Health Equity Innovation Program 1: Advancing Food and Nutritional Security Webinar Transcript

Thursday, March 31, 2022

MARTINA GILL:
Thank you for joining today's webinar. At this time, I'm going to pass it over to Sibel Ozcelik.

SIBEL OZCELIK:
Afternoon. Thanks so much, Martina. My name is Sibel Ozcelik, and I'm the Acting Deputy Director of the Division of Delivery System Demonstrations within the Seamless Care Model Group of the CMS Innovation Center. First off, thank you for joining us today for our second VBID Health Equity Innovation Program webinar. With a focus on advancing food and nutritional security, the purpose of this webinar is to highlight opportunities for Medicare Advantage Organizations or MAOs uniquely available in the VBID model to identify, develop, and address health disparities related to food and nutritional security. [00:00:58]

We'll help clarify the connections between the VBID model and this important social needs area. But more importantly, we provide some tangible examples of how you, as an MAO, can connect these concepts on your own and in a way that makes sense for the population we serve. Before diving in, I want to put out a disclaimer. It's our favorite slide that our goal here today is for educational purposes and general information sharing, as noted here. [00:01:28]

We're so excited to have a packed agenda, and we'll be hearing from experts, including Doctors Hilary Seligman and Seth Berkowitz, and from healthcare innovators currently participating in the VBID model. During this session and subsequent Health Equity Incubation sessions focused on transportation and housing, we'll follow a standard format as outlined here. First, we'll provide background, target populations, and existing evidence base supporting interventions to address the social need of focus. Then we'll translate that evidence base and the strategy into concrete benefit design opportunities with a focus on how plans can leverage VBID Model components. [00:02:10]

Three, we'll provide lessons learned and best practices for implementation, and four, discuss data and evaluation strategies. At the end, we'll always save time for a brief Q and A, so please throughout this webinar submit your questions through the Webex Q and A feature. Now, to get us started, I'll pass it over to Laurie McWright, the Seamless Care Model's Group Deputy Director, for a brief welcome. Laurie. [00:02:37]

LAURIE MCWRIGHT:
Thank you, Sibel. I'd also like to welcome everyone to this webinar. And thank you for

your time today. The VBID Team has worked hard to assemble an outstanding set of speakers and information to share with you today. As we get started, I wanted to really emphasize how much of a priority area health equity is for CMS moving forward. And for me, health equity is really a guiding principle of our health plan innovation work. In addition, the partnership between CMMI and the Medicare Advantage Organizations, I believe, is a real opportunity for learning about how to take the support of underserved populations enrolled in Medicare Advantage in a VBID plan to the next level and more truly understand how to address health disparity. [00:03:41]

So to get us started: here at CMS we define health equity as "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 hard to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people that are served by our programs by eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved and providing care and support that our enrollees need to thrive. [00:04:44]

I think it's safe to say that the VBID Model Health Equity Incubation Program fits well into this vision and reflects the priority and emphasis we are placing on health equity within the VBID Model. The program will certainly serve as a central pillar of the planned learning, but it is our hope that the program will go well beyond the information sharing and lead to concrete action by our plan. In addition, we hope today and future sessions will accomplish four goals. First, encourage innovation in the most promising focus areas, including benefits and initiatives to advance food and nutritional security. [00:05:34]

Second, we also hope to optimize design and implementation of best practices related to social needs like food and nutrition. Third, we'd like to build an evidence base for quality improvement and medical cost savings related to food and nutrition benefits through better data collection and evaluation. And finally, we hope to inform new directions in the MA program. Ideally, we'd like to see more plans propose interventions related to advancing food and nutritional security in order to support learning and evaluation in the model. And we hope that each intervention will be rooted in the current evidence of how to best deliver these benefits. [00:06:21]

Part of success here will be ensuring the model is collecting useful and actionable data on food and nutrition benefits and social needs, which will allow us to create a true learning network where plans can tackle common challenges around new and innovated benefits. We look forward to sharing results as we sift through our data. It is our hope that we can actually act as a convener to improve quality and implementation in advancing food and nutritional security through shared data and insight. [00:07:01]

Now, we've covered the Health Equity Business Case in VBID in our last incubation session, but I wanted to highlight its importance again in that the business case for

investing in health equity and how we believe that VBID can actually be a core part of your health equity strategy. For example, first, increasing member engagement and retention. We have seen where plans that offer supplemental benefits like meals receive a higher net promoter score and experience higher member retention. [00:07:46]

Second, improved star ratings with an accompanying increased benchmark rate can yield increased member satisfaction and improved quality. Third, there are opportunities for participating or prospective MAOS to offer benefits to unique populations that cannot be offered in other MA program, like targeting by low-income subsidy status, which allows a greater customization of benefits to address health equity issues in underserved populations. Fourth, there is certainly a business case to be made that addressing health-related social needs in member populations will drive down spending and lower utilization of lower-value services. [00:08:35]

And in fact, this will be a large focus of today's discussion. Finally, we can minimize cost by better focusing interventions to those who need them most, like low-income subsidy individuals. And I might add that target populations will also be a subject of today's discussion. Now, it's noted at the bottom of this slide, in addition to improving member health and promoting health equity, there is definitely a strong business case for plans to participate in VBID and leverage the model's waiver authority to address health disparities overall. [00:09:14]

Now, with that, it is my absolute pleasure to turn it back over to Sibel Ozcelik and our other speakers. Thank you. [00:09:20]

SO:
Thanks so much, Laurie. And now we'll be transitioning to focus on today's topic: advancing food and nutritional security. To kick us off, I'll be handing it over to Dr. Hilary Seligman to talk about tangible strategies for health plans that advance food and nutritional security, discuss the current evidence base, and cover identification of need and prevalence of members with food insecurity and/or malnourishment. Dr. Seligman is a professor at the University of California, San Francisco and is truly a leading expert in US food insecurity and its health implications across the wide course. [00:09:57]

With that, I'll turn it over to Dr. Seligman. Dr. Seligman, thank you for joining us today. [00:10:02]

HILARY SELIGMAN:
Thank you so much to everybody and for the opportunity to speak with you today. I'm going to focus today particularly on strategies for health settings. So just to make sure that we're all starting on the same page, 2020 data just released by the USDA suggests that one in nine US households, or about 10.5 percent of US households in the United States, were food insecure at some point in 2020. This 10.5 percent prevalence of food insecurity was not related only to the pandemic. [00:10:47]

I want to remind people on the call that the prevalence of food insecurity has been

between about 10.5 and 15 percent for the last 20 years. So food insecurity is not just a consequence of the pandemic. It was with us before. And it will continue to be with us until we have made systems and structural solutions to help address it. [00:11:21]

The 10 percent US average rate of food insecurity hides tremendous disparities in food insecurity rates by race and ethnicity, with more than 20 percent of Black non-Hispanic and more than 15 percent of Hispanic households in the US reporting food insecurity in the most recent data released by the USDA. How does this compare to food insecurity rates among Medicare and Medicaid populations? In Medicare populations you can see data here from before the pandemic, from 2017, and what you see is similarly that Black and Hispanic households have a much higher rate of food insecurity, and in fact, it is much higher than the US average. [00:12:12]

We don't have data, or I'm unaware specifically for prevalence data among Medicaid populations in dually-eligible populations. What you can see from one of the studies that was done in collaboration with Dr. Berkowitz as well is that the prevalence of food insecurity in Medicaid and dually-eligible populations is between three and four times higher than that in Medicare populations. [00:12:52]

