Value-Based Insurance Design (VBID) Model's Health Equity Incubation Program

Advancing Health Equity in Diabetes Care and Outcomes

June 30, 2022
Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

PART ONE
3:00 – 3:10 PM ET

WELCOME & CMMI'S FOCUS ON IMPROVING EQUITY IN DIABETES CARE

SPEAKER

Purva Rawal, PhD
Chief Strategy Officer
Center for Medicare and Medicaid Innovation, CMS

Disclaimer

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Health equity means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes. CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive.[1]

[1] See more at https://www.cms.gov/pillar/health-equity#:~:text=Health%20equity%20means%20the%20attainment,language%2C%20or%20other%20factors%20that

The Problem: The Prevalence and Cost of Diabetes

Diabetes affects many individuals, negatively impacts health outcomes, and carries high costs. Effective behavior change can reduce the risk and complications of type 2 diabetes

While Many are At-Risk for Diabetes, Few are Aware

1 in 2 Adults over age 65 have prediabetes[1]

however…

Only 1 in 7 adults aged 65 and older with prediabetes are aware of their condition[1]

Diabetes is Highly Prevalent and Growing

One in four adults over age 65 have diabetes[2]

and…

Prevalence of diabetes is expected to double by 2050 among adults[3]

Diabetes Burdens the System with High Costs

2.3x Diabetes causes individuals to spend 2.3 times more on health care per year[5]

$104B Annual Medicare cost of care for Americans 65+ with diabetes [4]

Adults with diabetes have twice the hospitalizations and ED visits, and take a larger number of prescription drugs[2]

Source: 1) https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf ; 2) http://www.diabetes.org/diabetes-basics/statistics/
3) https://www.cdc.gov/media/pressrel/2010/r101022.html; 4) James Boyle, et al., "Projection of the Year 2050 Burden of Diabetes in the US Adult Population: Dynamic Modeling of Incidence, Mortality, and Pre-Diabetes Prevalence," Population Health Metrics 8, no. 29 (2010): 1–12; 5) http://www.diabetes.org/advocacy/news-events/cost-of-diabetes.html.

More on Prevalence and Disparities of Diabetes[1]

Prevalence

- According to the American Diabetes Association (ADA), **1.4 million Americans will be diagnosed with diabetes this year** alone.
- According to the CDC, those with diabetes who are over 50 will, on average, **die 4.6 years earlier, develop disability 6-7 years earlier and spend 1-2 more years in a disabled state**.
- The CDC also tells us that in 2019, the "prevalence" or number of existing cases of diabetes in the US, across all ages, was **11.3% of the population or 37.3** million individuals.
- As shown on the previous slide, about **a quarter of those over 65 have been diagnosed with diabetes (24.4%),** but if you add the **4.7% of this age group** that **is undiagnosed**, there are close to **16 million people over age 65 who are diagnosed and estimated as undiagnosed for diabetes.**

Disparities in the Burden of Diabetes

The rates of diagnosed diabetes in adults of all ages, by race/ethnic background, are:

- **14.5%** of American Indians/Alaskan Natives
- **12.1%** of non-Hispanic blacks
- **11.8%** of Hispanics
- **9.5%** of Asian Americans
- **7.4%** of non-Hispanic whites

[1] Sources: https://www.diabetes.org/about-us/statistics/about-diabetes; and https://www.cdc.gov/diabetes/index.html

The Voluntary VBID Health Equity Incubation Program

Program Overview

The **Health Equity Incubation Program** serves as the central pillar of planned learning activities with the goal of:

- Encouraging innovation in most promising focus areas;
- Optimizing design and implementation best practices; and
- Building evidence base for **quality improvement and medical cost savings** related to social needs interventions.
- Inform new directions in MA program

Sessions and Technical Assistance *(Recordings and slides from prior sessions are posted on the VBID website)*

Initial VBID Business Case Session
September 2021 – December 2021

Engaged MAOs in **"Health Equity Incubation Sessions"** in the form of webinar and follow-up one-on-ones that focus on **VBID health equity business case**

Technical Assistance
January 2022 – December 2022

During **Health Equity Incubation Sessions**, the VBID Team will engage MAOs in health equity focused technical assistance (TA) and leverage use cases and case studies tailored to **the most promising focus areas** (e.g., food and nutrition, diabetes and transportation).

Learning and Performance Feedback
2023 and onwards

In the longer-term, the VBID Team plans to create a learning network, where plans can tackle common challenges around health equity. An essential part of this learning network will be tailored feedback based on plan data.

