Thoughts from our chief medical officer

Humana Looks Homeward

One of the things that really attracted me to Humana was our model, which integrates the payer and the provider around patients in the home. A big focus of my work prior to Humana was about understanding how the payer and provider can better integrate – how to align incentives to foster deep partnership. I spent time at CMS in the Center for Medicare & Medicaid Innovation working on value-based payment models; at a large, vertically integrated health system with a health plan; and at a retail pharmacy partnering with risk-bearing providers. I think our model – to deliver more patient-centered, convenient care in and around the home – is the right one, and we are poised to meaningfully disrupt the marketplace.

One of the things that is cool about working for a Medicare Advantage plan is that we have a lot more flexibility concerning how we engage and support home healthcare and how we work with our network physicians. Providing actionable data and promoting data interoperability are essential so that physicians and other healthcare providers can have an expanded view of their patient's health picture. At Humana, we're able to be more creative and cooperative in supporting physicians working to improve the health of their patients.

Right now, part of that expanded health picture includes understanding the breadth of patients' social, behavioral and physical health needs. We've heard a lot of discussion about social determinants of health (SDoH), and many of you are likely already incorporating these facets into your practices. Medscape and the American Academy of Family Physicians (AAFP) recently surveyed primary care physicians around SDoH and the results were pretty interesting.

For me, it's clear that by working closely with our physicians, community partners and other healthcare providers within the flexibility of a Medicare Advantage plan, we can be most innovative and nimble to meet the needs of those we serve, improving health while reducing cost.

William Shrank, M.D.

Chief Medical and Corporate Affairs Officer

Fixing food insecurity

Treating food insecurity as a clinical gap in care

Drs. Toyin Ajayi and Andrew Renda

A group of physicians and healthcare leaders convened at a recent Humana event to discuss what the medical practitioner's role should be in addressing food insecurity as part of improving patient outcomes. Below, Drs. Ajayi and Renda summarize the discussion.

It's an unfortunate truth that in our current healthcare system, too-short, too-packed appointments often mean that providers do not have time to understand all that is going on with their patients beyond the walls of their practices. While the treatments we prescribe address their physical symptoms, we know little about the social, economic and environmental challenges our patients face that impede their health. These social determinants of health (SDoH) – such as reliable transportation, nutritious food, stable housing, community and human connection – are critical to health and well-being. Yet, the way that medicine is still widely practiced, especially in lower-income communities, is extremely costly and fragmented, and it fails to produce the health outcomes and cost efficiencies we all want.

One of the most prevalent, most harmful barriers to good health is lack of access to enough nutritious food. Food insecurity leads to higher rates of chronic disease, emergency department visits and hospitalizations, driving $77.5 billion in related healthcare costs. We cannot expect to improve health and reduce costs if we do not first ensure that patients eat well. This is no small issue: Adults experiencing poverty, who presumably lack consistent healthful food, are at higher risk for diabetes, heart disease, stroke, depression, disability – even premature mortality.

So why is food insecurity not considered a clinical gap in care? Shouldn't all providers have a responsibility to diagnose SDoH as they would other medical conditions?

These were the questions posed to a group of physicians and healthcare leaders at a recent TEDMED event, convened by Humana, at which participants sought to understand what the medical practitioner's role should be in addressing food insecurity as part of improving patient outcomes.

Addressing food insecurity will require a major restructuring of the roles and responsibilities of healthcare providers. Beyond that, we need to implement interventions using technology platforms, validated screening tools and referral sources, as well as new code sets and payment models, to enable physicians to make food-insecurity assessment standard practice.

How do we make this work?

Community provider-driven care teams. For physicians to feasibly address food insecurity and other SDoH requires a significant shift to a team-based approach, one reaches well beyond the walls of the medical practice and into the communities where patients live.

This team-based, flexible approach is the foundation that Cityblock Health is built on. Multidisciplinary care teams are led by Community Health Partners – individuals from within the community who understand the experiences of people living there. Community Health Partners meet patients where

they are, taking time to understand what is going on in their lives and connecting them to the right resources. They enhance the clinical team's understanding of patients' realities and design interventions for their specific needs. Team-based models necessitate a significant role change for physicians, who will have to work closely with non-medical, community-based partners.

