



Value-based Care Report

Highlighting physician progress
and patient outcomes

Physicians in value-based agreements with Humana are evolving and seeing results. This report details three key areas of data: prevention, outcomes and cost and payments for Humana Medicare Advantage individual members assigned to primary care physicians in value-based agreements.

Humana shares these results annually to spotlight physicians' progress and to highlight how the company supports them helping their patients achieve their best health.

As with the previous five years' results, the 2018 statistics cannot be directly compared year over year due to multiple demographic changes in Humana's member population.

Humana[®]

[ValueBasedCare.Humana.com](https://www.humana.com/valuebasedcare)

Table of contents

01 | Introduction

- 01 | The transition toward value
- 03 | Breaking down the value-based continuum

05 | Prevention

- 05 | Prevention insights from value-based care (VBC) settings
- 07 | Annual wellness visits
- 08 | Pharmacy: A collaborative focus on adherence
- 09 | Population health: Local strategies with big results

11 | Outcomes

- 11 | Outcomes insights from VBC settings
- 13 | Exceeding patient expectations and experiences
- 14 | Kindred at Home: Bringing physicians' care into the home

15 | Cost and payments

- 15 | The cost of care in value-based settings
- 17 | Investing in practice sustainability
- 19 | The case for bundled payments
- 20 | A new dialogue between payers and physicians

21 | Conclusion

- 21 | A look ahead
- 22 | Adding virtual care in 2020

23 | Authors

The transition toward value

William Shrank M.D., MSHS
CHIEF MEDICAL AND CORPORATE AFFAIRS OFFICER

The case for value-based care (VBC) continues to gain strength as we see more physicians participating, investing in new forms of care delivery and taking on greater financial risk for the management of populations.

The collaboration between health care providers and payers is intensifying.

An integrated approach, value-based care relies on health plans, physicians, clinical providers, hospitals and communities to make a unified effort to improve health outcomes. The goal is to focus on value and move away from the traditional fee-for-service system—one that incentivizes providers to deliver more services, routinely resulting in fragmented care and leaving patients to navigate a complex system by themselves.

As expected, progress takes time. While payment models can be changed quickly, the full transformation to coordinated, integrated care requires ongoing partnership and work.

Despite all of the change, one element has stayed consistent and critical: data

Transparency and sharing actionable data has connected health care providers like never before, expanding our understanding of the very personal challenges and needs of our patients. First, we're working to connect with physicians via their electronic health record through our relationship

with EPIC to make actionable, patient-centric data easier to access. Second, we recognize that social and environmental factors are critical to health, so we are asking our home health nurses, along with associates at other patient touchpoints, to begin screening patients for these social determinants.

At Humana, data shows that value-based care is working to improve the health and experience of patients and providers.

Two-thirds of Humana individual Medicare Advantage (MA) members are assigned to primary care physicians with value-based agreements.

- That's 53,400 physicians that we are working with closely, supporting them in the care of their patients and helping them make these positive health outcomes possible.¹

Physicians in value-based arrangements encouraged more engagement from their Humana-covered MA patients in 2018, resulting in:

- Higher rates of preventive care and screenings (up by 21% in some areas), compared to non-value-based arrangements¹
- Fewer emergency room visits and hospital admissions (down by 7% and 5%, respectively), compared to non-value-based arrangements¹
- Higher overall Healthcare Effectiveness Data and Information Set (HEDIS) scores (43% higher compared to those treated at non-value-based practices)¹

PCP practices in Humana MA value-based payment agreements received more of the health care dollar spent nationally on health care costs than their fee-for-service counterparts.

Physicians in value based arrangements with Humana received 15.5 cents for every national health care dollar spent, while physicians in fee-for-service settings received only 6.3 cents for every health care dollar spent.¹ The national Medicare average is 4.88 cents.²

Humana value-based care physicians earn an average of 167% of Medicare's fee schedule.¹

Those physicians in the most advanced stage of our primary care continuum earn 250% more than the Medicare fee schedule on average.¹

As debate ensues both on Capitol Hill and across the country about how to cure our ailing health care system, health and well-being companies like Humana are demonstrating that MA has many structural solutions in place to improve the health of our members, make health care more affordable and improve the consumer experience.

That's partly because MA serves as a rich laboratory for value-based care, fostering integrated and coordinated management of chronic conditions and a holistic view of the patient.

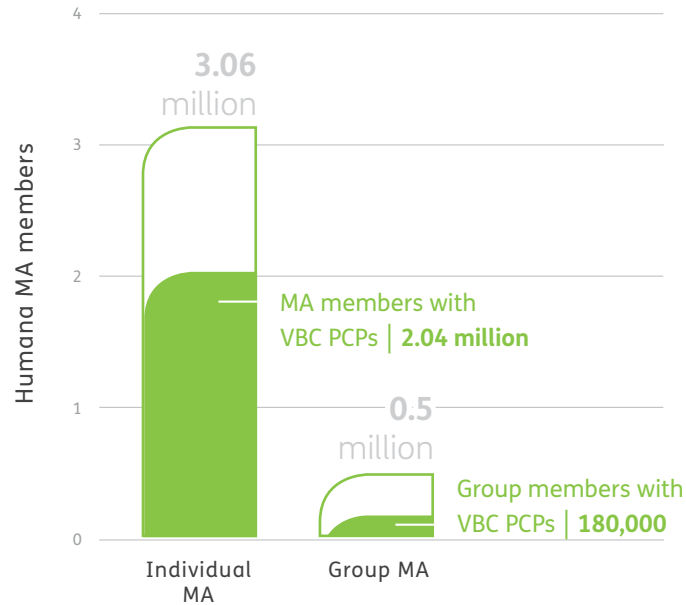
Moving the industry forward with a focus on value is not something we can do alone. Our dialogue with physicians, community organizations and other health care providers is essential to developing a sustainable health care system that improves population health and reduces costs for everyone. ■

“

This is our sixth year reporting our value-based care results, and again, you'll see how support for this model continues to grow.

”

WILLIAM SHRANK, M.D.



As of Dec. 31, 2018

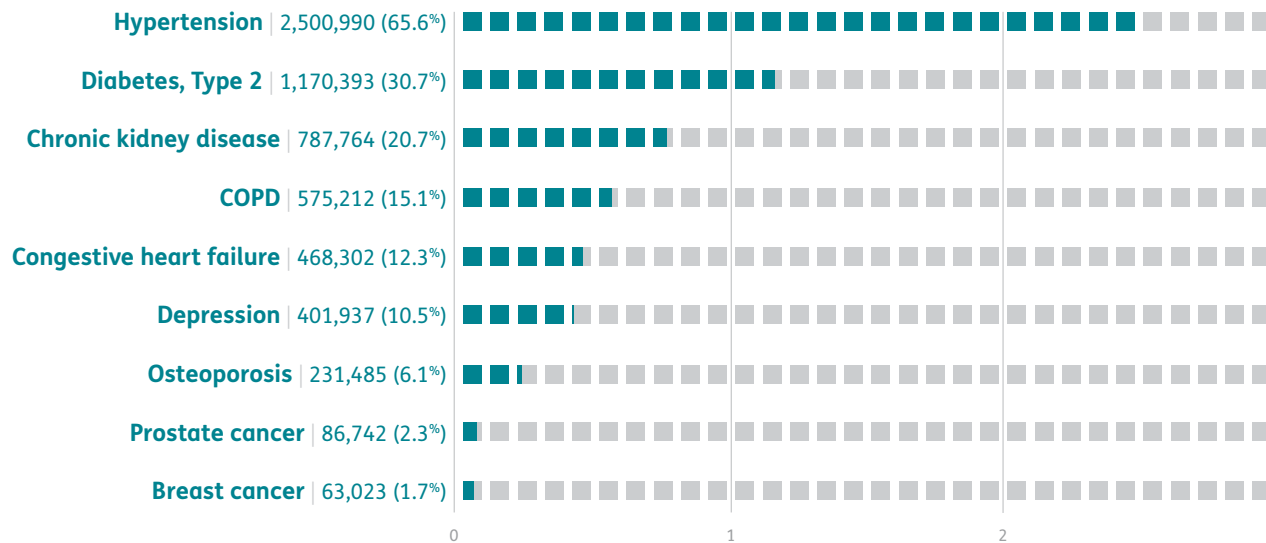
Humana at a glance

As of Dec. 31, 2018, 53,400 primary care physicians have value-based relationships with Humana. Those affiliations include more than 1,000 agreements in 43 states and Puerto Rico.

As of Dec. 31, 2018, Humana's total MA membership was approximately 3.56 million members, including roughly 3.06 million individual MA members.¹

Of Humana's individual MA membership, **67%**, or 2.04 million, is affiliated with primary care physicians in value-based agreements. Roughly 36% of group MA membership is with value-based physicians.¹

Humana MA members (in millions)¹



Chronic conditions

90.5% of Humana MA members have at least one chronic condition.¹

82.6% of Humana MA members have at least two chronic conditions.¹

The graphic to the left shows common conditions that existed among all Humana MA members during calendar year 2018. Figures include both partial- and full-year members. The numbers exceed the total Humana MA membership due to co-morbidities.

Breaking down the value-based primary care continuum

Jonas de Souza, M.D., MBA
DIRECTOR, CORPORATE STRATEGY

As the health care industry shifts away from the traditional fee-for-service (FFS) structure to focus on value, Humana has designed a series of value-based care models so physician practices can find the model that works best for their practice and patients. Humana relies on physician input around operational needs, infrastructure and other practice characteristics to develop designs that support successful transitions.

The continuum, shown on the facing page, begins with the current state for many groups—FFS—and extends to global value (or full accountability), in which practices assume total responsibility for, and management of, their patients' care.

Sixty-seven percent of Humana MA members are assigned to primary care physicians who have value-based agreements with Humana. Most of those (36% of total MA members) are assigned to PCPs earning a bonus plus shared savings, an upside-only agreement where they receive a combination of fees for services, quality bonuses and limited shared savings for Medicare Parts A, B and D.

It's important to note that the continuum is not designed to advance all PCPs to global value, but instead to meet them where they are.

Physicians in value-based contracts receive incentives for the quality care they provide, regardless of where they are on the scale. However, incentives are increased for improvements in quality, outcomes and cost-effectiveness as one moves further along the path.

Humana's continuum of programs supports transitions from non-value-based care to value-based care by helping PCPs develop population health management capabilities, enabling them to pinpoint root causes and take preventive steps.

By sharing actionable data, Humana offers physicians and other health care providers an expanded view of their patients.

This transparency means we can work together to develop a more seamless health care delivery system to provide the highest quality of care. ■

A closer look

The path to value-based care is a journey, often with several twists and turns.

Below are three practices of varying sizes from around the country that have found success in value-based care. Follow the links to learn how they're not just making it work—but thriving.



