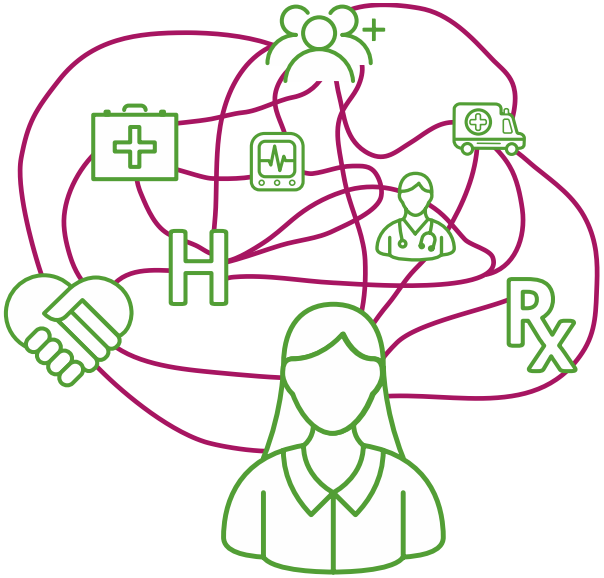
2018 Humana Physician Quality Rewards Program

Medicare Advantage Medical Home

January 2018

Humana

Health care is moving from traditional care to integrated care

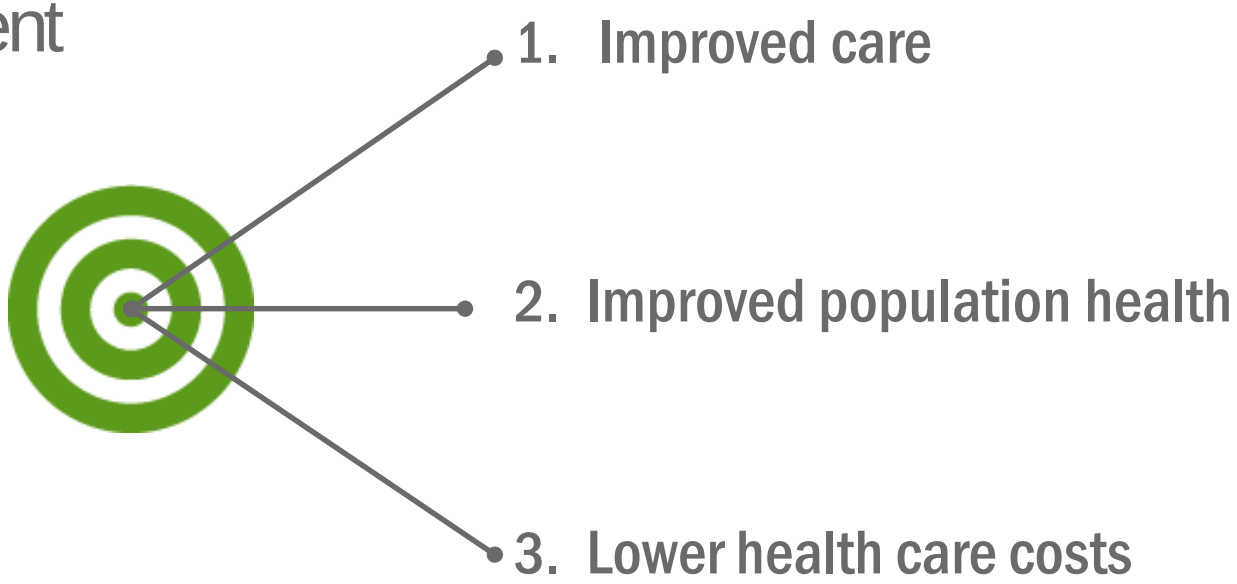


Fee-for-service Model

Value-based Care Model

Focused On the Triple Aim

Humana's value-based reimbursement model



30 years Over 30 years of diverse, value-based relationship expertise

PCP-centric

Capabilities that enable high-performing value-based agreements

Patients Treated by Physicians in Humana Value-Based Arrangements: Better Outcomes and Lower Costs than Traditional Fee-for-Service Models

