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

Advancing Food and Nutritional Security

March 31, 2022
Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services

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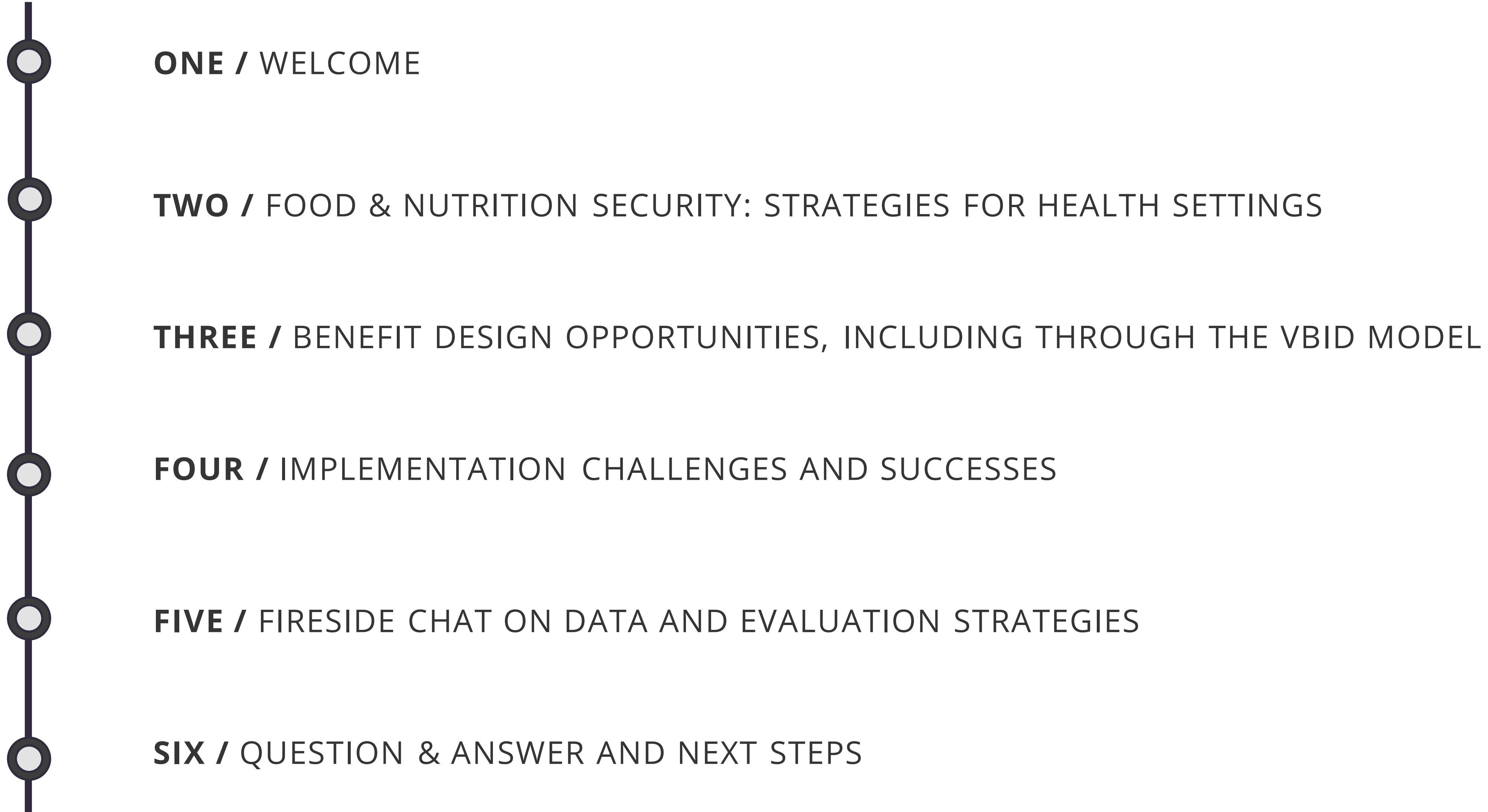

ONE / WELCOME

TWO / FOOD & NUTRITION SECURITY: STRATEGIES FOR HEALTH SETTINGS

THREE / BENEFIT DESIGN OPPORTUNITIES, INCLUDING THROUGH THE VBID MODEL

FOUR / IMPLEMENTATION CHALLENGES AND SUCCESSES

FIVE / FIRESIDE CHAT ON DATA AND EVALUATION STRATEGIES

SIX / QUESTION & ANSWER AND NEXT STEPS

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PART ONE
3:00 – 3:10 PM ET

WELCOME

SPEAKERS

Laura McWright, JD, MSW
Deputy Director, Seamless Care Models Group,
Center for Medicare and Medicaid Innovation, CMS

Sibel Ozcelik, ML, MS
Acting Deputy Director, Division of Delivery System Demonstrations,
Center for Medicare and Medicaid Innovation, CMS

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.

Addition of the Voluntary VBID Health Equity Incubation Program

Health Equity Incubation Program Overview

The **Health Equity Incubation Program** will serve 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

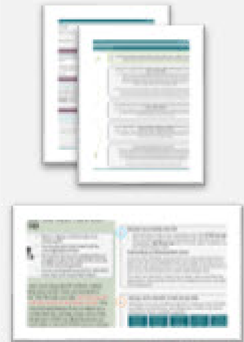
Upcoming Sessions and Technical Assistance

Initial VBID Business Case Session
September 2021 – December 2021

Engage 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).



Learning and Performance Feedback
2023 and onwards

In the long-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.

VBID Health Equity Business Case

INCREASE MEMBER ENGAGEMENT & RETENTION

Plans that offer supplemental benefits like meals have been shown to **receive a higher net promoter score and higher member retention.**[1]

IMPROVE QUALITY & MEMBER SATISFACTION

Focusing on social needs is correlated with positive quality of life and member satisfaction[7]**.**

According to a 2020 McKinsey study, **MA plans with an average customer experience measure rating of 4 or more Stars added 2.1 times more net members** in 2019 than their less customer-friendly competitors.[2]

OFFER BENEFITS ONLY AVAILABLE TO MODEL PARTICIPANTS

VBID Model participants can **offer unique features only available to participating plans,** such MA and Part D RI Programs, and importantly, targeted non-primarily health-related supplemental benefits.* **VBID tests greater customization of benefits to underserved populations.**

LOWER MEDICAL SPENDING & UTILIZATION OF LOW-VALUE SERVICES

Addressing health-related social needs in member populations has been shown in other contexts to:

- Significantly lower healthcare utilization[3]
- Significantly lower Emergency Department (ED) visits[4]
- Significantly lower medical spending[5]
- Better chronic disease management [6]

MINIMIZE COSTS BY BETTER FOCUSING INTERVENTIONS

Additional targeting flexibilities available to VBID Model participants, such as targeting by socio-economic status, test the benefits of allowing plans to **focus interventions on populations where the largest health improvements can be realized**.

