analytics in an effort to identify opportunities in their member population. They then develop programs designed to address a particular health equity concern or social need.

The critical task, however, is seeking to scale and grow these programs beyond targeted, one-off pilot efforts. The CMS call for greater effort means that there's significant work to be done to align and amplify an organization's programming and impact at scale.

One particular focus for health plans is health disparities. Health disparities are often due to unaddressed social determinants of health (SDOH), implicit or explicit biases and ineffective communication because of the lack of a trusted messenger. SDOH, the conditions in which people are born, grow, work, live and age, significantly influence health outcomes. Biases, both implicit and explicit, pervade health care, affecting patient outcomes. These biases, often based on race or gender, can lead to disparities in care quality.

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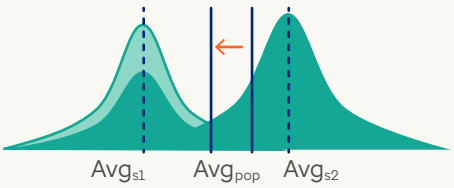
CMS has signalled its strong interest in trying to measure health disparities and health-related social needs as part of its emphasis on health equity.

As a result, both health plans and health systems have a growing interest in screening for member social needs, and developing systems and building relationships within the community to address them. Both payers and providers are learning the benefits of addressing these needs like housing, social isolation, and food insecurity for improving the overall health and health outcomes for members.

Changes in the clinical, regulatory and competitor landscapes demand urgent action

Demographic and societal shifts

- Poor performing groups will have a greater contribution in dragging down the average if they are predicted to grow in your market (e.g., elderly patients, diabetes prevalence and associated complications).
- By 2030, 22% of the U.S. population will be ages 65+, up from 16.9% currently. Proportion of non-Hispanic white adults will decline from 77% to 55% in the same time period.



CMS

- CMS proposes a health equity index (HEI) reward, beginning with the 2027 Star Ratings, specifically designed to create an incentive to reduce disparities in care. A reward of half a star is available for obtaining high measure-level scores for the subset of enrollees with specified social risk factors.
- The Biden administration is approving state requests to use Medicaid funding on groceries and nutritional counseling. Last year, CMS approved Medicaid spending for food programs in Arkansas, Oregon and Massachusetts. These policy changes will help explore how "food as medicine" programs may improve health and reduce overall medical costs.

Competitors

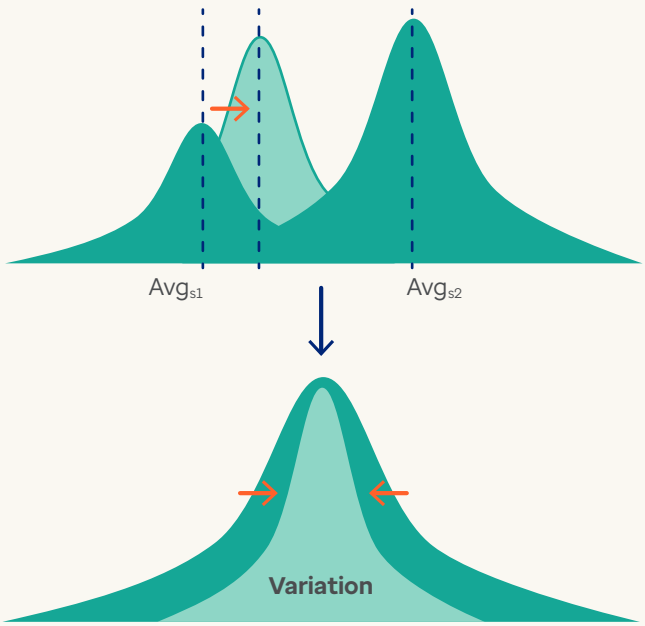
- 61 health plans have received NCQA health equity accreditation.
- Elevance Health (formerly Anthem): 93% of Medicaid members are now served by a health plan that has earned this health equity accreditation, a scale unmatched in the industry.
- Recent analysis from Press Ganey indicates as many as 80% of MA plans are at risk for losing at least one Star Rating across 2023.
- Financial impact of lost Star Ratings leads to reduced member benefits, fewer creative engagement campaigns and lower retention rates.

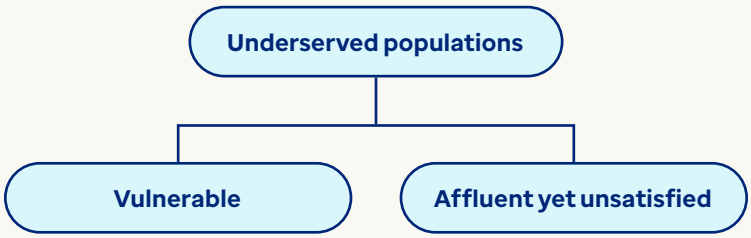
Explicit bias in health care refers to conscious attitudes and beliefs about others, which can affect treatment recommendations. Implicit bias, on the other hand, is unconscious and can sometimes contradict our personal beliefs, leading to unintentional behavior that harms certain groups. For instance, a health care professional might unconsciously associate certain racial or ethnic groups with negative stereotypes, affecting their interactions with these groups.

