Humana Physician Quality Rewards Program 2014
Medicare
Humana’s Accountable Care Continuum
Provider Quality Rewards

- **HEDIS®-based quality metrics**
  - Star rewards
    - Annual payout percent-of-claims opportunity
- **Clinical + HEDIS-based quality metrics**
  - Model practice
    - Quarterly shared savings opportunity
- **Certification recognition**
  - Medical home
    - PMPM monthly care coordination opportunity
- **Value-based opportunity to manage cost**
  - Value-based
    - Monthly PMPM global capitation

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*Value-focused Path to Accountability Full Accountability*
Humana’s Accountable Care Continuum
From Pay for Production to Pay for Value

HEDIS-based quality metrics

Providers are rewarded annually for meeting 2/3 of NCQA HEDIS metrics

VOLUME
Star rewards
Annual payout percent-of-claims opportunity

VALUE
Quality Focused Path to Accountability Full Accountability

Humana
National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) Measures

1. Breast Cancer Screening
2. Colorectal Screening
3. Diabetes Treatment Management
4. LDL Control
5. A1c Control
6. High-risk Medications

Quality-only Reward
Star Rewards Program

Quality-only Reward

- Humana-covered patients attributed/assigned to a physician’s practice for MA PPO, MA HMO-FFS and MA PFFS
- Practice goal to meet is two-thirds of the six NCQA HEDIS measures at the CMS 5-star Level
- Rewards payments are paid on an annual basis
- Practices can participate in one program at a time
- Measures may be adjusted based on CMS priorities

*Limited to Humana participating providers
Humana’s Accountable Care Continuum
From Pay for Production to Pay for Value

HEDIS-based quality metrics

Clinical + HEDIS-based quality metrics

Practices are rewarded for meeting each individual NCQA HEDIS clinical quality metric/shared savings opportunity.

VOLUME

Star rewards

Model practice

Annual payout percent-of-claims opportunity

Quarterly shared savings opportunity

VALUE

Quality Focused

Path to Accountability

Full Accountability
NCQA HEDIS Measures and Clinical /Strategic Initiatives

Reward payments for each individual measure met at CMS 5-star level

HEDIS Measures
1. Breast Cancer Screening
2. A1c Control
3. LDL Control
4. Colorectal Screening
5. Diabetes Treatment Management
6. High-risk Medication

Clinical and Strategic Initiatives
1. 30-day Readmission Rate
2. ER Utilization per 1,000 members
3. Medication Adherence
4. Use of Disease Management Programs
5. Patient Experience Rating as “Annual Kicker”

Annual Bonus:
Patient Experience Rating of 80% or greater
New in 2014: Modeled after CMS surveys

The measure will be based on the categories shown here with an aggregated annual target of 80%.

Member surveys are made by outbound VAT calls similar to the CMS CAHPS/HOS survey patient experience program.

Access to Care 92.3%
- Scheduling – 95%
- Wait times – 87%
- Referrals – 95%

Coordination of Care 90.5%
- RX review – 93%
- Informed about specialist care – 88%

Patient Discussion 54.6%
- *Reducing falls – 60%
- *Bladder Control – 40%
- Physical Activity – 64%

*Health Outcomes Survey (HOS) is done each spring as a random sample of Medicare beneficiaries drawn from each participating MA Organization.
*Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a series of patient surveys rating health care experiences in the U.S.
Model Practice Program

**Path-to-Accountability Rewards***

- Includes HEDIS measures like the Star Rewards Program, but also includes additional clinical measures recommended by Humana’s Quality Organization.
- Unlike Star Rewards, rewards for Model Practice are paid for meeting each individual measure achieved *(new in 2014)*.
- Designed for physicians with panels of over 300 Humana-covered patients.
- For Humana-covered patients attributed/assigned to a physician’s practice for MA PPO, MA HMO-FFS and MA PFFS.
- Reward payments are paid quarterly.
- Practices can participate in one program at a time.

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Humana’s Accountable Care Continuum
From Pay for Production to Pay for Value

- **HEDIS-based quality metrics**
  - **Star rewards**
    - Annual payout percent-of-claims opportunity

- **Clinical + HEDIS-based quality metrics**
  - **Model practice**
    - Quarterly shared savings opportunity

- **Certification recognition**
  - **Medical home**
    - Shared savings/PMPM monthly care coordination opportunity

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Providers must meet HEDIS and clinical quality metrics/payments based on care coordination opportunities depending on level of certification.
Medical Home

Path-to-Accountability Rewards

• Targets higher functioning practices:
  - Infrastructure well defined with evidence of team functioning and access to care
  - Health information technology, such as electronic health record (EHR) and electronic prescribing (eRx) systems

• Medical Home measures are the same as the Model Practice measures with additional measures focusing on the full spectrum of patient care.

• Monthly care coordination payment covers physician cost of Medical Home certification, additional resources required for utilization measures and overall practice enhancements.

