Winning the Arms Race in Social Determinants of Health

A Presentation to the 21st Annual Industry Collaboration Effort Conference

JOHN GORMAN
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NIGHTINGALE PARTNERS

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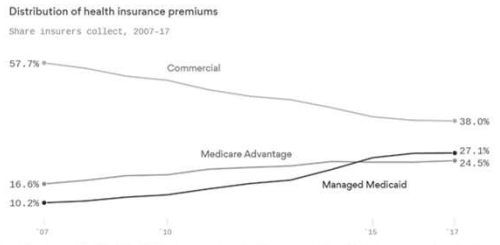
CUT TO THE CHASE!

- Medicare Advantage and Medicaid remain the sole sources of revenue growth for plans, providers, pharmacies and PBMs
- Medicare Advantage and Medicaid are the biggest laboratories for SDOH, enabled by new policies and abundant evidence
- SDOH interventions are only hope to "bend the curve" on health care expenditures
- *"A Darwinian and Edisonian moment"*

2

COMMERCIAL INSURANCE DECLINING; GOVERNMENT PROGRAMS SURGING



Adapted from Lane et al., 2018, "Best's Market Segment Report: U.S. Government-Related Health Insurance Business Continues to Grow Despite Risks"; Chart: Axios Visuals

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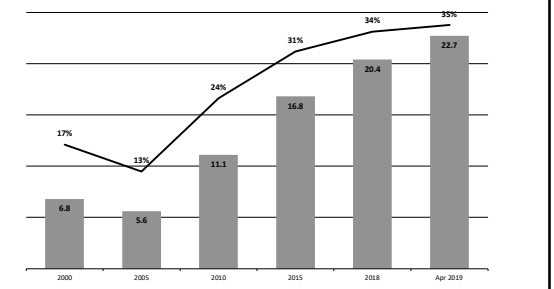
MEDICARE ADVANTAGE'S STUNNING GROWTH



NOTES:
1. Includes All MA Plan Types
2. Source: CMS MA State/County Penetration
3. Total Medicare Beneficiaries as of April 2019 = 65 million

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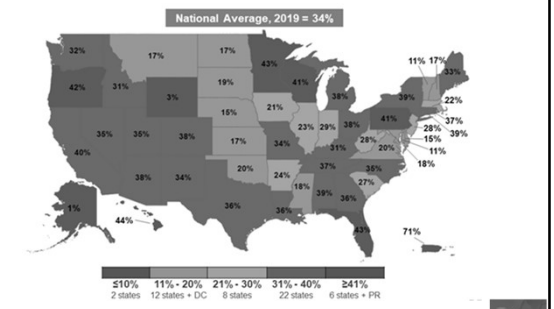
MEDICARE ADVANTAGE ENROLLMENT PENETRATION RATES, 2019



NOTE: Includes cost plans, which comprise the majority of enrollment in MN, ND, and SD, as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses.
SOURCE: Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2019.

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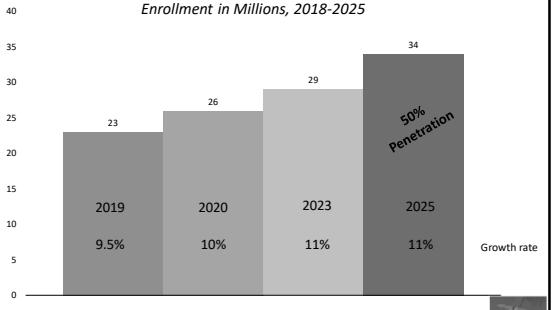
EXPLOSIVE GROWTH IN MEDICARE ADVANTAGE CONTINUES "4-EVA"

Enrollment in Millions, 2018-2025



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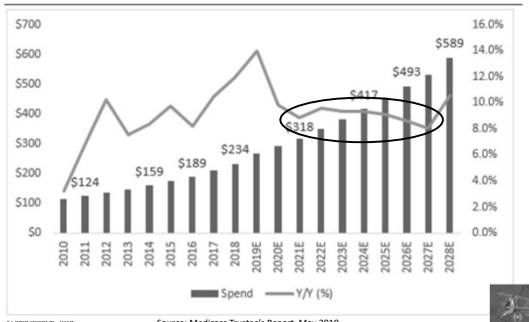
MEDICARE ADVANTAGE PAYMENTS TO PRIVATE INSURERS, 2010-2028