Both types of biases can significantly impact patient care and outcomes, leading to disparities in treatment, inaccurate diagnoses or delays in diagnosis. Therefore, it's crucial for health care professionals to be aware of any biases they may have and work on overcoming them. This is a key step toward achieving health equity and improving patient outcomes.

The complexity of these issues increases when considering the heterogeneity within seemingly similar groups. For example, a Black man in Alabama may have a vastly different experience than one in Baltimore due to differences in local policies, socioeconomic conditions and access to health care resources. This underscores the importance of considering local contexts and individual characteristics when addressing health disparities, but becomes a hinderance in constructing scalable solutions.

Improving segment performance reduces overall variation of the population





Sample personas/groups

- Lower-income individuals on Medicaid
- Self-insured individuals and families
- Historically marginalized racial minorities
- Pregnant women of color covered by Medicaid

Sample personas/groups

- Working professional LGBTQ+ communities
- Socio-culturally hesitant health care consumers (e.g., retired auto workers)
- Commercially insured pregnant women of color experiencing bias-in-care

A trusted messenger in health care is an individual or organization that has established credibility within a community and can effectively communicate and advocate for health-related issues. They play a crucial role in addressing health disparities by bridging the gap between health care providers and communities, particularly those that are underserved or marginalized.[1]

One example of a trusted messenger, community health workers (CHWs), are often members of the communities they serve, sharing similar experiences with community members, which allows them to relate to patients and build relationships. They are equipped with knowledge and resources to assist residents with health care concerns, health education, and questions. CHWs serve as a bridge to connect members of the community to services and programs to meet their needs – including social needs.[1]

Another example is the Good Health & Great Hair program by Kaiser Permanente, which brings health care to barber shops and salons in predominantly Black and Latinx neighborhoods in Baltimore. This program recognizes that receiving health care from a trusted messenger makes a difference in addressing health disparities.[2]

So, how can we scale these solutions that are often unique to particular communities or particular contexts?

1. America's Health Rankings. Population – adults ages 65+ in United States.
2. The Institute. Health equity: trusted messengers in the community. February 23, 2023.

Data insights allow Optum to construct unique population thumbprints that help us understand the particularities of markets, populations and disparity, and identify similarities across an organization's membership. We can take the insights from those thumbprints to tailor customized health equity programs designed to address the unique needs of a market and its populations.

Another scalable element in health care is the backend, non-member-facing operating asset. While members may not interact with these systems directly (examples include claims payment, medical policy and VBC payment models), they play a crucial role in ensuring efficient and effective service delivery. By improving these assets, payers can increase their capacity to serve more member segments, improve operational efficiency and enhance patient outcomes.

Addressing this dual mandate is a complex task that requires careful navigation and strategic planning, as actions that benefit one aspect may negatively impact the other. Excessively focusing on data insights and increased market understanding improves knowledge and opportunities but doesn't unlock the operating capital to address their needs.

Therefore, addressing a dual mandate necessitates a comprehensive understanding of the system's intricacies, a clear vision of the desired outcomes and a strategic approach to balance competing demands.

The solution: Equity by design

Given the challenges, solutions have to be uniquely local, which poses challenges for bringing solutions to scale.

Equity by design offers payer partners a comprehensive approach to addressing these dual demands. It starts with a thorough, well-researched effort to understand the local market:

- Identifying key market trends
- Deriving consumer insights
- Highlighting key SDOH challenges and opportunities across the market

We leverage these multiple data points to drive a strategy that aligns the health plan's mission and capabilities to open up new opportunities to address disparities and social needs. For equity by design, we develop a clear roadmap, partnership assessment and feasibility analysis to support a go-forward plan. We then close with a well-developed business case that underscores the impact of taking these efforts to scale.

Fundamentally, equity by design is the thoughtful construction of local solutions through trusted messages and scalable infrastructure to flex and adapt to meet the current and future market's needs.

How do payers make an impact?

We recommend a build, buy, partner approach based on data-driven insights that emphasizes local community value by ensuring a trusted messenger. The decision to build, buy or partner involves weighing various trade-offs.

- **Building** allows for complete control over the product or service, ensuring alignment with the company's needs and vision. This approach requires significant resources and carries the risk of failure.
- **Buying**, such as acquiring a company or licensing a product, provides immediate access to established technology or expertise and can offer competitive advantages. This approach can be costly, and integration can be challenging.
- **Partnering** allows companies to leverage the strengths of another organization, leading to shared risks, costs and access to new markets or technologies. This approach requires finding a reliable partner with aligned goals who can present issues around control, profit sharing and conflicts of interest.

Each option has its benefits and challenges. The choice depends on a careful evaluation of the current and future market direction and patient population.

To learn more, contact your Optum representative or visit optum.com/contact-us.

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