Health Equity Innovation Program 2: Advancing Health Equity in Diabetes Care and Outcomes Transcript

Thursday, June 6, 2022

John Cialek:
Welcome to all attendees, panelists and speakers. I'm now going to pass it over to Purva Rawal to kick us off.

Purva Rawal:
Hi everyone, thank you so much. I just want to say good afternoon, my name is Purva Rawal, and I'm the Chief Strategy Officer at the Center for Medicare and Medicaid Innovation (CMMI) here at CMS [Center for Medicare and Medicaid Services]. I'm really excited to welcome you all today for our second Value-Based Insurance Design, or VBID, Health Equity Incubation Program Webinar. Our focus today is on improving equity, care, and outcomes for beneficiaries with diabetes.

I just want to start by saying that the work you all are doing is critical to helping us achieve our goals to advance equity, and to close disparities in outcomes and care for our beneficiaries. We know that diabetes is a critical area for us to make progress together. The purpose of today's webinar is to highlight opportunities uniquely available in the VBID model to identify, develop, and address health disparities related to diabetes. We will help clarify the connections between the VBID model, and additional opportunities to address the clinical and social needs of our beneficiaries with diabetes. Our team will provide tangible examples of how Medicare Advantage Organizations can connect these concepts in a way that makes sense for the populations that we serve. [00:01:20]

We will also hear from speakers from three Medicare Advantage organizations that are leading the way in doing just that. And by that, I mean they're leveraging the flexibilities available in the VBID Model to improve care and outcomes for their enrollees with diabetes, by addressing their social needs. [00:01:40]

And with any webinar, there's always a disclaimer, so before digging in, I wat to put out a disclaimer that our goal here today is really for educational purposes only, and will be in there, some general information sharing is noted on this slide. [00:01:59]

We have an exciting and packed agenda. You're going to be hearing today from experts, both in diabetes care, and as I said earlier, Medicare Advantage organizations that are paving the way with new initiatives, for their enrollees with diabetes, through their VBID interventions and beyond. We're really excited that representatives from Banner Health, located in Arizona, Presbyterian Healthcare Services (PHS) from New Mexico, and Health Partners Plan (HPP) from Pennsylvania have agreed to participate and share their experiences and stories with us, and

hopefully create some new learnings and opportunities for all of you out there listening today. [00:02:35]

During this session, and subsequent Health Equity Incubation Program sessions, we're going to be focusing on other social needs as well, such as transportation and housing, and we'll try to follow a standard format. So first, we want to be able to provide relevant background information on target populations, and describe the existing evidence base that supports interventions, to address the social need of focus for that particular session. Second, we want to translate the evidence base and strategies into concrete benefit-design opportunities that focus on how plans can leverage VBID Model components to address those social needs. Third, we want to provide lessons learned and best practices for implementation. And then fourth, we want to be able to discuss data and evaluation strategies. And at the end, we've saved time for a brief Q&A, so please submit your questions to the WebEx Q and A feature. [00:03:32]

I'd like to start this presentation by spending some time emphasizing a priority area for CMS, and what I hope will be the foundation of our health plan innovation work going forward, and that is of health equity. This is likely familiar to many in our audience today. I'm sure that's why many of you are doing the work that you're doing and have joined. But here at CMS, we're defining health equity as the attainment of the highest level of health for all people, and are working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people we serve. [00:04:06]

As many of you may know, the Innovation Center recently released a strategic refresh last October, and one of the key objectives of that strategic refresh was to embed health equity in all of our models. We also see health disparities as a key dimension of quality, and reducing disparities is a key part of improving healthcare quality and outcomes for beneficiaries as a result. Webinars such as today's, where we're focused on improving equity, care, and outcomes for Medicare beneficiaries with diabetes, is an important part of how we want to operationalize this goal across CMS and within the Innovation Center. [00:04:40]

Some other important objectives from the Innovation Center strategy moving forward are supporting care innovations for beneficiaries and for providers, and to promote affordability. The VBID model provides an opportunity to do just that, with its focus on targeting benefits, rewards, and incentives, where they can produce even more value, especially for our beneficiaries with chronic health and social needs, such as food and housing insecurities, within the Medicare Advantage space. [00:05:07]

I know this audience already appreciates that diabetes is a diagnosis that can be associated with a variety of potential challenges for beneficiaries, and therefore, it's one of the highest-impact areas, with the potential to add tremendous value, by improving the care that beneficiaries receive, and by improving access to needed care, and services that can improve health outcomes in quality of life. This can include addressing the upstream barriers to care by meeting beneficiaries social, as well as their clinical needs. We know this is an area of great interest, and where we can make some serious inroads together. [00:05:42]

So I wanted to take just a few moments next to review the data, and some of the compelling reasons we see focusing on improving diabetes care within EBIT as a lynch pin of advancing value and improving quality for beneficiaries. [00:05:58]

This summarized the tremendous opportunity we have to improve care and outcomes in diabetes. It also illustrates the imperative for us to improve care and outcomes in diabetes. Beginning with a look at pre-diabetes, a staggering one out of every two people over the age of sixty-five years have pre-diabetes. I think this also signals a greater future burden for beneficiaries in terms of their quality of life, their ability to manage disease, and the financial costs that they, and the health system incur. [00:06:28]

Diabetes also causes individuals to spend more than double what they might otherwise have spent on their healthcare, and imposes a massive $104 billion in costs in the Medicare program. It's also important to note what recent research findings tell us about the overall direction of diabetes trends, and that's one of the things you want to be able to do through these webinars, is really help illustrate, use evidence and research to illustrate the extent of a problem, and then be able to build that evidence base for successful and promising interventions. [00:06:59]

A recent finding from a large study published in the *New England Journal of Medicine* noted that after more than a decade of progress, from 1999 to the early 2010s, glycemic and blood pressure control declined in adult study participants with diabetes. And similarly, a study recently supported, reported in the *Journal of the American Medical Association* (JAMA) concluded that the estimated prevalence of diabetes increased significantly between 1999, 2000, and then 2017 to 2018. So, from 1999 to 2018. Only an estimated 21% of adults with diagnosed diabetes achieved all three risk factor control goals in 2015-2018, so I think this tells us that a lot of the indicators are at a population health level and are moving in the wrong direction. There's a lot of the work to be done. At the same time, there's really an opportunity here to hopefully impact some of these trends and improve quality and outcomes for beneficiaries. [00:07:38]

The point I'd really like to emphasize is twofold, and it relates to the urgency of our shared work in addressing the diabetes epidemic among Medicare beneficiaries. First, the impending wave of newly diagnosed beneficiaries is going to be imposed on a financing and delivery system that doesn't provide equitable access to the right care, care that's delivered in a culturally sensitive way, and care that's delivered efficiently to those that need it most. Second, we have flexibilities within the VBID Model, that give us new tools to target beneficiaries, and provide a range of health and social needs- related services to those who most need them. [00:08:34]

And as a proof point of this opportunity, we can point to a recent study published in *JAMA* that found that 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. The study pointed to the importance of targeting high-need areas of a core strategy to improve the overall quality of diabetes care. So, through our VBID partnerships we can strengthen the evidence base of what works, and what doesn't, in the provision of these supplemental benefits, so that we're targeting those in greatest need, and where we have the most opportunity to improve quality in outcomes. [00:09:16]

According to the American Diabetes Association (ADA), 1.4 million Americans will be diagnosed with diabetes this year alone. Let that number sink it; it's a staggering number. According to the CDC, those with diabetes who are over 50 years of age will on average die 4.6 years earlier. They'll develop a disability six to seven years earlier, and spend one to two 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. And as shown on the prior slide, about a quarter of those over 65 years of age have diabetes. But if you add the 4.7% percent of this age group that is undiagnosed, there are close to 16 million people over the age of 65 years who are diagnosed and estimated as undiagnosed for diabetes. [00:10:17]

