

As one of the nation's leading health benefits solutions companies, Humana has developed effective and comprehensive care management models and provider engagement models that have consistently resulted in lowering claims trend and improvements in member health status. Humana's response details the integrated clinical strategies it applies to Medicare and commercial members. While these processes are applicable to California's Dual Eligible Medicaid beneficiaries, some of the processes would require slight modifications and enhancements to address the unique needs of certain segments of the Dual Eligible population.

Humana proposes to apply the integrated care management models described in the following pages to assist California in integrating services for and managing the Dual Eligible populations. The model would include, but not be limited to:

- Comprehensive and Integrated Care Management Capabilities including:
- Long-term care management
- Complex case management (Humana Cares)
- Chronic condition management
- Managed behavioral health
- Health risk assessment
- Remote patient monitoring system
- Member messaging addressing gaps in care*
- HumanaFirst[®] – 24 hour nurse triage hotline*
- Management of Non-emergent ER Visits
- Humana Provider Rewards Programs
- Pharmacy Integration with Medical Offerings
- Fraud and abuse services

**Services available in multiple languages*

Humana has operated Dual Eligible Special Need Plans (DE SNPs) since 2006. In 2011, Humana had DE SNPs in four states and Puerto Rico and is expanding into additional states in 2012. Taking into account the unique needs of duals, Humana has worked diligently to build plans that provide benefits and supports tailored to these needs. Humana currently has contracts with two state Medicaid agencies and Puerto Rico and is in the process of contracting with additional states to coordinate the provision of services to duals.

Comprehensive and Integrated Care Management Capabilities

Humana's clinical guidance solutions are based on processes, programs, and tools to achieve efficiencies that result in better health outcomes, improved member satisfaction, and lower costs. Humana works with members to choose the right level of care. For example, Humana has successfully redirected many procedures to outpatient care and worked with members to avoid complications and readmissions.

Improving the physical and social well-being of members is achieved through highly integrated acute and chronic condition management, including home visits, discharge planning and care

coordination, and an integrated approach to medical and behavioral care. Humana's experience has proven that education and guidance convert passive healthcare users into active healthcare consumers who work better with their doctor, make smart choices, improve their health, and save healthcare dollars. The addition of Humana's Provider Rewards programs enhances the engagement between a provider and member, to further the effectiveness of the care programs. Our approach to care management is described in more detail below.

Utilization Management

Humana performs the following utilization management services for its members:

Preauthorization and Prospective Management

Humana has identified a selected set of inpatient, ambulatory, and procedural services requiring preauthorization based on medically-accepted guidelines. The complete preauthorization review list is published on **Humana.com** for provider and member access under "Tools and Resources." The member's provider is responsible for initiating a prospective request for services. Humana's interactive voice response system and website provide fast and efficient ways for physicians and facilities to initiate requests and are available 24 hours a day, seven days a week. Call center representatives are also available to answer questions and provide guidance to providers regarding interactive voice response system usage.

Concurrent Review

Concurrent review is an assessment of ongoing medical services and/or treatments to determine that the member's course of care is proceeding according to the attending physician's orders, and is within industry-accepted standards for inpatient length of stay. Concurrent review is also conducted to initiate discharge planning and case management for the member. The nurse works collaboratively with the facility staff and supports the attending physician's directions for discharge with the member and facility discharge planner. The nurse maintains contact with the facility, attending physician, and member throughout the stay.

Case Management

Humana's case management program offers support to members during or immediately following an acute health event. Nurses assess members for risks as well as opportunities to coordinate care and provide support and guidance to optimize health outcomes. These regionally-located nurses help members maintain their dignity and independence while preserving access to care. They serve as the primary facilitator to an inter-disciplinary team responsible for the care plan, the discharge plan, and ongoing care after discharge.

Humana applies a two-prong case management approach, each tailored to the member's needs, in collaboration with the member's clinical team. The traditional case management program offers support to members during or immediately following an acute health event. These nurses, called senior case managers, assess members for risks, identify opportunities to coordinate care, and provide support and guidance to optimize health outcomes.

Discharge Planning

Timely and appropriate discharge planning is an essential component of both the concurrent and case management processes. The case manager collaborates with the attending physician, the primary care physician, the member and/or the member's family, and the facility's discharge planning staff to facilitate a smooth transition to the appropriate next level of care. While most of Humana's nurses work with facility discharge planning staff and providers telephonically, Humana's case managers and utilization staff have access to medical records for all members. This access to medical records ensures a safe and efficient transition of care planning process for the member and member's family.

