Meridian of Michigan, INC., H5475, H5786, H5779
Dual-Eligible (Subset – Medicare Zero Cost-sharing) Special Needs Plan

Model of Care Score: 91.88%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

Meridian Advantage Plan is a Medicare Zero-Cost-Sharing, Dual Eligible (Medicare & Medicaid) Special Needs Plan (D-SNP) for Qualified Medicare Beneficiaries (QMB+). 59 percent of the members are female and 41 percent are males. The average age is 54 years old. The cultural and ethnic composition through member-reported data reveals 36 percent of the population identified themselves as White (Non-Hispanic), 36 percent Black (Non- Hispanic), 24 percent did not provide their race, 2 percent Asian, 1 percent Hispanic, 1 percent American Indian or Alaskan Native and <1 percent as Other. English is the most common language spoken by the Meridian Advantage dual-eligible population. The most common conditions based on claims data are behavioral health (including depression, schizoaffective disorder and anxiety), diabetes and COPD.

Provider Network

Meridian contracts with many providers including, but not limited to, internists, medical specialists such as cardiologists, neurologists, behavioral and mental health, nursing and allied health professionals. Network facilities include hospitals, diagnostic radiology centers, physical/rehabilitative centers, laboratories, skilled nursing facilities and durable medical equipment vendors. Meridian providers serve as gatekeepers who determine which services members need.

Care Management and Coordination

Meridian performs a comprehensive health risk assessment (HRA) for every Meridian member within the first 90 days of enrollment. The initial HRA is completed by a Meridian care coordinator under the direction of a nurse. The HRA may be completed either telephonically or through the mail. A reassessment of the member's plan of care is conducted at least annually and includes information on the medical, mental, psychosocial, functional, environmental and financial status of the member.
The care coordinator, member, and the interdisciplinary care team (ICT), develop an individual plan of care unique to the member based on the results of the most current HRA; a plan of action is developed to address these areas of concern. The care coordinator is responsible for communicating the plan of care to providers when facilitating appointments or services.

The care coordinator is assisted by a team of consultants, including, but not limited to, a nutritionist/dietician, clinical pharmacist, medical director and behavioral health consultants. Further support may come from social workers, discharge planners, case coordinators and other staff who support members and providers through all phases of care. The ICT meets weekly to review cases (initial, reassessments, and transitions of care) and updates the member's plan of care accordingly. The member's primary care provider and/or specialist(s) are provided a written copy of the member's initial and subsequent HRA as well as their acuity level. Results are also available via Meridian's web portal.

The care coordinator is responsible for driving the interventions within the plan of care. Special emphasis is given to assist the member in recognizing their role as a daily self-manager, as well as the family or caregiver's engagement in the member's overall self-management success. The goal is to obtain member information, with collaboration from the PCP to customize and design an effective care plan.

This Model of Care summary is intended to provide a broad overview of the SNP's Model of Care. Although the full extent of any Model of Care 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: http://medicaremeridian.com/mi/