The USDA officially has been measuring food insecurity rates for many decades. The term "nutrition security," which is often being used in relationship to food security, includes the construct of food security but also puts it into a frame that includes diet quality and equity. And one way to simply and easily understand food security and nutrition security is that the emphasis on food security is on having enough calories. The emphasis on nutrition security is having the right calories. [00:13:33]

But I will remind people that food security also includes access to nutritious food, and nutrition security also includes access to adequate calories. So again, it's same work that was done with Dr. Berkowitz that has long been hypothesized: a bidirectional relationship between food insecurity and poor health where food insecurity, because of the dietary coping mechanisms that it creates, predisposes people to poor health. Poor health increases people's healthcare expenditures, and the increased healthcare expenditures make it more likely that people will experience food insecurity because money available in the household budget for food is reduced by the healthcare expenditures. [00:14:19]

What we now know is that the predominant arrow goes from food insecurity to poor health and not from poor health back to food insecurity. And this really suggests that the further upstream we can intervene on food insecurity, the better we will do at eliminating poor health outcomes and reducing disparities in health outcomes across at-risk populations. And so this really motivates what I like to call this "screen and intervene" model. [00:14:50]

And in this conceptual model, if we are able to identify food insecurity in the clinical setting by a positive screening test and we can refer to someone in the clinical setting who can connect the individual who is screening positive for food insecurity to a

community or federal program that provides increased access to food, that that increased access will improve diet quality, food security, and clinical satisfaction. And that will result in improved health and utilization outcomes. [00:15:23]

This is the conceptual framework that has really motivated the "food is medicine" movement. And it starts with clinical screening that in most cases has been conducted with the Hunger Vital Sign, and I just want to make sure we say that word: Hunger Vital Sign. So, if you are interested in implementing screening programs, this is the most evidence-based screening tool to use. [00:15:44]

Based on the data that has been collected from the increased interest in providing food and nutrition resources in the clinical setting, a number of microsimulation models have been created that focus specifically on Medicare and Medicaid populations, such as this one. And they do suggest that providing healthy food is cost-effective and can improve health outcomes and that the cost effectiveness is primarily driven by prevention of diabetes and cardiovascular disease and their complications. [00:16:16]

And I think we'll dive into that a little bit more. The question that I'm going to address in my setting is how do we prescribe healthy food to Medicare and Medicaid populations? And I will start then with a definition of "food is medicine". The definition of "food is medicine" intervention that I like the best is "the integration of a specific food and nutrition intervention in or in close collaboration with the healthcare system. And this includes a number of different interventions that we'll talk about in the next few minutes. [00:16:49]

Most of these interventions are targeted towards individuals with or at high risk of a serious health condition such as diabetes or hypertension, but in some cases they also prioritize people who are with or at high risk of food insecurity for primary prevention of disease such as obesity, diabetes, et cetera. And a lot of the evidence base for these programs has been created with longstanding attention to cancer and HIV populations. So this is the road map I'm going to use for the rest of my time today. [00:17:27]

Really, the road map is showing you the "food is medicine" interventions that I like to bucket into three categories: On-site programs are programs that are developed and implemented in the healthcare setting. Community programs are programs implemented by community partners, usually nonprofit organizations that the healthcare partner provides a referral to. And then there is a spectrum of federal nutrition programs, and when a clinician is providing a referral to the federal nutrition program in the healthcare setting, that qualifies as a food is medicine intervention. [00:18:06]

This I show you so that you see sort of the universe of potential interventions that have been explored. The challenge that we will talk about, upcoming, is choosing the right "food is medicine" intervention for the right person. And as you can imagine, some of these interventions are much more comprehensive. Those more comprehensive interventions are targeted more towards treatment and are more expensive, whereas those that provide, for example, healthy food for people who are able to shop and cook for

themselves, focus more on prevention and are much less costly to implement. [00:18:46]

And these cost differentials make a big difference in the cost effectiveness discussions. So let me start with SNAP because we have the most data about the health outcomes associated with SNAP, or the Supplemental Nutrition Assistance Program, formerly the Food Stamp Program. And as I said before, if enrollment occurs in or is facilitated by the health system, we call this a food is medicine intervention. And once you are enrolled, you are able to redeem your benefits for any foods except for some prepared foods at approved vendors. [00:19:20]

There is very strong evidence now from well-controlled trials that prove, I would say, that SNAP improves health outcomes, reduces medication nonadherence, and reduces healthcare expenditures. One of the interesting things to look at is the share of Medicaid enrollees enrolled in SNAP because eligibility criteria for Medicaid and SNAP are substantially overlapping. And so what you see here is that many, many people enrolled in Medicaid are still not enrolled SNAP. And so there are tremendous opportunities, I think, to make co-enrollment easier and to very quickly provide a "food is medicine" intervention to many people enrolled in the Medicaid program. [00:20:08]

Kaiser, for example, offers support for SNAP enrollment to any one of their Medicaid beneficiaries. WIC also meets the definition of a "food is medicine" intervention. WIC, of course, is only available to pregnant and post-partum women and children under the age of five. It offers a specific package of healthy food items, so addresses the nutritional security aspect of this. And again, there's strong evidence that WIC improves dietary intake, birth outcomes, immunization rates, and child academic performance, so likely a highly cost-effective program. [00:20:49]

Now, I'm going to move away from the federal nutrition programs and towards programs that are generally implemented by community partners based on a referral from a healthcare provider. And so in most cases there's a partnership between the healthcare provider and the community-based organization, and there is in the programs that work best by directional communication between the two. In Medically Tailored Meals, meals are tailored to the medical needs of an individual patient. Those meals are either picked up or delivered to the home, usually by the community-based organization. [00:21:27]

And there is relatively strong evidence now, mostly conducted by Dr. Berkowitz, that suggests that these interventions can reduce hospital admissions and readmissions, lower medical costs, and improve medication adherence. They're obviously, though, suitable just for populations with the highest burden of disability and illness because these are prepared meals, not raw ingredients. So they're relatively high cost and nonetheless they're likely cost-effective for high-risk populations. [00:21:27]

The challenge is that it's easiest to demonstrate a return on investment for these interventions over a short time window because people are so high-risk, if they qualify, but we may not want all of our investment to be targeted towards this population because there is less opportunity for prevention. And over a long time period, supporting dietary

intake earlier in the course of disease will likely have an even greater return on investment. Medically-tailored groceries are less costly because they are raw ingredients, not prepared meals. [00:22:28]

They are sometimes delivered by the same organizations as medically-tailored meal but are often created by food banks that can be picked up at local food pantries or occasionally delivered to home. They often target a healthier population that needs less support with meal preparation, but we don't have as much health impact data on medically-tailored grocery programs. I do not think as an expert in this area that there is a reason to think that they function differently than other "food is medicine" interventions as long as they reduce food insecurity and support dietary intake similar to the other food is medicine interventions we're discussing today. [00:23:09]

Preliminary evidence suggests they do, but our evidence for this intervention is much lower than for medically-tailored meals and the federal nutrition programs. Produce prescriptions are cash value on a voucher or an electric benefits transfer card, a debit card that you can take to your local store or a farmers market and redeem it for fruits and vegetables. And these are also considered a "food is medicine" intervention if that produce prescription is being offered by the clinician. [00:23:39]