Following discharge from an inpatient facility (i.e., hospital, long-term acute care facility, skilled nursing facility, rehabilitation center), a member of the regional case management/utilization management team places a call to the member to ensure the following items are in place:

- Member received discharge instructions and fully understands their condition(s) and post-discharge care.
- Member is in a safe environment and a caregiver/support system is able to adequately provide post-discharge support.
- Member was able to obtain all post-discharge medications and understands how to take them, can identify side effects and complications, and knows when to report concerns. Additionally, if the member cannot afford medications, the case management team works with the member on obtaining medications from community resources, pharmaceutical companies, or contacts the physician's office for assistance.
- Home health services, durable medical equipment, etc. are in place, if needed.
- Follow-up doctor's visits and outpatient care are arranged according to post-discharge instructions.
- No complications or new problems have occurred without being reported to the physician.
- Member understands when to report any complications to their physician and when to seek medical care.
- If behavioral health needs, such as depression or anxiety, are identified after the inpatient stay the member is referred to appropriate support.

The goals of the discharge planning program are to avoid readmissions and unnecessary emergency room visits, ensure member is in a safe environment and receiving the care they need, coordinate any medical services that are still needed or unaddressed, and educate members on the types of things they need to know and do to avoid complications. Additionally, readmission rate is one metric in Humana's Provider Rewards program and is designed to encourage patients to be seen by their PCP upon discharge from an inpatient facility.

If concerns are identified, a home visit consultation may be scheduled with one of Humana's locally-based field case managers. If a member is found to have any ongoing health needs, they are scheduled for appropriate follow up with a case manager, and contacted accordingly. Any concerns requiring follow-up care will be reported to the member's physician.

Long-term Care Management

In August 2008, Humana acquired Green Ribbon Health to initiate a new complex care management program for chronically ill Medicare Advantage members. The model is integrated into Humana's overall healthcare strategy and is now known as Humana Cares. The program combines both acute care and chronic care management delivered both telephonically and on-site for more than 100,000 members of Humana's insurance plans. This program is for members who have high need and are at high risk for facility admission or readmission.

This complex care model offers chronically ill members and their caregivers health support, education, and special services to help them take better care of their individual health needs. Humana Cares is a multi-disciplinary, member-centric holistic model. Eligible members are assigned a primary Humana Cares manager who works with the member telephonically. The manager may also engage the support of the field care manager, an experienced registered nurse or social worker, who can conduct in-person, onsite assessments in a member's home, nursing home, hospital, etc. A community health educator supports the team by assisting members in connecting with community resources, such as transportation, respite care, food, home modifications, durable medical equipment, and home health coordination or alternative living arrangements.

Education is an important component of Humana's transition initiatives. Humana Cares offers educational materials and personal assistance to both the participant and the caregiver. Humana strives to ensure the participant and the caregivers understand the various options available to them through their medical benefits and through the various community resources in their area.

In addition, Humana Cares utilizes a comprehensive, internally developed community resource directory created to identify and refer people to appropriate alternative services. The directory contains financial assistance programs, service providers, support groups, agencies, associations, and professional organizations, along with the services they provide and contact and referral information. The directory of resources is divided into various categories and subcategories including geographic locations, disease states served by the resources, categories of unmet needs that the resources provide, type of resources provided, and various other search categories.

The key to Humana's approach is that all activity starts with the member's individual needs. There will be four distinct components of the program to aid the members, including the level of care assessment, the development of a community living transition plan, transition coordination, and post-transition continuous monitoring and care management.

1. The Level of Care Assessment

Registered Nurse (RN) and Social Worker Supported

The philosophy of independent living and the direct experience of many community service providers throughout the nation is that the level of community support available to the individual, not the type or severity of disability, is the key factor in successful community integration. However, people are often in nursing facilities due to health-related conditions. Generally, people living in nursing homes have increased health needs. If the person moving

to a nursing facility has significant medical considerations, these issues need to be extensively planned for and addressed by medical professionals. The fear of not receiving proper medical care can be a major reason why nursing home staff and even families think that a person cannot live in the community. In addition, it is often difficult to find primary care physicians in the community who are easily accessible to the individual.

A case manager, who is also an RN, functions as the leader of a team of field care workers and social workers. A comprehensive assessment is performed to identify individuals' physical, mental and emotional capabilities, strengths, abilities, and wishes in order to ensure that the return to the community is consistent with what they want. The assessment process also provides an opportunity to identify additional issues which need to be addressed such as alcohol or substance abuse, mental illness, or criminal record so that appropriate interventions can be planned. These interventions are considered with equal importance as other health interventions.

Information gathered during the assessment process is one of the key components in developing the written plan for the person's transition to the community. Assessments for each service specifically describe the type of service necessary and the required frequency and/or intensity, as well as the purpose of the service. To facilitate this, Humana uses validated and tested technology for identification of functional level that provide the case manager with specific care needs and type of care needs. This tool measures how much care an individual may require and identifies other services that may be necessary for a safe living situation in the community. The overall functional ability is broken down by three domains, basic mobility, daily activity, and applied cognition.

These domains are used to objectively evaluate and assess the individual's needs in terms of the burden of care (hours of caregiver care per day required) or other identification of risk factors and stratification of member population. This allows Humana's team to structure a specific service and coordinate the service in the most integrated setting.

