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The Social Determinants of Health Arms Race in Medicare Advantage

presented to

Industry Collaboration Effort

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Meet the Speaker

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President Biden is ushering in a Golden Age of health equity.

SDOH arms race well underway in Medicare Advantage and Medicaid.

SDOH account for *60-80% of health spending.*

SDOH interventions reliably yield 3-8X ROI in reduced health costs.

Addressing poverty is the best path to bending the curve.

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SDOH Benefit Landscape

Health Related Supplemental Benefits

2016

MA plans can offer additional primarily health-related medical services, i.e., dental, vision, and hearing.

Supplemental Non-Medical Benefit Expansion

2019

Broader MA and Part D benefits are considered primarily health related, i.e., transport, meals, adult day care.

Flexibility in Uniformity Requirements

2020

MA plans can offer disease-tailored benefit designs, including lower cost sharing for certain services or supplemental benefits not available to all enrollees.

Special Supplemental Benefits for the Chronically Ill (SSBCI)

2020

Plans can offer disease-tailored benefits design, including lower cost sharing for certain services or supplemental benefits not available to all members.

SDOH Benefit Landscape

Guiding Principles

- Clear and easy to understand
- Equitable and targeted to those with greatest need
- Designed to be manageable and sustainable
- Evolve with experience and data supporting their effectiveness
- Compliant: no inducements or referrals

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Evidence for Improved Outcomes from SDOH Action

Researchers and Publication	Year	Type	Method	Results	Link to Study	
Feinberg, Passaretti, Coolbaugh, Lee, & Hess NEJM Catalyst	2018	Medically Tailored Meals	In 2016, Geisinger Health System sought to combat diabetes in Pennsylvania. Their partner, Fresh Food Farmacy, delivered 175,000 meals and provided each patient with 15 hours of nutrition education.	Over 18 months, Geisinger recorded a >40% decrease risk of and an 80% reduction in cost for patients, from an average of $240,000 pmpy to $48,000 pmpy.		80% MedEx Savings
Pruitt, Emechebe, Quast, Taylor, & Bryant Population Health Management	2018	Peer Support	A national Medicaid and Medicare Advantage health plan coordinated social supports for their members through an internal peer-based call center.	Members with their social needs met experienced a $2,443 PMPY savings in health care expense.		$2,443 PMPY Savings
Nichols & Taylor Health Affairs	2018	NEMT	Applied the Vickney-Clarke-Groves mechanism to evaluate the economic value of addressing transportation.	Researchers found $4B in annual savings with traditional NEMT in Medicaid and an incremental $537M in annual savings when scaled nationally.		$4B/Y Medicaid Savings
Christiansen & Morning University of Nevada, Nevada Health & Human Services Report	2017	CHW	Researchers evaluated a community health worker (CHW) operated by a managed care organization for a Medicaid super-user population in Las Vegas, NV between 2015 and 2017 using a pre-/post-intervention evaluation.	Researchers found a 1.8:1 overall ROI on the adoption of a CHW program resulting in an average 8% overall cost.		1.8x ROI
National Institute of Diabetes and Digestive and Kidney Diseases	2002	Behavioral Health	The NIDDKD studies the impact of lifestyle changes and medication adherence on preventing type 2 diabetes.	Researchers found lifestyle changes reduced participant risk of developing Type 2 diabetes by 58% and medication by 31%.	NIH	58% Reduced Risk

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SSBCI Growth

	Benefit	Number of Plans Offering in 2020:	Number of Plans Offering in 2021:	Enrollment in 2021 Plans: *(As of April 2021)*
Special Supplemental Benefits for the Chronically Ill (SSBCI)	Food and Produce	101	347	1,964,965 beneficiaries
	Meals (beyond limited basis)	71	387	1,529,531 beneficiaries
	Pest Control	118	208	1,471,089 beneficiaries
	Transportation for Non-Medical Needs	88	177	1,000,026 beneficiaries
	Indoor Air Quality Equipment and Services	52	140	742,663 beneficiaries
	Social Needs Benefit	34	227	914,897 beneficiaries
	Complementary Therapies	1	0	N/A
	Services Supporting Self-Direction	20	96	558,100 beneficiaries
	Structural Home Modifications	44	42	91,633 beneficiaries
	General Supports for Living	67	150	867,839 beneficiaries
	"Other" Non-Primarily Health-Related SSBCI *(See SSBCI section for other SSBCI)*	51	208	864,299 beneficiaries
	TOTAL (offering Non-Primarily Health-Related SSBCI):	245	831	3,278,602 beneficiaries
	Primarily Health-Related SSBCI	22	111	830,717 beneficiaries
	TOTAL (offering any SSBCI):	267	942	4,109,319 beneficiaries

