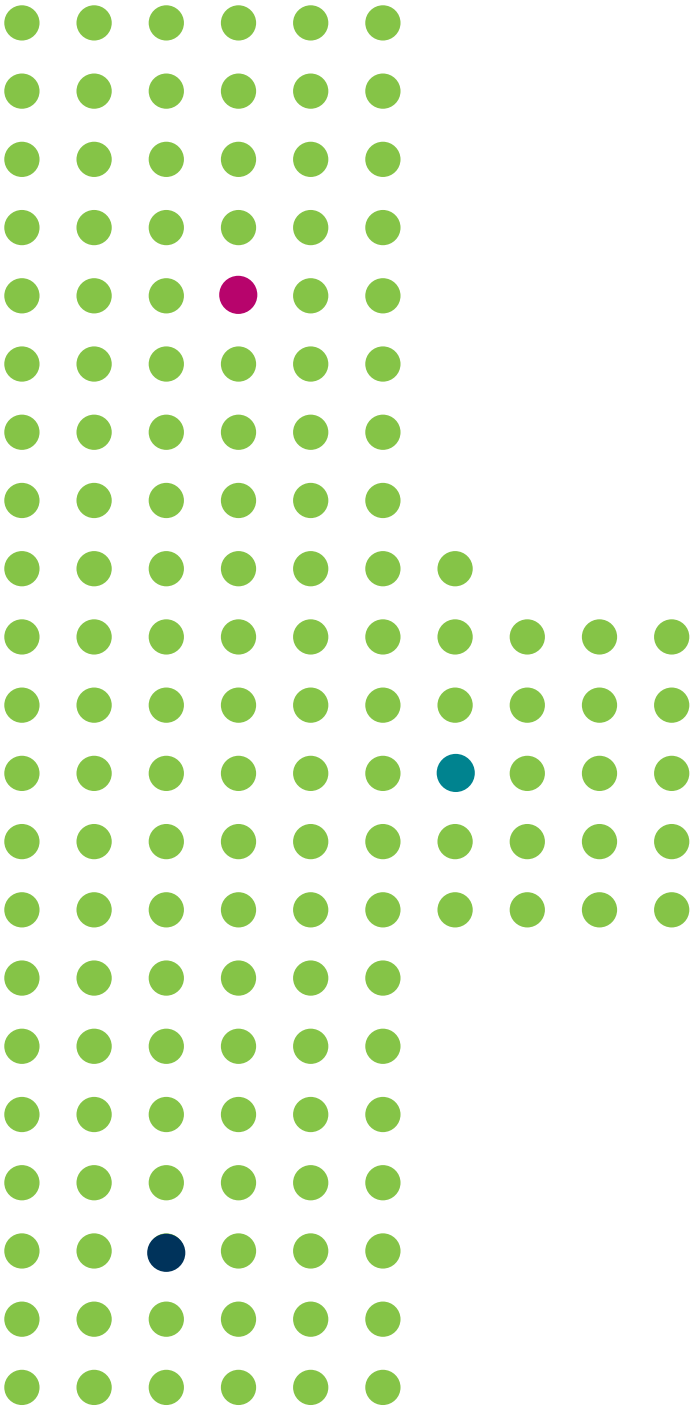
April 2021

Access to Healthcare Issue Brief

BOLD GOAL
POPULATION HEALTH STRATEGY
OFFICE OF HEALTH AFFAIRS AND ADVOCACY

The intent of this brief is to increase knowledge and inform our stakeholders of opportunities to address social determinants of health, a core function of Humana's Bold Goal, Population Health Strategy. Our Bold Goal is to improve the health of the people and communities we serve by making it easier for everyone to achieve their best health.



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Introduction
- Timely use of Health Services to Achieve the Best Health Outcomes
- By the Numbers

Timely and Appropriate Use of Health Services to Achieve the Best Health Outcomes

In order for the healthcare system to operate effectively, patients must be able to access health services. However, millions of people in the United States continue to experience tangible and intangible barriers to access. Tangible barriers may include lack of or insufficient insurance coverage, distance and lack of transportation, inconvenient hours of operation, inadequate accommodations for language spoken or functional limitations, as well as pandemic-related "medical distancing." Intangible barriers may include health literacy proficiency, real or perceived bias, different cultural norms, and misinformation.

The following brief provides a review of some of the key factors influencing the complex, multifaceted issue of healthcare access. It also highlights research on interventions and cross-sector efforts to improve access, as well as potential areas of exploration for the healthcare industry.

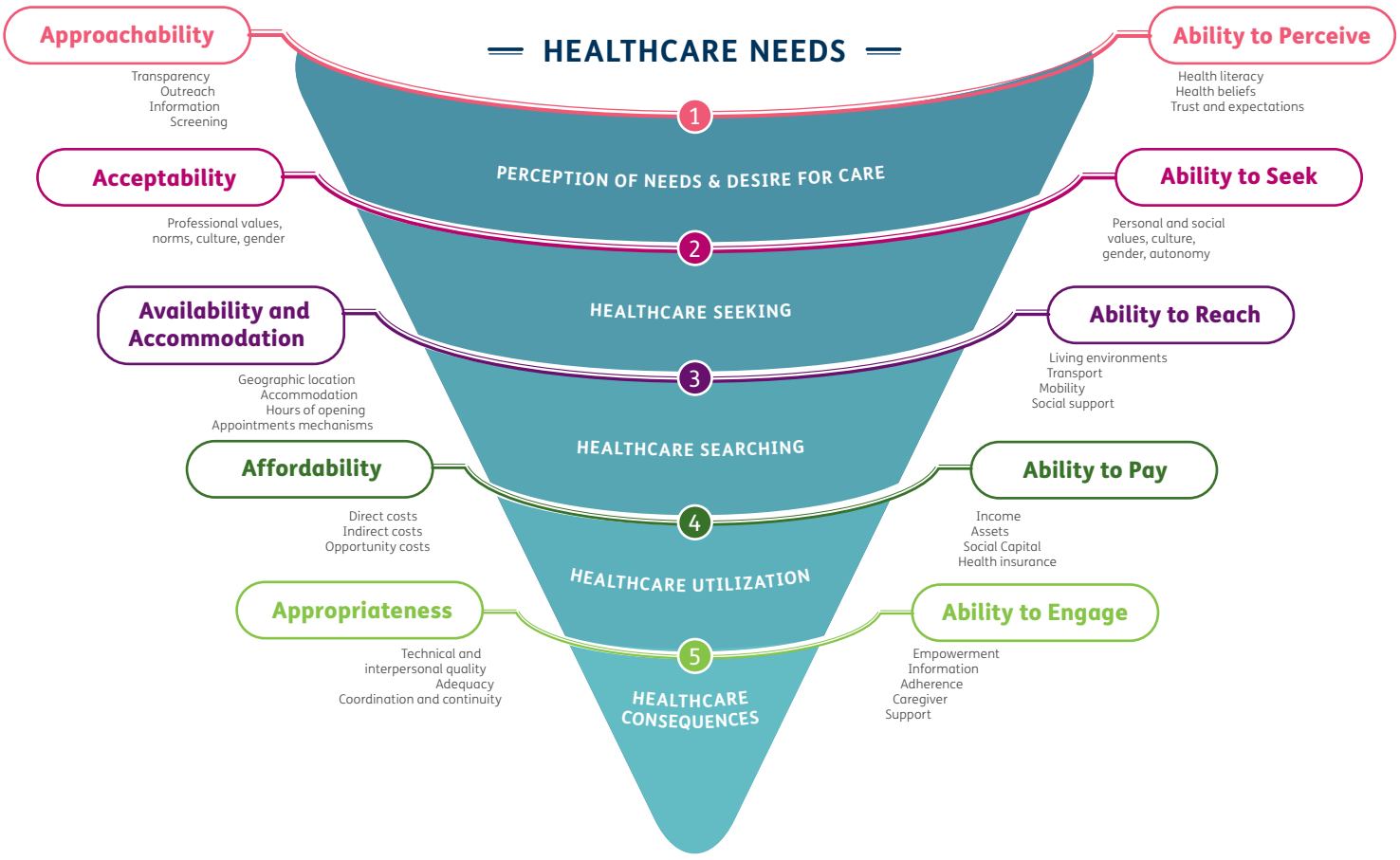
By the Numbers

23.6% — **Of people in the U.S. lacked a consistent primary care provider primary care provider, which is statistically unchanged over the previous decade**

