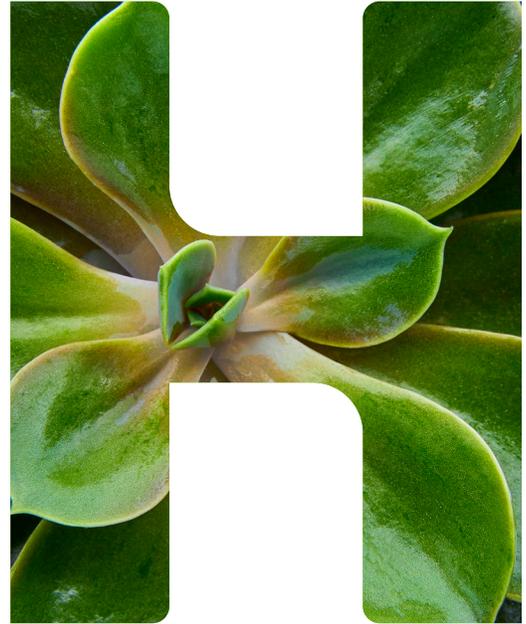


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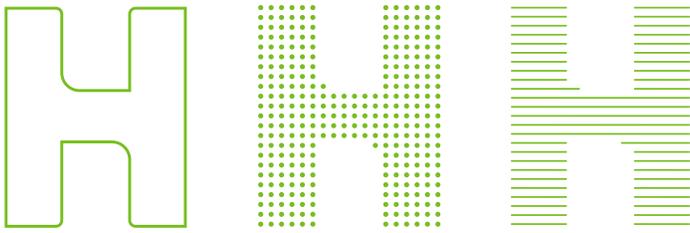
Health equity issue brief

Identifying and addressing
racial and ethnic health
disparities experienced by
Humana's members



Humana



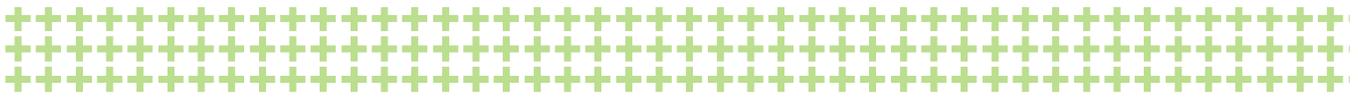


Humana is dedicated to improving the health of every person we serve. We have been at this for a while. Building trust and taking care of people has always been core to our values and our company’s purpose and mission. However, we recognize that it is only with the elimination of the avoidable, unjust, and unfair barriers that stand in the way that our members and patients may achieve their full health potential.

We further understand that we have a responsibility to our stakeholders to help build a sustainable future and that the future success of our company, in all facets, is interdependent upon our continued attention to environmental, social, and governance (ESG) practices. We believe that sustainable future includes us connecting environmental and social factors that influence health outcomes and addressing identified issues, gaps and/or disparities to advance health equity for our members and patients – regardless of their demographics, geography or socioeconomic status.

CMS defines health equity as

the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes.¹



Humana's health equity evolution

With over 60 years of long-standing, comprehensive commitment to our members across the United States, we know that our role in healthcare goes beyond being a good corporate citizen, it also means tackling the larger issues that stand in the way of healthy communities. In 2015, Humana declared a Bold Goal to improve the health of the members and communities we serve and established a dedicated team to tackle social determinants of health (SDOH) and health-related social needs (HRSNs).² Working closely with physicians, clinicians, community partners and national leaders – such as Volunteers of America, Feeding America and March of Dimes – we began testing and scaling interventions to “treat” social needs and expand community capacity to address SDOH. Many of these involve deep community collaborations, such as establishing a process to screen patients for food insecurity in their doctor’s office and immediately connect them to the local food bank for entitlement program enrollment and emergency food provision. Others are interventions that we are incorporating into the health plan benefits we provide to members.

As part of this effort, Humana is also committed to accountability on these investments and outcomes. We published an annual Bold Goal progress report from 2016 to 2021 to provide transparency on efforts to improve population health and address SDOH and HRSNs.³ We also publish an annual Impact Report with data on all measures that encompass Humana’s ESG impact platform. Our 2021 report highlights these initiatives and disclosures across five key metrics categories that align to our strategy for how we will advance health equity, address needs in our communities and drive sustainable change with shared value.⁴ Quantitative and/or qualitative metrics within each category track, monitor, measure and report our performance.

In February 2021, we expanded our Bold Goal effort by launching “Louisville Community of Opportunity” in our headquarters city.⁵ The program focused on collaboration with new and existing partners in Louisville’s West End with the goal of eliminating obstacles to quality healthcare by addressing SDOH, such as food security, while increasing access to care and healthcare education. Humana established a dedicated team of associates to work on the Community of Opportunity effort, partnering with and supporting black-owned businesses and organizations that serve the black community in Louisville.

Also in 2021, Humana became the first national health plan to create the role of Chief Health Equity Officer (CHEO). This leader provides strategic direction in developing clinical programs, education, and communications that address underlying drivers of disparities in healthcare, with the express goal of fostering more equitable care and health outcomes.

