SCOPE OF WORK

Respondents are asked to propose a Care Coordination model for Oklahoma eligible ABD SoonerCare enrollees according to the outline below:

A. High-Level description of the recommended Patient-Centered service delivery model
1. Name and describe Respondents chosen model including reason for selecting the model

Meridian Health Plan (Meridian) recommends a Fully Capitated Managed Care Organization (MCO) service delivery model. The Fully Capitated MCO model has become a prominent and popular choice for many State Medicaid agencies when determining the most efficient systems for delivering Medicaid benefits. The MCO model allows State agencies, through the application and approval of Centers for Medicare and Medicaid Services (CMS) Waivers (e.g. Waiver Section 1115, State Authority Section 1932(a), Waiver Section 1915 (a) (b)), to develop managed care delivery systems administered by Managed Care Organizations (MCOs). Through fully capitated managed care, MCOs assume full-risk and responsibility for administering the benefits beneficiaries are eligible to receive. Covered benefits are established by the State and outlined within the contracts between the MCO and the State. The scope of benefits covered by the MCOs can vary. State agencies determine which services MCOs administer through contract terms. Services covered by MCOs range from physical benefits, behavioral health services, Long-Term Supports and Services, dental and vision benefits, and pharmaceutical benefit administration.

MCOs can deliver a plethora of benefits to State Medicaid agencies and beneficiaries. When compared to fee-for-service (FFS) or Primary Care Case Management (PCCM) models, managed care delivered through MCOs (Health Plans), provides State agencies with more predictable costs, improved quality of care, fraud and abuse prevention, and improved access and coordination of care.

Medicaid Health Plans vs. Primary Care Case Management and Fee-For Service

	Health Plan	PCCM	FFS
Benefits to Members			
Identification card proving coverage	✓	✓	✓
A designated primary care physician	✓	✓	
Case management of primary care services	✓	✓	
Disease management	✓	✓	
Comprehensive case management	✓		
Quality standards and continuous quality improvement programs	✓		
National accreditation	✓		
Cost Containment			
Claims analysis	✓		
Utilization review	✓		

Improved generic utilization-Pharmacy	✓		
Using lower cost service where available	✓		
Cost predictability	✓		
Fraud, Waste, and Abuse Prevention	✓		

Predictability of Costs

State Medicaid agencies transitioning to a MCO model are typically in search of cost containment and potential healthcare cost reductions. Through fully capitated managed care, financial risk is transferred from the State to the Health Plan. The transfer of risk alleviates some of the variability States experience with traditional FFS models. Study's conducted by independent third parties have projected average annual savings for State programs that can range from two percent to 19 percent. Obviously, each State is unique in the size and scope of their respective programs. Factors such as population size, overall health of the population, and beneficiary utilization have significant effects on savings.

Improved Quality of Care

MCOs provide the opportunity for improved quality of care through the increased oversight of Health Plans, as required by Federal regulations. Federal regulations have established specific quality standards and expectations to ensure beneficiaries receive the highest quality of care and services from MCOs. In addition to Federal oversight, many States conduct their own audits of MCOs to ensure the organizations remain compliant with the obligations outlined in their contracts.

Unique to Medicaid Managed Care, States require Medicaid Health Plans to report critical performance measures, such as the Healthcare Effectiveness Data Information Set (HEDIS®), to reflect the Health Plan's performance. Requiring MCOs to report performance measures provides States with quantitative evidence as to the quality of care being delivered. Additionally, States can reference these performance measures to draft quality improvement plans to correct identified barriers to care delivery. Another tool utilized by many States is the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). CAHPS® allows beneficiaries to express their satisfaction with their MCO. MCOs can utilize the data produced through the CAHPS® to improve the delivery of care and modify care delivery to align with patient-centered care best practices.

Accreditation is a significant component of maintaining high quality patient-centered care. Contrary to State-managed FFS programs, MCOs have the opportunity to apply for and maintain accreditation through nationally recognized accrediting bodies. Many MCOs achieve accreditation through the National Committee for Quality Assurance (NCQA). Meridian's Michigan affiliate earned Excellent accreditation from NCQA in 2014 while its Illinois and Iowa affiliates earned Commendable accreditation the same year. These accreditation statuses, as well as top HEDIS® quality scores, led Meridian's affiliates in Michigan and Illinois to be ranked ninth and tenth in the nation according to NCQA's 2014-2015 Medicaid Health Plan Rankings.

Fraud and Abuse Prevention

Managed Care can also provide significant oversight and aid in the reduction of fraud, waste, and abuse to State agencies. Through claims review, utilization trends, and payment analysis, MCOs reduce improper payments, reduce waste, and reduce medically unnecessary services. Because MCOs develop and maintain their respective provider networks, provider oversight and education can have significant impacts on reducing fraud and abuse. Utilizing medically supported clinical guidelines, MCOs can ensure that members receive the most appropriate care, at the right time, in the most correct setting.

Improved Access and Care Coordination

Fully capitated managed care allows MCOs to negotiate payment rates with providers, allowing beneficiaries to have better access to care than those enrolled in traditional FFS programs. MCOs create an environment for patient-centered care by fostering an environment for integrated care delivery. Capitated managed care allows MCOs to offer providers financial incentives for delivering high quality preventive care. Through the use of Patient-Centered Medical Homes, shared-savings agreements, and value-based contracting, MCOs incentivize preventive screenings, chronic condition management, and emphasize medically appropriate treatment. The FFS model of care is not designed to manage the patient from a holistic perspective. Fully capitated managed care is especially designed to create efficiencies for delivering benefits for dually-eligible Medicare and Medicaid beneficiaries. MCOs have established systems to ensure beneficiaries receive the correct benefits they are eligible for, as well as, coordination with services that may be provided by Home and Community-Based Services Providers. MCOs synchronize the many components of care delivery into one efficient delivery system.

2. Describe how the model addresses the needs of the ABD patient population

In 2014, the Oklahoma Aged Blind and Disabled (ABD) population accounted for just over 16 percent of total SoonerCare enrollees. At the same time, the ABD population accounted for nearly 47 percent of total Oklahoma Medicaid spending. Cost containment and care coordination efforts will be critical to rein in these exorbitant expenditures and improve the quality of care being delivered. As noted above, MCOs can provide significant cost savings, added value, and improved outcomes for State Medicaid programs. Implementing a MCO model will provide patient-centered, integrated care delivery for Oklahoma's ABD patient population.

Keeping in line with the goals outlined within the Request for Information, managed care organizations can provide a market-based approach to integrative care delivery. The fully capitated managed care model allows Managed Care Organizations (MCOs) to streamline the delivery of care by ensuring that appropriate care is delivered at the appropriate time. MCOs approach care delivery from a holistic approach, integrating all levels and types of care into one streamlined system of care. Oklahoma's ABD beneficiaries require more than physical health benefit coordination. Recognizing that Oklahoma ABD beneficiaries may require services outside the scope of physical health services, the MCO model is designed to integrate all levels and types of services into one harmonious system.

Coordination for Beneficiaries' Chronic Conditions

MCOs can offer evidence-based, Disease Management (DM) programs developed from clinical guidelines to target chronic conditions. MCOs have the systems to incorporate a whole person approach to coordinating services and can emphasize the importance of coordinating services for all members' physical, behavioral, and social needs, including members with multiple co-morbidities. MCOs can provide DM programs that offer coordination of services for diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma, coronary artery disease (CAD), chronic kidney disease (CKD), end-stage renal disease (ESRD), and depression.

For example, Meridian Health Plan (Meridian) developed a Care Coordination Team (CCT) that engages members in DM programs by facilitating provider and member communication. These relationships break down traditional barriers to accessing care. Meridian engages members and providers in person when appropriate. Meridian Community Health Workers (CHW) provide face-to-face contact including working with members at their home, local community centers, in the hospital and emergency room, at provider office visits, during community events, and at health education workshops.

Meridian adopts clinical practice guidelines (CPGs) as the basis for DM programs and monitors adherence to these guidelines across the provider network annually. The adopted CPGs are developed by nationally recognized sources and organizations such as the Michigan Quality Improvement Consortium (MQIC); National Heart, Lung, and Blood Institute (NHLBI); and Institute for Clinical System Improvement (ICSI). Meridian promotes implementation of these CPGs via dissemination among practitioners in hard copy (upon request), electronically on the Meridian website, and via fax for updated CPGs when applicable. The CPGs are reviewed annually and updated as necessary by the Meridian Physician Advisory Committee (PAC) and approved by the Quality Improvement Committee (QIC), and Board of Directors (BOD).

The Quality and Performance Improvement department monitors adherence to CPGs annually utilizing Healthcare Effectiveness and Data Information Set (HEDIS®) measures when possible. If a HEDIS® measure does not exist relevant to the condition, Meridian will utilize other national and State-recognized performance measures.

Coordination with Behavioral Health Services

With a significant proportion of Oklahoma ABD members experiencing behavioral health conditions, in addition to chronic disease, integration of physical health and behavioral health benefits provide members with seamless coordination of care. MCOs have the knowledge and technical capability to administer behavioral health services in conjunction with physical services. Meridian Care Coordinators work in conjunction with internal Behavioral Health (BH) Case Managers to assist dual-eligible members with psychosocial issues, such as chemical and substance abuse, coordination of counseling for members with depression, schizophrenia, and bipolar disease. The BH Case Managers also address care needs, including shelter, utilities, food, and clothing. Licensed Clinical Social Workers (LCSWs) also work as BH Case Managers.

These LCSW Case Managers also connect members to community resources that address a myriad of needs and concerns in the community. If the member's major condition is only behavioral health related, the BH Case Manager will be assigned as the member's primary Case Manager.

MCOs provide members with comprehensive provider networks that ensure they have access to expert care when medically necessary. When MCOs administer behavioral health benefits, member confusion and the administrative burden of administering benefits is alleviated for providers, members, and State agencies. Meridian administers mental health and substance abuse services directly through its own contracted providers, ensuring that members receive the appropriate care at the needed time of service. Meridian provides these covered services in an effort to elevate the quality of life for individuals with mental illness, provide them the ability to receive treatment, and live, work, and socialize in a healthy way. The following services are provided through Meridian's contracted behavioral health providers.

- Inpatient hospitalization and detoxification
- Observation
- Electroconvulsive therapy (ECT)
- Psychological and neuropsychological testing
- Intensive outpatient program
- Psychiatrist; evaluations, medication administration, and monitoring
- Assertive community treatment
- Intensive family-based services
- Therapy and counseling (individual and group)
- Peer mentoring
- Parent advocate
- Psychosocial rehabilitation and support (PSR)
- Community support services
- Treatment plan development, review and modification
- Services provided by a certified community mental health center
- Behavioral health services provided by a Federally Qualified Health Center

Meridian is a leader in developing Medicaid provider networks in both urban and rural areas. By creating exceptionally strong and lasting relationships with contracted providers, Meridian supports the continuous elimination of barriers to access for members. These personal relationships are built through monthly face-to-face visits and also equipping providers with a vast array of technology to help them improve their administrative efficiency allowing them to focus on what they do best – delivering high-quality care. Meridian's providers are an extension of the Meridian Family and make significant contributions to Meridian policies and procedures.

Coordination with Home and Community-Based Service Waiver Benefits and Long-Term Services and Support

MCOs are designed to bridge care management processes with other providers such as home health and community-based service (HCBS) providers, many of which provide Long-Term

Services and Supports (LTSS) to beneficiaries. These services are designed to enhance independence and productivity consistent with the capabilities and preferences as identified by individuals and their primary care providers (PCPs). The MCO can provide case management activities which include assessment, support planning, support coordination, and transition planning. Individuals receiving these services have been determined eligible for services through a HCBS Waiver selected by the State for inclusion in its Medicaid programs. The extent and frequency of services shall be determined through collaboration between the member and the Case Manager in accordance with the benefit package.

The Meridian Care Coordination Team incorporates assessments and care plans completed by external agencies into one universal care plan for the member that is communicated back with the member's Integrated Care Team (ICT) including the member's PCP, specialist, and home care agencies. Also included in the ICT from the MCO are a Medical Director, Nurse, Pharmacist, Nutritionist and Behavioral Health Specialist. Each member is assigned to a Meridian Care Coordinator who is the point of contact and the one responsible for coordinating services needed for the member. The Care Coordinator also educates and explains the care plan in place to the member and sets individual goals with members based on consultation with the ICT and completed assessments. A Meridian CHW is the link between the member, the health plan, the provider, and any community based programs. The CHW is able to assist the member with coordinating services and implementing the individualized care plan. The CHW facilitates communication between the member and provider, transportation assistance, and scheduling or access issues while helping to eliminate socioeconomic barriers and monitoring adequacy and quality of services provided.

Meridian requires an initial assessment and periodic reassessments to make sure members are receiving appropriate services and detect any change in their health status that may require additional or more skilled level of care. Every effort will be made to maintain a member's ability to live in the community, up to and including home visits.

The member's Meridian Care Coordinator is always the primary point of contact to help members in case of an emergency to locate alternatives or use community resources available in the member's local area of residence. Back up plans and arrangements are included in the care plan and are discussed periodically by the member's ICT.

Collaboration with Local Agencies and Specialized Subcontractors

MCOs rely on the expertise and personalized care delivery provided by HCBS agencies. Specific to the ABD population, many beneficiaries require services which local and community based providers and organizations have expertise and unique capabilities to deliver the services. Meridian believes in partnering with expert subcontractors when greater expertise is needed to deliver the highest level of service in accordance with State contractual obligations. Whether affiliated or not, Meridian takes all measures necessary to extract the best performance possible from its subcontractors. This includes, but is not limited to, developing integrated systems to deliver information in real-time to Meridian, subcontractors, providers, members, caregivers, and those actively involved in the continuum of care. The goal is to create one seamless experience

for both members and providers. Meridian contracts with a broad range of agencies to deliver holistic patient-centered care.

