Humana Health Plan H2012 Humana Gold Plus
Dual-Eligible Medicare Zero Cost-sharing Special Needs Plan

Model of Care Score: 97. 50 %
3-Year Approval **January 1, 2014 – January 1, 2017**

Target Population

Humana's Dual-Eligible (DE) SNP population is identified through entitlement to Part A and enrolled in Part B of Medicare through age or disability, residence within the plan's service area, eligibility for and receiving assistance from the state including, but not limited to, Medicare costs share protection. DE members are more likely to be over 85 years of age or disabled, members who are under 65 become eligible for Medicare due to disability, and have greater limitations in Activities of Daily Living (ADL), with one third reporting impairment in three to six ADLs. This population also demonstrates higher rates of mental illness, cognitive impairment, and higher incidence of diabetes, stroke, and Alzheimer's.

Provider Network

Humana offers members of Special Needs Plans a comprehensive network of care centered on primary care providers (PCP) with medical and surgical specialists available to augment and support PCPs as well as the needs of the targeted populations. This network includes, but is not limited to, acute care facilities, long-term care facilities, skilled nursing facilities, laboratories, radiography facilities, rehabilitative specialists, mental and social health specialists, home health specialists, and end of life care specialists. Humana may grant approval for utilization of out-of-network facilities when appropriate. This includes primary care, specialty, ancillary, and facility types including but not limited to medical specialists, dialysis facilities and specialty outpatient clinics. Nursing professionals support the overall care management of the members specifically in the community and in the facility settings.

Care management and Coordination

The Humana Team delivers its services within a multi-disciplinary care team model. Care management is delivered by phone and/or within the member's place of residence whether that is an independent living residence, assisted living facility, behavioral community health center, skilled nursing facility, and hospital or rehabilitation facility. The interdisciplinary care team (ICT) is member-centric and based on a collaborative approach, which includes participation by members, their families, caregivers, PCP and/or specialists, care managers (who are RN's or the

care coordinator) and any number of additional support providers based on the members' ever-changing needs. At the center of the ICT model are the member and caregiver, the care manager and the member's PCP. The model of care is physician and provider-inclusive, with PCPs driving the medical treatment plan and care managers advancing the physician's treatment plan. The ICT's overall care management role includes member and caregiver assessment, reassessment, care planning and plan implementation, member advocacy, health support, health coaching and education, and support of the member's self-care management and care plan evaluation and care plan modification as appropriate.

The initial health risk assessment (HRA) is administered by phone to new Humana Medicare SNP members within the first 90 days of enrollment and then reassessed annually thereafter. The HRA can be completed face-to-face by field care staff who travel to the member's home or other place of domicile if they are unable to complete the assessment by phone or mail.

Care plans are created, reviewed, and updated with each member encounter by the care manager. The care plan is mutually designed with the member or caregiver, with the care manager responsible for coordinating the care plan interventions. The care manager, in conjunction with the member and ICT, coordinates efforts to make the individualized care plan (ICP) actionable. Care plan outcomes are tracked as progress toward agreed upon goals is assessed. With each member contact, progress toward these goals is assessed. Barriers to achieving identified goals are defined and discussed, and goals are modified as warranted or desired by the member and/or caregiver. The care plan also includes the beneficiary's health improvement. Humana conducts chart audits to assess quality and clinical efficacy of the care plan.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at: www.humana.com/SNP.