2016 Model of Care
Dual Eligible
Special Needs Plan

CarePlus Health Plans, Inc.

February 2015

CarePlus
HEALTH PLANS, INC.

INTRODUCTION:

CarePlus Health Plans, Inc., a subsidiary of Humana, Inc., is a Medicare Advantage Plan headquartered in Miami, Florida, offering an array of health plans for Medicare beneficiaries. CarePlus offers benefits and services to approximately 100,000 Medicare beneficiaries. Of these nearly 46,000 are enrolled in Special Needs Plans (SNP). Special Needs Plans provide opportunities to improve care through improved coordination and continuity of care.

CarePlus Special Needs Plans (SNP) not only provides medical and prescription drug coverage to individuals with specialized health needs, CarePlus provides meaningful opportunities to members to improve their health through enhanced coordination and continuity of care. CarePlus offers the following types of Special Needs Plans:

- Dual Eligible SNPs (D-SNP) for people who have both Medicare and Medicaid coverage

Medicare-approved SNPs are available to anyone who meets the specific eligibility requirements of the plan, live in the plan's service area, and enrolled in both Medicare Part A and Part B through age or disability.

Since January 2012, CarePlus has partnered with Humana At Home and with Humana Puerto Rico beginning April 1, 2017. Humana's programs for specialized care management for chronically ill Medicare Advantage members and health service offerings to improve the management of the SNP population. These care management programs combine both acute and chronic care management delivered both telephonically and on site to CarePlus members and are designed to link health care and social care, allowing members to remain as healthy, safe, and independent as possible.

To support the CarePlus partnership, Humana At Home and Humana Puerto Rico has a dedicated CarePlus team that uses a dedicated telephone line, electronic documentation platform, Humana At Home Medicare Domain Assessment Tool (mDAT) or Humana Puerto Rico Health Risk Assessment as the approved CarePlus Health Risk Assessment, educational materials and correspondence letters. CarePlus' Health Services staff compliment the Humana At Home and Humana Puerto Rico model by providing real-time hospitalization, transition of care support and vendor coordination to deliver comprehensive, just-in-time solutions that aim to mitigate complications and by providing Humana At Home and Humana Puerto Rico the expertise on CarePlus membership, network, benefit, and processes that maximize each member touch point.

CarePlus makes their biggest contribution through the core strength of health. There are three key points to CarePlus' well-being framework as seen in this diagram:

- Health is CarePlus' focus as a company, so it's at the center of the approach to well-being where we can make the biggest difference in people's lives

- True well-being comes from a combination of elements—purpose, belonging, security and health—that interact and support one another
- Health is multi-faceted, encompassing the emotional, spiritual and physical aspects of life

When CarePlus connects people to lifelong well-being, it creates better health outcomes that lead to fuller, happier lives and a stronger CarePlus.

In addition to providing members with opportunities to take charge of their health, CarePlus builds a therapeutic and trusting partnership with the member and his or her circle of significant others and caregivers. Care Managers assume the roles of liaison, coach, and advocate thereby establishing themselves as an integral part of the member's interdisciplinary care team (ICT). The program is designed to link health care and social care, allowing members to remain as healthy, safe, and independent as possible for as long as possible. In certain cases, members face difficult decisions; the program is also designed to assist members and their legal representatives when faced with end of life decisions, whether to prolong treatment or to stop treatment. Care Managers help make member's wishes clear to their healthcare providers, help members feel comfortable at end of life and deal with issues surrounding death.

MOC 1: DESCRIPTION OF SNP POPULATION (GENERAL POPULATION):

ELEMENT A: DESCRIPTION OF OVERALL SNP POPULATION:

Factor 1: Determining, Verifying and Tracking Eligibility:

CarePlus Health Plans follows all sales/marketing guidelines outlined by the Centers for Medicare and Medicaid Services to be compliant with identifying beneficiaries for the Dual Eligible SNP plan. CarePlus Health Plans offers Special Needs Plans for dual eligible members, targeting categories of dual eligible beneficiaries the state of Florida deems eligible. To qualify for the D-SNP, Care Plus validates that the beneficiary is:

- Entitlement to Medicare Part A and enrolled in Part B of Medicare through age or disability
- A resident within the plan's service area
- Eligibility is based on certain levels of Medicaid eligibility based on the specific requested plan

CarePlus agents attempt to capture the Medicaid number from the beneficiary to assist in the enrollment verification process. Market offices have designated staff to determine immediately a beneficiary's Medicaid eligibility using Emdeon, a vendor verification system that is a clearinghouse for all state Medicaid information. After-hours assistance if a market office is closed is available for identifying beneficiaries.

CarePlus' Dual Eligible SNP plans are specifically designed around the special needs of dual eligible members, including coordination with state Medicaid agencies, eligibility verification, network alignments, and agreements to coordinate payments without member involvement, often overlooked by traditional Medicare Advantage Plans. In addition, CarePlus' Dual Eligible SNP plan integrates the Part D Prescription Drug coverage. Dual members are not subject to the lock in enrollment period and may enroll or dis-enroll at any point during the year.

CarePlus is able to design the dual-eligible product with more emphasis on high-value value added benefits not covered by Original Medicare, Medicaid, or other MA plans. These benefits may include (but will vary by plan): preventive dental, preventive vision, fitness benefits, and non-emergency transportation to access plan benefits.

CarePlus' Dual Eligible SNP supplemental benefits, enhanced coordination of Medicaid and Medicare benefits and limited member costs allows for increased continuity of care. CarePlus sales agents present the features of the plan, pharmacy coverage, preventative services, and supplemental benefits along with including the guarantee that the state Medicaid agency will pay necessary premiums. The agent conducts a review of the contracted provider network including Primary Care Physicians and Specialists to ensure continuity of care.

CarePlus strives to provide emphasis on the importance of care management and why/how it helps them across their life span including the ability to answer health questions and evaluate treatment options. The Dual Eligible specialized Model of Care includes Health Risk Assessments, individualized plans of care, disease management, and access to care management services. Humana Care Managers and Humana Care Coordinators provide support to help members manage their healthcare needs, to ensure optimal health outcomes. Care Management is a resource to members for answering health questions, assisting with access to care, evaluating treatment options, assessing opportunities to coordinate care, designing treatment programs to improve quality and effectiveness of care.

Confirmation of Dual Eligibility Requirements:

CarePlus Health Plans confirm Medicare Advantage (MA) and SNP eligibility by the Enrollment Representative upon receipt of the Enrollment Request Form. Acceptable proof of Medicaid eligibility includes:

- A current Medicaid card
- A letter from the State agency that confirms entitlement to Medical Assistance
- Verification through a systems query to a State eligibility status system. CarePlus Health Plans utilizes the Florida Medicaid portal at https://portal.flmmis.com to confirm dual eligibility

An individual's current eligibility for the Medicare Part D Low Income Subsidy (LIS) or any other Medicaid status flag in CMS systems is not acceptable for initial or ongoing Medicaid eligibility

verification for the purpose of determining dual eligibility. For current members, the Billing & Enrollment department verifies continuing eligibility at least as often as the state Medicaid agency conducts re-determinations of Medicaid eligibility.

Verifying Eligible SNP Beneficiaries:

There are 3 phases of the verification of a member's Medicaid eligibility for members enrolling in a Dual Eligible Special Needs Plan:

- **Pre-Enrollment:** Agents verify the member's Medicaid level of eligibility at the time the application is completed
- **Time of Enrollment Processing:** All Dual Eligible SNP enrollment applications are automated including Medicaid eligibility verification, unless it is determined manual review is required
- **Post-Enrollment:** Dual Eligible SNP members are re-verified monthly to ensure they continue to be eligible for enrollment on the Dual Eligible SNP plan

In order to enroll in a Dual Eligible SNP, the member must have the proper level of Medicaid based on state guidance. To determine eligibility, CarePlus checks an online verification system (Emdeon) that allows access to each State's Medicaid Database. If the member has the proper level, they are enrolled in, or maintain enrollment in the plan.

Tracking Eligible SNP Beneficiaries:

Once enrolled, CarePlus validates the member's eligibility each month using the vendor, Emdeon's verification system to ensure that their level did not change. If the member loses their eligibility, they will go into a 6 month deeming period. If the member does not regain eligibility within 6 months, CarePlus is required to dis-enroll the member from the D-SNP. During the monthly re-verification of the member's Medicaid eligibility (post-enrollment), if the member appears to no longer have the level of Medicaid eligibility required for enrollment in their chosen plan, the member is sent a letter advising that if they do not regain the level of eligibility needed within 6 months, their enrollment will be termed at the end of the 6th month. If the member regains the required level of eligibility within their deeming period, they are sent a "Regain" letter advising they will remain on their Dual Eligible Special Needs Plan.

Factor 2 & 3: Identify Health Concerns:

As of December 2014, CMS had approved 318 Medicare Advantage contracts nationwide offering 566 SNPs with a total enrollment of 2,103,909 beneficiaries. The D-SNPs have the largest enrollment with 1,738,363 beneficiaries. In Q4 2014, the membership for CarePlus' Medicare Advantage Special Needs Plan (SNP) members who were care managed by Humana

At Home was over fifty thousand members. The projected enrollment for 2015 will continue to increase.

Broward County: CarePlus currently offers a Dual Eligible SNP in Broward County. The following demographic characteristics are based on the current CarePlus population who reside in Broward County. The Dual Eligible population in Broward is mostly black, female, between the ages of sixty and seventy-nine years of age, do not live alone, have three or more co-morbidities and the top relevant diagnosis is Diabetes Mellitus Uncomplicated. The majority rates their overall health as low risk, have low cognitive risk and low functional risk. The majority have medium social risk and low financial risk.

- 63% of the population are between the ages of sixty and seventy-nine years of age
- 38% are male and 62% are female
- 38% are Black, 35% are White, 14% are Hispanic, 2% are Asian or Native American and 10% have a race classification as other
- 66% speak English, 30% speak Spanish, 4% speak Creole, 0.1% speak Vietnamese
- 25% have zero co-morbidities, 37% have 1 to 2 co-morbidities and 38.6% have three or more comorbidities
- The following are the top five relevant diagnoses:

1. Diabetes Mellitus Uncomplicated (39%)
2. Moderate to Severe Chronic Kidney Disease (31%)
3. Diabetes Mellitus Complicated (28%)
4. Chronic Pulmonary Disease (27%)
5. Diabetes Mellitus Psychoses (20%)

Analyzing results of the completed Medicare Domain Assessment Tool (mDAT), the approved CMS Health Risk Assessment (HRA);

- 45% rated their health as fair or poor and 55% rated their health as excellent or good
- 49% had low risk for overall health risk and 43% had medium risk for overall health risk
- 91% had low cognitive risk
- 58% have low functional risk and 24% have high functional risk
- 42% have a low risk score for social risk and 44% have medium risk
- 63% of members rated their financial risk status as low

- 64% of members do not live alone and 71% have a friend or neighbor who could care for the member for a few days
- 77% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

Miami–Dade County: CarePlus currently offers a Dual Eligible SNP in Miami-Dade County. The following demographic characteristics are based on the current CarePlus population who reside in Miami-Dade County. The Dual Eligible population in Miami- Dade is mostly Hispanic, female, between the ages of sixty and seventy-nine years of age, do not live alone, have three or more co-morbidities and the top relevant diagnosis is Diabetes Mellitus Uncomplicated. The majority rates their overall health as low risk, have low cognitive risk and low functional risk. The majority have low social risk and low financial risk.

- 61% of the population are between the ages of sixty and seventy-nine years of age
- 38% are male and 62% are female
- 14% are Black, 32% are White, 40% are Hispanic, 0.5% are Asian or Native American and 13% have a race classification as other
- 20% speak English, 77% speak Spanish, 2% speak Creole, 0% speak Vietnamese
- 30% have zero co-morbidities, 29% have 1 to 2 co-morbidities and 38.2% have three or more comorbidities
- The following are the top five relevant diagnoses:

    1. Diabetes Mellitus Uncomplicated (35%)
    2. Chronic Pulmonary Disease (31%)
    3. Moderate to Severe Chronic Kidney Disease (27%)
    4. Diabetes Mellitus Complicated (25%)
    5. Diabetes Mellitus Psychoses (23%)

Analyzing results of the completed Medicare Domain Assessment Tool (mDAT), the approved CMS Health Risk Assessment (HRA);

- 44% rated their health as fair or poor and 56% rated their health as excellent or good
- 48% had low risk for overall health risk and 44% had medium risk for overall health risk
- 90% had low cognitive risk
- 58% have low functional risk and 25% have high functional risk
- 45% have a low risk score for social risk and 44% have medium risk
- 69% of members rated their financial risk status as low

- 70% of members do not live alone and 69% have a friend or neighbor who could care for the member for a few days
- 76% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

Palm Beach County: CarePlus currently offers a Dual Eligible SNP in Palm Beach County. The following demographic characteristics are based on the current CarePlus population who reside in Palm Beach County. The Dual Eligible population in Palm Beach is mostly black, female, between the ages of sixty and seventy-nine years of age, do not live alone, have one to two co-morbidities and the top relevant diagnosis is Diabetes Mellitus Uncomplicated. The majority rates their overall health as medium risk, have low cognitive risk and low functional risk. The majority have medium social risk and low financial risk.

- 69% of the population are between the ages of sixty and seventy-nine years of age
- 46% are male and 54% are female
- 35% are Black, 32% are White, 20% are Hispanic, 1% are Asian or Native American and 12% have a race classification as other
- 48% speak English, 38% speak Spanish, 13% speak Creole, 0% speak Vietnamese
- 30% have zero co-morbidities, 38% have 1 to 2 co-morbidities and 33.3% have three or more comorbidities
- The following are the top five relevant diagnoses:

    1. Diabetes Mellitus Uncomplicated (34%)
    2. Moderate to Severe Chronic Kidney Disease (26%)
    3. Chronic Pulmonary Disease (24%)
    4. Diabetes Mellitus Complicated (22%)
    5. Diabetes Mellitus Psychoses (15%)

Analyzing results of the completed Medicare Domain Assessment Tool (mDAT), the approved CMS Health Risk Assessment (HRA);

- 50% rated their health as fair or poor and 50% rated their health as excellent or good
- 45% had low risk for overall health risk and 46% had medium risk for overall health risk
- 89% had low cognitive risk
- 56% have low functional risk and 23% have high functional risk
- 42% have a low risk score for social risk and 44% have medium risk

- 62% of members rated their financial risk status as low
- 65% of members do not live alone and 71% have a friend or neighbor who could care for the member for a few days
- 75% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

Hillsborough County: CarePlus currently offers a Dual Eligible SNP in Hillsborough County. The following demographic characteristics are based on the current CarePlus population who reside in Hillsborough County. The Dual Eligible population in Hillsborough is mostly white, female, between the ages of sixty and seventy-nine years of age, do not live alone, have three or more co-morbidities and the top relevant diagnosis is Diabetes Mellitus Uncomplicated. The majority rates their overall health as medium risk, have low cognitive risk and low functional risk. The majority have medium social risk and low financial risk.

- 58% of the population are between the ages of sixty and seventy-nine years of age
- 41% are male and 59% are female
- 24% are Black, 40% are White, 24% are Hispanic, 1% are Asian or Native American and 11% have a race classification as other
- 53% speak English, 47% speak Spanish, 0.2% speak Creole, 0.1% speak Vietnamese
- 28% have zero co-morbidities, 37% have 1 to 2 co-morbidities and 36.5% have three or more comorbidities
- The following are the top five relevant diagnoses:

    1. Diabetes Mellitus Uncomplicated (37%)
    2. Chronic Pulmonary Disease (33%)
    3. Moderate to Severe Chronic Kidney Disease (26%)
    4. Diabetes Mellitus Complicated (26%)
    5. Diabetes Mellitus Psychoses (26%)

Analyzing results of the completed Medicare Domain Assessment Tool (mDAT), the approved CMS Health Risk Assessment (HRA);

- 52% rated their health as fair or poor and 48% rated their health as excellent or good
- 38% had low risk for overall health risk and 51% had medium risk for overall health risk
- 86% had low cognitive risk
- 52% have low functional risk and 26% have high functional risk
- 41% have a low risk score for social risk and 47% have medium risk

- 67% of members rated their financial risk status as low
- 63% of members do not live alone and 73%have a friend or neighbor who could care for the member for a few days
- 70% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

Pasco County: CarePlus currently offers a Dual Eligible SNP in Pasco County. The following demographic characteristics are based on the current CarePlus population who reside in Pasco County. The Dual Eligible population in Pasco is mostly white, female, between the ages of sixty and seventy-nine years of age, do not live alone, have zero co-morbidities and the top relevant diagnosis is Chronic Pulmonary Disease. The majority rates their overall health as medium risk, have low cognitive risk and low functional risk. The majority have medium social risk and low financial risk.

- 57% of the population are between the ages of sixty and seventy-nine years of age
- 39% are male and 61% are female
- 9% are Black, 67% are White, 11% are Hispanic, 1% are Asian or Native American and 13% have a race classification as other
- 76% speak English, 23% speak Spanish, 0% speak Creole, 0.04% speak Vietnamese
- 37% have zero co-morbidities, 37% have 1 to 2 co-morbidities and 26% have three or more comorbidities
- The following are the top five relevant diagnoses:

    1. Chronic Pulmonary Disease (28%)
    2. Diabetes Mellitus Uncomplicated (28%)
    3. Diabetes Mellitus Complicated (20%)
    4. Moderate to Severe Chronic Kidney Disease (18%)
    5. Diabetes Mellitus Psychoses (17%)

Analyzing results of the completed Medicare Domain Assessment Tool (mDAT), the approved CMS Health Risk Assessment (HRA);

- 53% rated their health as fair or poor and 47% rated their health as excellent or good
- 33% had low risk for overall health risk and 50% had medium risk for overall health risk
- 90% had low cognitive risk
- 44% have low functional risk and 30% have high functional risk
- 38% have a low risk score for social risk and 49% have medium risk

- 56% of members rated their financial risk status as low
- 62% of members do not live alone and 76% have a friend or neighbor who could care for the member for a few days
- 73% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

Pinellas County: CarePlus currently offers a Dual Eligible SNP in Pinellas County. The following demographic characteristics are based on the current CarePlus population who reside in Pinellas County. The Dual Eligible population in Pinellas is mostly white, female, between the ages of sixty and seventy-nine years of age, do not live alone, have one to two co-morbidities and the top relevant diagnosis is Chronic Pulmonary Disease. The majority rates their overall health as medium risk, have low cognitive risk and low functional risk. The majority have medium social risk and low financial risk.

- 56% of the population are between the ages of sixty and seventy-nine years of age
- 43% are male and 57% are female
- 17% are Black, 62% are White, 10% are Hispanic, 3% are Asian or Native American and 8% have a race classification as other
- 80% speak English, 18% speak Spanish, 0% speak Creole, 1% speak Vietnamese
- 26% have zero co-morbidities, 40% have 1 to 2 co-morbidities and 33.2% have three or more comorbidities
- The following are the top five relevant diagnoses:

    1. Chronic Pulmonary Disease (38%)
    2. Diabetes Mellitus Uncomplicated (30%)
    3. Diabetes Mellitus Psychoses (28%)
    4. Moderate to Severe Chronic Kidney Disease (20%)
    5. Diabetes Mellitus Complicated (18%)

Analyzing results of the completed Medicare Domain Assessment Tool (mDAT), the approved CMS Health Risk Assessment (HRA);

- 55% rated their health as fair or poor and 45% rated their health as excellent or good
- 38% had low risk for overall health risk and 45% had medium risk for overall health risk
- 90% had low cognitive risk
- 52% have low functional risk and 26% have high functional risk
- 31% have a low risk score for social risk and 55% have medium risk

- 66% of members rated their financial risk status as low
- 57% of members do not live alone and 75% have a friend or neighbor who could care for the member for a few days
- 70% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

Polk County: CarePlus currently offers a Dual Eligible SNP in Polk County. The following demographic characteristics are based on the current CarePlus population who reside in Polk County. The Dual Eligible population in Polk is mostly white, female, between the ages of sixty and seventy-nine years of age, do not live alone, have zero co-morbidities and the top relevant diagnosis is Diabetes Mellitus Uncomplicated. The majority rates their overall health as medium risk, have low cognitive risk and low functional risk. The majority have medium social risk and low financial risk.

- 57% of the population are between the ages of sixty and seventy-nine years of age
- 39% are male and 61% are female
- 21% are Black, 59% are White, 10% are Hispanic, 1% are Asian or Native American and 9% have a race classification as other
- 76% speak English, 23% speak Spanish, 0.3% speak Creole, 0.04% speak Vietnamese
- 48% have zero co-morbidities, 30% have 1 to 2 co-morbidities and 21.7% have three or more comorbidities
- The following are the top five relevant diagnoses:

    1. Diabetes Mellitus Uncomplicated (25%)
    2. Chronic Pulmonary Disease (22%)
    3. Moderate to Severe Chronic Kidney Disease (17%)
    4. Diabetes Mellitus Complicated (17%)
    5. Diabetes Mellitus Psychoses (17%)

Analyzing results of the completed Medicare Domain Assessment Tool (mDAT), the approved CMS Health Risk Assessment (HRA);

- 53% rated their health as fair or poor and 47% rated their health as excellent or good
- 37% had low risk for overall health risk and 48% had medium risk for overall health risk
- 89% had low cognitive risk
- 46% have low functional risk and 27% have high functional risk
- 39% have a low risk score for social risk and 49% have medium risk

- 61% of members rated their financial risk status as low
- 63% of members do not live alone and 74% have a friend or neighbor who could care for the member for a few days
- 73% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

Orange County: CarePlus currently offers a Dual Eligible SNP in Orange County. The following demographic characteristics are based on the current CarePlus population who reside in Orange County. The Dual Eligible population in Orange is mostly white, female, between the ages of sixty and seventy-nine years of age, do not live alone, have zero co-morbidities and the top relevant diagnosis is Diabetes Mellitus Uncomplicated. The majority rates their overall health as medium risk, have low cognitive risk and low functional risk. The majority have medium social risk and low financial risk.

- 61% of the population are between the ages of sixty and seventy-nine years of age
- 39% are male and 61% are female
- 23% are Black, 44% are White, 19% are Hispanic, 3% are Asian or Native American and 10% have a race classification as other.
  race classification as other
- 49% speak English, 49% speak Spanish, 1% speak Creole, 0.5% speak Vietnamese
- 35% have zero co-morbidities, 32% have 1 to 2 co-morbidities and 33.5% have three or more comorbidities
- The following are the top five relevant diagnoses:

  1. Diabetes Mellitus Uncomplicated (35%)
  2. Moderate to Severe Chronic Kidney Disease (29%)
  3. Chronic Pulmonary Disease (24%)
  4. Diabetes Mellitus Complicated (24%)
  5. Diabetes Mellitus Psychoses (19%)

Analyzing results of the completed Medicare Domain Assessment Tool (mDAT), the approved CMS Health Risk Assessment (HRA);

- 52% rated their health as fair or poor and 48% rated their health as excellent or good
- 38% had low risk for overall health risk and 50% had medium risk for overall health risk
- 87% had low cognitive risk
- 51% have low functional risk and 25% have high functional risk

- 42% have a low risk score for social risk and 45% have medium risk
- 61% of members rated their financial risk status as low
- 69% of members do not live alone and 70% have a friend or neighbor who could care for the member for a few days
- 70% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

Osceola County: CarePlus currently offers a Dual Eligible SNP in Osceola County. The following demographic characteristics are based on the current CarePlus population who reside in Osceola County. The Dual Eligible population in Osceola is mostly white, female, between the ages of sixty and seventy-nine years of age, do not live alone, have zero co-morbidities and the top relevant diagnosis is Diabetes Mellitus Uncomplicated. The majority rates their overall health as medium risk, have low cognitive risk and low functional risk. The majority have medium social risk and low financial risk.

- 59% of the population are between the ages of sixty and seventy-nine years of age
- 39% are male and 61% are female
- 10% are Black, 54% are White, 24% are Hispanic, 1% are Asian or Native American and 11% have a race classification as other
- 34% speak English, 66% speak Spanish, 0.2% speak Creole, 0.04% speak Vietnamese
- 43% have zero co-morbidities, 30% have 1 to 2 co-morbidities and 26.4% have three or more comorbidities
- The following are the top five relevant diagnoses:

    1. Diabetes Mellitus Uncomplicated (29%)
    2. Chronic Pulmonary Disease (22%)
    3. Moderate to Severe Chronic Kidney Disease (20%)
    4. Diabetes Mellitus Complicated (18%)
    5. Diabetes Mellitus Psychoses (18%)

Analyzing results of the completed Medicare Domain Assessment Tool (mDAT), the approved CMS Health Risk Assessment (HRA);

- 52% rated their health as fair or poor and 48% rated their health as excellent or good
- 37% had low risk for overall health risk and 50% had medium risk for overall health risk
- 86% had low cognitive risk
- 50% have low functional risk and 26% have high functional risk

- 45% have a low risk score for social risk and 45% have medium risk
- 58% of members rated their financial risk status as low
- 74% of members do not live alone and 67% have a friend or neighbor who could care for the member for a few days
- 66% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

Seminole County: CarePlus currently offers a Dual Eligible SNP in Seminole County. The following demographic characteristics are based on the current CarePlus population who reside in Seminole County. The Dual Eligible population in Seminole is mostly white, female, between the ages of sixty and seventy-nine years of age, do not live alone, have one to two co-morbidities and the top relevant diagnosis is Diabetes Mellitus Uncomplicated. The majority rates their overall health as medium risk, have low cognitive risk and low functional risk. The majority have low social risk and low financial risk.

- 59% of the population are between the ages of sixty and seventy-nine years of age
- 37% are male and 63% are female
- 30% are Black, 45% are White, 17% are Hispanic, 1% are Asian or Native American and 7% have a race classification as other
- 64% speak English, 35% speak Spanish, 0.5% speak Creole, 0.2% speak Vietnamese
- 30% have zero co-morbidities, 37% have 1 to 2 co-morbidities and 31.5% have three or more comorbidities
- The following are the top five relevant diagnoses:

    1. Diabetes Mellitus Uncomplicated (35%)
    2. Moderate to Severe Chronic Kidney Disease (31%)
    3. Chronic Pulmonary Disease (28%)
    4. Diabetes Mellitus Complicated (24%)
    5. Diabetes Mellitus Psychoses (15%)

Analyzing results of the completed Medicare Domain Assessment Tool (mDAT), the approved CMS Health Risk Assessment (HRA);

- 50% rated their health as fair or poor and 50% rated their health as excellent or good
- 38% had low risk for overall health risk and 50% had medium risk for overall health risk
- 90% had low cognitive risk
- 49% have low functional risk and 28% have high functional risk

- 45% have a low risk score for social risk and 41% have medium risk
- 61% of members rated their financial risk status as low
- 71% of members do not live alone and 72% have a friend or neighbor who could care for the member for a few days
- 69% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

Brevard County: CarePlus currently offers a Dual Eligible SNP in Brevard County. The following demographic characteristics are based on the current CarePlus population who reside in Brevard County. The Dual Eligible population in Brevard is mostly white, female, between the ages of sixty and seventy-nine years of age, do not live alone, have zero co-morbidities and the top relevant diagnosis is Chronic Pulmonary Disease. The majority rates their overall health as medium risk, have low cognitive risk and low functional risk. The majority have medium social risk and low financial risk.

- 58% of the population are between the ages of sixty and seventy-nine years of age
- 37% are male and 63% are female
- 21% are Black, 63% are White, 9% are Hispanic, 1% are Asian or Native American and 7% have a race classification as other
- 82% speak English, 17% speak Spanish, 0.2% speak Creole, 0% speak Vietnamese
- 39% have zero co-morbidities, 38% have 1 to 2 co-morbidities and 23.7% have three or more comorbidities
- The following are the top five relevant diagnoses:

    1. Diabetes Mellitus Uncomplicated (32%)
    2. Chronic Pulmonary Disease (28%)
    3. Moderate to Severe Chronic Kidney Disease (13%)
    4. Diabetes Mellitus Psychoses (12%)
    5. Diabetes Mellitus Complicated (12%)

Analyzing results of the completed Medicare Domain Assessment Tool (mDAT), the approved CMS Health Risk Assessment (HRA);

- 52% rated their health as fair or poor and 48% rated their health as excellent or good
- 35% had low risk for overall health risk and 49% had medium risk for overall health risk
- 85% had low cognitive risk
- 49% have low functional risk and 25% have high functional risk

- 35% have a low risk score for social risk and 51% have medium risk
- 57% of members rated their financial risk status as low
- 65% of members do not live alone and 69% have a friend or neighbor who could care for the member for a few days
- 71% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

Indian River County: CarePlus currently offers a Dual Eligible SNP in Indian River County. The following demographic characteristics are based on the current CarePlus population who reside in Indian River County. The Dual Eligible population in Indian River is mostly white, female, between the ages of sixty and seventy-nine years of age, do not live alone, have zero co-morbidities and the top relevant diagnosis is Chronic Pulmonary Disease. The majority rates their overall health as medium risk, have low cognitive risk and low functional risk. The majority have medium social risk and low financial risk.

- 63% of the population are between the ages of sixty and seventy-nine years of age
- 39% are male and 61% are female
- 16% are Black, 66% are White, 8% are Hispanic, 0% are Asian or Native American and 11% have a race classification as other
- 81% speak English, 19% speak Spanish, 0% speak Creole, 0% speak Vietnamese
- 46% have zero co-morbidities, 37% have 1 to 2 co-morbidities and 15% have three or more comorbidities
- The following are the top five relevant diagnoses:

    1. Chronic Pulmonary Disease (22%)
    2. Diabetes Mellitus Uncomplicated (22%)
    3. Solid Tumor (10%)
    4. Diabetes Mellitus Cancer (10%)
    5. Myocardial Infarction (10%)

Analyzing results of the completed Medicare Domain Assessment Tool (mDAT), the approved CMS Health Risk Assessment (HRA);

- 41% rated their health as fair or poor and 59% rated their health as excellent or good
- 34% had low risk for overall health risk and 44% had medium risk for overall health risk
- 88% had low cognitive risk
- 49% have low functional risk and 15% have high functional risk

- 32% have a low risk score for social risk and 54% have medium risk
- 46% of members rated their financial risk status as low
- 44% of members do not live alone and 78% have a friend or neighbor who could care for the member for a few days
- 76% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

Martin County: CarePlus currently offers a Dual Eligible SNP in Martin County. The following demographic characteristics are based on the current CarePlus population who reside in Martin County. The Dual Eligible population in Martin is mostly white, female, between the ages of sixty and seventy-nine years of age, do not live alone, have three or more co-morbidities and the top relevant diagnosis is Diabetes Mellitus Psychoses. The majority rates their overall health as medium risk, have low cognitive risk and low functional risk. The majority have medium social risk and low financial risk.

- 58% of the population are between the ages of sixty and seventy-nine years of age
- 17% are male and 83% are female
- 0% are Black, 67% are White, 0% are Hispanic, 0% are Asian or Native American and 33% have a race classification as other
- 67% speak English, 33% speak Spanish, 0% speak Creole, 0% speak Vietnamese
- 15% have zero co-morbidities, 31% have 1 to 2 co-morbidities and 54% have three or more comorbidities
- The following are the top five relevant diagnoses:

    1. Diabetes Mellitus Psychoses (62%)
    2. Chronic Pulmonary Disease (31%)
    3. Moderate to Severe Chronic Kidney Disease (31%)
    4. Diabetes Mellitus Cancer (23%)
    5. Diabetes Mellitus Complicated (15%)

Analyzing results of the completed Medicare Domain Assessment Tool (mDAT), the approved CMS Health Risk Assessment (HRA);

- 40% rated their health as fair or poor and 60% rated their health as excellent or good
- 40% had low risk for overall health risk and 60% had medium risk for overall health risk
- 100% had low cognitive risk
- 60% have low functional risk and 20% have high functional risk

- 40% have a low risk score for social risk and 40% have medium risk
- 80% of members rated their financial risk status as low
- 80% of members do not live alone and 60% have a friend or neighbor who could care for the member for a few days
- 40% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

Okeechobee County: CarePlus currently offers a Dual Eligible SNP in Okeechobee County. The following demographic characteristics are based on the current CarePlus population who reside in Okeechobee County. The Dual Eligible population in Okeechobee is mostly white, equal amounts of males and females, between the ages of sixty and seventy-nine years of age, do not live alone, have zero co-morbidities and the top relevant diagnosis is Peripheral Vascular Disease. The majority rates their overall health as low risk, have low cognitive risk and low functional risk. The majority have medium social risk and low financial risk.

- 100% of the population are between the ages of sixty and seventy-nine years of age
- 50% are male and 50% are female
- 0% are Black, 83% are White, 17% are Hispanic, 0% are Asian or Native American and 0% have a race classification as other
- 83% speak English, 17% speak Spanish, 0% speak Creole, 0% speak Vietnamese
- 43% have zero co-morbidities, 14% have 1 to 2 co-morbidities and 43% have three or more comorbidities
- The following are the top five relevant diagnoses:

    1. Peripheral Vascular Disease (43%)
    2. Diabetes Mellitus Uncomplicated (43%)
    3. Congestive Heart Failure (29%)
    4. Cerebrovascular Disease (29%)
    5. Diabetes Mellitus Complicated (29%)

Analyzing results of the completed Medicare Domain Assessment Tool (mDAT), the approved CMS Health Risk Assessment (HRA);

- 67% rated their health as fair or poor and 33% rated their health as excellent or good
- 33% had low risk for overall health risk and 33% had medium risk for overall health risk
- 100% had low cognitive risk
- 67% have low functional risk and 0% have high functional risk

- 0% have a low risk score for social risk and 33% have medium risk
- 33% of members rated their financial risk status as low
- 33% of members do not live alone and 33% have a friend or neighbor who could care for the member for a few days
- 67% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

St. Lucie County: CarePlus currently offers a Dual Eligible SNP in St. Lucie County. The following demographic characteristics are based on the current CarePlus population who reside in St. Lucie County. The Dual Eligible population in St. Lucie is mostly white, female, between the ages of sixty and seventy-nine years of age, do not live alone, have zero co-morbidities and the top relevant diagnosis is Diabetes Mellitus Uncomplicated. The majority rates their overall health as low risk, have low cognitive risk and low functional risk. The majority have medium social risk and low financial risk.

- 56% of the population are between the ages of sixty and seventy-nine years of age
- 41% are male and 59% are female
- 18% are Black, 53% are White, 18% are Hispanic, 0% are Asian or Native American and 11% have a race classification as other
- 54% speak English, 42% speak Spanish, 3% speak Creole, 0% speak Vietnamese
- 48% have zero co-morbidities, 29% have 1 to 2 co-morbidities and 24% have three or more comorbidities
- The following are the top five relevant diagnoses:

    1. Diabetes Mellitus Uncomplicated (28%)
    2. Chronic Pulmonary Disease (23%)
    3. Diabetes Mellitus Complicated (15%)
    4. Moderate to Severe Chronic Kidney Disease (14%)
    5. Diabetes Mellitus Psychoses (10%)

Analyzing results of the completed Medicare Domain Assessment Tool (mDAT), the approved CMS Health Risk Assessment (HRA);

- 55% rated their health as fair or poor and 45% rated their health as excellent or good
- 43% had low risk for overall health risk and 43% had medium risk for overall health risk
- 94% had low cognitive risk

- 57% have low functional risk and 20% have high functional risk
- 40% have a low risk score for social risk and 48% have medium risk
- 62% of members rated their financial risk status as low
- 82% of members do not live alone and 62% have a friend or neighbor who could care for the member for a few days
- 71% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

Duval County: CarePlus currently offers a Dual Eligible SNP in Duval County. The following demographic characteristics are based on the current CarePlus population who reside in Duval County. The Dual Eligible population in Duval is mostly black, female, between the ages of sixty and seventy-nine years of age, do not live alone, have zero co-morbidities and the top relevant diagnosis is Diabetes Mellitus Uncomplicated. The majority rates their overall health as medium risk, have low cognitive risk and low functional risk. The majority have medium social risk and low financial risk.

- 59% of the population are between the ages of sixty and seventy-nine years of age
- 40% are male and 60% are female
- 50% are Black, 36% are White, 3% are Hispanic, 3% are Asian or Native American and 9% have a race classification as other
- 95% speak English, 4% speak Spanish, 0% speak Creole, 0% speak Vietnamese
- 62% have zero co-morbidities, 28% have 1 to 2 co-morbidities and 10.1% have three or more comorbidities
- The following are the top five relevant diagnoses:

    1. Diabetes Mellitus Uncomplicated (20%)
    2. Chronic Pulmonary Disease (14%)
    3. Moderate to Severe Chronic Kidney Disease (8%)
    4. Diabetes Mellitus Psychoses (8%)
    5. Diabetes Mellitus Complicated (7%)

Analyzing results of the completed Medicare Domain Assessment Tool (mDAT), the approved CMS Health Risk Assessment (HRA);

- 52% rated their health as fair or poor and 48% rated their health as excellent or good
- 32% had low risk for overall health risk and 51% had medium risk for overall health risk
- 88% had low cognitive risk

- 47% have low functional risk and 28% have high functional risk
- 33% have a low risk score for social risk and 54% have medium risk
- 60% of members rated their financial risk status as low
- 52% of members do not live alone and 77% have a friend or neighbor who could care for the member for a few days
- 72% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

Lake County: CarePlus currently offers a Dual Eligible SNP in Lake County. The following demographic characteristics are based on the current CarePlus population who reside in Lake County. The Dual Eligible population in Lake is mostly white, female, between the ages of sixty and seventy-nine years of age, do not live alone, have zero co-morbidities and the top relevant diagnosis is Diabetes Mellitus Uncomplicated. The majority rates their overall health as medium risk, have low cognitive risk and low functional risk. The majority have medium social risk and low financial risk.

- 61% of the population are between the ages of sixty and seventy-nine years of age
- 36% are male and 64% are female
- 18% are Black, 62% are White, 10% are Hispanic, 2% are Asian or Native American and 8% have a race classification as other
- 80% speak English, 20% speak Spanish, 0.3% speak Creole, 0.1% speak Vietnamese
- 42% have zero co-morbidities, 35% have 1 to 2 co-morbidities and 22.5% have three or more comorbidities
- The following are the top five relevant diagnoses:

    1. Diabetes Mellitus Uncomplicated (27%)
    2. Chronic Pulmonary Disease (24%)
    3. Moderate to Severe Chronic Kidney Disease (17%)
    4. Diabetes Mellitus Uncomplicated (15%)
    5. Diabetes Mellitus Psychoses (13%)

Analyzing results of the completed Medicare Domain Assessment Tool (mDAT), the approved CMS Health Risk Assessment (HRA);

- 53% rated their health as fair or poor and 47% rated their health as excellent or good
- 36% had low risk for overall health risk and 49% had medium risk for overall health risk
- 86% had low cognitive risk

- 49% have low functional risk and 24% have high functional risk
- 41% have a low risk score for social risk and 46% have medium risk
- 57% of members rated their financial risk status as low
- 66% of members do not live alone and 71% have a friend or neighbor who could care for the member for a few days
- 72% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

Marion County: CarePlus currently offers a Dual Eligible SNP in Marion County. The following demographic characteristics are based on the current CarePlus population who reside in Marion County. The Dual Eligible population in Marion is mostly white, female, between the ages of sixty and seventy-nine years of age, do not live alone, have zero co-morbidities and the top relevant diagnosis is Chronic Pulmonary Disease. The majority rates their overall health as medium risk, have low cognitive risk and low functional risk. The majority have medium social risk and low financial risk.

- 53% of the population are between the ages of sixty and seventy-nine years of age
- 41% are male and 59% are female
- 19% are Black, 65% are White, 9% are Hispanic, 1% are Asian or Native American and 6% have a race classification as other
- 84% speak English, 16% speak Spanish, 0.2% speak Creole, 0% speak Vietnamese
- 43% have zero co-morbidities, 31% have 1 to 2 co-morbidities and 26% have three or more comorbidities
- The following are the top five relevant diagnoses:

    1. Chronic Pulmonary Disease (24%)
    2. Diabetes Mellitus Uncomplicated (24%)
    3. Moderate to Severe Chronic Kidney Disease (16%)
    4. Diabetes Mellitus Psychoses (15%)
    5. Diabetes Mellitus Complicated (13%)

Analyzing results of the completed Medicare Domain Assessment Tool (mDAT), the approved CMS Health Risk Assessment (HRA);

- 54% rated their health as fair or poor and 46% rated their health as excellent or good
- 36% had low risk for overall health risk and 48% had medium risk for overall health risk
- 87% had low cognitive risk

- 48% have low functional risk and 30% have high functional risk
- 36% have a low risk score for social risk and 47% have medium risk
- 60% of members rated their financial risk status as low
- 66% of members do not live alone and 67% have a friend or neighbor who could care for the member for a few days
- 66% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

Sumter County: CarePlus currently offers a Dual Eligible SNP in Sumter County. The following demographic characteristics are based on the current CarePlus population who reside in Sumter County. The Dual Eligible population in Sumter is mostly white, female, between the ages of sixty and seventy-nine years of age, do not live alone, have zero co-morbidities and the top relevant diagnosis is Diabetes Mellitus Uncomplicated. The majority rates their overall health as low risk, have low cognitive risk and low functional risk. The majority have medium social risk and low financial risk.

- 51% of the population are between the ages of sixty and seventy-nine years of age
- 41% are male and 59% are female
- 25% are Black, 68% are White, 2% are Hispanic, 0% are Asian or Native American and 5% have a race classification as other
- 97% speak English, 3% speak Spanish, 0% speak Creole, 0% speak Vietnamese
- 50% have zero co-morbidities, 34% have 1 to 2 co-morbidities and 16% have three or more comorbidities
- The following are the top five relevant diagnoses:

    1. Diabetes Mellitus Uncomplicated (26%)
    2. Chronic Pulmonary Disease (25%)
    3. Moderate to Severe Chronic Kidney Disease (12%)
    4. Peripheral Vascular Disease (12%)
    5. Diabetes Mellitus Complicated (11%)

Analyzing results of the completed approved CMS Health Risk Assessment (HRA):

- 48% rated their health as fair or poor and 52% rated their health as excellent or good
- 43% had low risk for overall health risk and 39% had medium risk for overall health risk
- 89% had low cognitive risk
- 50% have low functional risk and 27% have high functional risk

- 45% have a low risk score for social risk and 46% have medium risk
- 64% of members rated their financial risk status as low
- 59% of members do not live alone and 86% have a friend or neighbor who could care for the member for a few days
- 84% of the population answered not at all when asked how often they felt down, depressed or hopeless in the last two weeks

CarePlus D-SNP – Member Relevant Diagnoses by County:

DE - Member Relevant Diagnoses by County (Percent of Total SNP Type)							
Description	County						
	Miami-Dade	Orange	Broward	Hillsborough	Palm Beach	Osceola	Polk
Myocardial Infarction	10%	6%	9%	8%	8%	5%	6%
Congestive Heart Failure	11%	13%	11%	9%	9%	7%	6%
Peripheral Vascular Disease	16%	13%	13%	12%	13%	8%	7%
Cerebrovascular Disease	13%	14%	15%	12%	13%	11%	8%
Dementia	3%	2%	3%	2%	2%	2%	1%
Chronic Pulmonary Disease	31%	24%	27%	33%	24%	22%	22%
Diabetes Mellitus Uncomplicated	35%	35%	39%	37%	34%	g29%	25%
Diabetes Mellitus Complicated	25%	24%	28%	26%	22%	18%	17%
Moderate to Severe Chronic Kidney Disease	27%	29%	31%	26%	26%	20%	17%
Solid Tumor	9%	6%	11%	7%	11%	5%	4%
Metastatic Solid Tumor	1%	1%	1%	1%	1%	1%	1%
DM Cancer	10%	7%	11%	7%	12%	5%	5%
DM Psychoses	23%	19%	20%	26%	15%	18%	17%
DM ESRD	2%	2%	3%	2%	2%	1%	1%

DE - Member Relevant Diagnoses by County (Percent of Total SNP Type)							
Description	County						
	Pinellas	Seminole	Brevard	Lake	Pasco	Marion	Duval
Myocardial Infarction	10%	10%	6%	5%	7%	5%	2%

Congestive Heart Failure	10%	11%	9%	7%	10%	11%	5%
Peripheral Vascular Disease	14%	12%	8%	10%	10%	9%	6%
Cerebrovascular Disease	15%	14%	11%	11%	10%	10%	5%
Dementia	2%	2%	1%	1%	1%	1%	1%
Chronic Pulmonary Disease	38%	28%	28%	24%	28%	24%	14%
Diabetes Mellitus Uncomplicated	30%	35%	32%	27%	28%	24%	20%
Diabetes Mellitus Complicated	18%	24%	12%	15%	20%	13%	7%
Moderate to Severe Chronic Kidney Disease	20%	31%	13%	17%	18%	16%	8%
Solid Tumor	7%	9%	7%	7%	7%	7%	4%
Metastatic Solid Tumor	1%	1%	1%	1%	2%	1%	0.1%
DM Cancer	7%	10%	8%	7%	8%	8%	4%
DM Psychoses	28%	15%	12%	13%	17%	15%	8%
DM ESRD	2%	3%	2%	1%	1%	1%	1%

DE - Member Relevant Diagnoses by County (Percent of Total SNP Type)

Description	County					Total Members	Total Aggregate
	St. Lucie	Sumter	Indian River	Martin	Okeechobee		
Myocardial Infarction	8%	5%	10%	8%	14%	3,843	8%
Congestive Heart Failure	5%	3%	9%		29%	4,994	10%
Peripheral Vascular Disease	8%	12%	6%	8%	43%	6,343	13%
Cerebrovascular Disease	9%	6%	7%	8%	29%	6,034	12%
Dementia	3%	2%	4%	8%		1,098	2%
Chronic Pulmonary Disease	23%	25%	22%	31%	14%	13,634	28%
Diabetes Mellitus Uncomplicated	28%	26%	22%	23%	43%	16,537	34%
Diabetes Mellitus Complicated	15%	11%	7%	15%	29%	11,239	23%
Moderate to Severe Chronic Kidney Disease	14%	12%	10%	31%		12,374	25%
Solid Tumor	8%	6%	10%	23%		3,939	8%
Metastatic Solid Tumor	1%					378	1%

DM Cancer	8%	6%	10%	23%		4,113	8%
DM Psychoses	10%	7%	6%	62%		9,901	20%
DM ESRD	1%	1%		15%		912	2%

Source: Humana At Home Analytics and Reporting

Factor 4: Define Unique Characteristics of the SNP Population (D-SNPs):

As a result of enrollment qualifications for a D-SNP (low-income, disabled, older, and eligible for both Medicare and Medicaid), members have more complex medical needs and increased psychosocial needs. Sixty-three percent of members with both Medicare and Medicaid live in community settings and were found to have both chronic conditions and functional limitations, which represented 1.5 percent of the United States community-based population while accounting for six percent of national health care expenditures (1).

Socioeconomic factors relating to lack of income and education, and inability to work due to disability are predictors of physical and mental health problems. The same socioeconomic factors also delay access to care; separate Medicare and Medicaid sources for care contribute to fractioned and uncoordinated care and high utilization of emergency room and inpatient care. Cognitively, the D-SNP population demonstrates higher rates of mental illness, cognitive impairment, and higher incidence of Alzheimer's, a clear correlation between the population who receives dual eligible benefits and age of the beneficiary. Environmental hazards may worsen chronic or life threatening conditions, therefore the D-SNP population is highly susceptible to the effect of environmental hazards due to the high prevalence of chronic conditions. Environmental hazards may include inadequate heating and sanitation and structural problems. Additionally, chronic homelessness is prevalent among the D-SNP population. Hazards in a D-SNP member's home may contribute to falls, may result in nutritional deficiencies, and even death. Chronic homelessness adversely affects the ability for CarePlus to engage members to utilize care management services due to the difficulty in reaching members via phone and mail for engagement purposes.

Income also contributes to poor and unsafe living conditions within the community D-SNP population. Additionally, a significant percentage of dual eligible individuals are not engaged with long term supportive services in their state of residence. Long term supportive services provide quality services to the dual eligible population with proven outcomes such as independence, health, and quality of life.

Only a portion of beneficiaries receive full benefits and zero cost sharing. The limitations on coverage, premiums, deductibles, and coinsurance affect CarePlus members' accessibility to care and pose challenges when coordinating care.

The coordination with the Florida Medicaid office, which has its own due processes, makes managing this population complex. Major problems can exist in coordinating benefits, particularly for services such as dental, vision and transportation This disconnect between Medicaid and Medicare can contribute to poor quality of care delivery, and may also impact efficacy of care delivery such as post discharge support. CarePlus adheres to the terms within the state of Florida contract for coordination of Medicare/Medicaid benefits for the Dual Eligible population.

CarePlus experience also demonstrates a higher "unable to contact rate" in the D-SNPs than its other Medicare care management programs. There is an observed trend, for example of phones being turned off neared the end of the month as the member's financial resources are diminished. Interventions here may include helping members complete applications for Medicaid certification, utility and pharmaceutical subsidies. The model of care also supports an aggressive and multi-level operational strategy for engaging and retaining membership.

A barrier faced regularly within the D-SNP membership population is member ambivalence and readiness for change. Collaborative discussions between a Care Manager and a member to strengthen a member's motivation and commitment for change is critical for preventative healthcare and avoiding hospitalizations and readmissions. Motivational Interviewing is incorporated into associate training initially and yearly continuing education on Motivational Interviewing is completed.

CarePlus has developed a Model of Care to meet the needs of this population Special Needs Plans. This model of care is designed to improve care for members with complex needs, targeting improved coordination and continuity of care. CarePlus dual eligible SNPs offer the opportunity of enhanced benefits by combining benefits available through Medicare and Medicaid. CarePlus D-SNPs focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations, and helping beneficiaries move from high risk to lower risk on the care continuum. These clinical programs combine both acute and chronic care management delivered both telephonically and on site to CarePlus members.

1. Fox MH, Reichard A. Disability, Health, and Multiple Chronic Conditions Among People Eligible for Both Medicare and Medicaid, 2005-2010. Prev Chronic Dis 2013;10:130064. DOI: http://dx.doi.org/10.5888/pcd10.130064
2. Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending. http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8081.pdf.
3. Medicare-Medicaid Enrollee State Profile: Centers for Medicare and Medicaid Services. http://www.integratedcareresourcecenter.com. Accessed December 2014.
4. Alzheimer's Association: Alzheimer's Statistics. http://www.alz.org. Accessed December 2014.

ELEMENT B: SUBPOPULATION-MOST VULNERABLE MEMBERS:

Factor 1: Definition of Most Vulnerable Members:

CarePlus D-SNP members present as a diverse population with a small percentage bearing the most cost. CarePlus' most vulnerable population tends to be poor and report poorer health status, Humana At Home stratifies with a level of intervention of High Intensity and High and Humana Puerto Rico as Severe. The most vulnerable members (frail, disabled, members developing ESRD after enrollment, members near the end of life, and members with complex co-morbidities) are identified through:

- Humana At Home Claims Based Algorithm (CBA)
- New Member Predictive Modeling (NMPM) Data
- Utilization and Cost Data
- Medicare Domain Assessment Tool (mDAT) / Puerto Rico Health Risk Assessment Tool, CMS approved Health Risk Assessment
- Care Management Surveys
- Interdisciplinary Care Team Members
- Primary Healthcare Providers & Specialist Physicians
- Member Self Identification
- Program Referrals (Physician, Senior Case Managers, Utilization Managers, Behavioral Health, Pharmacy/Medication Therapy Management, etc.)

Multiple avenues of referral and identification of the most vulnerable population allow Care Managers to assist members in navigating the care system and obtain needed services in a timely manner. Members who are most vulnerable may have more urgent needs for care management services. Members may also be moved to a higher level of intervention enabling more based on established criteria and member needs.

Initial stratification identifying the most vulnerable population occurs using the Humana At Home proprietary CBA to identify appropriate members for each of Level of Intervention (LOI). This CBA score represents the likelihood the member will be in the top ten percent of cost next year. The CBA is a proprietary, robust analytics model, developed in house, using statistical techniques applied on internal claims data as well as utilizing publicly validated indicators of co-morbidity and disease indications. Humana at Home shares a monthly report with Humana Puerto Rico of CarePlus SNP membership that is used to identify members that may need more intensive interventions. Candidates are prospectively identified based on their predicted cost and the presence of chronic conditions, rather than reactively targeted because they have already become high-cost users and have high cost conditions. The CBA incorporates both public and proprietary algorithms, including:

- The Charleston Co-morbidity Index: 17 categories of co-morbidity based on ICD-9 codes
- The Frail Elderly Algorithm: Age-adjusted score for frailty and immobility

- Diabetes Mellitus Exclusion Criteria: Normally excluded from Diabetes Mellitus but good candidates for care management
- Medication Possession Ratio: Percentage of days member has appropriate prescription drugs on-hand
- End of Life Medication Scale: Value based on likelihood medication is being taken for end of life issues
- HEDIS Inappropriate Medication Indicator: Medicare members who were prescribed a drug that should be avoided in the elderly
- Major Poly-Pharmacy: Use of more than 5 medications for 60 days during year
- High Expenditures Now (HEN) and High Expenditures Now and Later (HENAL): Diagnoses and procedures found in low-cost to high-cost mining analysis that not represented in other indicators included in the model, indicative of chest, kidney, blood, infectious disease)

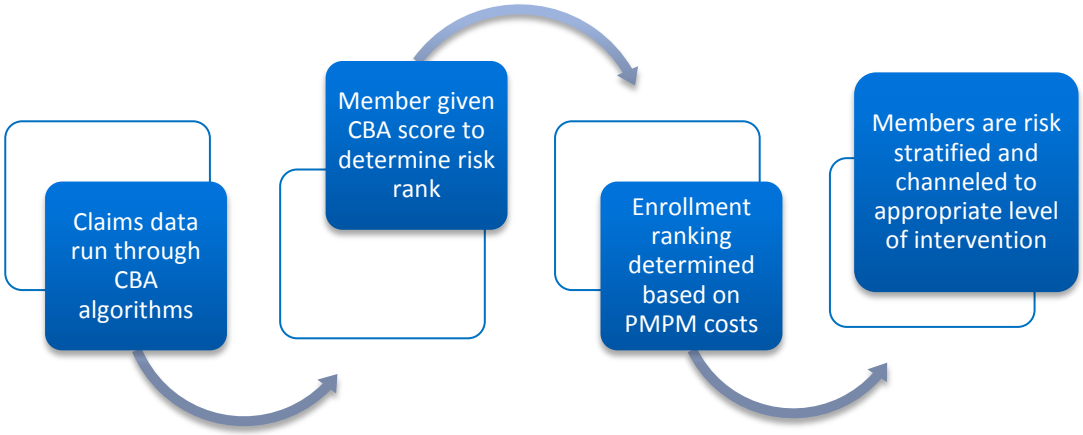
Each CBA is run monthly on all of CarePlus' respective Medicare member claims data. The source for this analysis is the members' medical and pharmacy claims data. Based on this predictive modeling tool and historical cost trend, members are ranked based on their CBA referral (risk) score and identified for the right level of intervention. Stratification is identified according to the following levels of intervention:

- Humana At Home High Intensity or Humana Puerto Rico Severe
- High
- Medium
- Low

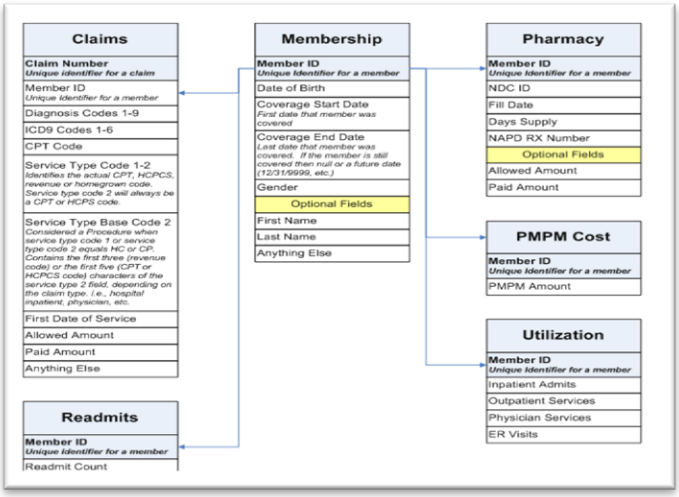
The CBA identifies certain combinations of co-morbidities, frailty, exclusion from disease management programs, predicted high cost claims, and pharmacy related issues (e.g. inappropriate medications, major poly-pharmacy, and medication adherence). All members must have some claims history to determine their CBA and all members are given a score, even if it is zero. Once members are assigned a CBA score, they are stratified further by their Per Member Per Month (PMPM) claims costs and given a priority level that determines how the member ranks in the list of eligible members. The cost percentiles are typically generated using 2 years of claims data however, if a member has fewer than 2 years, the algorithm will incorporate what is available.

CarePlus also utilizes Humana's New Member Predictive Model (NMPM) that accurately predicts high health care costs in order to proactively intervene to prevent a member from incurring higher costs. The New Member Predictive Model also allows for appropriate risk stratification to identify members who are considered most vulnerable prior to claims data being available. The NMPM utilizes advanced analytics with claims and non-claims data. Certain information is available at the beginning of the relationship with a member that accurately predicts their health. These data variables include CMS scores, Hierarchical Condition Categories (HCCs), lab data, demographic information, health assessment data, consumer data,

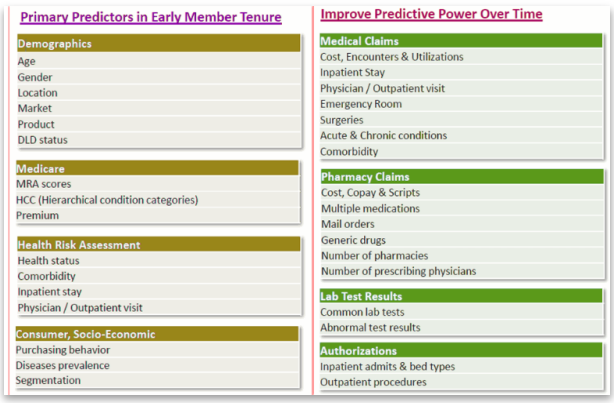
pharmacy claims, early claims, and authorizations.**Example: Humana At Home Claims Based Algorithm High Level Process Flow:**



Example: Humana At Home Claims Based Algorithm Data Requirements:



Example: New Member Predictive Model Variables:



Factor 2 & 3: Correlation Between Demographic Characteristics and Clinical Requirements:

CarePlus most vulnerable D-SNP population demographically is uniquely similar in demographic characteristics however uniquely different with overall risk to the overall D-SNP population.

Broward County: The most vulnerable population are mostly White, female, between the ages of sixty and seventy-nine years of age and do not live alone and live independently in their own home. Majority of members rate their overall health as fair or poor, have low financial risk related to meeting living expenses and functionally are low risk. Majority of members who are the most vulnerable do not feel down, depressed or hopeless and cognitively are at low risk.

- 56% of the population are between the ages of sixty and seventy-nine years of age, 18% are under sixty years of age and 26% are eighty years of age or older.
- 41% are male and 59% are female
- 37% are Black, 43% are White, 13% are Hispanic, 2% are Asian/Native American and 5% have a race classification as other
- 72% speak English, 26% speak Spanish, and 3% speak Creole
- 64% rated his/her health as fair or poor when compared to other people their age, and 36% rated their health as excellent or good
- 35% indicated they have had difficulty meeting living expenses within the past 3 months
- 12% have an overall health risk of high, 49% medium risk and 39% low risk
- 35% have a financial risk score of high and 65% have low financial risk
- 43% have a social risk score of medium and 41% have a low social risk
- 88% have a cognitive risk score of low and 12% have a high cognitive risk
- 36% have a functional risk score of high and 44% have low functional risk
- 64% do not live alone and 97% live independently
- 66% have not at all felt down, depressed, or hopeless within the past two weeks and 20% have felt down, depressed or hopeless several days within the past two weeks

Miami-Dade County: The most vulnerable population are mostly Hispanic, female, between the ages of sixty and seventy-nine years of age and do not live alone and live independently in their own home. Majority of members rate their overall health as fair or poor, have low financial risk related to meeting living expenses and functionally are low risk. Majority of members who are the most vulnerable do not feel down, depressed or hopeless and cognitively are at low risk.

- 55% of the population are between the ages of sixty and seventy-nine years of age, 9% are under sixty years of age and 37% are eighty years of age or older.
- 41% are male and 59% are female
- 15% are Black, 34% are White, 43% are Hispanic, 0.3% are Asian/Native American and 9% have a race classification as other

- 22% speak English, 76% speak Spanish, 2% speak Creole, and 0.2% have a language classification as other
- 56% rated his/her health as fair or poor when compared to other people their age, and 44% rated their health as excellent or good
- 28% indicated they have had difficulty meeting living expenses within the past 3 months
- 12% have an overall health risk of high, 51% medium risk and 38% low risk
- 28% have a financial risk score of high and 72% have low financial risk
- 44% have a social risk score of medium and 43% have a low social risk
- 87% have a cognitive risk score of low and 13% have a high cognitive risk
- 38% have a functional risk score of high and 44% have low functional risk
- 69% do not live alone and 98% live independently
- 61% have not at all felt down, depressed, or hopeless within the past two weeks and 26% have felt down, depressed or hopeless several days within the past two weeks

Palm Beach County: The most vulnerable population are mostly White, female, between the ages of sixty and seventy-nine years of age and do not live alone and live independently in their own home. Majority of members rate their overall health as fair or poor, have low financial risk related to meeting living expenses and functionally are low risk. Majority of members who are the most vulnerable do not feel down, depressed or hopeless and cognitively are at low risk.

- 61% of the population are between the ages of sixty and seventy-nine years of age, 20% are under sixty years of age and 19% are eighty years of age or older.
- 48% are male and 52% are female
- 32% are Black, 41% are White, 21% are Hispanic, 0.4% are Asian/Native American and 6% have a race classification as other
- 57% speak English, 33% speak Spanish and 10% speak Creole
- 63% rated his/her health as fair or poor when compared to other people their age, and 37% rated their health as excellent or good
- 36% indicated they have had difficulty meeting living expenses within the past 3 months
- 12% have an overall health risk of high, 48% medium risk and 39% low risk
- 36% have a financial risk score of high and 64% have low financial risk
- 40% have a social risk score of medium and 48% have a low social risk
- 89% have a cognitive risk score of low and 11% have a high cognitive risk
- 32% have a functional risk score of high and 47% have low functional risk
- 68% do not live alone and 99% live independently
- 65% have not at all felt down, depressed, or hopeless within the past two weeks and 25% have felt down, depressed or hopeless several days within the past two weeks

Hillsborough County: The most vulnerable population are mostly White, female, between the ages of sixty and seventy-nine years of age and do not live alone and live independently in their

own home. Majority of members rate their overall health as fair or poor, have low financial risk related to meeting living expenses and functionally are low risk. Majority of members who are the most vulnerable do not feel down, depressed or hopeless and cognitively are at low risk.

- 54% of the population are between the ages of sixty and seventy-nine years of age, 30% are under sixty years of age and 16% are eighty years of age or older.
- 39% are male and 61% are female
- 26% are Black, 46% are White, 23% are Hispanic, 1% are Asian/Native American and 5% have a race classification as other
- 55% speak English, 44% speak Spanish, 0.2% speak Creole and 0.1% have a language classification as other
- 59% rated his/her health as fair or poor when compared to other people their age, and 41% rated their health as excellent or good
- 25% indicated they have had difficulty meeting living expenses within the past 3 months
- 14% have an overall health risk of high, 56% medium risk and 29% low risk
- 25% have a financial risk score of high and 75% have low financial risk
- 45% have a social risk score of medium and 44% have a low social risk
- 81% have a cognitive risk score of low and 19% have a high cognitive risk
- 33% have a functional risk score of high and 40% have low functional risk
- 66% do not live alone and 99% live independently
- 58% have not at all felt down, depressed, or hopeless within the past two weeks and 25% have felt down, depressed or hopeless several days within the past two weeks

Pasco County: The most vulnerable population are mostly White, female, between the ages of sixty and seventy-nine years of age and do not live alone and live independently in their own home. Majority of members rate their overall health as fair or poor, have low financial risk related to meeting living expenses and functionally are high risk. Majority of members who are the most vulnerable do not feel down, depressed or hopeless and cognitively are at low risk.

- 54% of the population are between the ages of sixty and seventy-nine years of age, 33% are under sixty years of age and 13% are eighty years of age or older.
- 38% are male and 62% are female
- 9% are Black, 77% are White, 11% are Hispanic and 3% have a race classification as other
- 77% speak English and 23% speak Spanish
- 70% rated his/her health as fair or poor when compared to other people their age, and 30% rated their health as excellent or good
- 40% indicated they have had difficulty meeting living expenses within the past 3 months
- 19% have an overall health risk of high, 68% medium risk and 12% low risk
- 40% have a financial risk score of high and 60% have low financial risk
- 53% have a social risk score of medium and 32% have a low social risk
- 88% have a cognitive risk score of low and 12% have a high cognitive risk

- 33% have a functional risk score of high and 32% have low functional risk
- 46% do not live alone and 100% live independently
- 58% have not at all felt down, depressed, or hopeless within the past two weeks and 25% have felt down, depressed or hopeless several days within the past two weeks

Pinellas County: The most vulnerable population are mostly White, female, between the ages of sixty and seventy-nine years of age and do not live alone and live independently in their own home. Majority of members rate their overall health as fair or poor, have low financial risk related to meeting living expenses and functionally are high risk. Majority of members who are the most vulnerable do not feel down, depressed or hopeless and cognitively are at low risk.

- 51% of the population are between the ages of sixty and seventy-nine years of age, 34% are under sixty years of age and 15% are eighty years of age or older.
- 39% are male and 61% are female
- 18% are Black, 71% are White, 7% are Hispanic, 1% are Asian/Native American and 3% have a race classification as other
- 87% speak English, 12% speak Spanish, 0.4% speak Vietnamese and 1% have a language classification as other
- 65% rated his/her health as fair or poor when compared to other people their age, and 35% rated their health as excellent or good
- 31% indicated they have had difficulty meeting living expenses within the past 3 months
- 22% have an overall health risk of high, 50% medium risk and 28% low risk
- 31% have a financial risk score of high and 69% have low financial risk
- 50% have a social risk score of medium and 35% have a low social risk
- 88% have a cognitive risk score of low and 12% have a high cognitive risk
- 36% have a functional risk score of high and 35% have low functional risk
- 62% do not live alone and 95% live independently
- 55% have not at all felt down, depressed, or hopeless within the past two weeks and 24% have felt down, depressed or hopeless several days within the past two weeks

Polk County: The most vulnerable population are mostly White, female, between the ages of sixty and seventy-nine years of age and do not live alone and live independently in their own home. Majority of members rate their overall health as fair or poor, have low financial risk related to meeting living expenses and functionally are high risk. Majority of members who are the most vulnerable do not feel down, depressed or hopeless and cognitively are at low risk.

- 57% of the population are between the ages of sixty and seventy-nine years of age, 32% are under sixty years of age and 11% are eighty years of age or older.
- 37% are male and 63% are female

- 21% are Black, 66% are White, 9% are Hispanic, 1% are Asian/Native American and 4% have a race classification as other
- 73% speak English and 27% speak Spanish
- 66% rated his/her health as fair or poor when compared to other people their age, and 34% rated their health as excellent or good
- 34% indicated they have had difficulty meeting living expenses within the past 3 months
- 20% have an overall health risk of high, 55% medium risk and 25% low risk
- 34% have a financial risk score of high and 66% have low financial risk
- 44% have a social risk score of medium and 39% have a low social risk
- 85% have a cognitive risk score of low and 15% have a high cognitive risk
- 42% have a functional risk score of high and 30% have low functional risk
- 63% do not live alone and 99% live independently
- 55% have not at all felt down, depressed, or hopeless within the past two weeks and 26% have felt down, depressed or hopeless several days within the past two weeks

Orange County: The most vulnerable population are mostly White, female, between the ages of sixty and seventy-nine years of age and do not live alone and live independently in their own home. Majority of members rate their overall health as fair or poor, have low financial risk related to meeting living expenses and functionally are low risk. Majority of members who are the most vulnerable do not feel down, depressed or hopeless and cognitively are at low risk.

- 56% of the population are between the ages of sixty and seventy-nine years of age, 28% are under sixty years of age and 16% are eighty years of age or older.
- 36% are male and 64% are female
- 27% are Black, 49% are White, 18% are Hispanic, 2% are Asian/Native American and 5% have a race classification as other
- 59% speak English, 39% speak Spanish, 1% speak Creole and 0.1% speak Vietnamese
- 65% rated his/her health as fair or poor when compared to other people their age, and 35% rated their health as excellent or good
- 33% indicated they have had difficulty meeting living expenses within the past 3 months
- 16% have an overall health risk of high, 55% medium risk and 29% low risk
- 33% have a financial risk score of high and 67% have low financial risk
- 46% have a social risk score of medium and 39% have a low social risk
- 84% have a cognitive risk score of low and 16% have a high cognitive risk
- 34% have a functional risk score of high and 39% have low functional risk
- 65% do not live alone and 98% live independently
- 56% have not at all felt down, depressed, or hopeless within the past two weeks and 26% have felt down, depressed or hopeless several days within the past two weeks

Osceola County: The most vulnerable population are mostly White, female, between the ages of sixty and seventy-nine years of age and do not live alone and live independently in their own home. Majority of members rate their overall health as fair or poor, have low financial risk related to meeting living expenses and functionally are high risk. Majority of members who are the most vulnerable do not feel down, depressed or hopeless and cognitively are at low risk.