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Primarily Health-Related Benefits Growth

	Benefit	Number of Plans Offering in 2020:	Number of Plans Offering in 2021:	Enrollment in 2021 Plans: *(As of April 2021)*
Expanded Primarily Health-Related Benefits	In-Home Support Services	223	429	1,825,863 beneficiaries
	Adult Day Health Services	84	127	672,601 beneficiaries
	Home-Based Palliative Care	61	134	609,338 beneficiaries
	Support for Caregivers of Enrollees	125	95	560,565 beneficiaries
	Therapeutic Massage	230	176	464,823 beneficiaries
	TOTAL (offering at least 1 expanded primarily health-related supplemental benefit):	499	737	2,972,869 beneficiaries
	TOTAL (offering at least 1 benefit listed above)	**635**	**1,351**	**5,377,087 beneficiaries**

All supplemental benefits financed through rebates and premium dollars

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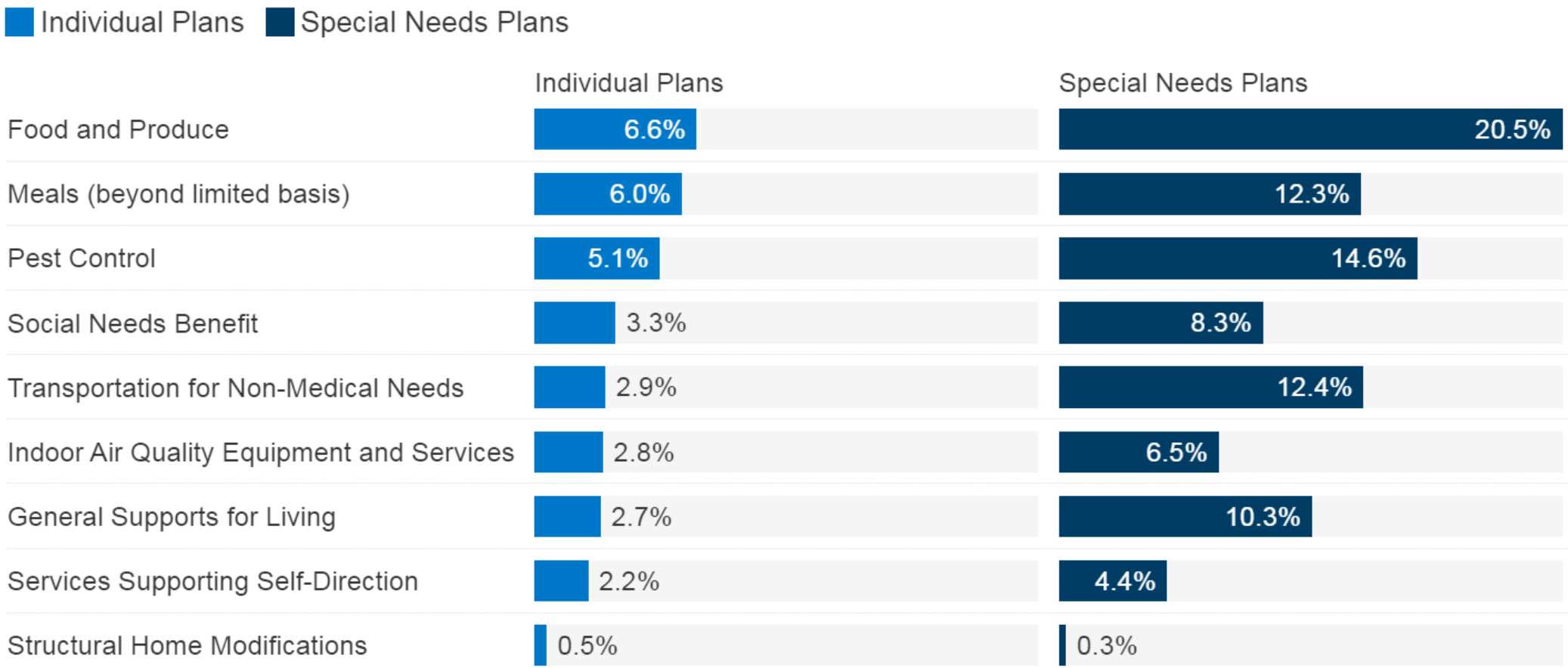
As of 2021, the vast majority of plans do not offer Special Supplemental Benefits for the Chronically Ill (SSBCI)

Share of Medicare Advantage Enrollees in Plans with Access to SSBCI Benefits, by Plan Type, 2021



