VBID Health Equity Business Case for MAOs Webinar Transcript

Martina Gill:
[00:00:00] Thank you for joining today's webinar. At this time, I'm going to pass it over to Jason Petroski.

Jason Petroski:
[00:00:07] Thank you. Good afternoon. My name is Jason Petroski, and I'm the Director of the Division of the Delivery Systems Demonstrations in the Seamless Care Model Group of the CMS Innovation Center. Thank you so much for joining us today for our webinar on the VBID Health Equity Business Case and Incubation Program Overview. The purpose of this webinar is to highlight opportunities for Medicare Advantage Organizations (MAOs) uniquely available in the VBID Model to identify, develop, and address health disparities. We will help clarify the connections between the VBID Model and health equity, but more importantly, we will provide a framework and some tangible examples of how MAOs can connect these concepts on their own and in a way that makes sense for the population that they cover.

[00:01:03] Before we get going here, I want to put out a disclaimer that our goal today is really for educational purposes and general information sharing, and that's noted here on this slide. So we wanted to start with health equity - what we'll do is start the presentation by spending some time emphasizing this key or priority area for CMS. And what will in this presentation you'll see be the foundation for health plan innovation work going forward.

[00:01:46] So what do we mean by health equity? As defined by Healthy People 2030, "Health equity is the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." This definition helps drive us to think about important ways to innovate, including through benefits that may not be primarily health-related but that address social determinants of health, like food, housing, and transportation, and that, as research reveals, can have a positive impact on reducing medical expenses and improving quality outcomes.

[00:02:36] I think here it's important to note we really view health equity as a critical pillar of our quality strategy and aim to make that case throughout this presentation. So we have a lot to go through in the next hour, but here is our bold agenda. Starting with a brief overview of the VBID Model and some context, then moving into features and opportunities presented in the model that align with the topic of promoting health equity and setting the context for why the model is prioritizing this work at this time. We'll also walk you through our approach to engaging plans around these opportunities and resources for plans to understand how to connect

the model components when we discuss the Health Equity Incubation Program, a key piece of this presentation.

[00:03:24] We also have some special guest speakers today as well from our Center for Medicare (CM) and the Office of Minority Health (OMH) who will help clarify what plans can do in their regular program or in the regular program versus the model and provide a fuller picture of the resources available at CMS for plans interested in health equity for Medicare and Medicaid enrollees. Finally, we have saved time for a brief Q and A, so please feel free to submit your questions through the WebEx Q and A feature during the presentation, and we'll try to address as many questions as we can or as many as we can in the time allotted.

[00:04:06] With this in mind, we'll start with a little background and context. As many of you know, the CMS Innovation Center has undertaken a strategic refresh based on 10 years of lessons learned in order to reestablish a shared vision of the healthcare system we're driving toward. That vision, building on the executive order shared here, selects a health system of the future that achieves equitable outcomes through high-quality, person-centered care for all. In thinking about achieving that goal, we see opportunities across the CMMI model portfolio, including the Value-Based Insurance Design or VBID Model.

[00:04:47] To talk a little bit more about that, I'd like to turn it over to the co-model lead of the VBID Model, Sibel Ozcelik. Sibel.

Sibel Ozcelik:
[00:04:55] Thanks so much, Jason. And now, that's a powerful vision, achieving equitable outcomes for all. And so now, in thinking about achieving that goal, we see great potential through the VBID Model, which really enables a special focus on meeting both medical and social needs. By partnering with Medicare Advantage Organizations or MAOs like yourself in attendance today, overall, as depicted on the slides here showing growth in model participation, partnership in the VBID Model has deepened since the model first began. The model has grown tremendously since 45 plans in 2017 to over 1,000 in 2022.

[00:05:34] And this number also translates to an increase in number and types of clinical and social needs focused interventions and importantly, their reach, with over 3.7 million enrollees projected to receive model benefits in 2022. To provide a high-level overview, the VBID Model has a broad array of complimentary MA [Medicare Advantage] health plan innovations, or what we call "programmatic flexibilities," with the goal of reducing program expenditures while importantly improving the quality of care for Medicare beneficiaries, including low-income beneficiaries.

[00:06:12] So what are these components? And there are a few, so hold on with me. The first component, and perhaps the component most directly related to health equity, is the targeting or targeted benefits by socioeconomic status (SES). So plans can use Low-Income Subsidy, or LIS-

or dual status as a way to target, reduce, or eliminate cost-sharing for Part D drugs or high-value Part C services or additional supplemental benefits like healthy foods cards. So being able to target by LIS or dual status really allows health-related social needs to be addressed at their core rather than using proxy variables to identify need.

[00:07:01] And this component has received really large adoption, and 98 percent of those targeted for VBID benefits will have been targeted by socioeconomic status. Now, the second component here of VBID on the slide allows MAOs to attach even more robust rewards and incentives to programs, including Part D rewards and incentives programs for MAOs that offer a prescription drug plan. So for example, an MA-PD (Medicare Advantage Part D) plan could provide rewards and incentives for enrollees who participate in, let's say, preventive health services, such as receiving covered Part D vaccines.

