The transition to value

Humana's 2020 Value-based Care Report

Helping people achieve their optimal whole-person health has long been a strategic imperative for Humana. To that goal, a new report shows that the company has lowered overall healthcare costs and helped deliver improved health outcomes for Humana Medicare Advantage beneficiaries affiliated with physicians in value-based payment models.

The annual Value-based Care Report, which can be accessed here, details how Humana uses a holistic approach to help beneficiaries manage numerous physical, behavioral and social challenges.

In particular, the report examines a number of social determinants of health, such as food insecurity and social isolation, and examines how physicians are managing and engaging patients to promote better chronic disease management and improve health outcomes.

The report's key findings:

- Humana Medicare Advantage members under the care of physicians in value-based agreements would have incurred an additional $3.5 billion in plan-covered medical expenses had they been under Original Medicare's fee-for-service model. Prevention screenings, improved medication adherence and effective management of patient treatment plans all contributed to creating these reductions.

- Humana Medicare Advantage members served by physicians/practices in value-based agreements had a 27% lower rate of hospital admission (131,200 fewer admissions) and visited emergency rooms 14.6% less often (110,700 fewer visits) compared with Original Medicare.

- Physicians in value-based agreements with Humana from 2016 through 2018 had a 4.44 average Healthcare Effectiveness Data and Information Set (HEDIS®) Star score at the end of 2018 based on 1.13 million Humana MA members, compared to a 3.10 HEDIS Star score for physicians serving 454,000 members in non-value based agreements.

- Humana Medicare Advantage members affiliated with physicians in value-based agreements received screenings as much as 21% more often in categories such as colorectal cancer, osteoporosis and blood sugar control than those in an MA non-value-based setting.

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2020 Vaccination Information

Fighting the flu in 2020

The Centers for Disease Control and Prevention (CDC) recommends that everyone 6 months and older get an annual flu vaccine.

The 2019 – 2020 trivalent seasonal flu vaccine covers the three flu strains that research suggests will be most common in the northern hemisphere:

- A/Brisbane/02/2018 (H1N1)pdm09-like virus
- A/Kansas/14/2017 (H3N2)-like virus
- B/Colorado/06/2017-like (B/Victoria/2/87 lineage) virus

Also available is a quadrivalent vaccine that will include the B/Phuket/3073/2013-like virus (Yamagata lineage).

Also relevant for the 2019-20 season:

- The Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics (AAP) recommend that any licensed influenza vaccine appropriate for the age and health status of a patient can be used with no specific preference given to either the LAIV4 (nasal spray) or inactivated influenza vaccine (shot).
- **Humana data confirms the appropriateness of the high-dose flu vaccine for older adults.** In a study presented at the American Public Health Association annual meeting in November 2018, high-dose trivalent vaccine for prevention of flu was more effective than standard-dose trivalent and standard-dose quadrivalent vaccines. View the full research here. View the infographic here.

Preauthorization news

The 2020 PAL, OrthoNet review and a useful tip

Preauthorization list updates. Humana has updated its preauthorization and notification lists for all commercial fully insured, Medicare Advantage (MA) plans and dual Medicare-Medicaid plans. The lists now include all CPT and HCPCS codes that require an authorization, making them more user friendly. The lists can be found here.

A tip for faster approvals

Did you know that you can get speedier approvals for select services on Humana's preauthorization list? Just enter the Availity Portal, answer a few clinical questions and upload relevant clinical information. If all necessary criteria are met, Humana will instantly approve your request. And even if it doesn't, the

answers you provide on the questionnaire and the information you upload will help Humana complete the review more quickly.

To save time when submitting your request for instant authorization, have on hand relevant clinical information from the patient's chart, including:

- Standard authorization information, such as requesting and servicing provider and/or facility
- Patient's signs and symptoms and their duration
- Related prior diagnostic tests and results
- Related patient medications and duration
- Relevant prior treatments or other clinical findings

All you have to do is sign in to the Availity Portal and create a typical authorization request, then check for the "Click to Complete Questionnaire" button. If the button is present, you can use it to expedite your preauthorization request. Click it, answer the questions, and you'll receive an immediate decision about preauthorization. If your request is pended, upload the relevant clinical information.

OrthoNet to review outpatient services in 2020

Starting Jan. 1, 2020, OrthoNet will begin clinical review of pre-authorization and retro-authorization (pre-claim) requests for outpatient therapy services. Review will include physical, speech and occupational services performed by licensed therapists in freestanding locations, physician offices, outpatient hospitals and skilled nursing facilities (when a member is not admitted to the SNF). OrthoNet will not review therapy services performed by chiropractors or services performed by licensed therapists in the home or while members are admitted to a hospital or SNF.

For therapy episodes of care that commence prior to Jan. 1, 2020, prior authorization will not be required for visits that occur before Feb. 1, 2020. After Feb. 1, prior authorization will be required. All members starting therapy on or after Jan. 1, 2020, will require all visits, other than the initial evaluation, to be prior authorized.