22 Million — **U.S. seniors lack broadband internet access, according to a report by the Humana Foundation and OATS, limiting their access to telehealth, social connection, and other basic needs**

50%+ — **Of U.S. counties do not have a licensed behavioral health provider according to the Health Resources & Services Administration (HRSA). The need is particularly acute for Black, Indigenous, and People of Color (BIPOC)**

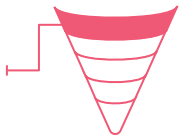
Five Dimensions of Accessibility



SOURCE: Levesque, Jean-Frederic & Harris, Mark & Russell, Grant. (2013). Patient-centered access to health care: Conceptualising access at the interface of health systems and populations. International journal for equity in health. 12. 18. 10.1186/1475-9276-12-18.

Access to healthcare may be defined in many ways that capture – to a greater or lesser degree – the complex interaction of supply - and demand-side influences. Exploring the concept using an established framework provides a basis for measurement and evaluation of accessibility, as well identification of potential policies and interventions to promote access.

Levesque et al. define healthcare access as, "the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use health care services and to actually have the need for services fulfilled." The authors further identify five dimensions of patient-centered access to healthcare – 1) Approachability; 2) Acceptability; 3) Availability and Accommodation; 4) Affordability; 5) Appropriateness – as well as corresponding abilities of healthcare consumers. The degree to which these dimensions are met may produce disparate consequences in terms of health, satisfaction, and financial security.



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Approachability
- Perception of Needs and Desire for Care
- Political and Regulatory Response
- Medical Misinformation is Creating New Barriers to Access
- What Humana is Doing
- What Others are Doing

Perception of Needs and Desire for Care

"Approachability relates to the fact that people facing health needs can actually identify that some form of services exists, can be reached, and have an impact on the health of the individual." (Levesque, 2013)

As with any other good or service, consumers must have a demand or desire for healthcare before they seek it out. However, there are many factors that influence demand, including awareness of both personal health needs and services available. There may be significant geographic and socioeconomic variation in awareness and approachability of the healthcare system, so healthcare providers must be intentional in planning and implementing their outreach and marketing strategies to be inclusive and approachable to all cultures and demographics.

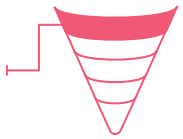
Broad, unfettered **access to primary care and the use of community health workers (CHWs)**, also known as navigators or *promotoras(es),* are two evidence-based strategies for improving this dimension of accessibility. Both facilitate person-centered care and navigation across all dimensions – physical, mental, and social – of health. According to the National Quality Forum's **Roadmap for Promoting Health Equity and Eliminating Disparities**, primary care providers (PCPs) are particularly valuable for "people with low health literacy, limited eHealth literacy, limited access to social networks for reliable information, or who are challenged with navigating a fragmented healthcare system," and CHWs facilitate critical clinical-community linkages. Not only has the **Community Preventive Services Task Force** found strong evidence supporting interventions engaging CHWs in diabetes management and prevention, cardiovascular disease prevention, and cancer screenings.

New research from a randomized control trial finds that **every dollar invested by a Medicaid payer in a CHW program posts a return of $2.47 within the fiscal year.**

Political and Regulatory Response

to Enhance Approachability of the Healthcare System

The **Center for Medicare & Medicaid Innovation** (the Innovation Center) supports the development and testing of innovative healthcare payment and service delivery models, and Primary Care Transformation is a key area of focus. **Primary Care First** builds off of the existing Comprehensive Primary Care Plus (CPC+) model to enhance the doctor-patient relationship by reducing administrative burden and rewarding improved outcomes for patients in Medicare Fee-for-Service (FFS). In 2020, **Humana announced** it will offer the model across the 48 contiguous states and the District of Columbia beginning in July 2021 to support the transition of primary care groups from fee-for-service to value-based care.



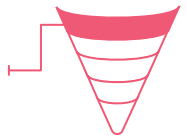
The Centers for Medicare and Medicaid Services (CMS) has taken steps to expand access to CHW's among vulnerable Medicaid beneficiaries. In 2013, **CMS issued** a final rule to expand the types of providers who are eligible to receive payment for delivering preventive services under Medicaid, giving states the option of allowing non-licensed providers such as CHWs to deliver such services as long as they are recommended by a physician or other licensed practitioner. A number of states currently have **CHW programs** in place, though the financing and certification models varies considerably from state to state. Most state Medicaid programs do not reimburse for CHW services, but several states, such as Florida and Louisiana, encourage their Managed Care Organizations (MCOs) to use CHWs, paid for through administrative costs. Many other state and healthcare organization CHW programs rely on public or private grant funding.

Medical Misinformation is Creating New Barriers to Access

Internet and social media platforms have allowed medical misinformation to proliferate and reach an ever-growing population. This threat became a public health crisis when the coronavirus pandemic struck the United States in 2020 and millions of Americans questioned not only the efficacy of mask wearing but also the severity of the virus itself. Many fear that misinformation will continue to hamstring recovery efforts by preventing Americans from receiving the COVID-19 vaccine. In response, President Joe Biden's Centers for Disease Control and Prevention (CDC) Director, Rochelle P. Walensky, MD, MPH, has stated she will **bolster the agency's presence** on social media to combat vaccine hesitancy and COVID-19 misinformation, and the CDC has awarded millions of dollars in grants to organizations for building trust and countering fear and misinformation.

In March 2021, the chief executive officers of Facebook, Google, and Twitter were called to testify before the House Committee on Energy and Commerce on social media's role in promoting extremism and misinformation. Among other steps, they discussed how their platforms are flagging and removing coronavirus misinformation and blocking chronic offenders. **YouTube** is partnering with reputable healthcare organizations such as Cleveland Clinic, the Mayo Clinic, the National Academy of Health, and Harvard's school of public health to bring more authoritative and accurate health content to its platform.

To coordinate and amplify public health messaging on COVID-19 and increase confidence in guidance from the CDC and public health officials, the CDC Foundation, de Beaumont Foundation, and Trust for America's Health have created the **Public Health Communications Collaborative (PHCC)**. One of the features is a **misinformation tracking and response tool** that provides real-time insights into misinformation that is circulating. In addition, Humana and the Humana Foundation have joined with other large corporations in a **large nationwide campaign**, led by **The Ad Council**, to bring critical vaccine information to the public to increase their confidence in getting the vaccine.

