Jefferson.

Prescriptions for Excellence in Health Care Newsletter Supplement
A collaboration between Jefferson School of Population Health and Eli Lilly and Company

Volume 1
Issue 15 *Prescriptions for Excellence In Health Care*
Issue #15 Spring 2012

Article 5

May 2012

Health Care Innovation in Medicare Advantage: The Humana Experience

Tom James MD
Humana, Inc.

ISSUE 15 SPRING 2012

Prescriptions for Excellence in
HEALTH CARE

A COLLABORATION BETWEEN JEFFERSON SCHOOL OF POPULATION HEALTH AND LILLY USA, LLC

Health Care Innovation in Medicare Advantage: The Humana Experience

By Tom James, MD

In 2010, the costs to the United States for Medicare services for its 46,589,141 beneficiaries were estimated to be $457.6 billion dollars - 12.6% of the entire federal spend.[1,2] Although escalating Medicare costs have been recognized as a serious problem for more than a decade, effective solutions have been elusive.

Medicare Advantage (MA) evolved from a program called Medicare + Choice (or Part C) that was introduced through the Balanced Budget Act of 1997. With the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, changes were made to the structure and reimbursement processes of Part C and the name was changed to Medicare Advantage. This offering of traditional Medicare plus additional benefits through private insurers was an effort to enhance benefits while controlling costs. Over the course of its history, federal modifications have made health plan participation more, or at times less, attractive.

With some 4.2 million members, Humana is the second largest participant in MA. Of these members, 1.9 million are enrolled in an MA health maintenance organization (HMO) or preferred provider organization (PPO) product and 2.3 million have elected a prescription-only Part D plan. Because of Humana's position in the MA space, and because of its 25 years of continuous Medicare experience, the organization has devoted significant resources to the development of programs that identify and fill gaps in care and gaps in support services for its MA membership.

The Current Environment for US Seniors

The United States is undergoing a demographic shock as the baby boomer generation enters the Medicare age group. Between 2006 and 2030, the senior population older than 65 years of age will grow at a rate 10 times faster than that of the working population. During 2011 alone, an estimated 7600 individuals turned 65 each day. Originally, Medicare funding was predicated on having a large enough work force population to financially support Medicare beneficiaries. As the balance between these populations has shifted, the pressure on the Centers for Medicare and Medicaid Services (CMS) to reduce costs, increase income, or develop a combination of both has increased.

MA helps to make the costs of care more predictable for CMS. Private health insurers that participate in MA are paid a capitation fee calculated on the basis of a risk-adjustment factor for each beneficiary who selects the MA plan. In return, the health plan must offer benefits that are equal or superior to those of traditional Medicare as well as additional benefits and/or cost reductions to the beneficiary. Unlike traditional Medicare, MA plans operate much like their counterparts for commercial plans by offering HMO or PPO benefit products. Currently, 25% of Medicare-eligible people join an MA plan because many beneficiaries benefit financially from the reduced out-of-pocket expenses.

The Patient Protection and Affordable Care Act (ACA) included provisions to reduce Medicare spending by initially freezing payments to MA plans at 2010 levels. In subsequent years, the aggregate payment will be reduced by an estimated 12% per year until payment to MA plans is at the level of traditional Medicare for similar population demographics.

Directions in Quality of Care

Over the past several years, CMS has encouraged significant advancements

(continued on page 2)

in measuring quality of care as experienced by the patient. These efforts have been in concert with the work of former CMS Administrator, Donald Berwick, MD, MPP at the Institute for Healthcare Improvement (IHI). From his work at IHI, Dr. Berwick has advanced the concept of the Triple Aim: improved care for the individual, better population health, and reduced health care costs through innovation in care processes. CMS has relied primarily on public display of data and on financial incentives/disincentives to drive the Triple Aim. Most of the information contained in its public displays (ie, Hospital Compare and Physician Compare Web sites) has been obtained from self-reported data. The value of such self-reported data is limited because of variation in reporting. Financial incentives to physicians have come through direct bonus incentives from its Physician Quality Reporting System and from implementation of electronic health records through the Meaningful Use legislation.

Although MA plans may participate in such CMS activities, they have greater opportunities to influence quality outcome processes. Indeed, CMS promotes quality competition among MA plans through bonuses paid for higher performing MA plans (ie, those with 3-, 4-, or 5-star ratings).

Humana's Approach to Improving Quality of Care for its MA members

Humana's approach to quality improvement is through measurement and analysis that recognizes the individual member's health knowledge, beliefs, and behaviors as a cornerstone - but also acknowledges the impact of caregiver influence, local medical practice patterns, and the role of population-based interventions. These concentric rings of influence on an individual member's health-seeking behaviors mean that there must be health plan strategies at a number of member touch points to truly have impact.