Source: Medicare Trustee's Report, May 2019

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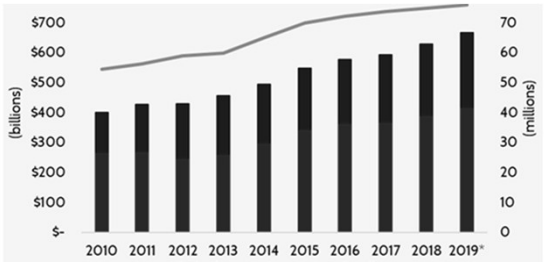
MEDICAID EXPENDITURES AND ENROLLMENT



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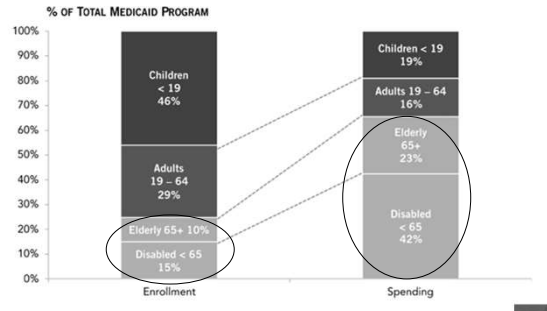
MEDICAID EXPENDITURES BY BENEFICIARY COHORT



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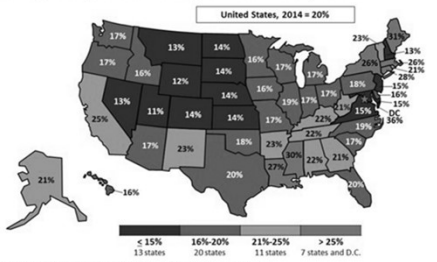
DUAL ELIGIBLES ARE THE INSURANCE INDUSTRY'S BIGGEST OPPORTUNITY

One in five people on Medicare receive assistance from Medicaid

Dual Eligible Beneficiaries as a Share of Medicare Enrollees, by State



SOURCE: Kaiser Family Foundation analysis of Chronic Conditions Warehouse 2014 data.

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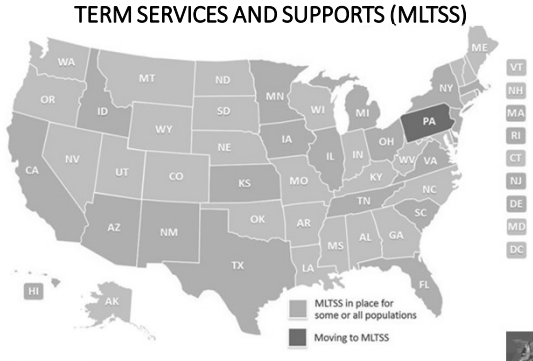
STATES WITH PROGRAMS FOR MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS)



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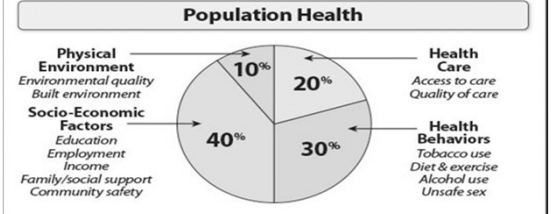
Social Determinants of Health

Population Health



Source: Authors' analysis and adaption from the University of Wisconsin Population Health Institute's *County Health Rankings* model ©2010, http://www.countyhealthrankings.org/about-project/background

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SDOH IS A TOP HEALTH SYSTEM PRIORITY

- Health systems are taking on more financial risk and those that are tax-exempt are seeking to protect their tax status by demonstrating their community benefit
- Asked to choose top strategic priorities now and in five years, 86% of health system execs said "social determinants of health" is a top three strategic priority
- 69% of academic medical centers said their future would lie in being a master of SDOH

Source: PWC Tax Policy Institute, July 2019

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MA SUPPLEMENTAL BENEFITS POLICY = GAME CHANGER

- CMS seeks to allow for benefits which ***"reduce avoidable emergency and healthcare utilization."***
- Opportunity for plans to offer SDOH benefits, include in the bid
- Challenges:
  - No new CMS payments for SDOH
  - In-house actuaries struggle to get their heads around non-clinical benefits
  - If plan invests its own capital, SDOH benefits impact premium