Florida Medical Clinic

[Humana.com/FMCRresults](https://www.humana.com/FMCRresults)

66

PCPs³

54

Locations³

12,950

Humana MA members³



Mercy Northwest Arkansas

[Humana.com/MercyResults](https://www.humana.com/MercyResults)

222

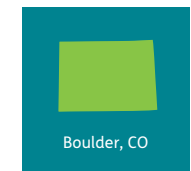
PCPs⁴

43

Locations⁴

3,500

Humana MA members⁴



Community Medical Associates / Boulder Community Health

[Humana.com/BCHresults](https://www.humana.com/BCHresults)

51

PCPs⁵

11

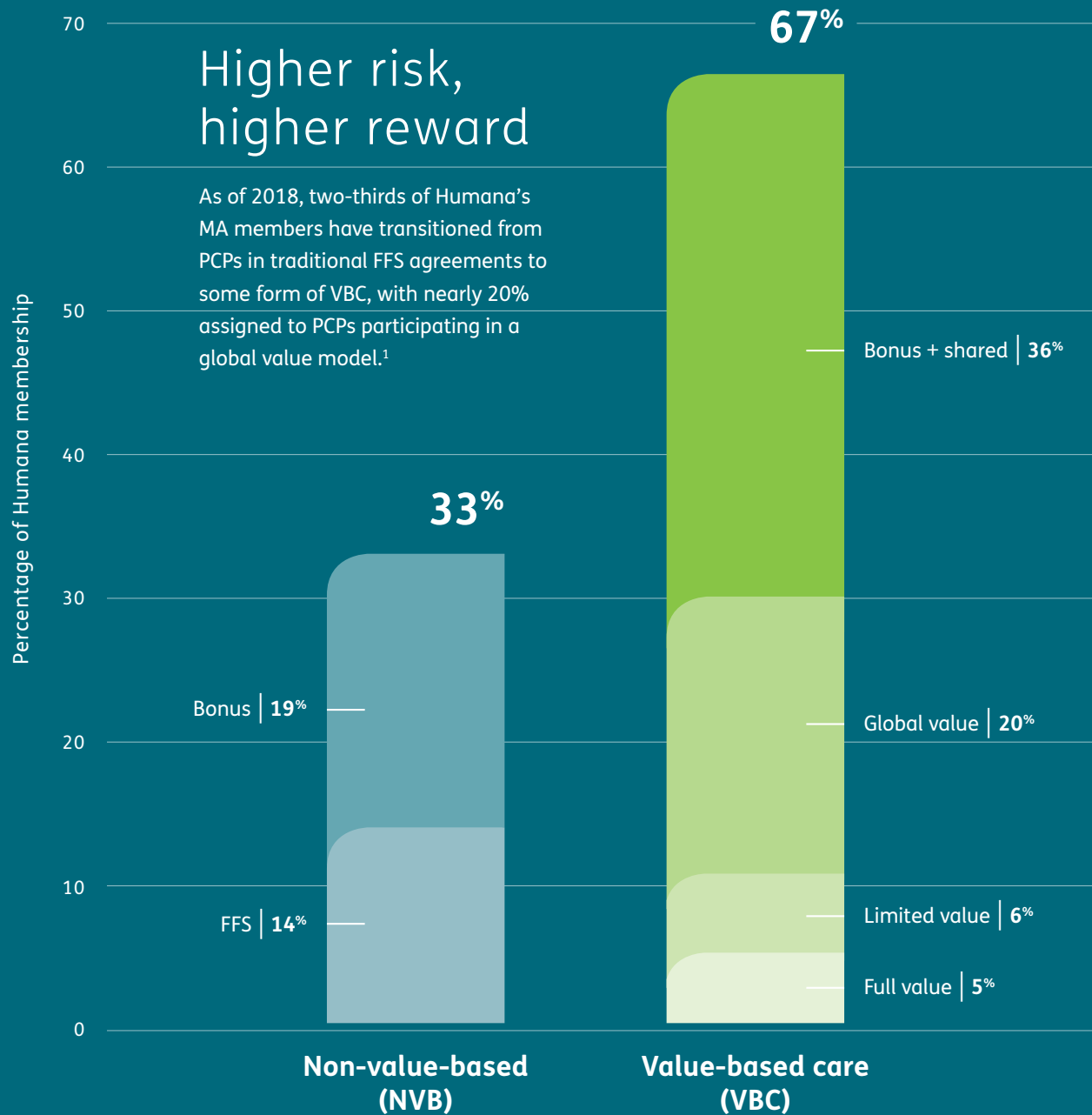
Locations⁵

940

Humana MA members⁵

Higher risk, higher reward

As of 2018, two-thirds of Humana's MA members have transitioned from PCPs in traditional FFS agreements to some form of VBC, with nearly 20% assigned to PCPs participating in a global value model.¹



The continuum explained

To support value-based care, Humana has developed a continuum of programs that offers financial rewards for improvements in quality, outcomes and cost.

- FFS**
 Pays for the services a patient receives
- Bonus**
 FFS + additional compensation for meeting quality measures
- Bonus + shared**
 FFS + bonus + potential for limited shared savings (upside only) in Medicare Parts A, B and D
- Limited value**
 FFS + bonus + care coordination payment + higher portion of shared savings in Medicare Parts A, B and D
- Full value**
 FFS + 100% responsible for Medicare Part B expenses and sharing of Part A (may have shared savings or complete responsibility for Part D)
- Global value**
 Full responsibility for Medicare Parts A, B and D through monthly capitated payments

Prevention insights from VBC settings

Adrienne McFadden, M.D., JD
REGIONAL VICE PRESIDENT, HEALTH SERVICES

Prevention forms the foundation for lifelong well-being.

Of course, preventive screenings don't catch everything. They do, however, frequently identify what may threaten our longevity. And while all physicians build routine screenings into their care regimens, those in value-based settings tend to see more of their patients getting them done.

Patients whose primary doctors were in a Humana Medicare Advantage value-based setting in 2018:

- Received preventive screenings at least 3% more often than those in an MA non-value-based settings.¹
- 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.¹
- Were more adherent to statins, hypertension and diabetes medications than those of non-value-based doctors.

Among Humana MA members, 90.5% have at least one chronic condition, and 82.6% have at least two, making prevention and medication adherence pivotal in managing these conditions.¹ As discussions with clinicians evolved, Humana has found ways to support their efforts through transparency and data sharing:

For example, Humana market representatives share predictive modeling data to identify opportunities with

patients who are noncompliant with preventive screenings.

The Humana Stars team presented bimonthly webinars on key Healthcare Effectiveness Data and Information Set (HEDIS®) measures, which detailed specifics about the measures, requirements for closing care gaps related to those measures, proper coding for associated screenings and measure-specific best practices. Each session was virtually attended by more than 1,200 physicians, administrators and other clinical staff from across the country.

Social determinants of health continue to be a critical piece of clinicians' care models, since we know they can contribute to an individual's well-being. Humana helped physicians address social determinants in two key ways:

- By sharing tools and resources with physicians and care teams, they were able to develop strategies aimed at keeping patients out of the hospital and preventing emergency rooms from being their primary option for care.
- Humana's Bold Goal initiative, a population health strategy aimed at improving the health of the communities we serve, teamed with community agencies to create proactive interventions, build

“

Clinical preventive services, such as routine disease screening and scheduled immunizations, are key to reducing death and disability and improving the nation's health.

”

HEALTHYPEOPLE.GOV

clinical programs and make additional resources available.

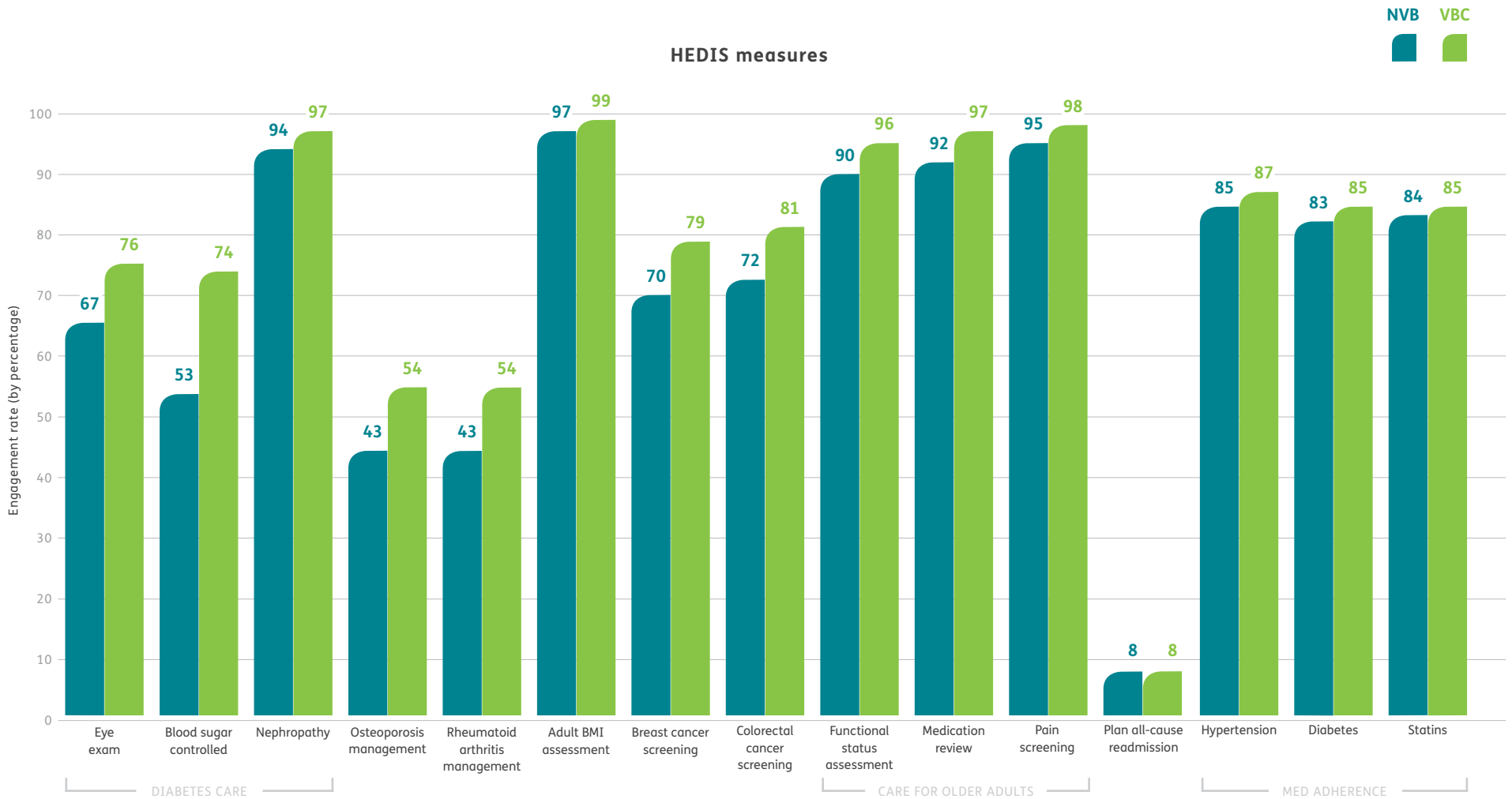
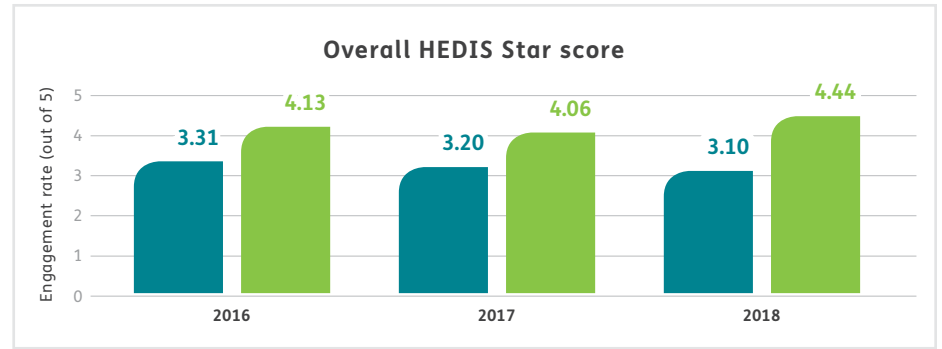
Overall, Medicare Advantage members living in one of the company's original seven Bold Goal communities across the country saw a 2.7% reduction (as of 2018) in self-reported unhealthy days since the initiative began in 2015.¹ ■