Cultural Considerations

The U.S. Department of Health and Human Services Office of Minority Health defines cultural and linguistic competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. Cultural competency is important as it is one of the main elements in closing the disparities gap in health care. In States where fully capitated managed care has been adopted by Medicaid agencies, cultural competence is a significant component of contract requirements between the State and MCOs.

Meridian delivers services in a culturally competent manner to all members and providers. Members' needs are accommodated, including those whose first language is not English, who are visually impaired, who are hearing impaired, who have physical disabilities, and/or who have cognitive disabilities. Meridian understands that members will be a diverse population with different literacy levels, learning styles, and capabilities, and Meridian respects members whose lifestyles or customs differ from the majority of the population. All Meridian Member Services staff is trained to recognize and respond to the needs of culturally diverse members.

Meridian addresses the special health needs of members who are poor, homeless, and/or members of a minority population group. The following practices are incorporated into Meridian polices, administration, and service: honoring members' beliefs, sensitivity to cultural diversity, and fostering in staff and providers attitudes and interpersonal communication styles which respect members' cultural backgrounds. Meridian has specific policy statements regarding cultural competency which are communicated to network providers and subcontractors.

Meridian recognizes that healthcare services that are respectful of and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse patients can have a big impact on positive health outcomes.

Culture and language influence members':

- Health, healing, and wellness belief systems
- Perception of illness, disease, and their causes
- Behaviors in seeking health care and their attitudes toward healthcare providers

Culture and language also influence the delivery of services by the provider who may have different views and values than the member, which could impact access and delivery of care for patients/members from other cultures. Meridian continuously strives to ensure that members receive services from the plan and its provider network in a culturally competent manner.

MCOs and Social Determinants of Health

Many Medicaid beneficiaries are impacted, not only by physical health conditions, but also other

social determinants. MCOs can play a significant role in coordinating care while factoring in the members' social determinants. Meridian recognizes the criticality of a population health management program centered on addressing social determinants of health. Utilizing existing tools, Meridian records behavioral, physical, cultural, environmental, and social factors that may be used for analysis in addressing population health management. Information related to transportation, housing, food access, unemployment, education level, race, ethnicity, gender, disabilities, age, primary language, ability, geographic location, and income level are collected through:

- The Meridian Health Risk Assessment (HRA)
- Electronic medical record (EMR) data
- Meridian's Health Habits Survey (available electronically via the Member Portal)
- The initial welcome call
- Contact with Care Coordinators, Case Managers, and CHWs
- Member enrollment file
- Member satisfaction surveys
- Data sharing and collaboration between community health partners; both regionally and State-wide

Meridian has historically incorporated social determinants of health into analysis using Meridian's proprietary software system, Managed Care System (MCS). MCS houses a plethora of information in a single location to aid in enhanced data analysis. MCS stores claims data, pharmacy data, HEDIS® data, laboratory data, member demographic information, provider information, utilization data, HRA results, eligibility status, supplemental/EMR data, transportation records, and a member contact log. Since MCS is an internally developed and maintained system, changes may be programmed to collect additional data elements when and if any are identified.

The objective of Meridian's enhanced data analysis plan resulting in intervention development and measurement is ultimately to decrease health inequities amongst Meridian members, while simultaneously promoting the highest standards of care and health outcomes for all Medicaid beneficiaries. Population health management is a collaborative effort amongst all regional/State-wide stakeholders who are involved in patient care and well-being. Providing robust data and analysis will assist in collaboration with these partners who rely on Meridian to assist them in identifying opportunities for improvement and intervention implementation.

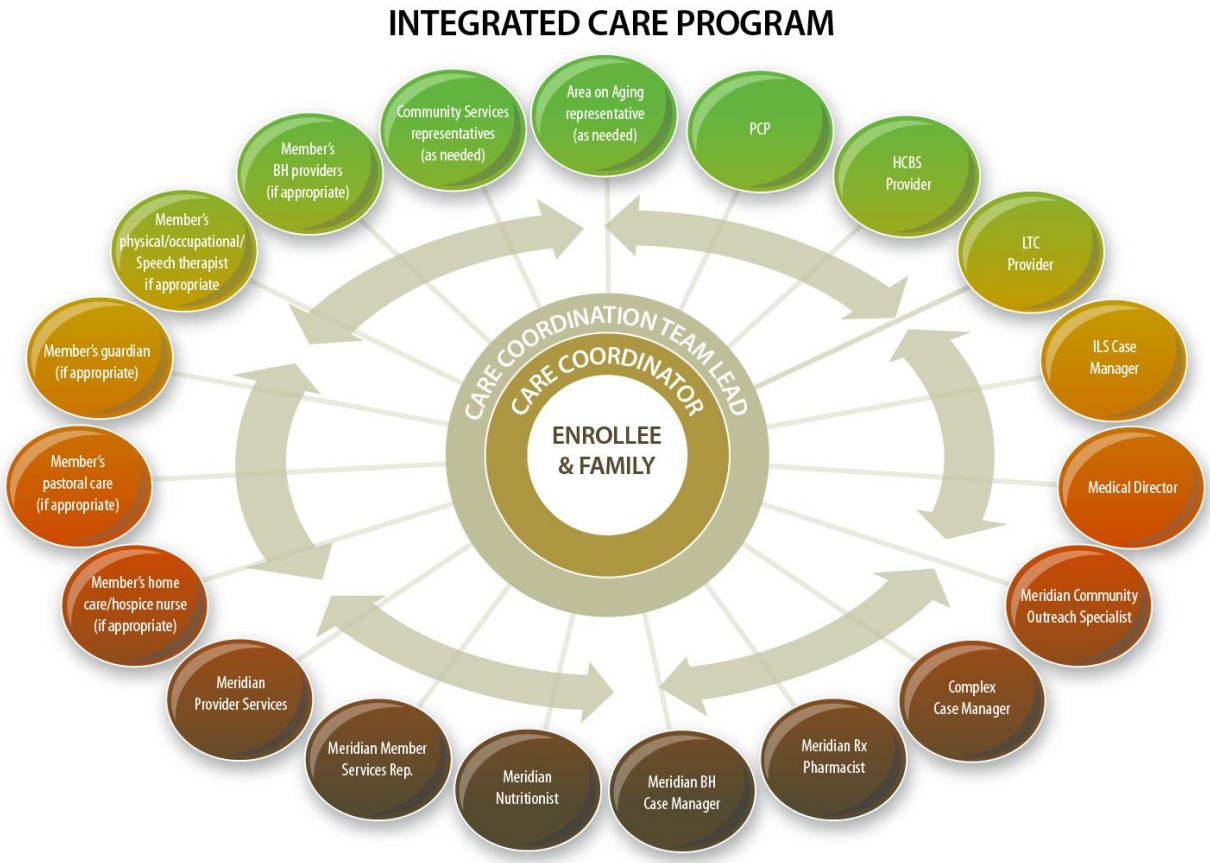
Improved Quality of Care

Through accreditation granted by national accrediting bodies such as the National Committee for Quality Assurance (NCQA), MCOs are held to national and industry standards. Accreditation received through national bodies like NCQA ensures that beneficiaries receive high-quality services. Quality is paramount at Meridian. As part of all current State contracts, an annual evaluation of the quality improvement program is produced. This report contains extensive statistical, anecdotal, and programmatic information about all aspects of quality care provision. The annual evaluation displays year-over-year performance and details special projects

addressing health concerns of members. The highlights of this report are reported in member newsletters following release of the report.

Meridian's Integrated Care Program

With nearly 18 years of Medicaid Managed Care experience, Meridian has thoroughly developed a holistic person-centered Integrated Care Program (ICP). Below is an illustration of Meridian's ICP. Implementing an MCO model would allow for the Oklahoma ABD population to receive services in a highly coordinated, integrated environment. Developing successful partnerships with community, State, and Federal agencies, MCOs can provide managed care services that improve health outcomes for the most vulnerable populations. Meridian believes that meeting members in the community allows Meridian to gain an accurate picture of their needs to provide personalized services. Meridian's holistic, integrated care plans empower members to make informed decisions regarding their health by actively participating in their care plan.



Meridian's programs combine a member-centered approach to care with technology, bridging the gaps that can occur in transitions of care. The focus on individual member needs starts at enrollment. Within 30 days of joining the plan, members receive a HRA. Based on the HRA results, MCS uses objective data and member interaction to stratify members into the appropriate risk categories. Based on member stratification, an appropriate Integrated Care Team is assigned

to coordinate the member's care. The ICT is overseen by a Medical Director. The Medical Director is available to provide clinical oversight, assistance in developing a final care plan and to define follow-up requirements and time frames. Clinical consultants also assist the ICT with specialty area care management such as Behavioral Health, Nutrition and Pharmacy needs. Encompassing medical, behavioral/developmental, and LTSS, this proactive approach allows the ICT to quickly identify and implement care coordination activities, resulting in improved member health outcomes. These coordination activities are especially important for dual-eligible and ABD members with multiple chronic medical conditions, often exacerbated by underlying behavioral health issues.

A key feature of the ICT is member involvement. Members are invited to participate in the team meetings, either by phone or in person. With caregivers also invited to attend, members are encouraged to learn about their medical conditions and strategies for self-management. This member education not only supports improved health outcomes, but also empowers members to take an active role in their own health care.

Overall Benefit to ABD Patient Population

MCOs have experience managing care for the full range of beneficiaries in many markets. Medicaid MCOs aid in the overall managed care targeted purpose of improving access to medical, mental, and social services, the improvement of access to affordable care, coordination of care, seamless transitions across healthcare settings, and access to preventive health services. Other objectives include appropriate utilization of services and improvement of reducing hospitalizations and nursing facility placements as well as improved health outcomes.

Meridian maintains ongoing quality improvement initiatives aimed towards innovative partnerships, beneficiary sensitivity, and effective relationships with providers to ensure the quality and safety of healthcare services received by its high-risk population.

3. Explain Respondents approach for implementation of the model

Should the State of Oklahoma and the Oklahoma Health Care Authority (OHCA) choose to select the Fully Capitated Managed Care Organization (MCO) model to administer benefits and provide care coordination for the Aged, Blind, and Disabled (ABD) beneficiaries, Meridian would suggest an implementation plan similar to the high-level timeline listed below:

Timeframe	Event
June 2016	RFP released
August 2016	RFP responses due
September 2016	State awards contracts to 2-3 Managed Care Organizations (MCOs) in order to ensure members have adequate choice and to prevent program disruption should a selected plan become unable to fulfill the contract obligations
October 2016	Execute contracts with MCOs

December 2016	Readiness Reviews for MCOs
January 2017	Go-Live

To ensure a seamless transition to a MCO environment, Meridian believes in and would advocate for open collaboration with the State during the implementation period. Aside from site visits, Meridian will provide all of the necessary components for a successful partnership prior to go-live, including:

- Project Management Team responsible for the overall implementation, managing to a detailed timeline and specific contractual obligations
- Information Technology Team tasked with integrating data and files with the State while also ensuring the necessary hardware/software development is performed to specification
- Clinical Team charged with the implementation and execution of all Case Management programs in line with the OHCA's requirements
- Client Support Team to assist with any questions/needs the state may have

Meridian's approach for implementing the Care Coordination program would focus on the following critical areas:

Systems Implementation

Meridian has a turnkey information management system with its proprietary Managed Care System (MCS), an integrated, enterprise-wide care management system. All Meridian functions are found within this single platform for healthcare optimization. Consistent with Meridian's belief in deeply rooted partnerships, the talented team of information technologists will identify and implement any custom changes needed for implementing the Care Coordination program for OHCA.

Provider Network Education

As a multi-State health plan, Meridian will apply its provider network development processes and practices utilized in other markets to develop a comprehensive provider network prior to implementation of the program. Also prior to implementation, Meridian will provide orientation and training for contracted providers to ensure a seamless transition upon go-live.

Enrollment in Program

Development of an enrollment algorithm will be critical to ensure the Fully Capitated Managed Care (MCO) model functions as intended. The algorithm for assigning enrollees to the MCOs should rely on an evaluation of the MCOs administrative and quality measures including, but not limited to, network adequacy, claims processing, compliance reviews, encounter data submission, and national standards such as Healthcare Effectiveness Data and Information Set (HEDIS®) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. Enrollment in the program should consider the member's choice. Beneficiaries should have the opportunity to choose the managed care plan in which they would prefer to enroll.

Therefore, Meridian would suggest a six-month voluntary enrollment period in which beneficiaries have the opportunity to choose a health plan. Following the six-month voluntary enrollment period, a mandatory enrollment period would begin. During the mandatory enrollment period, the State would assign beneficiaries to a plan, but have not selected a health plan on their own. By the end of the mandatory enrollment period, all beneficiaries should be assigned to a health plan.

The benefit of the mandatory enrollment period conducted by the State prevents the assignment of high-risk beneficiaries to one single health plan. This caveat helps to ensure an unfair distribution of beneficiaries, which could in turn hinder the quality of care delivered and the performance of a health plan.

Member Outreach Campaigns

Meridian is poised to execute an effective member outreach strategy that builds personal relationships and connects members with providers. Using all available communication mediums, Meridian takes pride in working with members at their level, in their communities, to best meet their individual health needs. Meridian would recommend that OHCA develop member outreach requirements that consider member demographics and mediums that may be most effective in reaching current and potential beneficiaries.

Member and Provider Education

Meridian's materials are developed in-house, customized to meet the expectations of the State partner agencies. Meridian includes member and provider education materials on the Meridian website for easy access and reference. Meridian also maintains a comprehensive electronic Provider Directory, as required by contracts. Meridian directories, as well as other education materials are available to members and providers whenever requested.

Disease Management and Case Management Program Implementation

Meridian's Disease and Case Management programs are fully integrated enterprise-wide. From the initial time of enrollment, MCS stratifies members into appropriate care programs based on objective and subjective data. Effective and ongoing communication with members is all part of Meridian's focus on quality.