The American Diabetes Association also breaks prevalence out by race and ethnicity, with disproportionately higher rates from diabetes for non-whites and Hispanics. This paints a picture of the burden of diabetes; it disproportionately affects non-white and senior populations, as shown on the slide here. Now with over 40% of Medicare beneficiaries choosing Medicare Advantage (MA), and with non-white beneficiaries increasingly choosing to enroll in MA, this picture tells us that diabetes is particularly an issue, and an opportunity for Medicare Advantage for all of us. While our foremost concern is the weight of a diabetes diagnosis on beneficiaries as evidenced by their pain, suffering, and loss of quality of life, the economic burden is also staggering, with diabetes accounting for one in every seven dollars spent on medical sots, and one in every four spent caring for people with diabetes. [00:11:12]

So taking a step back, not just looking at Medicare, but in the US overall, the total direct medical cost for diabetes in 2017 reached $237 billion, driven in large measure by the increasing prevalence of diabetes in the over-65 population. These costs are large, but as I mentioned earlier, we also know that individuals with diabetes are more likely to develop a disability, and they spend one to two more years in a disabled state. What does this mean? This means that the cost on unpaid caregivers is even greater on families as a result of diabetes. [00:11:53]

The Health Equity Incubation Program is the learning and diffusion arm of the VBID Model. And it plays a really important role. The program is designed to focus engagement and learning on the highest beneficiary impact areas, and to do this in partnership with Medicare Advantage organizations participating in the VBID Model, and more broadly, with CMS as an agency. With the increasing proportion of Medicare beneficiaries electing to enroll in Medicare Advantage plans, these partnerships with Medicare Advantage Organization leaders is essential to accelerating broad system transformation, as well as improved, quality outcomes for our individual beneficiaries. [00:12:30]

And before I complete my portion, my participation in today's webinar for which I am grateful, I want to end by again recognizing the leadership of the panelist organizations, Banner Health, Health Partners Plan, and Presbyterian Healthcare Services, for their innovations in diabetes care, as well as the work of so many of the organizations in attendance today. Encourage you to continue your efforts to improve the quality of diabetes care, including by working with us, the VBID Model, on the great team that's put together today's webinar. [00:12:57]

Now I'm going to turn things over to Dr. Mollie Howerton, Medicare Diabetes Prevention Program, or the MDPP Expanded Model Test Lead. She's going to delve further into the statistics on diabetes burden, costs, and opportunities for improvement, based on her extensive experience and expertise with the MDPP program. Thanks, Mollie. [00:13:20]

Mollie Howerton:
Good afternoon. Thank you for including me today as you consider opportunities for addressing diabetes-related disparities. I come to you from the perspective of developing and operating innovative diabetes programs at CMMI, first for the grant program with the National YMCA of the USA, and now as a lead for the newest CMMI diabetes program, the Medical Diabetes Prevention Program. It's an expanded model test that was one of the first models expanded to the CMMI's authority. [00:13:55]

I've worked in the diabetes prevention and program operation space for the past ten years, and share your excitement about the opportunities across private and public sectors to improve care and equity for people with diabetes. The Medicare Diabetes Prevention Program is an evidence-based lifestyle intervention to prevent type 2 diabetes. The goal of the program is for participants to achieve five percent weight loss through healthy diet, exercise, and stress management, reducing their risk for diabetes. MDPP is based on the CDC's national diabetes prevention program and has over 20 years of evidence on the program's effectiveness in achieving a clinically significant reduction in diabetes risk. [00:14:42]

Switching gears, I want to build on Purva's point regarding the burden of diabetes. It is noteworthy that although diabetes was listed as the eighth leading cause of death in the US in 2020, it is also a major driver of risk, and for outcomes, for five of the seven leading causes of death, which include heart disease, cancer, COVID, stroke, and Alzheimer's disease. One example, diabetes can cause heart attacks, heart failure, stroke, kidney failure and coma, and as you all know, cardiovascular disease in particular is the leading cause of death in adults with diabetes. In the US, diabetes is a leading cause of blindness in adults, kidney failure, and lower limb amputations. [00:15:34]

The pandemic has taught us that individuals with poorly controlled diabetes have at least a twofold greater risk of death from COVID. With diabetes, its complications are more common and more severe in low-income Americans, and Americans of color. As Purva indicated previously, if current trends continue, one in three Americans will develop diabetes in their lifetime. The cost of diabetes poses a financial burden in the US healthcare system and on society, with 67% of diabetes costs being paid for by Medicare or Medicaid. The most important statistic for you to remember is that one in every four healthcare dollars in spent on caring for people diagnosed with diabetes, which makes diabetes the most costly chronic condition in the US. [00:16:35]

So, this slide provides the county-level distribution of diabetes, obesity, and physical activity in 2019. Notice the overlap between the images, and how obesity is driving the diabetes epidemic. Given the natural history of diabetes and its similar problems with obesity and physical activity, we need models of care that increasingly incorporate strategies and care plan elements that address weight and physical activity in both clinical care, and supporting social needs

interventions. And I understand that later in the program today, we will be hearing from health plan innovators that are doing just that using the VBID flexibilities. [00:17:18]

I want to take a minute to point you to an important CDC resource as an interactive web tool that provides diabetes data at the national, state, and county levels, and by age, sex, race, ethnicity, and education. The website can be found at www.cdc.gov/diabetes/data, and the source is listed at the bottom of this slide. As part of the interactive tool, you can look at county-level data in both the state and national levels, for diabetes, obesity, physical activity, and run it against measures of social vulnerability. [00:17:56]

This slide provides a side-by-side view of county-level socioeconomic status elements of the social vulnerability index, and shows how it relates to diabetes prevalence. Social vulnerability refers to the resilience of communities when responding to or recovering from threats to public health. It can be used if there's a disease outbreak, or in the event of an emergency to identify populations that may need more help. When looking at these figures on the slide, keep in mind that the darker the color on the map, the higher the social vulnerability for that variable. In this case, the areas in dark red are the counties that experience the most poverty and other markers of low SES [Socioeconomic Status], and for the map on the right, diabetes prevalence, the counties with the darkest teal have the highest rates of diabetes. [00:18:51]

It's important to consider the overlap between these two maps. Which counties have the highest rates of diabetes, and also experience the greatest poverty, and the lowest SES? As Prava mentioned earlier today, recent published findings show that patients with diabetes who live in more deprived and rural areas are significantly less likely to attain high-quality diabetes care compared to those living in less-deprived or urban areas. As you think about the programs and services your plans offer, consider the importance of targeting high-need areas as a core strategy to improve the overall quality of diabetes care. The CDC data source is an excellent tool to find out more about the needs of enrollees in the specific geographic areas that you serve. [00:19:44]

This slide provides a side-by-side view of county-level minority status and language variable aspect of a social vulnerability index, and how it relates to diabetes prevalence. Again, counties highlighted in red have the highest numbers of non-white, non-English-speaking, and/or Hispanic populations. And as you consider programming, these maps highlight the urgent need and opportunity for culturally sensitive diabetes care that considers both age and language, and minority status. [00:20:21]

Next, I'm going to talk about the opportunities for improvement, and how we can better improve equity and access to diabetes care among members disproportionately impacted by diabetes. [00:20:37]

