H2012 Humana, Inc.
Dual-Eligible (Dual Eligible Subset-Medicare Zero Cost-sharing) Special Needs Plan

Model of Care Score: 88.33%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Humana is a Dual-Eligible Special Needs Plan (D-SNP) for members who are entitled to Part A, enrolled in Part B of Medicare and are eligible for and receive Medicaid assistance. Members must also reside within one of Humana Inc.'s service areas which extend across the United States and include the following states: Alabama, Arkansas, California, Florida, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Missouri, Mississippi, New Hampshire, New York, North Carolina, Ohio, South Carolina, Tennessee, Virginia and Washington.

Based on data from Humana's total D-SNP population, 84 percent of the membership speaks English and 53.4 percent of the population is White/Non-Hispanic; 28 percent is African American and 10.5 percent is Hispanic. Females account for 65 percent of the population and the average age of members is 66.5 years. Forty-five percent of the population has between one and three co-morbidities and the top three conditions include vascular disease (22.5 percent), chronic obstructive pulmonary disease (19.9 percent) and renal failure (19.7 percent). About eight percent of members fall into the high cognitive risk category, and the majority of members are considered to have low cognitive risk (65 percent).

Provider Network

Humana offers members a comprehensive network of care centered on primary care providers (PCP), medical and surgical specialists available to meet their needs. This network also includes, but is not limited to, acute care facilities, skilled nursing facilities, laboratories, radiography facilities, rehabilitative specialists, mental and social health specialists, home health specialists and end-of-life care specialists. In addition, the plan maintains a designated network of sub-acute, long-term care and assisted living facilities. When appropriate, Humana may grant members approval for the utilization of out-of network facilities.

Care Management and Coordination

Within 90 days of enrollment, a referral specialist, or care manager (CM), administers the initial health risk assessment (HRA) to members by phone, mail or in-person if necessary. The HRA assesses the member's health status and acuity level which, in turn, guides clinical interventions and development of the individualized care plan (ICP). All members complete the annual HRA

within 365 days of the prior HRA. In the event of a hospitalization or a change in health status, prescribed medications or utilization of services, reassessments occur more frequently.

Whether done by telephone, in-person or through a combination of the two methods, the CM develops the ICP in conjunction with the member and/or caregiver. Field care managers may also participate in the initiation and revision of an ICP when meeting in-person with members. The CM also includes information from interdisciplinary care team (ICT) members or external providers such as hospital discharge planners or disease management vendors in the ICP. The essential elements of the ICP include: a case management plan with prioritized goals that consider the member's and caregiver's goals, preferences and desired level of involvement; barriers to meeting goals or complying with the plan; a schedule for follow up and communication; a self-management plan and a process to assess member progress.

With each member contact, the CM assesses the member's progress toward his or her goals, defines and discusses the barriers to achieving the identified goals and modifies the goals as warranted or desired by the member and/or caregiver. When the member's health status, needs or utilization patterns change, the CM modifies the ICP. The CM also stores the modified ICP in the plan's secure, web-based documentation system where it is accessible to the rest of ICT. Upon request, Humana mails updated ICPs to the member.

At the center of the ICT are the member, caregiver(s), the PCP and the CM. The CM also engages other members of the ICT when required based on the member's needs. These ICT participants can include the medical director, clinical pharmacist, registered dietitian, social workers, behavioral health providers, medical specialists, community resource specialist, community health educators and a quality assurance specialist.

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