There are many state and local programs across the US, many of which are now funded by the USDA's Gus Schumacher Nutrition Incentive Program, otherwise known as GusNIP. There is lots of heterogeneity in the way these programs are deployed in different local communities. But there is rapidly-building evidence that they can improve dietary intake, improve food security, and support downstream health outcomes, particularly in modeling studies. One of the great benefits of this model is that they are suitable for populations with a lower burden of disability and illness and really might be able to address prevention in populations that have not yet developed chronic disease. [00:24:27]

And then there are a range of programs that are implemented on-site in healthcare settings: for example, a food pantry that is permanently located at a hospital or a clinic. It's often stocked or staffed by the local food bank. There are models of mobile food distributions at hospitals or clinics where the food bank comes in once a week, for example, or once a month to provide a pop-up food pantry. There are examples of take-home meals being provided by hospitals at discharge, particularly for diet-sensitive diagnosis like congestive heart failure. [00:25:02]

And the other model of on-site program is to embed eligibility workers for federal nutrition programs in the clinical setting with the understanding that our evidence for improved health outcomes with the federal nutrition programs is very, very strong. There have been some challenges with implementation of these efforts, though, and so one of the areas for increased research is to understand how best to deploy eligibility workers for the federal nutrition programs in the clinical setting. So there have been some challenges to the "food is medicine model". [00:25:37]

One is that they're often funded by short-term grants that the healthcare partners often do not have the capacity to keep rewriting. Access to these programs is often for a limited amount of time. Referrals to federal nutrition programs from the healthcare setting still create barriers for patients who are stymied by the fragmentation and inadequate funding of the safety net once they, for example, try to enroll in SNAP at the local SNAP office. There are challenges with priority populations changing. So your community CHNA [Community Health Needs Assessment] might have a priority population of people with diabetes this year. [00:26:23]

But next year it may switch to HIV, and that has been challenging for food is medicine providers. And finally, these interventions have often been implemented with the goal of demonstrating a return on investment, and that I think has stymied efforts to create programs that best meet prevention needs. So that is the model, the spectrum of potential opportunities that I know of. And with that, I will turn it over to the conference organizers. [00:26:50]

SO:
Thanks so much, Dr. Seligman, for that fantastic overview. Now, with that baseline, we'll now be focusing on benefit design, including unique opportunities available through the VBID Model. I'll now hand it over to Michael de la Guardia, who has been supporting the model and our health equity work this past year and is joining us from UC Berkeley's MBA and MPH program. Michael.

MICHAEL DE LA GUADRIA:
Thanks so much Sibel. Great, so here we go, I want to first start by clarifying what options are available to health plans already under MA [Medicare Advantage] and what additional options are available through VBID, to aid in our thinking. Two ways plans can roll out some of the benefits just discussed by Dr. Seligman. Out of this table here on the right side, we'll first talk about targeting. So VBID is unique in that it allows MAOs to target by LIS or dual status alone. And this is not allowed under SSBCI [Supplemental Benefits for the Chronically Ill] or UF [Uniform Flexibility] under the MA program. [00:28:03]

But under VBID, MAOs can also target by a combination of LIS or dual status and chronic conditions. Also, VBID allows for targeted benefits related to Part D, which is unique to the model and includes reduced or eliminated cost-sharing for Part D drugs as well. VBID also allows for new and existing technologies or FDA-approved medical devices as a mandatory supplemental benefit. Now, moving down here a bit on the rewards and incentives side, VBID has an RI [Rewards and Incentives] limit that is tied to the value of expected impact on enrollee behavior or the expected benefit, not the cost of the activity, and allows for to be related to Part D, again, something not permissible under the regular program. [00:28:55]

And finally, I'll just talk on this last piece here, MAOs can apply to participate in the VBID Hospice Benefit Component. And under this component, plans cover all of their enrollee's Medicare benefits, including hospice care, and can also offer transitional

concurrent care in hospice supplemental benefits. So here on this next slide, how do these flexibilities actually align with innovative food and nutrition benefits and interventions? On the targeting side under VBID, a health plan could offer a healthy food card or medically-tailored meals to all enrollees with LIS and remove any chronic condition requirement that would otherwise be required under the MA program. [00:28:55]

So whereas under the program, a targeted healthy food card does not meet the Uniform Flexibility requirements, not primarily health related and would not be universal, and under SSBIC, the benefit would have to be limited to specific conditions. But here under VBID, VBID is unique in that plans can consider social needs just as they would consider health needs and medical needs. Also under VBID, these benefits could be conditioned to those targeted enrollees who participate in a disease management program and/or see high-value providers such as providers who primarily serve underserved populations. [00:29:47]

So beyond direct food benefits, plans could also think about benefits like reimbursement of transportation to grocery stores or farmers markets. And then on the RI side, a health plan could provide a reward of, say, $100 in healthy groceries to incentivize utilization of high-value services, say by a certified nutrition specialist [CNS], for enrollees with LIS and with pre-diabetes. This could be complimented with other VBID interventions, like reduced cost-sharing, or a CNS visit, and this, I'll point out, is just a small sample of options, and we'll cover some more options during our panel discussion in a moment. [00:31:13]

That brings us to this next slide here, and throughout these incubation sessions we hope to find ways to make the Model flexibilities come to life a bit more and translate into tangible action. This is a slide we briefly featured in the last incubation session. But here we're highlighting the story of a beneficiary, Rosa. She has prediabetes and recently began taking Metformin. She receives low-income subsidies, struggles to afford healthy food, and can't access the few grocery stores nearby due to transportation limitations. [00:31:55]

Rosa recently joined a VBID plan that's offering a healthy food card, eliminated Part D cost-sharing, including for Metformin, and trips to the grocery store and pharmacy. So this was possible for the plan through VBID's LIS targeting. Such comprehensive social needs benefits may not have been economically feasible if the plan couldn't target by socioeconomic status. And as a result, here in this illustration, Rosa's been able to not only access needed medications but also healthy foods, addressing both medical and social needs. [00:32:36]

And so if we do take a step back, there are thousands of other Rosas out there that these types of interventions would help that are beneficiaries that are currently enrolled in your plan. And understand the needs of your enrollees is really the first step here. Not only can these benefits save money, but they also help improve quality of care, make patients feel like they have a little agency over their health, and address social needs for some of

the most vulnerable beneficiaries within Medicare Advantage. [00:32:36]

These benefits are readily available within the flexibilities authored under the VBID model. Now, with that, and now that we've covered some of the options that are available under the Model, let's talk to some of the current model participants about what rolling out these benefits could look like actually in practice. So I'll give our panelists a couple of seconds to join, and then we'll get started here. [00:33:41]

Today we're lucky to have three amazing panelists to talk about implementation challenges and success as it relates to advancing food and nutritional security in the Medicare population. I'm pleased to welcome Dr. Agrawal, Chief Health Officer who oversees Anthem's enterprise whole health strategy, including medical policy and clinical quality, as well as the company's industry-leading work to address health-related social needs. He also leads Anthem's community health work and the Anthem Foundation. [00:34:20]

We also have Dr. Renda, Vice President of Bold Goal and population health strategy at Humana where he leads Humana's vision to improve the health of the people and communities Humana serves by addressing social needs and making it easy for people to achieve their best health. And we are also joined by Leah Brucchieri, leader of Medicare Advantage special programs at Humana where she designs new and innovative benefits to address social determinants of health, close gaps in care, slow the progression of disease, and help seniors live their best lives while keeping healthcare affordable. [00:34:59]

Want to take a moment to thank all of our panelists for joining us today. [00:35:01]

ANDREW RENDA:
Thanks for having us.