There is increasing evidence that programs that combine both medical and non-medical components that address social determinants of health can reduce risk and improve clinical outcomes for patients with type 2 diabetes. One example: did you know that the risk of diabetes among the food insecure is about two times higher than those who have no food insecurity. There's strong evidence that ensuring people have access to healthy food can significantly lower healthcare utilization and costs, and result in a return on investment. For example, providing

home-delivered medically tailored meals for those with chronic conditions, or nutritional risk have been found to significantly lower inpatient utilization, 30-day readmissions, and overall medical costs. [00:21:27]

They've also had similar findings with home-delivered meals that are not medically tailored, and that they can also make a difference. For example, two studies found that meals on wheels programs for Medicare beneficiaries resulted in reduced hospitalizations, ED [Emergency Department] visits, and overall healthcare costs. And one study found that delivered medically tailored meals resulted in a larger return on investment than delivered non-tailored meals. For example, there was a $220-per-participant return on investment for medically tailored meals, and a $10-per-participant return on investment for the non-medically tailored meals. [00:22:12]

Other non-delivered food support programs such as Supplementation Nutrition Assistance Program, or SNAP, or food pharmacies had significantly reduced healthcare utilization costs for those with chronic conditions, low income, and food insecurity. Several studies have also found these programs can lower overall healthcare costs, particularly through reduced hospitalizations and ED visits. [00:22:35]

In terms of clinical outcomes, the use of food supplementation with referral and diabetes support have been shown to significantly improve [hemoglobin] A1C levels among participants, and these interventions raise important policy, research, and learning opportunities for you all. To what extent should food supplementation be accompanied by patient support and education in a referral to a primary care physician? So, consider that this could be an important research question for VBID, and learning opportunity for VBID participants on how you can use nutrition programs and supplemental programs to lower costs of care. [00:23:23]

Now let's talk about the impact of transportation and adding transportation services to members with barriers. Studies have shown that providing non-emergency medical transportation to low-income people, those with chronic conditions, or dually eligible enrollees can increase the receipt of outpatient preventive care. They can prevent expensive forms of care, and they can also produce a return on investment. For example, providing non-emergency medical transportation for Medicaid beneficiaries, and some dually eligible beneficiaries, has been shown to increase receipt of outpatient care, including primary care and physical therapy. [00:24:03]

Providing these transportation services to those with chronic conditions has also been shown to reduce healthcare costs. Several programs calculate a return on investment for transportation services, and with one study finding a return on investment of almost $3500 per person per month for dialysis patients, and about $792 for diabetes wound care patients. So, I understand the VBID health equity improvement program will be focusing on transportation as a vehicle to improve outcomes and equity later this year. [00:24:45]

Integration of medical care with non-medical care has led to significant improvements in hemoglobin A1C levels. For example, we already discussed the impact of food supplementation, but other interventions have been shown to improve A1C levels as well. For example, financial incentives, when they are paired with peer mentoring, key behaviors related to diabetes self-management, and glycemic control, has shown reductions in A1C levels. So note that VBID can

be used to build evidence related to structure of incentives, how often you should be providing incentives, and what amounts achieve diabetes-related outcomes. [00:25:34]

Other social determinants of health that you can target are housing and home modifications, and there's evidence that people who are homeless, or at risk for being homeless with housing can significantly reduce healthcare costs. If you provide them with housing, you can reduce the cost of care. Supporting housing has been shown to reduce ED visits, admissions, and inpatient days. These are all known to reduce total cost of care. The return on investment has been shown to be about $2200 per-person per-month, in one study, and an estimated $1.57 saved for every one dollar spent in another study. [00:26:18]

Another study evaluated the impact of housing vouchers, and showed that participants who received a housing voucher, plus moving specific counseling had a 4.3 percentage point drop in the prevalence of diabetes, relative to the control group, after ten to 15 years of follow-up. I'm going to say that again, because that's really impactful. When they receive vouchers, plus moving-specific counselling, they had a 4.3 percentage point drop in prevalence of diabetes after 10 to 15 years of follow-up. So it had lasting impact. [00:27:00]

Regarding home modifications, although the evidence on return on investment for home modifications is limited, one study shows that investing in home modifications can provide a positive return on investment for low-income adults. For example, one study found that a $2800 per person investment home modifications is associated with $20,000 in medical savings per person, and that represented a 600 percent return on investment. [00:27:30]

Counseling models often involve social workers who offer counseling support to support patients emotionally. They focus on addressing patient's social needs, and have been shown to reduce emissions and ED visits. In legal aid models, patients receive legal advice to address a variety of social issues that impact their health, including working with insurance companies and improving their housing environments. These case studies typically involve legal aid to at-risk or complex patients, and have been shown to reduce readmissions and ED visits and hospitalizations. [00:28:11]

As we consider life after COVID, and how we're going to care for patients, we want to consider the lessons learned and the opportunities that the pandemic presented us. Pandemic learnings from industry has spurred new approaches to diabetes management. For example, during the pandemic, we transitioned to a more partial care model. As we found during the pandemic, people with diabetes had a high risk of death from a serious complication, and we found that people with diabetes had a higher risk of serious complication death from COVID. [00:28:58]

So, as we think about virtual care, we embrace telemedicine across clinical specialties. CMS offered a lot of flexibilities, including care being delivered via telemedicine, and the medical community responded by offering both phone and video visits, versus in-person visits. One study found that there was 23-fold increase in weekly number of telemedicine visits compared with the pre-COVID period. [00:29:31]

Telemedicine and remote continuous glucose monitoring are two health-related technologies that became essential to the management of diabetes during the pandemic. One of the lessons learned from the pandemic is that telemedicine ensures continuity of care, and it ensures patients continue to receive their diabetes care. Patients generally were satisfied with this care. And so, telemedicine can take advantage of different intervention modalities and generally show, improvement in people's clinical diabetes management. [00:30:09]

Now the downside of telemedicine and inequities is that it did create some inequities during the pandemic. A wide ranging study published in December found that older people, women, Black and Latina individuals and patients with lower hospital income were less likely to use video for telemedicine care, and that older patients, Asian people, and non-English-speaking people had lower rates of completed telehealth visits. So even though telemedicine has potential to increase access to care among your members, consider that may leave other members behind. And as you consider the role of telemedicine and other remote technologies to manage diabetes care, it's important to consider how we can design our system to mitigate inequities. An important learning opportunity for VBID is to consider how to ensure that all VBID participants are equipped to effectively participate in telemedicine care. [00:31:10]

Just video visits are likely here to stay. The pandemic highlighted what was working and not working for people in general, and today, doctors are more of a ringmaster. They supervise the coordination of care. There is less need for frequent office visits, and more focus on supportive care such as medication management, lifestyle, and behavioral changes that can help patients control their diabetes. So much of the daily management of patient's diabetes is performed by healthcare professionals such as pharmacists, nurses managing medications, and nutritionists developing meal plans and fitness activities. [00:31:50]

Last we'll talk about getting people reconnected to healthcare. During COVID, people often defer their care due to concerns of COVID, with one study reporting that visit volumes decreased by 35 percent. Some of the delays were related to access issues for some segments of the population, so researchers at their urban institutes reported that Black and Latinx adults were more likely than white adults to report having wanted a telehealth visit, but not receiving one since the pandemic began. The difficulties getting a telehealth visit were also more common among adults who are poor, and poorer health, or had chronic health conditions. Now that we're moving into the post-pandemic world, we need to get people reconnected to their healthcare, and VBID wants to consider how they might do that. [00:32:42]