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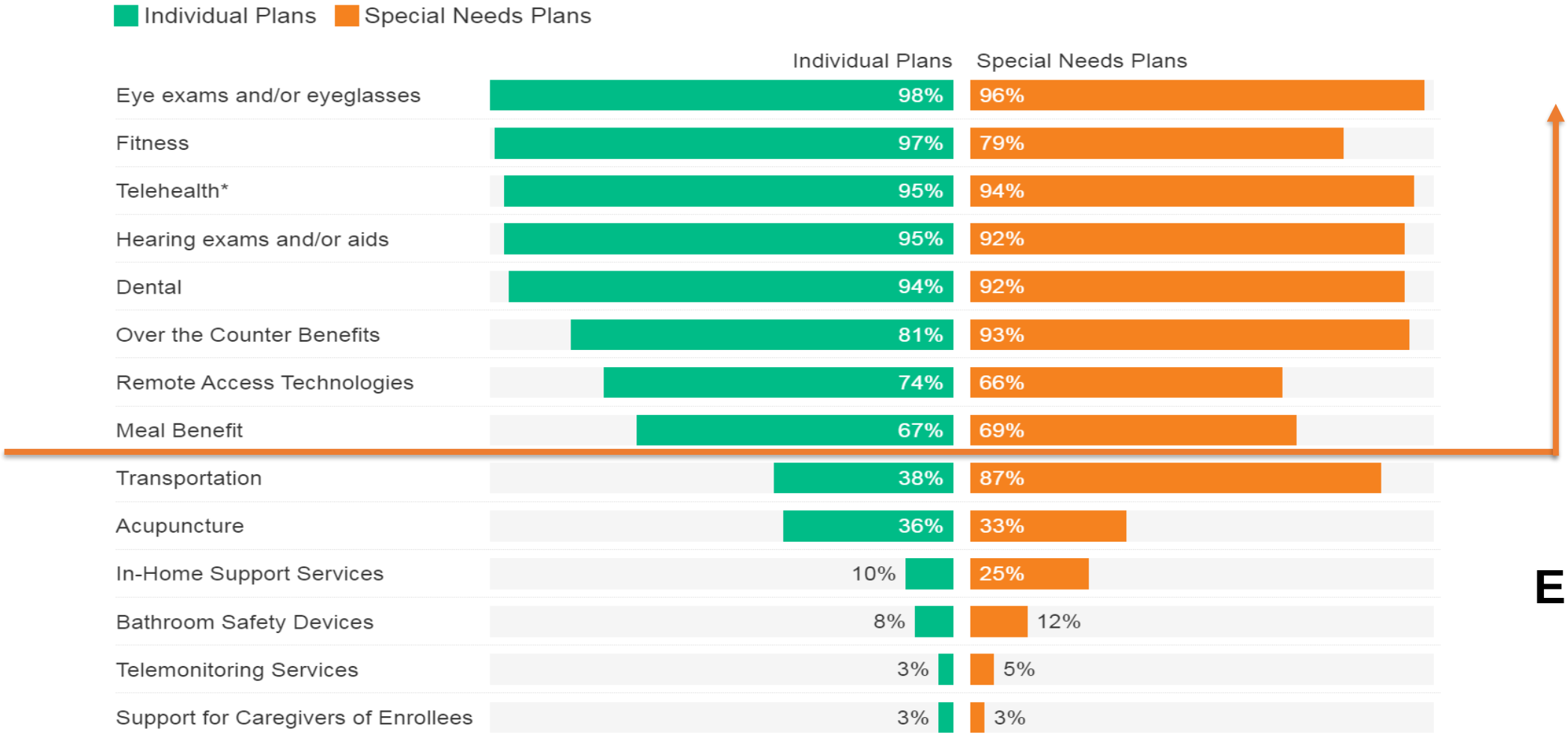
More than 90% of individual Medicare Advantage plans provide access to vision, fitness, telehealth, hearing, or dental benefits

Share of Individual and SNP Medicare Advantage Plans with extra benefits by benefit and plan type, 2022



"Table Stakes"

Emerging

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SDOH Benefit Landscape: Takeaways

- **48%↑ in Primarily Health-Related benefits in 2021**
- **253%↑ in SSBCI plan offerings in 2021**
- **More SNPs (29%) than Non-SNP (12.4%) Plans offer SSBCI**
- **Fastest Growing Health-Related Benefit 2021: 92% ↑ - In-Home Support Services**
- **Fastest Growing SSBCI in 2021**
    - 568%↑ - Social Needs Benefit
    - 445%↑ - Meals
    - 380%↑ - Services Supporting Self Direction
- **National plans and SNPs leading, local/regional plans lagging**