B. Populations Served

1. Identify proposed eligible populations ***(All members or target specific populations based on geographic areas, aid category, specific health conditions, etc.)***

Meridian Health Plan (Meridian) recommends that all members meeting the qualifications for benefits entitled to the Aged, Blind, and Disabled (ABD) population be included under a Managed Care Organization (MCO) model. The recommendation would be to include both children and adult beneficiaries. Meridian would also recommend that program be State-wide and available to beneficiaries qualifying for program.

2. For each of the populations selected, state whether services would be provided statewide, within certain county(s), or will Respondent employ regionalization
i. Define which county(s) in which the model would operate

Meridian Health Plan (Meridian) would recommend that the Fully Capitated Managed Care Organization Model (MCO) would operate in all 77 counties within Oklahoma. A State-wide program would allow for all Aged, Blind, and Disabled (ABD) beneficiaries to have adequate access to providers throughout the State regardless of their locality.

ii. Define which county(s) included in each region

Meridian would not recommend regionalizing this program. Regionalizing the MCO model could potentially limit access to critical providers outside of the specified regions which could potentially restrict care delivery. Regionalizing the MCO model would create a care environment that is bifurcated and inconsistent for both providers and members.

C. **Covered Services and Benefits**
1**. Describe proposed covered services and benefits for each population**

Meridian Health Plan (Meridian) would propose that the following benefits and services be provided for Oklahoma Aged, Blind, and Disabled (ABD) beneficiaries. Because the needs of the ABD population tend to be more, Meridian recommends that this list of covered services and benefits be used as a template for formulating a final list of covered services as desired by the State of Oklahoma. The managed care model should rely on the use of prior authorizations in order to ensure that medical services provided to members are medically necessary and/or appropriate, as well as conform to the State-mandated benefit plan. However, Managed Care Organizations should apply systematic evaluations to determine medical necessity and consider circumstances unique to the member requiring services.

Proposed Benefits in Scope
Physical Health Benefits
Behavioral Health Benefits (Inpatient/Outpatient)
Pharmacy Benefits
Long-Term Services and Supports (HCBS Waiver Services)

Proposed Mandatory Covered Services *Current Services Covered by SoonerCare		
Ambulance	Hemophilia	Physician services, including preventive services
	Hearing/Hearing Assistance Benefits	
Ambulatory Surgery Center Services	Home Health Services	Podiatry services

Behavioral Health and Substance Abuse Services (Inpatient/Outpatient)	Inpatient Hospital Services	Prescription Drugs and Insulin
Case Management Services	Inpatient Hospital Services in an Institution for Mental Disease for People who are 65 Years of Age or Older *	Prenatal, Delivery, and Postpartum Services (Maternity Services)
Chemotherapy and Radiation Therapy	Intermediate Care Facilities for Mental Health Services	Quitting Smoking & Tobacco
Child Health	Laboratory and X-ray Services	Rural Health Clinic (RHC) Services
Clinic Services including Renal Dialysis Services	Medical Supplies and Equipment, including Diabetic Supplies	Transplants that are Prior Authorized
Dental Services Vision Benefits	Mental Health and Substance Abuse Services	Transportation to Obtain Covered Medical Care
Dentures for Adults Residing in Nursing Facilities	Nurse midwife services	Tuberculosis Services
	NEMT (Non-Emergent Medial Transportation)	
Durable Medical Equipment and Supplies	Nursing Facility Services	Ultrasound Benefits
Family Planning Services and Supplies	Outpatient Hospital Services	Family Planning Services
Federally Qualified Health Center (FQHC) Services	Pregnancy Services (breastfeeding, etc.)	Home and Community-Based Services Authorized Under a Waiver

Proposed service for children qualifying for Oklahoma ABD benefits:

Proposed Services for ABD Children	
Hearing Aids	Other Medically Necessary Services
Immunizations	Physical and Occupational Therapy
Inpatient Hospital Services for Patients in Institutions for Mental Disease	Private Duty Nursing
Optometric or Optical Services, including Eye Glasses	Speech, Hearing, and Language Disorder Services
Orthodontics	

Meridian would also propose that the Fully Capitated Managed Care Organization (MCO) program include additional value added benefits such as the following:

Additional Value Added Covered Services	
Extra Pharmacy Benefits	No four prescription policy or limit per month.

Extra Transportation Benefits	Transportation to and from medical appointments, pharmacy, and medical equipment providers.
Nurse Advise Line	A nurse advice line should be available 24 hours a day, 7 days a week to call a nurse for advice.

2. Describe the clinical effectiveness and evidence-base supporting the proposed covered services and benefits

Fully Capitated Managed Care Organization (MCO) relies on collaboration between the State Agency, Managed Care Organizations (MCOs), and the States respective Medical authority. The proposed covered services include all of the services available to current SoonerCare beneficiaries. Meridian would propose that the current Medical Authority continue to review and make determinations of clinical effectiveness under the proposed MCO model. Managed care has proven to be more effective when all benefits are carved-in under the managed care model. When benefits are carved-in to the MCO, integration of care and improved care coordination occur.

In regards to Meridian's determination for covered benefits and services relies on the adoption of clinical practice guidelines (CPGs). Meridian monitors adherence to these guidelines across the provider network annually. The guidelines that are adopted are developed by nationally recognized sources and organizations such as the Michigan Quality Improvement Consortium (MQIC); National Heart, Lung, and Blood Institute (NHLBI); and Institute for Clinical System Improvement (ICSI). Meridian promotes implementation of these CPGs via dissemination among practitioners in hard copy (upon request), electronically on the Meridian website, and via fax for updated CPGs when applicable. The CPGs are reviewed annually and updated as necessary by the Meridian Physician Advisory Committee (PAC) and approved by the Quality Improvement Committee (QIC) and Board of Directors (BOD). Meridian Health Plan utilizes internal medical review criteria when rendering Utilization Management (UM) decisions. If Meridian internal medical review criteria are not present for a requested service, Meridian will utilize InterQual® Guidelines. Meridian internal medical review criteria are developed when utilization practice identifies opportunities that promote the development of new criteria or a revision/addition to existing practice guidelines.

3. Explain reason for any proposed non-covered services and benefits

Meridian Health Plan (Meridian) believes in a holistic approach to Medicaid managed care. Meridian would suggest including all benefits physical, behavioral, pharmaceutical, Long-Term Services and Supports, dental, and vision under a Fully Capitated Managed Care Organization (MCO) model. However, while Meridian proposes the incorporation of an extensive benefit package, Meridian would recommend the Oklahoma Health Care Authority (OHCA) maintain the required list of excluded benefits, as mandated by Medicaid agencies in other states in which Meridian operates.

The following are services prohibited or excluded under Medicaid:

- Elective abortions and related services
- Experimental or investigational drugs, procedures or equipment
- Elective cosmetic surgery
- Services for treatment of infertility and medication for erectile dysfunction

D. Provider Network

1. Describe provider network recruitment and retention, including types of providers *(for example primary care, specialty care, dental, HCBS, case/care management, LTC, other, etc.)*

Medicaid Managed Care Organizations (MCOs) have the experience and expertise in developing provider networks to ensure members have adequate access to care. Many State agencies mandate, within the contracts between the agency and the MCO specific, access requirements ensuring members can access care when necessary. Generally, for Medicaid lines of business, these requirements are based on a 30-minute/30-mile access standard for primary care providers (PCPs), specialist, ancillary providers, and hospitals. Meridian developed its own approach to developing and maintaining comprehensive provider networks. Meridian has experience in developing Medicaid provider networks for the Aged, Blind and Disabled (ABD) population in both urban and rural areas. Meridian's approach is to create exceptionally strong and lasting relationships with providers through the high levels of service offered, which results in the elimination of any access barriers for members. In addition, Meridian builds personal relationships through monthly face-to-face visits and equipping providers with a vast array of technology to help them improve their administrative efficiency allowing them to focus on what they do best – delivering high-quality care. Meridian also provides unique bonus opportunities for contracted PCPs and obstetrics/gynecologic (OB\GYN) providers based on quality and performance metrics.

Meridian's comprehensive provider networks include PCPs, specialists, Federally Qualified Health Centers/Rural Health Clinics (FQHC\RHCs), hospitals, ambulatory surgery centers, mental health providers, ancillary providers (i.e., durable medical equipment, home health, skilled nursing facilities, ambulance, laboratories, etc.), and pharmacies.

While every MCO has network strategies unique to their organization, Meridian's provider network recruitment efforts begin with a thorough market assessment. Prior to network recruitment, Meridian assesses the market and look for certain criteria to determine the best approach when entering a State for the first time. Once this has been determined by Meridian Executive Management, a review of the State's rural and urban areas is done to identify key providers that will initially be approached (hospitals, providers, etc.). Meridian then begins approaching these providers through a variety of means such as direct mailings, telephonic outreach, email communication, and face-to-face meetings. After discussion and presenting Meridian's business plan to the provider community, Meridian then initiates the contracting\recruitment process, which involves discussion and negotiation of the contract, credentialing process, provider orientation, and subsequent visits occurring on a regular basis to check in, deliver materials, and educate the provider on programs being offered by the State

and/or Meridian. Meridian values the expertise and capabilities of local and community-based providers and considers all opportunities for partnerships when building provider networks.

After a provider has been contracted with Meridian, work is done to make sure they are retained by providing high levels of service to the provider community. A few examples to demonstrate these services are:

- Timely claims processing (clean claims are processed and paid within 10 business days)
- Direct phone numbers for departments (i.e., Claims, Case Management, Member Services, Provider Services, Behavioral Health, Care Coordination, etc.)
- All incoming phone calls are answered within 30 seconds or less
- Simplified administration and authorization process (i.e., majority of routine outpatient surgeries are automatically approved online, etc.)
- Hassle free policies and procedures (i.e., Meridian will reimburse PCPs for well and sick visits during the same visit, etc.)

Meridian values provider partnership and thus maintains locally positioned Provider Network Development Representatives (PNDRs) who visit every PCP office and high-volume specialty care office on a monthly basis. At each visit, PNDRs educate PCPs\specialists and their staff about the latest policies and procedures, including wellness standards, HEDIS®, medical home guidelines, evidence-based practice guidelines, monthly education sheets, and Provider Portal education and instruction. The PNDRs also provide a customized report of assigned members still needing necessary preventive health services and the potential bonuses that can be earned for completing these services.

Each month, the PNDRs distribute an assortment of educational outreach material that is developed jointly by Meridian's Provider Services and Quality and Performance Improvement departments. These education sheets address different topics each month and include evidence-based medicine and practice guidelines, as well as billing and coding information. PNDRs are equipped with iPads, so that they have instant access to detailed information in a secure, safe, and Health Insurance Portability and Accountability Act (HIPAA)-compliant environment when responding to provider questions.

In addition, PNDRs are supported by Meridian's highly trained Provider Services staff to directly ask questions, offer suggestions, register complaints/concerns, etc. Meridian's toll-free provider hotline is directly staffed by Meridian Provider Services staff from 8 a.m. to 6 p.m. Monday through Friday, with additional phone coverage available seven days a week through an after-hours call center. The Provider Services staff receives extensive training to provide efficient, effective service, allowing providers to devote more time to serving members.

Aside from service level benefits, Meridian also offers its provider network a vast array of technology that is completely free for use. An example of this is the Meridian website. The website allows providers the ability to view and/or download the Provider Manual, monthly bulletins, forms, and educational materials. It also lists the Meridian formulary, medical policies, and the Provider Directory for providers to use and search through. Additional features offered

include the Provider Portal and online LiveChat functions. These materials are presented on the website in an organized and easily searchable format for providers to use daily with 24 hours a day, seven days a week access at the click of a mouse.

The Provider Portal is a secure, proprietary software program that offers unmatched flexibility and efficiency for network providers. Free of charge to all participating Meridian providers, the Provider Portal allows providers the ability to verify eligibility, view and submit claims, enter prior authorizations, obtain detailed member data and reports, enrollment lists, HEDIS® bonus information, provides self-reporting capabilities, and much more.

Meridian's LiveChat offers providers and their staff secure, HIPAA-compliant direct access to Provider Services staff members during normal business hours (8 a.m. to 6 p.m.) to exchange information and resolve any concerns they may have. After hours, providers may send a secure email, with prompt follow-up occurring the next business day by Provider Service staff.

Meridian has made a commitment to provider network retention through unique bonus opportunities. Meridian offers it's contracted PCPs and OB\GYNs HEDIS®\Quality Measure bonus programs, PCP Incentive Programs as well as the possibility for earning an extra performance bonus based upon adherence to specific preventative measures outlined by HEDIS® criteria. For example, if a member's assigned PCP completes four DTaP, three IPV, one MMR, three HiB, three Hep B, one VZV, and four PCV immunizations for that member within the guidelines set forth in Meridian's Performance\HEDIS® Criteria, then that PCP will be entitled to an additional $100 payment. This payment will be made in addition to any other bonuses that the PCP would be entitled to receive for completing these requirements.

Overall, Meridian works very diligently to develop expansive provider networks to ensure coverage for members. Meridian continuously monitors this network across the State to assure equality of service access and availability. If Meridian's monitoring ever shows the need for increased access to services, Meridian will review its action plan, make appropriate changes, and if needed, submit to the State for approval.

E. Provider Payment Structure
1. Explain provider payment methodology, assumptions, and constraints
a. Specific to covered benefits and services (As listed in Section 3.3,Item C)
b. Specific to other benefits and services
c. Show estimated amounts of provider payments for evidence-based performance outcomes *(for example amounts of withholds, performance payments based on quality metrics, etc.)*

<u>Fee-For-Service with Quality Incentives and PCMH Financial Support</u>
Meridian supports care coordination at the point of service through its PMCH Incentive Program, which has been in place since 2011. In this medical home model, a primary care provider (PCP) office coordinates inpatient and outpatient medical care for patients and tracks referrals to laboratories, pharmacies, and imaging centers. The PCMH model also promotes the use of electronic health records (EHRs) and registries, e-prescribing, and the use of evidence-based

clinical tools and templates, often built directly into the EHR systems. Meridian encourages Enrollees to build a strong relationship with their PCP and ensures that each Enrollee has access to an ongoing PCP to support their needs. Meridian's systems and processes provide PCPs with the information necessary to promote coordination of Enrollee services that take place outside of the PCP office. Meridian also supports the creation of medical homes for medically complex Enrollees.

