COVID-19 Update, BHCG 2019 Virtual Health Plan Results and Improving Health Outcomes

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Executive Summary

Representatives from employers, providers, brokers, consultants and other stakeholders attended BHCG's first symposium of the 2020 Delivering Value Series via webinar. Employers and communities are facing a multitude of challenges in the COVID-19 crisis. Attendees heard presentations and participated in a discussion about how to get people back to workplaces safely and how we can combat health disparities in underserved communities, given the impact the pandemic is having on them. The webinar also featured an in-depth look at BHCG's 2019 Virtual Health Plan cost and quality results that will help provide BHCG and member employers a roadmap for the future.

Introduction

- **COVID-19**
  - The crisis is affecting workplaces and hitting especially hard in the Milwaukee communities with health disparities
    - Will look at resources available to help support employers with the restart of the economy
    - COVID-19 has impacted the population on an unequal basis. UHC has looked at social determinants of health strategies since 2017 – employers can benefit as well

Katherine Bisek, UnitedHealth Group

Return to Work

- **Employers will be looking at doing a number of things when employees return to work**
  - Analog – listing symptoms on paper, etc., but looking at the whole gamut, including digital solutions
- **UnitedHealthcare looked at how they can help**
  - How can we manage the risk of people coming back and make sure people are healthy and stay healthy?
  - Spoke with 60 employers about returning to work; lots of different strategies, opportunities
- **Created a platform and app with daily checks – ProtectWell**
  - Partnered with Microsoft to make app as broad as possible
  - Employee app gives clearance through self-reported symptom checker to safely go to work or triaged if symptomatic on a daily basis – (QR code can be scanned when employee comes into the building); takes 15 seconds to complete
    - Allows employer to add special instructions and unique information
    - Offers workplace planning support through a dashboard
    - Optional, may be used for short time or specific sites or shifts as extra validation
    - In app store but invitation is needed from the employer
    - Uses health bot to be conversational and interactive (based on CDC guidelines)
  - Not charging for the app in 2020 but looking at subscription price for 2021
  - Employer console (not part of benefits; a function of workforce occupational health) meant to work with a return to work strategy
    - Can pull up reports, data and add messaging
  - Additional information regarding UnitedHealthcare partnership with ProtectWell can be found at https://weprotectwell.com

John Elliot & Bruce Weiss, MD, M.H.P., UnitedHealthcare

Virtual Health Plan Results & Social Determinants of Health

- **UHC looks at BHCG aggregate results continuously (150,000 members)**

- Phenomenal historical success – annual 1.2% average allowed per member month cost trend since 2015 (less than the national CPI)

- **Premium program**
  - In place 15+ years – looks at primary care physicians and specialists
  - Wisconsin was one of the first markets for the program
  - Physicians must meet quality criteria first and then cost-efficiency measures
  - Wisconsin is second in the country for the most Premium care providers (goal is to have 1/3 Premium care physicians in the network – WI has ranged from 38-41%)
- **Tiered benefit strategies**
  - Employers that use benefit incentives to support the use of Premium physicians averaged 42.4% utilization as compared to 36.1% utilization for those with no Premium benefit incentives in 2018-19
- **What social factors are influencing utilization and costs?**
  - Looked at Virtual Health Plan data for several years to find other factors besides financial ones
  - ER utilization rates by income and ethnicity
    - Rates are inversely related to income
    - Hispanics have higher ER utilization rates than western Europeans, African Americans even higher
  - Medically homeless (no PCP visits in two prior years and no wellness visits)
    - Males ages 40+ had higher rates – 24.9%; Females ages 40+ -- 15%
    - Initiated intervention in fall 2019 (sent out mailers to promote PCP)
    - Very encouraged with the program thus far (paused right now due to COVID-19); COVID-19 will cause delays and concerns
- **Improving outcomes by addressing social determinants of health**
  - Building infrastructure to redefine health – not just medical care, consideration of the whole person
  - Remove barriers that limit access and address health disparities; UHC recently announced additional $100 million investment in affordable housing
  - Improve overall health and wellbeing of all vulnerable populations
  - Looking for related changes that validate the need for social determinants of health
    - 40% of Americans can't afford a $400 financial emergency; 78% of Americans are living paycheck to paycheck; median income for commercial population is $60,000
    - 80% of health care is determined outside a doctor's office
  - In 2018 Centers for Medicare & Medicaid (CMS) allowed supplemental benefits designed to address social determinants of health
    - 91% of Medicaid plans report out social determinants of health – UHC very active in this area, especially with Medicaid plan (recognized for this work by *Healthcare Innovation)*
  - Larger employers are also starting to look at social determinants of health
- **Imputed market price valuation tool**
  - Value to consumers if services purchased out of pocket – tool to estimate the market value for social services in order to do the trade-offs on financial side
    - Substitute social services, compute what savings are

