H2949 Humana Health Plan, Inc.
Chronic or Disabling Condition (Chronic Lung Disorders) 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 chronic lung disorders (CLD) which includes the following four diagnosis: asthma, chronic bronchitis, emphysema, pulmonary fibrosis and pulmonary hypertension. Members eligible for the plan are those who are entitled to Part A, enrolled in Part B of Medicare, have a physician confirmed diagnosis of CLD, reside within the service areas of Clark and Nye counties 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. In addition, the network contains psychiatrists, clinical psychologists, clinical social workers, certified substance abuse specialists; ancillary providers (physical/occupational therapists and nurse educators) and nursing professionals (nurse practitioners and registered nurses).

Care Management and Coordination

Within 30 days of enrollment, each member completes an initial Nevada Care Coordination (NV-CC) Assessment; and within 90 days, the member completes an initial health risk assessment (HRA) either in person or telephonically. Member information collected during the assessment process includes: disease state, level of independence with activities of daily living, cognitive function, psychosocial needs, transportation needs, specialist needs, a history of falls and the risk for new falls. The interdisciplinary care team (ICT) can access the assessment results electronically through the plan's electronic health record system (EHRS). At a minimum, the member undergoes a reassessment annually and whenever he or she experiences a change in health status.

Based on the results of the assessment, risk stratification tool, utilization reports and a review of the electronic health record, the registered nurse care manager (RNCM) develops an individualized care plan (ICP) in collaboration with the member/caregiver. The RNCM incorporates the member and/or caregiver's input into the ICP to define problems, barriers, goals and timelines for 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 either access the ICP through the plan's EHRS or request a hard copy.

The ICT works together to manage the medical, cognitive, psychosocial and functional needs of the member. The ICT includes the following primary personnel: RNCM, PCP, member and/or his or her caregiver. The composition of the ICT may change based on the member's needs and transitions of care from one setting or service to another. Consequently, the ICT may expand to include: restorative health specialists, dietitians, pharmacists, disease management specialists (e.g. pulmonologists), end of life specialists, home health specialists, external social services specialists and surgical 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.