In addition to improving member health and promoting health equity, **there is a strong business case for MAOs to participate in VBID and leverage the Model's waiver authority to address health disparities.**

[1]XM Institute NPS and Customer Ratings Benchmarks, Qualtrics 2020, Qualtrics.com
[2]Refer to the McKinsey study
*Some marketing restrictions apply
[3]Berkowitz, et al., 2018; Martin et al., 2018
[4] Ibid
[5]Gurvey, et al., 2013
[6]Refer to the Project Angel Heart study
[7] Refer to the HMA MA Supplemental Benefits Report

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PART TWO
3:10 – 3:30 PM ET

Food & Nutrition Security: Strategies for Health Settings

SPEAKER

Dr. Hilary Seligman, MD MAS
Professor of Medicine and of Epidemiology and Biostatistics,
University of California San Francisco

Food & Nutrition Security: Strategies for Health Settings

Hilary Seligman MD MAS

University of California San Francisco

March 31, 2022

National Clinician Scholars Program

UCSF Center for Vulnerable Populations
Zuckerberg San Francisco General Hospital

1 in 9 US Households Food Insecure

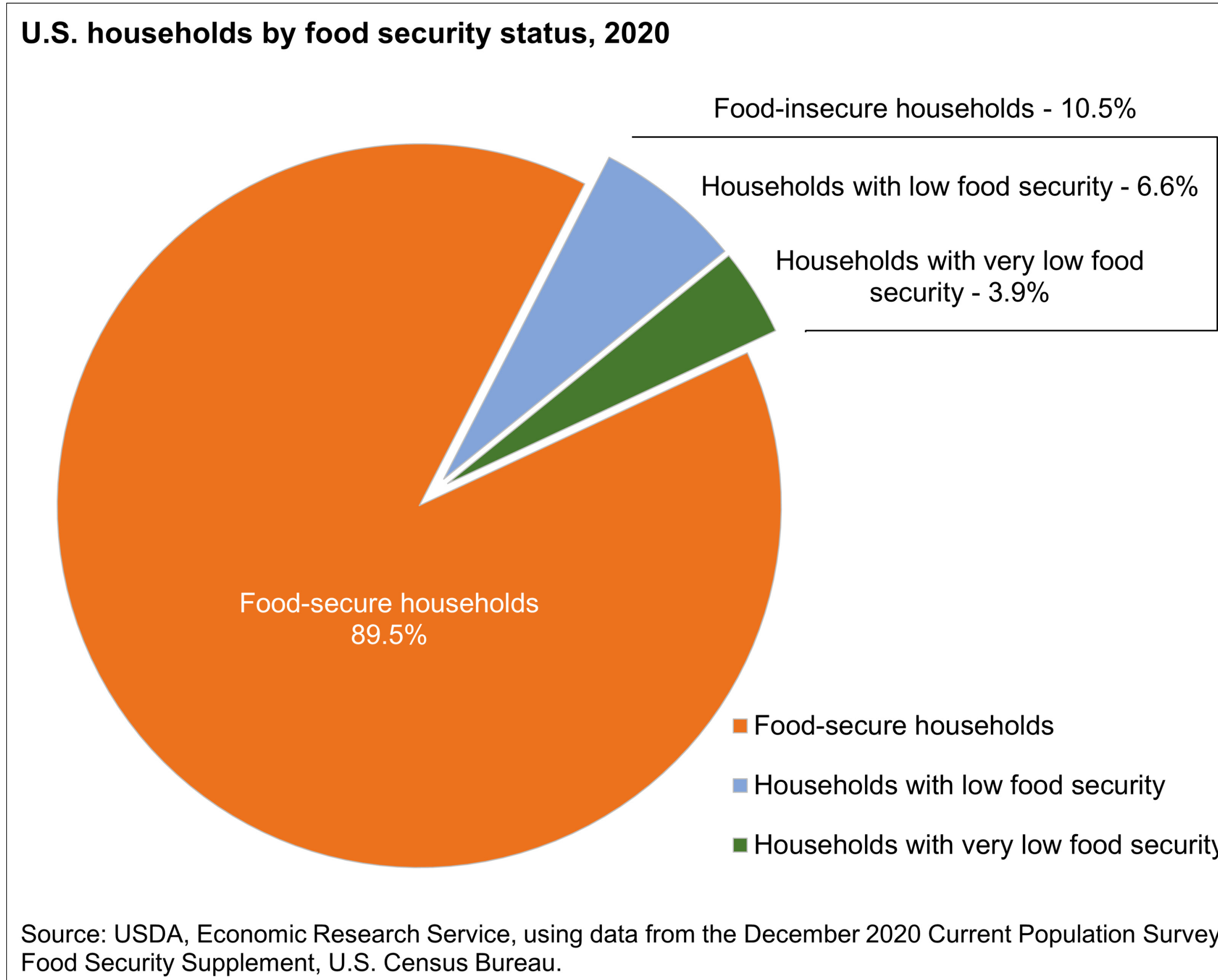
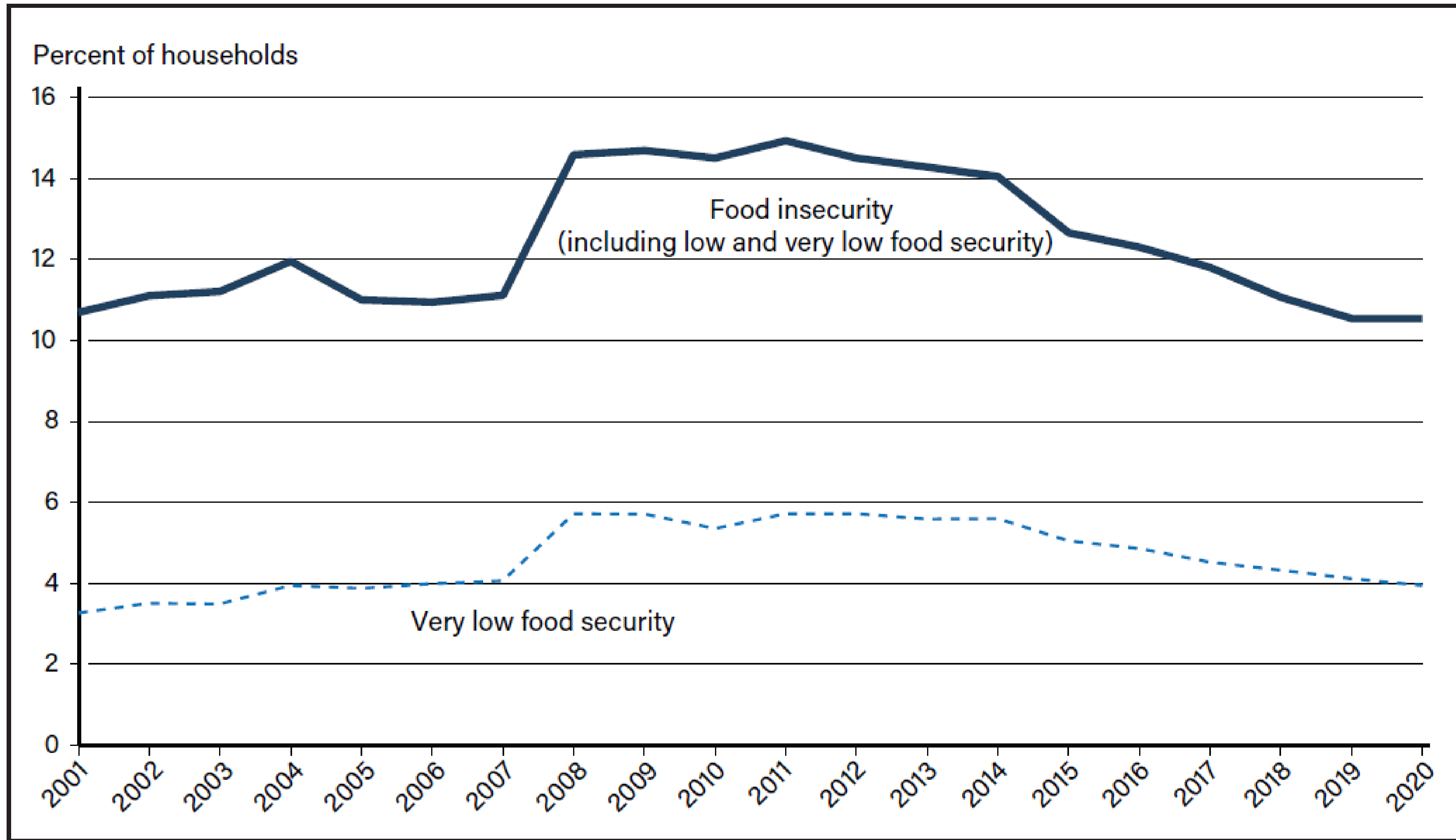
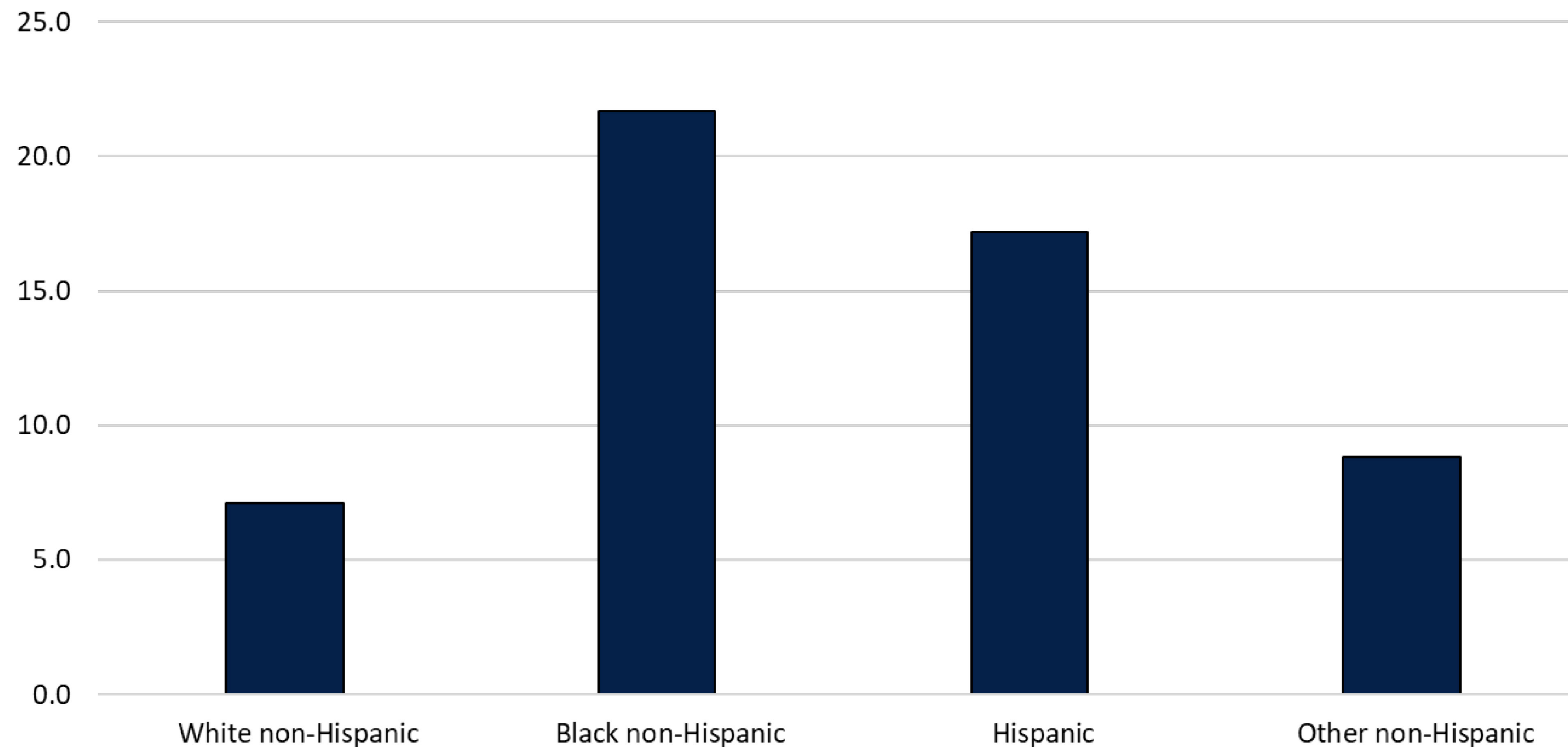