• To be eligible for the care coordination payment, practices must meet measure target goals on the same quarterly basis as they would for the Model Practice program.
Humana’s Physician Quality Rewards Program includes industry-standard measures and has been introduced to these health care industry organizations:

- Medical Group Management Association (MGMA)
- American College of Physicians (ACP)
- American Medical Association (AMA)
- American Academy of Family Physicians (AAFP)

In 2013, Humana paid $60 million in reward payments to provider practices across the country as part of our Provider Quality Reward Program.
## HEDIS Measures

<table>
<thead>
<tr>
<th>ID</th>
<th>Measure Name</th>
<th>Category</th>
<th>2013 4-Star</th>
<th>2014 5-Star</th>
</tr>
</thead>
<tbody>
<tr>
<td>C01</td>
<td>Breast Cancer Screening</td>
<td>HEDIS</td>
<td>74.0%</td>
<td>81.0%</td>
</tr>
<tr>
<td>C02</td>
<td>Colorectal Cancer Screening</td>
<td>HEDIS</td>
<td>58.0%</td>
<td>65.0%</td>
</tr>
<tr>
<td>C17</td>
<td>Diabetes Care: Blood Sugar Controlled – HbA1c</td>
<td>HEDIS</td>
<td>80.0%</td>
<td>84.0%</td>
</tr>
<tr>
<td>C18</td>
<td>Diabetes Care: Cholesterol Controlled – LDL</td>
<td>HEDIS</td>
<td>53.0%</td>
<td>59.0%</td>
</tr>
<tr>
<td>D14</td>
<td>High-risk Medication</td>
<td>Patient Safety</td>
<td>7.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>D15</td>
<td>Diabetes Treatment</td>
<td>Patient Safety</td>
<td>86.0%</td>
<td>87.0%</td>
</tr>
<tr>
<td>CMS ID</td>
<td>Measure Name</td>
<td>Definition</td>
<td></td>
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<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
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</tr>
<tr>
<td>C01</td>
<td>Breast Cancer Screening</td>
<td>The percentage of women 50 to 74 years of age who had one or more mammograms during the measurement year or the prior year to screen for breast cancer.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C02</td>
<td>Colorectal Cancer Screening</td>
<td>The percentage of patients 50 to 75 years of age who have had one or more appropriate screenings for colorectal cancer. Appropriate screenings are defined by any one of the following: fecal occult blood test during the measurement year; flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year; colonoscopy during the measurement year or the nine years prior to the measurement year.</td>
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</tr>
<tr>
<td>C17</td>
<td>Diabetes Care: Blood Sugar Controlled – A1C Poor Control</td>
<td>The reduction in the percentage of diabetic MA enrollees 18 to 75 years of age whose most recent A1c level is greater than 9 percent.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C18</td>
<td>Diabetes Care: Cholesterol Controlled – LDL</td>
<td>The percentage of diabetic MA members 18 to 75 years of age whose most recent LDL-C level during the measurement year was less than 100.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D12</td>
<td>Diabetes Treatment</td>
<td>The percentage of members who are also Medicare Part D beneficiaries and who were dispensed a medication for diabetes and a medication for hypertension. The health care provider must ensure that each eligible patient receives an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication, as recommended for people with diabetes.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Clinical and Strategic Initiative Definitions

30-day Readmission Rate
Only Medicare acute inpatient admissions are considered. A 30-day readmission is defined as an acute inpatient admission occurring within 30 days of the discharge date of the previous acute inpatient admission. The only exception to this is a same-day transfer. If a patient is discharged from a hospital and is then admitted to a hospital on the same day, the discharge status code is checked to determine if the second admission was a same day transfer.

\[ \text{Readmission Rate} = \frac{\text{(# of readmissions)}}{\text{(# of admissions)}} \]

ER Utilization/1,000
The emergency room 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 members. The ratio will be calculated on a quarterly basis.

Medication Adherence
The percentage of MA enrollees age 18 or greater who are prescribed a statin. Patients with less than a 5-day gap for a 30-day supply or a 15-day gap for a 90-day supply will be considered on-time for a refill. Rate accounts for all statin prescriptions that are filled by the attributed/assigned patients and evidenced by Humana claims. Rate also accounts for brand statins, generic statins and combination products containing statins.

\[ \text{On-time Refill Rate} = \frac{\text{(total number of patients refilling statins on-time)}}{\text{(total number of patients prescribed a statin)}} \]

Use of Disease Management Program
The number of members eligible to participate in a disease management (DM) program divided by the number of members enrolled into a DM program. This measure will be based on Humana’s Chronic Care Program, which focuses on diabetes, congestive heart failure, chronic obstructive pulmonary disease and coronary artery disease.

\[ \text{Use of DM Program Rate} = \frac{\text{(total number of members participating in a DM program)}}{\text{(total number of members eligible to be in a DM program)}} \]

Patient Experience Rating
This rating is derived from three key areas: access to care, coordination of care and member discussion with the provider (talk-to-treatment rate). Members attributed to the provider receive a post-provider-visit Voice Application Technology (VAT) survey with questions aligning with the three key areas. Responses are averaged in each category to create an overall member experience rating. Access to care focuses on scheduling and wait times, with members indicating whether they had difficulty scheduling an appointment or if they waited to see the doctor for more than 15 minutes. Coordination of care questions ask members 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 and physical activity and whether the doctor discussed treatment options.
Questions?

Contact your local Humana representative or contact Humana via email or by telephone:

Email: Providerengagement@humana.com

Phone: 1-800-626-2741 (Choose option 1)