Health Equity Innovation Program 3: Leveraging VBID to Improve Equity in Transportation Access Webinar Transcript

Thursday, September 15, 2022

John Cialek:
Thank you for joining. Now I'm going to pass to Abigale to start us off.

Abigale Sanft:
Thank you. Hello everyone, and good afternoon. My name is Abigale Sanft, and I am one of the co-leads of the Value Based Insurance Design, or VBID Model. We are so excited to have our distinguished speakers and all of you on the line with us today. [00:00:38]

So, before we begin to the content of today's presentation, I want to put out a disclaimer that our goal here today is really for educational purposes and general information as noted on the slide. [00:00:59]

We have an exciting and ambitious agenda in which you will be hearing from both experts in transportation access, and MAOs that are paving the way with new initiatives further enrolling space and transportation barriers through their VBID interventions and beyond. We will have two separate Q&A sessions, both with our national experts in transportation, and our participating MAOs. So, please submit your questions through the WebEx Q&A feature. And, as you may know, the Center for Medicare and Medication Innovation, or CMMI, recently completed a refresh of its core strategy, putting health equity at the center of everything that we do. I'm especially pleased to be able to join you all for this webinar focused on improving equity and access for Medicare beneficiaries that are facing transportation barriers. We see health disparities as a key dimension of quality and reducing disparities as a core strategy for improving healthcare quality and outcomes for beneficiaries. [00:02:01]

Another dimension of CMMI's go-forward strategy is accelerating the transition to value-based care, and the value-based insurance design, or VBID Model, provides an opportunity to do just that, with its focus on targeting benefits, rewards, and incentives, where they can produce even more value, especially to those enrollees with chronic health and social needs, like food insecurity, housing and utilities assistance, and transportation within the Medicare Advantage space. [00:02:33]

So before getting into some of the facts on transportation access in the US, we want to quickly go over what we're defining as transportation in this presentation, and what a transportation barrier is. Because access to both medical transportation and non-medical transportation can have an impact on health outcomes, we're going to be including both here when we talk about transportation. There is a lot of separate research on both types of transportation, and benefits related to both will be different. But, we think it would be unwise to not include either one in this discussion around transportation access. [00:03:10]

Medical transportation in this presentation will be centered around non-emergency medical transportation, rather than emergency medical transportation. Examples of non-emergency medical transportation would include rides to physician office visits or to pharmacies. Transportation barriers are any barriers that may lead to negative health outcomes that stem from a lack of transportation access. These barriers can include a number of factors, such as lack of access to a car, or public transportation, mobility limitations, finances, geography and distances to a provider, and many others. We will be talking more about how stakeholders can leverage VBID flexibilities to target some of these barriers later on in the presentation. [00:03:58]

To highlight how impactful transportation barriers can be to beneficiaries, and the problem with all transportation barriers, we wanted to take a few moments to review the data and some of the compelling reasons why we see that focusing on improving transportation access within VBID is a lynchpin of value and quality. [00:04:19]

So according to data from the National Health Interview Survey, in 2017 alone, 5.8 million Americans delayed medical care because they did not have transportation. And these Americans are disproportionately low-income and have chronic conditions. Additionally, transportation barriers are responsible for 25% or more of missed clinic appointments. These delays in medical care and missed clinic appointments can often lead to negative health outcomes. According to McKinsey's Consumer Social Determinants of Health Survey, Americans with unmet transportation needs are 2.6 times more likely to report multiple emergency room visits in a given year compared with those with adequate access to transportation. [00:05:10]

You've heard some of this from us before if you've attended our previous webinars, but the Health Equity Incubation Program is the learning and decision arm of the VBID Model. And the program is designed to focus engagement and learning on the highest beneficiary impact areas, and to do this in partnership with MAOs participating in the VBID Model, and more broadly with CMS and our external stakeholders you'll hear from today. With the increasing proportion of Medicare beneficiaries electing to enroll in MA plans, these partnerships with MAO leaders in value-based care are essential to accelerating the broad transformation to value-based care. [00:05:55]

To further discuss the current state of transportation access in America, an evidence-based strategy for improving transportation access, I'm going to turn it over to Lori Gerhard with the Association for Community Living, or ACL, where she will lead a discussion with a group of national experts in some of our federal partners on what is currently being done to reduce barriers.

Lori Gerhard:
Thank you, Abigale, for that kind introduction. Good afternoon, everyone, my name is Lori Gerhard, and I'm the Director of the Office of Interagency Innovations at the US Administration for Community Living, or ACL. We're honored to join the Centers for Medicare and Medicaid Services, the Center for Medicare and Medicaid Innovation, and the Federal Transit Administration, or FTA, along with our community partners from Massachusetts and Pennsylvania to share information about transportation partnerships and opportunities. [00:07:00]

Our agenda today will include an overview of federal programs, partnerships, and opportunities, followed by a panel conversation highlighting partnerships across community-based organizations, transportation providers, health plans and health systems in Massachusetts and Pennsylvania. We'll then have time for questions and answers. [00:07:24]

I'd like to introduce today's speakers. Danielle Nelson is a senior transportation analyst in the Office of Rural and Targeted Programs at the Federal Transit Administration, or FTA. Danielle manages the Coordinating Council on Access and Mobility, also known as CCAM, a federal interagency council working to simplify customer access to human services transportation by streamlining federal policy and implementing activities that incentivize coordinated delivery. Prior to joining FTA, Danielle worked at the US Department of Health and Human Services as an aging services program specialist, and before starting her federal career, she worked in a long-term care program and served as a volunteer commissioner for the Fairfax County Commission on Aging. Danielle holds a bachelor's [degree] of science in human development from Virginia Tech and a master's degree in public health in gerontology from George Mason University. [00:08:28]

Also with us today is Ms. Jennifer Raymond. Jennifer Raymond is the chief strategy officer and director of the Healthy Living Center of Excellence at AgeSpan, an area agency on aging, and aging and disability resource center in Massachusetts. Ms. Raymond is an experienced strategic thinker, coalition builder, and change leader. She's driven by the desire to create healthy communities for all. She takes pride in aligning social missions with business acumen, providing the best approaches to sustainability possible. As chief strategy officer, she builds cross-sector partnerships, creates shared alignment around a vision, and translates that vision into action. Jennifer holds a juris doctorate [degree] and a master's [degree] in business administration and has been recognized by the John A. Hartford Foundation as a national practice change leader. [00:09:21]

Also with us today is Dr. Sherry Welsh. She is the senior project manager at the Susquehanna Regional Transportation Authority, an administrator at rabbitCARES, and owner of High Climb Consulting. She was a champion for equity and inclusion access to the social determinants of health, and mobility as a fundamental right. Dr. Welsh has spent a large part of her career working in the public transportation industry through her work. She has become heavily involved in various community groups and committees focused on improving transportation services, for historically marginalized populations (specifically for families with lower income), older adults, persons with disabilities, and veterans. [00:10:06]