- 56% of the population are between the ages of sixty and seventy-nine years of age, 24% are under sixty years of age and 20% are eighty years of age or older.
- 39% are male and 61% are female
- 9% are Black, 60% are White, 25% are Hispanic, 1% are Asian/Native American and 6% have a race classification as other
- 38% speak English, 61% speak Spanish, 0.3% speak Creole and 0.3% have a language classification as other
- 65% rated his/her health as fair or poor when compared to other people their age, and 35% rated their health as excellent or good
- 34% indicated they have had difficulty meeting living expenses within the past 3 months
- 23% have an overall health risk of high, 53% medium risk and 24% low risk
- 34% have a financial risk score of high and 66% have low financial risk
- 42% have a social risk score of medium and 45% have a low social risk
- 82% have a cognitive risk score of low and 18% have a high cognitive risk
- 40% have a functional risk score of high and 39% have low functional risk
- 68% do not live alone and 99% live independently
- 52% have not at all felt down, depressed, or hopeless within the past two weeks and 29% have felt down, depressed or hopeless several days within the past two weeks

Seminole County: The most vulnerable population are mostly White, female, between the ages of sixty and seventy-nine years of age and do not live alone and live independently in their own home. Majority of members rate their overall health as fair or poor, have low financial risk related to meeting living expenses and functionally are low risk. Majority of members who are the most vulnerable do not feel down, depressed or hopeless and cognitively are at low risk.

- 51% of the population are between the ages of sixty and seventy-nine years of age, 29% are under sixty years of age and 20% are eighty years of age or older.
- 38% are male and 62% are female
- 29% are Black, 58% are White, 11% are Hispanic, 1% are Asian/Native American and 2% have a race classification as other
- 75% speak English, 24% speak Spanish and 1% speak Creole
- 64% rated his/her health as fair or poor when compared to other people their age, and 36% rated their health as excellent or good
- 30% indicated they have had difficulty meeting living expenses within the past 3 months
- 21% have an overall health risk of high, 57% medium risk and 22% low risk

- 30% have a financial risk score of high and 70% have low financial risk
- 40% have a social risk score of medium and 48% have a low social risk
- 88% have a cognitive risk score of low and 12% have a high cognitive risk
- 36% have a functional risk score of high and 39% have low functional risk
- 73% do not live alone and 96% live independently
- 60% have not at all felt down, depressed, or hopeless within the past two weeks and 26% have felt down, depressed or hopeless several days within the past two weeks

Brevard County: The most vulnerable population are mostly White, female, between the ages of sixty and seventy-nine years of age and do not live alone and live independently in their own home. Majority of members rate their overall health as fair or poor, have low financial risk related to meeting living expenses and functionally are high risk. Majority of members who are the most vulnerable do not feel down, depressed or hopeless and cognitively are at low risk.

- 60% of the population are between the ages of sixty and seventy-nine years of age, 29% are under sixty years of age and 11% are eighty years of age or older.
- 33% are male and 67% are female
- 20% are Black, 63% are White, 10% are Hispanic, 1% are Asian/Native American and 5% have a race classification as other
- 84% speak English and 16% speak Spanish
- 66% rated his/her health as fair or poor when compared to other people their age, and 34% rated their health as excellent or good
- 40% indicated they have had difficulty meeting living expenses within the past 3 months
- 26% have an overall health risk of high, 48% medium risk and 26% low risk
- 40% have a financial risk score of high and 60% have low financial risk
- 45% have a social risk score of medium and 39% have a low social risk
- 83% have a cognitive risk score of low and 17% have a high cognitive risk
- 41% have a functional risk score of high and 32% have low functional risk
- 60% do not live alone and 97% live independently
- 52% have not at all felt down, depressed, or hopeless within the past two weeks and 23% have felt down, depressed or hopeless several days within the past two weeks

Indian River County: The most vulnerable population are mostly White, male, between the ages of sixty and seventy-nine years of age and do not live alone and live independently in their own home. Majority of members rate their overall health as good or excellent, have high financial risk related to meeting living expenses and functionally are low risk. Majority of members who are the most vulnerable do not feel down, depressed or hopeless and cognitively are at low risk.

- 63% of the population are between the ages of sixty and seventy-nine years of age, 0% are under sixty years of age and 38% are eighty years of age or older.
- 63% are male and 38% are female
- 13% are Black, 63% are White and 25% have a race classification as other
- 88% speak English and 13% speak Spanish
- 25% rated his/her health as fair or poor when compared to other people their age, and 75% rated their health as excellent or good
- 75% indicated they have had difficulty meeting living expenses within the past 3 months
- 25% have an overall health risk of high, 25% medium risk and 50% low risk
- 75% have a financial risk score of high and 25% have low financial risk
- 25% have a social risk score of medium and 50% have a low social risk
- 100% have a cognitive risk score of low
- 25% have a functional risk score of high and 50% have low functional risk
- 50% do not live alone and 100% live independently
- 100% have not at all felt down, depressed, or hopeless within the past two weeks

Martin County: The most vulnerable population are mostly race classification as other, female, between the ages of sixty and seventy-nine years of age and live alone and live independently in their own home. Majority of members rate their overall health as fair or poor, have low financial risk related to meeting living expenses and functionally are medium risk. Majority of members who are the most vulnerable do not feel down, depressed or hopeless and cognitively are at low risk.

- 100% of the population are between the ages of sixty and seventy-nine years of age
- 33% are male and 67% are female
- 33% are White and 67% have a race classification as other
- 67% speak English and 33% speak Spanish
- 100% rated his/her health as fair or poor when compared to other people their age
- 0% indicated they have had difficulty meeting living expenses within the past 3 months
- 100% have an overall health risk of medium
- 100% have low financial risk
- 100% have a social risk score of high
- 100% have a cognitive risk score of low
- 100% have a functional risk score of medium
- 0% do not live alone and 100% live independently
- 100% have not at all felt down, depressed, or hopeless within the past two weeks

Okeechobee County: The most vulnerable population are evenly distributed as White and Hispanic, male and female, all are between the ages of sixty and seventy-nine years of age and live alone and live independently in their own home. Majority of members rate their overall

health as fair or poor, have high financial risk related to meeting living expenses and functionally are medium risk. Majority of members who are the most vulnerable nearly every day feel down, depressed or hopeless and cognitively are at low risk.

- 100% of the population are between the ages of sixty and seventy-nine years of age
- 50% are male and 50% are female
- 50% are White and 50% are Hispanic
- 50% speak English and 50% speak Spanish
- 100% rated his/her health as fair or poor when compared to other people their age
- 100% indicated they have had difficulty meeting living expenses within the past 3 months
- 100% have an overall health risk of medium
- 100% have a financial risk score of high
- 100% have a social risk score of high
- 100% have a cognitive risk score of low
- 100% have a functional risk score of medium
- 0% do not live alone and 100% live independently
- 100% have nearly every day felt down, depressed, or hopeless within the past two weeks

St Lucie County: The most vulnerable population are mostly White, female, eighty years of age or older and do not live alone and live independently in their own home. Members rate their overall health evenly between good or excellent and fair or poor, have low financial risk related to meeting living expenses and functionally are evenly divided between medium and low risk. Majority of members who are the most vulnerable do not feel down, depressed or hopeless and cognitively are at low risk.

- 33% of the population are between the ages of sixty and seventy-nine years of age, 25% are under sixty years of age and 42% are eighty years of age or older.
- 33% are male and 67% are female
- 8% are Black, 50% are White, 33% are Hispanic and 8% have a race classification as other
- 50% speak English and 50% speak Spanish
- 50% rated his/her health as fair or poor when compared to other people their age, and 50% rated their health as excellent or good
- 30% indicated they have had difficulty meeting living expenses within the past 3 months
- 20% have an overall health risk of high, 40% medium risk and 40% low risk
- 30% have a financial risk score of high and 70% have low financial risk
- 70% have a social risk score of medium and 20% have a low social risk
- 90% have a cognitive risk score of low and 10% have a high cognitive risk
- 40% have a functional risk score of medium and 40% have low functional risk
- 80% do not live alone and 90% live independently
- 70% have not at all felt down, depressed, or hopeless within the past two weeks and 10% have felt down, depressed or hopeless several days within the past two weeks

Duval County: The most vulnerable population are mostly Black, female, between the ages of sixty and seventy-nine years of age and do not live alone and live independently in their own home. Majority of members rate their overall health as fair or poor, have low financial risk related to meeting living expenses and functionally are low risk. Majority of members who are the most vulnerable do not feel down, depressed or hopeless and cognitively are at low risk.

- 57% of the population are between the ages of sixty and seventy-nine years of age, 37% are under sixty years of age and 6% are eighty years of age or older.
- 41% are male and 59% are female
- 55% are Black, 38% are White, 2% are Hispanic, 2% are Asian/Native American and 2% have a race classification as other
- 95% speak English and 5% speak Spanish
- 56% rated his/her health as fair or poor when compared to other people their age, and 44% rated their health as excellent or good
- 40% indicated they have had difficulty meeting living expenses within the past 3 months
- 23% have an overall health risk of high, 49% medium risk and 28% low risk
- 40% have a financial risk score of high and 60% have low financial risk
- 61% have a social risk score of medium and 28% have a low social risk
- 81% have a cognitive risk score of low and 19% have a high cognitive risk
- 28% have a functional risk score of high and 47% have low functional risk
- 47% do not live alone and 95% live independently
- 60% have not at all felt down, depressed, or hopeless within the past two weeks and 23% have felt down, depressed or hopeless several days within the past two weeks

Lake County: The most vulnerable population are mostly White, female, between the ages of sixty and seventy-nine years of age and do not live alone and live independently in their own home. Majority of members rate their overall health as fair or poor, have low financial risk related to meeting living expenses and functionally are low risk. Majority of members who are the most vulnerable do not feel down, depressed or hopeless and cognitively are at low risk.

- 60% of the population are between the ages of sixty and seventy-nine years of age, 31% are under sixty years of age and 9% are eighty years of age or older.
- 38% are male and 62% are female
- 21% are Black, 65% are White, 6% are Hispanic, 1% are Asian/Native American and 7% have a race classification as other
- 88% speak English and 12% speak Spanish
- 67% rated his/her health as fair or poor when compared to other people their age, and 33% rated their health as excellent or good
- 47% indicated they have had difficulty meeting living expenses within the past 3 months

- 19% have an overall health risk of high, 61% medium risk and 20% low risk
- 47% have a financial risk score of high and 53% have low financial risk
- 41% have a social risk score of medium and 45% have a low social risk
- 77% have a cognitive risk score of low and 23% have a high cognitive risk
- 37% have a functional risk score of high and 39% have low functional risk
- 65% do not live alone and 97% live independently
- 59% have not at all felt down, depressed, or hopeless within the past two weeks and 16% have felt down, depressed or hopeless several days within the past two weeks

Marion County: The most vulnerable population are mostly White, male, between the ages of sixty and seventy-nine years of age and do not live alone and live independently in their own home. Majority of members rate their overall health as fair or poor, have low financial risk related to meeting living expenses and functionally are high risk. Majority of members who are the most vulnerable do not feel down, depressed or hopeless and cognitively are at low risk.

- 51% of the population are between the ages of sixty and seventy-nine years of age, 34% are under sixty years of age and 15% are eighty years of age or older.
- 52% are male and 48% are female
- 15% are Black, 72% are White, 11% are Hispanic and 2% have a race classification as other
- 91% speak English and 9% speak Spanish
- 73% rated his/her health as fair or poor when compared to other people their age, and 27% rated their health as excellent or good
- 37% indicated they have had difficulty meeting living expenses within the past 3 months
- 20% have an overall health risk of high, 57% medium risk and 24% low risk
- 37% have a financial risk score of high and 63% have low financial risk
- 45% have a social risk score of medium and 37% have a low social risk
- 82% have a cognitive risk score of low and 18% have a high cognitive risk
- 53% have a functional risk score of high and 31% have low functional risk
- 65% do not live alone and 98% live independently
- 39% have not at all felt down, depressed, or hopeless within the past two weeks and 22% have felt down, depressed or hopeless several days within the past two weeks

Sumter County: The most vulnerable population are mostly White, female, under the age of sixty seventy-nine years of age and do not live alone and live independently in their own home. Majority of members rate their overall health as fair or poor, have low financial risk related to meeting living expenses and functionally are low risk. Majority of members who are the most vulnerable do not feel down, depressed or hopeless and cognitively are at low risk.

- 42% of the population are between the ages of sixty and seventy-nine years of age, 42% are under sixty years of age and 17% are eighty years of age or older.
- 33% are male and 67% are female

- 17% are Black, 83% are White
- 92% speak English, 8% speak Spanish
- 67% rated his/her health as fair or poor when compared to other people their age, and 33% rated their health as excellent or good
- 11% indicated they have had difficulty meeting living expenses within the past 3 months
- 33% have an overall health risk of high, 22% medium risk and 44% low risk
- 11% have a financial risk score of high and 89% have low financial risk
- 33% have a social risk score of medium and 56% have a low social risk
- 67% have a cognitive risk score of low and 33% have a high cognitive risk
- 33% have a functional risk score of high and 56% have low functional risk
- 78% do not live alone and 100% live independently
- 78% have not at all felt down, depressed, or hopeless within the past two weeks and 11% have felt down, depressed or hopeless several days within the past two weeks

CarePlus: Ages of Most Vulnerable Members:

Most Vulnerable Member Demographics by County (DE)							
County	Under 60 Years Old		60-79 Years Old		80+ Years Old		Total Members
	Members	%	Members	%	Members	%	
Brevard	49	29%	100	60%	18	11%	167
Broward	156	18%	480	56%	221	26%	857
Duval	30	37%	47	57%	5	6%	82
Hillsborough	292	30%	533	54%	163	16%	988
Indian River			5	63%	3	38%	8
Lake	31	31%	60	60%	9	9%	100
Marion	22	34%	33	51%	10	15%	65
Martin			3	100%			3
Miami-Dade	214	9%	1,370	55%	915	37%	2,499
Okeechobee			2	100%			2
Orange	284	28%	558	56%	155	16%	997
Osceola	86	24%	202	56%	73	20%	361
Palm Beach	89	20%	276	61%	84	19%	449
Pasco	30	33%	49	54%	12	13%	91
Pinellas	86	34%	128	51%	38	15%	252
Polk	100	32%	181	57%	34	11%	315
Seminole	46	29%	81	51%	32	20%	159
St. Lucie	3	25%	4	33%	5	42%	12
Sumter	5	42%	5	42%	2	17%	12
Aggregate	**1,523**	**21%**	**4,117**	**55%**	**1,779**	**24%**	**7,419**

Source: Humana At Home Analytics and Reporting

CarePlus: Gender of Most Vulnerable Members:

Most Vulnerable Member Demographics by County (DE)					
County	Male		Female		Total Members
	Members	%	Members	%	
Brevard	55	33%	112	67%	167
Broward	353	41%	504	59%	857
Duval	34	41%	48	59%	82
Hillsborough	390	39%	598	61%	988
Indian River	5	63%	3	38%	8
Lake	38	38%	62	62%	100
Marion	34	52%	31	48%	65
Martin	1	33%	2	67%	3
Miami-Dade	1,023	41%	1,476	59%	2,499
Okeechobee	1	50%	1	50%	2
Orange	357	36%	640	64%	997
Osceola	139	39%	222	61%	361
Palm Beach	214	48%	235	52%	449
Pasco	35	38%	56	62%	91
Pinellas	98	39%	154	61%	252
Polk	116	37%	199	63%	315
Seminole	60	38%	99	62%	159
St. Lucie	4	33%	8	67%	12
Sumter	4	33%	8	67%	12
Aggregate	**2,961**	**40%**	**4,458**	**60%**	**7,419**

Source: Humana At Home Analytics and Reporting

CarePlus: Race of Most Vulnerable Members:

Most Vulnerable Member Demographics by County (DE)											
County	Black		Hispanic		White		Asian/Native American		Other/Unknown		Total Members
	Members	%	Members	%	Members	%	Members	%	Members	%	
Brevard	34	20%	17	10%	106	63%	1	1%	9	5%	167
Broward	321	37%	110	13%	368	43%	14	2%	44	5%	857
Duval	45	55%	2	2%	31	38%	2	2%	2	2%	82
Hillsborough	253	26%	228	23%	454	46%	6	1%	47	5%	988
Indian River	1	13%			5	63%			2	25%	8
Lake	21	21%	6	6%	65	65%	1	1%	7	7%	100
Marion	10	15%	7	11%	47	72%			1	2%	65
Martin					1	33%			2	67%	3
Miami-Dade	375	15%	1,064	43%	838	34%	8	0.3%	214	9%	2,499
Okeechobee			1	50%	1	50%					2
Orange	265	27%	177	18%	484	49%	23	2%	48	5%	997
Osceola	34	9%	89	25%	216	60%	2	1%	20	6%	361

Palm Beach	142	32%	96	21%	184	41%	2	0.4%	25	6%	449
Pasco	8	9%	10	11%	70	77%			3	3%	91
Pinellas	45	18%	17	7%	180	71%	2	1%	8	3%	252
Polk	65	21%	28	9%	207	66%	3	1%	12	4%	315
Seminole	46	29%	17	11%	92	58%	1	1%	3	2%	159
St. Lucie	1	8%	4	33%	6	50%			1	8%	12
Sumter	2	17%			10	83%					12
Aggregate	**1,668**	**22%**	**1,873**	**25%**	**3,365**	**45%**	**65**	**1%**	**448**	**6%**	**7,419**

Source: Humana At Home Analytics and Reporting

CarePlus: Language of Most Vulnerable Members:

Most Vulnerable Member Demographics by County (DE)											
County	English		Spanish		Creole		Vietnamese		Other		Total Members
	Members	%	Members	%	Members	%	Members	%	Members	%	
Brevard	140	84%	27	16%							167
Broward	613	72%	220	26%	23	3%			1	0.1%	857
Duval	78	95%	4	5%							82
Hillsborough	546	55%	439	44%	2	0.2%			1	0.1%	988
Indian River	7	88%	1	13%							8
Lake	88	88%	12	12%							100
Marion	59	91%	6	9%							65
Martin	2	67%	1	33%							3
Miami-Dade	547	22%	1,887	76%	61	2%			4	0.2%	2,499
Okeechobee	1	50%	1	50%							2
Orange	592	59%	390	39%	14	1%	1	0.1%			997
Osceola	138	38%	221	61%	1	0.3%			1	0.3%	361
Palm Beach	257	57%	148	33%	44	10%					449
Pasco	70	77%	21	23%							91
Pinellas	218	87%	31	12%			1	0.4%	2	1%	252
Polk	230	73%	84	27%					1	0.3%	315
Seminole	120	75%	38	24%	1	1%					159
St. Lucie	6	50%	6	50%							12
Sumter	11	92%	1	8%							12
Aggregate	**3,723**	**50%**	**3,538**	**48%**	**146**	**2%**	**2**	**0.03%**	**10**	**0.1%**	**7,419**

Source: Humana At Home Analytics and Reporting

CarePlus: Health Risk of Most Vulnerable Members:

Most Vulnerable Health Risk Analysis by County (DE)							
County	Low Risk		Medium Risk		High Risk		Total Members
	Members	%	Members	%	Members	%	
Brevard	32	26%	60	48%	33	26%	125

Broward	216	39%	271	49%	65	12%	552
Duval	16	28%	28	49%	13	23%	57
Hillsborough	180	29%	347	56%	88	14%	615
Indian River	2	50%	1	25%	1	25%	4
Lake	15	20%	46	61%	14	19%	75
Marion	12	24%	29	57%	10	20%	51
Martin			1	100%			1
Miami-Dade	565	38%	752	51%	172	12%	1,489
Okeechobee			1	100%			1
Orange	202	29%	379	55%	108	16%	689
Osceola	62	24%	135	53%	60	23%	257
Palm Beach	114	39%	141	48%	36	12%	291
Pasco	7	12%	39	68%	11	19%	57
Pinellas	40	28%	72	50%	32	22%	144
Polk	56	25%	125	55%	45	20%	226
Seminole	25	22%	64	57%	24	21%	113
St. Lucie	4	40%	4	40%	2	20%	10
Sumter	4	44%	2	22%	3	33%	9
Aggregate	**1,552**	**33%**	**2,497**	**52%**	**717**	**15%**	**4,766**

Source: hCAT – mDAT Response Table

CarePlus: Health Rating Compared to Others of Most Vulnerable Members:

Most Vulnerable Health Risk Analysis - Question/Response by County (DE)					
Compared to other people your age, how would you describe your health?					
County	**Fair or Poor**		**Excellent or Good**		**Total Members**
	Members	**%**	**Members**	**%**	
Brevard	83	66%	42	34%	125
Broward	352	64%	200	36%	552
Duval	32	56%	25	44%	57
Hillsborough	365	59%	250	41%	615
Indian River	1	25%	3	75%	4
Lake	50	67%	25	33%	75
Marion	37	73%	14	27%	51
Martin	1	100%			1
Miami-Dade	828	56%	661	44%	1,489
Okeechobee	1	100%			1
Orange	446	65%	243	35%	689
Osceola	167	65%	90	35%	257

Palm Beach	183	63%	108	37%	291
Pasco	40	70%	17	30%	57
Pinellas	94	65%	50	35%	144
Polk	149	66%	77	34%	226
Seminole	72	64%	41	36%	113
St. Lucie	5	50%	5	50%	10
Sumter	6	67%	3	33%	9
Aggregate	**2,912**	**61%**	**1,854**	**39%**	**4,766**

Source: hCAT – mDAT Response Table

CarePlus: Financial Risk of Most Vulnerable Members:

Most Vulnerable Financial Risk Analysis by County (DE)					
County	Low Risk		High Risk		Total Members
	Members	%	Members	%	
Brevard	75	60%	50	40%	125
Broward	359	65%	193	35%	552
Duval	34	60%	23	40%	57
Hillsborough	462	75%	153	25%	615
Indian River	1	25%	3	75%	4
Lake	40	53%	35	47%	75
Marion	32	63%	19	37%	51
Martin	1	100%			1
Miami-Dade	1,066	72%	423	28%	1,489
Okeechobee		0%	1	100%	1
Orange	459	67%	230	33%	689
Osceola	169	66%	88	34%	257
Palm Beach	185	64%	106	36%	291
Pasco	34	60%	23	40%	57
Pinellas	99	69%	45	31%	144
Polk	150	66%	76	34%	226
Seminole	79	70%	34	30%	113
St. Lucie	7	70%	3	30%	10
Sumter	8	89%	1	11%	9
Aggregate	**3,260**	**68%**	**1,506**	**32%**	**4,766**

Source: hCAT – mDAT Response Table

CarePlus: Social Risk of Most Vulnerable Members:

Most Vulnerable Social Risk Analysis by County (DE)							
County	Low Risk		Medium Risk		High Risk		Total Members
	Members	%	Members	%	Members	%	

Brevard	49	39%	56	45%	20	16%	125
Broward	228	41%	239	43%	85	15%	552
Duval	16	28%	35	61%	6	11%	57
Hillsborough	269	44%	274	45%	72	12%	615
Indian River	2	50%	1	25%	1	25%	4
Lake	34	45%	31	41%	10	13%	75
Marion	19	37%	23	45%	9	18%	51
Martin					1	100%	1
Miami-Dade	646	43%	662	44%	181	12%	1,489
Okeechobee					1	100%	1
Orange	269	39%	317	46%	103	15%	689
Osceola	115	45%	109	42%	33	13%	257
Palm Beach	140	48%	115	40%	36	12%	291
Pasco	18	32%	30	53%	9	16%	57
Pinellas	51	35%	72	50%	21	15%	144
Polk	89	39%	99	44%	38	17%	226
Seminole	54	48%	45	40%	14	12%	113
St. Lucie	2	20%	7	70%	1	10%	10
Sumter	5	56%	3	33%	1	11%	9
Aggregate	**2,006**	**42%**	**2,118**	**44%**	**642**	**13%**	**4,766**

Source: hCAT – mDAT Response Table

CarePlus: Functional Risk of Most Vulnerable Members:

Most Vulnerable Functional Risk Analysis by County (DE)							
County	Low Risk		Medium Risk		High Risk		Total Members
	Members	%	Members	%	Members	%	
Brevard	40	32%	34	27%	51	41%	125
Broward	241	44%	115	21%	196	36%	552
Duval	27	47%	14	25%	16	28%	57
Hillsborough	246	40%	163	27%	206	33%	615
Indian River	2	50%	1	25%	1	25%	4
Lake	29	39%	18	24%	28	37%	75
Marion	16	31%	8	16%	27	53%	51
Martin			1	100%			1
Miami-Dade	658	44%	269	18%	562	38%	1,489
Okeechobee			1	100%			1
Orange	271	39%	182	26%	236	34%	689
Osceola	100	39%	54	21%	103	40%	257
Palm Beach	138	47%	59	20%	94	32%	291
Pasco	18	32%	20	35%	19	33%	57
Pinellas	51	35%	41	28%	52	36%	144

Polk	67	30%	63	28%	96	42%	226
Seminole	44	39%	28	25%	41	36%	113
St. Lucie	4	40%	4	40%	2	20%	10
Sumter	5	56%	1	11%	3	33%	9
Aggregate	**1,957**	**41%**	**1,076**	**23%**	**1,733**	**36%**	**4,766**

Source: hCAT – mDAT Response Table

CarePlus: Cognitive Risk of Most Vulnerable Members:

Most Vulnerable Cognitive Risk Analysis by County (DE)					
County	Low Risk		High Risk		Total Members
	Members	%	Members	%	
Brevard	104	83%	21	17%	125
Broward	488	88%	64	12%	552
Duval	46	81%	11	19%	57
Hillsborough	501	81%	114	19%	615
Indian River	4	100%			4
Lake	58	77%	17	23%	75
Marion	42	82%	9	18%	51
Martin	1	100%			1
Miami-Dade	1,296	87%	193	13%	1,489
Okeechobee	1	100%			1
Orange	578	84%	111	16%	689
Osceola	210	82%	47	18%	257
Palm Beach	258	89%	33	11%	291
Pasco	50	88%	7	12%	57
Pinellas	127	88%	17	12%	144
Polk	193	85%	33	15%	226
Seminole	100	88%	13	12%	113
St. Lucie	9	90%	1	10%	10
Sumter	6	67%	3	33%	9
Aggregate	**4,072**	**85%**	**694**	**15%**	**4,766**

Source: hCAT – mDAT Response Table

CarePlus: Environmental Living Situations of Most Vulnerable Members:

Most Vulnerable Environmental Risk Analysis - Question/Response by County (DE)						
Question	County	No		Yes		Total Members
		Members	%	Members	%	
Do you live alone?	Brevard	75	60%	50	40%	125
	Broward	351	64%	201	36%	552
	Duval	27	47%	30	53%	57
	Hillsborough	406	66%	209	34%	615
	Indian River	2	50%	2	50%	4
	Lake	49	65%	26	35%	75
	Marion	33	65%	18	35%	51
	Martin			1	100%	1
	Miami-Dade	1,025	69%	464	31%	1,489
	Okeechobee			1	100%	1
	Orange	448	65%	241	35%	689
	Osceola	176	68%	81	32%	257
	Palm Beach	199	68%	92	32%	291
	Pasco	26	46%	31	54%	57
	Pinellas	89	62%	55	38%	144
	Polk	143	63%	83	37%	226
	Seminole	82	73%	31	27%	113
	St. Lucie	8	80%	2	20%	10
	Sumter	7	78%	2	22%	9
	Aggregate	**3,146**	**66%**	**1,620**	**34%**	**4,766**

CarePlus: Environmental Living Situations of Most Vulnerable Population:

Most Vulnerable Environmental Risk Analysis Question/Response by County (DE)									
Where do you live?									
County	Assisted-living home		Independent home		Nursing Home		Other		Total Members
	Members	%	Members	%	Members	%	Members	%	
Brevard	4	3%	121	97%					125
Broward	9	2%	535	97%	2	0.4%	6	1%	552
Duval	1	2%	54	95%			2	4%	57
Hillsborough	5	1%	609	99%	1	0.2%			615
Indian River			4	100%					4
Lake	1	1%	73	97%			1	1%	75
Marion	1	2%	50	98%					51

Martin			1	100%					1
Miami-Dade	16	1%	1,464	98%	3	0.2%	6	0.4%	1,489
Okeechobee			1	100%					1
Orange	6	1%	674	98%	1	0.1%	8	1%	689
Osceola	1	0.4%	255	99%			1	0.4%	257
Palm Beach	3	1%	287	99%			1	0.3%	291
Pasco			57	100%					57
Pinellas	5	3%	137	95%	1	1%	1	1%	144
Polk			224	99%	1	0.4%	1	0.4%	226
Seminole	2	2%	109	96%	1	1%	1	1%	113
St. Lucie	1	10%	9	90%					10
Sumter			9	100%					9
Aggregate	**55**	**1%**	**4,673**	**98%**	**10**	**0.2%**	**28**	**1%**	**4,766**

Source: hCAT – mDAT Response Table

CarePlus: Financial Difficulties of Most Vulnerable Members:

Most Vulnerable Financial Risk Analysis - Question/Response by County (DE)					
Within the past 3 months, have you had difficulty meeting your living expenses?					
County	**Yes**		**No**		**Total Members**
	Members	**%**	**Members**	**%**	
Brevard	50	40%	75	60%	125
Broward	193	35%	359	65%	552
Duval	23	40%	34	60%	57
Hillsborough	153	25%	462	75%	615
Indian River	3	75%	1	25%	4
Lake	35	47%	40	53%	75
Marion	19	37%	32	63%	51
Martin			1	100%	1
Miami-Dade	423	28%	1,066	72%	1,489
Okeechobee	1	100%			1
Orange	230	33%	459	67%	689
Osceola	88	34%	169	66%	257
Palm Beach	106	36%	185	64%	291
Pasco	23	40%	34	60%	57
Pinellas	45	31%	99	69%	144
Polk	76	34%	150	66%	226

Seminole	34	30%	79	70%	113
St. Lucie	3	30%	7	70%	10
Sumter	1	11%	8	89%	9
Aggregate	**1,506**	**32%**	**3,260**	**68%**	**4,766**

Source: hCAT – mDAT Response Table

CarePlus: Behavioral Health of Most Vulnerable Members:

Depression Risk Analysis - Question/Response by County (DE)Most Vulnerable									
Over the last two weeks, how often have you felt down, depressed or hopeless?									
County	**Nearly Everyday**		**More Than Half**		**Several Days**		**Not At All**		**Total Members**
	Members	**%**	**Members**	**%**	**Members**	**%**	**Members**	**%**	
Brevard	21	17%	10	8%	29	23%	65	52%	125
Broward	38	7%	38	7%	113	20%	363	66%	552
Duval	8	14%	2	4%	13	23%	34	60%	57
Hillsborough	87	14%	22	4%	152	25%	354	58%	615
Indian River							4	100%	4
Lake	14	19%	5	7%	12	16%	44	59%	75
Marion	14	27%	6	12%	11	22%	20	39%	51
Martin							1	100%	1
Miami-Dade	125	8%	60	4%	389	26%	915	61%	1,489
Okeechobee	1	100%							1
Orange	85	12%	36	5%	182	26%	386	56%	689
Osceola	39	15%	11	4%	74	29%	133	52%	257
Palm Beach	22	8%	7	2%	72	25%	190	65%	291
Pasco	6	11%	4	7%	14	25%	33	58%	57
Pinellas	24	17%	7	5%	34	24%	79	55%	144
Polk	33	15%	9	4%	59	26%	125	55%	226
Seminole	10	9%	6	5%	29	26%	68	60%	113
St. Lucie	1	10%	1	10%	1	10%	7	70%	10
Sumter	1	11%			1	11%	7	78%	9
Aggregate	**529**	**11%**	**224**	**5%**	**1,185**	**25%**	**2,828**	**59%**	**4,766**

Source: hCAT – mDAT Response Table

CarePlus recognizes the diversity and complexity of the most vulnerable members and applies care strategies to target these complex care needs and vulnerable population subsets to create unique interventions. CarePlus programs combine both acute and chronic care management delivered telephonically and on-site. The programs are designed to link physical and behavioral health care to social care allowing members to remain as healthy and independent as possible.

Care Managers work one-on-one with a member to optimize their ability to access needed resources due to their socioeconomic status. Major problems can exist in coordinating benefits, particularly for services such as dental, vision and transportation This disconnect between Medicaid and Medicare can contribute to poor quality of care delivery, and may also impact efficacy of care delivery such as post discharge support. Care Managers often make 3 way calls with the member/caregiver to their primary healthcare provider's office, for example. CarePlus adheres to the terms within each state contract for coordination of benefits and also uses community resource database that provides those hard to locate, local services embedded in the community where the member resides.

The total healthcare expenditures for the most vulnerable population are higher than the remaining D-SNP population. From aggressive care transitions along with systems driven alerts for the Care Managers for post-discharge will continue to attack these utilization and cost issues. Interventions also work to leverage the special benefits augmenting these with additional resources and health support through Medicaid, other supplemental insurance like the Veteran's Administration, and the Community Resource Directory (CRD).

Addressing age, health literacy and elements of cultural diversity amongst the most vulnerable population are integrated into the model of care. For example, written materials sent to the member are a certain font size and are a 4th to 5th grade reading level. The majority of materials are available in English and Spanish. CarePlus, Humana At Home, and Humana Puerto Rico has bilingual staff and access to a language translation line as needed. All member materials need to be reviewed and approved through CMS extensive member communications approval process. Associates are also trained on Behavior Change (Prochaska and DiClemente) and Motivational Interviewing (Rollnick and Miller) evidence based theoretical frameworks, which provide strategies for evaluating understanding member perspectives i.e. reflective listening. Data for D-SNP members relevant diagnoses (high volume/high risk) are continuously reviewed and analyzed to identify initiatives and opportunities for improvement related to the member population. Managing these condition categories will lead to better health and decreased out of pocket dollars for members if they can better manage their condition and adhere to their treatment plan, thus avoiding preventable inpatient hospital stays and emergency room visits, while enhancing members' sense of well-being and satisfaction.

Factor 4: Establish Relationships with Community Partners:

Humana At Home and Humana Puerto Rico tailors care management services provided to CarePlus members who are considered most vulnerable based on the areas of risk that are identified through the approved CMS Health Risk Assessment. . The HRA is used to develop the Individualized Care Plan (ICP) to identify interventions for the member. Below are various ways Humana At Home, Humana Puerto Rico, and CarePlus partners with community resources and tailors these resources to help resolve areas of risk. Due to the immense issues that occur among the most vulnerable population, the process to identify specific community resources is described along with value added items and services available to members. The model of care relies on the expertise of the Care Manager to identify community resources and partners within the member's area of residence that would have the biggest impact on the areas of risk a member faces.

Community Resource Directory / Lists:

Humana At Home uses its Community Resource Directory and team of Community Resource Specialists to establish relationships with community partners and Humana Puerto Rico utilizes a list of community resources to identify the needed resources the partners provide in the local community in the area where CarePlus members reside. Services such as congregate meals, transportation to doctor's appointments, caregiver support group, grab bar and ramp installation are just some examples of these services.

Maintaining the best health possible is not achieved just by "managing a condition". A more holistic approach to a person's life is the best strategy to achieve optimal health. A member is impacted by many environmental and social factors not addressed by health care plans. If there isn't enough food to eat, transportation to get needed physician care or maintaining a safe home to live in to prevent falls, your health will be unstable.

The Community Resource Directory / List helps members who need additional resources other than the ones currently available in their home. The Community Resource Directory/List contains over 30,000 national, state and local community resources that Community Resource Specialists access, modify, and refer to members. The extensive resources range from but are not limited to Adult Day Care, Aging and Disability Resource Centers, Caregiver Programs, Elder Abuse Prevention Programs, Financial Assistance, Home Modification, Senior Housing Options, Senior Center Programs, and Transportation.

Humana At Home's process for partnering with providers within the community to deliver needed services to CarePlus' most vulnerable member includes a specific associate role, Community Research Specialists, who research, identify, and provides appropriate resources for our most vulnerable members.

To facilitate member or caregiver access to community partners and to maintain continuity of services, the CRS provides telephonic assistance to members, confirms receipt and

understanding of resource(s), confirms follow thru is completed or assists in overcoming potential barriers to successful intervention, facilitates 3-way calls to coordinate service delivery, provides updates and edits for Community Resource Directory (CRD). The Community Resource Directory is continually updated as additional community partners and resources are identified or as partners become unavailable. The CRD is accessed through secured documentation platform. The CRD is rigorously maintained to keep content accurate and current. All content is approved for use by staff and members. Resources are located in the CRD using the following functions:

- **Service State –** State must be selected first to start the search for resources.
- **Categories –** All resources in the CRD are assigned a Primary category. Secondary and tertiary categories are assigned as appropriate by the CRS.
- **County –** Narrows search by county or multiple counties.
- **Search –** Search by key word in the organization name or description of services (e.g.: red for Red Cross resources or food for all resources that provide food).
- **National Org** – Expands Search to include national resources.
- **Zip Code** – Narrows search by Zip Code location of the resource.

Resources included in the CRD:

- **National Organizations:** National resources approved and recognized by Humana At Home.

  Examples include: The American Heart Association; The American Diabetes Association; The National Organization of Rare Disorders; and The National Kidney Foundation.

- **Services Providing Assistance on a National Level:**

  Examples include: Disease Specific Support Groups and Education; Advocacy Groups; Caregiver Support; Prescription Assistance Programs; Medical Expense Assistance; Assistive Technology; Financial Assistance; and Food Banks.

- **State Funded Resources:**

  Examples include: Local Medicaid Offices; Food Stamps/Nutritional Services; and Temporary Assistance for Needy Families.

- **State Funded Resources for Older Adults**: Resources provided by the State Unit on Aging or Area Agency on Aging.

  Examples include: Adult Day Care; Aging and Disability Resource Centers; Caregiver Programs; Case Management; Elder Abuse Prevention Programs; Emergency Response Systems; Employment Services; Financial Assistance; Home Repair; Home Modification; Information and Referral; Legal Assistance; Congregate and Home Delivered Meals; Personal Care; Respite Care; Senior Housing Options; Senior Center Programs; Telephone Reassurance; Transportation; and Volunteer Services.

- **Community Based Not for Profit Organizations:**

  Examples include: Community Action Agencies; Food Banks; Financial Assistance; Legal Assistance.

- **Community Based Services provided by Faith Based Organizations:**

  Examples include: Faith in Action

Resources excluded from the CRD:

- **Resources provided by Humana At Home:**

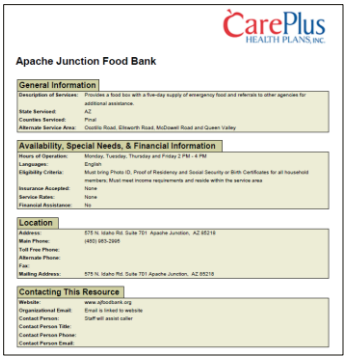
  Examples of excluded resources: Medication Treatment/Therapy Management (MTM); Silver Sneakers; Durable Medical Equipment; Mail Order Pharmacy; Well Dine (after discharge from hospital).

- **For Profit Companies that Provides Services to the General Public:**

  Examples of excluded resources: Long Term Care Facilities; Assisted Living Facilities; and Providers of Medical Services.

Associates are able to submit community resources for approval and inclusion in the CRD within twenty-four hours in order to meet a member's needs. The CRD is accessed through a secured site. Immediate request are reviewed by the CRS. If the resource meets the inclusion and exclusion criteria it will be published in the CRD within the 24 hour business timeframe to be available to members.

Example: Community Resource Information for Member:


CarePlus HEALTH PLANS, INC.

Apache Junction Food Bank

General Information

Availability, Special Needs, & Financial Information

Location

Contacting This Resource

Example: Broward County, Florida:

Broward County Sylvia L Poitier and Theodora S. Williams Senior Center and Alzheimer Day Care Centerhttp://www.adrcbroward.org. Provides; educational and recreational activities, nutrition program, health support, arts and crafts, adult day care, and other activities for area seniors. Provides; transportation to and from the center only. Offers special trips to community events,

luncheon outings, and specific retail vendors. Members of adult day care are provided transportation.

Edgar P. Mills Multi-Purpose Center http://www.broward.org. Provide the following services: integrated intake, assessment, and case management and rent/mortgage and utility assistance. The organization also offers information and referrals for the following: job training and employment; housing counseling; legal aid services; budget counseling; family support services; subsidized child care

Example: Miami-Dade County, Florida:

Jewish Community Services of South Florida, Inc. http://www.jcsfl.org/. Provides home delivered meals; information and referrals to various community agencies and adult day care; wheelchair accessible transportation; shopping assistance; supports numerous Miami area senior centers; clinical behavioral health services; substance abuse services; kosher food bank; minor home repairs etc.

North Dade Adult Day Care. http://www.miamidade.gov/. Provides a variety of health, social and related support services in a protective setting during the day. Each day, participants receive: nutritious meals (breakfast and a hot lunch); and transportation (if the family cannot provide it) to and from the centers.

Example: Palm Beach County, Florida

New Hope Charities, Inc - Main Office. http://www.newhopecharities.com/. Offers Food distribution to needy families; Health and Nutrition Classes, including nutritious snacks; Computer Learning Center; Recreational Programs; Literacy Classes for children and adults; ESOL (English Classes) for Adults; and more.

Specialized Adult Day Service Center - West Palm Beach. http://www.alzcare.org. Provides a day program for individuals living with Alzheimer's Disease. Day program services include the following: Routine health maintenance by a licensed nurse; An individually-tailored, therapeutic activities program; Care for incontinent and wheelchair-bound patients; Assistance with personal care; Nutritious meals and snacks served daily.

Value Added & Special Services:

CarePlus has developed value added items and special services for the identified D-SNP members and those members who meet the criteria of the CarePlus most vulnerable subpopulation. The services and resources offered address the medical, socioeconomic, psychological, and disease specific conditions faced by the dual eligible population for provision of care to this vulnerable population. For example, Humana At Home offers brief In-Home Surveys completed by an In-Home Care Manager for safety and accessibility. Referrals are made by Care Managers to Medication Therapy Management, a free service for eligible participants designed to meet individuals' specific health and pharmacy needs. Additionally, Care Managers offer community service referrals, for example referrals for assistance with activities of daily

living or palliative care. Care Managers offer end of life planning and social service interventions as needed including health education materials at no cost to the member.

Care Managers also are a key component to developing community partnerships, particularly the person-to-person contact. This field presence and the local connections the Care Managers and community health educators are able to establish with community-based services ensure members are connected with the appropriate resources in their own communities.

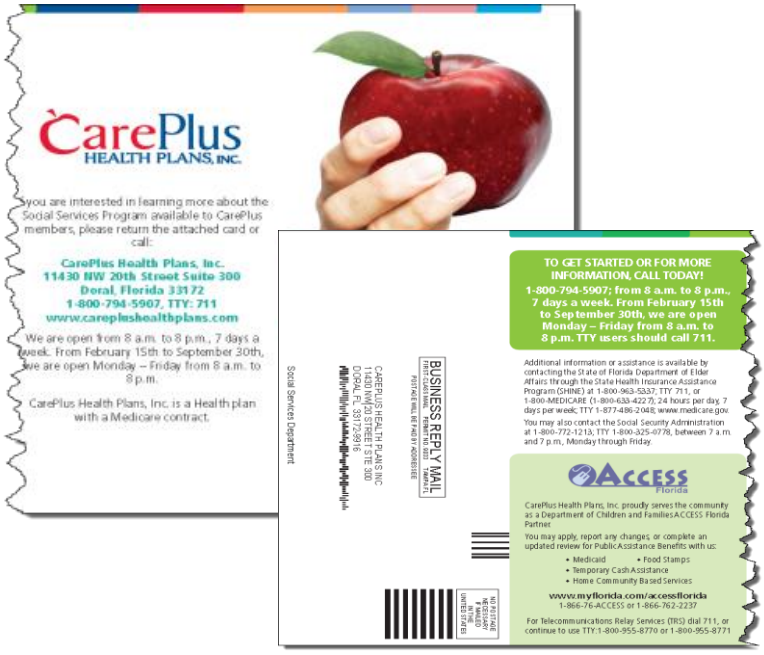
Examples of special services offered in 2015 include:

- Dental, Hearing, Vision services
- Chiropractice services
- Diabetic Supplies and services
- Foot Care
- Hearing services
- Outpatient Substance Abuse
- Transportation services
- Wig Benefit (Members in Miami-Dade County who have undergone cancer treatment)
- Mental Health Targeted Case Management services
- Assistive Care services
- Alcohol misuse couseling
- Depression screenings

CarePlus Social Services Department: State & Federal Financial Assistance Programs:

CarePlus makes every attempt to maximize access to state and federal programs. In an effort to provide CarePlus members with information about benefits they may be eligible to receive through Medicaid, the CarePlus Social Services Department evaluates and outreaches to assist the member in these efforts. The CarePlus Social Services Department supports members with financial needs to assess eligibility and facilitate application to a variety of state and federal programs. They also support the member with the recertification of dual eligibility. Members identified with limited income and assets are referred to this team for issues including, but not limited to: food stamps, Florida Comfort Choice or Senior Choice, and State and Federal financial support programs. Financial and social issues are identified as contributors to increased readmissions and ER visits in the elderly and chronically ill population.

Example: CarePlus: Social Service Brochure:



MOC 2: CARE COORDINATION:

ELEMENT A: SNP STAFF STRUCTURE:

Factor 1: Administrative Staff Roles and Responsibilities:

CarePlus, Humana At Home, and Humana Puerto Rico have a functional structure to ensure all required services are coordinated through qualified staff with appropriate oversight. Roles include clinical and administrative functions for CarePlus, Humana Puerto Rico and Humana At Home.

CarePlus and Humana Administrative Roles:

Appeals & Grievance Department: Designated staff who handles appeals and grievances by following processes outlined by CMS for addressing and responding to appeals and grievances and complaints and by following all regulatory requirements. This also includes notification of rights, prompt, appropriate action including set time frames for conducting a full investigation of the appeal or grievance and following all regulatory guidelines for written responses to the appeal or grievance.

Billing and Enrollment: Processes all enrollment and disenrollment requests and corresponds accordingly with CMS. This department also mails ID Cards, Evidence of Coverage, and SNP

Welcome Kits to members, processes premiums and changes on payments that member's request.

CarePlus Social Services Department: Educates members on available programs they may qualify for, and assists members to apply for public assistance through a variety of state and federal programs at no cost. This department also serves the community as a Department of Children and Families ACCESS Florida partner.

CarePlus Utilization Management: Collaborates with other health care providers in reviewing actual and proposed medical care and services against established clinical review criteria. The UM Nurse also assists with discharge planning for members admitted to inpatient facilities and is able to identify potential unnecessary services and care delivery settings and recommend alternatives where appropriate. The Utilization Management committee is responsible for review of utilization data and related statistics, analysis of trends, and recommendation for improvement strategies.

Claims Organization: Receives and processes claims in compliance with CMS guidelines and timeframes. Claims Organization offers Real Time Claims Adjudication enables providers to bill for service before the Member leaves the office and to receive a fully adjudicated response back –at the time of service. Claims Organization ensures prompt payment of claims within the time required by the agreement or the applicable regulation of the state of Florida.

Clinical Outcomes and Data Analytics (CODA): Specific oversight of data analyses for utilization is performed by the team including but not limited to building predictive models, shape study design for clinical interventions, developing and evaluating metrics on utilization and cost, and performing analytics on quality measures and shape strategy.

Corporate Compliance Department: Manages regulatory compliance requirements outlined by CMS. Establishes and implements effective systems for routine auditing and monitoring and oversees compliance with Medicare Part C and D requirements.

Credentialing Department: Establishes the qualifications of licensed professionals and organizational providers and assesses their background and legitimacy. This department ensures that all network practitioners and providers meet qualifications for credentialing and re-credentialing.

Member Services Representatives: Coordinates customer service and conducts welcome calls to provide guidance and support. Member Services Representatives ensure plan information has been received and is understood by the member, coordinates PCP assignment changes, and are also responsible for the clarification and resolution of issues and complaints. They work with members on an ongoing basis to help clarify information and resolve issues. This department also mails ID Cards, Evidence of Coverage, and SNP Welcome Kits to members.

Provider Engagement Division: Responsible for network development, contracting, and operational support. This department is also responsible for coordinating physician education and communication.

Quality & Accreditation Department: Designated staff that handles the QIPs (Quality Improvement Projects) and CCIPs (Chronic Care Improvement Programs), Accreditation submissions, and manages yearly HEDIS submissions for collecting performance data that is reported to the National Committee for Quality Assurance (NCQA) and Medicare specific measures are reported to CMS.

Quality Operations Department: Coordinates the adoption of Clinical Practice Guidelines (CPGs) from clinically sound and reputable agencies. Quality Operations organizes a corporate physician committee to review the guidelines and to provide recommendations for annual review by the Corporate Quality Improvement Committee (CQIC). Quality Operations ensures that providers use appropriate CPGs by completing a summary report, tracking data over a three year period to determine if clinical guidelines criteria have been met.

Risk Management: Responsible for investigating issues that may have a legal impact on Humana.

Special Investigations Unit (SIU) – Responsible for investigating alleged fraud, waste and abuse of insurance benefits.

Humana Oversight Roles:

Oversight functions are performed by various departments within the organization all of which report to the Corporate Quality Improvement Committee (CQIC) including the SNP Integrated Oversight Committee (SIOC) and the SNP Governance Committee.

Corporate Quality Improvement Committee: Reviews key management reports and other supporting materials on a periodic basis to analyze operational and clinical performance; reviews for adherence to defined requirements by achieving target indicators; and identifies any potential trends, issues, or barriers that might warrant further attention or review of existing operational/business processes. The CQIC voting members are:

- Humana Corporate Chief of Quality
- Humana Corporate Director, Quality Operations, Compliance and Accreditation
- Humana Clinical Advisor MD
- Humana Divisional Director, North Division, Quality Operations, Compliance and Accreditation
- Humana Director, National Network Operations
- Humana Director, HPS Patient Safety
- Humana Process Owner, Corporate Quality Operations, Compliance and Accreditation
- Humana Vice President, Clinical Quality & Outcomes
- Humana Divisional Director, Eastern Division, Quality Operations, Compliance and Accreditation

- Humana At Home Director, Quality Clinical Programs and Services
- Humana Compliance Advisor, Commercial and Specialty Compliance
- Humana Strategic Consultant, Corporate Quality Operations, Compliance and Accreditation
- Humana Manager, Corporate Quality Operations, Compliance and Accreditation
- Humana Director, Clinical Strategies
- Humana Divisional Director, East/West Florida Regions and Southern Division, Quality Operations Compliance and Accreditation
- Humana Divisional Director, Central and West Division, Quality Operations, Compliance and Accreditation
- Humana Vice President, Operations, Provider Development COE
- Humana Director, Clinical Intake Team
- Humana Regulatory Compliance Medicare/Medicaid
- CarePlus Divisional Director, Florida and Humana South Florida, Quality Operations, Compliance and Accreditation
- Puerto Rico Divisional Director, Quality Operations, Compliance and Accreditation

SNP Integrated Oversight Committee (SIOC): The overall activity and outcomes of Humana At Home are overseen by the SIOC. The SIOC reports to the Humana Internal Board/Management Team, through Humana's Corporate Quality Improvement Committee (CQIC). Additionally, the SIOC ensures the oversight at the Humana At Home level of integration of care transition protocols and data analyses of utilization. Members include but are not limited to:

- Senior Product Development Management, Process Consultant (Chair)
- Senior Vice President, Consumer Engagement
- Segment President, Retail
- Vice President, Product Design
- Strategic Executive
- Vice President, Humana At Home
- Director, Account Services
- Director, Risk Adjustment
- Director, Compliance
- Field Vice President, Provider Development
- Director, Financial Planning and Trend Analysis
- Strategic Consultant, Financial Planning and Trend Analysis
- Risk Leader, Medicare and Medicaid Compliance
- Risk Advisor, Medicare and Medicaid Compliance
- Director, Medicare and Medicaid Compliance

- Process Manager, Licensure and Business Partner Compliance
- Director, Senior Products Implementation
- Process Manager, CMS Contracting Management Unit
- Risk Advisor, CMS Contracting Management Unit
- Implementation Advisor, CMS Contracting Management Unit
- Directors, Market Quality Compliance
- Process Owner, Market Quality Compliance
- Manager, CarePlus Quality and Accreditation
- Market Vice President, Market Clinical Strategies
- Market Vice President, Market Clinical Senior Products (Chair)
- Director, PDP Product Design
- Director, Strategy and Business Planning
- MOC Implementer Representatives

SNP Governance Committee: Newly formed committee to oversee the standardization of the Humana Special Needs Plans across all Model of Care implementers. The committee will work to improve outcomes, increase transparency, create a forum to discuss SNP related issues and concerns, showcase best practice and streamline processes. Members include but are not limited to:

- Vice President, Senior Products
- Vice President, Product Design
- Vice President, Humana At Home
- Vice President, Product Development
- Director, Product Development
- VP, Compliance
- Risk Leader, Medicare and Medicaid Compliance
- Risk Advisor, Medicare and Medicaid Compliance
- Director, Medicare and Medicaid Compliance
- Process Manager, Licensure and Business Partner Compliance
- Director, Licensure and Business Partner Compliance
- Risk Leader, Licensure and Business Partner Compliance
- Consultant, Licensure and Business Partner Compliance

- Process Manager, CMS Contracting Management Unit
- Risk Advisor, CMS Contracting Management Unit
- Implementation Advisor, CMS Contracting Management Unit
- Directors, Market Quality Compliance
- Process Owner, Market Quality Compliance
- Director, Internal Audit
- Manager, Internal Audit
- VP, Internal Audit
- Regional President, Sr Markets - Regional
- Regional Medical Director, Market Clinical - Sr Prd – Regional
- Market Vice President, Market Clinical Strategies
- Market Vice President, Market Clinical Senior Products (Chair)
- Medical Director, Market Clinical Strategies
- MOC Implementer Representatives

CarePlus Oversight Roles:

CarePlus Health Services Quality Committee: The HSQC is a standing committee, which provides a quality improvement and health services forum for provider participants to represent the provider network, and to provide oversight of the clinical aspects of the Plan's Quality Improvement Program and the Health Services Program for the state of Florida. The HSQC identifies opportunities for improvement and assures a mechanism by which quality improvement strategies are developed. The committee also analyzes utilization data to identify trends and opportunities to improve the efficient delivery of quality medical care. This committee derives its authority from the Internal Board/Management Team via the Corporate Quality Improvement Committee. The HSQC has delegated peer review activities to the Peer Review Committee and credentialing decisions to the Humana Corporate Credentialing Committee. HSQC voting members include:

- Chairperson (shall not vote except in the instance of a tie)
- CarePlus Chief Medical Officer
- CarePlus Medical Director
- CAC Florida Medical Center Medical Director

- Network physicians, selected to provide perspectives from primary and specialty care from the geographic areas in the state of Florida

Humana Puerto Rico SNP Administrative & Oversight Roles:

Humana Puerto Rico Department Directors partner with other care management directors and teams to ensure appropriateness and quality standards are maintained, provide consultation and give clinical guidance as needed:

- Director of Operations
- Director of Health Services
- Medical Director

Humana Puerto Rico Quality Management Department supports clinical activities. As part of their processes, they work with each of the health plan areas to identify interventions to educate members, encourage preventive health interventions, identify, track and trend quality initiatives, and work with our provider community to educate them regarding member needs, and standards of care. QM also provides oversight and support to identify and mitigate potential quality issues (PQIs). Is also responsible for end-to-end chart audit processes including sampling, chart reviews, data analysis, and trend reporting. Facilitates clinical quality reviews on member records and critically evaluates the quality of direct member care management and coordination.

- Quality Review Program Front Line Leader
- Quality Review Nurse
- PODS Nurses

Healthcare Economics Unit (HCE) Data Analysis Unit work closely with Health Guidance Organization staff, business units and external partners to facilitate processes, analyze and report information and design solutions that support business needs. Assignments may include working with the business units, systems and data related to finance, medical claims, medical risk adjustment, membership profiling, provider networks, and quality.

- HCE Consultant
- HCE Data Analyst

Humana At Home SNP Administrative & Oversight Roles:

Humana At Home Department Directors partner with other care management directors and teams to ensure appropriateness and quality standards are maintained, provide consultation and give clinical guidance as needed:

- Director of Operations
- Director of Clinical Innovations
- Medical Director

Humana At Home Quality and Compliance Department facilitates all quality and regulatory activities to meet Humana At Home program compliance requirements in conjunction with NCQA, CMS, and quality programs.

- Quality Compliance Program Manager
- Quality Compliance Process Manager
- Quality Compliance Consultant
- Quality Compliance Analyst
- Quality Compliance Project Manager
- Quality Risk Management Consultant
- Quality Compliance Policy Consultant

Humana At Home Program Design in consultation with Clinical Operations facilitates end-to-end program development and supports the implementation plan for Humana At Home initiatives.

- Program Design Program Manager
- Program Design Process Manager
- Program Design Analyst
- Program Design Project Manager
- Clinical Quality Process Manager
- Registered Dietitian
- Clinical Pharmacist

Humana At Home Quality Management is responsible for end-to-end chart audit processes including sampling, chart reviews, data analysis, and trend reporting. Facilitates clinical quality reviews on member records and critically evaluates the quality of direct member care management and coordination.

- Quality ManagementProgram Manager
- Quality ManagementNurse
- Quality Management Analyst

Humana At Home Learning and Development Department responsibilities include the development and implementation of an education and training strategy to meet the needs of the Humana At Home SNP associates from initial onboarding through professional development.

- Learning and Development Program Manager
- Learning and Development Process Manager
- Learning Consultant

- Learning Specialist

Humana At Home Reporting & Analytics Department of Humana at Home supports the Quality and Compliance department of Humana at Home for an extensive set of compliance metrics, in addition to a wide variety of reporting requests. The Reporting & Analytics department of Humana at Home also proactively provides data to care management teams to identify and close compliance and performance gaps, as well as being directly responsible for the annual SNP Part C HRA reporting to CMS, and providing supplemental data for HEDIS for Care of Older Adults.

- Reporting & Analytics Manager
- Reporting & Analytics Data Analyst

Factor 2: Care Management Staff Roles and Responsibilities:

Humana At Home and Humana Puerto Rico operates within an interdisciplinary model of care and is responsible for coordinating care in a seamless manner across the continuum using an Interdisciplinary Care Team (ICT) approach for CarePlus members. The ICT's overall care management role includes member and caregiver advocacy, health support, health coaching and education and support of the member's self-care management and ICP.

Humana Puerto Rico:

CarePlus Primary Care Provider (PCP): Encourages health promotion and disease prevention in addition to routine primary care and coordination of specialty referral resources when necessary. As the clinical leader of the ICT the PCP contributes to the development of the care plan, ICT meetings, and coordinates care with other specialty providers as participants of the ICT.

Care Managers (CM): Humana Puerto Rico Care managers are registered nurses; with bachelor or master degree in nursing; and more than 3 years of clinical experience. The Care Manager has the responsibility for the management and coordination of member care. Care Managers will refer for an in home assessment for members in the severe level of intervention if warranted. Telephonic contact is initiated; and assessments are completed to identify member's needs. Needs are prioritized in the individualized care plan and services are coordinated accordingly.

Social Worker (SW): Humana Social Workers are the social service, mental health, and community resource expert for the Interdisciplinary Care Team. The Social Workers completes physical, psychological, emotional and environmental assessments, for the purpose of providing appropriate, timely interventions to ensure provision of optimal care. In addition, they work

collaboratively with other members of the Case Management Interdisciplinary team-to include; Care Managers, Field Case Managers, and community-based resources, etc.

Humana Puerto Rico Specialists: Provides assistance to members with questions, participate in care management program enrollment, and connects members with the appropriate care management staff and Humana resources. Specialists are responsible for initiating call attempts to complete Initial and Annual Health Risk Assessments.

CarePlus Medical Director: Provides physician oversight and consultation.

CarePlus Clinical Pharmacist: Provides pharmacy consultation and case review for members with complex medication needs. Provide monitoring, education and support for enrollee's medication regimens, which play a central role in many Medicare Medicaid enrollees' health care.

Behavioral Health Support: Behavioral health support is provided by independently licensed behavioral health clinicians who are immediately available to the ICT. The behavioral health support specialist may be a psychiatrist, psychologist, Master's degree level clinician, or nurse with psychiatric expertise.

CarePlus Field Case Manager (CPFCM): A registered nurse, licensed practicing nurse, or foreign medical graduate that provides onsite assessment and care coordination at the bedside when a member is in an in-patient status at an acute, rehabilitation or Skilled Nursing Facility, if needed. The CPFCM role assess, plan, implement, coordinate, monitor and evaluate the options and services required to meet the member's health and social service needs. The role is characterized by advocacy, communication and resource management to ensure appropriate, timely and quality transition of care. The CPFCM communicates and works collaboratively with the Humana At Home telephonic Care Manager to ensure continuity of care regardless of the place of service. The CPFCM also collaborates with other health care providers in reviewing actual and proposed medical care and services against established clinical review criteria. The CPFCM also assists with discharge planning for members admitted to inpatient facilities and is able to identify potential unnecessary services and care delivery settings and recommend alternatives where appropriate. The CPFCM holds a current license in the state of Florida and has clinical nursing experience, preferably in acute care, skilled, or rehabilitation clinical setting.

Humana At Home:

Members identified as high intensity and high levels of intervention (LOI) are assigned to a primary Care Manager who is a Humana Care Manager (HCM). Members identified as medium and low LOI are assigned to a primary Care Manager who is a Humana Care Coordinator (HCC). Members with an involvement level of Monitored are assigned to a Humana Care Coordinator

to provide outreach for member engagement. The core ICT may also include medical, social services, and behavioral health specialists.

Primary Healthcare Provider (PCP): The PCPs serve on the core interdisciplinary team and supports the member throughout the treatment regimen in conjunction with the Care Manager and other members of the member's interdisciplinary care team. CarePlus will work along the continuum of care to support PCPs to become Patient Centered Medical Home accredited.

Primary Care Managers:

Humana Care Managers (HCM): The HCM is a registered nurse or social worker. The HCM assumes responsibility for the management and coordination of care assigned members, as well as provides clinical support, consultations, and reviews for HCC staff. Telephonic contact is initiated, and surveys are completed per protocol on an as-needed basis. The HCM prioritizes member needs, educates and promotes member self-management strategies, initiates and updates the ICP, engages other members of the care team and refers to internal and external resources as necessary. HCMs who are registered nurses possess three or more years of clinical experience, and have exceptional communication, interpersonal and technical skills. Those that are social workers have a minimum of three years of case management experience and hold a Master's degree in Social Work (MSW), Master's degree in a related field, or Bachelor's degree in Social Work. Humana At Home staffs HCMs specializing in complex medical or behavioral conditions.

Humana Care Coordinator (HCC): Humana Care Coordinator (HCC): Responsible for engaging members in care management, identifying the individual member's stratification through the use of provided tools, reviewing the member's needs after discharge from an inpatient facility, making referrals as needed to appropriate levels of care, and referring the member to available Humana resources, community resources, and the ICT for assistance. The HCC provides ongoing support to SNP members in medium and low risk levels of intervention (LOI), and the Monitored involvement level, including assisting with Medicaid recertification, access to Medicaid benefits, and connections to community resources. Refers to HCM for member clinical issues, questions, and needs. HCCs have a minimum of two years combined experience as a medical assistant or certified nurse assistant, health related field, or care management, and/or degrees in psychology, health education, or social work.

Interdisciplinary Care Team Members:

1. **Referral Specialists, Referral Intake Specialists and Care Concierge Staff:** Provides assistance to members with questions, participate in care management program enrollment, and connects members with the appropriate care management staff and resources.
2. **Humana Care Manager - Social Services (HCM-SS):** The HCM-SS is the social service, mental health, and community resource expert for the ICT. The HCM-SS completes physical,

psychological, emotional, and environmental telephonic surveys geared toward the appropriate and timely provision of interventions leading to optimal care. They work collaboratively with other members of the ICT, including HCM, IHCMs, HCCs, and CHEs. HCM-SS have a minimum of three years of case management experience and hold a Master's degree in Social Work (MSW), Master's degree in a related field, or Bachelor's degree in Social Work (BSW).

3. **In-Home Care Manager (IHCM):** The IHCM is responsible for providing brief in-home surveys to SNP members stratified in all levels of intervention. The IHCM is a nurse or social worker, or other related discipline. Nurses in the IHCM role are licensed nurses or hold a degree in social work or related field i.e. gerontology. As part of the ICT and in conjunction with the primary care manager, IHCMs conduct health reviews and needs identification, plan, implement, coordinate, monitor, and evaluate the options and services required to meet the member's health and social service needs. This role supports care coordination, advocacy, communication, and resource management for the Member. This role may be filled by Humana associates or contracted network Care Managers. IHCMs possess 5+ years of experience in home care or care management OR have 3 years' experience with in-home care management with a Humana services or healthcare related degree/diploma.
4. **Community Health Educator (CHE) & Field Community Health Educators (Field CHE):** Provides connections to health education and community resources and has a keen knowledge of local, state and national health and social service agencies, community resources, and physician and provider services. CHEs hold Associates degree or higher in Mental Health or Health related field with 1-3 plus years of experience in health promotion, health coaching, health outreach and/or wellness education, as well as knowledge of community health and social service agencies and resources.
5. **Humana At Home Coach / Manager:** Supervises care management staff and supports ICT coordination to impact the member experience.
6. **Humana At Home Medical Director:** Provides physician oversight and consultation.
7. **Humana At Home Clinical Pharmacist:** Provides pharmacy consultation and case review for members with complex medication needs.
8. **Humana At Home Dietitian:** Provides dietary consultation and case review for members with complex nutritional needs.
9. **Hospitalist:** These individuals are physicians responsible for coordinating a hospitalized member's clinical needs throughout their admission and understand the overall care transition process back into the home and community setting.
10. **Community Pharmacists:** Provides pharmacy consultation and case review for members with complex medication needs. Community Pharmacists provide monitoring, education and support for member's medication regimens, which play a central role in many Medicare Medicaid members' health care.
11. **Behavioral Health Support:** Behavioral health support is provided by independently licensed behavioral health clinicians who are immediately available to the ICT. The behavioral health support specialist may be a psychiatrist, psychologist, Master's degree level clinician, or nurse with psychiatric expertise.

12. **Specialists:** A broad array of specialist physicians attend to members' specific needs to address chronic conditions as well as acute conditions that arise.
13. **CarePlus Field Case Manager (CPFCM):** A registered nurse, licensed practicing nurse, or foreign medical graduate that provides onsite assessment and care coordination at the bedside when a member is in an in-patient status at an acute, rehabilitation or Skilled Nursing Facility. The CPFCM role assess, plan, implement, coordinate, monitor and evaluate the options and services required to meet the member's health and social service needs. The role is characterized by advocacy, communication and resource management to ensure appropriate, timely and quality transition of care. The CPFCM communicates and works collaboratively with the Humana At Home telephonic Care Manager to ensure continuity of care regardless of the place of service. The CPFCM also collaborates with other health care providers in reviewing actual and proposed medical care and services against established clinical review criteria. The CPFCM also assists with discharge planning for members admitted to inpatient facilities and is able to identify potential unnecessary services and care delivery settings and recommend alternatives where appropriate. The CPFCM holds a current license in the state of Florida and has clinical nursing experience, preferably in acute care, skilled, or rehabilitation clinical setting.
14. Regional Associates – Facilitate and collaboratively work with HAH to administer and document the mDAT to improve star quality reporting. Regional Associates may include Clinical Quality Improvement Nurses and non-clinical Specialists. Quality Improvement Nurses are registered nurses/LPNs experienced in utilization management or hospital or physician office practice with knowledge of quality improvement focused on HEDIS, Stars, and CMS requirements. Specialists have a minimum of a high school degree and demonstrate excellent communication skills.

Factor 3: Coordination of Responsibilities and Job Title:

Humana Puerto Rico:

Coordination of staff responsibilities are identified by member risk stratification. Corresponding titles are a result of the members' severity level. The SNP operations team is led by CM Manager and Front Line Leaders who directly manage Care management staff, Social worker and Specialists.

The Care Manager serves as the primary point of contact for SNP members and is responsible for the implementation and oversight of all aspects of the plan of care. They also coordinate the ICT and engage field staff as needed based on member needs. Care Managers manage a seamless transition of care across the continuum through evaluation of member's needs after discharge from in-patient settings and by making referrals as needed to appropriate levels of care and resources. They identify barriers to achieving goals and facilitate member specific ICP interventions including education, referrals, and care coordination to address barriers to assist members in meeting their goals.