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SDOH SAVINGS WILL "BEND THE CURVE," ARMS RACE UNDERWAY

- $190 BILLION in preventable SDOH-related medical expense among seniors alone
- Heavy transaction activity in the space already in 2019:
  - Kaiser and United invest $400M in social services platform
  - Unite Us secures $35M in Series A financing
  - Solera secures $42M in Series C financing
- 14 health systems invest $700M in SDOH

After Buying Aetna, CVS Health Commits $100M to Address SDOHs

HEALTH TECH MATTERS

Signify Health acquires start-up TAV Health in multimillion-dollar deal

Centene Corporation Announces Formation Of Social Health Bridge To Address Social Determinants Of Health

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SDOH: THE EVIDENCE

Housing and Home Safety

- 1.56 million Americans are housing insecure.
  - On average, housing-insecure people visit the ER 5x per year.
  - Each visit costs on average $3,700; that's $18,500 spent per year for the average person and $44,400 spent per year for the highest users of emergency departments.
  - Housing insecure seniors incur this rate 8-10X, especially in winter.
- 1/3 of seniors fall every year. Total medical costs for falls among seniors total more than $31 billion annually, or about $12 billion in potential savings in Medicare Advantage alone.

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SDOH: THE EVIDENCE

Housing and Home Safety

- A NYC "Medical-Legal Partnership targeting patients with asthma found a 91% decline in ED visits/hospital admissions among those receiving housing services."
- A 2009 analysis of supportive housing in Los Angeles County showed that people with stable housing cost taxpayers 79% less than their homeless counterparts
- Anthem Indiana Medicaid launched the Blue Triangle transitional housing Program in May 2017, resulting in an $872 PMPM savings.
- UPMC Health Plan: savings of $8,472 PMPY, with pharmacy cost increases of $2,088 per year, due to better medication adherence. This resulted in net savings of $6,384 PMPY.

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SDOH: THE EVIDENCE

Housing and Home Safety

- Research consensus:
  - Health care costs for those in supportive/transitional housing are reduced by 59%.
  - Emergency room costs are decreased by 61%.
  - General inpatient hospitalizations are decreased by 77%.
- ***Housing often has high savings but large capital requirements and time to deploy.***

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SDOH: THE EVIDENCE

Social Welfare Benefit Enrollment

- A recent study found $2,120 per patient per year, or $26 PMPM, in proven annual medical expense savings for enrolling low-income seniors in existing benefit programs.
- Benefit enrollment also unlocks approximately $8 Billion in unclaimed risk adjustment revenue for Medicare Advantage and Medicaid insurers. 30-50% of "dual eligibles" qualifying for both Medicare and Medicaid (5-7 million) are not enrolled in Medicaid.

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SDOH: THE EVIDENCE

Community Health Workers (CHWs)

- An average savings of $2245 per member per year has been demonstrated with CHW services along with a significant reduction in utilization:
  - 12.6% decrease utilization
  - 18% to 11% reduced readmissions
- Typically, 20%-30% of a Medicare Advantage plan's membership is hard to reach over the phone and 10% are completely unreachable.
- CHWs play a vital role in reaching and engaging this population for intervention - including key Stars measures and cost-reduction efforts.

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SDOH: THE EVIDENCE

Transportation

- 2.3% of the US population are transportation disadvantaged. This number is much higher among the elderly at 20%.
- $37.5b in health care expenses are caused by patient no-shows in the US, with seniors and the low-income most likely to miss appointments and to use the emergency department as a source of primary care.

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SDOH: THE EVIDENCE

Food Security

- 12% of US families are food insecure. $77 billion in medical expenses are attributable to food insecurity each year, especially among the elderly and low-income.
- 34% of seniors in Medicare Advantage are known to be food insecure, with $51 billion in avoidable health care expense associated with malnutrition in seniors.
- 28% of diabetics were found to be food insecure among Geisinger Health System's population, who found savings as high as 80% from food programs; costs dropped an average of ***$192,000 per member per year***, with an average drop of $8000 with each drop in A1c point.

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SDOH: THE EVIDENCE

Loneliness and Social Isolation

- Social isolation and loneliness is estimated to cost $7B in additional Medicare expenses, and loneliness is equated with smoking 15 cigarettes per day in adverse health effects for seniors.
- 43% of those 65 and older express feeling lonely. 1 in 5 live alone. Loneliness is the primary driver of depression, which is known to be a 4x multiplier of chronic condition costs.
- The savings opportunity associated with addressing loneliness in Medicare Advantage alone is known to be over $2 billion annually.

