

A Q&A WITH WILLIAM H. SHRANK, MD, MSHS

Medicare Advantage Providers, Patients Connect Without a Playbook

Interview by Allison Inserro

To mark the 25th anniversary of The American Journal of Managed Care® (AJMC®), each issue in 2020 will include a special feature: an interview with a thought leader in the world of health care and medicine. The November issue features a conversation with William H. Shrank, MD, MSHS, chief medical officer of Humana.

AJMC®: Could you share what sorts of lessons you and Humana have learned over the past few months in terms of providing value-based care during the most challenging time for health care: the pandemic?

SHRANK: Well, we learned that those of our providers in our network who have engaged in really progressive contracts that are taking meaningful downside risk, and in particular those who are prepaid, were in a far better position financially to withstand the pandemic. But more importantly, they were in a considerably better position to be able to be nimble and flexible and really adjust the way they care for our members. They were able to more rapidly move to telehealth services, they were more rapidly able to adjust the way they interact with our members, there were more frequent “touch-bases” on the phone, and they were less concerned about maintaining billable visits and more focused on just what the totally unpredictable needs were of the members whom we serve together.

AJMC®: What are you hearing from providers about what they think they will need in 2021?

SHRANK: I would say there's a tremendous amount of uncertainty right now; there's a lot that we can't predict accurately with respect to the trajectory of the pandemic. And it is a pretty extraordinarily uncertain time in the setting of the election. Our providers are looking for a path to resiliency, and for many of them, that means exploring new ways of contracting with us that are more value-based. For others, it's looking at more short-term fixes. But in general, our approach is to work really closely with our providers and try to understand how we can be part of the solution: to help them, and to help them help our members through these really uncertain times.

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AJMC®: Speaking of members, what do you think they will need next year—again, knowing that everything is very uncertain—in terms of what they've told you that they appreciated this year?

SHRANK: We've learned a lot from them. We've learned that they very much appreciated and are far more willing, in Medicare Advantage in particular, to adopt and get comfortable with virtual care than some of us feared. We also learned that during the uncertainty of the pandemic, the barriers to just accessing basic health needs were profound. And it really accentuated or punctuated our belief that it's a key part of our role in Medicare Advantage, in particular, to partner with our members and really try to understand what their very personal needs are to achieve their best health. And we expect to continue to expand on how we leverage supplemental benefits to be able to help address those health-related social needs and take a really holistic perspective in supporting our patients, our members, to achieve their best health. We also are recognizing that there have been exacerbations around a whole host of behavioral health concerns in the setting of the strain from the pandemic and our efforts around creating access to virtual behavioral health. Facilitating behavioral health care is also at the core of our response and our approach to continuing to support our members.

AJMC®: Something I've heard repeatedly is the universal positive reaction to telehealth. Do you think other care delivery changes

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will remain? For instance, I read that you sent out kits for home screenings, such as for colon cancer and diabetes. Will those remain?

SHRANK: I believe so. I think that our members are realizing that more care can be delivered in the home and more services can be offered in the home. Preventive services are a great example. There is more appetite for that; in part, it was accelerated because our members didn't really want to go see their doctor [when they were concerned] about potential exposure in a physician's office. But like most other industries, that convenience and consumer-centricity of being able to deliver services in the comfort of one's home and for our members to be able to participate in preventive screening, as an example, or receive care within their workflow of when is best for them, rather than working around a schedule of a health care provider, is really appealing. So we think more and more of our members are going to choose with their feet and demand more care in the home. That's something that we are eagerly and actively engaged in and trying to produce for them.

Folks had to be willing to try new things during these really remarkable times, and it just facilitated that. Lots of times the hardest part is just getting started. Now that things have gotten started, they realize the benefits.

AJMC®: Talking about getting started, your viewpoint published in *JAMA* in October described 3 forces that determine whether low-value care can be de-adopted.¹ Can you talk about that briefly?

SHRANK: The idea is that we have spent a lot of time talking about how to address and accelerate adoption of new technologies and new innovative procedures or therapies. We do not spend an equivalent amount of time trying to understand how to de-adopt those therapies, procedures, and interventions that are not shown to provide value. At a time when we're spending upward of a trillion dollars a year on what most people would consider waste in our health care system, and considering that financial constraints are paramount and the rising cost of health care is a meaningful barrier—it's starting to crowd out other important social services, and education, and other services that we as a country need to offer—it's important to think hard about what we need to do to de-adopt those procedures or services or therapies that we appreciate are low value.

What we wanted to do is think through a framework of the key features to de-adoption, and we articulate that there are 3 key components. One is that you need evidence. Clearly, you need evidence that a service or procedure is low value. Second, eminence is important. It's helpful when societies or experts in a field take a position that's visible and qualify a procedure or a service as low value. But we also looked at some case studies and some examples, and it's pretty clear that in the absence of economic levers, whether [the levers have] to do with coverage or a variety of different economic tools that payers can use, you don't see really complete or a majority of de-adoption. But once you implement those economic levers, you're able to see much more meaningful behavior change.

AJMC®: Another challenge for payers is how to tackle both the social determinants of health and chronic conditions, which often go together in this kind of environment.

SHRANK: I have a lot to say on that. I would say, first, I think there's an opportunity for us as a health care system to reward risk-bearing providers or risk-adjusted health plans in a different way, one that accounts for social risk, in addition to physical health risk. In general, anybody who's bearing risk generally has received some sort of a risk-adjusted payment, largely based on their [patients'] codified chronic conditions or their codified diseases and other physical health risk factors.

We know that there's a bit of an arbitrary distinction between physical health and social context, because those are so highly related. And we also know that models that allow us to include social risk variables allow us to much better predict health care costs and health outcomes. So we're implicitly creating a system that de-incentivizes providers or plans to care for those who are socially vulnerable.

I think we need to move toward an environment where we include social vulnerability or social risk, along with physical health risk, in our risk-adjustment policies. There's no question to me that if you don't account for social health, if you don't account for health-related social needs, in the [treatment] of patients with a whole host of chronic conditions, it's very hard to manage those chronic conditions. It's very hard to manage diabetes or heart failure in a setting where those patients don't have a stable source of healthy food. It's very hard to manage [chronic obstructive pulmonary disease] in a setting where somebody does not have stable access to a safe housing environment. There are so many key relationships between social context and health outcomes for those with chronic conditions that it's really central for us to be able to think about, holistically, what a patient needs, and not just managing a specific condition or a set of conditions. And it's going to increasingly be a central part of how anybody who's bearing the risk for a population is going to focus on helping individual patients who have chronic conditions address their very personal barriers to achieving their best health, and that will include the features of their social context, or their health-related social needs.

AJMC®: Would you like to say anything else about the times we're living in, in terms of health care?

SHRANK: How much time do you have? *(Laughs.)* Obviously, these are pretty extraordinary times. We're not really following any playbooks. We're all acting in real time to figure out how to best care for the patients we serve. ■

REFERENCE

1. Powers BW, Jain SH, Shrank WH. De-adopting low-value care: evidence, eminence, and economics. *JAMA*. 2020;324(16):1603-1604. doi:10.1001/jama.2020.17534

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