

Spotlight Series

MCO Health Equity Efforts: AmeriHealth Caritas



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The NORC Medicaid Managed Care Organization (MCO) Learning Hub shares timely and relevant resources to support Medicaid MCOs and other stakeholders in improving their members' health and increasing advancements in health equity and health care transformation. We encourage you to share your experiences and feedback on future Medicaid MCO Learning Hub work so we can better serve your needs. To start the conversation or join our distribution list, please email us at MCOLearningHub@norc.org.

The Medicaid MCO Learning Hub "Spotlight Series" highlights key initiatives addressing health equity driven by, or in partnership with, MCOs to inform the Robert Wood Johnson Foundation (RWJF) and its grantees. In addition, the series provides MCOs, community-based organizations, states, and other key stakeholders with examples of successful models of organizations working together to advance health equity.

This "Spotlight" focuses on an MCO's efforts to more intentionally integrate health equity into their organization and health systems. Forthcoming Spotlight Series briefs will center on other existing initiatives and partnerships around health equity.

The World Health Organization (WHO) defines health equity as, "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically."¹ Advancing health equity is closely related to eliminating health disparities that often affect excluded or marginalized groups, including people of color and people with low incomes, among others. The health care crisis due to the COVID-19 pandemic paired with the

country's reckoning with racial injustices during 2020 have spotlighted existing and growing health disparities and health inequities, unleashing growing calls to action to address health inequities and social determinants of health (SDOH).

NORC's Medicaid MCO Learning Hub spoke with **AmeriHealth Caritas** staff to discuss their efforts to move toward health equity and mitigate systemic racism within their organization and through their relationships with other

¹ World Health Organization, https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3.

health care entities.* [AmeriHealth Caritas](#) is a mission-driven MCO operating in 13 states and the District of Columbia serving Medicaid, Medicare, and Children's Health Insurance Program (CHIP) members through its integrated managed care products, pharmaceutical benefit management and specialty pharmacy services, and behavioral health services.

Defining Health Equity

Q: How do you define health equity and how has that definition evolved?

The definition of how we examine health equity has evolved to meet the needs of our members. We understand that the concept of equity is not static; it must consistently meet the needs of the communities and individuals that we serve. In the early 2000s, we identified disparities and assessed the individual-level factors that may contribute to disparities. While this process and approach continues, we have evolved and built upon this foundation. The progression toward health equity has led to a much more *proactive* approach to ensuring all people have the opportunity to achieve their best health outcomes. Our equity paradigm can be classified into a two-fold definition: 1) the current concerns and needs, and 2) the underlying issues that led to those concerns. It is important to consider the dynamics of which issues are systemic and which are point-in-time.

AmeriHealth Caritas' definition of health equity includes the *who, what, and how*: who is being impacted, what people need, and how AmeriHealth Caritas can invest in people and communities to make sure they have what they need to grow and be resilient. Ultimately, we measure health equity as a successful culmination of these efforts to understand the needs of individuals, our associates, and organizations, promoting equitable access to opportunities, services, and resources.

“Our view of health equity is not static. We are responding to not only point-in-time moments but also the systemic issues that contribute to inequities.”

Strategies for Promoting Health Equity

Q: What strategies have helped you cultivate a culture of health equity within your MCO and across your health systems and providers?

STRATEGIES FOR BUILDING A CULTURE AROUND HEALTH EQUITY

- Train MCO staff as well as providers and their staff around biases, diversity, equity, and inclusion
- Collect and use race/ethnicity, language, SDOH, and other data to inform needs and efforts
- Develop strategic plans and set measurable goals to support health equity needs

HEALTH EQUITY TRAINING FOR PROVIDERS AND THEIR STAFF

Many of the experiences of individuals, most notably people of color, are hard to measure and collect. For example, Black women, in particular, have experienced micro and macro aggressions navigating the health system. It is important for providers and their office staff to step back and think about an individual's full lived experience, which includes understanding biases in how the system treats people as that often causes individuals to withdraw from the health care system and use emergency rooms when there would be opportunities for better outcomes through outpatient care.