Value-based care. Few reimbursement systems are currently set up to adequately pay medical practices for time and resources spent treating SDoH. Value-based models, in which reimbursements depend on patient outcomes, encourage and allow room for care teams to address all aspects of health – from medical and behavioral health conditions to social needs – as equally critical in every patient's care.

In value-based care models, then, we need to develop clear measures tied to addressing social determinants of health and their impact on outcomes.

Evidence and outcomes. Currently, there is limited evidence showing which approaches to SDoH are most effective at improving health outcomes and providing a return on investment. However, one example showing real benefits is the provision of medically-tailored, home delivered meal programs for the elderly. These programs have been shown to improve clinical outcomes, including blood pressure and diabetes control, and to help curtail emergency department visits and inpatient admissions for adults who are dually eligible for Medicaid and Medicare.

It's critical that we establish methods and metrics to expand evidence-based programs and measure various approaches that address SDoH. As part of that effort, Humana is currently working with the National Quality Forum to define quality measures around food insecurity. This effort will enable us to standardize benchmark measurements and expectations to help physicians effectively address food insecurity and to incentivize and compensate based on validated measures tied to patient outcomes.

We're in the early stages, but there is growing momentum for treating SDoH as clinical gaps in care. To make real progress toward that end, decision-makers across healthcare – from policymakers to health plan and health system executives – need to align on a shared vision and efforts to address patients' comprehensive health and social needs. Physicians alone cannot cure food insecurity, but we can be powerful partners in holistically addressing the needs of our patients and communities.

Toyin Ajayi, M.D., is the chief health officer at Cityblock Health, and Andrew Renda, M.D., is associate vice president, population health strategy, Bold Goal, at Humana.

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Success in value-based care

Assembling the missing pieces to achieve success in value-based care

At the 3rd Annual Value-Based Care Summit, hosted by Xtelligent Healthcare Media, Humana convened a group of forward-thinking industry leaders to discuss the obstacles, opportunities, and gaps in research surrounding value-based care.

"Our goal was to listen carefully to understand how Humana can remove barriers and make it easier to transition to value-based care while improving patient outcomes," said Worthe S. Holt, MD, vice president, Humana.

The group of clinical executives, quality improvement experts, physicians and other advanced practitioners and population health management directors identified several main obstacles affecting their ability to transition smoothly to value-based care. Additionally, these healthcare leaders offered a number of solutions to some of the most pressing questions facing healthcare.

Read a summary of the findings **here.**

Care Highlight™ is here
Humana's Care Highlight™ program is up and running

Patients have many choices when it comes to their care. To help inform their choices, Humana's Care Highlight™ Program aims to equip your Humana patients, as well as prospective Humana customers, with information about provider clinical quality and cost efficiency.

As part of this program, Humana shares physician performance ratings on the Find a Doctor tool at Humana.com. The primary intent of the program is transparency with customers. The ratings should be used only as a guide, and patients are encouraged to consider all relevant information and consult with their treating physicians when selecting a specialist.

The program was recently awarded the National Committee for Quality Assurance's Physician Quality (PQ) seal. The PQ seal represents the gold standard in physician measurement.

We appreciate your input to our programs and want to hear your ideas for improvement. To learn more about the Care Highlight™ program or to give us feedback on the program, please visit **humana.com/carehighlight.**

The risk of polypharmacy
Headline: Poly•pharmacy risks in older adults

Poly•pharmacy
noun
Derived from the Greek words for "many" (*poly*) and "drug" (*pharmacon*)

- While there is no absolute definition for polypharmacy, most clinicians agree that it signifies the patient taking five or more medications.

- The term also describes the use of more medications than are medically necessary. Medications that are not indicated, are not effective or constitute a therapeutic duplication are considered polypharmacy.[1]

Potentially inappropriate medication is a patient safety issue for our older adult population, especially for those who have multiple chronic conditions and take multiple medications.

