Q&A

Moving From Volume to Value: Humana's Approach to Addressing the Affordability Challenge

Interview With US Payer Michael Taday, PharmD, MBA, Humana

Value & Outcomes Spotlight had the opportunity to interview Michael H. Taday, PharmD, MBA, to get a payer perspective on the balance between value, access, and affordability of healthcare services. Michael is the vice president of pharmacy clinical strategies and operations at Humana, Inc, a US-based insurance company. He is considered an industry thought leader in pharmacy clinical programs, participates in multiple national advisory boards, and champions the role of the pharmacist through disruptive innovation methodologies.

Before joining Humana, Michael held various leadership roles in the pharmaceutical industry, pharmacy benefits management field, and retail pharmacy. Michael received his PharmD and MBA from the University of Maryland and a BS from the University of Arizona.

Value & Outcomes Spotlight: **Our feature article in this issue of Value & Outcomes Spotlight deals with the balance between value, access, and affordability of healthcare services. In your role at Humana, how do you mitigate affordability issues associated with high-cost and often life-saving treatments?**

Taday: Managing affordability in an age of rising healthcare costs is challenging, but increasingly important. At Humana, we've prioritized establishing affordability programs to ensure cost is not a barrier between our members and the most clinically appropriate treatment. In the past 5 years, we have launched almost a dozen programs focused on managing clinical care and affordability for prescription drugs alone. In each of these programs, we have empowered pharmacists leading clinical care teams to focus on the total cost of care and optimal outcomes.

One example is a program called ***Maximize Your Benefits.*** Through ***Maximize Your Benefits***, Humana continuously analyzes our members' prescription drug claims to identify opportunities for them to save money by switching to a lower-cost drug or by pointing them to other savings programs, such as foundation-based cost-sharing assistance. Once a savings opportunity is identified, we proactively reach out to our members and provide instructions on how to maximize their savings opportunities. We estimate that the program saved our members almost $20 million in 2018. >

Humana has also implemented interoperability tools like our real-time benefit tool (RTBT), ***IntelligentRx***, to support our members and their providers. Humana was the first Part D plan to provide real-time access to drug cost and formulary information to physicians and their patients through a RTBT. ***IntelligentRx*** enables physicians and their patients to make joint treatment decisions based upon efficacy and cost when prescribing. When presented with information on therapeutic alternatives and cost-sharing in an electronic medical record, prescribers using data from ***IntelligentRx*** switched to an alternative 37% of the time. This often results in lower out-of-pocket costs for our members and, in some cases, minimizes administrative burden for providers. The tool is currently available to 10.7 million Humana members, including individuals with Medicare, Medicaid, and employer coverage.

These are just 2 examples of how we're trying to balance the ever-increasing demands of managing the high cost of healthcare—particularly for prescription drugs—while also focusing on clinical value.

Do you see risked-sharing agreements of "pay for performance" models moving the needle on the affordability issue for US payers? What about subscription payment models?

We believe that moving from volume to value is essential to addressing affordability challenges. The traditional fee-for-service model provides misaligned incentives for everyone. We're really working to modernize payment models at Humana to decrease costs and drive towards optimal health outcomes. Currently, approximately one-third of Humana's individual Medicare Advantage members are cared for by providers in full-risk arrangements and another one-third are cared for by providers under value-based arrangements along the path of full risk. However, creating a value-centric system is not easy. One of the things we're working on is supporting providers transitioning into to risk-based arrangements. It's very different to take on risk if you have a smaller physician practice in comparison to a hospital system where there are hundreds of clinicians. One of the ways we are helping providers is with technology. By offering tools to provider clinicians with greater insights to the populations that they manage, we believe that we will create a partnership that will ultimately decrease costs and improve outcomes.