Members are stratified as Severe, High, Medium or Low and managed according their severity level by Care Managers who provide telephonic care management and care coordination services. Care Managers assist the member in connecting the member with community resources such as transportation, respite care, food, home modifications, durable medical equipment and home health coordination, and alternative living arrangements.

Humana Puerto Rico makes every effort to provide the right member with the right care management services at the right time to best meet the member's needs. Frequency of interaction is determined by the Care Manager and the member and is based upon ongoing evaluations of member needs and risk stratification. They have the flexibility to determine the need for more intensive outreach and to recommend additional team interventions. Members are encouraged to call their Care Manager at any time and to participate in establishing impactful interventions. In instances when a member's need level exceeds the current level of intervention members are moved to a new level of intervention.

In addition, members of the ICT will be assigned by the Care manager as member needs or ICT recommendations indicate. These assignments may include, but are not limited to, the following disciplines:

- Primary Care Physician
- CarePlus Member Services
- Community Resource Specialist
- Social Worker
- Home Health Services
- RxMentor for Medication Therapy Management
- RightSource for mail order pharmacy and Part B diabetes supplies
- Medical Specialists
- Therapy Service
- Any other agency/person(s) involved in the care of the member

Humana Puerto Rico activities may include but are not limited to:

- Conducting HRA and/or condition-specific individual member surveys, including medication reviews and depression screenings
- Developing individualized care plans (ICPs)
- Identifying and facilitating implementation of interventions related to the member's ICP
- Supporting self-care management and condition knowledge
- Care transitions support
    - General needs/ADL surveys
    - Discharge plan support
    - Cognitive evaluation and support
    - Medication review and adherence
    - Home Health Services/Durable Medical Equipment/home modification assistance
- Identifying and facilitating access to social services including:

- Transportation
- Meal delivery
- Community services
- Financial assistance
- Caregiver support resources
- Follow-up care appointments
- Language translation

- Facilitate referrals to health services including, but not limited to:
  - Medication Therapy Management
  - Humana Pharmacy
  - Behavioral health
  - Hospice

Humana At Home:

The Primary Care Manager serves as the primary point of contact for SNP members and is responsible for the implementation and oversight of all aspects of the plan of care. They also coordinate the ICT and engage field staff as needed based on member's needs. Primary Care Managers manage a seamless transition of care across the continuum through evaluation of member's needs after discharge from inpatient settings and by making referrals to appropriate resources. They identify barriers to achieving goals and facilitiate member specific ICP interventions including education, referrals, and care coordination to address barriers to assist members in meeting their goals.

Members also have access to CarePlus Nurse Care Hotline, 24 hours a day, seven days a week for triage and recommendations. By contacting CarePlus Nurse Hotline members have a direct line for answers to many health related questions. In addition, CarePlus nurses work with primary care physicians to ensure a member gets the best care possible. The Nurse Hotline can assist members with:

- Tips for healthy living
- Advice on minor illnesses or injuries
- Answering condition specific questions or even about upcoming surgeries, procedures, or preventive care such as immunizations

Care Managers make every effort to provide the right member with the right care management services at the right time to best meet the member's needs. Frequency of interaction is determined by the Care Manager and the member and is based upon ongoing evaluations of member needs and risk stratification. They have the flexibility to determine the frequency of outreach and to recommend additional team interventions. Members are encouraged to call their Care Manager at any time and to participate in establishing impactful interventions. In instances when a member's need level exceeds the current level of intervention members are moved to a new level of intervention. To accommodate operational changes, system

capabilities allow for changes in ownership to a new Care Manager. To ensure a seamless transition for the member, the newly assigned, Care Manager, on the next outreach call introduces themselves to the member. In some instances, a member whose level of intervention may improve the same process occurs allowing for ownership to be assigned to a new Care Manager and the same introductory outreach occurs.

In addition, members of the ICT will be assigned by the Care Manager as member needs or ICT recommendations indicate. These assignments may include, but are not limited to, the following disciplines:

- CarePlus Health Services Organization Prior Authorization Team
- Community Resource Specialist
- External Social Services
- Home Health Services
- Medication Therapy Management
- PresribeIT for mail order pharmacy
- Medical Specialists
- Therapy Service
- Any other agency/person(s) involved in the care of the member

Activities may include but are not limited to:

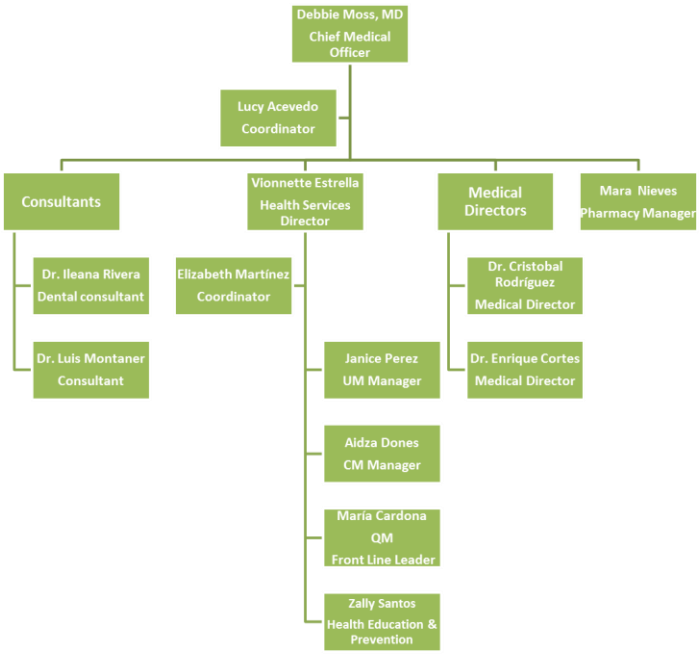
- Conducting mDAT and/or condition-specific individual member surveys, including medication reviews and depression screenings
- Developing individualized care plans (ICPs)
- Identifying and facilitating implementation of interventions related to the member's ICP
- Supporting self-care management and condition knowledge
- Care transitions support
- Identifying and facilitating access to social services including:
  - Transportation
  - Meal delivery
  - Community services
  - Financial assistance, including Dual Eligible/LIS Application
  - Caregiver support resources
  - Follow-up care appointments
  - Language translation
- Identifying and facilitating In-Home Surveys (IHS) for:
  - Observation of self-monitoring of blood pressure, blood glucose, foot check, weight
  - General needs/ADL surveys
  - Discharge plan support
  - Home safety surveys
  - Home Health Services/Durable Medical Equipment/home modification assistance
  - Cognitive evaluation and support

- Caregiver training and support
- Community based Social Service coordination
- End of Life/Advanced Directives
- Medication review and adherence
- Lifestyle habits

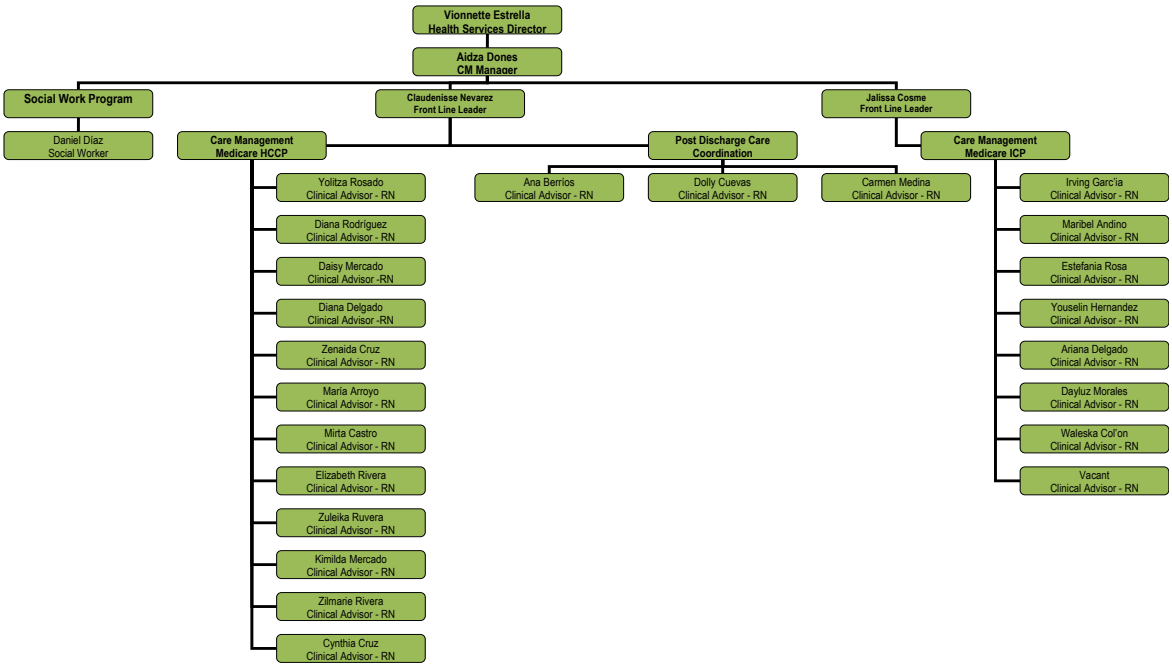
- Facilitate referrals to health services including, but not limited to:
  - Medication Therapy Management
  - Mail Order Pharmacy
  - Behavioral Health
  - Hospice

CarePlus Special Needs Plan Operations Organizational Chart:

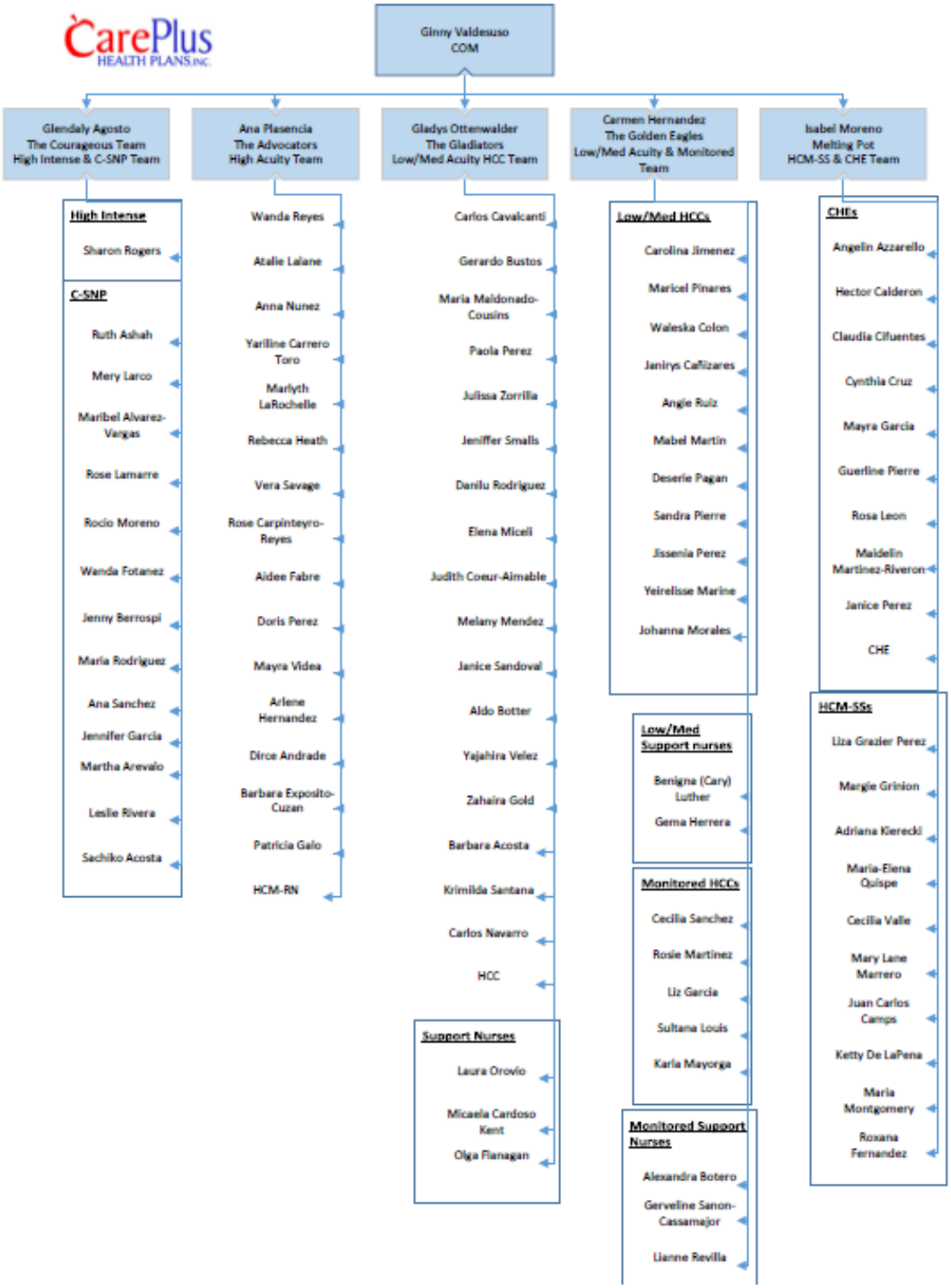
Humana Puerto Rico Health Guidance Organization:



Humana Puerto Rico Case Management Department:



Humana At Home:



CarePlus Member Experience Map with Coordination of Responsibilities:

Factor 4: Contingency Plan:

Humana Puerto Rico:

It is the Humana Puerto Rico associate's direct manager's responsibility to ensure continuity of care and also confirm that tasks sent to Care Managers who are not working at the time a task becomes due are addressed within the established timeframe. In the event that a Care Manager is no longer with the company, or that the associate is off from work for any reason, it is the responsibility of the front line leader to reassign the task for contact on the day the task is received to another Care Manager. Chart and telephonic audits are also performed to ensure ongoing continuity of staff functions. These audits are conducted to promote clinical best practice standards and confirm associate adherence to care management program policy and procedures. Humana Puerto Rico Care Management Front Line Leaders ensure documentation requirements are met and that all associates are working toward continuously improving their care management skills through call and chart audits. This helps the associates in establishing goal-directed member-focused contacts. The Quality Compliance Nurse assists the Care Management Team ensuring compliance with Model of Care (MOC) SNP requirements through quarterly audits and also identifies areas of opportunity that require follow-up by the associate to support Humana procedures and regulatory requirements.

Audits are focused either on a specific process that needs improvement, a full internal fact-finding project, or specific to regulatory requirements. The Quality Compliance Nurse meets with each CM managers during each audit cycle to review and provide interpretation of the audit definitions and results as to how the Front Line Leaders can utilize these results to coach their associates. This assists in maintaining consistency in interpretation, inter-rater reliability and in coaching.

Additionally, in the event of natural disasters, Humana Puerto Rico staff has virtual work Puerto Rico environments established to maintain continuity of care for members. Humana Puerto Rico associates reside in various geographic regions around the United States ascertaining the

ability to allocate staff to members as a contingency plan. In the event of inclement weather it is the responsibility of the Humana Puerto Rico In-Home Care Manager to contact the member to reschedule on-site visits if weather prohibits an onsite visit for the safety of the member and Care Manager. Processes developed include among others:

- Cross training to associates from different areas and departments in case of absenteeism, sick leaves, etc.
- Development of a Business Continuity Plan for the organization operational areas.
    - Plan Creation or Maintenance: Business areas will complete a Business Continuity Plan that describes the process to be followed in case of a disaster to minimize the impact in operation and services provided to our members.
- Time of Disaster:
    - A Crisis Management Team to assist in determining and prioritizing resources to support recovery efforts.
- Plan owners develop plans to support a worst-case scenario:
    - Facilities, associates, and/or technology is affected by the event
    - Event could occur during or after business hours
    - Entire building or campus is impacted and building is not accessible to this business area for extended period up to six months
    - Key business area associates are not available to assist in the recovery
- This plan supports tasks and resources from time of disaster notification to when the business areas can perform day-to-day processes using documented procedures.
- Business areas maintain day-to-day procedure documentation and store it on a file server (shared drive) backed up by Information Technology.
- Business areas have documented the system accesses necessary for associates to perform day-to-day processes.
- Business areas should create plans so others outside of this area with industry knowledge could complete the recovery of business processes.
- Pre-defined functional priorities will determine how the Crisis Management Team will allocate recovery resources during a disaster.
- Associates take company assigned laptops home with them at the end of each day.
- Business Function/Process Recovery Phase should include tasks, as appropriate, to:
    - complete salvage efforts;
    - reconcile, recreate, or re-request lost work-in-process;
    - determine regulatory impacts (waivers/extensions);
    - train new resources, if not completed elsewhere in the organization;
    - reschedule and process inputs/outputs to bring business process and systems current; and,
    - Modify day-to-day procedures to include manual procedures because of the event.
- Associates maintain critical information and/or data on file servers (shared drives) backed up by Information Technology and not on PC or laptop hard drives.

- Locations are five to ten miles from the affected Humana building or campus and survive the disaster event.
- Building evacuation plans and other life safety procedures are in place and exercised regularly.
- Information Technology and Application Teams can recovery IT Infrastructure and applications within 96 hours.
- In case of a widespread disaster, people are more concerned for their families and homes than the recovery efforts of their employer.
- Associates that are available to assist in recovery efforts may need to travel, work extended hours, work different shifts, or perform tasks outside of their normal job assignment.
- If associates required to recover business processes are unavailable, Humana will obtain resources from non-impacted business areas or outside sources that have skill sets relative to processes requiring recovery assistance.
- Business areas have considered legal and regulatory requirements in developing the Business Continuity Plan.

Humana At Home:

It is the associate's direct manager's responsibility to ensure continuity of care and also confirm that tasks sent to primary Care Managers who are not working at the time a task becomes due are addressed within the established timeframe. In the event that a primary Care Manager is no longer with the company, or that the associate is off from work for any reason, it is the responsibility of the coach to reassign the task for contact on the day the task is received to another Care Manager. HCM coaches have the opportunity to utilize the Coverage Team. The Coverage Team is specifically dedicated to assisting HCMs who may be out of the office, for example, due to family medical leave, bereavement and/or short term disability. The Coverage Team strives to provide comprehensive coverage by utilizing systematic tools that prioritize member outreach based on model of care priority. Responsibilities of the Coverage Team include, but are not limited to care transitions including admissions and discharges, evaluation of member health concerns and medications, ICPs and completing survey tools to meet regulatory compliance requirements.

Chart and telephonic audits are also performed to ensure ongoing continuity of staff functions. These audits are conducted to promote clinical best practice standards and confirm associate adherence to care management program policy and procedures. Humana At Home Quality Management Team assists Humana At Home Operations to support a smooth transition for new associates to achieve full productivity. The Humana At Home Quality Management Team supports and collaborates with managers and associates in integrating quality and ensuring documentation requirements are met and that all associates are working toward continuously improving their care management skills through call and chart audits. This helps the associates in establishing goal-directed member-focused contacts. The Humana At Home Quality ManagementTeam also identifies areas of opportunity that require follow-up by the associate to support procedures and regulatory requirements.

The Humana At Home Quality ManagementTeam conducts concurrent and cyclical audits. Audits are focused either on a specific process that needs improvement, a full internal fact-finding project, or specific to regulatory requirements. The Humana At Home Quality Management Team's program manager meets with each coach during each audit cycle to review and provide interpretation of the audit definitions and results as to how the coach can utilize these results to coach their associates. This assists in maintaining consistency in interpretation, inter-rater reliability and in coaching.

For roles that include direct contact with members, compliance is ascertained through the chart auditing process which includes both written and recorded records of contact. Associates are assessed annually through the Humana At Home Quality Review Tool. When found to be out of compliance with policies and/or processes related to their practice, or not meeting role expectations, the associate is provided guidance by their direct manager, and a plan for improvement is agreed upon and implemented. If improvement is not accomplished at the expected level, the manager contacts Human Resources for assistance and follows the Humana Associate Work-Life Policies & Processes.

Additionally, in the event of natural disasters, care management associates have virtual work at home environments established to maintain continuity of care for members. Associates reside in various geographic regions around the United States ascertaining the ability to allocate staff to members as a contingency plan. In the event of inclement weather it is the responsibility of the Humana At Home In-Home Care Manager and/or the CarePlus Field Case Manager to contact the member to reschedule on-site visits if weather prohibits an onsite visit for the safety of the member and Care Manager.

Factor 5: Initial and Annual Model of Care Training:

All associates working with SNP members receive mandatory training on the specific MOC elements; training will be conducted during new associate onboarding and annually thereafter. Mandatory annual SNP education is required in order to facilitate program requirements, enhance interdepartmental collaboration, and to emphasize care coordination, and will be conducted within the first quarter of each calendar year.

Humana Puerto Rico:

This includes all key roles within Humana's Interdisciplinary Care Team, including Care Managers, Social Worker, Specialists, the Medical Director, and the Clinical Pharmacist. This training is also mandatory for all staff who are responsible for training associates working with SNP members and for auditing the documentation completed by associates who work with SNP members.

Computer Based Training (CBT) modules are updated annually to provide associates with current year information as well as a review of unchanged information. The training records generated when the CBT is completed and stored in the Humana Learning Center allowing for

follow up at the earliest possible time, to assist SNP associates with becoming compliant with mandatory training. The SNP Model of Care Training will also be provided through live sessions to associates if any problem with the Computer Based Training (CBT) modules occurs.

New SNP Associate Training Overview:

- During new associate on-boarding, those working with the SNP population are provided one-on-one training by the Learning & Development Team.
- During new associate on-boarding, SNP associates are required to complete the Computer Based Training (CBT) MOC module accessed through the HLC or Humana Puerto Rico Training Site within the first thirty (30) days of employment.

Annual SNP Associate Training Overview:

- SNP associates are required to complete the annually updated CBT accessed through the HLC during the first quarter of each calendar year
- Contracted SNP associates are required to take and attest to the SNP training as part of their initial on boarding to Humana Puerto Rico. All those with current SNP assignments are sent annual reminders to complete the training. If a Care Manager receives a SNP assignment, they are instructed to complete the current years training if they have not already done so.
- Humana Puerto Rico also supplements this mandatory training with additional training modules to assist associates to access any further education, which they need

Training Strategies & Content:

Initial training for all associates working with SNP members is conducted as an integral part of orientation on-boarding program. Part of the training occurs face-to-face, and is provided by the Front Line Leaders. Part of the training includes the required completion of the computer-based SNP MOC training that includes the following content:

- What SNPs Are and Types of SNPs
- Enrollment, Plan Availability and Plan Year Requirements
- SNP Model of Care: Health Risk Assessment; Level of Intervention; ICPs; Health Surveys; ICTs; HEDIS and Quality Reporting

In addition, refresher and ad hoc training sessions are provided to both individual associates and groups of associates upon request or as deemed necessary. Refresher and ad hoc training sessions are conducted face-to-face and through the use of audiovisual conferencing capabilities available to all Humana Puerto Rico associates. These training sessions may consist of, but are not limited to:

- Updates to CMS SNP Requirements and Benefits
- Updates to Humana Puerto Rico SNP Model of Care
- Interdisciplinary Care Teams (ICTs) and Individualized Care Plans (ICPs)

Humana At Home:

This includes all key roles within the Interdisciplinary Care Team, including Care Managers, CHEs, HCM-SSs, Referral Specialists, Referral Intake Specialists, the Medical Director, Dietitian, and the Clinical Pharmacist. This training is also mandatory for all members of the Humana At Home Learning & Development Team and Humana At Home Quality ManagementTeam, who are responsible for training associates working with SNP members and for auditing the documentation completed by associates who work with SNP members. CarePlus staff inclusive of CarePlus Field Case Managers, CarePlus Medical Directors, SNP Project Managers also receive mandatory training available on the Humana Learning Center.

Computer Based Training (CBT) modules are updated annually to provide associates with current year information as well as a review of unchanged information. The training records generated when the CBT is completed and stored in the Humana Learning Center allowing for follow up at the earliest possible time, to assist SNP associates with becoming compliant with mandatory training. Network In-Home Care Managers complete the training in the Humana At Home training site. Completion is tracked and reported through survey monkey.

New SNP Associate Training Overview:

- During new associate on-boarding, those working with the SNP population are provided one-on-one training by the SNP Humana At Home Learning & Development Team.
- During new associate on-boarding, SNP associates are required to complete the Computer Based Training (CBT) MOC module accessed through the HLC or Humana At Home Training Site within the first thirty (30) days of employment.

Annual SNP Associate Training Overview:

- SNP associates are required to complete the annually updated CBT accessed through the HLC during the first quarter of each calendar year
- Contracted SNP associates are required to take and attest to the SNP training as part of their initial on boarding. All those with current SNP assignments are sent annual reminders to complete the training. If a Care Manager receives a SNP assignment, they are instructed to complete the current years training if they have not already done so.
- Humana At Home also supplements this mandatory training with additional training modules to assist associates to access any further education, which they need

Training Strategies & Content:

Initial training for all associates working with SNP members is conducted as an integral part of two-week orientation on-boarding program. Part of the training occurs face-to-face, and is provided by members of the Humana At Home Learning & Development and Humana At Home

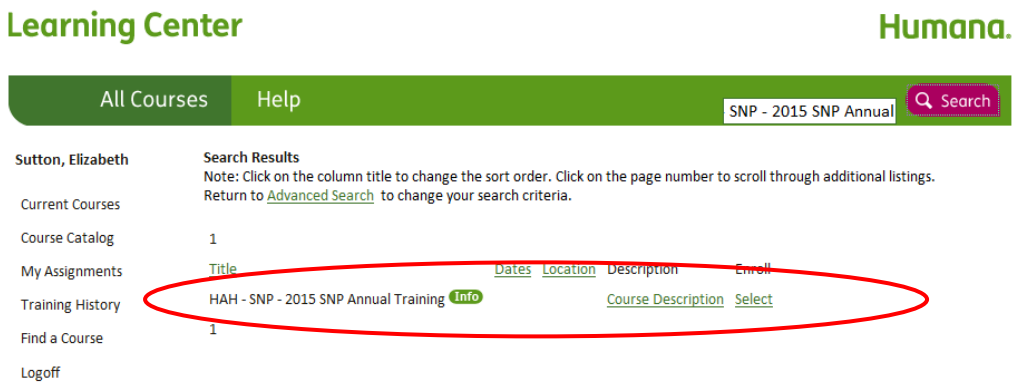
Clinical Strategy and Program Design Team (specifically, Trainers). Part of the training includes the required completion of two computer-based training modules that include the following content:

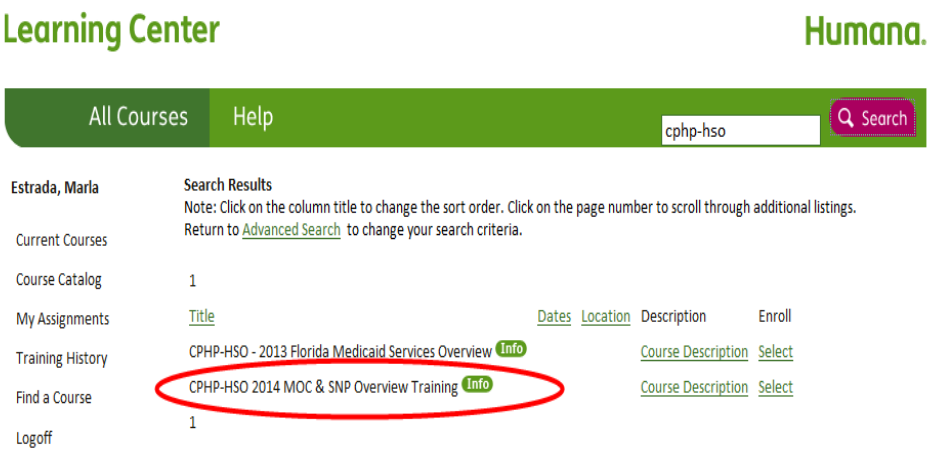
- What SNPs Are and Types of SNPs
- Enrollment, Plan Availability and Plan Year Requirements
- SNP Model of Care: Health Risk Assessment; Level of Intervention; ICPs; Health Surveys; ICTs; HEDIS and Quality Reporting

In addition, refresher and ad hoc training sessions are provided to both individual associates and groups of associates upon request or as deemed necessary. Refresher and ad hoc training sessions are conducted face-to-face and through the use of audiovisual conferencing capabilities available to all associates. These training sessions may consist of, but are not limited to:

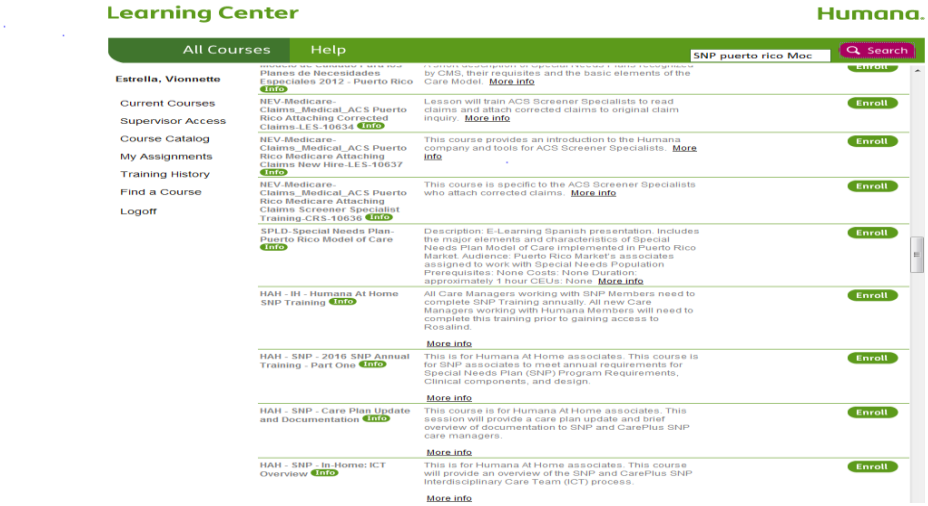
- Updates to CMS SNP Requirements and Benefits
- Updates to SNP Model of Care
- Interdisciplinary Care Teams (ICTs) and Individualized Care Plans (ICPs)

The Humana Learning Center: Computer Based SNP Training Module:





Example: Humana Puerto Rico: The Humana Learning Center: Computer Based SNP Training Module:



Factor 6: Maintaining Training Records:

Humana Puerto Rico:

All Humana Puerto Rico associates and network employees have individual training records. Computer-based modules and the completion of same modules are documented via Humana's Learning Center or Humana Puerto Rico's training site.

Each time an associate completes their scheduled training, Humana's Learning Center captures the time, date, and name and completion stamp. The Humana Puerto Rico training site captures a completed attestation verifying the associate has completed the training. This is

verification the associate completed the training and can be referenced, as needed at a later date. For Face to Face trainings signatures are collected from the attendees in the attendance sheet created for that purpose. The attendee list is captured, logged, and stored to make sure all associates have followed protocol and received the proper training in a timely manner.

A history of completed training sessions can be accessed by each associate's direct supervisor. Any refresher and ad hoc training sessions are monitored and tracked by the associate and by the associate's direct supervisor. The Care Management Manager utilizes the HLC CBT records and Humana Puerto Rico records to generate and reconcile reports for verification of adherence to MOC training performed during the calendar year. It is the responsibility of each associates direct supervisor to ensure compliance with the MOC training and to implement necessary corrective actions to ensure completion of the training. Challenges and barriers associated with the completion of trainings are documented within the yearly quality improvement model of care evaluation and recommendations on how to improve the challenges identified are incorporated.

Types of trainings available to associates include:

1. **SNP - Humana Puerto Rico 2016 Special Needs Plan:** This course is for SNP associates to meet annual requirements for Special Needs Plan (SNP) Program Requirements, care management components and design.
2. **Medicaid 101:** The Medicaid 101 course is designed to give learners the basic framework of Medicaid. The course contains the basics of Medicaid which includes eligibility and benefits. Medicaid 101 also covers Humana's involvement in the Medicaid program and includes information on Dual Demonstration, Long Term Care Services and Support, Non-Long Term Care Services and Support and offers additional resources.

Humana At Home:

All SNP associates and network employees have individual training records. Computer-based modules and the completion of same modules are documented via Humana's Learning Center or Humana At Home's training site.

Each time an associate completes their scheduled training, Humana's Learning Center captures the time, date, and name and completion stamp. The Humana At Home training site captures a completed attestation verifying the associate has completed the training. This is verification the associate completed the training and can be referenced, as needed at a later date. The same methods are applied for training via conference calls. The attendee list is captured, logged, and

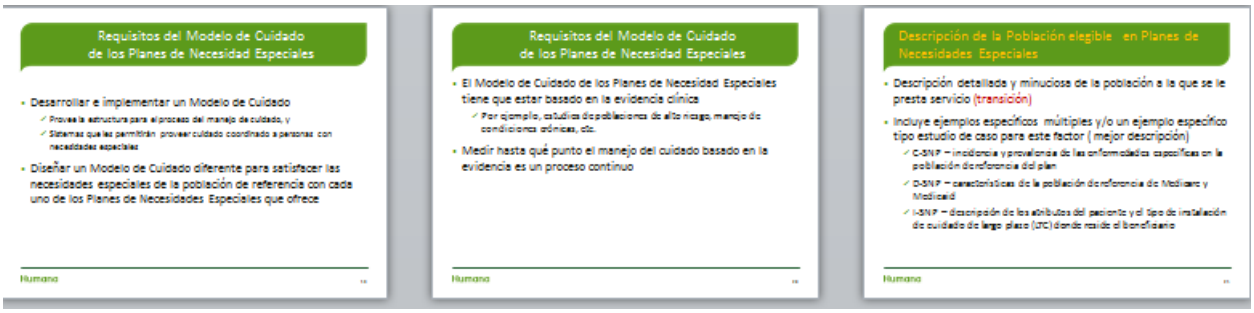
stored to make sure all associates have followed protocol and received the proper training in a timely manner.

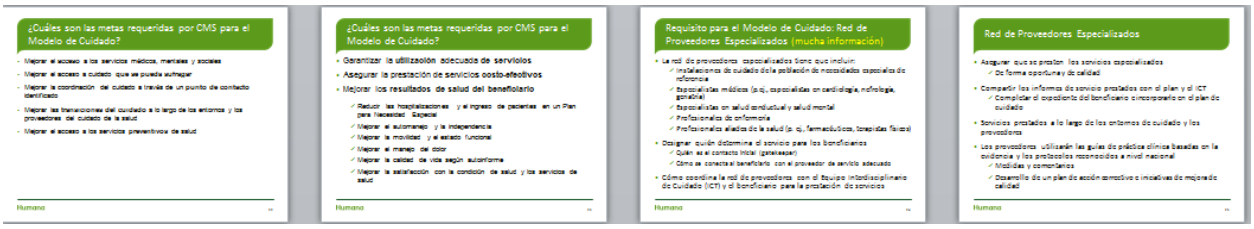
A history of completed training sessions can be accessed by each associate's direct supervisor as well as Humana At Home Quality Compliance Reporting Analysts. Any refresher and ad hoc training sessions are monitored and tracked by the associate and by the associate's direct supervisor. The Humana At Home Quality Compliance team utilizes the HLC CBT records and Humana At Home training site records to generate and reconcile reports for verification of adherence to MOC training performed during the calendar year. It is the responsibility of each associates direct supervisor to ensure compliance with the MOC training and to implement necessary corrective actions to ensure completion of the training. The Humana At Home Quality Compliance team evaluates the completion of all trainings within the yearly Quality Improvement and Model of Care Evaluation. Challenges and barriers associated with the completion of trainings are documented within the yearly quality improvement model of care evaluation and recommendations on how to improve the challenges identified are incorporated.

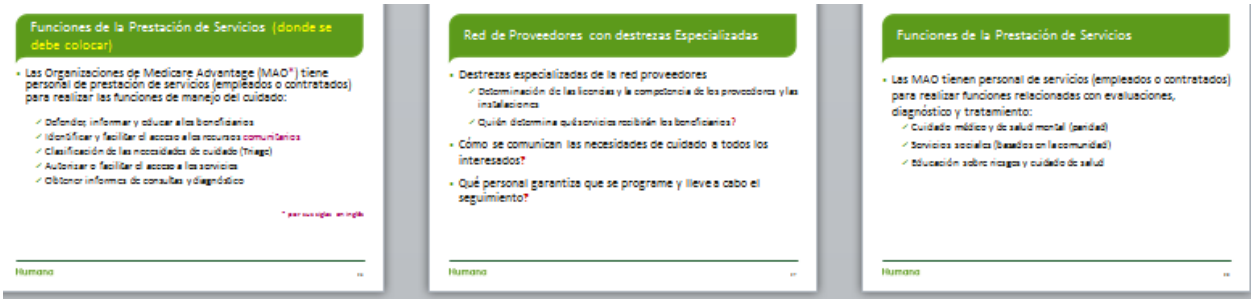
Types of trainings available to associates include:

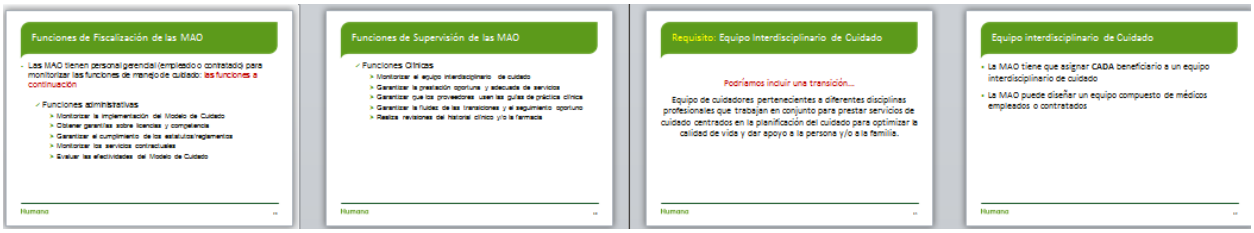
3. **SNP - 2015 Special Needs Plan:** This course is for SNP associates to meet annual requirements for Special Needs Plan (SNP) Program Requirements, care management components and design.
4. **Medicaid 101:** The Medicaid 101 course is designed to give learners the basic framework of Medicaid. The course contains the basics of Medicaid which includes eligibility and benefits. Medicaid 101 also covers involvement in the Medicaid program and includes information on Dual Demonstration, Long Term Care Services and Support, Non-Long Term Care Services and Support and offers additional resources.
5. **SNP mDAT Priority:** This module educates new SNP associates and review seasoned SNP associates on SNP's mDAT Priority Process. This module covers the following: Delineate the CMS Health Risk Assessment (HRA) requirements for SNP plans; Describe the process for prioritizing initial HRAs; Indicate the process for prioritizing annual HRAs; Review UTC process.
6. **SNP Transition of Care:** This module educates associates on Special Needs Plan's Transitions of Care. This module covers the following: CMS Standards; Policy/Process; Documentation; Transition of Care Document.
7. **SNP Specific HEDIS Measures:** This module covers information on additional HEDIS measures specific to the SNP population and documentation.
8. **Introduction to ICPs:** This module is a general overview of the key elements of an ICP, the documentation process, and correct documentation procedures. Including, identify the key elements of an ICP, how to look at a member's story and how the ICP emerges, and how to create a relevant ICP.

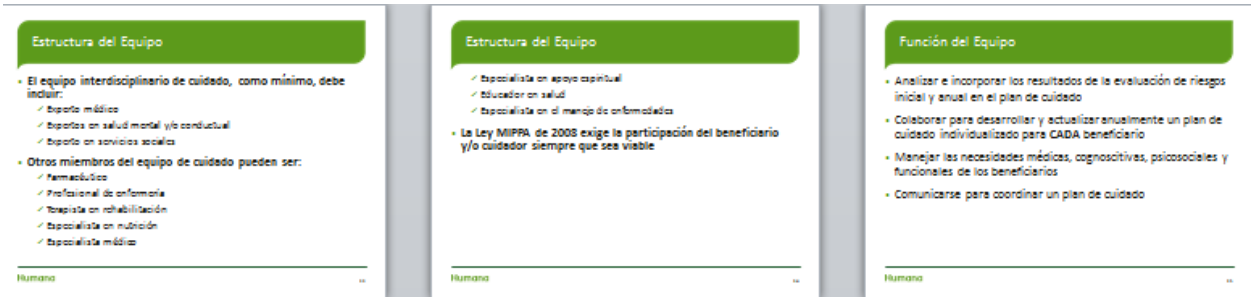
Example: Humana Puerto Rico SNP Model of Care Training Slides:


Requisitos del Modelo de Cuidado de los Planes de Necesidad Especiales
• Desarrollar e implementar un Modelo de Cuidado
✓ Provea la estructura para el proceso del manejo de cuidado, y
✓ Sistemas que les permitirán proveer cuidado coordinado a personas con necesidades especiales
• Diseñar un Modelo de Cuidado diferente para satisfacer las necesidades especiales de la población de referencia con cada uno de los Planes de Necesidades Especiales que ofrece
Humana
Requisitos del Modelo de Cuidado de los Planes de Necesidad Especiales
• El Modelo de Cuidado de los Planes de Necesidad Especiales tiene que estar basado en la evidencia clínica
✓ Por ejemplo, estudios de poblaciones de alto riesgo, manejo de condiciones crónicas, etc.
• Medir hasta qué punto el manejo del cuidado basado en la evidencia es un proceso continuo
Humana
Descripción de la Población elegible en Planes de Necesidades Especiales
• Descripción detallada y minuciosa de la población a la que se le presta servicio (transición)
• Incluye ejemplos específicos múltiples y/o un ejemplo específico tipo estudio de caso para este factor (mejor descripción)
✓ C-SNP – incidencia y prevalencia de las enfermedades específicas en la población de referencia del plan
✓ D-SNP – características de la población de referencia de Medicare y Medicaid
✓ I-SNP – descripción de los atributos del paciente y el tipo de instalación de cuidado de largo plazo (LTC) donde reside el beneficiario
Humana

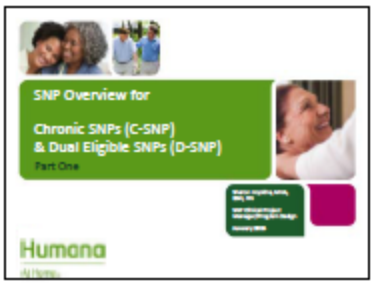

¿Cuáles son las metas requeridas por CMS para el Modelo de Cuidado?
- Mejorar el acceso a los servicios médicos, mentales y sociales
- Mejorar el acceso a cuidado que se pueda subrogar
- Mejorar la coordinación del cuidado a través de un punto de contacto identificado
- Mejorar las transiciones del cuidado a lo largo de los entornos y los proveedores de cuidado de la salud
- Mejorar el acceso a los servicios preventivos de salud
Humana
¿Cuáles son las metas requeridas por CMS para el Modelo de Cuidado?
• Garantizar la utilización adecuada de servicios
• Asegurar la prestación de servicios costo-efectivos
• Mejorar los resultados de salud del beneficiario
✓ Reducir las hospitalizaciones y el ingreso de pacientes en un Plan para Necesidad Especial
✓ Mejorar el automanejo y la independencia
✓ Mejorar la movilidad y el estado funcional
✓ Mejorar el manejo del dolor
✓ Mejorar la calidad de vida según autoinforme
✓ Mejorar la satisfacción con la condición de salud y los servicios de salud
Humana
Requisito para el Modelo de Cuidado: Red de Proveedores Especializados (mucha información)
• La red de proveedores especializados tiene que incluir:
✓ Instalaciones de cuidado de la población de necesidades especiales de referencia
✓ Especialistas médicos (p.ej., especialistas en cardiología, nefrología, ginecología)
✓ Especialistas en salud conductual y salud mental
✓ Profesionales de enfermería
✓ Profesionales aliados de la salud (p. ej., farmacéuticos, terapistas físicos)
• Designar quién determina el servicio para los beneficiarios
✓ Quién es el contacto inicial (gatekeeper)
✓ Cómo se conecta al beneficiario con el proveedor de servicio adecuado
• Cómo coordina la red de proveedores con el Equipo Interdisciplinario de Cuidado (ICT) y el beneficiario para la prestación de servicios
Humana
Red de Proveedores Especializados
• Asegurar que se prestan los servicios especializados
✓ De forma oportuna y de calidad
• Comparar los informes de servicio prestados con el plan y el ICT
✓ Completar el cuestionario del beneficiario circunspecto en el plan de cuidado
• Servicios prestados a lo largo de los entornos de cuidado y los proveedores
• Los proveedores utilizarán las guías de práctica clínica basadas en la evidencia y los protocolos reconocidos a nivel nacional
✓ Medidas y comentarios
✓ Desarrollo de un plan de acción correctiva e iniciativas de mejorado calidad
Humana


Funciones de la Prestación de Servicios (donde se debe colocar)
• Las Organizaciones de Medicare Advantage (MAO*) tiene personal de prestación de servicios (empleados o contratados) para realizar las funciones de manejo del cuidado:
✓ Defender, informar y educar a los beneficiarios
✓ Identificar y facilitar el acceso a los recursos comunitarios
✓ Clasificación de las necesidades de cuidado (Triage)
✓ Autorizar o facilitar el acceso a los servicios
✓ Obtener informes de consultas y diagnóstico
* por sus siglas en inglés
Humana
Red de Proveedores con destrezas Especializadas
• Destrezas especializadas de la red proveedores
✓ Determinación de las licencias y la competencia de los proveedores y las instalaciones
✓ Quién determina qué servicios recibirán los beneficiarios?
• Cómo se comunican las necesidades de cuidado a todos los interesados?
• Qué personal garantiza que se programe y lleve a cabo el seguimiento?
Humana
Funciones de la Prestación de Servicios
• Las MAO tienen personal de servicios (empleados o contratados) para realizar funciones relacionadas con evaluaciones, diagnóstico y tratamiento:
✓ Cuidado médico y de salud mental (pandas)
✓ Servicios sociales (basados en la comunidad)
✓ Educación sobre riesgos y cuidado de salud
Humana

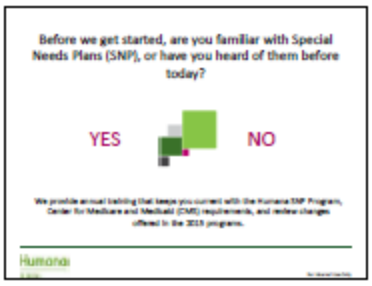

Funciones de Fiscalización de las MAO
- Las MAO tienen personal gerencial (empleado o contratado para monitorizar las funciones de manejo de cuidado: las funciones a continuación
✓ Funciones administrativas
› Monitorizar la implementación del Modelo de Cuidado
› Obtener garantías sobre licencias y competencia
› Garantizar el cumplimiento de los estatutos/reglamentos
› Monitorizar los servicios contractuales
› Evaluar las efectividades del Modelo de Cuidado
Humana
Funciones de Supervisión de las MAO
✓ Funciones Clínicas
› Monitorizar el equipo interdisciplinario de cuidado
› Garantizar la prestación oportuna y adecuada de servicios
› Garantizar que los proveedores usen las guías de práctica clínica
› Garantizar la fluidez de las transiciones y el seguimiento oportuno
› Realice revisiones del historial clínico y/o la farmacia
Humana
Requisito: Equipo Interdisciplinario de Cuidado
Podríamos incluir una transición...
Equipo de cuidadores pertenecientes a diferentes disciplinas profesionales que trabajan en conjunto para prestar servicios de cuidado centrados en la planificación del cuidado para optimizar la calidad de vida y dar apoyo a la persona y/o a la familia.
Humana
Equipo Interdisciplinario de Cuidado
• La MAO tiene que asignar CADA beneficiario a un equipo interdisciplinario de cuidado
• La MAO puede diseñar un equipo compuesto de médicos empleados o contratados
Humana


Estructura del Equipo
• El equipo interdisciplinario de cuidado, como mínimo, debe incluir:
✓ Soporte médico
✓ Soportes en salud mental y/o conductual
✓ Soporte en servicios sociales
• Otros miembros del equipo de cuidado pueden ser:
✓ Farmacéutico
✓ Profesional de enfermería
✓ Terapista en rehabilitación
✓ Especialista en nutrición
✓ Especialista médico
Humana
Estructura del Equipo
✓ Especialista en apoyo espiritual
✓ Educador en salud
✓ Especialista en el manejo de enfermedades
• La Ley MIPPA de 2008 exige la participación del beneficiario y/o cuidador siempre que sea viable
Humana
Función del Equipo
• Analizar e incorporar los resultados de la evaluación de riesgos inicial y anual en el plan de cuidado
• Colaborar para desarrollar y actualizar anualmente un plan de cuidado individualizado para CADA beneficiario
• Manejar las necesidades médicas, cognoscitivas, psicosociales y funcionales de los beneficiarios
• Comunicarse para coordinar un plan de cuidado
Humana

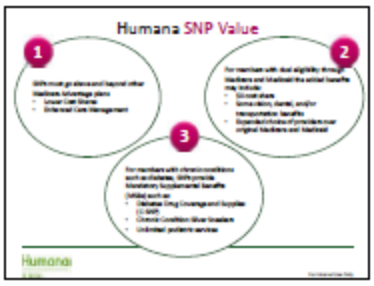
Example: Humana At Home SNP Model of Care Training Slides – Part One:

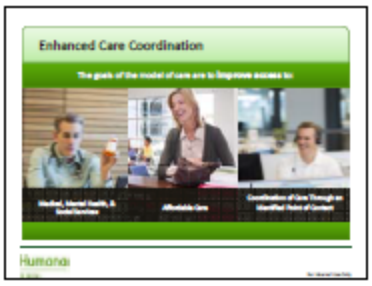

SNP Overview for
Chronic SNPs (C-SNP)
& Dual Eligible SNPs (D-SNP)
Part One
Humana


Presentation Topics for Annual Training
1. High-Level Overview
2. Chronic SNPs
3. C-SNP Enrollment
4. Dual Eligible SNPs
5. Dual Eligible SNP Member Materials
6. Pharmacy Resources
7. Member Communications and Materials
8. Appendix
Humana


Before we get started, are you familiar with Special Needs Plans (SNP), or have you heard of them before today?
YES
NO
Humana


What is a Special Needs Plan?
Special Needs Plans (SNPs)
- are a type of Medicare Advantage plan that includes Part C (medical) and Part D (drug) coverage
- provide coverage for vulnerable populations who often have multiple conditions and barriers to participating in self-care management
- provide members with guidance and resources that help provide access to benefits and information
- All of Humana's SNP plans are HMOs
Humana


Humana SNP Value
1
2
3
Humana

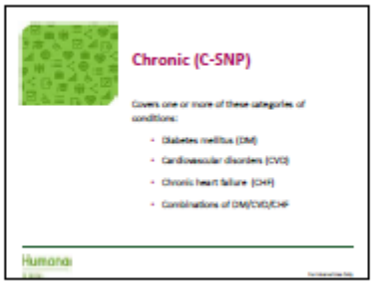

Enhanced Care Coordination
Humana

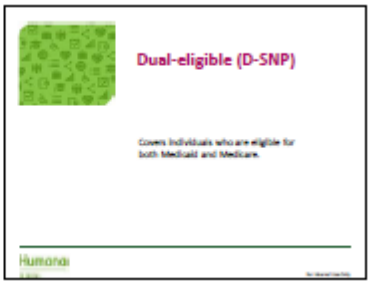

Enhanced Care Coordination
Humana


Enhanced Care Coordination
Humana


Special Needs Plans (SNPs)
Model of Care
Model of Care Elements
Humana

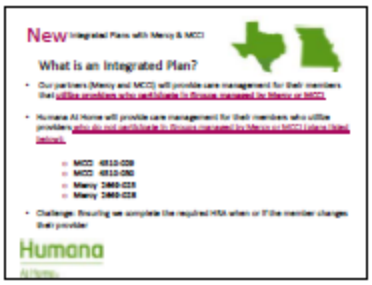

Chronic SNP
Dual Eligible SNP
Humana


Chronic (C-SNP)
Covers one or more of these categories of conditions:
Diabetes mellitus (DM)
Cardiovascular disorders (CVD)
Chronic heart failure (CHF)
Combinations of DM/CVD/CHF
Humana

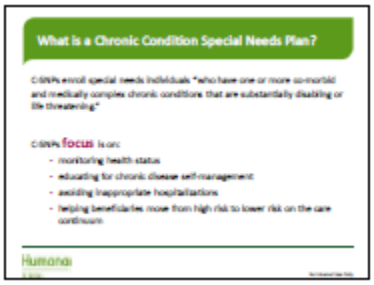

Dual-eligible (D-SNP)
Covers individuals who are eligible for both Medicaid and Medicare.
Humana

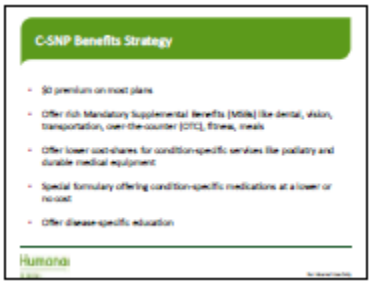

Service areas will vary


Humana Corporate Areas Managing SNPs
Humana At Home
CarePlus
Health Care Partners of Nevada
MCCI
Mercy
Puerto Rico


New
What is an Integrated Plan?

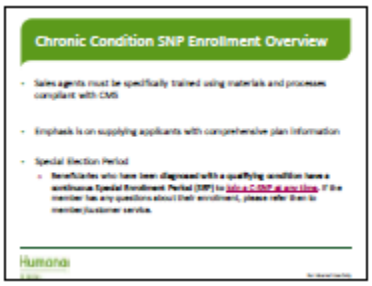

Chronic Condition SNPs

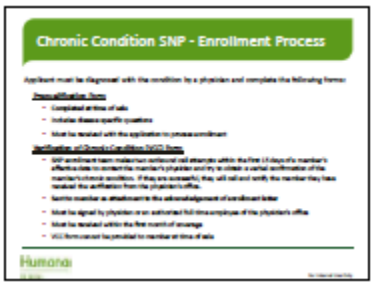

What is a Chronic Condition Special Needs Plan?

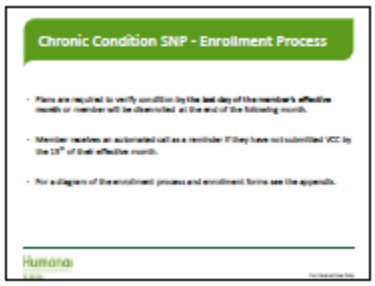

C-SNP Benefits Strategy

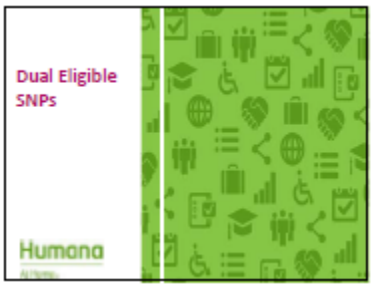

C-SNP Plans Offered


Chronic Condition SNPs Enrollment

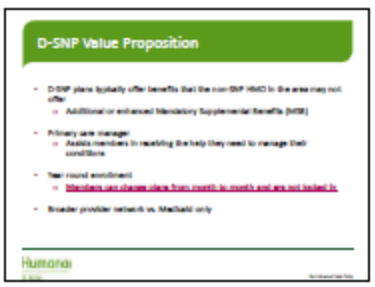

Chronic Condition SNP Enrollment Overview

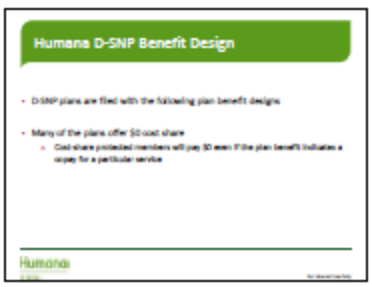

Chronic Condition SNP - Enrollment Process

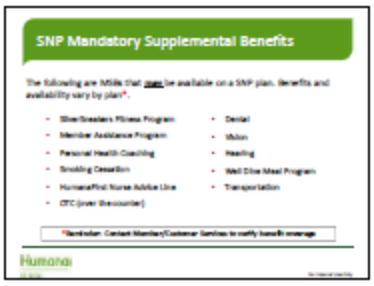

Chronic Condition SNP - Enrollment Process


Dual Eligible SNPs


Dual Eligible SNP Overview

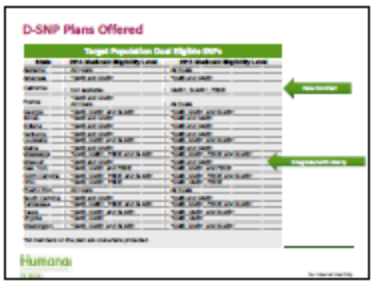

D-SNP Value Proposition

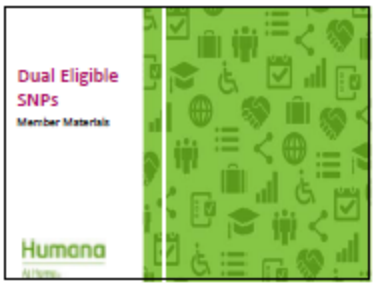

Humana D-SNP Benefit Design

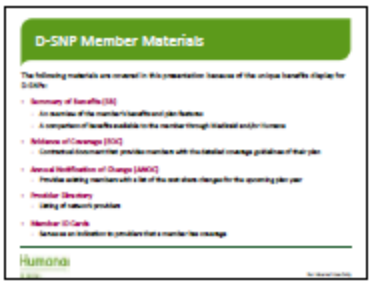

SNP Mandatory Supplemental Benefits
Humana


Medicaid Eligibility Levels for D-SNPs
(Common Medicaid Acronyms)
Humana


What is a Deeming Period?
6-Month Grace Period
Humana


D-SNP Plans Offered
Humana

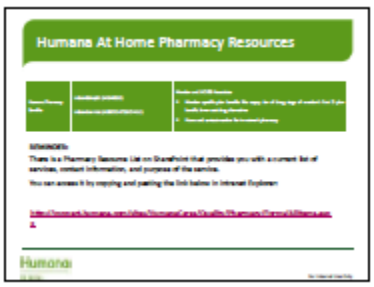

Dual Eligible SNPs
Member Materials
Humana


D-SNP Member Materials
Humana

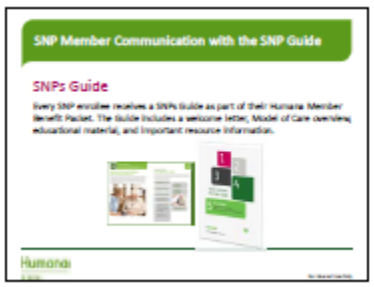

Medicaid Certified Providers
Humana


D-SNP Members & Their Cost-Shares
Humana


Pharmacy
Resources
Humana


Humana At Home Pharmacy Resources
Humana


CarePlus Pharmacy Resources
Humana

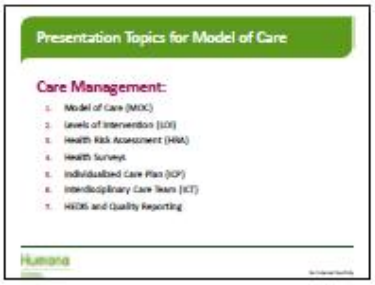

SNP Member Communication with the SNP Guide
SNPs Guide
Humana

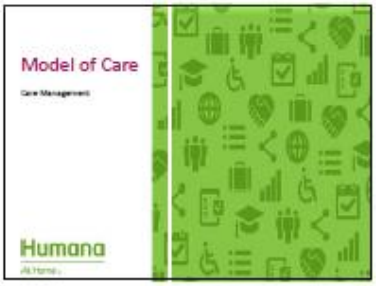

Questions
Contact your Manager/Coach for additional questions
and
Please take the Post Test for Part I
Humana

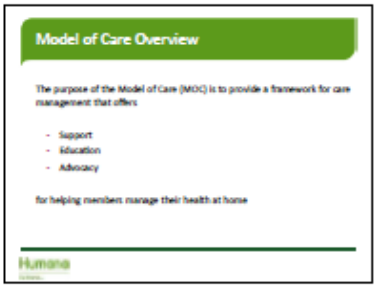

Appendix
Humana

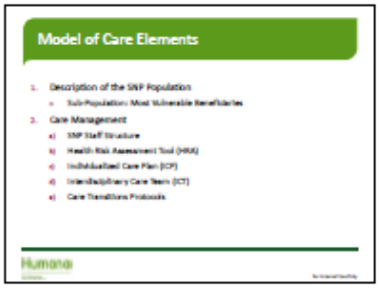

Pre-Qualification Assessment Form
Humana

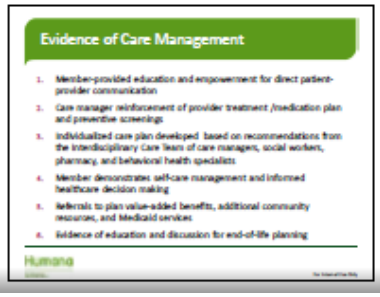
Example: Humana At Home SNP Model of Care Training Slides – Part Two:

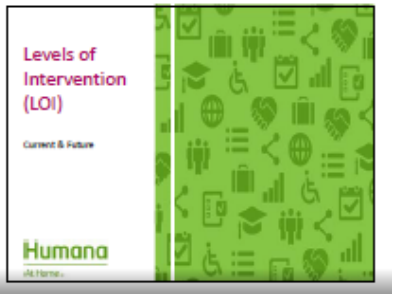


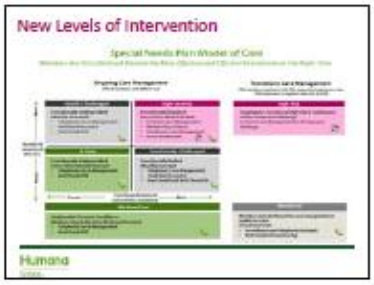


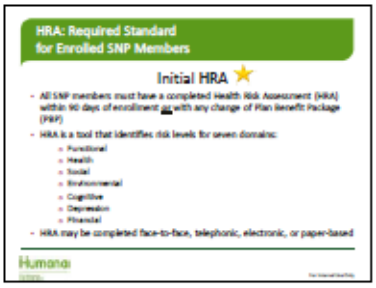




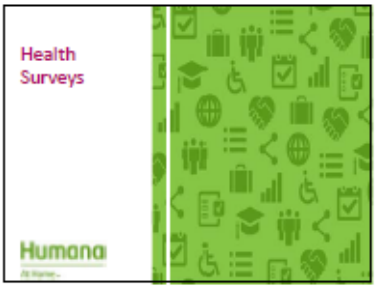


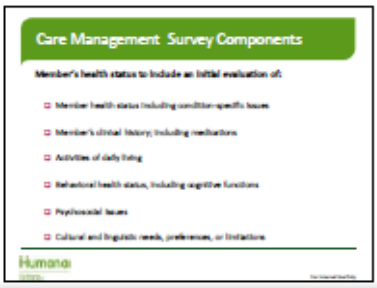


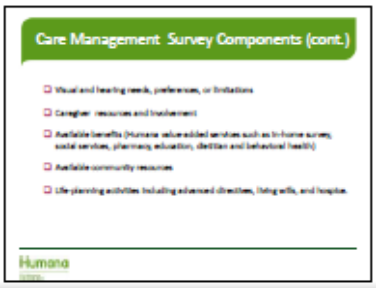


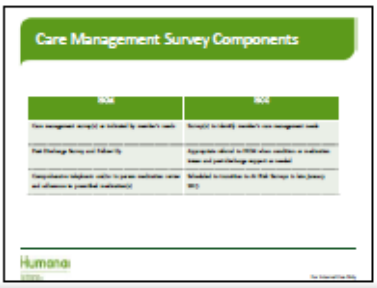

HRA: Required Standard for Enrolled SNP Members
Initial HRA
Humana

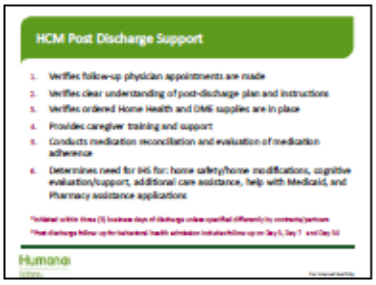

HRA: Required Standard for SNP Members with No Plan Benefit Package Change
Annual HRA
Humana

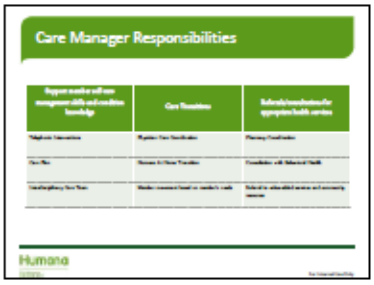

Health Surveys
Humana


Care Management Survey Components
Humana

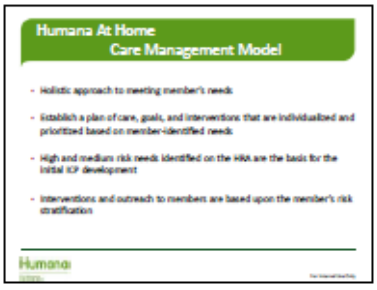

Care Management Survey Components (cont.)
Humana

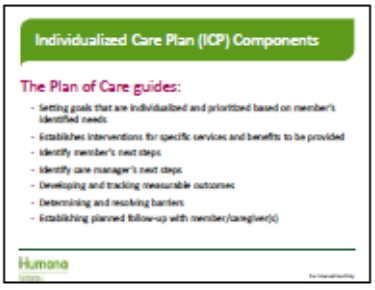

Care Management Survey Components
Humana

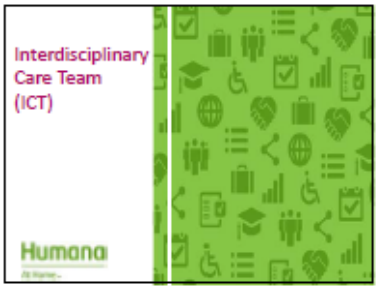

HCM Post Discharge Support
Humana

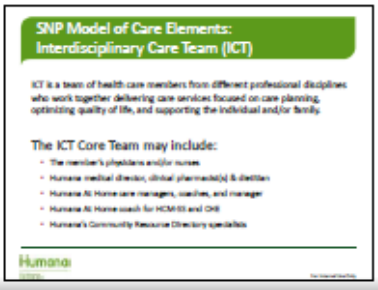

Care Manager Responsibilities
Humana

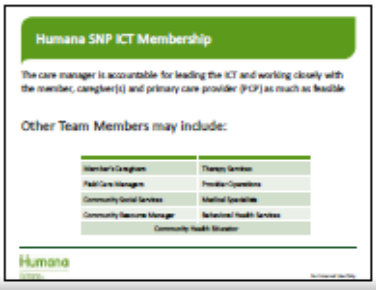

Individualized Care Plan (ICP)
Humana

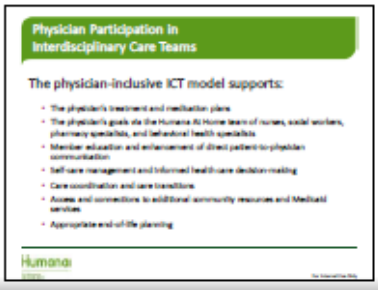

Humana At Home Care Management Model
Humana

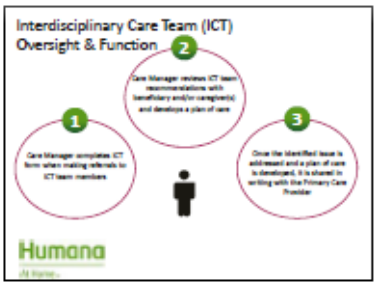

Individualized Care Plan (ICP) Components
The Plan of Care guides:
Humana


Interdisciplinary Care Team (ICT)
Humana


SNP Model of Care Elements: Interdisciplinary Care Team (ICT)
The ICT Core Team may include:
Humana

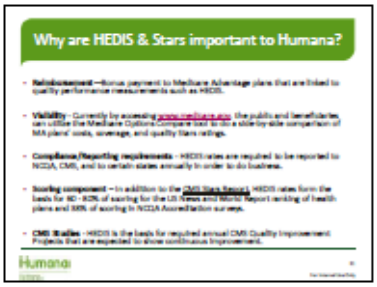

Humana SNP ICT Membership
Other Team Members may include:
Humana

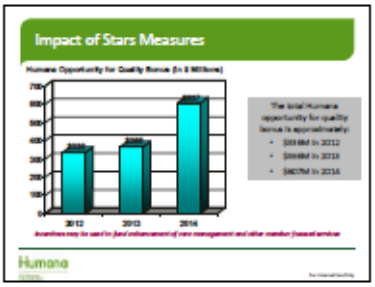

Physician Participation in Interdisciplinary Care Teams
The physician-inclusive ICT model supports:
Humana

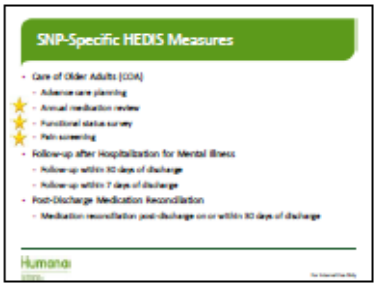

Interdisciplinary Care Team (ICT)
Oversight & Function
2
1
3
Humana

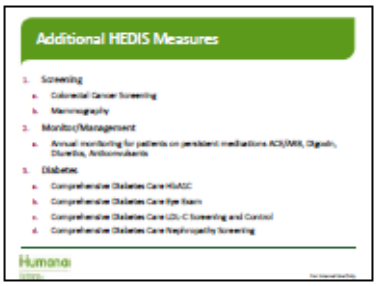

HEDIS &
Quality
Reporting
Humana

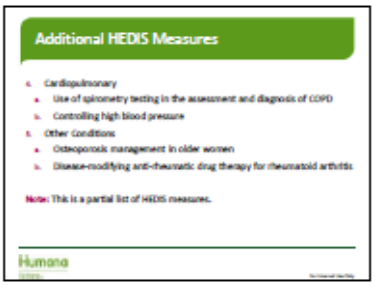

What is HEDIS and CMS Stars Report?
Humana

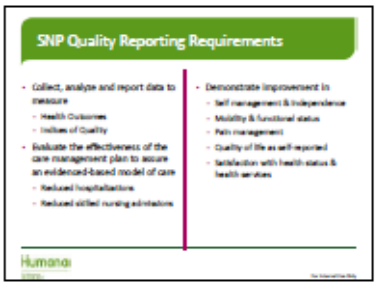

Why are HEDIS & Stars important to Humana?
Humana


Impact of Stars Measures
Humana


SNP-Specific HEDIS Measures
Humana


Additional HEDIS Measures
Humana


Additional HEDIS Measures
Humana

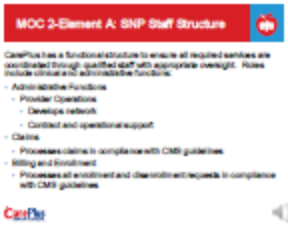

SNP Quality Reporting Requirements
Humana


Additional Questions?
Please reach out to the resources below
Humana


Questions
Contact your Manager/Coach for additional questions
and
Please take the Post Test for Part II
Humana

Example: CarePlus SNP Model of Care Training Slides:


MOC 2: Care Coordination


MOC 2-Element A: SNP Staff Structure


MOC 2-Element A: SNP Staff Structure (Cont'd)


MOC 2-Element A: SNP Staff Structure (Cont'd)


MOC 2-Element B: Health Risk Assessment

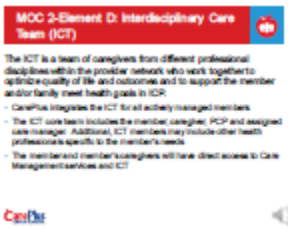

MOC 2-Element B: Health Risk Assessment (Cont'd)


MOC 2-Element C: Individualized Care Plan (ICP)

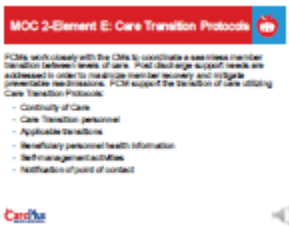

MOC 2-Element C: Individualized Care Plan (ICP) (Cont'd)


MOC 2-Element C: Individualized Care Plan (ICP) (Cont'd)


MOC 2-Element C: Individualized Care Plan (Cont'd)


MOC 2-Element D: Interdisciplinary Care Team (ICT)


MOC 2-Element D: Interdisciplinary Care Team (ICT) (Cont'd)


MOC 2-Element E: Care Transition Protocols

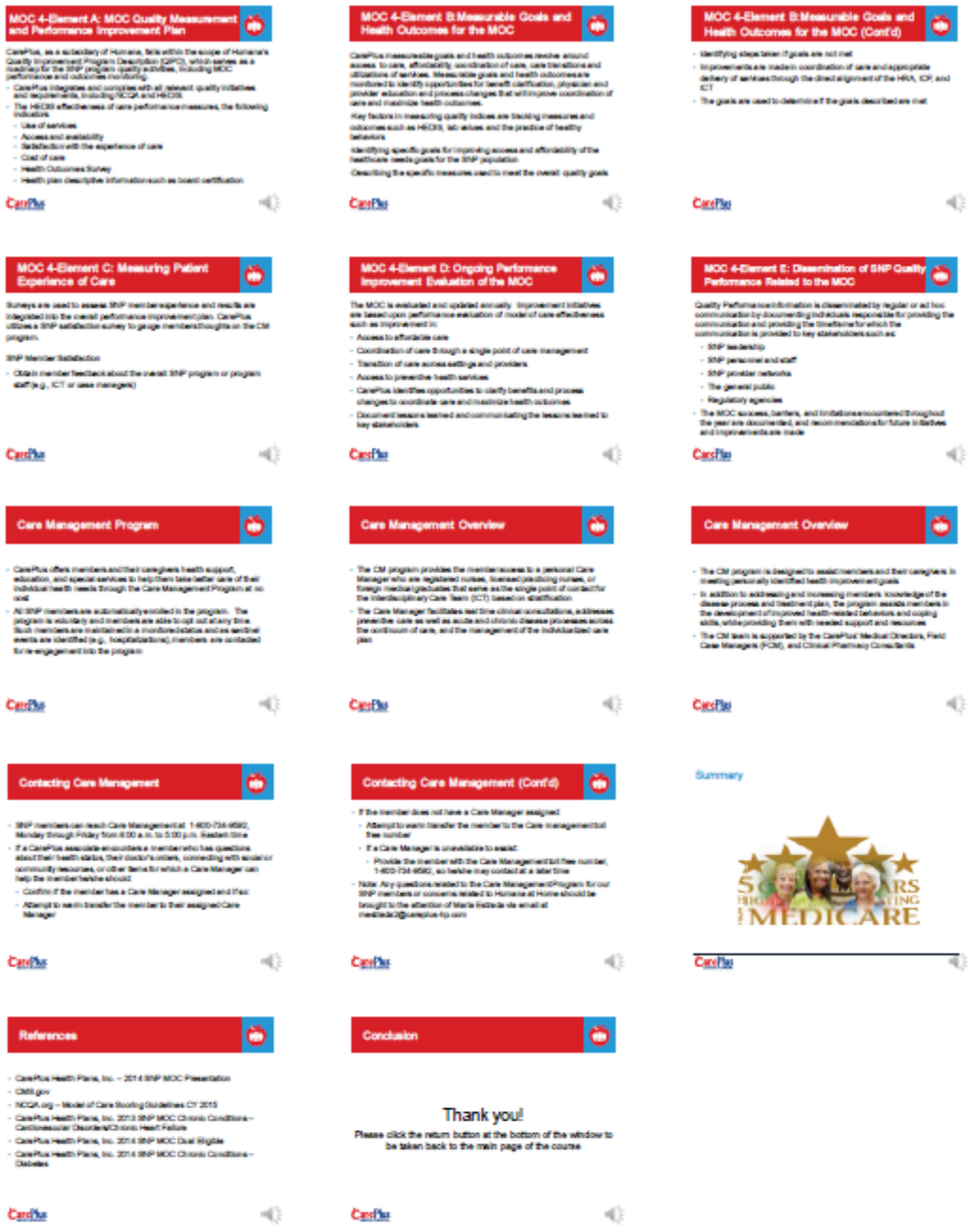

MOC 3: Provider Network


MOC 3-Element A: Specialized Expertise


MOC 3-Element B: Use of Clinical Practice Guidelines and Care Transition Protocols


MOC 3-Element C: MOC Training for the Provider Network


MOC 4: Quality Measurement and Performance Improvement


MOC 4-Element A: MOC Quality Measurement and Performance Improvement Plan
MOC 4-Element B:Measurable Goals and Health Outcomes for the MOC
MOC 4-Element B:Measurable Goals and Health Outcomes for the MOC (Cont'd)
MOC 4-Element C: Measuring Patient Experience of Care
MOC 4-Element D: Ongoing Performance Improvement Evaluation of the MOC
MOC 4-Element E: Dissemination of SNP Quality Performance Related to the MOC
Care Management Program
Care Management Overview
Care Management Overview
Contacting Care Management
Contacting Care Management (Cont'd)
Summary
MEDICARE
References
Conclusion
Thank you!
Please click the return button at the bottom of the window to be taken back to the main page of the course

Factor 7: Actions Taken When Trainings Are Not Completed:

Primary challenges associated with staff completing training modules includes scheduling time slots to complete training sessions while still being responsible for all other job functions. Secondary challenges include the Computer Based Training Module allows for associates to enter the training session and exit the training session without completing the module. Associates experience distractions (e.g. a member returning a phone call) while completing their daily responsibilities, the associate may accidently overlook exiting the module and fail to return to the CBT to complete. The CBT also requires associates to add training modules manually to their training courses, potential oversight may occur if the module is not added to an individuals' training schedule.