SHANTANU AGRAWAL:
Thank you.

MD:
We have about 30 minutes together today to cover a lot of ground. Most questions will be relevant, I'd say, to both MAOs, so we'll be sure to provide plenty of time for all of you to speak to the exciting work being done at your organizations. But perhaps with this first question, let's start with Humana. And if you could tell us a little about your food and nutritional benefits, including those offered under the VBID model, and if possible, tell us a bit about how you chose those benefits, and if you target your benefits to a specific population or used any of the SES targeting that that we chatted about. [00:36:08]

A lot packed in there, but hopefully we can get started with this intro question. [00:36:14]

ANDREW RENDA:
Yeah, Michael, I'll maybe start and then pass off to Leah. And I just wanted to say, first, just to put context around this, I think Humana's been working in the food insecurity space probably for five or six years now. So it's really important that we spend a ton of time serving our members using validated screening instruments, working on data analytics, predictive models, and we have an innovation pipeline. So a lot of those sort of test and learn things, when they are successful, then we can think about putting them into supplemental benefits. [00:36:44]

For example, we screened last year 100,000 of our MA members and found that the prevalence of food insecurity was 26 percent. So that's pretty high, and just to put a quick plug in, Monday, April 4, we have a *Health Affairs* article[1] coming out that actually talks about the prevalence of a variety of social needs in an MA population, and it has health equity views which are disaggregated by race and ethnicity. And Dr. Seligman was absolutely right. There are significant disparities between different groups. So have a look at that when it comes out next week. [00:37:17]

But we use that as actionable insight to develop these strategies and test these solutions. And, so now that we've done that, I think VBID is a fantastic opportunity to test, whether it's groceries or meals. And then I'll pass it to Leah to talk specifically about what we've done in the VBID space. [00:37:35]

LEAH BRUCCHIERI:
Absolutely. Thanks, Dr. Renda. So from a Humana perspective, we've really focused on providing a grocery benefit to date. It's structured as a directed spending card with amounts ranging from $25 to $100 monthly. They can be used to purchase food and beverages. We did elect to offer this to our LIS members only, specifically in our DSNIPs, due to the high prevalence of food insecurity and financial strain within that cohort. We also found or thought it was very important, as we looked at the benefit design, to mirror SNAP because we recognize that many of the members that we're targeting, based on their LIS status, also have SNAP benefits. [00:38:28]

And so we knew that creating confusion at the checkout line, you know, what program covers what item and really making that a program division would likely be a terrible experience. So we aligned with SNAP to make sure that if the benefit was easy for members to understand and easy for them to use as they use their traditional funds to really stretch their monthly food budget. [00:39:04]

MD:
Thanks. That's a great overview and I think helpful context setting as we dive a little deeper into some of these. I'll ask the same question now to Dr. Agrawal. On the Anthem side, talk about just orienting us to the food and nutritional benefits available at your organization and provide a bit of background there as well as on target populations.

[1] https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01547

SHANTANU AGRAWAL:
Yeah, thanks very much for the opportunity to be here and to be on this panel. And I think I really want to reflect a lot of what the other panelists have already said in terms of trying to take a really comprehensive approach to food. And I do think we're really following a pathway that Dr. Seligman pointed out as well. So we really provide food benefits as comprehensively as possible to three different populations: to our members across all lines of business; to communities writ large through our foundation primarily; and then third is to our own associates, our employees. [00:39:04]

And so I'll tell you a little bit about each of those programs because I do think that they're at various stages of evolution, and we're using each of those broad groups to learn more about what works when it comes to food. So on the member side, both in and out of VBID, we are providing three main programs. We have healthy food, which focuses on home delivery of tailored meals; healthy pantry which is shelf-stable pantry items, also coupled with nutrition counseling; and then healthy grocery, which is more of the grocery model with a card that Leah pointed out. [00:40:40]

We take a really similar approach there in terms of providing a monthly stipend essentially for members to be able to take advantage of. Now, you really teed up VBID well and what it allows us to do, so we're really trying to optimize our approach and VBID. Then at the same time, both healthy food and healthy pantry, we bring through the SSBCI benefit, primarily to kind of chronic disease populations. So that's sort of on the member-facing side. Through the foundation, over the last several years we have focused primarily on food insecurity. [00:41:16]

And I do want to reflect as well that Anthem's been focusing on food for a number of years. The foundation's work, we are now pivoting from addressing basic food insecurity to really thinking about food as a medical intervention almost. And so we are working with a host of nonprofit and CBO partners in order to do not only food screening but kind of health risk screening, provide food as an intervention, and follow people longitudinally over time. And because this is from our foundation, it really is to address community-level factors. [00:41:47]

It's not only focused on our members. And then finally, we've been on a journey for probably three years now really looking at food issues among our own associates. We have now surveyed our own associates. We have 90,000 associates inside Anthem. We've surveyed them for food insecurity, and where we found food insecurity we actually created what we're calling a life-essential kit. It actually is addressing health-related social needs a little bit broader than food. [00:42:18]

We evaluated our associates for a wide variety of needs, found that food, transportation, and caregiver support were actually the highest priorities for our own associates, and we created a life-essential kit around each of those. Food actually had the greatest uptake among the associates that qualified. And that really is a food benefit in the form of a grocery card, much like our healthy grocery program. Because these are our associates, we're actually able to track the impacts much more closely and have been able to use

both a survey instrument as well as other claims data to see what the impact of that food program is. [00:42:57]

Again, a multifaceted approach. Different places in terms of their evolution, but we want to see not only food insecurity being measured and addressed, but then hopefully over time we'll see the impacts on health. [00:43:12]

MD:
Great. Yeah, and I think we'll certainly come back to this measurement piece a little bit later in today's discussion, so definitely want to follow up on that in a bit. But maybe perhaps first, Dr. Agrawal, we can transition a bit to challenges. So I know you mentioned a number of benefits. But perhaps you could speak a little bit to what were some of the challenges you faced while implementing those? And then what have you done or do you plan to do to address those? And I think of challenges like scalability for some of these programs or building out a network, and of course many others, but perhaps you can speak a bit to that.