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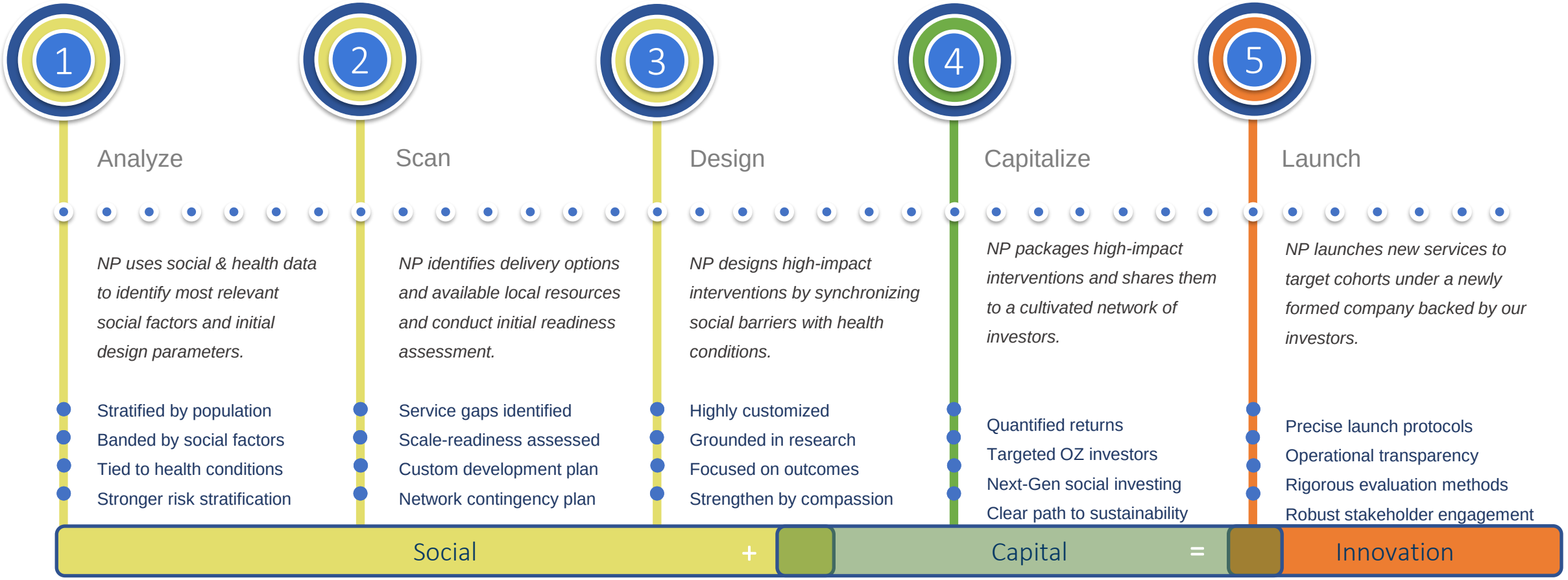
Social Health Innovation Process



Diligence and Analytics

1. Analyze
2. Scan
3. Design
4. Capitalize
5. Launch

Social Profile by Consumer

	Social Factor	Risk Score
1	**Unstable housing**	**28**
2	**Food Insecure**	**25**
3	**Financially Insecure**	**23**
4	**Exposed to poverty**	**20**
5	Food Insecure	**19**
6	High Crime Area	16
7	Personal Safety Risk	16
8	Social Isolated	15
9	Lacks Transportation	14
10	Primary Caregiver	14

Social Barriers by Population

	Social Factor	Prevalence
1	**Unstable housing**	**30%**
2	**Financially insecure**	**27%**
3	**Lack transportation**	**25%**
4	**Exposed to poverty**	**22%**
5	**Food Insecure**	**21%**
6	Lack of Employment	18%
7	Inadequate Healthcare	17%
8	Social Isolated	15%
9	Falls risk	12%
10	No diploma	11%

