Cariten (Humana) Health Plan, Inc.,
H4461, H1951, H1036, H0307, H1406, H2012, H4141 and H8953
Chronic or Disabling Condition (Cardiovascular Disorders, Chronic Heart Failure and Diabetes)
Special Needs Plan

Model of Care Score: 98.75%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

The target population for this SNP is individuals living with living with Cardiovascular Disorders (CVD), Chronic Heart Failure (CHF), and Diabetes (DM). The Centers for Medicare and Medicaid Services (CMS) identified four targeted CVD conditions for inclusion in CVD SNPs: Cardiac arrhythmias, Coronary artery disease, Peripheral vascular disease, and/or chronic venous thromboembolic disorders. CVD has a combined prevalence rate of 39.4% and CHF has a prevalence rate of 14.0% within the Humana SNP population. People living with cardiovascular disorders, heart failure, and diabetes have a significantly increased chance of impaired kidney function, blindness, neuropathy, high blood pressure, fluid buildup, arrhythmias, angina or myocardial infarction, and depression. The goal of the Humana Cares model is to assist members in meeting their personal health improvement goals as well as adhering to their provider's treatment plan. This includes development of improved health-related behaviors and coping skills, as well as increased knowledge about of the disease process and treatment plan.

Provider Network

Cariten Health Plan, Inc.'s network is centered on primary care with medical and surgical specialists available as needed. The network includes an extensive list of providers and facilities such as hospitals, long-term care facilities, skilled nursing, labs and radiography, mental and social health specialists, rehab facilities, home health and end of life specialists. If a member has a need that cannot be met by a network provider, Cariten Health Plan, Inc. may approve coverage for out-of-network facilities or providers. As this SNP focuses on members with diabetes, the network provides access to dialysis facilities and specialty outpatient clinics. Humana is encouraging its providers to move toward establishing recognized patient-centered medical homes and provides technical assistance, financial incentives and health information technology access to provider practices to increase adoption of medical home practices.

Care Management and Coordination

Humana Cares is the branded specialized care management program for chronically ill SNP members, combing acute and chronic care management using telephone and on-site methods. Humana uses

ongoing population assessment as well as individual health risk assessments (HRA) to determine member's care needs and to provide the appropriate level and intensity of interventions. The focus is on members who have high needs and are at high risk for a hospital admission or readmission. The program uses care managers (registered nurses) and community health educators to provide telephone contacts, in-home assessments and educational support. The care managers are the main point of contact for the member. They direct the interdisciplinary care team (ICT) and act as a member liaison and advocate. They coordinate care across the member's providers, managing the member's care plan and facilitating services the member may need such as community health, social services, mental health services or other providers.

The ICT is typically comprised of the member and/or member's caregivers, a primary care physician (PCP) and/or specialists, the care manager and other support providers based on the member's specific needs, for example, a clinical pharmacist, registered dietician or behavioral health specialist. The PCP drives the medical treatment plan and the care manager works with the member to help them follow the PCP's treatment plan. The ICT assesses the member, develops and implements the care plan, provides support, education and coaching to the member. The ICT evaluates and modifies the care plan as needed. The member plays an active role, to the extent possible, in the development of the care plan and any goals or treatments.

Each member receives an individualized care plan (ICP), which is created, reviewed and updated by the care manager, but is designed with the member. A member's progress toward treatment goals and health status are tracked via the care plan. All care plan information is shared with the member on an ongoing basis by the care manager. Key components of the ICP are prioritized goals that take into account the member's goals and preferences, identification of barriers to meeting goals, a member self-management plan, a process to evaluate progress against the goals and an outline of the specific services, resources and benefits that will be accessed to meet the stated goals and objectives, as well as to fill any gaps in the member's current level of care.

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