Scoring higher in provider engagement

Across nearly every care category, physicians in value-based care arrangements have scored higher than those in non-value-based (NVB) models, based on HEDIS scores.¹ The chart below shows the survey results for select measures among 2018 continuously enrolled Humana MA members, of which

847,961 were in non-value-based physician agreements vs. 1,852,193 in value-based physician agreements. With plan all-cause readmissions, lower numbers are more favorable.

To the right are overall HEDIS Star results for MA patients continuously enrolled during 2016, 2017 and 2018.



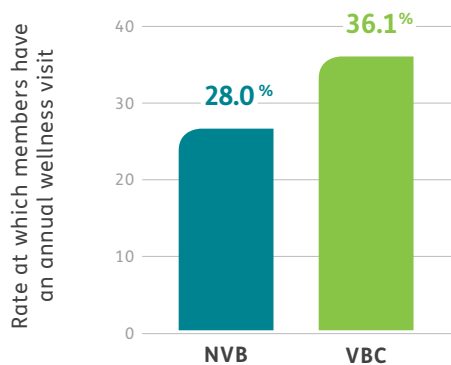


Annual wellness visits

Todd Prewitt, M.D.
CORPORATE MEDICAL DIRECTOR

Annual wellness visits serve as the basis for a patient’s care regimen over the ensuing 12 months. For physicians in value-based arrangements, the exam at no cost to Medicare members provides a critical opportunity for physicians to follow up on past and current treatments, review medical history and evaluate potential new issues. Annual wellness visits routinely uncover and diagnose issues, often catching problems early, leading to more successful treatment.

Because physicians in value-based agreements are held accountable for patient well-being, the annual wellness visit is a valuable tool for them, and they are conducted nearly 10% more frequently than for their Humana non-value-based colleagues.¹



Getting patients into the office on an annual basis for a proactive discussion on their health demands persistence and, sometimes, ingenuity.

Annual Wellness Days

- In Alabama and Tennessee, several physicians team with Humana to regularly hold a single-day event, which focuses on quality time with patients—not quantity of patients.

Automated systems

- At practices like Hatfield Medical Group in Phoenix, a computer database tracks its approximately 1,000 Humana MA members, alerts staff when it’s time for an annual visit, and triggers care coordinators to prioritize patients and call them to arrange visits. By early October, Hatfield already had performed annual visits with 82.7% of its Humana MA members, surpassing the number of those it reached in all of 2018.⁵

Intervention in action

- Patients like Larry Phillips of Gadsden, Alabama, are believers in the value of annual wellness visits. It’s at these one-on-one discussions at Doctors’ Care in Gadsden that he’s able to share in-depth details that help his doctor put together a holistic picture of factors inside and outside the clinical setting that are impacting his well-being.

His physician, Phillips said, goes so far as to ensure he has transportation to appointments, has nutritional food at home and that he properly follows his medication regimen.

“Her advice to me is, I guess, you would say for my benefit, and if I don’t take it, then I feel that I’m letting her down and myself down,” Phillips said. “She’s very concerned about my health, plus my personal life. If I have a problem, I can talk to her.” ■



Kabir Harricharan Singh, M.D.

FAMILY MEDICINE PHYSICIAN, UT MEDICAL CENTER’S
REGIONAL HEALTH CENTER—SEVIERVILLE

Dr. Kabir Harricharan Singh, a family medicine physician at the University of Tennessee Medical Center’s Regional Health Center—Sevierville, is a fan of annual wellness visits because they let him focus on preventing health problems instead of fixing them.

“
One thing I liked (about the Annual Wellness Day) is that for a patient it shows, ‘Here’s my primary care physician, here’s my payer, they’re working together. Both are working as a team to try to get me the best care.’
”

Pharmacy: A collaborative focus on adherence

Lilian Ndehi, PharmD, MBA, BCPS
DIRECTOR, PATIENT SAFETY AND PHARMACY STARS

When it comes to controlling chronic disease, medication management is a cornerstone of any treatment plan.

Patients with multiple conditions may see several specialists, so keeping track of their prescriptions can be difficult for the primary care physician trying to manage their care.

Humana recognized early on in value-based consulting with practices that they needed additional claims support to aid in meeting medication adherence measures. Provider engagement consultants share prescription fill claims data, provide pharmacy consult and provide information to patients to help them enroll in Humana Pharmacy, a mail-order solution, for maintenance medications.

Over the last 35 weeks of 2018, Humana Pharmacy Solutions identified practices with higher numbers of Humana patients who were non-adherent in their use of statins. Humana reached out to affected value-based groups. Humana Pharmacy Solutions provided updated data and pharmacist consults as needed.

During that period, adherence improved. Practices whose patients fell into the SUPD category (statin use in persons with diabetes) and used Humana Pharmacy to fill prescriptions saw an 8.74% increase in compliance rates.¹ In particular, when priority physician groups worked with their regional Humana pharmacist, they saw an even bigger increase—9.41%—in their SUPD patients' compliance.¹

Among value-based practices participating in the effort was Health Care Partners in Nevada (HCP-NV). It has more

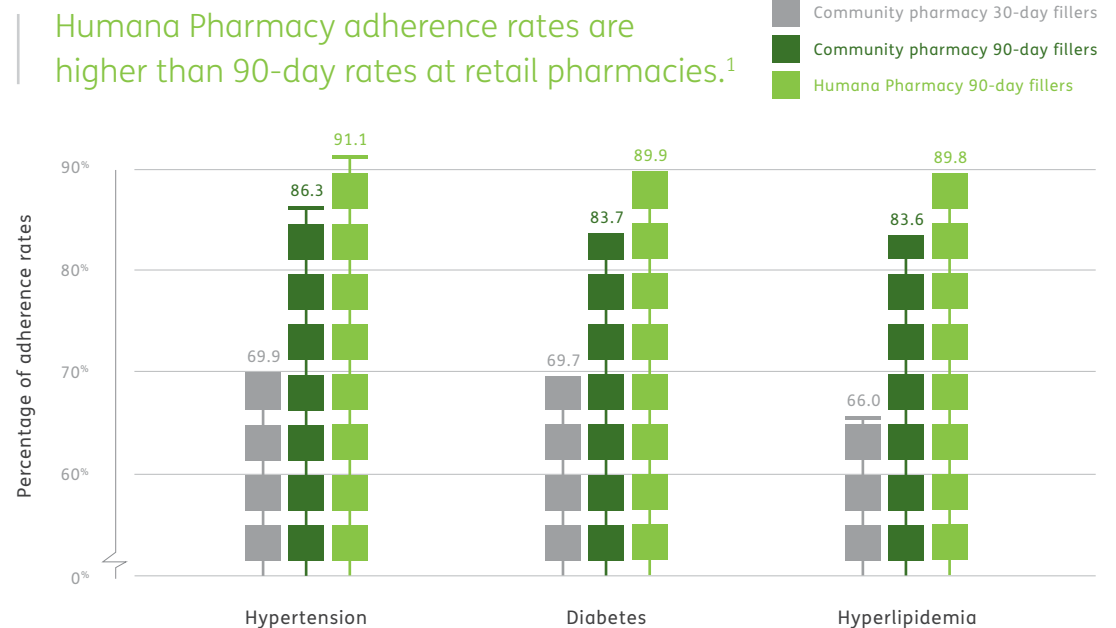
than 50,000 Humana MA-prescription drug plan members, with about 42,000 in HMO and about 8,000 in chronic condition special needs plans (C-SNPs) in 2019.¹

HCP-NV's own pharmacist, who has a team of three pharmacy technicians, works closely with Humana on patient safety measures, focusing on medication adherence for SUPD patients and controlling drug costs. The team calls patients and pharmacies and emails prescribers to ensure patients fill their medications in a timely manner. The team also gives all practice physicians report cards on how well they are managing patient safety measures, prescribing generic drugs and considering opportunities for lower-cost alternatives to high-cost medications. At quarterly HCP-NV pharmacy and therapeutics meetings, in which Humana participates, the team discusses its initiatives and goals

with physician champions. The cooperative environment paid off. In 2017, their patient safety measure resulted in a 3.5 Star rating and jumped to 4.1 Stars by the end of 2018.¹ Patient safety measures include adherence for hypertension, diabetes and statin medications.

One of Humana's standout value-based practices is Summit Medical Group in Knoxville, Tennessee.

In 2018, the practice hired a doctor of pharmacy, dedicated to Part D quality measure compliance, who looked at medication therapy management (MTM) measure compliance and how to close gaps. That review led to a new virtual platform, enabling pharmacists and practices to work together on patient populations, achieving more efficient and effective health outcomes. ■





Population health: Local strategies with big results

Andrew Renda, M.D., MPH

ASSOCIATE VICE PRESIDENT, POPULATION HEALTH STRATEGY

It's Saturday morning in early September at the Letcher County Farmers Market, and as the sun begins its climb across the sky, a handful of area residents already are lined up, waiting to sift through the fresh produce as quickly as local growers can set it out.

They come early to ensure the nutritious food they want—and need—isn't in short supply.

Farmers markets in Eastern Kentucky are weekly destinations for those in this mountainous region, where poverty is widespread and food insecurity is a focus of the clinical community.