Dr. Welsh, through her work with rabbitCARES, seeks to secure financial resources to support transportation needs that fall outside of the traditional transportation funding stream. Dr. Welsh is an active member of Healthy York and their access and empowerment community, the Pennsylvania Public Transportation Association, Community Transportation Committee, the American Public Transportation Association Mobility Management Committee, York County's Welcoming Workplaces and various service coalitions that promote diversity, equity, inclusion, and belonging. Dr. Welsh holds bachelor's and master's [degrees] of social work from Millersville University of Pennsylvania, as well as a PhD in social work from Morgan State University in Baltimore, Maryland. [00:10:57]

Now I'd like to share some information about the Administration for Community Living, or ACL, and our role in transportation. Our mission is to make community living a reality for all people, regardless of disability or age. We envision a world where all people regardless of their age or disability live with dignity, make their own choices, and participate fully in society. We know that partnerships are key to realizing this vision, and by working together and leveraging our collective knowledge, expertise, and resources, this vision is possible. And health plans play a key role in making this vision a reality. [00:11:40]

ACL funds a nationwide network of disability and aging organizations in all fifty states and US territories. The agencies we fund are staffed by people that live in the same communities as the people they serve. They know the community and the culture. The networks serve a diverse population and have decades of experience in helping people access and receive home and community-based services, including transportation and transportation-related services. These organizations work in partnership with providers, healthcare plans, systems, and others to streamline access to services for the people we collectively serve. [00:12:19]

ACL's transportation portfolio includes Assistive Technology Act Programs, or AT programs. These programs are available in all 56 states and territories. The AT programs help people of any age with a short or long-term disability discover and learn how to use the array of assistive technology, which includes no-tech, low-tech, and high-tech assistive technology available to increase a person's independence with transportation. The Eldercare Locator and the Disability Information and Assistance Line, or DIAL, helps older adults and people with disabilities and caregivers learn about transportation resources. Transportation is the most frequent inquiry to the Elder Care Locator. Over the past 12 months, over 32,000 transportation calls were received representing about 10 percent of total calls. Since inception in June 2021, DIAL has received over 1,100 inquiries related to transportation and mobility options. The information that Abigale shared earlier is really important, and transportation is frequently asked about through these information resources. [00:13:29]

In addition, the Centers for Independent Living's State Units on Aging, Area Agencies on Aging, and Aging and Disability Resource Centers help people enroll in publicly funded programs, bring together transportation resources, obtain transportation vouchers and rides, and learn how to use public transit system through travel training programs. In fiscal year 2018, approximately 16,900 people with disabilities received some type of transportation services, such as peer-to-peer training to learn public transit systems, transportation vouchers, and other types of transportation services. Over 20 million rides were provided to older Americans, and 2.3 million rides were provided that included assistance to support the person receiving transportation. [00:14:18]

ACL and the agencies we fund work in partnership to increase the availability, accessibility, and usability of transportation services. For example, transportation is one of the most commonly offered services by community-based organizations who are contracting with health plans. Other commonly offered services include social determinants of health assessments, nutrition, care management, and more. These partnerships increase the availability of transportation by investing in transportation services available in the community. Through a grant with the

Community Transportation Association of America, CTAA, who partners with US Aging, UMass Boston, ICI and DJV Consulting, ACL, and FTA has convened 42 community partnerships of people with disabilities, older adults, and transportation providers, to develop and implement solutions to transportation challenges. Visit https://transitplanning4all.org to learn about these solutions. [00:15:33]

The Americans with Disabilities Act Participation Action Research Consortium, also known as ADA-PARC, publishes maps that assist policymakers, community leaders, transportation developers, and state leaders in understanding transportation needs and opportunities for improvement. As a result of these maps, metropolitan leaders in one community decided to invest $73 million to improve the sidewalks and aspects to the public transportation system. [00:16:07]

Now I'd like to highlight a benefit design that could be replicated to provide beneficiary services that address social determinants of health. The Veteran Directed Care Benefit is a standardized framework with self-direction and a flexible service budget. The beneficiary determines how to use the flexible budget to purchase the service and goods that meet their unique needs. The benefit design enables customization of the benefit for each beneficiary, and the unique need, circumstances, and environment. For more information about the Veteran Directed Care Benefit, visit https://www.nwd.acl.gov , and select "Veteran Directed Care" under the "Our Initiatives" tab. The US Department of Veterans Affairs has developed a case mixed rate calculator to determine the flexible service budget amounts for every area of the country. [00:17:04]

Now it gives me great pleasure to turn the session over to my colleague, Danielle Nelson, at FTA. Danielle?

Danielle Nelson:
Hi Lori, thank you. As Lori mentioned, I am the staff lead for something called the Coordinated Council on Access and Mobility, or CCAM for short. It's a federal interagency council led and chaired by the Secretary of Transportation, with participation from ten other federal departments, including HHS. It was started by an executive order in 2004, but it was written into US DoT's authorization legislation so the work would continue. And it's all about - as Lori said earlier with that kind introduction - increasing the coordination of human services transportation for the three populations you see on the screen there. [00:17:48]

I thought it'd be helpful to explain, I'm at the Federal Transit Administration, which is where the Secretary of Transportation has designated the leadership of the CCAM. So my administrator, Maria Fernandez, leads the CCAM. And who are we? FTA, our mission is to improve public transportation for America's communities. I included a little slide there that includes dots of all of our grantees across the country, our public transit grantees, and we have grantees that do everything from ferry service to commuter rail to streetcars, fixed-route, demand response, rural transit, et cetera. [00:18:25]

I thought it would be helpful to give you guys an overview of FTA's funding. I'm sure you've all heard about the bipartisan infrastructure law, and the historic investment in public transportation. In 2022, this year, our formula program grants are now $14 billion, and our

discretionary grants are $7 billion, and I just highlighted in that pie chart two programs in my office are older adults as it's written in legislation, "seniors and individuals with disabilities program", which is $421 million this year, and then our formula grants for rural areas, which is $893 million a year. And those programs go through formula to the states. [00:19:10]

The CCAM has done a program inventory, where we worked across the 11 federal departments to see which federal programs can fund transportation. So, this is a public inventory, and there are 130 different programs. For the majority of them, transportation isn't the main purpose; it's an eligible expense. For example, at HHS, the Children's Health Insurance Program and the Centers for Independent Living are examples of programs you'll find in the inventory with very helpful information about what they can fund in transportation, such as can they fund one-call, one-click centers, mobility management, et cetera. [00:19:51]

The mission of the CCAM, as Lori said earlier, is to issue policy recommendations, as well as to implement activities that help improve the accessibility, efficiency, and availability of transportation, specifically human services transportation. And this is one example of an activity that CCAM has been undertaking. These are pilot program grants, called Innovative Coordinated Access Mobility, or ICAM, as it's in the statute. These are grants that FTA deploys, but in coordination with our CCAM partners, and they have a specific statutory requirement to focus on non-emergency medical transportation. Congress - when they put the CCAM into DoT's authorizing legislation, the previous one called the FAST Act- also put these pilot program grants into the legislation. [00:20:40]