2. Community Living Transition Plan

All participants have a person-centered, outcome-based service plan of care developed by the Humana Cares team to address all assessed needs and health and safety risk factors of members, as well as personal goals. The RN and social worker help to identify and coordinate specialized support in the medical, social, housing, and educational areas.

The transition plan outlines in detail how the transition will be implemented. This includes how support and services will be put into place, the timeline for doing so, and who will take responsibility for each activity.

Components of the plan are listed below:

- Housing
- Personal assistance
- Assistive technology

- Healthcare
- Mental health/addiction support
- Transportation
- Volunteering/employment
- Roles of family and friends
- Social, faith, and recreation
- Community integration
- Advocacy
- Finances

The community living transition plans are updated and revised as members' needs change. Members are informed of their right to change their plan at any time, and they acknowledge this by signing a plan checklist. The case manager monitors the service plan on a monthly basis to assure that services are delivered in the type, scope, amount, duration, and frequency in accordance with the plan. All service plans are reviewed and approved according to the procedures determined by the operating agency.

An important component of the care assessment is a home safety review. As part of the service, Humana recommends changes that will assist members on how to be safe in their home and be able to participate in activities of daily living. Humana refers members to community organizations or to partners that can assist with the modifications.

3. Transition Coordination

Transition coordination services are provided to persons residing in institutional settings prior to their transition. These services prepare them for discharge and assist during the adjustment period immediately following discharge from an institution. Pre-transition services help people gain access to needed waiver and other state plan services, as well as medical, social, housing, educational, and other services and supports, regardless of the funding source for the services or support to which access is gained. The case manager identifies and coordinates specialized support in the medical, social, housing, and educational areas. A key component of the transition coordination activities includes establishing relationships and working closely with facility social workers, circle of support, and state agencies. Ongoing coordination of the plan is handled differently, depending upon the qualified service package most appropriate for the individual transitioning.

Humana's program is designed to link healthcare and social care allowing members to remain as healthy and independent as possible. The integrated care management team handles everything from making sure participants have the right medications to transportation to medical appointments and shopping to having safety measures, such as grab bars and ramps, installed in their homes. These activities allow Humana to safely and effectively transition members out of a nursing home and to a more independent environment.

4. Post Transition: Living in the Community

Humana Cares institutes a seamless process to assure the member is smoothly transitioned from a facility to their desired destination. Some key elements of this effort involve caregiver education and training, medication reviews to assess understanding, access and compliance, assurance the right supportive services and DME are activated and in place, participants' understanding of the provider's plan of care, and follow-up appointments are made and kept. Humana places a call to the participant to ensure all supports are activated and in place. Periodic follow-up is scheduled that can be supplemented by an on-site care manager, or nurse practitioners visit as needed to support the individual throughout the 90-day period.

Additional goals post transition are to avoid facility or hospital readmissions and unnecessary emergency room visits, ensure recipients are in a safe environment and receiving the care they need, coordinate any medical services that are still needed or unaddressed, and educate participants and their caregivers on the types of things they need to know and do to avoid complications. Also, data is collected to determine which, if any, of the individuals will need ongoing or extended case management services after the 90 days.

The case management team provided:

- Post-transition follow up
- Community integration
- Monitoring and advocacy
- Follow-up schedule and checklists
- Support following the actual move to the community
- Follow up during the community transition process
- Community integration supports and opportunities
- Encouragement to the individual to become a self-advocate

Process

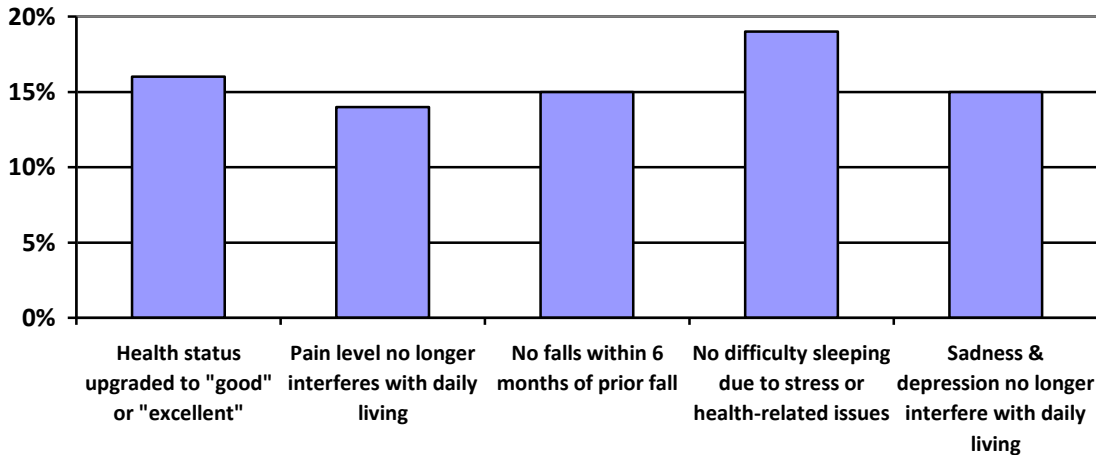
The program is designed to link healthcare and social care allowing members to remain as healthy and independent as possible. Humana Cares improves the quality of healthcare for the population of beneficiaries by:

- Assigning each member a dedicated Humana Cares manager who becomes the member's primary contact
- Building long-term relationships while connecting members to a multi-disciplinary team of care managers and social workers who conduct regular home visits
- Using evidence-based medicine to drive member adherence to proven standards of care

Empowering members to become more engaged in their health is a goal of Humana Cares. Through the team outreach approach, we motivate members to take an active role in monitoring their conditions and to make changes that can improve their overall health. We focus on the total health of the individual – not just a condition and a symptom. The success of this approach is shown in the results of an independent survey of Humana Cares members. 77% of the members surveyed reported agreement with the statement “as a result of the

program experience, I feel more prepared to manage my own health.” Other survey results are shown in the table below.

Life-Enhancing Progress Achieved Through Humana Cares Participation



Source: Self-reported study of over 2,000 Humana members managed through Humana Cares for more than one year.

Specifically, complex care management is designed to:

- Improve quality of life through holistic management,
- Improve access to care across providers and the community,
- Improve member self-care management skills,
- Prevent unnecessary hospital stays and emergency room visits, and
- Optimize Humana members' healthcare benefits.

The integrated care management team handles everything from ensuring members have the right medications to transportation to medical appointments and shopping to having the appropriate safety measures in their homes. Humana's transition process is outlined below.

- Prior to program implementation, the transitions team forms a stakeholders group comprised of key interagency representatives to facilitate clear communications and relationship building.
- A member of the Humana Cares transition team contacts transition candidates no less than three days after receipt of contact information.
- A meeting with the facility social worker and other stakeholders is scheduled.
- The initial session with candidates includes ensuring that individuals understand the transition process, their rights and responsibilities, and give informed consent.
- A checklist for transition is discussed, and there is also a discussion on the importance of their role in a successful transition.
- A comprehensive assessment tool is being utilized and documented via an electronic health record.

- The community living transition plan is developed with candidates and significant stakeholders.
- A timeline, and event schedule, and transition checklist is executed.
- Follow-up and monitoring processes both in person and telephonic is implemented.
- Regular meetings of all transition team members and the project coordinator are held and provide a vehicle for training, support, and sharing of individual expertise.

Humana Cares has been working closely with area agencies on aging since 2009. Humana has a long history of assisting individuals through the transition process and has multiple services and programs that the Humana Cares case managers will utilize in assisting individuals to develop solid transition plans, community connections, and needed supports. In addition, Humana's case managers use an electronic health record in the field which also facilitates efficiency and communications among all entities.

Managed Behavioral Health (MBH)

Humana provides behavioral health services through LifeSynch, its wholly owned subsidiary, which has offered managed behavioral health services since 1989. Humana provides an integrated treatment methodology designed to provide quality, cost-effective care.

The Humana managed behavioral health program coordinates utilization of healthcare resources by assessing member needs and then selecting services at an appropriate level of care. Managed behavioral health uses evidence-based approaches to provide continuous utilization reviews designed to evaluate changes in medical necessity, the effectiveness of treatment provided, and provider compliance in treatment approaches to assure best clinical practices. These management processes ensure that the treatment provided will result in maximum clinical benefits for members while ensuring cost-effectiveness.

Humana developed the managed behavioral health program to:

- Assure care is delivered at an appropriate level of service, in a safe treatment setting, using sound and effective treatment approaches
- Assist with the access to and coordination between levels of care, including arranging alternative levels of care, to deliver high-quality treatment services Continuously monitor, evaluate, and optimize utilization of healthcare resources in close collaboration with treatment providers
- Follow members throughout the healthcare delivery system to assure continuity of services, sound discharge planning, and support compliance with treatment
- Monitor utilization patterns of contracted providers and facilities to communicate potential quality of care issues to the Quality Improvement department for investigation and resolution
- Educate members, providers, and facilities about cost-effective delivery of healthcare services

Scope of Services

Humana's managed behavioral health services include:

- Services from a full, three-year National Committee for Quality Assurance (NCQA) accredited program
- Full Utilization Review Accreditation Commission (URAC) accreditation to provide case management and health utilization management
- A 24-hour, seven-day-per-week customer call center with a live answer response
- Telephonic counseling and crisis resolution services
- Access to Humana's own credentialed, nationwide network of more than 51,000 mental health and substance abuse treatment providers
- Accurate eligibility verification and benefit explanation for members in easy-to-understand language, avoiding industry jargon
- Behavioral health utilization management from clinicians who coordinate treatment and services for all levels of care
- Authorization and certification for all levels of care including inpatient, residential, partial-hospitalization, intensive outpatient, and general outpatient treatment
- Prospective and concurrent utilization review
- Discharge planning designed to reduce recidivism
- Treatment planning based on a recovery model of treatment with relapse prevention actively addressed
- Programming that helps members stay compliant with outpatient care including case management, telephonic support, and care planning
- Repricing of claims for Humana for mental health and substance abuse services paid at Humana's negotiated preferred provider rates
- Ongoing quality management

Easy Access to Care

Members or providers access behavioral health services by calling a toll-free phone number answered 24 hours per day, seven days per week.