[00:07:38] Now, the third component presented here on Wellness and Healthcare Planning or WHP is required for plans that choose to participate in the VBID Model. In essence, plans must have a strategy around improving or enhancing advanced care planning or WHP through the model. The fourth component or the Hospice Benefit Component tests the incorporation of the Medicare Hospice Benefit into the MA benefit package. And one aim here is to improve quality and access to hospice care by creating a more seamless care continuum.

[00:08:12] This fifth component, the cash or monetary rebates, provides a pathway for Medicare beneficiaries to share more directly in program savings by allowing in participating MAOs to offer a mandatory supplemental benefit that is in the form of cash or monetary rebates based to all enrollees in Model PBPs. And then, lastly, under the New and Existing Technologies component, MAOs can propose to cover new technologies that are FDA-approved or don't fit into existing benefit categories for targeted populations that would receive the highest value from the said technology.

[00:08:47] So, as is evident in the components that I just reviewed, VBID offers a unique opportunity for plans to address health inequities in their member populations through targeted benefits directed at underserved enrollees. So to realize the full value of the model and to address health inequities and continue to build on the existing partnerships, we're launching the Health Equity Incubation Program for model participants and those who might be interested in the model.

[00:09:23] Michael will be getting into the details of the program, and Michael will be speaking next. And I'll introduce him shortly. But here I want to take a moment to highlight the core goals and desired outcomes of the program. So, one: we want to encourage maximum MAO adoption in Model components to address health inequities in MA enrollee populations. So by articulating a clear business case for participating in the Model, we want to complement and accelerate your health plan's health equity strategies. And we hope to accelerate health equity-focused benefit designs and activities.

[00:10:02] Two: we want to provide guidance on technical systems to MAOs on how to best leverage Model components with a health equity lens. And so we want to provide guidance on best practices, lessons learned, and insights from CMS data, and we want to work together to improve the quality of benefit design and drive standardization that can help to increase the Model's impact on health equity. So those are the goals on the left side. And then we want to talk a little bit about the desired outcomes. Our hope is that those strategies and goals that I articulated will: drive a strategy that will result in a critical mass of interventions in the most promising focus areas; encourage MAOs to take full advantage of the model components to address health equity, and identify and scale best practices around health equity and health-related social needs (HRSNs) and supplemental benefits that are already in use within MA member populations.

[00:11:02] And then from a data standpoint, build and share an evidence base on quality improvement and medical savings related to health-related social needs. So in the slide here, we want to clarify what options are available to help plans under MA, and then what options are available through the VBID Model. I'll turn it over to my colleague Brandy Alston from CM or the Center for Medicare, to discuss options available under MA, including SSBCI or Special Supplemental Benefits for the Chronically Ill. Brandy?

Brandy Alston:

[00:11:37] Thank you, Sibel. Hello, everyone, my name is Brandy Alston, and I am with the Medicare Advantage policy division in the Center for Medicare. As Sibel mentioned, in this slide we're going to briefly go over some of the Medicare Advantage program requirements and clarify how the VBID Model differs and offers some further flexibilities on current program rules. So first, there is Special Supplemental Benefits for the Chronically Ill, also known as SSBCI. SSBCI allows MAOs to provide chronically-ill enrollees as defined in a statute and regulation with specified criteria with both non-primarily and primarily health-related supplemental benefits that have a reasonable expectation of improving or maintaining the health or overall condition of the chronically-ill enrollee.

[00:12:28] MA plans may consider any enrollee with a condition identified on the list of chronic conditions listed in chapter 16 B of the Managed Care Manual to meet the statutory criteria of having one or more comorbid or medically-complex chronic conditions that is life-threatening or significantly limits the overall health or function of the enrollee. Additionally, MA plans may consider any chronic condition not listed or identified on this list if the condition is life-threatening or significantly limits the overall health or function of the enrollee.

[00:13:07] Next, there is Uniformity Flexibility (UF). Under this flexibility, an MA plan may target enrollees for healthcare services that are medically related to the patient's health status or disease state. For example, reduced cost-sharing for eye exams for diabetics if the benefit is offered uniformly to all individuals with the same qualifying condition - and with that, I'll turn it over to Sibel, who will discuss some of the VBID flexibilities in these areas.

SO:
[00:13:55] Yeah, thanks so much, Brandy. That was super helpful. And so regarding VBID and targeting, VBID is unique in that it allows MAOs to target, as I had said earlier, by Low-Income Subsidy or Dual status alone. You can't do that under the program, under SSBCI or UF. So under VBID, MAOs can target a population also by a combination of LIS or Dual status with chronic conditions. The chronic condition can be unique or narrow, depending on how you want to target your population, the needs of your members. VBID also allows for targeted benefits related to Part D which is unique to the model, and that includes being able to reduce or eliminate cost sharing for Part D drugs.