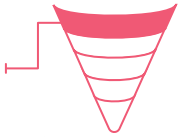


What Humana is Doing

Expanding access to and use of **primary care is a key pillar of Humana's corporate strategy and is integral to providing whole person care.** However, primary care is not a one-size-fits-all solution. Different patients, communities, and providers require different models of primary care to meet their unique needs and preferences. That is why Humana offers multiple primary care models, ranging from a variety of **value-based contracting** models that provide clinical, financial, and analytical services to support physicians to fully-or partially-owned clinics offering "next-generation" primary care. These primary care models also provide the flexibility to, for instance, fund clinic start-up costs for high-quality PCPs to be more accessible to medically under-served areas.

In March 2021, Humana **announced** a new brand – CenterWell – for a range of payer-agnostic healthcare services offerings. The first Humana-owned care services to adopt the new brand will be senior-focused primary care facilities that have operated as "Partners in Primary Care" in several states and as "Family Physicians Group" in the Orlando area. Many of the primary care centers are located in medically under-served areas throughout Florida, Kansas, Louisiana, Missouri, Nevada, North Carolina, South Carolina, and Texas, with plans for rapid growth in the coming months, including new centers in Atlanta, Houston, and New Orleans. All accept patients from many different Medicare Advantage MA plans and utilize multi-disciplinary care teams that include most or all of the following: a nurse practitioner, a physician assistant, a behavioral health specialist, social workers, clinical pharmacist, care coach and support staff.

> **"Humana is committed to leverage our business platforms to support local communities in their efforts to lower social and health disparities. This includes enhancing access to care by continuing to expand and build primary care centers in underserved markets"**
>
> Bruce Broussard, Humana President and CEO, Q4 2020 Results
> Earnings Call, February 3, 2021



Humana is integrating CHWs and other social health providers into care coordination models to improve approachability and holistically address the whole health needs of members. For Humana Healthy Horizons™ Medicaid beneficiaries in Florida and Kentucky, CHWs provide key clinical-community linkages to improve health management and outcomes. CHWs also serve MA members in certain markets, including those on **Author by Humana** plans. Author is a **new model** that provides tech-enabled personalized care. Initially launched for five MA plans in South Carolina, Author gives both members and providers direct access to a team of navigators who aim to address their needs. In addition, in 2021, Humana began piloting a new, tech-enabled chronic care management platform, Humana Care Support, which harnesses enhanced data analytics to create an integrated, personalized experience for members. **What members may notice most is their access to a multidisciplinary care team to address their individual, whole health needs.** The team includes a nurse, a pharmacist, a social worker, and a behavioral health expert.

Additionally, Humana recently announced the hiring of **Nwando Olayiwola, M.D., MPH, FAAFP, as Senior Vice President and Chief Health Equity Officer,** who began her role in April 2021. Dr. Olayiwola is a longtime advocate for the underserved and brings more than 20 years of experience in clinical and academic medicine, public health, and health systems redesign. In this newly created position, Dr. Olayiwola will set direction and establish strategy to promote health equity across all Humana lines of business, including care delivery assets, to increase access to care for underserved and disenfranchised populations.

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- Personal and Social Values, Norms, and Culture
- Political and Regulatory Response
- Native Americans
- What Humana is Doing

Personal and Social Values, Norms, and Culture

"Acceptability relates to cultural and social factors determining the possibility for people to accept the aspects of the service (e.g. the sex or social group of providers, the beliefs associated to systems of medicine) and the judged appropriateness for the persons to seek care." (Levesque, 2013)

Both clinicians and patients enter the healthcare system with their own personal values and beliefs, and these may inhibit access to quality care. This risk may be particularly acute for racial, ethnic, and religious minorities, socioeconomically disadvantaged and vulnerable populations, and women seeking reproductive healthcare services. As discussed in the September 2020 **Health Equity Issue Brief**, cultural competency training for providers, racially concordant clinicians, and integration of community members as CHWs may improve access to and compliance with care.

One area where misalignment of values and cultural norms often hinders access is end-of-life care. Individuals with **serious illness**, defined as "a health condition that carries a high risk of mortality AND either negatively impacts a person's daily function or quality of life, OR excessively strains their caregivers," require patient-centered care that respects patient preferences as they reach end-of-life. However, among the primary **patient-reported barriers** to accessing quality end-of-life care are: doctor behaviors; communication chasm between doctors and patients; family beliefs/behaviors; and cultural/religious barriers. All of these barriers are related to the **difficulty** patients, caregivers, and providers face in discussing such personally-held values and preferences, which are often perceived as "taboo" to discuss in formal settings. Patients and caregivers may view doctors as "insensitive" or "lacking empathy," while doctors may struggle with their oath to "do no harm" and view patients and families as unrealistic or irrational. However, improving the communication and shared decision-making skills of clinicians, as well removing the cultural stigma around end-of-life conversations, may make an impact.

Political and Regulatory Response

to Incorporate Wellness and Health Care Planning

In an effort to improve the quality of end-of-life care, the Innovation Center incorporated mandatory Wellness and Health Care Planning (WHP) into its **Value-Based Insurance Design (VBID) Model**. VBID allows MA organizations to test innovative plan design and cost-sharing structures to reduce Medicare program expenditures, enhance the quality of care for Medicare beneficiaries, particularly those with low incomes, and improve the coordination and efficiency of health services delivery. All MA organizations participating in VBID are required to offer each enrollee access to WHP, including advance care planning (ACP), to improve its effectiveness and impact in avoiding unwanted and unnecessary care.

Beginning in 2021, VBID also offers a **Hospice Benefit Component**, with will test the incorporation of the Medicare Part A Hospice Benefit into MA to assess the impact on care delivery and quality of care, especially for palliative and hospice care, for beneficiaries in MA plans. Currently, when an enrollee in an MA plan elects hospice, Medicare FFS becomes financially responsible for most services, while their MA plan is responsible for others, such as supplemental benefits, often resulting in fragmented care during this sensitive time.

Focus on American Indians and Alaska Natives

In accessing healthcare, American Indians and Alaska Natives (AI/AN) face compounding issues of being historically marginalized minority cultures with unique traditions, languages, and religious practices who often live in isolated, rural communities. In the last 200 years, in exchange for peace and possession of the indigenous lands of AI/AN, the United States government has made a number of promises pertaining to health and wellbeing in the form of treaties and legislation. AI/AN who live on federally-recognized Indian reservations receive care through the **Indian Health Service (IHS)**, which oversees the delivery of health services either directly through an IHS or tribal medical facility or through the Purchased/Referred Care (PRC) Program.

However, a 2018 report by the U.S. Commission on Civil Rights found funding levels for Native American tribes' education, public safety, healthcare, and other services to be **"woefully inadequate."** As a consequence, AI/AN still experience significant **barriers to health**, including discrimination when seeking healthcare, and their life expectancy in some states is 20 years shorter than the national average. The Biden Administration is prioritizing addressing these inequities, including urging Congress to dramatically increase funding for the IHS and invest $900 million in housing, infrastructure, and economic opportunities in its **Fiscal Year 2022 discretionary funding request**. In addition, some tribes have responded by establishing community-based health systems that incorporate physical, mental, emotional and spiritual wellness such as the **Nuka System of Care**. While established by Alaska Natives, this model has been adopted by other Indian health systems such as the **Cherokee Indian Hospital Authority** in North Carolina.