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SDOH: THE EVIDENCE

	Market Opp (MA Population)	% MA Population	Net PMPM* value (total membership)
Benefit Enrollment	$15B	Up to 40%	$11-40+
Food Security	$17.34B	15%	$8-21
Housing/ Home Safety	$11.6B	25%	$1-2.6
Loneliness Outreach	$2.1B	43%	$5-10
Community Health Workers	$30B+	30%	$12-50
Transportation	$9.68B	20%	$4.5-18
Palliative/ Complex Care	$30B+	2-5%	$7-26
Opioid MAT	$1.9B	0.5%	$1-4

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GUIDING PRINCIPLES FOR SDOH BENEFITS

- They should be clear and easy to understand
- They should be equitable and targeted to those with greatest need
- They should be designed to be manageable and sustainable
- They should evolve with experience and data supporting their effectiveness

Source: LTQA, July 2019

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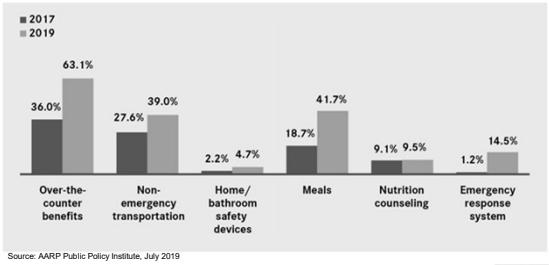
WHAT MA MARKET LEADERS ARE DOING ON SUPPLEMENTALS AND SDOH IN 2019

Percentage of Medicare Advantage Plans Offering Previously Allowed Supplemental Benefits, 2017 and 2019



Source: AARP Public Policy Institute, July 2019

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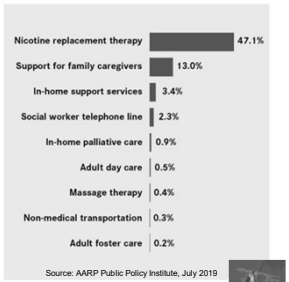
WHAT MA MARKET LEADERS ARE DOING ON SUPPLEMENTALS AND SDOH IN 2019

- In 2019 most MA plans focused on expanding previously-offered benefits
- Few embraced "next-gen" SDOH interventions like in-home support or adult day care
- Biggest question is how to finance these services long-term without impact to premium

Percentage of Medicare Advantage Plans Offering New Supplemental Benefits in 2019



Source: AARP Public Policy Institute, July 2019

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WHAT MA MARKET LEADERS ARE DOING ON SUPPLEMENTALS AND SDOH IN 2019

- Blues workgroup on supplementals, focus on palliative home care
- Anthem "Essential/Everyday Extras" (GA, IN, KY, MO, OH, VA, WI, TN, TX, NJ, CA, AZ):
  - Up to 16 home delivered "healthy" meals per health event, up to 64 per year.
  - Up to 60 one-way trips per year to health-related appointments.
  - Up to 124 hours of support from a home health aide or similar assistance.
  - A $500 allowance for home safety modifications.
  - Up to 1 visit per week for adult day services.
  - Up to 24 acupuncture and/or therapeutic massage visits.
  - In CA and AZ add a fitness program, acupuncture and/or therapeutic massage for pain management, and an outreach program aimed at addressing loneliness.

Anthem BlueCross BlueShield

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WHAT MA MARKET LEADERS ARE DOING ON SUPPLEMENTALS AND SDOH IN 2020

- Over-the-Counter (OTC): 80% of Nationals, 50% of Blues and 47% of Provider-Owned Plan products carry the benefit.
  - Among the larger Blues, there are various levels of OTC adoption:
    - High Adoption: Blue Cross NC (100%), BlueCrossMN (75%)
    - Medium Adoption: Blue Cross Blue Shield of Michigan (55%), Florida Blue (50%)
    - Low Adoption: Health Care Service Corporation (25%), Blue Cross Blue Shield of Massachusetts (0%), Excellus BlueCross BlueShield (0%)
- Meal Benefit: 64% of Nationals, 22% of Blues and 28% of Provider-Owned Plan products carry the benefit.
  - 95% of Cigna and 94% of Humana products include the benefit, while only 15% of United products do.
- Transportation Services: 46% of Nationals, 32% of Blues and 28% of Provider-Owned Plan products carry the benefit.
  - Anthem, Cigna and Molina all have transportation services included in over 70% of their products, with Aetna and Kaiser being at 19% and 29%, respectively.