SA:
Sure. So there are a host of challenges, and I'll try to cover what I can. So first, of course, I think it's important to note that even though there are programs that address food insecurity or food as medicine both in and out of VBID, that for most of our members and associates who have health-related social needs, they don't have these needs in isolation. And so I think both we can do a better job but also the flexibility and benefit design can allow us to string together more interventions for a wide variety of social needs. [00:44:27]

It's great to be able to address somebody's food need, but if we're not addressing their transportation needs, then they may not be able to get to a medical intervention any better than not addressing any of their social needs at all. So we've got to be able to link social needs, assessment, and intervention more with each other. And I think flexibility in benefit design can better allow us to do that. I think second is actually just assessing people for social needs. So we were able to leverage a survey of all of our associates. [00:45:01]

That got us the opportunity to learn from 90,000 people. We have 45 million members across all of the different lines of business. And so to be able to assess their social needs at scale is actually quite a challenge. And, there's a wide variety of approaches. We're trying to do that directly. We're trying to work with providers and other partners to get that information as well, but it is not trivial, obviously. Third, there are operational barriers. So, one data point that certainly we focus on is when you look at our healthy grocery program, which again provides a card with a set amount of money for a member to use in a grocery store, we find that 60 percent of members who qualify actually use the benefit. [00:45:44]

Now, when they use the benefit, they tend to use it completely. But we still have members who are not using the benefit, and that to me points out a host of operational

kind of logistical issues that we have to address in order to optimize even the benefits that we offer. This means working closely with members, working with the grocery stores, working with providers to make sure that members are aware and actually able to use that benefit. And finally, there are data sharing challenges as well. [00:46:10]

Right, so when you think about working with partners, being able to identify for them members that require a social needs screening or might benefit from an intervention, we have to be able to share data in a HIPAA-compliant way. And this is not a screed against HIPAA. It just implies that whether it's community-based organizations, grocery stores, or whatever, we've got to be able to share it in a way that meets that requirement. And that's also not a trivial barrier for many of our partners. And then ideally, for the purposes of measuring impact, we've got to be able to get data back from them, and again, do it in a secure and ideally seamless manner. [00:46:10]

So again, a wide variety of issues, but those are the kinds of things that I think we're learning as we implement these different programs. [00:46:51]

MD:
Great. Thanks so much. And then, Andrew, Leah, any thoughts on challenges on your end?

LB:
Absolutely. So the two that first come to mind for me really are really around accessibility. From a Humana perspective, we did start with that grocery card model initially. But what we found very quickly was that because we're operating in, I think, twenty states, as of a year or two, and even more today, that we were seeing more and more members who didn't have access to an in-network retailer. And of course, that creates a huge, huge challenge because we can want all of these innovative benefits, and add them to our plans, but if the infrastructure isn't there, if the access isn't there, the availability of the benefit, it doesn't benefit the member from a health perspective. [00:47:52]

One of the first things we did was actually look at enabling home delivery options as part of that grocery card benefit. So in addition to going to the store and purchasing in-person, having that in-person retail experience, we have online experience as well. The other thing that really comes into that accessibility equation is the ability to support differing levels of ability and access when it comes to home food prep within the community. And this goes back to some of the comments that Dr. Seligman made. [00:48:30]

You very quickly had to figure out how to vary solutions from home-delivered meals to vegetables and fruit that are pre-washed and pre-cut to ensure that beneficiaries who might have limited access, let's say, to a stove or an oven, could utilize the benefit and reap the health outcomes reward. We also had to ensure that the food that was available, and especially in the forms of pre-washed and pre-cut, was available to members with different levels of dexterity and ability just to navigate in the kitchen from a physical

perspective. [00:49:16]

And those were not simple challenges, as you can imagine, to address. But we have found that if you take that holistic approach with the type of benefits that we're talking about here today related to food insecurity, you can create significant impact when it comes to engagement. I think at our latest results we're at 85 percent utilization, and then of the members who are engaging with the program, they are using the vast majority of the benefit, month over month. [00:49:58]

AR:
Everything you said I agree with, but, another related challenge is that we need to be able to offer choice and good choices. And by that I mean you can take different sort of approaches to that, but I mean good choices in terms of nutrition, right. So in some cases people need low salt. They need low sugar. They need low carb, whatever it is, so we need to have flexibility and choice there. I think also increasingly we're recognizing that we need culturally sensitive, culturally specific type meals as well, so depending on who the person is, where they live in the country, they may want different types of food. [00:49:58]

And if we don't give that to them, then they're not going to benefit from the nutritional value of what we're offering, so just something else to kind of think about is good choices that meet the needs of the people we're trying to serve. [00:50:52]

MD:
Great. So I know, Leah, you mentioned a bit about utilization, and I'm curious, how does Humana plan to measure success for this benefit? So obviously there is utilization. I think there's a set of quality measures out there that may be more so emerging, and then there's other success metrics. Could you talk a little bit about how you think about measurement and then also, as you do answer that, maybe think about kind of the timeframe with which you're measuring impact, because I know that can sometimes be a challenge and was something that Dr. Seligman referenced as well.

LB:
Absolutely, and I'm actually going to phone a friend. Over to Dr. Renda.

AR:
Oh, yeah, well, I was going to say therein lies the rub, right. The timeline is the really important thing, and that's where leading indicators become just as important, if not more so than lagging indicators. So sort of writ large, our approach is similar, actually, to the VBID health equity business case that was shown at the very beginning of this webinar. We think about metrics in different categories. I would start with operational metrics. So are we executing on what we're trying to do? Are we delivering a service? [00:52:04]

Is it meeting needs? Is there a good experience around it? That kind of thing. Then we think about behavior change. So are people accepting the meals? Are they changing their behavior in a positive way that's going to influence their health? That's maybe the

second category. Then I get into the leading indicators, and those are the clinical and quality-type metrics that we look at. So Michael, you mentioned some draft measures and things that are coming out. We're watching them very closely. [00:52:31]

But actually looking at screening and intervening to address social needs is something that we monitor really closely. So when we can see through these solutions, as a sort of proximal outcome measure, we're looking at, are people more adherent to medications? Are they accessing care, seeing their primary care doctors? Are they doing these things to meet other quality measures, other clinical leading indicators? So that gives us an indication that they're moving in the right direction. They're doing the right thing for their health that we believe are going to lead to the health outcomes. [00:53:02]

And then the final category is those outcomes themselves, and those are health outcomes - are we preventing disease? Are we stabilizing chronic conditions, as well as the utilization and cost side? We want to see: is acute utilization reducing? They're not going to the ER, they're not going to the hospital, that type of thing. Then we look at a total cost of care. So broadly, it's those four buckets, and like I said, it's very similar to that business case model for VBID that was shown in the very beginning. [00:53:28]

LB:
And I would say, while it's too early to really talk about results yet because we're in the midst of a global pandemic and nothing has been standard for the past couple of years, we do hear directly from members exactly how important this type of benefit is to them. I mean, especially, when we do member call listening, and you can hear the emotional response. You know that food insecurity is having a huge impact, not only on physical health but on their mental health as well. [00:54:06]

We know today that we are eliminating or minimizing that stress point, and that's going to absolutely payoff in the behavior health space, from an anxiety and depression perspective by supporting agency, too, Michael, as you mentioned. Not only eliminate or helping address the financial strain but supporting their agency and ability to self-direct. [00:54:34]

AR:
And just one other thing really quick, and then I promise I'll be quiet. I think on the positive side we've had really good uptake. We've had very, very high use in the plans where we've deployed this benefit. So as a leading indicator, that indicates that we are in fact offering something that's desirable and that people are using it. So that's a good sign. On the challenge side, I'll say, when we're trying to measure outcomes, it becomes a challenge for us when, for example, with us, we've offered this VBID benefit on a vast majority of our DSNIP plans. [00:55:05]

When you do that, in order to measure outcomes, you got to have a good control group. We don't have a good control group anymore. So when it comes to actually matching against control population, we either have a synthetic one, or we're using non-DSNIP population, and so there's inherent challenges in actually demonstrating causative

outcomes of the intervention that we're trying to measure. [00:55:26]

MD:
That's very helpful. And then so I'll transition over then to Dr. Agrawal on the Anthem side. Same question around success measures. Maybe to give it just a slightly different flavor, I know you talked a bit about that you can do with your own associates versus kind of the general population. Maybe if you could highlight any success measures that you're focusing on, but any limitations when you think about, are you collecting data through the providers, through the organization itself, through the community-based organizations, and just anything around that maybe would be helpful to add a little bit to the discussion.