A Customer Care specialist will initially answer the phone to greet members, confirm eligibility, give an overview of benefits, and clarify any coverage questions. If members are requesting routine outpatient services, the Customer Care specialist will register the member, automatically authorizing 20 outpatient counseling sessions and 15 medication management sessions. Humana makes it easy for members to access basic behavioral health services. If members need assistance in identifying a provider or have additional questions, they can also speak to a clinical advisor for assistance.

The largest behavioral healthcare expense comes from a small percentage of members who use the majority of insurance services. It is this "high-use" population that benefits from having a seasoned behavioral health management company to control expenses while assuring efficient and effective care.

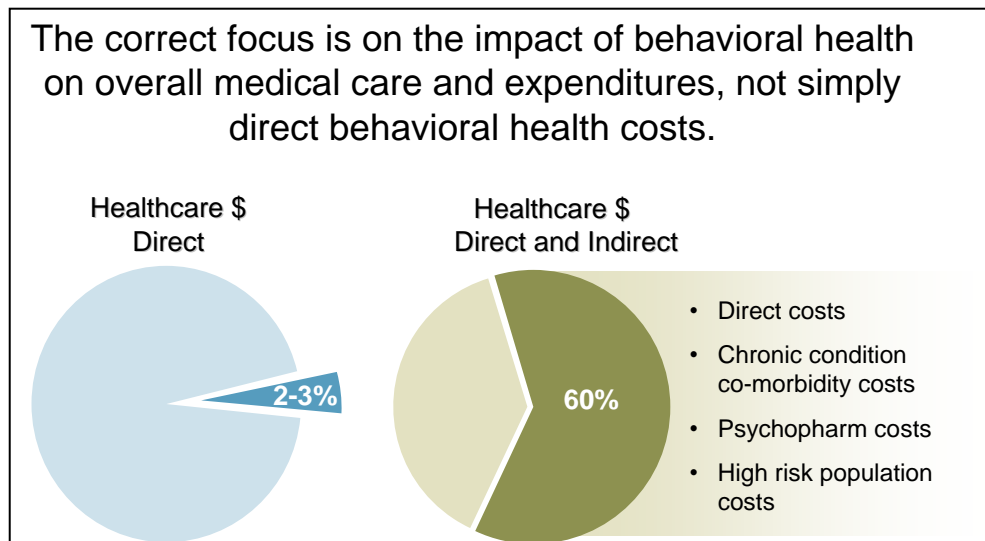
If members request a higher level of service beyond general outpatient care, including inpatient, residential treatment, partial-hospitalization, and intensive outpatient services, the Customer Care specialist transfers the call to a Humana clinical advisor for assistance. To access these higher levels of care, the clinical advisor will conduct a detailed telephonic assessment to determine need and then authorize services based on assessment results. The Customer Care specialist will also direct members or network providers to a clinical advisor when they call to request additional outpatient services beyond the initial authorization.

Humana AchieveSM

Humana proactively engages members with high-risk and co-occurring (medical and behavioral) conditions that typically utilize the bulk of healthcare dollars.

People with medical and behavioral health issues need care and treatment for both issues. This is especially the case when an acute medical problem or chronic condition exacerbates or creates a behavioral issue. The medical issues may worsen while the member becomes more depressed and anxious, creating a cycle of deterioration.

Studies show that members with concurrent behavioral and health issues have more difficulty adhering to treatment plans, poorer clinical outcomes, and increase general medical costs.



For this reason, Humana offers an integrated medical-behavioral healthcare program, named Humana Achieve. Humana Achieve proactively identifies and reaches out to help members who have co-occurring medical and behavioral issues get the treatment they need.

The Humana Achieve program:

- Produces measurable results in several areas:
 - Positively impacts unaddressed behavioral health issues that inflate more than 60 percent of all healthcare costs
 - Reduces unnecessary behavioral health expenditures

- Decreases medical costs in complex conditions
- Enhances treatment compliance
- Improves drug therapy adherence
- Increases member satisfaction
- Avoids duplication of services and medications, etc.
- Focuses on the participant to enhance integration and improves continuity of care
- Provides the administrative benefit of working with a single medical and behavioral vendor

Humana Achieve Results

Although there are no results for a Medicaid population, Humana Achieve has produced impressive results for its commercial and Medicare clients.

Commercial Clients

The results of a recent study conducted in 2009 showed an average annual savings of \$5,550 on healthcare expenses for Humana Achieve program members compared to a matched control group of members who did not participate.