In 2016, we called them "Rides to Wellness" grants, and there's a photo there on the screen of the Flint, Michigan project. And great news: a lot of the projects, even though their two-year pilot programs are sustaining using formula funds and other federal funds to keep the projects going. We did a program evaluation of the 2016 projects, 19 projects in total that are published, and there are some wonderful key findings in that research; we also mirrored the three goals of the project to the trip vein. The goals are increasing access to care, improving health outcomes, and reducing healthcare costs. And if you want to click on that, you can read about the projects in depth. At the bottom there is a link to the TRB, or Transportation Research Board, the equivalent of your IOM [Internet Only Manual]. It's a wonderful research board, and essentially the guidebook about helping communities improve transportation to healthcare services. It was published in 2021, has some great case studies, a lot of great examples like the two you're about to hear about, and more information. [00:21:55]

I wanted to leave you all with some technical assistance information that I thought would be helpful. I wanted to share with you one of our most recent ICAM, or Innovative Coordinated Access Mobility projects. We just announced the 2022 projects in June, and one of those projects is the Ohio Department of Transportation, which will receive $2.8 million. They are partnering with six other state agencies, including the state Medicaid and the state aging [agencies]. They are doing a project where they are serving four counties in southeastern Ohio through this pilot project, and they are creating a one-stop hub for trip scheduling and mobility management. There's a website at the bottom to learn more about that project, What is Mobility Ohio, Ohio Department of Transportation. [00:22:40]

This is the technical assistance information I spoke about: we have six different technical assistance centers we fund in our office that you can learn more by visiting National Aging and Disability Transportation Center (NADTC), National Center for Applied Transit Technology (N-CATT), National Center for Mobility Management (NCMM), National Rural Transit Assistance Program (National RTAP), Shared-Use Mobility Center (SUMC), and Transit Workforce Center (TWC). But what we did is create a Transportation Technical Assistance Coordination Library, or TTACL (because all governments have to have acronyms). TTACL is a one-stop shop, a platform that you can search for things across all of our technical assistance centers. If you're interested in transportation case studies that are specific to tribal communities, or older adults in bike share, you can type that into the search engine in TTACL, and up will pop that information across the six centers. And when you click on it, it will take you to that location in one of the centers. So, it's a one-stop-shop across all of our investments in technical assistance. [00:23:30] Of those six TAs , or technical assistance centers, three of them provide community grants that focus on improving and incentivizing partnerships to improve social determinants of health. For example, our National Rural Transit Assistance Program last year awarded 19 grants of up to $100,000 through the Community Rides Grant Program, and those were grants to help develop and strengthen partnerships between transportation and health organizations to help improve social determinants of health, specifically in tribal and rural communities. For the other two, there is more information if you'd like to hear about those grants; those are annual, if you'd like to click, National Aging and Disability Transportation Center (NADTC) community grants. The National Center for Ability Management's at the bottom, their next grant opportunity will be coming out soon if you're interested. [00:24:26]

This is a list of the regional liaisons for the National Center for Mobility Management. These are individuals who specialize in connecting transportation health partners and helping them bridge those two silos. DDoT's regions are the same as HHS'. I would recommend, if you're interested, in finding out who your transportation stakeholders are in your area. Reach out to these liaisons and they can help make that connection. With that, Lori, I'd like to pass it back to you. Thank you.

Lori Gerhard:
Thank you, Danielle. I'd like to move now to our community panel. These are just some additional resources, then you'll have our contact information. And so, our panelists, Ms. Jennifer Raymond and Dr. Sherry Welsh. Our first question will go to Ms. Jennifer Raymond. Jennifer, can you tell us about how your transportation benefit is structured, and what services are being provided, and what are the outcomes?

Jennifer Raymond:
Thank you, Lori, and thank you everyone for inviting us to this really timely discussion today. As Lori mentioned, we're an area agency on aging in Massachusetts, and one of more than 600 area agencies on aging, many of which provide transportation services, so I encourage you to make those connections. Our transportation service here at AgeSpan is one that we call CareRide, and it was originally designed to be a service that provided transportation only to non-emergency medical treatment, and we found very, very quickly through our partnerships with healthcare providers and managed care plans that there was starting to be more understanding around the role of social care. [00:26:39]

So today, our transportation benefit extends not only to non-emergency medical treatment, but also to social care in the areas of food access and housing. So, if you need a ride to the doctor's office or to the specialist's office, we can cover that. If you need a ride to the grocery store because there isn't a grocery store within walking distance, or on a bus line near you, we can provide that. If you need transportation to drop off your housing application or supporting documentation, we can provide that. [00:27:14]

We do use CareRide as really the provider of last resort. And what I mean by that is that we have worked with a platform called circulation, and built a system where we have uploaded all of the possible transportation providers in our region from regional transportation, all the way to grassroot organizations who use volunteers to provide transportation and friendly visitor programs. And so CareRide is designed to be a system that we're really looking at scanning the environment to make sure that there is no other viable transportation for you before CareRide comes in and provides that service. When we do provide the service, we use ShareRide like Uber and Lyft to do the majority of the transportation, but we also contract with providers who can provide handicap-accessible and handicap-friendly transportation. [00:28:15]

I think one of the key things about CareRide is that it comes with a person, meaning there is going to be an individual assigned to the consumer that is helping them to schedule the ride for our consumers that are digital-savvy. This can all be on their phone through an app or through otherwise-secure messaging. We're really talking with the consumer: we're getting them ready for the ride, we're sending them reminders about the ride the day before (which also serves as a reminder about their doctor's appointment), or about their other social needs' appointment. [00:28:53]

At the beginning, when they're new to the system, that person is going to be on the phone with them as they're waiting for the ride, and making sure that there's a comfort level maintained until they get into the ride. Obviously, when we give them a ride there, they're going to need a ride back 99 times out of a hundred, so the same process repeats itself. Many times, people then become familiar with the CareRide platform, so they don't need the intensity of the one-on-one handholding, particularly for those folks that are new to using transportation outside of family and friends that can be incredibly important. [00:29:31]

We do in some cases have grant funding that supports this work. In other cases, we contract with some of our healthcare partners, including one of our accountable care organizations. And payment is really on a flat-rate basis with three different categories: a short ride, a medium ride, and a long ride. The rate is a flat rate based on one of those three categories, and embedded in that rate is some of the administrative support that we've talked about. We're are really able, particularly with our contract, able to see nice outcomes, specifically related to folks actually showing up and making their scheduled medical appointments, and we've heard directly from providers about the impact that that has had on them in terms of no-shows [being prevented]. [00:30:30]

When it comes to our contracts where we provide the transportation to grocery stores or to drop off housing applications, we see that people are much more likely to complete their care plan,

their food access, or the nutrition plan. When we say, "We're going to come to your house, pick you up, bring you to the grocery store and come back when you're finished.". In a nutshell, that's how our benefit is structured, some of the outcomes we've seen, and we're now four years into the venture.

Lori Gerhard:
Thanks so much, Ms. Jennifer Raymond. And now we'll ask the next question to Dr. Sherry Welsh: Dr. Welsh, can you briefly describe your partnership with Geisinger Health Plan? What was Geisinger's interest in partnering with Rabbittransit, and how has the partnership with Rabbittransit impacted the members served by Geisinger?