Figure 3
Trends in the prevalence of food insecurity and very low food security in U.S. households, 2001-20



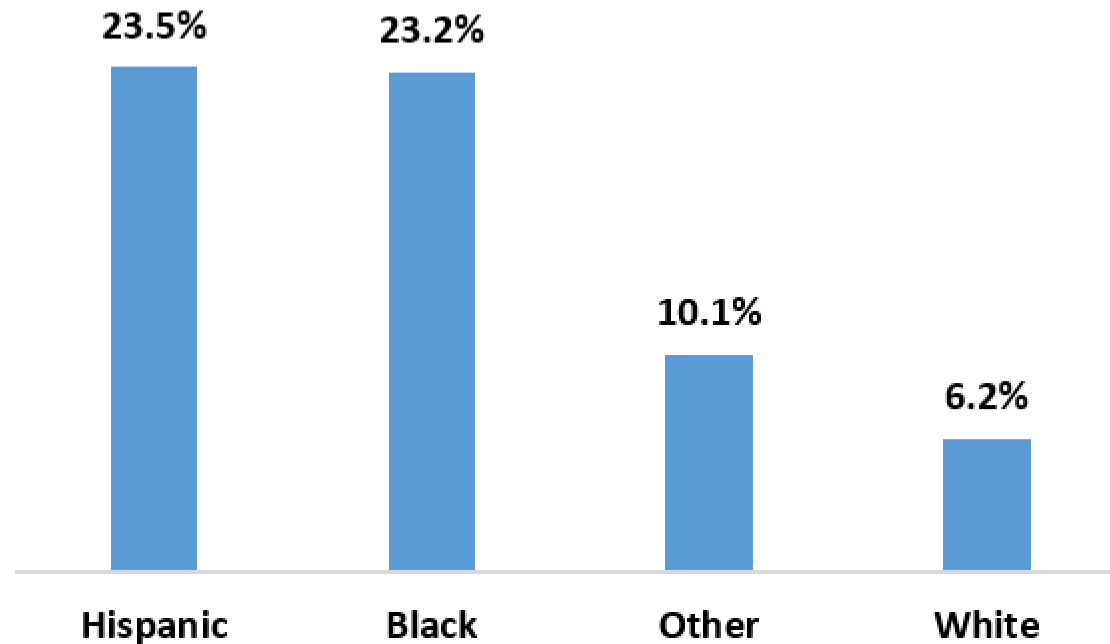
Source: USDA, Economic Research Service using data from U.S. Department of Commerce, Bureau of the Census, 2020 Current Population Survey Food Security Supplement.