Many of the shoppers on this day are patients of the non-profit Mountain Comprehensive Health Corp. (MCHC), sent there for healthy food from their physicians. They call it their "Farmacy." But here, food is the medicine instead of pills.

In the value-based care approach, clinicians are increasingly finding that patients need more than treatment for their presenting clinical complaint. In many cases, social, economic and environmental circumstances are at the root

of why patients aren't achieving their best health outcomes.

Food insecurity ranks among the most common of the social determinants and is one of Humana's areas of focus. Humana's Bold Goal, a population health strategy that uses the U.S. Centers for Disease Control and Prevention's Healthy Days assessment tool to measure unhealthy days, found that those who are food insecure experience 26.6 unhealthy days per month on average.¹

Practices like Mountain Comprehensive and Doctors' Care in Gadsden, Alabama, are addressing social determinants—particularly food insecurity—as part of their routine care.

At Doctors' Care, Dr. Stephanie Morgan uses her visits with patients to ask about all of the things taking place in their lives that potentially impact well-being.

One couple she recently saw together both had diabetes. During the visit, they talked about how to lower the couple's A1c levels through dietary changes to lessen their need for medications because Morgan understood that the cost of medications had been an issue. When Morgan asked the couple to describe their typical meal, they said it consisted mostly of beans and potatoes "because that's what we have."

In such cases, Morgan either adjusts medications or connects patients with food

pantries or other community resources that can assist from a nutritional standpoint.

Mountain Comprehensive started Farmacy in 2015 and is funded annually with more than \$65,000 in grants from the U.S. Department of Agriculture, Humana and other community groups and businesses.⁸

In 2018, Farmacy helped 366 patients, who collectively recorded an average weight loss of 1.1 pounds and roughly a quarter of a point decrease in BMI during the growing season.⁸

Dr. Van Breeding, director of clinical affairs for Mountain Comprehensive, said he also sees notable drops in A1c levels, blood pressure and cholesterol.

Vickie Litts dropped almost 30 pounds over the spring and summer months thanks to healthy doses of fresh fruits and vegetables she gets through Farmacy, along with being more active. Before being accepted into the program, she simply ate "whatever I had money for." Now, she's sharing the value of Farmacy with her family.

"I'm trying different vegetables that I've never tried before, like kale," Litts said. "I have grandkids that stay with me, and they love the apples and the peaches and the watermelon. They're actually learning to eat what's good for them, instead of junk." ■

Humana's Bold Goal

In 2015, Humana publicly announced a Bold Goal—to improve the health of the communities it serves 20% by 2020 and beyond. The Bold Goal has since become an overall population health strategy, centered around addressing the social determinants

of health (SDOH) through initiatives with key national and local partnerships. These partnerships have led to new resources that leverage technology and data to support community organizations, physicians and their patients. ■

Humana's population health resources for physicians

SDOH toolkits

A new educational resource for members and physicians on screening, referral and health impact of food insecurity and loneliness, found at PopulationHealth.Humana.com/resources

zoom in

A data visualization tool that aggregates public health data with key social determinants of health, allowing users to identify patient and community social health needs at a local level. The tool provides information for 250 cities across the country and is available to the public at zoomin.Humana.com


Social Health Access Referral Platforms (SHARP)


A tool developed for health care providers, case managers, social workers and community-based organizations that not only helps them refer patients to social needs programs but also tracks patient activity and shows what impact the program has on their health.

Food insecurity quality measures

Developed with the National Quality Forum, these measures are meant to elevate food insecurity as a critical gap in care and establish benchmarks for screening and referrals in clinical settings. The team is planning a best practices guide to include interventions and actions needed to prepare for measure implementation.

Humana is focused on food insecurity, loneliness and social isolation because they directly correlate with unhealthy days.

 Increased risks for seniors associated with food insecurity

 Increased risks for individuals associated with loneliness or social isolation

Of those who experience food insecurity, 66% report having to choose between food and medical care.¹⁵ Additionally, if you are lonely or socially isolated, you are 4x more likely to be rehospitalized within a year of discharge.¹⁶

 50% are more likely to have diabetes¹⁷

 64% will develop clinical dementia¹⁸

 60% are more likely to have congestive heart failure¹⁷

 43% of older adults report feeling lonely¹⁹

 30% report at least one activity of daily living limitation¹⁷

 29% die prematurely due to social isolation²⁰

Outcomes insights from VBC settings

Amal Agarwal, D.O., MBA
VICE PRESIDENT, RETAIL TREND AND INNOVATION

Between effective care management, increased prevention and patient engagement efforts, Humana MA members who saw primary care physicians in value-based arrangements were healthier and largely kept out of inpatient settings in 2018.

Better patient outcomes

Humana MA members attributed to physicians in value-based care arrangements were admitted to hospitals 27% less (131,200 reduced admissions)

“

It's time that we revisit this discussion about how to provide the high-value care patients deserve, providers desire and the public demands.

”

PETER PRONOVOST, M.D., Ph.D.
CO-CHAIR, U.S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES QUALITY SUMMIT

and visited emergency rooms 14.6% less often (110,700 fewer visits), when compared to patients in Original Medicare models. Measured against physicians in Humana non-value-based arrangements, those in Humana MA value-based agreements saw their patients admitted to a hospital 5.6% less (27,200 reduced admissions) and visiting an emergency room 7% less (52,800 fewer visits).

However, physicians in both MA value-based and MA non-value-based arrangements, implementing strategic post-discharge care plans and completing immediate follow-ups, experienced the same rate of patient readmissions at 8%.

Better data and communication

Quarterbacked by primary care physicians, coordinated care efforts proved critical in driving down utilization and admittance rates. Many physicians and their practices enlist a dedicated network of providers, with whom they share information to streamline care.

“Tom Brady can't win the Super Bowl by himself,” said Dr. Kabir Harricharan Singh, a family medicine physician at the University of Tennessee Medical Center's Regional Health Center—Sevierville. “He has to have everybody there.”

The use of data analytics also allowed for better monitoring and communication between practices and patients between visits.

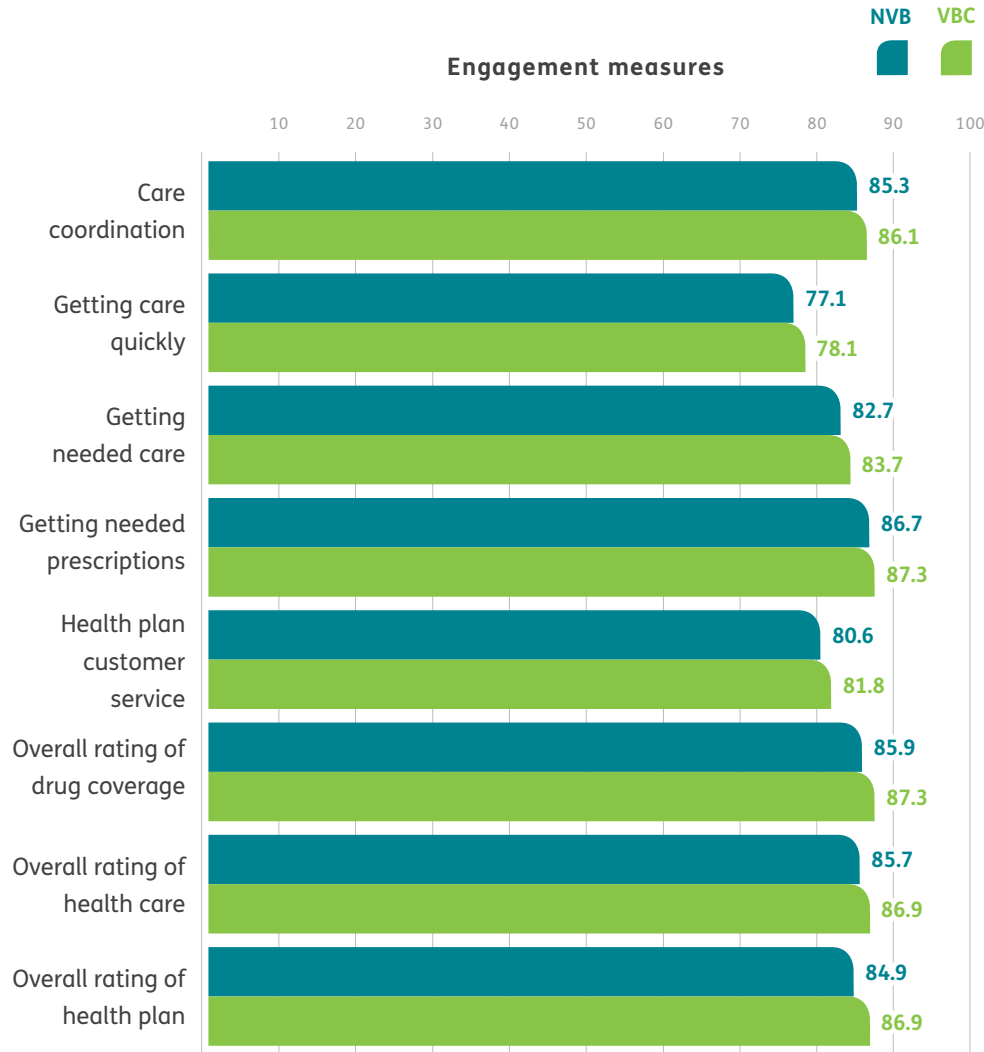
Better patient experiences

Through the Humana internal Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which surveys patients nationwide about their health care experiences, those patients whose physicians are in Humana MA value-based agreements rated higher overall than those in Humana MA non-value-based. In particular, patients gave value-based physicians higher marks when it comes to getting them needed care quickly.

In order to help drive value-based patient experience scores, Humana's Stars and quality teams conducted in-person training with several provider groups, highlighting location-specific scorecards, CAHPS measures, Star thresholds and patient-rating trends. The sessions were opportunities, too, for physicians and facility administrators to share best practices and ideas for improving the patient experience. ■

Engaged physicians make an impact

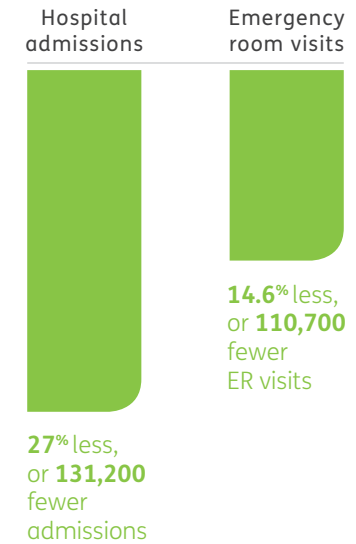
Patients clearly recognized physicians' efforts in care coordination and effective care management. In 2018, continuously enrolled Humana MA members with physicians in value-based agreements, (1,852,193 surveyed) rated their physician higher (3.4 Stars out of 5) than those 847,961 surveyed who were with physicians in Humana MA non-value-based agreements (2.9 Stars out of 5).¹ A difference of one point is important and in general represents as much as a 1-Star difference in performance on these measures.