[00:14:25] So imagine being able to eliminate the Part D drugs for all, all Part D drugs across all phases for all of your members who have or are receiving low-income subsidy. So that would be meeting a need and removing a barrier, really, to affordability for a lot of your members. And as I had mentioned earlier, VBID also allows the targeting of new and existing technologies or FDA-approved medical devices as another mandatory supplemental benefit. So now I'll pass it back over to you, Brandy, to talk a little bit more about what you can do around Rewards and Incentives or RI programs in the program.

BA:
[00:15:04] Okay, thank you. Next, with regard to Rewards and Incentives, the Part C Rewards and Incentives program must reflect the cost-value of the health-related activity and not the expected benefits. Part D Rewards and Incentives are only for a real-time benefit tool (RTBT).

SO:
[00:15:28] Yeah, and then on the VBID side, you're able to create a Rewards and Incentives Program with a reward or incentive that reflects the value of the expected impact on behavior or of the enrollee engaging that healthy behavior for that expected benefit, not just the cost of the activity. And then, under the VBID Model, you can create Rewards and Incentives programs related to Part D benefits. Brandy, back over to you.

BA:
[00:15:58] Next, with regards to the use of cash or monetary rebates, this is currently not allowed in Medicare Advantage - it's prohibited.

SO:
But then, under the VBID Model you can – I think that's another part of the model that's unique, that ability to share beneficiary rebates even more directly through a supplemental benefit that's in the form of cash or monetary-based that enrollees can choose to use towards rental assistance or food or address food insecurity needs or transportation needs, whatever it might be, empowering the enrollee to use the cash as they see fit. Brandy, back over to you.

BA:
[00:16:42] Finally, with regards to hospice: hospice is only available to MA enrollees through Original Medicare.

SO:
[00:16:42] And then under VBID, plans can choose to participate, and again, most all of these are optional for plans to pick and choose which one that they want to participate in, but MAOs can apply to participate in the VBID Model Hospice Benefit Component, and under that, plans cover pretty much all of their enrollee's Medicare benefits, including hospice. And then under the Model, plans can also offer what are called Transitional Concurrent Care services to help with those transitions into hospice as well as hospice supplemental benefits, which are supplemental benefits targeted once again just to hospice enrollees.

[00:17:31] So imagine, you know, some of those additional wraparound supplemental benefits you could provide to enrollees really in their most vulnerable time during hospice. And so thanks so much, Brandy, for walking us through sort of that comparison between MA and VBID. And I think in summary, what you can see is that MAOs participating in the VBID Model can better target or have more options to target enrollees, more widely use non-primarily health-related supplemental benefits, be less constrained by uniformity and offer certain benefits like sharing rebates in the form of cash that you can't do in the program.

[00:18:06] And I think this slide provides us with a natural stopping point to conduct our first live audience poll. So the question here on the right side of your screen: what initiatives programs, benefit enhancements, or analytics aimed at addressing health inequity are you currently doing or planning? Please take a minute to fill out the poll.

[00:18:28] So, I see the poll results have come in, and we have a number of plans that are offering Healthy Foods Grocery Cards, Medication Therapy Management (MTM) programs, Part C Rewards and Incentives. And I even seem some plans addressing social isolation, loneliness, and housing - this is great. So we're really excited to continue thinking about what are all of these initiatives, and how do they impact health equity, and how, again, through the Health Equity Incubation Program, can we further some of these initiatives?

[00:20:25] So here and some of you may have seen this slide already. I want to highlight the business case for investing in some of those initiatives that you already said you're doing and then also in others around health equity and how VBID can be a core part of your health equity strategy. So for example, increasing member engagement and retention where plans that offer supplemental benefits like healthy meals or grocery cards have been shown to receive a higher net promoter score and higher member retention.

[00:21:11] Second: improved star ratings and increased benchmark rate that can yield increased member-satisfaction and improve quality. Third: there are opportunities for participating or perspective MAOs to offer benefits to unique populations that can't be offered in other MA program spaces, like targeting by LIS, which allows for even a greater customization of benefits for health equity issues within underserved populations. Fourth: there is a business case that can be made around addressing health-related social needs in member populations which will ultimately drive down spending and lower utilization of low-value services.

[00:21:47] And then finally, we can minimize cost by better focusing interventions to those who need them most, like individuals with low-income subsidies. And so, as noted on the bottom of this slide, in addition to improving member health and promoting health equity, there's a strong business case for MAOs to participate in VBID and leverage the model's waiver authority to address health disparities. And now, I'm so excited to turn it over to someone who I'm inspired by every day, an incredible member of the VBID Model team and thought leader in the space of health equity within the Model, Michael de la Guardia. Michael.