Meridian provides monetary incentives based on progress at reaching milestones related to PCMH accreditation. Provider practices are encouraged to employ electronic tools (including registries), incorporate evidence-based guidelines for targeted chronic conditions, and incorporate team-based care into their operations. Provider practices receive technical assistance and funding to support project implementation. Meridian also provides assistance to PCPs in the meaningful use process and to providers in obtaining national PCMH certification through Utilization Review Accreditation Commission (URAC), National Committee for Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAAHC), and Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Meridian offers enhanced payments to PCMH-recognized practices through the payment of new billing codes (such as after-hours care), bonus payments based on HEDIS® scores, and a tiered administrative bonus payment based on performance.

PCMH Incentive Program

Patient Centered Medical Home (PCMH) Incentive Program	
Meridian PCP PCMH Bronze	
Qualifications • Contracted – Fee-for-Service • Open to and accepting new Meridian members • Meridian membership of 100+ • Level 1 NCQA recognition or score of 35-59 on Baseline Self-Assessment Tool (Passing all Must Pass Elements)	*Administrative Payment* • $1 PMPM • Meridian HEDIS® Bonus Program *$10,000 annual cap per provider
Meridian PCP PCMH Silver	
Qualifications • Contracted – Fee-for-Service • Open to and accepting new Meridian members • Meridian membership of 100+ • Level 2 NCQA recognition or a score of 60-84 on the Baseline Self-Assessment Tool (Passing all Must Pass Elements)	*Administrative Payment* • $2 PMPM • Meridian HEDIS® Bonus Program *$10,000 annual cap per provider
Meridian PCP PCMH Gold	
Qualifications • Contracted – Fee-for-Service • Open to and accepting new Meridian	*Administrative Payment* • $3 PMPM • Meridian HEDIS® Bonus Program

members • Meridian membership of 100+ • PCMH recognition by Joint Commission, URAC or AAAHC and/or level 3 NCQA recognition or score of 85-100 on the Baseline Self-Assessment Tool (Passing all Must Pass Elements)	*$10,000 annual cap per provider

Meridian's P4P HEDIS® Bonus Program is designed to increase provider adherence to clinical guidelines to enhance the health status of Meridian's membership. All contracted PCP and Obstetrics/Gynecology (OB/GYN) specialties automatically participate in the program.

Meridian uses multiple formats and forums of communication to ensure providers are aware of Meridian incentive programs:

- **Provider Bonus** – Providers are offered bonuses as part of the PCP Incentive Program for getting their Enrollees in for certain preventive visits
- **HEDIS® Report Cards** – Report cards are sent to providers giving the total number of tests performed for each Enrollee and the financial incentive given
- **Action Plans** – The disease management (DM) outreach process was enhanced to include faxing of condition-specific action plans to the Enrollee's PCP and mailing a copy to the Enrollee
- **Provider Education Flyers** – Providers are given an educational flyer each month regarding HEDIS® measures
- **Clinical Practice Guidelines** – The guidelines are available on the Meridian website and are distributed on the back of provider education flyers. Providers are notified of any changes to the guidelines via the website and fax blasts
- **DM Program Information** – Meridian provides information about DM programs on the Meridian website and in the Provider Manual so that providers are aware of the interventions being taken by Meridian. The information includes instructions on how providers can refer Enrollees to the program

Meridian is committed to ensuring that its Enrollees receive quality preventive health care. To encourage contracted providers to meet this goal, Meridian implements bonus programs based on specific HEDIS® measures.

Meridian pays a quality bonus to PCPs for many types of services. All eligible PCPs and OB/GYNs are able to receive a performance bonus for adherence to specific preventive measures based on HEDIS® criteria. These services are designed to keep Enrollees healthy. By providing incentives to those administering preventive care, Meridian lowers costs and improves Enrollee health status over the long term.

Meridian Health Plan

HEDIS® Bonus Program Overview

Body Mass Index (BMI)				
Service	Procedure	Bonus	Performance Criteria	Plans
Adult BMI - Ages 18-74	Adult BMI Recording	$5 per completed service	Reimbursement paid upon completion of BMI recording for members 18-74 years old. One paid per member per calendar year.	Medicaid
Child BMI Percentile - Ages 2-17	Child BMI Percentile Recording	$5 per completed service	Reimbursement paid upon completion of BMI percentile recording for members 2-17 years old. One paid per member per calendar year.	Medicaid
Comprehensive Child and Adolescent Care				
Service	Procedure	Bonus	Performance Criteria	Plans
Childhood Immunizations - Combo 3* Before Age 2	4 DTaP	$20 per series	Reimbursement paid upon completion of immunizations completed between 6 weeks (42 days) and 2 years of age.	Medicaid
	3 IPV/OPV		Reimbursement paid upon completion of immunizations completed between 6 weeks (42 days) and 2 years of age.	
	1 MMR		Reimbursement paid upon completion of immunizations completed before 2 years of age.	
	3 HiB		Reimbursement paid upon completion of immunizations completed between 6 weeks (42 days) and 2 years of age.	
	3 Hepatitis B		Reimbursement paid upon completion of immunizations completed before 2 years of age.	
	1 VZV		Reimbursement paid upon completion of immunizations completed before 2 years of age.	
	4 PCV		Reimbursement paid upon completion of immunizations completed between 6 weeks (42 days) and 2 years of age.	
$100	If an assigned member receives all of the qualifying immunizations under Combo 3 within HEDIS® guidelines, an additional **$100 bonus** will be paid to the assigned PCP at the time of completion. Combo 3 includes 4 DTaP, 3 IPV, 1 MMR, 3 HiB, 3 Hep B, 1 VZV and 4 PCV.			
Childhood Immunizations - Before Age 2	1 Hepatitis A	$20	Reimbursement paid upon completion of immunizations completed before 2 years of age.	Medicaid
	2 Rotavirus OR 3 Rotavirus	$20	Reimbursement paid upon completion of immunizations completed between 6 weeks (42 days) and 2 years of age. The number of rotavirus doses varies based on which vaccine is given. There is a 2-dose schedule and a 3-dose schedule. The vaccines are identified by different CPT codes.	
	2 Influenza	$20	Reimbursement paid upon completion of immunizations between 6 months and 2 years of age.	

Comprehensive Child and Adolescent Care				
Service	Procedure	Bonus	Performance Criteria	Plans
Well-Child Visits Well-Child Visits Ages 0-15 Months 0-15 Months	1-5 visits	$25	Please complete 6 visits per member prior to 15 months of age. According to age-specific EPSDT Visit Schedule. Bonuses paid for up to 6 per member between 0-15 months.	Medicaid
	6th visit	$100		
Well-Child Visit - Ages 3-6		$25	According to age-specific EPSDT Visit Schedule.	Medicaid
Adolescent Well Visit - Ages 12-21		$25	According to age-specific EPSDT Visit Schedule.	
Blood Lead Testing - Ages 0-2		$25	Complete one blood lead test by 2nd birthday.	

Comprehensive Women's Care				
Service	Procedure	Bonus	Performance Criteria	Plans
Breast Cancer Screening - Females ages 50-74	Mammogram	$50	One paid per calendar year.	Medicaid SNP Prime Complete
Cervical Cancer Screening - Females ages 21-64	Cervical Cytology	$25	One paid per calendar year.	Medicaid SNP Prime Complete
Chlamydia Screening - Females ages 16-24	Chlamydia Screen	$25	One paid per calendar year.	Medicaid

Comprehensive Diabetes				
Service	Procedure	Bonus	Performance Criteria	Plans
Comprehensive Diabetes Care - 18-75 year olds with diabetes (Types 1 & 2)	*HbA1c Screen	$25	At least one screen annually.	Medicaid SNP Prime Complete
	HbA1c Good Control (<7%)	$50	One paid per member per calendar year.	
	*Fundoscopic Eye Exam	$25	At least one annually, completed by an Optometrist or Ophthalmologist.	
	*Microalbuminuria Screen	$25	At least one screen annually.	
$100	*If an assigned diabetic member receives a qualifying HbA1c Screen, a Lipid Profile, a Fundoscopic Eye Exam and the Microalbuminuria Screen during the year within HEDIS® Guidelines, an additional **$100 bonus** will be paid to the assigned PCP.			
$100	**Additional Bonus Opportunity – If an assigned diabetic member's ending Blood Pressure and HbA1c levels are controlled, an additional **$100 bonus** will be paid to the assigned PCP. Controlled levels are HbA1c <7% and Blood Pressure <140/90. As of December 31, 2014 the last Blood Pressure and HbA1c levels received by Meridian for the calendar year are used to determine compliance. A lab test without a value is considered uncontrolled.			

Obstetrical Care (paid to servicing provider)			
Service	Bonus	Performance Criteria	Plans
Prenatal Care – Antepartum Care 4-6 visits	$100	All prenatal visit dates, LMP and EDD/EDC must be included. The first prenatal visit must be performed in the first trimester (<13 weeks), or within 42 days of enrollment.	Medicaid SNP Prime Complete
Prenatal Care – Antepartum Care 7+ visits	$200		
Postpartum Care	$100	Postpartum Care visit must be on or between 21 days and 56 days after delivery.	

Tobacco Cessation Counseling (paid to servicing provider)			
Service	Bonus	Performance Criteria	Plans
Tobacco Cessation Counseling - All genders ages 12 and up	$20	One paid per member per calendar year.	Medicaid, SNP, Prime, Complete
Healthy Michigan Plan (HMP) Health Risk Assessment (HRA) Program			
Service	Bonus	Performance Criteria	Plans
Initial Visit with PCP and Completed HRA - All genders ages 19 - 64	$25	Reimbursement paid once per member for initial visits performed within the first 150 days of enrollment and billed with the appropriate HRA CPT code 99420. Completed and attested HRAs must be received by Meridian within 30 days of initial visit.	Medicaid – Healthy Michigan Plan

Meridian data shows that providers with PCMH recognition have a 9% reduction in the overall cost of care as well as a 3% increase in HEDIS® scores compared to those not PCMH designated. Emphasis on these programs has allowed Meridian to again be the number one Medicaid health maintenance organization (HMO) in Michigan and ninth in the nation according to NCQA's Medicaid Health Insurance Plan Rankings 2014– 2015. Meridian earned the highest possible rating of five out of five for Consumer Experience, Prevention, and Treatment.

Shared Saving Model

Meridian's shared savings program sets a global budget based on the historical utilization of the provider's Enrollees. The provider is eligible for 25% to 75% of the savings below this global budget depending on the percentage of quality and administrative measures met. The provider will continue to receive FFS payments, PCMH payments, and P4P payments with Meridian's HEDIS® Bonus Program, and an administrative PMPM to coordinate the program throughout with quarterly reports demonstrating performance against this global budget. The administrative payment to coordinate the program is calculated outside the global budget and not charged against the shared savings pool.

Meridian uses the following contract language in agreements to ensure the model focuses on quality:"[Provider] agrees that payment of any Shared Savings Bonus is expressly contingent on meeting the Quality Performance Threshold for the Reporting Period. For purposes of this Agreement, in order to meet the Quality Performance Threshold [Provider] must meet at least the 75th percentile in 50% or more of the following HEDIS® measures:

1. [Up to seven HEDIS® Measures]
2. [Up to three Administrative Measures]

In the event [Provider] fails to meet the Quality Performance Threshold in a given Reporting Period, no Shared Savings Bonus will be due to [Provider] for that Reporting Period."

Meridian will align HEDIS® measures in accordance with MDHHS programs and NCQA standards. HEDIS® measures may include, but are not limited to:

- Annual Well-Child Visits
- Lead Screening
- Immunizations
- Prenatal Screening
- Postpartum Screening
- Body Mass Index

Meridian also includes administrative measures in this program as well. Administrative measures may include, but are not limited to:

- All Cause Readmission Rates
- Membership Thresholds
- Hospital Acquired Condition (HAC)/Hospital Acquired Infection (HAI) Incident Rate
- Potentially Avoidable Admissions
- Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS)
- C-Section Delivery Rates

Assumptions

Meridian has successfully implemented this model of contracting with Medicaid providers throughout the States of Michigan, Illinois, and Iowa. It is assumed that the approach utilized in other markets would seamlessly transfer in administering services for Oklahoma's ABD population. Meridian would advocate that its approach to program delivery and incentive plans coincide well with the provider community. The MCO approach could potentially benefit the Oklahoma marketplace for controlling costs and enhancing quality for the ABD population.

Constraints

Overall program constraints can be expected in any healthcare program due to political and fiscal constraints at the State and Federal level. The MCO model can alleviate many constraints in regards to payment between the MCO and providers, so long as the State agency responsible for reimbursing the MCOs properly allocates funds to the entity. As MCOs assume full-risk of healthcare delivery under a MCO model, budgetary, access, and quality constraints can be alleviated for State agencies. However, this alleviation is dependent on timely and fair payment between the agency and the MCO.

Other potential constraints revolve around provider commitment and acceptance of rates. MCOs rely on provider networks to ensure that care is delivered both timely and appropriately to all members. Having extensive experience establishing provider networks, Meridian has developed innovative contracting practices to incentivize and accommodate providers willing to contract with the health plan. Meridian has been an advocate for developing innovative approaches to improve the functionality and efficiency of the MCO model. Meridian stands by its approach and

capability of implementing the MCO payment model and distributing payments to contracted PCPs.

F. State Payment Structure

1. Explain how payments are made by the state to the party(s) responsible for the objectives of the recommended model (As listed in Section 3.1, Items A-K)

Under the Fully Capitated Managed Care (MCO) model, a set per member per month would be paid to the MCO on a monthly based upon the number of members the plan is assigned. The MCO would have the sole responsibility of properly administering all the covered benefits within this payment.

