H4003 MMM Healthcare Inc.
Chronic or Disabling Condition (Cardiovascular Disorder, Chronic Heart Failure and/or Diabetes) Special Needs Plan

Model of Care Score: 95.00%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Medicare y Mucho Más (MMM) operates a chronic condition plan in Puerto Rico. The plan has 117,405 special needs plan (SNP) members, of which 12,237 are in an MMM chronic condition SNP (C-SNP). MMM serves individuals who are eligible for Medicare Part A and Part B and have a specific chronic disease or diseases. Members enrolled in the plan's C-SNP are individuals who have co-morbid, severe or disabling chronic conditions and may represent a more challenging type of patient who requires specific health care services. Members who have a diagnosis of cardiovascular disorder, chronic heart failure and/or diabetes are eligible to participate in the SNP.

MMM's C-SNP has 47.3 percent female members and 52.7 percent male members. The majority of members are in the age band of 70-74 years old, with 58.5 percent of the membership being 74 years old or younger.

The target population has substantial health, economic and other disparities in Puerto Rico. Reports from MMM show that 72.2 percent of members have not completed high school; 49.3 percent of members have an income of $10,000 or less (indicating that they live at or near the poverty line) and 50.9 percent have problems with walking. A total of 31.5 percent of MMM members indicate that they live in their household by themselves.

Provider Network

Contracts are in place with a network of medical professionals to provide health care services to members with chronic condition. MMM's network provides specialized expertise to manage SNP member's physical and behavioral conditions. The provider network that focuses on C-SNP members includes, internal medicine, cardiologists, endocrinologists, mental health and other specialties.

MMM evaluates the adequacy of the network for the C-SNP population on an annual basis to guarantee compliance with provider-to-member ratios, while also taking into account any individual or regional needs of the membership. The annual assessment evaluates the most frequently visited provider specialties. If MMM identifies the need for additional physicians in order to comply with the network adequacy requirements or population needs, the plan contracts with additional providers.

Care Coordination

MMM utilizes a health risk assessment (HRA) to begin the care coordination process. The HRA acts as a screening questionnaire for estimating health problems, risk factors, and risk probabilities of the membership. The plan uses the HRA to assess a member's probable utilization of services, probability of repeated admissions and other health-related needs. The HRA also estimates cognitive needs and includes medical and mental health history.

Once the plan has collected and analyzed the HRA data, MMM develops an individual care plan (ICP) for all members and maintains it in an electronic health records system. The system takes into account clinical practice guidelines and recommendations from case management staff when building the care plan. The plan develops the ICP and evolves components as the member moves across care settings and experiences health status changes. Care plan components include, goals, preferences, limitations, problems, barriers and interventions. MMM develops all of the components according to input from the member, electronic algorithms, care planning staff, established self-management goals and objectives.

MMM maintains an interdisciplinary care team (ICT) to address SNP member's needs. The ICT consists of health professionals who are involved in the analysis of a patient's health outcomes, in order to set goals and establish alternate actions to improve member health status. The ICT works as an integrated team in order to set, modify or update care plan goals. MMM determines the ICT composition by the medical, mental and social needs of the member. Depending on member needs, the ICT analyzes health status, discusses care plans, adjusts goals, and recommends interventions to address specific member needs in order to improve their overall health.

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