Humana Puerto Rico:

The Director of Health Services leads and manages strategy and regulatory compliance to develop and implement integrated care management programs which are value added and meet best practice standards. Director of Health Services is responsible for the oversight of the model of care training, with said responsibility being delegated to the Care Management Manager.

All care management team members required training is tracked by each individual associate's immediate supervisor, they reconcile training records against records managed by those supervising or coaching associates who work with SNP eligible members.

The Humana Puerto Rico supervisors review associate education/training records to identify associates who have been non-compliant with any mandatory training/education, which includes but is not limited to mandated SNP MOC initial training or annual training within the prescribed amount of time. It is the responsibility of the associate's supervisor to initiate the documented non-compliance process for counseling and/or corrective actions if deficiencies are identified. After one-on-one training is completed, the new associate is required to complete the Computer Based Training (CBT) modules accessed through the Humana Learning Center (HLC) or the Humana Puerto Rico training site, which further records compliance with annual training

When a SNP associate is non-compliant with mandatory trainings, his/her supervisor initiates counseling within five (5) business days of identifying the associate is non-compliant. Counseling includes the following elements:

- Identify the required training or education that has not been completed
- Advise the associate that they have ten (10) business days to complete the required training from the date of initial counseling.
- Advise associate they are responsible for providing proof of completion of training to the supervisor within ten (10) business days of counseling
- Identify the manner in which the training is to be completed

- Explain to the associate that failure to complete the mandatory training process will result in a formal corrective action plan.

If the associate does not meet all of the above elements within the allotted time, the supervisor contacts Humana, Inc. (HR4U) for assistance with initiating a corrective action plan by the eleventh business day. All SNP associate counseling and corrective action plans related to mandatory training are reported to the compliance project manager by the 15th of the following month for reconciling reporting of associate required training by the associate's supervisor.

Example: Humana Puerto Rico Reporting of SNP MOC Training:

Course History Report

Report Start Date: 5/18/2015
Report End Date: 8/3/2015

Course Title: SPLD-Special Needs Plan-Puerto Rico Model of Care
Class Title:
Class Start Date:
Class End Date:

Member Name	Member Email	Member Phone	Status	Grade	Start Date	Completion
Nevarez, Claudenisse	cnevares@humana.com	787.993.7819	Completed Satisfactorily	0	5/18/2015	2015-05-18 00:00:00
Lago Castro, Elizabeth	elagocastro@humana.com	0	Completed Satisfactorily	0	5/27/2015	2015-05-27 00:00:00
Sierra, Gladys	gsierra@humana.com	0	Completed Satisfactorily	0	5/27/2015	2015-05-27 00:00:00
Cruz Galarza, Zenaida	zcruz_galarza@humana.com	0	Completed Satisfactorily	0	5/27/2015	2015-05-27 00:00:00
Berrios, Ana	aberrios@humana.com	787.282.7900 x4019	Completed Satisfactorily	0	5/27/2015	2015-05-27 00:00:00
Sosa-Isales, Ana	asosa-isales@humana.com	787.993.8106	Completed Satisfactorily	0	5/28/2015	2015-06-04 00:00:00
Aviles Torres, Jessica	javilestorres@humana.com	0	Completed Satisfactorily	0	5/28/2015	2015-05-28 00:00:00
Cuevas, Dolly	dcuevas@humana.com	787.993.7933	Completed Satisfactorily	0	5/28/2015	2015-05-28 00:00:00
Mercado, Kimilda	kmercado1@humana.com	787.993.7874	Completed Satisfactorily	0	6/1/2015	2015-06-01 00:00:00
Arroyo, Maria	marroyo1@humana.com	1.866.488.5992 xt.5588	Completed Satisfactorily	0	6/1/2015	2015-06-05 00:00:00
Rosado, Yolitza	yrosado1@humana.com	0	Completed Satisfactorily	0	6/2/2015	2015-06-02 00:00:00
Diaz Vega, Daniel	ddiaz_vega@humana.com	787.622.5850 x5850	Completed Satisfactorily	0	6/4/2015	2015-06-04 00:00:00
Medina, Moises	mmedina1@humana.com	0.000.0000 x0	Completed Satisfactorily	0	6/4/2015	2015-06-04 00:00:00
Morales, Alberto	amoralesviera@humana.com	0	Completed Satisfactorily	0	6/4/2015	2015-06-04 00:00:00
Vazquez, Eric	evazquez@humana.com	0	Completed Satisfactorily	0	6/4/2015	2015-06-04 00:00:00
Torres, Alexis	atorres3@humana.com	0	Completed Satisfactorily	0	6/4/2015	2015-06-05 00:00:00
Santos, Zally	zsantos@humana.com	787.622.5569	Completed Satisfactorily	0	6/4/2015	2015-06-05 00:00:00
Quinones, Linnette	lquinones2@humana.com	0	Completed Satisfactorily	0	6/4/2015	2015-06-04 00:00:00
Perez, Jocelin	jperez2@humana.com	787.622.5746	Completed Satisfactorily	0	6/4/2015	2015-06-04 00:00:00
Figueroa, Clara	cfigueroa@humana.com	0.000.0000 x0	Completed Satisfactorily	0	6/4/2015	2015-06-04 00:00:00
Burgos, Maylyne	mburgos@humana.com	0.000.0000 x0	Completed Satisfactorily	0	6/4/2015	2015-06-25 00:00:00
Maldonado-Perez, Marjorie	mmaldonado2@humana.com	787.622.5726	Completed Satisfactorily	0	6/4/2015	2015-06-23 00:00:00
Cardona, Maria	mcardona1@humana.com	787.993.7996	Completed Satisfactorily	0	6/4/2015	2015-06-09 00:00:00

Humana At Home:

Humana At Home Director of Quality Clinical Programs and Services oversees the Humana At Home Learning and Development, Humana At Home Quality Compliance, Humana At Home Quality Managementand Humana At Home Clinical Strategy and Program Design Teams. The

Humana At Home Director of Quality Clinical Programs and Services leads and manages strategy and regulatory compliance to develop and implement integrated care management programs which are value added and meet best practice standards. The Humana At Home Director of Quality Clinical Programs and Services is responsible for the oversight of the model of care training, with said responsibility being delegated to the Humana At Home Learning & Development Manager and Humana At Home Clinical Strategy and Program Design Manager.

All care management team members required training is tracked by both the Humana At Home Quality Compliance Team and by each individual associate's immediate supervisor. Members of the Humana At Home Quality Compliance Team also reconcile training records against records managed by those supervising or coaching associates who work with SNP eligible members.

Supervisors review associate education/training records to identify associates who have been non-compliant with any mandatory training/education, which includes but is not limited to mandated SNP MOC initial training or annual training within the prescribed amount of time. It is the responsibility of the associate's supervisor to initiate the documented non-compliance process for counseling and/or corrective actions if deficiencies are identified. After one-on-one training is completed, the new associate is required to complete the Computer Based Training (CBT) modules accessed through the Humana Learning Center (HLC) or the Humana At Home training site, which further records compliance with annual training

When a SNP associate is non-compliant with mandatory trainings, his/her supervisor initiates counseling within five (5) business days of identifying the associate is non-compliant. Counseling includes the following elements:

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- Advise associate they are responsible for providing proof of completion of training to the supervisor within ten (10) business days of counseling
- Identify the manner in which the training is to be completed
- Explain to the associate that failure to complete the mandatory training process will result in a formal corrective action plan.

If the associate does not meet all of the above elements within the allotted time, the supervisor contacts Human Resources for assistance with initiating a corrective action plan by the eleventh business day. All SNP associate counseling and corrective action plans related to mandatory training are reported to the compliance project manager by the 15th of the following month for reconciling reporting of associate required training by the associate's supervisor.

Supervisors are responsible for leading teams of associates who care for SNP members and are also responsible for identifying training needs and communicating this information to the Humana At Home Quality Compliance Team for follow up. The Humana At Home Quality

Management Team is responsible for auditing the documentation and quality of member written and phone records in the SNP program. When gaps are identified, this information is used to revise and/or revamp current training materials. Any other member of this team or of Operations may also identify a gap in training or need for training to be updated. This information is also relayed to the Humana At Home Learning & Development Team and Clinical Strategy & Program Design Team, who are then responsible for updating training materials as required.

Example: Humana At Home Quality Compliance Reporting of SNP MOC Training:

Humana. SNP Mandatory Training

% of Associates Who Completed SNP Annual Training

Manager/ Team	2013 P1 Training	2013 P2 Training	2014 Training
Alexander, Carol	100%	100%	100%
Butler, Ms. Allisa R	55%	55%	82%
Campbell, Ms. Amanda J (Amanda)	59%	58%	69%
Canney, Patti	34%	39%	84%
Dholichand, Syreeta	100%	100%	100%
Falanga, Ms. Rebecca Marie (Rebecca)	100%	100%	83%
Halbleib, Ms. Sharon M	96%	97%	100%
Hogan, Diane	91%	100%	100%
Lewis, Ms. Suzanne M.	50%	50%	50%
Lewis, Suzanne	100%	100%	100%
Montijo, Mr. Noel	77%	77%	86%
O'Hara, Ms. Mary Jo (Mary Jo)	75%	75%	100%
Simonsen, Ms. McKinzi L	66%	63%	81%
Suarez, Mr. Gonzalo	100%	100%	100%
Terminated/Transferred Associates	80%	83%	71%
Williams, Ms. Julia K	100%	100%	100%
Grand Total	**76%**	**76%**	**87%**

Note 1: Both the Learning Center and a list of training attestations from the SeniorBridge website are used to determine completion dates.

Note 2: 2013 Completion % may be skewed due to using Hire Date instead of the date the associate started on a team who supports SNP.

Associates Who Did NOT Complete 2014 SNP Annual Training

Manager/ Team	Coach/Supervisor	Associate
Butler, Ms. Allisa R	**Begley, Mr. Joshua W**	Dodson, Joni Beth (beth)
		Ferguson, Edie
		Moore, Carla D
	Butler, Ms. Allisa R	Woodward, Linda
		Barrett, Eltina E.
		LyDay, Leslie Jannette
		Reed, Michael Scott (Scott)
		Shick, Mary Katherine (Kathy)
		Sylvester, JaQuoia R
		Taylor, Vickie Louise (Vickie)
	Holness, Ms. Wendy	Davis, Leah
		Douglas, Sasha Teneal (Sasha)
		Forjet, Elizabeth S.
		Hoffman, Hannah
	Mattioli, David	Butler, Allisa R
	Shick, Ms. Mary Katherine (Kathy)	Carr, Shoshana (Nikki)
		Dupree, Lashay R.
		Worden, Terri
Campbell, Ms. Amanda J (Amanda)	**Campbell, Ms. Amanda J (Amanda)**	Neal, Trena Thomas (Trena)
		Signore, Jennifer (Jenn)
		Anosike, Clement
		Kelly, Charles P (Patrick)
		Pierce-Green, Stacy Rene
		Rivers-Dixon, Hilda F

ELEMENT B: HEALTH RISK ASSESSMENT TOOL:

Factor 1: Quality Content of the Health Risk Assessment (HRA) & Development of the Individualized Care Plan (ICP):

A Health Risk Assessment (HRA) is required by the Centers for Medicare and Medicaid Services (CMS) for all SNP members. CarePlus utilizes the Humana At Home Medicare Domain Assessment Tool (mDAT) and beginning April 1, 2017 the Humana Puerto Rico Health Risk Assessment tool as the approved HRA for SNP members. The mDAT is proprietary to Humana At Home and the Humana Puerto Rico HRA is proprietary to Humana Puerto Rico and produces a current health status profile and an overall risk score for each SNP member. The tool scores risk across seven health domains: medical, functional, social, cognitive, financial, behavioral (psychosocial & mental health) and environmental risk. The HRA focuses on the acute chronic needs of the member and examines:

- Falls or fall risk

- Presence of pain
- Difficulty sleeping
- Difficulty eating
- Difficulty with light to heavy housework
- Inability to manage money without assistance
- Difficulty bathing without assistance
- Forgetting medications and other memory problems
- Skin breakdowns
- Feelings of depression and isolation

The HRA:

- Provides a sound "snap shot in time" of the member's health status
- Is integral to Level of Intervention (LOI) stratification and guides operational processes for minimum contact frequency, care management interventions, and in-home survey referrals
- Validates strongly with health risk, frailty, and cost
- Adds a significant additional dimension of validity to our data analytics when coupled with claims and utilization data
- Provides care management guidance for ICP interventions and referrals
- Closely follows current care management survey pathways
- Benchmarks member status annually or with any major change in health (i.e., acute hospital admission, new diagnoses)
- Outcomes data is used in operational, financial, and executive analyses and reports

Use of HRA in Developing the Individualized Care Plan (ICP):

Humana Puerto Rico:

The HRA provides a foundation for the primary Care Manager to identify issues of concern. For actively managed members, ICPs are discussed and mutually designed with the member and/or caregiver and shared with physicians as appropriate to the plan of care. All members risk needs identified during completion of the HRA are incorporated into the ICP. Goals and objectives are established between the member and Care Manager and interventions are developed based upon the risks identified.

ICPs are created, reviewed and updated at a minimum with each successful member contact according to the level of intervention outreach protocol i.e., weekly, monthly, quarterly, etc. ICPs may also be updated with each transition and/or significant changes in member's health care status as agreed upon by the primary Care Manager and member.

The continuously updated ICP addresses the gaps in care identified and assigns benefits and special services to the member to meet prioritized goals. Additionally, based on risk score, the primary Care Manager identifies members of the ICT that support the member's risk areas identified. For example, members reporting eight or more medications may be referred to RX Mentor, the Medication Therapy Management program.

Care Managers have the opportunity to further evaluate members risk identified from the HRA with utilizing additional health surveys and screening tools to further identify appropriate interventions when developing the ICP with the member. Additional surveys or screening tools available include:

- CM General Assessment: The CM General Assessment allows Care Managers to gather additional information that may identify other member's needs that can be added to the ICP to promote clinical excellence, deliver required elements based on program telephonic and/or in person medication review and adherence evaluation.
- Social work assessment - is a comprehensive assessment that can be conducted and performed by the Social worker to evaluate additional member social needs that can impact member well-being.
- Medication Adherence Assessment: the assessment allows the Care Manager to identify potential barriers that can impact member adherence to pharmacology therapy to manage their chronic conditions. The results of the assessment are used as a trigger to refer members to the Medications Therapy Management program.
- Post Discharge Assessment: The Post discharge assessment is conducted by the Care Manager when a member has an admissions event and is discharged home. The assessment allows the Care Manager to support members through the transition event and to prevent future readmission. Problems encountered are added to the member ICP and shared with the member and provider.
- Chronic Conditions Assessment: The Chronic Conditions Assessment a series of assessment that addressed member specific needs on those conditions that are of high prevalence in the population, Including Diabetes, Asthma/COPD, Hypertension, Coronary Artery Disease. The assessments are conducted by the Care Manager on members identified with the abovementioned conditions and the identified needs are used to update members ICP.

The following roles are considered Humana Puerto Rico Care Managers:

Care Managers (CM): Care Managers (CM): Humana Puerto Rico Care managers are registered nurses; with bachelor or master degree in nursing; and more than 3 years of clinical experience. The Case Manager has the responsibility for the management and coordination of member

care. Telephonic contact is initiated; and assessments are completed to identify member's needs. Needs are prioritized in the individualized care plan and services are coordinated accordingly.

Humana At Home:

Following the introduction into the plan and completion of the mDAT, information from analytics, coupled with mDAT information, determines which primary Care Manager will assume responsibility for the member's care provision. The primary Care Manager is systematically assigned based on the member's level of intervention (LOI) allowing the primary Care Manager to outreach to the member in a timely manner to develop the ICP.

The mDAT provides a foundation for the primary Care Manager to identify issues of concern. For actively managed members, ICPs are discussed and mutually designed with the member and/or caregiver and shared with physicians as appropriate to the plan of care. All medium and high risk needs identified during completion of the mDAT are incorporated into the ICP. Goals and objectives are established between the member and primary Care Manager and interventions are developed based upon the risks identified. mDAT risk areas include:

- Health/Medical Risk
- Functional Risk
- Social Risk
- Cognitive Risk
- Financial Risk
- Environmental Risk
- Depression/Behavioral/Psychosocial/Mental Health Risk

ICPs are created, reviewed and updated with each successful member contact by the Primary Care Manager to document progress towards goals, as member's needs change, with each care transition and or significant changes in member's health status.

The continuously updated ICP addresses the gaps in care identified and assigns benefits and special services to the member to meet prioritized goals. Additionally, based on risk score, the primary Care Manager identifies members of the ICT that support the member's risk areas identified. For example, when cognitive or functional needs are identified, referrals to the Humana At Home In-Home Care Manager (IHCM) for a brief in-home survey may be made and members reporting eight or more medications may be referred to mail order pharmacy and/or the Medication Therapy Management program.

Primary Care Managers have the opportunity to further evaluate each medium and high risk identified from the mDAT with utilizing additional health surveys and screening tools to further identify appropriate interventions when developing the ICP with the member. Additional surveys or screening tools available include:

- Comprehensive Survey: The Comprehensive Survey allows primary Care Managers who are Humana Care Managers (HCMs) to promote clinical excellence, deliver required elements based on program telephonic and/or in person medication review and adherence evaluation.
- .
- The Member Survey is a comprehensive in-person survey conducted at the point of residency and performed by an In-Home Care Manager for members who receive a brief in-home survey.
- Patient Health Questionnaire (PHQ-9): The PhQ9 is a nine question multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression; a self-reporting tool that rates the frequency of symptoms; presence and frequency of suicide ideation.
- The HCM-SS Needs Survey is a telephonic survey that is used to evaluate the member's needs focused on the areas of concern identified by the primary Care Manager. The survey allows for the HCM-SS to identify and develop a plan of action with the member regarding their area of concern. The HCM-SS provides resources and referrals and follows up as needed.

The following roles are considered primary Care Managers:

Humana Care Managers (HCM): The HCM is a registered nurse or social worker. The HCM assumes responsibility for the management and coordination of care assigned members, as well as provides clinical support, consultations, and reviews for HCC staff. Telephonic contact is initiated, and surveys are completed per protocol on an as-needed basis. The HCM prioritizes member needs, educates and promotes member self-management strategies, initiates and updates the ICP, engages other members of the care team and refers to internal and external resources as necessary. HCMs who are registered nurses possess three or more years of clinical experience, and have exceptional communication, interpersonal and technical skills. Those that are social workers have a minimum of three years of case management experience and hold a Master's degree in Social Work (MSW), Master's degree in a related field, or Bachelor's degree in Social Work. The Humana At Home staffs HCMs specializing in complex medical or behavioral conditions.

Humana Care Coordinator (HCC): Responsible for engaging members in care management, identifying the individual member's stratification through the use of provided tools, reviewing the member's needs after discharge from an inpatient facility, making referrals as needed to appropriate levels of care, and referring the member to available Humana resources, community resources, and the ICT for assistance. The HCC provides ongoing support to SNP members in medium and low risk levels of intervention (LOI), and the Monitored involvement level, including assisting with Medicaid recertification, access to Medicaid benefits, and connections to community resources. Refers to HCM for member clinical issues, questions, and needs. HCCs have a minimum of two years combined experience as a medical assistant or

certified nurse assistant, health related field, or care management, and/or degrees in psychology, health education, or social work.

Factor 2: Dissemination of the mDAT (HRA) to the Interdisciplinary Care Team (ICT):

Humana Puerto Rico:

The MOC is member centric and based on an Interdisciplinary Care Team (ICT) approach, which includes participation by members, their families and/or caregivers, Primary Care Physicians (PCP), Care Managers, Social Workers, Field Care Managers and specialty physicians, ancillary providers and/or vendors involved in the treatment of the member.

The member's Care Manager leads the Interdisciplinary Care Team efforts and is responsible for coordinating care across the continuum. Based on members identified needs from the administration of the HRA, the primary Care Manager engages members of the Humana Puerto Rico Interdisciplinary Care Team (ICT), and, includes the member or member representative and the primary healthcare provider at minimum. In some instances, the primary Care Manager may invite the member's treating specialist and/or pharmacist to participate in the ICT.

The findings of a member's HRA are available to the ICT via the Humana Puerto Rico documentation platform for review, and used in providing care management services to SNP members. Stratification results and indicated needs are also discussed with each SNP member telephonically. This telephonic communication extends to caregivers and any other person(s) the member would like to have included. An ICP is also generated for members and mailed to the specific member's Primary Healthcare Provider for review and further input. The primary Care Manager also confers ICT recommendations with members and mutually integrates the results from the ICT into the ICP.

Humana At Home:

The MOC is member centric and based on an Interdisciplinary Care Team (ICT) approach, which includes participation by members, their families and/or caregivers, Primary Healthcare Providers (PCP), Humana Care Managers (HCM), Humana Care Coordinators (HCC), Humana Care Manager-Social Services (HCM-SS), In-Home Care Managers (IHCM) and specialty physicians, ancillary providers and/or vendors involved in the treatment of the member.

The member's primary Care Manager leads the Interdisciplinary Care Team efforts and is responsible for coordinating care across the continuum. Based on members identified needs from the administration of the mDAT, the primary Care Manager engages members of the Interdisciplinary Care Team (ICT), and, includes the member or member representative and the primary healthcare provider at minimum. In some instances, the primary Care Manager may invite the member's treating specialist and/or pharmacist to participate in the ICT.

The findings of a member's mDAT are available to the ICT via the documentation platform for review, and used in providing care management services to SNP members. Primary Care Managers use a specific ICT communication tool in the documentation platform to inform all internal associates of any and all ICT activity. The tool is designed to be used each time any two members of the ICT (including the member) communicate regarding needs and/or barriers identified as a result of completion of the mDAT. Stratification results and indicated needs are also discussed with each SNP member telephonically and/or in-person. This telephonic and in-person communication extends to caregivers and any other person(s) the member would like to have included. Primary Healthcare Providers are also notified when a member enters the D-SNP regarding the administration of the mDAT and contact information for the member's primary Care Manager to review results of the mDAT and provide further input when warranted. The primary Care Manager also confers ICT recommendations with members and mutually integrates the results from the ICT into the ICP.

Factor 3: Initial mDAT (HRA) and Annual Reassessment:

Initial mDAT (HRA) Process:

Humana Puerto Rico:

CarePlus Enrollment provides new member enrollment data to Humana Puerto Rico for the purpose of engaging members in care management. The initial HRA is administered telephonically to new Humana Medicare SNP members within the first 90 days of enrollment, for the purpose of providing continuity of care and appropriate coordination of clinical services. Since the member is most likely transferring from another health plan, continuity of care information is not always available. The HRA is also critical to effective risk assessment and channeling the member to the appropriate level of intervention.

Reminders are created in the Humana Clinical systems in the Care Management Specialist (CMS) queue for new members that need to have completed an HRA within the first 90 days of enrollment. Care Management Specialists will initiate telephonic attempts to reach all new members on their queue and asks for member's permission to complete the Health Risk Assessment when member is available and enroll in the Care Management program. Care Management Specialists (CMS) identifies if members have formally assigned a Power of Attorney (POA) authorizing another individual to act on a member's behalf during initial engagement. Documentation must be formalized, complete, and on file with Humana. All communication and exchange of information is done in compliance with HIPAA and confidentiality requirements. If a representative is on file and the member is unable to complete the HRA the (CMS) will complete the HRA with the member's representative. If a representative is not on file and the member is unable to complete the HRA, verbal permission may be provided to proceed with the completion of the HRA. Upon HRA completion, the member is systematically assigned to an available Care Manager transferring member's call. In

the event a Care Manager is not available to transfer the call the Care Management Specialist will create a Reminder in the Care manager queue to initiate a call attempt to the member in a future date and continue the care management process.

If the Care Management Specialist is unable to contact the member after three (3) they will follow the unable to contact process documenting the status in the Humana clinical system. A paper HRA survey will be mailed to member's address. If the member completes the survey and it is returned in the pre-addressed envelope, the Care Management Specialist will document the results in the HRA tool and assign the case to a Care Manager to initiate care management process creating a Reminder in the Care manager queue. If member refuses to participate in the Care Management Program, or is not reached following multiple attempts or does not respond to the survey by mail, the case is closed and documented as "unreachable" or "refused" HRA.

The HRA administered is utilized for the purpose of providing continuity of care and appropriate coordination of care management services. Since the member is most likely transferring from another health plan, continuity of care information is not always available. The HRA is also critical to effective risk evaluation and channeling the member to the appropriate level of intervention.

Humana At Home:

CarePlus Enrollment provides new member enrollment data to Humana At Home for the purpose of engaging members in care management. Upon receipt of enrollment data, Humana At Home uses proprietary algorithms encompassing medical, behavioral, pharmacy and lab data to stratify members upon enrollment to the SNP program. A complete profile is built on each member using the New Member Predictive Model, the predictive CBA risk score, historical claims data, and the mDAT. Methods of risk stratification and evaluating level of intervention are dynamic to best guide the most appropriate level and intensity of outreach. This is an ongoing and multi-pronged process, using data analytics and survey tools to drive best practice interventions to the right member.

Members are stratified following the CBA into levels of intervention: high intensity, high, medium and low based on pre-determined criteria, which is analyzed as data refreshes. The system logic factors in all of the criteria to place members in the right stratification. The algorithm results inform outreach prioritization for completion of the initial mDAT required to be performed within ninety (90) days of active SNP enrollment or change in Plan Benefit Package (PBP).

The initial health risk assessment (mDAT) is administered telephonically to new CarePlus SNP members or SNP members who change plan benefit packages within the first 90 days of enrollment, by Humana At Home Referral Specialist, primary Care Manager or other members of the Interdisciplinary Care Team (See Page 71 Staff Structure). Occasionally, as business needs

dictate, Regional Associates may assist with the administration and documentation of initial and annual HRAs (mDAT).If the member is unreachable by telephone to complete initial the mDAT or prefers to receive a written copy of the mDAT, a scan-able mDAT is mailed with directions for completion followed by telephonic or face-to-face contact upon receipt to discuss member responses. If member circumstances prohibit telephonic completion, the mDAT can also be completed face-to-face by In-Home Care Managers who travel to the member's home or other place of domicile.

The mDAT administered is utilized for the purpose of providing continuity of care and appropriate coordination of care management services. Since the member is most likely transferring from another health plan, continuity of care information is not always available. The mDAT is also critical to effective risk evaluation and channeling the member to the appropriate level of intervention.

Annual mDAT (HRA) Process:

Humana Puerto Rico:

Annual HRA using the same tool is performed within one year (365 days) of the previous HRA and annually thereafter. The annual HRA Reassessment can also be completed more frequently when, or as deemed appropriate by the individual member's care manager. The Care Management Specialist will follow the same process to complete member's contacts attempts for the Initial HRA.

The annual HRA can also be completed more frequently when any of the following occur, or as deemed appropriate by the member's primary Care Manager:

- Member inpatient facilities discharge
- Member-reported change in health status

Humana At Home:

Annual mDAT using the same tool is performed within one year (365 days) of the previous mDAT and annually thereafter. The annual mDAT can also be completed more frequently when any of the following occur, or as deemed appropriate by the member's primary Care Manager:

- Member hospitalization
- Member-reported change in health status
- Change in number of medications prescribed
- Other change(s) in member utilization of services

Beneficiaries that cannot or will not undergo an mDAT:

Humana Puerto Rico:

Humana Puerto Rico follows an aggressive unable to contact policy making a good faith effort at contacting members to engage in their care management benefit. A minimum of three contacts are made to reach the member for initial engagement. In the event they are unable to contact the member by telephone to complete initial HRA, a paper HRA is mailed with directions for completion followed by telephonic or face-to face contact upon receipt to discuss member responses.

Members who are unwilling to participate in the care management program or unreachable following unable to contact procedures are outreached to by a Humana Care management Specialist for annual follow-up and are placed in an "Active-UTC" status. The members who are unwilling to participate have a Basic Care Plan (BCP) that is located in the Humana Puerto Rico documentation platform. (SNP members who choose to take an active part in their care management have an active CARE PLAN in the documentation platform system). Basic Care Plans address general recommendations for member health and is mailed to the member and provider.
At any time during the year, during all successful outreach calls, low involvement level members are offered the opportunity to take a more active role in their care management. Those who choose to participate more actively in their care management are stratified per protocol, the HRA is completed, and the member is assigned to a Care Manager.

Humana At Home:

Humana At Home follows an aggressive unable to contact policy making a good faith effort at contacting CarePlus members to engage in their care management benefit. A minimum of three contacts are made at various times of the day to reach the member for initial engagement. In the event they are unable to contact the member by telephone to complete initial HRA, a scan-able HRA is mailed with directions for completion followed by telephonic or face-to face contact upon receipt to discuss member responses. If successful contact is made, the Care Manager reviews mDAT responses with member, identifying needs and problems as indicated. If the mDAT is incomplete, the Care Manager administers unanswered questions with the member. If the Care Manager is unable to contact the member, the Care Manager follows current UTC process based on level of intervention protocol. If member circumstances prohibit telephonic completion, the mDAT can be completed face-to-face by In-Home Care Managers who travel to the member's home or other place of domicile. Other additional arrangements may be made based on a member's specific disability.

Members who are unwilling to participate in the care management program or unreachable following unable to contact procedures are assigned to a Humana Care Coordinator for annual follow-up and are placed in the Monitored involvement level category. (SNP members who choose to take an active part in their care management have an active ICP in the

documentation platform). Monitored members also systematically receive a scan-able mDAT 90 days prior to their annual mDAT completion date.

At any time during the year, during all successful outreach calls, Monitored involvement level members are offered the opportunity to take a more active role in their care management. Those who choose to participate more actively in their care management are stratified per protocol, the mDAT is completed, and the member is assigned to an appropriate primary Care Manager related to the members new involvement level.

Factor 4: Plan & Rationale for Reviewing, Analyzing & Stratifying the mDAT (HRA) Results:

Humana Puerto Rico:

Humana Puerto Rico methods of risk stratification and evaluating level of acuity are dynamic to best guide the most appropriate level and intensity of intervention. The HRA (Health Risk Assessment) is comprised of a set of validated questions, after completion the risk scores are systematically computed and scored assigning a severity level for the member. Humana Puerto Rico IT Analyst is responsible for performing coding, testing, implementation, and support tasks in order to develop, maintain, and enhance computer solutions for business needs. Also, they partner with business leaders to transform business requirements into actual designs.

The Care Manager upon completion of additional assessments may reevaluate member severity level and frequency of interventions. Humana also uses proprietary algorithms encompassing medical, behavioral, pharmacy and lab data to stratify members upon enrollment to the SNP program. Members are stratified following the HRA into levels of care management: high medium, and low. The algorithm results in changes in severity level and frequency of interventions. This process affords the ability to outreach those members believed to be in need of greatest assistance in the most rapid fashion.

Following the stratification into severity levels of assumed care management for outreach prioritization, the assigned Care Manager, is prompted by their care management queue to analyze the HRA results. This analysis provides a foundation to identify issues of concern. The primary Care Manager telephonically outreaches to the member and on the first successful outreach with the member the Care Manager reviews the HRA results and utilizes the results of the HRA to mutually design the ICP with the member.

The Care Manager establishes goals, objectives, and interventions based upon the risks identified from the HRA with the member. Information gathered during the HRA process is also used by Care Managers to determine continuity of care needs and/or potential ICT needs for the member's ICP.

The findings of the member's HRA are available to Humana Puerto Rico SNP personnel and the Interdisciplinary Care Team via Humana Puerto Rico documentation platform for review, and used in providing care management services to members. The member's Care Manager reviews the HRA results with the member and their caregiver telephonically, should a member prefer to receive HRA results in written form, HRA information can be made available via mail. Should a member choose this scenario, a Humana Puerto Rico care management team member would request to review the information with the member once completed.

Humana At Home:

Methods of risk stratification and evaluating level of acuity are dynamic to best guide the most appropriate level and intensity of intervention. The mDAT (Health Risk Assessment) is comprised of a set of validated questions, after completion the seven domain risk scores are systematically computed and scored. Humana's Data Analytics and Quality Assurance Teams provide analyses and oversight of the tool. Humana At Home Technology Analyst is responsible for performing coding, testing, implementation, and support tasks in order to develop, maintain, and enhance computer solutions for business needs. Also, they partner with business leaders to transform business requirements into actual designs.

Humana At Home uses proprietary algorithms encompassing medical, behavioral, pharmacy and lab data to stratify CarePlus members upon enrollment to the SNP program. Members are stratified following the CBA into levels of care management: high intensity, high, medium and low. The algorithm results inform outreach prioritization for completion of the initial mDAT within 90 days of initial enrollment or a change in plan benefit package.

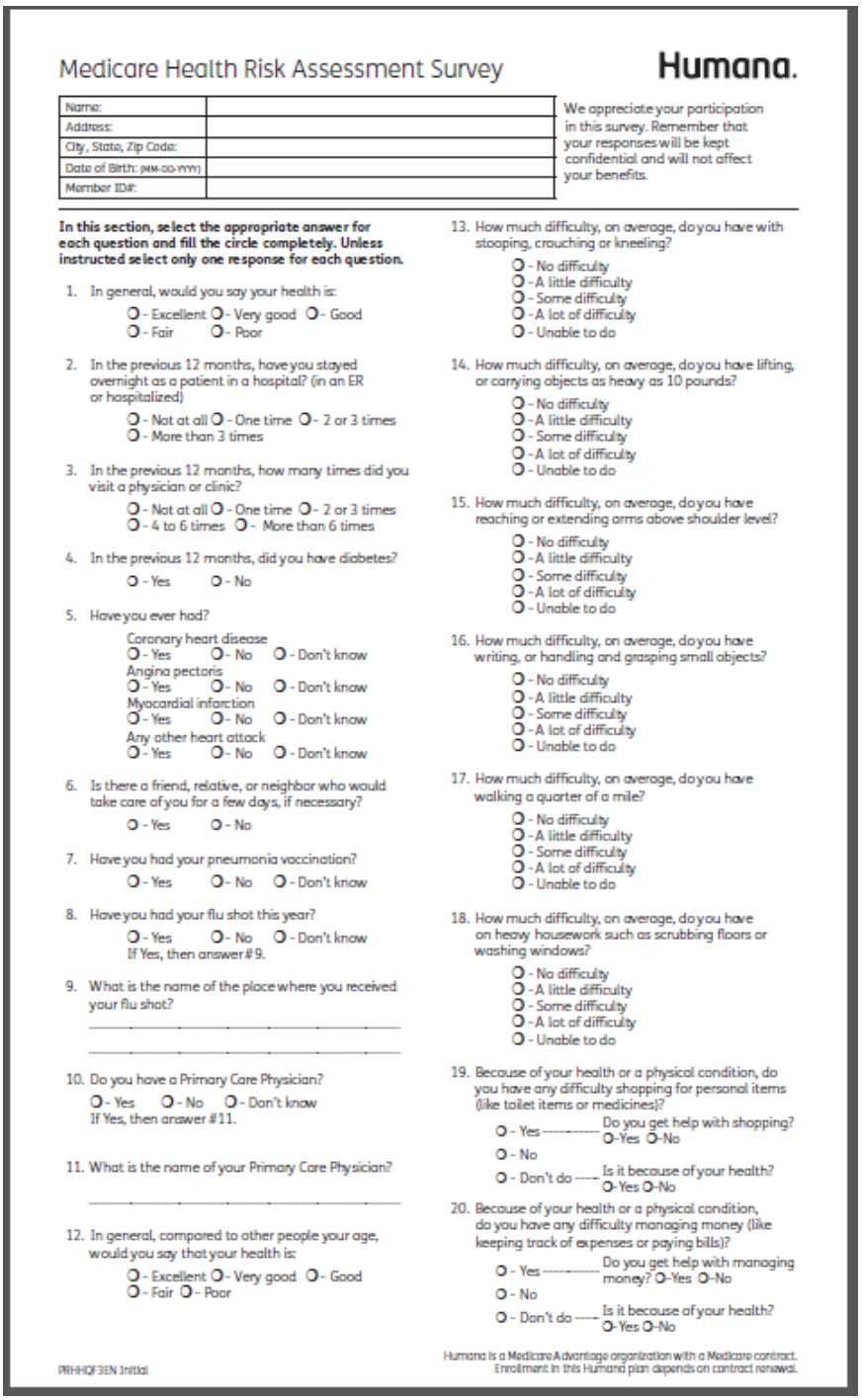
The algorithm results inform outreach prioritization for initial mDAT. This process affords the ability to outreach those members believed to be in need of greatest assistance in the most rapid fashion. Information from analytics, coupled with mDAT information, determines the contact frequency for outreach protocol.

Following the stratification into tiers of assumed care management for outreach prioritization, systematically a primary Care Manager is assigned, who is prompted by their care management roster to analyze the mDAT results. This analysis provides a foundation to identify issues of concern. The primary Care Manager telephonically outreaches to the member and on the first successful outreach with the member the Care Manager reviews the mDAT results and utilizes the results of the mDAT to mutually design the ICP with the member.

The Care Manager establishes goals, objectives, and interventions based upon the medium and high risks identified from the mDAT with the member. Information gathered during the mDAT process is also used by primary Care Managers to determine continuity of care needs and/or potential ICT needs for the member's ICP (See Page 106 – Use of mDAT to Develop ICP).

The findings of the member's mDAT are available to SNP personnel and the Interdisciplinary Care Team via the documentation platform for review, and used in providing care management services to members. The member's primary healthcare provider may be contacted verbally to review the member's mDAT results by the Care Manager for further review and input, additionally primary healthcare providers are notified when the member enters SNP care management to contact the primary Care Manager to discuss mDAT results as well. If a member requests their mDAT information be shared with providers in the network, including but not limited to behavioral health practitioners, allied health professionals, etc. who are not considered their primary care provider, the Care Manager obtains permission from the member to verbally contact the practitioner for their review and input. The member's primary Care Manager reviews the mDAT results with the member and their caregiver telephonically, should a member prefer to receive mDAT results in written form, mDAT information can be made available via mail. Should a member choose this scenario, a Humana At Home care management team member would request to review the information with the member once completed.

Example: Humana Puerto Rico Health Risk Assessment Tool:



Medicare Health Risk Assessment Survey

Humana.

Name:	
Address:	
City, State, Zip Code:	
Date of Birth: (MM-DD-YYYY)	
Member ID#:	

We appreciate your participation in this survey. Remember that your responses will be kept confidential and will not affect your benefits.

In this section, select the appropriate answer for each question and fill the circle completely. Unless instructed select only one response for each question.

1. In general, would you say your health is:
   - Excellent - Very good - Good
   - Fair - Poor

2. In the previous 12 months, have you stayed overnight as a patient in a hospital? (in an ER or hospitalized)
   - Not at all - One time - 2 or 3 times
   - More than 3 times

3. In the previous 12 months, how many times did you visit a physician or clinic?
   - Not at all - One time - 2 or 3 times
   - 4 to 6 times - More than 6 times

4. In the previous 12 months, did you have diabetes?
   - Yes - No

5. Have you ever had?
   - Coronary heart disease: Yes - No - Don't know
   - Angina pectoris: Yes - No - Don't know
   - Myocardial infarction: Yes - No - Don't know
   - Any other heart attack: Yes - No - Don't know

6. Is there a friend, relative, or neighbor who would take care of you for a few days, if necessary?
   - Yes - No

7. Have you had your pneumonia vaccination?
   - Yes - No - Don't know

8. Have you had your flu shot this year?
   - Yes - No - Don't know
   If Yes, then answer #9.

9. What is the name of the place where you received your flu shot?

   _____

   _____

10. Do you have a Primary Care Physician?
    - Yes - No - Don't know
    If Yes, then answer #11.

11. What is the name of your Primary Care Physician?

    _____

12. In general, compared to other people your age, would you say that your health is:
    - Excellent - Very good - Good
    - Fair - Poor

13. How much difficulty, on average, do you have with stooping, crouching or kneeling?
    - No difficulty
    - A little difficulty
    - Some difficulty
    - A lot of difficulty
    - Unable to do

14. How much difficulty, on average, do you have lifting, or carrying objects as heavy as 10 pounds?
    - No difficulty
    - A little difficulty
    - Some difficulty
    - A lot of difficulty
    - Unable to do

15. How much difficulty, on average, do you have reaching or extending arms above shoulder level?
    - No difficulty
    - A little difficulty
    - Some difficulty
    - A lot of difficulty
    - Unable to do

16. How much difficulty, on average, do you have writing, or handling and grasping small objects?
    - No difficulty
    - A little difficulty
    - Some difficulty
    - A lot of difficulty
    - Unable to do

17. How much difficulty, on average, do you have walking a quarter of a mile?
    - No difficulty
    - A little difficulty
    - Some difficulty
    - A lot of difficulty
    - Unable to do

18. How much difficulty, on average, do you have on heavy housework such as scrubbing floors or washing windows?
    - No difficulty
    - A little difficulty
    - Some difficulty
    - A lot of difficulty
    - Unable to do

19. Because of your health or a physical condition, do you have any difficulty shopping for personal items (like toilet items or medicines)?
    - Yes ——— Do you get help with shopping? Yes - No
    - No
    - Don't do ——— Is it because of your health? Yes - No

20. Because of your health or a physical condition, do you have any difficulty managing money (like keeping track of expenses or paying bills)?
    - Yes ——— Do you get help with managing money? Yes - No
    - No
    - Don't do ——— Is it because of your health? Yes - No

PRHHQF3EN Initial

Humana is a Medicare Advantage organization with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

21. Because of your health or a physical condition, do you have any difficulty walking across the room? (Use of cane or walker is OK).

O - Yes ——— Do you get help with light housework? O-Yes O-No
O - No
O - Don't do ——— Is it because of your health? O-Yes O-No

22. Because of your health or a physical condition, do you have any difficulty doing light housework (like washing dishes, straightening up, or light cleaning)?

O - Yes ——— Do you get help when walking? O-Yes O-No
O - No
O - Don't do ——— Is it because of your health? O-Yes O-No

23. Because of your health or a physical condition, do you have any difficulty bathing or showering?

O - Yes ——— Do you get help with bathing or showering? O-Yes O-No
O - No
O - Don't do ——— Is it because of your health? O-Yes O-No

24. Over the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things?

O - Not at all O - More than half the days
O - Several days O - Nearly every day

25. Over the past 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?

O - Not at all O - More than half the days
O - Several days O - Nearly every day

26. Over the past 2 weeks, how often have you been bothered by having trouble falling or staying asleep, or sleeping too much?

O - Not at all O - More than half the days
O - Several days O - Nearly every day

27. Over the past 2 weeks, how often have you been bothered by feeling tired or having little energy.

O - Not at all O - More than half the days
O - Several days O - Nearly every day

28. Over the past 2 weeks, how often have you been bothered by having poor appetite or overeating?

O - Not at all O - More than half the days
O - Several days O - Nearly every day

29. Over the past 2 weeks, how often have you been bothered by feeling bad about yourself – or that you are in a failure or have let yourself or your family down.

O - Not at all O - More than half the days
O - Several days O - Nearly every day

30. Over the past 2 weeks, how often have you been bothered by having trouble concentrating on things, such as reading the newspaper or watching television.

O - Not at all O - More than half the days
O - Several days O - Nearly every day

31. Over the past 2 weeks, how often have you been bothered by moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety of restless that you have been moving around a lot more than usual.

O - Not at all O - More than half the days
O - Several days O - Nearly every day

32. Over the past 2 weeks, how often have you been bothered by thoughts that you would be better off dead, or of hurting yourself.

O - Not at all O - More than half the days
O - Several days O - Nearly every day

33. Do you have planned surgery or hospitalization after the effective date of your enrollment?

O - Yes O - No

34. Are you currently receiving Home Health Care Services?

O - Yes O - No

35. Are you currently using any Durable Medical Equipment?

O - Yes O - No

36. Do you have any active medical treatment, such as chemotherapy, dialysis, etc.?

O - Yes O - No

37. Need to refill any of your medications before starting with Humana?

O - Yes O - No

38. How you would rate your satisfaction with Humana?

O - Very Satisfied
O - Satisfied
O - Neither Satisfied nor Dissatisfied
O - Dissatisfied
O - Very Dissatisfied

39. When thinking of your rating is there a certain area within Humana you are specifically thinking about, such as, Pharmacy, Benefits, Customer Service, Your Humana Agent, Claims, and Premiums or, was that just a General Overall Rating, or, did you have a different area in mind?

(check all that apply)

O - Pharmacy
O - Benefits
O - Customer Service
O - Your Humana Agent
O - Claims
O - Premiums
O - Was that just a general overall rating
O - Other area (specify): _____

Humana offers many health programs as part of your membership, at no additional cost. If your responses today indicate that any of our programs might help you, a Humana Case Manager may call you about joining a program.

Are you interested in obtaining additional information about our programs?

O - Yes O - No

Are you interested in being contacted by a nurse or a social worker to help you with your health problems?

O - Yes O - No

What is the best way to contact you?

Phone number

(_____) _____.

Do you have any preference about the best time to be contacted? Days of the week and time; please indicate your preference.

_____

_____

Humana.

PRHHQF3EN Initial

Humana is a Medicare Advantage organization with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

Example: Humana At Home mDAT (Health Risk Assessment):

Member H# _____ **Date:** _____

I

1. **Compared to other people your age, how would you describe your health? (SELECT ONE)**

   Excellent or good
   Fair or poor

2. **On a typical day, are any of these activities very difficult or impossible to do? Please answer "Yes" or "No" to each of the following.**

Activity	Yes	No
Stooping, crouching or kneeling?		
Lifting or carrying objects as heavy as 10 pounds, like a sack of potatoes?		
Reaching or extending your arms above shoulder level?		
Writing or handling and grasping small objects?		
Walking a quarter of a mile? That's about 2 or 3 blocks.		
Heavy housework such a scrubbing floors or washing windows?		

3. **Because of your health, is it too difficult or impossible for you to perform any of these activities without help from someone else? Please answer "Yes" or "No" to each of the following.**

Activity	Yes	No
Shopping for personal items, like toilet items or medicines?		
Managing money, like keeping track of expenses or paying bills?		
Walking across the room? (USE OF A CANE OR WALKER IS OK)		
Doing light housework, like washing dishes, straightening up or light cleaning?		
Bathing or showering?		

4. **Please answer "Yes" or "No" to each of the following. Have you had any…**

	Yes	No
Problems with sleep recently?		
Problems with eating recently?		
Falls in the past 6 months?		
Skin breakdowns or wounds recently?		
Pain that interferes with your life?		

5. **How many different prescription medications do you take?** ☐

6. **Do you live…** *(Please check all that apply)*

Alone?	
With a spouse?	
With a son or daughter?	
With other family?	
Other	

7. Is there a friend, relative or neighbor that would take care of you for a few days, if necessary? *(SELECT ONE)*

Yes ☐ No ☐

8. **Do you live in...**(SELECT ONE)

An independent house, apartment, condominium or mobile home?	
An assisted-living apartment or board and care home?	
A nursing home?	
Other?	

9. **Do you have any concerns about safety hazards in your home?** (SELECT ONE)

Yes ☐ No ☐

10. **What month were you born?**

Δ January	April	July	October
Δ February	May	August	November
Δ March	June	September	December

11. **How often do you have difficulty remembering to take your medication?** (SELECT ONE)

Never or rarely	
Once in a while	
Sometimes	
Usually	
All of the time	

12. **Over the last 2 weeks, have you had little interest or pleasure in doing things?** (SELECT ONE)

Not at all	
Several days	
More than half the days	
Nearly everyday	

13. **Over the last 2 weeks, have you felt down, depressed or hopeless?** (SELECT ONE)

Not at all	
Several days	
More than half the days	
Nearly everyday	

14. **Within the past 3 months, have you had difficulty meeting your living expenses?**

Yes ☐ No ☐

***** **Next mDAT Due:** ☐ 6 Months ☐ 12 Months

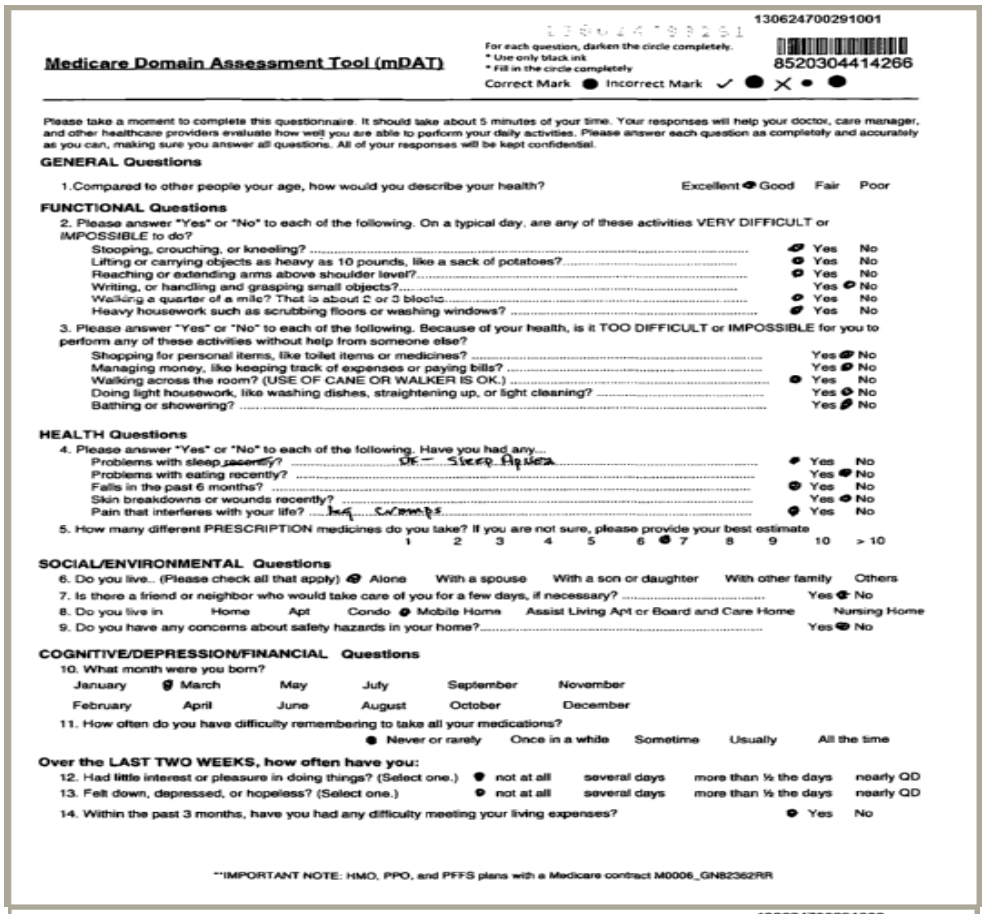
Example: Humana At Home Completed mDAT (Health Risk Assessment):

Name	DOB	ID CARD	MEMBER ID	MDAT	CARE MANAGER
[redacted]					

mDAT Risk Scores & Category Levels by Domain					
Health Risk Category	Health Risk Category	Overall Risk Score	Overall Risk Category	Functional Risk Score	Functional Risk Category
11.39	Medium	4.07	High	3.21	Low
Social Risk Score	Social Risk Category	Environmental Risk Score	Environmental Risk Category	Cognitive Risk Score	Cognitive Risk Category
0	Low	3.67	Medium	0	Low
Financial Risk Score	Financial Risk Category	Depression Risk Score	Depression Risk Category		
0.03	High	0	Low		

Cognitive/Depression/Financial Questions and Member Answers	
In what month were you born - respondent answered correctly?	Yes
How often do you have difficult remembering to take all your medications?	Never or rarely
How often (last 2 weeks) have you had little interest or pleasure in doing things?	Not at all
How often (last 2 weeks) have you felt down, depressed, or hopeless?	Not at all or Several Days
Within the last 3 months, have you had any difficult meeting your living expenses?	Yes
Functional Questions and Member Answers	
Do you find it difficult or impossible to stoop, crouch, or kneel?	No
Do you find it difficult or impossible to lift or carry objects (10lbs)?	Yes
Do you find it difficult or impossible to reach or extend your arms above shoulder level?	No
Do you find it difficult or impossible to write or handle/grasp small objects?	No
Do you find it difficult or impossible to walk 1/4 mile (~2-3 blocks)?	No
Do you find it difficult or impossible to do heavy housework?	No
Without help, is it difficult/impossible for you to shop for personal items?	Yes
Without help, is it difficult/impossible for you to manage your money?	Yes
Without help, is it difficult/impossible for you to walk across the room?	No
Without help, is it difficult/impossible for you to do light housework?	No
Without help, is it difficult/impossible for you to bathe or shower?	No
Health Questions and Member Answers	
Describe your health:	Fair or Poor
Problems sleeping recently?	Yes
Problems eating recently?	No
Falls in the past 6 months?	Yes
Pain that interferes with your life?	No
Skin breakdowns or wounds recently?	No
How many PRESCRIPTION medications do you take?	0-5
Social/Environmental Questions and Member Answers	
Do you live alone?	Family
Is there a friend/neighbor who could take care of you for a few days?	Yes
Do you live in an....?	House, Apartment, Condo, or Mobile home
Do you have any concerns about safety hazards in your home?	No

Example: Humana At Home Hard Copy/Scan-able mDAT (HRA):



130624700291001

Medicare Domain Assessment Tool (mDAT)

For each question, darken the circle completely.
* Use only black ink
* Fill in the circle completely

8520304414266

Correct Mark ● Incorrect Mark ✓ ● ✗ ● ●

Please take a moment to complete this questionnaire. It should take about 5 minutes of your time. Your responses will help your doctor, care manager, and other healthcare providers evaluate how well you are able to perform your daily activities. Please answer each question as completely and accurately as you can, making sure you answer all questions. All of your responses will be kept confidential.

GENERAL Questions

1. Compared to other people your age, how would you describe your health? Excellent ● Good Fair Poor

FUNCTIONAL Questions

2. Please answer "Yes" or "No" to each of the following. On a typical day, are any of these activities VERY DIFFICULT or IMPOSSIBLE to do?
   - Stooping, crouching, or kneeling? ● Yes No
   - Lifting or carrying objects as heavy as 10 pounds, like a sack of potatoes? ● Yes No
   - Reaching or extending arms above shoulder level? ● Yes No
   - Writing, or handling and grasping small objects? Yes ● No
   - Walking a quarter of a mile? That is about 2 or 3 blocks ● Yes No
   - Heavy housework such as scrubbing floors or washing windows? ● Yes No

3. Please answer "Yes" or "No" to each of the following. Because of your health, is it TOO DIFFICULT or IMPOSSIBLE for you to perform any of these activities without help from someone else?
   - Shopping for personal items, like toilet items or medicines? Yes ● No
   - Managing money, like keeping track of expenses or paying bills? Yes ● No
   - Walking across the room? (USE OF CANE OR WALKER IS OK.) ● Yes No
   - Doing light housework, like washing dishes, straightening up, or light cleaning? Yes ● No
   - Bathing or showering? Yes ● No

HEALTH Questions

4. Please answer "Yes" or "No" to each of the following. Have you had any...
   - Problems with sleep ~~recently~~? DE- Sleep Apnea ● Yes No
   - Problems with eating recently? Yes ● No
   - Falls in the past 6 months? ● Yes No
   - Skin breakdowns or wounds recently? Yes ● No
   - Pain that interferes with your life? leg cramps ● Yes No

5. How many different PRESCRIPTION medicines do you take? If you are not sure, please provide your best estimate
   1 2 3 4 5 6 ● 7 8 9 10 > 10

SOCIAL/ENVIRONMENTAL Questions

6. Do you live... (Please check all that apply) ● Alone With a spouse With a son or daughter With other family Others
7. Is there a friend or neighbor who would take care of you for a few days, if necessary? Yes ● No
8. Do you live in Home Apt Condo ● Mobile Home Assist Living Apt or Board and Care Home Nursing Home
9. Do you have any concerns about safety hazards in your home? Yes ● No

COGNITIVE/DEPRESSION/FINANCIAL Questions

10. What month were you born?
    January ● March May July September November
    February April June August October December
11. How often do you have difficulty remembering to take all your medications?
    ● Never or rarely Once in a while Sometime Usually All the time

Over the LAST TWO WEEKS, how often have you:

12. Had little interest or pleasure in doing things? (Select one.) ● not at all several days more than ½ the days nearly QD
13. Felt down, depressed, or hopeless? (Select one.) ● not at all several days more than ½ the days nearly QD
14. Within the past 3 months, have you had any difficulty meeting your living expenses? ● Yes No

**IMPORTANT NOTE: HMO, PPO, and PFFS plans with a Medicare contract M0006_GN82362RR

130624700291002

8520304414266

Please complete this section

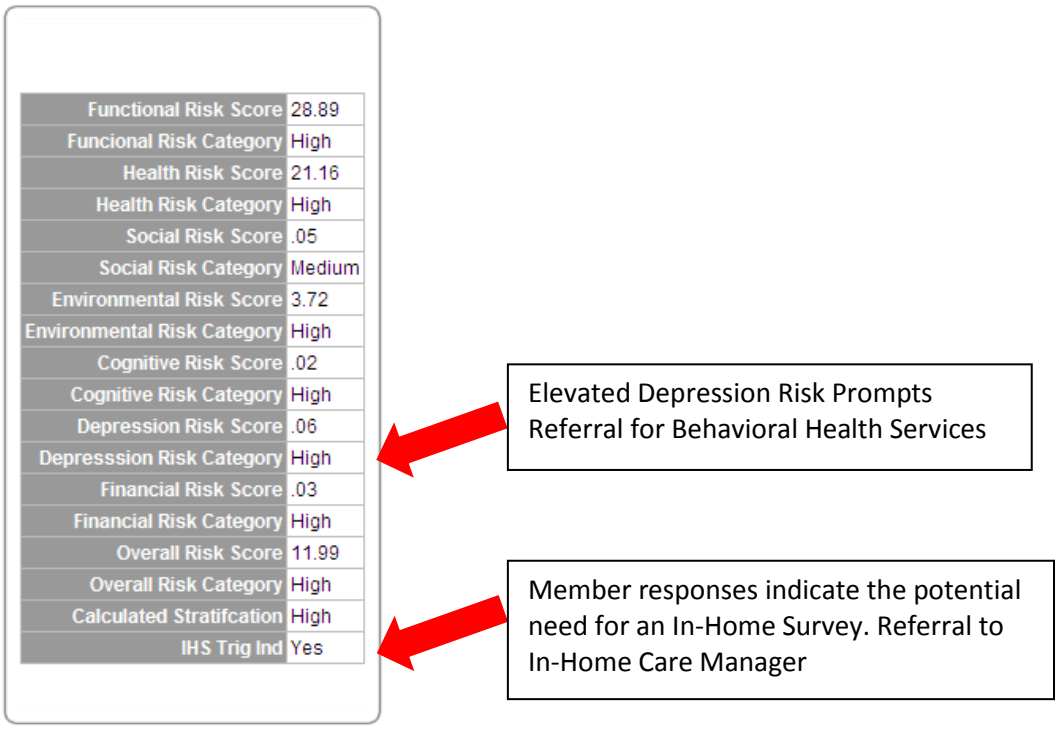
I attest (promise) that the information on this form is true and correct to the best of my knowledge. I understand that my signature, or the signature of the person authorized to act on my behalf, certifies that: 1) I have completed this form, or that 2) my representative is authorized to complete this form.

I understand that my signature – or the signature of the person authorized to act on my behalf under the laws of the state where the individual resides – on this document means I have read and understand the contents of this declaration. If signed by an authorized individual, as described above, this signature certifies that: 1) this person is authorized under state law to complete this form and 2) documentation of this authority is available upon request by Humana.

[redacted]

**IMPORTANT NOTE: HMO, PPO, and PFFS plans with a Medicare contract M0006_GN82362RR

Example: Humana At Home mDAT Scoring & Alerts for Supplemental Benefits



Functional Risk Score	28.89
Funcional Risk Category	High
Health Risk Score	21.16
Health Risk Category	High
Social Risk Score	.05
Social Risk Category	Medium
Environmental Risk Score	3.72
Environmental Risk Category	High
Cognitive Risk Score	.02
Cognitive Risk Category	High
Depression Risk Score	.06
Depresssion Risk Category	High
Financial Risk Score	.03
Financial Risk Category	High
Overall Risk Score	11.99
Overall Risk Category	High
Calculated Stratifcation	High
IHS Trig Ind	Yes

Example: Humana At Home Materials Mailed for mDAT Contact to Primary Care Provider:

CarePlus
HEALTH PLANS, INC.