So as we think about emerging trends in diabetes care, I want to put my diabetes prevention hat back on and remind you to screen your at-risk members for diabetes at least once a year, starting at age thirty-five, the US Preventive Services Task Force, updated recommendations on diabetes screening in August 2021, and change the starting age for diabetes screening from 40 to 35. The best way to prevent and mitigate diabetes burden is to delay the onset of diabetes through diabetes prevention programs, such as MDPP [Medicare Diabetes Prevention Program], or identify diabetes early, before it has a chance to progress to more severe disease. [00:33:27]

Other exciting things are diabetes reversal. According to recent research, type 2 diabetes cannot be cured, but individuals can have glucose levels that return to non-diabetes ranges, and that's

considered complete remission or pre-diabetes glucose levels, which are considered partial remissions. The primary means by which people with type 2 achieve their remission is by losing significant amounts of weight. Weight loss alone without surgery can be enough to put type 2 diabetes into remission, so that's very exciting, and then also how we use technology as part of diabetes care has really emerged during the pandemic, and will continue to have lots of great advances. We have smartphones to control medical devices via smartphone apps. We have remote insulin dosing, evaluating glucose management using 14-day assessments with a continuous glucose monitor. [00:34:35]

We also need to ensure as we take on these new technologies, or these technologies become more mainstream, that these devices are accessible to all populations. So how can we ensure that low-income populations, and populations disproportionately impacted by diabetes, have access to these tools and devices, and how can we make them accessible if the member has disabilities? How can VBID develop the capacity to support technology and enable interventions, and how can we make these technologies more accessible and equitable? [00:35:13]

In terms of individualized diabetes care, we want to put the person versus their diabetes at the center of healthcare. Keep in mind that diabetes is managed mainly by individuals, their families, their caregivers, in their homes and in their communities. This means that we need to make diabetes education and self-management programs accessible and equitable. For example, communications to members about diabetes-related services and programs to be promoted in a culturally, linguistically, and literacy-appropriate manner. [00:35:57]

I will put some of my resources in the chat [ROI evidence for SDOH and Nonmedical Interventions for Diabetes], and then I want to thank you for the opportunity to share my excitement about the programmatic opportunities to reduce risk factors for diabetes, and will now hand off the discussion to Abigale Sanft. She's the Model co-lead from VBID who is going to talk about how these evidence-based opportunities can be incorporated to Medicare Advantage Plan benefit packages using the flexibilities in the VBID Model. Thank you. [00:36:24]

Abigale Sanft:
Thank you, Molly. My name is Abigale Sanft, and I'm one of the VBID Model co-leads. With the information provided by our illustrious speakers at the top of our mind, we'll now move into a discussion of benefit design opportunities including those that can be operationalized through the flexibilities offered to MAOs [Medicare Advantage Organizations] under the VBID Model. [00:36:52]

For those of you who have attended any of our recent VBID webinars, this slide will be familiar to you. I want to start off first, as we typically do, by clarifying what options are available to health plans already under the MA program, and what additional options are available through VBID to aid in our thinking through the ways in which plans can implement benefits that advance equity in diabetes care. On the VBID side of this table, we'll first talk about targeting. VBID is unique in that it allows MAOs to target by LIS [Low-income Subsidy] or dual status alone, which is not allowed under SSBCI, or Special Supplement Benefits for the Chronically Ill, or UF, or Uniformity Flexibility. Under VBID, MAOs can also target by a combination of LIS or dual status and chronic conditions. VBID allows for targeted benefits related to the PartD

benefit, which is unique to the Model, and includes reduced or eliminated cost sharing for PartD drugs. VBID also allows for new and existing technologies or FDA-approved medical devices, as mandatory supplemental benefit. [00:38:02]

On the RI or Rewards and Incentives side, VBID has an RI limit that is tied to the value of the expected impact on enrollee behavior, or the expected benefit, not the cost of the activity, and allows for RI to be related to Part D, which is again, not permissible under the program. Finally, MAOs can apply to participate in the VBID Hospice Benefit Component. Under this component, plans cover all of their enrollee's Medicare benefits, including hospice care, and can also cover transitional concurrent care and hospice supplemental benefits. [00:38:41]

Now for this next slide, how many flexibilities actually align with innovative diabetes social and health-focused benefits and introduction. As our previous speakers noted, given the known disparities in diabetes care and outcomes, targeting to those most in need is particularly important in addressing diabetes. So, on the targeting side, under VBID, a health plan could offer a healthy food card, or medically tailored meal to all enrollees with LIS status, and remove any chronic condition requirement. [00:39:13]

Alternatively, a plan could choose to target a combination of diabetes and socioeconomic status, or cluster of diseases such as diabetes, hypertension, and/or obesity, whereas under the program, a healthy food card does not meet US requirements; it is not primarily health-related, and under SSBCI, the benefit would have to be limited to specific conditions. Here, VBID is unique in that plans can consider social needs just as they would consider health needs. Also under VBID, these benefits could be conditioned to those targeted enrollees who participate in disease management programs, and/or see high-value providers, such as providers who primarily serve underserved populations. So VBID-targeted benefits can improve access to care, such as by reducing barriers to medication adherence, by reducing Part D co-pays for diabetes medications, or even for all Part D drugs. [00:40:11]

Beyond direct food benefits, plans could think about benefits like reimbursement of transportation to grocery stores, or farmer's market. Plans could also consider adopting benefits to include visits to an exercise physiologist to create an entire package of targeted benefits, for comprehensive nutrition, exercise, and medication support. [00:40:34]

On the RI [Rewards and Incentives] side, plans could provide a reward of a hundred dollars in healthy food and groceries to incentivize utilization of high-value services by certified nutrition specialists, or CNS [Advanced Practiced Registered Nurse] for enrollees with LIS and with pre-diabetes. This can be complemented with other VBID interventions, like reduced cost-sharing for CNS visits. We'll cover some more options during our panel discussion in just a moment. [00:41:02]

As findings and evidence evolved in the areas of diabetes in SDOH [State Department of Health], such as the work published just this week in *Health Affairs* on type 2 diabetes prevention and outcomes, the VBID Health Equity Incubation Program will support alignment of these findings within VBID and within our VBID MAO partnership. [00:41:22]

So, throughout these incubation sessions, we hope to find ways to make these Model flexibilities really come to life a little bit more and translate them into tangible actions that you can take as you're thinking about your suite of benefits. You heard a little bit about how the opportunities to design tailored benefits for your enrollees with diabetes, but now we will talk about how they impact your enrollees in a person-centered manner. [00:41:52]

Here, we're highlighting the story of Elsa. She has diabetes, lives in a rural area, and is dually eligible for Medicare and Medicaid. She struggles to afford healthy food and can't access the few grocery stores nearby due to transportation limitations. And for those reasons, she struggles with adherence to her diabetes medication, and does not always receive routine monitoring. Elsa recently joined a VBID plan that's offering a number of important benefits. And through her dual-special needs plans, and care managers, she's been identified with a number of health-related social needs that lead to poor outcomes. [00:42:32]

When we think about Elsa's needs, we can consult a variety of evidence to identify ways to address some of these needs in a targeted manner. Targeting is especially important in diabetes given that, and recently noted in the health affairs article, diabetes is in the fragmented state of US healthcare and policy, that the most geographically and socioeconomically disadvantaged segments of the population have been especially hard-hit in interventions that reduce the risk for diabetes have not reached these populations. Other literature demonstrates a robust association between area level socioeconomic deprivation and diabetes care and quality, care quality in US primary care packages, 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. [00:43:29]

As Molly noted, 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. [00:43:53]

There's also a business rationale for offering targeted benefits based on chronic conditions or socioeconomic status. Outside of the Model, non-VBID plans may have tried offering similar benefits to all enrollees, but the direct cost of untargeted benefits can be high, with smaller returns, and cost avoidance. Under the VBID Model, plans can now target interventions that address health-related social needs, like transportation and nutrition, to those who can most benefit by targeting eligibility based on LIS status. [00:44:27]