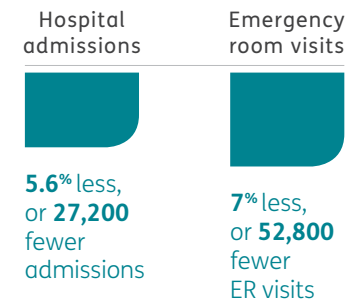
Better patient outcomes

Humana MA members attributed to physicians in value-based care arrangements during 2018 experienced fewer hospital admissions and ER visits, both when compared to patients in Original Medicare models and patients in Humana MA non-value-based arrangements.⁹

Compared to Original Medicare models



Compared to Humana MA non-value-based arrangements





Exceeding patient expectations and experiences

Z. Colette Edwards, M.D., MBA

NATIONAL MEDICAL DIRECTOR, ASSOCIATE HEALTH AND WELL-BEING

At a time when immediacy is as much expectation as quality, physician practices continue to devise strategies for administering care to meet the demands of both patients and clinical measures. Minimizing wait times and providing quality care are priorities, in particular, to physicians in value-based care where financial incentives are tied to these two goals.

Patient experience represents a pivotal part of the quality care equation and helps shape the way practices function day to day to meet their patients' needs and expectations. What makes patient experience scores so significant and insightful is that the ratings are derived from surveys of patients about their interactions with their physicians and practices at large. They're also part of the accountability structure for physicians in value-based arrangements.

The patient feedback, coupled with standards set by the Centers for Medicare & Medicaid Services (CMS), drives more in-depth care assessments and, ultimately, helps strengthen the patient-physician relationship.

In 2018, physicians in Humana Medicare Advantage value-based agreements received an 83.7 of 100 from their patients related to getting needed care. When it comes to getting that care quickly, patients gave their physicians a 78.1 of 100.

Both scores were higher than physicians in Humana MA non-value-based models, who received ratings of 82.7 and 77.1, respectively. A difference of one point in general represents

as much as a 1-Star difference in performance on these measures.

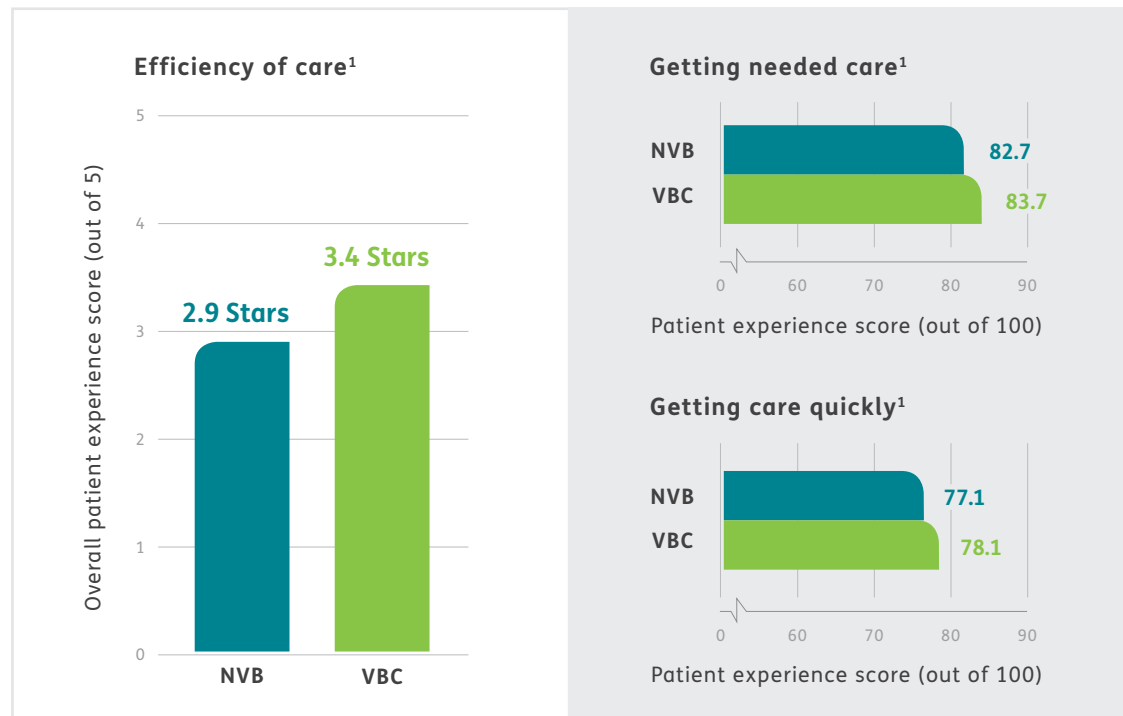
Getting needed care efficiently drove increased overall patient experience ratings for value-based physicians, who scored on average 3.4 Stars out of 5 compared to 2.9 Stars for physicians in Humana MA non-value-based arrangements, according to Humana internal CAHPS surveys.

Across the country, physician practices employ varied approaches to delivering care in ways that are accessible and convenient to patients. Some

extend hours of operations. Some accept appointments on weekends. Some perform home visits.

“The more often patients receive timely appointments and responses to their concerns, the more often they will call us first when they have a question or concern,” said Dr. Eric Penniman, executive medical director for Summit Medical Group. “This creates a strong relationship between our patients and their providers, which not only saves them money but improves their health outcomes as well.” ■

How did Humana-contracted physicians rank with patients?





Bringing care into the home

Kathy Driscoll, RN, BSN, CCM
CHIEF NURSING OFFICER

Patients want personal, effective and convenient care at less cost. They also want to age in the familiar surroundings of their home. Care providers want to make sure patients follow doctors' orders. In-home care offers the opportunity to do both—which not only squares with the key tenets of value-based agreements, but is critical to the future of health care. With the 2018 acquisition of a minority stake in Kindred at Home, the nation's largest in-home care provider, Humana is poised to extend the traditional care platform.

Why in-home care matters

- About 90% of Humana MA members have at least one chronic condition. Often, the fragmented systems that exist between hospital, PCP, lab and specialist can mean discharged patients don't have the support they need. Humana and Kindred at Home help simplify the transition to home health care, particularly for those living with chronic conditions.

What Kindred at Home does

- A dedicated team handles transition to home, minimizing administrative burden.

Patients receive placement into Kindred at Home and engagement from clinicians within 48 hours post-discharge. Humana and Kindred at Home clinicians collaborate to deliver post-discharge, temporary or longer-term care coordination and address medical, behavioral, financial and social barriers to care—including the coordination of additional resources, such as access to benefits specialists. Patients receive individualized support that aligns to both their doctor's treatment plans and quality-of-life goals.

What in-home care can do for patients

- Care at home is the most desired delivery option for patients. It's convenient, enables independence and avoids the use of skilled nursing facilities. Home care can also aid in slowing disease progression.

How it's being implemented

- Primary care physicians refer Humana MA patients to home care services. This adds value and care coordination—essential to the improvement of plan and physician quality.

In 2018, Humana conducted initial pilots in in-home caregiving, helping Humana leaders understand Kindred's reach, capabilities and opportunities. Upon seeing improved clinical outcomes, initial value-based care pilots are expanding.

Current markets with Kindred at Home care pilots:

- Charlotte, NC
- Cleveland, OH
- Dallas/Fort Worth, TX
- Richmond, VA
- Virginia Beach, VA

States where expansion is planned (90 Kindred branches):

- Georgia
- Kentucky
- North Carolina
- South Carolina
- Virginia
- West Virginia

To usher in the next wave of integration, Humana and Kindred at Home have invested in an interdisciplinary team of clinicians responsible for taking the best practices gleaned from pilot markets and applying those learnings across Kindred's geographic footprint. ■

Kindred at Home at a glance

Patients with Kindred at Home achieve better health outcomes

41
states

570,000
patients

5%

lower rate of avoidable hospitalizations than the CMS Home Health reported national benchmark for 2017

24%

lower admission rate than the CMS Home Health reported national benchmark for 2017

Upon completion of Kindred at Home care, eligible Humana Medicare Advantage patients may receive ongoing care management support from Humana At Home to help them live independently at home.⁹

The cost of care in value-based settings

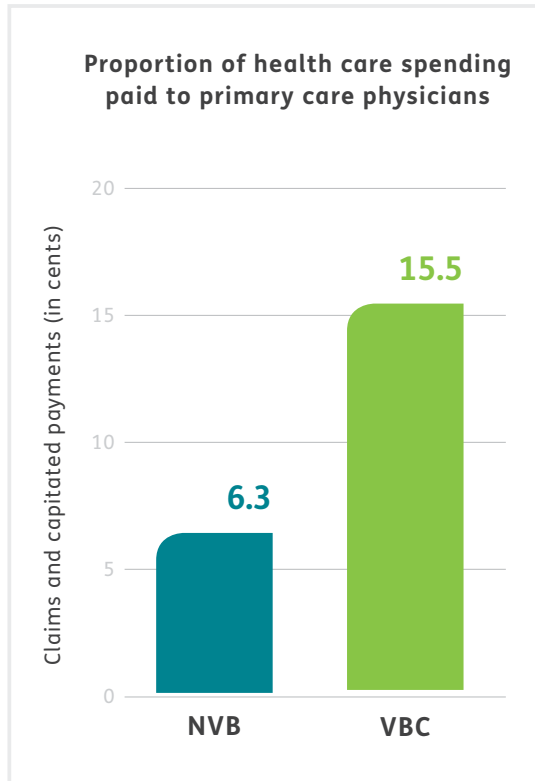
Derek Mydlarz, M.D., MPH
MARKET VICE PRESIDENT

Humana's value-based program continues to show its fiscal viability.

Prevention screenings, improved medication adherence and effective management of patient treatment plans all contributed to creating a 20.1% reduction in medical cost between Humana's MA value-based care programs and expenses associated with Original Medicare's fee-for-service model.⁹ That percentage amounts to \$3.5 billion in avoided covered medical expense that would have been incurred had patients been enrolled in Original Medicare.

Those reductions translated into substantial cost savings across the MA value-based continuum. For physicians in value-based contracts with Humana, 60% of them earned shared savings in 2018.

Physicians also received more of the overall health care dollar than their non-value-based counterparts. Physicians in value-based arrangements with Humana received 15.5 cents of every dollar spent on primary care for Humana MA members, while physicians in fee-for-service settings received only 6.3 cents for every dollar spent. Those amounts represent claims and capitated payments. PCPs in value-based settings are earning more as they assume the "quarterback role" in coordinating their patients' care.



Despite the margin between Humana value-based care and Humana non-value-based, both VBC and non-value-based per-dollar shares rank above the 4.88 cents of total Medicare spending that is dedicated to primary care nationwide, according to RAND Corp.