Oklahoma Health Care Authority (OHCA) should risk-adjust each MCOs rates, based on the relative morbidity of their enrolled members to the statewide population. The State should reserve the right to change risk adjustment models and tools. Total payments by the State will be risk score neutral, meaning MCOs' rates will be adjusted both up and down, according to the morbidity of their enrolled members relative to all enrolled members.

Risk adjustment should be calculated separately for the LTSS population and the non-LTSS population. To financially incent MCOs to deliver LTSS to the Elderly population in the least restrictive environment, the OHCA should blend the Institutional (e.g. Nursing Facility) and Home and Community-Based Services (HCBS) Elderly populations into one rate cell, to encourage management of the entry into institutions. OHCA or their consultants should apply a system of assigning severity (risk) to the individuals enrolled using claims data including diagnosis codes, services provided, and, possibly, pharmacy data. Once all of the individual risks have been assigned, a total risk score should be developed for each MCO. The risk score for all MCOs and any fee-for-service (FFS) population will be adjusted (normalized) to 1.0. This normalization should result in an adjustment factor which should be applied to the total risk score of each MCO producing their risk relative to the total risk of the entire population. In the case of a prospective risk adjustment, once sufficient enrollment information is available the MCO, relative risk score should then be used to adjust the capitation payments to the MCO either upward or downward. However, the total capitation payments will remain unchanged. In the case of a retrospective risk adjustment process, the risk scores will be used to move amounts paid to participating program contractors to adjust for the higher/lower risk covered during the SFY by each MCO, but with the total payments made by OHCA remaining unchanged.

2. Explain how proposed payments comply with existing and proposed Federal and State requirements

Demonstrated by the significant number of States utilizing the Centers for Medicare and Medicaid Services (CMS) waiver programs (Capitated Managed Care), the model and proposed payments outlined throughout this request for information (RFI) would comply with all State and Federal requirements, including the Affordable Care Act, and any other rules and contractual obligations agreed upon in any future request for proposal (RFP). If the MCO model were to be selected as the Oklahoma Health Care Authority's model of choice, selected Managed Care

Organizations through the RFP process would be expected to observe and comply at all times with all, then and current, Federal and State laws related to or affecting this RFI, including any law that may be enacted during the term of this RFI or the contract.

G. Impact of Model

1. Explain estimated implementation costs and anticipated savings, for years 1through 5

a. Methodology

Anticipated Savings

In 2009, a study prepared by third party reviewed 14 case studies on Medicaid managed care and the cost savings achieved by those States which have adopted Medicaid managed care. The study revealed overall program savings ranging from two percent to 19 percent. More specifically, the study reveals that over a four-year period, the State of Michigan experienced significant cost savings ranging from nine percent and increasing to 19 percent by year four. The table below illustrates the savings calculated through the study.

Michigan Medicaid Per Member Per Month Costs – FFS versus MCO

Fiscal Year	FFS	Medicaid MCO	Percent Difference*
2001	$177	$161	-9%
2002	$188	$162	-14%
2003	$199	$167	-16%
2004	$210	$170	-19%

The study concluded that savings realized varies significantly by State and the research clearly points to a reduction in inpatient utilization providing the majority of savings. However, many factors contribute to achieving savings through Medicaid managed care. Factors such as population size, population health, utilization rates, access to services, claims processing efficiency, and the political and fiscal environment within the State also contributes to savings.

To determine the potential impact of implementing the MCO model for the Oklahoma Aged, Blind, and Disabled (ABD) population, the savings experienced by the State of Michigan were applied to projections calculated for the Oklahoma ABD patient population. The expected savings by transitioning the Oklahoma ABD patient population to a MCO model are outlined in the table below. While Michigan may have experienced significant savings over the four-year period, it would be reasonable to assume a percent savings as the difference between each of the four years as the utilized methodology, rather than a compounding savings reach a total savings of 19 percent savings. The data expressed in the table below demonstrates annual savings per year as:

- Year 1 (Y1) – 9 percent
- Year 2 (Y2) – 5 percent
- Year 3 (Y3) – 2 percent
- Year 4 (Y4) – 3 percent
- Year 5 (Y5) – 1 percent
- Total savings cap at 20 percent from Y1 by Y5

Meridian Health Plan

Oklahoma Expected Savings transitioning to Medicaid Managed Care (2017-2022)									
State Fiscal Year	Adult and Child ABD Expenditures (47% of Annual Medicaid Expenditures)(1)	Adult & Child ABD Beneficiaries(2)	Average Annual Current Cost per beneficiary SoonerCare (3)	Average Monthly Cost SoonerCare (4)	Average Annual Cost with MCO (5)	Average Monthly Capitation Rate with MCO (6)	Estimated MCO Annual Cost for ABD population (7)	Annual Savings with MCO Model (8)	Annual Percent Savings(9)
2010	$2,044,870,360	144,848	$14,117						
2011	$2,077,118,470	148,962	$13,944						
2012	$2,241,925,850	150,383	$14,908						
2013	$2,338,052,600	152,705	$15,311						
2014	$2,457,807,190	154,094	$15,950						
2015	$2,599,720,815	156,526	$16,609						
2016	$2,749,828,522	158,959	$17,299						
2017	$2,908,603,439	161,391	$18,022						***Implementation**
2018	$3,076,546,009	163,823	$18,780	$1,565	$17,090	$1,424	$2,799,662,565	**$276,883,445**	**-9%**
2019	$3,254,185,572	166,256	$19,573	$1,631	$18,595	$1,550	$3,091,470,095	**$162,715,477**	**-14% (5%)**
2020	$3,442,082,032	168,688	$20,405	$1,700	$19,973	$1,664	$3,369,245,744	**$72,836,288**	**-16% (2%)**
2021	$3,640,827,621	171,120	$21,276	$1,773	$20,638	$1,720	$3,531,609,672	**$109,217,949**	**-19% (3%)**
2022	$3,851,048,766	173,553	$22,190	$1,849	$21,968	$1,831	$3,812,530,956	**$38,517,811**	**-20% (1%)**
Actual	Projections						**Total Projected Savings**	**$660,170,970.00**	

(1) Total expenditures taken from SoonerCare Annual Reports from 2010-2014. According to information provided by OHCA ABD population expenses average 47% of annual Medicaid spending. The average Oklahoma Medicaid expenditure growth trend over a three year period was 5.8 percent growth year to year. Trend was then calculated from 2014-2022
(2) Children and adult beneficiaries were identified from the SoonerCare Annual Reports from 2010-2014. A three-year average determined that population growth rate was 2,432 per year. Projections were then calculated using these figures
(3) Average annual cost is calculated dividing estimated adult and child ABD expenditures by total adult and child beneficiaries
(4) Average monthly cost SoonerCare is calculated dividing average annual ABD expenditures by 12 to express monthly cost
(5) Average annual cost with MCO is calculated dividing estimated annual MCO cost by population
(6) Average monthly capitated rate is calculated dividing average annual MCO cost by 12 to express monthly cost
(7) Estimated MCO annual cost for ABD population assumes annual savings of Y1-9 percent, Y2-5 percent, Y3-2 percent, Y4-3 percent, and Y5-1 percent. Total savings caps at 20 percent over a five-year period
(8) Annual savings with MCO model expresses the difference between annual SoonerCare expenditures and estimated cost for ABD population
(9) Annual percent savings is calculated applying the savings calculated in the study referenced in the above narrative and applying the difference between each year for a total savings from Y1 to Y5 capping at a total of 20% savings by Y5

Implementation Costs:

Vendor Implementation Cost: As noted previously, transitioning from a fee-for-service model to a Managed Care Organization (MCO) model transfers financial risk of administering the program from the State Medicaid agency to the MCO. Expected implementation costs for MCOs will vary depending on the size and scope of the project. Expenses related to licensure with State Insurance Commission, staffing, operations, and local infrastructure can be expected by MCOs selected to participate in the program.

The State should require selected MCOs to prepare financial reports and feasibility studies for determining the MCO's preparedness for participation in the program. Costs acquired for implementation should be the responsibility of the MCO, aside from those costs required by the State to administer the program.

b. Assumptions

Anticipating a go-live date of January 1, 2017, the following assumptions are made to estimate the potential impact of the MCO model:

Assumptions Implementing the MCO Model	
Program Selection	Assumes Oklahoma Health Care Authority (OHCA) selects the MCO model.
Program Implementation	Impact assumes a go-live date of January 1, 2017.
Savings Realized	Assuming a go-live date of 2017, it is assumed that realization of savings will begin in year 2018 as the first year of implementation generally encounters unanticipated expenditures associated with transition from FFS to MCO model.
OK ABD Expenditures	Expected savings assumes that total OHCA expenditures will increase by 5.8 percent each year per calculated average from 2012-2014.
ABD Population Demographics	It is assumed that the population included under this model will include both adult and child beneficiaries. It is also assumed that the population designated as ABD may include other beneficiaries at program implementation.
ABD Population Growth	It is assumed that the ABD combined adult and child population will increase by 2,432 beneficiaries per year. This assumption is based on a three year average population increase form 2012-2014.
Average Annual SoonerCare Cost	The average annual cost of delivering care to ABD members in the SoonerCare program is an average calculated by dividing estimated ABD expenditures by the total number of beneficiaries. This projection is a straight average. It is assumed that average cost of ABD beneficiaries is subjective to the individual.
Average Monthly SoonerCare Cost	The average monthly cost is an assumption that the member is eligible for benefits for 12 months. The calculation is an average calculated by dividing the average annual cost under SoonerCare by 12.
Estimated MCO Annual Cost for ABD population	Estimated MCO savings is calculated assuming ABD savings follow a similar pattern to those realized by the State of Michigan, capping out at a total savings of 20 percent from year one of program implementation. (i.e., Y1 9 percent, Y2 5 percent, Y3 2 percent, Y4 3 percent, Y5 1 percent).

c. Constraints

Anticipated constraints that are to be expected through the implementation of the Fully Capitated Managed Care Organization (MCO) Model may include the following:

Implementation Constraints

Implementing a new model of care delivery creates the opportunity for potential constraints, as with any implementation plan. As expressed in the methodology section, the potential for constraints to arise during implementation phase are likely to occur. Fortunately, MCOs have experience in implementing programs to achieve similar goals in other markets. Creating the opportunity for collaboration and input from

Enrollment Constraints

Changes in eligibility and transitory beneficiaries create a unique constraint for the MCO model. The alterations in enrollment can pose a significant administrative burden for the MCOs as continuous monitoring and evaluation of enrollment in necessary. Changes in eligibility can have a significant impact on beneficiaries overall health and long-term cost reduction goals. MCOs have developed technological systems to improve the process for monitoring and managing enrollment for MCO programs. While it is challenging to monitor beneficiaries' eligibility, MCOs are equipped to improve eligibility management.

Member Social Constraints

This is a significant constraint that affects the benefit that the MCO model can provide to Medicaid agencies. Many members have extenuating social circumstances in addition to physical health conditions. Factors such as homelessness, mental health conditions, substance abuse disorders, lack of reliable transportation, and minimal educational completion are only a consolidated list of potential social factors. These factors and many more can inhibit the affect that MCOs can offer State agencies. Through integration of services, such as Long-Term Services and Supports, MCOs can provide beneficiaries with additional coordination of care and access to services outside the scope of physical benefits. MCOs can be a reliable and dependable resource for beneficiaries who experience significant social disparities.

Access Constraints

As with any healthcare program, provider access in rural areas creates constraints that can affect the ability for the MCO to deliver care in rural areas. The limited number of providers in rural areas creates barriers to care for beneficiaries regardless of which model State agencies utilize to deliver benefits. However, MCOs have the knowledge and experience to incentivize providers and build networks, making care equitably accessible for beneficiaries.

Capitation Rate Setting

While MCOs can aggressively assist State agencies in producing savings for their Medicaid

programs, the savings realized is driven by the capitation rates. Actuarially sound rate setting is critical to ensuring capitation rates provide adequate funding to cover medical costs, operating costs, and administrative costs. In order for MCOs to be effective in reducing healthcare expenditures, there must be a balance between setting rates that are neither too high, nor too low. Rates set too high can lead to increase in expenditures for State agencies. Rates set too low, make it difficult for health plans to deliver on contractual obligations and for State agencies to retain and entice health plans.

2. Describe the quality and anticipated effect of the model on population health outcomes as related to *(materials provided in Respondent's Library)*:
a. CMS recommended benchmarks

Every State is unique in terms of the overall health of its population. The Fully Capitated Managed Care Organization (MCO) model can be implemented in any state. Due to the uniqueness of each State, Meridian Health Plan (Meridian) will establish a local Quality and Performance Improvement (QPI) department in Oklahoma that will focus on prioritizing population-specific health needs by frequently collaborating with community health partners (providers, hospitals, etc.). The QPI department will be headed by a director, with a background in nursing or an advanced graduate degree, and will be supported by local QPI department staff with similar degrees.

Using a local approach, Meridian will be able to develop strategic goals that align with the State's requirements as well as those benchmarks recommended by the Centers for Medicare and Medicaid Services. These goals will focus on controlling high blood pressure, prescription medications (i.e., high-risk medications), preventative care, tobacco cessation, health risk assessments, behavioral health, complex\chronic conditions, and many other items.

