Unleashing the Capabilities of MAOs to Deliver Health Innovation for Older Adults in Underserved Settings

MARTINA GILL: Thank you for joining the webinar on Unleashing the Capabilities of Medicare Advantage Organizations to Deliver Health Innovation for Older Adults in Underserved Settings. At this time, I'll turn the presentation over to Jason Petroski.

JASON PETROSKI: Thanks, Martina. Welcome, and thank you for joining us today for our webinar focused on Unleashing the Capabilities of Medicare Advantage Organizations to Deliver Health Innovation in Underserved settings. Today's webinar is a partnership between the Center for Medicare and Medicaid Innovation (CMMI), the Centers for Medicare and Medicaid Services (CMS), the Office of the Assistant Secretary for Health (OASH), and the Administration for Community Living (ACL). You'll get to hear today from these federal partners but also from our distinguished speakers who are innovators in health technology and care delivery. [00:00:54]

And on behalf of CMS's Innovation Center, and in connection with our efforts to pursue health plan innovation models and research, I hope today's webinar sparks innovation and creativity to improve care outcomes and equity. It underscores the Innovation Center's interest to better understand the needs of vulnerable and underserved populations and how to meet them. I hope attendees of today's webinar make it an important connection not only between the emerging technologies and approaches being discussed today and problems that have been challenging to solve, but also to the flexibilities being tested in the valued-based insurance design model and the opportunity to test these solutions. [00:01:40]

Thanks again to our federal partners, distinguished speakers, and to our audience for your time today. I'd now like to pass the baton to my Innovation Center colleague, who I get to spend a lot of time with day in and day out, and she's also, by the way, the co-model lead for the value-based insurance design model, Sibel Ozcelik. Sibel.

SIBEL OZCELIK: Thanks so much, Jason, for that warm welcome. To reiterate, CMMI is so excited to be partnering with OASH and ACL on this webinar. And together, with some of our amazing plan partners, we're hoping to cover, as you can see here, a pretty comprehensive agenda, focus on the opportunity and the possibility of unlocking technologies to promote health equity. This last year has been an extraordinary year for a number of reasons, and with that, a profound light has been shed on the disparities and how healthcare is being experienced and delivered across the US. [00:02:35]

And we've seen a number of players step up both from the public and private sectors to rapidly expand the use of technology to reach patients where they are, dramatically changing the delivery and experience of care. That said, with the growth of technology on one hand and the focus on disparities on the other hand, it's become more important

than ever to look at both together and ask the question: how can we leverage the ability of technology to promote health equity and promote better health outcomes for our most underserved communities? [00:03:05]

And today, with our wonderful speakers virtually here today from OASH, ACL, Point 32 Health, Highmark, and Humana, we hope to begin to answer that question. Today, you'll hear about some of the ongoing work within HHS as well as learn about innovations occurring broadly across payers in diverse areas from caregiver support of members with dementia, the role of telemedicine in helping address substance use disorder, and the role of predictive modeling in addressing not only medical but also social needs, especially for hard-to-reach, underserved populations. [00:03:37]

As many of you may have seen in a recent *Health Affairs* publication, 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 for. That vision, building on the executive order shared here, reflects 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 opportunity across the CMMI model portfolio, such as through the value-based insurance design or VBID model that is enabling a special focus on meeting social needs by partnering with Medicare Advantage Organizations or MAOs. [00:04:25]

And that partnership has deepened since the VBID model first began, as demonstrated on this slide, here depicting the growth in participation. The model has grown tremendously from 45 plans in 2017 to over a thousand in 2022. And this number also translates to an increase in the number and types of clinical and social needs focus interventions, and importantly, their reach. With over 3.7 million enrollees projected to receive model benefits in 2022. To provide a quick overview, and I promise these slides will be posted on the VBID model website by the end of next week along with the recording, the VBID model offers health plans a number of complimentary programmatic flexibilities with the goal of reducing program expenditures while improving the quality of care for Medicare beneficiaries. [00:05:21]

One key flexibility I want to focus on and want you all to focus on as you listen to our speakers today is what's in the first box here, the ability to target reductions and cost-sharing or offering of primarily or non-primarily health-related supplemental benefits, including new technologies to members with identified health conditions and/or who received low-income subsidies. And this includes, for example, technology-enabled mail delivery programs for enrollees who receive low-income subsidies, transportation for nonmedical needs, such as to grocery shopping or banking, again for, let's say, enrollees who have frailty needs or who receive low-income subsidies and are unable to afford such transportation; access to virtual community programs, counseling, or companion care to address social isolation, and assistive technologies or structural home modifications for enrollees who, again, may meet some frailty criteria or other identified targeting criteria by the plan. [00:06:03]

And it's largely this ability to target that positions health plans that participate in VBID to lead on health equity. And with MA [Medicare Advantage] enrollment rapidly increasing and becoming more and more diverse, as discussed on the slide, VBID can see as a key lever to address how to drive better outcomes and reduce disparities for MA enrollees who will likely make up more than half of the Medicare population the next 10 years. And it's this ability to address health equity that builds an important business case for MAOs participating in or considering participation in the model from increasing member engagement, retention, quality, and member satisfaction. [00:07:07]

In other words, addressing health equity makes business sense as well, and that's important as we know that achieving a vision for an equitable health system is not a job for the CMS Innovation Center alone. It will require partnerships across leaders like yourself who've joined this webinar, and the speakers on this call. And speaking of speakers, my time is up, and I'm so delighted to pass the mic to my extraordinary colleague, Dr. Vijeth Iyengar, the brain health lead and technical advisor to the deputy assistant secretary on aging within the US Administration on Aging and the Administration for Community Living, or ACL. [00:07:40]

VIJETH IYENGAR: Thank you, Sibel. It's wonderful to be here with you all today virtually. My name is Vijeth Iyengar. I'm with the US Administration for Community Living, and with the couple of moments I have with you today, my plan is to provide a brief high-level overview of the mission, values, and impact of our agency just in case, for those individuals attending the webinar that might not be familiar with what we do. ACL was initially established in April 2012, so we're hitting close to our decade mark. [00:08:26]

By bringing together the Administration on Aging, Office on Disability, and the Administration on Developmental Disabilities, ACL is responsible for increasing access to community supports while focusing attention on resources on the unique needs of older Americans, people with disabilities, family caregivers across their respective lifespans. Our primary mission driving us each and every day is to maximize independence, wellbeing, and health of older adults, people with disabilities across their lifespan, and their families and caregivers. [00:09:00]