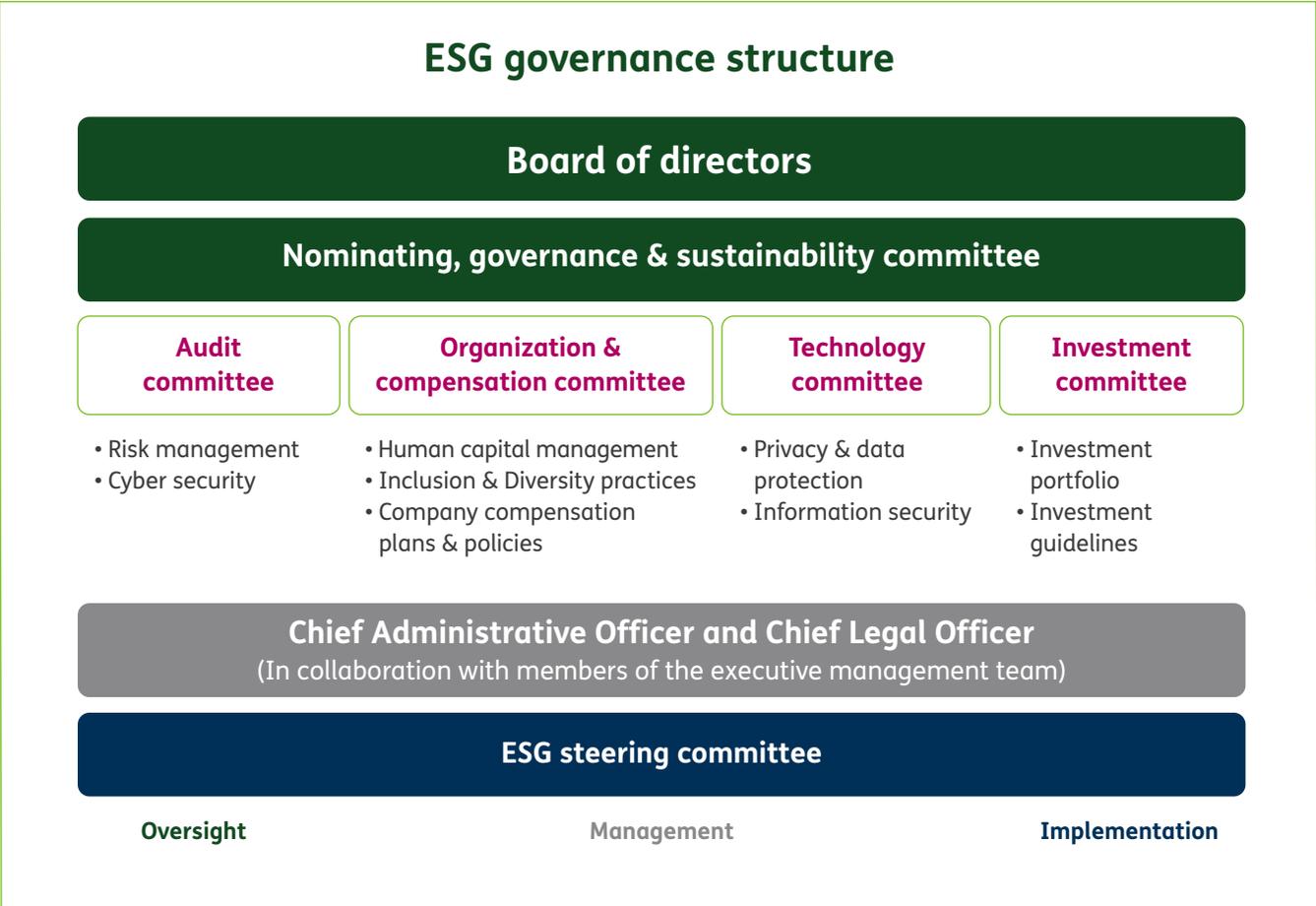
In 2021, Humana became the first national health plan to create the role of Chief Health Equity Officer (CHEO).

ESG governance structure

Our health equity work is supported through Humana’s strong ESG governance structure. In December 2020, the Humana Board of Directors reconstituted its Nominating and Corporate Governance Committee to include oversight of Humana’s ESG program. Now known as the Nominating, Governance & Sustainability Committee, it has responsibility for Board-level oversight of the company’s significant environmental, social, and related governance activities and practices.

The Nominating, Governance & Sustainability Committee receives formal ESG reports from management regarding the Company’s ESG initiatives, metrics, and progress on established goals, which includes health equity initiatives. In addition, Humana has an internal ESG Steering Committee, overseen by our Chief Administrative Officer and Chief Legal Officer, to guide the integration of our ESG efforts with our long-term business strategy. This ESG governance structure complements the long-standing responsibility of the Board of Directors and each of our Board committees in overseeing various aspects of the Company’s ESG-related risks and practices, as illustrated below.

To further ensure that health equity is weaved into the organizational fabric, strategic plan, and business goals, the CHEO, who serves as a Senior Vice President at Humana reporting to the company’s Chief Medical Officer, is appointed to the extended management team that meets regularly with Humana’s CEO and is a core member of the ESG Steering Committee.





