H5475 Meridian Health Plan of Michigan Inc.
Dual Eligible (Dual Eligible Subset - Medicare Zero Cost-sharing) Special Needs Plan

Model of Care Score: 91.67%
3-Year Approval **January 1, 2015 to December 31, 2017**

Target Population

Meridian Health Plan of Michigan (Meridian) is a Medicare zero-cost-sharing, Dual Eligible Special Needs Plan (D-SNP) for individuals whose income is no more than 80 percent of the federal poverty level and individuals whose income is between 80 and 100 percent of the federal poverty level. Meridian is a Medicare Advantage plan for individuals who are entitled to Medicare Part A and/or Part B and receive some form of Medicaid benefit.

An analysis of Meridian's dual eligible population reveals: 61 percent of members are female, and the average age of members is 54 years. Forty-two percent of members are White (Non-Hispanic), 38 percent are Black (Non- Hispanic), two percent are Asian and one percent are Hispanic. English is spoken by 89 percent of members. The top member-reported medical/chronic conditions are hypertension, chronic pain, behavioral/mental health and diabetes. The top member-reported behavioral health conditions are depression, anxiety disorder and bipolar disorder. Twenty-one percent of members report three to five chronic conditions, while 17 percent report six or more.

Provider Network

Meridian's provider network includes, but is not limited, to the following: primary care providers (PCP), nurse practitioners (NP), internal medicine, family practitioners, physician assistants (PA), doctor of osteopathic medicine (DO), doctor of medicine (MD); consultative and surgical specialists; mental health specialists, specialized mental health agencies with comprehensive programs, psychiatrists, psychiatric and mental health NPs, licensed clinical social workers (LCSW), psychologists; ancillary providers, physical therapists, occupational therapists, speech therapists, nutrition, durable medical equipment (DME); disease specialists; hospitals; long term acute care facility; inpatient rehabilitation; skilled nursing facilities (SNF); home health agencies (HHA); hospice; dialysis facilities; transplant facilities; gerontology; in home primary care services; pharmacies and mail order pharmacy; psychiatric hospital and mental health services provided in home and in facilities.

Meridian's network includes 47 hospitals, 113 physical/rehabilitative centers, 80 SNFs and 137 DME vendors. Meridian has 2,277 PCPs, 7,956 specialists and 47 Hospitals providers in-network. Medical specialists include, but are not limited to, 264 cardiovascular disease

specialists, 2,145 internal medicine specialists, 190 neurology specialists, 338 ophthalmology specialists and 63 endocrinology specialists. Behavioral and mental health specialists include, but are not limited to, 1,172 mental health and 79 psychology and 369 psychiatry specialists. Meridian has 189 family NPs and 695 PAs. The pharmacy network includes 2,686 retail and 131 LTC pharmacies.

Care Management and Coordination

A health risk assessment (HRA) is conducted by a care coordinator (CC) within the first 90 days of member enrollment. Upon completion of the HRA, the CC and the member complete additional assessments, if needed, discuss the results of the HRA including the meaning of stratification and member stratification level. The CC uses this information to develop an individual care plan (ICP). Goals and interventions are agreed upon by the member and CC. Each member's ICP is shared with the interdisciplinary care team (ICT) who reviews the member's medical history summary, results of the HRA, the initial ICP and goals. The ICP is updated to reflect ICT input. The ICP is shared with the member by telephone and a copy of the ICP and HRA are mailed to the member. The CC provides the member's PCP with a written copy of the HRA as well as the initial and updated ICP.

Along with the HRA, a medication log is completed. The HRA and the medication log are used as a personal heath record. This personal health record becomes the foundation of the member-centric ICP. The HRA forms the baseline data which is compared to the results of future annual reassessments which evaluate progress or changes in health and functional status. The PCP serves as the member's medical home and interacts with the member's ICT. They are responsible for working collaboratively with the member, ICT and Meridian CC staff to ensure timely access to quality care.

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: http://www.mhplan.com/.