Sherry Welsh:
Thank you for having me here today; I'm excited to be here. To jump right in here, several years ago we became involved with Geisinger through our nonprofit organization called RabbitCARES. As we all know, frequently we see negative healthcare outcomes in their patients, such as things like missed appointments and readmissions and emergency room visits, and no-shows to their scheduled appointments. A major part of the talent was the amount of time that was being spent by the social workers at Geisinger trying to navigate the transportation aspect of coordination of care given their geographic location. Where Geisinger is located, they span across multiple transit systems, and each of those have different complex procedures that the social workers were trying to navigate and decipher, jumping back and forth between those different policies and procedures. By working with us, they were able to focus on the medical aspect of care and really put the transportation back in the hands of the transportation professionals. [00:32:41]

As part of that project, Geisinger wanted to first have us do some mobility management of those trips. They also wanted to conduct a study to determine removing the barrier of transportation would that improve the healthcare outcomes that their patients were experiencing. So, they requested that Rabbittransit assist in facilitating those trips by way of that mobility management service that I mentioned. So as trips were coming then when they had patients that were struggling with transportation barriers, and so they reached out to us. We assisted with connecting those plans to the appropriate transit system. Another part of that was really just connecting them with the existing transportation services that many didn't know even existed. [00:33:32]

As part of that program, in the 2021-22 fiscal year we were able to provide 6,137 trips. When we ask what really is Geisinger's interest in partnering with Rabbittransit. I think first of all, hospital really wants to remove the barriers for their patients and staff. There is an added benefit in cost savings. One example, many of the patients that contacted us were for their oncology units, so they're cancer patients that were receiving chemotherapy. I didn't know this before I started with this project, but chemotherapy is really an individualized solution that's mixed up the day prior for the specific individual. [00:34:19]

What often happens is if the patient has an appointment schedule, and the transportation falls through - that solution that has been pre-mixed - ultimately, it ends up being disposed of. The cost of a chemotherapy treatment is, in essence, $40,000 per treatment. So, when that

transportation fell through because they didn't have a way to get to the hospital, it would be disposed of, and there was $40,000 dumped in the drain with it. So, you know, with the hospital partnering with us, they were able to then cover the cost of that trip, which you know, could cost $30 or something like that. So, each time that they did something like that, they were saving $39,970. [00:35:09]

The bottom line of that is, you know, yes, we can assist by covering for the cost of the transportation, but the cost savings really is out of this world. In addition to providing that next level of service for their patients, they also were improving their bottom line. So, I think it's multi-faceted in the benefits. [00:35:31]

The question is, how has the partnership with Rabbit Transit impacted the members served by Geisinger? And you know in the above example, we can see that the patient's healthcare option would be improved because they receive that chemotherapy treatment. Ultimately, when you have two agencies working together with the same goal, it only makes the impact greater. Thank you.

Lori Gerhard:
Thank you so much, Dr. Welsh. And I know we're running a little over on time, so we're going to hold questions until the end. And I'm going to turn things over to Aaron Tam, and we want to just thank the speakers for today's session, particularly our partners at FTA and CMS, for this opportunity to share information on transportation. I'll turn things over to Aaron.

Aaron Tam:
Thank Lori, and thanks to all our wonderful panelists for that insightful discussion. There were a lot of great resources provided by ACL there, so I just want to remind everyone that these slides will be released in a couple weeks after this webinar. My name is Aaron Tam, and I'm an analyst on the Value-Based Insurance Design (VBID) team. With the information provided by all these national experts at the top of our minds, we'll now move into a discussion on benefit design opportunities, including those that can be operationalized through the flexibilities offered to MAOs under the VBID Model. [00:37:05]

So those of you who have attended any of our recent VBID Models, this slide will be familiar to you. I want to first start off as we typically do by clarifying what options are available to health plans already under Medicare Advantage, and what additional options are available through VBID to aid in our thinking of ways plans can implement benefits that advance equity and transportation access. On the VBID side of this table, we'll first talk about targeting. VBID is unique in that it allows MAOs to target by low-income subsidy commonly referred to as LIS, or dual status alone, which is not allowed under supplemental benefits for chronically ill enrollees, which is referred to as SSBCI, or uniformity requirements under the MA program. Under VBID, MAOs can also target a combination of LIS or dual status and chronic condition. VBID allows for targeted benefits related to Part D, which is unique to the Model, and includes a reduced or a limited cost sharing for Part D drugs. [00:38:05]
VBID also allows for new and existing technologies, or FDA-approved medical devices as a mandatory supplemental benefit. On the rewards and incentives, or RI side, VBID has an RI limit that is tied to the value of the expected impact on enrollee behavior, or to expected benefit,

not the cost of activity, and allows for RI to be related to Part D, again not permissible under the MA program. Finally, MAOs can apply to participate in the VBID hospice benefit component. Under this component, plans cover all of the enrollee Medicare benefits, including hospice care, and can also offer transitional concurrent care and hospice supplemental benefits. [00:38:48]

How do these flexibilities actually align with innovative benefits that aim to remove transportation barriers? As our previous speakers have noted, given the known disparities in transportation access, targeting those most in need is particularly important in addressing transportation barriers. On the targeting side, under VBID, it helps benefits offer rides through vendors and community-based organizations like Rabbittransit, or AgeSpan, or issue flex cards to be spent on transportation to all enrollees with LIS or chronic health conditions. Alternatively, a friend could choose to target a combination of a chronic condition and socioeconomic status, whereas under the program, a non-medical-related transportation benefit does not meet uniformity requirements, as it is not primarily health-related, and under SSBCI, the benefit would have to be limited to a specific condition. [00:39:40]

Here, VBID is unique in that plans can offer transportation services to address social needs, just as they address health needs. Also, under VBID, these benefits could be conditioned to those targeted enrollees who participate in disease management programs, and/or see high value providers, such as providers who primarily serve underserved populations. These VBID targeted benefits can improve access to care, such as helping beneficiaries make it to their doctor's appointments on time at a higher rate, or promoting a healthy lifestyle by providing transportation to a grocery store through free rides. [00:40:16]

Beyond just providing rides through ride sharing, plans can find ways to address transportation barriers through other means, like through public transportation credit, or beneficiaries that have access to public transportation, or through things like roadside assistance, or auto repairs for beneficiaries who have cars. There is a wide array of potential interventions that VBID participants can utilize to meet beneficiaries where they are. [00:40:42]

On the RI side, plans can provide a reward of say, a $100 flex spending card to incentivize utilization of a high-value service, which can include participation in a care management program. By having access to transportation benefits, a beneficiary can more easily participate in the care management requirement, as compared to when they face transportation barriers. Transportation services could complement other VBID interventions like reduced cost sharing for use of high-value providers to ensure access to services. We'll cover some more of these options during our panel discussion in a moment. [00:41:15]

As findings and evidence evolve in the areas of transportation access, the VBID Health Equity Incubation Program will support alignment of these findings within VBID, and VBID-MAO partnerships. Now that we've covered some of these options that are available under the model, I'm going to hand it back to Aurelia who will talk to some of our current VBID Model participants about what transportation benefits look like in practice.