Another recent healthcare publication asked the question, can APMs or alternative payment models, in VBID improve the quality and value of care provided to the 37 million people with diabetes in the US, analyzing 13 studies. The author supported promising findings related to improvements in medication adherence using VBID and similar value-based approaches, and argued for more experimentation in the use of VBID to improve diabetes outcomes. [00:44:57]

For Elsa, the benefit to her plan's product team design to meet her needs include transportation assistance, a healthy food card, reduced Part D cost sharing, and rewards for refills of her oral

diabetes medication, and for regular visits to her PCP. Her plan expects savings from improved glucose control, avoided emergency department visits, and reduced complications from improved foot care. This was possible for the plan through VBID's LIS targeting. [00:45:30]

Such comprehensive social-needs benefits and Part D cost-sharing reduction may not have been economically feasible if the plan couldn't target by LIS. So flexibilities in the VBID Model related to Part D are especially important in diabetes, given that the findings from that same healthcare article that pharmacological and behavioral interventions reduce the risk for diabetes have not been implemented equitably. As a result of these innovative benefits, Elsa's been able to not only access her needed medications, but also healthy foods, addressing those medical and social needs. [00:46:08]

Taking a step back, there's thousands of other Elsas that these types of interventions would help that are currently enrolled in your plan, and understanding the needs of enrollees is the first step. Not only can these benefits help improve quality of care, make patients feel like they have more agency over their own health, and address social needs for some of the most vulnerable beneficiaries within MA, but they are also good business, as they save money for the enrollee and the plan, and are good health policy, preserving Medicare dollars. These benefits and flexibilities are readily available within the flexibilities offered under the VBID Model. [00:46:53]

Now that we have covered some of the options that are available under the Model, let's talk to some of our current VBID Model participants about what rolling out these benefits looks like in practice. I would ask our panelists to come on the line here. And today, we are so lucky to have amazing panelists with combined decades of experience, from three of our VBIDModel participants, to talk about implementation challenges and successes as it relates to advancing diabetes care and outcomes, including medication adherence in the Medicare population. [00:47:29]

I'm exceedingly pleased to welcome Reynalda Davis. She's Health Equity Officer at Banner Health, who leads the organization-wide effort to improve health equity. We also have Melissa Banik, who is the Vice President of Medicare Programs at Presbyterian Health Plan. And we also have Alyssa Mullen, who is the AVP of Quality Improvement and Performance, and Ramesh Vangala, who is the VP of Pharmacy Operations, both from Health Partners Plans. Thank you everyone for joining. I would first like to turn it over to Reynalda to give her introductory statement. [00:48:13]

Reynalda Davis:
Good morning everyone, and or afternoon, depending on where you are. I will state that I wish I was a chief. I'm a Director of Government Programs, but thank you, Abby, for the promotion, I will accept it wholeheartedly, as well as any salary and compensation, and time off that comes with that. Now, in regards to a little bit about me, I do run our government programs, which includes the Value-Based Insurance Design Program for Banner Health. We are very excited; this is our first year in the program, and really our first six months. So we are the new kid on the block, and we have a lot to share. My prior background is dealing with MA, as well as dual-plans, provider organizations, and a smattering of other things, include public health for a rural

state with the State of Kentucky, so I am very pleased to be here, and thank everyone for allowing me this chance to present some of what we're doing. [00:49:10]

Abigale Sanft:
Great, thank you Reynalda. I'll it over to Melissa Banik for her opening statement. [00:49:21]

Melissa Banik:
Thank you, Abigale. Thank you for inviting Presbyterian Health Plan to join in this panelist discussion today. [00:49:39]

I've wanted to share a little bit of information about our organization, for those of us who don't know who we are. Presbyterian Health Plan is part of a larger integrated health delivery system, Presbyterian Healthcare services. The organization has nine hospitals, over 1100 physicians, and the health plan. The organization has been serving New Mexicans for over 113 years. The health plan is a little younger. We've been serving Medicare Advantage members since the mid-90s, and today, the health plan serves about 30% of the MA enrollees in the state of New Mexico, so it's about 55,000 members. We're relatively small, but we feel like we're making a big impact in New Mexico. [00:50:32]

Earlier, we saw a lot of demographics nationally, and in some of those slides, you saw that New Mexico had a lot of counties that were very dark-colored in both the poverty levels, and the diabetes prevalence. This is a snapshot of New Mexico, showing you a little bit more specifically what we look like compared to the rest of the country. We're one of the largest states by land area, but the population density is pretty small compared to the rest of the United States. New Mexico is the sixth-most sparsely populated territory. And we're dealing with things like mountain ranges, deserts, government land holds and abundant forests, making it difficult for those residential terrain, and getting to needed care. [00:51:24]

And one other thing to note, that literally one third, or more than one third of the state's population live in that small county that you see kind of highlighted in the darkest color, Bernalillo, and then the rest of the population is distributed among the remaining 32 counties in the state. So, huge population density in that one area, and then it's very sparse, and in a lot of the rural areas. [00:51:54]

And just to give you a real brief introduction with regard to our value-based insurance design program, I know we're going to go into more detail later in the actual discussion, but we think we're relatively new to the game too. We entered in 2021, I know there are plans that are out there that have been in this program longer. So we still consider ourselves new, but I know from CMS's perspective, they're calling us a mature plan. We engaged in the, in addition to of course the wellness and healthcare plan, the two components that we chose for our VBID are the chronic condition and hospice, and we chose diabetes as that chronic condition because it is so prevalent in New Mexico. [00:52:33]

Our VBID is limited to three plans, and the diabetes component, just two of our plans in our kind of portfolio, but the population that can be impacted by this program, there's 30,000 members approximately in those two plans, and about 6,000 of them have been diagnosed with diabetes,

according to our claims data, and we have already seen about 5,000 of our members with diabetes have engaged in the program to date. Of course, that's since 2021. And we have seen some small measures that look like they're improving, but it's difficult to establish that absolute correlation. [00:53:20]

Just like others have mentioned, COVID has impacted the healthcare activities of our members, and we're hoping that they are starting, as we move into the endemic status, to seeking out more healthcare. But the healthcare disparities that are the discussion of today's topic, it's clear we need more data. As a health plan, not all of our product lines have the same data in our system, so we're in the process of trying to get our arms around that data, and we know how important it is to what we're trying to achieve here. [00:53:57]

A couple more key points, and then I'll turn it over. I mentioned that diabetes was an obvious choice for us, because of the prevalence, and we really hope that by removing some barriers, we can make some impacts, and we know that this Model is for that purpose to kind of test those things out, to see if removing some barriers do result in some improvement. So we'll move into the details I know during the discussion, so I'll turn over my time to the next individual. Thank you, Abigale. [00:53:32]

Abigale Sanft:
Thank you, Melissa. I'll turn it over to Ramesh and Alyssa for the HPP opening statement. [00:54:42]

Alyssa Mullen:
Thanks, Abigale. Hi everyone. My name is Alyssa Mullen, AVP of Quality Improvement and performance for Health Partners Plans. We're located in Philadelphia, Pennsylvania, and the majority of our membership is really in the five-county area around Philadelphia, but starting to expand a little. So we really wanted to touch on some of the approaches that we take in terms of rewards and incentives for our diabetes management. And to be honest, some of these programs that I'm going to speak about are really applied to our Medicare population as a whole, but we've really seen some nice impact in terms of being able to help to better manage our diabetic population. [00:55:25]