We're able to address our mission through funding and support from the Older Americans Act, which has allowed us to reach our services for nearly one in five seniors nationwide and empower seniors to remain at home through low-cost home and community based services. This is only accomplished through partnerships with various state units and travel organizations, area agencies on aging, and thousands of local service providers and hundreds of thousands of volunteers that have enabled us, according to data from fiscal year 2019, to provide millions of meals, rides, millions of hours of personal care, homemaker and chore services, case management, millions of contacts with caregivers, and providing respite care and over 559,000 ombudsmen consultations. [00:09:51]

This is made only possible through the Older Americans Act, which we're proud to support. So who do we serve out of these one in five nationwide seniors? Those that are

poor and near poor, so below 150 percent of the poverty line; those that are frail and vulnerable, so folks that live alone, that have diabetes, heart condition, racial and ethnic minorities and folks that live in rural areas; those that are at-risk for ER visits and hospitalizations, and those that are at-risk for nursing home admissions. [00:10:25]

So given the remit of the agency, the mission values, who we serve at the end of the day, we're especially a proud partner to join CMS, CMMI, and OASH on this particular webinar. And with that, short and sweet, if you would like to learn more about the agency and our mission or values, you can reach me at this email contact. And now with that, it's my great pleasure to introduce a dear colleague and frequently collaborate, Dr. Leith States, who's a Chief Medical Officer and Acting Director of the Office and Science and Medicine in the Office of the Assistant Secretary for Health (OASH) within the US Department of Health and Humans Services. Leith. [00:11:07]

LEITH STATES: Thank you very much, Vijeth, for that really kind introduction. Good afternoon, everyone. Thank you for joining today. My name is Leith States, and I'm really fortunate to be able to support the HHS mission from the Office of the Assistant Secretary for Health. That's a smaller staff division within HHS, and we typically serve as a collaborator, convener, and kind of a catalyzer for novel efforts across HHS, and that's how I've come to be such a frequent friend with Vijeth and with Sibel and Sheila from CMMI. [00:11:41]

Today I think what I would like to do is take a few minutes to share one of those activities with you and dive into some of the synergies and opportunities that I think are present at this opportune moment that we find ourselves in. And I'll also be serving as a moderator for the Q and A later in the session. As with any presentation, I got a little road map for us. I'll hit highlights on all and do deeper dives where I need to. Like any good private med pubic health doc, we've got some here. [00:12:21]

A quick word on the population shift we will be encountering over the next 40 years. Aging populations, those that are 65 or older and projected to be over 95 million by 2060. That takes us to conservative estimates of being at least 25 to 30 percent of the US population by that time compared to 17 percent at present with a likelihood of exceeding that 30 percent margin depending on what forecasting you look at. In that context of what the future holds, there's been an increased risk of mortality, morbidity that we're all aware for folks in this age range given the COVID-19 pandemic. [00:13:05]

Right here, you'll see just a bit of a dated slide now, but I think it's important to demonstrate that we all in some capacity have likely been impacted by someone in our family, in our close circle of friends, in our contacts that we know from 65 and older than have been affected in a greater way than those that are in the younger population. we've also seen, you know, as a foreseen function in mitigating COVID risk, we've had this rapid adoption of alternative delivery care models and utilization of patient-centered health technologies has by and large increased. [00:13:42]

The data collection, the growing evidence-based, the best practice identification, the model testing, and the policy development that are kind of sprouting from this have really

created an environment that is right for disruption. And if you even look at Congress today, there was a hearing on decreasing barriers, identifying obstacles to getting telehealth right, to making sure we do patient-centered health, IT health data in a way that is going to serve a new paradigm as opposed to just having it be an offshoot; a side line consideration that is a nice stand-in for but not a complement to the existing care delivery we have in this country. [00:14:29]

With that understanding, three things were really evident. Aging populations relative to total population were going to increase rapidly during our lifetimes., Emerging threats were likely going to subject this population to greater risk than others., Patient-centered health tech that could preventing, mitigating, or treating that risk had not been adopted widely enough to ensure sustainable growth from a system standpoint or a financial standpoint. That helped drive the collaboration that I'll be discussing briefly. [00:15:09]

As you can see here, partners from HHS included AHRQ, ACL, OASH, NIH, and you see that that wasn't limited to just our HHS partners but also the rest of the federal family, including the FCC, USDA, and though they're not listed on here, the Department of Energy and the Office of Science and Technology Policy from the White House. So sparing the details, we worked for quite a few months and subsequently got an RFI out onto the register, the federal register. So, we kept this open on the register for about four weeks, starting in November 17, 2020. [00:15:54]

The title here is "Landscape Analysis to Leverage Novel Technologies for Chronic Disease Management for Aging Underserved Populations." We had thousands of views on the post. We received 60 unique responses from a variety of organizations that you'll see listed here. I won't review all of this, but what I want you to capture here is that 52 percent of total responses came from health tech companies and professional associations. They all had some depth and breadth that applied a unique perspective to the question that we had posed. [00:15:54]

But, I think we picked up on four consistent themes or at least bucket areas that I'll review with you now. So what you'll see here, there are going to be four different areas. They're all streamlined to just look at policy considerations that were listed. I've done previous briefs that have much more expansive text, but given the space and time I have right now, I'm going to limit it to some of the policy considerations. For care plans and models, what we've found from respondents was a desire to see continued RPM and chronic disease management tied together in a manner that would allow efficient delivery of care while mitigating risk through limiting face to face interaction. [00:17:34]

This took on a variety of different forms, which I won't go into, but suffice it to say there were a variety of models presented for consideration or examples of models that had been utilized effectively from some MA organizations and from other types of nonprofit organizations to serve their communities in a more effective way, utilizing health teach of some variety. With digital health literacy, we saw two things that came up consistently. One of them may actually be something that has come up for folks that are in the audience now, this bridge between kind of the discharge the LTACH, the long-term acute

care hospitals setting where we might have access or could optimize care with remote patient monitoring but weren't necessarily getting the payment on the backend from CMS because it was not a covered expense or a covered item. [00:18:37]

The other piece, and I think is something that's probably come up for folks that have more rural or underserved populations that they serve. The consideration of audio only telehealth as opposed to video and how we ensure that folks that do not have access to broadband, do not have access to smart-enabled devices, have some other precluding reason to not use video other than a tech limitation, are still provided that opportunity to use telehealth and allow for providers to receive payment or delivery in that setting. [00:19:23]

Okay, so the next two here, remote healthcare delivery and remote health monitoring, are similar but distinct. With the remote healthcare delivery, the idea here was talking about the policy leverage that I think is inherent from the federal side in spurning development of the evidence base and ensuring questions like the one posed here in terms of why are we bifurcating what should be an interoperable or integrated payment delivery model, being RPM and telehealth? In some instances, there's just not evidence, and that's not because there is a lack of desire to provide for that model but because there is just an absence of quality evidence and quality questions being asked with the funding tied to it. [00:19:23]