Michael de la Guardia:

[00:22:28] Thanks so much, Sibel. Yeah, so now that we've done some of the framing, we want to talk tangibly about how our model is thinking about health equity in the MA space. And as mentioned earlier, we are planning a three-phase strategy for promotion and technical assistance, all packaged within what we're calling VBID Health Equity Incubation Program. Under this first phase, we want to start by building awareness of the model and how its components can be used to address health inequities in your member populations.

[00:23:12] And in addition to this webinar, we'll also be offering one-on-one sessions with health plans to provide assistance on leveraging the model to promote health equity, and plans can schedule these with the VBID Model Team at the link provided in the chat box, https://calendly.com/vbid/vbid-call?month=2021-12. You can also look online for our contact information. So that'll kind of wrap up that first phase of engagement. And then after that first phase, in the next few months we'll move towards a competency-building phase around health equity where we'll be launching a learning series that will involve case studies and use cases on Value-Based Insurance Design and health equity.

[00:23:47] We also plan to leverage this forum as a way to encourage uptake in interventions that show the most promise to improve measurement and understanding in areas such as food and nutrition, transportation, housing, reduced cost-sharing for Part D drugs, and diabetes. And ideally we would like to see several payers propose interventions in each of these areas in order to support learning and evaluation. For example, we'd love to see three or more payer interventions offering similar food and nutrition benefits, several offering transportation benefits, and then similarly, several in diabetes, particularly as it relates to health equity.

[00:24:41] And then with each rooted in the current evidence of how to best deliver benefits in these areas and the evidence of how to best serve these underserved communities. That brings us finally to this last phase at the bottom of the screen here. It's really part of a larger set of work on ensuring the model is collecting useful and actionable data which will allow us to create a true learning network. That's really part of the major goal there where plans can tackle common challenges around health equity, leveraging the incubation program as a convening forum, and we look forward to sharing results as we sift through the data, and it is our hope that we can act as a convener to improve quality and implementation through shared data and insights in this really very important area.

[00:25:31] Like we previously discussed, we want to focus on an initial set of promising focus areas. We want to work with you on identification of these areas so that together we can share best practices, lessons learned, data and outcomes, and guidance, really, on how to address both inequities across MA member populations. One of the focus areas we want to highlight is food and nutrition. This will be the focus of the next health equity incubation session. And there are really two distinctive Pathways here, as we think about it: Medically-Tailored Meals and its derivatives (like medically-tailored groceries), and then the second Pathway: Healthy Food Cards.

[00:26:22] And there's an increasingly strong evidence base related to these interventions' quality and medical savings. And we're hoping to scale best practices and also more standardization across these interventions with the hope being that you can invest in these interventions with more confidence and design benefits in an impactful way. And the hope would be that these sessions can also provide a common forum to really engage and innovate around these sorts of benefits. And then as we think ahead to future sessions, we are really hoping to get your feedback on what other needs you would be interested in having CMS guidance and learning sessions on.

[00:27:04] Here at the bottom, we have a list of social needs that align through the Accountable Health Communities Model framework, another CMS model, which also has a screening tool associated with each of these needs, and we're happy to share that tool if it's of interest to anyone on the call, and one thing I do want to note: we've been spending a lot of time on social needs, but want to recognize that health equity is much more than social needs. It's about access, healthcare quality, engagement, internal processes, representation, and much more. But social needs tend to be particularly relevant for benefit design, and hence the emphasis in today's discussion.

[00:27:46] But now we'll take some time to conduct a quick live poll to see which social needs are of most interest to this group, which will directly inform future sessions, so the poll should be launching right about now, and the question is: which health related social needs interventions would you most be interested in CMMI providing additional learning on, either in the form of webinars, use cases, case studies, or hearing from other players in the space (like CDC, for example)?

[00:28:12] Great, so looks like the results have been published, and we see a lot around food insecurity here, a bit around social isolation and mental health, and then seems like some around transportation needs as well. And as mentioned, this will be really helpful as we think about future sessions and things to focus on in these future sessions, so this sort of feedback will definitely inform the technical assistance and guidance that we hope to provide in the future.

[00:29:55] So, I think this slide hopefully gets at the core of where we see VBID and health equity interventions going. So for plans thinking about where to start, and even those who are

far along, we wanted to introduce a simple framework for how we are thinking about health equity and its tie-in to the model and value-based insurance and benefit design. And so this framework aligns to CMS's Office of Minority Health (OMH) Framework for developing a disparities impact statement, and you'll hear a bit more about that later in this presentation.

[00:30:30] The first element here is understand disparities within your population with a review of your demographic data elements. There are a number of publicly available resources here that plans could access, including census indicators. And we'll walk through an actual example in the next slide. But there's also HEDIS (Healthcare Effectiveness Data and Information Set) and CAHPS (Consumer Assessment of Healthcare Providers and Systems)-stratified reporting by race and gender that is available to all plans. And the next step of maturity would be using your own claims data and quality measures to identify disparities.