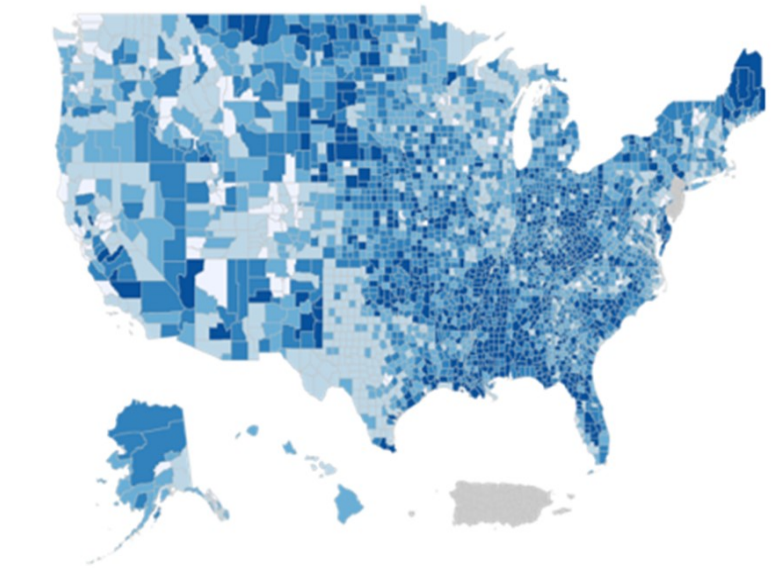
PART TWO
3:10 – 3:25 PM ET

CURRENT STATE OF DIABETES CARE AND OUTCOMES

SPEAKER

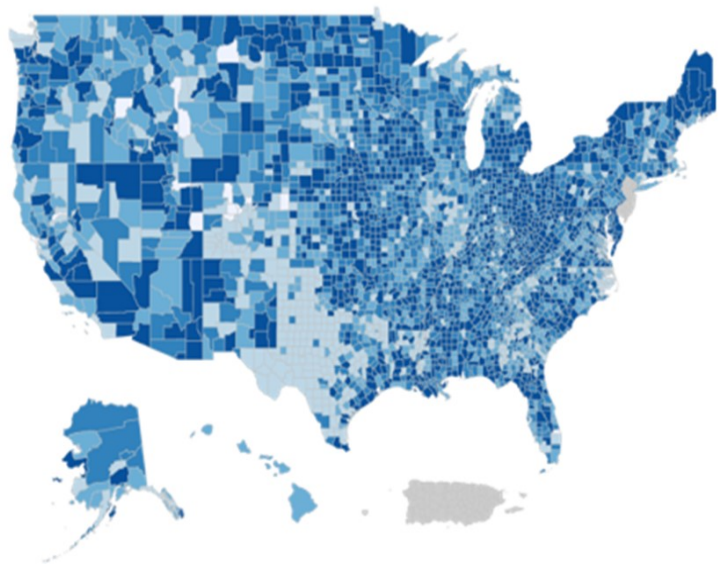
Mollie Howerton, PhD, MPH
Medicare Diabetes Prevention Program (MDPP)
Expanded Model Test Lead
Center for Medicare and Medicaid Innovation, CMS

County-Level Distribution of Diagnosed Diabetes, Obesity, and Physical Inactivity, 2019



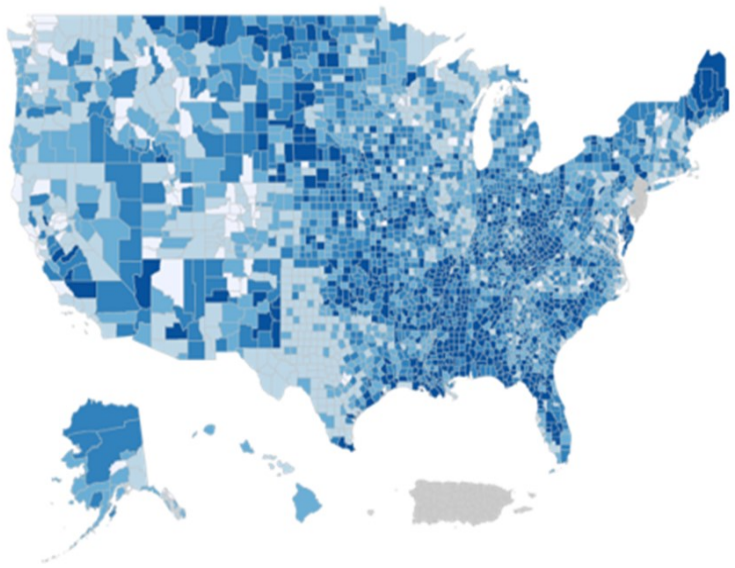
3.3%–6.5%	6.6%–7.3%	7.4%–8.4%	8.5%–10.0%	10%–19.5	No Data	Suppressed

