H2949 Humana Health Plan, Inc.
Chronic or Disabling Condition (End-Stage Renal Disease Requiring Dialysis, Any Mode of Dialysis) Special Needs Plan

Model of Care Score: 83.33%
2-Year Approval **January 1, 2015 – December 31, 2016**

Target Population

The Humana Health Plan, Inc. (Humana) Chronic Condition Special Needs Plan (C-SNP) is specifically designed for end-stage renal disease (ESRD) Medicare patients. The C-SNP is a partnership between Humana and two business units of DaVita HealthCare Partners, Inc.: VillageHealth and HealthCare Partners Nevada (HCPN). Members eligible for the plan are entitled to Part A, enrolled in Part B of Medicare and reside within one of the plan's service areas in the State of Nevada. The SNP must also receive CMS Form 2728 for ESRD for each member who wishes to enroll in the plan.

Provider Network

HCPN maintains an adequate network of medical and ancillary providers with expertise caring for the unique needs of the population, which includes: primary care practitioners (PCP) who specialize in internal medicine, family medicine and geriatrics. It also includes specialists in nephrology, 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).

Along with the specialties outlined above, the network includes services essential for the care of members with ESRD such as nephrology, dialysis centers, home health and hospice. Contracted facilities include: hospitals, intermediate care centers, after hours clinics, acute and long-term care, tertiary care (including kidney transplant facilities), imaging, lab, rehab, skilled nursing facilities and specialty outpatient clinics. Specialty services are contracted or available when needed on a case-by-case basis.

Care Management and Coordination

VillageHealth nurses (VHN) utilize an initial health risk assessment (HRA) to gather member information that includes but is not limited to: health status, clinical history, medication (past and present), functional status, mental health status, life planning activities, cultural and linguistic

needs, caregiver involvement and community resource needs. Reassessing members' needs is an on-going process and occurs with each member encounter based on the risk level as determined by the HRA results. At a minimum, however, members are reassessed annually.
Following the HRA, the VHN, in collaboration with the member and/or caregiver, develop the plan of care (POC) during dialysis sessions and/or telephonically. The contents of the POC varies based on the member's unique strengths, needs and primarily focuses on his or her expressed wishes and personal health goals including their preferences pertaining to advanced directives and end of life care. As the member's needs change, the VHN updates the POC and stores it electronically where the interdisciplinary care team (ICT) can access it as needed. Providers communicate their changes to the POC either verbally during ICT meetings or via fax or mail. VillageHealth staff mail or hand-deliver updated POCs to the member and his or her caregiver.

The ICT works together to manage the medical, cognitive, psychosocial and functional needs of the member. The ICT includes the following primary personnel: VHN, principal care practitioner (nephrologist), nurse practitioner and member/caregiver. ICT composition may change based on the member's needs and transitions of care from one setting or service to another. It may expand to include: 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 and social services specialists.

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.