<Insert Date>

<Insert provider name>
<Insert provider address 1>
<Insert provider address 2>
<Insert City, State Zip>

Dear Physician:

This letter is to let you know that your CarePlus-covered Medicare Advantage patient, <Insert member name>, <Insert member ID #>, has agreed to participate in the Care Management Program that is part of CarePlus' Special Needs Plan (SNP) benefits. This program supports your treatment and medication plan for your CarePlus-covered patient. Please review the attached Medicare Domain Assessment Tool (mDAT) Overview. This tool provides information from a recent health-risk assessment of your patient. Please call <insert member's Care Manager name>, the patient's Care Manager, with any questions, updates or health information, at 1-800-734-9592, <Insert Care Manger extension number>.

Our involvement provides your patient and <Insert either the word his or her> caregiver with a personal Care Manager who leads an interdisciplinary team of nurses, social workers, and behavioral health specialists. The Care Management Program includes ongoing telephonic and on-site health support, such as health education, reinforcement of your treatment and medication plan, in-home assessments, caregiver support and assistance with accessing community services so that CarePlus-covered patients remain independent and safe in their homes.

As the treating health care provider, you are an integral member of your patient's Interdisciplinary Care Team (ICT). It is important that we share pertinent information with you as we work with your patient. I may reach out to you to seek clarification to help support your plan of care and medication regimen. There may be times when I ask for your input and invite you to participate in a three-way call or care conference to resolve an emergent or persistent issue.

If you have any questions, please feel free to call [xxx-xxx-xxxx], from 8 a.m. to 5 p.m., Monday through Friday, Eastern time. TTY users should call <711.>

Thank you for taking care of our members.

Sincerely,

Dr. John McGoohan
Market Vice President
Enclosure: mDAT Overview

H1019_HSCMmDATPrvLE2014

ELEMENT C: INDIVIDUALIZED CARE PLAN (ICP):

Factor 1: Individualized Care Plan (ICP) - Essential Components:

Humana Puerto Rico:

All SNP members are required to have an active, individualized care plan (ICP) documented in the Humana Puerto Rico documentation platform. All members have an engagement care plan upon enrollment and an ICP is developed upon enrollment in active care management following the completion of the HRA. The ICP addresses severity levels identified through the HRA evaluation process and planned interventions; such as connections to benefits and special services in order to meet specific goals and objectives, the ICP also addresses prioritized goals. For actively managed members, all ICP information is shared, discussed, and mutually designed with the member and/or caregiver on an ongoing basis as the member works with his or her Care Manager.

ICPs are created, reviewed and updated at a minimum with each successful member contact according to the level of intervention outreach protocol i.e., weekly, monthly, quarterly, etc. ICPs may also be updated with each transition and/or significant changes in member's health care status as agreed upon by the Care Manager and member. The care management plan includes an assessment of the member's progress toward overcoming barriers to care and meeting treatment goals. When it has been identified that the member's agreed upon goals have not been met the following steps are taken:

- Barriers to achieving identified goals are defined and discussed
- Goals are modified as warranted or desired by the member and/or caregiver
- Alternative actions are created to succeed in achieving the newly identified goals
- Changes and revisions to the ICP are documented

Members' personal healthcare preferences are established during the administration of both the HRA and more specific surveys such as the general Care Management Assessment, Post Discharge Assessments and Medication Adherence among others. Preferences for care are then integrated into the ICP as appropriate. Humana Puerto Rico care management interventions can be broadly categorized by the Area of Focus and services specifically tailored to the beneficiary's needs which may include the following:

- **Medication Review:** Thorough and ongoing medication reviews, screening for member medication knowledge and adherence gaps, and offering of printed and/or verbal education on medications. Care Manages also arrange for pharmacist review of complex medication regimens, or regimens for which numerous interactions are identified through drug

interaction screening software and indicator flags. In addition, Care Managers coordinate and facilitate communication with the physician as needed, help members obtain devices that promote adherence (pill boxes, pill cutters, reminders, etc.), and refer members with financial need to pharmacy assistance programs.

- **Care Coordination:** The Care Manager leads the ICT and engages the support of other internal and external Humana resources, make appropriate referrals, participate in care team conferences, and request case reviews. The Care Manager also facilitates communication between members and physicians and providers regarding progress toward goals i.e., the need to adjust therapy to enable a member to reach goals, and refer members to physicians and providers to evaluate condition, symptoms, medication, end of life planning, durable medical equipment needs, and home health issues or needs.
- **Care Transitions and Post Discharge Support:** Care Managers work closely with the Utilization Management (UM) team to coordinate a seamless member transition between levels of care. Post discharge support needs are addressed in order to maximize member recovery and mitigate preventable readmissions.
- **Health Education:** Care Managers provide members with approved educational materials related to specific health conditions and concerns. They also provide verbal coaching and written education on other general health topics common in the Medicare population, along with referrals to community-based education resources.
- **Health and Function:** Evaluation of the member's physical and psychological health and functional status to provide education and health support, and assist the member and/or caregiver to manage their diseases as well as comorbid conditions such as COPD, CHF, depression, dementia, chronic kidney disease and end state renal disease to maintain optimal function and quality of life.
- **Interpersonal and Social Relationships:** Care Managers refer members to other ICT members, providers and community resources to address issues such as social isolation and social networking, cognition and dementia, elder abuse, and caregiver strain.
- **Knowledge of When to Call the Physician:** Care Managers assist members to be informed health care consumers and to establish a regular source of health care. They provide written and verbal education regarding warning signs of heart failure, diabetic complications, as well as common co-morbid complications including COPD, and depression. They also help members establish an emergency contact and action plan. Members may be supported via three way calls or warm transfers to physicians and providers for things like making an appointment or consulting with a pharmacist.
- **Preventive and Screening Services:** Care Managers educate and provide reminders for obtaining health and preventions screening tests and services related to HEDIS measures,

annual flu vaccine, colon and breast cancer screens, etc. They also support members in monitoring progress toward goals and self-management of their chronic health conditions.

- **Self-Care Management & Personal Healthcare Preferences:** Humana Puerto Rico supports self-care management and healthy behaviors based on the member's stage of readiness to change. Referrals are made to providers or community-based resources for smoking cessation, alcohol or substance abuse, nutrition, physical activity and weight management.
- **Connections to Community Resources**: Evaluating needs for additional resources and support services for members, often collaborating with other Humana Puerto Rico staff. This multidisciplinary team locates and helps members to access services that include transportation, meal services, pharmacy assistance, and help with Medicaid applications.
- **Coordination and Access to Benefits:** Primary Care Managers evaluate member needs and support awareness of access to plan benefits and assist in coordination Medicare and Medicaid benefits.

Humana At Home:

All SNP members are required to have an active, individualized care plan (ICP) documented and saved on a secure platform. All members have an engagement care plan upon enrollment and an ICP is developed upon enrollment in active care management following the completion of the mDAT. The ICP addresses each medium and high risk area identified through the mDAT evaluation process and planned interventions; such as connections to benefits and special services in order to meet specific goals and objectives, the ICP also addresses prioritized goals. For actively managed members, all ICP information is shared, discussed, and mutually designed with the member and/or caregiver on an ongoing basis as the member works with his or her primary Care Manager.

ICPs are created, reviewed and updated with each successful member contact by the Primary Care Manager to document progress towards goals, as member's needs change, with each care transition and or significant change in member's health care status. The care management plan includes an assessment of the member's progress toward overcoming barriers to care and meeting treatment goals. When it has been identified that the member's agreed upon goals have not been met the following steps are taken:

- Barriers to achieving identified goals are defined and discussed
- Goals are modified as warranted or desired by the member and/or caregiver
- Alternative actions are created to succeed in achieving the newly identified goals
- Changes and revisions to the ICP are documented

Members' personal healthcare preferences are established during the administration of the mDAT and more specific surveys such as theComprehensive Survey . Preferences for care are then integrated into the ICP as appropriate. Care management interventions can be broadly

categorized by the Area of Focus and services specifically tailored to the beneficiary's needs which may include the following:

Medication Review: Thorough and ongoing medication reviews, screening for member medication knowledge and adherence gaps, and offering of printed and/or verbal education on medications. Primary Care Manages also arrange for pharmacist review of complex medication regimens, or regimens for which numerous interactions are identified through drug interaction screening software and indicator flags. In addition, primary Care Managers coordinate and facilitate communication with the physician as needed, help members obtain devices that promote adherence (pill boxes, pill cutters, reminders, etc.), and refer members with financial need to pharmacy assistance programs.

Treatment Plan Support: Primary Care Managers support the member's self-efficacy and provide referrals for needed equipment supplies for self-management and self-monitoring. These supplies include blood glucose meters, blood pressure equipment, and weight monitoring devices. Primary Care Managers also arrange for in-person evaluation of self-management skill and support.

Care Coordination: The primary Care Manager leads the ICT and engages the support of other internal and external resources, make appropriate referrals, participate in care team conferences, and request case reviews. The primary Care Manager also facilitates communication between members and physicians and providers regarding progress toward goals i.e., the need to adjust therapy to enable a member to reach goals, and refer members to physicians and providers to evaluate condition, symptoms, medication, end of life planning, durable medical equipment needs, and home health issues or needs.

Decision Coaching: Primary Care Managers provide printed material and verbal education regarding end-of-life planning, including appropriate state forms to facilitate documentation of end-of-life wishes. Including referrals to community resources and other agencies such as hospice to assist members making end-of-life decisions. Primary Care Managers utilize evidence-based decision coaching tools such as Krames On-Demand.

Care Transitions and Post Discharge Support: Care Managers work closely with the Utilization Management (UM) team to coordinate a seamless member transition between levels of care. Post discharge support needs are addressed in order to maximize member recovery and mitigate preventable readmissions.

Health Education: Primary Care Managers provide members with approved educational materials related to specific health conditions and concerns. They also provide verbal coaching and written education on other general health topics common in the Medicare population, along with referrals to community-based education resources.

Independence at Home: Primary Care Managers work to maintain the member's safety and independence at home. They provide referrals for in-home environmental, safety, and fall risk surveys by an In-Home Care Manager. In addition, make external referrals to community-based services that can assist members in making home modifications that enhance function and safety.

Health and Function: Evaluation of the member's physical and psychological health and functional status to provide education and health support, and assist the member and/or caregiver to manage their diseases as well as comorbid conditions such as COPD, CHF, depression, dementia, chronic kidney disease and end state renal disease to maintain optimal function and quality of life.

Interpersonal and Social Relationships: Primary Care Managers refer members to other ICT members, providers and community resources to address issues such as social isolation and social networking, cognition and dementia, elder abuse, and caregiver strain.

Knowledge of When to Call the Physician: Primary Care Managers assist members to be informed health care consumers and to establish a regular source of health care. They provide written and verbal education regarding warning signs of heart failure, diabetic complications, as well as common co-morbid complications including COPD, and depression. They also help members establish an emergency contact and action plan. Members may be supported via three way calls or warm transfers to physicians and providers for things like making an appointment or consulting with a pharmacist.

Preventive and Screening Services: Primary Care Managers educate and provide reminders for obtaining health and preventions screening tests and services related to HEDIS measures, annual flu vaccine, colon and breast cancer screens, etc. They also support members in monitoring progress toward goals and self-management of their chronic health conditions.

Self-Care Management & Personal Healthcare Preferences: CarePlus and Humana At Home supports self-care management and healthy behaviors based on the member's stage of readiness to change. Referrals are made to providers or community-based resources for smoking cessation, alcohol or substance abuse, nutrition, physical activity and weight management.

Connections to Community Resources: Evaluating needs for additional resources and support services for members, often collaborating with other staff. This multidisciplinary team locates and helps members to access services that include transportation, meal services, pharmacy assistance, and help with Medicaid applications.

Coordination and Access to Benefits: Primary Care Managers evaluate member needs and support awareness of access to plan benefits and assist in coordination Medicare and Medicaid benefits.

Factor 2 & 3: Individualized Care Plan (ICP) Development Process & Personnel:

Humana Puerto Rico:

Each ICP is developed to addresses the following:

- Development of a care management plan, including prioritized goals that consider the member's and caregiver's goals, preferences and desired level of involvement in the care management plan
- Identification of barriers to meeting their goals or complying with the plan
- Development of a schedule for follow up and communication
- Development and communication of their self-management plans
- A process to assess their progress against care management plans

Each ICP outlines:

  - Goals and objectives as agreed upon by the member and/or caregiver
  - 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
  - End of life planning for members who have not participated in this type of planning and wish to do so
  - Any services or resources for which a member may qualify based on diagnoses, disability, or other criteria (such as financial) are included in the ICP to ensure members are able to access all appropriate programs
  - A follow-up schedule that allows both the member and his/her primary Care Manager to stay on track with meeting the stated objectives of the plan

ICPs are created, reviewed and updated at a minimum with each successful member contact according to the level of intervention outreach protocol i.e., weekly, monthly, quarterly, etc. ICPs may also be updated with each transition and/or significant changes in member's health care status as agreed upon by the primary Care Manager and member. The level of intervention outreach protocol is a dynamic designation and a means for the Care Manager to identify and stratify member's intensity of care management needs based on health outcomes. Care Managers have the option of moving members to a higher or lower level of intervention to increase outreach as the member's health care needs change.

The ICP is mutually shared, discussed, and mutually designed with the member and/or caregiver on an ongoing basis with his/her Care Manager. The Care Manager is responsible for coordinating the ICP interventions. The Care Manager, in conjunction with the member and Interdisciplinary Care Team, coordinates efforts to make the ICP actionable. Preferred updates

to the ICP are completed by the Care Manager, yet in their absence, Humana's systems and protocols allow the flexibility for covering staff to have editing access to member's records.

Collaborative discussions between a Care Manager and a member to strengthen a member's motivation and commitment for change is critical for preventative healthcare and avoiding hospitalizations and readmissions. The primary objective of the ICP is to guide best practice, support member goals, and delineate areas for physician input and care coordination.

Care Managers work with members through time to help them set and meet their goals. This activity and progress is tracked through the ICP. The continuously updated ICP addresses the gaps in care identified as medium and high risk from the HRA and the primary Care Manager assigns benefits and special services to the member to meet the prioritized care goals.

Humana Care Managers are the personnel responsible for developing the ICP in conjunction with the member and their caregiver. The ICP will also be inclusive of information provided by any or all of the following internal associates:

- Humana Puerto Rico Medical Director
- Humana Puerto Rico Clinical Pharmacist
- Social Service and Behavioral Health Specialists
- Health Coaches
- UM Staff

External input is also included in an ICP when available. External input may come from:

- Primary Healthcare Providers/Physicians
- Hospital Discharge Planners

In the event the member is unable to be reached or refuses participation in active care management, a Basic Care Plan is developed by the member's Care Manager in collaboration with the member's Primary Care Physician (PCP). The Healthy Action Plan is tailored to the member's SNP Type. The Healthy Action Plan is shared with the PCP and member when created and input is requested.

Individualized Care Plan (ICP) Personnel:

ICPs are initiated by Care Managers and developed in conjunction with the member and their caregiver. ICT members are also involved to support the member with education needs, linkage to community resources, achieving goals and ICP objectives. The following are the personnel responsible for developing the ICP:

Care Managers (CM): The CM is a registered nurse. The CM assumes responsibility for the management and coordination of care assigned members, as well as provides clinical support, and consultations. Telephonic contact is initiated, and surveys are completed per protocol on an as-needed basis. The CM prioritizes member needs, educates and promotes member self-management strategies, initiates and updates the ICP, engages other members of the care team and refers to internal and external resources as necessary. CMs who are registered nurses possess three or more years of clinical experience, and have exceptional communication, interpersonal and technical skills.

Social Worker (SW): Social Workers are the social service, mental health, and community resource expert for the Interdisciplinary Care Team. The Social Workers completes physical, psychological, emotional and environmental assessments, for the purpose of providing appropriate, timely interventions to ensure provision of optimal care. In addition, they work collaboratively with other members of the Care Management Interdisciplinary team-to include; Care Managers, Field Care Managers, and community-based resources, etc.

Humana At Home:

Whether done telephonically, in-person, or through a combination of the two methods, each ICP is developed to addresses the following:

- Development of a care management plan, including prioritized goals that consider the member's and caregiver's goals, preferences and desired level of involvement in the care management plan
- Identification of barriers to meeting their goals or complying with the plan
- Development of a schedule for follow up and communication
- Development and communication of their self-management plans
- A process to assess their progress against care management plans

Each ICP outlines:

- Goals and objectives as agreed upon by the member and/or caregiver
- 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
- End of life planning for members who have not participated in this type of planning and wish to do so
- Any services or resources for which a member may qualify based on diagnoses, disability, or other criteria (such as financial) are included in the ICP to ensure members are able to access all appropriate programs
- A follow-up schedule that allows both the member and his/her primary Care Manager to stay on track with meeting the stated objectives of the plan

ICPs are created, reviewed and updated with each successful member contact by the Primary Care Manager to document progress towards goals, as member's needs change, with each care transition and or significant change in member's health care status. The level of intervention (LOI) outreach protocol is a dynamic designation and a means for the primary Care Manager to identify and stratify member's intensity of care management needs based on health outcomes. Primary Care Managers have the option of moving members to a higher or lower level of intervention to increase outreach as the member's health care needs change.

The ICP is mutually shared, discussed, and mutually designed with the member and/or caregiver on an ongoing basis with his/her primary Care Manager based on each medium and high risk area identified from the mDAT. The Care Manager is responsible for coordinating the ICP interventions. The primary Care Manager, in conjunction with the member and Interdisciplinary Care Team, coordinates efforts to make the ICP actionable. Preferred updates to the ICP are completed by the primary Care Manager, yet in their absence, systems and protocols allow the flexibility for covering staff to have editing access to member's records.

Collaborative discussions between a primary Care Manager and a member to strengthen a member's motivation and commitment for change is critical for preventative healthcare and avoiding hospitalizations and readmissions. The primary objective of the ICP is to guide best practice, support member goals, and delineate areas for physician input and care coordination.

Primary Care Managers work with members through time to help them set and meet their goals. This activity and progress is tracked through the ICP. The continuously updated ICP addresses the gaps in care identified as medium and high risk from the mDAT and the primary Care Manager assigns benefits and special services to the member to meet the prioritized care goals.

Humana Care Managers and Humana Care Coordinators are the personnel responsible for developing the ICP in conjunction with the member and their caregiver. The ICP is inclusive of information provided by any or all of the following internal associates:

- Humana At Home Medical Director
- Humana At Home Clinical Pharmacist
- Humana At Home Registered Dietitian
- Humana At Home In-Home Care Managers
- Humana Care Manager - Social Services
- Behavioral Health Specialists
- Community Health Educators
- Community Resource Specialists
- CarePlus Field Case Managers

External input is also included in an ICP when available. External input may come from:

- Primary Healthcare Providers/Physicians
- Hospital Discharge Planners

- Disease Management Vendors

In the event the member is unable to be reached or refuses active care management, a Healthy Action Plan is developed by the member's Care Manager in collaboration with the member's Primary Care Physician (PCP). The documented Healthy Action Plan is tailored to the member's SNP Type and qualifying condition for those in a Chronic Condition SNP Plan. The Healthy Action Plan is shared with the PCP and member when created and annually.
Specific Chronic Condition Care Pathways are utilized to identify member problems, internal/external services/program/resource needs, barriers, and interventions. These Pathways are integrated into the care plan as appropriate and care plan outcomes are tracked as progress toward agreed upon goals is measured. With each member contact, progress toward these goals is evaluated. Barriers to achieving identified goals are defined and discussed, and goals are modified as warranted or desired by the member and/or caregiver.

Individualized Care Plan (ICP) Personnel:

ICPs are initiated by primary Care Managers who are HCMs or HCCs and developed in conjunction with the member and their caregiver. ICT members are also involved to support the member with education needs, linkage to community resources, achieving goals and ICP objectives. The following is a role description of the HCM and HCC who are the personnel responsible for developing the ICP:

Humana Care Managers (HCM): The HCM is a registered nurse or social worker. The HCM assumes responsibility for the management and coordination of care assigned members, as well as provides clinical support, consultations, and reviews for HCC staff. Telephonic contact is initiated, and surveys are completed per protocol on an as-needed basis. The HCM prioritizes member needs, educates and promotes member self-management strategies, initiates and updates the ICP, engages other members of the care team and refers to internal and external resources as necessary. HCMs who are registered nurses possess three or more years of clinical experience, and have exceptional communication, interpersonal and technical skills. Those that are social workers have a minimum of three years of case management experience and hold a Master's degree in Social Work (MSW), Master's degree in a related field, or Bachelor's degree in Social Work. The Humana At Home staffs HCMs specializing in complex medical or behavioral conditions.

Humana Care Coordinator (HCC): Responsible for engaging members in care management, identifying the individual member's stratification through the use of provided tools, reviewing the member's needs after discharge from an inpatient facility, making referrals as needed to appropriate levels of care, and referring the member to available Humana resources, community resources, and the ICT for assistance. The HCC provides ongoing support to SNP members in medium and low risk levels of intervention (LOI), and the Monitored involvement level, including assisting with Medicaid recertification, access to Medicaid benefits, and connections to community resources. Refers to HCM for member clinical issues, questions, and needs. HCCs have a minimum of two years combined experience as a medical assistant or

certified nurse assistant, health related field, or care management, and/or degrees in psychology, health education, or social work.

Factor 4: Individualized Care Plan (ICP) Documentation & Maintenance:

Humana Puerto Rico:

The ICP can be accessed and updated through Humana's secure, documentation platform and are available to internal associates including internal ICT participants. Copies of the ICP are mailed to the provider and the member. In addition, elements of the ICP are discussed as needed via phone with any or all members of the ICT, members and providers.

The security of all Humana documentation systems is under the guidance of Humana Security Administration. Access to documentation platform systems is granted only to those associates who have been deemed as requiring such access for the provision of care. Training regarding information security is mandated for all associates annually, and provided throughout the year in the form of email alerts to all associates. The privacy and confidentiality of all member information is stressed in both new hire and annual training on ethics and confidentiality. Privacy policies and issues are governed by Humana's Privacy Office. All communication and exchange of information is done in compliance with HIPAA and confidentiality requirements. All website utilization is login and password protected and member documentation is locked in designated areas. Protected Health Information (PHI) is maintained through shredding and monitored disposal of documents.

In addition, the documentation captured is stored and maintained in the documentation platform system's databases. Humana Puerto Rico follows the Humana Enterprise Security measures and access to the data is granted to specific groups of users only. As part of disaster recovery, Humana Puerto Rico also has a minimum of two (2) back-up copies of the local database that are stored at the Louisville Data Center for 15 days. After 15 days, they are sent to offsite storage.

Humana At Home:

The ICP can be accessed and updated through a secure platform and are available to internal associates including internal ICT participants. Copies of the ICP are mailed to the member upon request or when a member experiences a change in condition. Members are made aware of the ability to request ICP copies when enrolled in the program. Providers may also receive copies of ICPs via mail, upon request. In addition, elements of the ICP are discussed as needed via phone with any or all members of the ICT, members and providers. All associates are kept apprised of ICP changes via ICT activity.

The security of all documentation systems is under the guidance of Humana Security Administration. Access to documentation platform is granted only to those associates who have

been deemed as requiring such access for the provision of care. Training regarding information security is mandated for all associates annually, and provided throughout the year in the form of email alerts to all associates. The privacy and confidentiality of all member information is stressed in both new hire and annual training on ethics and confidentiality. Privacy policies and issues are governed by Humana's Privacy Office. All communication and exchange of information is done in compliance with HIPAA and confidentiality requirements. All website utilization is login and password protected and member documentation is locked in designated areas. Protected Health Information (PHI) is maintained through shredding and monitored disposal of documents.

In addition, the documentation captured is stored and maintained in the documentation platform databases. The database is backed up nightly and cloned at a minimum of daily to the Clinical Data Mart. Humana At Home follows the Humana Enterprise Security measures and access to the data is granted to specific groups of users only. As part of disaster recovery, Humana At Home also has a minimum of two (2) back-up copies of the local database that are stored at the Louisville Data Center for 15 days. After 15 days, they are sent to offsite storage.

Factor 5: Updates and Modifications to the Individualized Care Plan (ICP):

Humana Puerto Rico:

For actively managed members, all ICP information is shared, discussed, and mutually designed with the member and/or caregiver on an ongoing basis as the member works with his or her Care Manager. ICPs are created, reviewed and updated at a minimum with each successful member contact according to the level of intervention outreach protocol i.e., weekly, monthly, quarterly, etc. ICPs may also be updated with each transition and/or significant changes in member's health care status as agreed upon by the Care Manager and member. Additionally, when an annual HRA is completed, the Care Manager ensures the ICP is updated and modified based on any additional needs identified from the annual HRA. Modified and updated ICPs are housed and accessed through Humana's documentation platform and available to internal associates. Updated and modified ICPs are documented in the same platform and shared with the ICT through that platform. Copies of modified or updated ICPs are mailed to the member upon request. In addition, elements of the ICP are discussed as needed via phone with any or all members of the ICT, members and providers. Modified and updated ICPs are also shared with a member's provider(s), upon request. Updated or modified care plans also occur for members who experience planned or unplanned transitions.

Members who are unwilling to participate in the care management program or unreachable following unable to contact procedures are outreached to by a Humana Care management Specialist for annual follow-up and are placed in an "Active-UTC" status. The members who are unwilling to participate have a Basic Care Plan (BCP) that is located in the Humana Puerto Rico

documentation platform. (SNP members who choose to take an active part in their care management have an active ICP in the documentation platform system). Basic Care Plans address general recommendations for member health and is mailed to the member and provider.

Humana At Home:

For actively managed members, all ICP information is shared, discussed, and mutually designed with the member and/or caregiver on an ongoing basis as the member works with his or her primary Care Manager. ICPs are created, reviewed and updated with each successful member contact by the Primary Care Manager to document progress towards goals, as member's needs change, with each care transition and or significant changes in member's health status. Additionally, when an annual mDAT is completed, the primary Care Manager ensures the ICP is updated and modified based on any additional medium or high risk needs identified from the annual mDAT. Modified and updated ICPs are housed and accessed through a secure platform and available to internal associates. Updated and modified ICPs are documented in the same platform and shared with the ICT through the ICT tool. Copies of ICPs are mailed to the member when a change in condition occurs or upon request, and members are made aware of the ability to request ICP copies when enrolled in the program. In addition, elements of the ICP are discussed as needed via phone with any or all members of the ICT, members and providers. Modified and updated ICPs are also shared with a member's provider(s), upon request. Updated or modified care plans also occur for members who experience planned or unplanned transitions. In these instances, Transitions of Care – Care Plan are shared with the provider and member.

Example: Individualized Care Plan In-Progress:

PROBLEM: SOCIAL: Member lives alone and/or does not have support for cares (identified on Medicare domain assessment tool)		
	GOAL: Member will verbalize two strategies to reduce risk of social isolation within	
GOAL START DATE:	12/12/2014	
GOAL STATUS:	Met	
PRIORITY:	3	
BARRIERS:	Other	
OTHER:	MDAT RISK	
STATUS:	12/12/2014	Member denies risk. Member reports he lives with his with. Bexpositocuzan, RNHCM
	(Date)	Member agrees to In Home Survey with the Field Care Manager.
	Member will review community resource information provided by Social Services / Community Health Educator by the next call.	
MEMBER NEXT STEPS:	(Next follow up and Signature)	
	(Date)	Care Manager will review any new concerns on next call.
	Care Manager will review and reinforce education provided by Social Services / Community Health Educator.	
CARE MANAGER NEXT STEPS:	(Next follow up and Signature)	

Intervention	Intervention Status	Start Date	End Date
Evaluated living situation	Active	12/1/2014	3/1/2015

ELEMENT D: INTERDISCIPLINARY CARE TEAM (ICT):

Factor 1: Interdisciplinary Care Team (ICT) Membership:

Humana Puerto Rico:

Humana Puerto Rico delivers its services within a multi-disciplinary care team model. Care management is delivered telephonically and/or within member's place of residence. The Interdisciplinary Care Team (ICT) is member-centric and based on a collaborative approach. The ICTs overall care management role includes member and caregiver evaluation, reevaluation, care planning and plan implementation, member advocacy, health support, health coaching and education, support of the member's self-care management and ICP evaluation and modification as appropriate.

At the center of the ICT model are the persons who serve at the core and most closely interact with one another. The Care Manager functions as the single point of contact for all ICT participants and responsible for coordinating care across the continuum of need. Humana Puerto Rico ICT includes at minimum, the member and/or caregiver, the member's primary healthcare provider and the Care Manager. The Care Manager will be the one who facilitates the participation of members as part of their own ICT by directly interacting with the member, the member's caregiver and the member's primary healthcare provider.

The primary Care Manager identifies each Severe, High, Medium or Low severity level identified from the completion of the HRA to develop an ICP that includes specific interventions designed to meet each risk area. The Care Manager will identify which interventions need further collaboration from ICT participants including but not limited to dealing with acute and chronic needs as well as health promotion and crisis intervention. The composition and structure of the ICT supporting any given member will be driven by the member's specific set of medical, behavioral, long-term care and socio-environmental needs. There is not a one-size-fits-all model, members with complicated needs or co-morbidities will require more support and a correspondingly larger and more diverse care team. Living with complex and chronic health issues is a dynamic process and vigilance is necessary to anticipate problems before they manifest in costly exacerbations or quality of life deterioration. Additionally, the member or the caregiver may prefer that a specific provider or type of provider be present on their ICT.

Any number of additional support participants based on the members' ever-changing needs may be included as members of the ICT. These ICT participants may include but are not limited to the medical director, the clinical pharmacist, social workers, behavioral health specialists, community resource specialist and Health Coaches. Guiding approaches to member and

caregiver involvement in care planning and treatment are the principles of person-centered planning. For example, a member affected by serious mental illness may prefer his/her Care Manager from the mental health center where the member has received treatment and support for many years. A high risk member with housing issues may need more involvement from a social worker than a high- risk member who is living in the community with a dedicated caregiver. A member with a complex medication regimen may need a clinical pharmacist to provide review and support. The key elements and outcomes of Humana's person-centered ICP and ICT include:

- Forging an alliance between members and healthcare providers
- Developing the plan in partnership with the member (and family/caregiver as appropriate) and the provider/treatment team
- Ensuring the plan is individualized and based on member input regarding preferences, abilities, strengths, goals and cultural identity
- Ensuring written materials are readily understandable for the member
- Immediately directing the service delivery and recovery process
- Improving person-centered and individually defined recovery goals and outcomes

While the Interdisciplinary Care Team is a collaborative effort among the member, the Care Manager, the member's primary healthcare provider and other parties, the Care Manager, on behalf of the member, directs the ICT while acting as a member liaison and advocate. The model of care is physician and provider-inclusive, with PCPs driving the medical treatment plan and primary Care Managers advancing the physician's treatment plan. Improved coordination of care among health care providers will be achieved by having the Care Manager as the designated single point of contact and facilitator of seamless transitions of care across health care settings, care providers, and services.

Care Managers utilize the collaboration between ICT participants, who identify specific outcomes based on member need, to drive the telephonic or in-person communication with the member. The primary Care Manager relays ICT recommendations to the member and works with the member to change or make adjustments to the member's ICP on a continuous basis. Frequency of interaction is determined by the Care Manager and member and is based upon protocol and ongoing evaluations of member health outcomes, needs, and risk stratification.

The Care Manager has the flexibility to determine the need for more intensive outreach and to recommend additional team interventions on a continuous basis. Members are encouraged to call their primary Care Manager at any time and to participate in establishing impactful interventions.

Humana At Home:

Humana At Home delivers its services to CarePlus members within a multi-disciplinary care team model. Care management is delivered telephonically and brief in-home surveys are completed within a 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. The ICTs overall care management role includes member and caregiver evaluation, reevaluation, care planning and plan implementation, member advocacy, health support, health coaching and education, support of the member's self-care management and ICP evaluation and modification as appropriate.

At the center of the ICT model are the persons who serve at the core and most closely interact with one another. The primary Care Manager functions as the single point of contact for all ICT participants and responsible for coordinating care across the continuum of need. The ICT includes at minimum, the member and/or caregiver, the member's primary healthcare provider and the primary Care Manager. The primary Care Manager for members will be a HCM or HCC who facilitates the participation of members as part of their own ICT by directly interacting with the member, the member's caregiver and the member's primary healthcare provider.

The primary Care Manager identifies each medium and high risk area identified from the completion of the mDAT to develop an ICP that includes specific interventions designed to meet each risk area. The primary Care Manager will identify which interventions need further collaboration from ICT participants including but not limited to dealing with acute and chronic needs as well as health promotion and crisis intervention. The composition and structure of the ICT supporting any given member will be driven by the member's specific set of medical, behavioral, long-term care and socio-environmental needs. There is not a one-size-fits-all model, members with complicated needs or co-morbidities will require more support and a correspondingly larger and more diverse care team. Living with complex and chronic health issues is a dynamic process and vigilance is necessary to anticipate problems before they manifest in costly exacerbations or quality of life deterioration. Additionally, the member or the caregiver may prefer that a specific provider or type of provider be present on their ICT.

Any number of additional support participants based on the members' ever-changing needs may be included as members of the ICT. These ICT participants may include but are not limited to the medical director, the clinical pharmacist, registered dietitian, social workers, behavioral health specialists, in-home care managers, CarePlus field case managers, community resource specialist and community health educators. Guiding approaches to member and caregiver involvement in care planning and treatment are the principles of person-centered planning. For example, a member affected by serious mental illness may prefer his/her Care Manager from the mental health center where the member has received treatment and support for many

years. A high-need member with housing issues may need more involvement from a social services specialist than a high-need member who is living in the community with a dedicated caregiver. A member with a complex medication regimen made need a clinical pharmacist to provide review and support. Members who have or require specific dietary needs will benefit from having a Humana At Home Dietitian on the ICT. The key elements and outcomes of a person-centered ICP and ICT include:

- Forging an alliance between members and healthcare providers
- Developing the plan in partnership with the member (and family/caregiver as appropriate) and the provider/treatment team
- Ensuring the plan is individualized and based on member input regarding preferences, abilities, strengths, goals and cultural identity
- Ensuring written materials are readily understandable for the member
- Immediately directing the service delivery and recovery process
- Improving person-centered and individually defined recovery goals and outcomes

While the Interdisciplinary Care Team is a collaborative effort among the member, the primary Care Manager, the member's primary healthcare provider and other parties, the primary Care Manager, on behalf of the member, directs the ICT while acting as a member liaison and advocate. The model of care is physician and provider-inclusive, with PCPs driving the medical treatment plan and primary Care Managers advancing the physician's treatment plan. Improved coordination of care among health care providers will be achieved by having the primary Care Manager as the designated single point of contact and facilitator of seamless transitions of care across health care settings, care providers, and services.

Primary Care Managers utilize the collaboration between ICT participants, who identify specific outcomes based on member need, to drive the telephonic or in-person communication with the member. The primary Care Manager relays ICT recommendations to the member and works with the member to change or make adjustments to the member's ICP on a continuous basis. Frequency of interaction is determined by the primary Care Manager and member and is based upon protocol and ongoing evaluations of member health outcomes, needs.

The primary Care Manager has the flexibility to determine the need for more intensive outreach and to recommend additional team interventions on a continuous basis. Members are encouraged to call their primary Care Manager at any time and to participate in establishing impactful interventions.

Factor 2 & 3: Interdisciplinary Care Team Roles & Responsibilities and ICT Contribution to Improving the Health Status of SNP Beneficiaries:

Humana Puerto Rico:

Humana Puerto Rico includes at minimum, the member and/or caregiver, the member's primary healthcare provider and the primary Care Manager who is at the center of the Interdisciplinary Care Team, directing care decisions. The Care Manager for members facilitates the participation of members as part of their own ICT by directly interacting with the member and/or the member's caregiver and the member's primary healthcare provider.

Any number of additional support participants based on the members' ever-changing needs may be included as members of the ICT. The engagement of other members of the Interdisciplinary Care Team when required, based on each member's needs, is critical to the effectiveness of the ICT. Each member of the ICT contributes subject matter expertise allowing for goals and objectives to be precisely tailored to each member. These ICT participants can include the medical director, the clinical pharmacist, social workers, behavioral health specialists, community resource specialist and health coaches. There is not a one-size-fits-all model to care coordination or Interdisciplinary Care Teams; members with complex conditions, behavioral health needs, functional support, and /or social service needs may require more targeted interventions by the care team. Additionally, the member or the caregiver may prefer that a specific provider or type of provider be present on their Interdisciplinary Care Team.

Per member approval, a designated caregiver, spouse or family member or friend may support the member in the care management process. There may also be times when the caregiver may be the only point of contact the Care Manager has on behalf of the member's care. Three way calls, when feasible, or having the caregiver attend the home visit, are some of the ways this involvement is encouraged. It is also important for the Care Manager to be alert to signs of caregiver strain. Common interventions may be to offer a caregiver support resource, offer respite care or other supportive services like homemakers to alleviate some of the responsibilities of the caregiver.

ICT participants work actively to participate in the development, implementation, and management of the member's prioritized, ICP. ICT participants identify barriers to achieving goals and facilitate member specific care plan interventions including education, referrals, and care coordination to address barriers and assist members in meeting their goals.

The Care Manager communicates recommended interventions and schedules follow-up contact as appropriate with the member and/or caregiver and those members of the ICT who were identified, as indicated. Members are encouraged to contact their Care Manager at any time and participate in establishing impactful interventions. The member and/or caregiver have direct access to care management services and the ICT team by calling a direct toll free number contacting CarePlus Member Services Department and requesting to speak to their Care

Manager or ICT participant, and by requesting connection to another Humana department, e.g. pharmacy services.

The ICT contributes to improved health status of SNP beneficiaries in a number of ways including but not limited to quality of care, reducing unplanned transitions, increasing patient safety, and reducing medical errors. The ICT opens communication between members and their primary healthcare providers. Members receive the tools necessary to be motivated and ready for change. Education on lab results, medical concerns, and safety are all vitally important to the health status of a member. For example, a Care Manager may engage an ICT to review lab results and medication regime for a member who has a diagnosis of diabetes. Potential harmful drug to drug interactions or inclusion of ACE/ARB, for a member who is a diabetic is critical to their health status. Discussion around routine HbA1c tests and LDL Cholesterol Screening only increases a member's awareness of their condition. The ICT allows for collaboration by a variety of personnel with various subject matter experts, a clinical pharmacist reviewing medications, a social worker assisting with accessing benefits through entitlement programs, each individual contributes to health outcomes of a member.

The contributable benefits are unlimited and are reflective in the ability to move members to a higher or lower level of intervention through the course of the year. A member whose health status improves may be reflective in their overall risk score. Collaboration by the Care Manager, member, caregiver, primary care provider, and the ICT members produces true well-being and balance through core strength of health.

Humana At Home:

The ICT includes at minimum, the member and/or caregiver, the member's primary healthcare provider and the primary Care Manager who is at the center of the Interdisciplinary Care Team, directing care decisions. The primary Care Manager for members will be a HCM or HCC who facilitates the participation of members as part of their own ICT by directly interacting with the member and/or the member's caregiver and the member's primary healthcare provider.

Any number of additional support participants based on the members' ever-changing needs may be included as members of the ICT. The engagement of other members of the Interdisciplinary Care Team when required, based on each member's needs, is critical to the effectiveness of the ICT. Each member of the ICT contributes subject matter expertise allowing for goals and objectives to be precisely tailored to each member. These ICT participants can include the medical director, the clinical pharmacist, registered dietitian, social workers, behavioral health specialists, in-home care managers, CarePlus field case managers, community resource specialist and community health educators. There is not a one-size-fits-all model to care coordination or Interdisciplinary Care Teams; members with complex conditions,

behavioral health needs, functional support, and /or social service needs may require more targeted interventions by the care team. Additionally, the member or the caregiver may prefer that a specific provider or type of provider be present on their Interdisciplinary Care Team. (See Page 69 for Detailed Role Descriptions of ICT Participants)

Per member approval, a designated caregiver, spouse or family member or friend may support the member in the care management process. There may also be times when the caregiver may be the only point of contact the Care Manager has on behalf of the member's care. Three way calls, when feasible, or having the caregiver attend the in-home visit, are some of the ways this involvement is encouraged. It is also important for the Care Manager to be alert to signs of caregiver strain. Common interventions may be to offer a caregiver support resource, offer respite care or other supportive services like homemakers to alleviate some of the responsibilities of the caregiver.

Information gathered during the mDAT, the approved HRA and the development of the ICP is used by the Care Manager to drive the needs of the ICT. Based on members identified needs, the primary Care Manager makes appropriate referrals for consultations and/or services and initiates an ICT review via the ICT tool. Internal ICT participants are notified systematically by the ICT tool of the impending ICT. External ICT participants requested by the member are coordinated through the primary Care Manager. The ICT tool captures all communication among SNP associates, ICT participants and external stakeholders, to maintain effective and ongoing communication. The tool is used by the primary Care Manager to confer ICT recommendations with members to mutually integrate the results from the ICT into the members ICP. The Care Manager collaborates with the primary healthcare provider by written ICT reports highlighting areas of concerns and informing the provider of the ICT activity, inviting them to verbally contact the Care Manager or fax information they have to contribute to the plan of care, specialized services, or current care coordination efforts. The Care Manager acts as a liaison for the provider, communicating member care needs to ICT participants and incorporating relevant medical information from the provider into the member's ICP.

ICT participants work actively to participate in the development, implementation, and management of the member's prioritized, ICP. ICT participants identify barriers to achieving goals and facilitate member specific care plan interventions including education, referrals, and care coordination to address barriers and assist members in meeting their goals.

The primary Care Manager communicates recommended interventions and schedules follow-up contact as appropriate with the member and/or caregiver and those members of the ICT who were identified, as indicated. Members are encouraged to contact their Care Manager at any time and participate in establishing impactful interventions. The member and/or caregiver have direct access to care management services and the ICT team by calling a direct toll free number answered by the Care Concierge team, contacting CarePlus Member Services Department and requesting to speak to their Care Manager or ICT participant, and by requesting connection to another department, e.g. pharmacy services.

The ICT contributes to improved health status of SNP beneficiaries in a number of ways including but not limited to quality of care, reducing unplanned transitions, increasing patient safety, and reducing medical errors. The ICT opens communication between members and their primary healthcare providers. Members receive the tools necessary to be motivated and ready for change. Education on lab results, medical concerns, and safety are all vitally important to the health status of a member. For example, a Care Manager may engage an ICT to review a member who has hypertension and blood pressure is not controlled. Discussion around routine blood pressure medications, conversations to have with PCPs only increases a member's awareness of their condition. The ICT allows for collaboration by a variety of personnel with various subject matter experts, a clinical pharmacist reviewing medications, a Dietitian reviewing dietary concerns, a social worker assisting with accessing benefits through entitlement programs, each individual contributes to health outcomes of a member.

The contributable benefits are unlimited and are reflective in the ability to move members to a higher or lower level of intervention through the course of the year. A member whose health status improves may be reflective in their overall risk score. Collaboration by the primary Care Manager, member, caregiver, primary healthcare provider, and the ICT members produces true well-being and balance through core strength of health.

Factor 4: SNP Communication Plan:

Humana Puerto Rico:

Access and convenience are major goals of Humana Puerto Rico, and members need to feel secure in knowing they can get timely and accurate health information when they need it most. Humana Puerto Rico's communication approach is member-centric, individualized, proactive, and supportive. Members who actively participate in care management are assigned a Care Manager who works with the member through time, building a professionally based advocacy partnership. The Care Manager acts as the liaison, support coach, and advocate while the member determines the direction and purpose of communication. Members are encouraged to call their Care Manager whenever needed with questions or concerns. The Care Manager is continually assessing and responding to member needs during every encounter.

Communication with members is primarily telephonic because it provides a cost-effective way of reaching more members who are in need of care management services. However, outreach also includes face-to-face interactions, mailings, web-based materials, and voice activated technology. In-person communication occurs in the member's home or other setting with Field Care Managers. Educational materials and tools are mailed to members and are sometimes available via the internet. Communication efforts throughout Humana Puerto Rico are dynamic and meaningful to the member. Humana Puerto Rico activates all modes of member communication, which can include written, telephonic, internet, IVR, and in-person.

The ICT assists members in accessing benefit information, connecting with physicians by assisting in making appointments when needed, connecting to community resources. Proactive calls to remind individuals to schedule routine screenings are provided through Voice-Activated Technology calls, mail/letter campaigns, and Care Manager Outreach to members. The "24/7" nurse line focuses on triaging members to appropriate level of care and referrals to appropriate resources.

Details of every encounter with members are documented in Humana's documentation platforms. This documentation includes successful and failed attempts (phone calls), ICPs, progress notes, and scheduling of future calls or appointments. While level of intervention protocol sets and contractual service level agreements determine the minimums for contact frequency, the actual call frequency is left to the discretion of the Care Manager based on judgment and the member's needs.

Successful and unsuccessful contacts are tracked in the workflow applications. ICPs and progress notes also reflect contact activity. Inbound and outbound telephone calls are the predominant method of contact used by the care team. This leverages access, cost effectiveness, and outreach capability to members who need the services provided by Humana At Home.

Humana Puerto Rico adheres to all regulatory requirements (i.e., NCQA, URAC) and their own internal requirements for all written communications. Written communication and education is used widely by the care team to introduce and reinforce health behaviors and access to resources. Typically, multiple modes of communication and outreach are deployed.

All Care Managers will attempt warm transfers and three-way calls to promote seamless transfers that make for a positive member experience. Humana Puerto Rico's system provides an internal customer service directory that allows associates to tap into internal resources quickly. This avoids wait times and the need for the member to navigate multiple transfers or automated messaging.

Within a Medicare Advantage plan, there are often other resources such as Medication Therapy Management, pharmacy assistance, mail order pharmacy, wellness and health education, and behavioral health that assist in providing the member with needed services. The model is provider inclusive and the Care Manager facilitates member communication with their providers via three-way telephone calls. The Care Manager also involves and informs providers of the care management activities or any areas of concern uncovered in the course of care management by telephone. Additionally, after ICT meetings, the provider is also informed of areas of concern discussed by letter format. Access to member-specific information and goals

determined by the ICT are made available to internal ICT members in Humana's documentation platforms. Individualized meeting notes are recorded in each individual member permanent record, facilitating sharing of areas of concern, interventions planned, and recommendations made by Humana Puerto Rico's Chief Medical Officer, and/or Clinical Pharmacist, as well as other ICT members. Findings and recommendations of ICT meetings are shared with the PCP by mail and a written report.

ICT care coordination meetings may be scheduled or ad hoc, and may be held face-to-face, telephonic, web-based, or accomplished through written communication. The occurrence and frequency of the meetings are different for each member, based on the individual level of care and health care needs of the member.

The member and/or caregiver will have direct access to care management services and the ICT team through a direct, toll-free Humana Puerto Rico phone number. This number is answered by Customer Services who then directs the call to the member's Care Manager. The member and/or caregiver can also access care management services and the ICT team by contacting Humana's Customer Service Department and requesting to speak to the Care Manager or other care team member. The member and/or caregiver can also request to be connected to other Humana Departments, such as Pharmacy. PCPs are sent a letter informing them of this activity and inviting them to call the Care Manager or fax any updated information they have to contribute to the plan of care. Care Managers encourage the member to be an active health care consumer and to communicate directly with physicians when possible. If a member needs additional support to contact physicians or other providers, three-way calls may be made with the member, or the Care Manager will contact the physician or provider directly on behalf of the member.

All Humana Associates complete mandatory, Ethics and Privacy training upon hire and annually. All Associates are also required to comply with the Health Insurance Portability and Accountability Act (HIPAA) and Humana's policies regarding privacy and protection of personal health information.

Humana Puerto Rico has developed several targeted methods and key activities to address ICT needs, which include:

- Formal Interdisciplinary Care Team meetings are held as needed, with potential representation from nursing, medical services, pharmacy, behavioral health, social services, quality management and community resource specialties. Other disciplines may be engaged depending on member need. The Care Manager, as the team lead coordinates the recommended interventions with the member and the provider as feasible.

- Ongoing care coordination and consultations i.e. three-way calls or notification via electronic ICT tool, as part of the model of care delivery involves the care team members, as well as other disciplines at Humana i.e. RxMentor or APS (MBHO).
- The Care Manager maintains ongoing communication with the member/caregiver through scheduled or ad hoc inbound and outbound calls. Written communication is also incorporated to support and reinforce the plan of care.
- Primary care providers are sent a letter identifying areas of concern and are encouraged to provide input and call the Care Manager with additional information.

The communication mechanisms that Humana Puerto Rico has developed and implemented varies depending upon the type of barrier identified e.g. cultural diversity, physical challenges including hearing impairments, language barriers and cognitive deficiencies. Humana Puerto Rico associates utilize the following services to address member cultural diversity and physical challenges by addressing barriers to members receiving maximum benefits from and having an optimal experience with the care management services. To assist members, the following services are provided by Humana, Inc.:

- Collecting race/ethnicity and language data while providing protection for this data by adherence to the Health Insurance Portability and Accountability Act (HIPAA) guidelines. Members are notified of privacy policies.
- Providing access and availability of language services in the threshold languages of the membership. Spoken language services are provided to communicate with members in a language other than English. Members are notified of this service when contact is made.
- Providing member materials that adhere to CMS standards and Health Literacy standards.
- Providing and maintaining culturally and linguistically appropriate service programs by maintaining a written program description for improving culturally and linguistically appropriate services program is performed.
- Reducing health care disparities through the use of race/ethnicity and language data to access disparities, monitor and access the services, and measure CLAS and disparities.
- Assigning a Care Manager who is fluent in the member's primary language, if the member does not speak Spanish.
- Documenting cultural preferences in the care management applications, reviewing annually and revising as needed.
- Following the Americans with Disabilities Act (ADA) guidelines for members with disabilities who have hearing impairments, language barriers and cognitive deficiencies; by providing translation services when related to language barriers, alternate forms of communication for members with hearing barriers and cognitive deficiencies.

Hearing and Visual Impairments: Humana utilizes both TDD and the TDD Relays Service. The TDD phone is a small typewriter in which communication is typed rather than spoken. To use this method, both the sender and receiver must have access to a TDD phone. The TDD phone prints a tape (similar to calculator tape) of the conversation. The tape also acts as an answering machine when there is no attendant at the phone by automatically activating a pre-typed message requesting the member to leave their Humana Identification number. The TDD phone also informs members that they will receive a call back. The TDD Relays Service allows a hearing impaired person to communicate with an individual that does not have a TDD phone. An operator that has a TDD phone acts as an interpreter for the hearing impaired person by verbalizing what is typed into the TDD phone. The operator takes responses and types them back into the TDD phone for the caller to read. When an incoming call is received from a relay service, the attendant introduces themselves and states that they are with a relay service. The attendant then begins to relay information from the caller.

Cognitive Deficiencies: Humana Puerto Rico's communication approach is member-centric, individualized, proactive, and supportive. The Care Manager acts as the liaison, support coach, and advocate while the member and the member's representative determines the direction and purpose of communication. The Care Manager is supported by various Humana Puerto Rico roles and all associates continually assess and respond to member's cognitive needs during every successful outreach using various survey tools including the CMS approved Health Risk Assessment (HRA). Individualized Care Plans are developed for members who consent to be actively managed considering a member's cognitive risk and interventions are initiated to support a member and their representative by utilizing value added items. The Care Manager also engages the support and consultation of ICT participants to address medical, pharmacological, nutritional, sociological and behavioral issues that members face who are living with cognitive impairments.

Care Management Specialists (CMS) identifies if members have formally assigned a Power of Attorney (POA), Healthcare Surrogate, and/or Legal Guardianship authorizing another individual to act on a member's behalf during initial engagement. Documentation must be formalized, complete, and on file with Humana. All communication and exchange of information is done in compliance with HIPAA and confidentiality requirements. The (CMS) attempts to complete the HRA with the member. If a representative is on file and the member is unable to complete the HRA the (CMS) will complete the HRA with the member's representative. If a representative is not on file and the member is unable to complete the HRA, verbal permission may be provided to proceed with the completion of the HRA. Upon HRA completion, the member is systematically assigned to the appropriate Care Manager based on

the member's Severity Level. If the HRA is unable to be completed, the Care Management Specialists follows the unable to contact process making additional outreaches to complete the HRA. The Care Management Specialists also has the option of sending a paper HRA to the member for completion. If a member does have proper documentation on file, the member's assigned Care Manager is able to work directly with the member's representative. If the member does not have proper documentation on file, the Care Manager attempts to contact the member's primary healthcare provider to identify additional options for POA or legal representative. The Care Manager will make every effort possible to obtain POA to work with the member's representative and provide care management services to the member. When a completed POA is on file, the assigned Care Manager will utilize additional survey tools to further evaluate a member's cognitive limitations. When cognitive risk is identified, the Care Manager identifies value added items and services as potential interventions for the member and the member's representative. Based on the severity of the cognitive impairment the primary Care Manager is able to move the member to a higher level of severity. Care Managers also initiate an interdisciplinary care team (ICT) to consult with other disciplines. Other ICT members include but are not limited to referrals to Social Services. All Humana Puerto Rico Care Managers will follow outlined protocols initiating and updating ICPs and ICTs applicable to the member's identified cognitive impairment while providing on-going care management services.

Evidence Used to Verify Communications Have Taken Place:

The reporting relationship of Humana committees, both corporate and market-level, is designed to enhance the effectiveness of internal communication. A multi-disciplinary committee membership results in inter-departmental input and decision-making, which ultimately facilitates stronger communications throughout the organization. This structure also utilizes focused committees as a forum for solicitation of feedback from network providers. Committees are required to record meeting minutes, which promotes consistency in the documentation and follow-up of committee activities. Items discussed in committee meetings reflect documentation of conclusions, recommendations, action, and follow-up. Minutes are signed and dated by the chairperson or acting chairperson. Electronic signatures are acceptable and must be dated. Committee minutes are available at the next meeting for review and approval.

Other types of inter-departmental communication include memos, newsletters, e-mail, databases, Humana's Online Web Information Exchange (HOWIE), Share Point, and written reports. The QI Work Plan serves as a communication tool by tracking quality improvement activities and is reviewed on as needed basis and presented to the Humana Internal Board of

Directors quarterly and to CQIC annually. Humana recognizes the need for effective external communication as a key to quality care and service excellence. Humana communicates a variety of information to practitioners, providers, delegates, and members. Examples of provider communications may include but are not limited to:

- Letters/memos/faxes
- Committee minutes or reports
- Provider bulletins, notices, and newsletters
- Online and hard copy reports
- Provider educational sessions
- Written instructive communications
- Quality Improvement plans
- Internet/intranet (Humana Website, e-mail, databases)
- Clinical newsletters
- Provider Manual for Physicians, Hospitals, and Healthcare Providers

Examples of enrollee communications may include but are not limited to:

- Health fairs/community projects
- Benefit updates and individual mailings
- Targeted e-mail communications
- Humana's Website which includes secured information regarding enrollee claims, plan benefits, prescription drug coverage, participating providers, and links to health and wellness information

Humana At Home:

Access and convenience are major goals of the CarePlus model of care, and members need to feel secure in knowing they can get timely and accurate health information when they need it most. The communication approach is member-centric, individualized, proactive, and supportive. Members are assigned a primary Care Manager who works with the member through time, building a professionally based advocacy partnership. The Care Manager acts as the liaison, support coach, and advocate while the member determines the direction and purpose of communication. Members are encouraged to call their Care Manager whenever needed with questions or concerns. The Care Manager is continually assessing and responding to member needs during every encounter.

Communication with members is primarily telephonic because it provides a cost-effective way of reaching more members who are in need of care management services. However, outreach

also includes many face-to-face interactions, mailings, web-based materials, and voice activated technology. In-person communication occurs in the member's home or other setting with In-Home Care Managers and CarePlus Field Case Managers. Educational materials and tools are mailed to members and are sometimes available via the internet. Communication efforts are dynamic and meaningful to the member. CarePlus and Humana At Home activates all modes of member communication, which can include written, telephonic, internet, IVR, and in-person.

Details of every encounter with members are documented in CarePlus and Humana At Home documentation platforms. This documentation includes successful and failed attempts (phone calls), ICPs, progress notes, and scheduling of future calls or appointments. While level of intervention protocol sets and contractual service level agreements determine the minimums for contact frequency, the actual call frequency is left to the discretion of the Care Manager based on judgment and the member's needs.

Successful and unsuccessful contacts are tracked in the workflow applications. ICPs and progress notes also reflect contact activity. Inbound and outbound telephone calls are the predominant method of contact used by the care team. This leverages access, cost effectiveness, and outreach capability to members who need services.

CarePlus and Humana At Home adheres to all regulatory requirements (i.e., CMS) and their own internal requirements for all written communications. Written communication and education is used widely by the care team to introduce and reinforce health behaviors and access to resources. Typically, multiple modes of communication and outreach are deployed.

All Care Managers will attempt warm transfers and three-way calls to promote seamless transfers that make for a positive member experience. Systems provide an internal customer service directory that allows associates to tap into internal resources quickly. This avoids wait times and the need for the member to navigate multiple transfers or automated messaging. In-Home Care Managers and community health educators also use three-way calls with community agencies and providers to assist members in making the necessary connections to available resources.

Within a Medicare Advantage plan, there are often other resources such as Medication Therapy Management, mail order pharmacy, wellness and health education, and behavioral health that assist in providing the member with needed services. The model is provider inclusive and the Care Manager facilitates member communication with their providers via three-way telephone calls. The Care Manager also involves and informs providers of the care management activities or any areas of concern uncovered in the course of care management by telephone. Additionally, after ICT meetings, the provider is also informed of areas of concern discussed by letter format. Access to member-specific information and goals determined by the ICT are made available to internal ICT members in documentation platforms. Individualized meeting notes are recorded in each individual member permanent record, facilitating sharing of areas of concern, interventions planned, and recommendations made by medical directors, dietitians, clinical pharmacists, CarePlus Field Case Managers, as well as other ICT members, with all

members of the ICT via the member's Electronic Medical Record. Findings and recommendations of ICT correlating to ICP updates are shared with the PCP by mail and a written report.

ICT care coordination meetings may be scheduled or ad hoc, and may be held face-to-face, telephonic, web-based, or accomplished through written communication. The occurrence and frequency of the meetings are different for each member, based on the individual level of care and health care needs of the member.

The member and/or caregiver will have direct access to care management services and the ICT team through a direct, toll-free CarePlus phone number. This number is answered by a Care Concierge who then directs the call to the member's Care Manager. The member and/or caregiver can also access care management services and the ICT team by contacting CarePlus Customer Service Department and requesting to speak to the Care Manager or other care team member. The member and/or caregiver can also request to be connected to other departments, such as Member Services. PCPs are sent a letter informing them of this activity and inviting them to call the Care Manager or fax any updated information they have to contribute to the plan of care. Care Managers encourage the member to be an active health care consumer and to communicate directly with physicians when possible. If a member needs additional support to contact physicians or other providers, three-way calls may be made with the member, or the Care Manager will contact the physician or provider directly on behalf of the member.

All associates complete mandatory, Ethics and Privacy training upon hire and annually. All Associates are also required to comply with the Health Insurance Portability and Accountability Act (HIPAA) and policies regarding privacy and protection of personal health information.

Humana At Home has developed several targeted methods and key activities to address ICT needs, which include:

- Annual and immediate ICT reviews are requested by primary Care Managers via the ICT tool, an interactive web based application which captures multidisciplinary communication and coordination between ICT members.
- Ongoing care coordination and consultations with care team members, as well as other disciplines at Humana.
- The primary Care Manager maintains ongoing communication with the member/caregiver through scheduled or ad hoc inbound and outbound calls. Written communication is also incorporated to support and reinforce the plan of care.
- Primary care providers are encouraged to participate and provide input through contact with the Primary Care Manager or via letter or fax.
- Internal ICT meetings are held, at the discretion of the Primary Care Manager, to engage with other ICT team members including but not limited to: nurses, pharmacists, dietitians, behavioral health specialists, social service experts, quality management, community resource specialties and/or other disciplines depending on member need. The Primary Care

Manager, as the team lead, coordinates the recommended interventions with the member and the provider as feasible.

Grand Rounds:

1. **Inpatient Rounds:** Inpatient rounds are conducted on members who have been admitted to the hospital. CarePlus Field Case Manager (CPFCM) present member charts for those members who have been admitted to their assigned hospitals in specific geographic areas. Chart information is reviewed and discussed with the CPFCM and the assigned area Medical Director. The assigned area Humana At Home Coach attends the rounds to ensure proper utilization and care coordination as necessary. The Humana At Home Coach sends a report to the member's Humana Cares Manager with pertinent information to be entered into the ICT tool. The report is also sent to the CarePlus Medical Director and CarePlus leadership. The ICT tool is initiated by the Care Manager, information is entered into the form following outlined steps and the ICT tool is then resolved by the Care Manager. A telephonic follow-up is completed by the Care Manager with the member to update their ICP based on the ICT recommendations.
2. **Skilled Nursing Facility (SNF) Rounds:** A CarePlus Field Case Manager conducts rounds for members who reside in skilled nursing facilities. The information collected by the APRN is sent electronically to the Humana Care Manager, Humana Care Coordinator and the Referral Specialist's frontline leader. The Humana Care Manager and the Humana Care Coordinator initiates an ICT by opening an ICT tool. Information is entered into the form following outlined steps and the ICT tool is then resolved by the Care Manager. A telephonic follow-up is completed by the Care Manager with the member to update their ICP based on the ICT recommendations

The communication mechanisms developed and implemented vary depending upon the type of barrier e.g. cultural diversity, physical challenges including hearing impairments, language barriers and cognitive deficiencies. Associates utilize the following services to address member cultural diversity and physical challenges by addressing barriers to members receiving maximum benefits from and having an optimal experience with the care management services. To assist members, the following services are provided:

- Collecting race/ethnicity and language data while providing protection for this data by adherence to the Health Insurance Portability and Accountability Act (HIPAA) guidelines. Members are notified of privacy policies.
- Providing access and availability of language services in the threshold languages of the membership. Spoken language services are provided to communicate with members in a language other than English. Members are notified of this service when contact is made.
- Providing member materials that adhere to CMS standards and Health Literacy standards.
- Surveying and analyzing the practitioner network's cultural responsiveness by analyzing the practitioner network every 3 years and making the survey information available.

- Providing and maintaining culturally and linguistically appropriate service programs by maintaining a written program description for improving culturally and linguistically appropriate services program is performed.
- Reducing health care disparities through the use of race/ethnicity and language data to access disparities, monitor and access the services, and measure CLAS and disparities.
- Assigning a primary Care Manager who is fluent in the member's primary language, if the member does not speak English.
- Documenting cultural preferences in the care management applications, reviewing annually and revising as needed.
- Following the Americans with Disabilities Act (ADA) guidelines for members with disabilities who have hearing impairments, language barriers and cognitive deficiencies; by providing translation services when related to language barriers, alternate forms of communication for members with hearing barriers and cognitive deficiencies.

Hearing and Visual Impairments:

Utilization of both TDD and the TDD Relays Services for the hearing impaired. The TDD phone is a small typewriter in which communication is typed rather than spoken. To use this method, both the sender and receiver must have access to a TDD phone. The TDD phone prints a tape (similar to calculator tape) of the conversation. The tape also acts as an answering machine when there is no attendant at the phone by automatically activating a pre-typed message requesting the member to leave their identification number. The TDD phone also informs members that they will receive a call back. The TDD Relays Service allows a hearing impaired person to communicate with an individual that does not have a TDD phone. An operator that has a TDD phone acts as an interpreter for the hearing impaired person by verbalizing what is typed into the TDD phone. The operator takes responses and types them back into the TDD phone for the caller to read. When an incoming call is received from a relay service, the attendant introduces themselves and states that they are with a relay service. The attendant then begins to relay information from the caller. Additionally, translation services using American Sign Language interpreters are provided and provides documentation in large print, braille, and audio for visually impaired members and because a disproportionate number of SNP members lack a high school diploma or are illiterate. Written materials sent to the member are at a 4^{th} to 5^{th} grade reading level.

Cognitive Deficiencies: Communication approach is member-centric, individualized, proactive, and supportive. The primary Care Manager acts as the liaison, support coach, and advocate while the member and the member's representative determines the direction and purpose of communication. The primary Care Manager is supported by various Humana At Home and CarePlus roles and all associates continually assess and respond to member's cognitive needs during every successful outreach using various survey tools including the CMS approved Health Risk Assessment (HRA), the Medicare Domain Assessment Tool (mDAT). Individualized Care

Plans are developed for members who consent to be actively managed considering a member's cognitive risk and interventions are initiated to support a member and their representative by utilizing value added items and services inclusive of Humana At Home brief in-home care management surveys. The primary Care Manager also engages the support and consultation of ICT participants to address medical, pharmacological, nutritional, sociological and behavioral issues that members face who are living with cognitive impairments.

Referral Specialists (RS) identifies if members have formally assigned a Power of Attorney (POA), Healthcare Surrogate, and/or Legal Guardianship authorizing another individual to act on a member's behalf during initial engagement. Documentation must be formalized, complete, and on file. All communication and exchange of information is done in compliance with HIPAA and confidentiality requirements. If the member does not have the formalized paperwork on file, the RS assists the member by providing the Medicare Policy Services department information and/or requests a ROI form to be mailed to the address on file for the member to assign a representative. The RS attempts to complete the mDAT with the member. If a representative is on file and the member is unable to complete the mDAT the RS will complete the mDAT with the member's representative. If a representative is not on file and the member is unable to complete the mDAT, verbal permission may be provided to proceed with the completion of mDAT. Upon mDAT completion, the member is systematically assigned to the appropriate primary Care Manager based on the member's Level of Intervention. If the mDAT is unable to be completed, the RS follows the unable to contact process making additional outreaches to complete the mDAT. The RS also has the option of sending a scan-able mDAT to the member for completion. If a member does have proper documentation on file, the member's assigned primary Care Manager is able to work directly with the member's representative. If the member does not have proper documentation on file, the primary Care Manager attempts to contact the member's primary healthcare provider to identify additional options for POA or legal representative. The primary Care Manager will make every effort possible to obtain POA to work with the member's representative and provide care management services to the member. When a completed POA is on file, the assigned primary Care Manager will utilize additional survey tools to further evaluate a member's cognitive limitations. When cognitive risk is identified, the primary Care Manager identifies value added items and services as potential interventions for the member and the member's representative. Based on the severity of the cognitive impairment the primary Care Manager is able to move the member to a higher level of intervention. Primary Care Managers also initiate an interdisciplinary care team (ICT) to consult with other disciplines. Such as a brief In-Home Survey (IHS) with an In-Home Care Manager. A brief in-home survey is an added enhanced level of care management that allows the Care Manager to visit the member in their home, skilled nursing facility, even the hospital. With cognitively impaired members, in-home care management presence allows for direct observation of goals, barriers, and interventions for the member and the member's representative. Other ICT members include but are not limited to referrals to Humana Care Manager - Social Services and Community Health Educators through

the ICT tool. All primary Care Managers will follow outlined protocols initiating and updating ICPs and ICTs applicable to the member's identified cognitive impairment while providing on-going care management services.

Evidence Used to Verify Communications Have Taken Place:

The reporting relationship of CarePlus committees, both corporate and market-level, is designed to enhance the effectiveness of internal communication. A multi-disciplinary committee membership results in inter-departmental input and decision-making, which ultimately facilitates stronger communications throughout the organization. This structure also utilizes focused committees as a forum for solicitation of feedback from network providers. Committees are required to record meeting minutes, which promotes consistency in the documentation and follow-up of committee activities. Items discussed in committee meetings reflect documentation of conclusions, recommendations, action, and follow-up. Minutes are signed and dated by the chairperson or acting chairperson. Electronic signatures are acceptable and must be dated. Committee minutes are available at the next meeting for review and approval.

Other types of inter-departmental communication include memos, newsletters, e-mail, databases, online web information exchange (Hi!), Share Point, and written reports. The QI Work Plan serves as a communication tool by tracking quality improvement activities and is reviewed on as needed basis and presented to the Internal Board/Management Team quarterly and to CQIC annually. CarePlus recognizes the need for effective external communication as a key to quality care and service excellence. CarePlus communicates a variety of information to practitioners, providers, delegates, and members. Examples of provider communications may include but are not limited to:

- Letters/memos/faxes
- Committee minutes or reports
- Provider bulletins, notices, and newsletters
- Online and hard copy reports
- Provider educational sessions
- Written instructive communications
- Quality Improvement plans
- Internet/intranet (Humana At Home and CarePlus Website, e-mail, databases)
- Clinical newsletters
- Provider Manual for Physicians, Hospitals, and Healthcare Providers

Examples of member communications may include but are not limited to:

- Quarterly online newsletters and/or bulletins
- Health fairs/community projects
- Benefit updates and individual mailings
- Targeted e-mail communications

- Humana At Home and CarePlus' website which includes secured information regarding member claims, plan benefits, prescription drug coverage, participating providers, and links to health and wellness information

ELEMENT E: CARE TRANSITIONS PROTOCOLS:

Factor 1: Continuity of Care:

Humana Puerto Rico:

Humana Puerto Rico's objective to maintain continuity of care is to optimize a high quality member experience during care transitions in an effort to avert complications, unnecessary hospital re-admissions, and emergency room visits. Members are vulnerable to receiving fragmented and unsafe care when transitions occur. Humana Contigo works actively to coordinate transitions, when notified, before and after admission including transitions from home to a different health care setting, from one health care setting to another including but not limited to in-patient/acute facilities, skilled nursing, rehabilitation and long-term care/custodial facilities, and from a health care setting to home inclusive of members receiving home health care. This type of support is needed to ensure continuity of care.