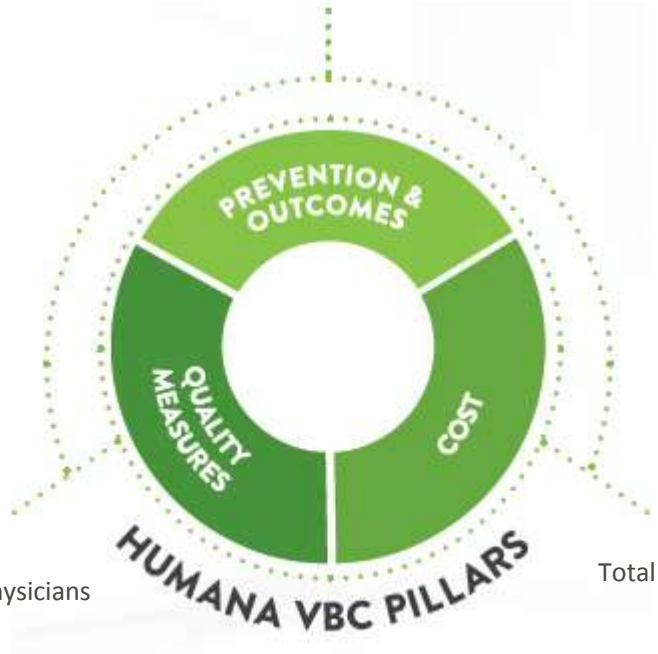
26 PERCENT — Higher HEDIS scores for physicians in a value-based setting, compared to standard Medicare Advantage settings.

15 PERCENT — Lower medical costs for patients treated by physicians in a Humana value-based setting, versus original fee-for-service Medicare.

PREVENTION*

+13% Colorectal cancer screenings

+8% Breast cancer screenings



OUTCOMES

Emergency department visits **7% fewer****

Hospital inpatient admissions **6% fewer****

QUALITY MEASURES

26% higher overall HEDIS scores for physicians

11 points higher Net Promoter Score***

COST

Total health care costs were **15% lower** vs. original fee-for-service Medicare

Total health care costs were **4% lower** vs. Humana standard Medicare Advantage (MA) settings

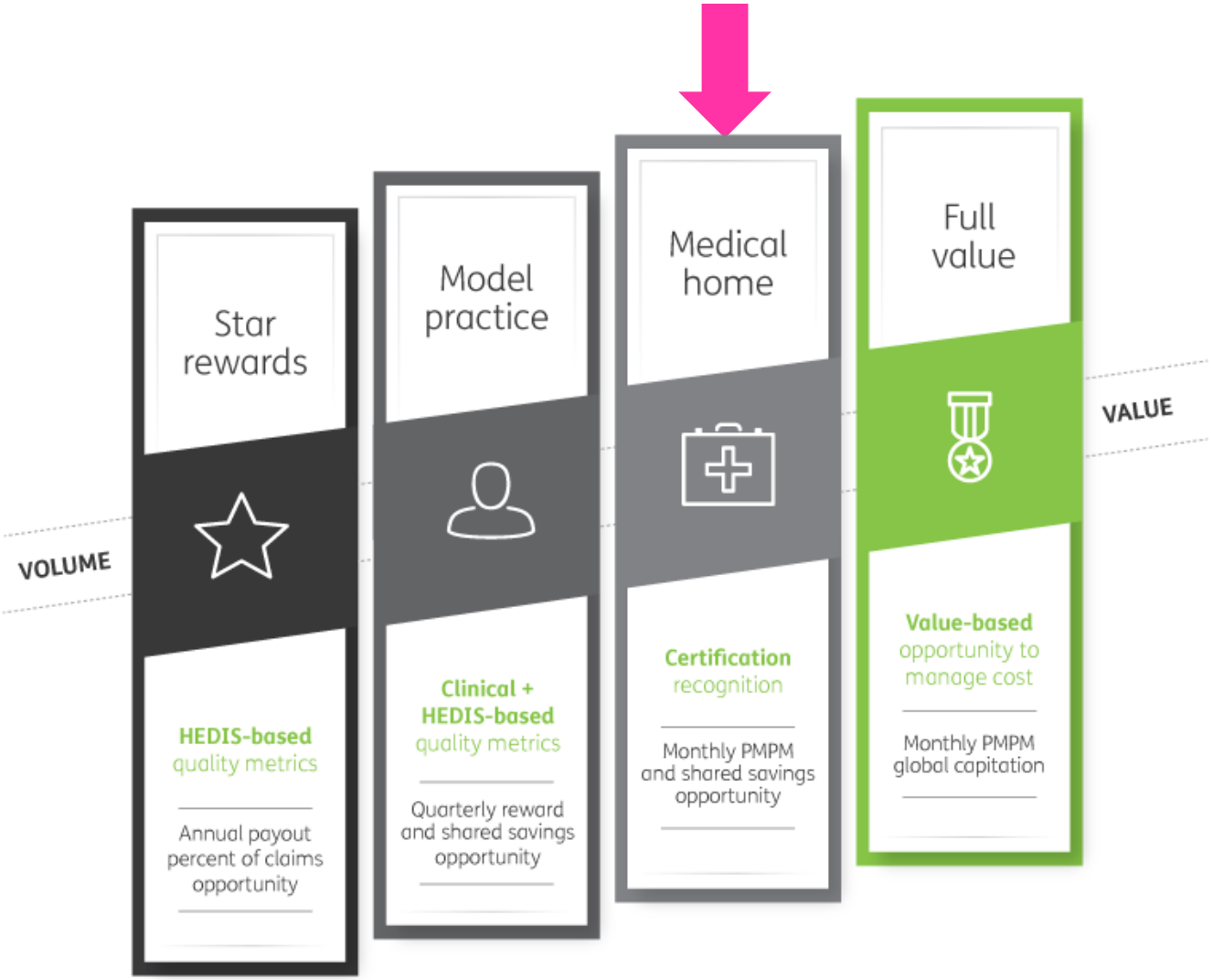
*Quality Measures" (Healthcare Effectiveness Data and Information Set, HEDIS) and "Prevention" results were from a study of 1.65 million Humana MA members affiliated with physicians in value-based agreements compared to 191,000 Humana MA members affiliated with physicians under standard MA settings.