So that is one area where remote healthcare delivery came into play in a pretty consistent basis in our responses. And then with remote healthcare monitoring, the question here, and some of these have been answered, and that's the reason that you see these for is that it provides a spectrum of activity that's happened already whether they have been responded to in part, and some have not been. The take-home there is that there is a spectrum of very rapid activity that's happening in that space, and it should be given the highlight, focus, and priority it deserves. [00:21:09]

The examples that I have here are for FUHCs and rural health clinics and CMS home health agencies. This had to do for the Federally Qualified Health Centers (FQHCs) in rural health clinics, the previous limitation where those entities could not serve as distant sites and patients could not have their home serve as an originating site. Thankfully, that is not the case at the moment. There are still issues with payment parity at those sites for providers that are rending care from those facilities. So it's not perfect, but it's a work in progress. [00:21:44]

Same thing for the capacity with the CMA home health agencies. For the CY '21 proposed rule for the fee schedule, there were some concessions made where permanence would be allowed for telehealth in some instances. This may go further as public comment has gained, but and refined, and there's feedback built in. But I think it makes sense that this and I'm getting the 10-minute mark. That's why I'm getting distracted here. Apologies. I sometimes get my mouth rolling here. [00:22:21]

What are we doing with this to disseminate the knowledge that we are finding, make sure it does not go unseen? We have JAMA health insights and a Mobi Health News piece. The contrast here is one is focused on equity and access. The other is focused on the business case. And that's important because there are a slew of activities at our secretary level, at the administration level with executive orders, with PHE (Public Health Emergency) being considered for extension or termination, with telehealth payment, broadband access, focus on equity, where there are multiple arguments and positions that need to be heard to ensure that we have an equity-based and program integrous model to follow that will allow for the systems, will allow for the development of the framework that can adequately ensure that we don't do something new in the wrong way, meaning go back to old ways of doing inequitable care. [00:23:29]

From that I will stop and pass it to Sibel. Thank you for your attention and look forward to the rest of the session.

SO: Thanks so much, Leith. And so with that I'll actually pass it along to Dr. John Wiecha, who is the Medical Director of a Senior Products division within Point 32 Health. Dr. Wiecha.

JOHN WIECHA: Yes, thank you very much. It's absolutely a delight to be with you all this afternoon sharing some of our experiences with what I think you'll find a rather novel approach to supporting caregivers, our health plan members with dementia. I'll spend a little time talking about our organization then go over some details around the actual program that we're using, and then move on to describing the impact that we're seeing in this pilot program, preliminary results on caregiver, self-report, and actually on direct patient, that is health plan member impact as well. [00:24:46]

So Point 32 Health is a relatively new organization. It's resulted from a combination of two nonprofit health plans here in New England: Harvard Pilgrim Healthcare and TUFTS Health Plan. The name actually, Point 32, refers to, as aspired by the 32 points on a compass and really refers to our dedication to guiding and empowering members to achieve healthier lives and outcomes. We serve over two million members now across five states. We have a broad spectrum of products and plans that we offer, several of which are extremely highly rated, including 4.5 rating NCQA for our Medicaid plan and a 5-star rating for six years in a row for our Legacy, as we call it, TUFTS Health Plan Medicare Preferred HMO. [00:25:49]

Just a note: these data are resulting from a pilot. They're preliminary, and the pilot continues and is in process So moving on to why we're focused on dementia and caregiver support. So as new here, certain conditions require a higher level of caregiver support, and there's three major examples here: Alzheimer's related dementia, stroke, Parkinson's disease. Although 15 percent of Medicare Advantage members have at least one of these conditions, as you can see, they're enormous drivers of both hospitalization and outside contributor to the risk of readmissions accounting for over half of all readmissions to the hospital. [00:26:45]

But we also know that dementia in particular is a cost multiplier on modifiable comorbid conditions. So one of the big challenges for health plans is that our conventional care

management strategies are unfortunately less effective for these conditions. They generally lack, unfortunately lack effective treatment and interventions. They aren't as amenable as other conditions to member self-management, promoting member self-management. And it's actually quite difficult to engage members who have, unfortunately, dementia in traditional care management programs, unless they engage in a role relatively early on. [00:27:26]

We do know that this burden this places on caregivers is substantial. For dementia, we know that caregivers have higher rates of physical and mental health disorders: stress, anxiety, depression. So we need to find better ways to support the caregivers so they can support their loved ones, our members, and achieve the quality outcomes without undo cost to the caregiver in terms of those physical and mental health index. And I can say on a personal level, having a father who had Alzheimer's, I can confirm the incredible stress involved with the situation and my own actual lack of support during this journey with him. [00:28:18]

So this is very much an issue related to underserved populations and minority populations. Blacks and Hispanics, for example, have a higher likelihood of developing dementia. Minorities are more likely to provide home-based care and are more likely, as a result, to develop worse physical health outcomes. And of course, the issues of low health literacy among minority populations introduce additional challenges. So given these needs, the need for caregiver support and the benefit of remote communications, now, particularly in this environment with COVID, and the development of evermore sophisticated technology, we decided to pilot test with a vendor, Ceresti, which has designed a tablet-based caregiver support system. [00:28:18]

How does this work? Caregivers are given a tablet that's preloaded with a variety of functions, and for simplicity, it's actually locked down, so they could not access the internet. The tablet provides a number of caregiver support functions, educational content on dementia. It allows reporting of patient status and escorts communication with a dedicated coach who's trained and has expertise in supporting caregivers. It only needs to be used about 10 minutes a day. It's very easy in terms of an interface to use. And it's of no cost to the caregiver or the member. [00:29:56]

And the overall objectives are listed here. And I would point out the lower right: become a more confident caregiver. This really speaks to the health psychology concept of health efficacy, which we know is an extremely important determinant in terms of health education and health behavior change. So the concept is that utilization of this app with education and support from the coach will result in improved relationships with loved ones with Alzheimer's, increase family connectedness, provide greater support for the coach, and ultimately, we're hoping we'll reduce utilization through emergency room visits and inpatient hospitalizations. [00:30:40]

There are two major objectives: improving caregiver effectiveness, as I mentioned via education coaching, and reducing hospitalizations via remote monitoring. So again, the application supports education, submitting assessment to the member, communication

with the coaches. The coaches are available almost real time and respond very quickly to questions that may be submitted by the caregiver through the app. These may be requests for services or clarification of benefits that are available. [00:31:21]