In the current Meridian-affiliated Stated, strategic plan centers on efforts to improve population health where success is monitored using Healthcare Effectiveness and Data Information Set (HEDIS®) and other measures. Meridian supports the enhancement of patient experiences through extensive care coordination, disease management programs, provider outreach, and member incentives. Meridian regularly seeks member input on health system experiences through focus groups and the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. This data is used to inform and modify Meridian programs and processes resulting in more positive experiences for members and better population health outcomes.

b. State identified areas including preventive screenings, tobacco cessation, obesity, immunizations, diabetes, hypertension, prescription drug use, hospitalizations, readmissions, emergency room use

Meridian recommends that the MCO model require Managed Care Organizations (MCOs) to incorporate services that focus on prevention and management of chronic condition. For example, Meridian tracks utilization of all physical and preventative services, behavioral health services, prescription drug services, hospitalizations, readmissions, and Long-Term Services and Supports (LTSS) through Meridian's Managed Care System (MCS). Claims data for all services

are entered and stored in MCS and the QPI department analyzes the claims data to identify the following:

- Utilization trends
- Healthcare Data Effectiveness Information Set (HEDIS®)
- Over- and under-utilization patterns
- Variation in practice patterns
- Opportunities in improvement

In addition, the QPI department staff is able to identify when a member is due for a service as MCS is able to pull HEDIS® information from the claims that are received and stored. When a member is missing a service, the 'H' alert for HEDIS® is triggered in MCS to inform Meridian staff that this member is due for the service. QPI Department staff and other staff in various departments work with both the members and providers to ensure that members have access to the services needed and assist with scheduling appointments and necessary transportation.

For physical services (preventative screenings, tobacco cessation, obesity, immunization, diabetes, hypertension, etc.) the QPI department staff focuses primarily on HEDIS® to determine utilization of these services. Examples of such HEDIS® measures include:

- Adult Access to Care
- Well-Child Visits
- Breast Cancer Screening
- Childhood Immunizations
- Tobacco Cessation

These measures are also supported by clinical practice guidelines (CPGs) adopted by Meridian and are used to ensure that providers are adhering to these guidelines. All of the CPGs are reviewed and approved by the Quality Improvement Committee (QIC) and are available on the Meridian website for providers to view. These include guidelines such as:

- Management and Prevention of Osteoporosis
- Routine Prenatal and Postpartum Care
- Diabetes Care
- Adult Preventive Services Ages 18 to 49

For behavioral health, Meridian provides all benefits and services deemed medically necessary that are covered under the contract with each State. Referencing the CPGs, Meridian does not arbitrarily deny or reduce the amount, duration, and scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. Through its Utilization Management procedures, Meridian may potentially place appropriate limits on services based on medical necessity criteria for the purpose of utilization control, in accordance with the overarching goals of the State.

In regards to claims data, it is synchronized with a continuously updated "Member Service Counts" module. This module includes visit tracking of chiropractic, vision, behavioral health services, as well as physical/occupational therapy, inpatient days, and skilled nursing facility days. Meridian staff keeps members and providers updated on the amounts remaining of those services that are limited. Meridian also uses this information for HEDIS® which allows Meridian to ensure analyze utilization and overall health of the membership. Such HEDIS® measures include Seven and 30 Day Follow-Up after Hospitalization and Adherence to Medication measures. Meridian also uses health assessments to help better serve members individually to their needs by addressing their physical and behavioral health.

Meridian also offers a LTSS program, which includes a comprehensive health risk assessment (HRA) tool that addresses a member's physical, social, development, behavioral, nutritional, environmental, and clinical areas. Meridian Community-Based Case Managers are expected to collect the information from the member or family caregiver within 60 days of enrollment. Reassessments are performed at least quarterly. The information obtained through the assessment is shared in the form of a summary profile and an individualized care plan that is shared with the member and/or their caregiver, along with the member's medical home. The Care Coordinator coordinates the services, inclusive of preventive health screenings, together with the member and/or caregiver, and the member's primary care provider and ensures that all appropriate handoffs occur.

During the initial HRA, a complete medication list is recorded for each patient. As a component of the care plan, interventions are designed around evaluating medication compliance, poly-pharmacy, medication education, and overall medication management.

Community-Based Case Managers will follow-up with members to verify compliance with medication plans and provide continuous medication alignment. The care management system can be modified to base interventions on any standards or models to ensure proper compliance and management. For example, triggers can be set in the system to apply interventions related to HEDIS® measures such as annual monitoring for patients on persistent medications.

c. Core measures identified within the Oklahoma Health Improvement Plan (OHIP) 2020
MCOs can assist State agencies in achieving the goals set forth in State-wide plans such as the OHIP 2020. Meridian has experience partnering with State agencies to achieve population health goals. Meridian offers these examples of its programs operating in other States that could align with the goals of the OHIP 2020:

- **Reduce adult smoking prevalence from 23.7 percent in 2013 to 18 percent in 2020 (2018 data)**

  In Iowa, Meridian's chronic obstructive pulmonary disease (COPD) Home Program successfully decreased the average rate of admission and emergency room visits per member from over three point three to approximately zero point two admits per member. Members in this program also received intensive smoking cessation education and

support. Of the members who completed the program, 66 percent successfully quit smoking.

Meridian COPD Home Program Results		
Members Completed	**Admissions**	**Admit/Member**
Admissions/Observations 2 Months Prior to Program		
82	277	3.37
Admission/Observations After Program Enrollment to 2 Months		
82	19	0.23

- **Reduce adolescent obesity prevalence from 11.8 percent in 2013 to 10.6 percent in 2020 (2019 data)**
  Meridian has partnered with education departments and agencies to promote and support efforts to improve child health. In Michigan, Meridian works with the school health network to promote immunizations, well-child and adolescent well-child visits, and lead screening. Due in part to these efforts, Meridian has consistently scored the highest of all Medicaid health plans in Michigan. In Iowa, Meridian has worked with the Linn County Community School District to obtain member information and encourage preventive services for children. Meridian will outreach to the Department of Education to explore opportunities to better serve Oklahoma's children.

- **Reduce infant mortality from 6.8 per 1,000 live births in 2013 to 6.4 per 1,000 live births by 2020 (2018 data).**
  In 2014, Meridian initiated a project with the Iowa Department of Public Health (IDPH) intended to prevent sleep-related mortality in infants. Meridian provided an analysis of infant mortality data examining racial disparity in sleep-related deaths and identified four counties in Iowa with high disparity or increased incidence of minority deliveries.

  Meridian and IDPH were able to secure more than $80,000 for the purchase of cribs, or more than 2,000 cribs. These cribs are being distributed at five Iowa birthing hospitals at time of delivery to women in need. In order to measure impact, The Maternal, Infant, and Early Childhood Home Visitation (MIECHV) program agreed to add safe sleep assessment questions to their survey. MIECHV is assessing the presence of safe sleep environments within intervention counties and in comparison counties. The result of this effort is a characterization of the prevalence of safe sleep environments, which will hopefully be higher in the intervention counties compared to non-intervention counties.

  Meridian has a vested interest in improving and promoting maternal and child health. Programs, such as Cribs for Kids, encourages mother to secure safe sleep spaces for children and also interaction with maternal home visitors. Peripheral benefits of the program may include more timely access of maternity care at intervention hospitals, better education and engagement with home visitation services, and increased feelings of support within intervention counties between members, Meridian, and home visitation services.

- **Improve population health – Reduce heart disease deaths by 11 percent by 2020 (2018**

data).
Meridian recognizes the significance of developing strategic goals to align with the healthcare system in each respective State it serves. Meridian's current strategic plan centers on efforts to improve population health where success is monitored using HEDIS® and other measures. Meridian supports the enhancement of patient experiences through extensive care coordination, disease management programs, provider outreach, and member incentives. Meridian regularly seeks member input on health system experiences through focus groups and the annual CAHPS® survey. These data are used to inform and modify Meridian programs and processes resulting in more positive experiences for members.

- **Reduce the prevalence of untreated mental illness from an 86 percent treatment gap to 76 percent in 2020**
  Meridian's clinical philosophy is grounded in the provision of an understanding, compassionate environment in which the unique clinical and social needs of each individual are addressed in the context of hope, recovery, resiliency, and independence. Meridian knows that health recovery is a deeply personal, unique, and self-determined journey through which an individual strives to reach his or her full potential in society. Individuals in recovery improve their health and wellbeing by taking responsibility in pursuing a fulfilling and contributing life while embracing the difficulties one has faced.

  Recovery from mental illness requires many elements, including developing hope, forging a new ability to self-manage, fostering supportive relationships, and pursuing meaningful life activities all while eliminating the stigma and discrimination associated with receiving treatment. Meridian's collaborative Stamp Out Stigma (S.O.S.) outreach program educates members on the importance of seeking needed care. S.O.S. is promoted through numerous media outlets, including social media, reaching millions potentially suffering from mental illness. Meridian Behavioral Health staff and programs purport the development of strengths, importance of recovery, and achieving the highest quality of life. Involving member family and supportive individuals are critical to a successful treatment process.

d. Respondent suggestions for other benchmarks

With the Fully Capitated Managed Care Organization (MCO) model, MCOs have the opportunity to develop internal benchmarks to evaluate the access to and quality of care delivered. Meridian offers evidence-based, Disease Management (DM) programs developed from clinical guidelines to target chronic conditions. Meridian also incorporates a whole-person approach to coordinating services and highlights the importance of coordinating services for all members' physical, behavioral, and social needs, including members with multiple co-morbidities. Meridian DM programs offer coordination services for diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma, coronary artery disease (CAD), chronic kidney disease (CKD), end-stage renal disease (ESRD), and depression.

Meridian's Care Coordination Team (CCT) engages members in DM programs by facilitating provider and member communication. These relationships break down traditional barriers to accessing care. Meridian engages members and providers in person when appropriate. Meridian

Community Health Workers (CHWs) provide face-to-face contact including working with members at their home, local community centers, in the hospital and emergency room, at provider office visits, during community events, and at health education workshops.

Meridian adopts clinical practice guidelines (CPGs) as the basis for the DM programs and monitors adherence to these guidelines across the provider network annually. The guidelines that are adopted are developed by nationally recognized sources and organizations such as the Michigan Quality Improvement Consortium (MQIC); National Heart, Lung, and Blood Institute (NHLBI); and Institute for Clinical System Improvement (ICSI). Meridian promotes implementation of these CPGs via dissemination among practitioners in hard copy (upon request), electronically on the Meridian website, and via fax for updated CPGs when applicable. The CPGs are reviewed annually and updated as necessary by the Meridian Physician Advisory Committee (PAC) and approved by the Quality Improvement Committee (QIC) and Board of Directors (BOD).

The QPI department monitors adherence to CPGs annually utilizing HEDIS® measures when possible. If a HEDIS® measure does not exist relevant to the condition, Meridian will utilize other national and State-recognized performance measures. An example of the specific CPGs utilized for each of the DM programs that Meridian could offer in Oklahoma are:

- Management of Diabetes Mellitus
- Adults with Systolic Heart Failure
- Adults with Systolic Heart Failure
- Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2011 update
- Asthma-Diagnosis and Management
- Screening and Management of Hypercholesterolemia
- Medical Management of Adults with Hypertension
- Screening, Diagnosis and Referral for Substance Use Disorders
- Diagnosis and Management of Adults with Chronic Kidney Disease
- Diagnosis and Management of Adults with Depression

Specific benchmark goals related to the DM programs monitor plan performance toward the 90th percentile for the following outcomes:

1. **Diabetes Management Program**
   a. Comprehensive Diabetes Care (HEDIS®)
   b. Emergency room visit rate/1,000 members
   c. Inpatient admission rate/1,000 members
   d. Diabetes and depression co-morbidity rate

2. **Congestive Heart Failure Program**
   a. Inpatient admission rate/1,000 members
   b. ACE inhibitor/ARB persistent medication monitoring rate (HEDIS®)
   c. Beta blocker persistent medication monitoring rate (HEDIS®)

3. **COPD**
   a. Emergency room visit/1,000 members
   b. Inpatient admission rate/1,000 members
   c. Pharmacotherapy management of COPD exacerbation (HEDIS®)
   d. Use of Spirometry testing in the assessment and diagnosis of COPD (HEDIS®)

4. **Asthma**
   a. Emergency room visit rate/1,000 members
   b. Inpatient admission rate/1,000 members
   c. Use of appropriate medication for people with asthma (HEDIS®)
   d. Medication management for people with asthma (HEDIS®)

5. **Coronary Heart Disease**
   a. Emergency room visit rate/1,000 members
   b. Inpatient admission rate/1,000 members
   c. Cholesterol management for patients with cardiovascular conditions (HEDIS®)
   d. Controlling high blood pressure (HEDIS®)
   e. Persistence of beta-blocker treatment after a heart attack (HEDIS®)

6. **Chronic kidney disease**
   a. Percentage of members with diabetes and/or HTN with creatinine/GF
   b. Percentage of nephrology referrals when GFR is below 60
   c. Percentage of members on nephrotoxic drugs
   d. Percentage of members with iron/ferritin test prior to Epogen initiation
   e. Percentage of members on ACE/ARBS

7. **End Stage Renal Disease**
   a. Percentage of hemodialysis versus peritoneal dialysis
   b. Percentage of members with first dialysis treatment as outpatient
   c. Percentage of members with AV fistula versus. catheter
   d. Percentage of members on nephrotoxic drugs

8. **Depression**
   a. Inpatient admission rate/1,000 members
   b. Follow-up after hospitalization for mental illness (follow-up in 7 and 30 days-HEDIS®)
   c. Antidepressant medication management (HEDIS®)

e. Considerations for Value-Based performance designs, specifically those that support and align with objectives identified within the Oklahoma State Innovation Model design

The Fully Capitated Managed Care Organization (MCO) model can provide opportunities for value-based care delivery not available through a traditional fee-for-service delivery model. Meridian is currently negotiating value-based, risk sharing agreements with providers in all lines of business. If selected as the model of choice, the OHCA should require MCOs to notify the

State of any risk sharing agreements arranged with providers and should require in the provider agreement submission of encounter data within 90 days of the date of service for any providers paid on a capitated basis.

Examples of value-based, risk-sharing agreements utilized by Meridian can be referenced in Section F. State Payment Structure.