Source: LifeSynch IMBH Commercial ROI study, April 2009

Medicare Clients

According to the same study, members who completed the Humana Achieve program realized an average annual savings of \$1,980 on healthcare expenses compared to a matched control group of members who did not participate. Medicare members who graduate from the Humana Achieve program show a clear reduction in the utilization of more expensive inpatient and emergency room services.

After graduating from Humana Achieve:

- Number of behavioral health-related inpatient facility visits per 1,000 dropped by more than 62 percent
- Number of behavioral health-related emergency room visits per 1,000 dropped by more than 63 percent
- Number of partial-hospitalization/intensive outpatient visits per 1,000 dropped by more than 27 percent

Source: LifeSynch Humana Achieve Medicare ROI Study, April 2009

Product Overview

Humana Achieve goes beyond traditional case management by taking aim at inefficiencies arising when co-existing medical conditions and behavioral issues are identified and treated separately. This integrated strategy seamlessly blends behavioral health and medical specialists to identify and coordinate the management of behavioral problems associated with chronic health conditions and acute medical programs. This holistic approach helps members expedite recovery and significantly lower costs.

Uniquely trained and dedicated behavioral healthcare advocates reach out to members with high-risk, co-occurring conditions to actively engage them in the development of their own integrated care plans. Functioning more as a coach, Humana advocates, specialists, and nurses are able to support, guide, and motivate members to take actions toward a healthier outcome for themselves and their families. Working collaboratively, both virtually and telephonically, with their medical counterparts and other disease management vendors, advocates ensure all aspects of the members' situation are fully addressed.

Health Risk Assessment

While claims-based analysis allows for effective identification of high-risk members, Humana strives to identify at-risk individuals before a condition develops or worsens. Claims-based approaches are limited because they require members to use the healthcare system to develop a history of healthcare usage. Humana believes that identifying members with high utilization earlier in the progression of their diseases or conditions provides a greater opportunity to impact their health and healthcare spending. Upon recognizing the benefit of earlier intervention through clinical programs and services, Humana developed and introduced the Humana Health Assessment in November 2005.

The Humana Health Assessment allows Humana to circumvent the claims lag by providing assistance and education to members who need it earlier in their condition or disease. This proactive approach facilitates better health, better savings, and a better health benefits experience for members.

Through answers to a confidential lifestyle questionnaire, Humana can identify health risks and steps to improvement for at-risk members. The Humana Health Assessment, which is fully integrated with all of Humana's health and wellness resources, serves as the initial health risk assessment that is used to identify lifestyle risks and health conditions among members. Because it is based on each member's individual responses, the Humana Health Assessment can provide members with immediate actionable steps for improving their health as well as an opportunity to join one of Humana's clinical guidance programs.

Specific outcomes of the Humana Health Assessment include:

- **Provides personalized results:** Members receive feedback with actionable steps toward improving their health
- **Offers quick identification into nursing and wellness programs and services:** Rather than wait for claims to be processed, members are routed to nursing and wellness programs more quickly, impacting their health earlier in the progression of their conditions or diseases
- **Engages members:** Feedback increases the members' awareness of their health situations and behaviors
- **Engages Providers:** Physicians are rewarded for their patients' completion of HRA.

Remote Patient Monitoring System

Humana Cares has the capability to design a remote patient monitoring system tailored to the needs of the California dual members included in this initiative. Currently, Humana Cares is partnered with Intel, Inc. to pilot a biometric monitoring program. Through Intel's sophisticated technology, Humana is able to remotely monitor members with congestive heart failure. The monitoring system, called Intel Health Guide, operates by first collecting vital health data in the member's home, then data is transmitted to the Intel Care Health Care Management Data Suite. Through a web-enabled dashboard, care managers monitor hundreds of members remotely and look for potential health problems. If the member's vital signs are within acceptable ranges, then the care manager takes no action. However, if the member's vital signs are not within acceptable ranges or scheduled health measurements have been missed, the care manager contacts the member by video conference or telephone to discuss the readings and his or her condition.

There are many advantages of offering a biometric monitoring system to members. By using the technology, members who are in remote areas with limited access to healthcare providers or transportation can be monitored by a clinician. It can also potentially reduce visits to the emergency room since the care manager monitors the member's vital signs and provides health consultation sessions with the member when needed. The monitors can give these members and their caregivers "peace of mind" as their nurse is only a phone call away. As added features, the technology has educational videos that members can view to educate themselves about self-managing their condition, and it allows the nurses to send customized assessment questions specific to that member's health issues.

Humana is in a unique position because it has an immense amount of data and information about its membership. From medical and pharmacy claims, to self-reported information, to biometrics and lab values, Humana understands its members' health and recognizes that putting this data to use is key to helping drive better health throughout the population. This is why Humana has invested more in the past few years on developing the Humana CareHub[®], its clinical IT infrastructure, than any other IT investment in the company's history. All Humana clinical associates utilize the same comprehensive system, enhancing clinical continuity, and coordination, including pre-certifications and authorizations, chronic or acute nursing programs, and behavioral health specialists.