[00:31:06] Then, second, after you identify disparities, understand the need of your target population. So if you have beneficiary-level social needs data that you or the providers you work with collect in claims, EMRs, or screening tools, use that to understand the need. Is financial strain driving low medication adherence? Is food insecurity driving poor A1C control? But if you're not ready to analyze your own claims data and screening tools, the CDC's Social Vulnerability Index (SVI) tracks certain social needs by county and by census track. And so does the area deprivation index.

[00:31:48] So these tools can be used to approximate social needs in your coverage areas for plans who are looking to just begin into diving into this area. Third, now that you have an understanding, understand disparities in need, you can use VBID components to address need in a targeted way through benefit design. And this is really where the VBID Model comes in. And then think about how targeting by socioeconomic status can be used, non-primarily health-related benefits like healthy food cards, reductions in Part D cost sharing, or elimination of Part D cost sharing and even rewards and incentives programs.

[00:32:29] And there are a number of questions you can ask yourself to help prioritize these efforts, including: is there a high volume of need or high level of disparity? Is the intervention cost-efficient or, at minimum, not prohibitively expensive to scale? Are there clear and obviously evidence-based interventions, and is the plan well-positioned to offer those interventions? Are there untapped benefits that enrollees are eligible for but not yet enrolled in where plans can provide navigation? For example, in California, 20 percent of those eligible for SNAP (Supplemental Nutrition Assistance Program) are not enrolled.

[00:33:01] And this next slide will carry through an example of this framework. So this slide will take the framework we just laid out and hopefully demonstrate how it can be applied to your plan and used to inform your VBID application. So it goes without saying, there's not one approach, but a plan just getting started could first gather and understand data on disparities by looking at CDC's social vulnerability index. This tool is publicly available and linked here. As

mentioned, the slides will be provided after today's presentation. And then ask the question: where geographically do we see the biggest population level disparities and health inequities in our coverage areas?

[00:33:50] Here you'll see in the map, the CDC SVI map below. Especially the area of Oakland faces high housing and transportation needs, much more so than the affluent areas of Walnut Creek and the East Bay suburbs that you see on the right-hand side of the map. And you can easily overlay this with health outcomes data available by geography through HRSA (Health Resources and Services Administration). And given this, you can think about your benefit design: how can you improve the health of beneficiaries living in Oakland? Based on this map, you may want to consider adding benefits to address housing needs and transportation needs targeted at enrollees receiving low-income subsidies.

[00:34:34] And that kind of translates nicely to this next slide. So here you can identify the VBID components that help you better design your benefits. So in the case we just mentioned, targeted benefits by socioeconomic status, and in this case, perhaps a benefit around nonemergency medical transportation that you could target specifically at LIS or something else. And in going through this whole process, you also have the start of your VBID application and a justification for part of your benefit package.

[00:35:08] More advanced plans would even more directly engage enrollees and analyze beneficiary-level data including social needs screening data to better understand need and drivers of poor health. So with that now I'll turn it over to Abigale, who is the Model Lead on the Part D side and supports on much of the VBID work.

Abigale Sanft:
[00:35:32] Thank you, Michael. So we wanted to provide some examples of VBID Model components tied to example interventions that we believe have a direct relationship to health equity - for example, the VBID flexibilities that we heard about earlier that may be targeted by socioeconomic status. So for beneficiaries that might have difficulty affording even the nominal LIS copay for their Part D drugs and having that copay as a barrier to medication adherence, a plan may choose to offer reduced cost sharing for Part D drugs so that all drugs have a $0 copay for LIS beneficiaries.

[00:36:16] This can help remove a financial barrier to accessing their needed medications, and that can help improve their adherence. As another example, for beneficiaries with LIS status that might have another chronic health condition, and we'll use cardiovascular disease (CVD) as an example here and in just a moment, but this could really be any chronic health condition. We can help to tailor benefits to those beneficiaries that are most in need. VBID's plans are able to offer a suite of benefits tailored to meet both the beneficiary's health and social needs.

[00:36:50] The first example falling under the CVD umbrella is VBID flexibility to offer a reduction in cost sharing for Part D drugs associated with CVD. So that might include high-intensity statins or antihypertensive drugs. And as a part of this sort of umbrella under CVD, the MAO might also want to include reduced cost sharing for cardiac rehab services. Another sort of tie-in here might be to couple that reduced cost sharing for cardiac rehab services with a reward program that would incentivize the use of these services for with beneficiaries with CVD.

[00:37:31] Additionally, under the new and existing technologies component, the plan may wish to cover a self-monitoring blood pressure gauge to encourage the use of blood pressure monitoring and incorporate a healthy foods card with additional messaging and education surrounding dietary changes that would be helpful for beneficiaries that have experienced a heart attack to help prevent a second heart attack and the associated hospitalization.