Disparities in Food Insecurity Rates by Race, 2020



Source: USDA, Economic Research Service, using data from the December 2020 Current Population Survey Food Security Supplement, U.S. Census Bureau

Food Insecurity Prevalence ~9% Among Medicare Beneficiaries



Source: AARP Public Policy Institute analysis of the 2017 Medicare Current Beneficiary Survey (MCBS)

Food Insecurity Prevalence Even Higher Among Medicaid Enrollees

Table 1: Demographics

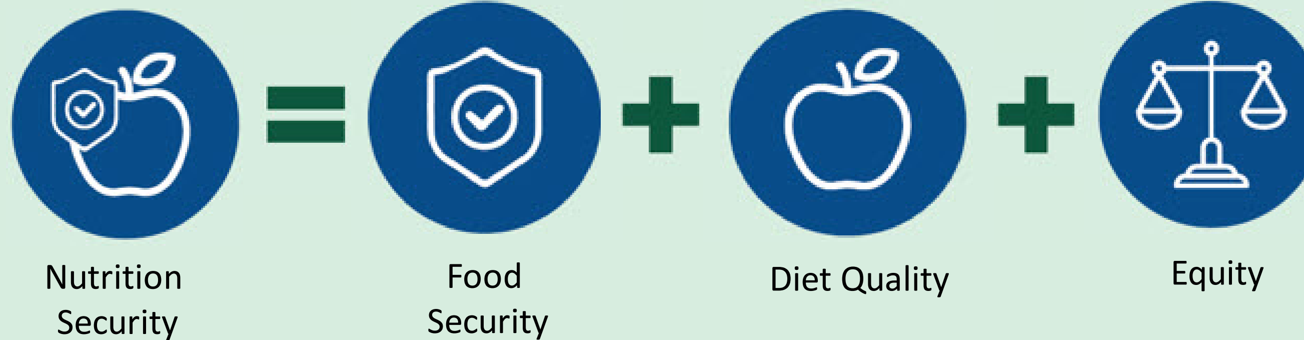
	Total *% (n) or Mean (SE)*	*Food Secure* *% (n) or Mean (SD)*	*Food Insecure* *% (n) or Mean (SD)*	*P-Value*
Insurance				
Private	63.0 (7,920)	67.6 (7,226)	34.1 (692)	<.0001
Medicare	7.7 (1,108)	7.7 (880)	8.1 (228)	
Other public	14.1 (3,725)	11.6 (2,592)	29.5 (1,131)	
Uninsured	15.3 (3,317)	13.2 (2,404)	28.3 (911)	

Note: Nationally representative, NHIS (2011) linked to MEPS (2012-13)
Reference: Food Insecurity and Health Care Expenditures in the United States, 2011-2013. Health Serv Res. 2018 06; 53(3):1600-1620. Berkowitz SA, Basu S, Meigs JB, Seligman HK.

Nutrition Security

WHAT IS NUTRITION SECURITY?

Consistent access to nutritious foods that promote optimal health and Well-being for all Americans, throughout all stages of life.

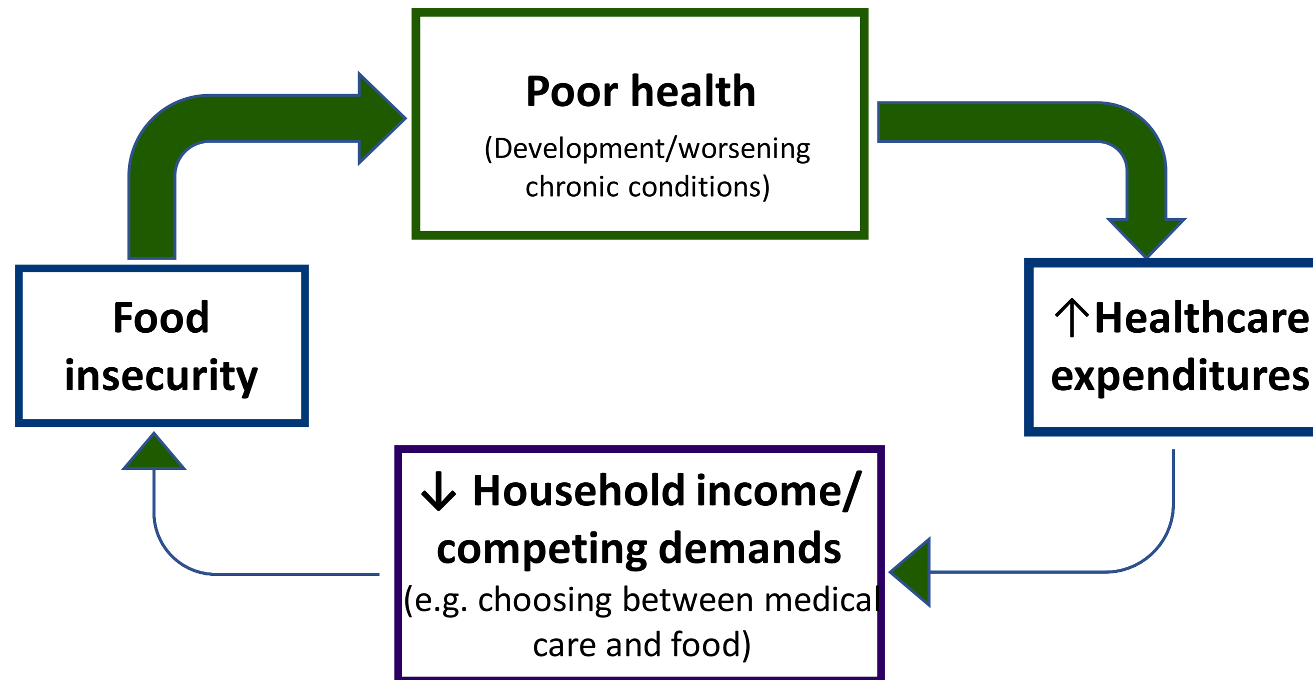


HOW DOES NUTRITION SECURITY BUILD ON FOOD SECURITY?

Food security is having ***enough*** calories.
Nutrition security is having the ***right*** calories.