That's down from 6%, according to the RAND study out earlier this year based on medical

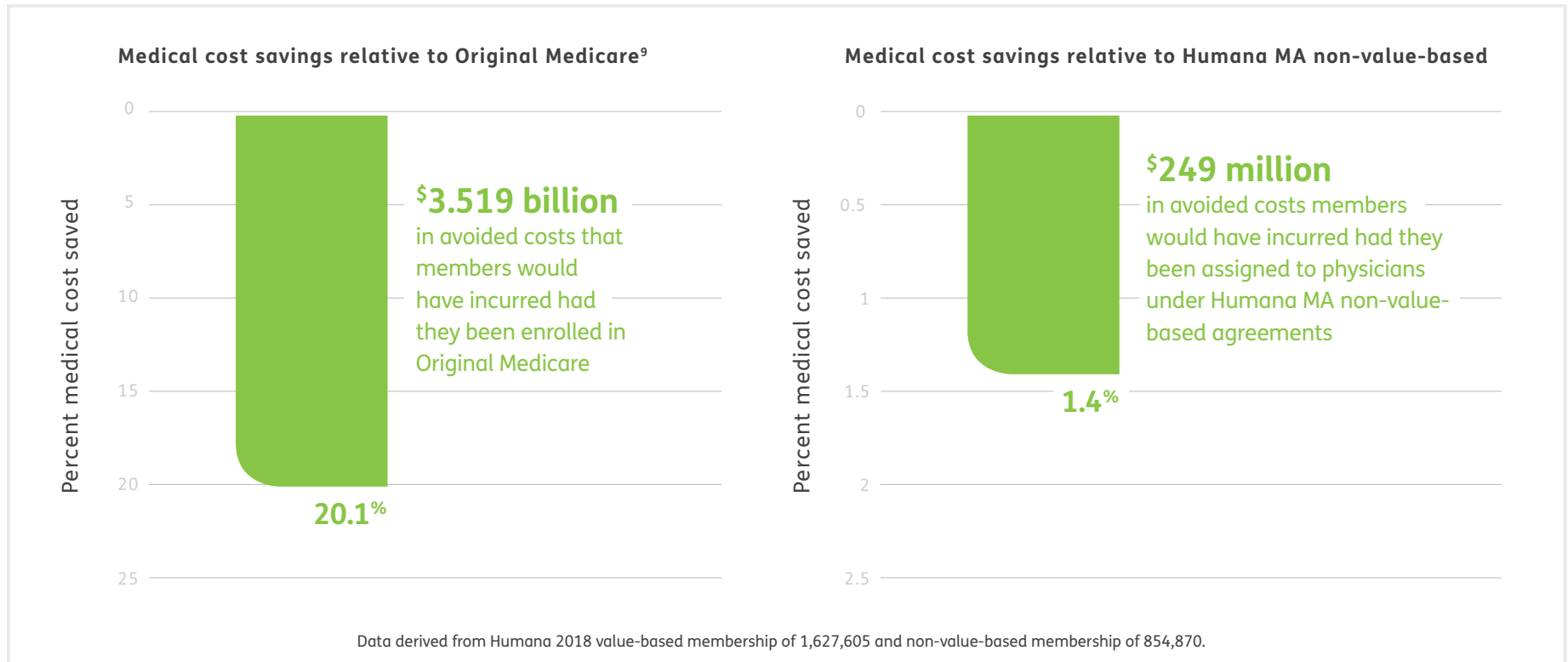
“
The move to value-based payment is complex, and when implemented correctly, serves to align the incentives and goals of group practices, physicians, payers and patients.

”
DR. HALEE FISCHER-WRIGHT
PRESIDENT AND CEO, MEDICAL
GROUP MANAGEMENT ASSOCIATION

care provided to more than 16 million fee-for-service Medicare beneficiaries during 2015.² Research analyzed outpatient care, hospital services and prescription medications.

When it comes to the cost of covered medical care between Humana value-based providers and Humana non-value-based providers, there was a small savings, with 1.4% lower

Value-based care reduces costs and increases savings



expenditures in value-based settings. That percentage amounted to \$249 million in avoided medical cost.

Value-based physicians are providing higher numbers of preventive screenings and visits than those in non-value-based agreements—and to many more members. The preventive screenings have upfront

cost, but the downstream utilization savings contribute to cost savings overall. Physicians in value-based arrangements are keeping members healthier, as evidenced by lower utilization, fewer readmissions, fewer emergency department visits and higher adherence rates.

While primary care remained the focus of Humana’s value-based efforts, the company

expanded its alternative payment offerings in 2018 to create opportunities for specialists. A total joint replacement bundled model was introduced, and three-quarters of the program’s physician participants received additional compensation for their work in effectively managing patient treatments throughout their episode of care. ■

Investing in practice sustainability

Rae Godsey, D.O., MBA

ASSOCIATE VICE PRESIDENT, HEALTH CARE
QUALITY REPORTING AND IMPROVEMENT

Many physician practices in value-based care arrangements are looking to position themselves for long-term sustainability and growth in the value-based space.

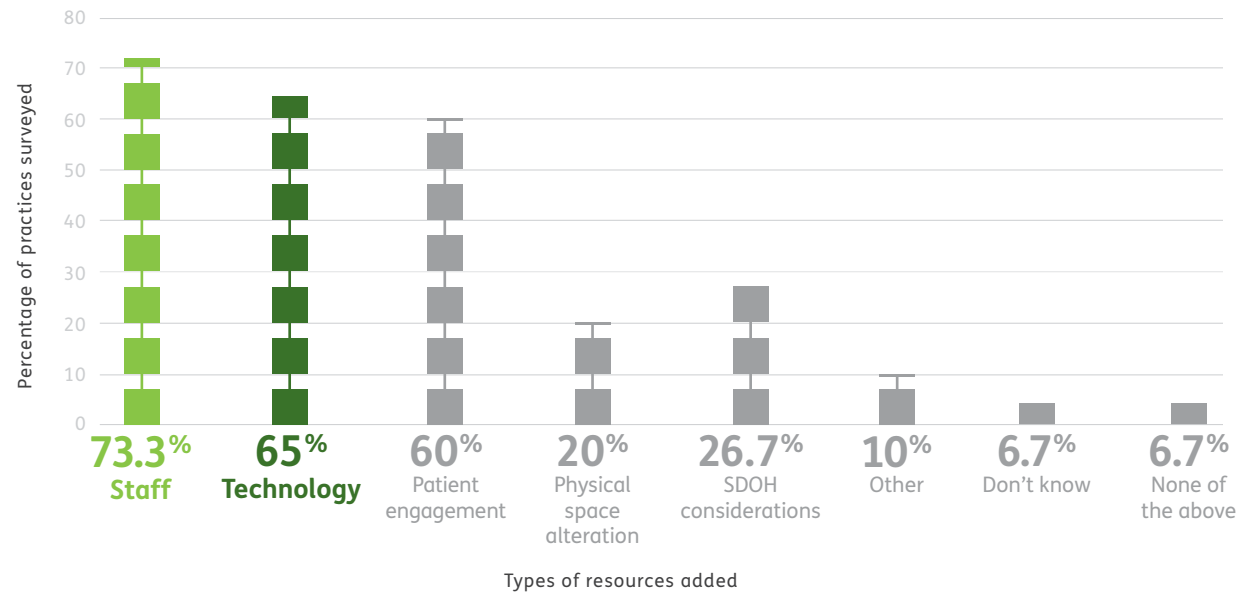
So how are they making that a reality? They are investing significantly in staff and technology, a new study reveals. The report, published by the Medical Group Management Association (MGMA) and commissioned in partnership with Humana, looked at how practices of varying size develop the infrastructure necessary for success in value-based care.

Some 73.3% added personnel to accommodate their shift to value-based care, with most of those roles being care coordinators, care managers, data analysts and quality improvement specialists.¹¹ On the technology front, practices continually recognize the value of data and have invested mostly in analytics, reporting systems and population health management tools.

Those practices surveyed by the MGMA share a fair amount of experience in the value-based space. Close to 65% of administrators indicated that their organizations have practiced value-based care for four years or more. The financial areas of focus for these value-based practices come as little surprise to MGMA leaders.

The path to value takes commitment

When asked what paid resources they were adding to aid in the shift to value-based care, practices noted that staff and technology topped the list.¹¹



As health care increasingly becomes an industry informed by technology and analytics, adequate resources are needed to function successfully in the digital environment.

“While the road from volume to value can be rocky at times, we were excited to find that many primary care practices were able to overcome technological and strategic obstacles to succeed in value-based payment arrangements,” said Dr. Halee Fischer-Wright, president and CEO of the MGMA. “There is opportunity to improve patient outcomes and reduce costs, but it’s important to recognize the significant upfront investment that’s required to thrive in this sort of environment.”

For Coastal Carolina Health Care, a multi-specialty group that employs 45 physicians

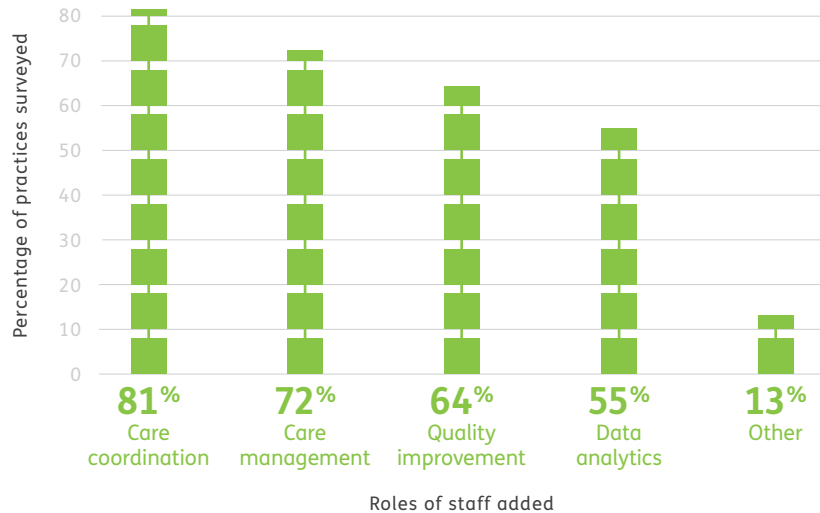
(30 of whom focus on primary care), the investments have paid off.

According to CEO Stephen Nuckolls, the group’s 19 locations across the New Bern, North Carolina, area have experienced over the last seven years shared savings with payers, increasing patient satisfaction, and drops of nearly 25% and almost 10% in hospitalizations and emergency room visits, respectively, among Medicare patients. Coastal Carolina cares for roughly 13,500 patients, including around 800 Humana members.¹² Building and solidifying the necessary infrastructure occurred not all at once for Coastal Carolina, but gradually over time.