SA:
Yeah, thanks. I think in terms of success metrics we're looking at a lot of the same things that Andrew and Leah have talked about. Right, so the early indicators, just the uptake, the effects on mental wellbeing, on financial security, and ultimately sort of on health outcomes. A lot of our member-facing work that I described is too early to really get to the ultimate health outcomes at this point, but we are tracking uptake. We're tracking utilization, for example, of the grocery cards, and then what those benefits are being spent on. [00:56:42]

I think the great thing on the member side is that we have a wide variety of sort of different kinds of interventions in play, right. So some are home-delivered meals. Others are home-delivered items with nutrition counseling and then grocery cards. So that's a wide variety of approaches that I think over time, as we see it play out, we'll be able to hopefully see those early indicators and the lagging indicators and figure out really what works. On the foundation side, for members, we can obviously get a lot of that data directly, and we can work with providers where necessary, particularly on the health outcomes data. [00:57:17]

We want to see certain of those care gaps close, like a hemoglobin A1C, for example, and that's data that we're going to get from a provider. On the foundation side, what we really pivoted to, because it's moved from food insecurity to food is medicine, we really encouraged our nonprofit and CBO partners to work with providers in order to be able to do the health risk assessment of it, in order to be able to collect health data. That work is very new. I mean, we've really done that pivot this year. We have a commitment to making $30 million worth of grants over the next three years, and the first set of grants have already gone out. [00:57:51]

On the associate side, that's actually where we've gotten the most experience so far. So it's been a couple of years of getting experience, same set of success metrics. What we have found is significant uptake of the benefit. I think to Leah's point earlier, we absolutely have found associates that reported increased mental wellbeing just by having access to the benefit. We found them reporting increased financial security because we've essentially freed up some of their income to be used in other areas. [00:58:23]

And it's been long enough now where we've actually started to see health benefits. So the associates that take advantage of this, and we actually do have a control group, again, because more of it is just sort, I guess, under our control, or we can exercise oversight of it. Compared to control, they are more likely to see an outpatient provider, less likely to go to the ER and be admitted. And so I mean, that's, I think, tremendous promise, right, that if we let this run long enough, and in this case it's been over a year, sort of beginning to now, we are really starting to see those really incredible health outcomes. [00:58:55]

And this is data that we want to be publicly transparent about. We're actually looking to publish it because I think it will be a model not just for our member-facing work, but we help the industry as well. [00:59:05]

MD:
Great. And one thing I know you've mentioned today is a bit about thinking about more so a portfolio of benefits and beyond just food as one social need. Could you talk a little bit more on that and what other social determinants of health or social-needs-related benefits do you think would be good to be paired with food benefits? Or maybe said differently, when you think about that portfolio, what are you thinking about on the Anthem side?

SA:
Yeah, that's a really important question. Thank you. So I do think it's important to assess social needs more broadly, right. So like other organizations, we have adopted the PRAPARE tool [Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences] as sort of our consistently-implementable screening internally, and the goal is to be able to get that screening at every possible venue, right. So there's no wrong door for the member. So if there's a case manager talking to the manager, they'd be able to conduct a screening. We would be able to leverage our community health workers in order to be able to conduct a screening. [01:00:11]

Providers could conduct it. We actually do have a provider-facing incentive program to incentivize them to conduct a screening. Once that happens, of course, we want to be able to connect members to social resources, whether it's directly through our own benefit design or through community-based organizations or the broader social safety net. We know there's a big gap, particularly in Medicaid. Actually, as was pointed out earlier, between those members that are in Medicaid but yet have not applied for or qualified for SNAP. [01:00:39]

So those are the kinds of discrepancies we need to narrow in order to make sure the member is getting sort of the optimal services that they need and deserve. So we do have both digital and nondigital ways of connecting our members to social and community-based resources, and again, are really looking to scale that so that it is available across all of our lines of business. I think it's that kind of approach that needs to be taken, right. It's comprehensive, understanding, and screening, and then getting resources matched to the member that is going to ultimately produce outcomes. [01:01:10]

If you tried to do one in isolation, you, frankly, would not see outcomes. You may not see return on investment because there will be another social barrier standing in the way. And so I think it's important to try to string as many of these together as possible. [01:01:24]

MD:
That's super helpful, and I think also speaks to the currents of a lot of things, social needs. And then I'll ask the same question to Humana. How do you think about a portfolio of benefits that address social determinants of health and pairing or thinking about what may complement some of the existing food and nutrition benefits that you're rolling out?

AR:
Yes, Michael, I'll start. I mean, we take a similar approach, I think, to what Dr. Agrawal described. We used the Accountable Health Communities comprehensive screener, but similar to PRAPARE, and then it assesses across multiple different domains. And then I think you have to take a portfolio approach because in some cases you're going to offer point solutions that are program, services, benefits in some cases, and other cases it's most appropriate to refer into a community-based resource. And we have community resource directories that we leverage to offer that. [01:02:23]

We have to be careful there that we're not sucking too much capacity out of those CBOs [Community-Based Organizations] in the communities themselves. But it's a mechanism certainly that we can use. But I think, again, bigger picture around that, and it's true for food specifically, is that we think about what are the root causes of the root causes? So in the case of what we're talking about here, food insecurity, why are they food insecure? Is it an access issue? Is it an affordability issue? We have to sort of understand what that looks like because the solution may look different. And so we have to take the portfolio approach there as well. [01:02:54]

In some cases, we want to bring food to a person: send them meals, send them groceries, or whatever it is. In other cases, we want to offer a grocery benefit where they can get there. In some cases, transportation may be the root cause, so we need to supply that so they can get to the grocery. And so we just have to understand the root cause of the root cause, and that helps inform what the solution looks like and what the next best action for that member is. Leah, would you add anything to that? [01:03:19]

LB:
I completely agree. And it's, I think, incredibly interesting when you look at the results of screeners and see the difference between the population that identifies, let's say, as experiencing financial strain versus food insecurity. You will see very different numbers, and yet you would expect, if you're experiencing financial strain you're also experiencing food insecurity. And so it's important to recognize that and understand it because to the member, they might not necessarily believe they're experiencing food insecurity. [01:03:59]

And so we have to take that comprehensive approach and make sure that we're meeting the needs, but, yes, the members have identified but also supporting healthy decisions from a complete care perspective. [01:04:14]

MD:
Great. And now we have about five minutes left, so I'll just go ahead and move to the last, kind of close-out question. But so I'd say if there's one thing you could share with another MAO looking to implement food and nutritional benefit to help them ensure success in that benefit, what would be that one thing you would share? We can start with Humana on this one.

LB:
I think for me, what's been so interesting, because I actually started in this role around the time we launched this benefit. So I've been with it from the beginning. And one of the things we've seen throughout the life cycle is that the cost of food has increased exponentially, month over month, year over year. In the three months into the COVID-19 pandemic, we saw that overall the consumer price index for the cost of food at home had raised 5.8 percent with significant increases in poultry and in meat and eggs. [01:03:59]

And that continued to increase year over year. I think the latest stat is 8.6 percent in the last 12 month with a 16.8 percent change in the beef index, for example. So we know that while these interventions are helping, there are also other forces at play that might be diminishing the buying power, for example. And so, just like you think about medical trends, just like you think about the cost of care increasing, think about the cost of food increasing and how that plays into your benefit design because we will continue to see those prices rise and diminish, I think, the impact of what's being offered today. [01:06:26]

MD:
Okay, thank you. And then now, Dr. Agrawal, a word of advice for any MAOs looking to take their benefits to the next level or get started in this space?

