

H5786 Meridian Health Plan of Iowa 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 Iowa (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.

Based on information derived from its other plans, Meridian expects its population that 61% of the enrollees will be predominantly female and thirty-nine percent (39%) males. The average age is 54 years old. The cultural and ethnic composition member data reveals 42% of the population identified themselves as White (Non-Hispanic), 38% Black (Non-Hispanic), 16% did not provide their race, 2% Asian, 1% Hispanic, <1% American Indian or Alaskan Native, <1% as Other. English was overwhelming the most common language spoken by Meridian Advantage dual-eligible population with a reported rate of 89%. Other non-English reported languages included 1% Albanian, 1% Arabic and 1% Spanish. 7% chose not to provide their spoken language.

The top member-reported medical/chronic conditions were hypertension, chronic pain, behavioral/mental health and diabetes. Of the 48% of enrollees reporting behavioral health conditions, the top three reported conditions were depression, anxiety disorder and bipolar disorder.

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, social workers, durable medical equipment (DME); disease specialists; hospitals; long term acute care facility; inpatient rehabilitation; skilled nursing facilities (SNF); home health agencies (HHA); hospice, dialysis and 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 7 physical/rehabilitative centers, 10 SNFs and 47 DME vendors. Meridian has 697 PCPs, 1,246 specialists and 17 hospital providers in-network. Medical specialists include, but are not limited to, 39 cardiovascular disease specialists, 325 internal medicine specialists, 15 neurology specialists, 27 ophthalmology specialists and 12 endocrinology specialists. Behavioral and mental health specialists include, but are not limited to, 1 mental health and 7 psychiatry specialists. Meridian has 365 family NPs and 238 PAs. The pharmacy network includes 681 retail and 41 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 health 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/>.