Medical Care Consortium (Humana), H4510
Chronic or Disabling Condition (Chronic Heart Failure and Diabetes) Special Needs Plan

Model of Care Score: 81.25%
3-Year Approval **January 1, 2013 – December 31, 2015**

Target Population

Medical Care Consortium, Inc. (MCCI) partners with Humana Health Plan, Inc. and is a provider based organization comprised of owned and contracted primary care networks, specialty networks, in addition to allied services and facilities networks. MCCI focuses on chronic care improvement management for its members suffering from congestive heart failure (CHF) and diabetes mellitus. Within the Texas market of the Humana population, there is a 14.14% prevalence rate of CHF, and a 50.29% diabetes prevalence rate. Additionally, there are 34,666 members with an average age of 71 years. People living with CHF and diabetes have a significantly increased chance of impaired kidney function, blindness, neuropathy, high blood pressure, cerebrovascular accidents, arrhythmias, coronary artery disease, myocardial infarction and depression.

Provider Network

MCCI offers a network of care centered on primary care with medical and surgical specialists available to augment and support the primary care providers. This network includes, but is not limited to, acute care facilities, primary care outpatient facilities, specialty care outpatient facilities, long term care facilities, skilled nursing facilities and inpatient and outpatient laboratories. The Registered Nurse Care Manager (RNCM) is responsible for the coordination of services and communicates with the stakeholders through face to face, online or telephone outreach. Physicians and providers agree to comply with MCCI's and Humana's quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures, as applicable to the specific physician or provider.

Care Management and Coordination

MCCI uses a health risk assessment (HRA) tool as an integral component of the clinical assessment process which assesses the patient's overall health, functional capacity and social, cognitive, financial, behavioral and environmental risk. MCCI administers HRAs by phone to new members within the first 90 days of enrollment and then within one year of previous assessment. More frequent reassessments can occur when appropriate, such as when a member is hospitalized, experiences a change in health status, number of medications, or utilization of services. MCCI shares HRA reports with members and with the members' primary care physician (PCP) for review and input. The findings of the HRA assessments are available to the Interdisciplinary Care Team (ICT) via secure email, fax or mailing for review.

The medical home team develops and implements individualized plans of care (ICPs) in conjunction with members/caregivers. While the RNCM contacts the member to perform the HRA, they also work with the member to identify goals and objectives for incorporation into the ICP. The ICP addresses the gaps identified through the assessment process and planned interventions, as well as the member's short and long term goals, specific services, end of life planning, qualifying services or resources and a follow-up schedule. The RNCMs create, review and update the ICP upon each member encounter, and field staff can also make revisions when meeting with the member face-to-face. The RNCM also shares all care plan information with the member on an ongoing basis and by mail when requested. MCCI documents and shares the care plan with the ICT using its proprietary care management suite.

The medical home/interdisciplinary care team (ICT) at a minimum includes the member and/or caregiver, the PCP, the primary RNCM and the medical social worker. The ICT may include additional members based on the needs outlined in the ICP, such as MCCI's medical director, restorative health specialists, dieticians, pharmacists, disease management specialists, end of life specialists, home health specialists, external social services specialists or surgical specialists. Members and/or caregivers have direct access to the Medical Home/ICT. RNCMs schedule and facilitate team meetings and interactions, and document care plans in the medical health records and care management database, to which all members of the medical home/ICT have access.

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 member needs.

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

www.humana.com/SNP