H. Anticipated Overarching Timelines *(including key activities and milestones)*

1. Development

Anticipating an operational effective date of January 1, 2017, per the timeline provided by Oklahoma Health Care Authority (OHCA), those Managed Care Organizations (MCOs) selected through the proposed request for proposal (RFP) process should develop a timeline similar to the timeline outlined below:

Date	Key Activities/Milestones
June 2016	• RFP released
August 2016	• RFP responses due

September 2016	• Network contracting, credentialing
	• Expected notification
	• Project planning
	  ○ Project team creation
	  ○ Project charter approval
	  ○ Project kickoff
	• Initial planning meetings
	  ○ Project team
	  ○ Subcontractors
	  ○ Coordination with State staff

October 2016	• Contract execution
	• Status meetings begin
	  ○ Internal meetings with implementation team
	  ○ Internal meetings with permanent staff
	  ○ External meetings with State staff
	  ○ External meetings with subcontractors
	• Development of claims system
	  ○ Programming functionality
	  ○ Test of file transfer protocols with State
	• Network orientation
	• Communication development
	  ○ Materials evaluated for demographic and cultural awareness
	  ○ Existing materials modified to contract specifications
	  ○ New material created
	• Care coordination and case management
	  ○ Development of training materials

	○ Coordinate/integrate with subcontractors
November 2016	• Completed communication materials submitted to State for review and approval • User acceptance testing and training of claims systems • Production of communication materials • Begin hiring/training (including customer service topics) staff • Preliminary distribution of member and provider materials
December 2016	• Readiness Review
January 1, 2017	• Go-live • Enrollment ○ Member health risk assessments ○ Member individualized care plans

2. Transition/Readiness Activities

Managed Care Organizations (MCOs) awarded a contract through the proposed request for proposal (RFP) process, should develop, in collaboration with the State, a transition and evaluation process that determines when functions will transition from the implementation team to the operations team at each respective MCO. MCOs should follow their own respective internal quality control process to ensure that systems related changes are thoroughly tested prior to their release into production. MCOs should also develop internal hiring and training processes to ensure staffing and education is timely and appropriate for enrollment levels. The selected MCOs should also ensure that they update their respective policies and procedures for compliance purposes.

MCOs should develop project teams which should meet regularly to monitor the progress of the implementation. MCOs should develop acceptance criteria and include gate reviews in the plan to ensure milestones and deliverables are met. The State should request project statuses and readiness reviews prior to go-live. Finally, MCOs should ensure that they follow the communications processes for external and internal communications, prior and throughout go-live.

3. Implementation of member enrollment

As aforementioned, in Section A-3, specific protocol for enrollment will need to be determined by the Oklahoma Health Care Authority (OHCA) for enrolling beneficiaries into the program. Meridian would advocate for the development of an auto assignment algorithm that measures the Managed Care Organizations (MCOs) on a number of administrative and quality measures including, but not limited to, network adequacy, claims processing, compliance reviews, encounter data submission, and national standards such as Healthcare Effectiveness Data and Information Set (HEDIS®) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. Enrollment in the program should consider the member's choice. Beneficiaries should have the opportunity to choose the managed care plan in which they would prefer to enroll. Therefore, Meridian would suggest a six-month voluntary enrollment period in

which beneficiaries have the opportunity to choose a health plan. Following the six-month voluntary enrollment period, a mandatory enrollment period would begin. During the mandatory enrollment period, the State would assign eligible members to a plan, but have not selected a health plan on their own. By the end of the mandatory enrollment period, all beneficiaries should be assigned to a health plan.

The benefit of the mandatory enrollment period conducted by the State prevents the assignment of high-risk beneficiaries to one single health plan. This caveat helps to ensure an unfair distribution of beneficiaries, which could in turn hinder the quality of care delivered and the performance of a health plan.

The OHCA should develop, in collaboration with selected MCOs, a monthly formatted enrollment file that is disseminated to the health plans on a monthly basis. (e.g., 834 formatted enrollment files). MCOs can than utilize this monthly enrollment file to update member eligibility. In addition to the monthly enrollment file, selected MCOs should also receive daily and weekly enrollment files and pending member update files.

4. Implementation of member service delivery

Also aforementioned in Section A Question 3, Meridian would advise a service delivery implementation described below.

Managed Care Organizations (MCOs) should be prepared to meet an operational effective date of January 1, 2017. To ensure a seamless transition to managed care, Meridian would advise that there be open collaboration between the state and the MCOs during the implementation period. Oklahoma Health Care Authority (OHCA) should be prepared to complete site visits and develop an implementation oversight plan prior to go-live. MCOs should pursue a similar implementation plan, outlined below, to ensure the program is implemented efficiently.

Systems Implementation

MCOs should prepare their respective systems to integrate the Oklahoma Aged, Blind, and Disabled (ABD) patient population prior to go-live. System testing and development in collaboration with the state and provider will ensure a seamless transition into the Fully Capitated Managed Care Organization (MCO) model. System readiness should include capabilities to:

- Send and receive monthly enrollment files
- Send and receive encounter/claims data
- Support provider e-portal and e-prescribing capabilities
- Support electronic data interface (EDI) for health record exchange
- Those capabilities OHCA determines necessary

Provider Network Development/Education

Prior to go-live, the selected MCOs should develop comprehensive provider networks ready to meet the needs of Oklahoma's ABD patient population. Networks should be reviewed by the OHCA using access analysis software to evaluate the MCOs network adequacy. Networks should be evaluated regularly prior to go-live and monthly following implementation. The network adequacy file plays a vital role in developing and supporting the auto assignment algorithm. Prior to January 1, 2017, all MCOs should provide orientation and training for network providers to ensure a seamless transition upon go-live.

Member Outreach Campaigns

MCOs should develop and prepare an effective member outreach strategy that builds personal relationships and connects members with providers. Using all available communication mediums, MCOs should take the necessary steps to best meet their individual health needs. OHCA and the State should determine appropriate member outreach responsibilities and include these within the contracts between the MCO and OHCA. Outreach strategies should be tailored to accommodate all comprehension levels specific to the Oklahoma ABD patient population.

Member Services, Disease Management and Case Coordination Program Implementation

Each MCO selected to participate in the program should obtain organizational personnel and develop customer service processes to efficiently provide assistance to members. These services should be tailored to accommodate all members regardless of demographics. MCOs should also develop Disease and Case Management programs to seamlessly integrate all elements of the proposed program. From the initial time of enrollment, MCOs should ensure members receive appropriate care based on objective and subjective data. MCOs should also establish a Quality Assurance and Process Improvement (QAPI) committee to oversee the program quality. Having a dedicated QAPI committee improves quality metrics, which can be evaluated through Healthcare Effectiveness Data and Information Set (HEDIS®) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey scores. MCOs should also acquire systems and personal to ensure the plan remains compliant with the obligations outlined within the contract between the OHCA and the MCO.

I. Market Feasibility
Provide considerations, observations and potential opportunities and/or threats related to:
1. Environmental conditions

Environmental Conditions and Observations	
Political Conditions	• Administration is committed to reducing the expenditures of high-cost Aged, Blind, and Disabled (ABD) beneficiaries • Oklahoma has been resistant to returning to a managed care model after unsuccessful capitation setting in 2003

	• Oklahoma is a non-expansion State • Oklahoma Senate did pass the Medicaid Privatization Plan in 2014 to establish a pilot study on privatizing the management of Medicaid services
Economic Conditions	• Similar to States with comparable populations, Oklahoma is spending less than other States on Medicaid expenditures • While expenditures are less, the Oklahoma Health Care Authority (OHCA) is expected to make nearly $40 million in budget cuts to the program • The expenditures of the ABD populations is unsustainable as 16 percent of the Medicaid population is spending nearly half of the Medicaid expenditures
Geographical Conditions	• Oklahoma's rural areas pose a potential network adequacy concern • Regionalized programs could pose a risk for access to care due to sporadic locations of beneficiaries

2. Conditions unique to the Oklahoma market:

Conditions Unique to Oklahoma Market	
Positive Metrics	**Strong Indicators**
• Oklahoma has a commendable approach to delivering Medicaid benefits through the primary care case management (PCCM) program • Care management appears to be priority for administration and Oklahoma Health Care Authority (OHCA)	• Oklahoma is making progress to address the rising cost of care for its dual-eligible population through anticipated Centers for Medicare and Medicaid Services (CMS) demonstration project • Thorough preparation for the request for proposal (RFP) release in 2016
Negative Metrics	**Weak Indicators**
• Not currently a Fully Capitated Managed Care Organization model state, implementing MCO for the Aged, Blind, and Disabled (ABD) population could be delayed due to administrative preparedness for the transition • Oklahoma ABD beneficiaries • Oklahoma loosing potential Medicaid funds by not expanding Medicaid	• Recent lobbying efforts by Medicaid managed care plans to return to the State haven't been successful • Oklahoma ended its SoonerCare Plus Medicaid managed care program in 2003, following a rate dispute with one of the leading contracted health plans

3. Conditions not unique to the Oklahoma market:

Conditions Not Unique to Oklahoma Market	
Positive Metrics	**Strong Indicators**
• Significant number of States moving to Medicaid managed care • Many anticipated non-expansion States moving to expansion	• States looking to rein in Medicaid expenditures
Negative Metrics	**Weak Indicators**
• Political opposition from both pro and anti-Medicaid managed care	• Unknown content of the request for proposal (difficult for Managed Care Organizations to determine feasibility

4. Availability and range of community resources

Incorporating community resources and other Long Term Supports and Service (LTSS) providers should be priority for those Managed Care Organizations (MCOs) selected to participate in this program. Including Home and Community-Based Services waivers and LTSS benefits within the benefit package under a fully capitated managed care organization model, will enable selected MCOs to better coordinate and partner with local and community-based providers and resources. Oklahoma has a significant number of community-based providers and resources that should be consulted and referred should the MCO model be selected by the OHCA. Examples of potential community resources to assist in delivering care for the Aged, Blind, and Disabled (ABD) population may include, but are not limited to, the following:

- Adult Day Services
- Advantage Program
- Grand families
- Long-Term Care Ombudsman
- Oklahoma Senior Corps Program
- Oklahoma State Council on Aging
- Pharmacy Connection Council
- Senior Farmers Market Nutrition Program (SFMNP)
- State Plan Personal Care

5. Existing and Proposed Federal regulation(s)

In addition to market feasibility and to remain compliant with existing and proposed Federal regulations, Managed Care Organizations (MCOs) selected to fulfill the MCO model should be required to comply with all of the applicable laws and requirement as in other markets. These Federal and State laws and regulations should include, but not be limited to the following:

- Title VI of the Civil Rights Act of 1964
- Title IX of the Education Amendments of 1972 (regarding education programs and activities)

- Age Discrimination Act of 1975
- Rehabilitation Act of 1973
- Americans with Disabilities Act
- Section 1903(m) and 1932 of the Social Security Act
- Patient Protection and Affordable Care Act (ACA)

As a Medicaid MCO, Meridian observes and complies at all times with all, then and current, Federal and State laws related to or affecting this request for proposal (RFP) or the contract, including any law that may be enacted during the term of this RFP or the contract.

In addition, Meridian will maintain compliance with all applicable Federal and State laws pertinent to member confidentiality and rights and ensure that its staff, network providers, and subcontractors take those rights into account when furnishing services to members. MCOs are responsible for being aware of changes in Federal and State laws and regulations as they affect the duties and responsibilities under a MCO contractual agreement.

6. Data Attainment, Cross-walking to Medicaid, and Use

The Managed Care Organizations (MCOs) selected to participate in the proposed MCO model should individually develop systems and processes to accommodate the Oklahoma Aged, Blind, and Disabled (ABD) population. The MCOs should also develop capabilities to integrate with the technological requirements at the agency level.

Meridian's approach to data attainment, cross-walking, and use revolve around its proprietary and custom developed Managed Care System (MCS). MCS is an integrated enterprise-wide solution that encompasses all aspects of operations. The end result is an integrated member/provider profile that delivers high quality of care with streamlined efficiency while being highly available. Meridian's integrated system is used to:

1. Manage member and provider data
2. Submit, approve, deny, and appeal authorizations
3. Pay and deny claims
4. Process, track, and report on member grievances and provider appeals
5. Initiate, investigate, and route fraud, waste, and abuse cases
6. Manage members in Case Management and Disease Management programs
7. Process authorizations
8. Process claims
9. Submit employee time sheets

Additionally, MCS allows many employees to manage their daily workflow through online work list screens, providing a single point to initiate, assign, and automatically route work to the appropriate destination. Consequently, MCS is an integral part of all Meridian functions. Its flexibility and ease of customization are significant factors in the continued success of Meridian as a whole.

Meridian's information technologies offer the following advantages:

Quality Workflow and Efficiency

Meridian's vision is to be the number one Medicaid health plan in Oklahoma based on quality, innovative technology, and service to members. Meridian's commitment to developing technology that improves capabilities to deliver high quality and efficient care drives the enterprise optimization approach when designing systems and applications. MCS automatically routes processes, ensuring consistent quality and rapid turnaround times. Meridian's attention to member, provider, and end-user needs assures continuous improvement, while also providing the adaptability to meet the needs of unique State requirements. The ability to customize MCS to meet unique or changing demands provides a notable advantage in the marketplace. Finally, Meridian's systematic focus on HEDIS® preventive care allows the plan to set the bar for what excellence in the industry entails.

Integration

Meridian's streamlined information flows through open connections to partner platforms providing a tremendous advantage when sharing information. Meridian sets the standard for linking applications between health plan, State, and outside vendors. As evidence, the State of Michigan uses Meridian as a test site when implementing new requirements, regulations, procedures, and systems. The use of common data formats, definitions, and types allows Meridian to act as a responsible data steward when working with State agencies.

Reliability and Security

Meridian provides highly available services ensuring that the advantages of these systems and applications are always accessible. Meridian's secure content delivery means that members and providers can rest assured that their data is safely used to better the quality of their care.

Analytics and Business Intelligence

Meridian's analytics intelligence allows it to identify member and provider trends. Improved decision-making improves high-quality service and delivers cost saving efficiencies. Information must be analyzed and dissected with extreme efficiency to truly improve health outcomes and manage costs. Meridian's expertise in data warehousing and mining provides the most accurate, cutting edge and up to date metrics available in the healthcare industry.