[00:38:08] So not only will these outlined flexibilities save money by improving adherence and preventing hospitalizations, they can also help improve quality of care and address social needs for some of the most vulnerable beneficiaries within MA, and they're readily available to be crafted within the flexibilities that are offered under the VBID Model. This type of combined set of interventions could target, as I mentioned, any number of chronic health conditions and could be appropriately tailored to reach the most in-need beneficiaries.

[00:38:43] As previously discussed, we're happy to work with plans to identify what sort of interventions are allowed under the model and encourage plans to think about social needs and how the model can be a helpful tool to address those. With this slide we wanted to provide an example that hopefully makes our health equity framework come to life a little bit more. So we're highlighting some examples here where health equity focused benefit design could really help make a difference in addressing disparities and improving healthcare quality in your plan.

[00:39:26] Rosa is a 70-year-old Hispanic female from Richmond, California. She has pre-diabetes and was recently put on Metformin. She receives low-income subsidies and struggles to afford healthy food for her whole family. There are very few grocery stores nearby that are served by her area's public transportation, and Rosa does not own a car to get to the grocery store. As part of your plan's health equity program, you may notice many Rosas and that there are significant racial and ethnic disparities in diabetes management and food insecurity.

[00:40:08] By tailoring benefits to those beneficiaries that are most in need, either based on LIS status or chronic condition, VBID plans would be able to offer a combined suite of benefits that are tailored toward many of Rosa's needs. And similar to what I mentioned in the previous slide, there are a number of opportunities that can help support Rosa in the VBID Model. In your VBID application, you could use estimated medical savings from lower utilization and fewer emergency department visits to bid lower on the benchmark rate and use the difference to pay for a healthy food card, a reduction in Part D cost sharing for Metformin, and/or many other social needs interventions that could be targeted based on LIS status.

[00:41:00] Other benefits to consider that would tangibly help Rosa could be reduced cost sharing for seeing a certified nutrition specialist, delivery of medically-tailored meals, or even coverage of non-emergency transportation to a farmer's market or grocery store on some regular basis to help with accessing those healthy foods. I just want to reiterate that there are thousands of other Rosas that these types of interventions would help that are currently enrolled in your plan. And again, not only do these interventions have associated evidence of cost savings, but they also help improve quality of care and address social needs for some of the most vulnerable beneficiaries within MA.

[00:41:46] And they're readily available within the flexibilities that are offered under the VBID Model. So this slide may be familiar to those of you who joined our cardiovascular disease-focused webinar with the CDC–Million Hearts® team. And we talked about some of these examples just a moment ago, but I wanted to show this slide to demonstrate how VBID components can be applied in multiple use cases and not only address social needs like food insecurity but also address chronic health diseases with large disparities in outcomes. For those interested in the examples that are presented on this slide, I would definitely suggest checking out the webinar on this topic, which can be found on the VBID Model web page.

[00:42:41] With that, I'll now turn it over to Alex, our colleague from the Office of Minority Health, to discuss other health equity resources available to plans.

Alexandra Bryden:
[00:42:50] Thank you, Abigale. I appreciate it. All right, so I think I'm playing clean-up here, so I'll try and keep this engaging. That was an incredible sort of overview and set of opportunities of ways to use the VBID Model to really address health equity, to advance health equity, and reduce or eliminate disparities among the populations that MA plans serve. But it can be really overwhelming. So hopefully I'll give a little bit of a breadcrumb here on how to start to do some of this work because in a theoretical construct. You know, it's easy to walk through the steps, but then we find that when folks get started, it can be really hard to find resources to do the things we want to do.

[00:43:49] So hopefully this helps. On this slide there are a few resources. I'm Alex Bryden. I'm from the CMS Office of Minority Health, so I sit here within CMS, and we work across all the CMS programs. And one thing that we do to develop tools and resources that external stakeholders can use, including MA plans, to help embed equity across their plan across their enrollees. So this slide has a list of resources that might be useful in particular for MA plans working within the VBID Model to reduce disparities and address health equity. The first is the disparities impact statement.

[00:44:33] There are tools that you can use to start a strategic approach. And Michael and Abigale and the VBID team just laid out that step-by-step approach. The Disparities Impact

Statement, which you can find online on our website, is a worksheet that will help you walk through those steps and sort of fill in answers. And it helps make things very tangible. It helps to be a shareable document that teams can use and pass around so that everyone's sort of on the same page in the leadership team, can be used to talk to the community and really sort of track progress, set goals, and identify specific populations and specific interventions.

[00:45:14] We also have data resources. Michael talked about our Stratified Reporting. There's also the Mapping Medicare Disparities Tool, which is an interactive mapping tool. You can see a little image of it on the screen in that sort of computer screen image. And this is fee-for-service data [FFS], but this can be used in complement with some of the CDC's data for area deprivation index or social deprivation index with our stratified reporting to really look at where there might be significant disparities in a particular area across chronic conditions in particular with prevalence, cost, and utilization.