**"Outcomes" and "Cost" results were from a study of approximately 1.4 million Humana MA members affiliated with physicians in value-based agreements compared to 216,000 Humana MA members affiliated with physicians under standard MA settings.

***"Net Promoter Score" results were from a total of 581 physician and/or staff interviews.

Humana's Value-based Continuum

From *Pay for Production* to *Pay for Value*



Medical Home Program

To be eligible, groups must be recognized as patient-centered medical homes (PCMH) or actively seeking recognition from any accrediting agency.

- Physicians with more than 250 Humana-covered patients can participate.
  - Includes Humana-covered patients attributed and/or assigned to a physician's practice for Medicare Advantage PPO, MA HMO-FFS and MA PFFS.
- Practices must sign an agreement to participate
- Infrastructure must be well-defined, with evidence of team functioning and access to care.
- Humana pays a monthly care coordination payment to help physicians cover the cost of recognition and care management.
  - Practices must meet measure target goals to be eligible

PPO: Preferred provider organization; HMO: Health maintenance organization; FFS: Fee-for-service; PFFS: Private FFS

Medical Home Program

Includes HEDIS measures and select strategic clinical initiatives

HEDIS measures

- Breast cancer screening
- Colorectal screening
- Comprehensive diabetes care — nephropathy screening
- Comprehensive diabetes care — HbA1c control

Clinical and strategic initiatives

- 30-day readmission rate
- Emergency room utilization per 1,000 patients
- Medication adherence
- Access to medical records
- Patient experience rating

HEDIS: Healthcare Effectiveness Data and Information Set

Humana's Provider Quality Rewards Program

$93 million

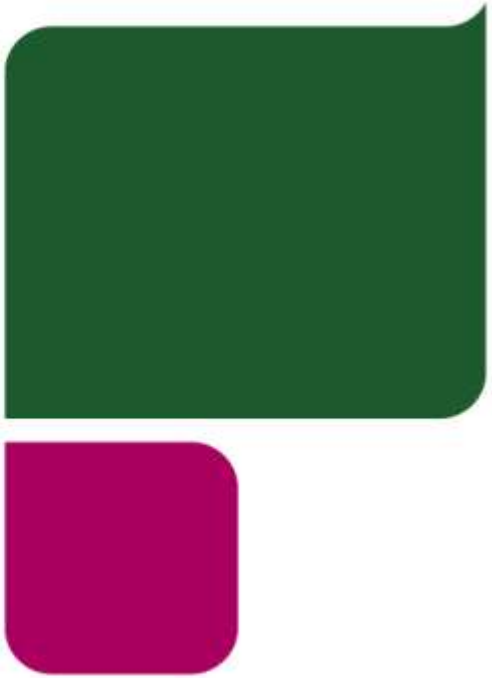
Payments distributed to physician groups across the U.S. that participated in the various Humana 2016 value-based programs

Quality measures

Humana's payments to physician groups were based partly on each group's ability to improve quality for measures including, but not limited to:

- Breast cancer screening
- Colorectal cancer screening
- Diabetes – nephropathy
- Diabetes – HbA1C control
- Avoidance of high-risk medications

Questions?