Analytic approach to identifying health disparities and prioritizing work

Humana recognizes that eliminating health disparities will only be possible with a critical understanding of our consumers and their needs. This understanding must include how member needs and health outcomes differ by race/ethnicity, geography, socioeconomic status, and other factors. We know that Black and Hispanic beneficiaries are more likely to enroll in Medicare Advantage (MA) than White beneficiaries⁶, so we further need to understand the demographic composition of Humana’s membership.

Humana is developing a health equity strategy that aligns the elimination of disparities and improved health and quality of life to enterprise value, which will ensure the sustainability of new programs or process improvement initiatives. To begin identifying disparities, Humana disaggregated a broad set of utilization, disease and event prevalence, and clinical quality measures by race and ethnicity. Where we identify meaningful differences, we will conduct root cause analyses to determine potential harms or protective factors, including HRSNs and provider value-based payment arrangements.

Data tools for understanding health disparities

Humana’s commitment to health equity and whole-person health has guided investments in an advanced data ecosystem to understand our members’ social and structural barriers to health and an infrastructure to facilitate personalized outreach and care. Below is a description of several of Humana’s tools for identifying disparities in health outcomes and access among our members and for informing intervention strategy. For a comprehensive description of Humana’s related data assets⁷ and ecosystem, please see our 2022 Social Determinants of Health Data Issue Brief.⁸



Population Health Analytics Suite is an innovative informatics tool that combines more than 90 data sets to aggregate and stratify business, clinical, social needs and community metrics for Humana’s membership. The tool’s hot-spotting capabilities allow clinical and population health teams to identify opportunities to improve health and reduce disparities at a hyper-local level. For example, in a recent paper examining the association between self-reported HRSNs and acute care utilization among older adults enrolled in MA, financial strain and unreliable transportation were each independently associated with increased rates of hospital stays (avoidable and all-cause), as well as 30-day readmissions. All HRSNs, except for utility insecurity, were independently associated with increased rates of emergency department (ED) visits.⁹ Our approach prioritizes leveraging data and consumer insights to differentiate consumers and delineate specific challenges they face to then identify and test solutions that have tangible impact and value to both the people we serve and the business.



Standardized screening for health-related social needs (HRSNs), such as housing instability, food insecurity and lack of transportation, is a critically important tool to help us understand the social and economic needs that individuals experience that affect their ability to maintain their health and well-being. Screening programs allow us to better identify unique member needs, address these needs through referral to appropriate Humana or community level benefits or programs, and inform health equity strategy and population health initiatives.

We have instituted broad screening of our members for HRSNs using validated screening tools and have expressed strong support of National Committee for Quality Assurance’s (NCQA) new Social Need Screening and Intervention (SNS-E) HEDIS® measure for Measure Year 2023.¹⁰ Humana screens members through health risk assessments, care management programs, and other member interactions using a variety of channels – in-person or telephonically by a nurse care manager or other clinician, interactive voice response (IVR), and digitally via web form. We also partner with health systems and clinicians to integrate HRSN screenings into their practices and share data with the health plan, which enables social risk-informed care coordination and connection to supportive benefits and resources.

Prevalence of self-reported health-related social needs among Humana’s MA population (2022)

		Race/ethnicity			
		Overall	White	Black	White - Hispanic
Social needs	Food insecurity	30.3%	25.5%	43.6%	38.1%
	Housing insecurity	4.8%	3.9%	6.4%	5.3%
	Transportation barriers	10.8%	9.0%	14.7%	13.7%
	% with 1+ HRSN	54%	49.9%	66.3%	60.0%

Source: Nationally representative survey of Humana MA-Individual membership conducted via multi digital channels in July 2022; n=45,490

Note: Race and ethnicity were self-reported by members during the survey



A metric assessing health disparities experienced by our members will also guide disparity-focused initiatives and enable us to track progress in achieving health equity over time. This novel measure—which was recently featured in the New England Journal of Medicine’s peer-reviewed journal, NEJM Catalyst Innovations in Care Delivery—was developed with the goal of measuring disparities in health behaviors and preventative care for MA members.¹¹ Looking ahead, Humana is building upon this measure to develop a **Health Equity Composite Measure** for MA that also encompasses measures of member experience, engagement, and health outcomes, as well as a Medicaid-specific index that incorporates maternal and child health outcomes.