Nuckolls figured that to keep making progress takes annual investments in equipment, software upgrades, staff and training. “Change is never easy,” Nuckolls said. “It’s not a sprint. It’s a marathon.” ■

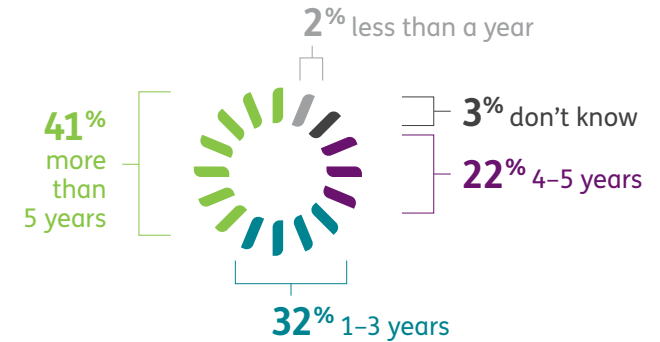
What types of **staff** additions are necessary for VBC?

Of those practices that invested in staff, this shows a breakdown of the types of roles that were added.¹¹



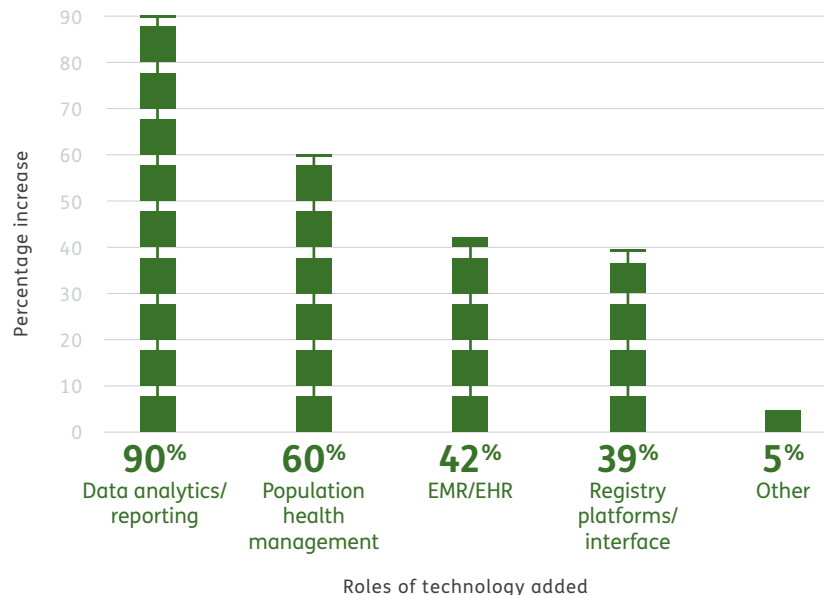
Those surveyed had a lot of experience running a value-based practice.

More than 63% of respondents had been in a VBC model for four or more years.¹¹



What types of **technology** additions are necessary for VBC?

Of those practices that invested in technology, this shows a breakdown of the type of tech that was added.¹¹



\$760 billion to \$935 billion of annual health care spending characterized as waste

Claudia Uribe M.D., Ph.D., MHA

ASSOCIATE VICE PRESIDENT OF RESEARCH AND PUBLICATIONS,
HUMANA HEALTH CARE RESEARCH

The rise of value-based care reflects a reaction to the high-cost, and at times, low-quality care experienced in the United States. Health care waste is a serious problem, and the rising and uncontrolled costs of health care remain one of the country's top political and social issues.

Seven years after a 2012 groundbreaking analysis on eliminating waste in the health care system was developed by Donald M. Berwick, M.D., MPP, and Andrew D. Hackbarth, M.Phil., Humana teamed with researchers from the University of Pittsburgh School of Medicine to re-examine the data. The new study found that reducing administrative complexity represents the biggest opportunity and that successful interventions could help reduce this waste by \$191 billion to \$282 billion a year, if scaled nationally.

The latest study can be accessed at jamanetwork.com/journals/jama/fullarticle/2752664.

The 2012 report is accessible at jamanetwork.com/journals/jama/article-abstract/1148376.

The case for bundled payments

David Annand, M.D.

REGIONAL VICE PRESIDENT, HEALTH SERVICES

Nearly double the number of specialist practices participating in a bundled payment model earned additional compensation in 2018, as compared to 2017. Designed to recognize specialists for the high-quality care they provide, bundled payment models are beginning to gain ground on improving quality at reduced costs.

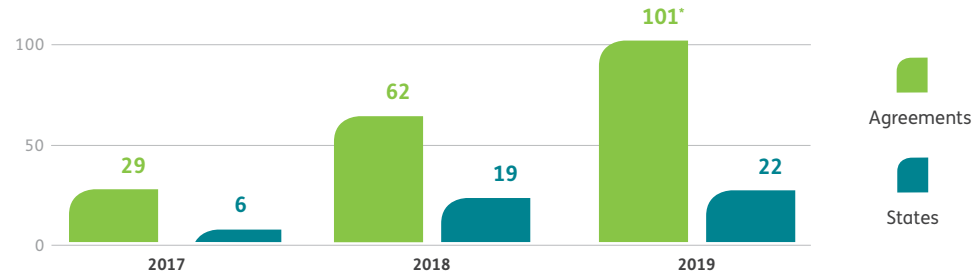
Around 75% of orthopedic groups performing total joint replacement (TJR) surgeries received gain-share as part of Humana's TJR bundle program, a jump from almost 45% a year earlier.¹ They also met each of the four required quality thresholds involving readmissions, infections, dislocations/fractures and contractions of deep vein thrombosis and pulmonary embolisms.

While bundled programs help manage costs, the quality of care delivered by physicians working in a bundle structure provides considerable benefits to patients, both short and long term. Patients who receive care from a bundle provider see a 7% lower readmission rate within 30 days of surgery and experience fewer common complications—16% fewer incidences of deep vein thrombosis/pulmonary embolisms, 19% fewer dislocations and fractures, and 15% fewer wound infections.

The reasons for the success

- Participating specialists are developing expertise around how to refine their approaches to best manage total episodes of care and leverage the support of an integrated care team.

Participation in Humana's bundled payment program has grown every year.¹



*Includes 78 total joint replacement agreements, 14 maternity and nine spinal fusion.

- Humana's local value-based care teams have worked closely with physician practices to overcome barriers and share actionable patient data that helps physicians identify opportunities best suited for their patients.

Humana launched its first bundled payment initiative in 2016 around total joint replacements. Success of that effort paved the way for the creation of a commercial maternity bundle in 2018 and two spinal fusion bundles this year.

Humana's bundled payment programs are retrospective, episodic, total cost-of-

care models that offer a value-based opportunity to specialists. The care arrangements focus on improving quality and outcomes and reducing costs across a patient's entire episode of care, offering the potential for additional payment for better outcomes.

Perhaps one of the biggest draws to the programs: Practices participate with no risk in the first year. If the cost of the episode of care exceeds an allotted amount, the practice absorbs no financial penalty. Practices do have the option to take risk in future years. ■

Value conversations: TJR bundled program

Ortho NorthEast has participated in the TJR bundled model for two years.



Gaining exposure to the bundle approach, Ortho NorthEast in Fort Wayne, Ind., spent its first year in the total

joint program assessing the landscape of its own practice. Leaders identified opportunities such as improved patient management and setting expectations for outcomes and costs.

In each of its first two years in the program, Ortho NorthEast earned shared savings, and used the added revenue to hire case managers who coordinate and align with surgeons to avoid confusion throughout the course of treatment.

“If bundled payments are to be the new reality, we were more concerned about changes in workflow, how all stakeholders were going to do their part and how everyone could stay informed,” said Mona Reimers, director of administrative operations for Ortho NorthEast. **“Our case managers have become the person our patients trust to guide them through the entire episode of care.”**

While practices such as Ortho NorthEast are succeeding in the bundle program, Reimers said the real success comes in seeing patients go home after surgery instead of to a skilled nursing facility or rehabilitation center—and without post-op complications.

“Our success comes from full-circle engagement between the health plan, the surgeon, case managers, our hospital partner and the patient,” she said. ■

A new dialogue between payers and physicians

Oraida Roman, MHA

VICE PRESIDENT, VALUE-BASED STRATEGIES

Value-based care and the underlying reimbursement models require different ways of thinking about the relationship between payer and provider.

This historically transactional relationship, driven in large part by non-value-based payment arrangements, often loses sight of what is most important: the patient.

A value-based model, however, moves the relationship toward a strategic partnership, aligning the goals of both payer and physician to efficiently drive better patient health outcomes.

As physicians continue to evolve their care models from mostly treating patients when they're sick to focusing on holistic well-being, negotiations regarding value-based contracts with payers have evolved, too.

The traditional “us vs. them” stance has transformed into collaborative discussions that strive for a win for all parties—patient, physician and payer.

The following are some of the key differences physicians and payers experience in their value-based contracting discussions:

- A focus and alignment on managing the patient's entire health needs, rather than reimbursement for specific treatments
- A new dialogue on improving patient outcomes together, with quality as a pillar of value-based programs
- An environment of sharing data and creating aligned goals, with the patient at the center
- An opportunity for physicians to learn more about value-based care and succeed without taking financial risk, as many value-based programs can offer upside-only or risk-free options

Adventist Health in Oregon entered into a value-based arrangement with Humana more than eight years ago and looks to expand that relationship for 2021.

“Contract negotiations are often challenging for both parties,” said Jeff Conklin, senior vice president and chief payer strategy officer for OHSU Health (which includes Adventist Health Portland.) “We've advanced our approach to a value-based model so that together with our payer partners we can focus on improving health and reducing cost while improving patient and provider satisfaction.”

“Developing arrangements that center around quality instead of quantity demand different types of conversations. What we experience now is greater collaboration with payers because both of us can and do succeed when patients are healthy.” ■



A look ahead

William Shrank M.D., MSHS

CHIEF MEDICAL AND CORPORATE AFFAIRS OFFICER

The time for change is now. Time to resist reactionary medicine. Time to embrace proactive care. Time to transform the state of patient well-being.

Together, with physicians and health care professionals, we are accountable for helping to improve and maintain the health of those we serve.

The Centers for Medicare & Medicaid Services readily acknowledges that compensating physicians for quality instead of quantity can be a game-changer in improving population health and providing financial stability. To further the transition, CMS plans to launch new direct-contracting pay models in 2020. These will provide additional opportunities to be part of value-based care for at least a quarter of people in traditional Medicare.

Unfortunately, public agencies often are prevented from enacting change quickly. Humana has an opportunity to test new initiatives in real time, incorporating different approaches designed to support physicians in improving patient health. We expect our efforts will go a long way in establishing new standards moving forward.

At Humana, we are tweaking the adage of “go big or go home” to “go big *and* go home,” putting more focus on in-home health

strategies that enable patients to be where they want to be—their own homes. We’re actively developing capabilities to deliver, at scale, care in the home by investing in Kindred at Home, the largest provider of home care in the United States, and integrating that care with primary care organizations.