Diagnosed Diabetes



10.5%–20%	20.1–23.3%	23.4%–26.4%	26.5%–30.6%	30.7%–45.4%	No Data	Suppressed

Obesity



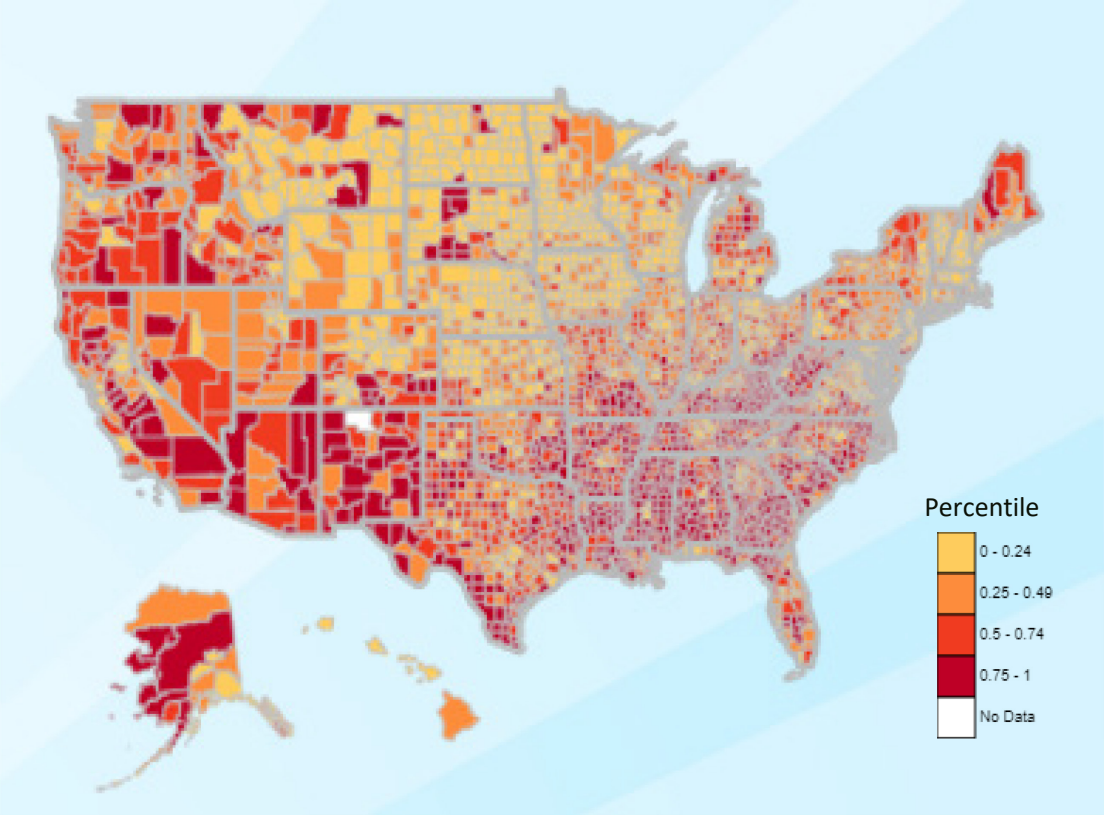
8.8%–16.9%	17%–19.8%	19.9%–22.4%	22.5%–26.2%	26.3%–42.4	No Data	Suppressed