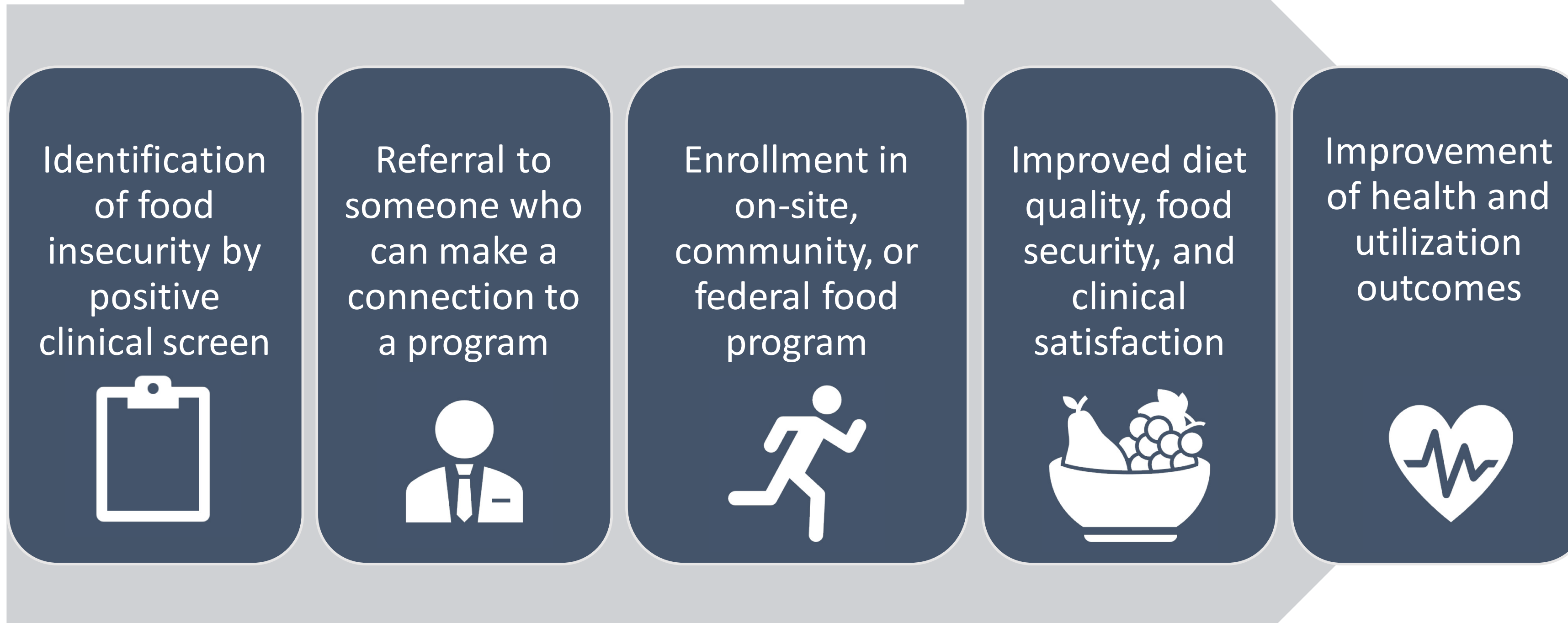
https://www.fns.usda.gov/resource/usda-actions-nutrition-security

Bidirectional relationship between food insecurity and poor health



Johnson, Palakshappa, Basu, Seligman, and Berkowitz. Health Services Research, 2021.

“Screen and Intervene”



Standardized Clinical Measurement: Hunger Vital Sign

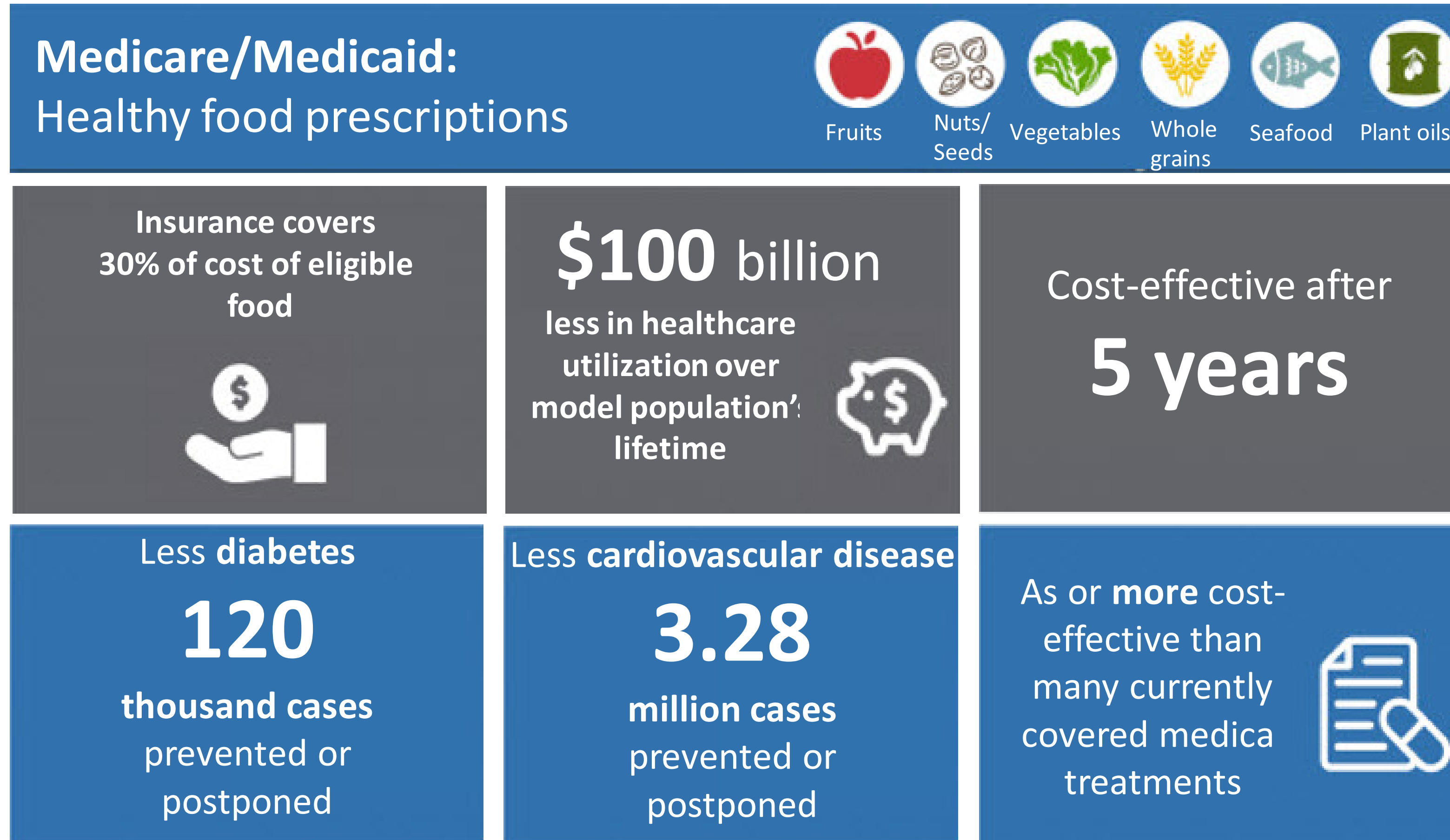
1. Within the past 12 months we worried whether our food would run out before we got money to buy more.
2. Within the past 12 months the food we bought just didn't last and we didn't have money to get more.