Programs that engage members one-on-one are directed at individuals with the greatest need; for instance, many of these are patients with catastrophic conditions. Case managers are true care coordinators and case management programs assist individuals with complex health care needs in navigating a very fragmented medical environment.

Humana Cares is a case management program that involves a team effort guided by a designated field coordinator (nurse) who visits the senior in her or his home to assess health care needs. For instance, many seniors take multiple medications and may become confused about their treatment regimens. After reviewing the medications in the member's home, the field coordinator may consult with a Humana pharmacist and the member's primary care physician to eliminate duplicate medications, medications that have expired, and medications that are no longer on the prescribed list of drugs.

Whether the nurse connects with the senior member by phone or in person, the patient's health literacy, beliefs, and values are assessed. This assessment is a critical part of patient-centered care. Even if the MA benefits are set, Humana can tailor programs to meet the patient's goals for care. In a study of the Humana Cares program, 77% of engaged members reported that they are more prepared to manage their own health. Some 15% reported no falls in the 6 months after engagement with Humana Cares, 16% believed that their health has improved because of the program, and 14% reported that depression no longer interferes with their daily living. These are powerful outcomes from a targeted program.

Many seniors, especially those who are frail, have caregivers who tend to their needs. Often these caregivers are daughters or sons of the elderly member, and in other circumstances they may be a sibling, cousin, friend, or community advocate. Caregivers often have greater facility with electronic or cellular modes for gaining information. Although the senior may trust only communication that is in person or telephonic, a caregiver who is equally facile with Internet or mobile applications may have access to much more information. Social media is becoming a significant source of information; for example, Humana includes more information aimed at the caregiver in its Humana Medicare Advantage Web site and in the MyHumana mobile application.

Population Management

The goals of population management for the Humana MA program are to provide care coordination services for those with catastrophic conditions and to provide support through in-person, telephonic, and Web-directed programs for those seniors with multiple chronic conditions. However, for those who currently are functioning well, the goal is wellness maintenance. Helping to keep Humana MA members active and aging confidently at home is essential. Multiple programs are geared toward engaging the senior in Humana's Fitness and Physical Activities benefits; for example, basic fitness center membership for individual or group level exercises, and programs such as Silver Sneakers are quite popular with seniors. Nearly 300,000 Humana MA members are enrolled in these programs, and 48% of the 102,000 members who participate actively report improvement in their sense of health and well-being.

Usable Information

In the United States, where paper medical records predominate, there is great variability in the level of appropriate care patients receive. MA health plans such as Humana's have great capacity to become information connectors for doctors and their MA patients. MA health plans are turning their large claims inventories into useful information databases. Rules engines work within the data

(continued on page 3)

This newsletter was jointly developed and subject to editorial review by Jefferson School of Population Health and Lilly USA, LLC, and is supported through funding by Lilly USA, LLC.

warehouses to define clinical episodes of care, attribute those episodes to the physicians responsible for managing the patient, and determine if anticipated preventive services were provided. The National Quality Forum (NQF), the National Committee for Quality Assurance, and the National Quality Strategy have reached a consensus regarding quality standards.

Using the rules engine from its data warehouse, Humana provides information to members in a format and font appropriate to the senior population. The same information is shared with Humana's network physicians in a letter that was developed with input from focus groups of practicing physicians. Experience has shown that information provided to doctors by insurance companies frequently is discredited because physicians feel that many such letters have been written in a patronizing manner, because the data do not appear credible to the physician, or because the format is not compatible with the office's management of paper. Humana has received positive input on its new format for information sharing. Importantly, there has been a documented increase in adherence to NQF-endorsed quality standards compared to traditional Medicare; for example, Humana members have a 9% higher rate of breast cancer screening, an 8.5% reduction in 30-day readmissions, and a 15.7% reduction in emergency room visits. These measures represent significant improvements in meeting quality standards.

MA programs, such as those offered by Humana, have the opportunity to improve care coordination for those with catastrophic illnesses, enhance education for those with multiple chronic conditions, and promote wellness among those with good functional capacity. Such programs emphasize quality and have the data to support it. Managed care programs have the potential to improve outcomes for more Medicare beneficiaries if more widely adopted.

Tom James, MD, *is Medical Director, National Operations Network, for Humana, Inc. He can be reached at tjames@humana.com.*

References

1. Kaiser Family Foundation. StateHealthFacts.org. http://www.statehealthfacts.org/comparemaptable.jsp?ind=290&cat=6. Accessed September 19, 2011.

2. US Government Printing Office. Budget of the United States Government: Detailed Functional Tables, Fiscal Year 2010. http://www.gpoaccess.gov/usbudget/fy10/fct.html. Accessed September 19, 2011.

This newsletter was jointly developed and subject to editorial review by Jefferson School of Population Health and Lilly USA, LLC, and is supported through funding by Lilly USA, LLC.