In January 2021, Humana's Medicaid division, Humana Healthy Horizons, **was selected** by the Oklahoma Health Care Authority to deliver healthcare coverage to Medicaid beneficiaries across the state, starting later in 2021. Humana Healthy Horizons is preparing to deliver high-quality, integrated healthcare services in Oklahoma, which is the state with the **highest percentage** of AI/ANs affiliated with federally recognized tribes. Joe Fairbanks, CEO of Humana Healthy Horizons in Oklahoma, belongs to the Leech Lake Band of Ojibwe and has worked with dozens of tribal health systems across the country to improve health quality and access to care. A number of key partnerships are already in place to meet the whole health needs of beneficiaries and communities, including addressing social and behavioral health needs. These include partnerships with March of Dimes Oklahoma to improve maternal and infant health outcomes and **Boys & Girls Club of America** to improve youth food security and support healthy behaviors.

What Humana is Doing

Humana is participating in various VBID models, **offering innovative benefits across a number of plans, all of which include Wellness and Health Care Planning**. Information about one of these VBID benefits, Humana's Healthy Food Card, can be found in the **December 2020 Food Insecurity Issue Brief**. Humana is also participating in the **MA Hospice "carve-in" model** with select plans in select counties in Colorado, Georgia, Indiana, Kentucky, Ohio, and Virginia.

Humana's partnership with the University of Houston to establish a new medical school and the Humana Integrated Health System Sciences Institute, as well as other partnerships to support the development of current and future generations of clinicians, are centered on health equity and ensuring equitable access to high quality healthcare. These programs emphasize inter-professional education – incorporating social workers and behavioral health professionals into medical care – and interpersonal communication skills that help bridge the gap in patient-provider values and preferences. Additional information about how Humana is promoting access through equity can be found in the September 2020 **Health Equity Issue Brief.**

IN THIS CHAPTER

Availability & Accommodation

Ability to Reach Healthcare

"Availability and accommodation refers to the fact that health services (either the physical space or those working in health care roles) can be reached both physically and in a timely manner." (Levesque, 2013)

Patients must be able to physically access appropriate healthcare services and providers, yet this access is sometimes restricted by characteristics of either the services or the individual seeking care. Those most at risk regarding this dimension of access include:

- Residents of rural areas
- Residents of marginalized, under-resourced urban areas
- Individuals with limited access to transportation
- Individuals with inadequate social support
- Individuals with functional limitations, such as seniors and people with disabilities
- Low-wage and hourly employees who may not be able to access care during traditional operating hours

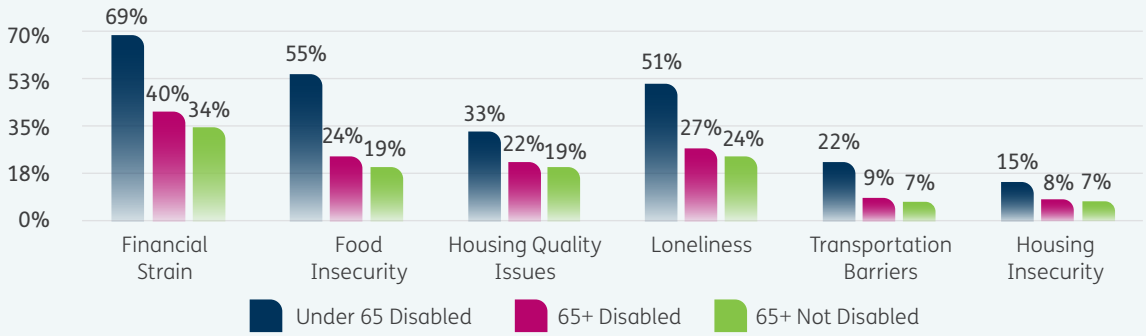
Of course, the coronavirus pandemic added additional barriers, as medical services were restricted or fear of contracting the virus led to "medical distancing." The Medical Group Management Association (MGMA) and Humana collaborated on a **research report** on deferred care during the pandemic. **It found that 97% of practices reported a drop in patient volumes by early April 2020, with 87% of patients citing safety as the top reason for deferring care.** While outpatient visits rebounded by October due to telehealth and updated facilities, some specialties still lagged behind, including pulmonology, otolaryngology, and cardiology, and months of preventative and diagnostic care were already missed.

People with Disabilities

One in four adults in the U.S. have some type of disability, the most common of which are mobility disabilities. Disability is especially common among older adults, women, and minorities, particularly American Indians/Alaska Natives, and compared to adults without a disability, individuals with disabilities are more likely to be obese, smoke, and have heart disease and diabetes.

Despite numerous protections guaranteed by federal and state laws, people with disabilities still face a myriad of barriers to accessing healthcare and frequently have unmet healthcare needs. Exam tables and chairs, imaging equipment, and weight scales are some of the most basic pieces of medical equipment, and yet these frequently present **accessibility and safety issues** for patients with disabilities. As a result, for example, women with disability are 30% less likely to receive **breast cancer** screening services and have a higher breast cancer mortality rate than other women. Due to inadequate equipment and professional training, accessibility can be even more limited for specialty care such as **obstetrics-gynecology** and **dental care**. (Access to dental care is also be limited due to gaps in Medicare and Medicaid **coverage** for oral healthcare.) Under the Affordable Care Act (ACA), the **U.S. Access Board** issued medical diagnostic equipment (MDE) accessibility standards in 2017. However, there is **no enforcement authority** for these standards, and they are not mandatory, though this could be addressed by the Biden Administration. Therefore, it is up to healthcare providers to adopt and adhere to them voluntarily.

Health-Related Social needs of Humana MA Members by Disability Status



SOURCE: Survey of Humana Medicare Advantage Individual members, November 2019-February 2020.

Individuals with disabilities may also face a number of less tangible barriers to health, including conscious or unconscious bias of clinicians and health-related social needs. An analysis recently published in ***Health Affairs*** found that 82% of U.S. physicians surveyed reported that people with significant disability have worse quality of life than non disabled people, and only 41% were very confident about their ability to provide the same quality of care to patients with disability. These potentially biased views may help health disparities to persist. When compared to Medicare FFS, **MA beneficiaries** are 64% more likely to enroll in Medicare due to disability. As such, the care coordination and non-medical benefits and services provided by MA plans may be key tools to address inequities.

Political and Regulatory Response

Emphasizes Ease of Use and Technology Innovation

Recruiting and retaining quality providers in underserved areas

The **Bureau of Health Workforce (BHW)**, located within the U.S. Department of Health and Human Services (HHS), is charged with strengthening the health workforce and connecting skilled healthcare providers to communities in need. This is accomplished through identifying geographic Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/Ps) for primary, dental, and mental healthcare to focus resources. BHW offers scholarship, loan, and loan repayment programs to individuals and schools to not only increase the supply of quality healthcare workers but also ensure equitable distribution.