Aurelia Chaudhury:
Thank you so much, Aaron. I'm Aurelia Chaudhury, and along with Abigale, one of the VBID Model co-leads here at CMMI. Today, we're very lucky to have with us amazing panelists - with decades of experience among them - from two of our VBID Model participants to talk about implementation challenges and successes related to improving transportation access in the Medicare Advantage population. I'm pleased to welcome Dr. Inés Hernández-Roses, Chief Medical Officer of MCS Healthcare Holdings, LLC, and Dr. Alexander Billioux, VP of Social Determinants of Health at United Healthcare Government Programs. I'll hand it off to Dr. Hernández-Roses to do a quick overview of MCS' work in this space. [00:42:27]

Ines Hernández-Roses:
Hi. I'm very thrilled to be here, and I want to thank the VBID group for the invitation. I have been with MCS in Puerto Rico for 17 years; that's how long our MA program has been active. Puerto Rico is a small island, only 100 miles by 35 miles, but we do have a population of a little over three million inhabitants. Forty-five percent of those, roughly of those, live below the federal poverty level. We have the highest penetration of Medicare Advantage in the whole nation, with around 80 percent of our Medicare beneficiaries on the island enrolled in a Medicare Advantage program. MCS in particular has over 210,000 MA members currently, and half of those are dually eligible members. [00:43:31]

The transportation situation in Puerto Rico is a particular issue in terms of access. Public transportation is not very consistent, even in urban areas, and it's virtually nonexistent in rural areas. So even though we're a small island, we do have significant limitations in mobility for our population that do not have access to their own private transportation. In addition to that, communities are not necessarily that well planned, so access to common community facilities are not that available for the population. [00:44:25]

There's also the recent phenomenon of migration of the young population, so our seniors, even those who had, historically, a very strong support system in their family for access to transportation have been suffering an additional burden in that sense. So, for all these things and those limitations that the Puerto Rican population has, the medical transportation benefit has been hugely popular in Puerto Rico historically for many years. It's consistent among all the Medicare Advantage programs on the island that will have a strong medical transportation benefit. When we were given access to the opportunity to include non-medical destinations, it became a very obvious choice for us, in terms of addressing social determinants of health, and whatever inequalities the population had. In terms of independence of the elderly, in terms of access to healthy food alternatives, financial independence, loneliness, all those things we had been able to address so far through our transportation benefit. [00:45:59]

These are the main categories that we chose to include in our non-medical transportation benefit. The health-related destinations continue to be the most popular overall for the whole population. We also included transportation - to places of worship, banks, and supermarkets – as well as for, payment of utilities or needs of service, and to the Medicaid office, because people would lose their Medicaid eligibility for not being able to keep their appointments. This was a very, very important for a dual population. [00:46:45]

There has been a pandemic limitation in which utilization of all services has been erratic. Puerto Rico had the biggest, or the most strict lockdown in the whole nation which impacted utilization across the board. We saw that the supermarket was the most popular destination aside from medical destinations, and that was followed by banking services and places of worship. We are looking at the utilization of the population in these new categories. Utilization in pandemic years is not representative of "normal" years, so what we want to do is to be able to compare 2022 which is behaving a little bit more normal. So we want to compare our population's profiles and utilization patterns now that the population is behaving more normally so we will have more reliable or comparable information. I am very pleased to be sharing this panel today with Dr. Alexander Billioux, so I'll leave the floor to him now.

Alexander Billioux:
Thank you, Dr. Hernández-Roses. I want to join the other panelists in thanking CMS, CMMI, and the VBID team in particular for inviting us to participate in this panel, [to] share some of our experience, and I'm looking forward to the discussion and questions that come up. So, within the United Healthcare family, I lead our social determinants of health and central care strategy. Before diving into a little bit about our transportation-specific benefit, I wanted to give some context on how we approach coming to this work not only in VBID and even SSBI, but more broadly across the organization. [00:48:55]

I don't think that I need to convince this audience of the importance of addressing social needs for members. But I'll just sort of, you know, reinforce the perspective that UHG has, which is really based in our mission: to help our members live healthier lives, and help the health system work better for everybody. And that means, in our opinion, really developing a social care strategy that's integrated with physical and behavioral healthcare, and that tackles the challenges in social care without medicalizing that area. [00:49:28]

There are some real challenges, I think, in taking these strategies to scale that we've really organized around, and has sort of defined our strategy. I think it's applicable certainly in the area of transportation. One is just the sort of inefficiency and inconsistency in being able to identify who actually has a need, and then being able to address those needs with consistency, especially on an island like Puerto Rico, I'm sure that Dr. Hernández-Roses has that challenge, but broadly across the country. With the catchment area that UHC has, we certainly have to be nimble and dynamic. [00:50:06]

I think the other challenge is really driven by the fact that we are engaging in delivery systems that are underfunded and fragmented, and here again in transportation, we see that, and that's one of the reasons that I think a lot of us really look at directly contracting when it comes to trying to solve needs for members. [00:50:28]

Our general approach at UHC when addressing social care is to work hard to close gaps for all of our members, and we do that through at least three key steps. First and foremost, as I said, is really trying to identify unmet needs amongst our members. That's the "understanding" piece of our strategy, done through a variety of different pathways of screening, but then incumbent upon us once we find out that a member has a need is really connecting them to resources. At times, that can be resources in their communities, other times, especially in the case of our MA

members and D-SNP [Dual-Eligible Special Needs Plans] members, where we have an existing benefit, it may be connecting them to that benefit, like transportation, to ensure that they're getting the services that they need to close the gap. [00:51:10]

Then we follow up with our members to identify whether their need has been met, and if not, continue to work with them until we have met their need. All of that information at the individual level is then really important for us to act upon and leverage at the community level, where we begin to see trends amongst our members; members across our lines of businesses that start to show us what kind of needs we see in communities, but also where there are gaps that we can have a role in trying to fill in community resources and capacity. And there we really try to work to expand to community capacity to benefit certainly the reach of our members, but also non-UHC members in those communities. [00:51:51]

To give you a sense again of the scale challenge that we have, just showing you a distribution of where our members are across the country that we've been able to identify unmet social needs. In 2021, we screened over of 4.1 million unique members alone, and here you see their distribution, the larger the circle, the larger the number of our members in that country with a need. And their needs are myriad, not just transportation. So, the real challenge for us is addressing the fact that most of our members with a need actually have more than one need on average. And I think that plays in really nicely to discussion, then, about transportation and the role that it can have. [00:52:35]

I think that role is, frankly, as a super-driver of health. That is to say, transportation is not only a need in and of itself for, say, getting to a medical appointment, but really, it enables that individual to meet other social needs, like employment, education, socialization, and, going back to the current (and certainly maybe waning) COVID-19 pandemic, social isolation has really spiked, part of that because of relative isolation that people without access to transportation have experienced for years. [00:53:14]