Today, we offer culturally and linguistically appropriate education training to all of our providers via an online e-learning module. Training covers topics such as developing a better understanding of cultural diversity, the importance of cultural competence in providing optimal health care, learning about effective cultural communication strategies when interacting with patients, and identifying resources to support cultural competence as a life-long learning process. We are building and accelerating our provider education training programs to work with providers around bias. We intentionally say bias versus *implicit* or *unconscious* bias because adding those descriptors tends to remove accountability for those biases. Our AmeriHealth Caritas District of Columbia plan

has implemented bias educational and training programs and we are expanding these offerings to our other markets.

In addition, our education programs reach both providers and administrative and other staff in provider offices, as members often talk about their “front desk experience” when they walk into a provider’s office. People experience provider visits in different ways and may be treated differently based on their income, where they live, and type of insurance. For example, a Medicaid member may hear from a neighbor with commercial insurance that their neighbor could obtain an appointment a lot quicker than the Medicaid member could.

During our trainings, we have heard from providers who pushed back and said that they did not believe front desk experience issues were a problem because they had not heard any complaints from their patients. Our facilitator reminded providers that people vote with their feet; if they have a negative experience with a provider office, rather than complain, they may not go back to that office. Providers can connect this to their own experiences in terms of not going back to a store if they do not like how they are treated. This reminder can help them recognize that lack of complaints did not necessarily equate to a lack of a problem. We work with providers to give them the tools they need to encourage changes in their own and their staff’s behavior and to improve their practice. We use evidence-based research to talk about power structures and how to improve their communication. We make our trainings interactive and conversational rather than just a presentation.

“An important piece is to talk about power dynamics, where power lies, and how that influences decisions that impact equity. That is important to understand where changes are needed to help us improve.”

We always ask for input and feedback from our providers, and they always note that the health equity trainings are useful or very useful. We also reach out to providers about 90 days after training to ask: what are two things you have done differently in your practice since our training? We work with providers to examine whether trainings are taking hold. We teach providers through these trainings how to eliminate bias. It is hard to measure this, but it is also hard to prove that the training is having the intended effect. But we try to provide opportunities for awareness-building and introspection.

“Some people think training is a panacea. Trainings give us the words, frameworks, and general understanding around these issues, but training alone does not make a difference. The key is getting providers to apply what they learn. Training is part of a larger conversation and a broader toolset to help put learnings into action.”

INTERNAL TRAINING FOR MCO STAFF

It is important to understand our role as an MCO and our impact on the community, which require us, as an organization, to create internal mechanisms to promote health equity in the care we deliver.

Health Equity Training. Within our organization, we have health equity trainings for our member-facing teams, which are similar to our provider trainings, to encourage them to think about their words and tone when interacting with members. For example, we do not want to jump onto every call with a member with the sole goal of pursuing our own agenda. Instead, we take time to understand where the member is; we encourage a person-centered approach. We try to build a level of awareness and sensitivity. When we transfer members for whom English is not their first language to other peers, we do a warm transfer to not make members feel like it is a bad thing that English is not their first language. We listen and obtain feedback from our member calls and use that data to determine the best training and support approach.

We also have a rigorous health equity training module for all associates that is updated annually. In addition, we work proactively to add new training and learning opportunities for our associates, so that they can continue to support their learning and outreach to the members and communities we serve on an array of topics, including sexual orientation, gender identity, immigration, racism, and ageism.

Our associate training is a set of packaged information our associates can use and access from our intranet. Our trainings are both self-created and leveraged from external partners. The good thing about curating tools from external partners is that we can choose the ones we believe work best for us and can lean on vendors’ expertise. Working with external partners also allows us to quickly roll out the training rather than starting from scratch and creating trainings ourselves.

Diversity, Equity, and Inclusion (DEI) Efforts. In addition, we have an overall DEI effort across all levels of the organization to make sure our staff is sensitive to and aware of how their behavior aligns with expectations. In addition to our associate training programs, we have provided forums to internally discuss contemporary issues, such as the civil unrest following the deaths of George Floyd, Ahmaud Arbery, and Breonna Taylor. Last summer, we brought in speakers to talk about institutional racism and began to address it within our own organization. We had small group conversations to allow people to express what they felt. We tried to build an understanding of the factors that impact equity, such as housing, racism/discrimination, xenophobia, and homophobia.