Healthcare providers should submit therapy requests directly to OrthoNet via its web portal, phone (1-844-938-0346) or fax (1-844-938-0353). Providers not currently registered are encouraged to visit www.orthonet-online.com or www.myoptumhealthphysicalhealth.com to create a user login prior to their first request. Doing so will allow time for processing.

Pharmacy news

Changes announced for 2020 formularies

Beginning Jan. 1, 2020, certain drugs will have new limitations or will require utilization management (e.g., prior authorization [PA] requirements, step therapy [ST] modifications and nonformulary [NF] changes) under the Humana commercial and Medicare formularies for the 2020 plan year. These

changes could mean higher costs or new requirements for Humana members who use these drugs. Humana encourages the use of generic and cost-effective brand medications whenever possible. Find all the details here.

Medicaid news

Humana takes over from CareSource

Kentucky Medicaid Update – Humana and CareSource have terminated the current alliance between the companies servicing the Kentucky Medicaid market, effective Dec. 31, 2019. Humana will become the existing contract's sole administrator effective Jan. 1, 2020. We'll have more news about this transition soon. Visit our Kentucky Medicaid page for more information.

CMS change in claim ID for 2020

The MBI has replaced the HICN

The Centers for Medicare & Medicaid Services (CMS) completed the transition from the older Social Security number-based Medicare ID, also known as a Health Insurance Claim Number (HICN), to a new Medicare Benificiary Identifier (MBI). Please remember that you must not use the the older HICN after Dec. 31, 2019.

Humana Medicare Advantage members should continue to present their Humana Medicare ID card when receiving medical services.

CMS transitioned to the new MBIs to help protect Medicare beneficiaries from identity theft. New Medicare ID numbers and ID cards were issued to all Medicare beneficiaries between April 1, 2018, and April 1, 2019.

Additional information about this change is available on CMS' "What do Medicare Beneficiary Identifiers (MBIs) mean for health care providers & office managers?" webpage.

New CMS SNF reimbursement policy

From RUGS to PDPM for SNF PPS

On Oct. 1, 2019, the Centers for Medicare & Medicaid Services (CMS) changed the reimbursement methodology for the Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS) from resource utilization groupings (RUGs) to the new Patient Driven Payment Model (PDPM).

To submit claims to Humana, healthcare providers should update their billing in accordance with CMS guidelines.

Humana will apply the new payment methodology where applicable and in accordance with CMS guidelines when paying the Medicare allowed amount.

A new authorization is required for Humana-covered patients discharged from an SNF after midnight. However, consistent with CMS' interrupted stay policy, the new authorization will not reset the variable per diem adjustment schedule. Humana will continue to determine pricing for these claims based on CMS' interrupted stay rules.

Providers who receive authorization from naviHealth should continue to follow the required Omnibus Budget Reconciliation Act (OBRA) Assessment Schedule, as directed by naviHealth, and use the PDPM code they received from naviHealth when submitting their claims. All other providers should follow CMS' expectations and schedule of assessments – as outlined by the CMS RAI-MDS 3.0 and Medicare billing manuals.

If you have questions, please contact your Humana market contractor representative as soon as possible.

For additional information about SNF PDPM, you can visit the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html.

Annual compliance training

Mandatory compliance training in 2020

If your organization supports Humana's Medicare Advantage plans, prescription drug plans and/or Medicaid plans, the Centers for Medicare & Medicaid Services (CMS) and Humana require that you, your employees and contractors receive training on fraud, waste and abuse (FWA) at orientation and annually thereafter.

For FWA training, your organization is responsible for:

- Creating or adopting FWA training content
    - If you prefer, you may use FWA material CMS posts on its website; or
    - You may use content pertaining to FWA from Humana's Standards of Conduct and Compliance Policy documents to supplement other training material. These documents are found on www.Humana.com/Fraud.
- Conducting and tracking the training

If your organization supports special needs plans and/or a Medicaid plan:

- Annual training separate from FWA training is required.

- Humana requires applicable organizations to submit an attestation to certify the SNP training and/or Medicaid training has been conducted this calendar year.

Visit our website today at www.Humana.com/ProviderCompliance for additional information on these training requirements.

Education and training

The Making It Easier series is even easier to access

Accessing a Making It Easier presentation is now easier than ever. When you click on the topic you have selected, the presentation will start immediately. The Guestbook has been removed, giving you easier access to all the information and other features on the page.

Two new topics have been added to this library of information about Humana's claims policies and processes.

Modifiers 76 and 77

This topic addresses Humana's policy on the use of modifiers 76 and 77 to indicate that a service is a repeat procedure. This presentation applies to claims submitted for professional and facility services for your patients with Humana Medicare Advantage, commercial and select Medicaid plans.

Genetic Testing: Billing and Coding for Medical and Laboratory Providers

This topic addresses Humana's billing expectations for coverable medically necessary genetic testing and how Humana will adjudicate and reimburse claims for those covered services. This information applies to claims submitted for your patients with Humana Medicare Advantage, select commercial and select Medicaid plans.