And the coach will respond if concerning data on health status is submitted by the caregiver. Interestingly, the educational content is tailored and customized to each member's individual characteristics. And now, in terms of reducing hospitalization, a system of predictive analytics provides the caregiver and the coach with information related to the highest probably of complications this health plan member is likely to experience. And likewise, the educational content is specific to the member, helping the caregiver to understand what are preventive strategies, early signs and symptoms, how to avoid emergency room visits and hospitalizations, when to contact a primary care provider or the coach, and again, guidance on how to access referrals to care management and other plan benefits. [00:32:19]

So this is what the tablet looks like to a caregiver, and as you can see, a very simple, pared-down graphical user interface with a simple tab for daily plan. That walks the caregiver through a series of activities that should be completed for that day. A messaging function, a library function for the educational content, the health reporting, and the contact strategies as well. And the caregiver is given a simple guide with reminders to complete the daily online assessment. [00:33:07]

And again, this include content recommendations that are algorithm-selected. They're appropriate for that individual member. The daily assessment is requested of the caregiver to rate if any of these events have occurred. Has there been a medical event, an ER visit, urgent care visit, a hospital admission perhaps, or a physician visit? And then are there any more acute issues that may have occurred, a fall, a change in medication, change in mental status, behavior, et cetera? [00:33:48]

And again, these data points then are forwarded to the coach who reviews them and is able to respond and triage based on that data. So a very simple daily assessment which is a key to early warning of developing complications to facilitate early intervention, again, hopefully to prevent emergency room or hospitalization. Again, data to the coach for review. And this is an example of what the coach might see in terms of a kind of dashboard of monitoring the members that they're responsible for: a summary and a control type panel. [00:33:48]

They're able to prioritize members who represent opportunities for early intervention, again, hopefully to keep the member healthy and out of the hospital. This is simply an example of what a chat or a communication function would look like using the tablet. Some caregivers may elect to use telephonic contact with a coach. Others may rely on, you know, this is a very familiar type of design. Some outcomes that we're seeing, again, very early on. About half of the caregivers are spouses. [00:35:20]

And we're seeing very high level of a monthly rate of engagement with their system. Over 93 percent of members and caregivers who have enrolled are utilizing this on a

monthly basis. And again, out of 65 percent, very high rate using on a weekly basis, on average among users, about 40 minutes per week of engagement with the system, and over two assessments on average are being submitted per week by caregivers, again, with that critical information for the coach, health status. And that's just a bit of information about what types of activities they're engaging in on a regular basis. [00:35:20]

A large proportion is related to accessing educational content on dementia. And then a fair amount on coaching, messaging, and submitting assessments. But again, I think that's a test to the thirst that caregivers have for learning more about dementia and how to best care for their loved ones. This really refers to impact on mental health of the caregiver. And if we look at impact on a metric which is developed by CDC, metric called the mental unhealthy days, the MUHD, which measures how many days during the past 30 days the caregiver reports that their mental health was not good. [00:36:04]

So, we see over the period of time that the pilot was running that the caregivers were engaged. A very significant drop in the self-reported mental unhealthy days from an average of over six down to almost half at 3.3 at the end of this evaluation period. So again, very encouraging preliminary data on caregiver impact. In terms of satisfaction, again, looking at a net promoter score, which is a measure of willingness of individuals to recommend a product or service to others, really, it's a good proxy of overall satisfaction. We find a very high proportion of promoters. [00:37:48]

The so-called passives are defined as satisfied with the program but not enthusiastic enough to recommend, relatively small number, and again, a very small number of more negative responses. So a high level of satisfaction with our utilization of this program. And I think some qualitative feedback from the caregivers really illustrates the benefit that they're experiencing. Here are some quotes: "I don't feel like I'm alone dealing with this." "It's so much easier to do the right things." "This is a godsend." [00:38:27]

"I dread the day that the plug is pulled on this." "This is pretty much my whole support system." "A lifeline for me." So again, I think this just indicates how significant a need this particular approach is meeting. So looking a little bit at impact on cost and utilization. So we do see at the end of the pilot program that we're starting to see very significant impacts on both cost and utilization. So overall, medical expense compared to a matched set of controls, three-to-one match set of controls, we see a significant reduction in cost per member per month. [00:39:25]

Over half reduction in overall costs, and a 64 percent reduction in medical cost among the highest precious utilizes. We also see very large reductions in admissions. Eighty percent reduction in admissions, acute care admissions. Forty-two percent reduction in emergency room visits. And 73 percent reduction in hospitals readmissions. So very encouraging preliminary results on these metrics as well. In addition, there's some very interesting emerging data that suggests that the total medical cost of the caregivers may actually also be reduced as well. [00:40:11]

In summary, we see this program as quite well-designed, very engaging, easy to use, obviously highly rated approach to supporting caregivers. The preliminary data suggests this may well impact utilization and cost, and we will continue to run out this pilot to examine process and outcomes data. Thank you very much.

SO: Thank you, Dr. Wiecha, for the helpful overview of your program and the outcomes in improving dementia care and caregiver support. And so with that, I'm very delighted to introduce Dr. Caesar DeLeo, who is the Vice President and Executive Medical Director of Strategic Initiatives within Highmark. Caesar.

CAESAR DELEO: Thank you, Sibel. Share my slides. It's covering up the presenter view, so And you see that? Sibel?

SO: Yes, we can see your slides.

CD: Very good. So thank you very much for having me today. I would sort of characterize this as reports from the field. I was asked to report on some of the experiences that we were experiencing at Highmark Health.

CD: Just a little background on Highmark. We're the fourth largest Blues in the US, $21 billion in annual revenues. We primarily serve the Pennsylvania, West Virginia, Delaware, and western and capital regions of New York. We have six million members. We have a number of subsidiaries, including United Concordia Dental, a reinsurance company, and a number of other subsidiaries. You can see that we're primarily Blues plans, and that includes both Medicare of different ilks, commercial, ACA [Affordable Care Act], and Medicaid plans. [00:43:13]

Overall, between all of our companies, we service 29 million lives, and we also have a delivery system of 14 hospitals or micro-hospitals, clinics and multiple physician employees. What I'm going to talk to you today is about our three-pronged approach to SUD [Substance Use Disorder] and how technology is used to carry that out. Our basic approach is prevention, mitigation, and treatment. And while there are many things that we do in all of these areas, I'm going to specifically focus on telemedicine and then profiling and academic detailing. [00:43:50]

So first, telemedicine, prior to the pandemic, we had large national vendors that made up approximately 50 percent of all of our telehealth, however, with the pandemic, we had to pivot, and the pivoting came, remarkably, from our own organic growth through our network providers. It did not come from vendors such that by 2021, our vendor slice of the telehealth pie was only 2 percent, and this is interesting the way that it broke down. About 32 percent is in behavioral health, and 52 percent in primary care. And you can see that share of behavioral health projected to increase and primary care to decrease. [00:44:44]