DATA

We have a wealth of data to see how outcomes are trending by certain disease states. We look at our data from multiple angles, including disparities by race and ethnicity, language, age, and location. We have been collecting race, ethnicity, and language data from our members for 10 years. We are also adding measures related to sexual orientation and gender identity. Much of the health equity focus is around race, ethnicity, and language, but other populations also face barriers to care, for example, lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) populations.

We also track SDOH needs, which allows us to measure the resource needs of our communities. We are now collecting SDOH data across 14 different domains from at least 25 percent of our households. We are working to improve the speed and accuracy in which we refer our members to the services they need and find ways to track whether they received those services and how they felt about it.

We are working nationally as part of the Gravity Project, an HL7 Fast Healthcare Interoperability Resources (FHIR) Accelerator Project, to ensure that the way we collect and document data is similar to others. The collection of race and ethnicity data is standard at this point. We hope through efforts like the Gravity Project that the collection of SDOH data will become more standardized, and that these data can be used to better understand the needs of the members and communities we serve.

SET GOALS AND DEVELOP STRATEGIC PLANS

We have set up structures to support our health equity activities across all AmeriHealth Caritas markets that match each community's needs. We develop specific goals based on identified health equity needs by looking at our data from multiple angles, including disparities by race and

ethnicity, language, age, location, and SDOH needs. Through our framework, we develop a strategic plan that we implement through cross-departmental participation. We use a root cause analysis process to identify our assumed questions, engage with the community, look at the evidence-based research to validate those needs, and identify how we can address them. Through that strategic plan development process and throughout the year, we measure the outcomes and impacts of our interventions and use that data to inform improvements for the next year.

Q: What milestones or benchmarks help you track your health equity goals and progress towards those goals?

It is important to understand how AmeriHealth Caritas is structured. There is a corporate infrastructure and we also work at the market level, which proliferates to plans operating across multiple product lines in seven states and the District of Columbia. There are health equity needs that the nation is experiencing as a whole. Still, there are also particular health equity needs depending on geographic location, not just at the state level but also where you live (e.g., urban versus rural).

[Seven of our nine Medicaid plans](#) have achieved Multi-Cultural Health Care (MHC) Distinction by the National Committee for Quality Assurance (NCQA), a standard that recognizes the provision of culturally and linguistically appropriate services to our members. While this does not mean our plans have achieved 100 percent health equity, reaching this milestone provides a building block of data and accountability structures around health equity.

Q: What are examples of some of your equity-related programs or interventions?

We will share examples from our plan, AmeriHealth Caritas District of Columbia, in addressing material health outcomes. Using our data, we can pinpoint precisely the two wards in the city where maternal health outcomes are much worse. We look at the emerging and promising practices that might address this disparity and ways to partner with other organizations to apply those strategies and address those needs.

TRANSPORTATION

Three years ago, we started promoting transportation as a benefit. The transportation support mechanism was shared rides — not Lyft or Uber, but a shared van that picks up members along the same route. Yet, a pregnant woman in her third trimester, for example, may decide that she would prefer a direct ride rather than waiting for the shared van, given other competing priorities. When we added a new option to our transportation program for using Lyft, which provides a direct ride to the appointment, it made a huge difference for our population. We saw increases in appointments kept. In qualitative interviews, we learned that this method took less time out of a member's day. If women had other children, they had to consider other factors when taking a shared van, including childcare to cover the time during the appointment. It was not that this population did not want the best outcomes for themselves and their babies. For them, the time it took to use a shared van was a real issue. In studies of this program, we found a higher degree of satisfaction and appointments kept by providing the Lyft option.

FOOD INSECURITY

We noticed that pregnant women who were diagnosed or managing diabetes and hypertension were also experiencing food insecurity. We established a partnership with Food and Friends and Howard University Hospital to provide meal delivery, nutritional education, and support to this group. However, in qualitative interviews, when we asked women what they thought of the food and if they were using the food, we learned that some women said they had not had the food. We learned that they were instead giving this food to their children rather than eating the food themselves. We changed our benefit to provide food for the household rather than just the mother. When we studied this intervention, we found that providing meals not only improved women's stability, but also that, overall, women in the group had better maternal health outcomes. This highlights the importance of learning, iteration, and involving the community's voice and our members.