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Appendix

Measure definitions

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HEDIS Measure Definitions

Measure	Definition	5-Star target
Breast cancer screening	Physician must ensure each female patient 50 to 74 years old receives a mammogram to screen for breast cancer every 27 months.	≥ 84%
Colorectal cancer screening	Physician must ensure each patient 50 to 75 years old receives a colorectal cancer screen. Appropriate screenings are defined as any one of the following: 1) Annual fecal occult blood test 2) Flexible sigmoidoscopy every five years 3) Colonoscopy every 10 years 4) FIT-DNA (commonly referred to by the brand name Cologuard) every three years 5) CT colonography every five years	≥ 80%
Comprehensive diabetes care — Kidney disease monitoring	Physician must ensure each patient with diabetes (Type 1 or 2) 18-75 years old has a kidney function test during the year.	≥ 98%
Comprehensive diabetes care — HbA1c poor control	Physician must ensure each patient with diabetes (Type 1 or 2) 18 to 75 years old has an HbA1c level no greater than 9. Humana uses the most recent HbA1c result for measure compliance determination.	≥ 80%

Clinical and Strategic Initiative Definitions

Measure	Definition	2018 target
30-day readmission rate (all causes)	Physician must ensure that the 30-day readmission rate is at or below target. A 30-day readmission is an acute inpatient admission occurring within 30 days of the discharge date of a previous acute inpatient admission. The only exception is a same-day transfer. This measure covers inpatient admissions to any facility exclusive of psychiatry/maternity/special needs facility and rehabilitation visits. The calculation is as follows: *Readmission rate = (number of readmissions) / (number of admissions)* 30-day readmission rate is calculated on a year-to-date basis.	≤ 10%
Access to medical records	Physician must ensure cooperation with all Humana medical record review requests without additional cost to Humana. If Humana reimburses the physician or physician's contracted vendor for the cost of providing medical records, the physician will not be eligible for a bonus on this measure.	100%

Clinical and Strategic Initiative Definitions

Measure	Definition	2018 Target
Cholesterol, diabetes and hypertension medication compliance	Physician must ensure that each eligible patient is prescribed a 90-day supply prescription, as appropriate, for cholesterol (e.g., statins), diabetes (e.g., noninsulin anti-diabetics) and/or hypertension management (e.g., angiotensin-converting enzyme [ACE] inhibitors, angiotensin receptor blockers [ARBs], direct renin inhibitors [DRIs]). The metric will be calculated as follows: *Number of qualifying 90-day prescriptions filled/ total number of qualifying prescriptions filled* The most recent prescription claim available for the patient will be used to qualify for the measure. It will also determine whether a prescription was written in a 90-day supply increment or a 30-day supply increment.	≥ 80%

Clinical and Strategic Initiative Definitions

Measure	Definition	2018 Target
ER utilization per 1,000 patients	Physicians must ensure their emergency room (ER) utilization per 1,000 patients is lower than the target identified through historical claims data. The ER utilization ratio is based on the total number of ER visits not resulting in an inpatient admission or an observation stay per 1,000 Humana-assigned/attributed patients. The ratio is calculated quarterly as follows: (ER visits in quarter x 1,000) x (number of days in the year/average days in the month for the measurement quarter) divided by the total number of patients assigned/attributed ER utilization per 1,000 patients is calculated based on visits during the measurement quarter.	Contract target

Clinical and Strategic Initiative Definitions

Measure	Definition	2018 Target
Patient experience rating	Physicians must meet or exceed the performance target on overall patient experience rating. Responses are averaged in each category to create an overall patient experience rating. Access to care focuses on scheduling and wait times, with patients responding whether they had difficulty scheduling an appointment or whether they waited for more than 15 minutes to see the doctor. Coordination-of-care questions ask patients if their doctor was informed about the care they received from a specialist and the prescription drugs the patient was taking. Patient discussion focuses on whether the doctor discussed falls, bladder control, physical activity and treatment options. Patient experience is calculated using results for the last 12 months.	≥ 80%

Humana Patient Experience Rating

Based on three categories of patient experience

Humana Patient Experience Measure

- Patient surveys are done using outbound voice-automated technology (VAT) calls, similar to the Health Outcomes Survey (HOS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®).

- The measure is based on access to care, coordination of care and patient discussion, with an aggregated target of 80 percent.

- We attempt to contact all patients with Humana Medicare Advantage coverage within 30 days of a PCP visit.