Humana Health H2649,
Chronic or Disabling Condition (Diabetes Mellitus) Special Needs Plan

Model of Care Score: 86.88%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

The targeted SNP population includes diabetic members enrolled in a Chronic Condition – Diabetes SNP. These members may have complex medical needs and increased psychosocial needs that impact compliance with diabetic care plans and health outcomes. In addition to addressing and increasing members' knowledge of the disease process and treatment plan, the program assists members in the development of improved health-related behaviors and coping skills, while providing them with needed support and resources.

Provider Network

Humana offers a comprehensive network of care centered on primary care with medical and surgical specialists available to augment and support primary care physicians (PCPs) as well as the needs of the targeted populations. Humana's network includes a range of specialist and facilities such as acute care facilities, long term care facilities, laboratories, radiography facilities, mental and social health specialists, home health specialists and end of life care specialists.

Care Coordination and Management

All SNP members are required to have an active, individualized care plan documented in Humana's care management system. Humana Enrollment collects new member enrollment data for the purpose of engaging members in care management and administering the health risk assessment (HRA) for SNP members. The HRA is administered by phone to new members within the first 90 days of enrollment for the purpose of grouping the membership by level of need, providing continuity of care and appropriate coordination of clinical services. The care manager schedules telephone and in-person contacts with the member and/or caregiver(s). They focus on interventions and goals contained within the care plan. Progress towards goals is documented in the care plan and discussed with the member and/or caregiver and the member's physician(s) as needed. In addition, elements of the care plan are discussed as needed and appropriate with members of the interdisciplinary care team (ICT).

Humana utilizes several risk stratification strategies to identify the right member for the right level of intervention and care management. Member claims are also risk stratified on a monthly basis. The HRA produces a current health status profile and an overall risk score, focusing on

seven health domains: functional, social, cognitive, financial, health, behavioral, and environmental risk. A complete profile is built on each member using the HRA, the predictive risk score, and historical claims data. The profile is then used to direct interventions targeted to concerns identified. Reassessment using the same tool is performed within one year of previous assessment.

The care plan addresses the gaps identified through the assessment process and planned interventions such as connections to benefits and special services, in order to meet specific short term and long term goals and objectives. For actively managed members, care plans are discussed and mutually designed with the member and/or caregiver, and shared with physicians as appropriate to the plan of care. Care plans are created, reviewed and updated with each member encounter by the nurse care manager.

Humana delivers its services within a multi-disciplinary care team model. Every SNP member is assigned to a care team. The principal care manager coordinates and engages other members of the interdisciplinary care team (ICT) when required, based on member needs. The ICT may be composed of but not limited to the Chief Medical Officer, the Clinical Pharmacist, social workers, a community resource directory advisor, dietician, a Diabetic Certified Educator (an RN) or other members of the SNP team including the team manager. In addition, when feasible, the member/caregiver and/or the member's provider are included in the ICT meeting. Other providers whom the member is seeing may be engaged to collaborate regarding areas of concern, as needed.

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