        - Create reporting tool to determine value of social referrals and collaborate with providers and social organizations
    - Data from 2017-2019
        - 2.4 million members have at least one social determinant of health -- 483,000 of those have both Medicare and Medicaid
        - 809,000 members were referred; 1.03 million referrals were made to other resources and agencies; $1.09 billion was the imputed market valuation (to members)
        - Dual special needs plans (D-SNPs) enroll individuals who are entitled to both Medicare and Medicaid e
        - Medicare Advantage dual special needs member imputed market price was $17 million

Ellen Sexton, UnitedHealthcare Community Health Plan of Wisconsin
Social Determinants of Health Pilot Program

- **Wisconsin initiative – UHC has 180,000 Medicaid members in all counties**
- **Chronic diseases account for 86% of the nation's health care costs**
    - How do we start to control costs and treat conditions?
- **Medicaid is a federal and state program (funded by both)**
    - Medicaid covers low income families (and childless adults in expansion states); 65+ with low income or disabilities; children; pregnant women
    - 65% of members work
    - Each state can do something different within federal guidelines
    - Mostly managed care; carve-out for certain services
- **Medicare (64 million) is not Medicaid (72 million)**
    - Eligibility – 65+ and long-term disability and/or end-stage renal disease
    - Acute, short-term care
    - Consistent eligibility and benefits (federal program) across states; private Medicare Advantage plans may provide additional benefits
    - 11 million people are eligible for both Medicaid and Medicare
- **Factors affecting health (clinical care factors are 20%; e.g., access, quality, etc.)**
    - 10% are physical environment (air quality, mold, etc.)
    - 30% are health behaviors (tobacco use, diet, etc.)
    - 40% are social and economic – social determinants (e.g, access to nutritious food, job opportunities, safety, etc.)
- **Social factors drive health care spending**
    - US is an extreme outlier in high medical vs. low social services spend
    - Cost is higher and we don't get better outcomes
- **One-third of Medicaid population has behavioral health conditions and access the ER at much higher rates**
    - 13-27% of ER visits could be managed in alternative settings, saving the US $4.4 billion in medical costs annually

- **Co-morbid members have 2X the amount of total expenditures**
- **Areas of complexity**
  - Medical (e.g., diabetics who need insulin at the right temperature)
  - Social (e.g., homeless, hungry, unemployed, etc.)
  - Mental health
  - Substance abuse
- **myConnections Housing First Plus program ("better care at lower costs begins with housing")**
  - Supports UHC mission – housing first concept (get them housing first, then focus on other needs)
  - Person-centered and trauma-informed care management
  - Works with county to find right landlord and living situation
  - Delivers lower spend and improved wellbeing
    - Many have $50-$100,000 in health care costs, paying rent is much cheaper
    - Wrap around medical and social services
- **UHC has begun the myConnections pilot program for Medicaid members (in four states)**
  - Wisconsin was one of the first states; very good initial results:
    - Three criteria – care management; must secure section 8 housing; and have supplemental income/job
    - 68% decrease in average monthly inpatient admissions
    - 69% decrease in average monthly ER visits
    - Some no longer on Medicaid
  - Frees up ER resources and improves overall health
  - Starting to look at what it means for commercial employers, helping individuals and managing health care costs

Rosamaria Martinez, Sixteenth Community Health Centers

Integration of Social Determinants of Health Screening in Primary Care

- **Clinic is screening patients in primary care for social determinants (not waiting for them to tell them)**
  - Many unmet social needs that impact ability to access care and benefit from services
  - Started looking at what could be done and screening patients – only seeing about 2% of its patient population for social services
  - Not easily done (what does it look like and where is the funding?)
    - Funding sources: Milwaukee Health Care Partnership Healthy Systems Shared Community Investment Fund and Wisconsin Partnership Program (WPP)
    - Changing the way they look at and deliver services (trying to get patients to help identify barriers)
- **Key concepts**
  - Universal screening of unmet social needs (30% in pilot had some sort of need)
  - Tiered level service delivery model

        - Not just surveys, integrating services into primary care
        - Strong volunteer component (Americorps members do screening)
    - Community relations and system change – identify systemic barriers and gaps and overlaps in service; work with community partners to address
    - Technology – need documentation and tracking – working on identifying data platform
- **Scope of services**
    - Send patients to appropriate services and to the right person
    - Housing, safety (domestic violence, etc.); family and social relations, basic needs and advocacy (legal, disability, etc.)
- **Community Information Exchange**
    - Looking for platform to integrate with electronic medical record – working with other health care providers and 211 system
- **Screening tool**
    - Housing – 6.5% do not rent or own; 18.5% are worried about losing housing
    - Safety – 15% say they do not feel safe where they live
    - Basic needs – 37% lacking some kind of basic need
    - Stress – 20% have stress
- **COVID-19 challenges**
    - Staff working remotely by phone
    - Updating resources
    - Assisting non-patients (social services)
    - Relief funds for food, rent and assistance
- **Upcoming work**
    - Define workforce capacity
    - How to incorporate the patient voice
    - Ongoing communication plan
    - Implement case management technology

Slides or a recording with slides from the webinar are available for review