Other recently updated presentations include:

- Tools and Resources for Physicians and Other Healthcare Providers
- Use of Non-Specific Procedure Codes
- Anatomical Modifiers
- Procedure-to-Procedure Code Editing

Look for these presentations and additional topics at Humana.com/MakingItEasier (https://www.humana.com/provider/support/tools/making-it-easier).

Claim payment policies

Find Humana's claims payment policies online

Humana publishes its medical claims payment policies online. The 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 claims payment policies. [LINK: www.humana.com/claimpaymentpolicy].

We recently published new claims payment policies on the following topics:

- Inpatient Readmission Review
- Modifiers CO and CQ

And we updated the following policies:

- Chronic Care Management and Principal Care Management
- Telehealth Services

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Medical coverage policies

New and revised medical coverage policies

New Policies

- Code Compendium (Laboratory)
- Prostatectomy

Policies with Significant Revisions

- Biofeedback
- Bone Density Measurement
- Capsule Endoscopy
- Carpal Tunnel Syndrome (CTS) Surgical Treatments
- Cold Therapy Devices/Heating Devices/Combined Heat and Cold Therapy Devices
- Comparative Genomic Hybridization/Chromosomal Microarray Analysis
- Cosmetic Surgery, Reconstructive Surgery, Scar Revision
- Diagnostic Esophagogastroduodenoscopy (EGD) or Esophagoscopy (age 59 or younger)
- Drug Testing
- Electrical Stimulators for Pain and Nausea-Vomiting
- Extended Ophthalmoscopy
- Fecal Incontinence Treatments
- Genetic Testing for Angelman Syndrome and Prader Willi Syndrome
- Genetic Testing for Carrier Screening
- Genetic Testing for Colorectal Cancer Susceptibility
- Left Atrial Appendage and Cardiac Structural Defect Closure for Stroke Prevention
- Multianalyte Assays with Algorithmic Analyses (MAAAs)
- Noninvasive Prenatal Screening

- Obstructive Sleep Apnea (OSA) and Other Sleep Related Breathing Disorders Nonsurgical Treatments
- Pharmacogenomics and Companion Diagnostics
- Serological and Fecal Testing for Inflammatory Bowel Disease (IBD)
- Skin and Tissue Substitutes Spinal Decompression Surgery
- Spinal Fusion Surgery
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)
- Ultraviolet Light/Laser Therapy for Skin Conditions
- Urinary Incontinence Evaluation and Treatments

Recent Humana research

U.S. healthcare wastage approaching $1T; and more

Featured research: Humana research unveils up to $935 billion of annual waste in the US health system

It has been nine years since Donald M. Berwick, M.D., MPP, and Andrew D. Hackbarth, MPhil, demonstrated that over 30% of healthcare spending is waste. Considering the attention healthcare costs are getting in our political landscape and the unsustainable rise in healthcare costs, we wanted to reassess. Our study demonstrated that the total waste estimate was between $760 to $935 billion per year, or approximately 25% of U.S. healthcare expenditures. The study provides separate estimates for six previously recognized waste domains: failure of care delivery, failure of care coordination, overtreatment or low-value care, pricing failure, fraud and abuse and administrative complexity. Chief Medical Officer Dr. William Shrank's team built on the previously published cost of waste estimates by estimating potential savings from scaling up interventions shown to reduce those wasteful expenditures. Potential savings ranged from $191 to $282 billion per year.

The study, "Waste in the US Health Care System. Estimated Costs and Potential Savings," was published online Oct. 15, 2019. View a related infographic here**.**

Check out these other recent publications:

- Responding to Dr. Roy Beveridge's leadership, a Humana-funded panel of **18 experts met to develop practical, broadly applicable definitions** for the terms value-based care, value-based payment and population health. View the research here.

- We know that **increased PCP visits may lead to improved health of patients with diabetes**, but what's the sweet spot? This research adds to the data needed to establish evidence-based guidelines for primary care provider encounter cadence. View the research here.

- **This review collected 15 studies analyzing discordant recommendations in guidelines on indications for imaging. Findings of this review might help clinicians more thoughtfully use guidelines and appropriate use criteria.** View the research here.

- **Value-based payment arrangements** with physicians appear to encourage greater use of primary care resources and less reliance on emergency department care. Results should be interpreted with caution because of several study limitations. We may learn more from longer follow-up of the same patient cohort. View the research here.

- Scoring **algorithms for the Charlson Comorbidity Index (CCI) received a much-needed update.** Prior to this research, no coding scheme had been published that included both ICD-9 and ICD-10 *c*ode tables for the 19 medical conditions that comprise the CCI score. View the research here.

Ways to connect: Have questions or want to share ideas for other research opportunities? Please write to research@humana.com.

Interested in seeing more research? Visit Humana's research site to learn about past research projects, listen to podcasts, and view videos that showcase Humana's commitment to research. Access our highlighted research here or visit our full research library here.