The Care Manager's goals for a member who has experienced or will experience a transition is to evaluate that the member's environment is safe, to evaluate whether the member is receiving needed care, and to facilitate any medical and other services that are still needed or unaddressed. The member and/or the member's caregiver are educated about available support, which can assist in meeting the goal of a safe and optimal transition and the return to optimal health status. In addition to responding to a transition that has occurred, Care Managers educate members about the transition process and how to prevent unplanned admissions. Additionally, for members identified as being at risk for a transition, the Care Manager coordinates services to assist in preventing unplanned admissions.

There are multiple types of transitions of care that can be identified to prevent any complications which may later possibly result in an unplanned transition. Examples of planned transitions include, but are not limited to:

- Planned hospital admissions from the member's usual setting to the acute care setting
- Planned outpatient procedures (i.e. ambulatory surgery centers)
- Planned hospital discharges to an acute rehabilitation setting or skill nursing facility
- Planned transitions from the member's usual setting to a long term setting (i.e. adult living facility USA)

Unplanned transitions, requires early identification, for appropriate interventions to ensure that the member has quality outcomes and the transition follow an appropriate level for the member. Examples of unplanned transitions include, but are not limited to:

- Admission to a hospital through an Emergency Room visit
- Emergency room visits, without admission
- Unplanned discharges (i.e. against medical advice or without appropriate planning)

In coordinating the transitions of care for a member, the Humana Puerto Rico Care Management Team will always treat members with respect, consideration and dignity. Every member will be given the right to receive considerate care which will protect their dignity and respect their physical, cultural, spiritual and social health.

Managing member's transitions needs:

For those members actively member by the care management team the following responsibilities will be completed:

- Attempt early identification of those member's with planned and unplanned transitions.
- Contact attempts should be initiated by the care manager within the first 24 hours of being notified of member discharge
- Identify the hospital review specialist as part of the ICT and utilize them during the discharge planning process.
- Communicate with other members of the ICT, as indicated, to plan, coordinate and implement member transitions needs.
- Ensure that the PCP has been notified of the admissions to hospitals, rehabilitations and skilled nursing facilities through a daily report posted for them to identify their member.
- Primary Care Physician (PCP) / Provider are communicating about the determination the same date the decision is being made accordingly to what is establish in CCMS. A confirmation by fax can be sent to the PCP / provider as per request.
- Monitor the care and needs of the member through the hospital review specialist.
- Coordinate with the hospital review specialist to ensure transition of care is managed for the appropriate level of care to meet the needs of the member.
- Ensure on-going communication with the PCP is occurring.

- Ensure that the member received a discharge call this could be either done through the intervention of the case manager or the coordination at the plan. This will ensure that following have been addressed:

    - Follow up appointment with PCP is schedule
    - Member received and understands discharge plans
    - Member has been notified and is receiving or schedule to receive, home nursing therapies (physical, occupational, speech therapy), home infusions, DME, and social services, as they were instructions ordered at the time of discharge
    - Member has received and has had all new prescription filled and understands the correct use of the medication
    - Member has been offered nutritional support (i.e. Well Dine program for Medicare) post discharge
    - If any of the above needs not successfully met, that intervention will be corrected and/or modified to respond to the member's needs.

Document appropriate event codes that will be used to track and report on the transition of SNP member:

- Document in CCMS all interventions and changes in the care plan
- For planned and unplanned transitions, communication occurs with the member and/or responsible party about the care transition process and changes about the member' health status and plan of care within one business days.
- All settings of care (i.e.; hospital, skilled nursing facilities, rehabilitation, outpatient centers, etc.) share the sending setting's care plan with the receiving setting within one business day of notification of the transition.

For those members not currently being followed by case management, the appropriate Humana associates will be responsible to manage the transition needs of the member. These include:

- Hospital inpatient, observation status acute rehabilitation, SNF, and members will be managed by the hospital review specialist
- Discharge calls to the member following a discharge to the home or a different setting, will be conducted by the assigned care management associate

- All member identified as requiring additional case management services will be referred to the care management team
- Appropriate referral to the care management team, as indicated when additional transition needs are identified

Improving Transitions of Care:

The care management team will attempt early identification of planned transition, through communication with the member or a caregiver, the PCP, and any other member of the ICT, with appropriate interventions to ensure quality transition outcomes, the latter will prevent future unplanned transitions.

The care management team will attempt to reduce the number of unplanned transitions, utilizing the following processes:

- Identifying members at high risk of an unplanned transitions by:
  - Ongoing review of stratification reports
  - Ongoing review of facility admission reports and those members identified as having readmissions
  - Ongoing review of utilization reports
  - Ongoing review of ER visit reports
  - Prescription data received via the HRA and/or care management assessments (i.e. Rx Mentor, potential drug interactions, high risk medications for elderly/frail members)
  - Ongoing review of laboratory

The care management team will attempt to identify and maintain the member in the least restrictive setting that is appropriate for the member's overall health status and medical needs.

Post Discharge Care Coordination:

As part of the Care Management process for identifying and coordinating transition of care needs for members, three (3) attempts will be made to contact all members discharged from an acute hospital/rehabilitation facility, or skilled nursing facility (SNF).

The Care Manager will attempt to identify via daily admission report any potential needs associated with, but not limited to, the following;

- Timely follow-up appointment with the PCP/Specialist
- Pharmacy/Medication reconciliation

- Home health nursing, drug/infusion therapy, DME
- Psychosocial issues
- Nutritional support

The Care Manager will attempt to contact member within the first 24 hours after discharge date identified in the daily report. If member still admitted, the Care Manager will do a second series of attempts after day 5 of the admission date, and finally a third series of attempts in the 15th after the admission date. The Care Manager will complete the Post Discharge Call Assessment within 15 business days from discharge for each assigned and assist with:

- Coordination of follow-up appointment, if the member does not have a follow up visit scheduled with the PCP or specialist.
- Obtaining medications, if the member report that he/she has not filled a prescription nor has any questions of concerns about medication, the Case Manager will contact the prescribing physician to advice of this information. The Case Manager will reinforce to the member the importance of bringing all medications to the follow up appointment for a reconciliation of medications.
- Ensuring ordered services were provided (i.e. home health nursing, DME, etc.), the Case Manager will call the vendor, ordering physician and/or PCP and mitigate any issues to ensure timely and appropriate delivery of service.
    - If a delay in service and/or potential quality issue is identified, upon resolving the issue, the Case Manager will complete form and report any incidents to Quality Management Department.
- Communication with Social Worker if potential social issues or any other case management services are identified.
- Scheduling of meal delivery program (Well Dine)

In addition to the above processes, CarePlus is made aware of transitions of care through daily notifications by facilities and providers. These notifications can come through various sources such as: Census Reports, Telephone/Fax Notifications, Transfer Sheets (typically for transitions from inpatient to inpatient or inpatient to a skilled nursing facility), and Face Sheets. As well as, the documentation system platform via electronic tasks, alerts, notification systems, and member/caregiver self-report.

These admissions require an authorization to be entered in the CarePlus documentation platform. For planned transitions, the Precertification Team follows the pre-service authorization process. For unplanned transitions, the Inpatient Team will

follow the process for approving admissions and extending lengths of stay at inpatient and observation hospital visits.

Daily, the authorizations generate a letter to the member's primary care physician and the requesting facility/provider notifying them of the change in care setting. The authorization also generates information that is populated in the CarePlus Census that is distributed to the PCP's and CarePlus Field Case Managers (CPFCM). In addition, to enhance coordination of planned transitions, the CPFCMs receive a Planned Transition of Care Form via email which advises the CPFCMs of the last PCP appointment on record and any known current needs related to the member's health condition, durable medical equipment, psychosocial, support system (caregiver/family), contact information/challenges, transportation, medication, cognitive status, allergies, treatment plans, and language preferences.

The Care Manager will conduct a pre-assessment of the member's admission based on the information available. Tools to accomplish the pre-assessment include information from the daily census report and the Planned Transition of Care Form including care management problems and interventions. All documentation is accessible via the CarePlus documentation platform. CPFCMs conducts onsite visits upon identification of a member's admission into a facility. The CPFCM is responsible for completing the following:

1. Scheduling on-site bedside visits in accordance with each facility's policies.

2. Conducting beside visit/inpatient review process: The CPFCM will visit with each member and their support system (caregiver/family) to discuss the reason for the admission, psychosocial issues, prior level of function, importance of follow-up with the member's PCP and specialists for continued care and medication reconciliation.

- When possible the CPFCM will schedule a follow-up visit with the PCP or specialist visit for the member
- Hand-deliver the following discharge materials during the bedside visit:
    1. **CarePlus Health Plans Discharge Booklet** highlighting the importance of scheduling a visit with the member's PCP and taking all discharge orders and medications to the visit. The discharge instruction card also provides contact information for the member to contact the care management department should additional assistance be required.
- The CPFCM will access and review medical records to facilitate the ICT Rounds/Concurrent Review process during which services rendered are evaluated.

Documentation of all pertinent information in the CarePlus documentation platform must occur within 24 hours of obtaining information of admission/discharge and concurrent review.

The CPFCM will facilitate and assist the member and caregiver/family in coordinating activities required for discharge as outlined by the hospitalist/attending physician in the discharge plan. In addition, the CPFCM will assist the hospital staff and PCP with any related activities that

support a safe transition. This coordination may include members of the ICT including but not limited to the in-house Care Manager, Care Management Coordinator, Inpatient Coordinator, Medical Director, and any other discipline as needed.

The CPFCM will identify changes in care settings between facilities and coordinate these transitions as needed with the receiving CPFCM, Medical Director, CarePlus and Humana At Home Care Manager, and other HSO designee as appropriate. If there is a change in CPFCM due to the change in care setting the releasing CPFCM will provide the receiving CPFCM with a report of the member's needs through a Transition of Care communication. This communication may occur verbally or via email and is documented within the CarePlus documentation platform. If any additional services are needed, the HSO staff will ensure requests are processed and communicated to members and/or providers.

CarePlus Census Communication for Transitions of Care: CarePlus recognizes that transitions of care are important events in a member's life where the plan can coordinate care and communicate with the Interdisciplinary Care Team. Various census communications are a mode of communicating member information for this purpose. The plan gathers the information on the census to coordinate care when member moves from one setting to another, such as when they are admitted or discharged from a hospital or skilled nursing facility. Without coordination, such transitions often result in poor quality care and risks to patient safety.

Inpatient Census: The hospital census communicates information regarding members planned and unplanned transitions from their usual setting of care to the hospital. When an authorization is generated in the system for planned and unplanned transitions of care, the case appears the next day on the Inpatient census; this is for the Medical Director to review during hospital rounds with the CarePlus Field Case Managers (CPFCM). The census is run daily and lists all members admitted in the hospital. Members appear on the census within one business day of admission for planned and unplanned transitions. The hospital census is reviewed by the CarePlus Medical Director during hospital rounds with the CarePlus Field Case Managers. The census is run daily and includes planned and unplanned transitions of care occurring on the previous day. The information includes but is not limited to Date, type of census, county, region, Primary Contract Network (PCN), member number, enrollment date, case management, member name, date of birth, Primary Care Physician name (PCP), hospitalist, attending physicians name, authorization number, hospital name, admission date, scheduled discharge date, actual discharge date, Geo, transfer, diagnosis, status, End Stage Renal Disease (ESRD), Hospice, Line of Business (LOB), last admission type and last admission date.

Skilled Nursing Facility (SNF) Census: When the CPFCM receives the approval from the Medical Director to transfer the patient to the next setting (Skilled Nursing Facility), the authorization generated for the transfer is populated onto the SNF census on the next business day for the Medical Director to review during SNF rounds with the Field Case Managers.

The Long Term Facility (SNF) census is run daily and lists all members admitted into the SNF. Members appear on the census within one business day of admission for planned and unplanned transitions. The SNF census is reviewed by the CarePlus Medical Director during SNF rounds with the CarePlus Field Case Managers. The census includes planned and unplanned transitions of care. The census includes information for the CarePlus Medical Director to identify members that are admitted for review. The information includes but is not limited to Date, type of census, county, region, Primary Contract Network (PCN), member number, enrollment date, case management, member name, date of birth, Primary Care Physician name (PCP), region, Primary Care network (PCN), member ID, attending physicians name, authorization number, facility name, admission date, days certified, scheduled discharge date, diagnosis, status, adjudicator, group, case management, last bed type, Line of Business (LOB) and SNF days used.

Humana At Home:

Humana At Home's objective to maintain continuity of care is to optimize a high quality member experience during care transitions in an effort to avert complications, unnecessary hospital re-admissions, and emergency room visits. Members are vulnerable to receiving fragmented and unsafe care when transitions occur. CarePlus and Humana At Home works actively to coordinate transitions, when notified, before and after admission including transitions from home to a different health care setting, from one health care setting to another including but not limited to in-patient/acute facilities, skilled nursing, rehabilitation and long-term care/custodial facilities, and from a health care setting to home inclusive of members receiving home health care. This type of support is needed to ensure continuity of care.

The Care Manager's goals for a member who has experienced or will experience a transition is to evaluate that the member's environment is safe, to evaluate whether the member is receiving needed care, and to facilitate any medical and other services that are still needed or unaddressed. The member and/or the member's caregiver are educated about available support, which can assist in meeting the goal of a safe and optimal transition and the return to optimal health status. In addition to responding to a transition that has occurred, Care Managers educate members about the transition process and how to prevent unplanned admissions. Additionally, for members identified as being at risk for a transition, the Care Manager coordinates services to assist in preventing unplanned admissions.

CarePlus is made aware of transitions of care through daily notifications by facilities and providers. These notifications can come through various sources such as: Census Reports, Telephone/Fax Notifications, Transfer Sheets (typically for transitions from inpatient to inpatient or inpatient to a skilled nursing facility), and Face Sheets. As well as, the documentation system platform via electronic tasks, alerts, notification systems, and member/caregiver self-report.

These admissions require an authorization to be entered in the CarePlus documentation platform. For planned transitions, the Precertification Team follows the pre-service authorization process. For unplanned transitions, the Inpatient Team will follow the process for approving admissions and extending lengths of stay at inpatient and observation hospital visits.

Daily, the authorizations generate a letter to the member's primary care physician and the requesting facility/provider notifying them of the change in care setting. The authorization also generates information that is populated in the CarePlus Census that is distributed to the PCP's and CarePlus Field Case Managers (CPFCM). In addition, to enhance coordination of planned transitions, the CPFCMs receive a Planned Transition of Care Form via email which advises the CPFCMs of the last PCP appointment on record and any known current needs related to the member's health condition, durable medical equipment, psychosocial, support system (caregiver/family), contact information/challenges, transportation, medication, cognitive status, allergies, treatment plans, and language preferences.

The Care Manager will conduct a pre-assessment of the member's admission based on the information available. Tools to accomplish the pre-assessment include information from the daily census report and the Planned Transition of Care Form including care management problems and interventions. All documentation is accessible via the CarePlus documentation platform. CPFCMs conducts onsite visits upon identification of a member's admission into a facility. The CPFCM is responsible for completing the following:

3. Scheduling on-site bedside visits in accordance with each facility's policies.

4. Conducting beside visit/inpatient review process: The CPFCM will visit with each member and their support system (caregiver/family) to discuss the reason for the admission, psychosocial issues, prior level of function, importance of follow-up with the member's PCP and specialists for continued care and medication reconciliation.

- When possible the CPFCM will schedule a follow-up visit with the PCP or specialist visit for the member
- Hand-deliver the following discharge materials during the bedside visit:
    2. **CarePlus Health Plans Discharge Booklet** highlighting the importance of scheduling a visit with the member's PCP and taking all discharge orders and medications to the visit. The discharge instruction card also provides contact information for the member to contact the care management department should additional assistance be required.
- The CPFCM will access and review medical records to facilitate the ICT Rounds/Concurrent Review process during which services rendered are evaluated.

Documentation of all pertinent information in the CarePlus documentation platform must occur within 24 hours of obtaining information of admission/discharge and concurrent review.

The CPFCM will facilitate and assist the member and caregiver/family in coordinating activities required for discharge as outlined by the hospitalist/attending physician in the discharge plan. In addition, the CPFCM will assist the hospital staff and PCP with any related activities that support a safe transition. This coordination may include members of the ICT including but not limited to the in-house Care Manager, Care Management Coordinator, Inpatient Coordinator, Medical Director, and any other discipline as needed.

The CPFCM will identify changes in care settings between facilities and coordinate these transitions as needed with the receiving CPFCM, Medical Director, CarePlus and Humana At Home Care Manager, and other HSO designee as appropriate. If there is a change in CPFCM due to the change in care setting the releasing CPFCM will provide the receiving CPFCM with a report of the member's needs through a Transition of Care communication. This communication may occur verbally or via email and is documented within the CarePlus documentation platform. If any additional services are needed, the HSO staff will ensure requests are processed and communicated to members and/or providers.

CarePlus Census Communication for Transitions of Care: CarePlus recognizes that transitions of care are important events in a member's life where the plan can coordinate care and communicate with the Interdisciplinary Care Team. Various census communications are a mode of communicating member information for this purpose. The plan gathers the information on the census to coordinate care when member moves from one setting to another, such as when they are admitted or discharged from a hospital or skilled nursing facility. Without coordination, such transitions often result in poor quality care and risks to patient safety.

- **Inpatient Census:** The hospital census communicates information regarding members planned and unplanned transitions from their usual setting of care to the hospital. When an authorization is generated in the system for planned and unplanned transitions of care, the case appears the next day on the Inpatient census; this is for the Medical Director to review during hospital rounds with the CarePlus Field Case Managers (CPFCM).

  The census is run daily and lists all members admitted in the hospital. Members appear on the census within one business day of admission for planned and unplanned transitions. The hospital census is reviewed by the CarePlus Medical Director during hospital rounds with the CarePlus Field Case Managers. The census is run daily and includes planned and unplanned transitions of care occurring on the previous day. The information includes but is not limited to Date, type of census, county, region, Primary Contract Network (PCN), member number, enrollment date, case management, member name, date of birth, Primary Care Physician name (PCP), hospitalist, attending physicians name, authorization number, hospital name, admission date, scheduled discharge date, actual discharge date, Geo, transfer, diagnosis, status, End Stage Renal Disease (ESRD), Hospice, Line of Business (LOB), last admission type and last admission date.

- **Skilled Nursing Facility (SNF) Census:** When the CPFCM receives the approval from the Medical Director to transfer the patient to the next setting (Skilled Nursing Facility), the authorization generated for the transfer is populated onto the SNF census on the next business day for the Medical Director to review during SNF rounds with the Field Case Managers.

  The Long Term Facility (SNF) census is run daily and lists all members admitted into the SNF. Members appear on the census within one business day of admission for planned and unplanned transitions. The SNF census is reviewed by the CarePlus Medical Director during SNF rounds with the CarePlus Field Case Managers. The census includes planned and unplanned transitions of care. The census includes information for the CarePlus Medical Director to identify members that are admitted for review. The information includes but is not limited to Date, type of census, county, region, Primary Contract Network (PCN), member number, enrollment date, case management, member name, date of birth, Primary Care Physician name (PCP), region, Primary Care network (PCN), member ID, attending physicians name, authorization number, facility name, admission date, days certified, scheduled discharge date, diagnosis, status, adjudicator, group, case management, last bed type, Line of Business (LOB) and SNF days used.

Discharge Notifications:

Upon notification of discharge, Primary Care Managers will review and assess post discharge coordination needs. Member outreach is attempted for post discharge assessment completion. Based on the member's identified needs, the member's plan of care and/or level of intervention may be updated and ICT members may be engaged. The Primary Care Manager will educate the member and/or caregiver on the following topics:

- Scheduling, preparing or assisting for a follow-up appointment with physician
- Understanding discharge plan, including pre and post medication needs, adherence, and self-management
- Recognizing signs, symptoms, responses to a worsening condition, and knowing when to call a doctor
- Utilizing available resources and providing referrals

The Care Manager utilizes and completes the Post-Discharge Survey to evaluate the member's needs.

Connecting Members to Appropriate Providers and Services:

When a member is identified at risk of having a transition, services are coordinated and member is educated about the transitions process goals and how to prevent an unplanned admission. If the member experiences a planned transition, the Care Manager ensures the member's questions are answered and any follow-up services needed are coordinated. During this process the Care Manager works directly with a variety of departments within the

organization to verify the member is connected to appropriate providers. CarePlus Field Case Managers ensure benefit information is understood by the member regarding their type of transition, coordinates PCP assignment changes, and are also responsible for the clarification and resolution of issues and complaints. They work with members on an ongoing basis to help clarify information, resolve issues, and identify providers within the network needed for follow-up services before and after planned and unplanned transitions. For example, the CarePlus Field Case manager would provide the member with available network options for Rehabilitative Skilled Nursing Care following an unplanned hospital admission or if facing a planned admission for a special surgery, the representative would be able to provide a listing of specialists in the provider network.

Humana At Home Care Managers utilize the assistance of the Humana At Home Community Health Educator to provide any necessary health education or location of any services outside of the network the member may need. For example, if the member is having a procedure on cataracts, the CHE would be able to provide written health education information on cataract surgery. The CHE would also be able to provide information on options for visual equipment to assist the member following the surgery. If the member recently had an unplanned transition, the CHE would be able to provide the member with materials on how to prevent a future readmission.

The members have access to Humana Care Managers - Social Service whose subject matter expertise is to locate and coordinate any necessary services for the member within the community providers. The member may live alone and be faced with returning home from an unplanned or planned transition without the funds to purchase additional home care services. The HCM-SS would be able to assist in locating low or no cost options to provide assistance in the home.

The Care Manager is also able to enlist the help of the In-Home Care Manager to provide in-person consultation and evaluation following an unplanned transition. The brief in-home survey allows for IHCM's to visit the member in the home following discharge. This field presence and the local connections the In-Home Care Managers have assist in establishing community-based services ensuring members are connected with the appropriate resources in their own communities.

The Care Manager provides the following services to SNP members maintaining continuity of care through transitions:

1. **Treatment Plan Support**: Care Managers support member's self-efficacy and provide or arrange a referral for needed equipment and supplies for member self-management/self-monitoring, such as for glucose, blood pressure, or weight monitoring; and arrange for in-person assessment of self-management skill support.
2. **Care Coordination**: Care Managers lead the ICT and engage the support of other internal and external resources, make appropriate referrals, participate in care team conferences, and request case reviews. Care Managers facilitate communication between members and

providers regarding progress toward goals (e.g., the need to adjust therapy to enable a member to reach goals), and refer members to providers to assess condition, symptoms, medication, end of life planning, the need for Durable Medical Equipment (DME), and home health related issues or needs.

3. **Decision Coaching**: Care Managers provide printed and verbal education regarding end-of-life planning, including forms to facilitate documentation of end-of-life wishes, and provide referrals to community resources and other agencies such as hospice to assist members in making health and end of life related decisions. Access to and utilization of evidence-based decision coaching tools (i.e. *Krames OnDemand*) assists with educating members.
4. **Health Education**: Care Managers provide members with approved educational materials (appropriate for their conditions), verbal coaching, written and verbal education regarding other general health topics common in the Medicare population, and refer to community-based education resources.
5. **Independence at Home**: Care Managers work to maintain members' safety and independence to remain in their home and provide referrals for in-home environment/safety/fall risk evaluations by an In-Home Care Manager; and/or make external referrals to community-based services that can assist members in making modifications to their home to enhance function and safety.
6. **Health and Function**: Care Managers assess and evaluate members' physical and psychological health and functional status, provide education and health support, assist members and caregivers to manage complex conditions such as COPD, CHF, depression, dementia, chronic kidney disease and ESRD, and maintain optimal function and quality of life.

Factor 2: Care Transition Personnel:

Humana Puerto Rico:

Care transitions and post-discharge support by CarePlus and Humana Puerto Rico are coordinated by Care Managers for all SNP members. The process includes collaboration with the Humana Care Manager In-Home Care Managers, Social Worker, Filed Care Manager, the Interdisciplinary Care Team (ICT), and where needed, the Primary Healthcare Provider (PCP). These resources participate to evaluate that the member's environment is safe, to evaluate whether the member is receiving needed care, and to facilitate any medical and other services that are still needed or unaddressed. The member and/or the member's caregiver are educated about available support, which can assist in meeting the goal of a safe and optimal transition and the return to optimal health status. In addition to responding to a transition that has occurred, Care Managers educate members about the transition process and how to prevent unplanned admissions. Additionally, for members identified as being at risk for a transition, the Care Manager coordinates services to assist in preventing unplanned admissions.

Care Managers (CM): Humana Puerto Rico Care managers are registered nurses; with bachelor or master degree in nursing; and more than 3 years of clinical experience. The Care Manager has the responsibility for the management and coordination of member care. Care Managers will refer for an in home assessment for members in the severe level of intervention if warranted. Telephonic contact is initiated; and assessments are completed to identify member's needs. Needs are prioritized in the individualized care plan and services are coordinated accordingly.

Social Worker (SW): The Social Worker is a member for the ICT. The SW completes a comprehensive telephonic or home surveys geared toward the appropriate and timely provision of interventions leading to optimal care. They work collaboratively with other members of the Humana Puerto Rico ICT, including Humana Care Manager. Social Worker have a minimum of three years of case management experience and hold a Master's degree in Social Work (MSW), Master's degree in a related field, or Bachelor's degree in Social Work (BSW).

CarePlus Field Case Manager (CPFCM): A registered nurse, licensed practicing nurse, or foreign medical graduate that provides onsite assessment and care coordination at the bedside when a member is in an in-patient status at an acute, rehabilitation or Skilled Nursing Facility. The CPFCM role assess, plan, implement, coordinate, monitor and evaluate the options and services required to meet the member's health and social service needs. The role is characterized by advocacy, communication and resource management to ensure appropriate, timely and quality transition of care. The CPFCM communicates and works collaboratively with the Humana At Home telephonic Care Manager to ensure continuity of care regardless of the place of service. The CPFCM also collaborates with other health care providers in reviewing actual and proposed medical care and services against established clinical review criteria. The CPFCM also assists with discharge planning for members admitted to inpatient facilities and is able to identify potential unnecessary services and care delivery settings and recommend alternatives where appropriate. The CPFCM holds a current license in the state of Florida and has clinical nursing experience, preferably in acute care, skilled, or rehabilitation clinical setting.

Humana At Home:

Care transitions and post-discharge support by CarePlus and Humana At Home are coordinated by Humana Care Managers, Humana Care Coordinators and CarePlus Field Case Managers for all SNP members. The process includes collaboration with the Humana Care Manager-Social Service (HCM-SS) associates, In-Home Care Managers (IHCMs), Community Health Educators (CHEs), the Interdisciplinary Care Team (ICT), and where needed, the Primary Healthcare Provider (PCP). These resources participate to evaluate that the member's environment is safe, to evaluate whether the member is receiving needed care, and to facilitate any medical and other services that are still needed or unaddressed. The member and/or the member's caregiver are educated about available support, which can assist in meeting the goal of a safe and optimal transition and the return to optimal health status. In addition to responding to a

transition that has occurred, Care Managers educate members about the transition process and how to prevent unplanned admissions. Additionally, for members identified as being at risk for a transition, the Care Manager coordinates services to assist in preventing unplanned admissions.

Humana Care Managers (HCM): The HCM is a registered nurse or social worker. The HCM assumes responsibility for the management and coordination of care assigned members, as well as provides clinical support, consultations, and reviews for HCC staff. Telephonic contact is initiated, and surveys are completed per protocol on an as-needed basis. The HCM prioritizes member needs, educates and promotes member self-management strategies, initiates and updates the ICP, engages other members of the care team and refers to internal and external resources as necessary. HCMs who are registered nurses possess three or more years of clinical experience, and have exceptional communication, interpersonal and technical skills. Those that are social workers have a minimum of three years of case management experience and hold a Master's degree in Social Work (MSW), Master's degree in a related field, or Bachelor's degree in Social Work. The Humana At Home staffs HCMs specializing in complex medical or behavioral conditions.

Humana Care Coordinator (HCC): Humana Care Coordinator (HCC): Responsible for engaging members in care management, identifying the individual member's stratification through the use of provided tools, reviewing the member's needs after discharge from an inpatient facility, making referrals as needed to appropriate levels of care, and referring the member to available Humana resources, community resources, and the ICT for assistance. The HCC provides ongoing support to SNP members in medium and low risk levels of intervention (LOI), and the Monitored involvement level, including assisting with Medicaid recertification, access to Medicaid benefits, and connections to community resources. Refers to HCM for member clinical issues, questions, and needs. HCCs have a minimum of two years combined experience as a medical assistant or certified nurse assistant, health related field, or care management, and/or degrees in psychology, health education, or social work.

CarePlus Field Case Manager (CPFCM): A registered nurse, licensed practicing nurse, or foreign medical graduate that provides onsite assessment and care coordination at the bedside when a member is in an in-patient status at an acute, rehabilitation or Skilled Nursing Facility if needed. The CPFCM role assess, plan, implement, coordinate, monitor and evaluate the options and services required to meet the member's health and social service needs. The role is characterized by advocacy, communication and resource management to ensure appropriate, timely and quality transition of care. The CPFCM communicates and works collaboratively with the Humana At Home telephonic Care Manager to ensure continuity of care regardless of the place of service. The CPFCM also collaborates with other health care providers in reviewing actual and proposed medical care and services against established clinical review criteria. The CPFCM also assists with discharge planning for members admitted to inpatient facilities and is able to identify potential unnecessary services and care delivery settings and recommend

alternatives where appropriate. The CPFCM holds a current license in the state of Florida and has clinical nursing experience, preferably in acute care, skilled, or rehabilitation clinical setting.

Factor 3: Applicable Transitions:

To ensure CarePlus SNP members care plans are transferred between health care settings when a member experiences a transition in care. CarePlus utilizes daily census reports to identify members with planned and unplanned admissions and discharges. CarePlus requires pre-authorization/authorization of any unplanned or planned admissions, pre-scheduled in-patient services. These authorizations make up the content of the census reports along with member demographic information. These census reports are available to the Care Management Team for review, identification, and implementation of actions related to the CarePlus care transitions process.

Daily, the authorizations generates a letter/face sheet summary of the member's admission to the member's primary care physician and the requesting facility/provider notifying them of the change in care setting. The census report information provides the Care Manager with the unplanned or planned admission or discharge date, facility name, place of treatment, and primary diagnosis.

When a CarePlus Care Management Team member receives the census report alerting that a member has experienced an unplanned transition or is scheduled for a planned transition, the Care Manager initiates outreach to the member following the notification to schedule an on-site visit. A system generated fax is also sent to the verified practitioner as notification of the admission. During this on-site visit, the CarePlus FCM reviews the member's plan of care, medical records and orders. The CarePlus FCM is in constant communication with the CarePlus Medical Director discussing the member's admission, procedures, and any other pertinent medical information. If at any time during the admission, the CarePlus FCM will request continuation of treatment if deemed necessary by the CarePlus FCM and Medical Record to ensure continuity of care.

For Humana At Home, the primary Care Managers document their actions regarding a member's planned or unplanned transition within the documentation system platform including that the members plan of care was reviewed and distributed and that the member's PCP was notified of the admission.

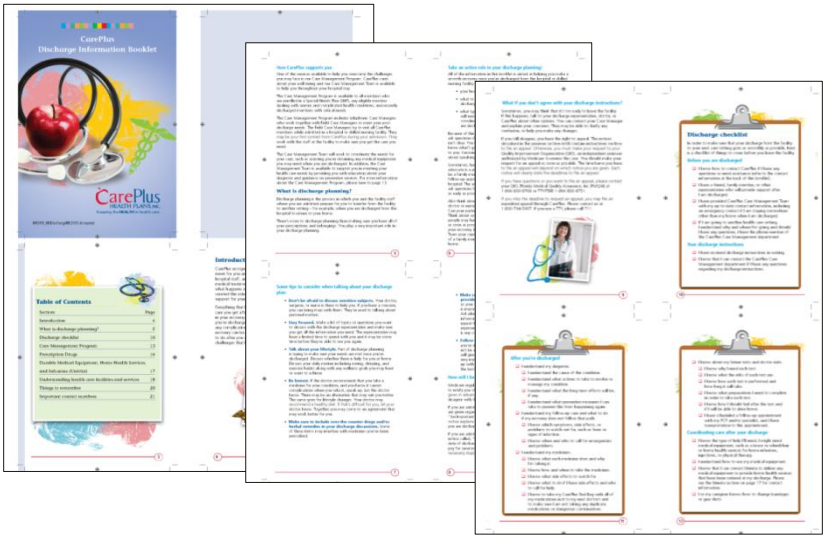
For Humana Puerto Rico, to ensure CarePlus SNP members updated Individualized Care Plans are transferred between health care settings when a member experiences a transition in care, Care Managers for all involvement levels are made aware care transitions on a daily basis through reminders within their care management queue, in some instances member/member's legal representative self-report transitions. Reminders in Humana Clinical system notify the Care Manager to access the individual member's event regarding their planned and unplanned admission or discharge. Reminder information provides the Care Manager with the unplanned

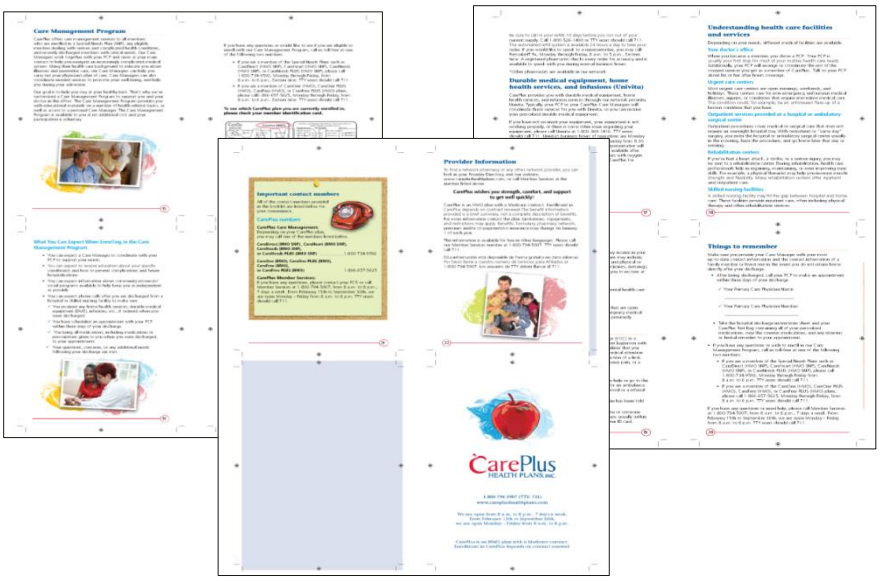
or planned admission or discharge date. The care manager will access the member's case and open the screen for the Transition Event that will contain the facility name, place of treatment, and primary diagnosis. The Care Managers document their actions regarding a member's planned or unplanned transition within the documentation system platform adding new problems/interventions/goals to the already created ICP as a result of the Transition event. An updated care plan is sent to provider and member upon request.

Upon discharge, the CarePlus reviews the discharge plan of care with the member and forwards all necessary plan of care information to the receiving facility if the member is being discharged to a skilled nursing facility or rehabilitation facility. The CarePlus FCM also ensures the member has the discharge plan of care and has made the necessary follow-up appointments with their primary care physician upon discharge from the facility.

CarePlus ensures members care plans are transferred between health care settings when the member experiences a transition in care by a report showing planned and unplanned transitions, dates of alerts, date of fax to receiving facility and date of provider notification.

Example: CarePlus Discharge Booklet Shared by CarePlus Field Case Manager:





Example: CarePlus Notification to PCP of Members Planned or Unplanned Admission:

CarePlus HEALTH PLANS, INC.

CarePlus Health Plans, Inc.
11430 NW 20th Street, Suite 300
Doral, FL 33172
Ph. 1-800-201-4305
Fx. 1-866-229-1538

Hospital name and address.

TOWN & COUNTRY HOSP
6001 WEBB ROAD
TAMPA, FL 33614

Patient:
DOB:
Plan ID: [redacted]

Authorization number.

Admit date

Our records indicate that the above member was admitted to your facility on: 07-10-2013
The authorization number for this admission is: 5463500*I
This admission has been authorized for: 4 days

Days approved

Concurrent reviews may be performed to determine medical necessity for additional days.

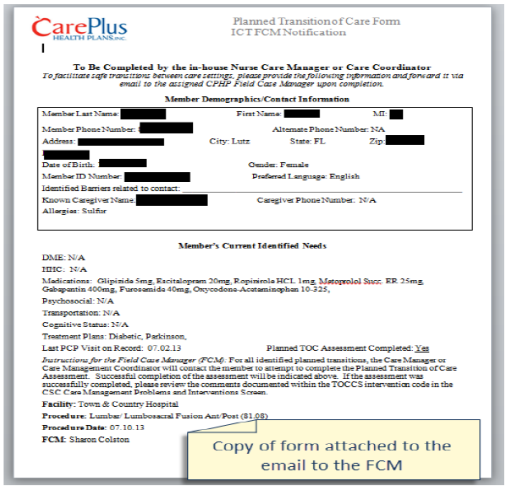
If you have any questions, please call the Utilization Management Team at: **1-800-201-4305**

Sincerely,

CarePlus Health Plans, Inc.
Utilization Management Department

CarePlus Health Plans, Inc. is a Health plan with a Medicare contract.

Example: CarePlus Transition of Care Form:



CarePlus HEALTH PLANS, INC.

Planned Transition of Care Form
ICT FCM Notification

To Be Completed by the in-house Nurse Care Manager or Care Coordinator
To facilitate safe transitions between care settings, please provide the following information and forward it via email to the assigned CPHP Field Case Manager upon completion.

Member Demographics/Contact Information

Member Last Name: [redacted] First Name: [redacted] MI: [redacted]
Member Phone Number: [redacted] Alternate Phone Number: N/A
Address: [redacted] City: Lutz State: FL Zip: [redacted]
Date of Birth: [redacted] Gender: Female
Member ID Number: [redacted] Preferred Language: English
Identified Barriers related to contact:
Known Caregiver Name: [redacted] Caregiver Phone Number: N/A
Allergies: Sulfer

Member's Current Identified Needs

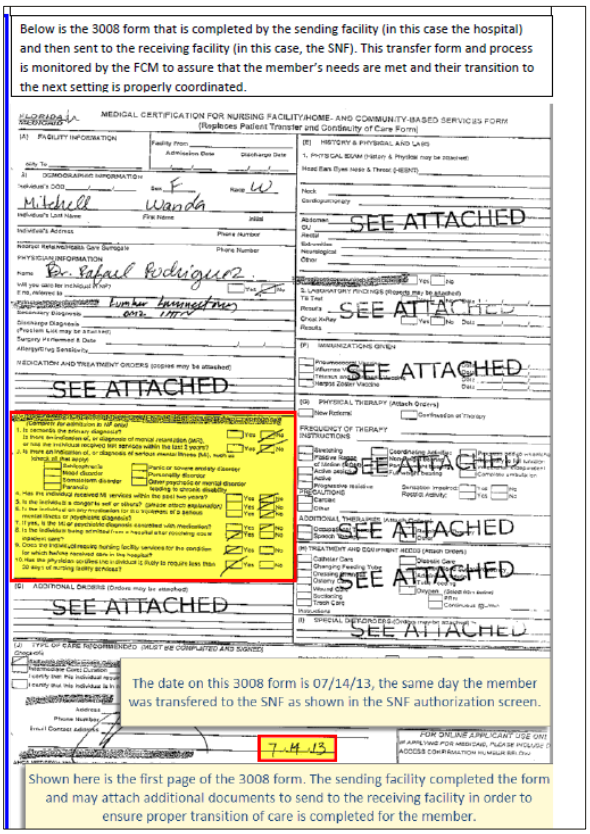
DME: N/A
HHC: N/A
Medications: Glipizide 5mg, Escitalopram 20mg, Ropinirole HCL 1mg, Metoprolol Succ ER 25mg, Gabapentin 400mg, Furosemide 40mg, Oxycodone-Acetaminophen 10-325,
Psychosocial: N/A
Transportation: N/A
Cognitive Status: N/A
Treatment Plans: Diabetic, Parkinson,
Last PCP Visit on Record: 07.02.13 Planned TOC Assessment Completed: Yes

Instructions for the Field Case Manager (FCM): For all identified planned transitions, the Care Manager or Care Management Coordinator will contact the member to attempt to complete the Planned Transition of Care Assessment. Successful completion of the assessment will be indicated above. If the assessment was successfully completed, please review the comments documented within the TOCCS intervention code in the CSC Care Management Problems and Interventions Screen.

Facility: Town & Country Hospital
Procedure: Lumbar: Lumbosacral Fusion Ant/Post (81.08)
Procedure Date: 07.10.13
FCM: Sharon Colston

Copy of form attached to the email to the FCM

Example: Discharge Plan of Care Sent to Receiving Facility:



Below is the 3008 form that is completed by the sending facility (in this case the hospital) and then sent to the receiving facility (in this case, the SNF). This transfer form and process is monitored by the FCM to assure that the member's needs are met and their transition to the next setting is properly coordinated.

MEDICAL CERTIFICATION FOR NURSING FACILITY/HOME- AND COMMUNITY-BASED SERVICES FORM
(Replaces Patient Transfer and Continuity of Care Form)

Mitchell Wanda F W

Dr. Rafael Rodriguez

SEE ATTACHED

The date on this 3008 form is 07/14/13, the same day the member was transfered to the SNF as shown in the SNF authorization screen.

7.14.13

Shown here is the first page of the 3008 form. The sending facility completed the form and may attach additional documents to send to the receiving facility in order to ensure proper transition of care is completed for the member.

Factor 4: Beneficiary Personal Health Information:

CarePlus SNP members have access to personal health information to facilitate communication with providers via a SmartSummary. A SmartSummary is an Explanation of Benefits mailed out upon processing of claim information. A SmartSummary are completed for non-participating provider claims, participating provider claims, along with Part D claims. The SmartSummary allow members access to their personal health information related to prescription drugs, diagnoses, and applicable procedures. By reviewing SmartSummary in detail, members become more aware of their health, prescriptions, and healthcare choices. They may find that they may realize they aren't sure why they've been prescribed certain medications. CarePlus encourages members to review their SmartSummary's and ask questions of their doctor or pharmacist. A member's SmartSummary includes relevant information that helps members:

- Engage – in their healthcare spending
- Know – about their total healthcare picture
- Decide – about their healthcare and their benefit

Humana Puerto Rico:

CarePlus members also have access to their Care Manager to obtain personal health information in addition members receive copies of their Individualized Care Plan via the mail for review with providers in other healthcare settings. Additionally, during transitions of care, members receive their Individualized Care Plans, which are reviewed in detail by the Care Manager.

Humana At Home:

CarePlus members also have access to their primary Care Manager to obtain personal health information in addition members are able to request copies of their Individualized Care Plan for review with providers in other healthcare settings. The member's primary Care Manager is the point of contact particularly for members who are unable to comprehend the Smart Summaries received to access their personal health information. Additionally, during transitions of care, members receive admission and discharge plans of care, which are reviewed in detail by the CarePlus Care Management Team.

Factor 5 & 6: Self-Management Activities & Notification of Point of Contact:

Humana Puerto Rico:

The member's Care Manager educates the member about their health status to foster appropriate self-management activities. Including but not limited to:

- **Health Education:** Care Managers provide members with approved educational materials related to specific health conditions and concerns. They also provide verbal coaching and written education on other general health topics common in the Medicare population, along with referrals to community-based education resources.
- **Health and Function:** Evaluation of the member's physical and psychological health and functional status to provide education and health support, and assist the member and/or caregiver to manage their diseases as well as comorbid conditions such as COPD, CHF, depression, dementia, chronic kidney disease and end state renal disease to maintain optimal function and quality of life.
- **Knowledge of When to Call the Physician:** Care Managers assist members to be informed health care consumers and to establish a regular source of health care. They provide written and verbal education regarding warning signs of heart failure, diabetic complications, as well as common co-morbid complications including COPD, and depression. They also help members establish an emergency contact and action plan. Members may be supported via three way calls or warm transfers to physicians and providers for things like making an appointment or consulting with a pharmacist.
- **Preventive and Screening Services:** Care Managers educate and provide reminders for obtaining health and preventions screening tests and services related to HEDIS measures, annual flu vaccine, colon and breast cancer screens, glaucoma eye screenings, etc. They also support members in monitoring progress toward goals and self-management of their chronic health conditions.
- **Self-Care Management & Personal Healthcare Preferences:** Humana Puerto Rico supports self-care management and healthy behaviors based on the member's stage of readiness to change. Referrals are made to providers or community-based resources for smoking cessation, alcohol or substance abuse, nutrition, physical activity and weight management.

Humana Puerto Rico trains their Care Managers in motivational interviewing an evidence based theoretical framework which provides strategies for evaluating understanding member

perspectives i.e. reflective listening. Motivational interviewing allows the Care Manager to verify the members understanding of their health condition whether it has improved or worsened and appropriate self-management activities. This approach increases members awareness of the potential problems caused by their health conditions, risks associated with their behavior that may have harmful effects on their conditions, and allows the member to envision a better future than what they face currently.

Notification of Point of Contact:

Humana Puerto Rico Care Managers and CarePlus Field Case Managers provide Transition of Care support, notification, and education to members during outreach calls. The purpose of these calls is to provide the member with the personnel responsible for supporting them through their care transition. The Care Manager provides their name and contact information to the member or the member's caregiver. Additionally, the Care Manager provides education to provide the member with information related to the care transition process, changes to the member's health status and plan of care and how to prevent unplanned transitions.

The education is provided using the post discharge survey and information obtained through educational resources. Information regarding health topics, medications, symptoms, and tests are available to share with the member verbally or printed and mailed as a PDF document. This application contains enhanced clinical features to assist associates with clinical decision support and member education.

Humana At Home:

The member's primary Care Manager educates the member about their health status to foster appropriate self-management activities. Including but not limited to:

- **Treatment Plan Support:** Care Managers support the member's self-efficacy and provide referrals for needed equipment supplies for self-management and self-monitoring. These supplies include blood glucose meters, blood pressure equipment, and weight monitoring devices. Care Managers also arrange for in-person evaluation of self-management skill and support.
- **Health Education:** Care Managers provide members with approved educational materials related to specific health conditions and concerns. They also provide verbal coaching and written education on other general health topics common in the Medicare population, along with referrals to community-based education resources.
- **Health and Function:** Evaluation of the member's physical and psychological health and functional status to provide education and health support, and assist the member and/or caregiver to manage their diseases as well as comorbid conditions such as COPD, CHF,

depression, dementia, chronic kidney disease and end state renal disease to maintain optimal function and quality of life.

- **Knowledge of When to Call the Physician:** Care Managers assist members to be informed health care consumers and to establish a regular source of health care. They provide written and verbal education regarding warning signs of heart failure, diabetic complications, as well as common co-morbid complications including COPD, and depression. They also help members establish an emergency contact and action plan. Members may be supported via three way calls or warm transfers to physicians and providers for things like making an appointment or consulting with a pharmacist.
- **Preventive and Screening Services:** Care Managers educate and provide reminders for obtaining health and preventions screening tests and services related to HEDIS measures, annual flu vaccine, colon and breast cancer screens, glaucoma eye screenings, etc. They also support members in monitoring progress toward goals and self-management of their chronic health conditions.
- **Self-Care Management & Personal Healthcare Preferences:** Humana At Home supports self-care management and healthy behaviors based on the member's stage of readiness to change. Referrals are made to providers or community-based resources for smoking cessation, alcohol or substance abuse, nutrition, physical activity and weight management.

Care Managers are trained in motivational interviewing an evidence based theoretical framework which provides strategies for evaluating understanding member perspectives i.e. reflective listening. Motivational interviewing allows the Care Manager to verify the members understanding of their health condition whether it has improved or worsened and appropriate self-management activities. This approach increases members awareness of the potential problems caused by their health conditions, risks associated with their behavior that may have harmful effects on their conditions, and allows the member to envision a better future than what they face currently.

Example: Humana At Home Learning & Development Motivational Interviewing Tools:


Patient Conversation Guide Based on Motivational Interviewing®

Patient Conversation Guide Based on Motivational Interviewing® (continued)

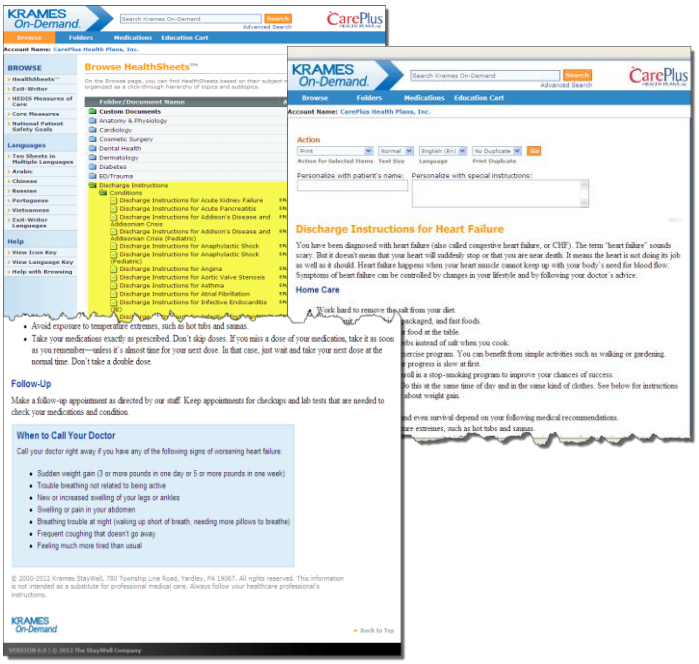
Notification of Point of Contact:

CarePlus Field Case Managers and Humana At Home Care Managers provide care transitions support, notification, and education to members during outreach calls and on-site visits. The purpose of these calls and visits is to provide the member with the personnel responsible for supporting them through their care transition. The Care Manager provides their name and contact information to the member or the member's caregiver. Additionally, the Care Manager provides education to provide the member with information related to the care transition process, changes to the member's health status and plan of care and how to prevent unplanned transitions.

The education is provided using the CarePlus Discharge Booklet, the post discharge questionnaire and information obtained through educational resources through Krames OnDemand. Krames OnDemand is an online tool which provides health conditions knowledge base and decision support. Information regarding health topics, medications, symptoms, and tests are available to share with the member verbally or printed and mailed as a PDF document. This application contains enhanced clinical features to assist associates with clinical decision support and member education.

Example: Available Educational Information on Care Transitions:

1. **Krames On-Demand Discharge Educational Fact Sheets for Members: Discharge Instructions for Heart Failure**



MOC 3: PROVIDER NETWORK:

ELEMENT A: SPECIALIZED EXPERTISE:

Factor 1: Specialized Network:

CarePlus offers SNP members a comprehensive care centered primary care network 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, rehab facilities, rehabilitative specialists, mental and social health specialists, home health specialists, and end of life care specialists. Although CarePlus' Special Needs Plans offer a comprehensive network of physicians and providers, should members develop needs for services outside the current network, CarePlus may grant approval for utilization of out-of-network facilities when appropriate.

CarePlus recognizes that SNP members have specific needs and may require the services of many different types of specialists and various other physicians and providers. CarePlus also recognizes that rapid access to these service providers is a main consideration for SNP members and CarePlus' network meets and, in some cases, exceeds all network access and availability standards. The physician and provider network that corresponds to the target population is represented by our provider directory. This includes primary care, specialty, ancillary, and facility types including but not limited to medical specialists, dialysis facilities and specialty outpatient clinics. CarePlus' existing provider networks are inherently designed to meet the specific needs of the SNP Program population as evidenced by:

- Contracted providers experienced in caring for our targeted population
- A culturally-driven provider network
- Providers located in geographic proximity to where the population resides

CarePlus also has established a member access plan. The access plan fosters member access to care through an adequate network of providers. The Access Plan activities are designed to:

- Facilitate timeliness of appointments and medical care both during and after office hours
- Meet the cultural and linguistic needs of the member population
- Measure performance against CarePlus standards for provider access and availability
- Identify opportunities for improvement
- Facilitate a sufficient number of primary care and specialty providers in the delivery system and align geographic distribution with the member population

The Provider Directory lists all provider specialties, addresses and telephone numbers and also allows SNP members to locate specific providers who are Medicaid certified to search for and

providers who speak secondary languages and find providers based on gender. . It also includes basic information about how to access covered services. The Provider Directory is provided at the time of enrollment, and at least every three (3) years after or at any time upon member request. The CarePlus website contains current directories at all times at http://www.care-plus-health-plans.com/provider-pharmacy-directories.asp. SNP members who face chronic conditions are able to locate providers who specialize in the chronic condition and accept both Medicare and Medicaid.

CarePlus contracts with local acute care facilities to provide acute medical inpatient services. However, a designated network of sub-acute, long-term care and assisted living facilities is also maintained. These facilities understand the complexity of managing institutionalized members and have the capability to participate in the care management program to promote delivery of the most cost efficient and medically appropriate care.

CarePlus also contracts with a full network of behavioral health providers across a spectrum of care levels: inpatient, partial hospital, intensive outpatient, mobile crisis teams, community-based crisis stabilization units, home-based therapy services, and standard outpatient mental health and addictions services.

Nursing professionals support the overall care management of the members specifically in the community and in the facility settings. Home Health RN's provide clinical evaluation and collaborate with Care Managers to assist in primary care services and ongoing evaluation. The general network of allied health professionals is comprehensive; however, a few of these are specially selected to support the needs of this population: Community Pharmacists to support medication reconciliation, especially during the care transition process and Home & Community Therapists who are specifically trained in improving functional performance for institutional equivalent members living in the community.

In 2016, the D-SNP service area is located in the following counties in the state of Florida: Brevard, Broward, Duval, Hillsborough, Indian River, Lake, Marion, Martin, Miami-Dade, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Seminole, St. Lucie, Sumter.

The following identifies the network adequacy available by county identifying availability of specialists to meet the top five most relevant diagnoses for the SNP population. Network Adequacy standards were exceeded for a majority of areas and specialties for both geographic distribution and the number of contracted providers. Where the network does not meet CMS access standards, Humana reviews local care patterns and provider availability to ensure members have access to needed care. In rural areas as well as counties with extreme access concerns, limited provider populations prevent plans from being able to meet the established standards.

Broward County:

1. Diabetes Mellitus Uncomplicated (39%)

- Endocrinology: Broward County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

2. Moderate to Severe Chronic Kidney Disease (31%)
   - Nephrology: Endocrinology: Broward County in the state of Florida passed CMS Specialty Network Adequacy for Nephrology.
3. Diabetes Mellitus Complicated (28%)
   - Endocrinology: Broward County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
4. Chronic Pulmonary Disease (27%)
   - Pulmonology: Broward County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.
5. Diabetes Mellitus Psychoses (20%)
   - Endocrinology: Broward County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

Miami–Dade County:

1. Diabetes Mellitus Uncomplicated (35%)
   - Endocrinology: Miami-Dade County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
2. Chronic Pulmonary Disease (31%)
   - Pulmonology: Miami-Dade County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.
3. Moderate to Severe Chronic Kidney Disease (27%)
   - Nephrology: Miami-Dade County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
4. Diabetes Mellitus Complicated (25%)
   - Endocrinology: Miami-Dade County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
5. Diabetes Mellitus Psychoses (23%)
   - Endocrinology: Miami-Dade County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

Palm Beach County:

1. Diabetes Mellitus Uncomplicated (34%)
   - Endocrinology: Palm Beach County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
2. Moderate to Severe Chronic Kidney Disease (26%)
   - Nephrology: Palm Beach County in the state of Florida passed CMS Specialty Network Adequacy for Nephrology.

3. Chronic Pulmonary Disease (24%)
    - Pulmonology: Palm Beach County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.
4. Diabetes Mellitus Complicated (22%)
    - Endocrinology: Palm Beach County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
5. Diabetes Mellitus Psychoses (15%)
    - Endocrinology: Endocrinology: Palm Beach County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

Hillsborough County:

1. Diabetes Mellitus Uncomplicated (37%)
    - Endocrinology: Hillsborough County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
2. Chronic Pulmonary Disease (33%)
    - Pulmonology: Hillsborough County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.
3. Moderate to Severe Chronic Kidney Disease (26%)
    - Nephrology: Hillsborough County in the state of Florida passed CMS Specialty Network Adequacy for Nephrology.
4. Diabetes Mellitus Complicated (26%)
    - Endocrinology: Hillsborough County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
5. Diabetes Mellitus Psychoses (26%)
    - Endocrinology: Hillsborough County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

Pasco County:

1. Chronic Pulmonary Disease (28%)
    - Pulmonology: Pasco County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.
2. Diabetes Mellitus Uncomplicated (28%)
    - Endocrinology: Pasco County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
3. Diabetes Mellitus Complicated (20%)
    - Endocrinology: Pasco County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
4. Moderate to Severe Chronic Kidney Disease (18%)

- Nephrology: Pasco County in the state of Florida passed CMS Specialty Network Adequacy for Nephrology.

5. Diabetes Mellitus Psychoses (17%)
   - Endocrinology: Pasco County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

Pinellas County:

1. Chronic Pulmonary Disease (38%)
   - Pulmonology: Pinellas County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.
2. Diabetes Mellitus Uncomplicated (30%)
   - Endocrinology: Pinellas County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
3. Diabetes Mellitus Psychoses (28%)
   - Endocrinology: Pinellas County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
4. Moderate to Severe Chronic Kidney Disease (20%)
   - Nephrology: Pinellas County in the state of Florida passed CMS Specialty Network Adequacy for Nephrology.
5. Diabetes Mellitus Complicated (18%)
   - Endocrinology: Pulmonology: Pinellas County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.

Polk County:

1. Diabetes Mellitus Uncomplicated (25%)
   - Endocrinology: Polk County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
2. Chronic Pulmonary Disease (22%)
   - Pulmonology: Polk County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.
3. Moderate to Severe Chronic Kidney Disease (17%)
   - Nephrology: Polk County in the state of Florida passed CMS Specialty Network Adequacy for Nephrology.
4. Diabetes Mellitus Complicated (17%)
   - Endocrinology: Polk County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
5. Diabetes Mellitus Psychoses (17%)
   - Endocrinology: Polk County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

Orange County:

1. Diabetes Mellitus Uncomplicated (35%)
   - Endocrinology: Orange County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
2. Moderate to Severe Chronic Kidney Disease (29%)
   - Nephrology: Orange County in the state of Florida passed CMS Specialty Network Adequacy for Nephrology.
3. Chronic Pulmonary Disease (24%)
   - Pulmonology: Orange County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.
4. Diabetes Mellitus Complicated (24%)
   - Endocrinology: Polk County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
5. Diabetes Mellitus Psychoses (19%)
   - Endocrinology: Polk County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

Osceola County:

1. Diabetes Mellitus Uncomplicated (29%)
   - Endocrinology: Osceola County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
2. Chronic Pulmonary Disease (22%)
   - Pulmonology: Osceola County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.
3. Moderate to Severe Chronic Kidney Disease (20%)
   - Nephrology: Osceola County in the state of Florida passed CMS Specialty Network Adequacy for Nephrology.
4. Diabetes Mellitus Complicated (18%)
   - Endocrinology: Osceola County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
5. Diabetes Mellitus Psychoses (18%)
   - Endocrinology: Osceola County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

Seminole County:

1. Diabetes Mellitus Uncomplicated (35%)
    - Endocrinology: Seminole County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
2. Moderate to Severe Chronic Kidney Disease (31%)
    - Nephrology: Seminole County in the state of Florida passed CMS Specialty Network Adequacy for Nephrology.
3. Chronic Pulmonary Disease (28%)
    - Pulmonology: Seminole County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.
4. Diabetes Mellitus Complicated (24%)
    - Endocrinology: Seminole County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
5. Diabetes Mellitus Psychoses (15%)
    - Endocrinology: Seminole County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

Brevard County:

1. Diabetes Mellitus Uncomplicated (32%)
    - Endocrinology: Brevard County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
2. Chronic Pulmonary Disease (28%)
    - Pulmonology: Brevard County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.
3. Moderate to Severe Chronic Kidney Disease (13%)
    - Nephrology: Brevard County in the state of Florida passed CMS Specialty Network Adequacy for Nephrology.
4. Diabetes Mellitus Psychoses (12%)
    - Endocrinology: Brevard County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
5. Diabetes Mellitus Complicated (12%)
    - Endocrinology: Brevard County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

Indian River County:

1. Chronic Pulmonary Disease (22%)
    - Pulmonology: Indian River County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.

2. Diabetes Mellitus Uncomplicated (22%)
    - Endocrinology: Indian River County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
3. Solid Tumor (10%)
    - Oncology- Medical, Surgical: Indian River County in the state of Florida passed CMS Specialty Network Adequacy for Oncology- Medical, Surgical.
4. Diabetes Mellitus Cancer (10%)
    - Endocrinology: Indian River County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
5. Myocardial Infarction (10%)
    - Cardiology: Indian River County in the state of Florida passed CMS Specialty Network Adequacy for Cardiology.

Martin County:

1. Diabetes Mellitus Psychoses (62%)
    - Endocrinology: Martin County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
2. Chronic Pulmonary Disease (31%)
    - Pulmonology: Martin County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.
3. Moderate to Severe Chronic Kidney Disease (31%)
    - Nephrology: Martin County in the state of Florida passed CMS Specialty Network Adequacy for Nephrology.
4. Diabetes Mellitus Cancer (23%)
    - Endocrinology: Martin County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
5. Diabetes Mellitus Complicated (15%)
    - Endocrinology: Martin County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

Okeechobee County:

1. Peripheral Vascular Disease (43%)
    - Vascular Surgery: Okeechobee County in the state of Florida passed CMS Specialty Network Adequacy for Vascular Surgery.
2. Diabetes Mellitus Uncomplicated (43%)
    - Endocrinology: Okeechobee County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
3. Congestive Heart Failure (29%)

- Cardiology: Okeechobee County in the state of Florida passed CMS Specialty Network Adequacy for Cardiology.

4. Cerebrovascular Disease (29%)
   - Neurology: Okeechobee County in the state of Florida passed CMS Specialty Network Adequacy for Neurology.
5. Diabetes Mellitus Complicated (29%)
   - Endocrinology: Okeechobee County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

St. Lucie County:

1. Diabetes Mellitus Uncomplicated (28%)
   - Endocrinology: St. Lucie County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
2. Chronic Pulmonary Disease (23%)
   - Pulmonology: St. Lucie County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.
3. Diabetes Mellitus Complicated (15%)
   - Endocrinology: St. Lucie County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
4. Moderate to Severe Chronic Kidney Disease (14%)
   - Nephrology: St. Lucie County in the state of Florida passed CMS Specialty Network Adequacy for Nephrology.
5. Diabetes Mellitus Psychoses (10%)
   - Endocrinology: St. Lucie County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

Duval County:

1. Diabetes Mellitus Uncomplicated (20%)
   - Endocrinology: Duval County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
2. Chronic Pulmonary Disease (14%)
   - Pulmonology: Duval County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.
3. Moderate to Severe Chronic Kidney Disease (8%)
   - Nephrology: Duval County in the state of Florida passed CMS Specialty Network Adequacy for Nephrology.
4. Diabetes Mellitus Psychoses (8%)
   - Endocrinology: Duval County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

5. Diabetes Mellitus Complicated (7%)
    - Endocrinology: Duval County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

Lake County:

1. Diabetes Mellitus Uncomplicated (27%)
    - Endocrinology: Lake County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
2. Chronic Pulmonary Disease (24%)
    - Pulmonology: Lake County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.
3. Moderate to Severe Chronic Kidney Disease (17%)
    - Nephrology: Lake County in the state of Florida passed CMS Specialty Network Adequacy for Nephrology.
4. Diabetes Mellitus Uncomplicated (15%)
    - Endocrinology: Lake County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
5. Diabetes Mellitus Psychoses (13%)
    - Endocrinology: Lake County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

Marion County:

1. Chronic Pulmonary Disease (24%)
    - Pulmonology: Marion County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.
2. Diabetes Mellitus Uncomplicated (24%)
    - Endocrinology: Marion County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
3. Moderate to Severe Chronic Kidney Disease (16%)
    - Nephrology: Marion County in the state of Florida passed CMS Specialty Network Adequacy for Nephrology.
4. Diabetes Mellitus Psychoses (15%)
    - Endocrinology: Marion County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
5. Diabetes Mellitus Complicated (13%)
    - Endocrinology: Marion County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

Sumter County:

1. Diabetes Mellitus Uncomplicated (26%)
   - Endocrinology: Sumter County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.
2. Chronic Pulmonary Disease (25%)
   - Pulmonology: Sumter County in the state of Florida passed CMS Specialty Network Adequacy for Pulmonology.
3. Moderate to Severe Chronic Kidney Disease (12%)
   - Nephrology: Sumter County in the state of Florida passed CMS Specialty Network Adequacy for Nephrology.
4. Peripheral Vascular Disease (12%)
   - Vascular Surgery: Sumter County in the state of Florida passed CMS Specialty Network Adequacy for Vascular Surgery.
5. Diabetes Mellitus Complicated (11%)
   - Endocrinology: Sumter County in the state of Florida passed CMS Specialty Network Adequacy for Endocrinology.

Factor 2 & 3: Licensure & Certification:

CarePlus physician and provider network is comprised of credentialed facilities, physicians, and providers. Credentialing is the process establishing the qualifications of licensed professionals/organizational providers and assessing their background and legitimacy. Our parent company's, Humana Credentialing Department oversees the credentialing and re-credentialing for all of medical and pharmacy. Our parent company follows all Federal and State laws and regulations. In instances where laws and regulations differ, the most stringent are followed. Practitioners who require credentialing include, but are not limited to:

Medical Practitioners:

1. Medical Doctors
2. Oral Surgeons
3. Chiropractors
4. Osteopaths
5. Podiatrists
6. Nurse Practitioners
7. Dentists
8. Optometrists

Behavioral Health Practitioners:

1. Psychiatrists and other physicians
2. Addiction medicine specialists

3. Doctoral or master's level psychologists who are state certified or licensed
4. Master's level clinical social workers who are state certified or licensed
5. Master's level nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed
6. Other behavioral health specialists who are licensed, certified, or registered by the state to practice independently

Practitioners who do not require credentialing include:

1. Practitioners who practice exclusively in the inpatient setting and who provide care for members only as a result of members being directed to the hospital or other inpatient setting
2. Practitioners who practice exclusively within freestanding facilities and who provide care for members only as a result of being directed to the facility
3. Pharmacists who work for a pharmacy benefits management (PBM) organization
4. Covering practitioners (e.g., locums tenens) who do not have independent relationship with Humana.
5. Practitioners who do not provide care for members in a treatment setting (e.g., board-certified consultants)
6. Rental network practitioners that are specifically out-of-area care

All licensed practitioners and providers who have an independent relationship with Humana require credentialing. Verification of credentialing information comes from one of the following sources:

1. The primary source, the entity that originally conferred or issued the credential, or
2. A contracted agent of primary source, or
3. Another National Committee for Quality Assurance (NCQA)- accepted source listed for the credential.

Appropriate documentation of verifications includes:

- Actual copies of credentialing information
- A detailed signed/initialed and dated checklist, including the name of the source used, the date of verification, the signature or initials of the person who verified the information and the report date, if applicable.
- Copies of credentialing information and checklist. If the checklist does not include checklist requirements, appropriate credentialing information must be included.
- Automated credentialing system, with electronic signature or unique electronic identifier of staff, including individual verifying the information, the date of verification, the source and report date, if applicable.

The verification time limit is 180 calendar days prior to the Credentialing Committee's decision, with the exception of education and training which has no time limit.

The decision to credential or re-credential practitioners is based on the criteria listed below, including, but not limited to, information gathered through the credentialing and re-credentialing process.

- Education and Training
- State License
- DEA and/or CDS Certificate
- Eligible for Medicare
- Eligible for Medicaid
- Professional Liability Insurance
- Claims History
- Work History
- Facility Privileges
- Federal, State and Local Sanction Free Status
- Prior Actions or Relinquishments
- Convictions
- Lack of Physical or mental Impairment
- Quality

Files meeting these criteria are approved by the Credentials Committee Chairman. Practitioners not meeting these criteria are presented to the Credentials Committee for review and decision. Denials are communicated to the practitioner in writing and contain the reason for denial.

Our parent company designates credentialing committees that uses a peer review process to make recommendations regarding credentialing decisions. The credentialing committee has the opportunity to review and offer input on the credentialing and the re-credentialing of all applicants; but, at a minimum, receives and reviews the credentials of practitioners who do not meet the plan's established criteria. The Credentialing's Committee reviews every practitioner's credentials and gives thoughtful consideration and meaningful advice before making decisions about a practitioner's ability to deliver care. The composition of the credential committees includes participating practitioners in both primary care and specialty disciplines. Clinical peer input from non-committee members may be accessed when discussing credentialing criteria for specific specialties. The Credentialing Committee meets as frequently as necessary, no less than quarterly, for the purpose of conducting credentialing and re-credentialing activities and approving credentialing and re-credentialing policies and procedures. Evidence of the Credentialing Committee meetings are documented in meeting minutes.