Physical Inactivity

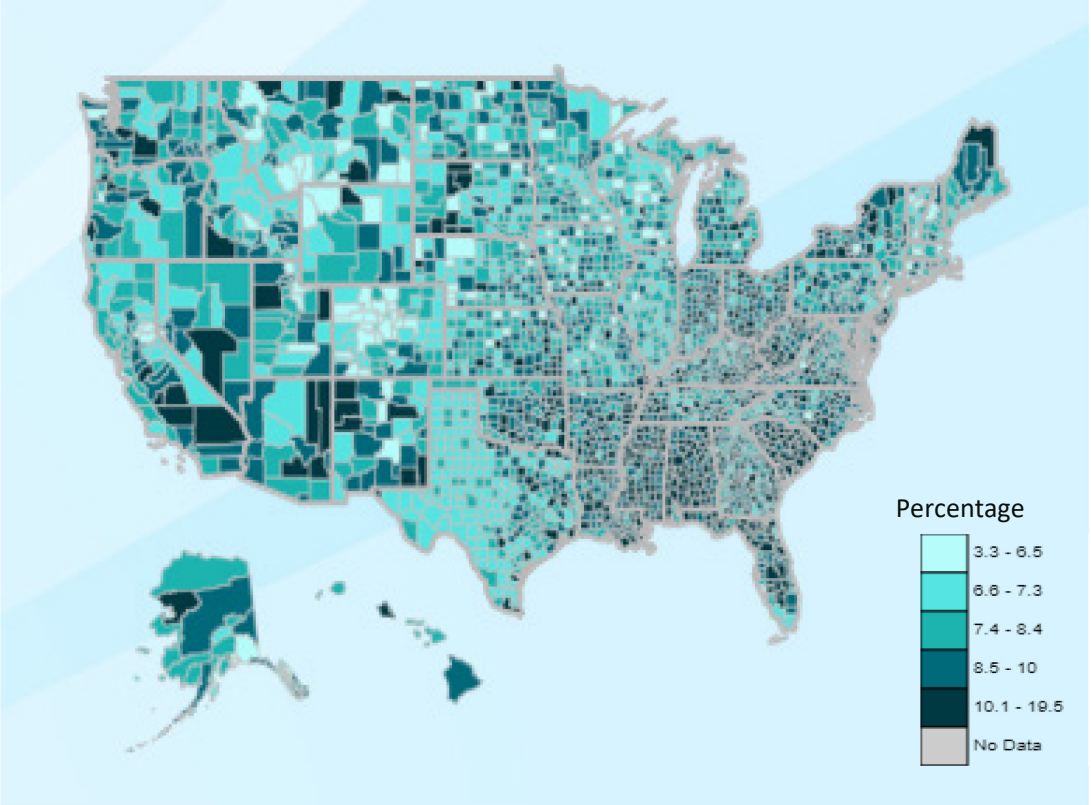
Source: ww.cdc.gov/diabetes/data

County-Level Distribution of Diagnosed Diabetes and Socioeconomic Status, 2018

- Socioeconomic Status; SVI Variable: Overall Socioeconomic Status; Natural Breaks; Year: 2018



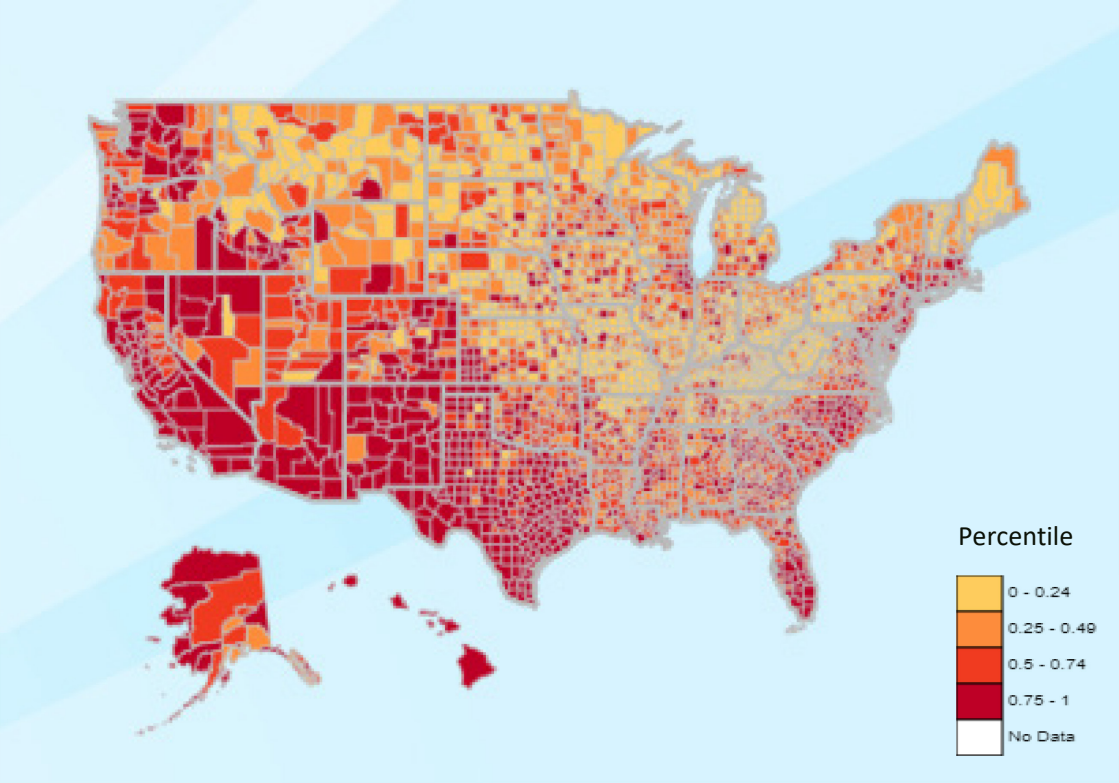
- Diagnosed Diabetes, Total, Adults Aged 20+ Years, Age-Adjusted Percentage, U.S. Counties, 2019