Nearly 50% of older adults take one or more medications that are not medically necessary. Research has clearly established a strong relationship between polypharmacy and negative clinical consequences.[1] Some of those consequences are:

- **Increased healthcare costs:** Polypharmacy contributes to a rise in costs for both the patient and the healthcare system. The elevated risk of outpatient visits and hospitalization stemming from taking a potentially inappropriate medication can increase medical costs by approximately 30%.[2]
- **Higher risk of adverse drug events (ADE):** Patients taking five or more medications had an 88% greater risk of experiencing an ADE compared with those taking fewer medications.[3]
- **Drug-to-drug interactions:** The likelihood of a drug-to-drug interaction increases 50% if a patient is taking five to nine medications. That risk jumps to 100% when a patient's regimen includes 20 or more medications.[4]
- **Nonadherence to medications:** Patients taking four or more medications are 35% more likely to not adhere to their regimen.[5]
- **Mental and physical risks:** Polypharmacy is associated with functional decline and cognitive impairment in older adults. Falls that result from polypharmacy may lead to increased morbidity and mortality.[1]

The American Geriatrics Society (AGS) Beers Criteria focuses on opportunities to decrease ADEs and complications for patients. AGS recommends:

- Avoiding concurrent use of three or more central nervous system (CNS) medications, as such use increases a patient's risk of falling
- Avoiding concurrent use of anticholinergic (ACH) medications, due to an increased risk of cognitive decline

In 2013, the Centers for Disease Control and Prevention (CDC) reported that opioids were associated with the most pharmaceutical-related overdose deaths in 2010 (75.2%), followed by benzodiazepines (29.4%). Concurrent use of benzodiazepines was associated with 30.1% of opioid overdose deaths, and concurrent opioid use was associated with 77.2% of benzodiazepine overdose deaths.[6]

For information about prescribing opioids, consult the following guides.

- Turn the Tide Opioid Pocket Guide
- CDC Pocket Guide – Tapering Opioids for Chronic Pain

Based on extant evidence, the Pharmacy Quality Alliance (PQA) developed and endorsed two polypharmacy measures for older adults and a performance measure to reduce the combined use of opioids and benzodiazepines:

- Polypharmacy: Use of Anticholinergic Medications in Older Adults (POLY-ACH)
- Polypharmacy: Use of Multiple Central Nervous System Medications in Older Adults (POLY-CNS)
- Concurrent use of Opioids and Benzodiazepines

The Centers for Medicare & Medicaid Services adapted these three performance measures for display in 2021 (using 2019 data) and 2022 (using 2020 data). Learn more.

References:

1. Maher RL, Hanlon JT, Hajjar ER. Clinical consequences of polypharmacy in elderly. *Expert opinion on drug safety*. 2014; 13(1): 10.1517/14740338.2013.827660.
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3. Bourgeois FT, Shannon MW, Valim C, et al. Adverse drug events in the outpatient setting: an 11-year national analysis. *Pharmacoepidemiology and Drug Safety*. 2010; 19:901–10.
4. Doan J, Zakrewski-Jakubiak H, Roy J, et al. Prevalence and risk of potential cytochrome p450-mediated drug-drug interactions in older hospitalized patients with polypharmacy. *Annals of Pharmacotherapy*. 2013; 47:324–32.
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6. Jones CM, Mack KM, Paulozzi LJ. Pharmaceutical overdose deaths, United States, 2010. *JAMA* 2013; 309(7):657-659. doi:10.1001/jama.2013.272. CDC guideline for prescribing opioids for chronic pain. http://www.cdc.gov/drugoverdose/prescribing/guideline.html.

Original Medicare E/M requirement
Clarification of E/M service documenting requirements

At the beginning of 2019, the Centers for Medicare & Medicaid Services (CMS) outlined changes in how providers should document evaluation and management (E/M) services for Original Medicare. Some providers have asked us if Humana is adopting those changes. We are not. CMS has not indicated that those changes apply to Medicare Advantage plans.

Key points:

- For 2019, CMS outlined Original Medicare changes to E/M documentation that will allow practitioners to avoid repetitious entries in the medical record.
- The changes address documentation of procedural elements that previously were required for various levels of E/M coding and claims payment.
- The rule does not impact CMS' Part C Medicare Advantage guidance requiring accurate and complete documentation, to the highest degree of specificity, for all conditions coexisting at the time of the encounter and requiring or affecting patient care management or treatment.
- For services provided to Medicare Advantage enrollees, practitioners should continue to document the relevant clinical information that supports every condition for all encounters.