PEER SUPPORTS

Many of the women we serve are not necessarily enamored with our health care system. There are many reasons for that, including racism and feeling like their voices and preferences are not respected in provider offices. We established a program with [Mamatoto Village](#), a community-based organization that works with pregnant women to provide comprehensive maternity guidance and support to Black and low-income women. Mamatoto Village uses community health workers (CHWs) and peer support to engage women who sometimes live in the same

environment, zip code, or block as the women to whom they conducted outreach. Prior to the pandemic, they did all of their work in-person or in some other location of their choosing.

Our program with Mamatoto Village has made a difference in terms of neonatal intensive care unit (NICU) admissions. We found that mothers also have greater satisfaction with the system, have longer gestation periods, and are keeping their six-week postpartum appointment.

We have similar experiences across our AmeriHealth Caritas markets where we have implemented comprehensive, community-based programs to address the issues of maternal outcomes and disparities. Our programs include providing peer support services for our members and offering a safe environment where they can speak to someone with whom they can relate.

MEDICAL-LEGAL PARTNERSHIPS (MLPS)

To understand factors that impact equity, it is also important to look at the legal system and specifically MLPs. MLPs are great vehicles and partners for MCOs because they help ensure concerns are addressed. For example, MLPs can provide support to families that have a child with asthma who is experiencing asthma stressors in their home environment. In Washington, D.C., the Children's Law Center is located within the Children's Hospital. AmeriHealth Caritas District of Columbia has contracted with them to do work for any of our members that we refer and are facing those types of challenges. If there are concerns around asthma, or if a family is in danger of being evicted and there are children in the house or a woman is pregnant, the Children's Law Center works with those families on our behalf. It is important to take a step back and think broadly about someone's life and help the whole person.

Challenges and Lessons Learned

Q. What have been some of the challenges in implementing health equity efforts?

Limitations in how MCOs can use Medicaid funds result in MCO-specific small-scale solutions to population health problems. For decades, we have documented the health care costs of members who have other needs. For example, individuals experiencing

homelessness with chronic conditions are twice as costly to a health plan as those who are not experiencing homelessness. Yet, we are very limited in how we can use our Medicaid dollars, which often leaves MCOs to craft their own solutions. This happens often, only at a much smaller scale. Some SDOH interventions are not reimbursable expenses from a Medicaid per member per month (PMPM) payment perspective, so we invest in these solutions with our administrative dollars.

Fragmentation across agencies and systems results in a lack of regulatory and funding alignment. We see that state- and city-based agencies are still not coordinated. The breadth of systems and services someone would need to address their needs, such as housing and other social services along with the health system, are not aligned. We need to re-align federal agencies and their regulations and not get stuck on the “wrong-pocket” discussion around how we can or cannot use dollars. We have seen great outcomes from blending funding streams and we need to think globally about the impact of using blended funding streams and how MCOs and CBOs play into those spaces. There is a lack of regulatory and funding alignment that prevents us from creating a commitment that bears fruit to consistent and sustainable changes.

Q. What have been the lessons learned to date?

KEY ELEMENTS FOR ACHIEVING HEALTH EQUITY

- Amplify member voices to understand individual and community needs
- Understand and address the structural factors (e.g., racism) that lead to health inequities
- Leverage data to identify disparities and trends
- Align with CBOs and other trusted entities in the community

Various elements are key to conducting health equity work:

- **Amplifying the voices of the communities we serve** and having them fully engaged. We need to be more inclusive of those we serve and understand people, communities, and their needs. This requires inviting members to tell us about those issues and continuously gathering member feedback to understand what works and what does not. Getting feedback directly from members takes the guessing out of our work and

provides a strong foundation to identify what resources communities need.

- **Understanding and addressing structural racism.** This is not just fixing the point-in-time symptoms but a journey of examining the most relevant factors that got us here. That requires data, advocacy, inclusion, and internal and external equitable processes.