Member Messaging Addressing Gaps in Care

The Rules Guidance eXchange component of CareHub powers tailored and targeted outreach through both direct messaging and nurse outreach. Clinical rules, in real-time, survey the population identifying non-compliance and condition specific gaps in care. The system's business rules evaluate each individual case and define specific outreach methods. These rules define the appropriateness of outreach and drive targeted communication to the member (through traditional mail, email, automated calls, etc.) and to nurses working with members

and providers. This multichannel, integrated approach leverages multiple touch points to optimize communications effectiveness and drive desired outcomes.

Humana's investment in integration allows it to deliver greater operational efficiencies, better clinical outcomes, and enhanced flexibility. Humana is able to match the right person with the right service or message at the right time. This industry leading approach can result in better health outcomes, better cost control, and a better benefits experience for the State.

HumanaFirst

HumanaFirst is a telephonic nurse triage and health planning service available 24 hours a day, seven days a week. Members can talk to a registered nurse about any immediate medical concerns, obtain health planning and support assistance, or access an audio health library. HumanaFirst is a quick and confidential way for members to decide whether they need to visit their doctor, seek urgent or emergent care, or begin treatment at home. It also alleviates unnecessary calls or visits to providers and helps to prevent inappropriate trips to the emergency room. Studies show that 35 percent of callers to HumanaFirst for immediate medical concerns decide to pursue an alternative, lower-cost care option. It is estimated that approximately 10 percent of callers requesting health planning and support are referred to a nursing program for ongoing support.

Management of Non-emergent ER Visits

Humana identifies members who visit the emergency room for non-emergent issues and conducts outreach to those members. If a member has a non-emergent ER visit, Humana initiates communication to the member regarding HumanaFirst, urgent care and retail clinic access, and the importance of maintaining a primary care physician. The outreach is conducted initially by mail. If there are multiple non-emergent ER visits, then a Humana nurse may reach out by phone.

SmartSummary

Consumer Research related to healthcare communications continues to highlight the need for targeted, personalized messages to consumers. Humana's Medicare SmartSummary responds to that need in effective, clear communications to its members. Members receive the SmartSummary communication monthly if they had a prescription or medical claim during the previous month. This statement includes:

- Prescription and medical claims detail
- A personal health record
- Medical and prescription spending
- Savings opportunities
- Information that Medicare wants you to know

Targeted, personalized messages may also appear on the SmartSummary. Through communications among Humana’s individual business areas, messaging is discussed and subsequently developed that prove beneficial to our members. For example, our Clinical Guidance Organization requests that a message be sent to members with a diabetes diagnostic code. A diabetes message is developed, reviewed by our business areas and approved by CMS.

The member receives their SmartSummary and the message appears in a particular “zone” within the SmartSummary. This message uses simplified language, plenty of white space for ease of reading and information that is pertinent to the member and his or her health condition. Messages are more than just informative; the member can take the suggested action within the message to positively influence their health.

Humana Pay For Performance: The Provider Engagement Model

Humana has developed a provider engagement model that aligns provider incentives and rewards to improve quality and lower costs. Recognizing that not all practices are alike, the engagement models are designed to meet providers where they are based on their practice characteristics. This type of developmental model encourages provider engagement and quality improvement at all levels. NCQA endorsed quality metrics are the foundation for all of our reward programs. Prior to roll out the program in 2010, Humana visited leaders of the various primary care organizations to obtain their input on the model, to understand some of the complexities and challenges inherent in introducing the engagement model. This model promotes continued improvement as providers move across the continuum of engagement. The engagement program is structured so that as providers demonstrate progress around improved outcomes and efficiency, they become eligible for higher rewards based on continued improvement in quality and patient engagement.

Currently, 75% of our Medicare Advantage membership receives care from a PCP in a quality based reward program.

Pharmacy Integration with Medical Offerings

Humana Pharmacy Solutions’ history and experience in managing integrated medical and pharmacy benefits enables it to develop a unique perspective and philosophy. Humana Pharmacy Solutions strives to develop a “total cost management strategy” while ensuring rich benefits are utilized effectively for patient care. Humana Pharmacy Solutions achieves these goals in a number of ways:

- Appropriate tier placement of drugs on the formulary
- Appropriate use of utilization management programs to promote member safety, adherence, and overall cost control
- Driving generic utilization
 - Humana Pharmacy Solutions focuses on educating the consumer on the value of generics and cost-effective brand-name agents.

- Many Pharmacy Benefit Managers utilize therapeutic interchange programs to actively convert members from low-cost brands to higher-cost brands to generate rebates. Humana Pharmacy Solutions will never utilize its therapeutic interchange program for this purpose.
- Innovative clinical programs and benefit designs
 - Humana Pharmacy Solutions offers original member education programs such as “Why Generics,” *Maximize Your Benefit Rx*, and *RxMentor*SM that focus on medication adherence, removing financial barriers, and education on the value of generics.