President Biden's **Fiscal Year 2022 discretionary funding request** to Congress includes a number of investments in the healthcare workforce. These include:

- **Expanding the behavioral health provider workforce** to combat the opioid crisis
- **Promoting health equity by increasing the diversity of the healthcare workforce** and expanding access to culturally competent care
- **Preparing for future public health crises by training a new epidemiologists** and other public health experts who can deploy and support state and local public health efforts

Accelerating telehealth adoption

When the pandemic hit, many in the healthcare community were optimistic about the use of telemedicine and other types of virtual care to replace canceled healthcare visits. However, with only **11%** of U.S. consumers having used telehealth in 2019, there were a number of obstacles to overcome to rapidly increase utilization as necessary. First, not all healthcare providers were already offering telehealth services, particularly small practices, specialists, and Medicaid providers. Telehealth services were reimbursed at lower rates than in-person services, and there were limitations on the health services that could be provided via telehealth for Medicare and Medicaid beneficiaries, as well as the type of provider and site of service for them (e.g. in many cases, a patient had to live in a designated rural area in order to receive the service, and a patient's home could not be the originating site of service). In addition, telehealth services are required to be provided with both audio and visual communication, which presents a challenge to patients and providers without broadband internet access or with low digital literacy. Finally, state-by-state variation in licensure and credentialing requirements limit the opportunity to leverage telehealth to address workforce shortages.

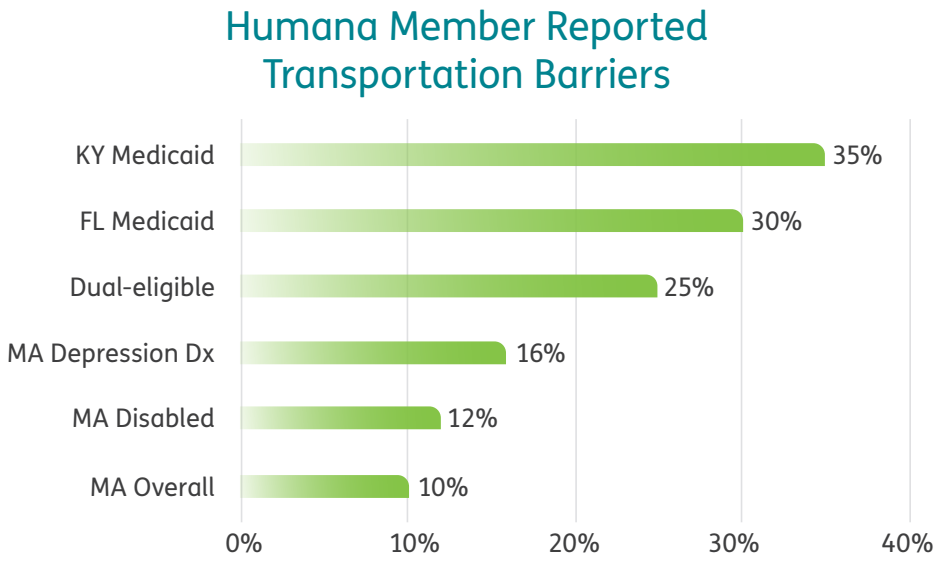
For Medicare beneficiaries, under authority granted by the public health emergency declaration, **CMS expanded** eligible services and providers and allowed flexibility for payers and providers to reduce or waive cost-sharing for telehealth visits. While these flexibilities will only be in effect during the public health emergency, an August 2020 **Executive Order** made permanent some of these policies for Medicare beneficiaries living in rural areas. In addition, CMS is permitting MA organizations and other organizations that submit **diagnoses for risk adjusted payment** to submit diagnoses for risk adjustment that are from telehealth visits; however, the telehealth services must be provided using an interactive audio and video telecommunications system.

Expanding access to telehealth for Medicaid beneficiaries is more complex, as each state has unique telehealth laws and reimbursement policies. The Center for Connected Health Policy releases an **annual report** summarizing these policies across the country. However, all states, **supported by CMS**, are responding the pandemic by **waiving certain restrictions** on distant and originating sites, modalities, and prior, in-person provider-patient relationships to enable the use of telehealth. As with Medicare, the majority of these flexibilities will expire at the end of the public health emergency declaration.

America's Health Insurance Plans (AHIP) has compiled a list of **policy recommendations** for federal and state policy-makers to strengthen and improve telehealth services after the pandemic. These and other policy changes will be necessary to expand access to care in more cost-effective, patient-centered settings through telehealth and home-based care, including reimbursement and financing models to support the transition and sustainability of services. However, as Congress considers making the pandemic telehealth expansion permanent, they will be **balancing concerns** about potential fraud and abuse, particularly targeting vulnerable seniors.

What Humana is Doing

Providing customers multiple ways to interact – on their terms – with healthcare is critical to personalized and holistic care. Transportation is a key barrier to health and health-related services access, particularly for the Medicaid population. In 2021, strategies to address transportation barriers includes non-emergency medical transportation (NEMT) benefits for MA and Medicaid members, as well as non-medical transportation benefits for MA members. More information about how Humana is addressing access barriers related to transportation can be found in the June 2019 **Transportation Issue Brief.**



SOURCE: Surveys of Humana Medicare Advantage Individual members (November 2019-February 2020), Humana Healthy Horizons (Medicaid) beneficiaries in Florida (January-February 2020) and Kentucky (November 2020-January 2021).

Prior to the COVID-19 pandemic, Humana was already investing heavily in virtual and **home-based care** – including **acquisitions** of Kindred at Home and Curo Health Services – as mechanisms to reduce access barriers, but consumer adoption and industry innovation have accelerated. **To combat "medical distancing" due to the pandemic, Humana expanded access to existing telehealth resources** by waiving cost-sharing for all telehealth visits for in-network providers – PCP and specialty, including behavioral health, as well as for telehealth services delivered through MDLive (for MA members and commercial members in Puerto Rico) and Doctor on Demand (for commercial members).

Humana is exploring new ways to deliver care to alleviate barriers for specific populations. For example, Humana has teamed up with telehealth company Doctor on Demand to launch a **new virtual primary care model**. Called On Hand, the plan gives commercial enrollees' access to a dedicated PCP, as well as urgent care and behavioral health, through video visits. Not only will this option provide schedule flexibility and ease for working adults, they are incentivized to engage in this integrated care model with lower monthly premiums.

Humana is expanding access to high-quality digital solutions to Medicaid beneficiaries, who frequently **miss out on** technological innovations in remote patient monitoring, telemedicine, virtual diabetes care, and behavioral health due to provider adequacy issues, state and beneficiary financial barriers, and variations in state regulations and credentialing that make it difficult to scale products. Humana Healthy Horizons in Kentucky offers virtual diabetes management through **Vida Health**. Vida's mobile-first platform gives eligible beneficiaries access to group coaching, in-app peer group support, digital therapeutics for diabetes and co-occurring chronic conditions, and more to help them manage their diabetes and whole health needs.

Humana is also taking steps to alleviate the burden on MA members living with multiple chronic conditions – such as cellulitis, kidney and urinary tract infections, chronic obstructive pulmonary disease (COPD), and heart failure – and their caregivers. Through a partnership with **DispatchHealth**, Humana will be able to provide hospital-level care in the home. When a member is experiencing an acute episode, DispatchHealth may be able to treat the member in their home, thereby avoiding emergency department visits, which frequently lead to inpatient hospitalizations for seniors and people with chronic conditions.

Emerging SDOH

Access to Broadband Internet & Digital Literacy

The COVID-19 pandemic highlighted the emerging social determinants of health (SDOH) of broadband internet access and digital literacy, as patients, students, workers, and isolated people of all demographics were forced to stay inside their homes. It is estimated that up to **half of the U.S. population** lacks broadband internet. This problem is especially pronounced in rural areas, where the cost of building the infrastructure has disincentivized private telecommunications companies from expanding service. In many low-income communities, families may have access but the internet service plans are cost-prohibitive.