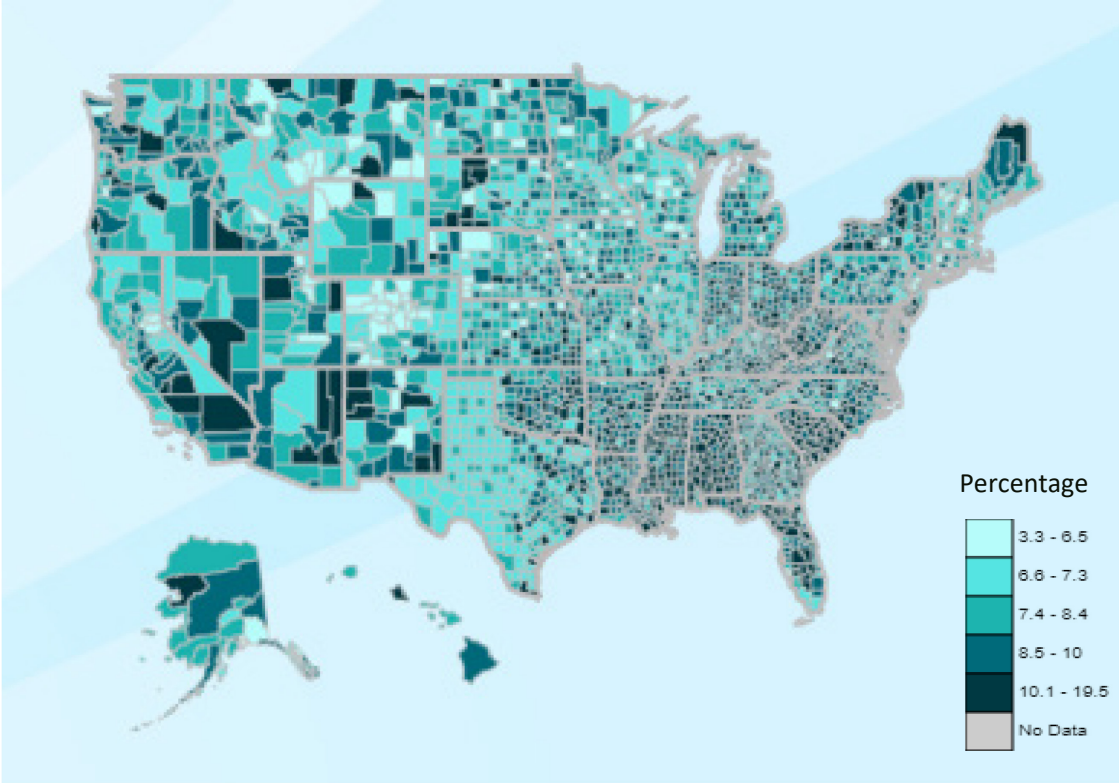
Source: ww.cdc.gov/diabetes/data

County-Level Distribution of Diagnosed Diabetes Minority Status & Language, 2018

- Social Vulnerability Index (SVI), Minority Status & Language (Overall Minority Status & Language), 2018



- Diagnosed Diabetes, Total, Adults Aged 20+ Years, Age-Adjusted Percentage, U.S. Counties, 2018



Source: https://www.cdc.gov/diabetes/data

Opportunities for Improvement

Addressing SDOH in Diabetes Care

- Food insecurity
- Transportation issues
- Integration of medical care with non-medical care
- Improving housing and home modifications
- Counseling and legal aid services

Lessons Learned from the Pandemic

- Virtual care
- Remote patient monitoring
- Hybrid model of care with remote and in-person visits
- Getting people reconnected to healthcare

Emerging Trends in Diabetes Care

- Pre-diabetes and diabetes screening starting at age 35
- Opportunities for managed care
  - E.g., diabetes reversal
- Using technology as part of diabetes care
  - Smart phones to control our medical devices via smartphone apps
  - Remote insulin dosing
  - Evaluating glucose management using a 14-day assessment with a continuous glucose monitor (CGM)
- Individualized diabetes care
  - Putting the person (vs their diabetes) at the center of healthcare

PART THREE
3:25 – 3:40 PM ET

BENEFIT DESIGN OPPORTUNITIES, INCLUDING THROUGH THE VBID MODEL

SPEAKER

Abigale Sanft
VBID Model Co-Lead,
Center for Medicare and Medicaid Innovation, CMS