So one of those approaches is really focusing on rewards and incentives, both for Part-C and for Part D. So we do offer rewards for members if they complete specific chronic care services and close that care gap. So, for diabetes, it's the retinal eye exam, and it's the kidney test. And then for Part D, we introduced that back in 2020, for the STARS [Medicare Program] with Diabetes Med Adherence Measure. And I think it's really interesting, so if we look at some of this data, you can see that in calendar year 2019, we did not offer that reward to the members. Moving into 2020 when we did, we actually saw that 60% of our members who were non-adherent in the previous year, and then got that reward in 2020, became adherent. So I think that just goes to show, we still have some work to do in terms of med-adherence, but it goes to show that that reward can go a long way, and we've found that to be pretty impactful. [00:56:27]

Our reward system is something where our members can earn dollars for closing some of those care gaps, and they can actually go into a portal and cash in. And you'll see up in the top-right of this slide some of the top retailers that our members use to cash in on those rewards and incentives that they've earned. So I think again, it's making sure that we have options for our members, and options that will make an impact, similar to what some of our other presenters and speakers have said. We do have a high-needs population, a lot of social determinants of health, so being able to offer some of these rewards, and a variety of rewards that they can use to help close some of those barriers in other areas of life, I think are really important. [00:57:20]

And then just to touch on a few other things, some of our diabetes management initiatives, again really around some of that med-adherence work in med-management support. We do really focus on 90-day prescriptions and mail-order conversion. Admittedly, I think we still have some work to do on our mail order conversion, but knowing that, at least getting the medications to the members' doorsteps is half the battle. They may still not take the meds, but at least they have them in hand. So really trying to push that with our members, educate them, make sure they know that they have that option, there is cost savings available, both a 90-day prescription, and mail order conversions, so if members choose one of those options, they pay two times the co-pay, so they actually save one co-pay for going that route, which we have found to be helpful as well. [00:58:16]

We've also made some partnerships with local pharmacies that can help support our diabetes members, or our members with diabetes and multiple comorbidities, so there are some pharmacies in the area where we have really great relationships. They do pill-packing; they'll deliver to the home. They will do additional touchpoints in between doctor's visits with those members, so it's just another person checking in on them with a different type of healthcare focus. And then finally, we work really closely with our provider network in educating them about the different resources and support services that we have internally, that they can tap into to help support our members and their patients. [00:59:02]

Abigale Sanft:
Great, well thank you Alyssa and HPP team. Now we'll go into a broader discussion here. And I'm hoping that we can kind of go around and have each of you to start tell us a little bit about the VBID interventions that you have included in your diabetes programs, why you selected these interventions, what you're hoping to accomplish with them, and just give our audience a little bit more context. So maybe we'll go in the same order. Reynalda, would you be able to start? [00:59:39]

Reynalda Davis:
I certainly can, and I want to make sure to clarify since I was remiss not to give more details about Banner Health, we're in Arizona. So our patient population are urban and rural around the Phoenix and Tucson areas. So our diabetes program from a VBID perspective that we wanted to tackle was around affordability, as well as trying to encourage healthy lifestyle as a whole. So we have our D-SNP plans, where we are a part of lowering LIS copays, where there are nominal copays as a part of our overall effort for VBID. And that would include any diabetes medications that our patients would have, or other needs as well. [01:00:23]

We also have a Dial Into Diabetes program. So this is a full-on self-management education-focused program. We have medical nutrition, therapy, education, encouragement, and focus on empowering our patients and our members for those lifestyle interventions that will help them get the health outcomes that we're all looking for, but more importantly, live the quality of life that they want. So within that, we have registered dieticians, we have RNs [Registered Nurses], and we have pharmacy support. We actually got an exercise physiologist to help provide that functional movement, and also when appropriate, exercise plans. [01:01:02]

We have social workers to help wrap their arms around our diabetic patients, and whatever that they're struggling with as a barrier that they identify as a goal of care, we are using that multidisciplinary team to drive different outcomes. We have in-person sessions, virtual, and really a lot to support that. We try as much as possible to follow the seven core behaviors from the diabetes education council, and that's kind of a bedrock of what we have based our program on. But from that standpoint, the goal is a collaborative effort for our patients within those VBID interventions from that. [01:01:43]

And as a sweetener to incentivize our patients to complete the program, which is about six or eight sessions at the minimum. We also have a gift card. So for those who graduate the program, they have a $25 gift card that's available for them, and really they still maintain the relationships with that care team for whatever they need, but we're trying to wrap our arms around such an important group for us. [01:02:11]

The other thing that's important from a consideration standpoint is that it's not just us preaching to them or talking to them. We're engaging at the level of patient activation where they are. So a lot of assessments in the beginning determine where they feel they're most at risk. And this is for any patient that has a diagnosis of diabetes, so that that way we're not only targeting those who are at high risk, but opening it up to all of those patients from a chronic conditions standpoint. So that's just a little bit of kind of our program. I will stop there to allow our other colleagues to talk about their programs. [01:02:53]

Abigale Sanft:
The floor is yours, Melissa, Alyssa, Ramesh. [01:03:02]

Alyssa Mullen:
One thing that I would add, I think that really adds to our program, that we've thought about in terms of diabetes management, is really making sure that our members have access to a nutritionist. What we often find it that, just first and foremost, access to fresh foods, nutritious foods, understanding what a healthy diet is, I think it's really easy for us as a health plan or provider to say, eat better, eat low-sugar diets. But what does that mean to a member, and are they going to ask those questions? So making sure that we built-in some benefits for nutritionists, we actually have twelve nutritionist visits per-year for our diabetes patients, which I think is really impactful, because that's not always available and accessible to members, so we found that that has made an impact as well. [01:04:10]

Ramesh Vangala:

I can just add from a pharmacy standpoint, I know for the VBID Model, we do have zero copays for our special plan, I think similarly to others, for all Part D drugs, not just diabetes, but for all Part D drugs. And even from the formulary management perspective, just trying to limit any barriers to having excessive prior authorizations or quantity limits, I think that kind of access to help, not just members, but I think providers, because they're the ones seeing the patients, and to ensure that their care is properly taken, I think that's one of the things that we're also trying. [01:04:47]

I know we alluded to this delivery, a lot of pharmacies do, and we're promoting the 90-day supply. A lot of that is there's less need for members who have transportation issues, that members can either get delivery, or if they have a 90-day supply, there's less times they'd have to go to the pharmacy. So we do promote that, and a lot of that collaboration is not just from the pharmacy side, but it's working with all our colleagues, our case managers, our nurses, and all those who sometimes have that face-to-face with the members, in providing that education and collaboration, so, thank you. [01:05:24]

Melissa Banik:
And just to add a little bit of information around what we chose to do. We've looked at two interventions to start with this program, and that was the reduced Part D cost sharing for the diabetic drugs, and rewards and incentives for health screenings that support the management of the disease. We chose the first intervention because we know that there are a lot of maintenance drugs that need to be in their routine, and they can be high-cost, so we really wanted to kind of remove that barrier if at all possible, and encourage that medication adherence. [01:06:01]

The other thing, we chose the second one, the rewards and incentives, to see if we could improve the number of those diabetic screenings that are out there, that we need them to do on a regular basis to really help manage their disease. And it was a way to hopefully get them engaged in the program. And we made our enrollment or eligibility to be engaged in the program relatively easy. You know, our disease management and healthcare, or care management plans. It didn't have to necessarily be through the health plan; if it was through their provider, it counts too. We're really trying to make sure that we're leveraging the relationships that they already have, and not limiting them. [01:06:43]