The plan formally re-credentials its practitioners at least every 36 months through information verified from the following primary sources:

- Current valid state license
- Current valid DEA/CDS, as applicable
- Board Certification, as applicable

- History of professional liability claims that resulted in a settlement or judgment paid on behalf of the practitioner (NPDB)
- Performance Indicators

The following information is documented on practitioner sanctions prior to re-credentialing, unless otherwise noted:

- State sanctions, restrictions on licensure or limitations on scope of practice
- Medicare and Medicaid sanctions, information

For practitioners contracted for federal programs, the following information is also documented:

- Medicare Opt-Out List
- Query to GSA
- Query to OIG
- State Medicaid Agency Sanctions, as applicable
- Performance Indicators

The plan monitors practitioner sanctions, complaints, and quality issues between re-credentialing cycles and takes appropriate action when it identifies occurrences of poor quality. In instances where the plan has taken action against a practitioner for quality reasons, the plan offers the practitioner a formal appeal process and reports the action to the appropriate authorities.

Ongoing monitoring of Provider competencies is performed and appropriate interventions are implemented by collecting and reviewing the following information at least monthly:

- Medicare and Medicaid sanctions
- Sanctions or limitations on licensure
- Medicare Opt-Out Listing
- Complaints
- Identified Adverse Events

The plan evaluates the quality of facilities with which it contracts. Each health care delivery provider is assessed prior to contracting and then at least every three years thereafter. This assessment includes:

- Confirmation that the provider is in good standing with state and federal regulatory bodies
- Confirmation that the provider has been reviewed and approved by an accrediting body (JC; AAAHC; CARF; CHAP; ACHC; AOA HFAP; AAAASF; ACR DNV-NIAHO; COA)
- Performance of an onsite quality assessment if the provider is not accredited

Pharmacy credentialing/re-credentialing assessment review also includes:

- Confirmation of National Council for Prescription Drug Programs (NCPDP)/National Association of Boards of Pharmacy (NAPB) number

- Current and valid DEA
- Current malpractice coverage

The medical facilities to be assessed include, but are not limited to:

- Hospitals
- Home Health Agencies
- Skilled Nursing Facilities
- Free-Standing Surgical Centers
- Inpatient, Residential, and Ambulatory Behavioral Health Facilities
- Hospices
- Clinical Laboratories
- Comprehensive Outpatient Rehabilitation Facilities
- Outpatient Physical Therapy and Speech Pathology Providers
- Pharmacies
- Providers of end-stage renal disease services
- Providers of outpatient diabetes self-management training
- Portable x-ray suppliers
- Rural Health Clinics and Federally Qualified Health Centers.

Behavioral healthcare facilities providing mental health or substance abuse services in the following settings are also assessed:

- Inpatient
- Residential
- Ambulatory

Factor 4: Provider Collaboration with the ICT/ICP:

Care coordination efforts are supported by all team members working in a shared documentation platform in the electronic medical record, with decision support and evidence-based guideline logic. Care coordination is crucial to ensuring an end-to-end member experience and continuity of care. The model of care is physician and provider-inclusive, with PCPs driving the medical treatment plan and Care Managers supporting the physician's treatment plan. Collaborative care referrals are engaged when certain expertise or skill set will benefit the member. Communication strategies such as care team meetings, case reviews, care rounds, and documenting in the same electronic member-centric record all work to support the team effort.

The ICT, with the PCP acting as the medical leader, determines through an individualized plan of care the services that the members may need to maintain, restore, or improve their current state of health. The Care Manager is responsible for coordination of services and facilitates:

- Communication among stakeholders
- Follow-up related to specialized service delivery

- Incorporation of new information into the plan of care related to specialized services
- Coordination of services across care settings and providers

PCPs communicate members' needs with specialists either through phone calls or via referral forms on which they write their expectations of the referred to providers. Specialists provide written consultation notes with treatment plan recommendations and follow-up expectations. Care Managers coach members to keep appointments and educate them on the importance of accessing appropriate care. Care Managers intervene when members are unable to get appointments in accordance with their schedules. Lastly, consultative documents are maintained in members' medical records at PCP offices.

Care Managers encourage the member to be an active health care consumer and to communicate directly with physicians and/or providers when possible. If a member needs additional support to contact physicians and/or providers, three-way calls may be made with the member, or the Care Manager will contact the physician or provider directly on behalf of the member. The medical director, clinical pharmacist, and dietitian are available to staff for consultations and case reviews. CarePlus and Humana At Home conduct scheduled case reviews with each of its care teams on a rotating basis.

Contracted physicians and providers agree to provide or arrange for professional medical or pharmacy benefits or specialty services for members of Special Needs Plans. The ICT is a team of care physicians and providers from different professional disciplines within the provider network and within organization who work together to deliver collaborative health care support. This support focuses on communication, care planning, optimizing quality of life, and advocacy for the individual and his or her family. The ICT works to integrate and support a holistic and member-centric model of care, delivering an end-to-end member experience that fosters communication between caregivers as the member moves along the life and health continuum.

The ICT will develop and implement an ICP with the member and/or caregiver. All care management and ICT activity will be documented in the documentation platform. Care coordination meetings may be scheduled or ad hoc, and will include members of the ICT and the member and/or caregiver. These interactions and meetings may be face-to-face, telephonic, web-based, or accomplished through written communication. The occurrence and frequency of the meetings are different for each member, based on the individual level of care and health care needs of the member.

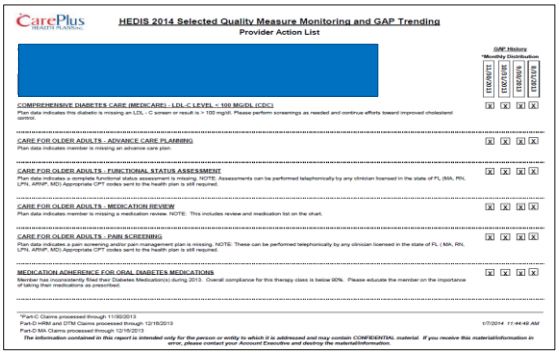
Development of an ICT summary is sent to primary healthcare providers informing them of this activity and inviting them to call the Care Manager or fax any updated information they have to contribute to the plan of care.

If the ICT determines that the member should receive services from additional providers of the provider network, the Care Manager, through coordination with the member's PCP/Medical Home, will reach out, assist, and collaborate with the provider network to ensure the timely delivery of the appropriate services. Once identified as a part of the ICT and or direct care team,

the providers become stakeholders in the patient overall care. Service needs, resources, and outcomes are communicated to stakeholders via the members ICP. The member's ICP is made available to the PCP and other providers via fax/mail and also communicated directly to providers by the Care Manager, as needed.

The Care Manager follows up with the member and the providers to ensure proper follow-up is scheduled and performed. In addition to verifying the delivery of services, the Care Managers ensure that the services are delivered in a timely manner, and may review services against established criteria, as well as obtain feedback from the member about their care and experience. Information on services provided is recorded in the member's ICP; authorization and claims are recorded. This information may also be communicated back to the member's PCP and maintained in the member's medical record.

Example: HEDIS Star Quality Report by member Distributed to Providers:



CarePlus HEALTH PLANS

HEDIS 2014 Selected Quality Measure Monitoring and GAP Trending
Provider Action List

[redacted]

GAP History
*Monthly Distribution
11/01/2013
10/01/2013
9/01/2013
8/01/2013

COMPREHENSIVE DIABETES CARE (MEDICARE) - LDL-C LEVEL < 100 MG/DL (CDC)
Plan data indicates this diabetic is missing an LDL - C screen or result is > 100 mg/dl. Please perform screenings as needed and continue efforts toward improved cholesterol control.

CARE FOR OLDER ADULTS - ADVANCE CARE PLANNING
Plan data indicates member is missing an advance care plan.

CARE FOR OLDER ADULTS - FUNCTIONAL STATUS ASSESSMENT
Plan data indicates a complete functional status assessment is missing. NOTE: Assessments can be performed telephonically by any clinician licensed in the state of FL (MA, RN, LPN, ARNP, MD) Appropriate CPT codes sent to the health plan is still required.

CARE FOR OLDER ADULTS - MEDICATION REVIEW
Plan data indicates member is missing a medication review. NOTE: This includes review and medication list on the chart.

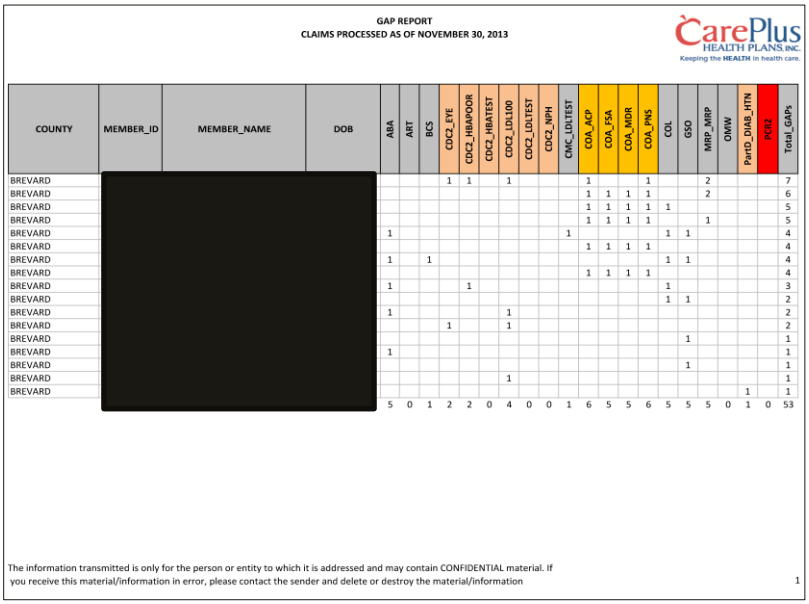
CARE FOR OLDER ADULTS - PAIN SCREENING
Plan data indicates a pain screening and/or pain management plan is missing. NOTE: These can be performed telephonically by any clinician licensed in the state of FL (MA, RN, LPN, ARNP, MD) Appropriate CPT codes sent to the health plan is still required.

MEDICATION ADHERENCE FOR ORAL DIABETES MEDICATIONS
Member has inconsistently filled their Diabetes Medication(s) during 2013. Overall compliance for this therapy class is below 90%. Please educate the member on the importance of taking their medications as prescribed.

*Part-C Claims processed through 11/30/2013
Part-D HRM and DTM Claims processed through 12/16/2013
Part-D MA Claims processed through 12/15/2013
1/7/2014 11:44:49 AM

The information contained in this report is intended only for the person or entity to which it is addressed and may contain CONFIDENTIAL material. If you receive this material/information in error, please contact your Account Executive and destroy the material/information.

Example: HEDIS Star Quality Report Distributed to Providers:



GAP REPORT
CLAIMS PROCESSED AS OF NOVEMBER 30, 2013

CarePlus HEALTH PLANS INC.
Keeping the HEALTH in health care.

COUNTY	MEMBER_ID	MEMBER_NAME	DOB	ABA	ART	BCS	CDC2_EYE	CDC2_HBAPOOR	CDC2_HBATEST	CDC2_LDL100	CDC2_LDLTEST	CDC2_NPH	CMC_LDLTEST	COA_ACP	COA_FSA	COA_MDR	COA_PNS	COL	GSD	MRP_MRP	OMW	PartD_DIAB_HTN	PCE2	Total_GAPs
BREVARD	[redacted]						1	1		1				1			1			2				7
BREVARD														1	1	1	1			2				6
BREVARD														1	1	1	1	1						5
BREVARD														1	1	1	1			1				5
BREVARD				1									1					1	1					4
BREVARD														1	1	1	1							4
BREVARD				1		1												1	1					4
BREVARD														1	1	1	1							4
BREVARD				1				1										1						3
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BREVARD																						1		1
				5	0	1	2	2	0	4	0	0	1	6	5	5	6	5	5	5	0	1	0	53

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ELEMENT B: USE OF CLINICAL PRACTICE GUIDELINES & CARE TRANSITION PROTOCOLS:

Factor 1: Utilization of Guidelines and Protocols:

CarePlus' credentialing process routinely checks and ensures that potential providers have the capabilities to provide evidence-based wellness, preventive care, and continual assistance for chronic conditions before being accepted into our networks. Evidence proves that preventive care and frequent/consistent care of chronic conditions lowers the advent of major conditions and decreases use of emergency room visits and readmissions. Providers are encouraged to meet these baseline criteria and routinely evaluated throughout their contract period with Humana. Humana also uses an Ingenix tool to analyze claims data and identify whether providers score lower for certain conditions than their specialty and geographic peer group. A summary report tracking data over a three year period is reviewed to determine if clinical guidelines criteria has been met. A process has been developed to identify outliers so that appropriate action can be taken.

Structure replicates the medical home structure with a team-based, multidisciplinary support unit. The team has a "hub and spoke" organization with the Care Manager and primary care provider reinforcing the member in the middle and other patient-specific functionalities serving as support and spokes. Our team approach ensures consistency of care and information with a unified IT system, frequent meetings/updates, and automatic system updates for emergency room visits and follow-up care and supporting providers as they move toward NCQA medical home certification. Providing technical assistance, financial incentives, and health information technology access to provider practices to increase adoption of medical home practices and rewards providers in increments as they achieve NCQA recognition. In addition, a process is in place to assist practices by helping them complete a gap analysis and subsequently working with them to develop capabilities to move them towards NCQA Patient Centered Medical Home (PCMH) certification. Incentives for providers are available through increased patient assignments as they demonstrate capability to deliver PCMH services.

Physicians and providers agree to comply with Humana's CarePlus' quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures, as applicable to the specific physician or provider. In addition, physicians and providers agree to comply with those policies and procedures, which are set forth in 's Physician's Administration Manual, CarePlus' Provider Manual, or its successor and bulletins or other written materials that may be promulgated from time to time to supplement the manual.

The manual and updated policies and procedures other written materials may be issued and distributed in electronic format. Paper copies may be obtained by physicians or other providers upon written request.

Physicians and other contracted providers shall prepare, maintain and retain as confidential the health records of all members receiving health care services, and members' other personally identifiable health information received, in a form and for time periods required by applicable state and federal laws, licensing requirements, accreditation and reimbursement rules and regulations to which physicians and providers are subject, and in accordance with accepted practices.

Physicians and providers shall obtain authorization of members' permitting CarePlus, and/or any state or federal agency as permitted by law, to obtain a copy and have access, upon reasonable request, to any health record of member related to health care services provided by physician or other provider pursuant to applicable state and federal laws. Copies of such records for the purpose of claims processing shall be made and provided by physician or other provider at no cost to the health plan or the member. All physicians, providers, and the health plan agree to maintain the confidentiality of information maintained in the health records of members, and information obtained from the health plan through the verification of member eligibility, as required by law.

Provider Quality Review:

CarePlus utilizes Humana and their policy to improve the quality and safety of health care services provided to its members by its providers through the use of a Provider Quality Review Process. Humana routinely reviews the quality of its contracted Providers, including both individual practitioners and health care entities. It does this by way of prospective, concurrent, and retrospective reviews. The Humana Health Plan Medical Director (HMD), with the assistance of the Quality Operations Compliance Department, identifies quality issues that may require attention. Initial inquiry may include communication with the affected Provider to gather additional information. The HMD may propose improvement steps on his own or submit the matter to the Peer Review Committee. The Peer Review Committee then meets and determines whether intervention is appropriate. All initial efforts to gather information about Providers are deemed "Inquiries" designed to enhance Humana/Provider communications and understanding about incipient problems and to implement improvement strategies without formal intervention. A formal "Investigation" begins only at such time as the Peer Review Committee expressly declares one or takes some affirmative corrective action. The Peer Review Committee then submits its recommendation to the Corporate Recommendation Review Committee (CRRC). The written decision, with reasons, of the CRRC is final.

Clinical Practice Guidelines:

CarePlus CPGs are adopted from clinically sound and reputable agencies. These guidelines are from national organizations generally accepted as experts in their fields such as, the American Diabetes Association (ADA), the American College of Cardiology (ACC), the American Heart

Association (AHA), the National Heart Lung and Blood Institute (NHLBI), the National Kidney Foundation (NKF), and the Agency for Healthcare Research and Quality (AHRQ).

The Behavioral Health CPGs are from national organizations such as the American Psychiatric Association and American Academy of Child and Adolescent Psychiatry. These guidelines were selected by Behavioral Health for behavioral health providers as the most frequently seen diagnoses among our members. The CPGs for Major Depression and Bipolar in adults were initially selected in 2004. Additional guidelines were selected in 2006 and later to round out our guidelines in an effort to include adolescents and children and substance use disorders in both the adult and youth population. Behavioral Health reviews the behavioral health CPGs annually and updates as needed.

The CPGs are available on CarePlus' Website at http://www.care-plus-health-plans.com/provider-forms.asp. Practitioners are informed of the availability of the CPGs in the Provider Manual.

The following is a list of specific targeted relevant diagnoses for each state listed under MOC 1: Factors 2 & 3: Identify Health Conditions applied to available Clinical Practice Guidelines available for provider use. Similar relevant diagnoses are grouped together as similar CPGs are available based on diagnoses (See Page 7 for percent of diagnoses within each state)

1. Diabetes Mellitus Uncomplicated (Broward, Miami-Dade, Palm Beach, Hillsborough, Pasco, Pinellas, Polk, Orange, Osceola, Seminole, Brevard, Indian River, Okeechobee, St. Lucie, Duval, Lake, Marion, Sumter); Diabetes Mellitus Psychoses (Broward, Miami-Dade, Palm Beach, Hillsborough, Pasco, Pinellas, Polk, Orange, Osceola, Seminole, Brevard, Martin, Duval, Lake, Marion); Diabetes Mellitus Complicated (Broward, Miami-Dade, Palm Beach, Hillsborough, Pasco, Pinellas, Polk, Orange, Osceola, Seminole, Brevard, Indian River, Martin, Okeechobee, St. Lucie, Duval, Lake, Marion, Sumter); Diabetes Mellitus Cancer (Indian River, Martin, St. Lucie)
    - American Diabetes Association (ADA), Executive Summary: Standards of Medical Care in Diabetes
4. Moderate to Severe Chronic Kidney Disease (Broward, Miami-Dade, Palm Beach, Hillsborough, Pasco, Pinellas, Polk, Orange, Osceola, Seminole, Brevard, Martin, St. Lucie, Duval, Lake, Marion, Sumter)
    - National Kidney Foundation Guidelines and Commentaries
5. Cerebrovascular Disease (Okeechobee)
    - 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8)
6. Peripheral Vascular Disease (Miami-Dade, Palm Beach, Okeechobee, Sumter)

- American Heart Association (AHA) Guidelines for Primary Prevention of Cardiovascular Disease and Stroke

7. Congestive Heart Failure (Broward, Palm Beach, Okeechobee); Myocardial Infarction (Indian River)
    - ACCF (American College of Cardiology Foundation)/AHA (American Heart Association) Guideline for the Management of Heart Failure: Executive Summary
    - American Heart Association (AHA) Guidelines for Primary Prevention of Cardiovascular Disease and Stroke
    - American Heart Association (AHA)/American College of Cardiology (ACC) Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease
    - ACCF (American College of Cardiology Foundation)/AHA (American Heart Association)/HRS (Heart Rhythm Society) Focused Update on the Management of Patients With Atrial Fibrillation
8. Chronic Pulmonary Disease (Broward County, Miami-Dade County, Palm Beach County, Hillsborough County, Pasco County, Pinellas County, Polk County, Orange County, Osceola, Seminole, Brevard, Indian River, Martin, St. Lucie, Duval, Lake, Marion, Sumter)
    - Global Initiative for Chronic Obstructive Lung Disease (GOLD)'s Global Strategy for Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease (COPD)
9. Solid Tumors (Indian River)
    - Cancer screening guidelines (all types). American Cancer Society Guidelines for the Early Detection of Cancer

Corporate Quality Operations Department coordinates the development, approval and distribution of new preventive health guidelines and clinical practice guidelines, and the revision of existing guidelines. The purpose of developing and communicating Clinical Practice Guidelines (CPGs) is to:

Verify state and federal regulations are followed:

- Comply with accreditation standards
- Adopt relevant, evidence based medical and behavioral health guidelines (preventive and certain non-preventive acute and chronic conditions) from recognized sources such as professional medical associations, voluntary health organizations and NIH Centers and Institutes
- Provide consistency throughout the organization

- Obtain input from key stakeholders (internal and external) prior to implementation of a Clinical Practice Guideline
- Promote physician involvement by communication of guidelines per the unsecured provider portal on Humana.com and other modalities such as the provider manual
- Monitor contracted provider services/care in accordance with guidelines

Factor 2 & 3: Exceptions to Clinical Practice Guidelines:

The CPGs are intended to serve as a resource for CarePlus-contracted physicians and may be used as a guide for managing or treating a clinical condition, or accomplishing a clinical service. Information contained in the guidelines is not a substitute for a physician's clinical judgment and is not always applicable to an individual.

As with all guidelines, the intention is to enhance, not replace, a provider's clinical assessment and decision-making. At least annually, Corporate Quality Operations Department will review the nationally recognized organizations' websites for updates to the adopted guidelines, appropriateness of clinical topic and whether the national guideline and organization being used remains the most widely accepted. Any recommendations for additional guidelines are also obtained and research is completed to gather necessary information for these guidelines to be considered including identifying the most appropriate nationally recognized organization.

Any proposed changes to the current CPGs or recommendations for new guidelines will be reviewed and approved initially by the Corporate Quality Medical Director, Corporate Quality Director and Managers, Corporate Accreditation Director and Market Quality Operations Directors. Any additional reviewers will be identified and their approval also obtained (i.e.; provider committee).

- The proposed changes or additional guidelines and any other input will be reported to the Corporate Quality Improvement Committee (CQIC) for review and approval.
- Once approved by the CQIC, the guidelines are submitted to the Physician Consultation Committee by the Medical Director for National Network Operations for review and approval.
- Corporate Quality Operations Department will provide notification of the updates to guidelines to the markets, providers and other key stakeholders as needed.
- Request for updates to Humana.com unsecured provider portal are made by completing and submitting a provider communication request to Corporate Provider Communications for review and approval through the Corporate Provider Communication Review process. Updates to the CPG provider handouts are also submitted for review and approval per this process.
- Approved documents are made accessible internally per the Quality and Accreditation SharePoint site.

- Communication to providers is done per the provider newsletter, Your Practice, provider manual or other methods such as handouts.

Humana publishes medical guidelines from a number of well-respected national sources. These guidelines may have some differences in recommendations. Information contained in the guidelines is not a substitute for a health care professional's clinical judgment and is not always applicable to an individual. Therefore, the health care professional and member should work in partnership in the decision-making process regarding the treatment plan.

None of the information in the guidelines is intended to interfere with or prohibit clinical decisions made by a treating health care professional regarding medically available treatment options for members. Particularly with specific vulnerable SNP beneficiaries, the provider's clinical judgment supersedes any recommended guidelines by Humana, the guidelines are available to enhance a provider's recommended plan of care for a member.

The primary care provider is responsible for the overall plan of care for the member and the Humana At Home Care Managers are advocates to assist the members to follow that plan of care. For example, an elderly individual who has a diagnosis of heart failure may be prescribed Digoxin which is considered a high risk medication for the elderly. A member's primary care provider will be notified of the rationale of the high risk medication however the provider is able to prescribe the medication with therapeutic monitoring dosage strategy.

In instances where a provider has chosen not to follow or has modified recommended guidelines based on clinical judgment, the Care Manager has access to current claims and medication data identifying non-compliance with recommended guidelines. Care Managers are able to make the necessary notations within the documentation platform including the ICP to advise providers recommended course of treatment.

The model of care is physician and provider-inclusive, with PCPs driving the medical treatment plan and Care Managers supporting the physician's treatment plan. Care Managers encourage the member to be an active health care consumer and to communicate directly with physicians when possible. Three-way calls may be made with the member, or the Care Manager will contact the physician or provider directly on behalf of the member to discuss the member's plan of care. The Care Manager will also advise the ICT team of the primary care provider's plan of care to ensure continuity across the continuum. Primary care providers are also sent a letter identifying areas of concern by the ICT and are encouraged to provide ICT input and call the Care Manager with additional information.

Factor 4: Care Transition Protocols:

CarePlus, Humana Puerto Rico, and Humana At Home Care Transition Protocols include notifying the provider of a planned or unplanned transition. CarePlus Care Transition Protocols include notifying the provider of a planned or unplanned transition.

To maintain continuity of care, providers receive notification of any care transition their member experiences. The provider receives the necessary information in order to initiate coordination and contact with the member. Additionally, the CarePlus Field Case Manager (CPFCM) who visits the member on-site is in constant contact with the CarePlus Medical Director regarding the member's status, procedures, and care needs. At any point in time, the CPFCM and Medical Director are able to request continuation of treatment for certain medical conditions to be covered. The decision to approve or disapprove a request for continuity of care is based on a review of the member's medical condition and treatment plan, accreditation standards, federal and state laws, rules and regulations. Requests for pre-authorization/certification for additional treatment needs are reviewed by CarePlus as organizational determinations by the CarePlus Pre-certification team, in these instances the cases are reviewed on a case by case basis to ascertain the members care is maintained when required during a planned or unplanned transition.

Secondary to receiving care transitions details on planned and unplanned admissions, the CPFCM is available for peer to peer consults with member's primary care physicians and the attending physician. This enables the primary care physician to verify continuity of care is maintained for the member during a care transition.

ELEMENT C: MODEL OF CARE TRAINING FOR THE PROVIDER NETWORK:

Factor 1: Initial and Annual Training:

Written provider contracts require all employed/contracted providers to deliver services in accordance with nationally recognized clinical protocols and guidelines when available. Provider Operations instructs providers via a fax blast or an article in the Provider Newsletter regarding the annual Model of Care training. In some cases, provider training may be facilitated in-person by a CarePlus representative.

Provider Operations instructs providers via a fax or letter campaign to complete training either via (i) web based training available through CarePlus' Health Plan's Provider Portal or (ii) request a face-to-face training by their designated Provider Operations associate. CarePlus also utilizes their Provider Newsletter to advise providers regarding the Model of Care training. Attestation of the completion of face-to-face and web-based training sessions is monitored by routine reports and data is available for review during CMS visits.

In addition, provider education is outlined within the CarePlus Provider Agreement SNP Attachment. Providers are trained notified through the following portals:

- CarePlus includes SNP information within the Provider Manual mailed to providers upon initial contract acceptance. This manual is also updated annually and is available on the CarePlus website and hardcopy upon request.

- Providers may be trained in person by the Provider Operations associates or access the SNP web-based training on the CarePlus website (http://www.care-plus-health-plans.com/provider-snp.asphttp://www.careplushealthplans.com/provider.asp)
- Provider Newsletter is printed with SNP updates

Factor 2: Evidence of Training:

As providers log into the CarePlus Provider Portal, they are required to enter basic demographic information to be used as an identifier for the provider(s) that this training covers; this is tracked at the Tax ID level. Once training is completed, the provider must attest that they have received the training. Once the provider attests that they have successfully completed the training, web based software provides acknowledgment that the provider is in compliance. This acknowledgement is tracked via the provider's Tax Identification Number and the data is then available for reporting purposes.

Provider Operations obtains evidence of completed training through the following methods:

- At the conclusion of a face-to-face training, the Provider Operations associate completes the SNP Attestation Form which includes an attestation from the Provider confirming receipt of the training and applicable materials.
- Providers who complete the web-based training are required to enter basic demographic information to be used as an identifier for the provider(s) that this training covers. At the conclusion of the presentation, the web-based software provides confirmation of completion and automatically generates a weekly cumulative report of all training completed during that time period.

Completed SNP Attestations and web-based training reports are tracked and the data is then available for reporting purposes.

Factor 3 & 4: Deficient or Incomplete Training:

Attestation of the completion of web-based training sessions Provider SNP trainings is are monitored by routine reports and data is available for review during CMS visits. Providers who are non-compliant with the have not completed the SNP Training are tracked and monitored via the routine reports available. For 2015, CarePlus is working to enhance these capabilities and improve the level of detail included in the reports associated with the compliance training modules.

Completion of web-based training sessions Provider SNP trainings is are monitored by routine reports and data is available for review during CMS visits. Providers who have not completed the SNP Training are tracked and monitored via the routine reports available. For 2015,

CarePlus is working to enhance these capabilities and improve the level of detail included in the reports associated with the compliance training modules.

Example: CarePlus SNP Provider Training 2015:

Chronic Condition HMO SNP Eligibility

- Entitled to Medicare Part A
- Enrolled in Medicare Part B through age or disability
- Resident within the plan's service area
- Diagnosed with diabetes in order to qualify for the CareDirect (HMO SNP) plan
- Diagnosed with CVD and/or CHF in order to qualify for CareHeart (HMO SNP) plan
- Not undergoing treatment for end-stage renal disease unless they are existing members of CarePlus at time of diagnosis

*Not available in all areas, other exceptions may apply

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Chronic Condition HMO SNP Eligibility, Cont.

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Chronic Condition HMO SNP Enrollment

- Applicant completes prequalification assessment and applicant verification, both of which can be completed in writing or telephonically.
- Prequalification assessment contains disease-specific questions to identify the applicant as having the qualifying chronic condition.
- Verification form allows CarePlus to confirm the diagnosis with the physician.

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Chronic Condition HMO SNP Physician Involvement

- Physician is asked to confirm applicant's verification form
- Physician must confirm diagnosis by the last day of the first month the member is enrolled

NOTE: If a member loses SNP eligibility, he or she will be disenrolled from the plan.

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CarePlus Dual Eligible SNPs

- CareNeeds (HMO SNP)
- CareNeeds PLUS (HMO SNP)

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CareNeeds (HMO SNP)/CareNeeds PLUS (HMO SNP) Enrollment

- Acceptable proof of Medicaid eligibility:
  - Current Medicaid card
  - Letter from the state Medicaid agency
  - Verification through electronic query of state Medicaid data system
- Continuous special election period begins when the applicant's plan becomes effective and continues as long as the applicant remains eligible for Medicaid.
- If a member becomes ineligible for the SNP (loses Medicaid coverage), CarePlus will notify the member and CMS will provide a Special Enrollment Period (SEP).

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CareNeeds (HMO SNP)/CareNeeds PLUS (HMO SNP) Eligibility

- Entitled to Medicare Part A
- Enrolled in Medicare Part B through age or disability
- Resides within the plan's service area
- Eligible for QMB or QMB+ Medicaid benefits from the state of Florida
- Not undergoing treatment for end-stage renal disease, unless they are existing members of CarePlus

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CareNeeds (HMO SNP)/ CareNeeds PLUS (HMO SNP) Eligibility, Cont.

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CareNeeds (HMO SNP)/CareNeeds PLUS (HMO SNP) Physician Involvement

- Health care providers should know about Medicaid benefits that are not covered by CareNeeds. Additional information can be found on the Agency for Health Care Administration (AHCA) website: http://portal.flmmis.com/FLPublicProvider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/42/Default.aspx.
- Health care providers should know how members can access these services
- Health care providers should not collect copayment, coinsurance, deductibles or other cost-share amounts from CareNeeds PLUS (HMO SNP) members

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CareNeeds/CareNeeds PLUS Physician Involvement, cont.

- Inform CarePlus of any changes in your participation in the Florida Medicaid Program
- Contact CarePlus for more information:
  - Contact your CarePlus provider service executive
  - Call the CarePlus provider operations help line at 1-866-220-5448, Monday through Friday from 8 a.m. to 4 p.m. Eastern time
- Access Florida Medicaid Program information:
  - http://ahca.myflorida.com/Medicaid/index.shtml
  - 1-888-419-3456

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SNP Members and Cost-shares

- SNP members who are cost-share-protected are not responsible for copayments, coinsurance or any other form of reimbursement to health care providers for medical services (including Part B drugs).
- Health care providers should submit claims to CarePlus. CarePlus will then coordinate reimbursement or the health care provider can bill the appropriate state agency for any additional reimbursement amount.
- Copayments are suppressed on member cards for $0 cost-share plans.
- If coinsurance is filed, it will NOT display on the card.

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Special Needs Plans (SNPs)

Part 1

- SNP history
- CarePlus SNPs
- Physician's Role and Involvement in SNPs

Part 2

- CarePlus SNP Model of Care

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Provider Information for 2014 Special Needs Plans (SNPs) Part 2: Model of Care (MOC)

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Overview of the Model of Care (MOC)

- Dependent on active involvement of the primary care physician
- Requirements include:
  - Initial and annual health risk assessments
  - Case management and individualized care plans
  - Dedicated interdisciplinary care team
  - Process for reporting health outcomes and quality

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Overview of the Model of Care, Cont.

- Member-centric and based on an interdisciplinary care team (ICT) approach
  - Care manager (CM) serves as the member's single point of contact
- Evidence-based management protocols or nationally recognized guidelines incorporated when applicable

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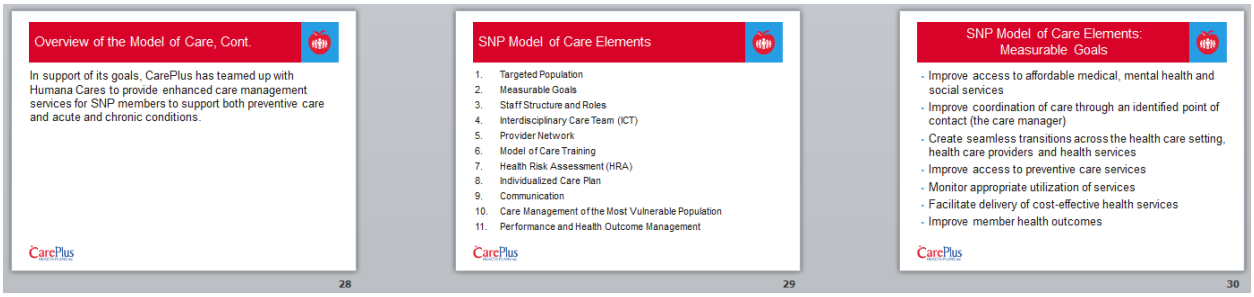
Overview of the Model of Care, Cont.
In support of its goals, CarePlus has teamed up with Humana Cares to provide enhanced care management services for SNP members to support both preventive care and acute and chronic conditions.
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SNP Model of Care Elements
1. Targeted Population
2. Measurable Goals
3. Staff Structure and Roles
4. Interdisciplinary Care Team (ICT)
5. Provider Network
6. Model of Care Training
7. Health Risk Assessment (HRA)
8. Individualized Care Plan
9. Communication
10. Care Management of the Most Vulnerable Population
11. Performance and Health Outcome Management
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SNP Model of Care Elements: Measurable Goals
- Improve access to affordable medical, mental health and social services
- Improve coordination of care through an identified point of contact (the care manager)
- Create seamless transitions across the health care setting, health care providers and health services
- Improve access to preventive care services
- Monitor appropriate utilization of services
- Facilitate delivery of cost-effective health services
- Improve member health outcomes
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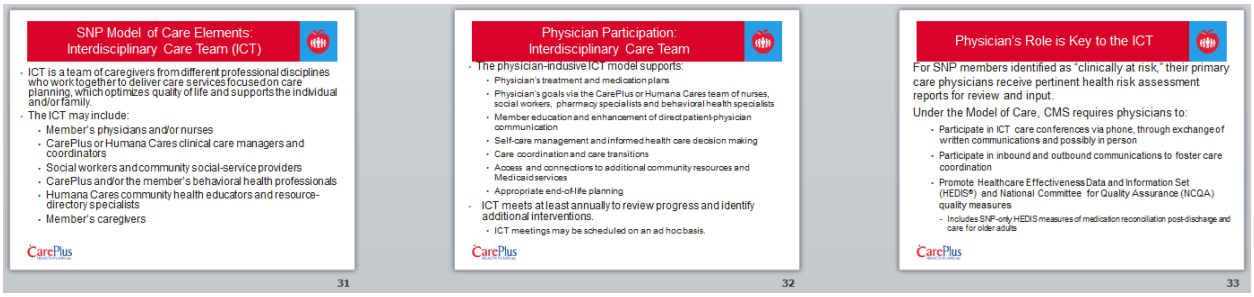
SNP Model of Care Elements: Interdisciplinary Care Team (ICT)
- ICT is a team of caregivers from different professional disciplines who work together to deliver care services focused on care planning, which optimizes quality of life and supports the individual and/or family.
- The ICT may include:
  - Member's physicians and/or nurses
  - CarePlus or Humana Cares clinical care managers and coordinators
  - Social workers and community social-service providers
  - CarePlus and/or the member's behavioral health professionals
  - Humana Cares community health educators and resource-directory specialists
  - Member's caregivers
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Physician Participation: Interdisciplinary Care Team
- The physician-indusive ICT model supports:
  - Physician's treatment and medication plans
  - Physician's goals via the CarePlus or Humana Cares team of nurses, social workers, pharmacy specialists and behavioral health specialists
  - Member education and enhancement of direct patient-physician communication
  - Self-care management and informed health care decision making
  - Care coordination and care transitions
  - Access and connections to additional community resources and Medicaid services
  - Appropriate end-of-life planning
- ICT meets at least annually to review progress and identify additional interventions.
  - ICT meetings may be scheduled on an ad hoc basis.
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Physician's Role is Key to the ICT
For SNP members identified as "clinically at risk," their primary care physicians receive pertinent health risk assessment reports for review and input.
Under the Model of Care, CMS requires physicians to:
- Participate in ICT care conferences via phone, through exchange of written communications and possibly in person
- Participate in inbound and outbound communications to foster care coordination
- Promote Healthcare Effectiveness Data and Information Set (HEDIS®) and National Committee for Quality Assurance (NCQA) quality measures
  - Includes SNP-only HEDIS measures of medication reconciliation post-discharge and care for older adults
CarePlus
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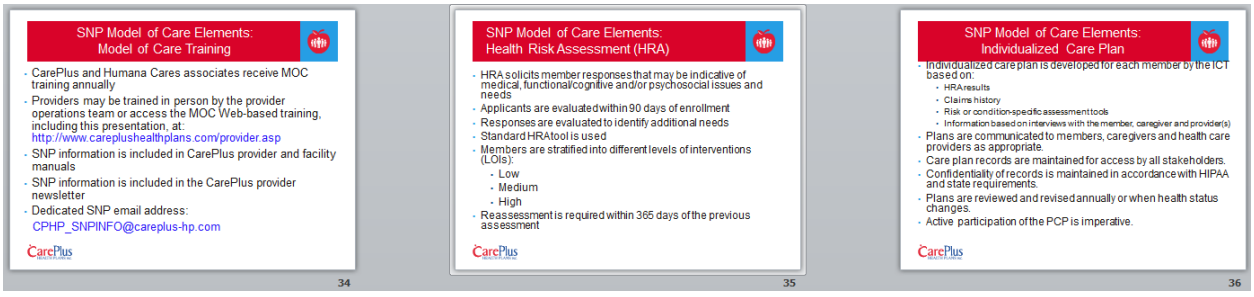
SNP Model of Care Elements: Model of Care Training
- CarePlus and Humana Cares associates receive MOC training annually
- Providers may be trained in person by the provider operations team or access the MOC Web-based training, including this presentation, at: http://www.careplushealthplans.com/provider.asp
- SNP information is included in CarePlus provider and facility manuals
- SNP information is included in the CarePlus provider newsletter
- Dedicated SNP email address: CPHP_SNPINFO@careplus-hp.com
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SNP Model of Care Elements: Health Risk Assessment (HRA)
- HRA solicits member responses that may be indicative of medical, functional/cognitive and/or psychosocial issues and needs
- Applicants are evaluated within 90 days of enrollment
- Responses are evaluated to identify additional needs
- Standard HRA tool is used
- Members are stratified into different levels of interventions (LOIs):
  - Low
  - Medium
  - High
- Reassessment is required within 365 days of the previous assessment
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SNP Model of Care Elements: Individualized Care Plan
- Individualized care plan is developed for each member by the ICT based on:
  - HRA results
  - Claims history
  - Risk or condition-specific assessment tools
  - Information based on interviews with the member, caregiver and provider(s)
- Plans are communicated to members, caregivers and health care providers as appropriate.
- Care plan records are maintained for access by all stakeholders.
- Confidentiality of records is maintained in accordance with HIPAA and state requirements.
- Plans are reviewed and revised annually or when health status changes.
- Active participation of the PCP is imperative.
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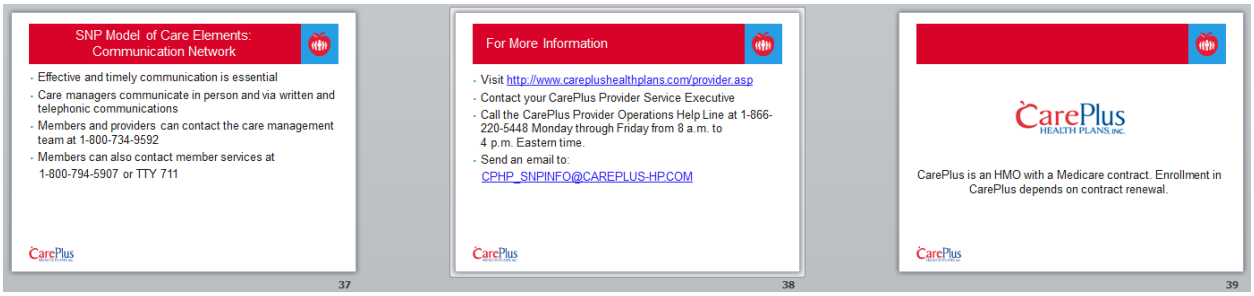
SNP Model of Care Elements: Communication Network
- Effective and timely communication is essential
- Care managers communicate in person and via written and telephonic communications
- Members and providers can contact the care management team at 1-800-734-9592
- Members can also contact member services at 1-800-794-5907 or TTY 711
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For More Information
- Visit http://www.careplushealthplans.com/provider.asp
- Contact your CarePlus Provider Service Executive
- Call the CarePlus Provider Operations Help Line at 1-866-220-5448 Monday through Friday from 8 a.m. to 4 p.m. Eastern time.
- Send an email to: CPHP_SNPINFO@CAREPLUS-HP.COM
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CarePlus HEALTH PLANS, INC.
CarePlus is an HMO with a Medicare contract. Enrollment in CarePlus depends on contract renewal.
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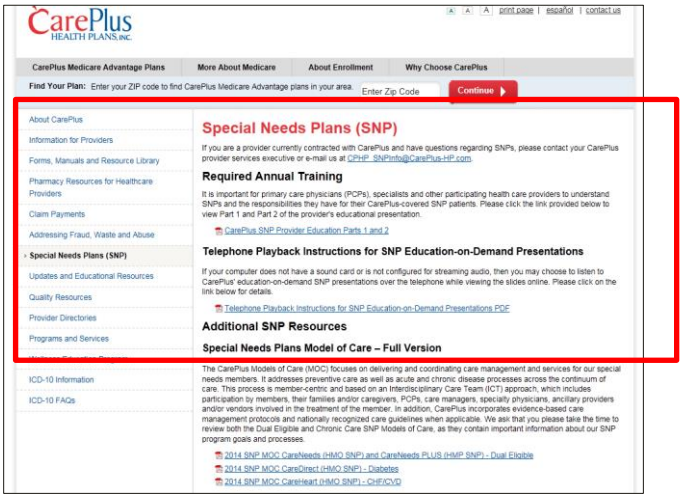
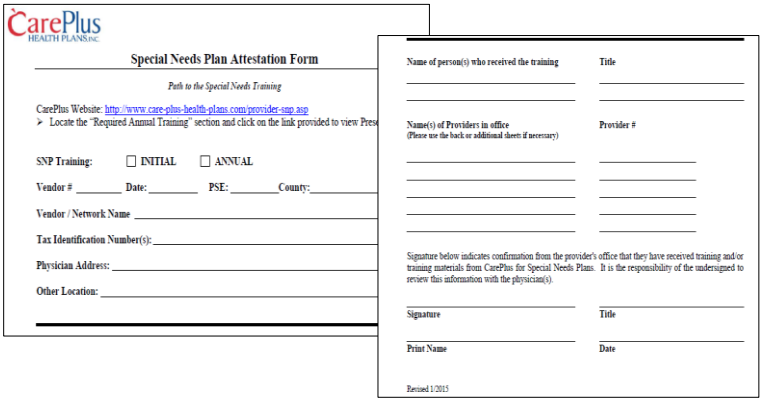
Example: CarePlus Website and Provider Portal to Access Web-Based SNP Provider Training:



Example: CarePlus Special Needs Plan Attestation Form:


CarePlus
HEALTH PLANS, INC.

Special Needs Plan Attestation Form

Path to the Special Needs Training

CarePlus Website: http://www.care-plus-health-plans.com/provider-snp.asp
- Locate the "Required Annual Training" section and click on the link provided to view Pres

SNP Training: ☐ INITIAL ☐ ANNUAL

Vendor # _____ Date: _____ PSE: _____ County: _____

Vendor / Network Name _____

Tax Identification Number(s): _____

Physician Address: _____

Other Location: _____

Name of person(s) who received the training | Title

Name(s) of Providers in office (Please use the back or additional sheets if necessary) | Provider #

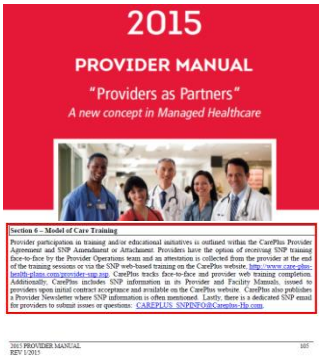
Signature below indicates confirmation from the provider's office that they have received training and/or training materials from CarePlus for Special Needs Plans. It is the responsibility of the undersigned to review this information with the physician(s).

Signature | Title

Print Name | Date

Revised 1/2015

Example: CarePlus Provider Manual SNP Training Requirements:


2015

PROVIDER MANUAL

"Providers as Partners"

A new concept in Managed Healthcare

Section 6 – Model of Care Training

Provider participation in training and/or educational initiatives is outlined within the CarePlus Provider Agreement and SNP Amendment or Attachment. Providers have the option of receiving SNP training face-to-face by the Provider Operations team and an attestation is collected from the provider at the end of the training sessions or via the SNP web-based training on the CarePlus website, http://www.care-plus-health-plans.com/provider-snp.asp. CarePlus tracks face-to-face and provider web training completion. Additionally, CarePlus includes SNP information in its Provider and Facility Manuals, issued to providers upon initial contract acceptance and available on the CarePlus website. CarePlus also publishes a Provider Newsletter where SNP information is often mentioned. Lastly, there is a dedicated SNP email for providers to submit issues or questions: CAREPLUS_SNPINFO@Careplus-Hp.com.

2015 PROVIDER MANUAL
REV 1/2015
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MOC 4: QUALITY MEASUREMENT & PERFORMANCE IMPROVEMENT:

ELEMENT A: MOC QUALITY PERFORMANCE IMPROVEMENT PLAN:

Factor 1: Delivering Appropriate Services to SNP Beneficiaries:

CarePlus' quality improvement program description (QIPD) contains detailed descriptions of quality improvement initiatives, which serve as a roadmap for the SNP program quality activities, including Model of Care (MOC) performance and outcomes monitoring. Key factors in measuring quality indices are tracking measures and outcomes such as HEDIS, lab values and the practice of healthy behaviors. This data is collected from numerous sources and reported in many ways, such as percent of targeted goal reached, and trends in service utilization. The QIPD is designed to detect whether the overall structure of the MOC accommodates members unique health care needs by establishing health outcomes and service goals to evaluate the effectiveness of the MOC.

The MOC is designed to link health care, behavioral health, and social care, allowing members to remain as healthy, safe, and independent as possible for as long as possible. The Care Manager functions as the single point of contact for all team members and is responsible for coordinating care across the continuum of need, managing the overall ICP and facilitating the services of community health, social service Care Managers, mental health professionals and other providers as needed. Improved coordination of care among health care providers will be achieved by having a Care Manager as the designated single point of contact and facilitator of seamless transitions of care across health care settings, care providers, and services.

SNP members are stratified using a combination of a predictive model, and cost and health risk assessment in order to proactively identify those at risk before health issues progress and require them to be hospitalized for treatment and care. These members include the frail, disabled, near end-of-life, members with multiple or complex chronic conditions and members with developing ESRD after enrollment. Assessment is an ongoing and multi-pronged process, using data analytics and clinical assessments to drive best practice interventions to the right member at an impact able time. The methods of risk stratification and assessing level of acuity are dynamic to best guide the most appropriate level and intensity of intervention.

The CarePlus continuous quality improvement plan focuses on the performance of the entire SNP population utilizing a multi-disciplinary approach. Barrier analysis is conducted to identify the root cause of the problem, explore alternatives, and develop and implement plans for improvement. Actual performance is compared with an expected value or a goal. An analysis of the results is conducted and effectiveness of actions taken. When a goal is not achieved, other initiatives may be implemented and a re-measure conducted.

CarePlus uses data collection, measurement, and analysis to track issues that are relevant to the SNP population. CarePlus has developed or adopted corporate quantitative measurement activities to assess performance, and identify and prioritize areas for improvement related to

medical and behavioral health issues. CarePlus identifies affected membership, selects appropriate samples, and collects valid and reliable data collected through tools. The quality improvement process activities include:

- Monitor system-wide issues
- Identify opportunities for improvement
- Determine the root cause
- Explore alternatives and develop a plan of action
- Activate the plan, measure results, evaluate effectiveness of actions, and modify approach as needed

In addition, CarePlus develops service goals to ensure the appropriate services are delivered to members. The developed goals include:

- Improving access and affordability of the healthcare needs for the SNP population
- Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the mDAT, ICP and ICT
- Enhanced care transitions across all health care settings and providers for SNP beneficiaries.
- Ensuring appropriate utilization of services for preventive health and chronic conditions.

Factor 2: Data Sources, Performance and Outcome Measures to Analyze, Evaluate and Report MOC Quality Performance:

The Quality Improvement Program Evaluation (QIE), performed annually by Humana At Home Quality Compliance Team and beginning in 2017 by Humana Puerto Rico for CarePlus in collaboration with Humana Corporate Quality Team, is an evaluation of the Quality Improvement Program. The annual QIE describes Model of Care success, barriers, and limitations encountered throughout the year, and recommendations for future initiatives and improvements.

This information is monitored to identify opportunities for benefit clarification, physician and provider education and process changes that will improve coordination of care and maximize health outcomes, member understanding of their specific conditions and compliance with preventive and ICP regimes.

This information will also be used to modify the MOC as opportunities are identified. Opportunities for improvement will include benefit changes/affordable care, policy changes, improved access to medical, behavioral and social services, physician and provider network coverage, process improvements, improved coordination and/or transition of care, improved health outcomes, system improvements, improved access to preventive services, and expansion of services or coverage.

Humana At Home and beginning April 1, 2017 Humana Puerto Rico generates SNP dashboard reports that track metrics and outcomes measured by cost, utilization, mDAT, and key quality indicators for CarePlus. The CarePlus SNP dashboard aligns with stated program goals and health performance measures, and is refreshed monthly. The CarePlus SNP dashboard reporting and analysis will provide the data needed to evaluate effectiveness of MOC, and serves as a basis from which the Humana At Home Quality Compliance team and beginning April 1, 2017 Humana Puerto Rico will identify process improvement.

Humana At Home Operations and Human Puerto Rico uses a wide array of real-time reporting tools to look at productivity in aggregate, team, individual associate, and member level data. These reports track member program status such as eligibility changes, contact activity (attempted and successful); mDATs, health surveys performed, and ICPs completed. Humana At Home Quality Compliance and Humana Puerto Rico also tracks ICT activities and referral activity to other CarePlus departments and/or value added items and services.

CarePlus utilizes Humana who works within the CMS requirements, and has developed a robust Quality Improvement Program for Special Needs Plans. Humana anticipates SNP program quality structure and documentation to align with this established SNP Quality Program, which includes Quality Improvement Projects (QIP) and a Chronic Condition Improvement Program (CCIP) for each plan.

Humana integrates and complies with all relevant Humana quality initiatives and requirements, including NCQA and HEDIS. In addition to HEDIS effectiveness of care clinical performance measures, the following indicators are also monitored:

- Use of services
- Access and availability
- Satisfaction with the experience of care
- Health Outcomes Survey
- Health plan descriptive information such as board certification

Other reports look at specific cost drivers to determine patterns of utilization and areas where interventions can be targeted. Monitoring member perception and satisfaction with program services (such as nurse case management) is another way the health plan monitors quality. Humana randomly selects Medicare members to conduct satisfaction surveys, collecting member feedback in areas such as nurse performance, responsiveness, and member overall satisfaction.

All associates are deemed to uphold the highest quality and productivity standards. They are subject to periodic, internal member record and recorded phone audits conducted for coaching, performance, and quality improvement purposes. These audits are performed by the associate's supervisor and the Humana At Home Quality Management Team and Human Puerto Rico. The associate also conducts self-audits of member records. Audit results are not shared outside of these parties, except to comply with other regulations or policies. This oversight

serves as an additional tool used for ongoing evaluation of the effectiveness of the MOC performance.

Components of the Overall Quality Improvement Program include:

- Humana has information systems designed to collect and maintain data. Humana's Information Security Agreement outlines the requirements for security and confidentiality of information, as well as appropriate use of Humana's property. Humana associates receive education on Information Management as part of Ethics training and attest to receiving this information annually.
- Performance monitoring is the key to measuring the effectiveness of the quality improvement program. Performance monitors are selected based on the Quality Improvement Program Evaluation from the previous year.
- An annual Chronic Condition Improvement Program (CCIP) is conducted to improve the health outcomes of dual-eligible, and chronic condition SNP members managed within Humana At Home care management program.
- The Health Plan conducts Quality Improvement Projects (QIP) on an annual basis to measure performance, apply interventions to improve performance, evaluate performance, and conduct periodic follow-up to measure effectiveness of interventions and outcomes. The projects are selected based on CMS requirements, others are selected based on high volume and high risk conditions prevalent in this population and have the potential for significant impact. Projects are selected based on satisfaction survey findings and/or specific service indicators.
- The model of care is evaluated and updated annually. Improvement initiatives are based upon performance evaluation of model of care effectiveness such as improvement in:
    - Improving access and affordability of the healthcare needs for the SNP population
    - Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the mDAT, ICP and ICT
    - Enhanced care transitions across all health care settings and providers for SNP beneficiaries
    - Ensuring appropriate utilization of services for preventive health and chronic conditions
- Quality initiatives are developed to improve preventive care rates, to address specific conditions relevant to the population, and/or as a result of review from specific areas of concern. There are many efforts underway to improve the HEDIS measure rates.
- Annual evaluation of member physical and mental health status is conducted if member population is ≥ 500
- Annual evaluation of member's experience is conducted if member population is ≥ 600.
- CarePlus has an effective procedure in place to develop, compile, evaluate, and report information to CMS for each Part C reporting requirement. The data elements reported under this measure are: number of new members, number of members eligible for an

annual survey, number of initial -HRAs performed on new members within 90 days of enrollment, and number of annual HRAs performed on eligible members.
- CarePlus has a standardized process for compiling the data required for Medication Therapy Management (MTM Part D) reporting required for the Centers for Medicare and Medicaid Services (CMS) as well as a quality review process.

Information Management:

CarePlus has information systems designed to collect and maintain data. The Information Security Agreement outlines the requirements for security and confidentiality of information, as well as appropriate use of the health plan's property. Associates receive education on Information Management as part of Ethics training and attest to receiving this information annually. Information Management systems provide:

- Data accuracy, completeness and integrity
- Data confidentiality
- Disaster Recovery Plan
- Database of participating providers
- Member database
- Record of grievances, appeals, and complaints
- Results of satisfaction surveys
- Data regarding access to care
- Demographic, cost, diagnostic, and service data
- Reports that assist the Plan in providing service
- Training modules from associates

Performance Monitoring:

Performance monitoring is the key to assessing the quality of healthcare services and measuring the effectiveness of the quality improvement program. Mechanisms are in place to encourage providers to participate in quality improvement initiatives for the health plan as well as governmental agencies such as CMS. Interventions are evaluated and refined to achieve demonstrable improvement in the QI program requirements and quality measures. Performance reporting includes measurement tools from internal quality processes and various regulatory agencies such as CMS. Quality outcome information is made available to CMS to assist members in comparing health coverage options and plan selection. Individual market indicators are found in the Market QI Work Plan and may include the following:

Administrative Indicators:

- **Associate orientation and training:** Associate orientation is conducted for associates to be aware of job expectations, responsibilities, and requirements. Ongoing associate training

includes, but is not limited to, annual ethics, privacy and HIPAA requirements, as well as education regarding accreditation and regulatory standards, system training, and Quality Department conferences.

- **Model of Care training:** Employees and contracted associates including providers participate in training on the SNP Model of Care both initially and annually. Training documentation and logs are maintained by the health plan, Humana Puerto Rico, and Humana At Home.
- **Monitoring Quality Improvement Program Status Reports:** A quarterly Quality Improvement Program Status Report is submitted to the Internal Board/Management Team quarterly through the CQIC. The Quality Improvement Program Status Report highlights accomplishments, revisions to the Work Plan, and regulatory updates. Coordinating the quarterly updates of the Quality Improvement Work Plan enables the exchange of information across multiple departments.
- **Strategic Business Plan:** Plan is revised and reviewed through individual markets. The Strategic Business Plan highlights the strategic imperatives targeted by each market for the upcoming year.
- **Regulatory and Structure and Process requirements:** Associates attend conferences, review bulletins, and conduct training and internal audits to verify compliance with regulatory and Structure and Process requirements.
- **Confidentiality and Conflict of Interest Agreements:** Associates are required to sign confidentiality and conflict of interest statements on an annual basis during the mandatory Corporate Ethics Training.
- **QI documents:** The annual written QI Program Description, Program Evaluation, and Work Plan are reviewed and approved by the Internal Board/Management Team through the CQIC.
- **Peer Review Activities:** Monitoring and identifying important aspects of care and resolving potential quality concerns are keys to achieving desire health outcomes. The Quality Operations Compliance Department reviews potential quality concerns and refers concerns to a Medical Director, and/or Peer Review Committee, as appropriate. Potential quality concerns may be identified through member complaints and grievances, ambulatory medical record review, external agency review requests, clinical program referrals, Humana At Home, inpatient medical record review, underutilization reports, and/or Utilization Management review.
- **Practice Guidelines Monitoring:** Clinical Practice Guidelines (CPGs) are adopted from clinically sound and reputable agencies and are reviewed and approved annually by the Corporate Quality Improvement Committee. These guidelines are taken from national organizations generally accepted in their fields as experts. The CPGs are intended to serve as a resource for contracted physicians and may be used as a guide for managing or treating a clinical condition or accomplishing a clinical service. Information contained in the guidelines is not a substitute for a physician's clinical judgment and none of the information contained within the guidelines is intended in any way to interfere with or prohibit clinical

decisions made by a treating physician regarding the medical care and available treatment options of members.

- **Ambulatory Medical Record Review:** Conducts annual review of medical records for a sample of primary care providers and/or high-volume specialists using a standard chart review tool. The purpose of the audit is to assess compliance with specific documentation components as delineated in the Provider Manual for Physicians, Hospitals, and Healthcare Providers. The medical record score is communicated to the provider along with any recommended corrective actions in an effort to improve performance.
- **Continuity and Coordination of Care:** CarePlus strives to promote a seamless delivery of medical care across a multitude of delivery sites and throughout the course of the disease process. Data are analyzed to determine areas where opportunities exist to improve continuity and coordination between settings of care and in transitions of care from one provider to another.
- **Communication and Collaboration on Behavioral Health Issues:** Collaboration with behavioral health to monitor and improve care coordination between medical care and behavioral health care. Analysis includes, but is not limited to, preventive care opportunities, HEDIS results, and management of co-existing medical and behavioral health disorders.
- **Physician Organized Delivery System (PODS) Program:** Engages providers to deliver the best care for their members, focused on members with complex chronic conditions

Evaluation and Trending: The QI program is broad in scope in order to monitor and evaluate the quality of care and service received by members. Data are tracked and trended monthly, quarterly, and/or annually as delineated in the QI Work Plan and baseline measurements are established. Opportunities for improvement and barriers are identified and root-cause analysis is conducted as needed. Interventions are selected and implemented as appropriate. Quality Improvement Projects (QIPs) are initiated as indicated and re-measurement is conducted in accordance with the Work Plan calendar. Continued follow-up and trending are encouraged of committee minutes, the annual QI Evaluation, and Quality Improvement Program Status Reports submitted quarterly to the CQIC.

Factor 3: Staff Involvement with Internal Quality Performance Process:

CarePlus fosters communication and partnerships across all levels, both internal and external, to facilitate the provision of quality, integrated healthcare services to all members. The reporting relationship of committees, both corporate and market-level, is designed to enhance the effectiveness of communication. A multi-disciplinary committee membership results in inter-departmental input and decision-making, which ultimately facilitates stronger communications throughout the organization. This structure also utilizes clinically-focused committees as a forum for solicitation of feedback from network providers.

Committees are required to record meeting minutes, which promotes consistency in the documentation and follow-up of committee activities. Items discussed in committee meetings reflect documentation of conclusions, recommendations, action, and follow-up. Minutes are signed and dated by the chairperson or acting chairperson. Electronic signatures are acceptable and must be dated. Committee minutes are available at the next meeting for review and approval.

Other types of inter-departmental communication include newsletters, e-mail, databases, online web information exchange (Hi!), Share Point, Microsoft Lync, Conference Calls, Buzz and written reports. The QI Work Plan serves as a communication tool by tracking quality improvement activities reviewed by the CQIC.

Humana At Home Quality Compliance Team and Humana Puerto Rico monitors and reports progress achieved toward quality goals utilizing various tools for CarePlus. Goals for the SNP program will be established by each SNP functional area and area leader and presented to the Corporate Quality Improvement Committee (CQIC). A quarterly review is conducted on the progress of the goals by the Humana At Home Quality Compliance Team and Humana Puerto Rico and presented to CarePlus, Humana Puerto Rico, and Humana At Home SNP Operations Department. Annually, Humana At Home and Humana Puerto Rico reports on the progress of the goals to the CQIC and twice per year reports to the SNP Integrated Oversight Committee (SIOC) on behalf of CarePlus. An improvement action plan is initiated for goals that are below the established benchmark. Program changes that are identified throughout the year are presented annually to the CQIC.

Annually, all aspects of the SNP QI Program are rigorously evaluated through a written process; this evaluation is the basis for any changes to the SNP QI Program in the upcoming year. This SNP Quality Improvement Model of Care Evaluation (QIE) is presented to the CQIC and is reviewed and approved or amended for CarePlus by Humana At Home. Subsequently, the SNP QIE is presented to the Internal Board/Management Team. The overall activity and outcomes of the SNP program will be overseen by Humana SNP Integrated Oversight Committee (SIOC), which reports to the Internal Board/Management Team, through Humana's Corporate Quality Improvement Committee (CQIC). The SNP Governance committee oversees the standardization of the Humana Special Needs Plans across all Model of Care implementers. The committee works to improve outcomes, increase transparency, create a forum to discuss SNP related issues and concerns, showcase best practice and streamline processes. Additionally, CarePlus collaborates with Humana's Quality Management team for HEDIS, NCQA compliance and CMS quality improvement projects. Overall accountability for the SNP MOC is governed by the SIOC, which works within Humana's quality committee structure.

Humana's Corporate Quality Improvement Committee meets monthly and various indicators (SNP MOC, HEDIS, Quality Improvement documents and projects) are monitored throughout the year. The SIOC Team meets quarterly; responsible Humana Puerto Rico and Humana At Home members report to the oversight group using an established dashboard on behalf of CarePlus. Barrier analysis and action plans may be requested by either committee.

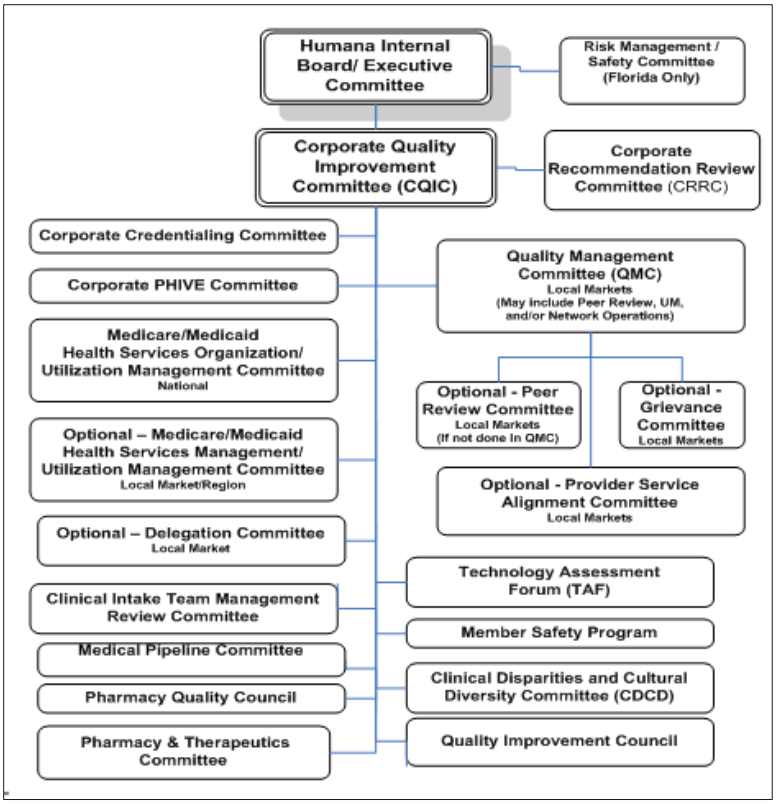
SNP Quality and Performance information will also be used to modify the MOC as opportunities are identified. Opportunities for improvement will include benefit changes/affordable care, policy changes, improved access to medical, behavioral and social services, physician and provider network coverage, process improvements, improved coordination and/or transition of care, improved health outcomes, system improvements, improved access to preventive services, and expansion of services or coverage.

In addition to corporate oversight of the model of care, CarePlus has designated Humana At Home Quality Compliance Team and beginning April 1, 2017 Humana Puerto Rico, as responsible for the oversight of model of care goals. Humana At Home also has a Quality Management Team responsible for auditing the documentation as does Humana Puerto Rico and quality of member written and phone records in the SNP program. When internal quality gaps are identified, this information is used to revise and/or revamp current processes and training materials. This information is also relayed to the Humana At Home Quality Compliance team and Humana Puerto Rico, who are then responsible for updating auditing materials as required. Managers responsible for leading teams of associates who care for SNP members are also responsible for identifying needs and communicating this information to the appropriate teams for follow up.