CD: And so currently we're running about 51 percent of our entire network is delivering behavioral health via tele. And this is similar across all of our regions. And one bullet that's not on this slide is that about 25 percent of our senior population has used telehealth in the past year at an average of 2.4 episodes per year. But that is primarily in primary care and not behavioral health or SUD. Due to the pandemic, we were also faced

with some other issues. And in West Virginia in particular, as the pandemic onset occurred, we were looking at a number of counties, 8 out of 55 had no waiver providers for the administration and prescription of MAT therapy [Medication-Assisted Treatment] or MOUD [Medication for Opioid Use Disorder] therapy and specifically suboxone. [00:46:44]

So we engaged a national pure telemedicine company called Bright Heart Health, to enter the state. They also participated with Medicaid and the rest of the insurers in that state by the end of 2021. Our results were that we had very poor uptake. So minimal uptake in that occurred, mostly across all insurers. Now, when we contrast that with our Alleghany Health Network, which is a little bit farther north near the W of the slide, in our addiction medicine service line, we actually noted a tremendous uptake of telemedicine. [00:47:37]

At one point, it was 91 percent at its peak, and the number of visits actually increased by 15 percent. Our preliminary takeaway learning from that was that a lot of our members want to have some sort of face-to-face relationship but not an exclusive telemedicine relationship. This probably needs to be broke down by the various demographics, but with our overall West Virginia experience, we were very surprised to have very little uptake. And as you know, West Virginia is the number one state in the US for overdose deaths for opioid use disorder. [00:48:21]

I'd like to talk to you about our academic detailing, or profiling and academic detailing for mitigation around opioid use disorder. So we'd profile all of our practitioners for West Virginia and Pennsylvania. In terms of their opioid prescribing across 10 different measures there are four key performance measure that we look at. These reports are sent to physicians initially on paper and then subsequently electronically. And as you can imagine, profiling and sharing information, comparing prescribers against their peers, is somewhat self-regulating. [00:49:09]

There are outliers who do persist, and then we have an escalating protocol of intervention by clinical pharmacists that actually speak to the office and to the practitioners, identify problems, deliver education, and come up with corrective action plans. In some situations we've had difficulty engaging some, and actually, many of these practitioners are no longer in our network, having already been engaged by law enforcement and our fraud and abuse areas. Within that profiling too we call out certain patients of theirs who may have critical alerts around opioid prescribing, and this helps the practitioner, informs them, and then they can take action accordingly. [00:50:06]

We launched this in 2016 and 2018 in Pennsylvania. To date we've had over almost 4,300 direct provider interventions impacting about 2,900 members with changes in therapy. This has also been very productive in terms of cost reduction. And this is overall cost reduction and mitigating the slow movement toward full opioid use disorder, overdose, and complications. So you can see over 42 million in savings, and then we are going to be expanding this into the Delaware and the New York market in the following year. [00:50:53]

I'll also note that along with this we've seen an increase in treatment by almost 31 percent, and overdoses have decreased by a third. And here are some specific metrics. You can see that in Pennsylvania, you can see the decrease in the number of members who are actually on opioids. The MEDD [Morphine-equivalent Daily Dose] risk population has decreased. Multiple prescribers have decreased. And polydrug meaning use of concomitant benzos and other sedatives has decreased as well. [00:51:35]

You can also see this in West Virginia, and I won't go through all of the specific numbers, but you can see across the board decreases, which has been fairly impressive. Now, one may ask the question, should not the PDMPs [Prescription Drug Monitoring Programs]be doing this on a state level? And I would respond that perhaps they should, but across our 50 states there are probably 50 ways or more to carry out profiling, and most states do not have academic detailing. Most states also prohibit health plans from having access to the PDMP. [00:52:17]

So health plans are really left with using the data that they have. So they aggregate all of their members, and they interact with practitioners. Aggregating the membership means putting ACA, Medicare, commercial, and Medicaid all together. We're interfacing with one or more practitioners, so it's easier for them to look at their whole portfolio of Highmark members rather than product by product. And then, well, I talked about mitigation. I'll just tough briefly on treatment. You can see that our treatment rate for all products combined has increased, however, when you disaggregate this, you see that there are differences between the Medicaid population, the Medicare Advantage, and the DSNP [Dual Eligible Special Needs Plans] populations, which we're further drilling down into, and I think I'm being signaled that I'm at end of time. [00:53:25]

And I look forward to your questions later.

SO: Oh, thank you, Caesar, for presenting on Highmark's experience with telemedicine, the data-driven profiling and academic detailing to approach substance use disorders. And so with that, I'm delighted to introduce our last speaker, a former colleague who I'm inspired by every day, Dr. Mona Siddiqui, who is the Senior Vice President for Enterprise Clinical Strategy and Quality at Humana.

MONA SIDDIQUI: Thank you, Sibel. Can you all see my screen?

SO: Yes.

MS: Perfect. Well, first of all, I just want to say how delighted I am to spend some time with former colleagues and friends. And I also just want to acknowledge the efforts that are required, as I know from past experience, in coming together across these different divisions. And just want to acknowledge and appreciate the efforts across ACL and OASH and CMMI coming together for this. So thank you, and really appreciate you including me in today's conversation. The way I would like to approach today is really maybe starting really high level for how we see the landscape and then talk through Humana's approach to investments in data and technology, and then ultimately how that helps us to do what we know we need to do within the space of taking care of vulnerable populations. [00:54:57]

So some of this will be a recap of Leith's earlier slides. And we did not share notes, but we'll start there with the high-level framing. So not surprising for any of us, spending in healthcare continues to grow at a rate faster than GDP and demands a larger share of our customer's incomes. Despite all of that spending, too many people are having a fragmented and complex set of experiences focused on episodic care that result in poor health outcomes. The complexity of the healthcare system is really magnified as a share of our population over 65 continues to increase, as you see here from the chart on the left. [00:55:50]

With the increase in age, unfortunately, often comes the onset of chronic conditions, and as you can see on the chart at the right, over 70 percent of seniors have at least two chronic conditions. The combination of advancing age and chronic conditions introduces even more complexity to an already complex system which all too often leads to poor health outcomes. I think this is why we're here today. The Medicare Advantage program is arguably one of the best examples of how to knit together a siloed health experience into a holistic health approach. [00:56:29]