SA:
Yeah. So I think the addressing the whole health of a person really demands understanding and addressing their social needs. And taking a portfolio approach, as we've been talking about on the panels, it's not just sort of one need or another. I do think we often associate social needs with low-socioeconomic status individuals. But let's be frank, everybody's got a social need. And so it is incumbent on us, I think, as an accountable entity for a person's health, to figure out what their needs are and get them addressed. [01:07:14]

And so if there's one piece of advice I have to my colleagues in the industry, it's this area, assessing and addressing needs, social needs, is completely business aligned. And if they have a challenging time making that argument internally, come talk to, I think, probably any one of us, and we can help them think through that. Because the fact is you

can either address the social need up front, or you can address all of the chronic illnesses, all of the unnecessary healthcare utilization on the back end, and frankly, that's clearly worse for us. [01:07:46]
It is clearly worse for the member. And they will question their relationship with you, the plan, if you are not making them healthy on the front end. [01:07:46]

MD:
That's a fantastic point to end on. And I want to thank all the panelists so much for your time. We really appreciate it. Some really impressive, really great work going on. And with that now, I'll hand it over to Abigale Sanft, who is our VBID Model co-lead. And she'll take over the presentation from here.

ABIGALE SANFT:
Thank you so much, Michael. Thank you to all of our panelists for that incredible discussion. I'm so excited to be joined by Dr. Seth Berkowitz. Dr. Berkowitz is an Assistant Professor of Medicine in the Division of General Medicine in Clinical Epidemiology at the University of North Carolina School of Medicine. His research involves population management, food insecurity, and cost-related medication underuse, among other areas. And in particular, he looks at interventions that address social and economic needs as a part of chronic disease management. [01:09:08]

Dr. Berkowitz, let's start with discussing the focus of some of your research, which has been around tying food interventions to health outcomes and medical cost savings. Many of the food interventions that we've seen and we've been talking about have been executed in pilot programs. Can you talk a little bit about the current data linking food interventions to health outcomes and cost savings and how a Medicare Advantage Organization, or MAO, could begin to collect some of the data for these programs? [01:09:35]

SETH BERKOWITZ:
Sure, yeah. So I think it's a great question, and I mean, I think we've gotten just a fantastic, very practical lesson in how organizations might do that from the last panelists, who I think are really clearly national leaders in doing this. I think you're right. I think there's been a trajectory in how this has gone. Things started with moving from "general poverty is bad for you" to sort of specific aspects of financial strain or health-related social needs, like food insecurity being associated with poor health outcomes in epidemiologic studies and from that, generating interest in interventions to address food insecurity and then seeing what the impacts on health or healthcare use or healthcare cost might be related to that. [01:10:24]

As with many fields, these kind of started with smaller pilot studies with a plan for them to progress into larger scale and more rigorous designs. We're, I think, in a very exciting time right now in that there have been a number of pilots that have had promising results, and that has spurred these larger-scale studies. But we're also in a relatively early phase in the sense that a lot of the larger full-scale trials have not yet been finished. I'm aware of multiple NIH- funded trials across different types of food-insecurity interventions in

different clinical conditions that are currently ongoing. [01:11:00]

Obviously there are many more interventions being conducted by either health insurers or plans or various healthcare organizations with foundation funding or with other funding sources, and so we're really in a time period where we're learning a lot right now, but I think it's fair to say that the evidence isn't fully settled on what the best interventional approaches are, what the full impacts, if any, of the interventions are on either health outcomes or health utilization or healthcare cost. And so while sort of a promising area, I think it's one that is kind of still developing. [01:11:38]

AS:
Yeah, yeah, I think that makes a lot of sense. I think that's part of the reason we're seeing so much increased interest in this area as well. Do you have any suggestions in terms of, like, what data collection would be important if MAOs want to begin to evaluate some of these benefits? You know, thinking about, maybe, beneficiary-level utilization, and nutrition information on the food that's actually being purchased with the food card, anything of that nature?

SB:
Yeah, so I think there are a couple considerations here. Fundamentally, I think the key is thinking about what you want to do with the information and why it's worth collecting because any type of evaluation, no matter how light touch, has a cost, both in financial terms and then as an opportunity cost for other things you could be doing. And so it's important to make sure that the information you're going to get out of the evaluation is something that's worthwhile. If we were in a situation where there were a number of, say, really well-established, well-validated interventions, we just know in general this type of intervention works in this situation for this outcome, then evaluation really may not be needed. [01:12:47]

Just in general, as you don't necessarily try to reprove that statins are reducing heart attacks for people with indications, you may not reprove the benefits of these things. But as you say, because we're at sort of an earlier phase, it certainly is very reasonable to think about coupling evaluation with the programs that are being implemented. From that point though, I think it really depends on what you're trying to do. And one reason that I think addressing either food insecurity interventions or health-related social needs interventions more broadly can be complicated is just the sheer number of outcomes that are plausibly affected. [01:13:27]

If you're giving someone a blood pressure medicine, the outcome you want to look at is blood pressure, maybe subsequent cardiovascular events, but it's fairly narrow. For a food insecurity intervention, there are many possible things. It could affect, control of chronic conditions like diabetes or high blood pressure. It could affect in-patient or out-patient utilization. It could affect, mental health or health-related quality of life for patient-reported outcomes around experience of care. [01:13:52]

For example, it could affect healthcare cost, and so because you have a really wide menu

of things to choose from, it puts even more emphasis on this idea of really wanting to have a clear sense of what you use it for. At the same time, though, it's important not to be too narrow in selecting the outcomes because there are all these potential effects that it may have, and if you only look at one or two, you may miss some of the effect that it's having, and in particular if you go then to relate that in a cost-effectiveness or return on investment sense, if you only have a narrow picture of the potential benefits of the program but you have the complete picture of the cost, then that may not give you a very full assessment. [01:14:32]

I don't know that I have a general-purpose thing to say. Yes, always check these outcomes or this data in these circumstances, but more just kind of the advice of thinking carefully beforehand (as I'm sure any of these organizations would) about what information you want and why, and then that can guide you into what you want to get. But also just kind of keeping an open mind about sort of taking a broad suite of things, and in particular that often means going beyond some of the easiest sources of data. [01:15:01]

I mean, as a plan you're going to have claims, obviously, and so that's a natural thing to look at, which makes perfect sense, but you really may want to supplement that with some other things collected from surveys or qualitative evaluation or other things to get a fuller picture of the effect of the intervention. [01:15:20]

AS:
Yeah, that's really helpful. And I think we heard a little bit earlier that some of those outcomes can be kind of challenging to measure. And these interventions affect different populations differently, of course. So wondering, based on the conversation related to health disparities around access to food and nutrition, do you have any suggestions for how MAOs can establish meaningful cross-sectional data cuts to determine whether their intervention is having a differential impact on underserved populations?