So, and we're trying to pull as much from the data that we have without them having to call us and say, how do I get engaged. Even the screenings, if they go out and they have one of the three screenings, if they haven't engaged in a disease management program, we're counting that screening as engagement, in that they are showing that there's a level of engagement and care about their disease, their healthcare management. So we really are hoping that these two particular measures that we started off with work, and we're not quite ready to decide to make additional changes yet, because we're still kind of looking at the data; we want to make sure that we're making data-driven decisions, that the interventions that we have are or are not resulting in benefits for our members for these patients, remembering that 25% of New Mexicans are at or below the federal poverty level, and that one-in-three of our New Mexicans live in rural areas, we're really trying to hit some of the key points with reducing the costs, and maybe helping them encourage them to get some of these tests done, especially now that we're moving out of the pandemic and into the endemic. [01:07:55]

Abigale Sanft:
Yeah, those are really great responses, and I think you all are kind of getting down the road where I was heading as well, which is, the social barriers to medication adherence, or accessing nutrition services, managing your glycemic control that might make managing diabetes as a condition, might make it a little bit more difficult. [01:08:25]

Melissa Banik:
Abigale, I wanted to share with you, we've just kind of started to collect some of this demographic information for our Medicare Advantage members. It wasn't something that we didn't have, all of this information, and we're in the kind of infancy stages there of gathering it. But we have seen from data we've collected from some of our other lines of business, specifically our Medicaid line of business, which we have found that the Native Americans in New Mexico have a much higher rate of diabetes and associated complications, compared to the general public. [01:08:57]

So, with our Medicaid members, we're actually looking at, and doing targeted and deliberate efforts to understand the challenges, and at the tribe level even, so there's multiple tribes in New Mexico. So we're really trying to get down to that level if we can, and looking at ways that we can be successful at approving the health and well-being of our Native American population. So, from a Medicaid perspective, we have an outreach team that literally engages with tribal representatives, local caregivers and members to have collaborative discussions, allow for shared developments, and interventions, and maybe even adoptions like delivery and collection of at-home A1C tests that maybe, we couldn't get any other way. [01:09:46]

So, we're hoping to build on that experience, with knowing that this is one of the problems, one of the barriers that we have in New Mexico, at least in the Medicaid line of business. We know a lot of our members, the populations are similar for Medicare Advantage. We're hoping to build on those efforts and bring some of that experience into our work that we're doing through the VBID program. [01:10:12]

Alyssa Mullen:
I would build on the social determinants of health piece. And we do a lot of work with our provider network as well, in implementing social determinants of health assessments, and submitting those screening codes and ICD-10 codes, so we can get a better picture of our membership and where we are experiencing barriers throughout our membership. And then internally, our Medicare care managers, as well as some of our internal outreach teams, do some screenings as well. [01:10:54]

And what we find is, for our diabetic population, a lot of food insecurity, and not just the ability to afford food -- that is an issue for a lot of our members -- but also good food versus bad foods that might be cheaper. Those dollar menus are attractive. Our care managers hear a lot that our membership doesn't have access, easy access, and convenient access to grocery stores or fresh foods. So, you know, trying to tap into some of our community resource organizations and community partnerships, and connect our members to fresh food resources. [01:11:37]

And then, you know, managing that with inflation and the economy. We're starting to hear more of that from our members that it's becoming harder to afford food, or potentially having to choose between food or other medications, which is why we think it's so important that we, there is some cost savings baked into our 90-day and mail-order. And then we also hear about transportation as well, as another barrier, being able to get to visits, being able to come into those follow-up appointments. [01:12:07]

Making sure that we are working with our provider networks to ensure that there are telehealth options, that we as a plan could provide telehealth options, looking into alternative ways to care for our members that have diabetes rather than your traditional, come into the office and see your provider. Those are some of the barriers that we run into, and just internally trying to get creative to figure out how we can overcome them, and how we can use the VBID to help support that as well. [01:12:48]

Reynalda Davis:
I think that both of the prior responses detail some very key barriers that we're all experiencing. I'd like to talk about some of the things that may make it difficult for our patients to engage, that may not be affordability; it may be around cultural sensitivity. So for Arizona, we also have pretty large tribal communities as well, and Spanish-speaking communities. So sometimes for what we're seeing with our programs, the engagement level is the language and cultural differences in how we engage, and how attuned to those nuances are we, as well as digital literacy. [01:12:30]

So while telemedicine is being used pretty high amongst our general populations, when you're talking about the D-SNP versus the general MA, those consistent differences, regardless of whatever challenges from a socioeconomic status are going on, are still a barrier to engage with the programs in a way that's going to be meaningful for the patient. It's also hard to track. Our Medicaid agencies are very good about race, ethnicity, and language data, or real data. Not as much with sexual orientation and gender identity, or SOGI [Sexual Orientation and Gender Identity] data, which we do know, there is studies to show that there are differences in how they engage with medical care as a whole, and diabetes prevalence. [01:14:19]

We are just beginning our journey of how do we get that primary care, or primary source data from our patients, whether it's from the providers who are collecting that and bringing that in, or us as a health plan. And we of course have our own SDOH screenings that we do as a health plan, and our various assessments, but we still have that challenge of, some of the patients who have been most engaged with our diabetes programs for VBID are also the ones who have those same barriers to engaging normally. And that's part of the reason they like the high-touch program that we have for care and case management, and they're engaging with us in different ways. So I think, there's a lot going on with our patients from that standpoint. [01:15:07]

One other thing that may be an important consideration are for those who have housing insecurity. So even if we like to engage consistently, some of the options with providing supplies, some of the options of just even communicating for a call, they may have turnover in places, and just other reasons why we cannot communicate consistently, that's impacting their

care. So that's something that we have seen ourselves, and we're trying to thread that needle very carefully and very consistently for our patients, but we're also trying to do it sensitive to how they would feel about that. [01:15:45]

Ramesh Vangala:
Thanks. Abigale, on the Health Partners side, we do offer an OTC [Over-The-Counter] benefit, and we allow members who have certain chronic conditions, such as diabetes, to use that benefit towards food and groceries. So I think that does help; there's always that issue with nutrition and ability to get good food, so that's something that we do allow as well for those members who meet the conditions. [01:16:22]

Abigale Sanft:
Yes, these are all incredible insights. I think in terms of challenges to implementing these interventions, I'm thinking a lot about the public health emergency and the impacts of COVID-19, economic concerns from your enrollees and making sure that they're able to even access their care, access to data and leveraging potential of other data sources, and also maybe coordination with other community-based organizations for referral. I'm wondering, you know, with those challenges kind of in mind, how are you planning to measure the impact of your intervention, and how are you kind of tracking your progress, you know, over time, towards what you're trying to accomplish? [01:17:15]

Reynalda Davis:
I think I'll take a stab at this question first. So, we have looked at short-term KPIs [Key Performance Indicators] and in longer-term KPIs. As Melissa stated before, it's very hard to have absolute correlation, since we're so new to this program, as far as what we're standing up. We have looked at what we're considering an engagement rate, which are the level of touchpoints from different sources with the program. We're also looking at the reach rate. How many patients are we actually having the opportunity to engage around, not just our healthy food card that we have as a component, but specifically for our Dial into Diabetes program, and then the graduation rates, ultimately, how many are completing the program, and at what point are they stopping. [01:18:05]

We have thought around efficacy of disease progression and their understanding of that as another way for short-term KPIs. Longer-term, obviously, we're going to try to look at expenditures, just from the claims themselves, and the health outcomes, and then the patient experience, not just with the programs, but how is their experience of their healthcare altered by being in this program? And if that is improving for them, using that is a good indication that we're going down the right path. [01:18:35]