Customers recognize this and continue to adopt Medicare Advantage. MA delivers 43 percent lower avoidable hospitalizations than fee-for-service Medicare. This saves considerable cost, which we plow back into our benefits for our members to be able to offer more holistic care, including things like food and transportation benefits. And the ability under MA to invest in benefits more attractive to diverse populations. Several structural forces are helping advance the changes necessary to our system. [00:57:06]

Advances in interoperability, although I think we all think they can happen faster, are making healthcare data more connected in context that matter. Advances in the internet of things are making healthcare data more abundant in our everyday life, including in our homes, on our wrists, and in our pockets. Advanced analytics are also enabling this more connected and abundant data ecosystem to be contextualized with insights that could lead to more timely, relevant, and convenient interventions. These technological advances are helping in part the advancement of value-based payment models, which align incentives more effectively to providers to get paid for doing the right things that deliver health outcomes versus getting paid for doing more things. [00:57:55]

We expect this march to more value-based reimbursement to continue to accelerate. And frankly, a more technology-enabled value-based context is shifting where and how care is delivered. These trends create significant opportunity. The complex and costly nature of our healthcare system and aging and increasingly chronic demographic trend and structural changes driven by technology and value-based payment models all suggest that winning models in healthcare must have three fundamental capabilities: one, holistic care with an outcomes-driven operating model; consumer centricity that is enabled by technology in a connected data ecosystem; and locally integrated healthcare capabilities. [00:58:49]

The set of chassis that really enable any organization to deliver on this opportunity have to be embedded in intentional technology and analytics choices that can lead to an

approach that is sustainable and scalable. While I know everybody is interested in advanced analytics and predictive modeling, I don't want to rush through the slide. It is critical to understand the foundation that needs to be built and the long-term investments that are required to build that foundation. For anyone who has done this, as I had to do at my previous role at HHS [US Department of Health and Human Services], the technology choices are only one aspect. [00:59:32]

There's an enormous culture change associated with working at a different operating model that need to be address proactively with any large enterprise, whether that's Humana or HHS. The right investments have a direct link to being able to meaningfully and measurably be able to impact health outcomes. Our clinical strategy is really focused on delivery on this expectation and on designing proactive care models with some core principles in mind. First, sustained engagement and trust are built through having the right care team in place and on our members have confidence that they are being served by the best clinicians. [01:00:16]

Models of care must provide effective and evidenced-base care while avoiding low-value care and complications. We know that the healthcare systems leaves many, and particularly seniors, feeling confused and lacking a sense of control, and our proactive care and engagement strategy create trusted relationships that empower our members with a sense of control. The foundation for this has really been our focus on having the right information at the right time powered by what we call the longitudinal human record. Our ability to leverage information from across the Humana ecosystem and our partners and use both traditional and nontraditional sources of data allows us to have a much more nuanced approach to segmentation and to deploy advance analytics and real time data to service the right members at the right time. And move towards personalized care models that deploy the correct information and the set of interventions from addressing social needs, behavioral health needs to connecting members to services in the home, pharmacy, primary care, and a range of partners on the Humana platform. [01:01:31]

Humana's platform approach also allows us to be rigorous in the development and refinement of these models and to take an approach of continuous tests to learn, which is so important to continue to refine the interventions that we deploy and think through how we deploy them, who we target, and who we may not target. As we get real time information regarding our members from across the care ecosystem, and this includes both our owned assets and our partners', we're able to leverage our approach to member segmentation and predictive analytics to identify the right intensity of assets across the care ecosystem that can be applied towards the immediate member need that maximizes that opportunity for member engagement, trust, and improved outcomes. [01:02:23]

We also continue to monitor program outcomes, even in interim member experience and feedback across subsegments to rapidly arrive at decisions regarding scaling, program refinement, or frankly, sunsetting. Ultimately, this information feeds back into what I described earlier, which is a longitudinal human record to rapidly and efficiently generate value for our patients and for Humana. So as we develop this learning ecosystem fueled

by having the right information at the right time, social determinants of health are incredibly important to incorporate given their, frankly, outsized impact on health outcomes. [01:03:07]

Historically, though, we haven't had a clear line of sight into the prevalence of the multitude of these needs across our membership. And we set out to address this by conducting a nationwide representative survey to understand these needs, their impact on health, and really figure out, what are the set of actions that we can take? As we survey patients with various serious and chronic medical conditions, a couple of themes emerged. One, across the entire population, almost half of the patients were acknowledging significant financial strain, significant enough that they find it difficult to pay for the basic needs like food, housing, medical care, and heating. [01:03:57]

A significant portion across all conditions also related that over the course of a year, they had experienced periods where either the food that they had bought just did not last, and they didn't have money to buy more, or they were worried that the food that they had would run out before they had access to more money to buy more food. A third to a half admitted to feeling lonely or isolated. These are significant and disturbing numbers across the board. Usurpingly, the prevalence of each of these risk factors is higher amongst those that are Black and Hispanic and particularly in the dual and LIS [Low-income Subsidy] segments. [01:04:43]

This information is really powerful to help us better serve our members across a range of touchpoints and to ensure that we're taking a consistent and enterprise approach to addressing our members' needs. Whether we reach out to them through our care management organization, our call centers, or our community neighborhood centers, having access to this information helps us ensure that we're addressing their most fundamental needs first. We can also take a much more targeted approach to designing our clinical programs to make sure that we're addressing the right needs for the right set of patients. [01:05:24]

I'm going to spend some time on this slide. This is a clear example of why understanding and addressing social needs is so critical. When we look at our members with diabetes, they have a high prevalence of at least one social risk, and our data shows that for every increase in an individual's social risk, their hemoglobin A1C control worsens significantly, as does their total cost. To me, this is an incredibly powerful visual for what so many patients are up against and why our approach to care has to be holistic to improve patient outcomes, address structural health inequities, and to address the cycle of increasing cost to the system. [01:06:15]

It is also why it's essential to ensure that the approach to SDOH [Social Determinants of Health] evolves into a sustainable and scalable model of care with an underlying business case and the chassis of Medicare Advantage and value-based care uniquely positioned to be able to deliver on this holistic approach. Our investments in technology and data infrastructure along with the significant learnings we've had over the last several years of our focused efforts in addressing the social determinant of health needs allow us to really

proactively work to identify and implement preventive measures that address these social risks and enable clinical programs to meet the member where they are. [01:07:00]

The investments in our data infrastructure that I discussed earlier are also key to not only connecting our members to local services but, frankly, to make sure that those gaps do, in fact, get closed. Clinical outcomes and social risk are deeply tied, as evidenced further by this data. Across every SDOH domain, for patients that have these risk factors, we see significantly elevated MERs. For those with multiple risk factors, which of course is highly prevalent, this increase is even higher. The takeaway here is obvious: [01:07:41]