SB:
Yeah, so I mean, it's obviously extremely important to look at these issues, and we do know that in general, if there is an explicit attention to these issues, we commonly see differential effects of interventions such that groups or individuals who have already experienced some injustice received less benefit from the intervention than other groups; in particular, we see this play out with racial and ethnic minorities or people with lower income levels, and many other groups across gender and other groups as well. [01:15:20]

I think having an intentionality around equity and wanting to look at that from the beginning is very important. On the other hand, it's important to sort of think carefully about how things may play out. So if the idea is that one group, because of, say, racism, for example, is in a worse starting position on average than another group, then in some ways it may be expected that the same intensity of intervention gets people not as far, doesn't produce the same impact. [01:17:08]

And so I think recognizing that having a clear sense of not just the fact that there's

injustice out there and we need to look at it, but really thinking about how that might impact the intervention - whether we might need to modify the intervention in particular ways to achieve more desired goals or those things is really important. At a minimum, I think monitoring for differential impacts makes sense, but going beyond that, I think it may be worth some upfront planning about the ways that particular types of injustice can lead to differential impacts and possibly try to preempt those as part of program design. [01:17:46]

AS:
Yeah. That's very helpful. And I guess maybe along those same lines, in terms of thinking about pre-planning, are there any challenges that you would perceive when plans are moving forward with their data collection and evaluation? For example, if they're coordinating among multiple retail vendors (which is a little bit of what we heard earlier) or community-based organizations being thrown into the mix as well?

SB:
Yeah, I think these can come up a lot. There is probably no end to the number of challenges that might come up. I'll say just some that I've heard about in my experience. So data sharing across multiple organizations is always challenging. I think what you might think of as the "resources landscape", so how people can make use of the resources that are provided or if your intervention is more about connecting people to existing resources rather than providing resources yourself, being very clear about what that is. [01:18:51]

If you're going to, say, refer someone to a food pantry - does that food pantry have capacity? What foods are on offer? Et cetera. So thinking carefully about that. So those, that kind of data sharing and coordination amongst multiple parties and thinking about the research landscape are two to, I think, really pay attention to. And then I think probably a third one, again, comes up when you want to move beyond the sources of data that we're maybe most comfortable with in health services research. [01:19:26]

Again, claims is probably the most straight-forward source of information to use, but it paints a more narrow picture than other sources, and so if you're an organization that, isn't as familiar with not just collecting data informed with surveys but actually really [and] doing that in a way that's representative. So how can you do either random sampling or stratified random sampling or other things to really get a representative picture of the people receiving the interventions, not just the people who happen to respond? [01:19:59]

Or how do you deal with rates of nonresponse and things like that when you're used to having pretty complete data from claims and other things? That can be another issue as well. [01:20:10]

AS:
Yeah. That's a really helpful answer. And of course, you know, you can't account for every challenge that's going to come up, but having some of those in mind at the start is

also sometimes helpful. Is there anything that you think, based on what you heard today, that we're leaving out of the conversation that you'd like to make sure to emphasize? So maybe, for example, about particular indicators of where the attention gaps might exist or publicly-available data sources that plans might be able to leverage or innovations in the space that are likely to emerge?

SB:
Yeah, well, I was saying, first off, I actually was very pleased to hear just sort of how comprehensive I think a lot of the efforts to-date have been. I think people, when [dealing with] this kind of field (or at least when I started getting into this field, five or 10 years ago) focus was almost solely on cost. And I think people have really taken a much broader view, and we heard that again and again by the panelists that this is really about taking care of people as people, looking at a broad range of potential outcomes, including things like net promoter rating, star ratings, things that really deal with the experience of care in addition to just cost of care, utilization of care and things like that. [01:21:33]

I think that's all really positive. Things to think about, so, just because you mentioned this, because of the rise of sort of area-level data, so being able to find areas that are more deprived within a given geography or things like that, there is probably increasing ability to identify those areas and potentially some desire to try to target interventions in those areas or those things. I'm of two minds about this: On one hand I think it might be much more efficient than trying to administer the Hunger Vital Sign to 100,000 people or 40 million people across a number of lines of business or whatever else. [01:22:18]

In that sense, you can see the efficiency gains. On the other hand though, just in my own work (and I think this has been noted in organizations doing this work as well), it's very common to find people who themselves are having difficulties but live in areas that might not be flagged in this way or come from sociodemographic backgrounds that you wouldn't necessarily expect to see high rates of food insecurity in or other things. And so I do always worry about the potential for sort of over-tailoring or over-targeting in our goal of trying to be efficient, possibly missing some people who really need assistance. [01:22:54]

I think there is an ongoing tension there that'll only continue to increase as our ability to be technically sophisticated about targeting increases, but it may really outstrip how much the knowledge that it's based on can tell us. [01:23:09]

AS:
Well, thank you. We really appreciated your willingness to lend your expertise to our discussion today. And now I will turn things over to Sibel.

SB:
Great. Thank you.

SO:
Thanks so much, Abigale. And so now we're approaching the end of our session. I want

to reiterate that through this webinar and future learning sessions, as part of the Health Equity Incubation Program, we hope to develop an ongoing forum for MAOs to innovate around health equity, social needs, and social determinants of health. Not only does the VBID Model provide a unique toolset for health equity innovation, but this model will provide a forum, an ongoing forum, for solving problems and challenges related to advancing health equity within the Medicare Advantage space. [01:24:00]

With that, we have about five minutes left, and so we'll open up the floor for any questions that have been submitted in the Q and A box. So far, I don't see any questions yet, but we do see some resources that folks have shared with us that we'll pass along to the group as a post-webinar deliverable. We'll just wait and see if there are any questions. [01:24:34]

LM:
Sibel, while we're waiting for questions, I can jump in here and just talk about the incredible technical assistance that I see the VBID Team provide the VBID plans across the spectrum from, policy questions and operational issues. So I would only imagine that that's going to continue while we focus more squarely on health equity issues and addressing the health disparity spectrum. And yeah, so just wanted to make sure people are aware that we get that when we're shifting focus and challenging plans to come in with new and different approaches that questions will come up, operational issues, and we stand ready to help people. [01:25:34]

And the discussion today, just incredible. Really appreciate all of the expertise and information shared by Anthem and Humana and our experts in the field. Really appreciate it. And maybe also a call out to Michael de la Guardia, our superstar intern. He's going to be wrapping up his time with us. We've kept him as long as we could. And he's done just an amazing job in pushing forward the health equity discussion and helping us conceptualize the Health Equity Incubation Program. And we wish him the best and know he will go on to do many great things. [01:26:21]

So do we have questions coming in? Let's see. [01:26:26]

SO:
Yeah, I think I see a few things, a couple of thank-yous to our wonderful panelists. There's a question about Hunger Vital Signs program and the MA population. I don't know if any of our experts on the line know more about that program. [01:26:50]

HS:
I don't know it specifically, but I'll put another resource into the chat box that allows you to see our state and local estimates of healthcare costs associated with food insecurity. It doesn't give you Hunger Vital Sign estimates of food insecurity at the state level, but it does give you a food insecurity prevalence estimate and again, an estimate of healthcare costs.

SO:

Thank you so much, Dr. Seligman. Okay. Well, I know we're almost at time. We just want to thank again the panelists, the incredible panelists that have joined us today. As next steps, we hope you'll be able to participate in an upcoming Health Equity Incubation session. We'll be hosting another session in June, and our focus there will be on diabetes and addressing diabetes from a holistic perspective. And lastly, please be sure to fill out the post-event survey where we ask feedback on which health equity topics your organization is most interested in. [01:27:50]

And that survey will directly inform what we cover in our next Health Equity Incubation session. Thanks so much. [01:28:14]