And as we work towards really trying to engage people digitally, and looking at more virtual options, I think there's still very much a critical need to actually move around in the fiscal environment, and transportation's key to that. You heard earlier the discussion about how many millions of Americans have delayed medical care as a result of lack of transportation. Within United Healthcare's experience, one in four of our members with a social need reports that transportation is a barrier for them, so it's a highly prevalent social need. [00:53:48]

From a health equity standpoint, this is really critical to our concerns at United Healthcare, as this worsens health disparities. Research has demonstrated again not only low-income populations, but specifically Hispanic/Latino populations, Medicaid and dual recipient populations, and importantly, individuals with disabilities are affected. When we think about the kinds of transportation options that we're trying to make available to our members, that's a really important category for us to be thinking about, especially as we start to partner with new business partners and innovative models, folks coming from other spheres into the medical sphere who may not be familiar with the specific needs that our members have. [00:54:32]

So just to touch on our experience before we go to the panel: we see high levels of utilization of our transportation benefit, certainly for medical purposes, getting to primary care appointments, therapy sessions, and to get to the pharmacy. But I really also want to emphasize that a transportation benefit is key to unlocking other social benefits for a member. We see our members accessing healthy groceries locally by leveraging our grocery program, I should say our grocery benefit, by using the transportation benefit to get to that grocery store, if home delivery's not available. Similar for over-the-counter medication purchases at the pharmacy. [00:55:14]

Not surprisingly, we continue to see a growth, then, in transportation benefit utilization amongst our members. In 2021, we had over 2.5 million trips through our VBID and other transportation benefit programs, and this year, through June, so the first half of the year, we already have made, seen our members make 1.8 million trips, a 44% increase. And we expect that robust utilization to continue through the remaining year. Looking forward, what we've learned from our experience is a need to continue to focus on expanded access, especially for populations with historic challenges with transportation, transportation deserts. [00:55:54]

We also want to ensure that there's better integration in this benefit, again across a member's benefit and care coordination, because of the central role that transportation can really play in being able to enable somebody to have that self-health stuff, efficacy and manage their care. Finally, I think we often overlook the member experience, and really need to be engaging our members - and we are engaging our members - in designing what that next generation of transportation benefit looks like, to ensure that we're delivering the same kind of seamless, integrated member-centered approach that we demand of our own transportation in our own lives. So, looking forward to the panel discussion and again, thank you for your time and the opportunity.

Aurelia Chaudhury:
Thank you both so much for that explanation and the helpful information. To start with, can each of you tell us about the VBID interventions that you've included to address transportation barriers, the populations you're targeting, why you selected these particular interventions, and what you hope to accomplish by adding them? And let's start with Dr. Hernández-Roses.

Ines Hernández-Roses:
Our first target population is the people who have a combination of a lower income and chronic disease. This is, first of all, for the medical transportation benefit, virtually the whole population. This has been around for years, more than tested its effectiveness, and become standard for our market to have the medical destination. For the non-medical destination, we're targeting, in particular, lower-income beneficiaries in our dual-special needs plan. This is a fully integrated dual SNP that we contract with both Medicare and the state-sponsored Medicaid health plan. And those are the ones that really are the heaviest users of the benefit. We also use it for chronically ill members in our non-SNP population. [00:58:32]

When we expanded to non-medical destinations, we were promoting independence in our elderly and/or disabled population. But when we look at it, we wanted to really impact things that were meaningful, both for the members and for the members' health. So, as Dr. Billioux was saying, food insecurity is not necessarily about affordability. We had designed already a benefit to assist

with affordability of healthy food, but people in isolated communities may not have access to healthy food if they can't drive a car. So, it became very obvious that the destination needed to include supermarkets and larger groceries that were probably available in the more rural communities, so they could not only have the money to do it, but also the accessibility. [00:59:50]

One thing that we look at also was financial independence. We wanted seniors to be able to manage their own finances, so we included banking institutions as part of the benefit. And then something that is really important, and that we have been looking very hard at, is the social isolation before COVID. Before COVID, it was already an issue, and that is why we included places of worship. Sometimes this is the only place where people go to have community support and to share time with their peers and their social group. So that was something that was obvious to us, and it's very popular also. [01:00:40]

We also wanted them to be able to access the wellness events that MCS provides, so we included that among the destinations. Because we wanted to promote health within, among everything that really impacts health, we wanted to look at the social determinants of health and how to support those in our design, and how to get them into preventive care and wellness. That was our main focus, and we have been looking at opportunities to address the social determinants of health for many years, and this really opened up a big opportunity to support our previous efforts in that line.

Alexander Billioux:
Yeah, our experience mirrors Dr. Hernández-Roses' quite a bit. Similarly, we have a broad transportation benefit outside of even VBID, because I think we've seen the impact from that work. But in the early days, certainly I think the lens through which we approached starting to provide transportation services was focused on those populations that we felt probably had the greatest medical need. Supporting those, just as you heard, with chronic conditions, multiple chronic conditions, individuals in a lower socioeconomic status, more likely to be facing a transportation barrier, making sure that there was going to be that benefit ready for them. [01:02:13]

Over time, I think especially as we've seen not only our own experience with members, but greater flexibility and support from CMS, we really are thinking about how does this, again, intersect with other social needs. We already talked about grocery stores, but just to emphasize the points that Dr. Hernández-Roses made as well, when we took a look at social isolation, places of worship, community centers as really critical places to connect people into, as well as places where they can use their broader benefits; for instance, going to the gym if they have the benefit for self-care in gym. So, that's broadening the aperture about how can we use this super-driver kind of lens to leverage that benefit to connect not just to, strictly speaking, medical care, but to a broader sort of care, that continues to shape our thinking again as we look forward.

Aurelia Chaudhury:
Thank you both. What data, whether data from beneficiaries, or from vendor networks, or from transportation benefit managers, are important to you in assessing the impact of providing

transportation benefits under VBID? What are the challenges that you face in collecting data and assessing that impact? And let's start with Dr. Billioux this time.

Alexander Billioux:
Sure, so we're pretty data-driven in our approach. We really want to understand, what's the need, who's the member, as I sort of said in my initial introduction. And the reason we want to get to that level of granularity is it lets us look at important intersections. For instance, we know that our members with, as I said, one social need or with any social need are more likely to have actually multiple social needs, 2.2 on average. Understanding that that member with a transportation need also has a food or a housing need is critical. We've learned that more than one in four of our members with a transportation need have an underlying healthcare access concern. More than one in three of those members have a challenge with their housing. Fifty percent of those members with a transportation need through our systems actually have food insecurity. And so understanding the interplay of these needs, then, helps us think about how to also ensure that we have the right benefit design for those other needs so that we're really trying to provide that whole-person care. In the way that we deliver that, however, as we're managing or engaging a member around the transportation, it queues up for us, other things that we need to ensure if that person's not forthcoming, needs we may want to investigate and serve, because we think that they may not be aware, for instance, that not only can we set up this transportation for your clinic appointment, but how's getting near the grocery store? How are you using your gym benefit? Did you know you can use the transportation for that? So that real, integrating, preventive upstream driving better health is a key way that we leverage data. [01:05:25]

The other side is a lot of boring but critical operational information about, how long is a member having to wait for a ride? What's the challenge with ride no-shows versus misallocation of going to the wrong corner, and that kind of work continues to allow us to focus on that customer experience. We really want to ensure that we're continually, like a transportation company, that we're focused on providing that best experience for the member, nine times out of ten or more. So data are really critical for us to not just say, "okay, well we've given you a benefit, we've connected you to it". We want to make sure it's delivering a consistently good experience, excellent experience for our members.