[00:45:51] We also have resources on this slide that are related to interventions. So once you've identified a population, once you understand from that population what the drivers are of the disparities, and where you really want to go. It's also important to try and find [provider] resources that can help with culturally and linguistically-tailored interventions. So we have a few resources that can help with that to make sure that whatever you're putting together, hopefully we're pointing you to things that could be useful for particular populations, particular cultures, and particular communities where something might have been developed that's tailored.

[00:46:30] We try to share that, package it up and share it so that it can be as useful as possible, and we're kind of spreading and sharing best practices or promising practices. We also have a couple of resources about developing a Language Access Plan. It may be the case that you find that some of the interventions might be best tailored in other languages. And so we have some step-by-step tools to think through how to tailor language services and how to setup language services. We also have similar resources related to accessibility [blind or have low vision or who are deaf or hard of hearing]. For example, if there's an intervention related to individuals with disabilities, thinking through some of the accessibility concerns or accessibility questions you might need to ask or you might need to ask providers.

[00:47:14] And then finally, there are training modules that I have linked here and staff training resources from case studies and some trainings on the Medicare Learning Network that can help with baseline knowledge about how to think about health equity and kind of give staff a level setting, and then also a couple of training modules for specific populations. One is related to the LGBTQ+ community and tailoring care for that community. And one is related to accessibility, physical accessibility and individuals with disabilities.

[00:47:48] So we have a number of resources on our web page. I encourage you to click around, and hopefully the resources that we have are helpful. But if any questions come up, we have an email address, HealthEquityTA@cms.hhs.gov . I lead our health equity technical assistance

team within our office, which provides technical assistance to external stakeholders, and the commitment that I make to you all and that we make internally is, you know, if you contact us, we will make sure that everything is seamlessly sort of coordinated with the VBID team so that whatever technical assistance (TA) you're coming in for, you get the right TA for you and we make sure that you have the best resources that we think you can have to help advance health equity among those you serve.

[00:48:33] And with that, I think I will turn it back to Jason. I hope this was helpful. Thank you so much.

JP:
[00:48:39] Yes, thank you so much, Alex. I really appreciate you speaking to those resources. As everyone can see, there are a lot of dots to connect here. I hope everyone on the webinar takes away a couple key points here. First of all, we're really trying to start a forum here for how MAOs can improve in the space of health equity, social needs, and social determinants of health. We are obviously putting a lot of resources and information in this presentation for you guys to think in that space, but we're also, just to reiterate the points that folks have made on this call, we're offering ourselves as a resource as well, so please reach out and contact us.

[00:49:30] We've also received questions on will we make these slides available? Yes, we will. We will probably be posting them to our VBID Model website. So you will be able to go through these slides and click on a bunch of the links. I think we're getting close to wrapping up the call here. I think given the comments I just made, I think we wanted to do one last poll of the audience, and then we'll move to some Q and A. The last question we have for you, and then we're going to answer some of your questions, is: what is the biggest impediment your organization faces in addressing health inequities in the populations you serve?

[00:50:10] If you guys can just fill out that last poll. In the meantime, we'll start pulling some of the questions that you guys have sent us and get ready to go through the Q and A.

[00:50:22] Okay. We'll give another minute here, just to see what the results look like, and then we'll move to Q and A.

[00:51:04] Okay, great. Some of the results are in. So looks like data challenges, operational challenges, definitely some good information for us to take back. Part of the reason for us doing these polls was also for us to think about how we can better structure some of the technical systems going forward. So we really do appreciate people participating in the polls and giving us your feedback. Okay, so with seven minutes left, let's go through some of the questions that we received. And what I'll do is I'll be playing the MC [master of ceremonies] here.

[00:52:05] I'll kind of "tee up" the questions, and I'll be "farming" them out to various folks or various panels here. Okay, so the first question I want to throw out is: what is the value of VBID to a plan who is already working in the health equity space? Michael, how about I tag you with that question?

MD:
[00:52:29] Yeah, sure. So we really view VBID as unique opportunity for plans to address health inequities in their member populations. It's really through targeted benefits directed at underserved enrollees. And it's the ability to target by socioeconomic status and really think creatively about social needs benefits and other supplemental benefits like reduced cost sharing for Part D drugs - I know we've mentioned it a fair amount. And that really makes VBID standout as a model with these strong health equity components. And then I'd say I'd think of VBID as offering your plan extra tools in its health equity toolbox.

[00:53:14] We're also, through the incubation program, providing plans an opportunity to learn from another. And benefit design and value-based insurance as it relates to health equity and social needs is still very much an emerging area, and it'll be helpful to think through these common challenges and pilot these initiatives, like how to roll out an equity-focused food and nutrition benefit. And that meaningfully impacts healthcare quality and outcomes. Hopefully that gives a bit of a flavor for what type of value it can add.