Some specific examples of innovative steps we’re taking include:

Moving dialysis into the home

- Our stake in Kindred aligns us with the new end-stage renal disease models being instituted by the U.S. Department of Health and Human Services as part of the “Advancing American Kidney Health” executive order. One model, in particular, promotes home dialysis by increasing payments to providers for certain home dialysis services.

Launching a national, value-based care oncology program

- This program is designed to provide more integrated cancer care for Medicare Advantage and commercial members to improve the patient experience and health outcomes for those with new or ongoing cancer diagnoses, through provider delivery of coordinated, cost-effective care.

Training health care leaders of tomorrow

- We’ve invested in the future of our health care system by teaming with the University of Houston to establish the Humana Integrated Health System Sciences Institute. This unique endeavor

seeks to train the health care leaders of tomorrow with a focus on advancing population health, improving health outcomes and expanding the use of value-based payment models.

In tandem with the physician and provider community, we’ve moved quickly toward value-based care. We thank and applaud those who have partnered with us, and we welcome others to join us as we work toward acceptance and adoption of this transformative model of care that helps patients live their best lives. The future of health care is taking shape. The time is now for all of us to help shape it. ■

“

Our administration is upending the status quo to empower patients to be informed consumers of health care, seeking out high-value providers ... those that deliver the highest quality care at the lowest price.

”

SEEMA VERMA

ADMINISTRATOR, CENTERS FOR
MEDICARE & MEDICAID SERVICES

Adding virtual care in 2020

Taft Parsons III, M.D.
CORPORATE MEDICAL DIRECTOR

Riding the momentum of a 2018 pilot, Humana's virtual care platform will become an added benefit in 2020 for all of its Medicare Advantage members.

Virtual care increases access and availability to primary care, urgent care and behavioral health services, enabling members to connect with clinicians whenever they want.

The expansion comes at a time when physician interest—and patient demand—are soaring. According to professional medical network Doximity, physicians who self-reported telemedicine as a skill doubled between 2015 and 2018, and that number is expected to increase 20% annually.¹³

Behavioral health uses have garnered the most physician interest, citing convenience, ease and speed of scheduling, and efficiency in sharing care notes as the biggest draws.

During the 2018 pilot, members who participated in virtual offerings felt it was a positive experience, highlighting three areas of impact:

- **Convenience** – Virtual care was particularly impactful to members with transportation struggles or who live in rural areas.
- **Timely access to care** – Members felt it was a viable alternative to an urgent care facility or emergency room if their primary care physician was not available.
- **Preferred care** – Members saw value in interacting with board-certified physicians.

Humana MA members will be able to see the same provider for telebehavioral health visits—critical to developing patient-physician trust, bolstering medication adherence and fostering continuity of care. ■

Citations

- ¹Figures derived from internal Humana October 2019 data
- ²“Primary Care Spending in the Fee-for-Service Medicare Population;” RAND Corp., 2019, https://www.rand.org/pubs/external_publications/EP67843.html
- ³Florida Medical Clinic October 2019 data
- ⁴Mercy Northwest Arkansas October 2019 data
- ⁵Community Medical Associates/Boulder Community Health October 2019 data
- ⁶Hatfield Medical Clinic October 2019 data
- ⁷<https://hungerandhealth.feedingamerica.org/2018/09/poverty-food-insecurity-rates-improved-2017-1-8-people-still-risk-hunger/>
- ⁸Mountain Comprehensive Health Corp. internal October 2019 data
- ⁹Humana Medicare Advantage member health results were limited to medical claims incurred during the 2018 calendar year. Humana compared members affiliated with providers in a value-based reimbursement model agreement versus an estimation of original fee-for-service Medicare medical costs using CMS Limited Data Set Files from 2017. Estimates of cost, admission and emergency department savings are subject to restatement with the availability of more current CMS data.
- ¹⁰“Academy Presents Advanced APM for Primary Care,” American Academy of Family Physicians, 2017, <https://www.aafp.org/news/macra-ready/20161221apmpaper.html>
- ¹¹Kindred at Home results for Kindred episodes only excluding risk, delegated and capitated. (N-1,971) October 2017-September 2018
- ¹²Medical Group Management Association-Humana, “Value-based Care in the Primary Care Environment,” October 2019
- ¹³Coastal Carolina Health Care September 2019 data
- ¹⁴<https://s3.amazonaws.com/s3.doximity.com/press/2019TelemedicineAndLocumTenensOpportunitiesStudy.pdf>
- ¹⁵Feeding America; www.feedingamerica.org/hunger-in-america/senior-hunger-facts
- ¹⁶Nicholas Nicholson (2012) A Review of Social Isolation: An Important but Underassessed Condition in Older Adults; The Journal of Primary Prevention June 2012, Volume 33, Issue 2, pp 137-152
- ¹⁷www.aaa1b.org/wp-content/uploads/2010/07/Health-Consequences-of-Food-Insecurity-final.pdf
- ¹⁸Holwerda et al, 2012 <https://jnnp.bmj.com/content/85/2/135>
- ¹⁹www.ncbi.nlm.nih.gov/pmc/articles/PMC4383762/
- ²⁰www.ahsw.org.uk/userfiles/Research/Perspectives%20on%20Psychological%20Science-2015-Holt-Lunstad-227-37.pdf

Authors



Amal Agarwal, D.O., MBA

VICE PRESIDENT, RETAIL TREND AND INNOVATION

Dr. Agarwal is a board-certified ER physician with clinical, entrepreneurial, administrative and operational experience. He serves as vice president of Retail Trend and Innovation, directly helping to transition the non-value-based model to a value-based care model through patient and physician engagement.



Rae Godsey, D.O., MBA

ASSOCIATE VICE PRESIDENT, HEALTH CARE QUALITY REPORTING AND IMPROVEMENT (HQRI)

Dr. Godsey is board certified in family medicine and has more than 19 years of clinical and managed care experience. In her current position at Humana as associate vice president/corporate medical director, she leads the Provider Support Team within HQRI with a focus on risk adjustment, quality and Stars.



David Annand, M.D.

REGIONAL VICE PRESIDENT, HEALTH SERVICES

Dr. Annand serves as Humana's regional vice president of Health Services for the Mid-South region. Dr. Annand is a board-certified anesthesiologist who holds a bachelor's of science, master's of science and MBA from the University of Tennessee and a medical doctorate from Wake Forest University.



Adrienne McFadden, M.D., JD

REGIONAL VICE PRESIDENT, HEALTH SERVICES

Dr. McFadden specializes in population health and health equity, dedicating much of her career to helping disadvantaged communities. Prior to Humana, she was the director of health equity at the Virginia Department of Health and served as senior adviser to the state commissioner of health.



Kathy Driscoll, RN, BSN, CCM

CHIEF NURSING OFFICER

Kathy serves as CNO, advancing the overall experience for Humana's community of 10,000 nurses, care managers and social workers. She previously served as vice president and chief operating officer for Humana At Home, leading clinical and home care operations as well as licensed and certified home health agencies.



Dariusz (Derek) Mydlarz, M.D., MPH

MARKET VICE PRESIDENT

Dr. Mydlarz is CMO for Family Physicians Group and market vice president for Florida Care Delivery Organization. He has diverse experience in value-based primary care and population health. He also directs the National Guard's preventive and occupational medicine programs at the Pentagon.



Z. Colette Edwards, M.D., MBA

NATIONAL DIRECTOR, ASSOCIATE HEALTH AND WELL-BEING

Dr. Edwards serves as the national medical director for Associate Health and Well-being, providing clinical and operational leadership to optimize the health and well-being of Humana's associates. She is an internist and gastroenterologist who received her bachelor's from Harvard, her medical doctorate from the Perelman School of Medicine at the University of Pennsylvania, and an MBA from the Wharton School.



Lilian Ndehi, PharmD, MBA, BCPS

DIRECTOR, PATIENT SAFETY AND PHARMACY STARS

Lilian leads an organization that develops and implements strategies to promote appropriate medication use with the goal of improving drug-related quality and health outcomes of members and optimizing plan performance ratings. Prior to her current role, Lilian was associate director of the Medication Therapy Management (MTM) Program and the Part B Step Therapy Drug Management Care Coordination Program.



Taft Parsons III, M.D.

CORPORATE MEDICAL DIRECTOR, BEHAVIORAL HEALTH

Dr. Parsons has been the psychiatric leadership behind Humana's strategy of integration of physical and behavioral health. These efforts include integration of functional teams, integration of physical and behavioral health policies and procedures, pushing a collaborative care clinical model with provider partners and working with innovative and digital partners to find unique solutions for Humana's membership with behavioral health needs.



William Shrank, M.D., MSHS

CHIEF MEDICAL AND CORPORATE AFFAIRS OFFICER

Dr. Shrank began his career as a practicing physician with Brigham and Women's Hospital and as an assistant professor at Harvard Medical School. At Humana, his focus is on the company's integrated care delivery strategy—a consumer-friendly, evidence-based, technology-enabled approach to health care.



Todd Prewitt, M.D.

CORPORATE MEDICAL DIRECTOR

Dr. Prewitt is corporate medical director for Population Health, researching slow progression of disease and delivering high-value clinical outcomes. As the enterprise medical policy physician, he ensures that evidence-based clinical interventions are made available for coverage to our members.



Jonas de Souza, M.D., MBA

DIRECTOR, CORPORATE STRATEGY

Dr. de Souza is a medical oncologist who has written several peer-reviewed articles about value-based reimbursement and personalized value in oncology. His work has been widely mentioned in the media, including The Wall Street Journal and The Washington Post.



Oraida Roman, MHA

VICE PRESIDENT, VALUE-BASED STRATEGIES

Oraida is responsible for supporting successful value-based provider relationships, with a focus on improving the provider experience and achieving Humana's path-to-value goals through strategies that develop, support and deploy the best programs, practices and capabilities.



Claudia Uribe M.D., Ph.D., MHA

ASSOCIATE VICE PRESIDENT OF RESEARCH AND PUBLICATIONS, HUMANA HEALTH CARE RESEARCH

Dr. Uribe is responsible for conducting rigorous scientific research and peer-reviewed publications aimed at generating necessary evidence for guiding decisions and interventions to enhance the efficiency, quality and outcomes in health care. She holds a Ph.D. in epidemiology from the University of Miami, a master's in health services policy and administration from The Ohio State University and a medical degree from Pontificia Universidad Javeriana in Bogota, Colombia.



Andrew Renda, M.D., MPH

ASSOCIATE VICE PRESIDENT, POPULATION HEALTH STRATEGY

Dr. Renda is leading insights, strategy and interventions to improve community health by 20%. He was a National Science Foundation undergraduate fellow at the University of Kentucky. He received his medical degree in clinical psychiatry from the Royal College of Surgeons in Ireland and his master's in public health from Harvard University.



ValueBasedCare.Humana.com