Often or sometimes true to EITHER question suggests food insecurity (97% sensitivity, 83% specificity)

For test characteristics among households with children: Hager, Pediatrics, 2010
For test characteristics among households without children, population-based: Gundersen & Seligman, PHN, 2017

Prescribing healthy food in Medicare/Medicaid is cost effective, could improve health outcomes

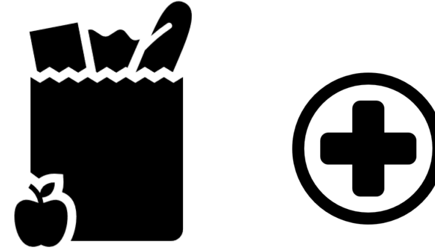
New study finds that health insurance coverage for healthy food could improve health, reduce healthcare costs, and be highly cost-effective after five years



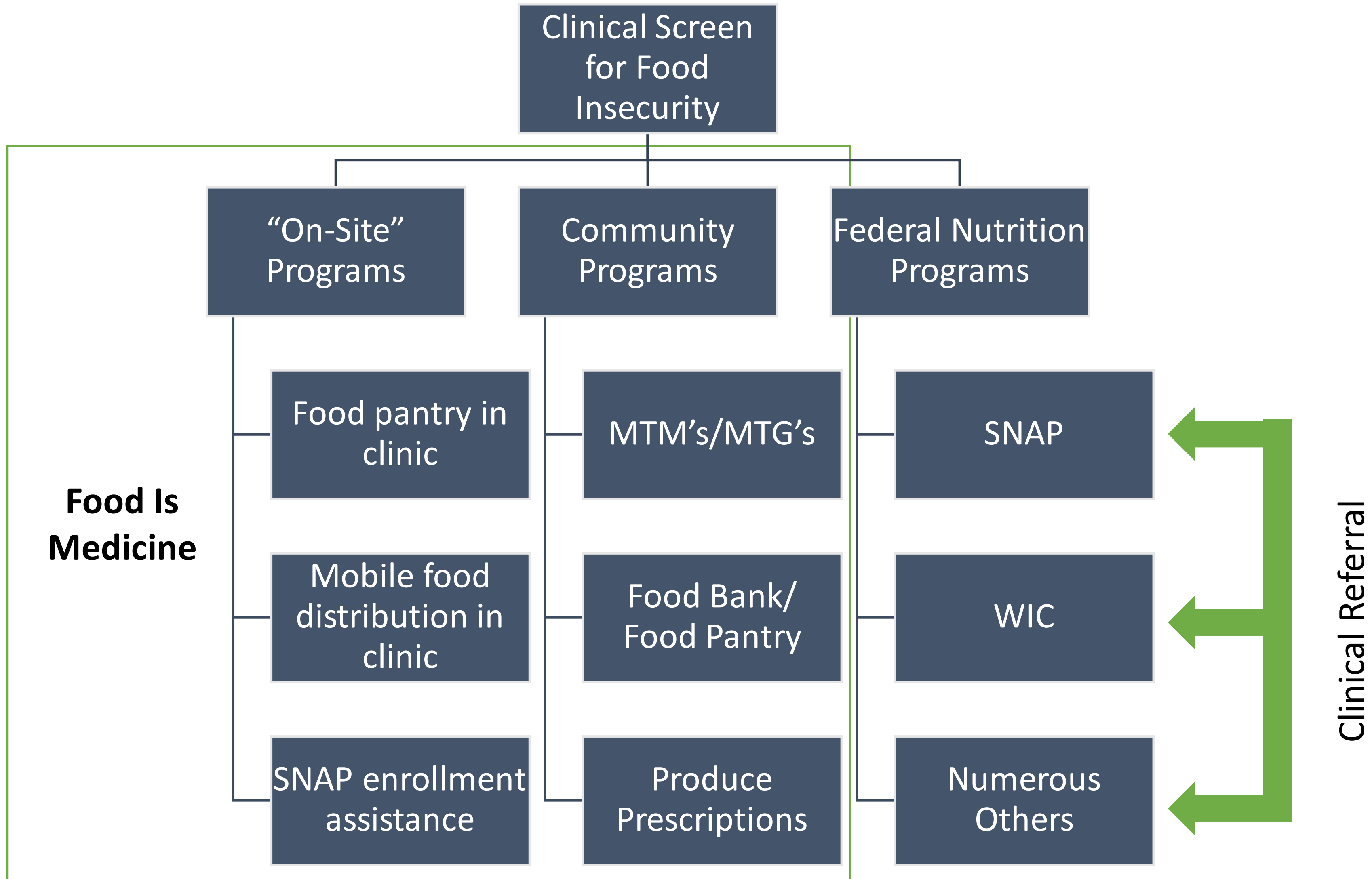
For more information, see "Cost-effectiveness of financial incentives for improving diet through Medicare and Medicaid: A microsimulation study" by Lee et al. (2019). https://doi.org/10.1371/journal.pmed.1002761

Gerald J. and Dorothy R. Friedman School of Nutrition Science and Policy at Tufts University

Food Is Medicine



- Integration of specific food and nutrition interventions in, or in close collaboration with, the health care system
  - Medically-Tailored Meals
  - Medically-Tailored Groceries
  - Produce Prescriptions
  - On-site interventions
- Target population: individuals with or at high risk for serious health conditions
  - Often prioritizes people with or at high risk of food insecurity
  - People with cancer and HIV were first recipients


Clinical Screen for Food Insecurity
"On-Site" Programs
Community Programs
Federal Nutrition Programs
Food Is Medicine
Food pantry in clinic
Mobile food distribution in clinic
SNAP enrollment assistance
MTM's/MTG's
Food Bank/ Food Pantry
Produce Prescriptions
SNAP
WIC
Numerous Others
Clinical Referral

