H2949 Humana Health Plan, Inc.
Chronic or Disabling Condition (Cardiovascular Disorders, Chronic Heart Failure and/or Diabetes) Special Needs Plan

Model of Care Score: 90.00%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

The Health Care Partners of Nevada (HCPN), a Humana plan, is a Chronic Condition Special Needs Plan (C-SNP) specifically designed for members with cardiovascular disease (CVD) including cardiac arrhythmias, coronary artery disease, peripheral vascular disease and/or chronic venous thromboembolic disorder; chronic heart failure (CHF); and/or diabetes mellitus (DM).

Members eligible for the plan are entitled to Part A, enrolled in Part B of Medicare, have a physician confirmed diagnosis of CVD, CHF and/or DM, reside within either Clark or Nye County and are not currently undergoing treatment for end-stage renal disease.

Provider Network

HCPN maintains an adequate network of medical and ancillary providers with expertise caring for the unique needs of the population. This network includes: primary care practitioners (PCP) who specialize in internal medicine, family medicine and geriatrics. It also includes specialists in: orthopedics, neurology, physical medicine and rehabilitation, cardiology, endocrinology, gastroenterology, pulmonology, rheumatology, oncology, podiatry, radiology and general surgery; psychiatry and clinical psychology. In addition, the network contains clinical social workers, certified substance abuse specialists and ancillary providers such as physical and occupational therapists.

The Provider Services department utilizes internal and external resources to verify that services are geographically accessible and consistent with local community patterns and standards of care. This department also collaborates with the contract department to build new networks.

Care Management and Coordination

Within 30 days of enrollment and annually thereafter, a registered nurse care manager (RNCM) conducts an initial Nevada Care Coordination (NV-CC) Assessment. The NV-CC Assessment gathers information on the member's history, needs and goals. Based on the results of the assessment, risk stratification tool, utilization reports and a review of the electronic health record,

the RNCM develops an individualized care plan (ICP), which includes short and long-term goals and engages the appropriate members of the interdisciplinary care team (ICT).

The RNCM incorporates the member and/or caregiver's input into the ICP to define problems, barriers, goals and timelines for goal achievement. The RNCM revises the ICP at least annually and following changes in the member's health status, as appropriate. The ICT and the member can access the ICP through the plan's electronic health record system or request a hard copy.

The ICT includes the following primary personnel: RNCM, PCP, the member and/or his or her caregiver. Based on the member's needs, the RNCM may add the following providers to the ICT: the medical director and/or lead physician, inpatient care management team, care manager assistant, social worker, dieticians, pharmacists, end-of-life specialists, home health care staff and social services specialists. Members have access to the ICT by telephone, through written communication and/or face-to-face encounters.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at: www.humana.com.