“Sometimes we leap forward to where we are today and do not give enough due to the structural components, the historical and pervasive nature of racism that causes inequities... Pervasive racism means under-resourced and walled-off communities, and that influences health and health outcomes. We can try to influence someone’s health, but if those other underlying factors aren’t addressed, their health won’t improve.”

- **Leveraging data to understand the needs of populations.** Much has been written about disparities based on race/ethnicity that have been highlighted during the COVID-19 pandemic, but we were not necessarily surprised. Based on our race/ethnicity and language data and measures, we have seen that disparities and disease burdens exist in inequitable ways. Data identify those trends, recognize needs, and understand what is and is not working.
- **Aligning with trusted entities in communities, like CBOs.** Consumer-facing organizations have been doing strong work with CHWs and other outreach workers to understand communities’ needs. MCOs are generally not at the top of the list of peoples’ trusted entities. Much change happens based on the speed of trust and engagement, so partnerships with these trusted entities are important to achieving health equity. At the same time, CBOs have not been adequately resourced, which needs addressing.

These are the pillars designed under our DEI umbrella that serve to illustrate our vision of equity. If we can advance these enablers around health equity, we can make a much more significant difference.

Q. What lies ahead for the future of health equity efforts?

Without a societal culture shift in the United States — making health equity the expectation — health equity will be difficult to achieve. Still, we have hope for what lies ahead. We see these changes happening in conversations

around voting rights, which are top of mind right now. If providers and systems understand that their money comes from consumers, it can force recognition and change how they serve their consumers. A fragmented system is difficult to change, but it is about building a movement and elevating voices to speak up about what is not right. We need to not just talk about what went wrong during this COVID-19 pandemic, but also the lessons learned from this experience and how we can use them moving forward.

Conclusion

Based on our conversation with AmeriHealth Caritas, there are various considerations for MCOs and other key stakeholders seeking to advance health equity efforts:

- Key elements to conducting health equity work include:
 - **Understanding the structural factors**, including racism and SDOH, that result in health inequities.
 - **Amplifying community voices** and ensuring they have a seat at the table to identify community needs and inform policy and program design. Incorporating member voices into the implementation of equity-related programs and interventions helps MCOs understand how programs are working and make real-time adjustments to these programs.
 - **Collecting and leveraging** race, ethnicity, language, sexual orientation, gender identity, other sociodemographic, and SDOH data are crucial to understanding and addressing the needs of the community and of specific populations.
 - **Partnering with CBOs** given their status as trusted entities in communities.
- When building a culture of health equity within their organizations and across their health systems, MCOs should:
 - **Train MCO staff and health care providers** and their staff to better understand health equity and structural racism and how biases affect care delivery
 - Collect and use race and ethnicity, language, and SDOH data to inform the development of health equity efforts and **track outcomes**
 - Use data and input from members to **develop annual strategic plans around health equity goals** and monitor progress towards meeting those goals
- **Addressing the SDOH needs** of members, including transportation, food insecurity, peer supports, and legal needs, can help members improve health outcomes and achieve greater satisfaction within the health care

system. Real-time evaluation and assessment of these programs is crucial to strengthening interventions.

- **Aligning regulations and funding streams** can promote a more whole-centered approach to care. Currently, federal limitations in how MCOs can use Medicaid funds for SDOH-related and other programs and interventions result in MCO-specific, small-scale solutions to population health problems. Consider how Medicaid can further support SDOH efforts and how blended funding streams can be leveraged to support this work.

*Interview has been edited for length and clarity.

ABOUT NORC MEDICAID MCO LEARNING HUB

The key goal of the NORC Medicaid MCO Learning Hub is to serve as a source of information, expertise, and best practices to support managed care organizations in moving forward with system reform. NORC and its partner organizations identify, develop, and disseminate promising approaches and emerging opportunities for MCOs to improve the physical health, behavioral health, and social needs of their members.

Your ideas and opinions are important to us. We welcome your feedback on future Medicaid MCO Learning Hub work or programs you are working on to better serve your needs.

We want to hear from you. Please contact us at MCOLearningHub@norc.org to start the conversation or join our distribution list.

www.norc.org/Research/Projects/Pages/medicaid-managed-care-organization-learning-hub.aspx

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