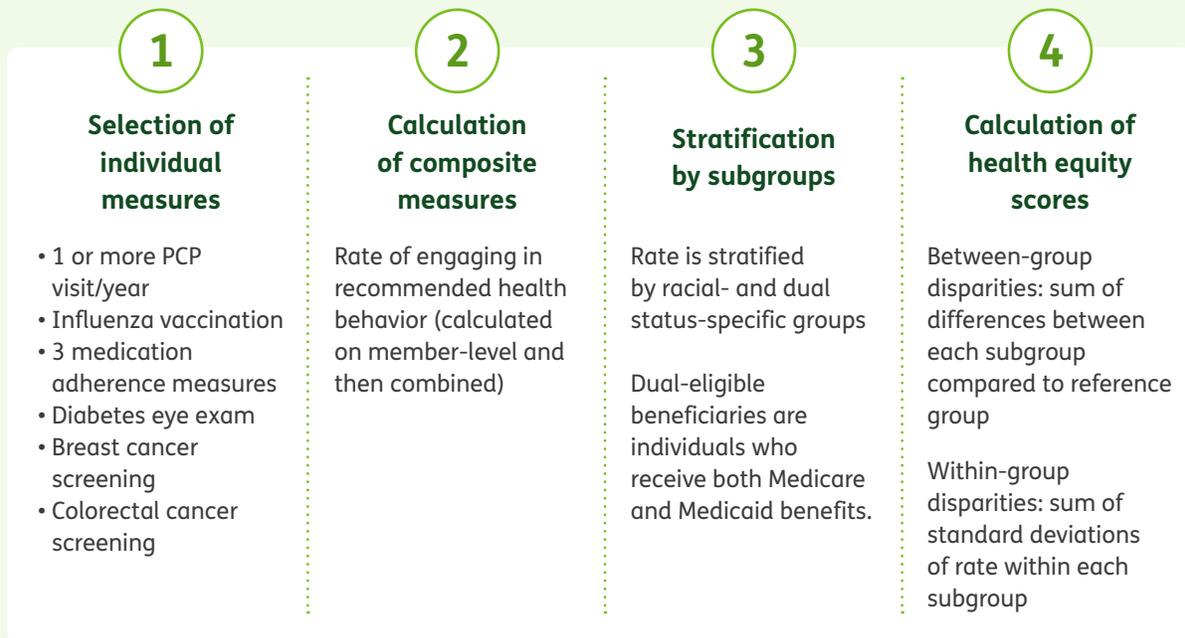
Building the foundation for reducing disparities in medicare advantage

Commentary by Kristin S. Russell, MD, MBA, Sai Ma, PhD, MPA, Mona Siddiqui, MD, MPH, MSE, William H. Shrank, MD, MSHS, J. Nwando Olayiwola, MD, MPH, FAAFP

Published in NEJM Catalyst Innovations in Care Delivery, May 26, 2022

Humana is committed to using data to inform strategies to improve health equity. We know that measurement is an essential tool, so leaders at Humana have taken actions to better understand disparities in members' health by developing a new health equity measure, which was introduced in a May 2022 NEJM Catalyst commentary.