7. Coordination of benefits and services between Medicare and Medicaid

Managed care can provide systems and organizational processes to coordinate benefits for those members who may be dually-eligible for both Medicare and Medicaid. Meridian has both technology-based solutions for benefit management, as well as, organizational practices for coordinating member benefits. Meridian provides members with streamlined coordination of benefits for those members eligible for Medicare and Medicaid benefits. Meridian's systems allow staff to monitor and coordinate services for members to ensure they receive services for

which they are eligible, regardless of payer. Medicare and Medicaid have differing rules and benefit structures which can lead to confusion for both members and providers. Meridian's Care Coordination staff act as liaisons between members and providers to help coordinate care as efficiently as possible to ensure the well-being and quality of care for members.

Meridian Care Coordinators are trained to provide coordination of benefits for dual-eligible members by:

- Giving prospective members information about benefits they are eligible to receive from both programs through materials that are specifically designed for dual-eligible members, combining information about both Medicare and Medicaid. This information can be presented both via mail and telephone
- Informing members about maintaining their Medicaid eligibility through referral to State personnel as well as assisting members who have lost their eligibility during the Medicaid re-application process. Meridian staff is able to identify changes in member eligibility by reviewing the coverage codes within the Meridian Managed Care System (MCS). Coverage codes indicate what type of coverage the member has on the specified date. If the staff member notices a change in the member's coverage code, he or she will contact the member to identify reasons for the change and provide guidance for how to change eligibility
- Providing information to members about benefits they are eligible to receive from both programs in the form of a detailed benefit package
- Giving members access to staff, in lieu of written documents, who can advise them on using both Medicare and Medicaid

8. Alignment of payment structures and goals

As the Oklahoma Health Care Authority (OHCA) seeks to rein in expenditures for the Aged, Blind, and Disabled (ABD) beneficiaries, the importance of Managed Care Organizations (MCOs) and the role they play in achieving this integration will continue to be vital. MCOs have the organizational and technical expertise to coordinate benefits and align payment structures to achieve the goals established by the State of Oklahoma through HB 1566.

Meridian shares the OHCA's goal of transforming the way care is delivered and managed for the ABD population. Meridian prides itself on partnering with State agencies to develop systems that reward improved health outcomes and reduces costs for episodes of care Through the Fully Capitated Managed Care Organization (MCO) model, MCOs can develop a partnership that targets inefficiencies within the current model, while identifying advantages within the current SoonerCare program and Federal initiatives, to create new approaches, provider partnerships, innovative cost saving programs, and products that can create a high-quality, cost-effective system that results in increased measurable goals and outcomes.

Meridian has been a leader in creating partnerships with providers and supporting health care and payment reform. These partnerships, delivery systems, and payment reforms include supporting and promoting these models of healthcare delivery:

- Patient-Centered Medical Home (PCMH)
- Accountable Care Organization partnerships
- Integrated Care Models of Care
- Integration of Behavioral and Medical Health Care

Patient-Centered Medical Home (PCMH)

Meridian has participated in a number of initial grant and Centers for Medicare and Medicaid Services (CMS) demonstration projects. Reducing Disparities at the Practice Site (RDPS) was a three year, multi-State grant project supported by the Centers for Health Care Strategy with funding from the Robert Wood Johnson foundation. This project, which included participation from plans, practices, and State Medicaid agencies from Michigan, Pennsylvania, Oklahoma, and North Carolina, helped Meridian learn and share best practices in supporting practices as they transition to the PCMH model of care. Meridian has implemented a comprehensive PCMH program that provides financial support and resources to practices that commit and then achieve medical home recognition. The key support mechanisms include:

- Funding for practice transformation activities. Meridian recognizes that practices need up-front financial resources in order to implement technology, evaluate and change work flows, and move from an episodic care model to one that provides care management and coordination at the point of service. Meridian provides a PMPM payment to eligible practices that make a commitment to achieving medical home recognition.
- Practice facilitation resources. Meridian has partnered with the Practice Transformation Institute (PTI) to provide education, practice evaluation, and support to help practices achieve the changes needed to achieve PCMH recognition. PTI is also a Utilization Review Accreditation Committee (URAC)-certified PCMH review organization that can conduct the URAC PCMH onsite review
- Care coordination support. Meridian has experience in care coordination, disease management, and case management with members. To help practices become a medical home, Meridian can provide education, training, and materials to help them take on care coordination for members at the point of care
- Ongoing additional financial payment. Meridian provides enhanced payments to PCMH recognized practices through the payment of new billing codes (such as after-hours care), bonus payments based on HEDIS® scores, and a tiered payment structure that provides payment at 110 percent, 120 percent, or 130 percent of Medicaid rates for practices that achieve PCMH recognition or certification from a national accrediting organization such as the National Committee for Quality Assurance, URAC, Joint Commission: Accreditation, Healthcare Certification (JCAHO) or Accreditation Association for Ambulatory Health Care (AAAHC)

Accountable Care Organization (ACO)

Meridian is exploring ways to integrate with new forming Accountable Care Organizations (ACOs). To encourage the delivery of high-quality, cost-effective care, broad consensus has developed on the need for providers to work together and become “accountable” for the delivery

of coordinated, comprehensive care with a focus on prevention, screening, and ongoing management of chronic disease rather than focusing on care at the point of service. To create accountability, financial incentives must encourage the provision of such care rather than discourage it, as they do today. ACOs have become the accepted name used to refer to the provider component of this transformation. PCMH and integration of care are at the foundation of formation of ACOs. Meridian is working with health systems to discuss possible future contracting arrangements that would include a shift of accountability and risk sharing to an ACO model of care.

Integrated Care Model

Clinical integration facilitates the coordination of patient care across providers, conditions, settings, and time resulting in effective, efficient, and patient-focused treatment. Streamlined processes, optimized outcomes and collaborative data networks break down the traditional silos of care and focus on evidence-based quality and the total value of care.

Meridian offers a Clinical Integration Implementation Kit solution to assist integration efforts and help providers create the necessary infrastructure required to coordinate care. The toolkit represents best practices to help identify risks and provide guidance on overcoming the challenges of implementing the integrated care model. Measures to improve communication and education, financial measures and models, information and reports, as well as process and systems integration are available. The kit eases the burden of managing the overall integration project, as well as the many corresponding changes and development related tasks needed for success.

J. Approach to Integration with Medicare
1. Considerations, observations and potential opportunities and threats related to
a. Existing and Proposed Federal regulation(s)

The Affordable Care Act (ACA) ushered in a new wave of regulations that seek to better align the coordination of Medicare and Medicaid benefits. The Centers for Medicare and Medicaid Services (CMS) are postured to lead these coordination efforts. Managed Care Organizations (MCOs) have significant opportunities to work with CMS to fulfill the goals outlined within the ACA and other Federal initiatives, including those designed to better integrate physical health, behavioral health, and Long-Term Services and Supports (LTSS) services.

As a Medicare/Medicaid Managed Care Organization (MCO), Meridian has experience working with both CMS and State agencies through the Medicare Medicaid Alignment Initiatives (MMAI) initiative in Illinois and the MI Health Link program in Michigan, also referred to as a Medicare-Medicaid Plan (MMP). Meridian also has experience operating a dual-eligible special needs plan (D-SNP) in Michigan, Illinois, and Iowa. Meridian's MMP product provides services for members who are entitled to Medicare Part A, enrolled under Medicare Part B, receive full Medicaid benefits, and live within a specified service area. Meridian Complete, the Meridian MMP (Medicare Medicaid Plan) product name, provides complex or vulnerable members with highly coordinated benefits, individualized care plans, and person-centered services. This

program also encompasses physical health services, behavioral health services, and LTSS. Meridian also operates Meridian Prime, a traditional Medicare Advantage plan for those that qualify for both Medicare Part A and Part B and thus qualify for Medicare Part C. Meridian administers Part D benefits through our Advantage-Plus Meridian (PDP) plan. Given the corporate focus on overall integration of care, Meridian already incorporates many elements that build the foundation for successfully managing the dual-eligible population. Meridian offers an established three (3) year CMS-approved Model of Care (MOC).

The currently pending and proposed "MegaReg" is also a consideration in recommending a Fully Capitated Managed Care Organization (MCO) model. Much of what is included in this proposed regulation is similar to those regulations overseeing Medicare, specifically Medicare Advantage Plans. If applied to the Medicaid environment, the MCO model would need to be modified to accommodate the proposed regulations.

Meridian has a proven record of successful partnerships with community, State, and Federal agencies, providing managed care services that improve health outcomes for the most vulnerable populations. Meeting the member in his or her community allows Meridian to gain an accurate picture of their needs to provide personalized services. This whole person, integrated care plans empower members to make informed decisions regarding their health.

b. Data Attainment, Cross-walking to Medicaid, and Use

The pursuit of electronic data interchanges (EDI) and integration with State and Federal healthcare information technology should be priority for the selected MCOs if the MCO model is implemented. MCOs have capabilities within their respective organizations to develop and streamline the data attainment process from State and Federal agencies. EDI assists in streamlining data exchange between providers, the MCO and State agencies. In addition to EDI capabilities, MCOs can offer systems designed to support integrated care which includes coordinating benefits across program plans. This integration can improve benefit coordination between Medicare and Medicaid benefits.

Meridian has been successful at cultivating relationships within its current markets. Meridian's Medicaid affiliate in Iowa has attained remote electronic medical record (EMR) access or electronic data exchange for more than 40 percent of its membership. Meridian uses a multi-faceted approach to growing its EDI program. QPI, Provider Services, Operations and the Information Technology departments work collaboratively to identify opportunities for new EDI partners. Meridian recognizes that clinical data, predominantly coded to HL7 standards, is just beginning to be used within payer systems to improve care and track quality. Traditionally, clinical stakeholders have been reluctant to share raw clinical data, but Meridian sees that mindset rapidly changing. Meridian has always been and plans to continue to be at the forefront of any initiative that can improve quality. Meridian plans to be more than ready to leverage this information to improve care.

Within each State where Meridian operates, it has initiated collaboration with the State-wide health information exchange (HIE) initiatives. Meridian coordinates and collaborates with the

health information exchanges in Michigan, Illinois, and Iowa to improve the integration of health information within the managed care environment. Meridian also participates in a national health information exchange collaborative.

Among the initiatives discussed is an admission, discharge, and transfer (ADT) alert initiative to transfer information from emergency rooms, inpatient admissions, and discharges from hospital systems. Meridian is evaluating the value and application of ADT information for utilization management, behavioral health, care coordination, and quality improvement.

c. Coordination of Benefits and Services between Medicare and Medicaid

MCOs should maintain systems, or partner with subcontracted entities that specialize in benefit coordination, to ensure proper payments are made by the correct entity. MCOs utilizing subcontracted entities to assist in coordination of benefits are generally mandated to oversee and monitor these subcontracted entities. Meridian utilizes the expertise of subcontractors to assist in verifying benefit eligibility. MCOs should also develop internal processes and systems to provide guidance on what benefits and services are available to each member. This process should include helping the member understand which benefits they qualify for under each program they may be eligible for. This is especially helpful for dually-eligible beneficiaries as some services may be covered under Medicare, but not Medicaid and vice-versa.

Meridian conducts two weeks totaling 80 hours of care coordination classroom training with overall dual-eligible member education built into this curriculum. Training includes a combination of Medicare and Medicaid benefits through providing staff with comprehensive information on both sets of benefits via multiple information channels. Care Coordinators also complete mandatory online trainings on dual-eligible and State-specific requirements. Meridian coordinates Medicare and Medicaid benefits and services for its members to ensure they receive services for which they are eligible, regardless of payer. Medicare and Medicaid have differing rules and benefit structures which can lead to confusion for both members and providers. Care Coordination staff act as liaisons between members and providers to help coordinate care as efficiently as possible to ensure the well-being and quality of care for members.

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- Informing members about maintaining their Medicaid eligibility through referral to State personnel as well as assisting members who have lost their eligibility during the Medicaid re-application process. Meridian staff is able to identify changes in member eligibility by reviewing the coverage codes within Meridian’s proprietary software. Coverage codes indicate what type of coverage the member has on the specified date. If the staff member

notices a change in the member's coverage code, he or she will contact the member to identify reasons for the change and provide guidance for how to change eligibility
- Providing information to members about benefits they are eligible to receive from both programs in the form of a detailed benefit package
- Giving members access to staff, in lieu of written documents, who can advise them on using both Medicare and Medicaid

Care Coordination Training staff distribute benefit grids to Care Coordinators to help them answer benefit questions. The benefit grids are updated regularly based upon contractual requirement and changes. The Utilization Management department houses these grids, which are available to all departments, so specific criteria for each line of business can be dictated to the member as appropriate. Trainees also receive guidance through formal training on the most prevalent differences between the line of business and what is/is not covered for the specific line of business.

All staff attends training specific to grievances and appeals. Each line of business is specified within the training and differences pointed out. Questions directed toward acknowledging these differences are included in this training, which help to assess the trainee's ability to differentiate between the applications of these materials for each line of business. Job aids are available for reference as well.

Other specialized training for Medicare has been developed and is required training for all staff entering Care Coordination. Trainees are assigned to staff proficient in their line of business and shadow these individuals as well as attend trainings specific to their line of business in order to see the application of materials received during training. During this time, trainees are supervised performing processes and facilitating coordination of care for members prior to engagement with members on their own.

d. Alignment of Payment Structures and Goals

Alignment of payment structures is critical to ensuring the goals established within this request for information (RFI) are achieved and maintained. MCOs selected to administer benefits through the proposed MCO model should develop internal systems, or partner with subcontracted entities, to ensure proper payment and benefit eligibility are monitored and properly administered. Cost avoidance achieved through proper third-party liability practices can improve overall program cost and improve care delivery for a low resource program.

Dual-eligible plans offer a unique benefit for State agencies. Through partnerships with MCOs, States can contract administrative functions out to MCOs who understand Federal and State payment responsibility. Proper payment by the correct entity aligns with the overall goals of this RFI-reduction of cost and improved care coordination.