MA Options

Category	Options Available Under MA*	Additional Options Available Under VBID
Benefit Targeting	• **Special Supplemental Benefits for the Chronically Ill (SSBCI):** Allows MAOs to provide chronically ill enrollees (as defined in § 422.102(f)(1)(i)(A) using three specific 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. ❖ While CMS may provide a list of chronic conditions, MA plans may consider other chronic conditions not identified on this list if the chronic condition is life threatening or significantly limits the overall health or function of the enrollee ❖ Targeting by low-income subsidy (LIS) or dual status alone is NOT allowed but 422.102(f)(2)(iii) permits MA plans to consider social determinants to help identify chronically ill enrollees whose health or overall function could reasonably be expected to improve or maintained with the SSBCI. **MA plans may not use social determinants of health as the sole basis for determining eligibility.** • **Uniformity Flexibility (UF):** Allows MAOs to target enrollees for healthcare services that are medically related to the patient's health status or disease state (e.g., reduced cost sharing of eye exams for diabetics) if the benefit is offered uniformly to all individuals with the same qualifying condition. Supplemental benefits must be primarily health related (§ 422.100(d)(2)(ii)) • **NOTE:** Part D reductions in cost sharing are **not** permitted under SSBCI or UF	Allows MAOs to provide enrollees with LIS/dual status or chronic condition(s) (or both) with: • Non-primarily health related supplemental benefits (allowed under SSBCI, but not UF) • Reductions in cost sharing for Part D drugs • New and existing technologies or FDA-approved medical devices as a mandatory supplemental benefit
Rewards and Incentives (RI) Programs	• Part C RI must reflect the cost/value of the health related activity and not the expected benefit • Part D RI only for Real Time Benefit Tool (RTBT)	• RI limit that is tied to the value of the expected impact on enrollee behavior or the expected benefit, within an annual limit • Part D RI outside of RTBT
Hospice	• Available to MA enrollees through Original Medicare	• MA plans participating in the Hospice Benefit Component generally cover ALL of their Medicare benefits, including hospice care. Can also offer transitional concurrent care and hospice supplemental benefits

**See 85 FR 33802 and 42 CFR 422.102(f)(1)(i)(B) for other requirements.*

VBID Flexibilities Supporting Improved Equity and Outcomes in Diabetes Care

Model Intervention	Example of VBID Model Intervention
Targeted Benefits by Condition, SES, or both	• Through VBID, plans may choose to **target enrollees for enhanced benefits based on both a diagnosis of diabetes and/or low income status, or a cluster of diagnoses** e.g. diabetes, hypertension and\or obesity. • **Benefits can be proposed to meet a range of clinical care and health-related social needs** including **supporting:** ➢ **access to care** through transportation benefits (for example to office visits or pharmacies) and removal of possible **financial barriers to medication adherence by reducing or eliminating cost sharing** for selected drugs, or all diabetes medications, or all Part D drugs across the board; ➢ **healthy nutrition** such as healthy food card, medically tailored meals, nutritional counseling and/or education; and ➢ **healthy lifestyle** such as visits to an exercise physiologists, exercise equipment, or participation in supportive group programs. • These **benefits can be offered individually or packaged** to create a comprehensive approach for high need enrollees with diabetes. Benefits may also be conditioned on participation in plan care management activities.
MA and Part D RI Programs	• Plans may also propose to **offer rewards and incentives that are tied to completion of care management activities and goals** for enrollees with diabetes. • Examples include adding an amount to a gift card for completion of each session in a series such as attending a nutrition education class with a larger reward for completion of the entire series, or for maintaining a weight and food intake log, or for a reward tied to each refill of specific diabetes or hypertension medications as part of a larger medication therapy management program.
Targeted Coverage of New & Existing Technologies or FDA Approved Medical Devices	• Plans may also propose to **offer targeted coverage of continuous glucose monitors for defined special populations that exceeds current coverage determinations**. • Similarly, plans may propose to **offer targeted coverage of blood pressure monitors and cuffs to enrollees with hypertension and/or diabetes to support enrollees with chronic conditions beyond diabetes**.

VBID Use Case: Elsa and Diabetes Management

1

- Elsa is a 65-year-old Asian Pacific female with type 1 diabetes and living in a very rural area. Because of her limited vision, she is dually eligible for Medicare and Medicaid.
- She has a family history of diabetes with complications that include lower extremity amputations, and she hopes for a better outcome for herself.
- Her vision and lack of transportation options mean she is often not able to refill her diabetes medications, even in those few months when she has money to pay the cost share. Her glucose control is highly variable as traveling to the doctor's office is challenging, limiting her access to routine monitoring.
- Elsa's grocery money runs out well before month end and her food choices are limited to non-perishables bulk items.

The diabetes care managers at Elsa's DSNP plan have identified Health-Related Social Needs (HRSNs) as a primary driver of poor outcomes and have worked with their product team to add a package of HRSN benefits for their low-income and clinically complex enrollees with diabetes.

For 2023, her plan will be participating in VBID and adding a package of HRSN benefits for transportation, healthy food, reduced Part D cost-sharing and rewards for refills of her oral diabetes medications, and for regular visits to her PCP. Her plan expects savings from improved glucose control, avoided ED visits and reduced complications from improved foot care.

2

Diabetes and health related social needs

- Recent literature demonstrates a robust association between area-level socioeconomic deprivation and diabetes care quality in US primary care practices, showing that adult patients with diabetes who lived in more deprived and rural areas were significantly less likely to attain high-quality diabetes care compared with those in less deprived and urban areas.
- Other literature shows a strong association between diabetes and food insecurity with improved dietary patterns and glycemic control when food insecurity is addressed.
- Using a package of interventions that address "whole person social needs" will support more equitable access to care for Elsa and a better opportunity to avoid the progression of her diabetes to costly complications and lower extremity amputation.