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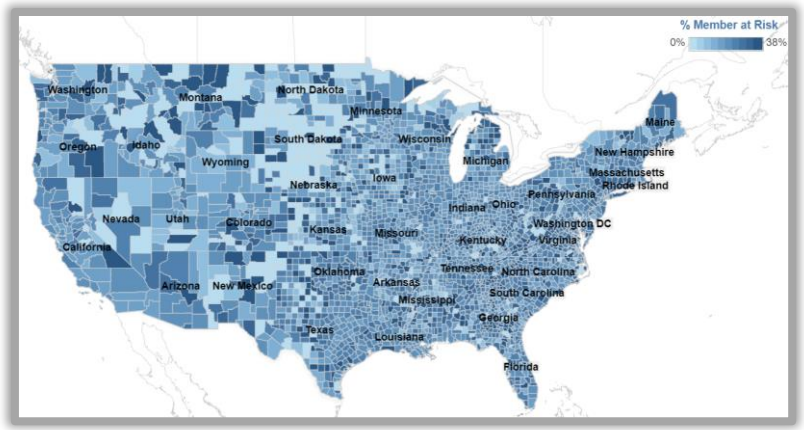
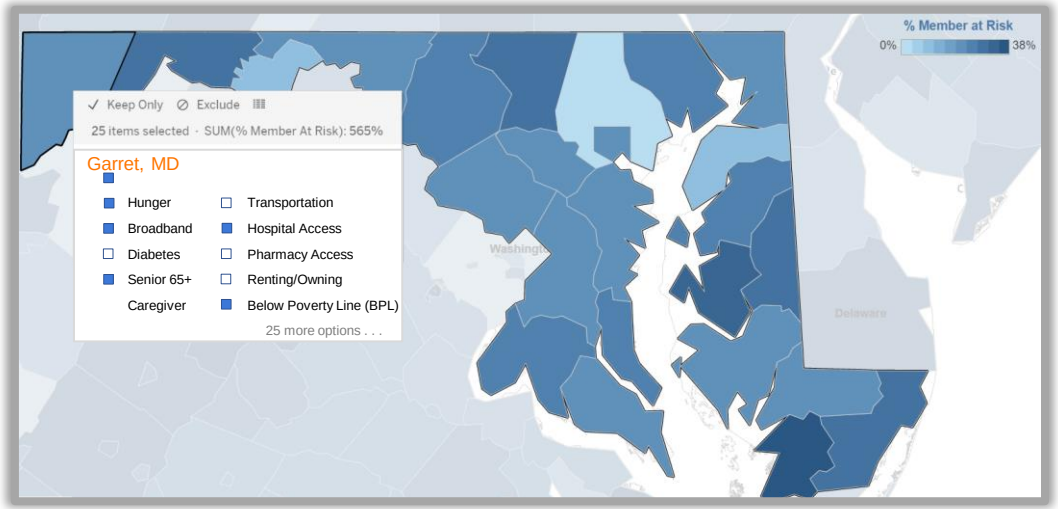
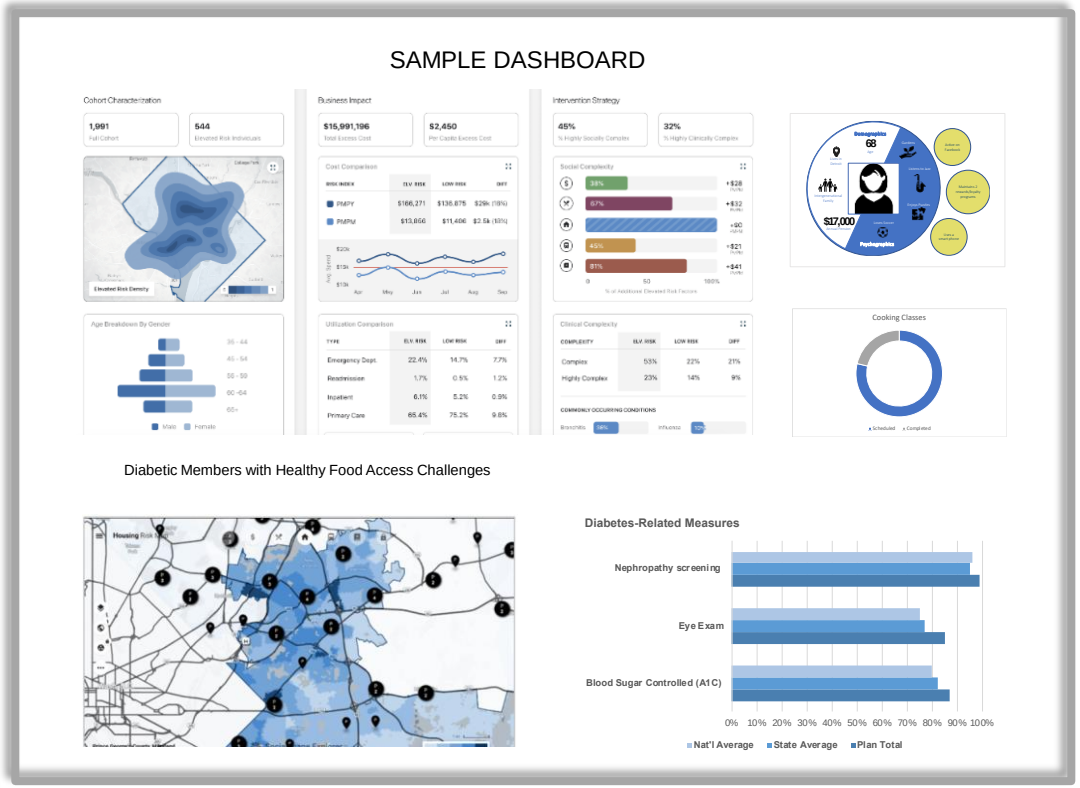
Identifying Need, Mapping Services