If we want improved health outcomes, improved health equity, and decreased cost to the systema, addressing social needs is fundamental. While we have made significant gains, I would be remiss if I didn't note some challenges that persist. Data collection here in this space is tough. It's often siloed, many times not incentivized to be collected at all. There is investment required to build the data and technology ecosystem that really allows an enterprise to do this work in a sustainable, scalable, and integrated way. [01:08:20]

Investments that Humana has been making in this space to allow us to be much more holistic and test and learn through the rapid approach I mentioned earlier, but this requires a concerted organizational effort. To be able to predict and often prevent social needs from worsening, multiple data sources are required that enable us to understand a member more holistically, and proactively target the right individuals at the right time. And frankly, sources of information from both inside an organization and outside. [01:08:55]

Honing our ability to predict means continuous iteration on predictive models to ensure that we are learning and constantly improving, dedicating, frankly, significant resource to this and creating internal expertise in this space. Given the challenges in data fidelity and when collecting SDOH data, we've invested in analytics and machine learning techniques to overcome these barriers. Using a sample of the validated survey instrument responses, we have built predictive models on our machine-learning platform extrapolating the inferences from our surveys to all of our Medicare Advantage populations. [01:09:45]

We have operational models aimed at identifying financial strain, causing instability, the transportation challenges, food insecurity, and social isolation. I've highlighted the inputs and performance of two here focused on transportation and financial strain. We have utilized our cloud infrastructure to create govern data products using these models and providing API [Application Programming Interface -based] access to various applications across Humana. We're also able to use insights from these models and personalization of our political program design and outreach. These aspects really are only possible because of the core investments that we have made across the enterprise. [01:10:36]

In isolation, these would not be scalable, but really having that organizational enterprise connectivity is essential. Operationalizing this work also means having the right information on our members, but having an approach where we prioritize our members

who have these basic needs that if unmet keep them from living healthy lives. And our technology and data investments enable us to leverage this information regardless of who may be seeing this member across the enterprise. I'll close with giving this final example of Humana's work in addressing food insecurity. [01:11:21]

There has been a significant path that has been traversed over the past many, many years from learning through partnerships and pilots, proactively serving member needs, delivering over one million meals last year that, frankly, also requires knowing who to reach out to, to expanding the post discharge food insecurity benefit. The healthy food card is a direct spend card to enable members to purchase approved groceries at a broad range of retailers. This year the program is serving approximately 450,000 low-income seniors and 77 plans across 25 states. [01:12:04]

And it's expected to support more than 650,000 next year. Our internal analysist evaluating the impact of this benefit on member health outcomes in claim spend demonstrates a significant reduction on member in acute admissions, and it's statistically significant trying to adjust to claims cost savings for participating member per month. The study also revealed the card benefit and the more the member spent, the greater the impact on their health and on savings. This final slide really speaks to our belief in holistic health and the need to make sure that we are progressing towards operational maturity for how we address the needs of our most vulnerable populations. [01:12:52]

Addressing health inequities and caring for vulnerable individuals is not the domain of any one part of an organization but the responsibility of the entire enterprise. And our foundational and ongoing investments, I believe, have laid the right road map for us to really seek that operational maturity and to have solutions that are scalable across populations. I also just want to acknowledge here that this is the work and effort of many, many, many colleagues and departments across Humana. I'm fairly new, and speaking on behalf of the efforts of the many who have been committed to this space for a long time, but appreciate the opportunity to be here today and present this work. [01:13:41]

So thank you, Sibel, and I will hand it back to you.

SO: Thank you so much, Mona. And so with that, we'll actually be turning over to our Q and A portion of the webinar. And so with that, I'll actually turn it over to Leith to kick this off.

LS: Those presentations were phenomenal. Thank you to our presenters. I think they have answered the mail more than adequately and shown kind of, I guess, the wide range of creation and innovation that we were looking for for this webinar. So thank you again to all the presenters. At this point, for those of you that are in attendance, we are a little light on questions, so please, it looks like whether it's in the chat box or whether it's in the Q and A, please, enter your questions. We'll go ahead and get things rolling, and I think I'll start with one that did come in for John Wiecha. [01:14:53]

And this has to do with the pilot, obviously, and how many caregivers total were involved in the pilot?

JW: Yeah, thanks for much. So there are 164 caregiver and member dyads that are in the pilot, so a fairly substantial number. Let me add to that. They were matched a three-to-one match with the control, so-called control caregivers and members who are not enrolled, and the data shows that there were very, very close comparison between the match controls and the members who were enrolled in terms of a whole variety of utilization metrics and financial metrics. They really looked like they were very valid controls for this pilot study.

LS: That's excellent. Thank you, John. That's always nice when you can get a nice comparative group in place. I'd ask a quick follow-up from that just with regards to the idea around having the tablet. Is there or was there consideration with regards to the caregiver access to data or to broadband access in terms of the selection criteria, or was that something included as part of the access to the tablet?

JW: You know, I'm not exactly sure about that particular inclusion criteria. I do know that the tablet, as I mentioned, is quite restricted in terms of what you know, access outside the actual Ceresti environment because what I think the vendor has found, that you know, once you start introducing access to the internet in particular, it quickly spirals into confusion and potential distraction. I do know that that was a very deliberate design decision. You know, I've worked in actually, in a space, my academic career, in the past and this environment around telemedicine and electronic support for chronic disease and behavior change, I will say that to the extent possible, simplifying the environment for the users is absolutely critical. [01:17:36]

And I do think that's one of the features of this particular vendor that they've been able to achieve that does account for the engagement and continued high usage. But, to answer your specific question, I have to find out if an inclusion criteria was availability of broadband access or if the tablet itself, you know, connects via wireless or telephonic connection.

LS: No, thank you. That's a good sanity check. There is power in simplicity, right? With decentralized clinical trials, there's been a lot of power to be gained in having community workers go out with non-wired tablets to bring on folks for clinical trials. That's a very interesting corollary with regards to vaccine and then looking at, you know, chronic disease management, so thank you for that, John.

JW: Yeah, actually, just received a little more information on that as we're chatting. So it looks like the caregivers connect the tablet via Verizon at no cost to the caregiver.

LS: Interesting, thank you. Let's see. Let me move to Mona for a moment. What is Humana's Return on Investment (ROI) on the food assistant program?

MS: So I will actually take a step back from that question and say there are some things for which I think the approach just needs to be different. When we think about addressing social needs, I think we have to move beyond just financial ROI to thinking about more holistic set of health outcomes. And that's really the approach that we're trying to take

here. You know, from some of the data that I shared with you today, what we're seeing is that if we don't address those fundamental needs, that the patient. This is obvious to all of us, right. [01:19:30]

We would just not be ready to engage in any other aspect of our healthcare in a meaningful way. I think we have to just step back and say what are the set of broader health outcomes that we care about, and what are the investments that we want to make sure that we're making for these vulnerable populations. So I don't think it's actually taking a very traditional approach.