Understanding the Business Value of Targeting

- Previously, non-VBID plans may have tried offering similar benefits to all enrollees outside of VBID, but the direct costs of untargeted benefits can be high, with smaller returns in cost avoidance.
- Under VBID, plans can now target interventions that address HRSNs like transportation and nutrition to those who can most benefit by targeting eligibility based on LIS status.

3

Tailoring a Suite of Benefits for Elsa through VBID

VBID allows for a more cost effective approach to tailoring a suite of benefits for high need enrollees.

Reduced cost sharing for Certified Nutrition Specialists (CNS)	RI Program for completion of care management activities/goals	Healthy food card	Targeted coverage of continuous glucose monitors	Coverage of non-medical transportation to pharmacies, grocery stories, farmers markets

PART FOUR
3:40 – 4:20 PM ET

LEVERAGING VBID FLEXIBILITIES TO IMPROVE CARE, OUTCOMES, AND EQUITY

SPEAKERS

Melissa Banik
VP, Medicare Programs
Presbyterian Health Plan

Reynalda Davis, MHA
Director, Government Programs
Banner Health

Health Partners Plans

Alyssa Mullen
AVP, Quality Improvement and Performance (QIP)
Health Partners Plans

Health Partners Plans

Ramesh Vangala
VP, Pharmacy Operations
Health Partners Plans

PRESBYTERIAN
Health Plan, Inc.

CMMI Diabetes Health Equity Incubation Program Webinar

Melissa Banik, PHP VP Medicare Programs

JUNE 30, 2022

Any viewpoints expressed in this presentation are solely those of the individual presenter and are not necessarily reflective of Presbyterian Health Plan, Inc.

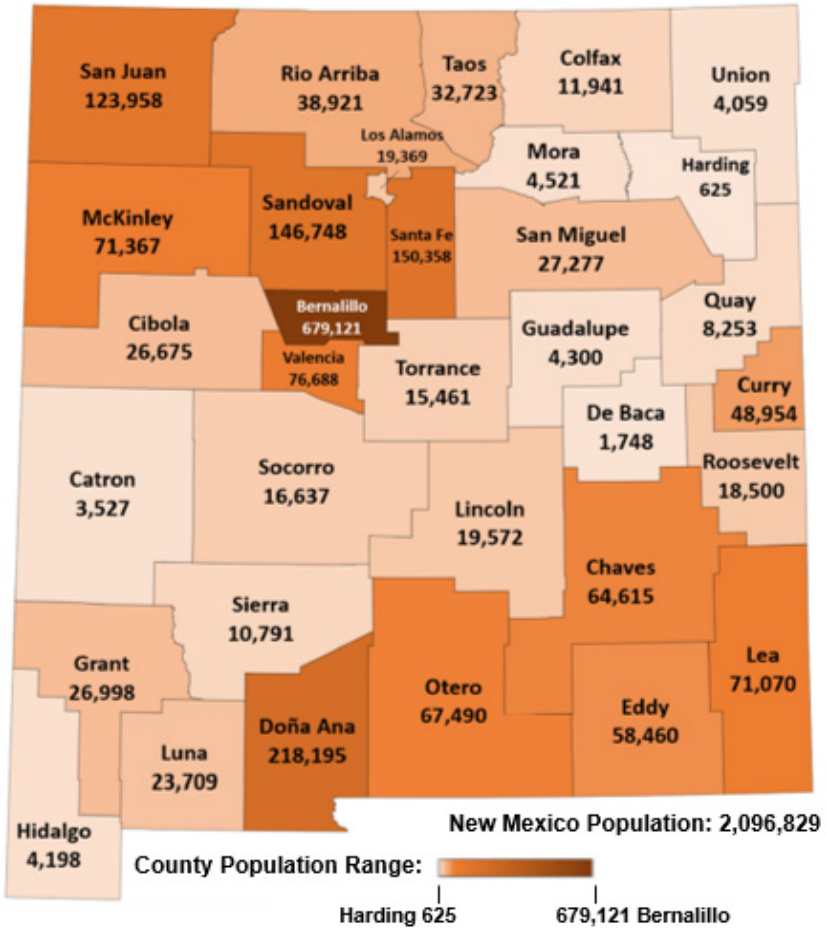
Presbyterian Organization: Past and Present

- When Reverend Hugh Cooper opened the Presbyterian Sanatorium in 1908, his goal was to provide quality care for those who otherwise could not afford it. For over 113 years, this core principle has driven the Presbyterian organization's commitment to providing quality and cost-effective care for all New Mexicans. Presbyterian Health Plan (PHP) is part of Presbyterian Healthcare Services.