Source: Pareto Intelligence, October 2019

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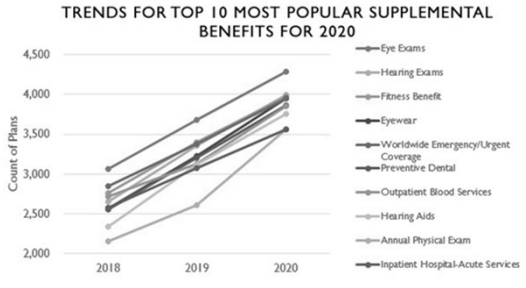
SUPPLEMENTAL BENEFIT OUTLOOK FOR 2020



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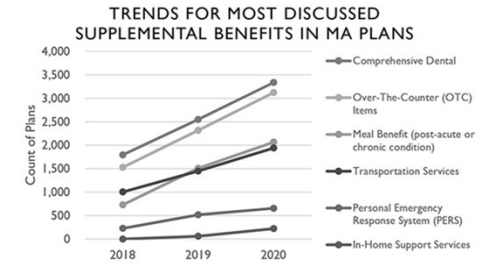
SUPPLEMENTAL BENEFIT OUTLOOK FOR 2020



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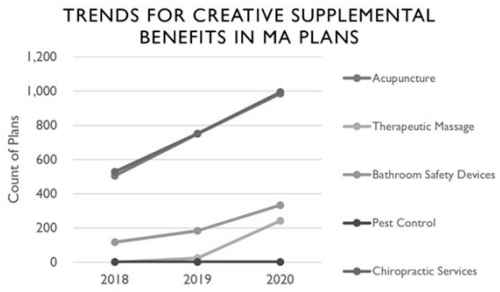
SUPPLEMENTAL BENEFIT OUTLOOK FOR 2020



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THE NEXT GENERATION OF MA BENEFIT DESIGN

- Reduce/eliminate copays and deductibles
- Tiered supplemental benefits
- Vision, dental, hearing, OTC = new table stakes

2021:
Opioid treatment
MTM/Polypharmacy
Mental/behavioral care access
Dementia care
Adult day care
Telehealth
Caregiver Support/Respite

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MEDICAID STATE OF PLAY ON SDOH

- 40 states are addressing SDOH through their Medicaid programs, mostly around partnerships with community organizations and agencies and care coordination
- 35/39 states now require managed care organizations (MCOs) to screen enrollees, provide referrals to services
- Moving community-based organizations away from grants toward billing for services under VBP contracts
- Emphasis on data collection and effectiveness measurement:
  - Z codes in ICD-10-CM, to help clinicians capture a patient's socioeconomic and/or psychosocial needs
  - Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool

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EXAMPLES OF MEDICAID SDOH ACTIVITIES

- MD, MA, NM, RI: requires MCO to identify homeless, link to housing
- FL, NE: requires coordination between plans and community resources for those who are food insecure
- KS, WV: requires the plan to assist members with work opportunities and identify/treat behavioral/medical needs preventing employment
- AZ, FL, IA, IN, KY, MI, NM, WI: healthy behavior incentive programs, e.g., obesity mitigation, SA treatment, smoking cessation

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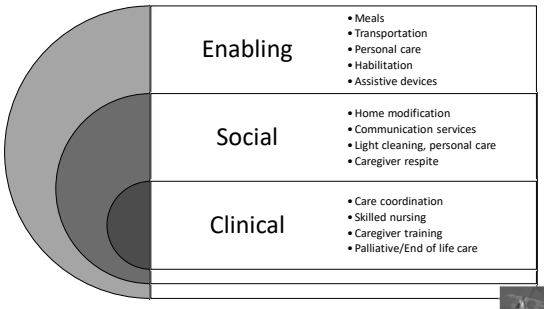
THE NEW NORMAL IN NETWORK MANAGEMENT