Health equity measure development steps

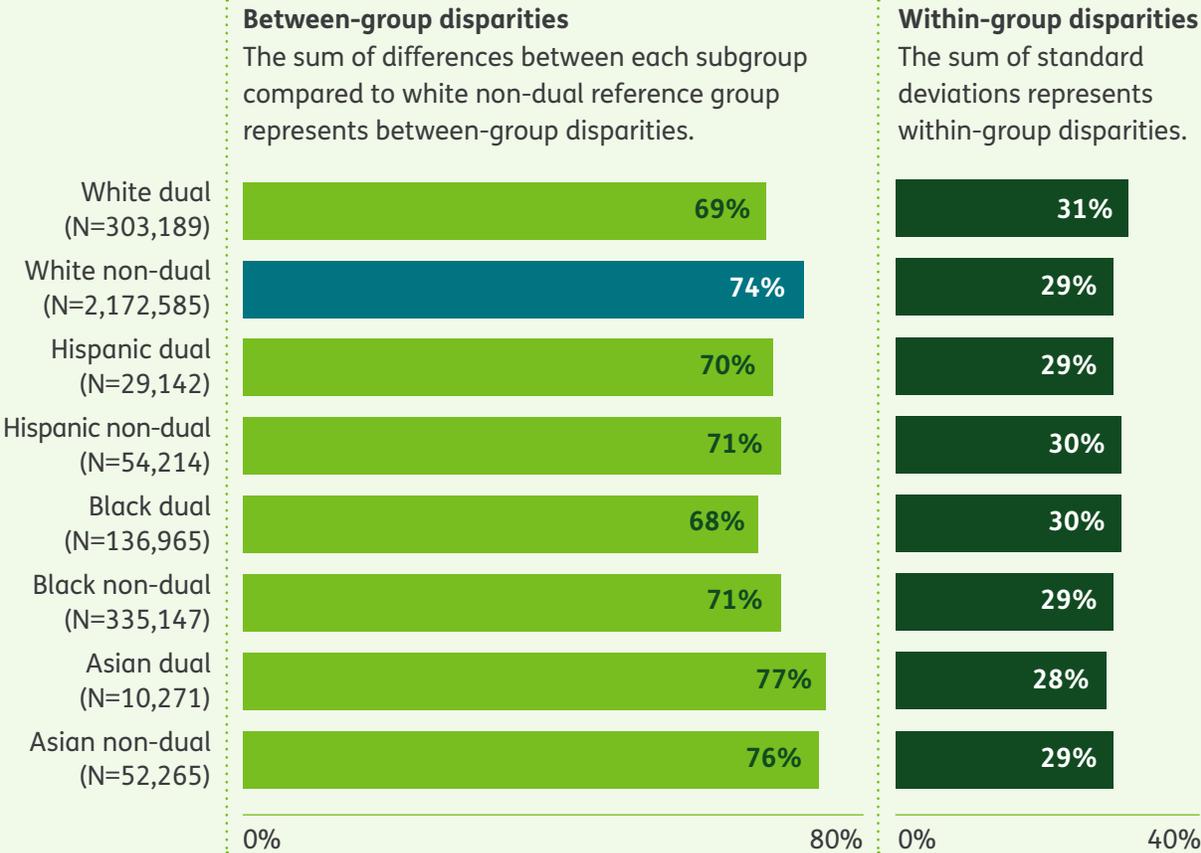


Source: The authors
NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

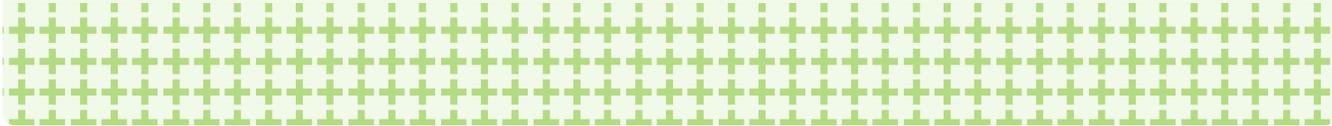


Our approach will help us to identify where disparities are largest in order to set strategic goals and take action. For example, by looking at between-group disparities, we observed that patients in the Black dual-eligible and White dual-eligible subgroups had the lowest average rate of engaging in recommended health behaviors (68% and 69%, respectively). By looking at within-group disparities, we see the greatest disparities with the White dual-eligible population. Understanding common characteristics of the patients with the lowest rates within each of these subgroups enables the design of more personalized and effective solutions.

Calculation of summary scores to track both between- and within-group disparities

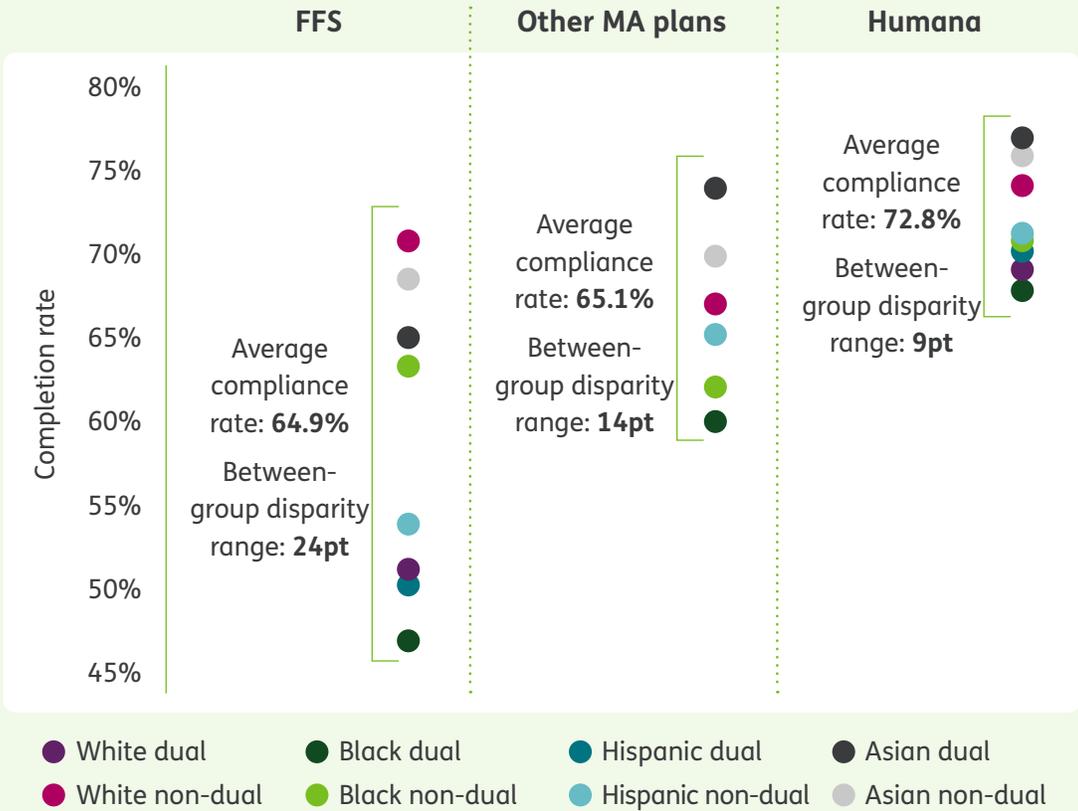


Source: The authors
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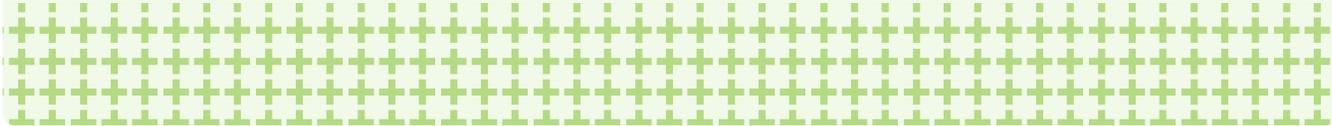
Working with our research partner, Inovalon, we were also able to benchmark our performance to fee-for-service (FFS) Medicare and other MA plans using 2019 data from the Inovalon MORE2 Registry. Overall, Humana members engaged in approximately 73% of applicable health behaviors. We further stratified each racial/ethnic subgroup by dual and non-dual status and found that the difference between the highest-performing and lowest-performing subgroups at Humana was 9 percentage points.