1. Analyze
2. Scan
3. Design
4. Capitalize
5. Launch







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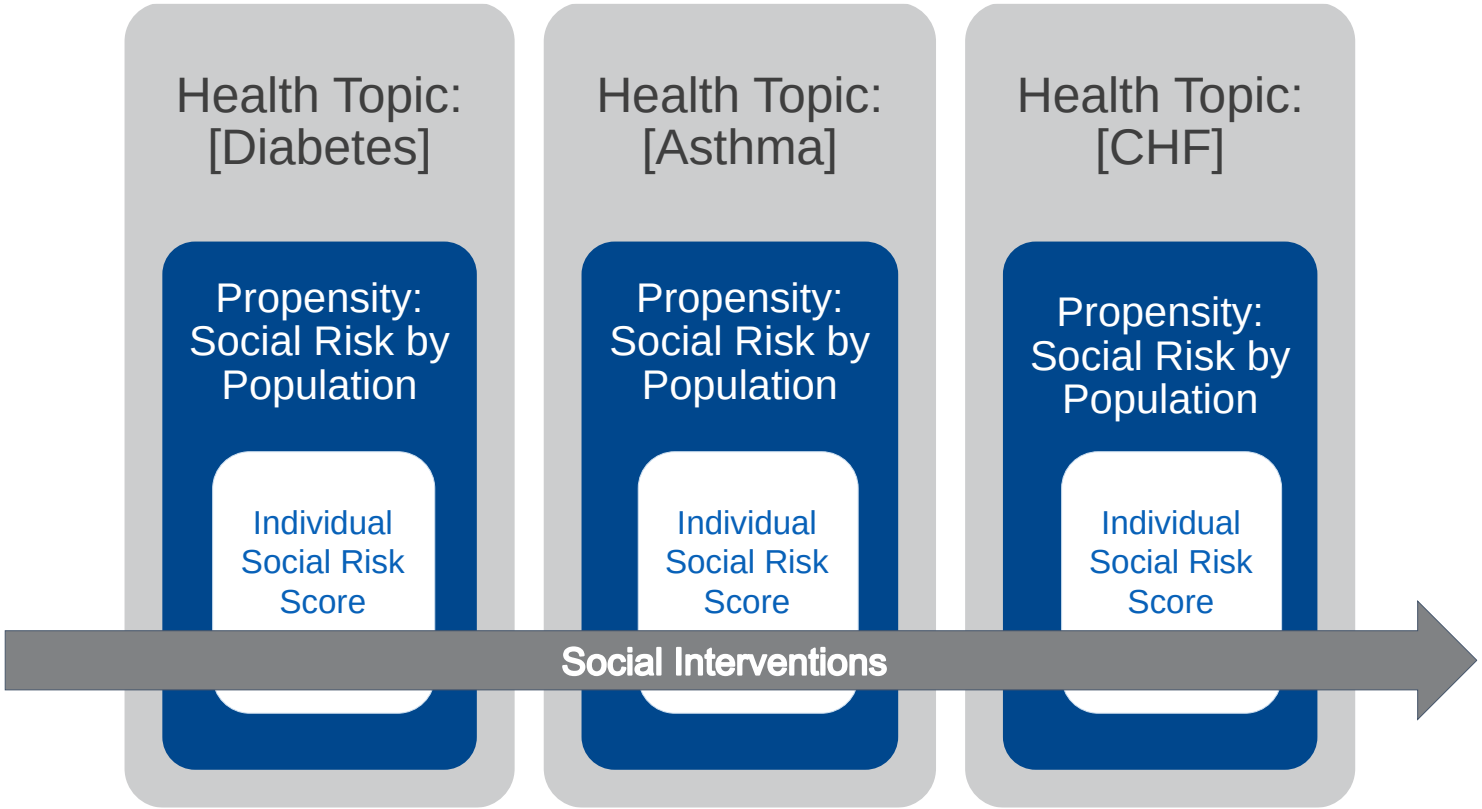
Translating Analytics to Action

1. Analyze
2. Scan
3. Design
4. Capitalize
5. Launch



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Funding SDOH Programs

1. Analyze
2. Scan
3. Design
4. Capitalize
5. Launch

Benefit Financing

On-Benefit	• Paid by plan and included in bid.
Mid-Year Benefit Enhancement	• Paid by plan and/or external financing.
Off-Benefit	• Administrative benefit. Paid by plan and/or external financing.
SSBCI	• Paid by plan and/or external financing and included in bid.