Food is Medicine

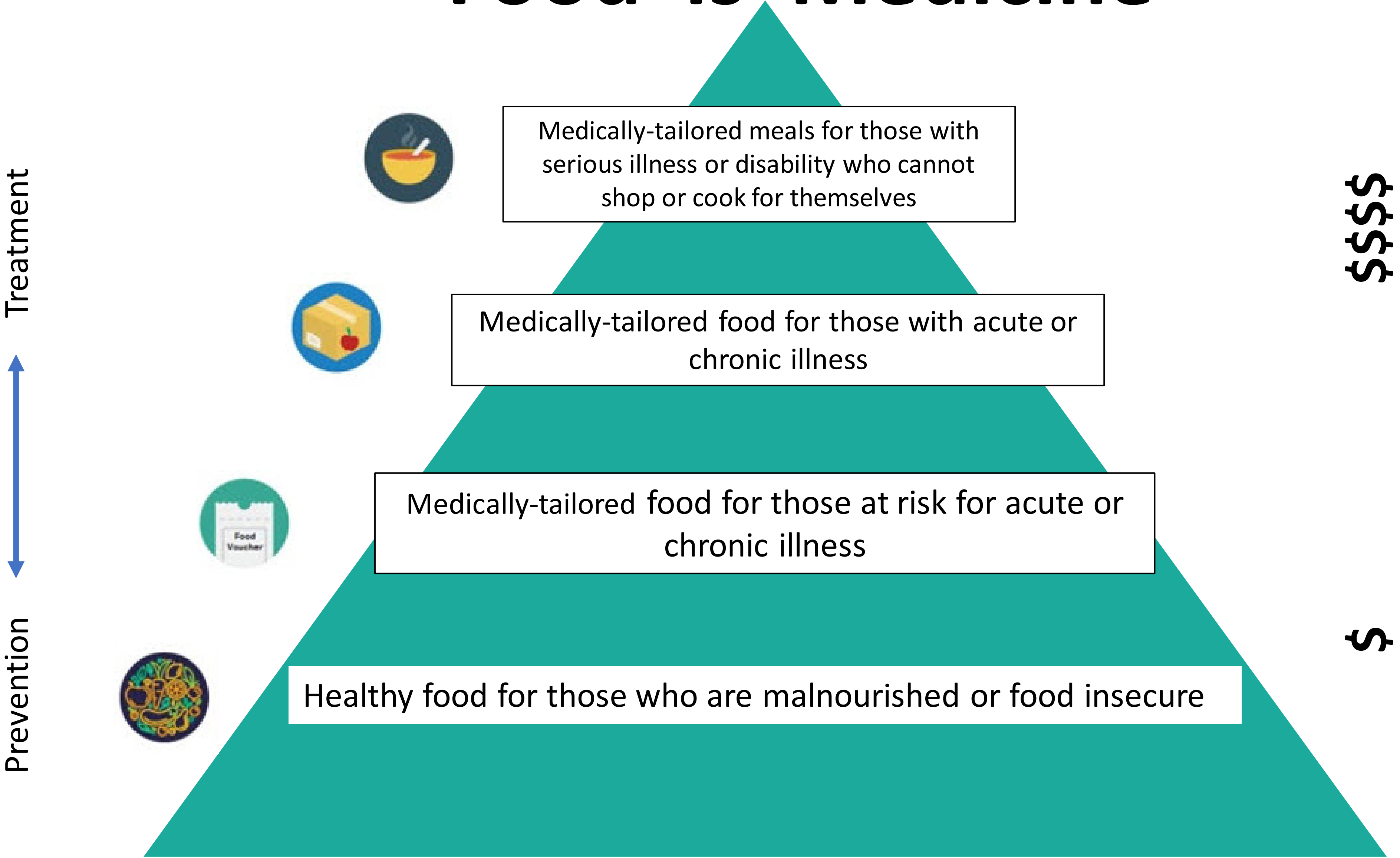
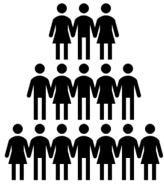


Image from Food is Medicine Coalition

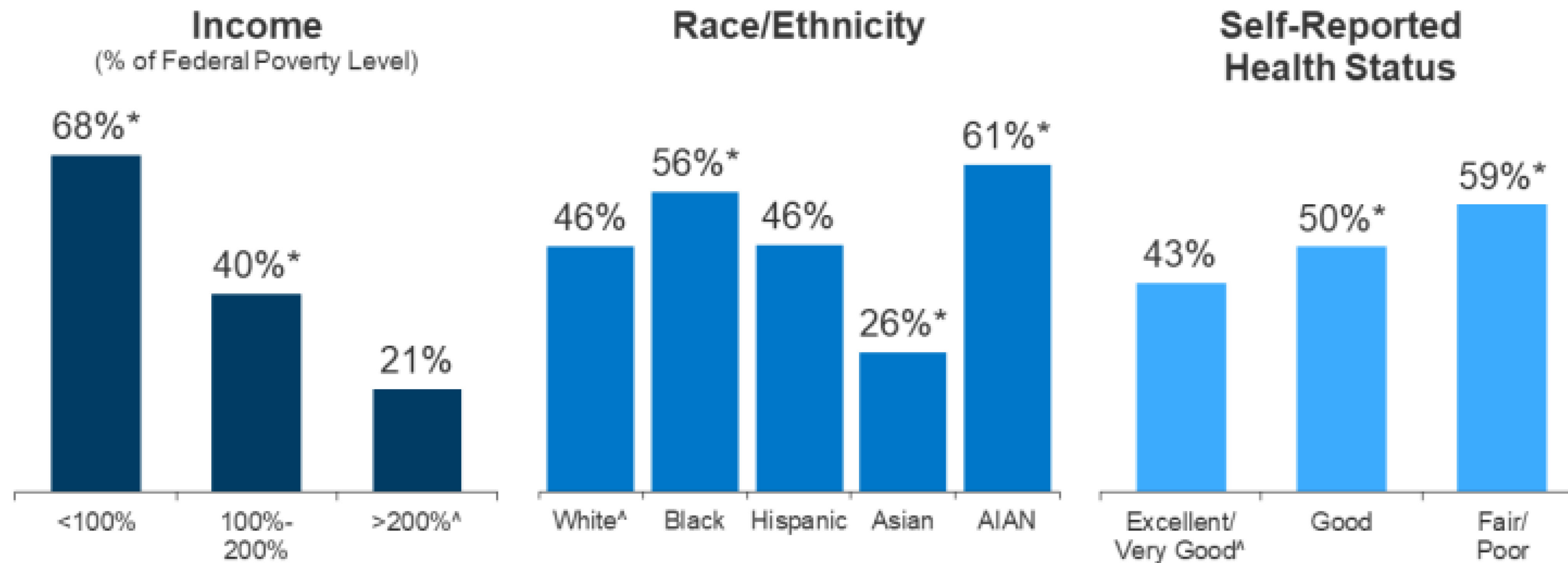


Federal Nutrition Programs: SNAP

- FIM intervention if enrollment occurs in, or is facilitated by, health system
- Benefits redeemable for all foods (except some prepared foods) at approved vendors
- **Very strong evidence SNAP improves health outcomes, reduces medication non-adherence, and reduces health care expenditures**

Figure 2

Share of Medicaid Enrollees Enrolled in SNAP by Income, Race/Ethnicity, and Health Status Prior to the Pandemic



NOTE: * Indicates statistically significant difference from the reference group (indicated with *) at the p<0.05 level. SNAP is the Supplemental Nutrition Assistance Program. The US Census Bureau's poverty threshold for a family with two adults and one child was $20,212 in 2018. AIAN refers to American Indians and Alaska Natives. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.
SOURCE: KFF analysis of 2018 National Health Interview Survey Data.