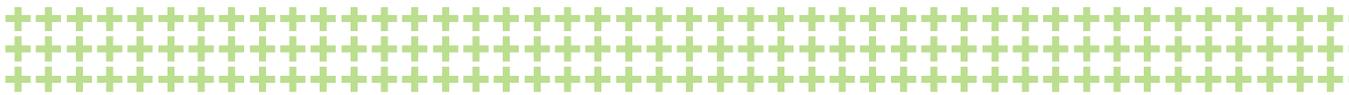
Health equity measure performance in 3 populations: Humana MA, Other MA Plans, and fee-for-service Medicare



Source: The authors
 NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

While this measure is a work in progress, we believe that it is important to share our learnings to create early transparency and drive synergy across the industry. In the meantime, we are working to operationalize this measure to impact how Humana prioritizes investments, decides what capabilities to build, and determines where to focus efforts.





Framework for health equity in health plans

Humana has identified a number of priorities and opportunities for health equity, some of which were captured in Dr. Olayiwola’s Health Affairs Forefront editorial in 2021, where she articulated 5 keys to successful health equity leadership in health plans.¹²

Humana’s 5 keys for achieving health equity

The 5 keys framework support Humana in developing, executing and scaling evidence-based strategies for achieving health equity via internal innovation and external partnerships, measuring progress with data analytics every step of the way.

CROSS-CUTTING LEVERS



Data analytics

Performance measurement



Research and innovation

Testing new, innovative programs



Cultural competence and implicit bias

Associate and provider training

DOMAINS



Social and structural determinants of health

- Food security
- Economic and housing security
- Health literacy



Comprehensive clinical care

- Access to primary, preventative and behavioral health care that is integrated with digital health, home care and pharmacy



Enhanced consumer journey

- Value based care
- Benefits improvement
- End-to-end member and associate experience



Academic partnerships and workforce development

- Higher education partnerships
- Advocacy
- Workforce development



Community engagement and partnerships

- Engaging and investing in community members and organizations

Health equity strategic focus areas

Humana's Health Equity and Community Engagement (HECE) team is prioritizing focus areas by identifying conditions and populations experiencing the most significant disparities, and we have found opportunities for improvement within our Black and Hispanic members with diabetes and hypertension. While there are many drivers of health disparities, the HECE team is focused on the following three primary drivers because of their demonstrable impact on health disparities as well as influence health outcomes and patient experiences:

1. **Improving access to care** by expanding utilization of primary care and preventative care services and minimizing issues associated with receiving care due to factors such as health literacy, geographic, cost or transportation barriers
2. **Improving quality of care** through steps such as developing a culturally empathetic communication approach to Humana's member/patient-centered care methods and leveraging clinical decision support tools, electronic health record integration, and clinician resources to provide evidence-based preventative and chronic disease care
3. **Addressing non-medical barriers to healthy living** such as HRSNs and health literacy as well as the broader social, physical, and economic environments in which our members and patients live and access care

The HECE team is structured to execute on these focus areas, with workstreams for:

- Strategic Implementation
- Community Engagement and Partnerships
- Policy and Insights
- Business Intelligence and Analytics
- Product Development
- Innovative Solutions and Training
- Business Operations and Market Integration

Foundational to each of workstreams is a data-driven, collaborative approach to identify health disparities and their root causes, co-create impactful solutions with business partners and to measure progress.

Humana has
a vision of
**influencing
and enabling
an equitable
healthcare
ecosystem**
so that every person
has a fair, just, and
dignified opportunity
to reach their full
health potential.



Examples of programs and initiatives to advance health equity

Humana is committed to co-creating solutions to address HRSNs and advance health equity among our members and in the communities we serve. In addition to soliciting qualitative and quantitative feedback from our members on the types of benefits and programs they are interested in, we partner with community-based organizations (CBOs), health systems and healthcare providers, and other stakeholders to design, test, and scale innovative solutions. These collaborations move us towards the goals of eliminating social and structural barriers to health to achieve health equity. Below are examples of our work to-date. For additional information, please see our Issue Briefs, such as our briefs on Food Insecurity, Housing and Access to Care.¹³

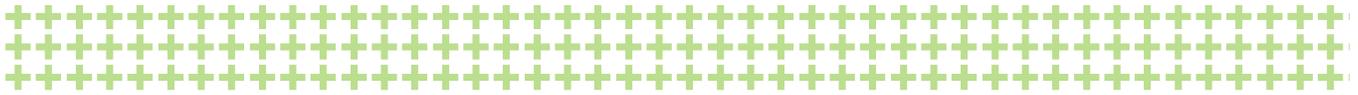
Proactive response to food insecurity

Through our research, we have learned that food insecurity is particularly high among MA members who are dually eligible for Medicare and Medicaid.¹⁴ That is why Humana leveraged the Medicare Advantage Value-Based Insurance Design (VBID) Model in 2020 to offer the Healthy Foods Card Benefit to members on select Dual Eligible Special Needs Plans (D-SNP) in several states.¹⁵ The benefit can be used to purchase healthy groceries at various national retailers and comes in the form of a wallet card that is loaded with a cash benefit each month.¹⁶

When it became clear that the COVID-19 pandemic was putting many of our members at even greater risk of food insecurity, Humana took advantage of CMS flexibility to offer mid-year benefit enhancements and expanded the number of plans offering the Healthy Foods Card Benefit. We also increased the monthly allowance on certain plans based on severity of need. In addition, to meet the basic needs of our membership overall, we quickly established a program to identify and respond to food insecurity. By the end of 2021, we served over 1.6 million meals and provided other social health supports for more than 94,000 individuals at risk of food insecurity.