While the federal government, through the Federal Communications Commission (FCC), has long recognized the importance of **telephone access**, financial assistance for broadband internet access is still limited and often reliant upon service providers to offer low-cost plans. However, the situation is improving. Healthy People 2030 has establish an **objective** to increase the proportion of people in the U.S. with broadband internet, and Congress included $7 billion to increase broadband internet access in the December 2020 COVID-19 **relief package**, including a new Emergency Broadband Benefit to help students' families and unemployed workers afford the broadband during the pandemic. Funding is also available for state and local governments to invest in broadband infrastructure under the **American Rescue Plan Act of 2021**. The Biden Administration has requested further investments in its **American Jobs Plan**, as well as the **Fiscal Year 2022 discretionary funding** request to Congress, with a focus on rural communities.

Beyond internet access, low digital literacy and design barriers in patient portals and health apps, issues that **disproportionately affect older adults**, especially those in poor health and living in underserved communities, can be additional barriers to health. Prior to the pandemic, 38% of adults over age 65 **reported difficulties** with telemedicine visits, and 72% of individuals 85 and older either lacked the technical experience necessary to participate in video visits or had issues due to physical disability. Frequently, health IT solutions are not designed with seniors or people with disabilities in mind, nor are they involved with user experience testing. The burden of connecting patients with low digital literacy often falls on their clinicians and caregivers. The consequences of this situation can be seen in the **disparity in access to COVID-19** vaccines between seniors with social support to help them navigate the online appointment portals versus who lack such support from digitally savvy family and friends.

To help bridge the digital divide, Humana's **San Antonio Bold Goal** and the Humana Foundation have collaborated with **Older Adults Technology Services (OATS)** to help seniors use technology to improve their health, finances, social engagement, learning, and creative expression. In 2020, the Foundation **invested** an additional $3 million in OATS to establish and lead **Aging Connected**, a consortium for accessible internet connections for older adults. Aging Connected will focus on getting at least one million disconnected seniors online, particularly those in marginalized communities, and will support equitable access to technology.

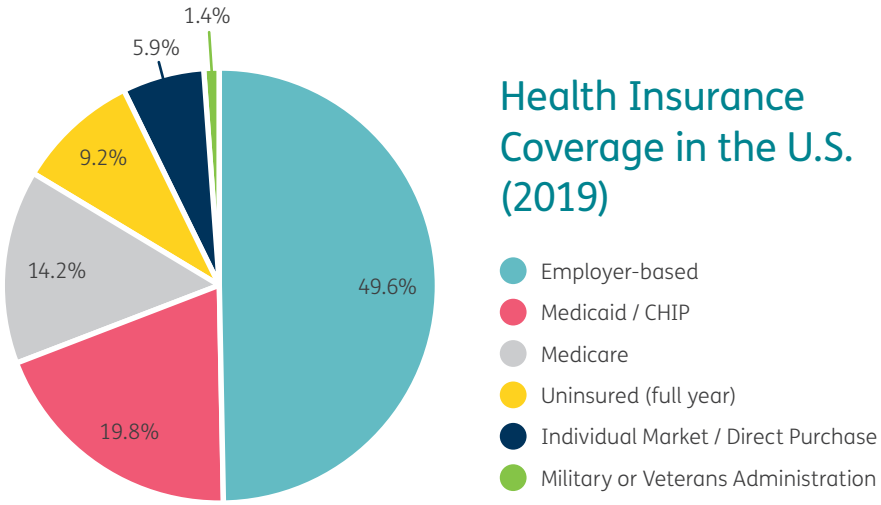
IN THIS CHAPTER

Affordability
- Cost of Healthcare Utilization
- Political and Regulatory Response
- What Humana is Doing
- What Others are Doing

Cost of Healthcare Utilization

"Affordability reflects the economic capacity for people to spend resources and time to use appropriate services. It results from direct prices of services and related expenses in addition to opportunity costs related to loss of income." (Levesque, 2013)

While people without health insurance can receive some degree of medical treatment in emergency departments, as mandated by the Emergency Medical Treatment and Labor Act (EMTALA), and federally qualified health centers (FQHCs), health insurance is required to access most types of healthcare in the U.S. Research links insurance coverage to **improvements** in financial security, health, and longevity. When the provisions of the Affordable Care Act (ACA) creating the individual marketplace, premium subsidies, and Medicaid Expansion went into effect in 2014, the uninsured rate dropped from 16.7% in 2013 to a low of 10.3% in 2016, according to the National Health Interview Survey.



SOURCE: Kaiser Family Foundation, with data from American Community Survey, 1-Year Estimates.
NOTES: For the purposes of this analysis, beneficiaries who are dual-enrolled in Medicare and Medicaid are included in the Medicaid/CHIP category.

Furthermore, many people in the U.S. with health insurance struggle with managing healthcare costs and being underinsured, meaning their out-of-pocket costs constitute an unaffordable share of their household income. For the nearly half of the U.S. population with employer-based health insurance, their **premiums and deductibles** are taking up an increasing portion of their incomes. Premium contributions and deductibles among enrollees in employer plans increased from 9.1% of incomes in 2010 to 11.5% of incomes in 2019. Further, according to research conducted by the **Commonwealth Fund**, in 2018, of U.S. adults ages 19 to 64:

- **45% are inadequately insured**, nearly the same as in 2010
- **37% reported having difficulty** paying their medical bills in the past year.
- **35% reported** at least one of the following cost-related access problems in the past year.
  - **Had a medical problem** but did not visit doctor or clinic
  - **Did not** fill a prescription
  - **Skipped** recommended test, treatment, or follow-up
  - **Did not get** needed specialist care

For example, many working-age U.S. adults with diabetes, one of the most common chronic conditions, **struggle to pay their medical bills**, including 60% of those without health insurance and 40% of those with insurance. People who are low-income, Black, or dealing with multiple chronic diseases were more likely to struggle with medical bills. This research found that, compared to people without diabetes, adults with the disease were 27% more likely to have trouble affording food, 30% more likely to skip or delay checkups due to costs, and 43% more likely to skip or delay medication refills. This missed or delayed care puts patients at higher risk for dangerously elevated blood sugar and complications like kidney failure, blindness, and amputations.

The simple intervention of reducing out-of-pocket costs for desirable health services and behaviors, such as **breast cancer screenings** and **cardiovascular disease management**, has proven effective. The Community Preventive Services Task Force found strong scientific evidence that lowering out-of-pocket medication costs for patients with high blood pressure and high cholesterol can help control both conditions. Particularly when combined with interventions aimed at improving patient-provider interactions and patient knowledge, this is effective in improving medication adherence and blood pressure and cholesterol outcomes.

Political and Regulatory Response

to Improving Affordability of Healthcare

Driving value over volume

One important avenue for reducing the cost of healthcare is improving the quality and efficiency of healthcare via **value-based payment models** and managed care. These models are accessible to patients often through MA plan or when states expand the use of value-based contracting through their managed care organizations and Section 1115 waivers. I**n 2018, Humana MA members cared for by physicians in value-based care arrangements had 27% fewer hospital admissions and 14.6% fewer emergency rooms visits, compared with fee-for-service Medicare.**

Not only have MA organizations driven the adoption of advanced value-based models, but plans must also **deliver value** by providing high quality, coordinated care while keeping costs low for **beneficiaries who are increasingly more likely to be low-income, a racial or ethnic minority, and have a disability or serious mental illness.** These savings enable MA plans to reinvest in improved coverage, lower premiums, and innovative services, programs, and benefits. For example, 80% of MA plans offer vision, hearing, wellness, or dental coverage, none of which are covered under Medicare FFS.