Help to improve your claim submissions
New Topics in the Making It Easier Series

Body text: The Making It Easier series is a library of information about Humana's claims payment policies and processes, with each topic addressed separately for easy access. The library includes a narrated video presentation and a printable tip sheet for each topic, all available 24/7 to be viewed at your convenience.

We continue to improve the Making It Easier series based on your feedback. Two topics added recently are highlighted below.

Claim Disputes and Corrected Claims: This material provides guidance about how to dispute a claim outcome or submit a corrected claim. It includes a description of each action and the criteria for determining which approach is correct. The presentation also outlines the information to be submitted and the process for each. It applies to medical claims only.

Understanding an Explanation of Remittance (EOR): This presentation provides guidance about how to access a remittance using Humana's online tools and how to interpret the information provided on remittances.

Other topics that have recently been updated include:

- Humana's Maximum Unit Values
- Application of Medicare NCD/LCD Guidelines
- Modifiers 59 and X{EPSU}

Look for these new presentations, and additional topics at **Humana.com/MakingItEasier**.

Find Humana's claims payment policies online
Updated claim payment policies available

Humana publishes its medical claim payment policies online. Information about reimbursement methodologies and acceptable billing practices may help physicians and other healthcare providers and their billing offices bill claims more accurately. This could reduce delays, rebilling and requests for additional information. Find the policies at **Humana.com/ClaimPaymentPolicies**.

Humana recently published new policies on the following topics:

- Missed appointments
- Ambulance transportation to a prior-authorized facility
- Electronic transactions
- Obstetrics

Latest changes to medical coverage policies
New and revised medical coverage policies

Humana's medical and pharmacy coverage policies are based on evidence published in peer-reviewed medical literature, technology assessments obtained from independent medical research organizations, evidence-based consensus statements and evidence-based guidelines from nationally recognized professional healthcare organizations.

Information about medical and pharmacy coverage policies can be found at **Humana.com/CoveragePolicies** by selecting "Medical and Pharmacy Coverage Policies" under "Resources." Policies can be reviewed by name or revision date. Users also may search for a particular policy using the search box. More detailed information can be found by reviewing "How to Read a Medical Coverage Policy" and "Understanding the Medical Coverage Policy Development Process" under “Helpful Links.”

Recent changes to medical and pharmacy coverage policies are listed below.

New Policies

- Molecular Testing for HLA-B*27 for Ankylosing Spondylitis

Policies with Significant Revisions

- Attention Deficit Hyperactivity Disorder (ADHD) – Diagnosis and Treatment
- Bunion and Bunionette Surgical Treatments
- Chiropractic Care
- Code Compendium (miscellaneous)
- Cognitive Rehabilitation
- Deep Brain Stimulation (DBS) and Cortical Brain Stimulation
- Direct-to-consumer (DTC) Laboratory Testing and Mobile Health (mHealth) Applications
- Fusion Imaging
- Genetic Testing for Hereditary Ataxias
- Genetic Testing for Muscular Dystrophy and Spinal Muscular Atrophy
- Implantable Infusion Pumps for Pain or Spasticity
- Injections for Chronic Pain Conditions
- Mobility Assistive Devices (wheelchairs)
- Molecular Diagnostic Testing for Reproductive Health
- Molecular Markers in Fine Needle Aspirates of Thyroid Nodules
- Pharmacogenomics and Companion Diagnostics
- Pharmacogenomics – Cytochrome P450 Polymorphisms and VKORC1
- Platelet Derived Growth Factors for Wound Healing
- Prosthetics
- Reduction Mammaplasty
- Rheumatoid Arthritis: Biologic Markers and Pharmacologic Assessment
- Sleep Studies, Adult

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Humana conference schedule

Look for Humana at a Conference near You

Humana will be attending the following conferences in 2019:

- American Academy of Family Practitioners (AAFP), Sept. 24–28, Philadelphia, Pennsylvania
- Medical Group Management Association (MGMA), Oct. 13–16, New Orleans, Louisiana , opens new window

Physicians and other healthcare providers are encouraged to mark their calendars for these events. Humana representatives look forward to meeting all types of healthcare practitioners.