Beginning in 2023, the Healthy Foods Card will expand to become the Healthy Options allowance and help Humana MA members on D-SNP plans, as well as select Chronic Condition Special Needs Plans (C-SNPs) and non-SNP plans, pay for essential living expenses like eligible groceries, over-the-counter (OTC) products, utilities, rent, pet care and more to support their health and quality of life.¹⁷ While the current VBID Model is anticipated to end December 31, 2024, Humana supports either extending the performance period or codifying the flexibility of MA plans to target benefits based on socioeconomic status and need.

**Humana is committed to co-creating solutions to address HRSNs
and advance health equity among our members**



Linking housing and healthy families

Drug use during pregnancy can lead to a host of problems, and after birth, or when a pregnant parent stops taking the drug, a baby may experience Neonatal Abstinence Syndrome (NAS), which is a group of conditions caused by withdrawal from certain drugs, most often opioids. Successful NAS prevention and treatment requires integrated prenatal and postpartum care and support from medical and behavioral health providers, CBOs and peer support. However, there are substantial barriers to parents accessing support, including but not limited to insufficient capacity and fear of losing custody of their children, separating families, and straining mental health.

Family-focused treatment is an effective, holistic model where parent and child receive residential treatment together, thereby breaking the cycle of addiction, reducing health effects and costs, and preserving the family unit. Family-Focused Recovery (FFR) goes beyond residential treatment and provides wraparound social services – including counseling, workforce development, life skills coaching, housing and family support – for the family’s long-term recovery and success.

Humana has partnered with Quantified Ventures to expand access to this model of treatment through a \$5 million investment in a new fund to help Volunteers of America (VOA) sustainably scale its FFR program. The fund – which is designed to encourage further investment from other funders – is providing VOA affiliates with access to capacity-building services and innovative, outcomes-based financing to help VOA scale to meet increasing demand in the communities they serve.¹⁸ In 2022, through a partnership with Humana Healthy Horizons® and HECE, the program expanded to Kentucky, Ohio and Louisiana.¹⁹ The outcomes being measured through these investments include parents who complete the program and length of Neonatal Intensive Care Unit (NICU) stays for their babies.

Addressing housing needs through SSBCI

Through Special Supplement Benefits for the Chronically Ill (SSBCI) – one of the two pathways established by recent of bipartisan legislative and regulatory changes whereby MA plans may offer specialized benefits to address SDOH – Humana is able to assist members with housing needs via its Flexible Care Assistance benefit. This benefit allows the care team to help with housing quality issues (ex. a member in need of window AC unit, pest control, minor repairs, etc.). Top requests for 2022 included utility assistance and housing payment support, followed by food support and copay assistance. The benefit is available to members on select plans nationwide in 2023, with dollar amounts ranging from \$500 - \$300/month. Through these benefits, Humana is working to alleviate financial strain, thereby enabling individuals to begin to address higher-level needs.

Tools for delivering culturally competent care

It is crucial to equip providers with the needed tools to deliver culturally competent care and strategies to neutralize biases in the clinical setting to deliver on Humana’s promise of whole person care to members. To that end, Humana launched a pilot program in August 2022 to provide cultural humility and implicit bias training for clinicians at Conviva, Humana’s network of primary care providers in South Florida.²⁰

Chartis Just Health Collective, a division of Chartis, a leading healthcare advisory and analytics firm, was selected as a partner for these trainings after a competitive process. The training program will help providers define and understand cultural humility and implicit bias and how both relate to health equity and belonging. Humana will evaluate the pilot on the following outcomes: cultural humility awareness, intent to mitigate bias and improvement in patient trust and experience. If successful, we anticipate bringing the training model to Humana-owned and affiliated clinical assets.

Supporting physicians in helping patients achieve their best health

We know that value-based care positions practices to drive change through the integration of resources, infrastructure and programs designed to remove barriers; however, we also know that population-level factors (ex. physical, built, social, and policy environments) can have a greater impact on health outcomes than individual-level factors²¹ and to date, many clinician groups have already begun work to address health equity within their own practices. Humana supports our value-based providers by sharing not only clinical but also social risk data and by providing resources to help them address the needs of their patients. These include access to Humana Community Navigator and toolkits and guides for identifying, intervening and coding for HRSNs (ex. a physician guide to address SDOH in patients and an SDOH provider coding guide). We have also launched a value-based program specifically to incentivize social need-informed care.

In Phoenix, Equality Health (EH) is focusing on cultural competency within its multi-disciplinary care management team. As a result of their efforts, EH patient engagement in its care management programs increased because when a patient feels understood, they more easily establish trust with their provider and engage in a more positive way. EH’s care management team successfully enrolls 75% of patients in its care management programs once making initial contact. The approach has resulted in lower hospital readmission rates for the practice’s attributed Humana membership — from 16.4% in 2020 to 9.5% in 2021.