External Financing Sources

Federal Government	• e.g. COVID relief bill
State Government	• State program funded.
Private	• Funded by local stakeholders, foundations, philanthropy, and/or private investors.

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Member Data Sources

Data Source	Data Type	Pros	Cons
Internal Health Plan	• Claims • Health Risk Assessments (HRA) • Electronic Health Record (EHR) • Behavioral health screening • Annual wellness visits • Member service calls • Employees	• Ability to gather point of care information or infer from other data sources	• Lack of standard collection method across industry • Limited out of network data
External Provider/Health System	• Z-Codes • School Health Centers • Employees	• Identifies persons with potential health hazards related to socioeconomic and psychosocial circumstances	• Structure of data is not comprehensive and not widely adopted • Prevalent inaccuracies and differences in collection method
External Private	• Data Vendors • Community Based Organizations (CBOs)	• Well organized and collated (vendors) • Variety of non-medical data points	• Costly to acquire and access (vendors) • Interoperability between CBOs and between CBOs and plans/providers
External Public	• Community Health Assessments (CHA) • Public health • Government (CDC, HHS, BLS, etc.)	• Contains information such as geo-zone, housing, education, employment, and transportation.	• Rarely reported at the individual level • Dated data collection and methods
External Direct from Consumer	• Surveys • Patient Reported Outcomes (PROs) • Social Media • Biometrics • Consumer activity	• Real-time and current data points • Best source of psychosocial data	• Prevalent self-reporting bias

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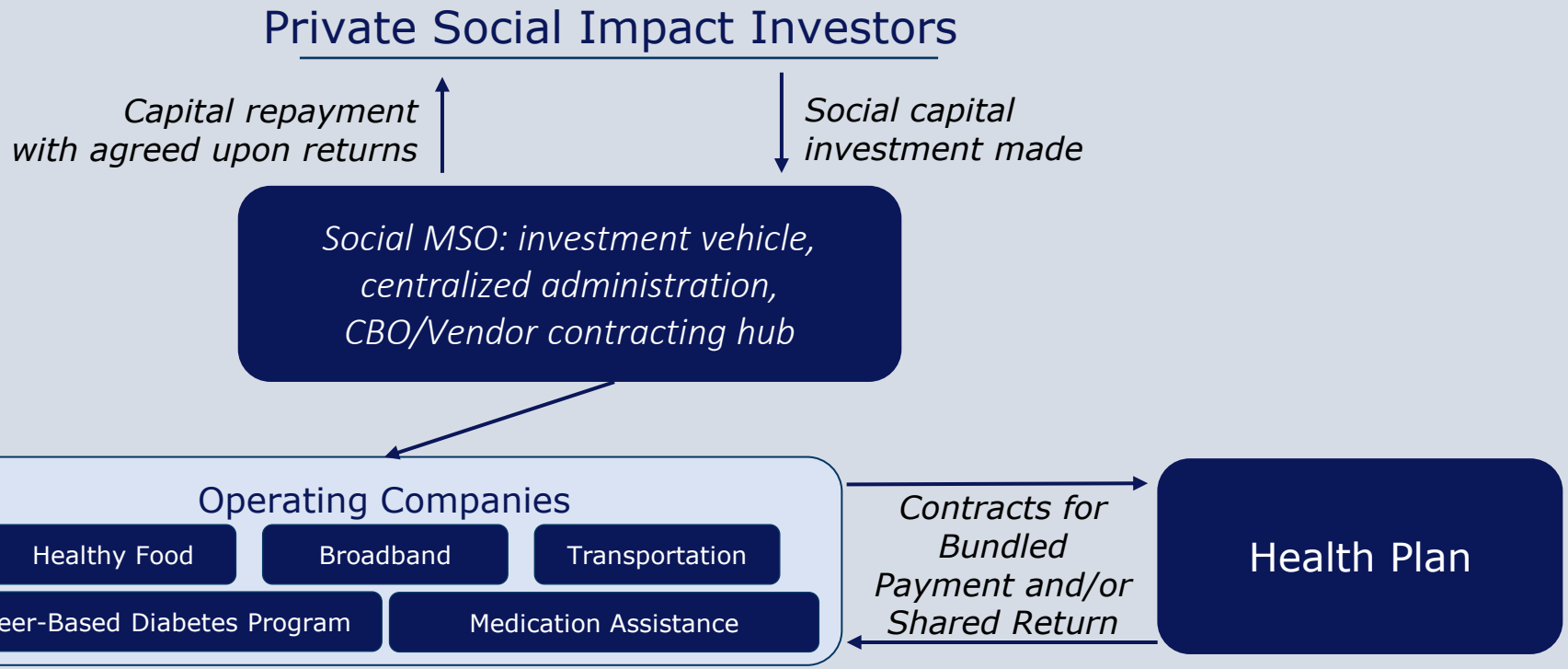
"Social MSO" Structure Design