Federal Nutrition Programs: WIC

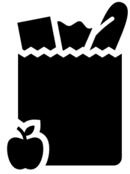
- Already meets the definition of a FIM intervention
- Benefits are a specific package of healthy food items specific to age
- **Strong evidence WIC improves dietary intake, birth outcomes, immunization rates, child academic performance**

Medically Tailored Meals

- As a FIM intervention, the referral comes from the health care setting
- Meals tailored to the medical needs of the individual patient that are either picked up or delivered to the home, usually by a partnering community-based organization
- **Relatively strong evidence suggests these interventions can reduce hospital admissions and readmissions, lower medical costs, and improve medication adherence**
- Suitable for populations with the highest burden of disability and illness

Medically Tailored Meals

- Relatively high cost, but likely cost-effective for high-risk populations
- Challenge
  - Easiest to demonstrate an ROI for these interventions over a short time window
  - We may not want all of our healthcare investment in FIM interventions to be targeted toward this population
    - Less opportunity for prevention (disease has already occurred)
    - Over longer time periods, supporting dietary intake earlier in the course of disease (or, even better, at the stage of prevention) will likely have the greatest ROI



Medically Tailored Groceries

- Raw ingredients that must be assembled into meals at home
- Sometimes operationalized by the same organizations as medically-tailored meals as a way to ease off the program; more often operationalized by food banks
- Lower cost service than medically tailored meals; targets a healthier population that needs less support with meal preparation
- **Very little health impact data**
  - **No reason to think they function differently than other FIM interventions as long as they <u>reduce food insecurity and support dietary intake</u> similarly**
  - **Preliminary evidence suggests they do**

Produce Prescriptions

- Cash value (on voucher or EBT card) redeemable for fruits and vegetables at a farmers market or retail store
- When tightly linked to health care, these are FIM interventions
- State and local programs across the US, many funded by USDA's Gus Schumacher Nutrition Incentive Program (GusNIP)
- Lots of heterogeneity across programs
- **Moderate evidence, but rapidly building**
    - Improved dietary intake
    - Improved food security
    - Modelling studies show substantial downstream impacts on health outcomes and health care costs
- Suitable for populations with the lowest burden of disability and illness
    - Often targeted toward those with or at high risk of chronic disease, but can be used for prevention in less targeted populations

On-Site Programs

- Onsite food distribution
  - Food pantry permanently located at hospital or clinic, stocked and/or staffed by Food Bank
  - Mobile food distributions at hospital or clinic
  - Take-home meals provided by hospital at discharge
- Eligibility workers for federal nutrition programs embedded in the clinical setting
  - Evidence for federal nutrition programs is strong
  - Implementation science efforts needed to best understand how to best deploy eligibility workers in clinical setting

Challenges → Reduced Impact

- Often funded by short-term grants that someone has to keep re-writing
- Access is often for a limited amount of time
- Referrals are still limited by fragmentation and inadequate funding of the social safety net
- Priority populations often change
- Often implemented with the goal of demonstrating an ROI to the health system

Barnidge EK, Stenmark SH, DeBor M, Seligman HK. The Right to Food: Building Upon "Food Is Medicine". Am J Prev Med. 2020 Oct;59(4):611-614.

PART THREE
3:30 – 3:35 PM ET

BENEFIT DESIGN OPPORTUNITIES, INCLUDING THE VBID MODEL

SPEAKER

Michael de la Guardia,
Pathways Graduate Student Intern,
Center for Medicare and Medicaid Innovation, CMS

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MA Options

Category	Options Available Under MA*	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
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.*

Current VBID Model Components and Health Equity

Model Intervention	Example
Targeted Benefits by Condition, SES, or both	• Plan offers **healthy food card or medically tailored meals** targeted to enrollees with LIS and hypertension (paired with messaging around DASH diet) – alternatively, plan could offer this benefit to all enrollees with LIS • Plan can also propose for CMS consideration and approval provision of a benefit that is not primarily health related for a targeted population that does not meet the definition of "chronically ill enrollee" in 422.102(f)(1)(i)(A) but is within the scope of the VBID Model limits for targeting enrollees. For example, the plan could propose **targeting enrollees facing food insecurity** as diagnosed by their PCP or through a standard screening tool (e.g., AHC).
MA and Part D RI Programs	• Plan could provide **reward to incentivize utilization of high-value services by a certified nutrition specialist** (CNS) for enrollees with LIS with pre-diabetes. o This could **be complemented with other VBID interventions** like reduced cost-sharing for CNS visits or Metformin
Targeted Coverage of New & Existing Technologies or FDA Approved Medical Devices	• Plan offers **targeted coverage of blood pressure monitors and cuffs** to enrollees with hypertension • Plan offers **targeted coverage of continuous glucose monitors** for defined special populations

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VBID Use Case: Rosa and Food Insecurity

1

- Rosa is a 70 year old Hispanic female from Richmond, CA
- She has pre-diabetes and was recently put on Metformin
- She receives low income subsidies (LIS), struggles to afford healthy food for her whole family
- There are few grocery stores nearby serviced by public transportation and Rosa does not own car

As part of your plan's health equity program you may notice many "Rosas" and that there are significant racial and ethnic disparities in diabetes management and food insecurity.

In your VBID application, you could use estimated medical savings from lower utilization and fewer ED visits[1] to bid lower on the benchmark rate and use the difference to pay for healthy food card, reduction in Part D cost sharing for Metformin, and/or many other social needs interventions that are targeted based on LIS status.

2

Diabetes and Food Insecurity

- **Existing literature and pilot studies show a strong association between diabetes and food insecurity and improved dietary patterns and glycemic control when food insecurity is addressed[2]**
- **The CDC found that the annual per capita excess cost for non-disability Medicaid enrollees with diabetes in the state of California was $8,530[3] (other studies show similar increases in Medicare population)**
- **By using a combination of interventions, including lifestyle interventions like healthy foods, health plans can lower the chance Rosa develops diabetes**

Understanding and Addressing Rosa's Food and Nutrition Needs

In the past, Non-VBID plans may have tried coordinating with community organizations to prevent costs like those highlighted above, but direct interventions (e.g., healthy food cards) were expensive because they must be provided to all enrollees, not just the enrollees who couldn't afford healthy meals.

Under VBID plans can now invest directly in interventions that address HRSNs like food insecurity by using targeting eligibility based on LIS status.

3

Tailoring a Suite of Benefits for Rosa through VBID

VBID allows for a more cost effective approach to tailoring a suite of benefits to your high cost and high need enrollees (e.g., enrollees with LIS and pre-diabetes).

- Reduced Cost Sharing for Certified Nutrition Specialists (CNS)
- Delivery of Medically Tailored Meals for Diabetes
- Healthy Food Card
- Targeted Coverage of Continuous Glucose Monitors
- Coverage of Non-Medical Transportation to Grocery Store / Farmers Market

1) Estimates require approval in application and will vary from plan to plan 2) Gucciardi, Enza, et al. "The Intersection between Food Insecurity and Diabetes: A Review." Current Nutrition Reports, vol. 3, no. 4, 2014, pp. 324–32. PubMed Central, doi:10.1007/s13668-014-0104-4. 3) https://www.cdc.gov/pcd/issues/2018/18_0148.htm

PART FOUR
3:35 – 4:00 PM ET

IMPLEMENTATION CHALLENGES AND SUCCESSES

SPEAKERS

Dr. Shantanu Agrawal, MD, M.phil
Chief Health Officer
Anthem

Dr. Andrew Renda
VP, Population Health Strategy
Humana

Leah Bruchieri
Director, Retail Product Development
Humana

PART FIVE
4:00 – 4:15 PM ET

FIRESIDE CHAT ON DATA AND EVALUATION STRATEGIES

SPEAKER

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

Dr. Seth Berkowitz
Assistant Professor of Medicine at the University of North Carolina at Chapel Hill School of Medicine in the Division of General Medicine & Clinical Epidemiology

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Question & Answer

Next Steps

Next Steps and Future Sessions on the Horizon

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

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

3. Schedule 1-on-1 with VBID Model Team via VBID@cms.hhs.gov in the next one to two weeks 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)

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Thank you for joining us today!

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

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