- PHP has served Medicare members since the mid-1990s; is the only health plan that has continuously served members in managed Medicaid since 1997; and launched a dual eligible special needs plan (D-SNP) in 2017. Today PHP serves 30% of MA enrollees; 53% of Medicaid enrollees and 68% of D-SNP enrollees in New Mexico.

New Mexico's Geographic & Demographic Profile

- New Mexico, the fifth-largest state by land area, covers 121,356 square miles. The state's average population density is only 17 people per square mile, considerably lower than the national average of 87 people per square mile.
- New Mexico is the sixth most sparsely populated territory in the country, with several mountain ranges, deserts, government land holds, and abundant forests making for difficult residential terrain.
- More than a third of the state's population live in Bernalillo County with the rest distributed in the state's remaining 32 counties.



Value-Based Insurance Design

PRESBYTERIAN
Health Plan, Inc.

Value-Based Insurance Design & Provider Training

Value-Based Insurance Design (VBID)

- PHP entered in 2021
- Engaged in chronic condition (diabetes) and hospice VBIDs
- Diabetes was chosen due to NM-specific population needs
- Out of an enrollee population of ~30k, about ~6k diabetes VBID eligible members, and of that ~5k engaged
- Difficult to establish absolute correlation, but we saw stronger relative performance (less deterioration) in 2021 diabetes measures compared to other HEDIS metrics

Application of Health Equity

- Clear need to identify and act on healthcare disparities
- Need data first, offering CME-eligible training to providers throughout state on key health equity topics, including capture of SDOH and race/ethnicity data
- Will improve ability to analyze results and potential disparities, getting ahead of more formal and rigorous NCQA requirements

Diabetes Value Based Insurance Design (VBID)

Our Diabetes VBID was an obvious VBID choice:

- Proportion of population
- Perceived ability to impact (to be tested)
- Benefit barriers
  - High need for maintenance drugs, often high-cost
  - Lack of diabetes-specific member incentives

The VBID we designed . . .

- Requires engagement in diabetes disease management
- Our plans also participate in the Part D Senior Savings Plan Model as well as VBID; upon engagement in disease management, automatic enrollment in VBID program:
  - Full coverage of insulin through the Part D donut hole
  - $0 dollar Tier 2 copay for non-insulin diabetic drugs
  - Reduced Tier 3 copay non-insulin diabetic drugs
  - Incentives payable for completion of HEDIS CDC measures – A1c, nephropathy, and retinopathy screenings
  - Enhanced coverage available upon DM engagement, with continued eligibility through end of the benefit year

CMMI VBID: HPP's Approach to Diabetes Management

Rewards and Incentives:

- HPP started offering Part D incentives in 2020.
- Below is data for a subset of members who earned rewards either in 2020, 2021 or during both years as compared to baseline (CY 2019).
- Highlight: 60% of members who were nonadherent in 2019 (and then rewarded in 2020) became adherent in 2020!

	Outcome
CY2019: 17.34% nonadherent to oral diabetes meds	
CY2020: 14.54% nonadherent to oral diabetes meds	60.48% of CY2019 nonadherent became compliant CY2020
CY2021: 12.79% nonadherent to oral diabetes meds	45.73% of CY2020 nonadherent became compliant CY2021

Top Retailers for R&I
Walmart
Rite Aid
Family Dollar
Dollar General
Walgreens
CVS Pharmacy
Nations OTC/Indy

Eligible and Earned Activities

Part C Activity	# Eligible	# Earned	% Earned	% Earned CY2020	$ Earned
Diabetes Retinal Eye Exam	3,653	2,112	58%	54% **(+4%)**	$52,800
Diabetes Kidney Tests	4,705	2,375	50%	-	$59,375

Part D Activity	# Eligible	# Earned	% Earned	$ Earned
Diabetes Medication	1,446	1,324	92%	$72,000

Other Diabetes Management Initiatives

- Focus on 90-day Rx – cost savings for members
- Focus on Mail Order Conversion – cost savings for members
- Partnerships with local pharmacies that provide ancillary services like home delivery, pill packing, etc.
- Member and Provider Network education about resources and support services

Question & Answer

Next Steps

Next Steps and Future Sessions on the Horizon

1. Provide feedback on future health equity TA that will be valuable to your organization

2. Schedule 1-on-1 with VBID Model Team via VBID@cms.hhs.gov in August 2022 and identify cross-functional members of your team that could benefit from understanding the realm of targeted benefits allowed under the VBID Model (e.g., clinical team)

3. Participate in upcoming health equity Incubation sessions that will provide a deeper dive into how to best leverage the Model to address Transportation (in September 2022)

Thank you for joining us today!

Please email us with questions or to discuss your interests at VBID@cms.hhs.gov