The goal of this structure is to bring additional resources to the community and a platform for SDOH benefits management.



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"Social MSO" Design Process

Prompts

- Anytown, USA
- Members with Diabetes
- Lines of Business: Medicare Advantage
- Presenting Social Challenges:
  - Limited healthy food options
  - Inconsistent transportation
  - Housing instability
  - Literacy

Assumptions

- Population:
  - Total Population: 5,000
- Cost and Design:
  - Penetration: 15% diagnosed; 20% rising risk
  - Target population: ~1,750 total
  - Cost: ~$750 per diabetic member per month
  - Current Contact Rate: 50-75%
  - Current Diabetes Quality Score: 3.0

Recommendations

- Areas of Focus
  - Offer a Diabetes Prevention Program
  - Introduce healthy food resources
  - Expand peer-based health education
  - Medication assistance (affordability)
  - Wrap around transportation
  - Weave broadband into interventions above

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Savings Model Example and Impact of Broadband

Blended Population	Medicare Advantage	
Premium	971.29	
MedEx	786.74	81%
Net Adjusted	91.30	9%
Gross Margin	93.24	10%
Ave. Tenure	44	
Net Present Value	4102.73	

Diabetic Population		
Premium	971.29	
MedEx	1,536.74	158 %
Net Adjusted	91.30	9%
Gross Margin	-656.76	-68%
Ave. Tenure	44	
Net Present Value	-28,897.24	

	Medicare Advantage			
	No Broadband		With Broadband	
Enrollment	5,000		5,000	
Diabetes	750	15%	750	15%
Risking Risk	1,000	20%	1,000	20%
Target Population	1,750	35%	1,750	35%
Find	875	50%	1.313	75%
Reach	438	50%	1,116	85%
Engage	153	35%	390	35%
Complete	138	90%	351	90%

Lift driven by access to social media, online tools, and use of psycho-graphics

Rounded for illustration

	Cost PMPM	Estimated Savings PMPM	Net Estimated Savings PMPM	Medicare Advantage			
				Freque-ncy	Est. Cost PMPY Engaged = 390	Est. Savings PMPY Completed = 351	Net Difference
DPP	$50	$200	$150	25%	$60,000	$200,000	$140,000
Level 1: Healthy Food Options	$200	$325	$125	5%	$50,000	$75,000	$25,000
Level 2: L1 + Peer Based Nutrition Education	$400	$750	$350	10%	$200,000	$325,000	$125,000
Level 3: L2 + Transportation	$425	$800	$375	25%	$50,000	$850,000	$800,000
Level 4: L3 + Medication Assistance	$525	$1,025	$500	35%	$90,000	$1,500,000	$1,410,000

Program Cost PY	Savings PY	Net Savings PY	ROI
$500,000	$3,000,000	$2,500,000	5X

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Measuring Success

Data drives the design of interventions that are hyper-focused on target populations that is then rigorously evaluated using both academic and industry-leading methods across three high-impact areas – member engagement, health outcomes and financial return.

Member Engagement

- Greater member loyalty and length of tenure
- Increases in member selection/plan choice
- Higher NPS scores among providers and members

Health Outcomes

- Quantifiable lift in HEDIS and STARS quality scores
- Fewer missed or late appointments
- Increased compliance with prevention/treatment plans

Financial Return

- Revenue optimization, more risk pool payments
- Fewer liquidated damages and less reliance on EDs
- Higher scoring RFP responses from social innovation

Compliance Considerations

- If on-benefit (in bid), SDOH benefits must be offered uniformly and consistently without cost sharing
- If off-benefit (administrative), eligibility clearly defined and uniformly applied to established members without cost sharing
- No cost-shifting to CMS, members or other entities
- SDOH benefits cannot be used as inducements to join a plan or generate referrals
- 2017 Safe Harbor for transportation services

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Thank you!

Chairman and Founder, Nightingale Partners

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