But we're definitely looking at this as a phased approach. You're not going to be able to have all the answers of, this is the right direction, because it's so new. And when you're overlaying SDOH and health equity lenses, from that standpoint, I think it's even more critical to have fine-tuned and tailored questions and engagement with the members, so we understand what actually works for the populations that we serve, and try to do more of that. So we're looking at all of those from that standpoint of measurement, but that is something I think that's going to be an imperative and adaptive process as we know more. [01:19:14]

Melissa Banik:
I agree. Ours is kind of in the same place, Reynalda. We're looking at some immediate things that we might be able to try to make a correlation to, and then kind of looking long term. One of the easier ones for us to look at right now is the rewards and incentives, and seeing if we're seeing a higher number of those tests coming in, that the claims demonstrating these tests have been happening, and I can say that from 2021 to 2022, I am seeing an increase. So that's good, but what I don't know yet is if those same individuals have those tests done before we gave them incentives, so that's the next step in our evaluation. We're looking, and we've got the numbers showing the increases in the tests, but, in the screenings, I want to look at it from a member perspective now, kind of layering it on top of each other to see, did those same members have those tests before we started rewarding them, because I really want to see if the rewards are helping them do this, or if they would have done it anyway. [01:20:23]

And the other one that we're looking at his medication adherence. And again, once our members are engaged, we're keeping them in the program through the end of the year. We tried to make sure that they weren't rolling in and out because they missed something, so we're keeping them in, but we want to look at that to see if the adherence to their maintenance drugs and their necessary drugs is better. Now that they have this reduced cost-sharing, or is it the same, those are the things we still need to look at. [01:20:55]

Alyssa Mullen:
And I think on our end, we have seen in the data, you know, we continue to track it, but we have seen that, we have that big jump of members that were previously noncompliant that became compliant when they had that reward offered for the med adherence from '19 to 2020. So continuing to track that, and seeing, for those that earned that reward and cashed in on that reward, what was their compliance, what did their compliance look like, as compared to the rest of the group? [01:21:32]

I think where it's a little bit, I know Melissa and Reynalda said it, but it's harder to make that correlation between offering the OTC benefits for food and groceries, and then correlating that to A1C reduction or med adherence. You know, we can make some assumptions, but we also need to have that data too, and being able to work with some of our community resource organizations, and referrals to them, and closing that loop. So there's a lot of moving pieces, and I'll admit, I think we're still working on that and how we do close that loop to see those correlations. [01:22:18]

I think the other piece is that, when we're working with a lot of these members, and we're talking about this population, a lot, it may not be isolated to diabetes. They've got other comorbidities that we're treating at the same time. So, you know, how do we kind of separate that out to do the analysis specifically on diabetes, and I don't know if that's always necessary to look, just under that one lens, but I think those are all those competing factors that we're working on. So I'm glad we're having that conversation. If anyone has figured out how to do it, let us know, but I think it's a work in progress. [01:23:02]

Abigale Sanft:

Great, well you all have alluded to this. I know I heard from Alyssa, a big jump in adherence. But I wanted to kind of end by asking if you could speak about any of the favorable impacts that you might have seen from your program, or even, just like anecdotal feedback from your enrollees or things like that that that you would share with our audience today. [01:23:29]

Reynalda Davis:
I think I will start just with that. So our Dial Into Diabetes program has in-person and virtual sessions for classes like know your nutrition, or know your numbers, and we were surprised that 60 to 70 percent of Spanish-speaking persons were interested in the program. And so we knew we'd have a proportion, but not such a high engagement. And that was really exciting for us to see. Not only that, it made us have to think more critically about interpretation and translation services for all of the different parts of the program, and what that looks like from a time perspective for our patients, and then also for our teams. Because at any point in time when you're adding additional people in the mix, that can take longer. So we were being mindful to have really curated, really targeted interactions, that were engaging for our members, and when that came up, it was really exciting. We've got some really good patient stories that they've loved our sessions that we have, they love our exercise physiologists that they're working with. [01:24:37]

So those were the things that we were hoping to hear, but we were a little bit surprised by who has been engaging thus far, so it lets us know that, you know, we may need to reach out to some other groups to help target that, but it's been really a joy to hear all of the different pieces that they love. And that they tell their family. Even though their family doesn't have the plan, you know, now, it is a family collaborative affair. [01:25:08]

Melissa Banik:
I can just add, I mentioned or I alluded to the fact that our diabetic screenings, the number have gone up. In 2021, we issued 6700 rewards cards, and breaking that down by the three screenings, we had over 2,000 A1C tests, more than a thousand, well actually more than 1100 nephropathy screenings, and nearly 3500 diabetic eye screens. In 2022 alone, the first six months, we've engaged, that first one, that was with 4500 members. In 2022, we now have 5500 members engaged in the program. And in the first six months, we have over 4,000 of each of the three screenings. So we are seeing a nice uptick there. And just, like I said, I want to go back now and see if these are new screening for these members, if we have closed some of those gaps, or if these are the same, it's just, that next level when we need to dig in a little deeper. But we look at this as a success, for sure. [01:26:12]

Ramesh Vangala:
From my side, if I could just add, from the pharmacy side, there's been a lot of positive feedback with the ability to get delivery for some of the medications from the pharmacy side. And I think the pill packing, the special packaging really helps from an adherence compliance perspective. Many of us have members who have multiple comorbidities, multiple drugs, so remembering what you have to take in the morning, afternoon, I think it becomes a challenge. So some of those programs, when we've been able to engage members, have been successful, to keep them that compliant, to keep them engaged in taking their medications, so I think that's been a positive sign there. [01:27:00]

Abigale Sanft:
I'll agree, and I just want to thank all of our panelists. You know, I think we've brought to life the way that you have taken the flexibilities and really adapted them to meet the needs of your enrollees. And you know, we know this is an ongoing effort, so we're really happy to be partnering with you all here. We are now approaching the end of our session, and I just wanted to reiterate that through this webinar and future learning sessions, as part of the Health Equity Incubation Program, we hope to develop a forum from MAOs to innovate around health equity, social needs, social determinants of health, and not only does the VBID Model provide a unique toolset for health equity innovation, but this program will provide a forum for solving common problems and challenges relating to health equity in the Medicare Advantage space. [01:27:52]

And with that, we'll open the floor for questions, prioritizing those that have been submitted through the Q and A feature, and one that I have seen come in, will the slides be available today? And the answer to that is that the slides will be available, including the slides, transcripts, and an audio recording of this webinar, and it will be posted to this VBID Model webpage for downloading a week or two after this webinar. So, you can be on the lookout for those materials on the website. [01:28:32]

And just as a reminder, we're using the Webex Q and A feature. I see one question about offering a reward for the completion of a Comprehensive Medication Review, or CMR, as part of your MTM program. And that is something that would be generally permissible through the Part D RI component of the VBID Model. Plans can incentivize healthy behaviors and assign a value to that where they think that incentivizing that behavior will lead to improved health and improved outcomes for enrollees. [01:29:23]

All right, given the time, I want to thank everyone for submitting their thoughtful questions, and thank all of our panelists and speakers for presenting us with a lot of different perspectives about benefit design and the importance of addressing diabetes care. As next steps, we hope that you'll be able to participate in upcoming Health Equity Incubation sessions. Our next session will be in September, and will focus on another important social need, which is transportation. [01:30:08]

And lastly, please be sure to fill out the post-event survey. We ask for feedback on which health equity topics your organization is most interested in, and that will directly inform what we plan to cover in the next Health Equity Incubation session. Thank you for joining us, and have a great rest of your afternoon.

END OF VIDEO FILE