Aurelia Chaudhury:
Thank you, and Dr. Hernández-Roses?

Ines Hernández-Roses:
We're also monitoring the boring operational statistics, very important, and also the customer experience. We look at cancellations and whether they were driven by the member, or by some dissatisfaction with the service itself. And we want to monitor difference in health outcomes or in utilization patterns. And this has been a particular challenge, because the pandemic years are not behaving normally. So, utilization of practically all services has gone down since 2020 and most of 2021, so it's just now coming back to more normal levels. We're planning to monitor that more closely now. The data we have gathered regarding utilization is not really that solid because of those external circumstances that have affected all our utilization patterns. [01:07:23]

So that is one challenge that we have in collecting data. The other is members who disenroll, members who move from one benefit to the other, and it's a little bit harder to monitor. We are also planning on doing very broad member satisfaction surveys for all the benefits that we do that are not the standard Medicare benefit to help us with the future design.

Aurelia Chaudhury:
Thank you so much. So, knowing what you know now, is there anything that you would share with another MAO that's looking to enhance their transportation benefit under VBID? Or consider implementing a VBID flexibility to help address transportation barriers? And we can begin with you, Dr. Hernández-Roses.

Ines Hernández-Roses:
Well I don't know if this is something common. Way back when, many years ago, when we started with the medical transportation benefit, one of the things that wasn't included at first and we had to fix it almost immediately was including a companion, allow a companion with a member in the transportation. The other things that have been more related to the pandemic, for example, shared rides are very common in this type of transportation. Minivans and larger vehicles for people who have disabilities and can accommodate, and the vendor would plan the routes so they could control costs that way. When the pandemic came along, nobody wanted to share a ride, so that is a fix that we had to do. [01:09:10]

We have encountered difficulties with driver availability. I think this is also something that nationally, you know, in all industries, with that pandemic circumstances, have found a challenge with people, finding workers, and that hasn't been an exception with transportation and driver availability. We also have a bit of a technology challenge here. Our vendors need to improve their technology so there's better planning of the routes and communications with the members. Seniors are very tech-savvy now, so they want to be able to look at their phone and see where's my driver, how much longer I'm going to have to wait. So that is something that we need to improve, and our vendors need to improve so we serve the population more effectively. [01:10:10]

We also need to explore more alternatives to expand the benefit to other things, as Dr. Billioux was saying, people with multiple needs, multiple social and medical needs that we can serve. And this is very popular, very effective, and very much needed in Puerto Rico, so we're really focusing on how we can continue enhancing it.

Alexander Billioux:
Yeah, I agree with Dr. Hernández-Roses. I would add, or maybe sort of expand on, especially the piece around really working tightly with your vendors to think about what is that communication with the member going to look like, both in good times in bad, what's going to be the process when a ride is missed, or the timing is off, and trying to streamline that. I think a lot of our members, or rather members all over have stories about having to wait too long for a ride. And you think about, just how challenging that is, we all have busy lives. No different for somebody who's trying to get to a clinic appointment. [01:11:16]

Really thinking about what is the streamlined communication when we're sort of working, especially through a vendor organization with some layers between the member and the person who's actually delivering the services, how are we going to try to work together with the great 2022 technology that we have, to really make that as streamlined as possible? I think approaching your transportation benefit from the beginning, not just as, "we need to have a benefit", but really "how am I going to make this failsafe", and then when there is failure, as seamless as possible, I think is critical. [01:11:50]

I think the other thing that I would say is, I think especially for our members that are reliant on our transportation support, especially members in, say, rural areas, I think appreciating that the person delivering that transportation almost becomes a part of the care team, and in fact, in many ways, they become a part of the care team, there's a relationship that builds with that consistent, or that could build, depending on the way you build that program, that could build between that member and the person who's providing their transportation. At the very least, that's important for member satisfaction and member service.

But it also provides another opportunity for somebody who's consistently seeing your member, especially a vulnerable one, or a member with multiple chronic conditions, and can tell you early on if they have a pathway to do that when things are starting to go awry for that member, if something's a little bit off. And I think that appreciation of, it being an extension of your care team, rather than just a vendor or an external service you're providing your member. This can be a member of your external care team, if done correctly. I think that's an opportunity.

Aurelia Chaudhury:
Thank you so much. So the last question for me, I'll begin with Dr. Billioux: where do you hope to get next with your transportation benefit? And how could the VBID Model support your ongoing work in improving care outcomes and equity for your members with transportation barriers?

Alexander Billioux:
Well, thanks for that question. I think, I hit on it a little bit. I mean, we're continuing to look at how transportation really fits within overall unlocking the care and other benefits for members. So how is this a key part of ensuring that our members are maximizing their benefits for their health, and being really thoughtful about that, doing that in a way that again prioritizes their experiences, because we know that that correlates too with the continued utilization of that benefit, continued engagement and care, and all the things that we're going to care about downstream. [01:13:48]

I didn't say it, but I agree with Dr. Hernández-Roses. We also look very much at both interim and sort of more late-stage outcomes data, and it's been really tough to do that during the pandemic with utilization patterns down, but utilization's going to pick back up, and I think, you know, it's going to be really important for us to have an eye on what impact this is having and what populations are not accessing from a health equity standpoint. What do we need to do to address lower than expected (or lower than probably appropriate) utilization amongst different populations to make sure people feel welcome to use their benefits? So those are some of the areas we're focused on.

Ines Hernández-Roses:
So we're looking at maybe expanding the benefit to make it look more like maybe an allowance, and the member have a broader choice of transportation alternatives, that is one thing that we want to look at very closely. Additionally, we'd like to identify through the members what else are we missing, and what other destinations would support their social needs or their companionship needs, that is something that we want to look at. We'd also want to look at our current benefit and see what is really adding value. For the member, in terms of their medical outcomes, their utilization patterns are important to consider. So that's where we're focusing on. If you compare 2022 to 2021, 2020, it's going to be looking like everybody's sicker because they're using more, the healthcare systems, so that is why the comparison is a little bit of a challenge, or quite a bit of a challenge. So, we need to look at this very closely and look at more healthcare outcomes than utilization patterns, because of that noise that we're getting. [01:15:58]

But I think the fact that we are getting this flexibility to address what, before social determinants of health became sort of like the buzzword, we used to call them, "non-medical needs that impact health". And we have been working for those since 2007, so it's really exciting that these flexibilities are being allowed, and that we can see the impact in the membership.