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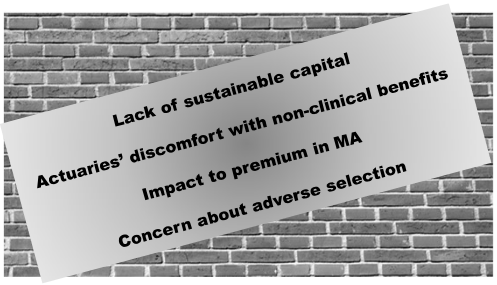
BARRIERS TO SDOH BENEFITS



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EXTERNAL SOURCES OF CAPITAL FOR SDOH

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THREE TAX INCENTIVES THROUGH OZs

Temporary Deferral

A temporary deferral of inclusion in taxable income for capital gains reinvested into an Opportunity Fund. The deferred gain must be recognized on the earlier of the date on which the opportunity zone investment is disposed of or December 31, 2026.

Step-Up Basis

A step-up in basis for capital gains reinvested in an Opportunity Fund. The basis is increased by 1-% if the investment in the Opportunity Fund is held by the taxpayer for at least 5 years and by an additional 5% if held for at least 7 year, thereby excluding up to 15% of the original gain from taxation.

Permanent Exclusion

A permanent exclusion from taxable income of capital gains from the sale or exchange of an investment in an Opportunity Fund if the investment is held for at least 10 years. This exclusion only applies to gains accrued after an investment in an Opportunity Fund.

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ALMOST 9,000 OPPORTUNITY ZONES

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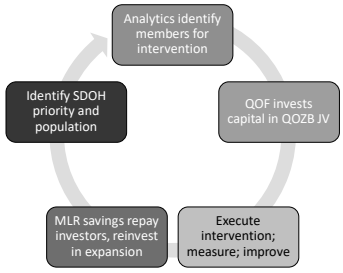
OPPORTUNITY ZONES AND SDOH FINANCING



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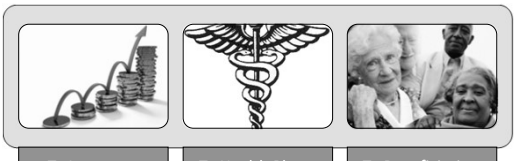
NIGHTINGALE'S VALUE PROPOSITION



To Investors:	To Health Plans:	To Beneficiaries:
Long-term OZ tax shelter, favorable IRR, quantifiable social impact	"De-risking" social benefits, accelerating savings, move to value	Access to new benefits and services that improve quality of life and cost of care

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NIGHTINGALE USE OF FUNDS: PROJECTS A - D

Approximately $43.7 million

Project A: Community Health Workers

Investment: Provide a hub for CHWs regarding technology, patients and services

NGP Role: Coordinate vendor and Plan/Provider to establish savings targets; administer necessary investment and human capital to execute developed strategy

Implementation Cost:

Years 1 & 2 - $4.5 million

NGP Shared Savings:

Year 4 – $15.3 million

Year 5 – $16.1 million

Project B: Homelessness

Investment: Tenant-centric programs to reduce health system costs and outcomes

NGP Role: Coordinate vendor and Plan/Provider to establish savings targets; administer necessary investment and human capital to execute developed strategy

Implementation Cost:

Years 1 & 2 - $10.9 million

NGP Shared Savings:

Year 4 – $22.6 million

Year 5 – $23.8 million

Project C: Diabetic Meals

Investment: Clinically tailor meals for diabetic and HTN Patients

NGP Role: Coordinate vendor and Plan/Provider to establish savings targets; administer necessary investment and human capital to execute developed strategy

Implementation Cost:

Years 1 & 2 - $11.5 million

NGP Shared Savings:

Year 4 – $20 million

Year 5 – $60 million

Project D: Transportation

Investment: Digitally-enabled transportation across various ride options

NGP Role: Coordinate vendor and Plan/Provider to establish savings targets; administer necessary investment and human capital to execute developed strategy

Implementation Cost:

Years 1 & 2 - $3.75 million

NGP Shared Savings:

Year 4 – $5.8 million

Year 5 – $6.1 million

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JOHN GORMAN
Founder and Chairman

202-255-6924

John.Gorman@NightingalePartners.org

Tweeting @JohnGorman18

https://www.linkedin.com/in/john-gorman-098b265/

ANDREY OSTROVSKY, MD
Chief Executive Officer

443-857-8199

Andrey.Ostrovsky@NightingalePartners.org

https://www.linkedin.com/in/andreyostrovskymd/

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