RightSource[®] Specialty

Humana offers its specialty services through Humana’s wholly-owned specialty pharmacy, *RightSource*[®] Specialty. Specialty drugs, also known as high tech or biotech agents, are specialized therapies developed for chronic, complex illnesses and have the following characteristics:

- Special handling, storage, and/or shipping requirements
- Requires nursing services or special programs to support patient compliance or adherence
- Requires disease-specific treatment protocols
- Limited distribution requirements
- Injections, infusions, or oral products
- High cost, typically more than \$500 per treatment episode

Ordering and Prescription Processing

Humana members order prescriptions from *RightSource* Specialty by mail or their doctor submits prescriptions by fax or phone. When *RightSource* Specialty receives a prescription they follow-up with the members’ physician with any question or clarification needed. During standard prescription processing, the physician is alerted to the progress of the referral/prescription as needed.

Care Management

A Specialty Care Coordinator contacts the member to schedule the shipment of the medication. Based on the medication and the member’s disease, Specialty Nurses begin care management protocols addressing adherence and compliance and guiding the member towards management of their condition.

Care management includes knowledge assessments, routine clinical screenings for side effects, as well as coordination of any programs for which the member may be eligible or interested. These programs may include financial assistance, pharmaceutical specific care programs, or case management programs offered as part of the medical benefit.

The specialty pharmacy coordinates and verifies benefits for the member and provides an estimated cost share. *RightSource* Specialty also provides support with member cost share through Patient Assistance Programs (PAP). Payment is processed and the medication is

shipped to the member with appropriate patient education materials and ancillary supplies (i.e., alcohol swabs, needles, and sharps' container for proper needle disposal) at no additional cost to the member.

Refill Reminders and Ongoing Support

RightSource Specialty contacts the patient prior to the next refill of the specialty medication, to arrange for the next delivery of medication and supplies, and verify the shipping address (home or work). Members also have ongoing access to a pharmacist's support 24 hours a day, seven days a week.

Medication Therapy Management (MTM)

Medication Therapy Management (MTM) is a federally mandated program created by the Centers for Medicare & Medicaid Services (CMS) to optimize therapeutic outcomes, reduce adverse drug events, and address issues with improper medication adherence. All MTM services are provided at no additional cost to members.

Humana's MTM program is unique because Humana is the only national plan that offers both telephonic and face-to-face consultations. During MTM consultations, Humana customizes clinical protocols based upon the member's level of risk and severity. If needed, Humana coordinates the member's care to align with both the medical and the pharmacy plans. In order to qualify for MTM, the member must:

- Have at least three of the following chronic diseases:
 - Chronic Heart Failure
 - Diabetes mellitus
 - Dyslipidemia
 - Hypertension
- Use eight or more chronic condition Medicare Part D medications in a 90-day period
- Have an anticipated spend of more than \$3,000 per year on total prescription drug costs

After identifying members who are eligible for MTM, an algorithm is used to calculate a score for each member. This score determines which members receive an invitation to call Humana for a consultation. Incoming calls are provided a telephone-based consultation or referred for a face-to-face consultation with a pharmacist, based upon the severity score and the information provided by the member. In addition, certain disease states or recent hospitalizations move a member to a higher-priority intervention.

Medicare-eligible members that do not qualify for MTM may qualify for Humana's *RxMentor* program if they:

- Have at least one of the chronic conditions listed above
- Take at least four chronic medications
- Have an anticipated spend of more than \$3,000 per year on total prescription drug costs

Members are identified based on a three-month analysis of pharmacy claims data and referred to *RxMentor*. Members may also be referred to the program from other Humana clinical programs.

Pharmacists engage members in both MTM and *RxMentor* via face-to-face consultations at network pharmacies or via telephone through Humana's staff pharmacists. During the consultation, the pharmacist provides the member:

- A comprehensive medication review that identifies gaps in medication therapies, possible lower-cost alternatives, and recommendations for optimizing drug therapy and maintaining compliance with provider instructions
- Safety precautions to avoid adverse reactions from potential drug interactions
- Drug information to increase health literacy

After the consultation, the member and the member's provider(s) receive a follow-up communication, alerting them to any potential medication issues and requesting a prescription for a lower-cost medicine (when appropriate).

Through participation in these programs, members are empowered to:

- Increase adherence to treatment plans
- Save money with lower-cost alternatives to prescribed medications
- Improve quality of life and avoid acute episodes of illness

Fraud and Abuse Services

Humana's special investigation unit is responsible for detection, prevention, and recommendation of process improvement for health insurance and prescription fraud, waste, and abuse. Humana implemented the first prepayment fraud detection software in the industry to identify suspected claims prior to payment. Humana's staff investigates and works with appropriate law enforcement agencies when dealing with insurance fraud, waste, abuse, and identity theft by providers, insureds, agents, company associates, and other individuals.