Importantly, MA plans deliver cost savings to members. With cost of prescription drugs being a key burden on seniors, according to one recent study, between 2015 and 2017 MA beneficiaries' costs for Part D drugs were approximately **44% lower** compared to those with FFS Medicare. MA members also spend less when **admitted to the hospital**, with seniors on FFS plans spending an average of seven times more out-of-pocket on inpatient hospital costs than their peers on MA. Further, MA plans protect seniors from catastrophic healthcare costs by limiting out-of-pocket costs.

In response to the coronavirus pandemic, CMS granted a number of regulatory waivers to ensure beneficiaries are able to access healthcare and other health-related basic needs. In an April 21, 2020 **memorandum** to MA organizations, CMS stated it would use its statutory discretion in 2020 to "adopt a temporary policy of relaxed enforcement in connection with the prohibition on mid-year benefit enhancements." These enhancements may include expanded or additional benefits or more generous cost-sharing as long as they "are provided in connection with the COVID-19 outbreak, are beneficial to enrollees, and are provided uniformly to all similarly situated enrollees." The more generous cost-sharing was embraced by plans, who were able to use this flexibility to help reconnect members to healthcare.

Supporting access and affordability

Expanding health insurance coverage and improving healthcare affordability are high priorities for the Biden Administration. In fact, one of President Biden's first **executive actions** upon taking office was on strengthening Medicaid and the ACA and to announce a Special Enrollment Period for uninsured and under-insured Americans to seek coverage through the Federally Facilitated Marketplace. With a Democratic majority in Congress, albeit slim, it is likely that some related legislation will be enacted. Some proposals under consideration include:

- **Stabilizing** the ACA Individual Marketplace
- **Extending the Medicaid coverage period for women after giving birth** (the state of **Illinois** recently received a waiver to extend postpartum coverage to one year) and inmates being released from prison
- **Boosting Medicaid funding to states to shore-up budgets** and expand covered services, particularly for behavioral health and substance use disorders
- **Numerous measures to improve the affordability of prescription drugs** such as reducing barriers to generic and biosimilar development and market entry to increase competition and access

Congress enacted the Families First Coronavirus Response Act in March 2020 to respond to the public health emergency. Among numerous other provisions, this legislation puts a freeze on **Medicaid disenrollment** during the public health emergency, essentially providing continuous eligibility to all current beneficiaries and new enrollees in Medicaid unless they move out-of-state or request voluntary termination. However, this freeze does not apply to CHIP.

The most recent COVID-19 stimulus package, the **American Rescue Plan**, enacted into law on March 2021, included a number of provisions to expand healthcare access enhancing premium subsidies for lower- and middle-income families enrolled in health insurance marketplaces, subsidizing premiums for continuation health coverage (COBRA), and providing incentives for states who have yet to expand Medicaid eligibility to cover their "expansion" population. The legislation also sought to alleviate financial strain on individuals and families through additional relief payments, extending enhanced unemployment and Supplemental Nutrition Assistance Program (SNAP) benefits, and increasing and making refundable the Child Tax Credit.

Some states are also taking action to curb the cost of healthcare. For example, **Kentucky** recently enacted legislation to make insulin more affordable for people residents with diabetes. The bill limits the cost of insulin to $30 per 30-day supply for Kentuckians with state-regulated healthcare plans or plans purchased on the marketplace exchange, state employees, and people under group plans.

What Humana is Doing

Humana's **2021 Medicare Advantage and Prescription Drug plans** with member access to care and affordability in mind. Benefits may include:

- **$0 telehealth copays for PCP visits,** urgent care, and outpatient behavioral health, $0 copays for COVID-19 testing, and a Health Essentials Kit that includes useful items for preventing the spread of COVID-19 and other viruses like the flu
- **$0 copay for COVID-19 treatment** and 14 days of home-delivered meals
- **Insulin Savings Program (ISP)** to help members save on their diabetes medications; members will pay no more than $35 for a 30-day supply of select insulins
- **Healthy Foods Card, which was first offered in 2020**, providing qualifying members a monthly allowance, depending on location, of up to $75 to purchase approved food and beverages at a variety of national chains
- **Extra benefits like dental, vision, over-the-counter (OTC) allowance**, fitness program memberships, and home-delivered meals following an inpatient hospital stay
- **Access to preferred mail-order cost sharing at Humana Pharmacy**, where they may enjoy additional savings and the ease of prescriptions being delivered right to their door

In addition, Humana is participating in CMS's Part D Senior Savings Model, which Humana calls the **Insulin Savings Program**. The program offers low-cost, predictable copayments – a maximum of just $35 per month for select insulins – for diabetic members with certain Medicare Advantage Prescription Drug (MAPD) plans and all Humana Premier Rx Plan prescription drug plans. Further, covered insulin prescriptions will not be subject to a deductible or any coverage gap cost increases throughout the plan year.

IN THIS CHAPTER

Appropriateness
- Opportunity and Capacity for Quality Care
- Political and Regulatory Response
- What Humana is Doing
- What Others are Doing

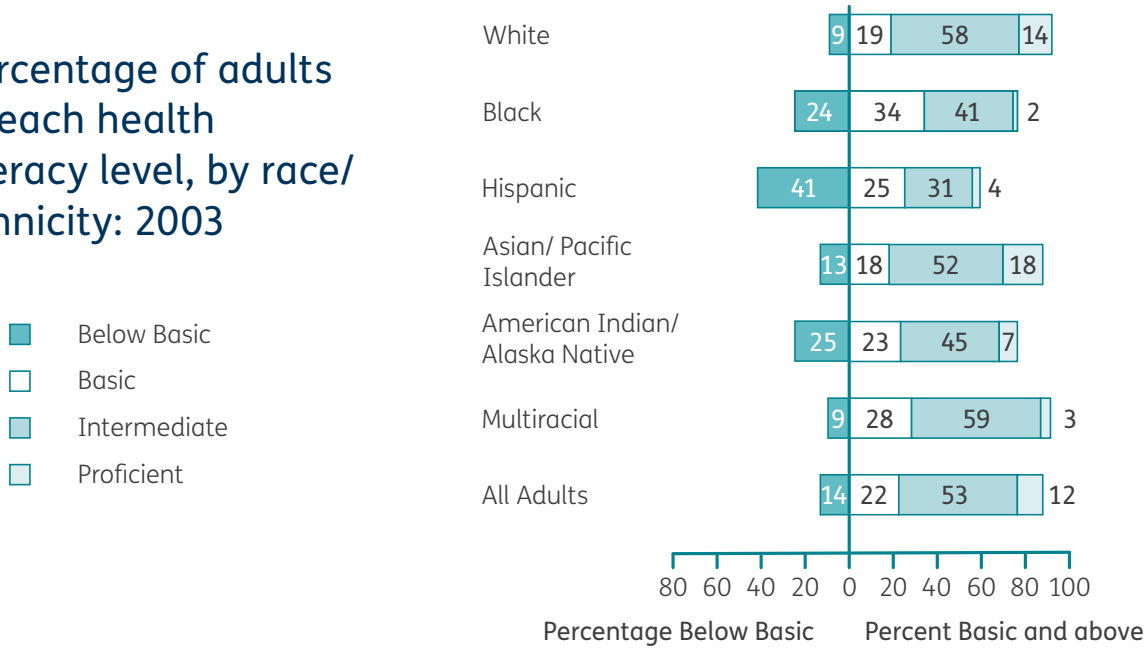
Opportunity and Capacity for Quality Care

"Appropriateness denotes the fit between services and clients need, its timeliness, the amount of care spent in assessing health problems and determining the correct treatment and the technical and interpersonal quality of the services provided." (Levesque, 2013)

The final dimension of access **requires that patients receive the right care, in the right place, at the right time.** In order for this to happen, patients must have access to good quality health services and be fully engaged in their own care through shared decision-making and disease self-management. As such, effective patient-provider communication and patient health literacy are key, as they allow patients to receive the care they need that is in accordance with their values and preferences and to adhere to their treatment regimen. Medicare recipients with higher health-literacy levels are more likely to receive preventive care such as flu shots and visited the hospital less than those at a lower health-literacy level, according to a **research report**, and seniors living in counties with the highest health literacy experience **better health outcomes**.