Humana priorities to pursue

Looking ahead, we recognize that there is still much work to be done to create a more equitable healthcare system. We have already identified several priorities to pursue in the coming year to help advance our strategy.



Humana is committed to identifying additional populations who are experiencing disparities in health outcomes and experiences because we can only address those disparities that we can see and measure. We are establishing strategies for identifying people who identify as members of these population groups, disaggregating health and healthcare data to identify disparities, and then investigating the root causes and potential remedies for disparities.



While expanding our focus, we will not lose sight of the populations that are currently part of our health equity strategy – people of racial or ethnic minorities, who live in rural areas, who are dual-eligible or low socioeconomic status, and who are veterans or active-duty service members and their families. **We have opportunity to promote self-identification of these attributes and structural drivers of health to deepen our understanding of the needs and barriers facing our members.** This includes member-reported:

- Race and ethnicity
- Functional limitations and accessibility needs
- Health literacy barriers
- Perceptions of healthcare discrimination



We will finalize development of our Health Equity Composite Measure and use it to assess our progress toward more equitable health experiences and outcomes for the people we serve. This will hold us accountable for not only improving overall quality of care but quality for vulnerable and historically marginalized groups as well. We intend for the Health Equity Index to be an internal and external tool to transparently measure progress.



There is still much to learn about how to effectively address health disparities. **We are also committed to continuing to work with Centers for Medicare and Medicaid Services (CMS), state Medicaid agencies, and others in the healthcare industry** to share insights and best practices, as well as to collaborate to eliminate structural barriers to health equity.

Conclusion

Health equity is core to Humana's business strategy, and we look forward to sharing more about actions taken and progress made. Humana has demonstrated a commitment to measurement, accountability and transparency through our Bold Goal initiative and intends to continue in this spirit with our Health Equity initiatives. With the expansion of Humana's commitment to health equity in 2023, we will continue to communicate the accountability measures and reporting cadence.

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Journal articles

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Humana publications and resources

Issue briefs

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Loneliness & Social Isolation Issue Brief, October 2021. https://populationhealth.humana.com/wp-content/uploads/2021/10/SDOH-Issue-Brief_Loneliness_October2021-EXTERNAL.pdf

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Access to Healthcare Issue Brief, April 2021. https://populationhealth.humana.com/wp-content/uploads/2021/04/AccessToHealthcare_IssuesBrief_External_8.5x11.pdf

Food Insecurity Issue Brief, December 2020. https://populationhealth.humana.com/wp-content/uploads/2020/12/FoodInsecurityIssue_8.5_11_MainExternal.pdf

Health Equity Issue Brief, September 2020. https://populationhealth.humana.com/wp-content/uploads/2020/09/2020_HealthEquity_IssueBrief_External.pdf

Housing Policy Brief, June 2020. https://populationhealth.humana.com/wp-content/uploads/2020/06/Humana_HousingBrief_Final_External_version_2020.pdf

** Find full catalogue of Issue Briefs at <https://populationhealth.humana.com/policy-briefs/>

Resources and toolkits

Financial Strain for Seniors, November 2022, <https://populationhealth.humana.com/resources/financial-strain-for-seniors/>

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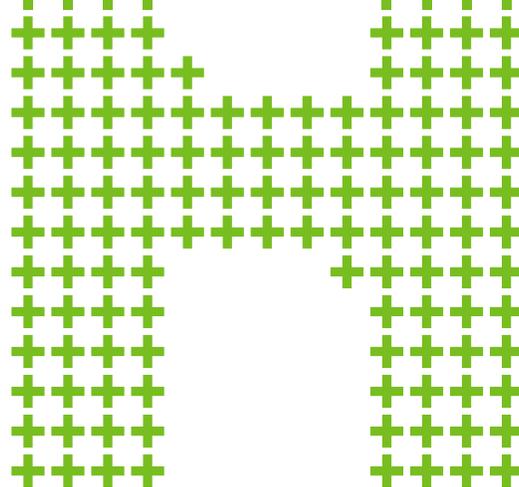
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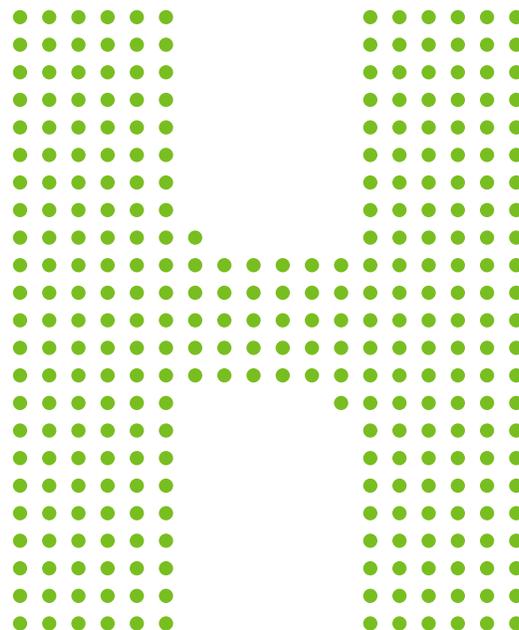
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