Aurelia Chaudhury:
All right, well thank you both so much for those thoughtful answers, and for your very informative presentation. We are now approaching the end of our session, and I want to reiterate that through this webinar and future learning sessions that are part of the Health Equity Incubation Program, we hope to develop a 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 innovations, but this program will provide a forum for solving common problems and challenges related to health equity in the Medicare Advantage area. [01:16:58]

So with that, I'm going to open the floor for questions, prioritizing those that have been submitted through the Q&A feature which appear in the chat function of the WebEx. And let's begin, there was one question submitted to Jennifer: Did you want to recap the question and provide your answer?

Jennifer Raymond:
Sure, thank you. Just want to make sure I see the question appropriately here. As I understand it, the question was around our CareRide model and why we chose to start a program rather than contract with local providers. And it's a really great question, and the answer is that we did both. We do contract with some local providers to assist with transportation needs. What we found is that for some of the population that were in the most need of transportation, there were going to be some other complicating factors. They were going to be frail, they were going to need some mobility assistance, or they otherwise needed that additional support of a community outreach worker or community health worker who was going to be able to provide that more intense, robust time of transportation assistance. So that was really why we chose to build something that wasn't currently out there in the environment. [01:18:27]

The other piece to that, sort of as we're thinking about this health equity piece, was the language barriers that we often times found with many of our consumers and their transportation providers, so when we hire community outreach workers that reflect the communities that they serve, they oftentimes come with that additional language and cultural capacity and it just makes a smoother transition for the consumer.

Aurelia Chaudhury:
Thank you so much, Jennifer. Our next question was for Aaron. Aaron, do you mind recapping the question and giving your answer?

Aaron Tam:
Sure. So the question was, how does VBID fund these programs, and what is the VBID dollar limit. So for that, the VBID Model does not provide additional dollars to Medicare Advantage organizations; rather, it gives flexibilities to participating MAOs to target certain populations, such as those enrollees with low-income subsidies, and MAOs can use their rebate dollars to fund these benefits.

Aurelia Chaudhury:
Thanks so much, Aaron. The next question is for our panelists, Dr. Billioux and Dr. Hernández-Roses. The cost and impact of lack of transportation have on healthcare quality life. Is there any sense of the cost due to poor customer service, or lack of communication? There can be many situations where individuals get frustrated because of the system or the process, or the communication that they give up or cancel appointments. In addition to investing in transportation, is there incentive to invest in communication tools, scheduling tools, driver training, or other pathways to address this? And we can begin with Dr. Hernández-Roses, please.

Ines Hernández-Roses:
Hi, yes, they're not very, very frequent, but we have had instances of cancellation because of member dissatisfaction with the system. We have had issues with traffic being a barrier, especially, or particularly in urban areas. We have issues of heavy rains causing flooding, you know, all sorts of uncontrollable situations. And there's also, you know, the vendor-based failure that have caused some cancellation. We monitor those very closely. The vendor has a very good system and backup system for when there is one particular instant of a driver-driven failure. [01:21:09]

We do recognize the need to invest in better communication systems and more technology for the benefit. This is also a challenge in our island, but it is, I would say, the most important next step for improving the service and effectiveness of the program. The driver training is very solid, and we don't really get any complaints related to the drivers themselves, more than maybe "I waited longer than I thought I should have, and I didn't know, and I got anxious, maybe because I didn't know why the delay". So that is where communication tools are very, very important to add to this benefit.

Aurelia Chaudhury: Go ahead, Dr. Billioux.

Alexander Billioux:
I was going to say, I think it's a great question. I don't have financial data around it, but I think the cost impact is probably manifested frankly in downstream cost of care, right? So, if the visit that's missed is something critical for that member, maybe it's getting their weight checked, and they're on diuretics, and there would have been an adjustment to their diuretics for their congestive heart failure, and because we missed that, now we've got an emergency department utilization, those are sort of examples where not having the ability to support that outpatient medical care access certainly can have an impact.[01:22:58]

And then I think more broadly, when we think about just again wellness and health, like I may not be using my silver sneakers program because I just don't have a way to get to the gym. And by us making that modest investment and making sure that they have regular access, and promoting that healthy lifestyle, along with the grocery benefit, you know, we may be saving significant dollars. And that is an area where we are looking. Where those fail, we obviously try to minimize the failures, but where those fail, I can imagine that all those sorts of benefits are removed.
[01:23:28]

And just for context, I mean, I said that we had 2.5 million rides rather in 2021, I think we have a success rate in those rides of 99% or greater. But still 99%, that one percent at that scale is 25,000 rides that didn't go the way we wanted them to. And that's a pretty large amount for us to address. So, we can continue to try to get really granular with the detail and try to learn from each of those instances where something didn't go right to figure out how do we work with our partners that deliver these services to ensure high fidelity to excellent customer service.

Aurelia Chaudhury:
Thank you so much. And I think Danielle, did you have anything to add here, or Jennifer?

Danielle Nelson:
No, I think that's great, thank you.

Lori Gerhard:
And Aurelia, this is Lori at ACL. I did want to share, too, that the transit planning for all those 42 communities that we worked with, we learned through some of those local community investments through people with disabilities, older adults, people with chronic conditions. Participating with transportation drivers, they talked about this very issue of communication tools, scheduling tools, driver training. And they've come up with some really good solutions; in fact, Ride Connection in Portland, Oregon, actually hired a person who had end stage renal dialysis and needed to have transportation to do sensitivity training for the drivers, so that they had better understanding of the needs that the person was experiencing, and why they might not be ready when they're there to pick them up, and it improved satisfaction immensely.[01:26:12]

And in Tennessee and Kentucky, there was some work being done with the university and bus drivers. The bus drivers were having trouble communicating with people who were not communicating verbally. So together, they developed a transportation app, the engineering department at the university helped them build that app, and it improved satisfaction for the

riders and the frustration for the drivers went down immensely. So, I think by listening to the people in our communities that are experiencing these challenges and getting their input is really a great strategy to find solutions.

Aurelia Chaudhury:
Thank you so much for adding that, Lori. Those are really wonderful stories to share. I believe our last question from this Q&A is going to be for Sherry. Sherry, how do we define improved health outcomes, and how can we measure them?

Sherry Welsh:
Being the transportation provider, we don't define the outcome. Really, it's up to the healthcare facilities and the sites. For them, the healthcare outcomes are measured primarily in the form of decreases in missed appointments, readmissions, emergency room visits, and then decreased appointment no-shows. At the end of the day, improved healthcare outcomes are really the fact that people are receiving the treatment that is prescribed.

Aurelia Chaudhury:
All right, thank you so much, Sherry. And thank you so much to all of our panelists for providing us with your time, your insight, your careful and measured responses to the questions here. The VBID Health Equity Incubation Program community is what we make of it, and we are so grateful for all of you for making it into the rich and vibrant community that we find here. As next steps, we hope that you will be able to participate in the upcoming Health Equity Incubation sessions. Our next session will be in December, and will focus on another important need: housing and supports for living. [01:27:23]

Lastly, please be sure to fill out the post-event survey. We ask for feedback on which health equity topics your organization is the most interested in. That survey will directly inform what we plan to cover in 2023 in our Health Equity Incubation session. Thank you all so much to our panelists, to our attendees, and to the CMMI team, and have a good rest of your afternoon. Thank you.