The only **comprehensive assessment of health literacy** the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions was conducted in 2003. It found that 14% of adults in the U.S. had "below basic" health literacy, while only 12% qualified as "proficient." Hispanics had the lowest health literacy of any race/ethnic group measured, and 49% of people with less than a high school diploma had "below basic" health literacy.

Percentage of adults in each health literacy level, by race/ethnicity: 2003



SOURCE: U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, **2003 National Assessment of Adult Literacy**.

NOTES: Detail may not sum to totals because of rounding. Adults are defined as people 16 years of age and older living in households or prisons. Adults who could not be interviewed because of language spoken or cognitive or mental disabilities (3% in 2003) are excluded from this figure.

Political and Regulatory Response

Focusing on Quality Measures Drives Appropriate Care

There is a broad array of quality measures that may be used to assess and compare the quality of care provided by healthcare organizations. One of the most widely used quality measure sets is the Agency for Healthcare Research and Quality's (AHRQ) **Healthcare Effectiveness Data and Information Set (HEDIS)**, which are predominantly process measures, but there are many quality measures available. A good practice in evaluating whether a measure is good is to confirm that the **National Quality Forum (NQF)**, which checks each measure it endorses against a list of criteria, has endorsed it.

Classifications of Healthcare Quality Measures

Type of Measure	Description	Examples
Structure	Healthcare provider's capacity, systems, and processes for providing high-quality care	Ratio of providers to patients Whether a healthcare organization uses electronic health records
Process	What a provider does to maintain or improve health Clinical best practices Most common, publically reported quality measures	Percentage of people receiving preventive services (such as mammograms or immunizations) The percentage of people with diabetes who had their blood glucose tested and controlled
Outcome	Reflect the impact of the healthcare service or intervention on the health status of patients May require risk-adjustment methods to account for factors beyond the provider's control	Surgical complications and mortality rates Preterm birth rate

SOURCE: Agency for Healthcare Research and Quality (AHRQ)

To participate in the Medicare, Medicaid, and ACA Individual Market programs, healthcare organizations – plans and facilities – must meet minimum quality and safety criteria, as well as report on how they are meeting HEDIS and other quality measures to CMS. However, CMS and many states also use quality measures to incentivize higher quality (or penalize low quality) in managed care programs and to inform consumers about the quality of care to anticipate from various providers and payers. While quality performance is important in Medicaid, it is often challenging to assess. Medicaid data are less accessible, slower to get, and often incomplete. Beneficiaries may also be auto-assigned to plans and only be eligible for short time periods and intermittently. Some states, such as **Washington**, are investing in health information exchanges (HIEs) and a Master Person Index to better track and share data between stakeholders.

CMS uses a variety of quality measures that are updated annually for Medicare Parts C (MA) and D Stars Ratings and Quality Bonus Payments (QBPs). Increasingly, CMS is incorporating and increasing the weights of certain patient experience and access measures, and in bonus year 2024, these measures – a combination of certain patient-reported measures from the **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** and the **Health Outcomes Survey (HOS)** and measurements using administrative data – will account for 53% of the overall Stars Rating and bonus potential. **These measures emphasize this final dimension of access, assessing if patients are treated with respect, get appropriate support understanding their treatment and health plan, and receive effective care coordination.**

Bonus Year 2024 Star Ratings and Quality Bonus Payment Patient Experience Measures (all 4x weighted)

CAHPS	• Getting Needed Care	
	• Getting Appointments (Care Quickly)	• Rating of Drug Plan
	• Customer Service	• Core Coordination
	• Rating of Health Care Quality	• Getting Needed Drugs
	• Rating of Health Plan	
CMS Administrative Data	• Call Center TTY/FL Part C	• Complaints
	• Call Center TTY/FY Part D	• Members Choosing to Leave the Plan
Independent Review Entity (IRE)	• Timely Decisions About Appeals	• Review Appeal Decisions

While "increasing the health literacy of the population" is an **objective** of Healthy People 2030, it is currently only in "research" status, meaning that no evidence-based interventions have been identified to address it, and there is limited data available. Patient-reported measures such as those in the CAHPS survey may be indicators of health literacy and effective patient-provider communication, but more research is necessary to understand how to improve and measure these critical facets of healthcare access.

What Humana is Doing

Humana is deeply invested in providing the highest quality of care for our members. This not only includes **striving for the highest possible plan quality ratings, but also working across the industry to identify and promote innovative ways to advance quality.** Humana's Chief Medical & Corporate Affairs Officer William Shrank, MD, is help guiding healthcare organizations as a member of the NCQA Board of Directors. Dr. Shrank and other clinical leaders have collaborated with NQF on advocating for incorporating **social risk** into population health models and establishing quality measures for addressing health-related social needs such as **food insecurity**. Humana clinical quality leaders have also documented our corporate journey to streamline and **prioritize quality measures** to better support value-based payments by reducing complexity and helping physicians focus on meaningful measures.

Humana supports the health literacy of members in a number of ways. We provide all member materials in plain language to help them better understand the terms and provisions of their insurance plan and screen members for health literacy and other communications barriers during care management programs to ensure they receive appropriate assistance. Humana Healthy Horizons has also incorporated the national culturally and linguistically appropriate services (CLAS) standards into our overall Medicaid Population Health Strategy.

IN THIS CHAPTER

Recommendations
- Humana's Priorities to Pursue in the Future

Humana's Priorities to Pursue in the Future

With five dimensions of access, there are many opportunities for Humana to make it easier for our members to achieve their best health by improving access to care.

Routinely screen members for access barriers such as health literacy, broadband internet access, digital literacy, transportation, and financial strain and connect them with services and supports.

Expand use of CHWs, patient advocates, and other non-clinical professionals assist with care navigation, particularly those members low health literacy or facing other systemic barriers to access

Root out bias – by race, ethnicity, culture, age, disability, income – in healthcare through broad cultural competency and implicit bias training, eliminating any bias in clinical algorithms, and incorporating health equity into quality measurement.

Incentivize or require contracted providers to install medical diagnostic equipment that meet accessibility standards, and use the Provider Finder tool to highlight disability-friendly providers.

Identify more opportunities to hear the voice of our consumers such as through patient advisory councils evaluating new digital solutions.

Support the development of interpersonal communication and shared decision-making skills among healthcare providers, including providers in value-based relationships with Humana, those employed by Humana, and the next generation of clinicians in medical school.

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