MMM Healthcare Inc., H4003
Chronic (Cardiovascular Disorders, Chronic Heart Failure and Diabetes)
Special Needs Plan

Model of Care Score: 90.00%
3-Year Approval **January 1, 2012 to December 31, 2014**

Target Population

MMM offers a C-SNP called Supremo for members in Puerto Rico with severe or disabling chronic conditions and co-morbidities that require costlier treatment. This coverage option is available for members that have diabetes, chronic heart failure and cardiovascular disease. Eighty-six percent of MMM's members are over 65 years old. Twenty-two percent of these members are in the 70-74 age range and 18% of its members are over 85 years old.

Provider Network

MMM's provider network contains specialized expertise to manage all members' physical and behavioral conditions. The network includes specialists in cardiology, endocrinology, behavioral specialists, and allied health professionals who coordinate members' care and service with the primary care provider (PCP). The network includes hospitals and other facilities such as: urgent care centers, skilled nursing facilities, ambulatory surgical centers, as well as rehabilitation and mental healthcare facilities around the island. MMM contracts with an extensive durable medical equipment network and homecare servicing providers for members seeking to remain in the community.

Care Management and Coordination

MMM's health risk assessment (HRA) tool is a screening questionnaire for estimating health problems, risk factors and risk probabilities of elderly people. MMM utilizes it to assess a member's probable utilization of services, probability of repeated admissions and other health-related needs, by inquiring on the medical, psychosocial and functional needs of the special needs individual. It estimates cognitive needs and includes medical and mental health history. The tool covers areas such as: age/gender, general perception of physical and behavioral health, hospitalizations, doctor or clinic visits, the existence of diabetes, heart disease, arthritis, high blood pressure, frailty risk level, depression risk level, incontinence, falls risk, nutritional risk, caregiver availability, osteoporosis risk, smoking and/or alcohol use, functional level, medications, advanced directives and preventive activities such as glaucoma screening, Influenza (flu) and pneumonia vaccines.

The initial HRA is completed by phone within 90 days of the member's effective date and within 12 months of the last HRA or more frequently if required by the members' health status.

The interdisciplinary care team (ICT) receives the HRA report and analyzes existing data, stratification results and input to determine a member's SNP category (frail/elderly, multiple

chronic conditions, end of life, ESRD). The team also evaluates the risk level or acuity (high, moderate or low), and what actions are needed to provide coordinated care (medical, mental health, social services and education regarding health risks and care options.)

Based on the HRA responses, a series of health recommendations will prompt the development of an individualized care plan (ICP). Every member reached and assessed has an ICP created using information from HRA results, and when feasible, with the input of the member or caregiver. ICPs are comprehensive and incorporate evidence-based practices for chronic conditions as well as psychosocial needs and includes: problems, goals, objectives, interventions and specific services and benefits to be provided. The complexity of the ICP matches the member's stratification level and MMM shares the ICP with the member/caregiver and PCP by mail no later than thirty (30) days after the HRA assessment. In addition to initial stratification, the plan reviews data, monitors for changes in condition and re-stratifies members to ensure that resources are focused appropriately for every member.

The ICT is a workgroup that is composed of the member (when feasible), care managers, registered nurses, social workers, health educators, behavioral/mental health practitioners, PCPs, medical directors, and may include primary, ancillary and specialty care providers, among others. Its main care management role is to develop clinical algorithms that automatically trigger the ICP based on the answers to the HRA questions. It also ensures that interventions are based on members' individualized needs and include: active involvement of the individual or caregiver, communication with the PCP and mental provider.

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.mmm-pr.com.