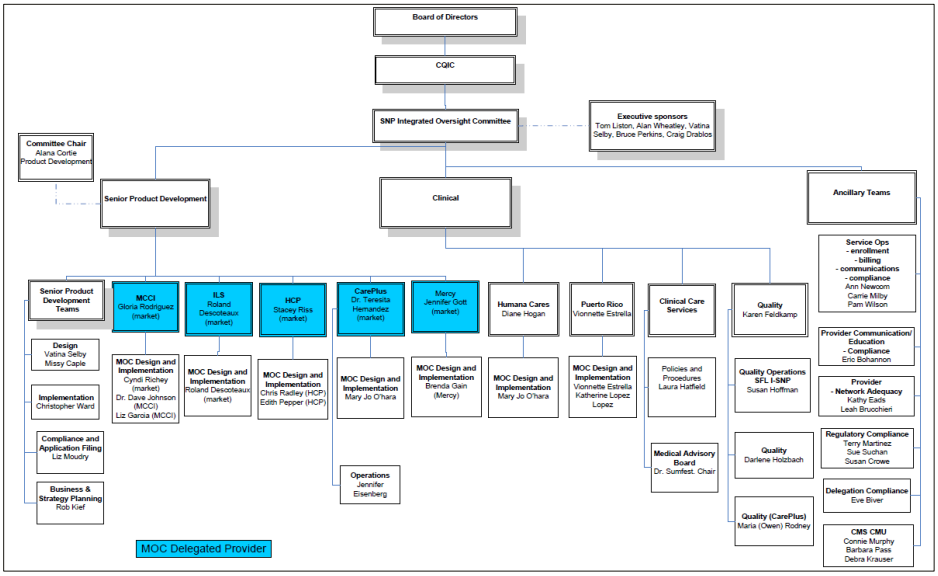
Reference MOC 2: Element A: Factor 1: Corporate Quality Improvement Committee (CQIC), SNP Integrated Oversight Committee Staff Roles & Responsibilities and SNP Governance Committee

Reference MOC 2: Element A: Factor 1: Humana At Home Quality Compliance Team Staff Roles & Responsibilities

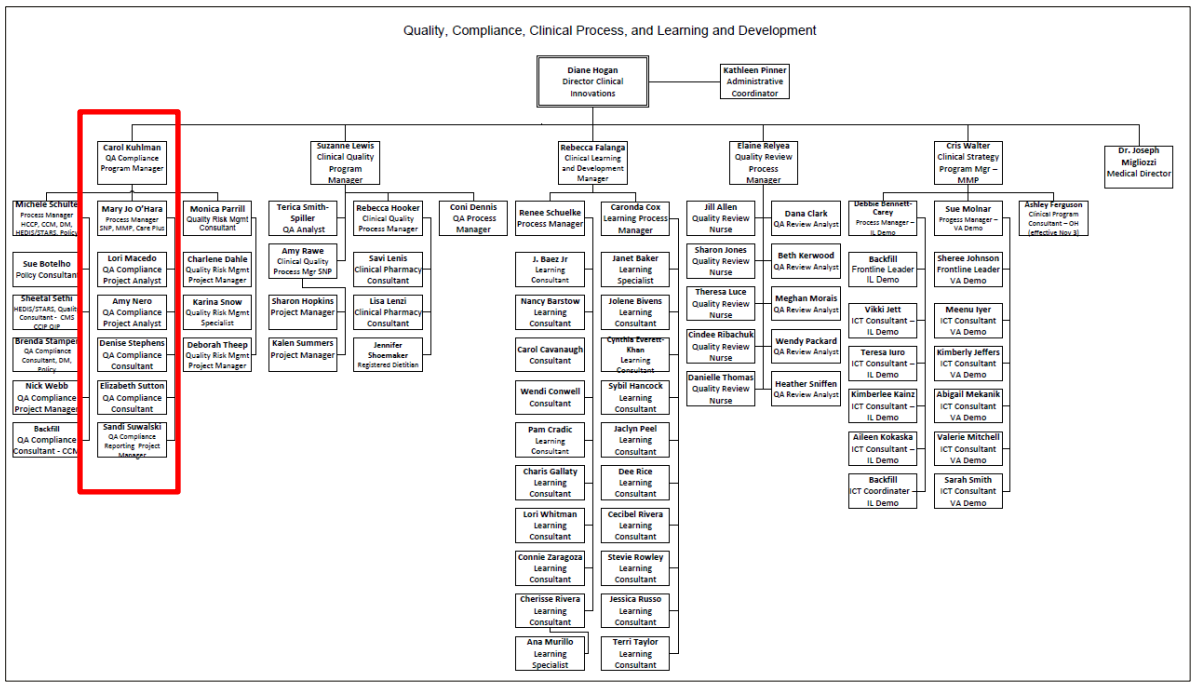
Example: Organizational Structure of Humana Quality Program:



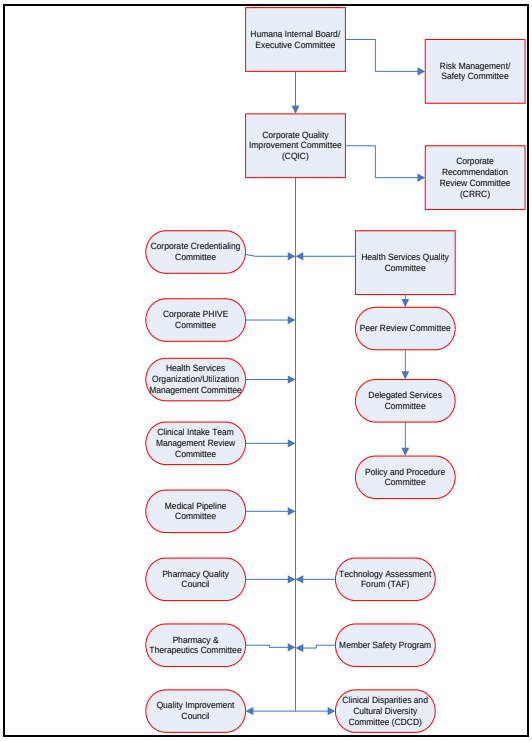
Example: Organizational Structure of SNP Integrated Oversight Committee:



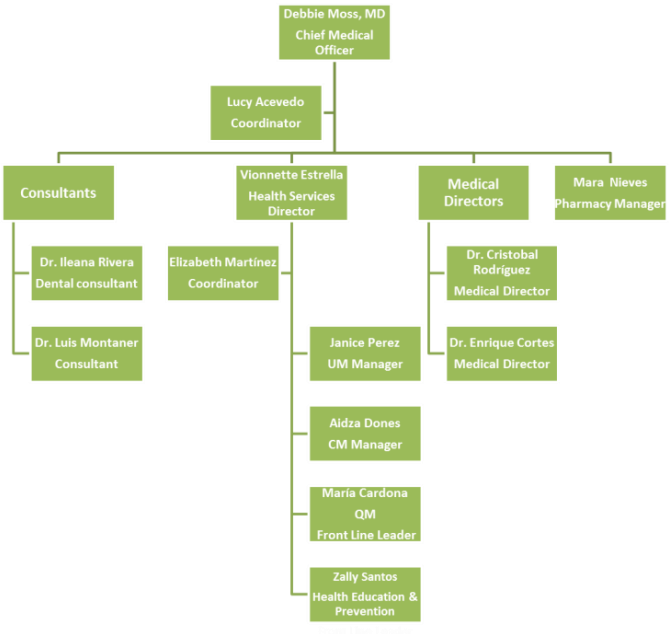
Example: Humana At Home Quality, Compliance, Process, & Learning Development Team:



Example: CarePlus Health Services Quality Committee:



Example: Humana Puerto Rico Health Guidance Organization



Factor 4: Integration of SNP Goals & Outcomes into Performance Improvement Plan:

The CarePlus MOC offers members and their caregivers health support, education, and special services to help them take better care of their individual health needs. The program allows for real time clinical consultations and member reassignments depending on the severity and needs of the member. It is designed to assist members and their caregivers in meeting personally identified health improvement goals. 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.

The model of care is evaluated and updated annually. Improvement initiatives are based upon performance evaluation of model of care effectiveness such as improvement in:

- Improving access and affordability of the healthcare needs for the SNP population
- Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the mDAT, ICP and ICT
- Enhanced care transitions across all health care settings and providers for SNP beneficiaries
- Ensuring appropriate utilization of services for preventive health and chronic conditions

Indicators include, but are not limited to:

- SNP Model of Care Enrollment/Membership

- Initial & Annual Health Risk Assessment (HRA) Completion
- Individualized Care Plan (ICP) Completion
- Interdisciplinary Care Team Meetings/Reviews
- Care Transitions – Post Discharge Outreach
- Utilization Management (ER Visits, Readmissions, Admissions)
- Referrals to Value Added Items & Services

Clinical and Process Indicators: Humana At Home and Humana Puerto Rico tracks and monitors health outcome measures on a monthly basis using a specific SNP MOC dashboard for CarePlus. Goals are established through analysis of quarterly measurement period results and trends. Benchmarks are established from trending performance outcomes and established industry norms when available. If goals are not met within established timeframes, improvement action plans will be implemented and monitored at minimum monthly. Overall effectiveness of the program will be evaluated annually within the SNP Quality Improvement Model of Care Evaluation (QIE). The overall activity and outcomes of the SNPs will be overseen by Humana SNP Governance Committee, Humana SNP Integrated Oversight Committee (SIOC) which reports to the Humana Internal Board/Management Team, through Humana's Corporate Quality Improvement Committee (CQIC).

This information will also be used to modify the MOC as opportunities are identified. Opportunities for improvement will include benefit changes/affordable care, policy changes, improved access to medical, behavioral and social services, physician and provider network coverage, process improvements, improved coordination and/or transition of care, improved health outcomes, system improvements, improved access to preventive services, and expansion of services or coverage.

In addition to clinical performance and outcomes, tracking and trending service and quality issues will enhance communication, address specific member issues, and help identify potential network or care issues.

Ongoing review and analysis of MOC measures serve as the basis for improvement opportunities including staffing, communication, and documentation processes. Additionally, Humana At Home and beginning April 1, 2017 Humana Puerto Rico has developed a CarePlus SNP Dashboard that reports member utilization activity, referral activity (behavioral health, community resources, hospice, etc.), interdisciplinary team contacts, hospitalizations, and other indicators to gauge interactions, effectiveness, and opportunities.

Humana Puerto Rico - CarePlus Goals and Health Outcomes for the Model of Care:

Overall Measure:	Member Engagement in Care Management	Health Outcome Measure
Description:	Engage members to actively participate in care management services	Improving access and affordability of the healthcare needs for the SNP population
Owner:	Humana Puerto Rico	
Data Point:	CCMS Clinical System	
Benchmark:	15% - SNP Aggregate 2013 Results	
Goal:	70% of members enrolled in a SNP plan will be managed	
Report Name:	Humana Puerto Rico SNP PPME Dashboard	
Reporting Timeframe:	CY 2017, Monthly	
Remeasurement:	CY 2018	

Overall Measure:	Initial Health Risk Assessment	Health Outcome Measure
Description:	Successful completion of initial Health Risk Assessment (HRA) for SNP Members	Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the HRA, ICP and ICT
Owner:	Humana Puerto Rico	
Data Point:	CCMS Clinical System	
Benchmark:	55% -SNP Aggregate 2013 Results	
Goal:	70% of members enrolled in a SNP plan eligible for an initial HRA will have the HRA completed within 90 days of enrollment in the SNP plan	
Report Name:	Humana Puerto Rico SNP PPME Dashboard	
Reporting Timeframe:	CY 2017, Monthly	
Remeasurement:	CY 2018	

Overall Measure:	Annual Health Risk Assessment	Health Outcome Measure
Description:	Successful completion of annual Health Risk Assessment HRA) for SNP Members	Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the HRA, ICP and ICT
Owner:	Humana Puerto Rico	
Data Point:	CCMS Clinical System	
Benchmark:	52% - SNP Aggregate 2013 Results	

Goal:	80% of members enrolled in a SNP plan eligible for an annual HRA will have the HRA completed within 365 days of the prior HRA	
Report Name:	Humana Puerto Rico SNP PPME Dashboard	
Reporting Timeframe:	CY 2017, Monthly	
Remeasurement:	CY 2018	

Overall Measure:	Individualized Care Plans (ICP)	Health Outcome Measure
Description:	Engaged members will have an individualized care plan	Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the HRA, ICP and ICT
Owner:	Humana Puerto Rico	
Data Point:	CCMS Clinical System	
Benchmark:	52% - Aggregate SNP 2013 Results	
Goal:	70% of members enrolled in a SNP plan will have an individualized care plan (ICP)	
Report Name:	Humana Puerto Rico SNP PPME Dashboard	
Reporting Timeframe:	CY 2017, Monthly	
Remeasurement:	CY 2018	

Overall Measure:	Interdisciplinary Care Team Review	Health Outcome Measure
Description:	Engaged members will be managed by an Interdisciplinary Care Team	Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the HRA, ICP and ICT
Owner:	Humana Puerto Rico	
Data Point:	CCMS Clinical System	
Benchmark:	52% - Aggregate SNP 2013 Results	
Goal:	70% of members enrolled in a SNP plan will have an annual ICT review	
Report Name:	Humana Puerto Rico SNP PPME Dashboard	
Reporting Timeframe:	CY 2017, Monthly	
Remeasurement:	CY 2018	

Overall Measure:	Increase Access to Social Services	Health Outcome Measure

Description:	Engage members who require social services to utilize Social Service Care Managers	Improving access and affordability of the healthcare needs for the SNP population
Owner:	Humana Puerto Rico	
Data Point:	CCMS Clinical System	
Benchmark:	2% - Aggregate SNP 2013 Results	
Goal:	4% of members enrolled in a SNP plan will be referred to Social Service Care Managers	Ensuring appropriate utilization of services for preventive health and chronic conditions
Report Name:	Humana Puerto Rico SNP PPME Dashboard	
Reporting Timeframe:	CY 2017, Monthly	
Remeasurement:	CY 2018	

Overall Measure:	**Increase Access to Pharmacy Assistance**	**Health Outcome Measure**
Description:	Engage members to utilize pharmacy management services including RX Mentor/MTM/Community Pharmacists	Improving access and affordability of the healthcare needs for the SNP population
Owner:	Humana Puerto Rico	
Data Point:	CCMS Clinical System	
Benchmark:	2% - Aggregate SNP 2013 Results	
Goal:	4% of members enrolled in a SNP plan will be referred to RXMentor/MTM or Humana Puerto Rico Clinical Pharmacist	Ensuring appropriate utilization of services for preventive health and chronic conditions
Report Name:	Humana Puerto Rico SNP PPME Dashboard	
Reporting Timeframe:	CY 2017, Monthly	
Remeasurement:	CY 2018	

Overall Measure:	**Increase Access to Behavioral Health Services**	**Health Outcome Measure**
Description:	Engage members who require behavioral health services to utilize LifeSynch/PsychCare	Improving access and affordability of the healthcare needs for the SNP population
Owner:	Humana Puerto Rico	
Data Point:	CCMS Clinical System	
Benchmark:	3.0% - Aggregate SNP 2013 Results	
Goal:	4% of members enrolled in a SNP plan will be referred to Behavioral health	Ensuring appropriate utilization of services for

Report Name:	Humana Puerto Rico SNP PPME Dashboard	preventive health and chronic conditions
Reporting Timeframe:	CY 2017, Monthly	
Remeasurement:	CY 2018	

Overall Measure:	Post-Discharge Follow-Up within 3 Business Days	Health Outcome Measure
Description:	Post discharge contact with SNP members who experienced a transition within a specified timeframe	Enhanced care transitions across all health care settings and providers for SNP beneficiaries
Owner:	Humana Puerto Rico	
Data Point:	CCMS Clinical System	
Benchmark:	Baseline	
Goal:	25% of SNP members enrolled will have successful post discharge outreach less than or equal to 3 business days	
Report Name:	Humana Puerto Rico SNP PPME Dashboard	
Reporting Timeframe:	CY 2017, Monthly	
Remeasurement:	CY 2018	

Overall Measure:	Post-Discharge Follow-Up within 10 Business Days	Health Outcome Measure
Description:	Post discharge contact with SNP members who experienced a transition within a specified timeframe	Enhanced care transitions across all health care settings and providers for SNP beneficiaries
Owner:	Humana Puerto Rico	
Data Point:	CCMS Clinical System	
Benchmark:	Baseline	
Goal:	50% of SNP members will have successful post discharge outreach less than or equal to 10 business days	
Report Name:	Humana Puerto Rico SNP PPME Dashboard	
Reporting Timeframe:	CY 2017, Monthly	
Remeasurement:	CY 2018	

Overall Measure:	Reduce Occurrences of Care Transitions	Health Outcome Measure
Description:	Reduce inpatient hospital admissions	Enhanced care transitions across all health care
Owner:	Humana Puerto Rico	

Data Point:	Claims	settings and providers for SNP beneficiaries
Benchmark:	267.0 Hospital Admissions Per 1000 - Aggregate SNP 2013 Results	
Goal:	Reduce hospital admissions by 1.5% from prior year end results	
Report Name:	Humana Puerto Rico SNP PPME Dashboard	
Reporting Timeframe:	CY 2017, Monthly	
Remeasurement:	CY 2018	
Description:	Reduce readmission rates from prior year	Enhanced care transitions across all health care settings and providers for SNP beneficiaries
Owner:	Humana Puerto Rico	
Data Point:	Claims	
Benchmark:	25.56% - Aggregate SNP 2013 Results	
Goal:	Reduce by 1 percentage point from prior year end results	
Report Name:	Humana Puerto Rico SNP PPME Dashboard	
Reporting Timeframe:	CY 2017, Monthly	
Remeasurement:	CY 2018	
Description:	Reduce emergency room visits from prior year	Enhanced care transitions across all health care settings and providers for SNP beneficiaries
Owner:	Humana Puerto Rico	
Data Point:	Claims	
Benchmark:	542.0 ER Visits Per 1000 – Aggregate SNP 2013 Results	
Goal:	Reduce by 1.5% from prior year end results	
Report Name:	Humana At Home SNP Dashboard	
Reporting Timeframe:	CY 2016, Monthly, Ad-Hoc	
Remeasurement:	CY 2017	

Overall Measure:	**Satisfaction with Care Management**	**Health Outcome Measure**
Description:	SNP engaged members will overall be satisfied with Humana At Home services	Improving access and affordability of the healthcare needs for the SNP population
Owner:	Humana Puerto Rico	
Data Point:	Annual Member Satisfaction Survey	
Benchmark:	96% - 2013 Satisfaction Rate	
Goal:	95% of members enrolled in a SNP plan will be satisfied with the overall Care Manager and program	

Report Name:	Member Satisfaction Survey Analysis
Reporting Timeframe:	CY 2017, Annual
Remeasurement:	CY 2018

Humana At Home - CarePlus Goals and Health Outcomes for the Model of Care:

Metric	2016 Goal
Percent of members actively engaged in care management	75%
Percent of Part C initial Health Risk Assessments completed	75%
Percent of Part C annual Health Risk Assessments completed	75%
Percent of completed Health Risk Assessments or compliant HRA Exclusion	90%
Percent of Individualized Care Plans completed or compliant ICP Exclusion	90%
Percent Completed Basic Care Plans to Members and Providers	90%
Percent of Interdisciplinary Care Teams or compliant Exclusion	90%
Percent of Members with HRAs, ICPs, BCPs and ICTs in appropriate sequence	90%
Rate of Members Referred to Behavioral Health	10%
Rate of Members Referred to Mail Order Pharmacy	14%
Rate of Members Referred to Pharmacy Services	25%
Rate of Members Referred to Social Services	50%
Rate of Post Discharge Surveys Completed within 3 Days	50%
Rate of Post Discharge Surveys Completed within 10 Days	50%
Rate of Acute Readmissions	Reduce by 1% from prior year
Admissions per Thousand (APT)	Reduce by 1.5% from prior year
Emergency Room Visits per Thousand (VPT)	Reduce by 1.5% from prior year
Member Satisfaction	97%

ELEMENT B: MEASUREABLE GOALS & HEALTH OUTCOMES FOR THE MODEL OF CARE:

Factor 1: Identification of Goals & Health Outcomes for D-SNP Beneficiaries:

Health outcome and service goals are established to perform ongoing evaluation of the effectiveness of CarePlus D-SNP MOC. In order to achieve the overall goals of the program, CarePlus has established measurable goals to evaluate and measure the quality of care, outcomes, service, and access for members. For each metric, goals have been established based on current experience and evidence-based medicine found by researching current literature and utilizing current NCQA standards and guidelines. Humana At Home and beginning April 1, 2017 Humana Puerto Rico will complete trend and statistical data analysis on each measure to determine if the specific goals are met and utilize continuous quality improvement techniques while striving for goal achievement on behalf of CarePlus. Benchmarks are established from trending performance outcomes and established industry norms when available.

CarePlus developed measurable goals and health outcomes used to improve the health care needs of CarePlus D-SNP members. These goals address the D-SNP members needs and attempts to encourage engagement with a members health care needs, educate the members on the available services and how the services can be used, and allows members to make consciousness decisions about their healthcare and their benefits. The following goals are applicable to the health, social, environmental needs of D-SNP members:

- Engage members to utilize pharmacy management services including Medication Therapy Management/Community Pharmacists: Ensuring engagement with pharmacy services allows Humana At Home to educate and engage members in their prescribed medications.
- Engage members to utilize mail order pharmacy services to reduce monthly prescription expenditures: D-SNP members face economic hardship, this specific goal ensures members are receiving proper financial assistance with their prescribed medications.
- Engage members who require behavioral health services to utilize Behavioral Health: D-SNP members face mental health issues that affect all aspects of their daily life. This goal ensures members who do require behavioral health services have access to specific behavioral health vendors that provide integrated care.
- Engage members who require social services to utilize Humana At Home Social Service Care Managers or Humana Puerto Rico Social Services: D-SNP members encounter daily social and financial needs. This goal ensures members who do need assistance with discussing, locating and coordinating services to assist members identified need.
- Reduce emergency room visits from prior year: D-SNP members tend to be in poorer health and have higher rates of ED visits. In most cases members have lack of access to appropriate

care settings and tend to have urgent and more serious issues. This goal ensures CarePlus is focusing on reducing the number of ED visits and ensuring Care Managers are improving access to appropriate care settings to better address the health need.

- Promote Care of Older Adults Measure HEDIS Measure: Promote pain and functional screening, implementation of advanced care directives and medication review. Reported annually via the CarePlus SNP Quality Improvement Model of Care Evaluation.

Reference MOC 4: Element A: Factor 4: Goal Outcome Tables for specific goal and health outcome details (See Page 229).

Factor 2: Beneficiary Health Outcomes used to Measure Overall SNP Outcomes:

Reference MOC 4: Element A: Factor 4: Goal Outcome Tables (See Page 229).

Factor 3: Assessment & Tracking of Health Outcome Goals:

Humana At Home and beginning April 1, 2017 Humana Puerto Rico will track and monitor health outcome measures on a monthly or quarterly basis using a suite of dashboard reports, and quality audit metrics for CarePlus. In 2014, Humana At Home began to analyze goals related to health outcomes at the member level detail for CarePlus. The CarePlus dashboard reports at an aggregate level, PBP level, and by SNP type. In 2015, CarePlus will begin to analyze goals related to health outcomes at the member level detail. The ability to report off member level detail will enable Humana At Home and Humana Puerto Rico to identify CarePlus members who need specific intervention or follow-up based on their health outcomes.

Goals are established through analysis of annual measurement period results and trends. Utilization goals are established based on SNP plan performance as compared to overall CarePlus performance and HEDIS performance outcomes measures and goals established based upon aggregate health plan benchmarks and National Committee for Quality Assurance (NCQA) Quality Compass HEDIS Means and Percentiles. HEDIS measure goals are set to improve year over or to meet at least 50th Percentile or greater.

Example: CarePlus SNP Dashboard:

Key Performance Indicators	2014 Goal	AGGREGATE															
		Q1 2013		Q1 2014		Q2 2013		Q2 2014		Q3 2013		Q3 2014		Q4 2013		Q4 2014	
Members Managed	78%	20,017	72.6%	23,335	67.8%	21,709	72.9%	26,346	68.5%	23,417	72.9%	30,597	66.8%	25,796	72.7%	34,566	68.3%
HRAs[1]																	
Members eligible for an initial HRA								10,098				17,091				20,488	
Initial HRA within 90 days of enrollment	78%							6,153	60.9%			10,154	59.4%			13,719	67.0%
Members eligible for an annual HRA								28,128				28,392				30,168	
Annual HRA within 365 days of previous HRA	78%							7,662	27.2%			9,013	31.7%			12,157	40.3%
Combined HRA Rate									36.1%				42.1%				51.1%
HRA Star Rating	5								2				2				3
Care Management																	
Total Members with Care Plan	78%	6,182	22.4%	7,690	22.4%	10,228	34.3%	11,807	30.7%	13,300	41.4%	14,857	32.4%	15,967	45.0%	17,830	35.2%
ICT Activity																	
ICT Meeting/Review Total	75%	52	0.2%	1,958	5.7%	156	0.5%	4,578	11.9%	181	0.6%	8,686	19.0%	13,960	39.3%	16,848	33.3%
Referral Activity[3]																	
Behavioral Health																	
PsychCare Referrals	4%	214	0.8%	269	0.8%	409	1.4%	641	1.7%	568	1.8%	1,613	3.5%	835	2.4%	2,596	5.1%
Social Services																	
HCM-SS Referrals	75%	777	2.8%	1,184	3.4%	1,537	5.2%	2,326	6.0%	2,118	6.6%	3,690	8.1%	2,855	8.0%	4,949	9.8%
Mail-Order Pharmacy																	
Prescriblt Rx Referrals	10%	187	0.7%	80	0.2%	360	1.2%	643	1.7%	428	1.3%	2,659	5.8%	538	1.5%	4,250	8.4%
Pharmacy Services																	
MTM (Outcomes) Referrals (2013)		0	0.00%		*N/A*	1	0.00%		*N/A*	2	0.01%		*N/A*	3	0.01%		*N/A*
MTM (Outcomes) & Clinical Pharmacist Referrals[4]	3%	4	0.01%	5	0.01%	9	0.03%	8	0.02%	15	0.05%	13	0.03%	17	0.05%	15	0.0%
IHS Referrals	20%	584	2.1%	860	2.5%	1,163	3.9%	1,498	3.9%	1,709	5.3%	2,159	4.7%	2,333	6.6%	2,852	5.6%
Transitions of Care																	
# of discharges		2,640		3,432		5,318		7,181		8,381		11,464		11,258		14,964	
Post Discharge Assessments <=3 Days	30%	1,154	43.7%	1,083	31.6%	2,390	44.9%	2,401	33.4%	3,710	44.3%	3,642	31.8%	4,864	43.2%	4,716	31.5%
Post Discharge Assessments <=10 Days	78%	1,439	54.5%	1,508	43.9%	2,957	55.6%	3,245	45.2%	4,593	54.8%	4,989	43.5%	6,044	53.7%	6,548	43.8%
Utilization Activity[5]																	
Readmission Rate	14.5%																
Emergency Room (ER) Visits Per 1000	525.6																
IP Admits Per 1000	380.3																

Factor 4: Process for Health Outcomes that Meet Goals

Recognizing the need to maintain appropriate accountability of the processes affecting CarePlus members, Humana At Home and Humana Puerto Rico strives to partner with all internal departments and associated delegated external entities in the ongoing monitoring process for quality improvement. In this role, Humana At Home and Humana Puerto Rico has outlined key operational metrics as well as delineated organizational responsibilities for effective management of quality improvement efforts for CarePlus. Additionally, Humana At Home and Humana Puerto Rico has established a means for ongoing communication and accountability throughout the organization.

Overall goals and objectives of the Quality Improvement (QI) Program include, but are not limited to, the following:

- To promote activities that will result in better communication between departments, and improved service and satisfaction to members, practitioners, providers and associates
- To identify and resolve issues related to member access and availability to health care services
- To provide a mechanism whereby members, practitioners, and providers can express concerns to Humana At Home regarding care and service
- To provide customer service that is effective in responding to member, practitioner and provider needs and requests

- To provide a process through which pertinent member information is collected and analyzed; and improvement actions are implemented by a health plan committee comprised of participating physicians and health plan staff
- To monitor coordination and integration of member care across practitioner and provider sites.
- To guide members to achieve optimal health by providing tools that help them understand their health care options and take control of their health needs

The Humana At Home Quality Compliance Team oversees the quality improvement program for CarePlus SNP plans and beginning April 1, 2017 Humana Puerto Rico. The Humana At Home Quality Compliance Team and Humana Puerto Rico represents a multi-disciplinary, cross-functional team comprised of clinical and administrative personnel who provide subject matter expertise and operational oversight for the Quality Improvement Program activities and recommends policy decisions. This group facilitates implementation of quality improvement processes across the organization by planning, analyzing, and evaluating quality improvement activities. The Humana At Home Quality Compliance team and Humana Puerto Rico promotes objective and systematic monitoring and evaluation of consumer and client health services and facilitates compliance with regulatory requirements.

Humana Puerto Rico:

Quality Improvement Committee (QIC) provides operational oversight for the market Quality Improvement Program activities, and recommends policy decisions. The QIC facilitates integration of operational processes across the market by planning, analyzing, and evaluating quality improvement activities. The QIC promotes objective and systematic monitoring and evaluation of consumer and client health services and facilitates compliance with regulatory requirements. The QIC is responsible for review and approval of the QI Program Description, QI Annual Evaluation and QI Work Plan. The QIC reports to the Corporate Quality Improvement Committee and is chaired by the market Medical Director. The QIC meets every other month, or more frequently as needed.

Humana At Home:

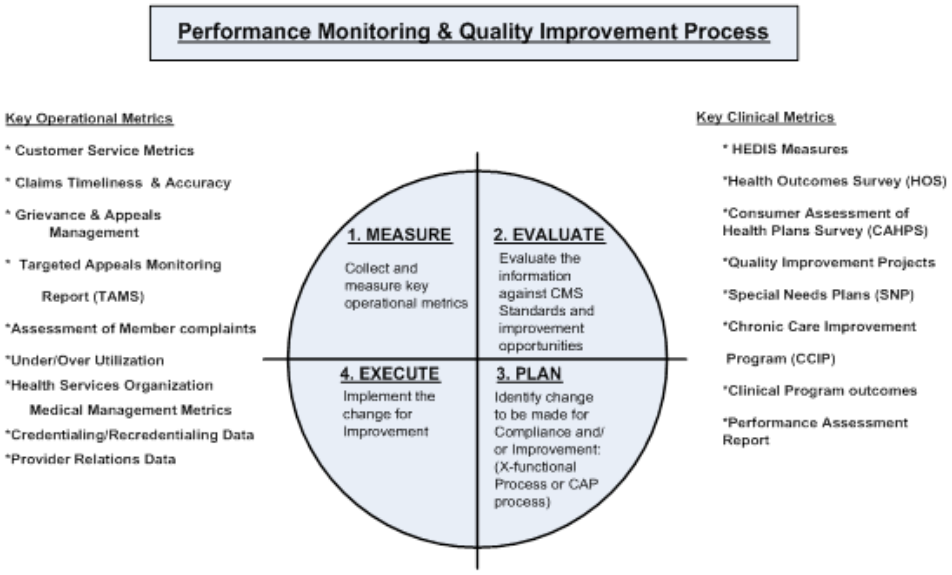
The Humana At Home Quality Compliance Team is led by the Humana At Home Quality Compliance Process Manager who provides oversight to the Humana At Home Quality Compliance Reporting Analyst and Project Manager, who coordinates acquisition of data from Humana At Home sources, CarePlus sources, and Humana sources. The Process Manager also provides oversight to the Quality Compliance Consultant who is responsible for drafting the QI

Program Description and collecting, tracking and analyzing the data on which the Quality Improvement Annual Evaluation is based.

The QI Program Description and the Quality Improvement Annual Model of Care Evaluation are then submitted to the Humana Corporate Quality Improvement Committee (CQIC) for review and approval. The CQIC reports to Humana's Internal Board / Management Team, which is chaired by the corporate Chief of Quality. The team meets monthly, or more frequently as needed. All data reports are housed electronically.

The process includes the following components:

- Monitoring system-wide issues
- Identifying opportunities for improvement
- Determining the root cause
- Exploring alternatives and developing a plan of action
- Activating the plan, measuring the results, evaluating effectiveness of actions and modifying the approach as needed



CarePlus SNP Quality Improvement Program is evaluated annually and includes formal assessments, including chart audits, surveys, and program evaluation. The results are documented in an end-of-year Quality Improvement Evaluation (QIE). The assessment/reassessment of the Models of Care include the following;

- Review of current performance against expectations and results
- Performance monitoring reports – trends and patterns
- Documented review of program materials – policy updates and process changes
- Implementation of agreed upon process improvements
- Evaluation of performance once plan is implemented and any other issues identified as potentially harmful to members/providers
- Implementation of improvement action items with issues identified during the course of the year

Adequate Health Information – Ongoing performance is monitored by the Corporate Quality Improvement Committee (CQIC) conducting various activities including the following: Key stakeholders, departments, and ad hoc quality teams meet regularly to discuss any potential issues and identify areas for improvement. These teams include but are not limited to the following:

- Health Services Organization
- Behavioral Health Task Force
- Customer Service/Claims Payment
- Grievance & Appeals
- National Network Operations
- Delegation
- Credentialing
- Quality Operations Compliance and Accreditation
- Local markets
- Quality Improvement and Stars Maximization Teams
- Compliance
- Corporate Providers' Services
- Clinical Operations

Within these teams, the following processes are performed: Operational data and clinical metrics are defined, monitored, and reported on a regular basis.

- Meetings are held routinely with a prepared agenda that delineates specific topics for discussion and areas of improvement. Data is reviewed and analyzed. Follow-up actions are then discussed and documented for further dialogue.
- Key findings from the meetings are summarized and reported to CQIC according to the CQIC Reporting Calendar.

- Communication with key stakeholders is accomplished in a variety of ways including participation during the CQIC meetings, ad hoc meetings, and meeting minutes.

Reviews of Performance Reports and Key Performance Indicators:

- The CQIC reviews key management reports and other supporting materials on a periodic basis to analyze operational and clinical performance; reviews for adherence to defined requirements by achieving target indicators; and identifies any potential trends, issues or barriers that might warrant further attention or review of existing operational/business processes.
- Materials to be reviewed, at a minimum, include the CQIC Executive Summaries and associated detail; and trended analysis reports.

Any feedback or comments regarding key metrics, findings, and conclusions derived from the information are forwarded to the Humana Internal Board/Management Team. Once reviewed and recommendations/approvals received by the Internal Board/Management Team, the results are dispersed to appropriate stakeholders. Significant Problems Corrected – Focused assessment of high-risk areas is performed at the local market level. Local markets monitor and trend member complaints and potential quality of care issues, and conduct provider site visits and audits. Data is collected to assess and promote accurate, timely and complete medical records by providers. Deficiencies are addressed through provider education or other improvement action. Office site visits are performed to monitor compliance with standards. Key findings are reported to the CQIC on a quarterly basis on the Quarterly QI Status Report.

Factor 5: Process for Health Outcomes that Do Not Meet Goals:

If performance goals are not met within established timeframes, or continue trending below the benchmark, a root cause analysis is performed and an improvement action plan is initiated. Improvement action plans will be implemented and monitored at least monthly, and may include:

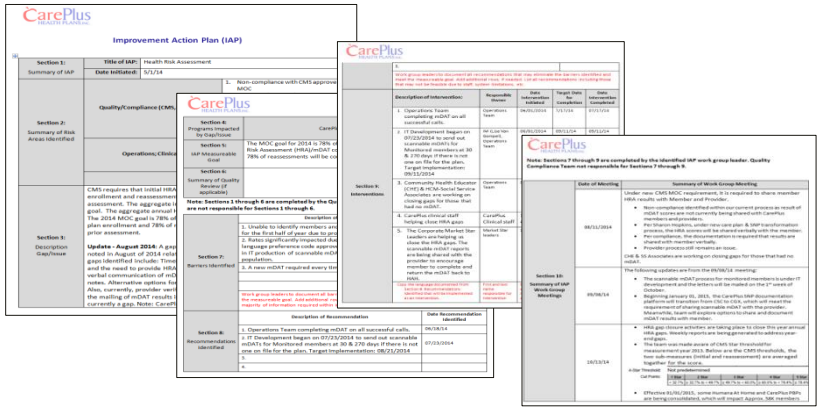
- Associate refresher education related to the Centers for Medicare and Medicaid Services' goals and identification of individual member needs which correlate with these goals, including available tools and resources utilized to meet member needs.
- Process reviews to include revision of and implementation of new or revised processes.
- Associate education related to current and/or revised processes.
- Review and revision of member outreach, educational materials and activities. Member notification and education about any implemented changes.

- Review and revision of provider outreach, educational materials and activities. Provider notification and education about changes and program activities.
- Review and implementation of an escalation process to communicate identified GAPS with corporate partners.

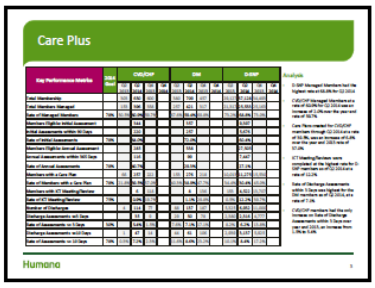
Once recommended actions are implemented, evaluation of the effectiveness of changes will be made. In addition to Improvement Action Plans, Humana At Home incorporates quality performance improvement into quality improvement projects for CarePlus. These projects are created to focus interventions for outcomes improvement.

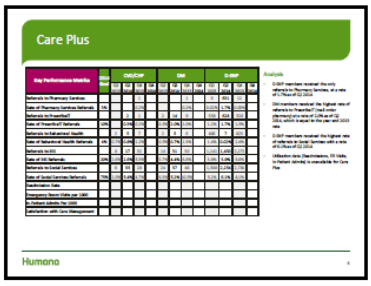
- Improving access and affordability of the healthcare needs for the SNP population
- Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the mDAT, ICP and ICT
- Enhanced care transitions across all health care settings and providers for SNP beneficiaries.
- Ensuring appropriate utilization of services for preventive health and chronic conditions.

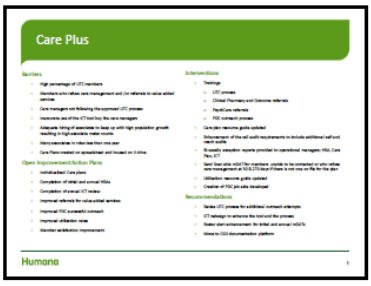
Example: Improvement Action Plan – Health Risk Assessment SNP Compliance Gap:



Example: CarePlus MOC Mid-Year Reporting







ELEMENT C: MEASURING EXPERIENCE OF CARE (SNP MEMBER SATISFACTION):

Factor 1: SNP Specific Survey:

Annually, CarePlus conducts a SNP specific telephonic member satisfaction survey using an external vendor. The survey's focus is on higher acuity members because the SNP members are touched more often by the program and are therefore best equipped to evaluate satisfaction. The sample disposition details are evaluated yearly by CarePlus to determine effectiveness and the survey is conducted at the Plan Benefit Package level for all SNP PBP's.

Secondary to the SNP specific member satisfaction survey, CarePlus utilizes the Consumer Assessment of Healthcare Providers and Systems Survey (Wilkerson & Associates). The CAHPS is a member satisfaction survey that is conducted annually to commercial, Medicaid and Medicare members. The surveys are administered in the early spring by mail, with telephonic follow-up for non-responders. CarePlus utilizes an NCQA certified survey vendor that conducts the CAHPS survey for Commercial, Medicare and Medicaid members. The vendor works with CarePlus to develop CAHPS custom questions and provide results for each market and line of business, as well as providing extensive analysis of the results. Several similar questions make up a "composite" and scores are provided for each: some are used for NCQA scoring. Below is a listing of the composites:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Claims Processing
- Shared Decision Making
- Plan Information on Costs

Additional Measures and Questions:

- Health Promotion and Education

- Coordination of Care
- Rating of Personal Doctor
- Rating of Specialist
- Rating of Health Care
- Rating of Health Plan

The following HEDIS Effectiveness of Care Measures are collected via CAHPS survey methodology rather than through claims data:

- Aspirin Use and Discussion
- Medical Assistance with Smoking and Tobacco Use Cessation
- Flu Shots for Adults Ages 50-64
- Flu Shots for Older Adults
- Pneumonia Vaccination Status for Older Adults (Medicare only)

Humana At Home:

Additionally, Humana At Home implemented the Compliments/Inquiries/Complaints/Occurrences (CICO) application in January, 2012 for CarePlus. This application allows for Humana At Home associates to document compliments, inquiries, complaint, and occurrences received from member, member's family, providers or others about Humana At Home CarePlus services, programs or other areas. CarePlus believes that having access to this information throughout the year provides opportunities for improvement of services and programs. CarePlus also recognizes the importance of having the opportunity to acknowledge associate interaction and programs that contribute positively to members' experiences.

Factor 2: Rationale for SNP Member Satisfaction Survey:

The rationale of SNP specific member satisfaction survey is to:

- Measure overall satisfaction among Medicare members who have Special Needs Plans and report at the Plan Benefit Package (PBP) level.
- Evaluate levels of satisfaction with the program and Care Manager.
- Evaluate how well the program is meeting members' needs.
- Identify areas of strength and opportunities to improve member experience and program outcomes.
- Meet the CMS requirement to conduct an annual survey of program participants.

Member Satisfaction Survey measures include:

- The level of satisfaction with the program, the Care Manager and their knowledge.
- How well interactions with the program meet members' needs.
- How well the program equips members to self-manage

Survey questions evaluating satisfaction with the program and the care manger were based on a five point scale with one (1) the least positive and five (5) the most positive. Likelihood to recommend the Care Manager service and likelihood to recommend CarePlus overall used a 11-point scale with zero (0) meaning not at all likely and ten (10) meaning very likely. Question wording is evaluated on a yearly basis to ensure comparison year over year. In 2014, question wording included the following:

1. First, **please think about CarePlus overall.** Using a scale where zero (0) means "not at all likely" and ten (10) means "extremely likely," how likely would you be to recommend CarePlus to a friend or relative?
2. Now, please use a scale where zero (0) means "strongly disagree" and ten (10) means "strongly agree" with this statement. CarePlus really **cares about my health and well-being.**
3. Now, let's talk about the conversations you've had with CarePlus about your health. Overall how would you rate the CarePlus Care Manager who worked with you? Using a scale where 1 means "poor" and 5 means "excellent," **how would you rate your Care Manager?**
4. How would you rate your CarePlus Care Manager for being **knowledgeable**? Using a scale where one (1) means "not at all knowledgeable" and five (5) means "extremely knowledgeable," please tell how you would rate your Care Manager on being knowledgeable.
5. **How likely are you to make a change in how you take care of your health** as a result of working with your CarePlus Care Manager? Using a scale where (1) means "not at all likely" and five (5) means "extremely likely," please tell me how likely you are to make a change in how you take care of your health.
6. Please use a scale where one (1) means you "strongly disagree" and five (5) means you "strongly agree" with this statement: As result of your experience with your Care Manager, you feel more prepared to manage your own health.

The SNP specific survey is administered telephonic and the goal of the survey is to sample at least 30 members within 25 Plan Benefit Package that are considered most vulnerable. Results are reported in a graphic format; for each PBP and for the aggregate total. The total aggregate scores are weighted based on the correct proportionate number of members served by each PBP.

The Humana At Home Quality Compliance Team who brings an understanding of processes completes the final analysis of the findings for CarePlus. The analysis includes a quantitative

data analysis that incorporates aggregated results and trends over time. The Humana At Home Quality Compliance Team also identifies actions and interventions and barriers for improvement. The Humana At Home Quality Compliance Team identifies as many opportunities as possible and prioritizes them based on its analysis and their significance for concerns to members. Deficiencies are priortized according to the significance to members and the degree of impact and the ability to quantify results. For each opportunity or barrier, the Humana At Home Quality Compliance Team identifies its reasons for taking (or not taking) action.

Factor 3: Integration of the SNP Satisfaction Survey into the Performance Improvement Plan:

The final SNP member satisfaction survey, proposed actions for improvement and subsequent improvement outcomes are reported annually within the CarePlus SNP Quality Impvoement Model of Care Evaluation to Corporate Quality Improvement Committee. Additionally, the overall satisfaction with the Care Manager is an identified Model of Care goal for CarePlus. *Reference MOC 2: Element A: Factor 1: Corporate Quality Improvement Committee (CQIC) and SNP Integrated Oversight Committee Staff Roles & Responsibilities See Page 63 and Reference MOC 4: Element A: Factor 4: Measureable Goals and Health Outcomes for the Model of Care See Page 229.)* The model of care is evaluated and updated annually. Improvement initiatives are based upon performance evaluation of model of care effectiveness.

Factor 4: Steps to Address Issues Identified in SNP Satisfaction Survey:

If the performance goal related to overall member satisfaction trends below the benchmark, a root cause analysis is performed, an improvement action plan is initiated. Performance improvement plans will be implemented and monitored at least monthly, and may include:

- Associate refresher education related to the Centers for Medicare and Medicaid Services' goals and identification of individual member needs which correlate with these goals, including available tools and resources utilized to meet member needs.
- Process reviews to include revision of and implementation of new or revised processes.
- Associate education related to current and/or revised processes.
- Review and revision of member outreach, educational materials and activities. Member notification and education about any implemented changes.
- Review and revision of provider outreach, educational materials and activities. Provider notification and education about changes and program activities.
- Review and implementation of an escalation process to communicate identified GAPS with corporate partners.

Once improvement actions are implemented, evaluation of the effectiveness of changes will be made quarterly, or as specified within the Improvement Action Plan. In addition to

Improvement Action Plans, Humana At Home and Humana Puerto Rico incorporates quality performance improvement into quality improvement projects for CarePlus. These projects are created to focus interventions for outcomes improvement.

ELEMENT D: ONGOING PERFORMANCE IMPROVEMENT EVALUATION OF THE MOC:

Factor 1: Description of the Ongoing Performance Improvement Evaluation:

The CarePlus SNP Quality Improvement Model of Care Evaluation (QIE), performed annually by Humana At Home Quality Compliance Team and beginning in 2017 by Humana Puerto Rico is an evaluation of CarePlus' SNP Quality Improvement Program. The annual SNP QIE also serves as a tool to summarize MOC performance, describing the SNP Model of Care success, barriers, and limitations encountered throughout the year, and recommendations for future initiatives and improvements. The CarePlus SNP QI Program Description is developed utilizing the information and insights obtained from the SNP QI Evaluation.

This information is monitored to identify opportunities for benefit clarification, physician and provider education and process changes that will improve coordination of care and maximize health outcomes, member understanding of their specific conditions, compliance with preventive and ICP regimes, and modification of the MOC as opportunities are identified.

Opportunities for improvement may include benefit changes/affordable care, policy changes, improved access to medical, behavioral and social services, physician and provider network coverage, process improvements, improved coordination and/or transition of care, improved health outcomes, system improvements, improved access to preventive services, and expansion of services or coverage. In addition to performance and outcomes, tracking and trending service and quality issues will enhance communication, address specific member issues, and help identify potential network or care issues.

Humana Puerto Rico:

The Humana Puerto Rico Quality Management Department in collaboration with Humana Puerto Rico Operations Department incorporates SNP Model of Care performance, limitations encountered throughout the year, and recommendations for future initiatives and improvements. An electronic copy of the signed report is maintained in Humana Puerto Rico's shared drives and copies made available to all Humana SNP team members and stakeholders as needed.

Humana At Home:

The Humana At Home Quality Compliance Team in collaboration with Humana At Home SNP Operations Team and Humana At Home Quality ManagementTeam incorporates SNP Model of Care performance, limitations encountered throughout the year, and recommendations for future initiatives and improvements. An electronic copy of the signed report is maintained in

Humana At Home's shared drives and copies made available to all SNP team members and stakeholders as needed. Corporate Quality Improvement Committee and SNP Integrated Oversight committee meeting minutes are also maintained electronically.

Similarly, CarePlus Quality Improvement (QI) Program Evaluation is an assessment of the CarePlus Quality Improvement Program in the calendar year. The CarePlus QI Program Description and Work Plan are developed utilizing the information obtained from the QI Evaluation.

Factor 2: Utilization Results to Continually Assess and Evaluate Quality:

Humana At Home Quality Compliance Team and beginning April 1, 2017, Humana Puerto Rico monitors and reports progress achieved toward quality goals utilizing various tools for CarePlus. These include various reports, aggregate and detail level, run at various time frames including monthly, quarterly, twice per year and annually. The data are compared to determine the effectiveness of the goal. Goals for the SNP program will be established by CarePlus based on recommendations outlined by the Humana At Home Quality Compliance team and Humana Puerto Rico's Quality Management Department and are presented to the CQIC. A quarterly review is conducted on the progress of the goals and presented to Humana Puerto Rico, Humana At Home SNP Operations staff, CarePlus staff and twice per year are reported to the SNP Integrated Oversight Committee. A root cause analysis will be conducted on all goals that are unmet. An improvement action plan is initiated for goals that are below the established benchmark. Program changes that are identified throughout the year will be presented twice per year to the SNP Integrated Oversight Committee and annually to the Corporate Quality Improvement Committee.

Annually all aspects of the CarePlus QI Program are rigorously evaluated through a written process; this evaluation is the basis for any changes to the QI Program in the upcoming year. The CarePlus Quality Improvement Model of Care Evaluation is presented to the CQIC and is reviewed and approved or amended. Subsequently this report is presented to the Internal Board/Management Team. The overall activity and outcomes of the SNP program will be overseen by Humana SNP Integrated Oversight Committee (SIOC), which reports to the Humana Internal Board/Management Team, through Humana's CQIC. Additionally, CarePlus, Humana Puerto Rico, and Humana At Home collaborates with Humana's Quality Management team for HEDIS, NCQA compliance and CMS quality improvement projects. Overall accountability for the SNP MOC is governed by the SIOC and SNP Governance Committee, which works within Humana's Quality committee structure.

Factor 3: Responding to Lessons Learned through MOC Performance Evaluation:

The CarePlus SNP quality and performance information will also be used to modify the MOC as opportunities are identified. Opportunities for improvement will include benefit

changes/affordable care, policy changes, improved access to medical, behavioral and social services, physician and provider network coverage, process improvements, improved coordination and/or transition of care, improved health outcomes, system improvements, improved access to preventive services, and expansion of services or coverage.

If areas of improvement are identified, a root cause analysis will be completed and improvement action plans will be implemented to identify and implement recommendations and improvements. Once improvement actions are implemented, evaluation of the effectiveness of changes will be made as specified within the improvement action plan. In addition to improvement action plans, Humana At Home incorporates quality performance improvement into quality improvement projects for CarePlus. These projects are created to focus interventions for outcomes improvement.

Factor 4: Performance Improvement Evaluation & Key Stakeholders:

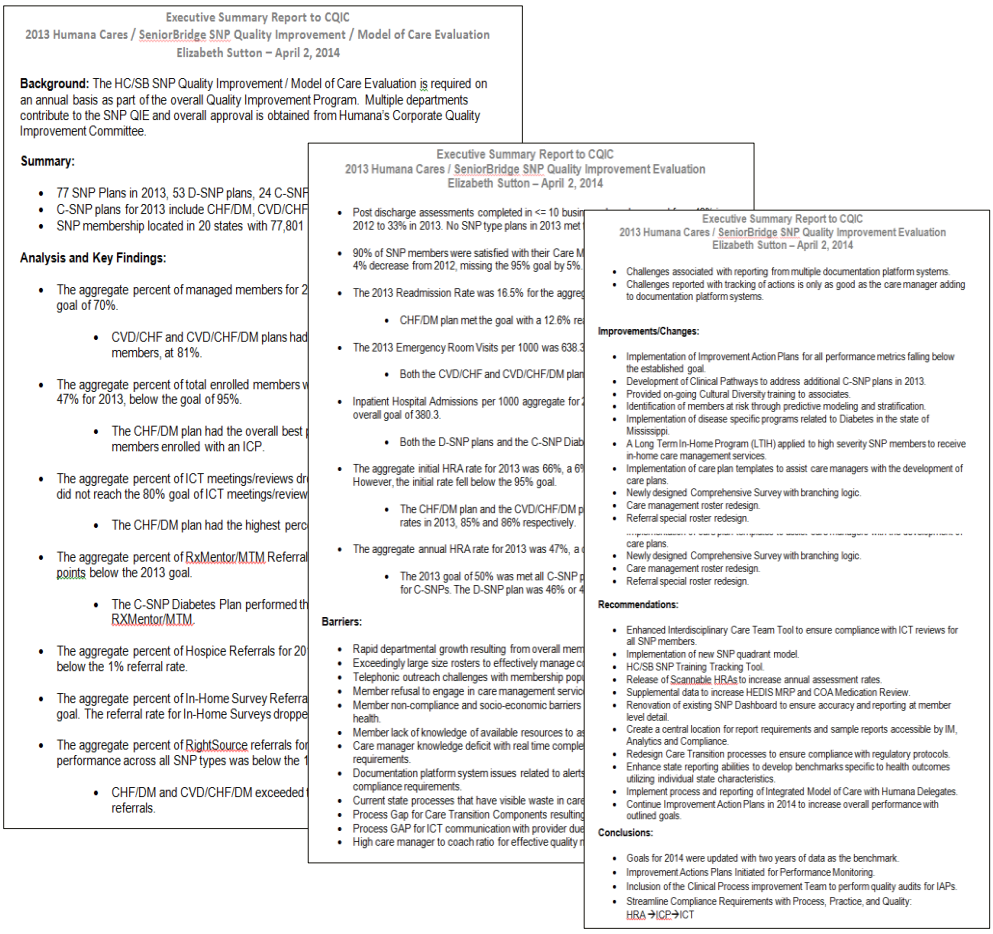
Humana At Home Quality Compliance Team and beginning April 1, 2017 Humana Puerto Rico's Quality Management Department performs oversight of program activities and evaluate the program effectiveness, operational processes, quality improvement activities, and identify opportunities for improvement for CarePlus. The CarePlus SNP Quality Improvement Model of Care Evaluation is presented as an Executive Summary to the Corporate Quality Improvement Committee. Additionally, Humana At Home reports twice per year to CarePlus MOC goal performance to the SNP Integrated Oversight Committee (SIOC). The SIOC promotes objective and systematic monitoring and evaluation of services and facilitate compliance with regulatory requirements including the Model of Care goals and health outcomes. These committees follow-up on planned program and quality strategies throughout each year with members, make policy recommendations and verify compliance with committee recommendations related to all SNP activities including provider and associate training.

Results are communicated in numerous print and electronic formats including statistical reports, e.g., Dashboards, Power Point Presentations, e.g. Quarterly Dashboard Summaries, and formal reports, e.g. SNP Quality Improvement Model of Care Evaluation. Materials are distributed electronically and key findings incorporated into provider materials and corporate communiqué. The Humana Internal Board/Management Team delegates oversight of the quality improvement program to the Corporate Quality Improvement Committee (CQIC). This committee provides operational oversight for the Quality Improvement Program activities and recommends policy decisions.

Each executive summary presented contains background information, analysis, barriers identified, improvement/changes, conclusions and recommendations. Part of the executive summary includes lessons learned. During the committee meeting a discussion occurs between key stakeholders, the committee provides recommendations, and follow-up items are suggested. Documentation of the executive summary presented along with the committee discussion is included within the meeting minutes available electronically via a SharePoint

platform. Follow-up items documented within the committee minutes are scheduled for discussion at a later date. *Reference MOC 2: Element A: Factor 1: Corporate Quality Improvement Committee (CQIC) and SNP Integrated Oversight Committee Staff Roles & Responsibilities for voting members of the CQIC See Page 63).*

Example: Executive Summary Report to Provide Updates to Key Stakeholders Internally:



Executive Summary Report to CQIC
2013 Humana Cares / SeniorBridge SNP Quality Improvement / Model of Care Evaluation
Elizabeth Sutton – April 2, 2014

Background: The HC/SB SNP Quality Improvement / Model of Care Evaluation is required on an annual basis as part of the overall Quality Improvement Program. Multiple departments contribute to the SNP QIE and overall approval is obtained from Humana's Corporate Quality Improvement Committee.

Summary:

- 77 SNP Plans in 2013, 53 D-SNP plans, 24 C-SNP
- C-SNP plans for 2013 include CHF/DM, CVD/CHF
- SNP membership located in 20 states with 77,801

Analysis and Key Findings:

- The aggregate percent of managed members for 2 goal of 70%.
  - CVD/CHF and CVD/CHF/DM plans had members, at 81%.
- The aggregate percent of total enrolled members w 47% for 2013, below the goal of 95%.
  - The CHF/DM plan had the overall best p members enrolled with an ICP.
- The aggregate percent of ICT meetings/reviews dr did not reach the 80% goal of ICT meetings/review
  - The CHF/DM plan had the highest perc
- The aggregate percent of RxMentor/MTM Referral points below the 2013 goal.
  - The C-SNP Diabetes Plan performed th RXMentor/MTM.
- The aggregate percent of Hospice Referrals for 20 below the 1% referral rate.
- The aggregate percent of In-Home Survey Referra goal. The referral rate for In-Home Surveys droppe
- The aggregate percent of RightSource referrals for performance across all SNP types was below the 1
  - CHF/DM and CVD/CHF/DM exceeded t referrals.

Executive Summary Report to CQIC
2013 Humana Cares / SeniorBridge SNP Quality Improvement Evaluation
Elizabeth Sutton – April 2, 2014

- Post discharge assessments completed in <= 10 busin 2012 to 33% in 2013. No SNP type plans in 2013 met
- 90% of SNP members were satisfied with their Care M 4% decrease from 2012, missing the 95% goal by 5%.
- The 2013 Readmission Rate was 16.5% for the aggreg
  - CHF/DM plan met the goal with a 12.6% re
- The 2013 Emergency Room Visits per 1000 was 638.3
  - Both the CVD/CHF and CVD/CHF/DM plan
- Inpatient Hospital Admissions per 1000 aggregate for 2 overall goal of 380.3.
  - Both the D-SNP plans and the C-SNP Diab
- The aggregate initial HRA rate for 2013 was 66%, a 6 However, the initial rate fell below the 95% goal.
  - The CHF/DM plan and the CVD/CHF/DM p rates in 2013, 85% and 86% respectively.
- The aggregate annual HRA rate for 2013 was 47%, a
  - The 2013 goal of 50% was met all C-SNP p for C-SNPs. The D-SNP plan was 46% or 4

Barriers:

- Rapid departmental growth resulting from overall merr
- Exceedingly large size rosters to effectively manage c
- Telephonic outreach challenges with membership popu
- Member refusal to engage in care management servic
- Member non-compliance and socio-economic barriers health.
- Member lack of knowledge of available resources to a
- Care manager knowledge deficit with real time comple requirements.
- Documentation platform system issues related to alerts compliance requirements.
- Current state processes that have visible waste in care
- Process Gap for Care Transition Components resulting
- Process GAP for ICT communication with provider due
- High care manager to coach ratio for effective quality r

Executive Summary Report to CQIC
2013 Humana Cares / SeniorBridge SNP Quality Improvement Evaluation
Elizabeth Sutton – April 2, 2014

- Challenges associated with reporting from multiple documentation platform systems.
- Challenges reported with tracking of actions is only as good as the care manager adding to documentation platform systems.

Improvements/Changes:

- Implementation of Improvement Action Plans for all performance metrics falling below the established goal.
- Development of Clinical Pathways to address additional C-SNP plans in 2013.
- Provided on-going Cultural Diversity training to associates.
- Identification of members at risk through predictive modeling and stratification.
- Implementation of disease specific programs related to Diabetes in the state of Mississippi.
- A Long Term In-Home Program (LTIH) applied to high severity SNP members to receive in-home care management services.
- Implementation of care plan templates to assist care managers with the development of care plans.
- Newly designed Comprehensive Survey with branching logic.
- Care management roster redesign.
- Referral special roster redesign.

- Newly designed Comprehensive Survey with branching logic.
- Care management roster redesign.
- Referral special roster redesign.

Recommendations:

- Enhanced Interdisciplinary Care Team Tool to ensure compliance with ICT reviews for all SNP members.
- Implementation of new SNP quadrant model.
- HC/SB SNP Training Tracking Tool.
- Release of Scannable HRAs to increase annual assessment rates.
- Supplemental data to increase HEDIS MRP and COA Medication Review.
- Renovation of existing SNP Dashboard to ensure accuracy and reporting at member level detail.
- Create a central location for report requirements and sample reports accessible by IM, Analytics and Compliance.
- Redesign Care Transition processes to ensure compliance with regulatory protocols.
- Enhance state reporting abilities to develop benchmarks specific to health outcomes utilizing individual state characteristics.
- Implement process and reporting of Integrated Model of Care with Humana Delegates.
- Continue Improvement Action Plans in 2014 to increase overall performance with outlined goals.

Conclusions:

- Goals for 2014 were updated with two years of data as the benchmark.
- Improvement Actions Plans Initiated for Performance Monitoring.
- Inclusion of the Clinical Process improvement Team to perform quality audits for IAPs.
- Streamline Compliance Requirements with Process, Practice, and Quality: HRA → ICP → ICT

ELEMENT E: DISSEMINATION OF SNP MOC QUALITY PERFORMANCE:

Factor 1: Communication Process with Shared Stakeholders:

The CarePlus SNP Quality Improvement Model of Care Evaluation is presented as an Executive Summary to the Corporate Quality Improvement Committee. Each executive summary presented contains background information, analysis, barriers identified, improvement/changes, conclusions and recommendations. Part of the executive summary

includes lessons learned. During the committee meeting a discussion occurs between key stakeholders, the committee provides recommendations, and follow-up items are suggested.

Committee meetings are held in-person, telephonically, and via web based interactive platforms including the use of Lync and Webinars. Documentation of the executive summary presented along with the committee discussion is included within the meeting minutes available electronically via a SharePoint platform. Follow-up items documented within the committee minutes are scheduled for discussion at a later date. Past meeting materials are available for reference for staff and shared stakeholders.

Factor 2: Frequency of Communications with Stakeholders:

Humana's Corporate Quality Improvement Committee meets monthly and various indicators (MOC, HEDIS, Quality Improvement documents and projects) are monitored throughout the year. The SIOC Team meets quarterly; responsible Humana At Home and Humana Puerto Rico members report to the oversight group using an established dashboard for CarePlus. Barrier analysis and action plans may be requested by either committee. Ad hoc meetings are scheduled when necessary. Committee members are notified electronically of the ad hoc meeting. SNP Governance Committee meets monthly to oversee the standardization of Humana's SNP Program.

Committees are required to record meeting minutes, which promotes consistency in the documentation and follow-up of committee activities. Items discussed in committee meetings reflect documentation of conclusions, recommendations, action, and follow-up. Minutes are signed and dated by the chairperson or acting chairperson. Electronic signatures are acceptable and must be dated. Committee minutes are available at the next meeting for review and approval. All meeting materials are stored electronically via a SharePoint platform, minutes are also posted to the site for review. Materials are available by meeting date and materials are available in the future for reference.

Other types of inter-departmental communication include memos, newsletters, e-mail, databases, online web information exchange (Hi!), SharePoint, and written reports. The QI Work Plan serves as a communication tool by tracking quality improvement activities and is reviewed on as needed basis and presented to the CQIC annually. CarePlus recognizes the need for effective external communication as a key to quality care and service excellence. CarePlus communicates a variety of information to practitioners, providers, delegates, and members.

Factor 3: Methods for Ad Hoc Communication with Stakeholders:

Ad hoc communication between stakeholders is performed similarly to that of regularly scheduled meetings. Communication occurs electronically via online/virtual meetings. Minutes are also required for ad hoc communication which promotes consistency in the documentation and follow-up of committee activities. Items discussed in committee meetings reflect

documentation of conclusions, recommendations, action, and follow-up. Minutes are signed and dated by the chairperson or acting chairperson. Electronic signatures are acceptable and must be dated. Committee minutes are available at the next meeting for review and approval. All meeting materials for ad hoc communications are also stored electronically via a SharePoint platform; minutes are also posted to the site for review. Materials are available by meeting date and materials are available in the future for reference.

The CQIC Committee Chairperson, Corporate Chief of Quality and the SIOC Committee Chairperson, Senior Product Development are responsible for providing communication to the appropriate stakeholders. Other types of inter-departmental communication include memos, newsletters, e-mail, databases, online web information exchange (Hi!), SharePoint, and written reports. The QI Work Plan serves as a communication tool by tracking quality improvement activities and is reviewed on as needed basis and presented to the CQIC annually. CarePlus recognizes the need for effective external communication as a key to quality care and service excellence. CarePlus communicates a variety of information to practitioners, providers, delegates, and members.

Factor 4: Individuals Responsible for Communicating Performance:

Humana At Home Quality Compliance Team and beginning April 1, 2017 Humana Puerto Rico's Quality Management Department, in collaboration will facilitate the collection, reporting, and documentation of data to conduct ongoing MOC evaluation for CarePlus.

Humana Puerto Rico:

Humana Puerto Rico project managers and Health Care Economics (HCE) reporting analysts will collaborate with Humana Puerto Rico data source owners to collect report and analyze identified performance outcomes metrics.

The **Humana Puerto Rico Health Services Director** is primarily responsible for overseeing, developing, monitoring, and maintaining quality assurance and clinical processes integral to the Humana model of care delivery. The Director works to meet best practice standards of care, upholding CMS, HEDIS, NCQA, and URAC requirements, and the success of our associates and Humana's business strategy. The Director effectively manages associates and leads the department's productivity, continuously assessing existing clinical and quality processes in order to seek continuous process improvements and meet compliance requirements. The

Humana Puerto Rico Care Management Manager is responsible for end-to-end program and quality oversight and monitoring of the program metrics, clinical process development, and implementation of the model of care. The **Humana Puerto Rico Quality Front Line Leader is** responsible for direct oversight of staff that develops, monitor and maintain quality assurance

and clinical processes integral to Humana Puerto Rico. The Quality Management Department serves to assure model of care delivery meets or exceeds regulatory requirements.

The primary source of data for Humana Puerto Rico SNP applications is the CCMS Clinical system. This system imports, processes, and exports all member data related to HRA's ICP's and ICT's. This information is processed and sent to various applications and used for workflow, data mining, trending, and reporting purposes. Humana Puerto Rico and SNP leadership staff access data via this warehouse for performance and outcomes monitoring purposes.

The Humana Puerto Rico HCE Department prepares monthly, quarterly MOC performance dashboard metrics related to each MOC goal for Humana Puerto Rico Operational Leadership and other key stakeholders. All Humana Puerto Rico personnel and staff have access to quarterly dashboard metrics through SNP SharePoint and are able to be referenced at any time throughout the calendar year. On an annually basis, the SNP Quality Management Department prepares performance results and presents current rates to Humana Puerto Rico QIC for review and modification of the following years MOC goals. Bi-annually, Humana Puerto Rico reports quality performance results to the SNP Integrated Oversight Committee. The results reported to the SIOC are integrated into Humana's Quality Improvement Progress Report that is made available to provider networks and SNP beneficiaries via public provider portal and public member portal. The general public may also access the results via these two sources as well.

Additionally, on an annual basis the Humana Puerto Rico Quality Management Department develops and presents the Quality Improvement Evaluation and the Quality Improvement Program Description along with ad hoc reporting of executive summaries to Humana Puerto Rico Operational Leadership and the Corporate Quality Improvement Committee. The CQIC reports findings of MOC performance to the Humana Board of Directors. If at any point during the calendar year, a regulatory agency requests Humana Puerto Rico quality performance results, results are able to be produced for review.

Ad hoc reporting executive summaries include other regulatory compliance requirements. Each executive summary presented contains background information, analysis, barriers identified, improvement/changes, conclusions and recommendations. Part of the executive summary includes lessons learned. During the committee meeting a discussion occurs between key stakeholders, the committee provides recommendations, and follow-up items are suggested.

Committee meetings are held in-person, telephonically, and via web based interactive platforms including the use of Lync and Webinars. Documentation of the executive summary presented along with the committee discussion is included within the meeting minutes available electronically via a SharePoint platform. Follow-up items documented within the

committee minutes are scheduled for discussion at a later date. Past meeting materials are available for reference for staff and shared stakeholders.

Humana At Home:

Humana At Home project managers and reporting analysts will collaborate with Humana At Home and CarePlus data source owners to collect, report and analyze identified performance outcomes metrics.

The **Humana At Home Director, Quality Clinical Programs** and leads and is primarily responsible for overseeing, developing, monitoring, and maintaining quality assurance and clinical processes integral to the model of care delivery. The Director works to meet best practice standards of care, upholding CMS, HEDIS, NCQA requirements, and the success of our associates and business strategy. The Director effectively manages associates and leads the department's productivity, continuously assessing existing clinical and quality processes in order to seek continuous process improvements and meet compliance requirements. The **Humana At Home Quality Compliance Program Manager** is responsible for end-to-end program and quality oversight and monitoring of the program metrics, clinical process development, and implementation of the model of care. The **Humana At Home Quality Compliance Process Manager** is responsible for direct oversight of staff who develop, monitor and maintain quality assurance and clinical processes integral to Humana At Home. The Quality Compliance Team serves to assure model of care delivery meets or exceeds regulatory requirements. The **Humana At Home SNP Quality Compliance Consultant** is responsible for developing, monitoring and maintaining quality assurance and clinical processes integral to Humana At Home.

The primary source of data for CarePlus SNP applications is the internally developed data warehouse. This warehouse imports, processes, and exports all member data. Labs, medical/pharmacy claims, and member eligibility are generally imported monthly, labs values are imported monthly, and application data such as mDAT information are imported daily. This information is processed and sent to various applications and used for workflow, data mining, trending, and reporting purposes. Humana At Home and SNP leadership staff access data via this warehouse for performance and outcomes monitoring purposes.

Humana At Home Quality Compliance Team prepares monthly MOC performance dashboard metrics related to each MOC goal for CarePlus, Humana At Home SNP Operational Leadership and other key stakeholders. All CarePlus and Humana At Home personnel and staff have access to monthly dashboard metrics through SharePoint and are able to be referenced at any time throughout the calendar year. The SNP dashboard is inclusive of two years of MOC goal performance. On an annually basis, the Humana At Home Quality Compliance Team prepares performance results and presents current rates to CarePlus leadership and Humana At Home SNP Operation Leadership for review and modification of the following years MOC goals. , Humana At Home reports quality performance results to the SNP Integrated Oversight Committee for CarePlus. The results reported to the SIOC are integrated into Humana's Quality

Improvement Progress Report that is made available to provider networks and SNP beneficiaries via the public provider portal and public member portal. The general public may also access the results via these two sources as well.

Additionally, on an annual basis the Humana At Home Quality Compliance Team develops and presents the CarePlus SNP Quality Improvement Evaluation and the SNP Quality Improvement Program Description along with ad hoc reporting of executive summaries to CarePlus leadership, Humana At Home Operational Leadership and the Corporate Quality Improvement Committee. The CQIC reports findings of MOC performance to the Humana Internal Board/Management Team. If at any point during the calendar year, a regulatory agency requests Humana At Home quality performance results, results are able to be produced for review.

Ad hoc reporting executive summaries include other regulatory compliance requirements. Each executive summary presented contains background information, analysis, barriers identified, improvement/changes, conclusions and recommendations. Part of the executive summary includes lessons learned. During the committee meeting a discussion occurs between key stakeholders, the committee provides recommendations, and follow-up items are suggested.

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