JP:
[00:53:49] Thank you, Michael. Okay, so we have a couple more questions that have come in. Let's see. The next question is: is there data that gives estimates of the decreased cost of medical expenses due to the use of VBID among the plans that have participated? And let me break that into two pieces - someone also asked what does VBID stand for? So Sibel, can you answer the question on data but also reiterate what our acronym terminology is here in the government?

SO:
[00:54:23] If you know anything about the government, it's that we love our acronyms and alphabet soup, but VBID stands for Value-Based Insurance Design. So Value-Based Insurance Design, and then just to your trickier question, so currently we do have valuation results for what we call VBID 1.0 or the original form of the VBID Model. But that was the initial version of the model, and it was very limited in scope, and it doesn't reflect all of the flexibilities and current components that we spoke about on this webinar, like the ability to target benefits by low-income subsidy or LIS status.

[00:55:01] And so as part of the CMMI model's evaluation efforts, once we have enough data, we all know how long encounter data takes and the run-out time there, we'll publish publicly a report on early impacts and experiences with the transformed VBID 2.0 model. And you should expect that in the next year or two. But in the meantime, we do encourage plans to use the peer-reviewed published research that is likely available for the intervention to understand the evidence-based, the date of interventions. There's a litany of information around healthy meals

and food-as-medicine and interventions that address food insecurities, for example, and non-emergency medical transportation.

[00:55:54] There's some evidence-based research on housing as well. So really encourage folks to check out what's been published in these spaces.

JP:
[00:56:09] Thanks a lot, Sibel. Okay, so let's see - we have another question here. Abigale, I'm going to ask you if you can jump in and take this one. The question is: what if our plan is thinking of a new benefit structure - one that could make an impact on health equity, but we are not sure whether the benefit design fits within the VBID Model or not? Is there a way, before submitting bids, that we can get feedback on design to see if it will fit within the parameters of the VBID Model and/or the MA program? Abigale, do you mind helping with that question?

AS:
[00:56:47] Yeah, thanks, Jason. Prior to bid submissions, CMS reviews all of the proposals' applications to participate in the model, but in general, if you have an idea that you're thinking about, please reach out to the VBID Model team. The VBID mailbox is VBID@cms.hhs.gov . You know, any questions, ideas that you would like input on, we're happy to provide it, happy to schedule time to talk through sort of where you're thinking and how you're thinking about the VBID Model. And we really encourage dialogue with plans even prior to submitting your VBID application and bid submission because it will save you time when you're preparing those things and really make sure that you've sketched out the evidence base and things like that. So definitely reach out to the VBID mailbox at VBID@cms.hhs.gov .

JP:
[00:57:56] Thanks, Abigale. Okay, so I think we have time for one last question, and I think I'm going to send this one Sibel's way. Sibel, the question is: is participation in this program that we're talking about, the Health Equity Incubation Program, is it voluntary? Can you take that one?

SO:
[00:58:17] Oh yeah. Participation in Health Equity Incubation Program is completely voluntary and open both to participating plans in VBID as well as non-participating plans or MAOs. And so as discussed, I think, importantly on this presentation, health equity will be a foundation for all of our models within the center. And that means that when you develop programs specifically with health equity in mind or not, we'll be reviewing and viewing model implementation operations and design and application review through that lens, and our hope is that these sessions will demonstrate that a health equity focus is also worthwhile and achievable business and organizational strategy that plans should be considering.

[00:59:05] And so, you know, overall we hope that you'll find these sessions helpful, and we really look forward to partnering with plans as we move forward with the Health Equity Incubation Program. Thanks, Jason.

JP:
[00:59:19] Thanks, Sibel. So unfortunately, I think we've run out of time to answer additional questions. But we will definitely take the questions that we received that we weren't able to address and take them back and make sure that we speak to them in materials, et cetera. Just wanted to go through the next steps and really wrap up our time here. We definitely appreciate everybody's time today. You spent a whole hour. We went through a lot of material. We're definitely looking forward to hearing feedback from everybody on the future of health equity and our technical assistance and how valuable that will be to your organization.

[00:59:57] We're hoping you'll be able to participate in upcoming Health Equity Incubation Session. We've also offered, you know, as you heard through this presentation, the opportunity to actually connect with our team, to connect with folks at CMS. So please take us up on that opportunity, and as we've mentioned a couple times, we appreciate the engagement, and we'd rather have the discussion now than during bid season. I'm sure you guys feel the same way. Lastly, I think we wanted to see if we could ask you guys for one last piece of feedback: please be sure to fill out the post-event survey where we ask for feedback on which health equity topics your organization is most interested in.

[01:00:44] The survey will directly inform what we plan to cover in the next Health Equity Incubation Sessions. And with that, I think I'll wrap up. Happy holidays to everyone, and thank you again so much for spending the day with us, or the afternoon. Talk to you soon.