LS: That makes sense. It's almost a composite ROI. It's not just the money, right. Actually, oh, wait, back to John now. What is the admin lift is involved with a caregiver and making sure all the appropriate HIPAA forms, other privacy security considerations are met?

JW: Well, that's a great question. Unfortunately, I don't have to that level of detail. I apologize. But I'd be happy to research that with a vendor and find out more details about how that was done. So I would be happy to offer to get back to you with more details on that, if that would be helpful.

LS: I'm sure the audience would find it helpful. Thank you, John. Over to Vijeth, now, you discussed the inequity between rural and urban as well as racial inequities, but was their combined rural race or urban race inequities observed?

VI: Yeah, I probably need a little bit more context to that question. The attendee's referring to one of the articles that we co-authored in a couple of venues. A lot of that analysis was distilled from the input for the RFI [Request for Information]. But the rural-versus-urban distinction was pretty apparent in terms of flagging a case for drivers of health inequities, but I don't know if there was disaggregated data within rural urban based on SES [socioeconomic status] demographic, but that's certainly something that that's apparent in the literature, and then we can follow up on.

LS: Thanks, Vijeth. Let's see, actually, one for Caesar: Have you been able, with the data you presented, to overlay or are there plans to overlay rates of chronic pain optimization or utilization of alternative pain management therapies within the population of providers and patients who you've provided?

CD: Not so much that, but we are looking at different slices of opportunity, including postsurgical opioid prescribing and management of chronic pain profiling and coming up with the profiles for specific types of management, chronic pain, MOUD, et cetera.

LS: Excellent, thank you. Let me shift to Sibel. When is the next opportunity to apply for VBID, and given the interest in health equity, will you be encouraging innovations in any particular areas?

SO: Thanks, Leith, for that question. So the next opportunity. As many folks online know, we released a RFA, or request for applications, every year for the VBID model, and so we'll be releasing that as announced, I think last week, later in the fall, probably around late November, early December, and we'll open up applications for the 2023 plan year. We from a model perspective, we'd really like to see a critical mass of plans testing in areas to really target historically underserved populations and provide them with really meaningful supplemental benefits to meet their needs. [01:23:30]

So some of our priority areas include food and nutritional interventions, like the one that Mona spoke about, which is, you know, one of the Viva model interventions that Humana is testing. Another area that we really want to focus on is specifically around cardiovascular disease and diabetes. Those are some of the areas that we hope to see more interventions in in supporting our goals around health equity and improving or reducing disparities.

LS: Thank you, Sibel. And in a sense, we have, looks like five or less minutes to go. If the Medicare Advantage Organizations online have a concept that is kind of an innovative benefit, maybe something off the beaten trail similar to what we've heard today, but they're not sure if it fits in with current VBID flexibilities or where they may be going in the future, is there someone that they can be working with to understand how the benefit could fit in the VBID restrictions?

SO: Yeah, that would be us! So please, please don't hesitate to reach out to the VBID model team. Our email address is VBID@cms.hhs.gov. We really encourage plans to start an early dialogue with us, you know, reach out to us now, even if it's an idea for 2023 or 2024. We recognize that plans are thinking about their benefit designs for the next plan year or have already started over the summer. We'd love to work with you on any of your ideas and innovations around supplemental benefits and benefit designs and think through how to shape those interventions together to really make for a good test, and most importantly, again, address health equity. [01:25:31]

LS: Now, Sibel, follow-up to this. Would this include dementia, substance use disorder and oncology?

SO: Yes, as I had mentioned, there are lots of different way to target specific populations for supplemental benefits or reduce or eliminate cost sharing. And so you could imagine coming up with a benefit design or a pool or a combined package or suite of benefits that would, let's say, address the needs of an oncology patient who might also be of low income, for example, or address other social needs such as food insecurity or transportation needs. It would include all off the above, and we can work with you with plans on how to shape those benefits to really address those needs. [01:26:22]

LS: So it looks like we have a couple more. This one is, "Are there any updates coming regarding the public health emergency declaration in telehealth waivers if CMS plans to continues telehealth for Medicare Advantage.

SO: So we'll take that question back and do a little bit more research. I think right now CMS is looking to evaluate how telehealth and telemedicine is being used in MA. You all should hear more from CMS in the coming months on that. [01:27:02]

LS: I'll speak to that in a, I guess, little carve out way. If you want to look at that question from another angle, Medicare in general, we're looking at fee for service. Those are the things that were modified with the waivers, with the waivers, with the telehealth flexibilities that came around from the PHE [Public Health Emergency]. Medicare Advantage has not been touched during that time in terms of what can and cannot be done because Medicare Advantage is, you know, by its definition, it's novel. It's innovative. It has other strings attached as opposed to the fee-for-service framework. [01:27:45]

So that's another way to answer or frame the question. So in as much as Medicare Advantage is staying the same as it was through the period before the pandemic, through the pandemic, and into now, I think you'll see the same conditions exist. There's also one final question, if we have a moment. Any thoughts on how to continue CMS waivers for members having hospital at home? So kind of the home health?

JP: Yeah, this is Jason. I'll jump in there. You know, I think that's something we all adopted to take back. You have kind of the Innovation Center team here, and I think that question's kind of outside of the scope of our purview, but we can certainly think about it.

SL: I believe I'll hand it to Sibel for closing remarks. Thank you, Jason. Appreciate it.

SO: Yeah, thank you, Jason, and thank you, Leith, for walking us through that Q and A portion. So I'll keep it brief, as we're at time. Just want to thank our speakers today as well as our partners from OASH and ACL for joining us in this webinar. I think we've learned quite a lot from all the speakers this afternoon from how technology can help us better understand disparities and the social contexts in which Americans live to how a deeper focus and the extent to which telemedicine and leveraging that technology can be sustainable and really support reaching patients where they are. [01:29:33]

Lastly, in the third speaker presentation, we heard about how technology and data together can promote a more holistic approach to delivering healthcare. From this webinar we've learned so much, and we know that there's so much more to do, and I think there's a lot of growth opportunity, and specifically leveraging the ability of technology to promote health equity and better outcomes for our most underserved communities. And so with that, we'll close up. Another big thank-you to our analysts here this afternoon, and again, please don't hesitate to reach out to us or discuss your interests in the VBID model by reaching out to VBID@cms.hhs.gov. [01:30:15]

MS: Thank you.

SL: Thank you.

CL: Thanks very much.