The subscription model works in very specific scenarios. The way Louisiana shaped its agreement on sofosbuvir/velpatasvir (Epclusa®) Gilead Sciences, Inc, Foster City, CA for hepatitis C for their Medicaid population is an example of where it is effective due to the size of the population and the curative nature of the drug—and we really applaud them on finding a way to make that possible. In other cases, there are lot of technical challenges to the subscription model and other longitudinal models in the prescription drug space. We've executed over 50 of these contracts, and unfortunately, outcomes-based contracts remain the exception—not the norm—and they don't produce the best arrangement in every situation. We're evaluating what we've learned from these contracts and trying to figure out the best way to apply it to future outcomes-based arrangements.

Discuss the role real-world evidence and big data are playing in informing healthcare decisions for payers.

At Humana, we fundamentally believe that every patient should be able to access, share, and control their own personal healthcare data. Providing consumers with more control over their health data will allow them to be more fully engaged in the care decision-making process—and that should occur regardless of where a patient is receiving care or who their insurance provider is. Currently, Humana supports clinicians by conducting a rich analytics review of claims to help identify opportunities for clinical interventions or when there are potential gaps in care. However, these efforts have not come without challenges. Currently, our healthcare system has inconsistent standards for clinical data sharing which makes it difficult for data to move effectively and efficiently with the patients that own that information.

The Centers for Medicare and Medicaid Services (CMS), together with its partners at the Office of the National Coordinator (ONC), has been focused on ways to minimize these challenges through new programs that encourage data sharing between beneficiaries, providers, health plans, and the government. CMS and ONC currently have a joint proposal on requiring open APIs (application programming interface) which we are really excited about and strongly support. Humana believes that open APIs and standardized data sets will be critical to unlocking the data currently captured in electronic medical records to help patients and providers with care plans regardless of the setting. CMS is also working on programs like Blue Button 2.0, which allows Medicare beneficiaries to securely share their health information with clinicians or even download it into an app on their phone, and data sharing agreements where Part D plans will receive medical data for beneficiaries to support more informed clinical decision making.

Humana is also working to expand opportunities to use data to support our members beyond what happens within our walls. In the past 6 months, we've announced 2 partnerships to increase the breadth and depth of our data use. The first is a partnership with Epic, where we will be able to tap directly into the medical record system to help improve the timeliness and accuracy of Humana-generated knowledge, ease administrative burden on providers and members, and help providers make the best decisions for patients at the point-of-care through the delivery of timely, meaningful member insights. The second partnership is with Microsoft, which will provide us with the ability to apply sophisticated analytics to our members' records and, in turn, provide clinicians and care teams with the opportunities to make a difference in patients' health.

From your vantage point, what will be the disruptive technologies or innovations that will revolutionize how we deliver and pay for healthcare in the next 10-20 years?

One of the things that we have heard loud and clear from patients is that there needs to be a shift from the traditional care settings of hospitals and nursing homes towards the home. This request is backed up with research and outcomes data proving that care in the home results in greater patient satisfaction,

makes it more likely that patients stick to their care plans, results in equal or better health outcomes, and potentially lower healthcare costs when compared to institutional settings.[1-3] One of the keys to improving the experience for our members when receiving medical care in the home will be scaling technologies that are currently in place—this will be things like remote monitoring, telehealth connections, and electronic medical records—to support patients, their caregivers, and onsite home healthcare clinicians. For example, remote monitoring can be used to collect and disseminate information to all members of a care team in real time and allow for treatment adjustments to be made if necessary. Today we have some of that functionality in place, but it has not been scaled largely, which will be essential in building the infrastructure to support the home. In addition to scaling the technology, reimbursement mechanisms will also need to evolve to allow, and even incentivize, patients to receive care in nontraditional settings. This is something that we're encouraging CMS to consider and we're currently developing models to support. We recently acquired a significant stake in Kindred at Home (the largest home health agency in the country), with the goal of bringing all of these complicated pieces together to make aging in place a reality for our members. An effective and efficient model for keeping people at home is one of our major goals as a company, and we're excited about what we can do to support our members and their families.

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